



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Notes

Mental Health Board

Wednesday, March 13, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

BOARD MEMBERS PRESENT: M. Lara Siazon Argüelles, Chair; Ellis Joseph, MBA, Vice Chair; David Elliott Lewis, Ph D, Secretary; Sgt. Kelly Dunn; Kara Chien, JD; Virginia S. Lewis, LCSW, MA; Lena Miller, MSW; and Terence Patterson, EdD, ABPP.

BOARD MEMBERS ON LEAVE: Wendy James; Alyssa Landy, MA; Alphonse Vinh and Errol Wishom.

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); LaVaughn Kellum King; Jo Elias Jackson; Dale Milfay; Crystal Marsonia, Westside Cal-Works Counseling Services; San Francisco Sheriff Ross Mirkarimi; Mahanadi Clay; Vivian Impernale; Brenda Barros, SEIU 1021; Teresa Luokuot; Pastor Daniel Solberg, St. Paulus Lutheran Church; Domingo McFaul; Minister Andreus Pielhoop; Brian Tseng, POC (Physicians Organizing Committee) Operations Manager; Geoffrey Wilson, MD, President of POC; Brenda Barros; Scott Weaver; Dale Milfay, Andrea Feloe and six members of the public.

CALL TO ORDER

Ms. Argüelles called the meeting of the Mental Health Board to order at 6:42 PM.

ROLL CALL

Ms. Brooke called the roll. Quorum was not attained.

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.

Please see the attached March 2013 Director's report.

Ms. Robinson highlighted the following items included in the March Director's report.

She said that the Triple P – Positive Parenting Program has evolved over the past 35 years. On February 20, 2013 David Bornstein from the New York Times wrote the Benefits of Positive Parenting (<http://opinionator.blogs.nytimes.com/2013/02/20/helping-the-parents-to-spare-the-children/>).

The smoking rate between adults with mental illness and adults without mental illness is 70% higher. Smokers with mental illness smoke more cigarettes (331 vs. 310 cigarettes per month) than smokers without mental illness. Both groups have the same desire and ability to quit smoking.

She announced that since September 2012, Chinatown North Beach Mental Health (CTNB) clinic has provided services in smoking reduction/cessation. By incorporating mindfulness exercises with peer support and education, the clinic has seen positive results.

She stated that as a result of the Katie A statewide lawsuit, Children Youth and Families (CYF), Human Services Agency (HSA) and child welfare did a two day inter-departmental planning summit on March 4th and March 5th, 2013.

She said that, unfortunately, the public at large still has a much distorted view of mental illness. Such a distortion has further stigmatized, and marginalized people with mental illness, including persecution and disenfranchisement. It is fallacious to believe that people with mental illness commit more violent crimes than people without mental illness do. In fact, more often than not people with mental illness are easy targets for victimization and exploitation. She hoped that the new modified Associated Press Stylebook, which is often used by journalists and people in the media will increase public awareness on mental illness.

She talked about dialectical behavior therapy (DBT) which was founded in the early 1990's by Dr. Marsha M. Linehan. Although DBT originally addressed symptoms of borderline personality disorder, recently, DBT has been effective in treating patients who present varied symptoms and behaviors associated with spectrum mood disorders including schizophrenia. Recent works suggests DBT effectiveness in helping sexual abuse survivors and clients/patients with chemical dependency.

The independent External Quality Review Organization (EQRO) conducted a three-day review last month. In about three months, she expects the report on the review which she believes will be positive.

On May 15, 2013, Richmond Area Multi-Services (RAMS) instead Community Vocational Enterprises (CVE) will be funded by CBHS to provide vocational training for people with mental illness. Since 2011, CVE has been on a corrective action plan due to its financial decline. But, we expect them to re-contract with CBHS in about 18 months after the program reaches sustainable financial stability.

Dr. David E. Lewis inquired as to how San Francisco ranked among other California counties and Medi-Cal eligibility, which is Medicaid in California, during the EQRO review.

Ms. Robinson stated that the EQRO brought and shared lots of comparative data. But the State of California only reports on San Francisco Medi-Cal population. Comparing to other California counties, San Francisco has a higher 30-day hospital readmission rate as San Francisco has spent more money on diagnosing psychoses. The final report from the EQRO will be available on the public website.

Mr. Joseph commented that the \$2,000 Medi-Cal ceiling has resulted in people revolving in-and-out of Medi-Cal eligibility and services.

Ms. Robinson stated that the new Obama Care in 2014 should provide a bridge extending Medi-Cal eligibility up to the 138% FPL rather than the current 133% FPL.

Monthly Director's Report March 2013

1. ASPE Research Brief Estimates ACA will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans

The U.S. Department of Health and Human Services (HHS) has issued through its Office of the Assistant Secretary for Planning and Evaluation (ASPE) an ASPE Research Brief, "*Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*," explaining how the ACA "will provide one of the largest expansions of mental health and substance use disorder coverage in a generation." The report notes that – overall – some 62.5 million Americans will "benefit from federal parity protections as a result of the ACA." These Americans include 11 million who are currently in individual plans, 24.5 million now in small-group plans, and 27 million who are currently uninsured, all of whom will be required under the EHB final rule to have mental health and substance use disorder coverage as one of 10 required benefit categories.

2. New York Times Does a Story about Triple P

In February, Stephanie Romney, PhD, Director of The Parent Training Institute, was interviewed by David Bornstein, a reporter with the New York Times, about Triple P. The story came out in the 2/20/13 paper and it does a nice job of highlighting both the science behind the intervention and the positive impact that it has on families. Here is the link:

<http://opinionator.blogs.nytimes.com/2013/02/20/helping-the-parents-to-spare-the-children/>

3. Mental Health Association of San Francisco and San Francisco's Suicide Prevention to Begin Suicide Attempt Survivor's WRAP Support Group

MHASF and San Francisco Suicide Prevention are proud to announce the first Suicide Attempt Survivor's WRAP Support Group, which will begin in April. For more information contact:

Mental Health Association of San Francisco

Contact: Jennifer Awa

Phone Number: 415-341-9507

4. Kidney Failure Related to Synthetic Marijuana

16 cases of kidney failure related to synthetic marijuana have been reported by poison control and emergency rooms from Kansas, Oklahoma, Oregon, New York, Rhode Island and Wyoming. Products similar to marijuana, called 'cannabinoids' are sometimes sold online, so they could cause problems in any state. Some names for these products are K2, spice, lava, flame, Mr. Happy, clown loyal, etc. Young people sometimes use these substances, thinking they are safer than marijuana and 'legal'. The ages of the persons who developed kidney failure ranged from 15 to 33, and some of them needed dialysis. If you serve an adolescent and young adult population, you may want to post an alert in your office.

