



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board Meeting
Wednesday, [February 18, 2015](#)
City Hall, 2nd Floor, Room 278
One Carlton B. Goodlett Place
San Francisco, CA
6:30 – 8:30 PM

BOARD MEMBERS PRESENT: David Elliott Lewis, PhD, Co-Chair; Wendy James, Vice Chair; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Ulash Thakore-Dunlap, MFT; Deborah Hardy; Terence Patterson, EdD, ABPP; Harriette Stevens, EdD; Njon Weinroth; Idell Wilson; and Errol Wishom, Co-Secretary.

BOARD MEMBERS ON LEAVE: Ellis Joseph, MBA, Co-Chair; Virginia S. Lewis, MA, LCSW; Adrian Williams and Vanee Tran, MS.

BOARD MEMBERS ABSENT: Andre Moore

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Derek Knight; Cheri Renee Watkins; Mercedes Crosser; Angelica Almeida, AOT Director; [five](#) additional members of the public

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:35 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

ITEM 1.0 REPORT FROM COMMUNITY BEHAVIORAL HEALTH SERVICES DIRECTOR

Dr. David Elliott Lewis introduced CBHS Director Jo Robinson to give the director's report.

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

Ms. Robinson said that CBHS plans to complete the Diagnostic and Statistical Manual-Fifth Edition (DSM-V) transition from the DSM-IV (fourth) edition by October 1, 2015. It is published by the American Psychiatric Association and it's the primary manual used by clinicians to provide a formal diagnosis of mental health disorders. Trauma informed trainings will continue in March 2015. The training sessions are for training various departmental staff and training trainers. Then, trainers will

team up with staff who have lived experience to train administration, maintenance and facility services. The goal is to train all City and County civil service employees.

At the state level, California Senator Mark Leno has expressed a commitment to author legislation for Peer Support Certification. His legislation would provide strong support for peer specialists and add them to the Medicaid State Plan. CBHS is preparing to host Daryl Steinberg, who served in the California State Senate from 2008 to 2014, and Sacramento legislative staffers to tour San Francisco's crisis services. One of the visiting sites is DORE Urgent Care Clinic. Also, CBHS is seeking to expand the warm line program to 24/7. This is staffed by many peers with lived experience.

She announced that, in a few months, a psychiatric peer respite called Hummingbird Place will be opened with the eventuality of becoming a 24/7 drop-in program. Another peer respite program with some over-night beds is the Behavioral Health Center at San Francisco General Hospital (SFGH). She encouraged the board to invite peer-respite staff to come in and talk about their services.

She also introduced Angelica Almeida as the new Assisted Outpatient Treatment (AOT) Director, who is very familiar with psychiatric services as she was formerly from Jail Psychiatric Services (JPS). She received the top score on the Civil Service exam.

Ms. Hardy asked for the number of calls to the Warm Line.

Ms. Robinson said the Warm Line has received over 300 calls since July 2014.

1.2 Public Comment

Mr. Knight inquired about the opening of the Hummingbird Place and about the peer respite certification.

Ms. Robinson said a 30-day soft opening period as a trial time will begin in March 2015.

The certification for peer specialists is still at the early stage of development. It needs to pass in the California Senate and Assembly and then be approved by Governor Brown.

Monthly Director's Report **February 2015**

1. Medication Safety – It takes Two!

Ever wonder why you are asked to confirm your full name and date of birth when picking up medications at the pharmacy or receiving a medication in the hospital or clinic? This practice – using two patient identifiers – helps confirm that the right person receives the right medication. Using two patient identifiers when providing care, treatment or services is one of The Joint Commissions (TJC) National Patient Safety Goals. In fact, it is the first goal listed for all TJC National Patient Safety Goal programs, including ambulatory health care, behavioral health care, critical access hospital, home care, and hospital.

The reason this goal is so important is because patient misidentification can lead to serious medication errors. Using two identifiers unique to the individual, such as full name and date of birth, is an effective strategy for matching the right treatment to the person for whom the treatment is intended. Other acceptable identifiers include an assigned identification number (e.g. medical record number), telephone number, or other person-specific identifier.

BHS Pharmacy staff recently met with DPH Nursing staff to review the importance of the two identifier practice, and to strategize on overcoming barriers in ensuring this practice is performed consistently. Handouts on using two identifiers were provided to nursing staff, with the intention of posting the handouts in clinic medication rooms to encourage the culture of using two identifiers.

Although it may seem like a simple strategy, there are barriers to ensuring two identifiers are used each and every time before a medication is dispensed or administered to a patient. Some staff may feel that it is impersonal and awkward to use two identifiers repeatedly with familiar patients. Even with patients that are well known to staff, it is important to consistently use two identifiers. Not only does using two identifiers help identify the individual, it also ensures that the right treatment matches the right person. Educating patients on the risks of patient misidentification and explaining that the two identifiers is for their safety may help reduce concerns of appearing impersonal and supports their wellness and recovery. Sometimes language barriers can make it difficult to confirm person-specific identifiers. Staff may want to utilize a translator and ask the patient for an identification card to confirm the patient's identity in such cases. Another potential issue is time and workload - a staff member may have several patients waiting to receive medications. In such cases, it is better to ask for help than to skip verifying two identifiers.

Taking the time to ask each patient every time before providing treatment for two identifiers is an important medication safety strategy. It is also a way to engage patients in their treatment, and an opportunity to educate patients on medication safety. As a health care worker, you are looking out for your patient's safety when you ask them for two identifiers. As a patient, you are ensuring that you are receiving the treatment that was intended for you. Remember, it takes two!

(See Attachment 1 & 2)

2. Greetings from CalMHSA!

Please find attached to this email, the January News to Use! The theme of this month's "News to Use" is: [African American Community Partnerships Aim to Reduce Mental Health Disparities](#).

