



Edwin Lee  
Mayor

## SAN FRANCISCO MENTAL HEALTH BOARD

---

1380 Howard Street, 2<sup>nd</sup> Floor  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@mhbsf.org  
www.mhbsf.org  
www.sfgov.org/mental\_health

### **Adopted Minutes**

Mental Health Board

Wednesday, July 10, 2013

City Hall

One Carlton B. Goodlett Place

2<sup>nd</sup> Floor, Room 278

San Francisco, CA

**BOARD MEMBERS PRESENT:** Ellis Joseph, MBA, Co Chair; David Elliott Lewis, Ph D, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Sgt. Kelly Kruger; Lena Miller, MSW; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS.

**BOARD MEMBERS ON LEAVE:** Marlene Flores; Errol Wishom.

**BOARD MEMBERS ABSENT:** Melody Daniel, MFT.

**OTHERS PRESENT:** Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Marlo Simmons; Rhea Bailey, MPH; Wendy Yu; Toni Parks and two members of the public.

### **CALL TO ORDER**

**Mr. Joseph** called the meeting of the Mental Health Board to order at 6:45 PM.

### **ROLL CALL**

Ms. Brooke called the roll.

### **AGENDA CHANGES**

There were no changes to the agenda.

### **ITEM 1.0 DIRECTOR'S REPORT**

## **1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.**

**Ms. Robinson** highlighted the following items which are included in the July Director's report.

She reported that the FY 2013-14 budget for the Department of Public Health (DPH) is complete, and there was some more money added for the department.

Moments after the Asiana flight 214 crash on Saturday July 6<sup>th</sup>, 2013, she immediately went to San Francisco International Airport. Also, at the same time, other DPH officials were within minutes at the airport as well to quickly respond to the victims of the disastrous flight which was full of 15-17 years old Chinese students and Korean passengers.

In the first hours of breaking news, there was a convergence of the San Francisco Emergency Disaster team, DPH and CBO volunteers with disaster training to help out at the airport. CBHS deployed 17 Cantonese, Mandarin and Korean speaking mental health specialists who were there until 1 AM on Sunday. Every day since the incident, CBHS mental health therapists have been available to everyone to address the trauma.

For example, passengers needed anxiolytic to reduce anxiety for returning flights to their home countries. For those passengers whose medications were consumed in the inferno, their prescriptions were quickly refilled by doctors. There were lots of first-time away from home 15-17 year old students who had put their money in their suitcase cases, which they had no access to as everyone was trying to evacuate the plane. Provision for emergency money was made to get them through a few days.

**Dr. Patterson** inquired about food provision for the Asiana flight 214 victims.

**Ms. Robinson** explained that upon the final approach to SFO, the crash occurred at 11:04 a.m. According to survivors and rescuing staff, United Airlines, Asiana's partner in Star Alliance, did not urgently coordinate food services. Victims of the crash reported that they were denied access to food, and eventually they got food after 10 PM that day. She emphasized that many students were victims of the crash.

Although Subway was contracted to provide sandwiches to the victims, the company seemed to be more of a hindrance than helpful. Subway was very slow at responding to the plight of the victims, despite pleading from officials.

**Dr. David Elliott Lewis** asked what operational weaknesses came out during debriefing.

**Ms. Robinson** stated that as a part of disaster planning for the future, they should include on-call psychiatrists and phone chargers. Being told to leave all their personal belongings behind during the evacuation from the inferno, passengers were only able to take their cell phones with them as they scrambled out of emergency exits.

She mentioned other issues that need to be addressed with Red Cross officials.

For example, when the surviving high school students regrouped right after evacuation, they realized that their two friends were unaccountable for. In the immediacy, the students were instinctively concerned and wanted to find their missing friends. So they reached out to authorities for help.

But the authorities would not respond to their requests about their friends fates because they had not notified the students' parents or next of kin yet, which is a federal regulation. Most students were

very upset with the authorities because the students were left feeling exasperated and kept guessing about what happened to their friends as they stood by helplessly wondering if they had abandoned their missing friends whom may have been succumbed alive in the inferno. An extra layer of trauma was added because their survivor guilt kicked in.

Another example is the survivors, of which many of them were just high school students, were not allowed access to psychiatric first aid professionals. The FBI and United Airlines investigators sequestered the victims from having any contact with CBHS clinicians and therapists in order to obtain eye-witness accounts of the crash.

**Ms. Bohrer** mentioned that she was very impressed with Mayor Ed Lee's response to the incident and wondered if there is there any way the board can recognized the volunteers.

**Ms. Robinson** stated that she would get the list of the volunteers.

## **1.2 Public Comment**

No public comment.

## **Monthly Director's Report** **July 2013**

### **1. CBHS and SFGH Respond to SFO Plane Crash Disaster**

Seventeen members of a CBHS mental health disaster emergency response team rushed to San Francisco International Airport on Saturday July 6 to provide counseling, reassurance and comfort to the passengers of the Asiana jet liner that crash landed at San Francisco International Airport. In the days following, CBHS continued to provide disaster mental health assistance to the passengers and their families at the assistance center in Burlingame that was established by the National Transportation Safety Board, United/Asiana Airlines, and the Red Cross. In particular, a good number of CBHS counselors who were fluent in the Korean and Mandarin languages were able to deploy to support the victims.

CBHS extends sincere gratitude to each and everyone who helped respond to the disaster mental health needs of the passengers of the Asiana flight, and their families. Counselors and program managers from Comprehensive Crisis Services, Sunset, RAMS, Citywide Case Management, Central City Older Adults, South of Market, OMI and Mission Mental Health clinics, and from the Chinatown Public Health Center, all assisted in the disaster mental health response. Thank you to all dropped everything at a moment's notice, and worked long hours and stayed late into the night at SFO and at the assistance center, providing support to all who were affected by the disaster.

Dozens of volunteers throughout the San Francisco Department of Public Health also showed up to help. Much of the activity and response occurred at San Francisco General Hospital where the trauma team, medical and support staff tended to 53 of the crash victims. Edward Chow, MD, Vice President of the San Francisco Health Commission, thanked and commended DPH employees and contractors for their "excellent and professional response."

Meanwhile, San Francisco DPH has announced that mental health counseling services are available to anyone who witnessed or was deeply affected by the incident. Many people were on the ground

when the incident happened and witnessed the tragedy--some as travelers, others as workers, staff and responders. CBHS is encouraging anyone who feels a need to talk to a counselor to call 3-1-1 and ask for mental health counseling. The services will continue for as long as needed.

## **2. Licensed Mental Health Services Provider Education Program and Mental Health Loan Assumption Program**

Below are descriptions of two financial incentive programs for qualified mental health providers to repay their educational loans.

