



Edwin Lee  
Mayor

## SAN FRANCISCO MENTAL HEALTH BOARD

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### **Adopted Minutes**

Mental Health Board  
Wednesday, [July 16, 2014](#)  
City Hall  
One Carlton B. Goodlett Place  
2nd Floor, Room 278  
San Francisco, CA  
6:30 PM – 8:30 PM

**BOARD MEMBERS PRESENT:** Ellis Joseph, MBA, Co-Chair; David Elliott Lewis, PhD, Co-Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien; Andre Moore; Terence Patterson, EdD, ABPP; Harriette Stevens, EdD; Errol Wishom; and Idell Wilson.

**BOARD MEMBERS ON LEAVE:** Vanae Tran, MS

**BOARD MEMBERS ABSENT:** Sgt. Kelly Kruger

**OTHERS PRESENT:** Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of CBHS; Gene Porfido, Tom Waddell Health Clinic Advisory Board; Debra Hardy; Reuben David Goodman; and [two](#) additional members of the public.

### **CALL TO ORDER**

**Dr. David Elliott Lewis** called the meeting of the Mental Health Board to order at 6:34 PM.

### **ROLL CALL**

Ms. Brooke called the roll.

### **AGENDA CHANGES**

No changes to the agenda.

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

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

**Ms. Robinson** said on July 8, 2014 the Board of Supervisors approved the implementation of Laura's Law in San Francisco, also known as Assisted Outpatient Treatment (AOT). The law is designed for the extraordinarily hard-to-engage mental health clients. In the process of implementing AOT, she reviewed how other three California counties apply Laura's law services and programs. She pointed out that the approved San Francisco's version of AOT included a couple of stipulations.

One of the stipulations is the "Care Team" provision which is a group of stakeholders or licensed clinicians, peer specialists and family members. The team will work with a person who is hard-to engage and has a chronic, severe mental illness, at the initial court hearing to try to engage that person in a voluntary treatment program.

The second stipulation is the transport clause which means that should a patient/client warrant an immediate transport to a hospital, then, whenever possible and safe, an ambulance will be called for to provide transport rather than the police.

She added that the AOT implementation is expected to occur in FY 2015-2016 because the implementation process requires time for budget approval for contracts with community based organizations for full service partnerships and housing services.

**Ms. Virginia Lewis** asked about the composition of the AOT advisory group.

**Ms. Robinson** recalled, written into regulation of Laura's Law, a panel called the "Care Team" will be made up of an oversight committee of representatives from the sheriff office, a family liaison, a peer specialist, the public defender's office, the mental health director, and the director of Public Health.

**Dr. David Elliott Lewis** asked what happens if there is a refusal to AOT treatment, since some people believe that AOT is a coercive tactic imposed by the court system.

**Ms. Robinson** said CBHS will work closely with the district attorney's (DA) office to show a fact pattern of the referred person who meets necessary AOT conditions. Going in front of a judge for a full AOT hearing, the referred person can be represented by the public defender's office ensuring patient's rights are not violated. Although the hearing does not include a jury, the hearing can have witnesses too for the due process.

**Ms. Virginia Lewis** inquired on the advisory group time duration.

**Ms. Robinson** said it was yet to be determined whether the advisory group will be an ongoing engagement or just only for the implementation period.

**Dr. Patterson** emphatically commented that the oversight or advisory committee seemed to be stocked up with public officials and only ONE family member and a peer specialist.

**Ms. Robinson** also mentioned about the Central City Older Adult outpatient clinic on Van Ness. The clinic received an updated, remodeled front lobby from the First Impressions Vocational Remodeling Program. This vocational program was a collaboration with MHSA, UCSF Citywide and Asian Neighborhood Design.

## **1.2 Public Comment**

**Ms. Hardy** asked about AOT costs, itemizing AOT costs and language of Laura's Law.

**Ms. Robinson** estimated the initial implementation to be about \$1.4 million for about 30 San Franciscans. The “Care Team” advisory does not know yet about itemized costs. There will be a Request for Proposals (RFP) to provide services for Laura’s Law clients/patients. The complete resolution including language of Laura’s Law is available on SFGov.org.

**Mr. Porfido** commented that there is no enforcement.

**Ms. Robinson** commented that AOT is really ONLY an engagement tool, not intended to be a coercive treatment at all. The Welfare and Institutions (WIC) Code Section 5150 has the criteria for follows up every six months for re-evaluation to see if AOT is still deemed necessary.

**A Member of the public** pointed out that there are religions prohibiting any modern medicine intervention because there is a notion that people with mental illness ought to suffer because it is “God’s will.” Therefore, a person with severe mental illness could invoke religious rights to undermine AOT.

