SAN FRANCISCO MENTAL HEALTH BOARD

Edwin Lee
Mayor

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

Adopted Minutes

Mental Health Board
Wednesday, October 15, 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, PhD, Co-Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Co-Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Sgt. Kelly Kruger; Terence Patterson, EdD, ABPP; Harriette Stevens, EdD; and Idell Wilson.

BOARD MEMBERS ON LEAVE: Ellis Joseph, MBA, Co-Chair; and Errol Wishom, Co-Secretary.

BOARD MEMBERS ABSENT: Vanae Tran, MS., Andre Moore

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; Reuben David Goodman; Stephen R. Jaffe, Esq., The Jaffe Law Firm; Deborah Hardy; Mercedes Crouser; Ulash Thalcore-Dunlap; Benny Wong; Dave Limcaco; and 10 additional members of the public.

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:30 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** announced that the finance committee just approved San Francisco's Mental Health Plan and is forwarding the plan to the Board of Supervisors for their final approval.

She highlighted the 2014-2015 Mental Health Loan Assumption Program (MHLAP), and mentioned that there are 70 interns in the system.

She informed the board that Alice Gleghorn who was CBHS Deputy Director for over five years will be leaving the organization. As of December 1st, 2014, Ms. Gleghorn will be the Santa Barbara County Mental Health Director.

1.2 Public Comment

No public comments.

Monthly Director's Report
October 2014

1. 2014/2015 Mental Health Loan Assumption Program (MHLAP)

The Health Professions Education Foundation is pleased to announce that the **2014/2015 Mental Health Loan Assumption Program** (MHLAP) Cycle is now open. The program cycle will close on **November 30, 2014**. Please encourage all potential applicants to go to https://calreach.oshpd.ca.gov to complete their application. A new application must be submitted each time you apply. Last year's application will not be accepted. For resources on how to apply, please visit www.healthprofessions.ca.gov/.

Eligibility Requirements:

- Applicants may work or volunteer with an organization which is administered, in whole or part, by the County Mental Health Department including County Mental Health funded contractors, subcontractors and Juvenile Halls.

- Applicants must be working or volunteering in a hard-to-fill or retain position in any capacity that meets your County Mental Health workforce needs. The County Mental Health Director may determine what professions or positions fit their criteria for their County.

Attached is a copy of the Frequently Asked Questions (FAQs). If you have any updates regarding a change to your counties MH Director/Designee, notify us as soon as possible. Please feel free to call us with any questions.

Constantino Raya| Program Officer
Tino.raya@oshpd.ca.gov
P (916) 326 3655

KC Mohseni | Program Officer
Kc.mohseni@oshpd.ca.gov
P (916) 326 3648 F (916) 324 6585

Kulwinder Kaur | Program Officer

Kulwinder.kaur@oshpd.ca.gov
P (916) 326 3644 F (916) 324 6585

(See Attachment 1)

2. CalMHSA Announcements

***Two Grants Opportunities Offer Ways to Expand Each Mind Matters Reach**:*

CalMHSA Express

- ***The Each Mind Matters Community Engagement Grant** will be awarded to community-based organizations or counties to engage communities in, and expand the reach of Each Mind Matters.*
- ***The Stigma and Discrimination Reduction (SDR) Speakers' Bureau Grant** will be awarded to individuals or organizations that operate Speakers' Bureau activities to allow speakers and Speakers' Bureaus to enhance SDR messages and provide stipends to speakers.*

Visit here for more information and the application. Contact: info@eachmindmatters.org.

***CalMHSA Partners with California Reducing Disparities Project (CRDP) to Reach Diverse Communities**:*

CalMHSA Express

New tools and resources help to address suicide prevention, student mental health and stigma reduction among California's diverse populations, particularly the African American, Asian/Pacific Islander, Latino, LGBTQ and Native American communities. Visit the CalMHSA CRDP website to access these resources and information for the CRDP Program Partners. Contact: Lee Anne Xiong at LeeAnne.Xiong@CalMHSA.org.

***Free Suicide Prevention Virtual Training for Educators and School Staff**:*

CalMHSA Express

Educators and school staff are invited to join California Department of Education and its partners across the state in preventing youth suicides by refreshing their knowledge and skills in talking with students in distress by accessing Kognito At-Risk. The online program trains participants to identify psychological distress and build intervention skills by talking with virtual students and connecting them to support. This online training is FREE and can be shared with school colleagues. Access Kognito At-Risk by going to California's course home page until December 31st, 2014. Contact: Monica Nepomuceno at MNepomuceno@cde.ca.gov.

