



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board
Wednesday, [February 12, 2014](#)
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
San Francisco, CA
6:30 PM – 8:30 PM

BOARD MEMBERS PRESENT: David Elliott Lewis, Ph D, Co-Chair; Wendy James, Vice Chair; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Sgt. Kelly Kruger; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS; and Errol Wishom.

BOARD MEMBERS ON LEAVE: Ellis Joseph, MBA, Co Chair; Lena Miller,.

BOARD MEMBERS ABSENT: Melody Daniel, MFT; MSW Virginia S. Lewis, MA, LCSW, Secretary; and Andre Moore

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Craig Murdock, Behavioral Health Access Center; Steve Benoit, Mental Health Access Program; Emilio Orozco, Treatment Access Programs; Toni Parks, Victor Gresser, Peer-to-Peer and Vocational Services; Dan W. Lee and eight members of the public.

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:40 PM.

ROLL CALL

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

AGENDA CHANGES

Dr. Lewis requested an agenda change to move Item 3.3 to the beginning of the meeting Dr. David Elliott Lewis read the resolution commending Ms. Terry Byrne from MHA-SF for her work but no vote was taken because quorum had not been established.

Terri Byrne has been working in the mental health field for over 37 years. She has witnessed firsthand the transformation of the mental health system. She is currently

working at the Mental Health Association of San Francisco as the Program Coordinator of the Stigma Elimination Program, S.O.L.V.E. (Sharing our Lives Voices and Experience). The Best Job She Has Ever Had! Terri is able to facilitate conversations about the discrimination of people with mental health challenges and educate audiences about how they can fight stigma along with a dedicated speakers bureau of peer educators.

Terri was inspired to create the Do Send A Card Project after hearing Dr. Elyn Saks speak. Dr. Saks spoke of how much support, how many phone calls, flowers and gift baskets she received when in the hospital for medical reasons, and how she received not a call, a card, flowers or anything when she was in the hospital over a dozen times for mental health reasons. At the end of her presentation, Dr. Saks encouraged the audience to “Do Send Flowers.” Knowing that sending flowers would be cost prohibitive- with the support of MHASF, Terri started the card project. MaryEllen Copeland (WRAP creator) learned about the project and put information in her newsletter which has generated interest from across the country. MHASF receives handwritten messages of hope from people who have been in psychiatric hospitals, who have felt forgotten and who want to reach out to others to let them know that they are not alone! On the first Monday of each month, SOLVE visits the patients on the psychiatric unit at SFGH and distributes the cards and talks about hope and recovery. MHASF has set up a website where people can send messages of hope electronically that will be transcribed to greeting cards and hand delivered for them. For more information please see these web sites.

dosendacard.org

<http://www.mentalhealthsf.org/support-us/do-send-a-card/>

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, Director of CBHS, gave the February 2014 director’s report.

She thanked the board for sending her the summary reports for programs reviewed by board members. She reads them carefully and they are very important..

She said the request for proposals (RFP’s) to conform healthcare services to the Affordable Care Act will be sent to most CBHS programs. In the CBHS system, there are substance abuse outreach clinics that provide care to clients with substance abuse disorders. One issue in the RFP is requiring counselors in primary care clinics to provide counseling and a “warm handoff” to primary care staff. Besides having mental health counselors, all outpatient and residential treatment programs need to have substance abuse counselors as well, because outcomes are better if programs treat both mental health and substance abuse disorder components at the same time. Also, the Mayor’s Office asked for a series of stakeholder meetings to explore how people with hard-to-treat illnesses can be better served.

The City and County of San Francisco received an award and recognition from the California Department of Rehabilitation (DOR), and the Chinatown Child Development Center was recently awarded a small grant from the Chinese Community Health Care Association (CCHCA) for working with 7-12 year old children with attention deficit hyperactive disorder (ADHD).

A Crisis Triage grant that is worth \$16.8 million over four years was awarded for San Francisco to both enhance child and youth crisis triage services and to establish a peer operated crisis and triage warm line serving children and adults. She recognized Eduardo Vega of MHA-SF, for his commitment and work with California Senate Leader Daryl Steinberg to help get the grant for the City.

Dr. David Elliott Lewis asked about returning financial support to programs that were affected during the economic down-turn years.

Ms. Robinson believed funding support may help, but she has not seen much of the monies.

Ms. Bohrer was impressed with Comprehensive Crisis Services' (CCS) work.

Ms. Robinson explained that CCS is replicating an Alameda County crisis program for youth.

1.2 Public Comment

Mr. Vega was excited about having Crisis Triage available 24/7 to serve all districts in San Francisco from Nob Hill to Bayview Hunters Point.

Crisis Triage can provide referrals and can collaborate with the Peer Warm Line, which partners with San Francisco Suicide Prevention.

Ms. Robinson said that CBHS and MHA-SF are collaborating with other Bay Area counties on utilizing peer-run supportive services.

Monthly Director's Report **February 2014**

1. A Woman's Place Behavioral Mental Health Program

A Woman's Place Behavioral Mental Health, Community Awareness & Treatment Services' (CATS) new Medi-Cal program, was launched July 1, 2013. It is located at two sites: A Woman's Place Drop-In at 211-13th St. and A Woman's Place at 1049 Howard St., and is aimed at dual diagnosis, chronically homeless women. Very low threshold services at AWP Drop-In allow staff to engage homeless women who would otherwise remain under served, and to enroll them in Medi-Cal while connecting them with benefits and other needed services. As a result, 32% of women enrolled in the Mental Health Program were placed into housing, 26 % were placed into a higher level of care, and 42% continued receiving service in A Woman's Place Behavioral Mental Health program. In addition, because of the seamless services between the two sites, women readily move onto

shelter and residential services from AWP Drop-In Center to A Woman's Place. Participation in the Medi-Cal program has greatly enhanced our mental health capacity, as well as generated Medi-Cal dollars with considerable savings to the Mental Health General Fund.