***Licensed Mental Health Services Provider Education program.*** This program is for psychologists, postdoctoral psychological assistants, postdoctoral psychological trainees, clinical social workers and marriage & family therapists who have unrestricted licenses, registrations or waivers. Awardees can receive **up to \$15,000** in educational loan repayments; and the aforementioned roles must work or intern in a qualified facility providing direct patient care for a minimum of 32 hours per work for 24 months. The FY13-14 application cycle opens on July 1, 2013 on CalREACH and applications are due by October 1, 2013. For full details visit [www.healthprofessions.ca.gov](http://www.healthprofessions.ca.gov)

***Mental Health Loan Assumption Program.*** This program encourages mental health providers to practice in underserved California locations in designated hard-to-fill/retain positions. Awardees can receive **up to \$10,000** in educational loan repayments. Eligible applicants must work or volunteer in the public mental health system for at least 20 hours per week, may not have another service obligation commitment from June 2014 to June 2015 and have a commercial or government educational loan that needs to be repaid. The FY13-14 application cycle open on July 1, 2013 on CalREACH and applications are due by October 1, 2013. For full details visit [www.healthprofessions.ca.gov](http://www.healthprofessions.ca.gov)

## **3. Emerging Drug Trends 2013: Beyond Synthetics and Bath Salts**

Date & Time: Wednesday, July 24, 2013, 1:00 PM EDT, 12:00 PM CDT

Speakers:  
Ken Dickinson, MS, RHP, Director of Marketing  
Gaudenzia Treatment Center

Join this webinar and get a brief review of the current trends associated with the synthetic drugs known as “Bath Salts” and the “Synthetic Cannabinoids.” The focus will be on introducing and discussing newer emerging substances, some of which are being promoted as alternatives to K2/Spice and Bath Salts.

Some of the trends to be discussed include the increase in usage of Kratom, an unregulated leaf, and the re-emergence of hallucinogens such as DMT and 2 C1, as well as other compounds emerging from chemists in Europe.

Learning Objectives:

- Learn about emerging drug and synthetic drug trends while identifying resources that help participants to stay current and possibly ahead of the curve.

- List the desired effects as well as mental, emotional, behavioral, physical, toxic, and withdrawal effects associated with these emerging drugs.
- Learn about the latest developments in drug testing and how to take advantage of new technology in drug testing.

For more information regarding Continuing Education Credit for this program, go to:

[http://www.behavioral.net/webinar/emerging-drug-trends-2013-beyond-synthetics-and-bath-salts?WA\\_MAILINGLEVEL\\_CODE=&spMailingID=41958438&spUserID=NTA3NTMzOTk5MzAS1&spJobID=193592360&spReportId=MTkzNTkyMzYwS0#CEInformation](http://www.behavioral.net/webinar/emerging-drug-trends-2013-beyond-synthetics-and-bath-salts?WA_MAILINGLEVEL_CODE=&spMailingID=41958438&spUserID=NTA3NTMzOTk5MzAS1&spJobID=193592360&spReportId=MTkzNTkyMzYwS0#CEInformation)

Can't attend? Register anyway and get full access to the on-demand presentation and slides. If you have any questions, please email [webinars@vendomegrp.com](mailto:webinars@vendomegrp.com)

#### **4. Tobacco Sales to Youth Slip** – an article from SFGate.com

Fewer youths are buying tobacco in San Francisco. Illegal sales of tobacco to youngsters was down more than two percent between June 2011 and June 2013, according to figures released Tuesday by the San Francisco Department of Public Health.

Much of the decline can be attributed to rigorous enforcement, including sting operations by the San Francisco Police Department, and a robust education program designed to alert retailers to the potential consequences of selling tobacco products to young people, according to health plan coordinator Derek Smith.

Of the 1,016 licensed tobacco retailers in the city, 454 were the target of sting operations during this period. Police issued 61 citations to stores willing to sell tobacco products to 16- and 17-year-old decoys who could not produce identification.

Retailers caught selling tobacco products to minors can have their permits revoked for 25-30 days and the individuals responsible for the sale can be ticketed and fined.

While the dip in scofflaw merchants is encouraging, the city still has a rate of illegal tobacco sales nearly five percentage points higher than the state average. Of the retailers visited by police in San Francisco decoys, 13.4 percent sold tobacco to the undercover decoys. Statewide, that number drops to 8.7 percent.

The high rate is likely due to the fact that San Francisco is a small city with high population density and large concentrations of tobacco retailers in low-income neighborhoods like the Tenderloin and Hunter's Point, Smith said.

Research conducted by the Tobacco Use Reduction Force, a group of seven young people who each represent a different neighborhood, found that of the more than 1000 tobacco retailers in the city, 517 were located in just three of the eleven districts, all with a lower than average median income.

“These high concentrations normalize the use of tobacco in disadvantaged communities,” said Avni Desai, program coordinator at the Youth Leadership Institute, which runs the TURF program. “It creates a health disparity.”

## **5. RAMS Peer Specialist Mental Health Certificate Program is Accepting Fall 2013 Applications**

RAMS, in collaboration with SFSU, is excited to announce that the Peer Specialist Mental Health Certificate Program is currently accepting applications for the Fall 2013 Class!

Funded by the Mental Health Services Act (MHSA), the Peer Specialist Mental Health Certificate Program provides a 12-week long training for consumers of behavioral health services or family members who are interested in becoming peer counselors/peer specialists in the field of community behavioral health.

We are looking for individuals who are:

- at least 18 years old
- residents of San Francisco
- have completed at least a high school level education or GED
- current or past consumers of behavioral health services and/or family members
- interested in helping others in the community behavioral health setting

Application and course timeline is as follows:

Monday, July 1st - Application Release

Tuesday, July 16th - Optional Program Open House (see attached flyer for details)

Friday, August 9th @ 5:00pm - Application Deadline

Week of August 26th - Notification of Application Status

Friday, September 6th - Registration Forms Due for accepted applicants

Tuesday, September 17th, - 1st Day of Class

Tuesday, December 17th, - Last Day of Class

Attached are the program brochure, open house flyer, and application form. Kindly distribute this to those in your network and your consumer community, as applicable. Please feel free to contact Program Coordinator, Christine Tam, MA, LCSW at (415) 668-5955 x386 or [christinehtam@ramsinc.org](mailto:christinehtam@ramsinc.org) should you have any questions. Materials are also available for download at: <http://ramsinc.org/peerspecialistmhcert.php>

We look forward to receiving the applications, Fall 2013 class, and beginning another great cohort!

(See attachments 1, 2, 3)

## **6. Consumer and Family Conference: Food, Mood & Move**

July 19, 2013

10am-2pm

St. Mary's Cathedral Conference Center

1111 Gough Street

Speakers:

**Laura Brainin-Rodriguez MPH, MS, RD**

Coordinator, Feeling Good Project  
SF Department of Public Health, Nutrition Services

**Chloe Yu BA, BS, RD and Erica Eilenberg, MPH(c)**

Feeling Good Project  
SF Department of Public Health, Nutrition Services

**Carmen Bogan MBA**

Physical Activity Coordinator  
Network for a Healthy California Bay Area Region

Providing nutrition and physical activity education as part of mental health and substance abuse services poses particular challenges for mental/behavioral health and recovery service providers. This may be due to lack of knowledge on the part of providers or difficulty figuring out how to integrate this information into service delivery. In addition low income diverse populations may face difficulties in accessing healthy foods and opportunities to be physically active due to a lack of resources in their communities.