Register for the Northern CA Suicide Prevention Summit*: The Bay Area Suicide and Crisis Intervention Alliance (BASCIA) in partnership with Didi Hirsch Mental Health Services, and funded by CalMHSA, is holding its First Annual Suicide Prevention Summit on October 24th, 2014, in Oakland from 8:30 am – 3:00 pm at Samuel Merritt University. The Summit will feature the Emerging Best Practices in Suicide Prevention that were developed by Didi Hirsch in partnership with statewide subcontractors through the Statewide Suicide Prevention Networks project. For more information about the Summit or how to register, please contact Paul Muller at pmuller@mullerandsmith.com.*

3. Behavioral Health Services Internship Program

We have welcomed 70 new interns into our system of care for the academic year 14/15 from colleges and universities throughout the Bay Area and around the country. They are training in a variety of placements; crisis services, behavioral health homes, substance use disorder programs, and case management services. These training sites are not only supporting the development of their clinical skill sets but they are providing an opportunity for our consumers to benefits from the rich diversity that exists in this cohort of students. Our interns were officially welcomed at the Intern Orientation last month, where they received a thorough introduction in the philosophy and programs that encompass our behavioral health system. We are looking forward to an exciting year of training and growth as the interns mature on their path toward becoming an integral part of the behavioral health workforce.

4. New Web Location for DPH Education and Training

Our link to Education and Training has moved. It is now under the section titled, "The Most Popular DPH Topics", found on the bottom right of the main page.

http://www.sfdph.org/dph/default.asp

(See attachment 2)

5. Sleep Hygiene

Insomnia or sleep disturbances arise from an array of causes such as medical conditions, psychiatric illnesses and medications or may originate independently. Clinical evidence suggests a close synergistic relationship between psychiatric disorders and insomnia. More than half of insomnia cases may be related to anxiety, depression, or psychological stress. Furthermore, sleep patterns are disrupted in substance use disorders due to neurotransmitter imbalances and physiological stressors. Regardless of the etiology, sleep deprivation poses a great health hazard by increasing the risk for stroke, cardiovascular disease, obesity, mental impairment, and poor quality of life. Individuals with psychiatric illnesses may become more vulnerable to future relapses of anxiety, mood, or substance use disorders. For this population, treatment of underlying psychiatric conditions should be first optimized. Although medications such as anticholinergics, benzodiazepines, and other sedative-hypnotics are commonly prescribed to promote sleep, their use should be reserved for patients who have failed non-pharmacological and behavioral therapy. Sleep medications – whether prescribed or obtained over-the-counter – cause various side effects ranging from falls in the elderly (associated with sedative hypnotic use) to anticholinergic activity consisting of urinary retention, blurry vision, confusion, and memory loss. In order to avoid sleep medications' adverse effects, behavioral intervention and sleep hygiene need to be primarily addressed.

Improving sleep hygiene is the first-line treatment of choice for most patients. The practice involves controlling behavioral and environmental factors that may disrupt or interfere with sleep. Observing the following tips and techniques may ensure a more restful sleep that promotes daytime alertness while preventing sleep disorders:

- Don't try to force sleep. If you have difficulty falling asleep for more than 20 minutes in bed, get up and engage in a relaxing activity before returning to bed.
- Avoid spending time in bed when not sleeping (e.g. watching television). The bed should only be used for sleep and sexual intercourse.
- Only sleep as much as needed to feel rested (generally 6-8 hours for most people)
- Maintain a regular sleep schedule with the same bedtime and wake-up time.
- Decrease caffeine intake and avoid caffeinated beverages after noontime.
- Avoid alcoholic beverages, smoking or nicotine products near bedtime.
- Avoid going to bed hungry. Try to have a light snack two hours prior to bedtime.
- Ensure a comfortable bedroom environment including light, noise, and temperature.
- Address concerns or worries before bedtime by making a list of tasks or responsibilities for tomorrow.
- Exercise regularly (preferably 4 hours before bedtime).

Various techniques may reduce anxiety and improve relaxation to ensure an effective, restful sleep. Individuals may practice deep breathing exercises which involves inhaling slowly and deeply through the nose, and exhaling deeply through the mouth for several minutes. Progressive muscle relaxation has also been effective for certain patients; the exercise involves gently contracting muscles for one to two seconds and relaxing, beginning with muscles in the face and slowly progressing downwards to the toes. Practicing a mindfulness exercise such as paying attention to physical sensations (i.e. breathing, pulses, and other body processes) may also promote relaxation.

Treating insomnia is a gradual process that varies based on the condition's severity and patient's comorbid illness(es). Although mild insomnia can often be prevented or treated by practicing good sleep hygiene, a more severe case of chronic insomnia needs to be closely monitored. Underlying health problems that may trigger sleep disturbances should be first addressed, which may include additional pharmacologic agents. Overall, treatment of a client's mental health illness including substance use disorders should be optimized in conjunction with improving sleep hygiene. With all cases of insomnia, behavioral approaches and relaxation techniques should be attempted to help individuals maintain a restful and healthy sleep pattern.

