Mental Health SF Implementation Working Group
Approved Meeting Minutes

May 25, 2021 | 9:00 – 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., Dr. Monique LeSarre, Psy. D., Jameel Patterson, Andrea Salinas, L.M.F.T., Sara Shortt, M.S.W., Amy Wong.

Committee Members Absent: Phillip Jones

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 acknowledged the API community and other world issues.

Jennifer James, IWG Facilitator from Harder+Company Community Research, reviewed the meeting goals and agenda and group agreements. She also reviewed the MHSF components, along with a reminder of the various staff who participate in those components.

3. Discussion Item #1: Approve Meeting Minutes

No comments or amendments from IWG members on the April 2021 meeting minutes.

4. Public Comment for Discussion Item #1

No public comment.

5. Action on Discussion Item #1

Member Hammer moved to approve the April 2021 meeting minutes; Member Chen seconded the motion. Meeting minutes were approved by the IWG.

6. Discussion Item #2: Principles to Apply When Developing MHSF Recommendations

Facilitator Jennifer James introduced the discussion group that met to refine the IWG's principles to apply to future recommendations for MHSF components.

Member Eisen presented the updated Principles that incorporate the changes submitted by IWG members. These changes were incorporated in collaboration with Member Shortt and Member Buford. She reviewed the changes made around language in the original principles and the other items from the discussion group for equitable health practice.
https://www.sfdph.org/dph/files/IWG/Discussion_Item_2_Principles.pdf

Discussion:

For Principle #6, Member Fields inquired as to who decides what an "adequate level" encompasses. He feels that it is very vague but indicated that he does not want to wordsmith. He stated that he hopes this vagueness can be addressed in the future and expressed his hopes that someday the treatment will go beyond "adequate." Member Shortt informed that this was part of the Prop C legislation and that it was incorporated into the MHSF language.

Member Hammer expressed her appreciation for the work done with these Principles. She suggested that in order to stay consistent with best practices, Principle #1 should reflect "multiple assessments." Eisen agreed and stated that this would show that there should be continued assessments with the needs moving forward and not just a singular assessment.

"Member Buford reminded the group that there are no "clients" or "patients" – just "individuals" – and that providers should be aware of how individuals are addressed as part of this program. He acknowledged that there are many different professions that might use different terms.

Member Chien indicated that it is important for IWG to get enough beds and resources for individuals that are concerned. She also addressed Principle #2, stating that members in jail should be prioritized for treatment.

Member Patterson praised the principles that were developed. He suggested that there is a need to define mental health, as well as the degrees of mental health. He continued by stating that sometimes people are not viewed as having mental health issues and that maybe those people's mental health should be considered.

Member Salinas stated her appreciation for the additional proposal for the creation of living wage positions for MSHF positions, particularly for non-profit provider to recruit and retaining staff. She highlighted that this affects the care that is provided to individuals receiving services and that if there is constant down-staffing, individuals get less time with providers. She brought up that a potential issue is parity across systems and the inevitably there will need to be an increase in the salaries of all positions. She echoed Member Chien's comment regarding forensic individuals needing services.

Facilitator James indicated that Chair LeSarre identified that this item requires more significant conversation and that the discussion group should review the language in the recommendations. The discussion group will take the IWG's discussion and make adjustments to the principles as needed.

7. Discussion Item #3: Street Crisis Response Team Recommendations

Facilitator James reminded the IWG group of the process to date in developing SCRT pilot recommendations.
https://www.sfdph.org/dph/files/IWG/Discussion_Item_3_SCRT_Recommendations.pdf

Member Salinas, the "captain" of the SCRT discussion group, shared the most up-to-date document with SCRT recommendations, reading it out loud for the IWG. She read each item in the document and paused after each to get feedback from the IWG.

Discussion:

Recommendation #1

There was discussion around the programs listed. Member Hammer expressed that the current language sounds like the list is exhaustive. Member Shortt asked for clarification regarding whether the IWG intends for the list to be exhaustive. Member Hammer suggested not including a list of specific response programs at all. Member Eisen agreed and stated that there are many more programs coming out, per the Mayor's office.