**A Member of the public** mentioned that Laura’s law expenses more likely will be much higher for the Department of Public Health of San Francisco when non-Laura’s law rural counties do patient dumping in San Francisco.

## Monthly Director’s Report July 2014

### 1. Medication Orientation Class at OMI Family Center

Engaging clients in mental health treatment can be a challenge. OMI Family Center is in the process of restructuring the flow of patients throughout its clinic with the goal of promoting overall wellness and recovery. One aspect of this restructure is the implementation of Medication Orientation Classes. Historically, at OMI Family Center, clients scheduled for psychiatric medication evaluations would fail to show for these initial appointments at a rate of 66%, decreasing physician productivity and lowering timely access to care. The entire medical team at OMI Family Center developed the Medication Orientation Classes as a means to engage clients in treatment and set the tone for best practices related to safe medication prescribing at the clinic. The classes occur once per week and can accommodate up to six clients. They initially were led by a psychiatrist, but have been since delegated to the clinical pharmacist, Reisel Berger PharmD.

The classes start with a general overview of the clinic, emphasizing the importance of having a primary care provider and setting the expectation of wellness and eventual step down to primary care once stabilized. The importance of coming to appointments on time is mentioned, as is the proper process for requesting medication refills. Instructions on how to access crisis services is explained. Clients receive written documentation of the above. After this initial orientation, clients are split up and seen individually by the clinical pharmacist, nurse or a psychiatrist. General background information is collected including medical illnesses, current medications, medication allergies, primary care provider, recent hospitalizations, substance use and current suicidal/homicidal ideation. Vital signs are measured and evaluated. Consents for releases of information are explained and signed if necessary. Once this information is collected, the client is scheduled for a psychiatric medication evaluation. If the client fails to show for their initial evaluation, they must attend the Medication Orientation Class again. The class has decreased the no-show rate for psychiatric evaluation appointments by 53%.

In addition to the above information that is collected, the clinical pharmacist performs and documents some or all of the following in order to assist in safe, effective and timely access to medications: identifies prescription drug coverage plan and assists in navigation of pharmacy related-issues; runs a CURES patient activity report to identify concerning activity related to prescription controlled substances; designates preferred pharmacy in OrderConnect; documents primary care medications in OrderConnect and screens for drug interactions and other medication-related problems; performs medication reconciliation using client interview and primary care medication list (if available).

The Medication Orientation Classes assist the psychiatrists at OMI Family Center by preemptively identifying medication-related problems, and attempts to set the stage for wellness and recovery. Clients can be identified early on for interventions such as smoking cessation, metabolic monitoring and polypharmacy reduction. Clients benefit from this process as issues related to medication coverage can be identified and figured out sooner than usual. The process is modified as necessary to best serve the needs of the clients and staff at OMI family center.

## **2. Behavioral Health Court and Citywide Forensics' Supported Employment Program featured in SAMHSA Newsletter**

The June 2014 issue of the SAMHSA GAINS Center eNewsletter spotlighted the successes of San Francisco's Behavioral Health Court and the Citywide's Supported Employment Program. The article is copied below in full, and can be found at <http://gainscenter.samhsa.gov/eNews/june14.html>

San Francisco's [Behavioral Health Court](#) (BHC) was created in 2002 in response to the increasing numbers of mentally ill defendants cycling through the jails and courts. The mission of BHC is to enhance public safety and reduce recidivism of criminal defendants who suffer from serious mental illness by connecting them with community treatment services, and to find appropriate dispositions to the criminal charges by considering the defendant's mental illness and the seriousness of the offense. At any given time, there are approximately 140 defendants participating in BHC. Since its inception, 251 defendants have graduated from the program.

Upon acceptance into the program, BHC clinical providers develop an individualized treatment plan for each client that includes intensive case management, medication management, psychiatric rehabilitation, supportive living arrangements, and substance abuse treatment. Throughout their participation in BHC, clients attend regular judicial status hearings. In order to graduate, clients must participate in BHC for a minimum of one year, demonstrate consistent engagement in treatment, and remain arrest free.

BHC's Supported Employment Program, run by [Citywide Case Management Forensics](#), provides additional support to clients with major mental illness by helping them to find and maintain employment. The goal is to provide competitive work in settings that match the capabilities and interests of clients who have traditionally faced barriers to competitive employment.

BHC is committed to providing a seamless continuum of care beginning with in-jail services, transitional care prior to release, and early release into the community. [Jail Psychiatric Services](#) (JPS) provides psychiatric treatment to inmates and is the first link to the continuum of care

model. JPS screens inmates for BHC eligibility, presents the case to the BHC legal team, and provides case management services as clients leave the jail and connect with community treatment providers. The continuum of care concept is one of the most innovative in the county and is responsible for enhancing a client's successful return to the community.