Resources:

"An Overview of Insomnia." http://www.webmd.com/sleep-disorders/guide/insomnia-symptoms-and-causes.
WebMD, Web. 9 September 2014.

Neubauer, David N. "Insomnia and Psychiatric Disorders." http://www.medscape.org/viewarticle/480681.
Medscape, Web. 9 September 2014.

Thorpy, Michael. "Sleep Hygiene." http://sleepfoundation.org/ask-the-expert/sleep-hygiene. National Sleep Foundation, Web. 9 September 2014.

Author:

Kevin T. Le
Doctor of Pharmacy Candidate, 2016
University of California, San Francisco
CBHS Pharmacy Intern

6. Jail Health's Behavioral Health and Reentry Program Awarded Grant for Project MAPS

Jail Health's Behavioral Health and Reentry program has been awarded a $1,392,568.00 grant over 4 years for Project MAPS (Mentoring and Peer Support). The program will collaborate with and draw clients from three collaborative court programs - the Behavioral Health Court, the Drug Court, and the Veterans Justice Court. MAPS will employ, train and support a diverse peer team consisting of 1 full-time Lead Peer Mentor and 5 half-time Peer Mentors who will utilize evidence based practices to encourage, support, and foster treatment success and recidivism reduction among the members of its target population. The mentor team will be supervised and supported by a full-time MSW Level Project Coordinator who will provide ongoing mentor support and ensure that mentors are accessing and utilizing Supported Employment resources, including job training and ongoing mental health and/or substance use disorder counseling. Each peer mentor will be teamed with an average of 6 collaborative court clients at a time, with an average length of support of 6 months per client, although the relationship could last as long as 12-18 months. The project will serve a total of 252 individuals with co-occurring disorders who are leaving jail over a 42 implementation period from April 1, 2015 through September 30, 2018. The project will measure a range of key outcomes related to both clients and Peer Mentors, including client mental health status and substance use and Peer Mentor employment advancement. Through the MAPS project, Jail Health Services will explore the effectiveness of an ambitious peer support intervention which has the potential to serve as a national model for enhancing the quality and impact of collaborative court services by supporting criminally-involved men and women with co-occurring disorders as they cope with behavioral health issues and strive to attain stability and self-sufficiency.

7. Children, Youth and Families (CYF)

Recognizing the impact of trauma not just at the individual level, but the systems level, the Bay Area region of California seeks to create a shared and trauma informed regional infrastructure to implement, sustain, and improve services for children and youth affected by trauma. The City and County of San Francisco Department of Public Health (SFDPH) was awarded a four year, 4 million dollar SAMSHA grant to convene and support the Bay Area Trauma Informed Systems of Care (BATISC) initiative as a regional collaborative of seven Bay Area counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara and Santa Cruz.

The initiative builds on the work of the San Francisco Trauma Informed Systems Initiative and will focus on creating a trauma informed region in order to reduce disparities in behavioral health access and improve the provision of trauma-informed services. To coordinate and facilitate this regional effort, the Bay Area will create a unique center purposed to promote the development of trauma informed systems and positioned to serve participating counties in Northern California. The BATISC Center will support the creation of a

regional infrastructure that recognizes and responds to trauma in a culturally and linguistically competent, family-driven, youth-guided and evidence-based manner.

Within the BATISC structure, initiative activities will take place through partnership with children, youth, and families impacted by trauma and with a focus on reducing health and access disparities specifically for children ages 0-5, foster care and juvenile justice-involved children and youth, and transition aged youth. In order to enhance the quality of care, BATISC will also coordinate the creation of behavioral health and medical homes to serve children and youth placed "out-of-county." The implementation of a Bay Area Trauma Informed Systems of Care initiative and the formation of the BATISC Center will provide the needed coordination for county systems, resulting in more effective and seamless care in partnership with youth and families.

CYF System of Care represented DPH to the "Unaccompanied Minors" hearing held by Joint Select Committee, comprised of members from the Board of Supervisors & Board of Education's. DPH's current efforts include (1) systems coordination via Behavioral Health Services; and (2) service capacity via our Primary Care Services & Other Specialty Services.

I. Overall systems coordination via Behavioral Health Services
Behavioral Health Services, Children Youth & Families System of Care have been conducting the following activities to coordinate services:

- In collaboration with F5SF, HSA, MCAH, Primary Care, develop a First Encounter Check List for providers to screen for unaccompanied minors safety & bio-psycho-social needs during their initial contacts so that providers can determine linkages to other special services.

- Coordinated a Behavioral Health Treatment Providers meeting to discuss service coordination to align & orient each other to current behavioral health treatment providers' efforts for this population.