2. Award and Recognition from California Department of Rehabilitation

The City and County of San Francisco received an award and recognition from the California Department of Rehabilitation (DOR) in December for "being the exemplary employer of the year for the San Francisco District for Fiscal Year 2012-13". DOR recognized CBHS in particular for its efforts in opening the door for employment opportunities for individuals with disabilities. In addition, 207 CBHS consumers were successfully placed in an employment position within the competitive workforce with the support of the collaborative DOR/CBHS Vocational Co-op Program in FY12-13. The current program providers are RAMS Hire-Ability, UCSF Citywide Employment Program and Caminar Jobs Plus. Together with the hard work of all program staff, CBHS and DOR will continue to share in the mission of creating employment, independence and equality for San Francisco consumers.

3. New Videos Bring Each Mind Matters to Spanish Speakers

CalMHSA Stigma and Discrimination Reduction contractor, Runyon Saltzman & Einhorn (RS&E), recently released two Spanish-language videos at www.EachMindMatters.org. Counties, community-based organizations and CalMHSA grantees can use these short videos to help reduce stigma and discrimination among community members and decision makers. Additional videos will be posted to the website in the first quarter of 2014 – stay tuned! Contact: Ashley Bradley at abradley@rs-e.com.

4. Each Mind Matters Launches New Spanish Language Campaign

Starting this year, SanaMente: Movimiento de Salud Mental de California will debut as the Spanish-language message for CalMHSA's public awareness campaigns and mental health programs statewide, with the goal to bring together coordinated efforts within the Latino community. All member Counties will receive SanaMente informational materials in the coming weeks and logos, fact sheets, and other interactive tools are available online. Spanish-language videos focused on hope, recovery and resilience can be viewed and downloaded here. For additional information on available materials, contact Aubrey Lara at aubrey.lara@calmhsa.org or (916) 389-2622.

5. Whistleblower Program

See Attachment 1.

6. Mental Health Programs See Increases in Federal Funding for Fiscal Year 2014

President Barack Obama signed the \$1.1 trillion spending bill that funds the federal government through the end of September 2014. The compromise package passed both houses of Congress

overwhelmingly last week and was signed by the President the day before federal funding was set to run out, avoiding another government shutdown. The spending bill funds every agency of the federal government. According to a press release shared by Mental Health America, the 2014 spending bill provides important increases for the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH). Mental Health America notes a 13 percent increase in funding for mental health services and supports in the federal spending bill. Specifically, the bill includes \$1.1 billion for mental health programs, which is \$136 million more than the 2013 enacted level, whereas overall funding for SAMHSA will be set at \$3.63 billion. According to Mental Health America, the spending plan provides the first meaningful increase in funding for the Center for Mental Health Services in over a decade. With respect to the National Institute of Mental Health, NIMH will receive \$1.45 billion, the National Institute on Drug Abuse (NIDA) will receive \$1.03 billion, and the National Institute on Alcohol Abuse and Alcoholism will receive \$430 million. The bill also provides \$1 billion for the Prevention and Public Health Fund of which \$62 million shall go to SAMHSA. Additional programmatic funding highlights are noted below.

- \$40M for Project AWARE state grants (Advancing Wellness and Resilience in Education, Now is the Time)
- \$15M for Mental Health First Aid (Now is the Time)
- \$20M for Healthy Transitions (Now is the Time)
- \$50M for PBHCI – Primary and Behavioral Health Care Integration
- \$49M for Suicide Prevention Activities
- \$46M for National Child Traumatic Stress
- \$35M for Project LAUNCH
- \$2M for National Strategy for Suicide Prevention from Prevention Fund
- \$5M for Tribal Behavioral Health Grants
- \$8.1M for Minority Fellowship Program (CMHS only)
- \$35M for Behavioral Health Workforce
- \$2.0M for the Consumer & Consumer Support T.A. Centers
- \$5.0M for the Consumer and Family Network Grants

7. MHSOAC Announces Intent to Award Triage Personnel Grants

The Mental Health Services Oversight and Accountability Commission (MHSOAC) announced its intent to award Triage Personnel Grants to 22 counties on January 23rd after a unanimous Commission vote on staff recommendations. Senate Bill 82 authorized the MHSOAC to administer a competitive grant program to increase the capacity of triage personnel across the State. San Francisco is one of the counties that will receive this grant.

8. Children's System of Care

Following a successful Family Support Night in January, the Children's System of Care is gearing up for a second cohort of Positive Parenting Program (Triple P) that will be offered to parents and caregivers by the Family Involvement Team, beginning in February. All graduates of parenting classes are invited to join Sista Circle, a weekly support group that offers solutions to parenting issues. Our family specialists also continue to be involved in the IASC pilot project that seeks to

implement a systems change in how mental health services are delivered to children and youth in foster care. In addition, CSOC is gearing up for a second cohort of medicinal drumming which will begin in February.

9. Chinatown Child Development Center

Two clinicians at the Chinatown Child Development Center, Dr. Hang L. Ngo and Grace Fung, were recently awarded a small grant from the Chinese Community Health Care Association (CCHCA) for a grant proposal entitled "Linguistically and Culturally Appropriate Group Therapy Treatment for Chinese Children with ADHD and Their Caregivers Based on a Modified Version of the Family STARS Program©." Grant funds will be used to run a 10-week clinical trial of group therapy for children aged 7-12 who have been diagnosed with ADHD, and their caregivers, based on a researched model called Family STARS. Family STARS has been shown to be effective in reducing ADHD symptoms in children and in increasing the parenting skills of their caregivers in support of their treatment. Hang and Grace will modify the interventions of the Family STARS program so that interventions are linguistically and culturally appropriate for this client population of first-generation, American-born Chinese children and their immigrant, monolingual, Cantonese-speaking caregivers. Children and their caregivers will attend weekly group therapy sessions for 10 weeks, with pre-, post-, and 6-month post-trial behavioral and parenting skills assessments administered to measure treatment outcome and sustainability of treatment effectiveness. Data from this clinical trial will inform effective treatment interventions for Chinese/Chinese-American children with ADHD and their caregivers. Funding from the CCHCA grant will cover costs for materials for the group sessions and incentives for parents attending the group sessions.

