SAN FRANCISCO MENTAL HEALTH BOARD

**Mayor Edwin Lee**

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# Adopted Minutes

Mental Health Board Meeting
Wednesday, September 16, 2015
Department of Public Health
101 Grove Street
3rd Floor, Room 300
6:30 PM – 8:30 PM

**BOARD MEMBERS PRESENT:** Kara Chien, JD, Chair; Ulash Thakore-Dunlap, MFT, Vice Chair; David Elliott Lewis, PhD, Secretary; Deborah Hardy; Wendy James; Virginia S. Lewis, MA, LCSW; Toni Parks; Harriette Stevens, EdD; Njon Weinroth; Adrian Williams; Idell Wilson and Benny Wong, LCSW.

**BOARD MEMBERS ON LEAVE:** Terry Bohrer, RN, MSW, CLNC; and Vanae Tran, MS.

**BOARD MEMBERS ABSENT:** None.

**OTHERS PRESENT**: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, MFT, Behavioral Health Director; Terry Kupers; Jess Montejano, Supervisor Mark Farrell aide; Gene Porfido, Tom Waddell Medical Center; Jason Norelli, Leaders in Community Alternatives; Jon Lee, Family Service Agency; Mellissa Belbahri, Epiphany Center; Shereen Dajani, Progress Foundation; Maria M. Perez, LSC; Karen Shein, JD, Adult Probation/Reentry Council, Kathleen Wallace, SF First; Dana Arnett, Mental Health Association of San Francisco; Phalicia Jee, San Francisco School District; Genevieve

Cyrs, OTTP-SF; Corey Price, MFT Graduate Student at San Francisco State University (SFSU); Jennifer Cruz-Rios, SFSU; Marcia Clay; Genetta Williams; Roma Guy, Taxpayers for Public Safety; Jenny Poretz, Community Works; Jakki Bedsde, Misssey, Inc.; Mark Nicero, SF Sheriff's Department; Kevin Fieldly; Nina Catalano, Alameda County Public Defender's Office; Tracy Lido; Claudia B. Haas; Karen Masi, SF Public Defender's Office: Mental Health Unit; Jessica Walker, Bridge Network; Joanna Hernandez, Five Keys Charter School; Rosa Coy-Chan, Homeless Outreach Team of San Francisco (HOT); Daniel Meyer, Public Defender's Office; Hongmai Truong, Richmond Area Multi-Services (RAMS); Peggy Fava, Bridge Network; Ida McCruz, SFSD; Jacob Savage, Concrn.com; Alexis Warrington, SFSU: Counseling; Phoebe Vander Horst, City College of San Francisco: Way Pass; Joe Lee, Life Long Medical Care; and 20 additional members of the public.

## CALL TO ORDER

**Ms. Chien** called the meeting of the Mental Health Board to order at 6:40 PM.

## ROLL CALL

Ms. Brooke called the roll.

## AGENDA CHANGES

No changes in the agenda.

## ITEM 1.0 REPORT FROM BEHAVIORAL HEALTH SERVICES DIRECTOR

**Ms. Chien** introduced Jo Robinson, Director of Behavioral Health Services (BHS) to give her director's report.

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

**Ms**. **Robinson** shared a few items. As of 8/21/2015 Marlo Simmons, former director of Mental Health Service Act programs (MHSA), is the new Deputy Director of BHS. It was exciting news for the executive team because it has been operating for a year and half without a deputy director.

She mentioned that President Obama wanted to raise more public awareness about suicide and signed a proclamation on September 7, 2015 to designate September 10th as World Suicide Prevention Day.

She announced that the 5th Annual Mental Health Services Act (MHSA) Awards Ceremony will be on October 15, 2015. The celebration will recognize individuals for their path to wellness and recovery.

Angelica Almeida is the new Assisted Outpatient Treatment (AOT) director, and the program's implementation will begin on November 1, 2015.

**Dr. David Elliott Lewis**, clarified that the MHSA Award Ceremony will start at 10:30 am to 1:30 pm at the Scottish Rite Masonic Center, 2850 19th Ave, San Francisco CA, 94132. He will be co-MCing the celebration.

**A Member of the Public** shared that she has a schizophrenic son and wanted to know more about Laura's Law implementation.

**Ms. Robinson** stated that there have been public meetings and future meetings will be posted.

**1.2 Public Comment**

No public comments.

**Monthly Director's Report**
**September 2015**

## Monthly Director's Report
## SEPTEMBER 2015

EachMind MATTERS
California's Mental Health Movement

### 1. WORLD SUICIDE PREVENTION DAY, 2015

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA - A PROCLAMATION

All people deserve the opportunity to live healthy, rewarding lives. No American should have their potential limited, have their life cut short, or be deprived of their fullest measure of happiness because they do not have the mental health support they need. On World Suicide Prevention Day, we reaffirm our belief that mental health is an essential part of overall health, and together, we renew our commitment to supporting and empowering all Americans to seek the care they need.

Suicide is often related to serious depression, substance use disorders, and other mental health conditions. That is why recognizing severe psychological distress and ensuring access to the care and services needed to diagnose and treat mental illness are crucial to our efforts to prevent suicide. Individuals can also experience emotional and mental health crises in response to a wide range of situations -- from difficulties in personal relationships to the loss of a job to bullying at school. And for some of our Nation's veterans and military service members, these challenges are compounded by the invisible wounds of war. Tragically, these crises can sometimes involve thoughts of suicide -- and we must do more to support those suffering.

All Americans can take part in promoting mental well-being and preventing suicide. Everyone can contribute to a culture where individuals are supported and accepted for who they are -- no matter what they look like, who they love, or what challenges they face -- and where it is okay to ask for help.

We can do more to recognize the signs of mental health issues early and encourage those in need to reach out for support. And we must remind our loved ones that seeking treatment is not a sign of weakness; it is a sign of strength. If you or someone you know is in need of help,

the National Suicide Prevention Lifeline offers immediate assistance for all Americans at 1-800-273-TALK. Veterans, service members, and their loved ones can call this number to reach the Veterans Crisis Line, and they can also send a text message to 838255.

The Affordable Care Act extends mental health and substance use disorder benefits and parity protections to over 60 million Americans, helping men and women across our country access critical care. Protections under the health care law prohibit insurers from denying coverage because of pre-existing conditions, like a diagnosis of mental illness, and require most insurance plans to cover recommended preventive services without copays, including behavioral assessments for children and depression screenings.

In February, I was proud to sign the Clay Hunt Suicide Prevention for American Veterans Act to help fill serious gaps in serving veterans with post-traumatic stress and other illnesses. This law builds upon our ongoing efforts to end the tragedy of suicide among our troops and veterans. Last year, I announced 19 Executive actions to make it easier for service members and veterans to access the care they need when they need it, and our Government has focused additional resources on mental health services, including increasing the number of mental health providers at the Department of Veterans Affairs.

My Administration is also committed to doing all we can to empower those facing challenges and hardship. We are dedicated to combating bullying, harassment, and discrimination in our schools and communities. We are doing more to guarantee all veterans and members of our Armed Forces -- as well as their families -- get the help they deserve while they are serving our Nation, as they transition to civilian life, and long after they have returned home. And across the Federal Government, we are working to ensure all Americans are supported in times of crisis.

Suicide prevention is the responsibility of all people. One small act -- the decision to reach out to your neighbor, offer support to a friend, or encourage a veteran in need to seek help -- can make a difference. It can help energize a national conversation and a changing attitude across America. If you are hurting, know this: You are not forgotten. You are never alone. Your country is here for you, and help is available. As we pause to raise awareness of the importance of suicide prevention, let us remember all those we have lost and the loved ones they left behind. As one people, we stand with all who struggle with mental illness, and we continue our work to prevent this heartbreak in our communities.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim September 10, 2015, as World Suicide Prevention Day. I call upon citizens, government agencies, organizations, health care providers, and research institutions to raise awareness of the mental health resources and support services available in their communities

and encourage all those in need to seek the care and treatment necessary for a long and healthy life.

IN WITNESS WHEREOF, I have hereunto set my hand this ninth day of September, in the year of our Lord two thousand fifteen, and of the Independence of the United States of America the two hundred and fortieth.