- Initiated discussion with SFUSD's Students Families & Community Support Services (SFCSS) and Special Ed (SPED) to ensure linkage to DPH behavioral health services is in place.

II. Capacity via Primary Care Services & Other Specialty Services

- Health Care – unaccompanied minors can access primary care services regardless of status via the Family Health Center, which includes the Refugee Medical Clinic. Located at San Francisco General Hospital, FHC offers a full range of services including:

- Additionally, FHC links patients to Population Health Division's Newcomers Health Program. In partnership with FHC, the New Comers Health Program can connect youth who are granted asylum status to federal benefits, such as comprehensive health screening & exams and social services.

- Other Specialty Services

  Maternal Child & Adolescent Health's (MCAH) Public Health Nurses can serve two subset within the unaccompanied minor's population:

- Pre-natal & post-partum care for pregnant youth. This is especially helpful when serving unaccompanied minors who are pregnant.
- Health care coordination for unaccompanied minors who are in foster care system.

L.E.G.A.C.Y. (Formerly CSOC)

L.E.G.A.C.Y. is once again partnering with BIH (Black Infant Health) to provide enhanced services to women of color in the Bayview Community with a post-partum parenting workshop. The free 8-week (10/7 – 12/9/2014) workshop for new mothers provides a healthy meal, peer and provider support and teaches parenting skills. This workshop is being held is being held at the L.E.G.A.C.Y. office Tuesdays 12:30P-2:30P.

On Saturday, October 4th, L.E.G.A.C.Y. participated in the 7th annual Southeast Community Commission Health Fair held at CCSF Southeast campus. SFDPH was heavily represented at this wonderful community event. L.E.G.A.C.Y. participated for the third consecutive year with an information table.

L.E.G.A.C.Y. is preparing for our annual Halloween Event. The event will be held on October 27th, 5:30P – 8P. Our staff with support from FMP (Family Mosaic Project) staff, are busily preparing activities (face painting, treat bag decorating, arts and crafts). The American Licorice Company once again donated cases of treats for our in house trick-or-treating.

Foster Care Mental Health

FCMH has been busy piloting a new team structure that will be the corner stone of our new Attachment-Based, Trauma Informed, Long Term Care Coordination Model. The new teams are implementing new practices and are working hard, in partnership with Protective Social Workers within Human Service Agency, to create new protocols for screening and assessing each newly detained child in the Foster Care System. We look forward to sharing the outcomes of our pilots over the next several months.

Substance Use Disorder Prevention Programs

The California Department of Health Care Services' Strategic Prevention Framework requires counties funded through the Substance Abuse Prevention and Treatment Block Grant to report annually on progress toward local strategic prevention goals and objectives. Consistent with this state requirement, BHS has supported building system and provider capacity to evaluate whether evidence-based and local promising prevention practices are meeting the desired outcomes for children, youth, and families served by these interventions. Fiscal Year 2014-15, BHS is funding the Youth Leadership Institute (YLI) to oversee an evaluation of youth-led, neighborhood-based environmental prevention (EP) projects that will be implemented consistent with the Communities Mobilizing for Change on Alcohol (CMCA) Framework. This evaluation will provide the department and the substance use disorder prevention provider network with data to inform future program planning. The CMCA Youth Participant Pre-Test and Post-Test Questionnaires contain a series of items that will measure the impact of provider EP projects on youth knowledge, attitudes, beliefs and behaviors on alcohol use, consistent with the San Francisco Substance Use Disorder Prevention Services Strategic Plan goals to reduce the initiation of alcohol use by middle school students and to reduce binge drinking by

high school students. In addition, the survey instruments will measure youth development skills gained through youth involvement in EP adult-youth leadership activities.

Mission Family Center

August and September were back-to-school months, and as a result, MFC has seen an increase in the number of referrals as families and teachers get acclimated to the new school year. We are handling these new referrals in record time as our Intake PDSA continues to flourish!

In addition, the MFC staff has taken on the challenge of responding to the increased arrival of refugee children, youth and families from Central America and is participating in DPH efforts to meet their needs in a culturally and linguistically appropriate manner. MFC has also responded to the increased violence in our neighborhood during the month of September. Staff members have participated in the facilitation of community debriefings, and some of us participated in a march on Friday 9/26/14 in a continued effort to raise our voices for peace.

And last but not least, MFC has been collaborating with our CBHS-Adult Program building neighbors to create a unified building approach to safety. Our three program directors have been planning in the last several months, and participated in the first inclusive building safety meeting on 8/29/14. Going forward our goal is to have unified building safety meetings quarterly.

Southeast Child & Family Therapy Center

School is back in session and the Southeast Child/Family Therapy Center is providing services wherever they are needed. We have staff at the following schools, providing consultation, individual and group therapy: SF Community, ER Taylor, Guadalupe, Bret Harte, Visitacion Valley Middle and Burton High. We have started an Incredible Years parenting group that will run through December. We are running a PDSA to increase access to psychiatry using multiple measures. We are saying good-bye to Metzi Henriquez who is returning full time at CARECEN. We look forward to continuing to coordinate services with her and thank her for her contribution to the clinic in the past year.