5. Sacramento Bee Writes about San Francisco's Library Social Worker Program

<http://www.sacbee.com/2013/02/17/5196254/san-francisco-library-offers-refuge.html>

6. Treatment Episode Data Set - Discharges aged 12 and Older from Substance Abuse Treatment Programs

This report presents results from the Treatment Episode Data Set (TEDS) for **discharges aged 12 and older from substance abuse treatment in 2009**. The report provides information on treatment completion, length of stay in treatment, and demographic and substance abuse characteristics of discharges from alcohol or drug treatment in facilities that reported to individual State administrative data systems. Some highlights of the report:

Discharges by Type of SA Service

Of the 1,620,588 discharges aged 12 and older in 2009:

- 42 percent were discharged from outpatient treatment
- 20 percent were discharged from detoxification
- 12 percent were discharged from intensive outpatient treatment
- 11 percent were discharged from short-term residential treatment
- 8 percent were discharged from long-term residential treatment
- 6 percent were discharged from medication-assisted (i.e., using methadone or buprenorphine) opioid therapy or detoxification
- Less than 1 percent were discharged from hospital residential treatment

Reasons for Discharge

Of the 1,620,588 discharges aged 12 and older in 2009:

- 47 percent of the discharges completed treatment
- 14 percent of the discharges were transferred to further treatment
- 25 percent of the discharges dropped out of treatment
- 7 percent of the discharges had treatment terminated by the facility
- 2 percent of the discharges were incarcerated
- 6 percent of the discharges failed to complete treatment for other reasons

**Percentages do not sum to 100 percent because of rounding.*

Treatment Completion by Service Type

The treatment completion rate was 47 percent for discharges aged 12 and older from all service types

combined. For individual service types, treatment was completed by:

- 66 percent of discharges from detoxification
- 59 percent of discharges from hospital residential treatment
- 52 percent of discharges from short-term residential treatment
- 49 percent of discharges from medication-assisted opioid detoxification
- 46 percent of discharges from long-term residential treatment
- 42 percent of discharges from outpatient treatment
- 35 percent of discharges from intensive outpatient treatment
- 14 percent of discharges from outpatient medication-assisted opioid therapy

Median Length of Stay (LOS)

The median LOS in treatment by type of service was:

- 161 days for discharges from outpatient medication-assisted opioid therapy
- 92 days for discharges from outpatient treatment
- 60 days for discharges from intensive outpatient treatment
- 59 days for discharges from long-term residential treatment
- 22 days for discharges from short-term residential treatment
- 13 days for discharges from hospital residential treatment
- 6 days for discharges from medication-assisted opioid detoxification
- 4 days for discharges from detoxification

The median LOS by type of service, limited to only those who completed treatment, was:

- 197 days for discharges completing outpatient medication-assisted opioid therapy
- 124 days for discharges completing outpatient treatment
- 90 days for discharges completing long-term residential treatment
- 85 days for discharges completing intensive outpatient treatment
- 27 days for discharges completing short-term residential treatment
- 19 days for discharges completing hospital residential treatment
- 5 days for discharges completing medication-assisted opioid detoxification
- 4 days for discharges completing detoxification

For the full report, please go to: <http://www.samhsa.gov/data/2k12/TEDS2009N/TEDS09DWeb.pdf>

7. Smoking among U.S. adults with mental illness 70 percent higher than for adults with no mental illness – assessment and intervention is important

Studies show need for enhanced prevention and quitting efforts for people with mental illness.

Adults with some form of mental illness have a smoking rate 70 percent higher than adults with no mental illness, according to a Vital Signs report released today by the Centers for Disease Control and Prevention in collaboration with the Substance Abuse and Mental Health Services

Administration (SAMHSA). The report finds that 36 percent of adults with a mental illness are cigarette smokers, compared with only 21 percent of adults who do not have a mental illness.

According to the report, nearly 1 in 5 adults in the United States – about 45.7 million Americans—have some type of mental illness. Among adults with mental illness, smoking prevalence is especially high among younger adults, American Indians and Alaska Natives, those living below the poverty line, and those with lower levels of education. Differences also exist across states, with prevalence ranging from 18.2 percent in Utah to 48.7 percent in West Virginia.

Combined data from SAMHSA’s 2009–2011 National Survey on Drug Use and Health (NSDUH) were used to calculate national and state estimates of cigarette smoking among adults aged 18 years and older who reported having any mental illness. Mental illness was defined as having a diagnosable mental, behavioral, or emotional disorder, excluding developmental and substance use disorders, in the past 12 months.

“Smokers with mental illness, like other smokers, want to quit and can quit,” said CDC Director Tom Frieden, M.D., M.P.H. “Stop-smoking treatments work-and it’s important to make them more available to all people who want to quit.”

The report confirms that on average adult smokers with mental illness smoke more cigarettes per month than those without mental illness (331 vs. 310 cigarettes). Adult smokers with mental illness are also less likely to quit smoking cigarettes than adult smokers without mental illness. “Special efforts are needed to raise awareness about the burden of smoking among people with mental illness and to monitor progress in addressing this disparity,” said SAMHSA Administrator Pamela S. Hyde.

To address the high rates of tobacco use among persons with mental illness, SAMHSA, in partnership with the Smoking Cessation Leadership Center (SCLC), has developed a portfolio of activities designed to promote tobacco cessation efforts in behavioral health care. SAMHSA and the SCLC developed and implemented the 100 Pioneers for Smoking Cessation Campaign, which provide support for mental health facilities and organizations to undertake tobacco cessation efforts.

SAMHSA and the SCLC expanded the Pioneers Campaign by working with states through Leadership Academies for Wellness and Smoking Cessation, whose goal is to reduce tobacco use among those with behavioral health needs and staff. Participating states bring together policymakers and stakeholders (including leaders in tobacco control, mental health, substance abuse, public health, and consumers) to develop a collaborative action plan.

CDC also works closely with national partners, state tobacco control programs, and other stakeholders to address smoking among individuals with mental illness. For example, the Break Free Alliance, a CDC grantee, is working with national partners to address tobacco use in this population.

8. Smoking Reduction/Cessation Groups at Chinatown North Beach

Since September 2012, Chinatown North Beach (CTNB) Mental Health Clinic has been offering smoking reduction/cessation groups with a mindfulness component, in English and Chinese

(Cantonese). The goals of these groups are to promote smoking reduction/cessation and wellness by providing education, anti-smoking therapeutic aides (including introduction to mindfulness), and peer support.

Facilitating these groups are Kim So-Che PharmD, bilingual clinical pharmacist, Serina Deen MD, UCSF Public Psychiatric Fellow, and Wan Fen (Angel) Liu, MHSA-funded bilingual public service aide. The clinical pharmacist provides smoking cessation education, oversees nicotine replacement therapy, and facilitates the group discussions. For the English sessions, Dr. Deen introduces mindfulness exercises that are adapted works from Drs. Judson Brewer and Jon Kabat-Zinn. The public service aide translated these exercises and leads the mindfulness component for the Chinese sessions. Due to positive client interest in continuing mindfulness at home, we are in the process of recording audio CDs in English and Cantonese for client's home use.

To date, CTNB has facilitated one English-speaking and one Chinese-speaking group. These groups consisted of 6-8 weekly meetings with monthly follow-up based on participant interest. There are plans for more English and Chinese groups throughout the year.

9. Children, Youth and Families

On March 4th and 5th, Children, Youth and Families co-hosted a two day interdepartmental planning summit for implementation of the Katie A. statewide lawsuit.

The original complaint was filed in July of 2002 to obtain wraparound and therapeutic foster care services for children in or at risk of placement in foster care or group homes. The final settlement was approved in December of 2011.

Class Members: The settlement identifies a class of children who must be provided better services through what is being called the Core Practice Model or CPM. In addition, a smaller subset within this larger class must also be provided with a set of intensive services in addition to the CPM.

1. The main class of children and youth whose needs are to be addressed through the reforms mandated by the settlement are those who are:
 - a. In foster care or at imminent risk of placement. For purposes of this case, "imminent risk of foster care placement" means that within the last 180 days a child has been participating in voluntary family maintenance services or voluntary family reunification placements, and/or been the subject of either a telephone call to a Child Protective Services hotline or some other documentation regarding suspicions of abuse, neglect, or abandonment in foster care; and,
 - b. Have a mental illness or condition that has been documented, or, if an assessment had been conducted would be diagnosed with a documented mental illness or condition; and,
 - c. Who need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary

services in the home or in the home-like setting, to treat or ameliorate their illness or condition.