10. Comprehensive Crisis Services

The Comprehensive Crisis Services (CCS) team responded to numerous Adult, Child, and Crisis Response crisis calls. There was a notable increase from a slower December in terms of crises and the need for our team to triage or respond in the field with crisis assessments and evaluations. Over the last weekend in January, members of Child Crisis Treatment Team stepped up to watch a 12-year old youth who was on a 5150 hold and for whom there was no crisis bed available. Our staff worked around the clock while the team diligently tried to identify a crisis bed. This effort highlighted the need for additional crisis services in the community. In addition, CCS has received a grant to fund an expansion of our community outreach programs.

11. Early Childhood Mental Health Consultation Initiative

As a follow-up from last month, we will be holding a full-day retreat in mid-February with Early Childhood Mental Health Consultation Initiative (ECMHCI) program directors to begin prioritizing and planning action steps to resolve the identified core issues that will drive the work forward and standardize components of service delivery. In addition, CBHS and ECMHCI providers will be meeting with Children's Council of San Francisco to begin the rollout of mental health consultation to the Family Child Care Quality Network (FCCQN) which is administered by Children's Council. The FCCQN is comprised of 190 family child providers citywide that provide early care and education to over 1,700 children, aged birth to 5, and is currently the largest organized family child care network in the country.

12. Family Mosaic Project

Last year, Family Mosaic Project (FMP) conducted a focus group with parents and caregivers to gather information regarding client satisfaction with services and areas where service improvements could be made. In response to this important program quality improvement feedback, Family Mosaic will conduct four groups for clients:

- a) A youth group for boys to discuss issues and themes of transitioning from boys to men.
- b) A parent/caregiver group to focus on identifying either parenting styles and which are effective or areas of need.
- c) A summer group for young girls to improve socialization skills through jewelry making projects.
- d) A leadership group to expose youth to various leadership opportunities and government agencies throughout San Francisco.

13. Foster Care Mental Health

Foster Care Mental Health had a wonderfully productive staff retreat this month, reviewing our clinical and demographic data and working on refining our vision and mission statements. Our staff also focused on self-care assessment and practiced wellness strategies. We are close to hiring our first Health Worker III and are heavily involved in reviewing applications for two new 2930 social work positions.

14. Interagency Services Collaborator (IASC)

We continue to implement requirements under *Katie A.* (IASC). We have been trying new strategies to improve practice, test these strategies, and identify where further improvements can be made. Starting in February 2014, Human Services Workers will bring their requests for Intensive Treatment Foster Care to our MAST meeting. We are hoping this will ensure better collaboration and delivery of Intensive Home Based Services and Intensive Case Coordination.

15. Juvenile Behavioral Health and Integrated Treatment Services

In partnership with the Juvenile Probation Department, Juvenile Behavioral Healthcare Services received two grants from U.S. Department of Justice totaling \$1 million to increase treatment capacity and effectiveness for youth with co-occurring disorders and their families. SF Youth Back on TRACK (Treatment to Recovery through Accountability Collaboration and Knowledge) is designed to improve collaboration between probation and behavioral health providers and to enhance existing services so treatment is comprehensive, family-focused and evidence-based. The Family Intervention, Reentry and Supportive Transitions (FIRST) program will enhance juvenile reentry services by adding intensive family therapy that begins with youth and families 2-3 months prior to discharge in residential placement and continues through their transition back to life in the community. Both grants have significant training and coaching resources designed to introduce and sustain practice change.

As part of efforts to prepare Child, Youth and Family System of Care providers for Drug Medi-Cal certification, Dr. Steve Wu at FMP and Rita Perez at SF AIIM Higher will participate in a 1-month pilot of the Comprehensive Health Assessment for Teens (CHAT), a self-administered, computer-based version of the Teen ASI. The goal is to gather information from clinicians, youth and families about the CHAT's ease of use, comfort, and utility.

16. Mental Health Services Act Crisis Triage Grant

A four-year, \$16.8 million Mental Health Services Act (MHSA) Crisis Triage grant has been awarded to the Child, Youth and Family System of Care to both enhance child and youth crisis triage services and to establish a peer operated crisis and triage warm line serving children and adults. When in crisis, San Francisco children and youth have been assessed and treated in inappropriate settings, including adult crisis and emergency rooms, or transported to hospitals away from their family and community. In addition, there is a shortage of hospital beds. The MHSA Crisis Triage grant will help improve and enhance the capacity to divert and prevent hospitalization and to create more flexible, culturally reflective and available mobile crisis capacity to reach children, youth and families within the context of their family, community and school.

17. Parent Training Institute

In January, the Parent Training Institute (PTI) received funds from First 5 San Francisco to support three new Triple P training and implementation initiatives in spring 2014:

- a) Triple P Group Stepping Stones which is a parent training program for caregivers with children who have developmental disabilities - groups will be run by staff from Support for Families of Children with Disabilities;
- b) Teen Group Triple P which is for caregivers of teens;
- c) Primary Care Triple P which will be piloted in five primary care clinics with Dr. Jamal Harris, M.D., heading up the initiative and the PTI providing training and implementation support.

18. School-Based Mental Health

The Department of Public Health (DPH) and the San Francisco Unified School District (SFUSD) continue with planning meetings with Educational Related Mental Health Services and SOAR (formerly known as ED Partnership) providers to discuss and strategize service delivery model and expectations. Highlights include planning with providers to address what immediate changes can take place in SOAR classrooms, such as implementation of a milieu model whereby therapists provide consultation to teachers and paraprofessionals and the use of best practices to address student behavioral needs. In February, DPH will join SFUSD on site visits to classrooms.

19. Southeast Child and Family Treatment Center

In January, several teens and their parents/caregivers completed a teen anger management program with Ines Betancourt and Joy Gamble. This was a weekly group for the teens in which they could practice anger management strategies. Twice per month, the teens' parents and caregivers also learned the strategies the teens were learning, including ways to manage their emotions and support

their children. Another teen group will be starting in February using drama therapy techniques to improve coping skills, problem solving, self-esteem, and socialization. In addition to these teen groups, our staff are providing services in more schools. Currently, we are serving SF Community, Hillcrest Elementary, Guadalupe Elementary, Visitacion Valley Middle, and ER Taylor Elementary Schools. We will soon serve children and youth at Bessie Carmichael Elementary, Bret Harte Middle, and Burton High Schools.