Chinatown Child Development Center

CCDC participated in the 19th Annual Chinatown Community Health Fair. It was held at Chinatown YMCA (855 Sacramento Street) on Saturday, October 11th from 10 am to 3 pm. CCDC's staff was stationed at our table/booth to hand out brochures regarding to our mental health services and answer general questions.

CCDC will be hosting our quarterly "CCDC Parent Advisory Board Meeting" on November 1, 2014 from 10:00 am to 12:00 pm. Topic of discussion revolves around how CCDC can efficiently deliver and improve quality of services, increase communication between clients and providers, and other relevant topic regarding the Affordable Care Act.

8. 2014 MHSA AWARDS CEREMONY

The MHSA Awards Ceremony is an Innovations project that publicly honors current and former clients in MHSA-funded programs in San Francisco. Consumers/peers are recognized for the personal achievements in wellness and recovery in a formal celebration that includes a delicious sit-down meal, entertainment, and awards.

The 4th Annual MHSA Awards Ceremony was held on October 2nd, 2014, and by what we have been hearing, it was the most moving and powerful event yet! It was held at the beautiful Scottish Rite Center. Jeffrey Greer of Recovery Theater was our MC; we had a guest pianist and violinist, inspirational speeches and poems, delicious food catered by Episcopalian Community Services (ECS), and amazing dessert baked by the AAIMS Project (an MHSA INN funded program). This year theme was "Breaking the Chains of Stigma.

The nomination criteria was developed by the planning committee, and is as follows:

- Advocacy: Reducing stigma related to mental health conditions through signing petitions, registering to vote or attending a rally, being on a speaker's bureau, working/volunteering as a peer in a mental health program.
- Reuniting/rebuilding connections with family members (parent, child, sibling, partner, etc.).
- Employment – Honors individuals who are successfully volunteering, interning, or employed part-time or full-time. An individual's employer or supervisor may verify these awards.
- Independent living – Honors members who have successfully obtained and kept housing independently of family, Board & Care, and other assisted living.
- Pursuing educational goals- Honors those who have successfully enrolled in an educational course, certificate program, vocational program, community college, university, etc.
- Financial independence – Honors those who have completed the Financial Planning process and agreed to obtain a payee for financial stability, has own checking account, or is financially independent.
- Reduce the impact of substances - Honors those who have successfully reduced the impact of substance use in their lives, embracing harm reduction and/or abstinence. (This award is self-reported.)
- Working on decreasing stigma
- Graduating from Behavioral Health Court, off probation or parole, stabilized in the community.
- Graduated from RAMS, SFSU, CCSF, or another Mental Health Certificate Program.
- Attending trainings for personal or professional growth.

At this highly anticipated event:

- 80 Consumers received 1 Bell Awards (excelled in 1 area for at least 3 months)
- 60 Consumers received 2 Bell Awards (excelled in 3 areas for at least 6 months)
- 50 Consumers received 3 Bell Awards (excelled in 5 areas for at least 12 months)
- 2 Consumers received the "Breaking the Chains of Stigma" (excelled in 6 or more areas for over 12 months)
- 2 Teams were awarded Outstanding Team of the Year. (AAIMS Project and The Transgender Health Services Team)

Close to 350 mental health clients and guests, and providers attending this celebration.

What is perhaps most unique about the MHSA Awards Ceremony, is that this large event and *all* of the activities leading to the event are planned and coordinated by a 17-member *consumer* planning body, with the assistance of the Mental Health Association of San Francisco and MHSA. Most of the members of this committee are past award winners. The planning process for this event usually takes 6 months and includes outreach, event theme selection, selecting award criteria, logistics, décor, presenting awards, and entertainment planning. It truly is the party of the year!

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 vita.ogans@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

Ms. **Robinson** commented that at the 4th Annual Mental Health Award Ceremony, over 200 clients were recognized for their achievements. Since there is so much stigma against and marginalization toward people with mental illness, the award ceremony not only re-affirmed wellness and recovery but it was also a public event with celebration with family and friends and community leaders.

Dr. David Elliott Lewis added that people with mental illness who strive for wellness and recovery feel validated by the award.

Ms. **Robinson** said the department is in the final interviewing phase to hire a clinical coordinator who will ensure community programs are oriented toward wellness and recovery. She hopes to announce the new person at the November 2014 meeting.

Ms. **Virginia Lewis** requested an update about the progress of Laura's Law implementation.