2. The subclass of the main class includes those children and youth who are experiencing a need for intensive services, are full-scope Medi-Cal eligible, meet medical necessity, have an open child welfare services case, and meet either of the following criteria:
 - a. Are currently in or being considered for wraparound, treatment foster care, or a specialized care rate due to their behavioral health needs; or,
 - b. Are currently in or being considered for placement in an RCL 10 or above group home, psychiatric hospital, or 24 mental health facility, or have experienced 3 or more placements within 24 months due to behavioral health needs.

The Summit focused on developing a implementation vision for San Francisco. Representatives from HSA, Education, Probation, CBHS, Family Partners and CBO's currently providing intensive services brainstormed ideas, evaluated our current system and sketched initial concepts for system enhancements. A small work group collected the data at the end of day 2 and organized it into a work plan and process map moving forward. The meeting was a great example of inter-departmental collaboration.

The Trauma-Informed initiative is moving forward. A core group has begun to sketch out a principles, practices and implementation plan for developing and delivering the curriculum across Community Programs and CBO's. The current timeline is to complete a draft curriculum by the end of June. July and August 2013 will be spent vetting the curriculum with all the key stakeholders including local trauma experts across the developmental continuum, administration, line staff, CBO's and people with lived experience. In September of 2013 the goal is to pilot a training in order to work out glitches and make modifications. The goal is to begin rolling the training out in January 2014 by having some large trainings and train the trainer modules.

10. Marsha Linehan, developer of DBT, tells her story of her own struggles with borderline personality disorder – A powerful illustration of recovery

http://www.nytimes.com/2011/06/23/health/23lives.html?pagewanted=1&_r=0&ref=health

11. Veteran's Program in San Francisco County Jail

The San Francisco Sheriff's Department's **COVER** Program (Community of Veterans Engaged in Restoration) is designed to serve the increased number of justice-involved veterans who are incarcerated in the San Francisco County Jails. San Francisco County is one of the first jail systems nationally to respond to the call for "comprehensive, integrated treatment...in a single venue" for the veteran population. Clients who meet the criteria for participation in the COVER Project are identified upon arrest by the San Francisco Sheriff's Department. The inmates are subsequently transported to the COVER Project at County Jail 5 in San Bruno.

The therapeutic core of the COVER Program is composed of daily groups tailored to address the specific psychological needs of the veteran population. The program's therapeutic groups are

grounded in evidence-based-practices that include Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy, and Thinking for a Change. Additionally, the veterans attend non-violence communication and conflict resolution groups as well as parenting and relapse-prevention classes. Clients also receive individual weekly face-to-face therapy and psychiatric medication management as indicated.

The COVER project collaborates and works closely with other interdepartmental and community agencies that include, Jail Psychiatric Services, the Veteran's Administration, San Francisco Swords to Plowshares, the San Francisco Sheriff's Department, Community Works, San Francisco's Community Behavioral Health Services, and Asian American Recovery Services.

12. California Mental Health Services Authority Reports that the Associated Press will Include Guidelines for Reporting on Mental Illness

CalMHSA's collective effort to change public attitudes around mental illness took a giant step forward today: The Associated Press, an international news organization, will include guidelines for reporting on mental illness in its influential AP Stylebook. Known as the "The Journalists' Bible" for its influence on the media industry, the publication is widely used by print, broadcast and online newsrooms and taught in journalism classes, so the new guidelines present an opportunity to significantly improve the way the news industry reports on mental illness.

The new entry in *The Associated Press Stylebook* directs news media to avoid describing people as mentally ill unless someone's mental health is clearly pertinent to a story and the person's diagnosis is properly sourced. The new entry addresses the assumption that mental illness is a factor in violent crime and identifies that people with mental illness are more likely to be victims of crime rather than perpetrators. It also suggests a more precise use of language, such as avoiding derogatory terms in health and non-health stories.

As you know, the news media's impact on public attitudes is profound, and ensuring that media portrayals of mental illness and individuals living with mental challenges are accurate and balanced is an important part of the Prop 63 (MHSA) supported efforts the California Mental Health Services Authority (CalMHSA) is making on behalf of counties to reduce stigma and discrimination that prevents people with mental illness from seeking services. The new guidelines for the AP were developed with our partner, the Entertainment Industries Council, as part of CalMHSA's Stigma and Discrimination Reduction Prevention and Early Intervention Initiative.

An EIC analysis of stories published in more than 20 English- and Spanish-language newspapers in California over 12 months revealed that most coverage about people with mental illness is negative and much of it links mental illness with dangerousness. The analysis, coupled with EIC's survey of 40 California reporters, shows that members of the news profession could benefit from specific guidelines and more resources to help with their coverage of mental health. In response, EIC, through the TEAM Up project, is developing a wealth of resources in English and Spanish for reporters that will supplement AP's mental health guidance. To download the materials, visit www.eiconline.org/calmhsa.

Press releases from the National Association of Broadcasters and AP can be found at

<http://www.nab.org/documents/newsRoom/pressRelease.asp?id=2886> and
<http://www.ap.org/Content/Press-Release/2013/Entry-on-mental-illness-is-added-to-AP-Stylebook>

13. Richmond Area Multi-Services, Inc. Recruiting for i-Ability: Vocational IT, Helpdesk Training Program

RAMS Hire-Ability is pleased to announce the orientation & recruitment for the i-Ability: Vocational IT, Helpdesk Training program (Cohort 4). This new 9 month cohort will begin **May 13, 2013** and end **February 2014**. They will be holding two orientation sessions this month for prospective client applicants as well as interested service providers. It is strongly encouraged that applicants attend one of the orientation sessions. The orientations will be held on Thursday March 14th at 10:00 AM and Friday March 15 at 3:00 PM. As space is limited, please call (415) 282-9675 to RSVP. Please refer to the attached flyer for eligibility and further information about the program. Please share this information with any of your clients that might be interested in this program.

14. Opening of the Re-Entry Pod at the San Francisco County Jail #2

Sheriff Mirkarimi and Probation Officer Chief Wendy Still announced the opening of the Reentry Pod, located at County Jail #2. The Reentry Pod is a collaborative effort which joins pre and post release programs for offenders to improve public safety, reduce recidivism and provide the necessary continuum of resources for a successful reentry into our communities and the tools to complete community supervision productively.

For months before Public Safety Realignment (AB109) took effect on October 1, 2011, the Adult Probation Department, Sheriff's Department, Court, Community Behavioral Health Services, and other City partners worked together diligently to safely and successfully implement this truly historic reform that shifted responsibility for many lower-level felony offenders from state to county jurisdiction. San Francisco rapidly and effectively implemented a comprehensive local strategy for implementing these far reaching and unprecedented reforms, which included in-depth community and client input. The Reentry Pod is a key component of San Francisco's Realignment implementation strategy.

The populations to be served by the Reentry Pod are individuals who will be released to the AB109 supervision of the Adult Probation Department upon completion of their custody sentence. These individuals include state prisoners who will be transferred to the Reentry Pod for the remaining months of their prison time before being released to the supervision of the Adult Probation Department under post release community supervision (PRCS), as well as individuals who are sentenced locally to jail and mandatory supervision under what is known as a split sentence (1170 (h) (5) (B) p.c.).

Community Behavioral Health Services will be providing important transitional care services to those individuals housed in the Re-Entry Pod, through the provision of bridge case management, authorization and placement into health care services, and ongoing care coordination. These services will be provided through the Behavioral Health Access

Center (BHAC), located at 1380 Howard St., 1st Floor. For additional information, contact Craig Murdock at (415) 503-4732.