Please take a few minutes to read the newsletter, and learn about what types of CalMHSA suicide prevention activities that are happening statewide and locally.
(See Attachment 3)

New DHCS Director for Department of Health Care Services

Governor Jerry Brown selected Jennifer Kent as the new Director of DHCS; she fills the position formerly held by Toby Douglas and began her new role on February 9.

Peer Certification

California Behavioral Health Director's Association (CBHDA) is sponsoring Peer Support Certification legislation. Senator Mark Leno has agreed to be the author. "Peer Specialists" would also be added as a provider type in the Medicaid State Plan. A lot of work remains to get the bill through the legislature and signed by the Governor.

"Bridge to Reform" Waiver Renewal Workgroups

DHCS convened the final meetings of its stakeholder workgroups this week. The groups inform the 1115 Waiver renewal proposal. CBHDA is working with others to advance behavioral health priorities in the Waiver.

CalMHSA Programs Deliver Positive Outcomes

Emerging evidence shows that the statewide initiatives are "reaching targeted California populations, reducing mental illness stigma, increasing the number of Californians with the skills to intervene with and refer individuals with mental health challenges, and disseminating evidence-based practices through online resources and strategic collaborations." View the latest findings from RAND's comprehensive evaluation here. This new report from the RAND Corporation's independent review of CalMHSA's Prevention and Early Intervention Initiatives (PEI) shows these public health programs are making a difference in reducing stigma, preventing suicide, and improving student mental health. The RAND Corporation's snapshot of early, short-term PEI outcomes finds CalMHSA programs are "successfully launched and already showing positive outcomes." Contact: Nicole Eberhart at eberhart@rand.org.

3. Welcome Back Jim Stillwell!

We are pleased to announce that our longtime colleague Jim Stillwell is back from retirement, taking a part time role supporting Substance Use Services (SUD) in our department. We look forward to the benefits of his skill, experience and generosity of spirit.

4. Interesting Facts about the Differences between DSM IV and 5:

1. The DSM is now titled with a number 5 instead of a Roman Numeral V because the intention is to produce updates without having to wait for a whole new volume. So look for interim changes which will include new research, possibly new diagnoses, or changes to current diagnostic criteria.
2. There is a Coding Correction published by the APA in March of 2014. It contains corrections to certain codes and is particularly important for those of you who are coding the major neurocognitive disorders. Make sure you download this and make the corrections to your books. The electronic app has been updated already.
3. "Splitting" is a term used quite a bit in DSM 5. Splitting happens when formerly combined diagnoses are split into separate diagnoses OR where diagnostic classes are split into one or more. An example of the former is agoraphobia and panic disorder which are now split into two separate diagnoses in recognition that they do not always occur together. An example of diagnostic class splitting are BiPolar Disorders and Depressive Disorders now split into two separate diagnostic chapters instead of the former combined Mood Disorders.
4. "Lumping", also an often used term in DSM 5, is the opposite of "splitting". Lumping happens when formerly separate diagnoses are lumped together into one. Probably the most well publicized example of lumping is with Autism Spectrum Disorder. In this case 5 formerly separate diagnoses including Autism, Asperger's, PDD, Rhetts Disorder and Childhood Disintegrative Disorder are now "lumped" into Autism Spectrum Disorder. DSM states that research does not support separate disorders but rather a single disorder with a spectrum of severity.
5. The DSM 5 is very focused on risk. As a result there are a number of new specifiers (some with codes and some that can only be documented in the narrative diagnosis) that are focused on increased risk. A very interesting new one is the "with anxious distress" specifier for the Bipolar and certain Depressive Disorders.
6. There are no more axes. As a result diagnosticians must order as primary, secondary and tertiary the diagnoses of those with multiple diagnoses including psychiatric, substance use, and medical disorders.

5. Naloxone Overdose Rescue Kits

CBHS pharmacists Michelle Geier and James Gasper have published an article describing their pioneering work in providing Naloxone overdose rescue kits at the pharmacy window for clients in treatment for opioid addiction.

(See Attachment 4)

6. Toby Ewing is New Mental Health Services Oversight and Accountability Commission Executive Director

Sacramento—The Mental Health Services Oversight and Accountability Commission (MHSOAC) is pleased to announce it has named Toby Ewing as Executive Director.

Ewing has served as a consultant to the California State Senate Governance and Finance Committee for the last four years. State Senator Lois Wolk, former Chair of the Senate Governance and Finance Committee said, “Toby Ewing is a great choice to lead the Mental Health Services Oversight and Accountability Commission. He is well known as a reformer and champion of oversight and improving outcomes of government programs. He knows our mental health system well, how it works and how it doesn’t, and will be quick to take a strong leadership role at a time when it is needed.”

Ewing also served as Director of the California Research Bureau from 2009 to 2011. From 1999 to 2006, he was a Project Manager with the Little Hoover Commission, an independent body charged with improving government. During his tenure, Ewing was project manager for several reports on state policy issues including mental health and child welfare.

Ewing did his undergraduate studies at Grinnell College and received a Ph.D. in Sociology from Syracuse University. Honored as a Fulbright Scholar in the mid-1990s, he facilitated and documented a complex community development initiative in Costa Rica.

“Toby Ewing brings a wealth of experience in state government, public policy and mental health,” said MHSOAC Chair Dr. Victor Carrion. “We very much look forward to working with Toby as we move into an important time in communicating and evaluating the positive outcomes of Prop 63 programs to demonstrate what it has done for hundreds of thousands of Californians.”

As Ewing steps in, current MHSOAC Executive Director Sherri Gauger is retiring for the second time in two years. Gauger stepped back into the role of Executive Director after leaving at the end of 2013, a retirement that lasted six months before rejoining the Commission in June of 2014.

“We would like to say a profound thank you to Sherri for her dedication to public service, particularly in her work with the Commission and Prop 63,” said Chair Carrion. “She has brought the Commission to a new level with her outstanding commitment and leadership.”

