



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board

Wednesday, January 9, 2013

City Hall, Room 278

San Francisco, CA

BOARD MEMBERS PRESENT: M. Lara Siazon Argüelles, Chair; Ellis Joseph, MBA, Vice Chair; David Elliott Lewis, Ph D, Secretary; Kara Chien, JD; Alyssa Landy, MA; Virginia S. Lewis, LCSW, MA; Lena Miller, MSW; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS; Errol Wishom.

BOARD MEMBERS ON LEAVE: Sgt. Kelly Dunn; and Wendy James.

BOARD MEMBERS ABSENT: Lynn Fuller, JD.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Cecile O'Connor, RN, Executive Director of Dore Urgent Care; Erin Durrah; Idell Wilson; Matthew Green, Conard House, Shelter Monitoring Committee; Ralph Fein, MD; Terezie Bohrer; and three members of the public.

CALL TO ORDER

Ms. Argüelles called the meeting of the Mental Health Board to order at 6:40 PM and welcomed everyone to the new year.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

Sgt. Kelly Dunn was unable to be at the meeting to speak so. Cecile O'Connor, Executive Director of Dore Urgent Care and Jo Robinson, Director of Community Behavioral Health Services covered the topics that Sgt. Dunn was going to cover.

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 began her report with a follow up to the discussion about the Wellness and Recovery Model that the board discussed at the December 1, 2012 working retreat. She shared the 35 page report called STUDENT SUCCESS PROGRAM – Progress Report: the First Two Years, August 31, 2010 to June 30, 2012 and the Multi-Site Holistic Wellness Program Evaluation Summary Report November 2012.

Also the Tree of Hope visual was mentioned at the December 2012 board retreat. She explained that the five-foot Tree of Hope, was an innovative simple visual project started at the OMI Family Center (Ocean Mission and Ingleside). The essence of the project was strengthening wellness and recovery through collaborative efforts among all clinics, clients, family members, caregivers, friends and staff. The Tree of Hope is laden with both inspiring and heart-felt messages as leaves, and these leaves are symbols of nurturing and strengthening of communities. The tree is now on full display in the OMI clinic's reception area.

Please see the attached January 2013 Director's report.

Monthly Director's Report January 2013

1. San Francisco State University Releases Two Year Outcome Report on Student Success Program

The College of Health and Human Services at San Francisco State University has received funding through both the Mental Health Services Act (MHSA) and the University to support students who are preparing for careers in public health. Called the Student Success Program, they employ a wrap-around and multidisciplinary approach, assisting students in building a healthy and stable lifestyle while in school. Their services are student driven, focusing on the students' short and long-term goals, individual and environmental strengths and assets, potential challenges to academic success, and the types of supports that they believe would be helpful in navigating the university system. The attached report covers progress from the first two years of the program. (See attachment 1)

2. Outpatient Services Documentation Standards and Practices

The documentation manual is now posted. This manual will be posted at the following web site: <http://www.sfdph.org/> As with any manual, updates will need to be made as policies and regulations change. When updates are distributed, please be sure to replace old sections with updated sections.

3. SFSU Student Success Program: 2-year Progress Report

The Student Success Program (SSP) supports students who are preparing for careers in the behavioral health and the human services, by assisting them in building healthy and stable lifestyles while in school. The goals of the SSP are to increase access, enhance retention and maximize graduation rates among students and family members with lived behavioral health experience. SSP

services are student-driven and include counseling, coaching, advising, crisis intervention, career planning and professional development, peer mentorship, community building and social activities.

Findings revealed over the past 2 years

- Students reporting behavioral health issues are significantly more likely to enumerate a multiplicity of needs & goals related to physical & mental health, academic performance, relationships, as well as financial & material stability
- In the course of students' ongoing relationship with the SSP, they become more interested in serving the community as providers or advocates
- Most frequently presenting issues: challenges related to physical and mental health, getting back on track academically after setbacks related to life stressors, loneliness and isolation
- Services are most effective when implemented in an open-ended fashion over an extended period of time
- Drop-in services are effective, with 1,124 contacts between August 22, 2011 and May 19, 2012

Highlights

- During its first two years of operation, the SSP has served (130) students through intakes and individual services
- 21 students who were served by the Student Success Program (SSP) during its first two years of operation have graduated
- Of those 21 students who graduated, 71% were either employed or were volunteering in a position related to mental health; and 15 identified as consumers or family members
- SFSU was awarded an MHSA Student Mental Health Initiative grant (\$410,000) to provide campus-wide prevention and early intervention programming – including curriculum development and training, peer-to-peer support and suicide prevention – which will substantially increase the reach of the Student Success Program

4. County, State and Federal Initiatives – Child, Youth and Families System of Care

A number of county, state and federal initiatives will define CYF work plan for 2013. Some of these have clear directions, others need more organization but they all involve building strong collaborative relationships internally and externally. These initiatives are:

- Continued integration of Behavioral Health and Primary Care in San Francisco;
- Federal health care reform;
- Improve Substance Use Disorder treatment in CYF;
- Make our EHR user friendly and efficient;
- Integration of Healthy Families into MediCal;
- Implementation of Katie A. statewide (entitlement of at risk or dependent foster care youth to mental health services);
- Continued rollout of Educationally Related Mental Health Services (ERMHS formerly 3632);
- Trauma informed care;

- Indications that EPSDT will become outcome based statewide; and
- Realignment of behavioral health funds to the county from the state.