15. City College of San Francisco: Community Mental Health Certificate Program

The MHS-funded Community Mental Health Certificate Program at City College of San Francisco has been approached by the Bay Area Community College Consortium (BACCC) to either replicate or expand its work so that other community colleges in the region will be able to deliver this exemplary workforce development program and grow the mental health workforce in their own areas. On May 22, 2013 the BACCC will convene a meeting of regional community colleges, county workforce development representatives and industry stakeholders (e.g. county hospitals, nonprofit hospitals and HMO administrators, community based organizations) to continue the dialogue of mental health workforce development and role that community colleges play. Dr. Sal Nunez, Director of the Community Mental Health Certificate Program, and two of his students will speak to the group about their program and the realized benefits from the program.

16. Community Defined Evidence and Indigenous Wellness Research Institute

On March 21, 2013, the staff from DPH's Office of Quality Management (OQM), Children Youth & Families System of Care (CYF SOC), Adult/Older Adult System of Care (A/OA SOC) and Population Health & Prevention (PHP) will have a rich Learning Session with Dr. Ken Martinez from the Technical Assistance Partnership for Child and Family Mental Health and Dr. Bonnie Duran from the University of Washington's Indigenous Wellness Research Institute. Dr. Martinez will speak about the field of Community Defined Evidence as it relates to Evidence Based Practices; and Dr. Duran will discuss her work at the Indigenous Wellness Research Institute and its implications for public health.

17. CBHS completed our annual External Quality Review Organization (EQRO) Site Visit

CBHS completed our annual External Quality Review Organization (EQRO) site visit on March 5 - 7, 2013. The Department of Health Care Services (DHCS) contracts with APS Healthcare to conduct annual independent reviews of each county's quality improvement, performance management, and IT systems, with a special focus on the role of consumers and providers in working with CBHS central administration to improve the quality of care.

The EQRO review was extensive and involved numerous staff presentations, site visits, consumer/family member focus groups, and staff group interviews. We want to extend our sincere thanks to all of the staff and consumers who participated in this important review.

The review included the following site visits and focus groups:

- A site visit at the Gender Services Program at 755 S. Van Ness Ave, and a focus group with transgender consumers and family members who participate in the Transgender Support Group at 1380 Howard St.

- A site visit at DORE Clinic (Progress Foundation) and a focus group with consumers who had recently experienced psychiatric hospitalization or crisis services.
- A site visit at South of Market Mental Health Services, Integrated Services Program, and a focus group with consumers who are receiving primary care services at South of Market Mental Health through a SAMHSA Primary Behavioral Health Care Integration grant.

Staff Interviews included 10 Adult System of Care clinical line staff, 10 Children, Youth, and Families clinical line staff, 8 Civil Service Clinical Program Managers, 8 Contract Provider Managers and Administrators, central Fiscal and Billing staff, and key Information System Managers.

Staff presentations included the Wellness and Recovery Model, Performance Management Data Dashboards, Timeliness of Care, Functional Outcomes, Disparities, Transitions in Care, Primary Care and Behavioral Health Integration, Telepsychiatry, Consumer Employment, and Performance Improvement Projects.

APS Healthcare staff will produce a final report by the beginning of June that will provide important feedback to the county, with recommendations on how we can improve our work. This report is also sent to DHCS and CMS (the federal Center for Medicaid and Medicare Services). Past EQRO review reports for all California counties can be found at www.caeqro.com.

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

Ms. Cross requested to include SROs and homeless shelters in CBHS smoking cessation/reduction programs.

Ms. Robinson stated that DPH has no jurisdiction over SRO's and homeless shelters and recommended Ms. Cross bring the smoking cessation/reduction issue to the Human Services Agency (HSA) and the Board of Supervisors.

Ms. Impernale was a former director of CVE and commented that several CVE clients were successfully transitioned into positions of staff and some clients went on to become case managers.

Ms. Robinson mentioned that the RAMS director is committed to continuing employing former CVE clients during the transitional period.

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 her staff has almost completed the 2012 annual report and the report will be available soon.

The Bay Area Community College Consortium (BACCC) would like to replicate the Community Mental Health Certification Program that was offered at City College of San Francisco at other community colleges.

We are providing collaborative trainings with California Institute of Integral Studies (CIIS) to engage the indigenous population in wellness.

2.2 Public comment

Ms. Milfay asked for clarification on intensive programs for people too ill to help themselves.

Ms. Robinson stated that programs providing full service partnerships (FSP) do outreach to people with severely incapacitating mental illness.

Ms. Milfay asked if MHSA funding is adequate enough for people too ill to obtain services.

Ms. Robinson stated that the FSP funding for clients is available only when clients meet the required levels of medical necessity.

ITEM 3.0 PRESENTATION: TRAUMA SUMMIT REPORT, LENA MILLER, MSW

3.1 Presentation: Trauma Summit Report, Lena Miller, MSW

Trauma Summit Report is attached to the end of the minutes

Ms. Argüelles introduced Lena Miller, who has one of the Mental Health Professional seats on the Mental Health Board. She co-produced the Trauma Summit in November 2012.

Ms Miller stated that over 60 people came to the summit. There were representatives from different communities, the San Francisco Department of Public Health to the peace keeping agencies.

She said that Ken Epstein and Jo Robinson have been providing statistics about PTSD. These statistics are necessary to provide a comprehensive picture to help us transform services for families and communities affected by community violence.

Ken Epstein focuses on the pervasiveness of community trauma and the prevalence of PTSD in District 10, which is part of the Southeast sector of San Francisco. PTSD has manifested largely through depression and anxiety.

The psychological pain of community violence affects everybody from infants to the elderly. In response to under resourced mental health services and wellness care programs, District 10 people have been self medicating their psychological pain through whatever substances they could find.

She pointed out that in general over 60% of the people who are actively receiving sustainable wellness and recovery services do become better and healthier. Comparing to the national average,

treatment does help individuals and families get better. She believes that more mental health services for District 10 are needed and District 10 clients would benefit from treatment just as much as the national average.

She added that since District 10 is predominantly African descent Americans, culturally appropriate treatment are beneficial. For example, mindfulness is more effective than just talk therapy alone. The others are programs and services that address trauma from historical and inter-generational perspectives.

Dr. Patterson stated that the report was excellent and added that trauma is often accompanied by co-occurring diagnoses such as anxiety, depression and acting out which are symptoms preceding PTSD. He would like to see psycho-education be part of the trauma recovery process. Clients need home-based wellness and community outreach services. He would like the board to advocate for an increase of services in District 10 and Western Addition neighborhoods.

Dr. Lewis congratulated Ms. Miller for her report that is both in-depth and broad in breadth. He asked if mindfulness is incorporated in recovery.

Ms Miller stated that during the trauma summit most attendees recognized mindfulness as both standard and necessary therapy in diffusing many anxieties. She said that she personally combines both yoga and mindfulness in her own self monitoring. Now mindfulness has become the therapeutic norm. Mindfulness is well appreciated as a way to teach people to get in touch with their bodies and working on self healing.

Dr. Lewis asked what top priorities are that the City can do for District 10.

Ms Miller said that unresolved traumatic events just perpetuate further community violence, and she would like to see more social services including trauma trainings be deployed soon.

Dr. Patterson asked about what District 10 would like to see happen first.

Ms Miller responded by saying that too many witnesses have vicarious trauma from homicides. These people, although received initial crisis care from CRN (Crisis Response Network), they are not receiving follow up care afterward. For example, kids are not getting follow up mental health care or after school trauma care enough. The other is the city leaders need to recognize more retaliatory incidents that have torn families apart.

Ms. Robinson pointed out the City's Crisis Response Team (CRT) does follow up and planned to introduce Ms. Miller to Ms. Stephanie Felder who is the director of CRT.