The MHSOAC is the oversight body for Proposition 63, the Mental Health Services Act (MHSA). Voter-approved Prop 63 is funded by a one percent tax on millionaires and has generated more than \$11 billion for public mental health programs since 2005.

7 Two CBHS staff to advise UCSD on Evaluation Recovery Orientation of Counties

Gloria Frederico, MFT, and Diane Prentiss, MA MPH, attended in February, the first meeting of a statewide advisory workgroup focused on Recovery Oriented practices in mental health services. Transforming mental health services to be more recovery oriented is a primary objective of the Mental Health Services Act (MHSA – Proposition 63), which was enacted ten years ago. The Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted with UC San Diego to conduct evaluation research into how effectively Recovery practices are being implemented in California counties.

The contractors will begin with "A National Framework for Recovery-oriented Mental Health Services" developed by the Australian Health Ministers' Advisory Council. They will work to build consensus about definitions and measures of Recovery through the Recovery Orientation Advisory Group, which includes stakeholders from several counties.

Ms. Frederico was recently hired as the Wellness and Recovery Coordinator for CBHS and collaborates on many projects with Ms. Prentiss, the lead MHSA Evaluator for CBHS.

Since the enactment of MHSA in 2005, CBHS has launched many initiatives to transform itself into a more recovery oriented system, including:

- \$10 million in MHSA-funded mental health programs
- Participation in several Californian Institute for Behavioral Health Solutions (CIBHS)-sponsored Recovery Collaboratives, involving multiple counties
- Piloting Wellness and Recovery Management (WMR) groups
- Launching a local Mini Collaborative focused on Recovery.

Diane and Gloria have begun to share with the advisory group many of CBHS's lessons learned, and plan to bring back to San Francisco new information about effective and impactful Recovery practices.

8. Diane Prentiss to serve on California MHSOAC Evaluation Committee

The Mental Health Services Outcomes Accountability Commission (MHSOAC), also known as the "Commission", oversees the implementation of the MHSA across the state, develops statewide strategies to overcome stigma about mental illness, and advises the Governor and the Legislature on mental health policy. The Commission recently selected Diane Prentiss, MA, MPH, to serve as a new member on its Evaluation Committee. The Evaluation Committee specifically designs and oversees numerous statewide evaluations of MHSA and communicates findings and recommendations to the Commission, state policymakers and community stakeholders. Ms. Prentiss is an epidemiologist and lead evaluator of Mental Health Services Act, in the Office of Quality Management of CBHS. She applied to serve as a committee member after attending Evaluation Committee meetings for several years as a member of the public. Ms. Prentiss will serve the two year term, 2015-17.

9. Children, Youth and Families (CYF)

CYF System of Care celebrates Maryanne Mock's upcoming retirement in April 2015

Ms. Mock has been serving as the Director of SE Child Family Therapy Center since 1992. Prior to that, she served as the assistant director for 5 years, an activity therapist for 4 years, and she even served 1 year as a graduate intern. As a result of Ms. Mock's steadfast leadership, straight forward, compassionate and transparent style, a strong program with diverse staff has been built to serve one of San Francisco's highest needs and multicultural client populations. We appreciate her can-do attitude, tenacity and ability to foster creative interventions to meet the needs of our community. Her last day in the office is April 10th, 2015. We will miss her.

Chinatown Child Development Center

CCDC has been working on our internal PDSA (Plan, Do, Study, Act) regarding to step down/triaging cases that are in need of medication support. Majority of our children seen at the clinic are referred by, but limited to, parents, teachers, and pediatricians in concerns of ADHD symptoms. Clinicians provide individual, family, and case management services; in conjunction with medication support from our psychiatrist. We are formulating a plan to work mutually and collaboratively with the community pediatricians such that our children will continue to receive medication support once they are able to manage some of the ADHD symptoms. Currently, CCDC is working together with Dr. Bella Yu, psychologist, at North East Medical Services (NEMS) to improve the flow and continuation of medication support for our children and families such that we can help our youths succeed.

Comprehensive Crisis Services

In the month of December, the Comprehensive Crisis Services Team had a productive Staff Retreat facilitated by Joanne Wile, addressing issues ranging from operational concerns to team-building exercises. Unfortunately, in January, we also had to say goodbyes to a few of our highly dedicated staff, our Medical Director, Assistant Director, and the last of our BHC staff. Nevertheless, our team had an eventful December month of 2014. The Child Crisis team provided 47 crisis evaluations out in the field and 23 of these assessments were conducted at the CSU. We continue to strive for seamless coordination and partnership with CSU to provide our children and families with excellent crisis intervention and stabilization services by discussing flow, enhancing communication, and ensuring needed follow-up. The Mobile Crisis Treatment Team is adjusting well to the additions of new OD's and continues to serve the community by providing crisis interventions in the field. We look forward to the new year of opportunities to deliver greater services to meet the needs of our children and families in San Francisco.

Crisis Stabilization Unit

We are starting the interviewing process for the manager of the third mobile treatment team. The Crisis stabilization Unit at Edgewood has served over 100 clients since opening in August. The *WarmLine* has received over 300 calls since opening in July. Both programs have met and surpassed their mid-year goals.

L.E.G.A.C.Y.

L.E.G.A.C.Y. is looking forward to 2015. Two of L.E.G.A.C.Y.'s main focuses this year will be assisting and supporting our TAY population in their transition to young adulthood. Another main area of focus will continue to be providing effective and responsive services to families in District 10. With that in mind, we are currently actively recruiting for young adults age 18-24 with current or previous systems involvement to convey their stories of transitioning from youth to adulthood. We welcome stories both of successes as well as failures, with the hopes of educating providers on effective strategies that assist youth transitioning to adulthood. Participants will be compensated for their participation.

We are once again partnering with Black Infant Health as our shared goal is to provide services to families in District 10. As BIH is located in the Western Addition, L.E.G.A.C.Y. provides a space to bring their effective and innovative services to this community.