Ms. **Robinson** stated that there are three remaining Assisted Outpatient Treatment (AOT) implementation meetings left. Then, the committee will submit the plan to the City Attorney's Office for a final review.

In the implementation plan, the department will hire an AOT director who, preferably, will be a clinical psychologist. The new AOT director should start in January 2015 to start the process of educating staff and the public about Laura's Law.

The Mental Health Board will have a say on the implementation plan. The full implementation of AOT should be by November 2015.

Ms. **Virginia Lewis** asked who will provide the services.

Ms. **Robinson** said AOT services can be either by current contractors or by a request for proposal (RFP) process.

2.2 Public comment

Ms. **Hardy** commented that she would like know how many people are on the AOT implementation committee and would like to know about the AOT budget.

Ms. **Robinson** said the AOT implementation committee has about 15 members and AOT budget must be approved by the Board of Supervisors for the November 2015 implementation. As for as the hiring of an AOT director goes, the AOT budget only budgeted for a director position to start helping with the AOT implementation.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

A member of the public stated that although peers can quickly relate to a person in crisis sympathetically from lived experience without much explanation. But lived experience alone is no substitute for the rigorous trainings required of clinicians responding to a crisis.

3.2 PROPOSED RESOLUTION Be it resolved that the minutes for the Mental Health Board meeting of September 17, 2014 be approved as submitted.

Unanimously approved

3.3 **Resolution**: Be it resolved that the Mental Health Board urges Community Behavioral Health Services to increase the Mobile Crisis Treatment Team to 24/7.

> **RESOLUTION (MHB – 2014-05)**: Be it resolved that the Mental Health Board urges the Health Commission and the Board of Supervisors of San Francisco to increase funding of the Mobile Crisis Treatment Team to include peer (mental health consumer) members and expand its overall services to seven days a week, 24 hours a day.
>
> WHEREAS, the Mobile Crisis Treatment Team, which is a program of Community Behavioral Health Services (CBHS) in the Department of Public Health, has helped many people in crisis since it was founded in 1995; and,

WHEREAS, Mobile Crisis is crucial for cost-effectiveness by reducing the use of the most expensive services such as Psychiatric Emergency Services or the psychiatric inpatient wards at San Francisco General Hospital; and,

WHEREAS, Mobile Crisis is a critical service for family members of people with serious mental illnesses who can call upon it when they see a loved one showing the warning signs of distress or decompensation; and,

WHEREAS, the San Francisco Police Department is a strong supporter of Mobile Crisis and frequently calls upon it saving the police department significant costs in terms of officer time plus freeing up officers for doing other police duties; and,

WHEREAS, a mental health crisis can and does occur at any time of day or night including weekends and not just during normal nine to five, Monday through Friday business hours,

WHEREAS, walk in afterhours and weekend mental health crisis services are extremely limited and non-existent in most neighborhoods,

WHEREAS, the value that peers – those with lived experience with mental illnesses in engaging and communicating with those suffering a mental health crisis has been repeatedly demonstrated and has been increasingly accepted as important in any overall treatment engagement strategy, therefore,

BE IT RESOLVED, that the Mental Health Board recommends to the Health Commission, the Board of Supervisors, and the Mayor, that the Mobile Crisis Treatment Team be funded at a level which allows it to operate 24 hours a day, seven days a week and be funded to also include peer members to improve outreach effectiveness.

Ms. **Bohrer** suggested an increase in funding to include three (3) mental health peers, since a person in crisis often feels a peer can intuitively connect and understand his/her despair and pain without having to explain much to the peer. She would like to have a peer at each shift.

Sgt. Kruger said she personally had worked for the San Francisco Mobile Crisis Team and wondered how a peer might respond to a person in crisis on a clinical level.

Dr. **David Elliott Lewis** mentioned that peers may see person in crisis at their worst moment in life!

The board voted to make a few grammatical word changes. The resolution was unanimously approved.

Unanimously approved

ITEM 4.0 PRESENTATION: OVERVIEW OF THE LANTERMAN-PETRIS-SHORT ACT (LPS LAW) FOR INVOLUNTARY COMMITMENT TO A PSYCHIATRIC FACILITY AND ITS IMPLEMENTATION IN SAN FRANCISCO. STEPHEN R. JAFFE, ESQ., THE JAFFE LAW FIRM, SGT. KELLY KRUGER, SAN FRANCISCO POLICE DEPARTMENT, WENDY JAMES, VICE CHAIR, MENTAL HEALTH BOARD.

4.1 Presentation: Overview of the Lanterman-Petris-Short Act (LPS Law) for Involuntary Commitment to a Psychiatric Facility and its implementation in San Francisco. Stephen R. Jaffe, Esq.,

The Jaffe Law Firm, Sgt. Kelly Kruger, San Francisco Police Department, Wendy James, Vice Chair, Mental Health Board.