CBHS Child, Youth and Families System of Care will be working with CBHS leadership, staff and stakeholders to form work plans that will successfully implement these initiatives.

5. Providers 2012

To: All San Francisco Children Youth and Families Providers
From: Ken Epstein

I want to take a moment to say thank you for all the service you provide to the children, youth and families of San Francisco. I know the work we collectively do each day is constantly challenged by internal and external barriers. Yet each day, each one of your agencies and programs, seeks to change something in the lives of the children, youth and families you touch. For this we are grateful.

I have now been Director of Children Youth and Families for over 5 months. My welcoming has been very warm and my learning curve very steep. While I have been involved in the San Francisco system of care for over 25 years, I am humbled by the complexity and challenges inherent in building, sustaining and improving the services we provide. At the same time I feel fortunate to work in such a diverse and vibrant environment of ideas, programs and clinical practices.

In the coming year it is my goal to begin to establish a process of leadership that incorporates all the strengths of the San Francisco community, addresses honestly the barriers and constraints and work towards shaping the entire system to be a model for California and the nation. There is simply no reason why San Francisco should not be the center point for innovation and practice excellence.

Specifically, below are some of the initiatives and processes I intend to oversee as we move towards a shared vision of excellence, participation and success in our provision of behavioral health services to those most in need.

- **Trauma Informed Initiative:** Many of you have participated in the initial meetings to discuss our plan to become a trauma informed system throughout the life cycle. This means that all of our work will be influenced by a foundational understanding of trauma from birth to death, and all service providers from clerk to psychiatrist will have a shared terminology and knowledge about trauma. We are currently finishing the process of vetting the idea with providers, administrators and people with lived experience. In the next five months we will develop a curriculum and a way to deliver the training in a sustainable way. The hope is to begin training by the fall of 2013. In the next six months we will be initiating small acts of change that will infuse the process with excitement and allow us to test out some new ideas.
- **Substance Abuse Treatment for Children, Youth and Families:** Some of you have participated in some conversation about some of the resources and gaps in our current system for treating substance abuse in youth. We have also discussed this issue with our partners at Human Services Agency, Probation and Education. In the coming year we will begin a planning process to look at the gaps and strategize about how to meet the identified needs.

- **Clinical Excellence:** In the coming year we will establish some forums to exchange successes, best practices, innovative models and even failures to learn together how to best build an effective treatment system for the children, youth and families. We are hoping to integrate clinical presentations into the providers meeting quarterly and establish some other forums for sharing best practices.
- **Children, Youth and Family Advisory Group:** I am planning on establishing an advisory group of youth and families with lived experience in a system of care to sort through the ways our system does or does not meet the needs of the folks we serve. I intend to have an organizing meeting in the next 2-4 months and structure the advisory committee around the feedback from the initial focus groups.
- **Providers Meeting:** Provider relations are central to a functional system. Once a month we come together as a system. This meeting has currently been focused on important operational issues. It is equally vital to have a space for us to talk together about the challenges in the system and to strategize about ways to address those challenges programmatically and clinically. I intend to reorganize the providers meeting to meet the ongoing need to address operational needs and develop a place to discuss strategy. *For now I am asking for volunteers to meet with me to discuss how best to do this.* Stay tuned for an announcement for a meeting.
- **Internal organization:** As some of you may know there were three key retirements besides Sai Ling Chan-Sew. We are currently filling these three positions and this will help us operate more efficiently. Currently the managers you interact with daily have been carrying a double load. They have been incredible but we need more support to move the system forward effectively.
- **Integrating county, state and federal initiatives:** Perhaps for those of us that have been in the field for a while we have seen other times with tremendous change in mental health and substance abuse. However, I will argue that the next few years will witness significant change and it will take tremendous effort to not only meet the demands but to exceed them and create a better system of care for our youth and families. Some of the most recent changes involve:
 - Integration of Behavioral Health and Primary Care in San Francisco
 - Federal health care reform
 - The integration of Healthy Families into Medical
 - Implementation of Katie A. statewide (entitlement of at risk or dependent foster care youth to mental health services)
 - The continued rollout of Educationally Related Mental Health Services (ERMHS formerly 3632)
 - Indications that EPSDT will become outcome based statewide
 - Realignment of behavioral health funds to the county from the state
- **Building strong relationships with our county child and youth serving partner agencies:** San Francisco has many multi-agency initiatives and it is this very process that makes our

future so bright. At the same time it is these relationships and the different missions of each agency that can sometimes complicate our collaboration. I will be working on developing a shared vision that allows the agencies to grow collaborative prevention and intervention initiatives and creative funding.

- **Outcomes and performance:** Children’s System of Care has been working for over five years on developing a system wide outcomes and performance evaluation system that begin to inform us collectively about how we are doing, individually how each program and service is doing and most importantly are we impacting the lives of the children, youth and families we serve. Outcomes are a complicated subject and my intention is to present the data we have, discuss it in the aggregate with larger groups, specifically with individual programs and incorporate all of that feedback into a system improvement process. If we do this right together we will be able to use data that we have, incorporate data that you have, and discuss data that may be missing to generate a picture of where our system is today and where we need to improve the system.