Family Mosaic Project

In November 2014, staff completed a "strengths and needs" assessment of the agency. One area of need that was identified was that of training and learning. Based on this data and input from staff, Family Mosaic Project developed an on-going training curriculum for 2015. The topics for training will include behavioral interventions/strategies, best clinical practice models, diagnosis, medications, community resources and

safety planning. In January 2015, our topic for training was on children/youth who refuse to go to school. These trainings included diagnosis associated with poor to non-attendance of school, medications recommended to treat the diagnosis, behavioral interventions to use with teachers, parent/caregivers and clients, and community resources for families dealing with truancy and poor school attendance.

Mission Family Center

January was a very busy month for Mission Family Center (MFC). Children and youth who had received gifts during the holiday season created a beautiful handmade thank-you card which was delivered to the Sheriff's Office along with thank you cards from the MFC staff. We conducted 17 intakes which represent the greatest number of intakes in one month thus far during this fiscal year. MFC staff initiated on-site mental health services at John O'Connell High School this month and participated in an evening family & community meeting organized by the principal to discuss a critical incident. MFC collaborated with our CBHS partners to provide emergency response services and outreach to the 54 residents displaced by the fire at 22nd & Mission Streets, the majority of whom were Spanish speakers, and 15 of whom were children and adolescents. We ended the month with our annual BOCC site visit and look forward to that report.

Southeast Child & Family Therapy Center

SECTC had 33 intake slots available in January and of these 16 were scheduled and 10 were completed. We continue with our PDSA to improve access to psychiatric evaluations, compiling data and reviewing next steps. The PLAAY (Preventing Long term Anger and Aggression in Youth) team has been working on developing community partners and will begin training soon. The mindfulness/self-esteem group for adolescent girls is about to start. As the longtime program director, Maryanne Mock, will be retiring, with her last day being 2/13/15, a transition plan has been put in place. Ines Betancourt, LCSW will be the acting director and Lucia Hammond, LMFT will be the acting assistant director. Psychologists, Toni Jung and Vilma Entrenas-Yepez, have also agreed to take on some administrative and supervisory tasks. This is a very well qualified team.

Substance Use Disorder Prevention

One of our substance use disorder prevention goals is working towards the reduction of binge drinking by 9th graders in the city. In FY 2013 – 2014, a primary objective for achieving this goal was the engagement of a minimum of 100 youth in the planning, development, implementation, and evaluation of neighborhood-based youth-led environmental prevention projects focused on reducing the impact of alcohol advertising in San Francisco. These projects were developed and implemented within the Communities Mobilizing for Change on Alcohol, an NREPP evidence-based environmental prevention framework, and facilitated by 9 community-based prevention contractors. We are pleased to report that our prevention contractors engaged 233 youth in environmental prevention activities, which means as a group, exceeded our objective of engaging 100 youth by 133%.

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 UPDATES AND PUBLIC HEARINGS

2.1 Mental Health Services Act Annual Update: Public Hearing

Ms. Robinson said the next MHSA advisory meeting is on February 25, 2015 from 2 pm – 4 pm at 1380 Howard St. in room 424.

She informed the board that Gloria Frederico, MFT is the new Wellness and Recovery Coordinator.

She mentioned that under MHSA, CBHS is considering developing a program that could provide peer support for socially isolated older adults who experience very little interaction and support from family and friends. They are preparing to launch a pilot program to offer transgender clients access to mental health care and supportive services in wellness and recovery.

2.2 Public comment

No public comments.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 Proposed Resolution: Be it resolved that the minutes for the Mental Health Board meeting of January 21, 2015 be approved as submitted.

Unanimously approved

3.3 RESOLUTION (MHB-2015-03): THE MENTAL HEALTH BOARD URGES THE MAYOR, THE HEALTH COMMISSION AND THE BOARD OF SUPERVISORS TO MAINTAIN THE CURRENT BUDGET FOR COMMUNITY BEHAVIORAL HEALTH SERVICES AND RETRACT THE REQUIREMENT OF \$8 MILLION IN CUTS FOR FISCAL YEAR 2015-16.

WHEREAS, San Francisco is enjoying significant prosperity and the end of years of severe budget crisis in public health and human services, and;

WHEREAS, the overall budget for the City of San Francisco is expected to have a significant surplus for the next fiscal year, and;

WHEREAS, Community Behavioral Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-Mc Corquodale guidelines as detailed and mandated in the Welfare and Institutions code for the State of California, and;

WHEREAS, the Mental Health Board believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the-art services the City has developed through years of intensive effort, and;

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco maintain the current budget for Community Behavioral Health Services and retract the requirement made at the beginning of the two year budget that asks Community Behavioral Health Services to cut \$8 million in services for fiscal year 2015-16.

Unanimously approved

ITEM 4.0 ELECTION OF OFFICERS.

4.1 Public Comment

No Public Comment

4.2 Report from Nominating Committee

The Nominating Committee stated that the nominees at the January 21, 2015 meeting were: Chair: Kara Ka Wah Chien, Vice Chair: Ulash Thakore-Dunlap and Secretary: David Elliott Lewis. Dr. Patterson nominated Wendy James at the January meeting for the position of Chair, however, Ms. James has declined.

Dr. Patterson took a moment before electing new officers to commend out-going co-chair Dr. David Elliott Lewis for his leadership March 2013 – February 2015.

4.3 Election of Officers

The elected officers are as follows:

Chair	Kara Chien
Vice-Chair	Ulash Thakore-Dunlap
Secretary	Dr. David Elliott Lewis

ITEM 5.0 PRESENTATION: COMMUNITY BEHAVIORAL HEALTH SERVICES VISION AND CHALLENGES FOR 2015, JO ROBINSON, DIRECTOR, COMMUNITY BEHAVIORAL HEALTH SERVICES

5.1 Community Behavioral Health Services Vision and Challenges for 2015, Jo Robinson, Director, Community Behavioral Health Services.