The purpose of this workshop is to provide training on what constitutes healthy eating, how to assist clients in assessing their overall diet quality, tips and resources on how to eat healthy on a budget and how to reduce intake of foods and beverages of low nutritional value. It will also give providers an opportunity to become familiar with simple low cost ways to promote physical activity to their clients as a way to improve their physical and mental health. The course will be taught at an intermediate level, and is appropriate for currently licensed professionals and current recovery service providers, as well as those working in primary care settings.

## **7. Iraqi Refugees Support Group**

This year MHSA has begun funding the Arab Cultural and Community Center (ACCC) of San Francisco ([www.arabculturalcenter.org](http://www.arabculturalcenter.org)) to provide **culturally sensitive mental health support to Iraqi refugee females** who are struggling with severe depression, anxiety and isolation. Since the start of the war in Iraq, tens of thousands of refugees have been resettled in the US and almost 14,000 in California. The Bay Area has seen a dramatic influx of refugees these past five years, mainly from Iraq and more recently a few from Syria. Many of these refugees are suffering from extreme symptoms associated with the traumas of war and relocation.

One Iraqi refugee mother who called the ACCC said, “I feel very depressed as I lost everything in Iraq. I often just want to stay in bed as I have no reason to get up. I live in a dangerous neighborhood where I don’t know any of my neighbors. I don’t know any other refugees here as we were resettled far from each other. I have a college degree from Iraq but don’t even know how to take the bus here! I am so isolated and lonely.”

In Iraq and other countries in the Arab world, receiving mental health services often carries a negative stigma for the client. Many clients are afraid of seeking mental health services as they will be stigmatized by their community as being crazy. Some clients worry that this could affect their

chances of marriage and/or chances of marriage for their children as it may be construed that the therapist is dealing with a problem that might be genetic and thus can be inherited.

The support group aims to provide a space where refugee women can receive mental health support within a culturally acceptable channel without the worry of acquiring the stigma associated with going to see a therapist. The support group is a safe place for the women to bond with each other, share with each other, cook together, and learn essential life skills together. It provides a place where they can learn about topics such as depression, PTSD, health and wellness in a supportive environment. This support group is also a safe space where women can seek help confidentially about mental health services and other needed health referrals.

## **8. CBHS Conflict of Interest Policy for interactions with the Pharmaceutical Industry**

Community Behavioral Health Services (CBHS) strives to provide quality, evidence-based client care, and create a treatment environment that is free from the undue influence of the pharmaceutical industry. The CBHS conflict of interest policy addresses the relationship between CBHS and the pharmaceutical industry. Its intent is to prevent conflicts of interest and ensure that selection of medications for CBHS clients is based upon objective clinical and scientific evidence. The policy is in alignment with recently revised policies from academic medical centers, self regulated PHARMA guidelines, the Office of the Inspector General, San Francisco Conflict of Interest policies, and NIH guidelines on research.

The policy applies to interactions between CBHS facilities, CBHS staff and all pharmaceutical industries. CBHS facilities include mental health and substance abuse client clinics, programs, urgent care centers, contractors, and individuals who contract with CBHS for the provision of services to CBHS clients. CBHS staff includes all civil service and CBHS-funded program employees including those who are paid, voluntary, or in training.

Pharmaceutical industry representatives (PIRs) are not allowed in any client care facility, including client treatment areas, waiting rooms, clinic entrances, and other protected care areas. The presence of pharmaceutical industry representatives in care areas may infringe upon client confidentiality and creates the appearance that a CBHS facility is receptive to the commercial interests of pharmaceutical companies.

Drug samples, vouchers or drug specific discount cards are prohibited in CBHS facilities. Drug sampling is a marketing tool that encourages physicians and clients to rely on medications that are expensive, but not necessarily more effective than other available drugs. The long term cost of continuing these medications far outweighs any short term savings.

The pharmaceutical industry may not offer or provide any gifts to CBHS staff including meals, medical education (directly or as grants or sponsors), branded office supplies, textbooks, or material items (pens, mugs, pad etc). Evidence shows that gifting can influence prescriber behavior by creating a sense of obligation and reciprocity, resulting in increased prescribing of the company's drugs.

For more information, please refer to the CBHS Policy and Procedure 5.00-03, “Conflict of Interest Policy on Interactions Between CBHS and the Pharmaceutical Industry,” or contact CBHS Director of Pharmacy Gloria Lee Wilder, PharmD at 255-3703 or gloria.wilder@sfdph.org

**9. Katie A.**

Below is the initial plan for developing an implementation plan for Katie A. CYF has established a joint leadership team with HSA. This summer we are continuing our planning process. We have applied to the State to be part of the learning collaborative which will involve working with other counties to develop and innovate Katie A. related services. In September we are planning to have a stakeholders group to present our Readiness Assessment, Service Plan and our intended Deliverables. With the help of our facilitators we will be using the Plan/Do/Study/Act (PDSA) methodology to test small changes. It is our view that by developing a team to innovate we will learn about how best to spread these changes across the system.

<b>AIM:</b>	
Design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency and well-being of children, youth and families that have been involved in or at risk of involvement in Foster Care, Probation, Special Education and are struggling with the complications of behavioral health issues. The goal is to design a system that will serve the Katie A. and non-Katie A. children and families alike.	
<b>Key Goals:</b>	
<ul style="list-style-type: none"> <li>• Improve the availability of services</li> <li>• Improve the effectiveness of services</li> <li>• Increase family and youth involvement in policy and agency decision making</li> <li>• Increase the availability and accessibility of interagency training on best practices</li> </ul>	
<b>Guidance Statement:</b>	
<ol style="list-style-type: none"> <li>1. San Francisco will build on its existing Foster Care Mental Health system and initiate testing of organizational changes that achieve:             <ol style="list-style-type: none"> <li>a. Increased capacity to routinely do timely screening and assessment of all children entering foster care for mental health treatment needs</li> <li>b. Increased coordination of care between CBHS and HSA, as well as with other public and private agencies, families and youth, and other stakeholders</li> <li>c. Increased in-home capacity</li> </ol> </li> </ol>	
<b>DELIVERABLES</b>	<b>DATES</b>
1. Increase the availability of intensive community based services designed to limit placement instability	
2. Increase culturally modified, evidence informed treatments, particularly for youth between ages of birth to 5 years and ages 16-22 years	