These are the highlights of the initiatives I am hoping to support this year and beyond. I am sure that as things go there will always be something that filters from youth and families or from providers or from policy makers that will shift the priorities. However, it is my challenge to keep the overall vision in mind, align that with all of behavioral health and within the context of the Public Health agenda and mission. I look forward to all of your participation going forward.

6. HOPE

The O.M.I. Family Center has been participating in a 15 month long statewide learning collaborative sponsored by the California Institute of Mental Health. The O.M.I. Family Center is one of 17 teams throughout California who are working together to learn how to advance Wellness and Recovery Practices into our daily clinical work.

The “Tree of Hope” project was born out of the idea of creating a collaborative project for all clinic clients, family members, caregivers, friends and staff to complete together that would build awareness of the importance of strengths in our lives and in particular in our path to wellness and recovery.



The first image is of our 5 foot felt tree entitled “Growth of Hope” which was located in the clinic waiting room. Each leaf on the tree is a strength which was identified by a client, family member, friend, or staff as being important to them. Each person who came into the waiting room was given the opportunity to choose a leaf and to write a strength that they presently have or one that they wish to develop. This very simple idea generated many heartfelt responses and really demonstrated the importance of hope in all of our lives.

This week, the state officially began the transition of Healthy Families Program enrollees to Medi-Cal. As you may recall, last year's budget trailer bill (AB 1494) required the state to obtain federal approval *prior to* the start of the Healthy Families transition. The federal approvals necessary were amendments to California's existing Section 1115 "Bridge to Reform" waiver, as well as the state's Medicaid Title 19 State Plan. The amendments to the 1115 waiver, effective January 1, 2013, will secure enhanced federal funding for Medi-Cal primary care providers January 1, 2013 to December 31, 2014, and ensure no violations of Medicaid rules pertaining to comparability. The Title 19 State Plan Amendment (SPA) will add the new coverage group (previously the Healthy Families Program) to the Medi-Cal program. Once approved, the effective date of the Title 19 SPA will be September 1, 2013.

The 1115 waiver requirements for "monitoring" the transition are incorporated in the approved, amended "Special Terms and Conditions." According to Department of Health Care Services (DHCS), the monitoring framework will ensure minimal disruption in access to services for children transitioning, and will "provide a process for ongoing data collection, analysis, and a means by which the Department can make adjustments to transition schedules in order to ensure access to and continuity of care. The monitoring will focus on the extent to which the health and dental plans, behavioral/mental health services, and alcohol and substance use services are meeting the needs of the transitioned children and the extent to which eligibility is maintained for these children."

After receiving federal approval of California's existing federal Section 1115 waiver on December 31, 2012, approximately 197,000 children in phase 1-A counties were officially transitioned to Medi-Cal on January 1. Phase 1-A counties (where children are enrolled in a Healthy Families health plan that is also a Medi-Cal managed care health plan in their county) include: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego. The next group of such children in phase 1-B (approximately 95,000 children) are slated to transition to Medi-Cal on March 1. However, prior to initiating each phase, the state must release an implementation plan that describes health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

9. Primary Behavioral Health Care Integration - South of Market Behavioral Health Clinic

The San Francisco Department of Public Health was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Primary Behavioral Health Care Integration (PBHCI) for consumers with serious mental illness (SMI). The grant funding is supporting integration of care and the creation of a health home for clients at South of Market Mental Health Services (SOMMHS). Because the program includes a tremendous amount of technical support and funding for evaluation, we anticipate that this program will serve as a model for DPH in its ongoing efforts to integrate services.

SAMHSA's Goals

The purpose of SAMHSA's program is to support the delivery of coordinated and integrated mental health and primary care services. The goal is to improve the physical health status of

adults with SMI who have, or are at risk for, co-occurring primary care conditions and chronic diseases. Such services support the triple aim of improving the health of those with SMI; enhancing the consumer’s experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care. The program’s goals are:

- Improved access to primary care services;
- Improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease;
- Increased availability of integrated, holistic care for physical and behavioral disorders; and
- Better overall health status of clients.

Grant Objectives

1. Serve 550 clients with SMI who were referred by clinicians at SOMMHS (SFFIRST, ISC, FACT, etc)
2. Provide routine screening (BP, HgbA1c) and twice annual primary care visits
3. Provide all clients with RN care coordinator
4. Develop and implement wellness activities
5. Create integrated data systems
6. Facilitate integrated care (case conferences, information sharing, huddles, etc)

Clients seen through PBHCI to date

~35% of SFFIRST clients are enrolled in onsite primary care
 ~ 5% of ISC clients are enrolled in onsite primary care

On average, clients have been open at SOMMHS or SFFIRST for more than two years and receiving onsite primary care for more than one year.