Dr. David Elliott Lewis welcomed Stephen R. Jaffe who will give us an overview of the LPS Law, then Sgt. Kelly Kruger will share how it is implemented in San Francisco and Wendy James will share her personal experience.

Mr. Jaffe briefly explained the LPS Law. First, he emphasized that LPS conservatorship is not the same conservatorship as probate's conservatorship. In LPS, there are four (4) levels of public intervention according to the California Welfare and Institutions Code (WIC).

- WIC 5150 is for involuntarily detaining people who are in an imminent danger to self (DTS) and/or danger to others (DTO) or gravely disabled. 5150 is a 72 hour hold.

Dr. **Patterson** wondered about detaining a person in crisis for a 5150 and determining that person to be medically necessary for an involuntary 5150 hold.

Sgt. Kruger added that as long as a responding law enforcement official believes that there is probable cause then a person is transported to a receiving facility for involuntary examination of 5150.

Without care or treatment, the person in crisis is likely to suffer from neglect or refuse to care for himself or herself and such refusal could pose a threat of harm to his or her wellbeing; and there is a substantial likelihood that without care or treatment, the person will cause serious bodily harm to himself, herself or others in the near future as evidenced by recent behavior.

Ms. Robinson asked when a 5150 actually starts.

Mr. **Jaffe** said it is the treating doctor who makes the final determination if a 5150 hold is warranted, since there are many possible outcomes following examination of the patient. This includes the release of the individual to the community (or other community placement), a petition for involuntary inpatient placement (what some call civil commitment), involuntary outpatient placement (what some call outpatient commitment or assisted treatment orders), or voluntary treatment (if the person is competent to consent to voluntary treatment and consents to voluntary treatment).

The next three (3) levels of intervention are.

- WIC 5250 is a 14 day hold with the same criteria as WIC 5150
- WIC 5750 is temporary conservatorship for a 30 day hold. There are more rights to protect with due process for free legal representation to a hearing.
- The LPS conservatorship is a permanent conservatorship for a year with annual re-evaluation. Usually, if a conservatee has no family or friend to be a conservator, then the Office of Public Guardians, who are public employees, can step in to be the conservator.

A 5150 can be initiated by judges, law enforcement officials, physicians, or mental health professionals. Each state in the Union has its own 5150-like code, albeit different names of course. For example, Florida's Baker Act is equivalent to California's WIC 5150.

Ms. **Bohrer** asked about having legal representation at level three.

Mr. **Jaffe** emphatically said that any conservatee can demand representation at any level, provided the conservatee can afford the legal fees. The right to a jury trial is not revoked if you are to be conserved.

Dr. David Elliott Lewis wondered how many WIC 5750 cases in San Francisco.

Mr. **Jaffe** responded there are not a lot, but he does not have the data to substantiate per se.

Sgt. Kruger talked about San Francisco Police Department's general order for psychological evaluation of adults.

The SFPD General order, in essence, requires responding officers to intervene when there is reason to believe that a person is mentally ill and because of his or her mental illness, the person has refused voluntary examination.

When a concerned citizen calls the police for intervention, it is helpful to provide a summary rather a lengthy history to the responding officer, because police just need to know "WHY" there was a need to call the police.

For example, a police officer responded to an incident where a person was in the middle of an acute crisis. Furthermore, the person has black belt, is a Vietnam veteran, and has acute psychosis. The officer also observes the person has a Rambo-like knife in their sock. In this scenario, there is an imminent risk to violence and a safety risk. When police detain a person in acute crisis, the person must be put in hand cuffs for transport safety.

But transport is sometimes an issue. If a person has a medical issue then transport should be done by an ambulance rather than in a police vehicle. Sometimes it is possible for a clinician to safely transport a non-threatening client. Police should not be used all the time for transport, but should be when public safety is an issue.

Dr. **David Elliott Lewis** asked about taking a person in crisis to DORE Urgent Care rather than to the San Francisco General Hospital's Psychiatric Emergency Service (PES) department.

Sgt Kruger said that officers frequently take people to Dore Urgent Care. However if they may have committed a misdemeanor or felony, then officers take them to PES.

Ms. **Robison** mentioned that DORE Urgent Care is just a voluntary clinic.

Dr. **Patterson** asked about Tarasoff for a clinical psychologist who sees a client without mental illness.

In clinical psychological practice in the United States, duty to warn requires a clinician who has reasonable grounds to believe that a client may be in imminent danger of harming others to warn the possible victims. Duty to warn is among the few exceptions to a client's right to confidentiality and the therapist's ethical obligation to maintain confidential information related in the context of the therapeutic relationship.

Sgt Kruger said Tarasoff would not apply because there is no incident of mental illness.

She provided some recent statistics. In 2013, PES showed 7,359 holds with 90% determined to be medical necessity for 5150. It appears that there is a rise of 1,000 new cases annually. 75% of the 5150 reports were written by law enforcement officers.