Item postponed.

ITEM 6.0 PUBLIC HEARING OF ASSISTED OUTPATIENT TREATMENT PLAN FOR SAN FRANCISCO

6.1 Public Hearing of Assisted Outpatient Treatment Plan for San Francisco.

Ms. Robinson reviewed the attached PowerPoint and introduced the new AOT Director, Angelica Almeida.

Ms. Hardy asked for an explanation of the civil standby terminology.

Ms. Robinson referred to Sgt Kruger to explain the meaning.

Sgt Kruger explained that civil standby means a San Francisco police officer will be present but the officer will stay out of the person's peripheral vision, so that a clinician can interact with the client to ascertain if AOT is appropriate. So civil standby means the officer just acts as an observer and only intervenes if the situation gets dangerous.

Dr. Patterson asked about the criminality element for AOT non-compliance.

Ms. Robinson emphasized that being non-compliant with the AOT court order does not automatically constitute contempt of court.

Ms. Chien said that Judge Peter Bush and Judge Andrew Chang will take turns in presiding over mental health issues.

Ms. Bohrer asked if the judges hearing cases will receive any special training in AOT.

Ms. Robinson assured the board that these judges are very well versed in hearing mental health issues.

Dr. David Elliott Lewis acknowledged AOT benefits, but wondered how the Care Team encourages referred persons to stay engaged.

Ms. Robinson said it is the referred person who sets the tone while the Care Team makes all necessary accommodations to help the referred person succeed.

Mr. Weinroth asked how San Francisco's AOT compares to other Bay Area counties.

Ms. Robinson shared that Nevada County was the first to implement AOT. Although LA County has a lawsuit opposing AOT implementation, LA, Solano, and Contra Costa counties approved AOT implementation. While San Diego, Santa Clara and Santa Barbara counties are still considering AOT, San Mateo did not approve AOT.

Ms. Hardy commented that Nevada County had more people who volunteered to accept AOT services.

Ms. Bohrer suggested taking a look at how many people are diverted from AOT because there are alternatives to AOT.

Ms. Robinson said San Francisco's Board of Supervisors approved AOT in 2014 and will track the number of people who are diverted to voluntary programs.

In terms of financial commitment, she expected a range of \$30,000 -- \$35,000 per AOT person. AOT clients must be placed in safe drug free neighborhoods and will initially start at a residential care facility at the Behavioral Health Center. She also said that staff for all adult mental health care will be educated on AOT, and she expects the jail system will provide the most AOT referrals.

Ms. Stevens asked about financial eligibility criteria.

Ms. Robinson said there are no financial exclusions for AOT services, meaning AOT is inclusive for clients with or without private health insurance, as the AOT law does not explicitly say only Medi-Cal people can qualify. CBHS will seek payment from private insurance when applicable.

Dr. David Elliott Lewis asked for Angelica Almeida's opinions on engaging people in AOT services.

Ms. Almeida shared that she believes in the strength-based recovery and wellness model and hopes clients with severe mental illness can voluntarily accept AOT services.

Ms. James asked about residency status for AOT.

Ms. Robinson said the state law requires a potential AOT person to have San Francisco residency.

6.2 Public comment

Ms. Courser asked about optional languages.

Ms. Robinson said the department has staff with foreign language capability from Chinese, Spanish, Tagalog, Russian to Vietnamese.

Ms. Watkins asked for the projected number of AOT clients.

Ms. Robinson shared her research data shows about 37 people will qualify for AOT services.

Mr. Knight said that Kendra's Law in New York has very few people who have gone all the way through the system.

Ms. Robinson explained that New York is very different than San Francisco in terms of AOT implementation.

Mr. Knight asked about the role of peer specialists and if the system prefers a person with institutionalized experience.

Ms. Robinson said it can be easier to have a peer with lived experience as he/she can often empathize with and provide engagement for a person in need of mental health services. Peers can inspire a person to get help for himself/herself and to feel hopeful!

6.3 Proposed Resolution: (MHB 02-2015) be it resolved that the mental health board has reviewed the Assisted Outpatient Treatment plan for San Francisco.

APPROVED: Terry Bohrer; Kara Chien; Ulash Thakore-Dunlap; Deborah Hardy; Wendy James, David Elliott Lewis; Terence Patterson; Harriette Stevens; Njon Weinroth; and Errol Wishom.

OPPOSED: Idell Wilson.

Ms. Wilson qualified her opposition, stating that she did not have adequate time to peruse the AOT Plan, since the digital copy was sent out to her a few weeks ago during the time her computer malfunctioned.

ITEM 7.0 REPORTS

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

Ms. Brooke reported the following:

1. The Trauma Committee meets next Tuesday February 24th, 2015 at 10:00 AM.
2. The Program Review Committee meets next Thursday February 26th at 10:00 AM.

7.2 Report of the Co-Chairs of the Board and the Executive Committee.

Dr. David Elliott Lewis recognized that Mr. Wishom ends his six-year term serving on the board and presented him a commendation plaque.

For serving on the board for six years, and as Secretary for the past two years;

For contributing valuable and important information about the experience of being a consumer of community mental health services;

For passionately advocating for consumers, family members and underserved communities in San Francisco;

For being a voice for those who are not able to speak for themselves;

For attending City events, Supervisor meetings, and community gatherings to represent the board;

For the many program reviews you have completed including several where you stepped in at the last moment for another board member;

For your wonderful sense of humor, compassion, and empathy for others;

For complementing city staff when they have done a good job or run an effective program and always saying a gracious thank you to presenters to the Mental Health Board.

For your consistent support and encouragement of the Mental Health Board staff.

As the out-going chair, he thanked the board for selecting him as the board's co-chair.