BHC has reduced costs and recidivism:

- On average, each participant saves the criminal justice system over **\$10,000** during the first year of BHC (as compared to the previous year).
- BHC participation reduces the probability of a new criminal charge by **26 percent** in the 18 months after entering the program.
- BHC participation reduces the probability of a new violent criminal charge by **55 percent** in the 18 months after entering the program, when compared to other mentally ill inmates.

In 2008, BHC received a 'best practices' [award](#) from the [Council on Mentally Ill Offenders](#) (COMIO). Recipients of this award are recognized for successfully managing a program that reflects best practices in California, for treating mentally ill patients, to decrease the likelihood of their involvement with law enforcement, and to increase the likelihood of an effective transition back into the community.

### **3. Transgender Outreach Project**

The Transgender Outreach Project, to better serve this community, promotes safer sex practices by providing condoms, lube, and information to encourage safer sex. We believe in taking care of ourselves and have peer-to-peer conversations about health care and behavioral health. We promote wellness and recovery and trust that healthier lives happen through education, jobs, and appropriate support. This project is peers helping peers in every aspect of their life: the place they live; the people they live with; their friends and acquaintances; the things they do or don't do; the things they own; their work; even things like pets, music, and how it affects how you think and feel. If they are concerned about their mental health or the quality of their life, with support we can do many things to help them make the changes in their life that will help them feel much better about who they are as transgender people and help them think about those areas of their life that may need to be changed with positive changes they could make by having a team.

The Transgender Outreach Project is about:

- Creating Change
- Regaining Control of their Life
- Improving the Lifestyle we live
- Home/Where and Who we live with
- Employment or Careers
- Providing Education
- Health Care Services
- Behavioral Health Services
- Loving yourself
- Support with Groups

A group is held every Thursday from 3:00—4:30pm at 1380 Howard Street. For more information, please contact Jami Armstrong at 415-255-3615.

#### **4. California Mental Health Director's Association and County Alcohol and Drug Program Administrators Association of California Alcohol Have Merged**

The CMHDA and CADPAAC combining to be one association is in progress. At the June 12 CMHDA/CADPAAC joint All Member meeting a new association name was selected – the County Behavioral Directors Association of California (CBHDA). CBHDA will advocate for quality, cost-effective, culturally competent behavioral health care for Californians. The necessary documents for name change, by-laws updates, etc., are being prepared. Staff has also interviewed several design/website companies to create logo and website design options.

Until further notice, CBHDA staff emails remain @cmhda.org, and the website [www.cmhda.org](http://www.cmhda.org).

#### **5. TAY Drop-In Center Directory**

After more than a year of extensive research, outreach and editing, CAYEN is excited and proud to announce our first release of the [TAY Drop-In Center Directory](#)! This directory contains drop-in centers specifically serving Transition Age Youth in California and is a great resource for anyone looking to find mental health resources within their county, whether you're a provider, someone seeking services, or just interested in what's available.

Included in this Directory is a list of drop-in centers serving Transition Age Youth organized by county, as well as a resource section that includes mental health crisis lines, youth advocacy programs, and other mental health resources.

I highly encourage you to distribute and share this Directory with your networks, so that more of the public is aware of what services are available to TAY in their area.

At this time, we are only offering this Directory electronically, and a copy will be available on our website. We'd also like for you to be aware that this document is a living document, and updates will be made on an annual basis.

If you know of any additional organizations or resources that you think should be included, please send us an email at [reachout@ca-yen.org](mailto:reachout@ca-yen.org).

We hope you and others find this Directory helpful. Again, please help us distribute this important information!

(See Attachment 1 to view the Directory)

#### **6. SB 1045 has been Signed by Governor Brown**

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law also provides for the Medi-Cal Drug Treatment Program (Drug Medi-Cal), under which each county enters into contracts with the State Department of Health Care Services to provide various drug



treatment services to Medi-Cal recipients, or the department directly arranges to provide these services if a county elects not to do so. For purposes of Drug Medi-Cal, existing law requires that the maximum allowable rate for group outpatient drug free services be set on a per person basis and requires that a group consist of a minimum of 4, and a maximum of 10, individuals, at least one of which must be a Medi-Cal eligible beneficiary.

This bill would instead require a group to consist of a minimum of 2 and a maximum of 12 individuals, at least one of which is a Medi-Cal eligible beneficiary. The bill would also require, if one of the individuals in a 2-member group is ineligible for Medi-Cal, that the individual who is ineligible for Medi-Cal be receiving outpatient drug free services for a substance abuse disorder diagnosed by a physician.

#### BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

#### SECTION 1.

Section 14021.6 of the Welfare and Institutions Code is amended to read:

##### **14021.6.**

(a) For the fiscal years prior to fiscal year 2004–05, and subject to the requirements of federal law, the maximum allowable rates for the Medi-Cal Drug Treatment Program shall be determined by computing the median rate from available cost data by modality from the fiscal year that is two years prior to the year for which the rate is being established.

(b) (1) For the fiscal year 2007–08, and subsequent fiscal years, and subject to the requirements of federal law, the maximum allowable rates for the Medi-Cal Drug Treatment Program shall be determined by computing the median rate from the most recently completed cost reports, by specific service codes that are consistent with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(2) For the fiscal years 2005–06 and 2006–07, if the State Department of Health Care Services and the State Department of Alcohol and Drug Programs determine that reasonably reliable and complete cost report data are available, the methodology specified in this subdivision shall be applied to either or both of those years. If reasonably reliable and complete cost report data are not available, the State Department of Health Care Services and the State Department of Alcohol and Drug Programs shall establish rates for either or both of those years based upon the usual, customary, and reasonable charge for the services to be provided, as these two departments may determine in their discretion. This subdivision is not intended to modify subdivision (h) of Section 14124.24, which requires certain providers to submit performance reports.

(c) Notwithstanding subdivision (a), for the 1996–97 fiscal year, the rates for nonperinatal outpatient methadone maintenance services shall be set at the rate established for the 1995–96 fiscal year.

(d) Notwithstanding subdivision (a), the maximum allowable rate for group outpatient drug free services shall be set on a per person basis. A group shall consist of a minimum of 2 and a maximum of 12 individuals, at least one of which shall be a Medi-Cal eligible beneficiary. For groups consisting of two individuals, if one of the individuals is ineligible for Medi-Cal, the individual who is ineligible for Medi-Cal shall be receiving outpatient drug free services for a substance abuse disorder diagnosed by a physician.

(e) The department shall develop individual and group rates for extensive counseling for outpatient drug free treatment, based on a 50-minute individual or a 90-minute group hour, not to exceed the total rate established for subdivision (d).

(f) The department may adopt regulations as necessary to implement subdivisions (a), (b), and (c), or to implement cost containment procedures. These regulations may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of these emergency regulations shall be deemed an emergency necessary for the immediate preservation of the public peace, health and safety, or general welfare.

**7. San Francisco's Board of Supervisors Approves Laura's Law  
Offers Option to Family Members  
Assisted Outpatient Treatment Focused on Specific Small Group  
Statement by *Barbara A. Garcia, Director of Health***

With today's progress toward passage of Laura's Law, or Assisted Outpatient Treatment, San Francisco is closer to providing another intervention for family members who are concerned for the welfare of their loved ones who struggle with severe mental illness. The goal is to help prevent adults with mental illness from cycling through the emergency and acute hospitalizations that could have been avoided with successful engagement in outpatient treatment in the community. This provides the opportunity to improve their quality of life and bring peace of mind to their families.

In keeping with San Francisco's values, our version of Assisted Outpatient Treatment strengthens the multiple opportunities to engage individuals in voluntary treatment before and during the court process. In addition, our ordinance ensures that individuals who are referred but do not meet the strict eligibility requirements of the law are offered the mental health services they need.

The law includes the creation of a Department of Public Health team to oversee its implementation. The team will be made up of a forensic psychologist, a peer who has dealt with mental illness and a family liaison who has a relative with mental illness. The team will try to engage a mentally ill person referred under Assisted Outpatient Treatment with voluntary treatment first.

While it will be helpful to some patients, Assisted Outpatient Treatment is not a panacea for the problem of mental illness in our society. It is a very specific tool, focused on a narrow population – those with documented severe mental illnesses, whose conditions are deteriorating, and who are not engaged in treatment.

To qualify, the person must have a serious mental illness that resulted in a psychiatric hospitalization or incarceration twice in the past three years or resulted in violent behavior to themselves or someone else in the past four years. Though outpatient treatment can be court-ordered, medication cannot.

We expect Laura's Law/Assisted Outpatient Treatment to apply to fewer than 100 people in San Francisco. It will not solve the problem of chronically homeless, mentally ill people.

To ensure it is done right, the law also provides for more training and education for staff members who will implement Laura's Law and make decisions about involuntary treatment. An advisory group to oversee its implementation would also provide another safeguard.

In the event that someone is compelled by the court to seek outpatient treatment, we hope that they would access the care and experience improvements, including reduced involuntary hospitalizations.