Member Salinas suggested adding that the mapping should be done before any other programs are implemented. Member Shortt expressed that it is critically important.

Member Wong indicated that she would like to see a few examples of SCRT Programs to remind everyone of other programs, so that there is no duplication of services.

Chair LeSarre indicated that some program names should be listed to give everyone and idea of what is being referred to. She also agreed that the IWG wants to explicitly convey that they do not want any new programs funded without this mapping or without the IWG's input.

Member Patterson agrees that they should continue mapping and discussing how to make improvements. He added that they could then make changes. He provided an example of large number of resources downtown and that it is challenging to expand those resources to make them accessible to people in other residential areas.

Member Fields suggested that this item should have examples because people are aware of some programs but not others. He stated that although SCRT is a pilot, it is already being replicated in other communities without an analysis or the data that would deem the pilot successful. He expressed that the IWG has a responsibility to ask which parts of analysis are needed before they decide if something is a good idea and is working.

Member Arai stated that there are similar programs in other areas and would like to compare the SCRT to those programs to determine efficacy. He also brought up that there should be consistency in the document for the name Street Crisis Response Team. Member Salinas clarified that "Crisis Response Street Team" is verbatim from the legislation and that the program that Dr. Almeida is putting together is "Street Crisis Response Team" (SCRT).

Member Hammer requested a status update on the mapping request from the last IWG meeting. She expressed concern regarding the last sentence, given that some of the programs mentioned are not specifically MHSF programs. She wants the IWG to be clear on what SCRT Programs that are part of the MHSF and the legislation that the IWG wants to provide recommendations on.

Member Buford asked which member from SFDPH Implementation team was present during this meeting. He asked for clarification on the role of the IWG so that they do not overstep their boundaries. Marlo Simmons replied that the mandate for the group is to advise City Hall on the implementation of MHSF. Marlo expressed that the conversation around that one item may be overly detailed. She also stated that if DPH launches something that is not part of MHSF, it will not fall into the purview of the IWG. Member Buford recommended that when members make recommendations that they do not overstep their boundaries or create conflicts of interest.

Member Fields stated that the recommendation might be that before expanding and increasing a commitment to SCRT model, the effectiveness of the program and increasing SCRT should be considered in the context of other services provided by the county. He reiterated the importance of having data before expanding or replicating a program.

Member Buford reiterated that the IWG should be mindful of how detailed they get, given that the IWG is an advising body.

Facilitator Ashlyn Dadkah inquired if the conversation should move forward, given the time. Chair LeSarre indicated that the conversation should continue. The Chair echoed Marlo Simmons' comment regarding looking at the overall view. Facilitator James asked that the conversation be kept high-level, because of time constraints. Member Hammer suggested that it might make sense for Dr. Almeida to comment on the SCRT and to answer some of the questions that the IWG have.

Recommendation 1B

Member Fields requested the language change from "clients" to "individuals."

Recommendation 3

Member Patterson suggested that the group think about recommending that SCRT team respond to calls with the police. He expressed that sometimes there is no one at those calls who can mediate.

Member Buford requested clarification between 800A and 800B. He also expressed that a situation with weapons involved might need police response. He wants to know why the suggestion was made for SCRT to respond, when there could be a potential danger to SCRT. Member Salinas indicated that this is almost verbatim what the IWG discussed in this last meeting and expressed that the IWG should be cautious about bringing up items that had previously been agreed upon by the IWG. She continued to state that the conversation had been about the weaponizing of 911 calls. She reiterated that the IWG discussed that houseless mentally ill individuals have been killed by the police because they had items on them that were perceived as weapons. She also indicated that 800A would be a call that might include a household weapon and the SCRT would not be deployed.

Member Arai checked with the group about calling individuals mentally ill and suggested that it be switched to people struggling with mental health issues.

Dr Hillary Kunins praised the group for their comments regarding the language used to refer to individuals. She expressed her gratitude for the IWG making recommendations in all the domains they are tasked with. She suggested that the group not go back and discuss items that have been previously agreed to by the group. She recommended to find a tracking method offline in order to keep the group moving forward.