Ms. Chien commended Ms. Miller for the impressive report and asked how churches and community centers in District 10 have mobilized and responded to community violence.

Ms Miller replied that community violence is so severe that all interventions have been deployed. Different groups have different capacities and resources, and the DPH has responded. She felt more pro-active participation would help a lot also.

Ms. Argüelles announced that Sheriff Ross Mirkarimi just joined the meeting tonight and invited the sheriff to talk.

Sheriff Mirkarimi said that the county jail is disproportionately made up of African descent Americans. Now the jail sites are predominately made up of inmates with untreated mental illness. He stated the jail system is becoming the default place for people with mental illness. For example, elderly, homeless people and Iraq and Afghanistan veterans are being incarcerated. In jails, inmates

are triaged and 70,000 units of services were provided in 2012 by Jail Psychiatric Service. He felt the jail at best is just providing temporary palliative care. He encouraged the Mental Health Board to look at the issue of large numbers of mentally ill people in the jail system.

3.2 Public comment

Ms. King was a former board member and is currently employed by CBHS. She said that spirituality is important to wellness and recovery. She is currently facilitating RSSE (Reducing Stigma in the Southeast Sector). She said that so many District 10 residents have talked about seeing violence in front of the Boys and Girls Club in Visitacion Valley. She added that children are seeing other kids being riddled with bullets.

She was at the November 2012 Trauma Summit. She feels there is a need to get people who live in the community trained in recovery services. She believes the WRAP (Wellness Recovery Action Plan) would be helpful. She hopes more funding will be available soon.

Ms. Jackson works at the San Francisco General Hospital (SFGH) and lives in District 10. She would like to see more programs in schools, more surveys from the community to learn about needs, more outreach, and residents being treated with value.

Ms. Impernale said she served on a two-month jury for a District 10 defendant. She learned that there is a fear in the community to speak up against perpetrators because the community is afraid of retaliation to their families and other relatives. District 10 witnesses are too intimidated to speak up against those who commit homicide. There is a need for more general services.

Mr. Weaver stated that he has suffered from bi-polar disorder. He has been at OMI Clinic since 2007. He believes OMI has helped him to become functional. He believes that District 10 alone is not only being affected by mental illness. There are other people in the community who suffer just as much. He recommended the book called the Color of Water by Ruth McBride Jordan.

ITEM 4.0 ACTION ITEMS

For discussion and action

4.1. Public comment

Ms. Argüelles said that the quorum has still not been reached so no votes will be taken tonight on any action items. However, Brian Tseng, Operations Manager and Geoffrey Wilson, MD both from the Physicians Organizing Committee (POC) will provide a brief overview of the issue regarding Sutter Hospital for both the benefit of the board members and the public. The resolution will be voted on at the next board meeting.

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

[Tabled until April Board meeting due to not meeting quorum](#)

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of February 13, 2013 be approved as submitted.

[Tabled until April Board meeting due to not meeting quorum](#)

4.4 PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the city of San Francisco but also strongly urges the city to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

Dr. Geoffrey Wilson has been at SFGH Jail Psychiatric Services' inpatient unit, which is part of Psychiatric Emergency Services unit, for 35 years. He stated that he was only speaking on behalf of the Northern California for Physicians Organizing Committee (POC).

He described briefly that Sutter Health is the parent company of California Pacific Medical Center (CPMC). After Sutter Health acquired St Luke's Hospital in 2001, CPMC closed down 32 psychiatric beds in 2004 over the objection of the San Francisco Health Commission.

Now Sutter Health/CPMC is in the process of building its fifth hospital called Cathedral Hill Hospital and remolding St Luke's Hospital in San Francisco. These two hospitals would add 630 beds, but there are no psychiatric crisis beds allocated because Sutter believes that psychiatric services are not profitable.

He agreed with Sheriff Mirkarimi that San Francisco county jails are becoming the holding place for people with mental illness because there is a growing mentally ill population in San Francisco especially among the elderly, homeless people and Iraq and Afghanistan veterans.

The increasing demand for services for people with mental illness is very strong in San Francisco. Medi-Cal uses extreme criteria for accepting patients with acute psychosis. He urged the board to approve the proposal. People with mental illness are disenfranchised, and he believes that people with mental illness are entitled to psychiatric care but services for them are being denied because of their psychiatric disability.

Public Comment

Ms. Barros has worked at Laguna Honda Hospital for 30 years and represents nurses and certified nurse aides (CNA's) said that she is a strong proponent of peer support. But she believed that both extensive psychiatric care and more psychiatric beds are necessary.

Ms. Jackson stated emphatically that 38 psychiatric beds are not enough for the growing population of San Francisco!

Ms. Milfay favored the resolution because of the loss of over 100 acute psychiatric beds, and because of decreasing day treatment programs. She pointed out that in 1996 St Francis Hospital had 50 voluntary and involuntary psychiatric beds, but currently the hospital only has 25 involuntary beds.

There is a shortage of psychiatric beds in San Francisco. She said Langley Porter which is operated by UCSF is currently under remodeling. In 2004, psychiatric beds at St Luke's Hospital were shut down. The current 15 psychiatric beds at CPMC are dilapidated. The bed shortage is reaching a critical point.

She mentioned that her son was turned away for a psychiatric bed because he was perceived as not being sick enough. She believes people with acute mental illness need all levels of services.

Ms. Luokuot, with SEIU 1021 asked “Why aren’t we [San Franciscans and the BOS] trying to get Sutter Health/CPMC to abide by its contractual obligation to reinstate psychiatric beds?”

Mr. Tseng stated that Sutter Health/CPMC substitution of inpatient care with community programs is inappropriate in an urban setting like San Francisco.

Mr. Weaver stated that San Francisco should require other hospitals like UCSF, Kaiser Foundation, and Dignity Health to have psychiatric beds as well.

Mr. Silver said that San Francisco Cares has a mixed clientele in desperate need for services. He has talked to San Francisco supervisors, but they seemed to be unaware and underappreciated the risk of the psychiatric bed shortage.

Mr. Feloe, with the San Francisco Night Ministry stated that the true need for mental health services is actually much higher than what is reported in the press.

Ms. Luokuot mentioned that her son is now in jail for three years because he was arrested for illicit drugs.

Dr. Wilson stated that he spoke on behalf the POC and felt that Sutter should be held accountable for reducing psychiatric beds.

Pastor Daniel Solberg from Saint Paulus Lutheran said that families in Western Addition are seeing an increase in recent war veterans with PTSD.

Minister Andreus Pielhoop from German Evangelical Lutheran Church-St Matthews provides night ministry. Not many worshipers welcome unbathed disheveled homeless person sitting next to them. He believes there ought to be a strong community response to Sutter/CPMC for the breached agreements of psychiatric beds and inpatient services.

Member of the public who works for Westside Crisis Services supported the resolution and felt that there is not enough collaboration among providers and there is a need for aftercare follow up.

Member of the public who is with SF Cares endorsed the resolution. She mentioned that a hospital rationalized the denial of an in-patient bed to a woman with acute mental illness with the excuse that the woman was deemed to be not seriously ill enough!

Ms Miller empathized with what the public just expressed. She pointed out the board does not have the power to change Sutter Health/CPMC and urged the public to take a step father by going the BOS. She said that power concedes nothing without demand.

Dr. Patterson said that board members need to keep individual supervisors abreast of public concerns. He wanted clarification on psychiatric beds from Dr. Geoffrey Wilson.

Dr. Geoffrey Wilson said that at SFGH there are 19-20 acute beds on 7A, 12 acute beds on 7B and 19 acute beds on 7C.

Dr. Patterson wanted to know about beds for minors with acute psychiatric illness.