3. Increase family and youth involvement in policy, planning and management decisions for both CBHS and HSA	
4. Design and utilize a <i>brief version of the CANS</i> tool that will be used for all youth referred to foster care	
5. Embed a Foster Care Mental Health Assessment Team in HSA	
6. Child and Family Teams (CFTs) to be expanded for all youth upon entering foster care and will include Clinician from Assessment Team. This Clinician becomes the child’s “Central Point of Contact” and remains involved with them throughout their time in Foster Care	
7. Service providers offering intensive care coordination and intensive in-home services will increase their use of trauma-informed, attachment-based, and resiliency-focused evidence based practices, including those that are adapted to increase culturally competency	
<b>DELIVERABLES</b>	<b>DATES</b>
8. Develop a Joint Management Team between CBHS and HSA, including its structure, purpose, and processes	
9. Identify the role of youth and families on the Joint Management Team and offer training, coaching, and mentoring so they can effectively fulfill this role	
10. Offer trainings on strength-based, collaborative approach for engagement (from the Core Practice Model) to all direct service staff interacting with the youth and families from the following agencies: child welfare, juvenile justice, mental health and special education	
11. Expand the nature and range of services available to youth in foster care needing intensive mental health services. Services will reflect the following principles: <ul style="list-style-type: none"> <li>a. Services are attachment-focused, resiliency-based and trauma informed</li> <li>b. Treatment is focused on securing meaningful and permanent relationships while helping children and youth heal from trauma, abuse and neglect</li> <li>c. There is at least one constant helper involved in the child or youth and family’s healing process</li> <li>d. Intensive treatment is provided flexibly, involving family, caregivers and the child or youth in all aspects of decision-making</li> <li>e. Behavioral treatment is a planned intervention with a clearly defined goals that are collaboratively planned between the youth, family, and their care provider</li> </ul>	
12. Establish structure and processes for an Implementation and Improvement Team that includes key system of care supervisors, managers, and youth and family partners. This team meets with	

Executive Management Team 1x per month and with a larger stakeholders group (inclusive of juvenile probation, the schools, representatives from provider network, and youth and families) 1x per quarter to review successes and barriers to achievement of SF's Katie. A. Charter	
13. Design a San Francisco Training Manual for providers delivering Intensive Home Based Services (IHBS) and Intensive Case Management (ICC). Also increase collaborative training between HSA and CBHS	
14. Increase Out-of-County Services through contracts with community-based organizations to provide more flexible services in larger geographic area	
15. Attachment and Trauma Training, including a focus on disproportionality	2-3 years
16. Attachment/Trauma Focused Foster and Parenting service models	2-4 years
17. Increase ITFC Slots	2-4 years

### **Trauma Informed Training:**

The trauma informed training initiative is moving forward. Over the past couple of weeks we have had four focus groups to discuss why we are planning on doing a system wide training, some of the curriculum outline and the training delivery mechanism. In coming weeks we will be presenting to Hunters Point Family, TAYSF, and Hope SF. In September the CYF, Adult, Older Adult and Substance Abuse Providers will meet together to discuss and comment on the curriculum and the ideas about how best to deliver the curriculum. In late September we are planning on doing a run-through of the entire curriculum with a select group of non-clinicians to make sure the ideas translate to support and administrative staff. In October we will present to the Change Agents. Between October and January we will refine the curriculum with the intention of rolling it out across community programs in January.

### **10. Wellness and Recovery – Strengths Assessment**

There are times in our work when we will inevitably feel stuck in helping our clients move forward in their efforts to achieve a higher stage of recovery. These impasses in treatment can be frustrating for all parties and often result in an increased sense of hopelessness for our clients and for us as clinicians.

OMI Family Center recently participated in the CIMH Advancing Recovery Practices learning collaborative and began to incorporate into our work a clinical tool which focuses on a client's strengths rather than symptoms and impairments. The Strengths Assessment was developed by Dr. Rick Goscha and Kansas University School of Social Welfare.

At first glance the Strengths Assessment seems quite simple; however, it is truly a dynamic tool. It changes the conversation in the therapeutic hour and as a result a working partnership is created with the shared goal of helping the client move closer to achieving the life of their choosing. When the

conversation shifts in therapy from focusing on deficits to focusing on strengths it is amazing to see the energy and excitement that can be generated from a well-executed Strengths Assessment.

Please take a few moments to review the Strengths Assessment, in the appendix attached at the end of this Director's Report. If you are interested in learning more about how to use this dynamic tool or have any questions, please feel free to contact Gloria Frederico, MFT at [Gloria.Frederico@sfdph.org](mailto:Gloria.Frederico@sfdph.org)

### **11. Dr. Tom Bleecker Invited to Expert Panel on Integrated Health Care**

The California Institute for Mental Health (CiMH) has invited Dr. Tom Bleecker, a senior Research Psychologist in the Office of Quality Management, to join an Expert Panel of California and National experts to guide and inform changes that will be pursued in a learning collaborative to improve the physical health status of individuals living with mental health, substance use, and physical health conditions. Learning collaborative participants will be introduced to key care coordination processes and client self management approaches to support the physical health of clients, with a particular focus on cardiovascular disease and diabetes risk factors. This coordination will result in a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness. The Expert Panel meeting will be held in Sacramento, California on August 19th and 20<sup>th</sup>, 2013.

We congratulate Dr. Bleecker on his selection for the expert panel, which follows his insightful presentation of our evaluation of the Primary Behavioral Health Care Integration grant at the California Innovations Summit on May 22, 2013, where he participated in a panel presentation with CBHS Director Jo Robinson and Dr. Deborah Borne. The Summit highlighted San Francisco's model of integrating health care into a behavioral health program at South of Market Mental Health, along with integration models presented by several other California counties.

### **12. Health Disparities and Hepatitis C**

The Impact of life changing break-through in rapid testing and treatment could be huge. The San Francisco Hep C Task Force will host an open meeting with pharmaceutical representatives to explore the strategies to use the innovations to reduce hepatitis related health outcome disparities. For more information: [james.stillwell@sfdph](mailto:james.stillwell@sfdph) (415) 596-5750.

August 8, 2013 at 5:30pm  
Quan Yin Healing Arts Center  
Suite 405  
695 Mission Street  
San Francisco, CA 94103

---

*Past issues of the CBHS Monthly Director's Report are available at:*  
<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>  
To receive this Monthly Report via e-mail, please e-mail [reanna.albert@sfdph.org](mailto:reanna.albert@sfdph.org)

**Item 2.0 MENTAL HEALTH BOARD ACKNOWLEDGEMENTS:** Cecile O'Connor, Dore Urgent Care, Melissa Nau, MD, San Francisco General Hospital Psychiatric Emergency Services (PES) Director.

The Mental Health Board enjoys highlighting and acknowledging the accomplishments of exceptional people serving Community Behavioral Health Services and our community. Tonight the board acknowledged Dr. Melissa Nau, Medical Director of Psychiatric Emergency Services at San Francisco General Hospital and Cecile O'Connor, Executive Director of Dore Urgent Care Clinic.

**Dr. David Elliott Lewis** presented Dr. Nau an appreciation plaque for her exceptional work with patients and staff in Psychiatric Emergency Services at San Francisco General Hospital. He also presented another plaque to Ms. O'Connor for her leadership in developing, expanding and sustaining Dore Urgent Care Clinic, a project of Progress Foundation.

### **ITEM 3.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS**

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

#### **3.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update, Marlo Simmons, Director**

*Marlo Simmons power point document is at the end of the minutes*

**Dr. David Elliott Lewis** welcomed Marlo Simmons, Mental Health Services Act Director who presented the Annual Update of the programs currently funded. State law requires that the Mental Health Board review the Annual Update.