Facilitator James reminded the group of the time. Due to technical difficulties, she coordinated with Chair LeSarre via chat and noted that the chair will allow 15 minutes to continue the conversation and then move to level of agreement.

Member Shortt expressed that the SCRT has been framed as an alternative to police response. She believes that bringing in the police is problematic. She suggested that they should consider limiting police involvement as much as possible because people living with mental illness die when police are involved.

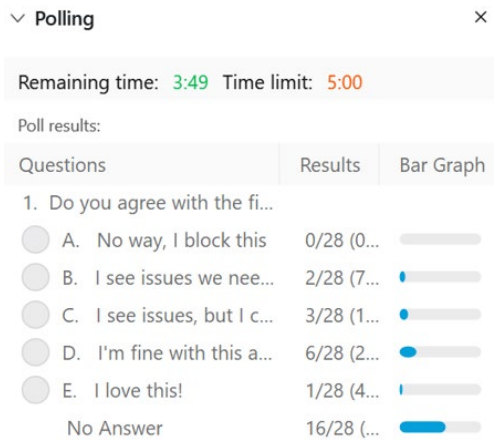
Recommendation 3D(iv)

Member Salinas suggested that SFDPH should be responsible, instead of IWG, based on the discussion. Member Shortt agreed that it should be both agencies responsible.

Member Salinas checked with IWG to ensure that the IWG agreed with the change that Member Arai suggested.

Facilitator James check in with Chair LeSarre and the chair closed conversation to assess the Level of Agreements with the current slate of SCRT recommendations.

8. Poll #1 Level of Agreement



Facilitator James invited IWG Members who voted "2" to express their concerns.

Chair LeSarre indicated that she would like to change her response from C to D.

Member Buford reported that he has some issues with the recommendations and there were some disagreements with the terminology. He also indicated that he is willing to move forward and agree with the majority.

Member Hammer expressed confusion around 800A and 800B calls and requested clarification from Dr. Almeida before the IWG accepts SCRT Recommendations. Dr. Almeida defined Priority A and Priority B calls for members. Member Hammer expressed concern regarding the IWG suggesting deploying SCRT to all 800A calls. Dr. Almeida wondered if the IWG would like to contemplate whether 800A calls should be responded to after reviewing data from 800B calls. Member Hammer suggested that the IWG consider expanding the scope of SCRT to all calls in the future.

Member Patterson voiced his concern that SCRT team should be dispatched with the police. Member Hammer responded by saying that SCRT should respond to all 800B calls before sending out to 800A.

Member Salinas stated that IWG needs more data and referred to the April update from Dr. Almeida. She asked if there is data on the number of 800B calls that are not being responded to. Dr. Almeida reviewed data from 3 teams. She stated that the goal is to respond to all 800B calls eventually. She also informed the IWG that once all 6 teams are working, the plan is to dispatch medical and that police would no longer be a back-up for SCRT.

Chair LeSarre inquired about the non-800 number. Dr. Almeida indicated that there is not a date yet for its implementation, due to regulatory issues.

Member Fields inquired about the percent of calls that SCRT is able to respond to. Dr. Almeida indicated that the trend has been that as the SCRT becomes more rooted in the community, they respond to more calls. She indicated that it is more appropriate to look at the statistics on a city level, given that SCRT responds to multiple geographic areas.

Given that all members are now at a level 3-5 level of agreement, Chair LeSarre closed the agenda item.

9. Public Comment for Discussion Item #3

Sarah Larson commented that referring to consumers as individuals is too vague. She stated that it is important to map the services that are available. She feels that sometimes programs and contracts are renewed, despite not meeting community needs. She also talked about equitable behavioral health practices and that oversight is important. She identified that the Board and Cares that she works at are overseen by General Hospital and administrators and not Board of Behavioral Health. She continued to state that there is a shortage of leadership who understand the nuances of behavioral health. She expressed that she believes that there should be at least one mental health professional overseeing that and that there is also a shortage of beds.

10. SCRT Final Vote Item #3

Unanimous vote to approve the SCRT Recommendations.