Assisted Outpatient Treatment will complement the Department of Public Health's comprehensive behavioral health system that provides voluntary client-centered, culturally competent, evidence-based mental health and substance abuse treatment services to more than 30,000 residents annually. The system also provides involuntary care for people who are deemed to be a danger to themselves or others, or gravely disabled due to mental illness. San Francisco's services cover a full spectrum from prevention to crisis, acute and long-term care, with a goal of wellness and recovery for all clients.



Laura's Law will add another option for family members seeking to help a severely mentally ill relative. We welcome this effort to expand care to those who need it.

### **8. Central City Older Adults at 90 Van Ness Lobby Reimagined by First Impressions**

The First Impressions Vocational Remodeling Program, a MHSa collaboration with UCSF Citywide outpatient behavioral health program and in collaboration with Asian Neighborhood Design, completed the front lobby makeover for Central City Older Adults, the older adult focus specialty behavioral health outpatient clinic located at 90 Van Ness Avenue.

The total time involved seven consecutive Fridays through the months of late May and most of June. During the interim of the construction, patients were re-directed to an alternate waiting area. The First Impressions crew was very responsible and did a wonderful job of being low-key and non-intrusive.

After garnering feedback from the staff and clients, the First Impressions Team set out transforming the relatively small waiting area at Central City Older Adults into a warm, welcoming and modern environment for patients.

In an acknowledgement of our commitment to environmental wellness, a "Living-Wall" was constructed, new high quality low gloss flooring was installed, and an amazingly space saving wall mounted multiple display fan improves client access to required postings, artwork, and maps. A new work-station was designed with the latest horizontal lattice style wood work, again, conveying a sense of organization and warmth, while ensuring added separation and buffering of PHI material from the waiting room area. Additional front lobby improvements will take the form with the eventual inclusion of ergonomic chairs, and tables.

Great job First Impressions! We now have a first rate waiting area at Central City Older Adults and we have clients learning marketable skills.





## **9. San Francisco's Collaborative Court Programs**

Attached is a new document from San Francisco's Collaborative Court Programs. The focus is on Program Activities for 2013. The statistics presented in this report vary between programs, largely based on length of time in operation and the availability of data. We are open to feedback about your agency's informational needs, which will help enhance future reports we provide to the community.

The Programs highlighted in this document include: Adult Drug Court, Behavioral Health Court, Community Justice Center, Dependency Drug Court, Intensive Supervision Court, Juvenile Reentry Court, San Francisco Achievement Collaborative Team, and the Veterans Justice Court.

Thank you again to all of our partners. This is a collaboration in the truest sense.

(See Attachment 2)

## **10. Community Program Planning best practices for MHSA-funded programs statewide**

In June, Diane Prentiss, Program Evaluator in the Office of Quality Management for CBHS, was invited to represent San Francisco at a discussion of Community Program Planning (CPP) best practices for Mental Health Services Act (MHSA)-funded programs statewide.

The purpose of the Promising Practices Summit was to discuss the results of the statewide evaluation of community planning practices and to identify promising practices in alignment with MHSA principles, and have the potential to lead to positive client and community outcomes. This highly participatory meeting helped identify and prioritize promising CPP practices to be included in guidelines, training, and technical assistance for counties and MHSA stakeholders.

Other counties in attendance were: Los Angeles, Stanislaus, Modoc, Almador and San Bernadino. In addition, Mental Health Association of SF participated, as did members and advocates from other peer-led organizations (PEERS, Consumer Self Help). The lively discussion revealed top priorities in engaging community members in program planning, such as working with key principles in mind and utilizing data-informed practices, as listed below.

### **CPP Guiding Principles**

1. Be strategic
2. Focus on strengths and aspirations
3. Develop partnerships
4. Be accountable
5. Build capacity
6. Be inclusive
7. Be prepared to share power and release control
8. Plan for the long-haul

### **CPP Data-informed Practices**

1. Use the MHSA principles as a foundation to develop and conduct all CPP activities
2. Establish flexibility with CPP staffing
3. Use multiple methods of outreach to increase access and input
4. Emphasize the CPP process as a local planning process driven *by* the community *for* the community
5. Maintain a high level of engagement and regard for stakeholder participation
6. Train stakeholders to participate meaningfully in CPP activities
7. Make the purpose, expectations, and impacts of stakeholder participation explicit
8. Dedicate efforts to increase accessibility by making reasonable accommodations
9. Plan ahead, be well-organized and respect stakeholders' cultures