Open	With primary care at matched DPH clinics *	With primary care onsite
175 (SFFIRST)	105	65
1072 (SOMMH outpatient)	476	77
*TWHC, HUH, SOM, SEHC, Glide, Potrero Hill, Castro Mission, MNHC		

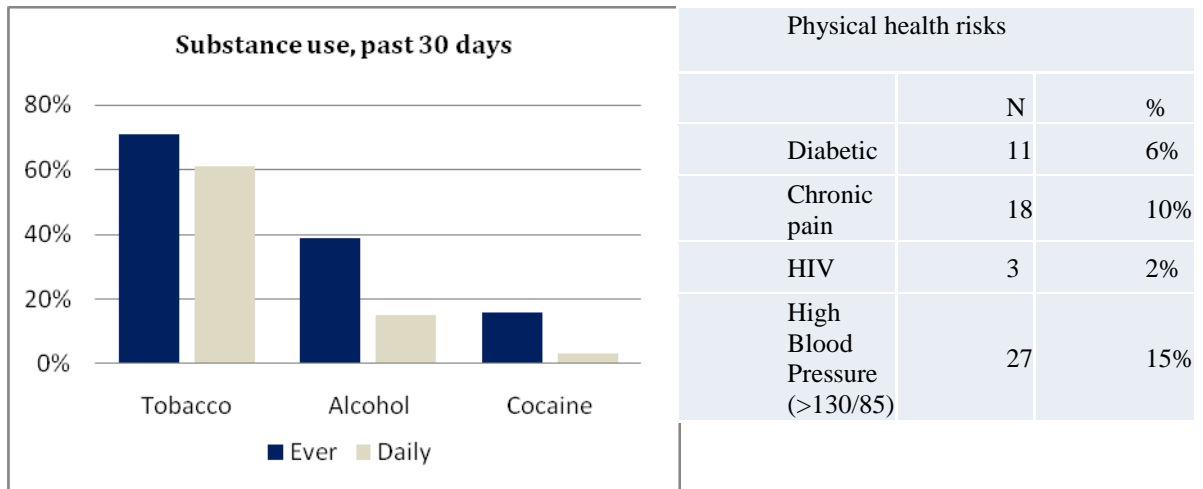
To meet grant goals, more than 10 clients per month need to be referred & enrolled in PBHCI

Since July, about 5 clients per month have been enrolled

Based on our measures, this is what we can know about clients served to date:

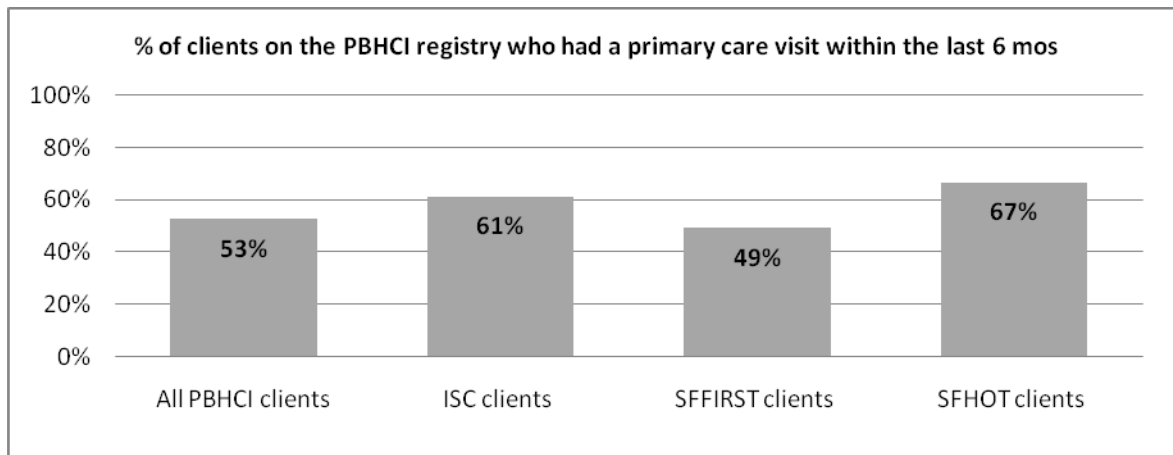
- ✓ Most are daily smokers

- ✓ 6% are at significant risk of metabolic syndrome
- ✓ The most common principal diagnosis is schizophrenia (47%)
- ✓ Over 40% were admitted to PMR or EMR in the past 12 mos & many had multiple hospital stays
- ✓ About half show symptoms of trauma & 1 in 5 were depressed most of the past 30 days
- ✓ Most would rate their health as good or better



And about services:

- ✓ 53% of PBHCI clients had blood pressure as part of primary care visit in the past 6 mos
- ✓ 51% of PBHCI clients had HgbA1c drawn as part of primary care visit in past 12 mos
- ✓ 43% of PBHCI clients had fasting labs drawn as part of primary care visit in past 12 mos



10. Men and Women Are Helped Differently by Alcoholics Anonymous

Men and women benefit in different ways from Alcoholics Anonymous (AA), a new study suggests.

Men benefit more from avoiding companions who encourage drinking and social situations in which drinking is common, according to Health24. Women benefit from the program by having increased confidence in their ability to avoid alcohol when they feel sad, anxious or depressed.

“Men and women benefit equally from participation in AA, but some of the ways in which they benefit differ in nature and in magnitude,” lead researcher John F. Kelly, PhD, of the Massachusetts General Hospital Center for Addiction Medicine said in a news release. “These differences may reflect differing recovery challenges related to gender-based social roles and the contexts in which drinking is likely to occur.” One-third of AA’s members are women, the article notes.