BARACK OBAMA

**2. JUST RELEASED: HANBOOK FOR RECOVERY AFTER A SUICIDE ATTEMPT**


*A Journey Toward Health & Hope: Your Handbook for Recovery After a Suicide Attempt* can now be ordered and downloaded from the SAMHSA Store. This new booklet is designed to help people who have attempted suicide take their first steps toward healing and recovery. Tools and stories in the booklet come from first-hand experiences of individuals who have survived a suicide attempt and their supporters. It is the hope of the writers that their personal knowledge about the challenges of suicide attempts and the steps to successfully recover will help readers learn they are not alone, how to develop hope, and most importantly, how to stay safe in challenging times.

Allowing the reader to move at his or her own pace, the booklet speaks to questions such as, "How did I get to this point?" and "Am I the only one who feels this way?" The booklet also includes evidence-based information on:

- Taking the first steps: Talking with others about your attempt, re-establishing connections, planning to stay safe, and finding a counselor
- Moving toward a hopeful future: Finding and maintaining hope, staying in control by being organized, taking medication, and maintaining a healthy lifestyle
- Using practical, personalized tools, such as a Safety Plan
- Finding online resources for more information.

Get Your Copy Today!

## 3. IN CELEBRATION OF 'NATIONAL RECOVERY MONTH'

*The 'Recovery Happens' Planning Committee and Voices of Recovery San Mateo County*

***Is proud to present***

**RECOVERY HAPPENS DANCE**

AND **FREE** screening of

***… A ground breaking film about Recovery and Hope***

**ALL ARE WELCOME**

**When: Saturday, September 26th**

***Where: Friendship Hall, 416 Second Avenue, San Mateo, CA***

**Times:** Movie Screening begins at 5pm Recovery Happens Dance Begins at 8pm

**Music by DJ-Still Buzy**

The screening is free. Dance Ticket Price: $5.00. Groups rates available for all treatment programs. Hot dogs, beverages and snacks will be available for purchase to support Recovery Happens events. Donations to support our Recovery Happens Celebrations will be accepted, but not required. Seating will be limited, so RSVP is highly recommended. For Group Ticket Sales and reservations,
please call Ray Mills at (650) 630-4211 or email at rmills@vorsmc.org.

**More Film Info: http://theanonymouspeople.com/movie/faq/**

### 4. STIPENDS FOR MFT S

California Educational MFT Stipend Program Application Materials For 2015-16 – *Application Process is now open!*

The California Educational MFT Stipend Program will be awarding up to 111 stipends of $18,500 each for use by selected students to defray the cost of their graduate education. Selected stipend recipients are required to complete one year of paid or unpaid employment at a mental health service agency operated by or affiliated with a county's mental health or behavioral health department in California. The 2015-16 California Educational MFT Stipend

Program provides information on eligibility, application requirements, qualifying criteria, selection process, and employment/placement payback obligations.

For full details please visit the web link: http://pgi.edu/page.php?id=350

## 5. OVERDOSE PREVENTION DAY 2015

Overdose deaths outnumber deaths from motor vehicle crashes, according to the Centers for Disease Control and Prevention, and in 2013 an average of 120 Americans died from a drug overdose every day. August 31 was International Overdose Prevention Day.

San Francisco had special cause to celebrate this year. In July a deadly white powder was being sold to heroin users that turned out on analysis to be Fentanyl. The DOPE project reports 75 overdose reversals by alert San Franciscans who use drugs and look out for their friends. These overdose reversals were accomplished by use of naloxone, a rescue opioid antagonist that can be sprayed into the unconscious person's nostrils, or injected.

To learn more, or to obtain training and naloxone supplies, visit:

http://harmreduction.org/our-work/overdose-prevention/bay-area-dope/

## 6. 5TH ANNUAL MHSA AWARD CEREMONY – SAVE THE DATE!!!

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 **5th Annual MHSA Awards Ceremony** will take place on **Thursday, October 15th from 10:30-1:30** at Scottish Rite Masonic Center.

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!

Should you have any questions, please feel free to contact Lisa Reyes at 415-255-3613.

## 7. BEHAVIORAL HEALTH SERVICES CLINICAL SUPERVISION INITIATIVE

The Clinical Supervision Initiative continues to move forward with the support of our BHS leadership; we are currently organizing work groups for both the CYF and AOA sections of Behavioral Health Services and are vetting two training models that may be used to train our workforce. We are identifying the participants who will work within each system of care's work group; these staff will provide input to inform the content of the clinical training, identify sustainable processes to support our clinical supervisors in local learning communities, and help the leadership team identify the unique needs of their programs and system of care. This important process will help us create a training model that meets the unique needs of our systems clinicians and provide a model that informs the ongoing practice improvement needs of our department.

The training models that we are vetting will be assigned the task of educating and training our clinical supervisors to support our clinician's development by practicing from a reflective frame work, focusing on their supervisees individual skill development, learning the benefits of being a safe container for their staffs emotional responses while they provide care to our clientele, and how to implement these skills within the priorities of our system of care (Trauma Informed, Whole Person Care, Cultural Humility, Wellness & Recovery.) These foundational skills will help our system supervisors be further empowered in providing clinical supervision, support increased job satisfaction among our behavioral health staff, and improve the quality of care for our diverse client population. We are excited about the progress that has been made in identifying and prioritizing the supervision needs of our department and look forward to the feedback that our assigned work groups will provide our leadership team.

## 8. BOARD OF BEHAVIORAL SCIENCES UPDATES

**Examination News**

**EXAMINATION RESTRUCTURE - EFFECTIVE JANUARY 1, 2016**

Effective January 1, 2016, the Board's examination process will be changing. New exams will be implemented for all LCSW and LMFT candidates, and registrants (ASWs, MFT Interns and PCC Interns) will be mandated to take a California Law and Ethics Exam, as specified below.

**WHAT IS CHANGING?**

- **Registrants** will have to take the California Law & Ethics Exam to renew. Also, to be issued a second registration number registrants will have to pass the California Law & Ethics Exam.
- **LMFT** applicants will be required to pass two new exams that replace existing exams.

- **LCSW** applicants will be required to pass two new exams that replace existing exams.
- **LPCC** applicants will continue to take the California Law and Ethics Exam and the National Clinical Mental Health Counseling Exam.
- **LEP** applicants will continue to take the LEP Written Exam.

**HOW WILL THE EXAMS CHANGE AFTER JANUARY 1, 2016?**

- **A California Law and Ethics Exam** will replace the Standard Written Exam for LMFT and LCSW applicants. For LPCC applicants this exam will not change. It is designed to assess the applicant's knowledge of and ability to apply legal and ethical standards relating to clinical practice. This will consist of 75 multiple-choice items administered over a two-hour period. The re-exam waiting period for the exam is 90 days. The Law and Ethics Exam Plans outline further information about these exams.

- **The National Clinical Exam** administered by ASWB will replace the Clinical Vignette Exam for LCSW applicants. It is designed to assess an applicant's knowledge of psychosocial principles and methods in treatment and their application, and the ability to make judgments about appropriate techniques, methods and objectives as applicable to the profession's scope of practice. This exam consists of 150-item multiple choice questions administered over a four hour period. The re-exam waiting period for the exam is 90 days. When you have met the eligibility requirements for the Clinical Exam, BBS will send your eligibility information to ASWB, and will also notify you of your eligibility to take the clinical exam. Once you receive the notification you may contact ASWB to register for their Clinical Exam. The ASWB Candidate Handbook for the Clinical Exam includes a variety of information as does the "Content Outline and Knowledge Skills and Abilities".
- **A California Clinical Exam** will replace the Clinical Vignette Exam for LMFT applicants. It designed to assess an applicant's knowledge of psychotherapeutic principles and methods in treatment and their application, and the ability to make judgments about appropriate techniques, methods and objectives as applicable to the profession's scope of practice. This exam consists of 200-item multiple choice questions. The re-exam waiting period for the exam is 120 days.
- **LEP Exams -** There are no new exams. LEP applicants will continue to take the LEP Written Exam.