**Ms. Simmons** said, prior to the Health Commission meeting for approval, the MHSA annual report is posted for a 30 day review.

**Dr. Patterson** asked if MHSA fund are distributed proportionately among California counties.

**Ms. Simmons** replied that San Francisco suffered in the original allocations of MHSA funding because we were not permitted to include the number of people who were homeless in our numbers of people with mental illness. We expected \$50 million the first year and received only a \$15 million allocation.

**Ms. Virginia Lewis** wanted to know why our count of people who were homeless was not included especially since San Francisco has become the dumping ground for the most homeless people with mental illness.

**Ms. Simmons** said that since quantitative data for the exact numbers of people who are homeless is hard to come by, the numbers were not permitted.

**Ms. Robinson** explained the other part of funding shortages for San Francisco homelessness is a political issue. During the first realignment in 1991, San Francisco did financially well and other

county councilpersons and city leaders resented us. Since the 1991 realignment, San Francisco has not done well in the MHSA formula.

**Ms. Simmons** said MHSA funding includes a provision for Full Service Partnerships (FSP) services and program. She introduced Rhea Bailey, who is the programs manager of MHSA, who talked in-depth about the FSP in San Francisco.

**Ms. Bailey** said the essence of FSP for recovery is “whatever it takes” to support adults with severe mental illness (SMI) and support children with severe emotional disorders (SED). For example, FSP coordinates emergency and permanent housing and works on transitioning clients to lower levels of care. Clients in FSP include people who are homeless, clients with dual diagnoses, elderly, immigrants and disenfranchised people.

**Ms. Virginia Lewis** asked for the breakdown.

**Ms. Bailey** said there are 915 clients in total in the program with about 200 children as clients. 57% is for adults.

**Dr. David Elliott Lewis** asked for the staff to client ratio.

**Ms. Bailey** The mandated ratio per statute is 1:12 or 1:15 ratios.

**Ms. Virginia Lewis** asked about referrals and any waitlist.

**Ms. Bailey** said that referrals can be from hospitals, drug courts, other CBHS programs, Citywide Forensics, and the San Francisco jail system. The waitlist is a work in progress, and Sidney Lam is in charge of that waitlist.

**Ms. Robinson** added that intensive case management programs are not receiving any financial support from MHSA dollars. So the housing component and FLEX funding are utilized to help clients with recovery.

A challenge for FSP is clients do not want to leave the program. Since FSP provides lots of supportive services that clients do not find somewhere outside of FSP, FSP just offers too much of a safety bubble for people with SMI and SED.

**Ms. Virginia Lewis** asked what happened to clients who don't want to graduate from FSP.

**Ms. Robinson** said, in the protective environment of FSP, clients like the services so much that they do not want to leave FSP. Clients are not penalized. The program tries to give clients opportunities to seek meaningful employment so they do not always see themselves as mental health clients forever. Many clients need a job in a protective and nurturing environment.

**Ms. Bailey** said there is a cultural shift for both clients and staff to increase hope for clients to empower themselves. The shift is very different than the medical model, because a diagnosis is just a small piece of a person and it does not define who the person is!

**Ms. Robinson** stated that anyone who is a member of San Francisco Healthy Families will need a case manager through the Affordable Care Act (ACA).

**Ms. Virginia Lewis** wondered how clients stay engaged in FSP because in her private practice she has seen a pattern emerge from isolated clients when they become a no-show for appointments.

**Ms. Bailey:** The clinical management model has been practiced in SF for years. Now the Affordable Care Act will require the clinical management model in health plans.

**Ms. Miller** commented that in the MHSA updates, the breakdown of generalized services does not seem to address specificity with respect to client's ethnicity. For example, there appears to be a discrepancy and disproportion in vocational services between people of color and white.

**Ms. James** asked for statistics for services for older adults/seniors.

**Ms. Bailey** said older adults/seniors have different needs in services. In the older adults/seniors population, they see more isolation and clinical depression. The programs try to provide linkage to encourage older adults/seniors to engage in their communities.

**Ms. James** inquired about relapse in older adults.

**Ms. Bailey** informed the board that older adults who have relapsed do not need to go back to square one of recovery, and staff stay in touch closely with older clients.

**Ms. Virginia Lewis:** inquired about the data collection process.

**Ms. Simmons** said it is self reporting and client satisfaction surveys are collected during program review period.

Under SF MHSA service categories, #2 we are required to spend 20% of the MHSA funding on mental health promotion and Prevention and Early Intervention (PEI). For example, we have population-focused mental health promotion. Barbara Garcia's commitment to health disparity is to make investments in the API, African American and Arab communities. We are also focused on transgender client and transgender support services.

**Ms. Robison** commented that the original supporters of MHSA focused on FSP. But, recently there was bad press and unfair criticism, about how MHSA dollars were being spent in the realm of innovation. For example, the peer support staff wanted a stress reduction program. When the media learned that our yoga cost \$600 for a whole year, the media sensationalized the spending.

**Ms. Chien** said she is every impressed with the 5% spending on innovation programs under Innovation. She asked for comparative data between the effective usage of dollars in Innovation services and programs versus the traditional services and programs.

**Ms. Simmons** said their FSP data collection on is very strong showing how clinical services are yielding great results. But prevention data collection is not something we collect. We can see which treatments work effectively. But she is not sure of any comparative data.

**Ms. James** wanted to know about vocational training program funding for things like uniforms.

**Ms. Simmons** responded that funding for work uniforms would be in FSP.

### **3.2 Public comment**

No public comment.

### **ITEM 4.0 ACTION ITEMS**

**Dr. David Elliott Lewis** mentioned that in addition to approval of minutes for the May Board Meeting, the board will be voting on the MHB not having a meeting in August 2013 which was proposed by the Executive Committee.

#### **4.1 Public comment**

No public comments.

**4.2 PROPOSED RESOLUTION:** Be it resolved that the minutes for the Mental Health Board meeting of June 12, 2013 be approved as submitted.

Unanimously approved

**4.3 PROPOSED RESOLUTION:** Be it resolved that the Mental Health Board will not meet in the month of August 2013.

Unanimously approved

#### **ITEM 5.0 REPORTS**

For discussion

##### **5.1 Report from the Executive Director of the Mental Health Board.**

Ms. Brooke announced the following:

1. For those of you who knew Willie B. Kennedy a former Supervisor and recent member of the Southeast Commission passed away and there is a celebration of her life tomorrow and a funeral service on Friday.
2. Wednesday, July 17th is the second forum entitled Managing Stress: Coping Mechanisms for Economic Fatigue at the Holiday Inn Civic Center. This is part of SFMHEF's Path to Mental Wellness Expo in February 2014 which will be at the Oakland Convention Center.
3. Friday July 19th from 10 – 2, Consumer and Family Member conference. Lunch will be served.
4. Thursday August 29th at the Southeast Commission Facility SFMHEF will hold a conference about trauma assessment, diagnosis and treatment planning with Gena Castro Rodriguez.