The researchers studied more than 1,700 participants in AA, 24 percent of whom were women. They were enrolled in a study called Project MATCH that compared three alcohol addiction treatment approaches. The study tracked participants’ success in maintaining sobriety and whether they attended AA meetings. It also evaluated specific measures, such as participants’ confidence in their ability to stay sober in certain situations.

In both men and women, AA participation increased confidence in the ability to deal with high-risk drinking situations, and increased the number of social contacts who supported their recovery efforts. For men, the effect of both of those changes on the ability to stay sober was twice as strong, compared with women in the study. Women were much more likely than men to benefit from improved confidence in their ability to stay away from alcohol when they were sad or depressed.

11. Consumer Portal Surveys

Behavioral Health Information Systems is looking forward to implementing the Consumer Portal in mid 2013. We look forward to continuing our partnership with RAMS vocational programs in implementing the Consumer Portal. We have been actively working with the Client Council and RAMS staff to develop a Consumer Portal Survey aimed to assess the computer use among clients. Please be on the lookout for the survey and encourage your clients to complete them. Those of you who attended the Adult Provider meeting were able to pick up paper versions of the survey in the threshold languages. Electronic versions will be sent out this week. For more information, please contact pablo.m.munoz@sfdph.org.

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

1.2 Public Comment

No public comment.

ITEM 2.0 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.

2.1 Mental Health Services Act Updates

Ms. Robinson announced that an RFQ was released recently to suggest how to make clinics more welcoming and community friendly. Vocational clients are provided opportunities to learn about painting and laying carpets, and the budget for remodeling some clinics is estimated to be about \$250,000.

Ms. Landy inquired about the Sandy Hook School shooting and the December 24, 2012 shootings in New York and wondered about the preparedness in San Francisco.

Ms. Robinson said that the San Francisco Crisis Team does not normally work after hours but have extended their services in response to the shootings. The Department of Children Youth and Families (DCYF), and Family Youth Services have campus crisis staff who made home visits to people in distress.

She mentioned that CBHS turned press calls over to the Mental Health Association (MHA) of San Francisco, and Eduardo Vega, Executive Director of MHA-SF, recently was on NPR (National Public Radio).

She said that San Francisco County does not take a position on Laura's Law, and its implementation for the county is up to the San Francisco Board of Supervisors.

Mr. Wishom mentioned that 938 Mission St. is a beautiful building.

Ms. Robinson said that, as of 2012, Homeless Connect is available and accessible daily.

2.2 Public comment

No public comment.

ITEM 3.0 PRESENTATION: OVERVIEW OF SERVICES AVAILABLE AND SYSTEM RESPONSE TO ADULTS AND JUVENILES IN CRISIS IN SAN FRANCISCO: KARA CHIEN, MENTAL HEALTH BOARD MEMBER AND SF PUBLIC DEFENDER AND SGT. KELLY DUNN, MENTAL HEALTH BOARD MEMBER AND SF POLICE SARGEANT.

3.1 Presentation: Overview Of Services Available And System Response To Adults And Juveniles In Crisis In San Francisco: Kara Chien, Mental Health Board Member And SF Public Defender And Sgt. Kelly Dunn, Mental Health Board Member And SF Police Sergeant.

Ms. Argüelles introduced the following persons. Kara Chien is a member of the Mental Health Board and a San Francisco deputy public defender who is the Mental Health Unit managing attorney. Cecile O'Connor is the Executive Director of Dore Urgent Care. Jo Robinson, now the Director of Community Behavioral Health Services, was formerly the executive director of Jail

Psychiatric Services. The presenters will provide an overview of crisis response services for adults and juveniles in crisis.

Ms. O'Connor is an RN, and prior to her current position she was with San Francisco General Hospital's Psychiatric Emergency Services (PES). She is now the Executive Director for DUCC (Dore Urgent Care Clinic) which was opened in 2008. Like PES, Dore/DUCC is another triage clinic that does assessment and provides stabilization for clients in an acute border-line escalating psychiatric crisis. Both PES and DUCC/Dore are 24x7 and medically staffed centers. Unlike PES, DUCC is for clients who do not require involuntary treatment, seclusion or restraint. DUCC accepts clients brought in by county behavioral health providers, all law enforcement agencies from SFPD to CHP to Campus Police and Mobile Crisis.

Although PES has seen about 500 people per month, hospitalization has reduced. This reduction is attributed to a greater collaboration in the last five years between PES and Dore where acute border-line escalating crises are triaged quickly to prevent a full-blown debilitating psychosis.

As of January 1, 2013, the EST (Engagement Specialist Team) program targets people known as higher users of multi-service systems because these people have chronic, severe and persistent mental illness coupled with physical problems but they have difficulty staying engaged in treatment and/or services.

Dore works with TAP (Treatment Access Program). San Francisco has more people 5150'd than other counties in the State of California. Progress Foundation has crisis component and ADU (Acute Diversion Unit), one of the 10 programs in Progress Foundation.

Ms. Landy asked what happens if DUCC clients will not stay engaged voluntarily.