20. TBS

In January, there were 49 TBS cases open and seven referrals on the waiting list. Two clients were placed on the waiting list due to Medi-Cal inactivation that may be resolved.

21. Trauma Informed Systems Training Initiative

The Trauma Informed Systems (TIS) Training initiative has been approved by the San Francisco Director of Health. Beginning in February, the TIS team will start with a half-day training for all staff on universal and culturally specific aspects of trauma with the goal of developing foundational understanding of trauma and shared language across all sectors of the workforce. More information will follow about the training schedule.

22. In Our Own Voice (IOOV) Focus Groups Gather Perspectives from Diverse Communities

NAMI CA has conducted 12 focus groups statewide with members of the Native American, African American, Asian and Pacific Islander and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities to gather feedback which will inform the cultural adaptation of IOOV. The focus groups allowed NAMI CA to recruit individuals living with mental health conditions from diverse cultural and linguistic communities to share their stories in the IOOV program. Upcoming focus groups (through May 2014) will support the new IOOV adaption that is in progress.

23. Affordable Care Act (ACA) and the Jail

The health disparities that exist in our communities are concentrated in the population that cycles in and out of our jails and prisons. Jails, in particular, represent one of the largest catchment areas for people with substance use and mental health conditions, infectious diseases and other chronic health problems. Compared to the general population, the jail population has disproportionately high rates of chronic medical conditions, substance use disorders, serious mental illness, and co-occurring substance use and mental health disorders. Their health problems have significant impacts on the communities from which they come and to which, in nearly all cases, they will return. In the San Francisco County Jail, Jail Health offers extensive mental health, substance abuse and medical treatment. However, if these services do not continue in the community due to a lack of health insurance, we will not see a significant, long term impact on individual and public health.

Two studies done in the San Francisco County Jail have shown that treatment and services provided to inmates has a direct effect on public health. In the first, *Impact of Chlamydia Screening at County Jail on Community Prevalence of Chlamydia in Females: A Comparison of the Jail Screening Program with Chlamydia Positivity at Two Health Centers San Francisco, 1997 - 2001*, it was found that chlamydia screening in the San Francisco County Jail from 1997 to 2001 appears to be

responsible for a significant decrease in chlamydia rates among young women tested at Southeast Health Center. The second, *Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail, 2008*, found that inmates who received discharge planning—namely, inmates who were HIV positive—were more likely to have a regular source of care after release from custody than were inmates who did not receive this service.

The vast majority of jail detainees have no private or public health insurance. Under the ACA, estimates suggest that up to 90% of men and women in county jails are now eligible for healthcare coverage. Should continuous, integrated healthcare services become widely available for jail populations, a reduction in criminal behavior and repeated incarcerations associated with chronic health conditions is expected. Jail Health anticipates that including healthcare enrollment services in our reentry planning efforts has the potential to significantly increase the likelihood that formerly incarcerated individuals will access and continue treatment in the community, which in turn will positively affect public health and recidivism rates.

Washington State studied the impact of extending chemical dependence treatment to low-income individuals, a group that was frequently involved with the criminal justice, and found:

- Average medical cost savings of \$2,500 annually per person treated.
- Reductions in arrest rates ranging from 17 percent to 33 percent.
- Additional estimated savings of \$5,000 to \$10,000 per person treated for local law enforcement, jails, courts, and state corrections agencies, all from reductions in crime.
- An increase of \$2,000 in average annual income for people who received substance use disorder treatment.

In addition, according to the National Institute on Drug Abuse (NIDA), for every dollar spent on addiction treatment programs, there is an estimated \$4 to \$7 reduction in the cost of drug-related crimes. With outpatient programs, total savings can exceed costs by a ratio of 12:1.

Thus far Jail Health Services has successfully enrolled 22 individuals in healthcare and assisted upwards of 60 individuals with beginning the healthcare enrollment process. We anticipate that those numbers will grow significantly once our enrollment specialist becomes certified and we are able to do enrollment in the intake jail.

24. OBIC and the Jail

It is estimated that 12-15% of the inmate population has a history of heroin addiction, most of whom do not receive drug abuse treatment, either during incarceration or upon release. As a consequence, re-addiction to heroin typically occurs within one month of release from incarceration, increasing the likelihood of death from overdose; HIV infection; hepatitis B and C infections; increased criminal activity; and re-incarceration. Buprenorphine, an opioid agonist has been found to be highly effective in reducing heroin use in the community and retaining patients in treatment and is being increasingly used in place of methadone. Jail Health Services began prescribing Buprenorphine to inmates for opiate maintenance approximately 6 months ago. To ensure continuity of care upon release from custody, it established a linkage to community treatment for these patients through the Department of Public Health's Office-Based Induction Clinic (OBIC). All patients started on

Buprenorphine in jail are provided information about and referred to OBIC for follow up care. Jail Health Services then tracks these patient's court dates so that they can notify OBIC when the individual is released from custody. Thus far, approximately 50% of patients prescribed Buprenorphine in jail have connected with OBIC upon release from custody at least once for continued care.

25. Directing Change High School Video Contest

Students throughout California are invited to Direct Change. A student video contest to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students. The winning teams and their associated schools will win cash prizes, qualify to win mental health or suicide prevention programs for their schools and will be recognized at an award ceremony at the end of the 2013-2014 school year. Submission Deadline: March 1, 2014

At a glance the contest:

- Is open to high school students in California (regardless of what type of school they attend)
- Invites students to develop 60-second films about suicide prevention or ending the silence about mental illness during the 2013/2014 school year
- Awards both the winning team and the associated school a \$500 cash prize (each)
- Enters each school into a drawing for a free suicide prevention program or mental health program
- Recognizes students and schools at an award ceremony in Sacramento at the end of the school year

For contest rules and information visit: www.directingchange.org

This year, NAMI California is partnering with the Directing Change Contest and is taking the lead in the promotion, implementation, and judging for the “Each Mind Matters: Ending the Silence of Mental Illness” category.