For more information, please visit the BBS web page at www.bbs.ca.go

**9. (AOA) ADULT AND OLDER ADULT SYSTEM OF CARE UPDATE (AOA)**

OMI Clinic steps up outreach to clients discharged from the hospital:

When OMI Family Center staff saw an increase in "gold card" priority referrals for them to follow-up on clients discharged from the San Francisco General Hospital psychiatric ward, they also saw a high rate of no-shows of these clients to the expedited appointments given them at the OMI Clinic. Aside from missing an opportunity to connect with these clients as soon as possible after their hospital discharge, the appointment no-shows also created inefficiency with unkept client appointments. As part of the "gold card" protocol, OMI expedites the case assignment of clinicians and appointment time slots for these inpatient referrals, and when clients do not show, valuable clinician time is lost.

Ensuring timely follow-up treatment of clients discharged from psychiatric inpatient is also important because 10% of such clients in San Francisco end up being re-hospitalized a week after discharge, and over 20% get re-hospitalized a month after discharge. Almost half of clients discharged from psychiatric inpatient in San Francisco are also not able to be seen for outpatient follow-up within a week of hospital discharge, and over one-fourth are not able to be seen within a month.

To better ensure successful follow-up of clients after psychiatric hospitalization, OMI administrative staff began calling each client over the phone the day before their appointments to remind them. The expectation was that by doing this OMI's gold card clients would have a better show rate.

The data showed significant improvement as result in appointment show rates. During the baseline week in July when no reminder phone calls took place, OMI's two gold card appointments that week were no-shows. In the following weeks when phone calls were done, 50% of gold card referrals kept their appointments and had service episodes opened.

OMI recognizes that even though a much better show rate was effected by the reminder phone calls, much still needs to be done to improve engagement in the community with clients discharged from psychiatric hospitalization. Among the barriers OMI staff noted were incorrect client phone numbers provided, and insufficient outreach to engage clients who miss their appointments. One recommendation OMI has is to use peer system navigators to provide this linkage from the inpatient units to the clinics.

rams
www.ramsinc.org

## 10. RAMS PEER INTERNSHIP PROGRAM

The RAMS Peer Internship Program is with the “Division of Peer-Based Services” for individuals with lived experience who are a consumer of behavioral health services, a former consumer, a

family member of a consumer, and/or currently a peer provider working for a community agency providing behavioral health services.

The Internship Program encourages both Consumer and Peer Practitioner to utilize lived life experience, when appropriate and at discretion of the peer, in peer-to-peer service settings to benefit the wellness & recovery of other peer members / clients being served.

Our internship schedule complements the busy lifestyle of a working adult who is looking to fortify skills, build community & peer network, and gain more knowledge of behavioral health services. Peer Interns work in a variety of roles during the course of scheduled rotations between sites with other Peer Interns, including but not limited to: peer counselors at community-based mental/behavioral health sites, system navigators in direct service as health care enrollers, in front-line of customer service with current or new consumers of Behavioral Health Services, administrative support for
behavioral health programs & initiatives, and co-facilitators of a variety of peer support groups.

The Internship Program offers a collaborative learning – peer supported environment, in which Peer Interns work with other Peer Practitioners throughout the 9-month program. Peer Interns will
receive weekly supervision and also attend at least two formal trainings per month provided by RAMS for additional professional development.

The Internship Program also provides weekly group supervision from a Peer Supervisor, as well as ongoing individual supervision from a site supervisor.

The Peer Internship Program is a 9-month, 20 hours/week, paid ($12.25/hour), under RAMS "Division of Peer-Based Services". The Internship Program respects your privacy and adheres to the confidentiality rules and regulations that apply. Should you have any questions, please feel free to contact us at (415) 579-3021 or peerinternship@ramsinc.org.

Thank you for your interest in the Peer Internship Program.

Attachments 1 & 2

**11. DEPARTMENT OF CHILDREN, YOUTH & FAMILIES (DCYF)**

Trauma Informed

As part of SFDPH's efforts to become trauma informed system, more than 2,000 staff members have completed a plan for a Commitment to Change project. These employees have committed to making one small trauma informed change in their work-lives to help improve our system for everyone. The TIS Evaluation team has followed up with more than 400 of these employees to find out about their experience with the project and how it impacted their daily work-lives.

Chinatown Child Development Center

Chinatown Child Development Center welcomed and hosted students from Japan who attend Alliant International University. Approximately thirty students came and visited our clinic. We provided an in-service training to the students regarding the services provided by San Francisco Health Network. Dr. Helena Chan provided an education seminar to the students pertaining to Eating Disorders. Students from the program were impressed with the services the City provides as well as the informative educational materials provided by Dr. Chan.

Mission Family Center

August 2015, was a busy month for Mission Family Center (MFC). We reduced our wait list from 24 to 10 as a result of hiring Rosa Lutrario, our new staff person in July; we are preparing to provide specialty mental health services in the schools – John O'Connell High School, Marshall Elementary School, and hopefully Mission Education Center; the entire staff participated in the new Treatment Plan of Care webinar; we got ready for the upcoming collaborative CYF Community Advisory Board meeting; and we participated in a focus group for clinicians with UCSF-SFGH affiliates to help inform a school-based curriculum for reunified families. MFC continues to host the monthly Unaccompanied Minors Treatment Providers' meetings; Jose Hipolito represented us at the Chicano/Latino/Indigena Health Equity Work Group; and Jose Hipolito, Dr. Rody & Robán San Miguel attended Mission Neighborhood Health Center's open house. Our Program Director continues to participate in the Bay Area Collaboration of American Indian Resources (BACAIR) Round Table and work toward practice improvement successes with regard to properly tracking children and youth eligible for the Indian Child Welfare Act (ICWA) and follow the spirit of ICWA for all native and indigenous families regardless of tribal enrollment. Last but not least we were able to bring on our newest staff person, Jose Luis Villarce, MFT as of 8/31/15 – more to come on Jose Luis next month.

Southeast Child Family Therapy Center

We are happy to share that the PLAAY (Preventing Long Term Anger and Aggression in Youth) group celebrated the graduation of 5 African American teen boys alongside their caregivers at Palega Recreation Center on September 3rd. It was a festive celebration with the boys sharing their Capoeira skills and was finalized with a group / family drumming circle. We were happy that Max Rocha was able to attend. We also want to thank our supportive partners who supplied gift cards and other program support for the boys and family, in particular Bonnie Friedman of LEGACY and Danijela Zlatevski of the Family Training Institute. We wouldn't have done it as well without the support and the dedication of our staff here at SE: Joy Gample, Shakira De Abreu, Luisa Villagomez and Sue Kuyper. Kudos to all.

We welcome three new student interns to Southeast for this academic year. We also are glad that 5 clients from Southeast participated in the CYF Community Advisory Board on September 1st. We are looking forward to seeing how we can respond to the work of the CAB.

The Parent Training Institute

The Parent Training Institute begins in the Fall with many new developments. The most exciting development is the PTI has recently expanded into a more comprehensive program encompassing several family-focused initiatives in addition to Triple P and the Incredible Years. One of the initiatives is

an evidence-based program called Supporting Father Involvement, which will begin implementation in late 2015 / early 2016. We have also recently hired three new staff: two part-time bilingual (Spanish-English) site liaisons and a part-time bilingual (Chinese-English) MPH focused on supporting Triple P implementation. Finally, the outcomes for Triple P continue to be very good, and effects are maintaining over time, up to 12 months following completion of the class.