Ms. O'Connor stated that PES will step in, if necessary. However, none of Dore clients have ever been referred to PES.

Dr. David Lewis asked for the number of 5150 cases per year.

Ms. O'Connor stated that she does not have the 5150 statistics. She suggested that Sgt. Dunn would be the one with the tracking database.

Dr. David Lewis asked how many nights has Dore turned away people.

Ms. O'Connor stated that the current capacity is four clients per licensed staff.

Ms. Virginia Lewis asked about the outcome statistics on discharged clients.

Ms. O'Connor stated that statistics are electronically maintained.

Ms. Virginia Lewis asked about how many discharged clients return to their homes or go into residential care facilities.

Ms. O'Connor stated that the Avatar system tracks that information.

Ms Robinson said that ADU might provide the after-discharge statistics.

Ms. O'Connor added that CBHS maintain the statistics to be available for Medicare and MediCal.

Dr. Patterson asked what happens to a person with escalating crisis from a private home.

Ms. O'Connor said that anyone presented to the DORE Urgent Care Clinic is triaged and Mobile Crisis can bring in clients too. SFPD has used SFGH more the DUCC.

Mr. Wishom speaking on behalf of consumer advocates testified that DORE was very good and effective in stabilizing him including providing after care services and follow up support.

Please see the power point presentation prepared by Ms. Kara Chien at the end of the minutes.

Ms. Chien has been a Deputy Public Defender for 23 years. She has been working exclusively in the Mental Health Unit for 12 years. She represents mentally ill clients in both civil and criminal commitment proceedings. She represents patients being held in SFGH for involuntary treatment due to mental disorder. She represents clients in forced medication hearings, also known as Reise hearings. She also represents clients in forensic commitment where her clients are being confined in state hospitals because they were found not guilty by reason of insanity.

She explained that usually when people with mental illness are taken into police or sheriff custody, they often arrived at County Jail No.1 where JPS (Jail Psychiatric Services) can triage them immediately and placed them in County Jail No. 5 located in San Bruno with follow-up psychiatric treatment. The courts may release the mentally ill defendant with a follow-up referral for appropriate services during the pendency of the criminal proceedings. If the person requires medical attention while in custody, then that person is transferred to San Francisco General Hospital (SFGH) Unit 7D for medical treatment. If a person is found to be acutely psychotic while in custody, then that person is transferred to SFGH Unit 7L for psychiatric evaluation and treatment. JPS can assess for clinical appropriateness and recommend clients for the Behavioral Health Court (BHC) as well. Essentially, JPS provides psych housing, treatment and referrals for mentally ill defendant in custody.

In misdemeanor cases, if a mentally ill defendant is found to be incompetent to stand trial, then referrals are made to a locked psychiatric facility for stabilization until the defendant becomes trial competent. Sometimes if they have misdemeanor charges and chronic mental illness, but have strong family support and strong connection with their community providers, then a referral can be made for these clients to live in the community while continuing with psychiatric treatment. In felonious cases, unfortunately in most cases, defendants are sent to the state hospitals for treatment to regain their trial competency.

Juveniles are treated differently. The court may release a juvenile defendant back to home or a residential facility like Edgewood if the minor is found to be incompetent to stand trial. Some mentally ill juvenile may be sent to McCauley (St. Mary's Hospital) for brief involuntary treatment or Metropolitan State Hospital for long-term treatment, although the latter type of hospitalization is very rare. It is more common for juveniles who are 17.5 years old to be transition into adult mental health system. Once they become 18 year old, they will be able to access services provided by CBHS.

For individuals who may have capacity to stand trial with severe mental illness, BHC which was created in 2002 in response to the increasing numbers of mentally ill defendants cycling through the jail and court system. The mission of BHC is to enhance public safety and reduce recidivism of criminal defendants who suffer from serious mental illness by: 1) connecting them with community treatment services; 2) finding the appropriate dispositions to the criminal charges; and 3) requiring regular check-ins with the court. BHC is a collaborative effort of the San Francisco Superior Court, Office of the District Attorney, Office of the Public, Defender, Adult Probation Department,

Department of Public Health, Jail Psychiatric Services, Jail Aftercare Services, UCSF Citywide Case Management Forensics and the Sheriff's Department.

Ms. Wishom testified that BHC placed him in community care which helped him in his wellness and recovery, empowered him to enjoy a fuller and more productive life and graduated him from the program. Now, he leverages his lived experiences to be on the board to offer hope to people suffering from mental illness.

Ms. Chien stated that BHC is a nation model. The San Francisco Community Justice Center (CJC) created in 2009. The Center is geographically based court serving in the Tenderloin, Civic Center, and Union Square and SOMA neighborhoods. The Center is a court program and social service center that addresses the primary issues facing criminal defendants. Working in partnership with city agencies and community groups, the center values accountability and immediate intervention to prevent cycles of recidivism while improving the lives of CJC clients and community residents. A defendant at CJC has the same legal right as a defendant in criminal court.

The Wellness Court locates in the Juvenile Justice Center. The primary goal is to connect minors with severe emotional and developmental issues to the community-based providers and to receive appropriate services. GGRC (Golden Gate Regional Center) provides services and supports to minor with developmental disabilities. Minors who are confined in the Juvenile Justice Center are rarely sent to McCauley for involuntary treatment. Each year, only one to two minors are sent to hospital from the Center for acute inpatient psychiatric treatment.