The California Department of Education is supportive of the contest and encourages schools and students to participate. These initiatives are funded by the Mental Health Services Act (Prop 63) and administered by the California Mental Health Services Authority (CalMHSA), an organization of county governments working to improve mental health outcomes for individuals, families and communities.

For more information email stan@directingchange.org or call (619) 518-2412.

26. Medication Adherence

Medication adherence is an extremely common challenge that all health care teams are facing. An “adherent” patient takes their prescription exactly as prescribed, refills without interruption, and takes each dose as scheduled, the majority of the time. Patients taking their prescription drugs as they see fit or not at all have been identified as a leading cause of disease destabilization.

Unfortunately, this practice is fairly common, as medications taken as directed for chronic conditions are reportedly as low as 50%, with only 1/3 of new prescriptions ever even being picked up and initiated.

At CBHS, stabilization is critical for our clients moving towards wellness and recovery. It is also core to our department's mission to "protect all San Franciscans," as poorly controlled mental illness can increase the risk for homelessness, hospitalization, incarceration and reduce the quality of life. In patients with bipolar disorder, schizophrenia or depression, adherence rates may be even lower than the general public, which can contribute to chronic instability and reoccurring psychiatric emergencies. Non-adherent clients are on average 3.7 times more likely to be hospitalized due to relapse within 6 months to 2 years compared to adherent ones. Clients who prematurely stop their medications are also at high risk for complications; some reports show that half of clients with major depressive disorder stop taking prescribed antidepressants after as little as 3 months. Besides relapse, the decision to abruptly discontinue treatment can cause uncomfortable and frightening withdrawal symptoms. Not only can an ineffective regimen leading to symptom cycling and relapsing be very traumatic, but it is also a significant financial burden to our health care system, where re-hospitalizations alone have been estimated to cost nearly 100 billion dollars per year. Besides the imperative to provide the best care for our clients, even more pressure is on the horizon with the Affordable Care Act, which mandates medical facilities be rated and reimbursed based on quantifiable outcomes.

Poor adherence limits a care teams' ability to make accurate assessments and establish effective treatment plans. Within our system we have some tools which can help identify clients who may be at risk for poor adherence. One of these tools is the Adult Needs and Strengths Assessment (ANSA), which is administered at intake and annually. This assessment has a section dedicated to evaluating medication perceptions and reported adherence. Those showing moderate to high risk for adherence issues can be identified and given extra attention to optimize medication insight and drug regimen palatability. Another tool is the pharmacy, which at a minimum can report if a client picks up their medications regularly and depending on their relationship with that client, may be able to offer even more information, especially if cost is a barrier. Being able to recognize factors that contribute to non-adherence can assist in targeting candidates suitable for extra prevention efforts. Honesty between client and provider can help in designing a realistic drug regimen that will be taken as directed.

Many factors contribute to non-adherence. Common modifiable factors include lack of insight, complicated drug regimens with multiple daily doses, unwanted side effects, and partial or no efficacy. These can and should be assessed on a regular basis. Being honest with clients about common adverse effects, how they can be managed if they occur, and when to expect improvement in symptoms can be extremely helpful. Many psychiatric medications are not fully effective overnight and take time to build-up to effective concentrations in the body; side effects may even appear before benefits, which can be discouraging to clients if they are unaware. Client insight can be encouraged by asking open ended questions about how their medication is helping them and what fears or concerns they have. Side effects can often be managed by changing dosing schedules, i.e. taking overly sedating medications at bedtime, using the lowest effective doses, taking those hard on the stomach with a small meal, etc. Once an effective dose has been established, immediate release medications can often be consolidated to once daily dosing if an extended release formulation is

available. Clients who cannot avoid multi-dose regimens and have trouble remembering if they have taken their medications can be taught how to use a medi-set or have their medications bubble-packed depending on their pharmacy.

Pharmacists can offer expertise on drug therapy, which can be helpful in developing strategies for maximizing the effectiveness and palatability of a prescription regimen. At CBHS Pharmacy we have a team of psychiatric clinical pharmacists dedicated to assisting prescribers in this process. We offer consultative services for troubleshooting side-effects, complicated regimens, managing drug costs, and providing advice regarding alternate treatments. We can also conduct client interviews to help identify barriers to compliance and work as part of the care team to generate possible solutions. Together as a team we have the best chance of improving the care to those we serve.

27. Working and SSI/SSDI by Victor Gresser

On January 31, 2014, I attended "Working and SSDI/SSI" workshop offered by the Positive Resource Center (PRC), which serves the HIV/AIDS and mental health communities in San Francisco. The workshop is offered to the public, regardless of HIV/AIDS status, on the last Friday of every month and educates attendees about the ins-and-outs of how Social Security benefits are affected by earned income and cash gifts. The presenter, Amy H. Orgain, Esq. from AIDS Legal Referral Panel, gave a thorough and easy-to-understand presentation about the very complex series of events and calculators that the Social Security Administration (SSA) uses to adjust Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) monthly benefits.

SSDI topics included: Trial Work Period; Extended Period of Eligibility; and Substantial Gainful Activity. For SSI, Ms. Orgain used examples and the SSA calculator to illustrate how earned income and cash gifts impact benefit amounts. Also covered were: income-related events that result in termination of benefits and how they can be avoided, options for settling overpayments, what factors enable a beneficiary to restart benefits once they have been discontinued and navigation of the restart process, different ways clients can submit monthly earnings reports, how qualified work-related expenses can be deducted from client earnings, and how to communicate these expenses to SSA.

This workshop was excellent! I highly recommend it to any clients working or considering work in their future, and all clinicians working with them. Since many consumers are reluctant to pursue work because they fear losing or reduced benefits, this information is very helpful, if not essential. In fact, the workshop is so well-presented and informative, CBHS Peer-to-Peer and Vocational Programs is hoping PRC will be able to present it in our Monthly Peer Trainings series, perhaps as early as May of this year.