## **11. Trauma Informed Systems Initiative**

Trauma is a public health issue and can impact any of us regardless of age, gender, class or any other aspect of culture, and can have lasting effects on the way we experience our day to day lives, our relationships, and even the way our brains are wired. Trauma has been clearly linked to a higher risk of serious diseases, such as those of the heart, lungs, and liver. In response, San Francisco DPH is joining other localities such as the City of Philadelphia and the State of Maine in implementing a system-wide initiative to help us understand the effects of trauma on ourselves, our colleagues, the communities we serve, and our system. Through this understanding, we will be able to more effectively respond to trauma's effects and increase wellness and resilience for everyone in the DPH system. A key component of the initiative is a system-wide training of our workforce that will develop a foundational understanding and shared language, and that can begin to transform our system from one that asks "what is wrong with you?" to one that asks "what happened to you?" Our vision is to develop a new lens with which to see our interactions that reflects an understanding of how we, our colleagues and the people we serve experience trauma in both shared and unique ways. We'll explore ways to respond through this lens guided by six principles of trauma-informed systems: Trauma Understanding, Safety and Stability, Cultural Humility and Responsiveness, Compassion and Dependability, Resilience and Recovery, and Empowerment and Collaboration.

Participants will be guided through this half-day, interactive training by members of our Trauma Informed Systems workgroup, ending with each participant identifying specific and attainable ways to respond in a trauma-informed way within their own roles in their own work setting.

## Learning Objectives

- Understand the effect of chronic stress and trauma in our lives and in the lives of those we serve
- Understand fundamental effects chronic stress and trauma on our brains and bodies
- Learn about the impact of organizational trauma on individuals & on organizational functioning
- Understand and apply principles of trauma-informed systems
- Learn strategies to develop individual & organizational resilience in order to create and maintain more healthy, trauma-informed response

**The intended audience is DPH staff, only. The course is repeated, please register only for one. There are no CEs being offered.**

To register, please visit:

[https://101g-xnet.sfdph.org:4443/pls/vrds\\_htmldb/f?p=111:1:0::NO::F111\\_HETC\\_PROGRAM\\_PK,F111\\_CART\\_N\\_AME:2363,SC\\_OQM](https://101g-xnet.sfdph.org:4443/pls/vrds_htmldb/f?p=111:1:0::NO::F111_HETC_PROGRAM_PK,F111_CART_N_AME:2363,SC_OQM)

For more information on how to attend one of our trainings and the Trauma Informed Systems Initiative, contact our Coordinator, Kaytie Speziale at [Kaytie.speziale@sfdph.org](mailto:Kaytie.speziale@sfdph.org) or 415-255-3614.

**Tell us your clinic story and we will add it to the upcoming Director's Reports.**

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*Past issues of the CBHS Monthly Director's Report are available at:*

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail [reanna.albert@sfdph.org](mailto:reanna.albert@sfdph.org)

## ITEM 2.0 MENTAL HEALTH SERVICE ACT ANNUAL 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 Annual Update: Public Hearing

No MHSA updates were reported at the meeting.

### 2.2 Public comment

No public comments.

## **ITEM 3.0 ACTION ITEMS**

### **3.1 Public comment**

No public comments.

**3.2 PROPOSED RESOLUTION** Be it resolved that the minutes for the Mental Health Board meeting of June 18, 2014 be approved as submitted

Unanimously approved

**3.3 PROPOSED RESOLUTION:** Be it resolved that the Mental Health Board will not meet in the month of August 2014.

Unanimously approved

**3.4 PROPOSED RESOLUTION:** Be it resolved that the Mental Health Board thanks the Mayor of San Francisco and the Board of Supervisors for recognizing the importance of mental health and substance abuse services, as indicated by zero cuts to the budgets for Community Behavioral Health Services.

Unanimously approved

## **ITEM 4.0 PRESENTATION: DISCUSSION REGARDING THE MENTAL HEALTH BOARD DUTIES AND RESPONSIBILITIES**

### **4.1 Presentation: Discussion regarding the Mental Health Board duties and responsibilities.**

**Dr. David Elliott Lewis** said the executive committee wanted the board to reflect back to the 2013 Board Retreat to prioritize topics both in depth and in breadth for the next three board meetings from September, October and November.

He also, asked the board to take into consideration the recent passage of Laura's Law implementation for San Francisco.

**Ms. Brooke** read the list of issues highlighted at the December 7, 2013 2013 Board Retreat.

1. CBO's are unable to renew their leases because they are priced out of the market, and there is a big concern that community programs may become inaccessible.
2. Seniors are vulnerable to isolation and loneliness and their senior mental health disorders are not being addressed adequately.
3. There are insufficient inpatient emergency psychiatric beds at SFGH
4. There is a lack of mental health treatment by local emergency rooms.
5. The board should submit editorials to the media
6. San Francisco needs to have after-hours mental health crisis response.
7. Mental health services in jails are inadequate due to an increase in criminalization of people with mental illness.