7.3 People or Issues Highlighted by MHB: Suggestions of people and/or programs that the board believes should be acknowledged or highlighted by the Mental Health Board.

No people or issues were highlighted

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

Dr. David Elliott Lewis mentioned the 7th International Conference, Together Against Stigma: "Each Mind Matters." He said the following board members were at the three-day conference: Ms. Thakore-Dunlap, Ms. Hardy, Ms. James, Ms. Stevens, and Ms. Wilson, as well as himself.

Ms. Wilson shared that there was a lack of diversity to reflect the different populations in San Francisco at the conference.

Ms. Hardy shared that she would like to have seen more interest in care for severely mentally ill people but overall she felt the conference started out very good and was informative.

Ms. James shared that she attended the Coming Out workshop discussion about disclosure of mental illness and she thought it was very enlightened.

Mr. Weinroth mentioned he recently attended a conference on motivational interviewing, and found it to be very helpful.

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

Dr. Patterson suggested chronic trauma and violence issues impact on youth and families in Bayview Hunter's Point and Western Addition and would like the board to revisit the District 10 report that was completed by former board member Ms. Lena Miller.

7.6 Public comment.

A public member shared that, although the "Each Mind Matters." was very informative, he felt the conference was skewed more toward academic research. He would prefer to see more presentations about front-line delivery of mental health care with a comparison and contrast of programs efficacy among various countries. For example, the U.S. recently adopted the Affordable Care Act to include mental health care parity which reduces the stigma by incorporating mental health care screening into the routine annual physical care. So how does the U.S.'s new healthcare model compare to other socialized medicine countries like the U.K, the E.U, Australia and/or Japan.

8.0 Public Comment

No public comments.

ADJOURNMENT

Meeting adjourned at 8:31 PM.



African American Community Partnerships Aim to Reduce Mental Health Disparities

Just as cultural factors shape the understanding of mental health and the experience of mental health challenges, cultural understanding is needed to ensure all of California's diverse communities can attain mental wellness. Through local, culturally-relevant services and statewide Prevention and Early Intervention programs administered by the California Mental Health Services Authority (CalMHSA), California counties are helping transform our state's mental health system to reduce disparities faced by our diverse populations, including our African American community.

Culturally Relevant Stories

"The lack of understanding Blacks in America has created a deficit of unmet needs, especially in mental health." - [California Reducing Disparities Project African American Population Report](#)

African American community members can face unique forms of stigma, sometimes rooted in historical factors that have led to mistrust of health or mental health professionals.

Through Each Mind Matters: California's Mental Health Movement, more African Americans are coming forward to confront shame and fear associated with mental health challenges by sharing their stories of resilience and recovery. Visit [Each Mind Matters' Great Minds Gallery](#) to hear these first-person stories. The videos are available on DVD at [Each Mind Matters](#).



[Watch Michelle's Story](#)



[Watch Keris' Story](#)



[Watch Oscar's Story](#)



[Watch Monique's Story](#)

"Culture plays an incredibly important role in the cause and reasoning of mental health. Cultural beliefs can shape the way people identify stress and the way they seek help."

- Reverend Dr. Oscar Wright, CEO, United Advocates for Children and Families

Engaging Mind and Spirit

The [Mental Health Friendly Communities](#) (MHFC) pilot program builds partnerships between county mental health providers and faith-based organizations. The goal of the pilot program is to promote understanding of the cultural connection between spirituality and wellness in an effort to learn more about meeting the unique needs of African American communities. Contact Minister Monique Tarver at moniquetarver@yahoo.com for more information, and how to join a local MHFC.



Mental Health Friendly Community

Community Voices Shape Services

- CalMHSA's partnership with the Center for Dignity, Recovery and Empowerment builds statewide resources to address the diverse needs of California's communities through culturally appropriate approaches. The clearinghouse of resources at the Center's [Promising Practices Program](#) makes available best practices that have been successful in meeting the African American Community's mental health needs.
- California's successful "Know the Signs" suicide prevention campaign has been shown to increase public awareness of suicide risk and build confidence in taking action. The campaign has been adapted to reach African American communities with appropriate messengers and an emphasis on trusting instincts when community members sense something is wrong. Ads direct viewers to www.suicideispreventable.org. All materials are available in the [Resource Center at Your Voice Counts](#).



Creating Hope for the Next Generation

CalMHSA's partnerships are creating new understandings that offer hope that our next generation of African American young people will see greater access to mental health resources and fewer disparities in their lifetimes.

- [Directing Change](#), a student video contest empowers California's youth to tackle the public health issues of suicide and stigma by producing public service announcements. "[Pain Never Lasts](#)," by UC Riverside students, tells youth that they are not alone.
- [Scarlett's story](#) for [Walk In Our Shoes](#), a program that uses real life stories to engage students in a conversation about our differences and prevent negative behaviors associated with mental health stigma, tells students that recovery is real and possible.
- CalMHSA's partnership with the [California Reducing Disparities Project](#) strengthens the cultural considerations needed to serve the diverse populations with researched-based tools. The "[Beyond the Beat and Lyrics](#)" video highlights how stigma and discrimination affect mental health outcomes for transition-aged African American males.
- CalMHSA's student mental health partnerships promote wellness and academic success for African American students. As examples, UC Irvine hosts ongoing support groups for African American students and deploys staff to provide a safe place for students to process reactions to potentially emotional events. Fresno City College hosted a "Building Health Throughout the Community" event that raised awareness of mental health resources and opened a conversation about stigma with African American students.