Dr. David E. Lewis stated that Sutter Health plans to spend about \$2.5 billion dollars. He urged the public to bring the issue to the BOS meetings, which occurs every Tuesday and asked them go contact their district supervisors.

Ms. Virginia Lewis mentioned that yesterday she and Dr. David E. Lewis attended the BOS meeting. Supervisor Jane Kim wanted more information on psychiatric care in San Francisco. She applauded the work of the Physicians Organizing Committee.

PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the City of San Francisco but also strongly urges the City to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

WHEREAS, the need within San Francisco for both inpatient psychiatric hospital beds and outpatient community mental health services exceeds their current availability.

WHEREAS, the costs to the community of untreated mental illness are tragic including domestic abuse, school violence, substance abuse, homelessness, emergency room visits, suicide plus all the resulting and outward radiating trauma impacting surrounding family and friends.

WHEREAS, CPMC's non-profit tax exempt status earns it close to \$90 million annually in tax exemptions in San Francisco.

WHEREAS, non profit hospitals as part of their community benefit obligations must provide their fair share of mental health as well as medical health services.

WHEREAS, four years after acquiring St. Luke's in 2001 from the Episcopal Diocese, CPMC's parent company Sutter Health closed St. Luke's 32 bed inpatient psychiatric unit which violated a brokered agreement with the state attorney general's office and despite unanimous opposition from the San Francisco Health Commission, leaving St. Luke's without any psychiatric beds.

WHEREAS, this new development agreement does not provide for any restoration of these inpatient psychiatric beds and leaves both St. Luke's and Cathedral Hill hospital without a single psychiatric bed.

WHEREAS, San Francisco General Hospital's Psychiatric Emergency Services (PES) unit is often crowded beyond capacity and consequently forced to turn away patients.

THEREFORE, BE IT RESOLVED that the Mental Health Board of San Francisco urges the Board of Supervisors and the Mayor to ask Sutter Health and CPMC to restore a minimum of 38 inpatient psychiatric beds at either St. Luke's and/or their

new Cathedral Hill hospital plus provide funding for follow up community residential care and also provide more support for community mental health programs all of which can help reduce the need for inpatient treatment.

No quorum for necessary vote tonight.

ITEM 5.0 ELECTION OF OFFICERS

5.1 Public Comment

5.2 Report from Nominating Committee

The Nominating Committee stated the nominees at the November 15, 2012 meeting as: Co-Chairs: Dr. Terence Patterson and Virginia Lewis, Co-Vice Chair: Ellis Joseph and Wendy James; Secretary: Dr. David E. Lewis. Since then, Dr. Patterson and Ms. Lewis decided not to run for Co-Chairs. In their place, Mr. Joseph and Dr. Lewis offered to run for Co-Chair. Ms. James will still run for Vice Chair and Ms. Lewis has volunteered to run for Secretary. Additional nominations can be taken from the floor at this time.

5.3 Election of Officers

This item was tabled due to lack of quorum.

ITEM 6.0 REPORTS

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

Ms. Brooke announced that the 2012-2013 Program Review schedule is in process and we have five programs line up in the next few weeks. Loy will be handling the program review arrangements.

She focused on appointments to the board by David Chiu, Mark Farrell, Malia Cohen, and the Rules Committee.

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

Ms. Argüelles said “As all of you know, I have a daughter with mental illness. Sometimes she will sign a consent form that gives me permission to talk to her doctors or programs and other times she won’t. So I want to share a very important option for family members to at least be able to provide information to our loved one’s providers even if we can’t have a discussion. This form is in your packet and also available for the public. It can be faxed 24/7. You won’t get a response back because that would violate privacy but you are able to share critical information that might help your family member.”

Ms. Robinson explained that the form is an adjunct to help patients get better treatment. She pointed out that when people in the middle of psychiatric crisis, often they may omit important information to providers.

Ms. King added that notations on certain detrimental side effects of medications are important to attending clinicians.

Dr. Geoffrey Wilson said that medication notations are important to health care providers.

Ms Argüelles said that this will be the last board meeting that she chairs for the Mental Health Board. She has been on the board since 2008 and really enjoyed the experience

She said that she is expecting her seat to be filled at the Rules Committee Hearing on March 21st, so this will be my last official meeting. However, she will be at the April meeting to say a formal farewell.

The Executive committee meets Thursday, February 21st 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.

6.3 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.

No discussion

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

Dr. David E. Lewis reported that he has been working closely with the BOS and with MHSA to create a Mental Health Policy Committee.

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

Ms. Miller hoped the board will go forward on the Trauma Summit report by inviting District 10 people in to talk about their first hand experiences and by advocating more services for the district.

Ms. Virginia Lewis would like a presentation from the Physicians Organizing Committee.

Dr. David E. Lewis wanted a presentation about peer-run crisis respite.

Ms. Virginia S. Lewis would like to have a psychiatrist on the board.

6.6 Public comment.

Ms. Jackson suggested clinicians should include mental health care as a part of the annual checkup for children and mental health screening for everybody should become normative care.

Member of the public explained that feelings of anxiety, depression and loneliness, panic, anger, frustrations and depression co-occur and manifest themselves in times of crisis. As they move through challenging thoughts, feelings and impulses, people still need non-medical alternatives in a comfortable, non-judgmental environment to empower themselves to explore viable options to reduce their susceptibilities to the pressures that cause overwhelming emotional distress in the first place.

ITEM 7.0 PUBLIC COMMENT

Ms. Nancy Cross proposed annual audits on homeless shelters and SRO's. For example, an audit on how nutritionists address food. She believes that the building inspectors don't address windows.

Member of the public requested the board to consider adult bullying in work place.

ADJOURNMENT

Meeting adjourned at 9:02 PM.

Trauma Summit Report to be included in the final minutes

The Impact of Community Violence and Trauma on Youth and Families

“Violence is the leading cause of years of life lost in Bayview Hunters Point, as well as the leading cause for black men in San Francisco....Adolescents and young adults experience the highest homicide rates....Root causes of violence include poverty, oppression, mental health and family dynamics. Risk factors include witnessing acts of violence, access to firearms, alcohol use, incarceration, media, and community deterioration. All of these causes and risk factors for violence are present in Bayview Hunters Point. Among males in 94124”¹

-Mitchell Katz
*Recommendations for Improving the
Health of Bayview Hunter's Point Resident*

Since the mid 1980's the Southeastern Section of San Francisco, currently known as District 10, has been plagued with overwhelming violence that has personally affected almost every member of this close-knit, working class community. Every homicide impacts the families, friends, and neighbors of each perpetrator and victim in a manner that, until recently, has not been tangible or quantifiable. The cumulative impact of these homicides is a general sense of trauma experienced by the entire community. Lack of acknowledgment and services for mental health and healing needs of the families, witnesses, and neighbors, of both victims and perpetrators further compounds the trauma by silently conspiring with it.

Community violence has a devastating impact on young people because it challenges their basic belief that the world is safe, predictable, and controllable. Community violence threatens formation of healthy attachments and erodes children's capacity to experience trust, develop self-confidence and autonomy (Garbarino et al., 1992), and is one of the strongest predictors of aggression among youth (Attar, Guerra, & Tolan, 1994; Bell & Jenkins, 1993; Gorman-Smith & Tolan, 1998; Osofsky, Wewers, Hann, & Fick, 1993;). According to social researcher, Elijah Anderson (1982, 1992), children, particularly adolescent boys, “must learn to negotiate with the street culture to survive and are often forced to choose between the values and behaviors of the street and those that could lead to a better future.” Children learn to become violent in an effort to command respect and decrease their own vulnerability. Although much of the research regarding youth violence, focuses on peer pressure, a need for acceptance, and corrupted rites of passage rituals, violence among youth usually develops from more painful and desperate origins. Adolescents who are victimized or humiliated often relieve it by lashing out, so that violence becomes a transcending experience (Fuentes, 1998). Thus, a cycle of destruction develops where children who are victimized by violence process the trauma through victimizing other children in their environment.