A portion of the California Welfare & Institutional Code addresses community mental health services. The Lanterman Petris Short Act (LPS), California Welfare and Institutions Code Sections 5000-5550, cover the services and treatment provided to individuals who are found to be gravely disabled. The following hospitals such as CPMC, Langley Porter, St. Francis, SFGH and Jewish Home are designated facilities to provide involuntary treatment. Jewish Home provides treatment for geriatric patients who are gravely disabled and needs conservatorship services. Welfare and Institutions Code (WI Code) Section 5150 provides for a 72- hour hold for involuntary evaluation and treatment, and WI Code §5120 provides for a 14-day hold for further involuntary evaluation and treatment. A peace officer, mobile crisis team member, member of the staff evaluating facility, or other professional person as defined by the county may initiate 5150 hold. Minors with grave disability as a result of mental illness are not mixed with adults in terms of housing in a hospital setting. Each minor who is detained must receive a clinical multidisciplinary evaluation by properly qualified professionals, and the minor's family or living environment must also be evaluated; an after-care plan must be developed for each minor who is considered for release from involuntary treatment.

If the treatment team finds the patient is still gravely disabled, the team will file a recommendation and petition for temporary conservatorship (30 days). During the 30-day temporary conservatorship, if the patient is still found to be gravely disabled and unable to manage his or her basic needs such as food, clothing and shelter, a permanent conservatorship may be established. The duration for the permanent conservatorship is one year. It is renewable annually.

Community Independent Pilot Project (CIPP) is a pilot project, which provides individuals who are gravely disabled to be placed on LPS Conservatorship with community placement. Generally, the LPS conservatees are initially placed in civilian locked facilities for treatment and stabilization. LPS-CIPP is an innovative two-year program with about 7 participants. Before becoming director of CBHS, Jo Robinson was with JPS and brought CIPP to fruition to provide clients with both

conservatorship and medication therapy in the community rather than in a locked facility. The CIPP participants have the same legal right to judicial review provided by WI Code. The spirit of CIPP is to provide the least restrictive placement for the conservatees and the most humane way to help participants avoid cycles of de-compensation, which sometimes results in loss of independence and re-hospitalization.

Ms. Lewis asked about criteria for CIPP referrals.

Ms. Chien said that a client with multiple repeated hospitalizations in a short time period is one of the key criteria for CIPP referrals.

Ms. Robinson added that CIPP is a voluntary program with collaboration between the Office of Conservatorship Services, the Department of Public Health Placement Team, the Offices of the Public Defender and the District Attorney.. Other people include co-ordination with physicians and psychologists who specialize in mental health treatment, community mental health providers and the San Francisco Superior Court.

Ms. Robinson San Francisco provides three comprehensive crisis units working in the same building. Child Comprehensive Crisis located in BVHP (Bayview Hunter's Point) operates on a daily 24x7 schedule. Mobil Crisis responded to adults six-days per week until 11 PM, but they stop accepting call at 10 PM in order to adequately wrap up any currently outstanding crises. And the Crisis Intervention Response Team handles homicides and extreme violent cases.

Ms Miller asked if the comprehensive crisis system is different than CRN.

CRN is the Community Response Network to address youth gang violence issues by incorporating existing neighborhood services, funded programs and coordinating these efforts across programs and agencies. The CRN was founded in the Mission District in 2004. It is also known as the Southeast CRN. The Community Care Response Team is available for support at the crime scene, the hospital, in the home, or in the neighborhood. The CRN Initiative focuses its work in three core service areas:

- *Care management services and development*
- *Street level outreach*
- *Crisis response/healing strategies*

Ms Vinh asked about volunteer opportunities for crisis services.

Ms. Robinson said “No formal program for volunteers yet but we do have peer services”.

3.2 Public comment

No public comment.

ITEM 4.0 ACTION ITEMS

For discussion and action

4.1. Public comment

No public comment.

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of November 14, 2012 be approved as submitted.

Unanimously approved.

4.3 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board Retreat on December 1, 2012 be approved as submitted.

Unanimously approved.

ITEM 5.0 REPORTS

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

Ms. Brooke announced that at the December 2012 Working Retreat the board decided to focus program reviews on programs and services in the Bayview Hunter's Point or the Southeast Sector of San Francisco.

She announced that at the December 7th, 2012 Consumer and Family Member Conference the board taped a video titled "Creating a Safe Space".

She also suggested to the board that any board member could do short public video on his/her board interests.

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

Ms. Argüelles hoped everyone had a pleasant holiday and are ready to meet with members of the Board of Supervisors and do program reviews. The retreat went very well. It was a beautiful location, great food and having Michelle Magee from the Harder Company donate her time to facilitate made it a very good experience for all.

The Executive committee meets Thursday, January 17th at 6:30 at 1380 Howard Street in Room 515. All board members are welcome to attend the meeting as well as members of the public.

5.3 Report from Nominating Committee, Chair: Wendy James

Ms. Argüelles said that the nominating committee will announce the slate of officers nominated for 2013, to be voted on at the February 2013 meeting. Additional nominations can be made from the floor as well.