Assisted Outpatient Treatment

San Francisco's AOT Implementation Plan San Francisco's Mental Health Board Plan Review February 18, 2015

Welfare and Institutions Code 5345-5349.5

San Francisco Health Code 4111-4119



AOT Implementation Committee Members

Tanya Mera	Jail Health Services
Greg Barge	DA's Office
Kavoos Bassiri	CBO
Gifford Boyce Smith	NAMI
Kara Chien	PD's Office
Virginia Dario Elizondo	City Attorney's Office
David Fariello	CBO
Anne Fischer	Nami
Martin Kritzay	Probation
Kelly Kruger	SFPD
David Elliot Lewis	SFMHB
Katherine Miller	DA's Office
Jess Montejano	BOS
Jacob Moody	CBO
Ali Riker	SFSD
Julian Sapirstein	Superior Court
Mary Wiss	Superior Court
Jo Robinson	DPH

- ✓ AOT Care Director - Licensed Psychologist with court experience
- ✓ Peer Specialist
- ✓ Family Liaison

Will be responsible for:

- ✓ Consulting with the City Attorney to establish AOT confidentiality requirements
- ✓ Ensuring the team is properly trained
- ✓ Overseeing AOT investigations, activities, court appearances and reports
- ✓ Keeping the Director of Behavioral Health informed of all AOT activities

- ✓ Develop a fact sheet for the public.
- ✓ Develop public information website regarding San Francisco's AOT Program.
- ✓ Arrange for secure phone/fax/internet transmission for AOT referrals.
- ✓ Communicate with mental health partners and other stakeholders regarding AOT.
- ✓ The AOT Team shall develop and provide training to mental health treatment providers for the purposes of improving the delivery of services to individuals referred for AOT services. (Cal. Welf. Inst. Code § 5349.1(a), S.F. Health Code § 4117.)

The Care Team will verify that the requesting party is a “Qualified Requesting Party” (QRP).
(Cal. Welf. Inst. Code § 5346(b)(2), S.F. Health Code § 4114(a).)

- ✓ (a) If a party requesting AOT assessment is not a QRP the AOT Care Team follows DPH protocol for a request for services and provide a list of appropriate services.
- ✓ (b) If the party requesting AOT assessment is a QRP, the AOT Care Team will begin to engage the Referred Individual (“RI”) and conduct the investigation to determine eligibility.

- ✓ The Care Team responds within 5 business days with an initial intervention and offer appropriate voluntary services to the RI, including, when clinically indicated, Full Service Partnerships (FSP).
- ✓ The Care Team provides the RI an information sheet on Patients' Rights.
- ✓ For a period not less than 30 days, the Care Team attempts to engage the RI and encourage voluntary participation in a mental health treatment program before any petition is filed.
- ✓ However, if significant further deterioration is occurring as documented by Care Team reports, a petition may be filed prior to a full 30 days of outreach and engagement.

- ✓ The Care Team contacts the QRP with recommendation whether RI will receive AOT services under Cal. Welf. Inst. Code §§ 5345-5349.5 and S.F. Health Code §§ 4111-4119.
- ✓ Information gained from the QRP (and from any contact made with the RI) is used to individualize and customize this initial offer of services. This initial offer will take into consideration the RI's unique needs, stated preferences, services available, and the Care Team's determination of the appropriate level of care.
- ✓ Any AOT evaluation that involves an individual currently enrolled in a treatment program must determine that all outreach and engagement efforts available through that program have been thoroughly attempted and have been unsuccessful.
- ✓ In an emergency, the Care Team may request services from Mobil Crisis to ensure the RI's safety.
- ✓ If the RI refuses the services offered, either initially or within 6 months of agreeing to any service offered as part of this initial intervention, the Care Team may commence investigation for the purpose of filing a petition. (Cal. Welf. Inst. Code § 5346 S.F. Health Code § 4115.)

- ✓ The AOT Director determines whether RI meets all eligibility criteria under the law.
 - ✓ If the RI is a resident of the County of San Francisco, the AOT Director will initiate a thorough investigation to determine if the RI meets AOT eligibility criteria. (Cal. Welf. Inst. Code § 5346, S.F. Health Code § 4115.)
 - ✓ If RI is in acute crisis appropriate crisis intervention and referrals will be made.
- ✓ The Care Team works with the RI, the QRP, and significant individuals in the RI's life to gather the necessary information to determine if the AOT criteria is present.
- ✓ The Care Team investigation follows all applicable provisions of all federal and state privacy laws in the course of the investigation, as advised by counsel.

- Care Team investigates the following:
 - Available health and hospitalization records.
 - Available mental health history.
 - Available incarceration history and mental health treatment during incarceration.
 - Current living situation.

The AOT checklist will be completed to determine if the RI meets each AOT criterion. The checklist may also support other factual findings in court. If the Care Team cannot fully complete the checklist, the reasons for the lack of completion must be recorded and the AOT Director must determine whether or not further steps toward preparation of a petition shall occur.

Development of a Treatment Plan

- ✓ Once the Care Team determines the RI is an appropriate candidate for treatment services, the Team will develop an initial Treatment Plan.
- ✓ The Care team continues to update the initial Treatment Plan with information discovered during the investigation and to formulate a practical strategy to engage the RI in the field or the office.
- ✓ The Care Team may work with the RI's existing support system (family, friends, etc.) to engage RI and develop a working relationship.
- ✓ If the RI has a history of violence, or the Care Team has reason to suspect the RI may become violent (e.g., recent reports that the RI's behavior is getting more aggressive) the Care Team can request law enforcement to serve as a civil standby. The Care Team will make a clinical determination of necessity of law enforcement involvement for staff and/or public safety, with consideration of the likely effect on the relationship with the RI.