More information about PRC's trainings can be found at:

Benefits Counseling: http://positiveresource.org/benefits_trainings.asp

Employment Services: http://positiveresource.org/emp_overview.asp

Workshop Calendar: <http://positiveresource.org/workshops.asp>

Next workshop: Friday, February 28th, 2014, 10AM-12PM, 785 Market Street (at 4th Street), 10th Floor

28. SAMHSA Issues ICD-10 Fact Sheet

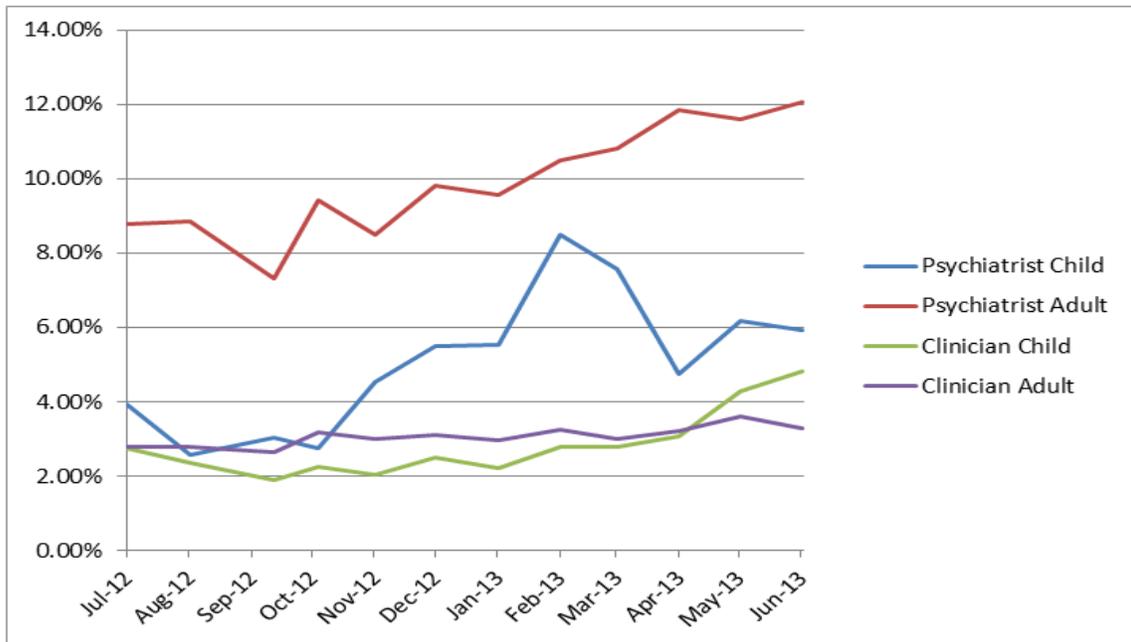
The Substance Abuse and Mental Health Services Administration has issued a fact sheet answering common questions on ICD-10 implementation for behavioral health care providers. Hospitals and other entities covered by the Health Insurance Portability and Accountability Act, which includes providers of mental health and substance abuse services, must transition to the ICD-10 coding system for medical diagnoses and inpatient procedures by October 1st. For additional resources on ICD-10 implementation, visit www.ahacentraloffice.org.

29. Behavioral Health “No-Shows” by Month FY 12-13

One of the Timely Access indicators we are required to track for the Department of Health Care Services (DHCS) is our rate of “no-shows¹”. No-shows are defined as appointments for those clients who do not show for their appointment at their scheduled appointment time, and do not call to cancel or reschedule. While the ultimate goal will be to reduce the number of no-shows so that clinic time is being maximally utilized, we must also work on increasing accurate documentation of all no-shows so that we can determine an accurate baseline for improvement. Target rates for no-shows for primary and behavioral health care are typically around 10%. However, our no-show rates documented in Avatar fall far below that. The data below represent the no-shows documented in Avatar for all outpatient mental health services provided in Fiscal Year 2012-2013. The no-show rates are separated for psychiatrists’ appointments with children (those under 18 years old) or adults, and clinicians’ (all non-psychiatrists) appointments with children or adults. All no-show rates increased over the course of the year, with a notable increase in adult psychiatry no shows from 8.77% per month in July of 2012 to 12.07% in June of 2013. This increase in psychiatry no-shows followed a focused effort on the part of psychiatrists to regularly use the no-show service code in Avatar, therefore we see this increase as a positive step toward improving data quality. Please see the attached memo for more guidelines on the definition of a no show, as well as how to document a no-show in Avatar. See Attachment 2.

¹ No Shows rates are calculated by dividing the number of no shows by the number of no shows plus attended appointments.

Month/Year	Psychiatrist Child	Psychiatrist Adult	Clinician Child	Clinician Adult	Overall Average by Month
Jul-12	3.94%	8.77%	2.74%	2.77%	4.55%
Aug-12	2.58%	8.87%	2.35%	2.79%	4.15%
Sep-12	3.04%	7.31%	1.91%	2.63%	3.72%
Oct-12	2.76%	9.42%	2.24%	3.17%	4.40%
Nov-12	4.52%	8.51%	2.04%	3.00%	4.52%
Dec-12	5.50%	9.81%	2.49%	3.09%	5.22%
Jan-13	5.53%	9.59%	2.21%	2.96%	5.07%
Feb-13	8.49%	10.50%	2.79%	3.25%	6.26%
Mar-13	7.56%	10.83%	2.80%	2.99%	6.05%
Apr-13	4.76%	11.86%	3.08%	3.22%	5.73%
May-13	6.20%	11.60%	4.28%	3.60%	6.42%
Jun-13	5.94%	12.07%	4.83%	3.29%	6.53%
Annual Average	5.07%	9.93%	2.81%	3.06%	5.22%



30. Save the Date for the Tools for Change Conference

On March 7th-8th, 2014, the Center for Dignity, Recovery, and Empowerment, a project of the Mental Health Association of San Francisco, is hosting its second annual Tools for Change Conference. Tools for Change is the first international conference focused on lived experience and culture change around mental health and mental illness, and will unite international thinkers, researchers, consumers, community leaders, advocates and other change agents in two days of

learning, partnership, and activism to strengthen our communities to support mental health and recovery. This year's conference features a keynote address as well as fundraiser benefit with former Surgeon General Dr. David Satcher. Register for the Conference here. Contact: Khoi Pham at khoi@mentalhealthsf.org.