## 12. Drug Medi-Cal Billing Manual

The Department of Health Care Services is pleased to announce that the updated DMC Billing Manual has been posted to the DHCS website.

http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/DMC_Billing_Manual%20FINAL.pdf

## 13. AOT FACT CORNER

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|---|---|
| What is AOT? | AOT stands for Assisted Outpatient Treatment. This program is an engagement and outreach tool designed to assist individuals with a severe mental illness who are not engaged in care with linking to outpatient services. In some cases where an individual meets the AOT criteria and is unwilling to be linked to services despite multiple attempts to engage them, the individual can be court ordered into outpatient treatment. The law was passed in California in 2002 and the San Francisco Board of Supervisors adopted the legislation in July 2014. |
| Who is eligible for AOT? | This program is for adults (age 18 and over) who have a known mental illness, are not engaged in care, are on a downward spiral, and meet strict eligibility criteria. |
| How do I refer someone to AOT? | When San Francisco's AOT program begins this Fall a public information website will be available with details on how to make a referral via email or fax. Individuals will also be able to call the AOT Office to make a referral and a TDD, local number, and toll free numbers will be available. |
| Who will be providing the AOT services? | The AOT Care Team will consist of a director (Angelica Almeida), peer (TBD), and family liaison (TBD). The peer and family liaison positions will be Health Worker II classifications (2586) and have not yet been filled. ***The jobs are posted at www.jobaps.com/SF and the filing deadline is Friday September 18, 2015 at 5:00 pm.***<br><br>UCSF's Citywide Case Management will be providing the treatment for individuals who are court ordered into outpatient treatment. Alison Livingston has accepted the position as Team Lead for this program. Welcome aboard Alison! |
| Where do I learn more about AOT? | Angelica Almeida is the director of the AOT program in San Francisco and can be contacted at 415-255-3722 or angelica.almeida@sfdph.org. |

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

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*Past issues of the CBHS Monthly Director's Report are available at:*
**http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp**

To receive this Monthly Report via e-mail, please e-mail vita.ogans@sfdph.org

**Item 2.0 Mental Health Service Act Updates and Public Hearings**

**2.1 Mental Health Services Act Updates**

**Ms. Robinson** stated that while MHSA-SF is searching for a new director, an interim MHSA director is already in place.

She informed that the RAMS Peer Internship program is for peers with lived experience to benefit from and gain more knowledge of behavioral healthcare services.

**2.2 Public Comment**

No public comments.

**ITEM 3.0 ACTION ITEMS**

**3.1 Public comment**

**3.2 Proposed Resolution**: Be it resolved that the minutes for the Mental Health Board meeting of July 15, 2015 be approved as submitted.

Unanimously approved.

**ITEM 4.0 PRESENTATION: THE STRUGGLES OF PEOPLE WITH MENTAL ILLNESS IN JAILS AND PRISONS, DR. TERRY KUPERS**

**Ms. Chien** introduced Dr. Terry A. Kupers. He is a physician and psychiatrist with a Masters in Public Health (MPH). He will give us a presentation about the experience of people with mental illness in jails and prisons. He is a Professor at The Wright Institute and Distinguished Life Fellow of the American Psychiatric Association. He provides expert testimony in class action litigation regarding the psychological effects of prison conditions including isolated confinement in super maximum security units, the quality of correctional mental health care, and the effects of sexual abuse in correctional settings. He is author of Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (1999) and co-editor of Prison Masculinities (2002). He is a Contributing Editor of Correctional Mental Health Report. He received the 2005 Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI).

**4.1 Presentation: The Struggles of People with Mental Illness in Jails and Prisons, Dr. Terry Kupers**

**Dr. Kupers** said that it is an honor to be here with you. San Francisco is at the cutting edge of a whole lot of things as you know. There are 2.5 million people who are incarcerated in the U.S jail and prison system now, and, that means 10 to 20 million who have been incarcerated in recent times and getting out. It is very hard for people getting out of jail to adjust to living in the

community, particularly if they have a mental illness. The population in prisons and jails has multiplied geometrically in recent decades. It is about seven times the number since the early 1970's. A growing proportion suffer from serious mental illness. As a society we have been deciding to put people with mental illness behind bars. We have been criminalizing mental illness. The National Sheriff Association and the Treatment Advocacy Center published reports in 2014 that concluded that 10 times as many people with serious mental illness are in jail and prisons as are in psychiatric hospitals. We have a serious problem.

Here's what I think is the main issue for criminal justice today. When we put a person behind bars there is a lot of public sensibility aimed at punishing people harshly. Let's throw the book at them. Let's lock them up and throw away the key. The real issue we need to be concerned about is whether what we do to them when they are behind bars is going to make them more or less likely to return to substance abuse or crime when they get out. That is the issue I keep looking at with correctional practices. I have been an expert witness in class action lawsuits and that is one of the things I look at. That correlates precisely with recidivism. If we do things to people that make them more likely to return to substance abuse and crime, there is going to be a higher rate of recidivism. The recidivism rate has been rising in this country for quite a long time.

Think about schizophrenia as one mental disorder. For example, if a someone has an acute psychotic episode, usually in their late teens or 20's, and we get to them and we supply them with good treatment, a half-way house, the kind of community mental health services that are available in a community like San Francisco, the family stays in touch with them and they get the kind of treatment they need, they are very likely to do well and to live a pretty good quality life. You take that same person and you deprive them of a home, in other words being homeless; they do substances; they get abused one way or another out on the streets such as getting raped, beaten, arrested or whatever. Now, the prognosis is going to be a lot worse, and that is what we are dealing with in the criminal justice system. A stunning statistic is that in prison, 50% of successful suicides occur in solitary confinement and the suicide rate in prisons is higher than in the general public. Way more now in this country we put people into solitary confinement and that's where the suicides occur.

So people with mental illness going into the criminal justice system are really up against it. People with mental illness entering the jails and prisons have two routes to get into trouble. One of them is as a victim. They get beaten, raped; their things are stolen. When you go to jail or prison the most important thing you have are friends. People who victimize look for people with less friends to protect them because they never know whether the friends will retaliate. People with mental illness on average don't have as many friends as other people. They are often loners so they are victimized more often. They are also less able to follow rules and in jail and prison there are lots of rules. They break the rules and they get sent to solitary confinement. People with mental illness are the prime targets of officer abuse as well (excessive use of force), such as tasering, pepper spraying and cell extractions. This happens disproportionately with people with mental illness. They get victimized and then they get sent to isolation for their own protection.

Thus besides the stigma of mental illness they get victimized. Or, people with mental illness are less able to follow rules. In the criminal justice system, the Sheriff may be reluctant to put a person with mental illness, for their own protection, with the general population, thus, the person with mental illness is put into isolation of security housing units (SHU). In SHU, the prison staff may ignore the person with mental illness or they don't know what to do with them because they

don't have much to offer. So they are sent to isolation several months at a time over and over again. Again, that is where suicide is most likely to happen!

But the admirable exception is San Francisco which has been on the cutting edge of many things. One of them is having a good jail mental healthcare system called Jail Psychiatric Services (JPS) which was implemented under Jo Robinson. But in most jails people spend the majority of the time alone in their cells because people don't know what to do with them.

One of the big issues we have in community mental health is continuity of treatment. If someone is in treatment it is really critical that there not be a period where they don't get their medications, don't see their therapist or their case manager. Traditionally, going to jail means cutting off medications because when a person arrives at jail they usually don't have their pills with them at the time of the arrest. Jail staff have to check to see if they are really on pills and not just trying to abuse them, and there is a discontinuity. If they have been taking antidepressants, they may fall into depression or if taking anti-psychotics they may have a psychotic episode, or mood stabilizers and have a manic episode. And that happens at the front end when they come into jail. It takes a while to get them into treatment. And then at the back end when they leave jail, there is a problem with continuity. Again San Francisco is an admirable exception. The continuity of medication can also be a problem upon their release from jail. If they don't have antidepressants then they can fall into depression. Or if they don't have anti-psychotics then they can experience psychosis. Thus continuity of treatment and medication after the release is important to reduce recidivism, and propensity for illicit drugs. Furthermore, upon release from jail, they are more likely than not to become homeless.

Rehabilitation is critical. One of the purposes for putting people in jail is to punish them harshly and when we do that, when harsh punishment is the primary motivation in corrections, people come out very damaged. They get brutalized; they spend time in isolation.

Rehabilitation is the same in prison as rehabilitation in the community. When we do community mental health what we say to someone who is coming into a half-way house: "you need to have an activity 20 hours a week. If you want to go to community college and take classes, that is fine, or go to the Salvation Army and volunteer, that is fine, but you have to do something. That is rehabilitation. In prison, there are vocational training programs, there are substance abuse programs, etc. That's rehabilitation. There are classes, but not enough. The budget is not big enough but we encourage people to go and use them. People with mental illness need mental health treatment first so they can function in the rehabilitation programs.