##### **5.2 Report from the Chair of the Mental Health Board and the Executive Committee.**

**Dr. David Elliott Lewis** attended the Board of Supervisors meeting last Thursday and said the BOS did a great job in honoring the former Supervisor Willie B. Kennedy.

The supervisors did a tribute to Mr. Lou Giraudo who is well-known in San Francisco as a civic leader, a former police commissioner and president and Boudin Bakery co-owner. He was very influential in reviving the troubled \$2.5 billion Cathedral Hill project. Mr. Giraudo is a key negotiator with officials at CPMC Sutter Health for more psychiatric beds in San Francisco for non-privately insured patients.

**5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.**

None recommended

**5.4 Report by members of the Board on their activities on behalf of the Board.**

**Ms. Miller** reported that she attended the CALMHB/C in San Mateo and found it to be very informative.

**5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.**

**Dr. Patterson** suggested having Supervisors Malia Cohen and London Breed to a board meeting.

**Ms. Virginia Lewis** asked to have a data person from DPH to talk about health parity – analysis on the Affordable Care Act.

**5.6 Public comment.**

**Ms. Robinson** suggested a presentation about vocational rehabilitation.

**ITEM 6.0 PUBLIC COMMENT**

**Ms. Parks** thanked the board for helping her when she had an acute psychiatric breakdown.

**ADJOURNMENT**

Meeting adjourned at 8:34 PM.

*Marla Simmons power point document*

# MENTAL HEALTH SERVICES ACT



FY 13/14  
Annual Update

**For Mental Health Care**



**www.YESon63.org**

- Enacted into law in 2005
- 1% tax on income over \$1 million
- Designed to transform the mental health system

**“As my life got bigger,  
my illness got smaller”**

-TAY Program Participant

## MHSA FY 13/14 Annual Update

- Updates on the implementation of previously approved MHSA Plans
- Descriptions of services delivered
- Highlights of outcomes of services provided in fiscal year 2011-12.
- Reports changes to programs and identify new investments planned for fiscal year 2013-14.

# MHSA Integration: Seven Service Categories

- #1: Recovery-Oriented Treatment Services
- #2: Mental Health Promotion & Early Intervention Services
- #3: Peer-to-Peer Support Services
- #4: Vocational Services
- #5: MHSA Housing Program
- #6: Behavioral Health Workforce Development
- #7: Capital Facilities/Information Technology



\* Note: Most SF MHSA service categories include programs supported by Innovation (INN) funding.

# S.F. MHSA Service Categories

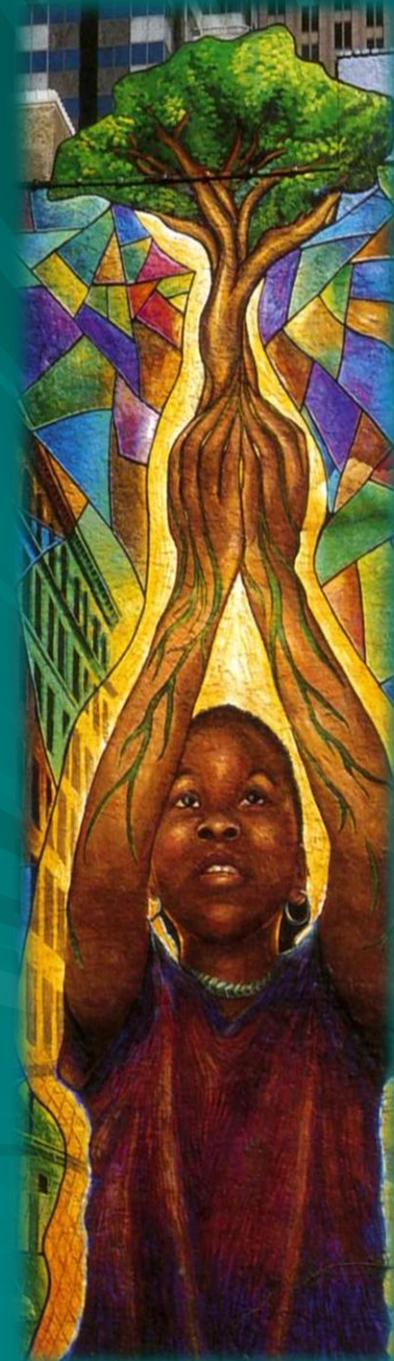
## #1: Recovery-Oriented Treatment Services

Services generally provided in traditional mental health system

- Full Service Partnership (FSP) Programs
- Behavioral Health Access Center
- Prevention and Recovery in Early Psychosis Program
- Trauma Recovery Programs
- Behavioral Health Integration into Primary Care and Juvenile Justice
- Dual Diagnosis Residential Treatment

### FY 13/14:

- Expansion/improvement of Full Service Partnerships
- Enhancing trauma treatment services in southeast



# S.F. MHSA Service Categories

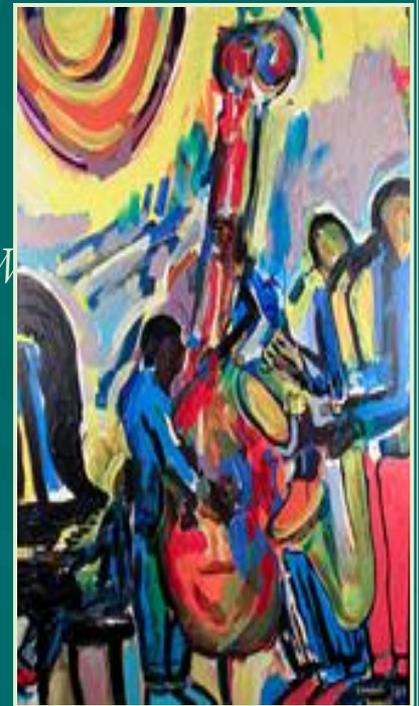
## #2: Mental Health Promotion and Early Intervention

(PEI) Raise awareness, develop protective factors, reduce stigma, intervene early and increase access

- ❑ Comprehensive Crisis Services
- ❑ School-Based Mental Health Promotion
- ❑ Mental Health Consultation and Capacity Building
- ❑ Population-Focused Mental Health Promotion (*NEW*)

- Asian and Pacific Islander (API)
- African American
- Native American
- Latino/Mayan

- Arab
- Homeless Adults
- Homeless or System Involved TAY
- LGBTQ



FY 13/14:

- ❑ Developing holistic wellness services for API and Arab communities
- ❑ Expanding and coordinating services for transgender clients

# S.F. MHSA Service Categories

## #3: Peer-to-Peer Support Services

Consumers and family members provide wellness, recovery and other support services to their peers.

- ❑ Based in clinic, community, residential and locked settings
  - Office of Self-Help
  - Pathways to Discovery
  - Peer-led Hoarding & Cluttering Program
  - Reducing Stigma in the Southeast (RSSE)
  - Children's System of Care (CSOC)
  - Transgender Support Services



### FY 13/14:

- ❑ New clinic-based pilot in partnership with NAMI
- ❑ Peer-to-Peer Services Coordinator – focus on helping develop training, job descriptions, promote professional development, establish clear outcome measures.