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

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

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: Mental Health Services Act Annual Update

Mr. Robinson announced that MHA-SF and MHSA are collaborating on WRAP support and that a couple of meetings will come up soon. On 2/19/2014, she invited everyone to attend the NAMI meeting at 6:30 PM at 1010 Gough. Also the Advisory meeting is on the same day at 1380 Howard St.

SF is piloting a program to better engage with the Asian Pacific Islander (API) population on health parity. There are three worksites, 10 agencies and 50 consumers to figure out how CBHS can better serve Asian Pacific Islanders.

2.2 Public comment

Ms. Yu suggested entrepreneurship advancement in peer vocational services. She also pointed out that the Chinese speaking population is made up of many people speaking different dialects and with different perspectives about mental health issues.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

[No public comments.](#)

3.2 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of January 8, 2014 be approved as submitted.

No vote was taken because quorum was not established.

3.3 PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Ms. Terry Byrne for her work with the Mental Health Association with the “Do Send a Card” program to send get well cards to psychiatric inpatients at San Francisco General Hospital and the stigma reducing SOLVE program (Sharing Our Lives, Voices and Experiences).

No vote was taken because quorum was not established.

ITEM 4.0 PRESENTATION: CRAIG MURDOCK, DIRECTOR, BEHAVIORAL HEALTH ACCESS CENTER (BHAC), MENTAL HEALTH ACCESS, TREATMENT ACCESS PROGRAM, AND THE OFFENDER TREATMENT PROGRAM.

4.0 Presentation: Craig Murdock, Director, Behavioral Health Access Center (BHAC), Mental Health Access, Treatment Access Program, and the Offender Treatment Program.

At the end of the minutes is Mr. Murdock’s presentation handout.

Dr. David Elliott Lewis introduced Craig Murdock, Director of Behavioral Health Access Center. He and his staff will provide information about Behavioral Health Access Center, Mental Health Access, the Treatment Access Program and the Offender Treatment Program. Mr. Murdock will introduce his staff members, Steve Benoit (MHAP) and Emilio Orozco (TAP).

Mr. Murdock said BHAC started four years ago with the purpose of creating a single portal with a low entry barrier for clients/patients in crisis to enter CBHS to access services. BHAC is in a co-location with three other programs Treatment Access Program (TAP), Mental Health Access Program (MHAP) the Offender Treatment Program (OTP), respectively.

For most clients, it is not very conducive to their recovery when there is a system that is based on “survival of the fittest” mentality. They want less bureaucracy, fewer barriers and hurdles, fewer forms, and shorter wait times for access to services.

At BHAC, there is language capability for seven languages on site. The center is a walk-in and has seen more patients with severe mental illness, substance abuse disorder and primary care issues.

Mr. Murdock introduced Steve Benoit, Director of MHAP

Mr. Benoit of Mental Health Access Program said he has been with the program for 13 years and has managed MHAP for four years. The program was opened in August 2008. He explained that MHAP is a phone-based system that staffed by five clinicians and 10 staff members.

The MHAP program gets about 270 unduplicated calls per month from people seeking mental health care and about 100 calls from providers seeking consultations. The clinicians do 20 minutes of

quality screening, in order to establish a next day appointment. MHAP networks with about 400 private providers. The Healthy San Francisco program has opened up the number of people MHAP is serving.

Mr. Murdock said he talked to the board about four years ago. He took back information and feedback to the BHAC department to implement many suggestions, in order to develop a stronger program.

Mr. Benoit introduced Emilio Orozco, NP.

Mr. Orozco of TAP said he has been with behavioral health for about 13 years and joined BHAC three years ago.

TAP screens and assesses clients with substance abuse disorders. He said not all clients who come to TAP are in acute crisis. Sometimes, clients come to TAP for shelter, and some clients just want to make a phone call.

Sometimes, TAP does a 5150 (72-hour psychiatric hold) if clinicians deem it medically necessary. Sometimes, a concerned family member might bring in a person for detoxification from alcohol or sometimes just to seek information to help their loved ones who might be in a mental health crisis.

Sometimes, TAP authorizes people to go to a substance abuse treatment facility or to Dore Urgent Care Center. The utilization rate at TAP is about 38-80 clients per day. TAP has 13 clinicians and an in-house pharmacy. Ambulatory detoxification is available, but it does not work for everybody.

Mr. Murdock invited board members to visit BHAC which serves about 5,000 clients/patients.

Dr. Patterson asked if BHAC access is a self-referral center.

Mr. Murdock said BHAC is usually agency referrals.

Mr. Orozco said there are other ways too. For example, clients can self-refer through DORE Urgent Care, and Psychiatric Emergency Services.

Mr. Murdock said self-referred clients need to inform BHAC, because the center is responsible for utilization review.

Dr. Patterson asked if there are any restructuring plans in response to the Affordable Care Act (ACA).

Mr. Murdock said there is a retooling of behavioral health and substance abuse with primary care under the ACA.

Mr. Wishom said he has been a member of UCSF Citywide for seven years. His case manager and psychiatrist still want him to stay with UCSF Citywide. But higher up personnel wanted him to leave UCSF Citywide program.

Mr. Murdock suggested clients/patients are welcome to come into BHAC to determine their continuity of care. If a client needs a change, BHAC will work with that client.

Dr. David Elliott Lewis asked how long clients wait for services.

Mr. Benoit said the wait time for access to services used to be four to six weeks long. Now, the time for MHAP is within 24 to 48 hours.

Mr. Murdock said there used to be a high drop-call rate due to a long hold time. Now that issue has been resolved. Service is based on triage, rather than first-come-first serve basis.

Ms. Robinson added the State's required time for access to service is 10 business days. But San Francisco has responded better. Usually, within 24 hours from intake to pre-treatment to assessment, clients in crisis can start treatment.

Ms. Bohrer said she is a San Francisco Suicide Prevention volunteer and very impressed with the presentation. She wondered if there is anything board members can do.

Mr. Murdock would like resources to expansion clinical staff and treatment capacity to serve more people in an optimal manner.