On average mental health treatment in jails and prisons is not adequate. People come in with very severe problems. Selectively, the people with the most serious problems are in the correctional system, so they come in with very serious problems. There isn't the budget to give them the treatment they need. In many jails all they are going to get is medication and they are going to sit in their cell the whole time they are in jail and that is going to be very bad for them.

It is very important in jails and prisons and it is even more important out in the community that people not be afraid of the individual who has been incarcerated and who also happens to have a mental illness. The fear creates a distance. In California, mental health treatment in the prisons for people with mental illness basically occurs in cages. There are cages in the treatment room, with four or five cages and this is group therapy. There is a distance that happens between the treating staff and the prisoners. It is not human. There is a dehumanization that occurs. If instead

we could look at people with serious mental illness as emotionally challenged but having some potential as a human being who could get out and do well in society, then we would encourage them to take part in rehabilitation programs. And more important, what we would do is form a therapeutic relationship with them where we have some influence and we could get them to cooperate with their treatment and they would do better.

I am unfortunately a trauma expert and the reason I am a trauma expert is that the people I work with are very traumatized. It is like doing military psychiatry. I do community psychiatry and in the community there is a lot of trauma. In the 1990's, there was a research study done in the south side of Chicago, where the poor and people of color mainly lived, which determined that 56% of 5th and 6th graders had seen a dead body, other than in a funeral situation. That was shocking to the mainly white mental health service community. That kind of trauma is going on, and the amount of domestic violence, the amount of drive by shootings, it is incredible.

There is a massive amount of trauma in the communities from whence people who go to jails and prisons mostly come. If someone is going to develop a mental illness, eventually they are going to hear voices, or be suicidal, and that is going to become the priority issue in their treatment but actually what is going to happen is that we are going to miss the fact that they are traumatized. People who are prone to schizophrenia, who are traumatized, are often going to hear voices instead of having flashbacks. When they have the experience that is post traumatic they are going to have the symptoms of their mental illness and we are going to treat them as someone suffering from schizophrenia but we forget that they have also had a massive amount of trauma and that probably went into the condition breaking out with schizophrenia or a psychotic episode.

Jail and prison are traumatic. Arrest is traumatic. When the person with mental illness gets to the yard they are going to get hassled. They are going to have to prove themselves. They probably are going to make the wrong moves. They are going to say the wrong thing to the wrong person, and it is going to be interpreted as either snitching by the other prisoners or rule violation by the guards. They are going to be put in isolation. Isolation has extremely detrimental effects on people with mental illness.

Isolation itself has detrimental effects on people who don't have mental illness, but even more for people with mental illness. For example, people who are relatively stable have a huge amount of anxiety, despair, growing anger, confused thoughts, become paranoid, exhibit concentration problems, problems with memory, compulsive impulses to do self-harm and suicidal thoughts. As I said, 50% of suicides happen in isolation. That is relatively stable people. Someone with the problem of bi-polar disorder, schizophrenia, and major depressive disorder, under the same stressors of solitary confinement, is going to break down in the way that they typically break down. I think trauma is the key to all of this. Right now, we just had a settlement of a lawsuit in California against Pelican Bay, about prison suicide while in solitary confinement. Not so many people will be put in solitary confinement and they won't be put there for so long because of a growing realization that it destroys people. And if we want to think about 93 – 95% of prisoners eventually going free; if we are going to put them in a situation that causes the kind of trauma and the kind of damage that is reported, that I investigate for these class action lawsuits in isolation, we are going to condemn them to failure when they get out into the community.

That is also what we health providers in the community have to realize; that when we see someone who has gotten out of jail or out of prison, they have probably been in solitary. They

have probably been traumatized. They have been hassled in the yard. They have had to fight. They were probably beaten, or beat up by the officers. So all those things become re-traumatization. They had earlier traumas. They go to jail or prison and they have more trauma.

One of the key things that has to happen when they get out is that the community mental health system has to be extremely conversant with what their experience was in jail and prison. They come out in one or another state of disarray. They are either shocked at being out in the community again or they are so damaged by being in isolation units that they want to stay in their room all the time. They are probably not prone to take part in treatment. And when we see them in treatment, what's really important is that we do trauma work with them. Trauma work has to do with empathizing with the kind of stress and the kind of abuse and the kind of horrors that they have been through, and giving them a safe place.

Judy Herman wrote in the book, Trauma in Recovery, that the first thing that happens for a person who has been traumatized is that they need safety. If someone has been raped; if someone has been in the Iraq war; they need a safe place where they can put themselves back together. We need to provide them with a safe place and it is a place where we understand their situation. We don't stigmatize them either for being in the criminal justice system or for having a mental illness. And we start to talk to them about what their experience was like. That's probably the key component of every treatment program, and whether that is a case manager reaching out to a homeless person who is having substance abuse problems or may have just got out of jail or prison, or whether it is seeing an outpatient in a public mental health clinic. What we have to do is say: "tell me what it was like". When they start telling us what it was like, we have to match that with some understanding we have of what typically happens in jail or prison. And we have to provide them with a certain amount of empathy and a certain amount of safety and then they can begin the treatment process.

I do a lot of cases about supermax isolation units, like at Pelican Bay or Corcoran in California. The general public sense of what is going on in places like Pelican Bay is that these inmates are the worst of the worst; these are heinous criminals. When you go in and talk to people in supermax confinement, what you find are just ordinary people. You find a range of intellect just like in the community. There are some dumb people and there are smart people, just like out here. There are some people who are severely mentally ill, and they don't quite know what is happening, and their mental illness is getting worse while they are in solitary confinement. They are not particularly dangerous. They got swept up in a dragnet of criminal justice substance abuse sentencing procedures, and although we have this stigma that people in isolation are the worst of the worst they are really actually just average people, and one or the other pathway has led them into isolation. But what is very important is that we understand that experience, and understand what happened to them.

Having been an expert witness in the Pelican Bay case that just settled, most people in solitary confinement in prison are convinced, and sincerely convinced, that the due process they received, for instance the hearing where they were told that somebody said they were in a gang was not fair.The person might say, "I'm not in a gang, show me the evidence." They are told, "We can't do that". Someone said you are in a gang so you are going to solitary confinement. The feeling is the experience of being wrongly punished and there is nothing they can do about it. And we on the outside are going to see this person, and see that they were in prison for eight years and four of them were in a super-maximum housing unit (SHU). or solitary confinement.

We have to avoid stigmatizing them. We have to listen to his story of how he was wrongly sent to solitary confinement. That is what is really important. I think the important thing is that we educate ourselves about what is really going on in the prison system and then we have some sympathy for the people who have been forced to go through that, and their families. This is all not easy on families. So I think we have to, instead of putting them in a cage, and dreading them and feeling that they are some kind of heinous criminal, we have to look at them as someone we usually see in community mental health. They have a mental illness. Instead of getting adequate treatment for their mental illness, and adequate housing in the community; we don't do this as a society. Instead of stigmatizing them for their criminal history and mental illness, we have to have some sympathy for the very rough road they have been on and offer them the services that we can offer.

I have come tonight with a person who has spent a number of years in prison.

**Dr. Kupers** introduced Mr. Kalima Durand whom he has worked with for many years to share his personal experience with the California Correction and Rehabilitations Department (CCRD).

**Mr. Durand** shared that he recently got out of prison after serving 46 years in various prisons in California. I would like to say that I assume that the goal of society when they send people to prison is to have them return to the community as people who can be an asset rather than a liability, and yet that is not what is happening in the California prisons today, and it has not been happening. I think the prison system has taken over and become a society unto itself. It determines its own rules. It determines what and who will get out and when and under what conditions. So it is the prison culture that we have to fit into and it determines what comes out of the prisons, and that is not always the best. I was told that I would never, ever get out, and yet people have supported me for the last 40 years and the parole board eventually got around to telling me that I would get out, but that all the changes that I had made such as going to college, being in groups, being involved with people, writing, and all the changes that I made were good but they would never have gotten me out. It is only because I had adequate support, beautiful support on the outside, that I was able to get out. And one of those supporters is Dr. Kupers, who wrote, came to visit me, wrote reports to the parole board and kept challenging some of the reports that the state doctors had written about me, and eventually I was given parole dates which the governor took, and eventually I got even beyond that. I am out here today because of my support.