11. Discussion Item #4: Drafting Drug Sobering Center Recommendations

Facilitator James provided a high level review of he Drug Sobering Center Issue Brief from the last meeting by Dr. Pating.
https://www.sfdph.org/dph/files/IWG/Drug_Sobering_Center_Issue_Brief_FINAL.pdf

Discussion:

Member Salinas indicated that she previously sent Dr. Pating questions regarding the Issue Brief.

Dr. Pating acknowledged that he has received the questions from Member Salinas. Dr. Pating read the questions regarding how the staff at the center will handle presentations of individuals on stimulants and behavioral/medical conditions and how the staff will be trained. The questions also asked how the Center would differ from Health 360 Detox. Dr. Pating responded that the Drug Sobering Center is not a clinical service and that it a low threshold harm reduction service to provide a safe space for people to come down from drugs. He emphasized that it is a shelter model and that clients don't enroll, they participate. He indicated that most staff will have lived experience and will not be medical – mirroring the composition of the community. He stated that the staff will be trained in milieu management, soft talk-down therapy, overdose response and violence assessment. He continued to say that there will be an EMT person on staff to provide a collaboration with coordination of medical services.

Member Salinas inquired about individuals that drop in and express suicidality and if the staff will be trained to administer suicide assessment and/or counseling.

Chair LeSarre reminded the IWG to send questions through the IWG's Information & Data Request form so that the whole committee can have access to the answers. She went on to suggest the Center have a respect scale so that participants who use the Center can report out a sense of respect and feelings of welcome.

Member Salinas addressed DPH Question 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*?). She noted the linkage to care to further detox and gave the example of going from the Drug Sobering center to other residential detox services.

Dr. Pating replied that it is the intention to provide referrals to other detox services. He also addressed another of Member Salinas' questions regarding the population of Drug Sobering Center. He indicated that it is anyone who is intoxicated with other drugs and that if they had alcohol intoxication those individuals would go to alcohol detox. He emphasized that there are 3 criteria for receiving services: directable, non-violent and medically stable and that Street Crisis would screen for those. Once the individual is sober, the Drug Sobering Center will work on next-step destinations.

Member Salinas inquired if Intensive Case Management (ICM) providers can refer individuals. Dr. Pating replied that anyone can be referred, if they meet the 3 criteria described.

Facilitator James introduced the MHSF IWG Drug Sobering White Board activity. This virtual white board was used for IWG members to post their recommendations for the Drug Sobering Center. As they posted recommendation ideas, Facilitator James read them aloud. Please see Appendix A for these ideas and draft recommendations.

After the white board exercise was complete, Facilitator James opened the floor for IWG members to provide feedback on the activity.

Member Hammer stated that she thought it worked well and that she would like to check in with members of the public to request feedback on the process.

Member LeSarre inquired if there is a possibility for a similar process for members of the community. Facilitator James noted that currently one is not scheduled.

12. Public Comment for Discussion Item #4

David Elliot Lewis expressed that the IWG makes it very difficult for him to speak and that he has been able to speak in the meetings previously via WebEx, without having to call in. He also stated that he has complaints that the public is excluded and that attendees cannot see other attendees and that if this were a meeting in person, they would be able to see each other. He also expressed concerns that he was not allowed to participate in the Jamboard activity and that there was not alternative for members of the public to participate. He expressed that the IWG claims to want the public to participate, but multiple steps have been taken to prevent the public from participating. He stated that the IWG can be more inclusive about notifying members of the public how to access the meeting.

13. Discussion Item #5: MHSF Foundation Building - Analytics and Evaluation Domain

Wendy Lee and Dr. Monica Rose presented on MHSF Analytics and Evaluation domain. Dr. Rose reminded the IWG that everything is currently a draft and the hope is that the IWG can provide feedback. Dr. Rose reviewed the purpose of MHSF as it is written in the legislation, the components of MHSF, and the aims of MHSF Analytics of Evaluation team.

Wendy Lee presented the Key Performance Indicators (KPIs) used to assess the progress of meeting the goal of MHSF, examples of KPIs for each domain, examples of MSHF Analytics and Evaluation work to date, and the process of developing MHSF evaluation.