When fear and violence become the norm in a community, these consistent stressors play a critical role in the development and maintenance of psychological problems (Banez & Compas, 1990). Persistent feelings of not being safe often result in a state of chronic threat, generating thoughts, feelings, and behavior characteristic of Post Traumatic Stress Disorder (PTSD) symptoms (Pynoos et al., 1996; Schwab-Stone et al., 1995). In fact, there is strong and

¹ Katz MD, Mitchell, *Health Programs in Bayview Hunter's Point & Recommendations for Improving the Health of Bayview Hunter's Point Residents*. San Francisco Department of Public Health, 09/19/2006

consistent relationship between exposure to community violence and PTSD symptomatology (Kliewer, Lepore, Oskin & Johnson, 1998; Mazza & Reynolds, 1999). More than one quarter of children exposed to trauma develop Post Traumatic Stress Disorder. (Amaya-Jackson, 1995; Perry & Azad, 1999). This phenomena has reached such dramatic proportions that PTSD is becoming a common diagnosis among young, African American males, nationwide.

Studies reveal that 30–40% of youth exposed to community violence develop Post Traumatic Stress symptoms such as re-experience (nightmares, intrusive thoughts, and flashbacks), avoidance of traumatic triggers and emotional numbing (constriction of affect) and physiological hyperarousal (hypervigilance, insomnia, behavioral problems; Berman, Kurtines, Silverman, & Sarafini, 1996). These symptoms impact behavioral and emotional development as well as academic performance (Carrion, Weems, Ray, & Reiss, 2002). Moreover, the physiological consequences of stress affect not only mental health, but have been shown to correlate with non-psychological medical conditions (Dong et al., 2004; Dube et al., 2009).

Youth in Southeastern section of San Francisco, including Bayview Hunters Point, Potrero Hill, and Visitacion Valley, particularly African American boys and young men, suffer from overwhelming rates of what is referred to as Ongoing Traumatic Stress Disorder (“OTSD”). Data from clinics in Bayview Hunters Point reveal that 67% of youth have been exposed to at least 1 Adverse Childhood Experience (ACE), with 12% of patients exposed to > 4 ACEs (a critical threshold). Children with a > 4 ACEs have twice the odds of being overweight/obese and 32.6 times more likely to have learning/behavior problems in school (*Journal of Child Abuse and Neglect*, 6/2011). Research reveals a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. Disease conditions including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, as well as poor self-rated health also showed a graded relationship to the breadth of childhood exposures. The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative. Bayview Hunters Point residents experience high numbers of chronic illness, depression and premature mortality (SF Healthy Homes Project “Community Health Status Assessment”).

Fortunately, there is new attention and research devoted to the impacts and treatment around trauma related to community violence, particularly within the Southeastern Section of San Francisco. Barbara Garcia, Director of San Francisco Department of Public Health has identified trauma services and health disparities among African Americans in San Francisco as among the top three priorities for the department. Dr. Nadine Burke Harris' Center for Youth Wellness, in partnership with the Stanford Early Life Stress Research Program (ELSRP), part of the Department of Psychiatry and Behavioral Sciences in the Division of Child and Adolescent Psychiatry at Stanford University, has been working to develop and implement a multidisciplinary approach focused on improving health outcomes for children exposed to adverse childhood experiences (ACEs) and chronic stress.

With the City's commitment to providing resources and attention to the issue of trauma related to community violence, new research and treatment methods, and the ongoing commitment to various community members, service providers, and survivors, to provide healing services, this is an opportune time to implement comprehensive strategies to decrease community violence and suffering, while improving the physical and mental health of community members that have been impacted by violence.

Trauma in San Francisco's Southeast Sector: By The Numbers

"Homicide is primarily a problem of the young, as judged by the age of the victims. Young adulthood is a dangerous period for young black San Franciscans."

-Trauma Foundation
Profile of Injury in San Francisco

For calendar year 2012, there were 69 homicides (63 incidents) and 315 shootings that injured 141 people. Over 39% of the shootings and 25% of homicides occurred in Bayview Hunters Point. Shootings are often the most revealing measure of violence as homicide, particularly in Bayview Hunters Point; as, the nearby San Francisco General has the best trauma ward in the country. Furthermore, 53% of homicide victims and 63% of shooting victims were African American, with 39% between the ages of 18-25 years old.

These extremely high rates of shootings and homicides have had a particularly devastating impact on the community, resulting in ongoing, historic, and specific trauma. According to data compiled by the San Francisco Department of Public Health (DPH), in March 2013, over 44.33% of District 10 residents who have come to a clinic for services reported that they have been exposed to at least one trauma, versus 36.45% in other areas. There is also a significantly higher incidence of both PTSD and exposure to trauma in D10 as compared to other areas. The incidence of PTSD was 17.70% for residents of D10 as compared to 14.20% in other neighborhoods. It is important to note that these statistics only capture data from people who have actually come in to a DPH clinic seeking mental health services. It is suspected that the actual impact and number of people exposed to trauma, community wide, is actually significantly higher. Additionally, PTSD is a very specific diagnosis with specific symptoms. Not everyone who is exposed to trauma suffers from PTSD. Often times, exposure to trauma results in more common diagnoses, including depression, anxiety and substance abuse.

In fact, depression is the most prevalent issue affecting these clients from District 10 with 66.5% of clients having depressive symptoms at an actionable level. Anxiety is next most prevalent (51.7%) followed by Adjustment to Trauma (40.5%). Nearly half (48.1%) had Substance Abuse as an actionable item. In the Life Domain Functioning domain, Family Functioning is an actionable problem for 45.2% of clients, followed by Social Functioning (36.4%), Employment (31.8%), and Physical/Medical problems (25.6%). Just over 10% of these clients were classified as a Danger to themselves, and 8.1% had Criminal Behavior at an actionable level.

While these statistics paint a very troubling picture of the mental health of many D10 residents, they also bear out what the attendees of the D10 Trauma Summit know: With support our community can heal.

Adult Needs and Strengths Assessment (ANSA) is an instrument that the Adult/Older Adult System of Care uses to rate client and family needs and strengths since 2010. Comparing the profile of the initial ANSAs to the ANSAs conducted subsequently shows many positive outcomes for D10 clients. In terms of Strengths, the proportion of people who had strong levels Optimism increased from 46.0% to 49.4% and Community Connection increased from 36.1% to 42.7%.

In the Needs domains, the proportion of people with Substance Abuse as an actionable problem decreased from 48.1% to 38.8%, the proportion of people with actionable levels of Depression decreased from 66.5% to 46.2%, Anxiety decreased from 51.6% to 38.0%, and Adjustment to Trauma decreased from 40.4% to 25.7%.

In the realm of Life Domain Functioning, the proportion of clients with Family Functioning as an actionable need decreased from 45.1% to 39.2%, Social Functioning as an actionable need decreased from 36.3% to 31.6%. The proportion with Physical/Medical actionable needs decreased from 25.5% to 20.8% and the proportion of clients with Employment as an actionable need decreased from 31.8% to 23.1%.

The proportion of clients at risk decreased as well. Danger to Self decreased from 10.8% to 5.8% and Criminal Behavior decreased from 8.0% to 4.7%.