I do believe what the board told me that no matter what I said, no matter what I did or what I accomplished would not have been enough without the support that I had. And so I think that this is important, that people inside must have the support of the outside community. And the outside community should know what it is that they expect of prisoners. You don't want the same thing coming back or something worse than what you sent in there, I'm sure. So we need a system that is better than what we have right now. A 70% recidivism rate that is currently in California; if this were a business, it would be shut down. It would go out of business and I think the same thing should be of California prisons. The people who run the prisons have a culture that they run it by. That is why people cannot come out of there able to function in society. I think we need to look at that, and I thank you for listening to me today.

**Ms. Williams** shared that in listening to this, and when you talk about trauma, what really depresses me is when Dr. Kupers indicated that the kids in Chicago's south side children were being traumatized and surrounded by domestic violence and then there is an expectation that

these children will function well in society. It is not taken into account that these children are already damaged by the time they reach a certain age because they are exposed to this trauma. And consequently you see them going to prison. You see them not fitting in well at school, with behavioral problems and more. She thanked the speakers for enlightening her about the prison situation because it just seems like with African American youth, because they are so exposed to violence and they are exposed early in their lives, that it is from cradle to prison. It is a self-fulfilling prophecy because they are traumatized and people are not taking that into account so they are ostracized in school and labeled as behavioral problems rather than dealing with the trauma and experience that they have had.

**Dr. Kupers:** I think it is a very important issue and what we tend to do if we develop a program like Behavioral Health Court (BHC), and we do diversion, what we want is to pick the people who are most likely to succeed in our diversion program. And so what we tend to do on average is to say we will take people with nonviolent and non serious crimes. That is a good start but we have to go to the rest of the people. Most people I see and meet in prison are very ordinary people. They are 30 to 40 years old by the time I see them. I ask them what the conditions are like and what they feel about how they have affected them, solitary or crowding. They are ordinary people and they would do better and they would be peaceful in a situation in the community where they had their needs met. For instance, housing they could afford, some training and a job that they could do. They would cooperate and they would do great.

The Behavioral Health Court, which San Francisco has, and a lot of counties have, has been extremely successful. All the clinical research shows that it is very positive. Diversion works. That is, if you have someone with a substance abuse problem and you send them to jail or prison, we get a flat curve. If they go into prison with a substance abuse problem, they may not use when in jail (some do, but it is a small minority), they will come out and return to substance use if they do not get significant treatment. On the other hand if we put them in a community program with trained people who do substance abuse work and they complete the program, the likelihood that they are going to be clean and sober after three years is 80%. So what sense does it make to violate someone's parole or probation because they have a dirty urine? They should be in substance abuse treatment. Putting them behind bars is going to make them more likely to have a substance abuse problem in the future, and similarly with all the other problems.

So while I think it is a good thing to start with the minor crimes and the nonviolent offenders, to reduce the prison population by offering people services they need in the community is going to pay off, we need to move up that hierarchy to more serious crimes, to more violent crimes. When I have a patient of mine who was being violent with the police and they are taking him to an emergency room or the police station, they call me up and I say put them on the phone with me. I ask him what he is doing. He will say, "I don't know, something just came over me." I say, "here is what I want you to do, I want you to turn around and say to that officer, I'm sorry sir, I just really messed up, I'm calm now. I'm okay, and I want you to come see me in the morning." And he will do it. If we didn't have that relationship and he saw a strange psychiatrist in the emergency room or psychologist at the jail, nothing like that would happen. It is my relationship with him which is going to smooth things out and give him a chance to back down and get out of trouble.

That is what we should be doing with the people we are sending to prison. People we send to prison don't have relationships with anyone. They don't have social services. They tend to have

dropped through the cracks in our social safety net, because we have been reducing the funding for our social safety net. What we need to do is establish those relationships, and then we can work with people who have done more serious and more violent crimes. And we can prevent them from doing more in the future.

**Ms. Virginia S. Lewis** said this board is concerned about the people who return from prison to San Francisco and the need for crisis intervention training in jails for sheriffs. She and her colleague met with the Sheriff about this training and were told that the jail is a powder keg waiting to explode and part of that has to do with the lack of training that the guards receive. It is particularly severe with mentally ill inmates.

**Dr. Kupers** said that San Francisco has the only therapeutic community in the country. You have substance abuse treatment in the jail. You have anger management, one of the models for the entire country. When people get to jail it is usually because the public safety net has failed them. And most of them can be helped with one program or another. I have studied rehabilitation outcome studies because that becomes a very important point of debate. Very hard-core law and order people will say rehabilitation doesn't work. The truth is that it works if you put the right person in the right program. If you put someone who has trouble managing their anger in an anger management group that is effective, they are going to do better. The same with substance abuse and the same with job skills. If you put someone in a training who is able to handle the skills for that job, they are going to leave jail or prison and do well. In spite of all the hype in the media, most people go to prison or jail when they are very young for a very short term for a very minor crime. The question that doesn't get looked at enough is what do we do with them inside that makes them more likely to do a more serious crime in the future.

I testify a lot about solitary confinement. Jail is typically solitary confinement. Prison, for people who have trouble managing their emotions and their behavior is going to be solitary confinement. The solitary confinement is going to break them. Then their mental illness is going to have a worse disability and a worst prognosis. We should be doing something entirely different. The fact that they have wound up in our court means we have failed to provide the services to straighten out their path, and we have to work harder to find some services that can help them. It is much easier to do that in the community. In fact it is so destructive, the traumas that occur in jail and prisons, that it would make total sense to invest the money in diversion programs in the community and give them the help they need. And they would then get their life together. When I say "they", I am talking about a majority of them, not everyone. . About 60% - 70% of the people we send to prison could be helped in community mental health and not have to be part of the criminal justice system. Then we have only a few of the hard-core problems and we would have the resources to deal with them because we aren't spending that money on a large number of people who need more minor services.

**Dr. David Elliott Lewis** asked how San Francisco county jails do better in rehabilitation than other counties and what improvements are needed.

**Dr. Kupers** said San Francisco is better. I was involved in a sex abuse case where officers were raping women prisoners in another state. I had to make a recommendation. This was Federal Court in Michigan, to the court on how to solve the problem. For instance, having men in women's units of the prison and I didn't know the answer to that . When I contacted Jo Robinson, she put me in touch with the undersheriff who told me about the protocol used in the San Francisco County Jail to protect women in particular and gays from sexual abuse by staff.

There has been an investment in public service programs in San Francisco which is different than other areas. Another example was when the realignment was announced, District Attorney Gascón actually welcomed the change to have the community provide behavioral health services and keep people out of jail. , The DA of Los Angeles said that was a terrible idea and instead, overcharged everybody so a lot of them are going to avoid realignment and be sent right to prison. They are two different attitudes. You have an attitude here supported by a public sensibility that the function of government is to help the most disadvantaged people. So we want substance abuse services, harm reduction programs, public health services, and mental health programs. You have a continuous case management program. One of the big problems in mental health treatment is that we will be treating someone and then they will be lost to follow up. They don't show for their appointment and can't be found, so the file is closed. Three years later they come back and they need mental health treatment. Nobody asks them where they have been. If we asked we would learn that it is jail or prison, and their condition is worse, their disability worse and their prognosis worse.

If instead of doing that we would deal with their getting arrested as a symptom of their mental illness and we would put intensified mental health resources into their case, which is exactly what happens in BHC. We take people who need mental health treatment and say that the treatment is not working because they are doing drugs, breaking laws and ending up in court, so let's do something else. Let's give them a case manager, make consequences of their bad behavior, and the judge will say that if you don't show up for your substance abuse treatment appointment, I'm going to throw you in jail. Most people comply. That is a good use of government to get people who need a little boost to get them going.