8. There is a revolving door of acute patients with mental illness due to premature discharge and improper follow up care.
9. Board members need to educate themselves on the Lanterman Petris Short Act (LPS) policies and issues.
10. The budget inequities perpetuate a dual system of public vs. private care.
11. There is a strong correlation between trauma and violence and mental health and substance abuse.
12. Inaccurate mental illness diagnosis can manifest into devastating impact.
13. There is a 6.5 year gap delay between mental illness symptoms and receiving proper treatment.
14. The board would like to see presentations from Ron Patton on conservatorship and Joan Cairns on jail psychiatric care.

**Dr. Patterson** expressed his priorities for items 7 and 11. He also stressed the need for coordination such as having a site visit and then a presentation from that program, followed by the development of action items.

**Ms. Wilson** said that she would like to see a program review training to be given before board members go out to do actual site visit.

She also would like follow up presentations regarding a lack of acute inpatient emergency psychiatric beds at San Francisco General Hospital.

**Dr. Patterson** suggested an in-depth presentation on psychiatric beds at San Francisco General Hospital, since there is a chronic shortage of psychiatric beds at SFGH.

**Ms. Virginia Lewis** shared that private hospitals in San Francisco have routinely turned away non-privately insured patients. There is an under capacity for private hospitals' psychiatric beds, but non-privately insured people cannot utilize the available beds.

**Dr. David Elliott Lewis** asked about the declining trend of available beds in board and care homes in San Francisco.

**Ms. Robinson** suggested extending an invitation to Acting Director Kelly Hiramoto, LCSW from Community Care Management Transition to talk about residential care facility/elder (RCF/E) housing.

RCF/E is and provides 24 hours services for adults and older adults with mental illness and dual diagnosis and encourages independence in as many areas of living as possible from medication dispensing to adherence.

**Ms. Chien** offered to be a co-presenter with Sgt. Kelly Kruger in, item 9, Lanterman Petris Short (LPS) Act. Ms. Chien is a lawyer for the Public Defender's Office and Sgt. Kruger is with the San Francisco Police Department, and both are board members and can offer different views on WIC 5150, from San Francisco Police Department and the Public Defender's Office perspectives.

**Dr. Patterson** would like the board to focus on Psychiatric Emergency Service (PES) and a psychiatric ward site visit.

*The following three topics were prioritized for the remaining of the year.*

1. *Jail Psychiatric Care follow up.*



2. *Bed Flow for people from Psychiatric Emergency Services (PES) to Acute Beds at San Francisco General Hospital to transitional community bed placement to permanent housing such as Cooperatives and Board and Care homes.*
3. *Lanternman Petris Short (LPS, Welfare and Institutions Code 5150 that states when a person can be hospitalized for being a danger to themselves, a danger to others or gravely disabled. How is this law implemented in San Francisco?*

**Ms. Robinson** suggested an invitation be extended to Institute of Medical Quality in San Francisco [www.imq.org](http://www.imq.org) to hear about the standards they have for mental health care in jails. She believed that the institute would provide the board both in-depth and in breadth on care deliverance.

According to the institute, “The Institute for Medical Quality’s (IMQ) mission is to be an innovative leader in improving the quality of care provided to patients across the continuum of health care by encouraging, developing and implementing programs which effectively measure and improve the quality of care provided to people in California and beyond.

In support of its mission, IMQ will conduct educational programs and will evaluate health care delivery. It will be responsive to diverse constituencies, and its outcomes will be patient-oriented and population-based.”

**Mr. Moore** said there is not enough support to fund trauma related care for the Bayview View Hunter’s Point in District 10. He noticed a trend in attrition of programs and services. For BVHP youth at-risk of community violence, they don’t have after school programs available to keep them occupied during their free time. For example, there are no tutors to help with homework after school or academic enrichment programs.

**Ms. Robinson** said DPH responded to Lena Miller’s BVHP report with more allocation of resources started in FY 2013-2014.