Intervention with Referred Individual (“RI”)

- ✓ The Care Team contacts the RI and attempts to secure RI’s consent for an assessment. If consent is obtained, the RI is considered a “Client”.
- ✓ If consent is obtained, the Care Team conducts an assessment including a mental status exam.
- ✓ If the Care Team determines that the RI does not need Behavioral Health services, the RI is informed how he/she can obtain other appropriate services and the file is closed. S.F. Health Code § 4114(f).
- ✓ The Care Team explains the initial Treatment Plan (“Treatment Plan”) to the Client who is given the opportunity to participate in the Treatment Plan and the opportunity consent to the services voluntarily.
- ✓ If the Client consents to the assessment and the initial Treatment Plan, the Client is given resources to begin treatment.
 - ✓ If the Client fails to follow up with the Treatment Plan, the mental health treatment agency will contact the Care Team to determine the next steps.
- ✓ If the Client consents to the assessment, but refuses the Treatment Plan, the Care Team will refer the matter to the District Attorney to determine if a petition should be filed with the court.
- ✓ If the Client does not consent to the assessment, the Care Team will refer the matter to the District Attorney to determine if a petition should be filed with the court.
- ✓ The Care Team requests written consent from the Client for release of medical information.

- ✓ If the AOT Director determines that the Client is in need of, but refuses treatment, the Director will prepare a referral packet for the District Attorney containing:
 - ✓ The AOT Checklist.
 - ✓ The recommended Treatment Plan.
 - ✓ The assessment and mental status exam.
- ✓ The District Attorney will determine whether each of the jurisdictional factors are present which support a Petition to the court for AOT.
- ✓ The Director must demonstrate that the necessary elements can be proven by clear and convincing evidence. (Cal. Welf. Inst. Code § 5346(b)(3), S.F. Health Code § 4115(e).)
- ✓ The District Attorney, the Public Defender and the court will work together to develop necessary forms and procedures for AOT Petitions.

- ✓ If the District Attorney determines that a petition should be filed with the court, the District Attorney will prepare the following documents:
 - ✓ Verified Petition for an Order Authorizing Assisted Outpatient Treatment.
 - ✓ Affidavit of a licensed mental health treatment provider (“Provider”).
 - ✓ Notice of Hearing with Certificate of Service.
 - ✓ [Proposed] Order Authorizing Assisted Outpatient Treatment.

Requirements of the Petition

The Affidavit in support of the Petition must allege pursuant to Cal. Welf. Inst. Code § 5346(b)(5)(A)-(B) and S.F. Health Code § 4115(c):

- ✓ The Provider has personally examined the Client no more than 10 days prior to the filing of the petition,
- ✓ The facts and reasons why the Client meets AOT criteria,
- ✓ The Provider recommends AOT for the Client,
- ✓ The Provider is willing and able to testify at the hearing on the petition, and
- ✓ No more than 10 days before filing of the petition, the Provider made attempt to elicit the cooperation of the Client but has not been successful.

If a Petition is filed, the Client is entitled to be represented by an attorney. The Client may retain counsel of his/her choice at her own expense. If the Client elects, the court will appoint the Public Defender or another attorney to represent the Client. The Client shall pay the cost of the legal services if he or she is able. (Cal. Welf. Inst. Code § 5346(c); 5346(d)(4)(C), S.F. Health Code § 4116(a)(3).)

- ✓ The petitioner shall cause a copy of the Petition and the Notice of Hearing to be personally served on the Client as arranged by the AOT Team.
- ✓ The AOT Team may request law enforcement provide “civil standby protection,” if warranted by the circumstances.
- ✓ The Client will be informed by the AOT Team of resources that can be provided to ensure that the Client can attend his/her hearing.
- ✓ The petitioner shall send a copy of the Petition and Notice to the Public Defender’s Office, the county office of patient rights, and the current health care provider appointed for the Client, if known. (Cal. Welf. Inst. Code § 5346(c) and S.F. Health Code § 4116 (a)(1).)

The court shall set a hearing date on the Petition five business days after the Petition is filed. The hearing may be continued for good cause. (Cal. Welf. Inst. Code § 5346(d).)

After a petition is filed, but before conclusion of the hearing on the Petition, the Client and the Treatment Team may enter into a settlement agreement for voluntary treatment as set forth in Cal. Welf. Inst. Code § 5347.

If a Settlement Agreement is not reached, the court proceeds with a hearing pursuant to Cal. Welf. Inst. Code § 5346(d).

The licensed mental health treatment provider must submit a written Treatment Plan to the court at the time of the hearing. Cal. Welf. Inst. Code § 5346(e).

- ✓ The AOT Team must provide the services set forth in the Settlement Agreement or the Treatment Plan ordered by the court and will continue efforts to implement the Treatment Plan.
- ✓ At intervals of not less of not less than 60 days during an assisted outpatient treatment order, the director shall file an affidavit with court that the Client continues to meet the criteria for AOT. The Client is entitled to a hearing on whether he/she continues to meet the criteria for AOT.
- ✓ If a Client who is subject to court ordered treatment refuses to participate in the AOT program, the court may order the person to meet with the AOT Team. The AOT Team must attempt to engage the Client's cooperation. If in the clinical judgment of a licensed mental health treatment provider the Client has failed or refused to comply with treatment ordered by the court, and the provider made efforts to solicit clients, the Client may be subject to a 5150 hold pursuant to Cal. Welf. Inst. Code § 5346(f), if the Client otherwise meets 5150 criteria.
- ✓ If a Client does not comply with the terms of a Settlement Agreement, the licensed mental health provider may request a hearing on noncompliance pursuant to Cal. Welf. & Inst. Code §§ 5347(b)(5) and (6).

Involuntary administration of medications **is not unauthorized** under Cal. Welf. Inst. Code §§ 5345-5349.5. (See, Cal. Welf. & Inst. Code §§ 5332-5336, for involuntary medication procedures.)

- ✓ If the Client has achieved the purposes of AOT and is no longer in need of AOT, the petitioner may request the court to terminate AOT.
- ✓ Upon completion of AOT, the AOT Team will make appropriate referrals for continued treatment.

A court order for AOT expires 180 days after the date of the order. If the AOT Team determines that Client's condition requires further assisted outpatient treatment, the AOT Team may apply to the court for up to an additional 180 days of AOT before the expiration of the initial 180 days using the same procedures set forth above.