**Mr. Wong** commended Mr. Durand for his courage to stand up and talk about his experience because it is not easy and Dr. Kupers for his work with incarcerated people such as Mr. Durand so he has a chance to stand up and talk to us today.

**Dr. Kupers** said that Kalima has made an extraordinary voyage during his time in prison. He has been a counselor to younger offenders who he helped stay out of trouble in the prison and it is my honor to have him with me here tonight.

**Dr. Stevens** asked about how the programs, services and policies would support keeping young Latino and African American children in school and out of jails or prisons.

**Dr. Kupers** said the first thing that has to happen, we have in the cultural war in our country, the awful tendency to make certain people into non people. Lock them up and throw away the key which is a saying that actually covers a dirty secret in our society. We take people who are convicted of crimes and lock them up somewhere and we forget about them and we don't want to know what happens to them. Horrible things happen to them. I think it is very timely that Kalima came tonight because we have to remember if you have two and a half million people behind bars, it is a significant amount of the population. Probably five to ten times that many people have been behind bars. They are regular people. They have regular needs. Some have disabilities and a subset have mental health problems. They need mental health services. The fact that they did a crime doesn't change that. It doesn't change that they are a human being. It doesn't change that they need certain services to maximize their usefulness in society. One of the first things that has to happen is a change in attitude by mental health staff. When staff in a half-way house or day treatment program hear that a person coming to their program has been in the criminal justice system, they get nervous because of the stigma we have about criminals,

even though they are really no different than the others in their caseload. They are just people who got trapped in the criminal justice dragnet. There are exceptions. There are murderers among us and we have to do something about that, but they are rare. Most people go to prison or jail for very minor offenses. Since the 1970's, most are drug related. We could do better with them to straighten them out and send them on the right path.

**Ms. James** asked about the jail population who are getting older and have chronic health issues and wondered if there are any special treatment for them.

**Dr. Kupers** We miscalculated in this country, the public sensibility, with the sentencing, with the three strikes laws, the truth in sentencing, all of this that has happened in the past several decades. Most crime is committed by youngsters. Gang violence is teenagers. There are some people who stay in gangs for a while after that but most of the more severe crime happens with young people. If you give them three strikes and you give them three consecutive life sentences without parole, they are going to get to be 70 or 80 years old in prison and they are going to have the same health problems that the rest of us have. And we are going to be taking care of them in prison and they are going to have worse problems because the food is not real healthy. The healthcare problems of prisoners are significant and the healthcare is not that good, so they are going to have even worse problems.

What are they doing in prison 60 years after they did something as a teenager? Do we know that much that we think this 16 year old who did something should be in prison for 80 years? Do we know who that person is going to be even ten years from now?

President Obama is right now working on sentencing. He feels we have been over-sentencing people and one of the groups he wants to go after is the discrepancy in crack and powder cocaine sentencing. It was ten times; one year for powder possession but ten years for crack. Who has crack and who has powder? It was definitely a racial and class bias. Obama is going through the prisoners in the Federal prisons and looking at their records. Those who were sentenced unfairly and harshly for crack, for example they have been in 16 years and it would have been six or ten years for powder, he is letting them out. He is pardoning them.

We should be thinking about that across the board. All of the sentencing guidelines need to be revised. They were made in another day and there was a bit of hysteria about crime and we thought we wanted to put people away forever. It was a mistake, as was solitary confinement. We need to go back now and reconsider how we treat those individuals. They are members of our community. They are fathers, sons, brothers, sisters and mothers. We need to provide them with the resources to enrich our communities rather than breaking them down and depriving them so they are going to be a burden from then on.

**4.2 Public Comment**

**Ms. Karen Shane** works in the San Francisco adult probation department of the Re-Entry division and staffs the San Francisco Re-Entry Council. She was speaking as a person with a formerly incarcerated loved one, her friend Kalima. She said re-entry is an enormous strain on the formerly incarcerated person but also on family, loved ones and friends. It takes far more than a village to welcome someone back into society, after having spent 46 years in prison. When Kalima got out he needed immediate medical care. The prison system failed to provide adequate care. While in jail, he became an invalid and was confined to a wheel chair. Immediately, after leaving prison, the community had to scramble to find him housing. He was

also required to do after-prison programming four times a week which took him several hours to get to each time, sitting in a group for something he may or may not need He had to find a mosque for his spirituality. His needs are many still. Now he must have dentures, glasses and hearing aids. For being seventy-nine years of age, Mr. Durand has done remarkably well.

If we multiply one Kalima by thousands of incarcerated people like him – approximately 25,000 to 30,000 people coming out yearly from prisons, and multiply that by the number of people coming out of jails, then we see there is an enormous public health problem and we need to figure out how to deal with it.

**Ms**. **Rebecca Young** is an attorney at the Public Defender's Office in San Francisco. She said approximately 40% - 45% of her case load are people with Axis I disorders, (bipolar disorder, PTSD) , often complicated by substance abuse. All of her cases are in county jail. She cannot get them out of custody. Judges are afraid of her clients. Bail is set very high and if they have priors no bail will be set. Even when they have a diagnosis they are not always funneled to BHC. For clients with priors, it means disqualification from BHC. She has to fight tooth and nail to get her clients into BHC, because it is dominated by what the prosecution wants. For example, one of her clients made just a verbal threat in a state of an acute psychosis many years ago, but then you have to plead that to a strike offense and the District Attorney demands a plea of guilty before he would consider BHC, but with no guarantee though, allowing that client to participate in BHC. Sometimes, she wondered if the BHC model is really a cooperative and compassionate model at all.

She mentioned trauma is a precursor to schizophrenia and asked if there are any empirical readings available to inform her and to help her represent her clients who are mentally ill.

**Dr. Kupers** said he is a strong advocate for thru care meaning that both mental health and correctional communities need to understand the life trajectory of a person suffering from one disorder or another disorder and what happens to them. Typically with schizophrenia they will have their first breakdown in their teens or early 20's. They will have a succession of breakdowns; there will likely be substance abuse, and they will start settling down as they head into their 30s. If they have had good treatment, they will learn how to take their medication and stay out of trouble. They will learn that substance abuse is harming them, and they will get off the substances and they will have a relatively stable life after that. That is a life trajectory. However, if this same person were incarcerated it will only spiral out of control and go downhill.

People with serious mental illness on average don't do well with saying "good bye". If you form a relationship with them and then you end it, for example, a person living in a half-way house for six weeks to three months, or treatment is with an intern who will be there for nine months and they say goodbye and either get other services or they don't. People with serious mental illness often experience someone leaving them as abandonment. At every step in the system we should be reducing the number of partings a person experiences. There should be staff that follows them and introduces them to the next person who will be doing their case management.

When you go to jail or prison, visiting is very critical. Since it is extremely hard to have visiting in state prison, he believes a city like San Francisco should have a shuttle bus for families to visit and maintain contact with the incarcerated person so the continuity of the relationships with the family and children can be maintained. When someone on our caseload gets locked up, we can start a process of figuring out who needs to visit them in jail or prison and how we can use public

services to increase the visitation. With quality contact with loved ones throughout the .prison term, research has shown that recidivism is a lot lower. They maintain their sense of being meaningful in the community and in their family.

For empirical readings on schizophrenia and trauma, he recommended the book Trauma and Recovery by Dr. Judith Lewis Herman. He also suggested Treating Schizophrenia by Werner M Mendel who was a psychiatrist at the University of Southern California and who specialized in schizophrenia and had poignant descriptions of the patients he had treated.

**Mr. Victor Gresser** shared that in spite of his mental illness, he is able to be on Behavioral Health Services (BHS) staff and found the presentation to be extremely moving. He said money from the 80's that was pulled during the de-institutionalization era emptied out state hospitals and put people with mental illness into the public sphere. Was that money moved to the prison system?

He believes the number of people with mental illness does not necessarily rise but where they are being "stored" changes throughout history.

The other issue was around stigma. He has seen people, starving, dirty, bare footed and homeless. For example, the night before he attended the presentation, at about 11 PM he met a person with mental illness begging him for spare change because that person was recently released from jail. Thus where can the general public get help for someone in such a predicament? Victor also manages a stigma busting group every Thursday to develop programs to address stigma.