**Mr. Wishom** has observed PES as both a consumer and a peer and noted that there are often empty beds.

**Ms. James** said she can provide her personal experience at PES.

*The following recommendations were made in the FY 2013-2014 Annual Report in Chairs letter:*

1. Add street signage to all community mental health clinics to inform their neighborhoods and those traveling through of the free mental health services available.
2. Run a public education campaign to inform all of the availability of free community mental health services. This should occur through multiple ways. These can include advertising on billboards, flyers handed out at street fairs and outdoor public events as well as radio spots. All flyers should include a phone number and a website to learn more.
3. Expand and improve mobile outreach by including multi-disciplinary teams with peers. Have them canvas areas of high need such as the Tenderloin, Western Addition and South East sectors of the city.
4. Decrease the wait time to be connected to mental health treatment after initial intake, assessment or triage.
5. Each community mental health clinic should have a mobile outreach team that canvases the surrounding neighborhood to inform and engage residents. Each team of at least 3 should include a peer.

6. Create a citywide mental health resource list made available through a website, phone number and an Android and iPhone app.

#### **4.2 Public Comment**

**Mr. Porfido** said he was on the AOT committee. He would like to know what peer services are available for consumers.

**Dr. David Elliott Lewis** said Mental Health Association (MHA-SF) has compiled a list of peer-based services.

**Ms. Hardy** asked about 5150's.

**Ms. Robinson** explained that SFPD can write a 5150 report, but it is up to a psychiatrist to make the actual determination, if 5150 is warranted. In other words, just because someone was brought into PES under 5150 for evaluation does not mean that hospitalization automatically happens. If the referred person was deemed not to qualify for medical necessary, then no further treatment is needed.

**A member of the public** observed and is concerned about the general public perception of 5150 being seen more as criminal rather than medical. Compounding that attitude is the fact the jail system has become the default institution for people with mental illness, if, 5150 records are publically accessible just like the criminal records then both family members, and the 5150 person are vulnerable to exploitation and prejudice when mental illness is a criminalized genetic trait.

#### **ITEM 5.0 REPORTS**

For discussion

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

**Ms. Brooke** reminded the board about the following:

- She announced there are currently four seats available on the Mental Health Board: mental health professional, family member, public interest and consumer seats.
- She will be on vacation Tuesday July 22<sup>nd</sup> – Tuesday July 29<sup>th</sup>, next week, and will not be answering her cell phone or checking email.
- July 30<sup>th</sup>, 2014 is the San Francisco Health Network's Lunch Party. It is the delivery system for San Francisco.
- September 10<sup>th</sup>, 2014 is the Consumer Family Member Conference. The key note speaker will be Judith Martin, MD who specializes in addiction recovery.
- September 11<sup>th</sup>, 2014 is Vicarious Trauma and Self Care Training at the Oakland City Center.

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

**Dr. David Elliott Lewis** reported that he received a Metropolitan Transportation Agency response thanking the board for the Golden Gate Bridge resolution, which was about building a safety net for the Golden Gate Bridge to save lives of people attempting suicide by jumping off the Bridge.

### **5.2a Report on Laura's Law debate between David Elliott Lewis, PhD and Stephen R. Jaffe, Esq.**

**Dr. David Elliott Lewis** reported briefly on Laura's Law. AOT will be implemented in San Francisco, and he hoped it will be implemented in a way that helps people with very severe mental illness who are hard-to-engage in treatment, although he opposed implementation of the law earlier.

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

None mentioned.

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

**Dr. Patterson** participated in the Laura's Law debate on KPFA radio on July 8, 2014. The congenial dialogue was between Dr. Terence Patterson a professor of psychology at the University of San Francisco as well as a member of the Mental Health Board of SF and Anna Krieger a Civil Rights Litigation Fellow at Disability Rights CA.

**Ms. Virginia Lewis** reported that she met with supervisors: Norman Yee, Mark Farrell, and Malia Cohen.

**Dr. David Elliott Lewis** met with supervisors: Norman Yee, and Eric Mar

**Ms. Bohrer** met supervisor Norman Yee and legislative aides of supervisors David Chiu, Mark Farrell and Jane Kim.

**Ms. Chien** met with Supervisor Mark Farrell and legislative aide of Supervisor Jane Kim. Supervisor Jane Kim read Dr. David Elliott Lewis' letter on opposing Laura's Law for San Francisco to the board of supervisors.

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

**Ms. Bohrer** volunteered to be a program review trainer during the December 2014 retreat. Idell Wilson volunteered to assist her.

### **5.6 Public comment.**

No comments were made.

## **ITEM 6.0 PUBLIC COMMENTS**

**Ms. Hardy** asked for clarification about the transport amendment to the Laura's Law, AOT.

**Ms. Robinson** said treating clinicians can request that a client they have 5150'd be transported by an ambulance rather than by a police.

**A member of the public** believed being transported by ambulance rather than police would decriminalize and de-stigmatize people with mental illness. Well respected scientific literature has published studies showing that there is no increased violence rates of people with mental illness and the general population.

**ADJOURNMENT**

Meeting adjourned at 8:35 PM.