Discussion:

Member Salinas expressed her concerns that the focus is on the homeless population. She stated that there are residents and Transition Age Youth (TAY) that are housed and have serious mental illness (SMI) and substance use disorder (SUD) challenges. She also addressed the part of the legislation referring to individuals released from the county jail and how those individuals are waiting months is

jail because they are waiting for services, but that there is no intermediate care available between Intensive Case Management (ICM) and outpatient services.

Dr. Rose stated that services are available to everybody, not just people experiencing homelessness - the legislations is not exclusive. She indicated that the services are prioritized for people experiencing homelessness. She also stated that under the Office of Coordinated Care, it proposed to expand ICM. She acknowledged that a lot of this is in draft and that she is unsure how the individuals being released from jail will be addressed.

Member Fields echoed Member Salinas regarding the legislation's language and listed target populations. He expressed his concern that the legislation did not include Early Intervention models to prevent homelessness. He addressed the fact that family members who are dealing with SMI member must make their family member homeless in order to get prioritization. He also asked if the one of the key indicators was reduce hospitalization and involuntary treatment or to reduce administrative days in the hospital. He also inquired which stakeholders are being engaged in the conversation.

Dr. Rose agreed that looking at the homeless population is too narrow, but part of the work is to see the impact of that population. She addressed that the administrative days is part of the work looking at new beds and facilities. She gave the example of a psych inpatient being able to step down when they need it, so that they do not prolong the hospital stay, but that this is a specific KPI. She clarified that looking at overall domains, they will be looking at admissions and readmissions to psych inpatient, medical emergency department (ED), Psychiatric Emergency Services, and other crisis questions.

Marlo Simmons stated that they have not done anything with the domains around the evaluation plan. She reminded the IWG that this is the beginning of the conversation. She echoed Dr. Rose's prioritization of those individuals experiencing homeless and that some funds come from Proposition C, which focuses on that population. She expressed that addressing this population will be beneficial for the larger population.

Member Chien addressed the capacity of step-down facilities for individuals who are involuntarily in inpatient units. She asked how the IWG can make recommendations to facilitate the movement of those facilities. She provided data for the number of individuals in jail who are waiting for a bed in mental health diversion. Chair LaeSerre clarified if Member Chien is asking for this data to be tracked. Member Chien agreed. She also indicated that she understands that Prop C specifies a certain population but that others should not be neglected – particularly the AAPI community.

Dr. Rose indicated that she recently saw a table that specifies which types of beds are being created. She inquired about how the data that Member Chien is referring to can be accessed.

Chair LaeSerre expressed concern where equity, cultural relevance, cultural capacity get measured.

Dr. Rose identified that there is a lot of work that needs to be done into what work is being done and that those concerns from Chair LeSarre are being addressed. She expressed the challenges in tracking and showing the disparities.

Member Eisen inquired where these slides are. Facilitator James indicated that it is part of the slide deck that goes out after the meeting.

14. Public Comment for Discussion Item #5

David Elliott Lewis advocated for expansion of the SCRT team so that they can handle indoor and outdoor events for both housed and unhoused individuals. He also stated that expansion of 724 is

crucial. He added that there needs to be a way to coordinate between the various response teams and a way to coordinate with the police. He stated that the police have their own response team and there is need to coordinate because not all calls are dispatched as Code 800.

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

Member Fields expressed his frustration that there is a template being developed for additional beds and services. He is concerned that they will bring the plans back to the committee before asking the IWG for input. He asked the Department to stop making financial commitments without contacting the IWG. Dr. Rose addressed that it was a visualization of the types of beds that need to be created, but that it was just a draft.

16. Adjourn

Facilitator James indicated that the facilitation team will request feedback from the IWG regarding the IT issues in today's meeting.

The next meeting will be on June 22, 2021 from 9:00 AM- 1:00 pm

Meeting adjourned at 1:10 PM (estimated)

See next page for Appendix A, raw results of the virtual white board for the IWG's Drug Sobering Center recommendation brainstorm.