She said that Wendy James chaired the Nominating Committee which met in November 2012 to select a slate of officers to be elected in February 2013. She has termed out as Chair and additional nominations can be made from the floor as well.

No nominations from the floor were made today.

She also mentioned that the nominating committee decided to try something a little different this year so as to give more people the opportunity to develop leadership roles on the Mental Health Board. Instead of a single Chair and Vice Chair position, they nominated two co-chairs and two co-vice chairs, and one secretary. Here is the slate which will be voted on at the February 13th, 2013 meeting. Additional nominations can be made from the floor in February as well.

Co-Chairs: Virginia Lewis and Terence Patterson

Co-Vice Chairs: Ellis Josephs and Wendy James

Secretary: Dr. David E. Lewis

5.4 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.

Ms. Argüelles asked if there are any people or issues that board members would like to suggest to the Executive Committee for highlighting at the November 2012 meeting.

Dr. David Lewis said he was contacted by a BART representative who would like to do a presentation to the board on AB716. He believed that AB716 implementation would give BART cart blanche to socio-profiling people with mental illness. And he is against AB716 because stigma and discrimination are being disguised as a public safety in BART's "Stay Away" Safety program.

"How are non-violent people with mental illness being a threat to BART's public safety", he wondered!

5.5 Report by members of the Board on their activities on behalf of the Board.

Ms. Miller submitted the Trauma Summit report from the November 13, 2012 Trauma Summit. She reported that she met with Supervisor Malia Cohen and brought up issues that were mentioned in the summit.

Ms. Wishom reported that he, Mr. Vinh, Ms. Chien and Ms. Arguelles and board staff attended the December 7th 2012 Consumer and Family Member Conference.

Dr. Patterson reported the he will meet with Supervisor David Campos next week and plans to talk to the supervisor about findings at the Southeast Trauma Summit.

Ms. Lewis plans to meet her supervisor and would like to talk about the Southeast Trauma Summit with her supervisor.

Ms Landy mentioned that San Francisco supervisors have a Face book presence and they can be contacted that way too.

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

Ms. Argüelles suggested an invitation to the BART representative to the January 17th, 2013 Executive Committee meeting.

5.7 Public comment.

No public comment.

ITEM 6.0 PUBLIC COMMENT

No public comment.

ADJOURNMENT

Meeting adjourned at 8:15 PM.



OVERVIEW OF ADULTS AND JUVENILES IN CRISIS

INTERACTING WITH
THE CRIMINAL JUSTICE SYSTEM
&
THE MENTAL HEALTH SYSTEM



CRIMINAL JUSTICE SYSTEM

- Jail Psychiatric Services
 - Housing
 - Treatment
 - Referral for services
- Incompetent to stand trial
 - Adults
 - Juveniles

CRIMINAL JUSTICE SYSTEM

- BEHAVIORAL HEALTH COURT (BHC)
 - Eligibility – Axis 1 diagnosis
 - Program entry is at the discretion of the District Attorney
 - Limited to criminal cases in which the behavior that led to the offense was related to mental illness

CRIMINAL JUSTICE SYSTEM

- THE SAN FRANCISCO COMMUNITY JUSTICE CENTER (CJC)
 - Tenderloin, Civic Center, Union Square and SOMA neighborhoods
 - Format - court program and social service center
 - Goals – accountability and immediate intervention to prevent cycle of recidivism

CRIMINAL JUSTICE SYSTEM

- WELLNESS COURT
 - Juvenile Justice Center
 - Minors with severe emotional and developmental issues

PSYCHIATRIC COURT

- California Welfare & Institutions Code
- Lanterman-Petris-Short Act (LPS Act)
 - Individuals who are gravely disabled
 - Who are in need of treatment but are unwilling or incapable of accepting it voluntarily; and
 - Who are recommended for conservatorship by the professional in charge of an LPS evaluation or treatment facility designated by the county

PSYCHIATRIC COURT

- WI CODE §5150 – 72 hour hold
 - Legal criteria – “Grave disability” defines as “ a condition in which a person, as a result of mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.”

PSYCHIATRIC COURT

- WI Code §5250 – additional 14 day hold for further treatment
- Legal criteria – The patient is, as a result of mental disorder or impairment by chronic alcoholism, a danger to others, or to himself or herself, or gravely disabled.

PSYCHIATRIC COURT

- Temporary Conservatorship (WI Code §5352.1)
 - Legal criteria – Any person who is gravely disabled as a result of a mental disorder, or impaired by chronic alcoholism.

PSYCHIATRIC COURT

- Permanent Conservatorship
 - Conservatorship based on “graved disability”
 - Conservatorship based on “a substantial risk of harm to others” (a.k.a. Murphy Conservatorship)
 - a trial incompetent defendant is found not to have a substantial likelihood to regain trial competence

PSYCHIATRIC COURT

- LPS CONSERVATORSHIP – COMMUNITY INDEPENDENT PILOT PROJECT (CIPP)
 - Conservatee lives in community
 - Conservatee does not have a right to refuse psychiatric medication
 - Conservatee works closely with his or her case manager and outpatient team
 - Conservatee checks in regular with the presiding judge regarding his or her progress