Ms. James asked how the public hears about BHAC.

Mr. Murdock said through calling 311 or viva voce.

He said, unfortunately, BHAC is flooded with non-San Franciscans trying to get care for themselves or their loved ones.

Dr. David Elliott Lewis asked about people in the early recovery process in need of an on-going weekly therapy.

Mr. Murdock said BHAC will provide therapeutic services with such a client as long as medicallydeemed necessity and so long as there is a referral.

4.2 Public Comment

C.W. Lewis asked about board and care people who need to day treatment services but they don't have access to a wellness center. Thus, board and care people in crisis often end up wandering on the streets and in Golden Gate Park.

Mr. Murdock said when people are in crisis they can drop in to BHAC for assessment during business hours from Monday to Friday.

Ms. Robinson said the Sunset board and care is opening up a wellness center.

Sgt Kruger said Westside Crisis Clinic opens on Saturdays but not Sundays and wondered how redirecting is working out for people.

Ms. Robinson said all clinics have drop-in hours.

Mr. Benoit said people call MHAP. Then, MHAP can match clients to a culturally appropriate venue.

Ms. Bohrer asked what happens to people in crisis on weekends.

Ms. Robinson said Mobile Crisis, DORE and Westside can be contacted.

Ms. Yu suggested using live-chat technology for people with social media savvy.

Ms. Robinson said San Francisco is looking into texting technology.

Ms. Bohrer said San Francisco Suicide Prevention has live-chat capability for people in crisis.

Ms. Yu wondered about the wait time for access to substance abuse treatment.

Mr. Orozco said some places have no wait time. Currently, there are 125 residential treatment beds in San Francisco.

ITEM 5.0 REPORTS

For discussion

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

Ms. Brooke made the following announcements

- Upcoming Trainings: February 20th: Trauma Informed Care. March 13th, Girls and the Juvenile Justice System with Wendy Still. All board members are welcome to attend.
- More program reviews for fiscal 2013-2014 are being set up
- Re-appointments: We have received confirmations of re-appointment for Terry Bohrer, Kara Chien and David Lewis. Terry Patterson's application has been submitted.
- Re-appointment members who need to seek re-appointment to the board received their application packet in their envelope, except for Kara Chien who has already submitted hers.

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

Dr. David Elliott Lewis announced that the Executive Committee has changed its meeting time to the daytime. The next meeting is Thursday, February 20th, 2014 at 11:00 AM at 1380 Howard Street, Room 424. All board members as well as members of the public are welcome to attend.

5.3 Report from Nominating Committee

Dr. David Elliott Lewis said the Nominating Committee, David Elliott Lewis, PhD, Ellis Joseph, MBA, Alphonse Vinh and Wendy James proposed the current officers for re-election. Additional nominations can be made from the floor and elections will be March 12, 2014.

- Ellis Joseph, MBA: Co-Chair
- David Elliott Lewis, PhD: Co-Chair
- Wendy James: Vice Chair
- Virginia Lewis: Secretary

Mr. Wishom nominated himself for secretary

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

No issues or people were highlighted

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

Mr. Vinh mentioned that two weekends ago he did senior crisis training for volunteers for the Friendship Line.

Dr. David Elliott Lewis announced a two-day Annual Tools for Change Conference on March 7-8, 2014 at the Hilton Hotel in Union Square.

Ms. Bohrer met recently with Supervisor David Chiu to discuss his possible change of his previous position against Laura's Law.

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

Mr. Vinh suggested mental health in the senior population and he would like a presentation from the Institute on Aging in San Francisco.

5.7 Public comment.

No public comments.

ITEM 6.0 PUBLIC COMMENT

No public comments.

ADJOURNMENT

Meeting adjourned at 8:35 PM.



Behavioral Health Access Center

SF HEALTH NETWORK

Behavioral Health Services



- Treatment Access Program
- Mental Health Access Program
- Offender Treatment Program
- CBHS Pharmacy

Behavioral Health Access Center (BHAC)

**1380 Howard St., First Floor
San Francisco, CA 94103
At 10th St.**

**Proximity to BART & Muni
South of Market/Central City location**

Why BHAC?

- Integrated collection of services
- Co-location draws on efficiencies and shared expertise
- Assists client in navigating access to care
- Consolidated care with access to treatment, treatment engagement,
- Narcotic replacement therapy, medications, primary care services
- Removes “survival of the fittest” element to accessing care.
- Provides organization and infrastructure for a uniform system wide wait list.
- Treatment matching to an appropriate level of care.

Treatment Access Program (TAP)

- **Coordinated access to indigent substance abuse and co-occurring disorder treatment clients**
- **Clinical Assessment/Treatment Matching**
- **Treatment Engagement**
- **Placement authorization**
- **Health Screenings**
- **PPD/TB placement**
- **Medications**
- **Direct access to social model detox and medically supported detox**
- **Utilization Review**

Mental Health Access

- Crisis intervention to seriously mentally ill by phone or in person.
- Direct access to CBHS clinics within the system of care.
- Assessment and placement authorization into the Private Provider Network (PPN)
- 24 hours/7 days
- Eligibility Unit for enrollment into benefits including SF PATH and Medi-Cal.

Offender Treatment Program (OTP)

Forensics Case Management for:

SACPA/Prop. 36

AB109 (Realignment) offenders

BASN (Parolees)

Serial Inebriates

Chronic Offenders

OTP detail to the CASC (Community

**Assessment and Services Center) operated by
the Adult Probation Department.**

The Numbers FY12-13

<u>Program</u>	<u>Unduplicated Clients</u>
Treatment Access Program	2,448
Offender Treatment Program	476
Mental Health Access	2,890
TOTAL:	5,814

Thank you. Gracias. Eskerrik asko. Salamat.Merci. Danke.
σας ευχαριστώ. با تشکر از شما. Спасибо. Asante. நன்றி.
Cảm ơn bạn. תודה. Grazie. Հնրհակալուրդուն. Gràcies. Dank u. hvala
Terima kasih. 谢谢. Go raibh maith agat. Dziękuję. Obrigado. 감사합니다.



Behavioral Health Access Center

Community Behavioral Health Services