Ms. **James** shared her lived experience seven (7) years ago when she was at the darkest moment in her life. Her despair and hopelessness was precipitated during the 2008 Great Recession. In a short period of time, her life crumbled rapidly and all culminated in the loss of her house, job, unemployment benefit, and Electronic Benefit Transfer (EBT).

During that period, she lost everything and was homeless. As a last resort and desperate, she went to the Golden Gate Bridge's North Tower, which is in the Marin county jurisdiction. Out of despair and extreme psychological pain, she felt that her third attempt to jump could succeed.

But, she ended up in a Marin county hospital where clinicians triaged her and arranged for her transfer back to San Francisco General Hospital the next day for ongoing care, because she was a San Francisco resident.

Upon her reflection back to that time period of her life, there was a sense of hopelessness. Now she has housing, income and family.

4.2 Public Comment

Ms. Hardy shared that she had a brother who suffered schizophrenia around his 30's that resulted in his premature death in his 50's. She wondered about the difference between Mobile Crisis and SF HOT.

Ms. **Robinson** said Mobile Crisis specifically addresses mental health crisis situations and SF HOT is the Homeless Outreach Team responding to homelessness.

Ms. **Crouser** wondered about the adequacy of police officers for San Francisco's rapidly growing population.

Sgt. Kruger said the Board of Supervisors approved 2,400 officers. But there is a shortage of officers due to retirement and low recruitment. Currently, there are about 1,600 officers available for the growing San Francisco. Now, money is approved for police academy recruiting efforts.

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:

- Northern California Suicide Prevention Summit, October 24th, 9 – 3 pm at Samuel Merritt University Health Education Center. See flyer.
- The MHB has been invited to do test calls to ACCESS. Steve Benoit and Michelle Meier are offering a brief 30 minute training on Tuesday, October 28th from 11:30-12:30 to review the Test Call Protocol, Script, and Summary Form. They will also be extending the training an additional half hour to provide some role play for those that requested it.

- The following organizations are scheduled for the 2014-2015 Program Review.
    - 10/27/2014 Dr. David Elliott Lewis and Dr. Terence Patterson visit SF General Hospital.
    - 10/22/2014 Wendy James and Dr. David Elliott Lewis visit Horizons Unlimited.
    - 10/29/2014 Virginia Lewis and Harriette Stevens visit Mental Health Association – SF.
    - 11/07/2014 Virginia Lewis and Terry Bohrer visit Health Right360.
    - 11/13/2014 Sgt. Kelly Kruger and Errol Wishom visit Swords to Plowshares.

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

The next meeting of the Executive Committee is tomorrow, Thursday, October 16th, 2014 at 10:30 AM in Room 417 at 1380 Howard Street.

Dr. **David Elliott Lewis** said that at the September 18, 2014 Executive Committee meeting, the committee decided to form a committee to plan the board retreat for Saturday, December 6th, 2014. Dr. Terence Patterson is the Chair of planning the 2014 retreat.

The Behavioral Health Leadership Team meets the first Tuesday of each month to review quality improvement (QI) information about CBHS programs. Two members of the Mental Health Board are invited to attend as observers to this meeting. The next meeting is Tuesday, November 11th from 11:00-1:00 in Room 515. Different board members can attend but you will need to let Ms. Brooke know ahead if you wish to go.

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.

Sgt Kruger nominated Eve Meyer who runs the Suicide Prevention Program in San Francisco.

Dr. **David Elliott Lewis** nominated soon to retire San Francisco Police Commander Richard Corriea.

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

Ms. **Bohrer** reported that she met with Supervisor Mark Farrell to talk about the Laura's Law, when he came by her building.

Ms. **Stevens** reported that she met with Supervisor Mark Farrell to keep him abreast of the board activities.

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

Ms. **Bohrer** suggested extending an invitation to the new appointed head of the Crisis Intervention Team of the San Francisco Police Department. She also suggested a presentation by the Network of Care representative, by a homeless connection service whether it be Homeless Connect or Homeless Outreach Team (HOT).

Ms. **Robinson** stated that San Francisco used to be involved in the Network of Care for Behavioral Health

5.6 Public comment.

Mr. **Porfido** thanked the board for having a meet and greet before the board meeting.

Ms. **Virginia Lewis** has observed that Gene Porfido has attended many board meetings and contributed many interesting comments.

ITEM 6.0 PUBLIC COMMENTS

Mr. **Porfido** thanked board members for arriving early for the meet and greet session for prospective members who are interested to be on the Mental Health Board.

Ms. **Virginia Lewis** commented that she has seen Gene Porfido regular presence at the board meetings.

ADJOURNMENT

Meeting adjourned at 8:35 PM.