These profiles suggest that time spent in treatment for residents of District 10 is yielding positive outcomes. Over 60% of District 10 residents are actively involved with the treatment process, which is consistent with mental health clients nationwide. The overall picture painted by these statistics is that D10 residents are disproportionately impacted by violence and mental health disorders resulting from the violence; moreover, with treatment and support, they demonstrate a great capacity to heal and are actively engaged in their own healing process. It is vital that the City invest resources into this community to build the capacity of existing mental health providers and support new strategies around trauma related healing services. The Southeast Trauma & Healing Plan begins to address the existing inequities in mental health services that have contributed to the ongoing and cyclical nature of the trauma in District 10. With proper support and evaluation this model can be replicated in similar communities throughout the United States.

Southeast Trauma Summit

For over three decades violence has shattered the fabric of communities within San Francisco's Southeast Sector or "District 10". Today, what is being referred to as Ongoing Traumatic Stress Disorder (OTSD) affects the majority of young people and their families, with devastating long-term, physical and emotional impacts. While community violence and OTSD have been identified by community members, public health representatives, and the City as one of the most important issues impacting District 10, little has been done to provide systematic and sustainable healing and treatment service.

On November 13, 2012 approximately fifty providers, experts and members of the City and County of San Francisco convened for the Southeast Trauma Summit to create a practical plan to effectively address the healing needs of residents impacted by community violence and trauma within District 10. The purpose of the summit was to:

1. Identify best practices for trauma related to community violence in the Southeast.
2. Identify service providers within the Southeast Sector to provide healing and treatment for youth and families impacted by trauma related to community violence.
3. Develop strategies to shift City funding to culturally competent providers within the Southeast sector to provide treatment and healing services for trauma related to community violence.

The goal of the Southeast Trauma Summit was to gather the foremost experts in community violence and trauma within the Southeast sector to develop a systematic plan to shift resources to reliable service providers, who utilize best practices to treat and heal community members that are most impacted by community violence.

The following plan captures the dialogue and final presentations of the four groups tasked with identifying the primary issues and offering a plan to address them. Members of the summit self selected into one of four groups based on their expertise: 1) Children who are Hurt, Hurt Others; 2) Families of Victims and Perpetrators of Violence; 3) Community Impact; 4) The Role of Drugs and Alcohol in Community Violence. Interestingly, each of the groups independently identified almost identical issues and offered very similar plans. Therefore, the final plan presented in this report represents a very easily distilled composite of those plans that were developed and agreed upon by almost every professional and community member who has devoted their time, energy, and passion to working with victims, perpetrators, and survivors of community violence in District 10. It is time to begin healing the community. There is no longer the excuse that we didn't know or didn't no how.

Southeast Trauma & Healing Plan

District 10 will become a Healing & Wellness Zone that creates a community consciousness around healing and wellness, creates a shared language around trauma and mental health, and aligns existing community services and resources to ensure a coordinated system of care. The initiation and maintenance of this work will be carried out and coordinated by an independent organization that will serve as an organizing entity for existing providers, community groups, programs, and City departments serving victims and perpetrators of violence, and their families.

Healing Zone Umbrella Organization

The Healing Zone Umbrella Organization will be an independent body comprised of community-based organizations that specialize in trauma, policy makers, residents, and youth. The Healing Zone will be governed by a Board that operates from an authentic stance, be reflective of the population who experience trauma, and community driven. There will be two paid staff members: the Executive Director and an Administrative Assistant who carry out the daily goals and activities of the organization. There will be a priority in hiring individuals from District 10 and/or experience working with trauma and healing in District 10. The values of the board directing trauma related services include:

- transparency
- accountability
- advocacy/lobbying
- cultural relevance

The Healing Zone organization's functions will be to:

1. **Developing Asset Map:** Research existing programs and services and create an organized layout of all service providers.
2. **Standardized Assessment:** Create a standard assessment tool and conduct an assessment of organizations that provide mental health services. Standardization of assessment and outcomes should be promoted across agencies and would require reporting on number of persons served, agency services, and outcomes.
3. **Funding & Advocacy:** The board will oversee funding of services within District 10. Currently, the vast majority of existing funds are being allocated to mental health service providers, outside District 10, to provide trauma related services to District 10 population. The board would ensure funds are allocated to District 10 based providers and assist in increasing funding to increase capacity in existing organizations.
4. **Victims Assistance:** The Healing Zone Board will be the funnel through which all trauma related services are filtered. When a victim is identified, the board will assist in directing the individuals to appropriate services and provide a seamless hand off to District 10 agencies.

5. **Support Research & Education** on culturally-appropriate, best practices related to trauma informed care. Implement community led participatory research to ensure the community owns and takes the lead on the research that affects them.

Currently, the vast majority of mental health services are provided to residents of the Southeast Sector by mental health providers that are located outside of the community. Many of these services are not culturally competent and have poor outcomes for treating this population. Rather than resigning to low expectations and sense of hopelessness around the issue, it is City essential that officials remain committed to identifying effective strategies and that City funding is shifted to culturally competent providers, within District 10, to provide treatment and healing services for trauma related to community violence. The following best practices were identified as effective, community based practices for trauma related to community violence in District 10.

1. **Crisis Response:** Creation of multi-disciplinary teams utilizing Crisis Response Teams, victims' services, mental health clinicians and members of key hospital ER staff, spiritual staff, school staff and funeral directors:
 - Crisis response Team: A team of mental health professionals and community members trained in trauma and emergency response, who respond when violence occurs, to assist in de-escalating retaliation and further community violence and provide emergency counseling services;
 - Victim's Services: Provided to family members of victims of violence immediately after a homicide.
 - Mental Health Provider: A mental health provider who provides trauma interventions on site, at the time of first response, with follow-up services scheduled and delivered to family members and community members who were impacted by and/or witnessed traumatic event;
 - Key community and government providers work in cooperation with crisis response teams, victims services and mental health providers, key hospital ER staff, spiritual staff, school staff and funeral directors;
 - Implement standardization of mental health services for first responders (police, CRT, Victims's services and clinicians etc.) to process their own vicarious trauma.
2. **Home and Community Based Support and Intervention:** Provision of in-community groups and home visits to bring services into community.
 - In-home case management and mental health services visits to increase access, consistency and compliance with treatment;
 - The use of talking circles as groups which focus on community needs which reduce the stigma of attending a mental health group;
 - Groups utilize a model of peer and mental health professional partnership, to teach facilitation and leadership skills among peers.
3. **Community Resources** that are easily identified:
4. **Safe Houses** for families who are in danger;
5. **Strategies to Address Drugs** as self-medication for trauma, and attendant mental health symptoms of anxiety, depression, and PTSD;

6. **Greater Psych-education** within the community around parenting classes; health education, trauma, drugs, mental health and suicide/homicide/violence prevention;
7. **Wellness Models** that utilize culturally congruent arts and movement and health practices as community based interventions (dance, art, theatre, drumming, deep breathing, yoga, meditation, acupuncture, massage, and relaxation); and
8. **Trauma & Healing Training** services that are culturally congruent for service providers as well as for government agencies (teacher's, pharmacists, case workers, funeral directors, therapists, police, chaplains, emergency room workers, and physician's). Additionally, providing additional support, training and funding for the existing providers who are already utilized within the community.

The following service providers were identified within the Southeast Sector to provide culturally competent, place based healing and treatment for youth and families impacted by trauma related to community violence:

- Bayview Hunter's Point Foundation
- Bayview YMCA
- Black Coalition on Aids
- Center for Youth Wellness
- Edgewood
- Hidden Valley Ranch Program
- Hunters Point Family
- Jelani House
- Sage
- San Francisco Housing Authority
- Sojourner Truth Foster Care Center
- Southeast Crisis Response Network
- Southeast Health Center
- Third Street Youth