# S.F. MHSA Service Categories

## #4: Vocational Services

Assist consumers and family members in securing and maintaining meaningful employment

- ❑ Vocational IT Program
- ❑ Vocational Co-Op
- ❑ Supported Employment and Cognitive Training

### FY 13/14:

- ❑ New re-modeling program – *First Impressions*
- ❑ Vocational Services Coordinator
- ❑ Planning around CYF/TAY vocational services



# S.F. MHSA Service Categories

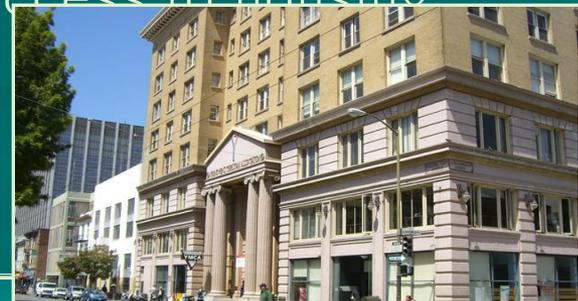
## #5: MHSA Housing Program

Continuum of accessible supportive housing to help formerly homeless clients

- ❑ Case management supports to find and maintain housing
- ❑ Short-Term Stabilization Housing (32 Units)
- ❑ Permanent supported housing for adults and older adults
- ❑ Transitional Housing for Transitional Age Youth (TAY)

## FY 13/14:

- ❑ Plan strategies for expanding access to housing
- ❑ Interest to buy 3 new units



# S.F. MHSA Service Categories

## #6: Behavioral Health Workforce Development

Recruit and develop a culturally competent recovery oriented workforce, including consumers and family members

- ❑ Mental Health Career Pathways Program (75 certificate graduates)
  - ❑ H.S. – Community College Certificate – CIIS
  - ❑ Peer Certificate
- ❑ Training and Technical Assistance
  - ❑ 12N – LGBTQI youth sensitivity training for providers
  - ❑ Seeking Safety
  - ❑ Wellness and Recovery
- ❑ Residency and Internship Programs
- ❑ Financial Incentive Programs
  
- ❑ FY 13/14:
  - ❑ Clinic Intern Coordinator
  - ❑ Workforce Assessment focusing on disparities
  - ❑ Continue WDET funding



# S.F. MHSA Service Categories

## #7: Capital Facilities/Information Technology

Acquire, develop, or renovate buildings for MHSA services; upgrades IT systems and improve consumers' access to personal health information.

- ❑ Sunset Mental Health Services JUST OPENED!
- ❑ Integrated Health and Homeless Clinic (IHHC) OPENING SOON!
- ❑ Southeast Health Campus
- ❑ Redwood Center (*project terminated*)
- ❑ Consumer Connect

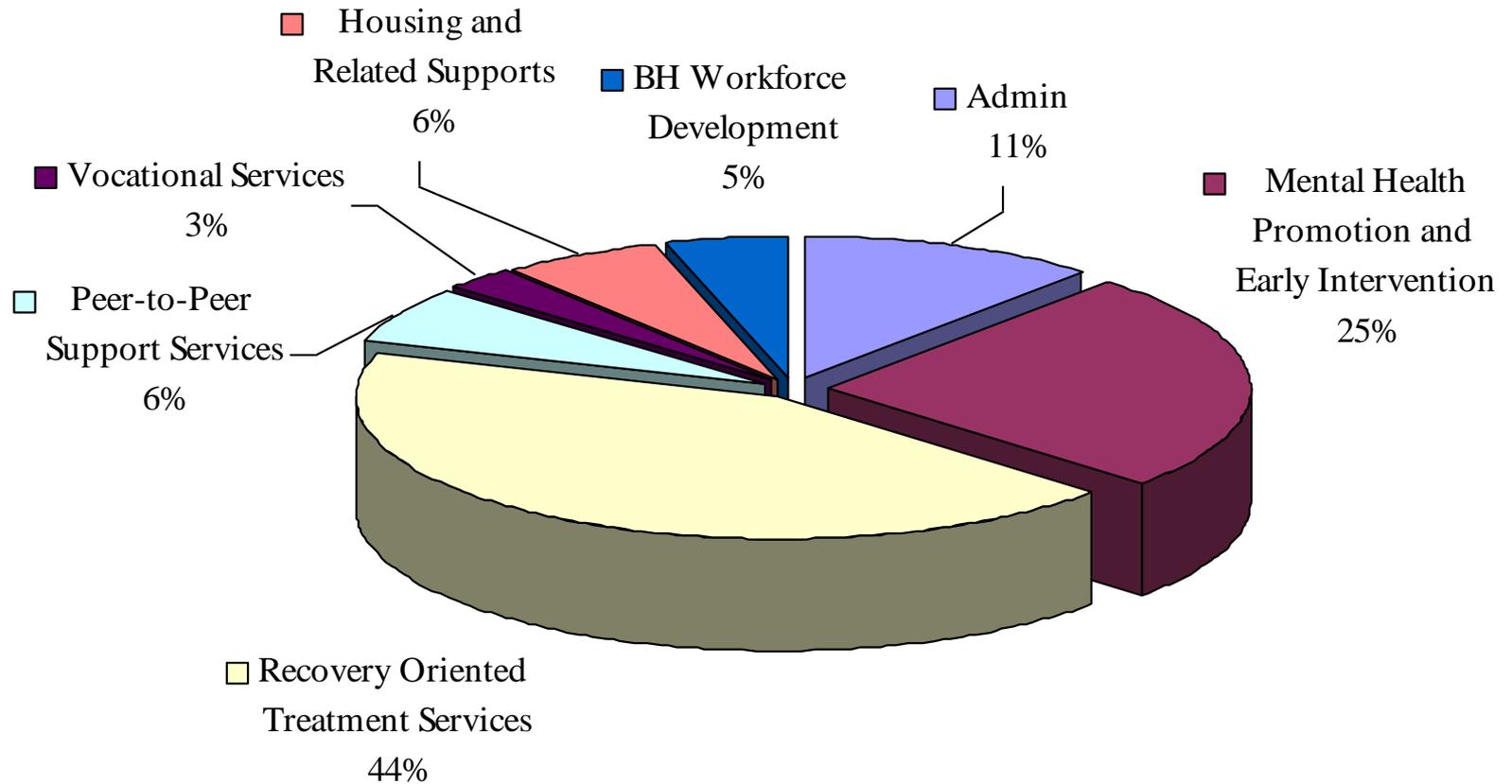
FY 13/14:

- ❑ IT Evaluation and Enhancements



## Estimated MHSA FY 11/12 Expenditures by Service Category\*\*

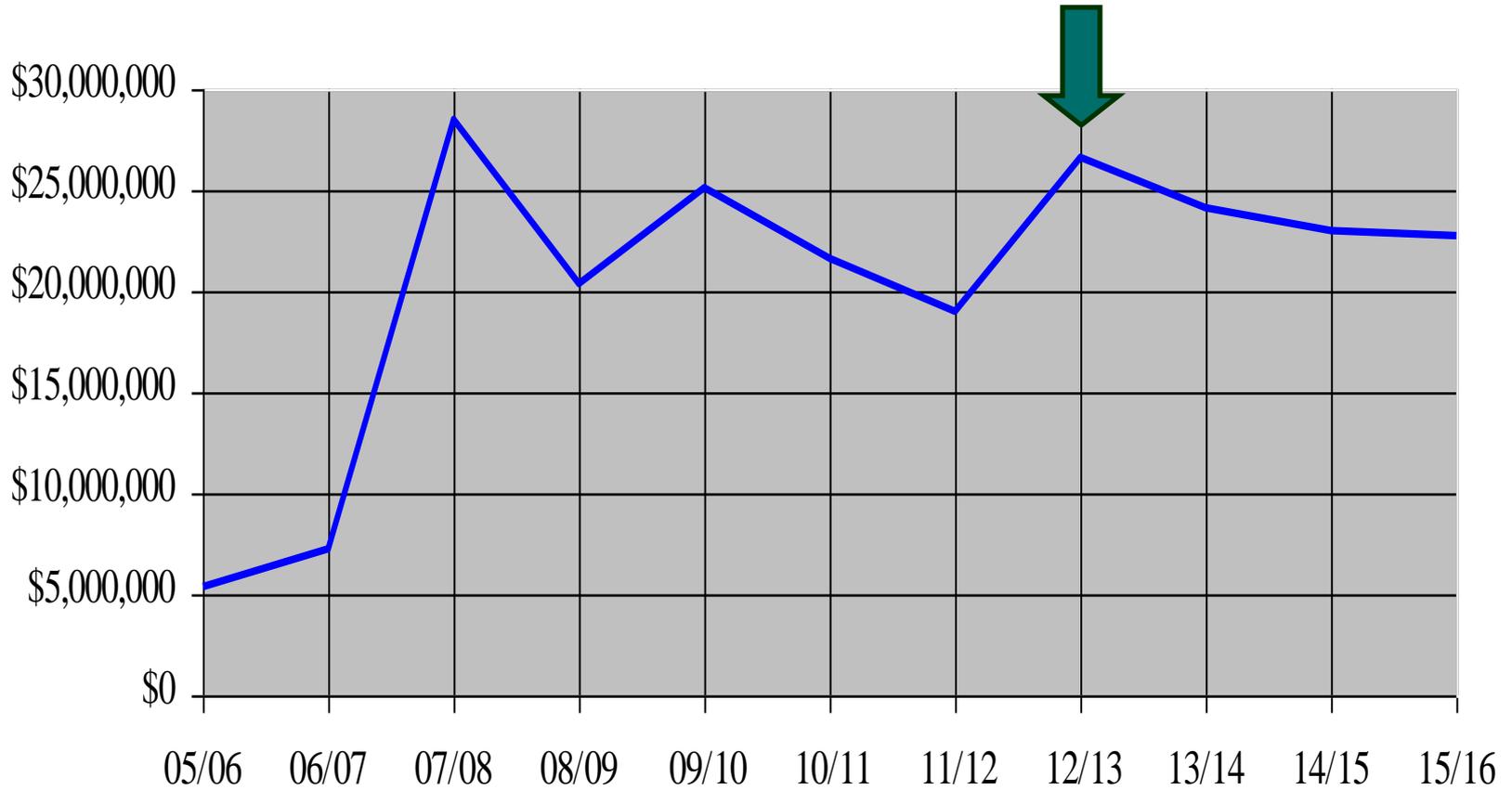
\*\* Does not include expenses for capital projects



Estimated FY 11/12 Expenditures = \$24.5 Million

# San Francisco MHSA Revenue by FY

*\*12/13 and beyond are estimated*



# Honoring MHSA Principles

- ❑ **Cultural Competence.** Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
  - ❑ Expanded access to Spanish and Arab bi-lingual services
  - ❑ Began planning to increase access for three API communities with the greatest health disparities
  - ❑ Medicinal Drumming Apprenticeship
  - ❑ Population Focused Service category helps address specific disparities and access issues for underserved communities
  - ❑ Learning Discussions with higher ed partners and leaders in indigenous wellness and community defined evidence

# Honoring MHSA Principles

- ❑ **Community Collaboration.** Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
  - ❑ Expanded collaboration with violence prevention providers, K-12 Schools, Higher Education, Primary Care, Juvenile Justice, Housing Developers
  - ❑ Implemented jointly funded programs with DCYF, HSA, MOH
  - ❑ Youth Commission and Human Rights Commission joined forces to develop the 12 N training
  - ❑ Fostering partnerships with African American and Samoan church leaders

# Honoring MHSA Principles

- ❑ **Client, Consumer, and Family Involvement.** Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.
  - ❑ Promoted a greater understanding of the value of involving consumers in all aspects of the system
  - ❑ Significant client participation on MHSA Advisory Board and other MH planning oversight bodies
  - ❑ Programs collecting meaningful client feedback (focus groups, individual interviews, community meetings) that Involvement in program development and evaluation
  - ❑ 28 programs funded by MHSA employ consumers

# Honoring MHSA Principles

- ❑ **Integrated Service Delivery.** Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families
  - ❑ BH staff in 10 Primary Care Clinics and Medical staff in 2 MH clinics
  - ❑ Behavioral Health Access Center
  - ❑ Promoting linkages with peer navigation – SFGH, Board and Care
  - ❑ IT and Capital investments supporting integration
  - ❑ Integration of Comprehensive Crisis Services
  - ❑ Using peers to engage socially isolated older adults in their homes

# Honoring MHSA Principles

- ❑ **Wellness and Recovery.** Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.
- ❑ Training for staff on wellness and recovery practices
- ❑ Learning Collaborative – Expanding PDSA “small tests of change”
- ❑ Annual Award Ceremony
- ❑ Establishment of Wellness Center at Sunset Mental Health Clinic
- ❑ Full Service Partnership Programs help clients maintain housing, integrate back into community, pursue meaningful activities, and gain strategies to cope with stress.
- ❑ Prevention and early intervention programs improve familiarity with behavioral health services and community supports and Increased knowledge of children’s emotional

## MHSA Program Challenges

- ❑ Turnover
- ❑ Limited capacity for evaluation and data collection
- ❑ Difficult to deepen consumer engagement
- ❑ Limited space to conduct programs
- ❑ Limited funding
- ❑ Limited capacity to support growth
- ❑ Growing and establishing partnerships



GOALS

## Looking Forward

### 3 Year Integrated Plan (2014 – 2016)

- A single plan that brings together all MHSA components
- Guided by State regulations
- Rooted in MHSA principles and goals, as well as previous community planning priorities
- Takes into account program outcome data and community specific needs and strengths

### Program Monitoring and Evaluation

- Develop shared outcomes across programs
- Better integrate MHSA into DPH contracting and program monitoring systems