**Dr. Kupers** responded by saying that what the public has been seeing in the last three decades is called "trans-institutionalization." Early in the 1950's de-institutionalization was a progressive idea. This idea resulted in the signing of the Community Mental Health Act by President Kennedy in 1963. It used to be that money was allocated to state institutions to over-medicate people involuntarily in order to keep them in a zombie like state. But that same money could be allocated to skilled clinicians in community mental health who can do a better job in providing compassionate care to people with mental illness.

Governor Reagan implemented de-institutionalization by closing down or de-funding state mental institutions without diverting resources to community mental health. So they de-institutionalized without setting up the diversion programs in the community. Then because of multiple historical events like the War on Drugs and biased sentencing resulted in a lot of people with mental illness going to jails and prison instead.

Currently, there is a revolution in psychopharmacology that produces good psychiatric medicines with less side effects, along with psychiatric rehabilitation. For an affluent family, they can get access to psychotropic medications. So it is not that medications are not available but it has more to do with social determinants of equitable distribution between the wealthy and the poor. Many people without means, usually people of color and the poor usually end up in jails and prisons instead of getting treatment.

**Mr. Jason Albertson** is a psychiatric social worker working with men who had been in California level four facilities. He found these men to be highly defensive, have social anxiety, social phobia and they have difficulty with engaging in therapy. These men tend to present symptoms of trauma. He asked who is doing the leading edge work to treat these people?

**Dr. Kupers** suggested reading Living in Prison, Violent Men, and The Disturbed Violent Offender by Hans Toch, PhD, Professor of Social Psychology at the State University of New York's School of Criminal Justice.

He explained that long periods of isolation increases their tendency for violence. For example, around 1980 he did a class lawsuit in Pelican Bay and learned that the number of days for a whole prison lock-down, meaning everyone in prison was in solitary confinement, in California prisons was usually eight months at a time. The violence rate stayed the same. People killed their cellmates. There was no improvement. Once lock-down was lifted, the violence rate went way up. There is a correlation that isolation increases the risk of violence.

Many prisoners have told him of the SHU Post Release Syndrome, meaning people in isolation for a long period have trouble relating to others. In one situation, he had a concerned family call him because they did not know how to reach their son who had spent eight years in Pelican Bay in the SHU. Upon the son's release to the family, their son spent most of his time alone in his own room and rarely interacted with other family members, not even joining the family at meals. People with the SHU Post Release Syndrome have a lot of anxiety, concentration problems, have trouble relating to other humans and generally don't trust people that easily. These people need time to reacclimatize with others socially. He suggested that the family bring him his meals to his room, assure him that the family loves him, and a few weeks later he was able to come out of his room and join his family.

People coming out of isolation have a lot of anxiety, concentration problems, difficulty relating to others, and trust issues. They haven't had any practice interacting with people. They need time to re-socialize, and to develop the skills. We need to be understanding about what they need to do to create a safe space for themselves.

California practices maxing out of the SHU meaning people are released right out of the SHU without at least a six month period of "reconditioning" into a facilitated setting like other states, to help them with relearning basic daily activities and social interaction. As a result of maxing out of the SHU, former inmates come out totally confused, get into a lot trouble, and a majority of them just withdraw into themselves. These people who may have spent 20 years in the SHU but who are now re-entering back into society need compassionate care and services.

**Mr. Charlie Berman** is social worker at Citywide Services. He shared that one of his Citywide clients went to jail for an assault but was deemed incompetent to stand trial and sent to a state hospital where he was stabilized, then returned to jail. Although he was accepted for BHC, no programs would accept his client because of the assault history, so the client was sent back into jail and spent months in solitary confinement. While in jail, his client's delusions increased; he thought the deputies were out to get him, and deputies had to do a cell extraction. He assaulted a deputy and ended up back in the state hospital. Some counties are doing competency stabilization in the jails. Can you speak about that?

**Dr. Kupers** said he admired people in social work for their dedication despite dwindling funding support from the government. The needs are there but the resources are not to help the most vulnerable in the society. Social service workers and teachers are not valued enough by society and government. We have de-prioritized using government to take care of the most disadvantaged among us, so we have defunded so many services. That puts people who do that work at a great disadvantage because you are trying to help people and you understand the

enormity of their needs, but you don't have the resources. You can't get them into an apartment, you can't get them into a vocational training program, you can't get them the mental health treatment they need, so you carry the burden. The reason that I applaud you all is that you have stayed with it. With the de-prioritization of funding, people in the field find that they are loosing the respect, prestige and stature for the work that they do. Two examples are public school teachers and social workers. They are underpaid and their work requires a huge amount of commitment, and as we make public education less of a social priority and the public safety net less a priority, people in those service positions start to feel abused by society and the job becomes much harder. So I applaud you for staying with it, with the relatively less resources. You meet your client and he doesn't know where his next meal is coming from or they don't know how to get to a mental health treatment situation particularly if they have just gotten out of jail or prison. They are terrified of being arrested every day out on the street. When you really relate to them as a human being, you feel what their life is like. That's extremely painful and then you try to do what you can, and it's always not enough because we don't have the resources to give them what they actually need. So we have to have some large system changes and we have to hang together. We have to talk to each other about the frustration of it all and why we do this work.

**A Member of the Public** said there is a lack of cultural humility toward African American women in the jails and prisons. We have women who are lifers who are getting out of prison after 27 and 30 years. They have to go to one facility where they have to sit in groups that they could have been teaching. There is a blackout time where you can't talk to your family. I know this because I have been inside myself for a very long time. Programs are there but there is no accountability to ascertain how effective programs are or have the cultural humility that is needed. We don't really have a place to send them, especially when you have children. Where is a middle-aged African American woman going who has been in prison 25 to 30 years? . San Francisco seems to be trying to get women of color who are poor out of the city. She suggested creating core college classes in the community colleges and the universities to educate students about what is happening in jails. There is such a lack of education among educated people as to what people go through in the jails and prisons.

**Dr. Kupers** said I agree with everything you said. I think the people who are punished the most in the criminal justice system are the families, particularly the children. We have re-unification laws and they are deadly. When a lawyer is called upon to defend a woman who then gets convicted of something and is going to do time, the first thing a good lawyer is going to recommend is to start working on the re-unification plan. We have extremely stringent requirements for mothers who are getting out of jail to get their children back. One of the biggest problems we have in society today is the fragmentation of families. And you find that the people who are in the most trouble out there are people who have had someone in their family who has done time and lost them, or people who have been fostered. Our foster care system is nothing to brag about, and we tend to have a lot of temporary placements with transferring people from one place to another. When they get to be 18, the kids in the foster care system are just released with nothing and on average they don't do well. It would be much better to put our efforts into unifying families, including families who have a member who has spent time behind bars. We should do everything we can. For example, we could publically support visiting. When a member of our community is behind bars, make sure that their family sees them while they are behind bars and then the post release planning has a way for them to leave jail or prison and

going straight when they get out and pay attention to that family and what they need to maintain the integrity of the family so that the next generation won't be in deep trouble.

**Ms. Guntherhouse** is the program manager of Way Pass, the women's aftercare program and supportive services she founded eleven years ago when she got out of prison. She went to City College but there were a lot of challenges and barriers. She recommended stopping the Health Right 360 monopoly because women are not really being helped by them. As a result, many women turned to her program for help because she offers them food, clothing and does everything that is supposed to be done by the city that is not being done She believes that Health Rite 360 is getting money for the lifers and not helping them. She suggested funding programs that help women find single housing units rather than just bunk beds like they had in jail. She was toothless, homeless and addicted; one of those people you stepped over in the library. She was in prison 45 years. She raised her children visiting them. She knows what is lacking in San Francisco. It is not doing such a great job. She doesn't have a question. She has answers.

**Ms. Kathleen Wallace** works as a peer counselor for the City and County of San Francisco. She shared her history of drug and alcohol use. She has a history of anger and violence. She believed each person has an opportunity to reach out and reach across the barriers of our American culture and institutional barriers, and make eye contact.

**Ms. Fava**. shared that she and three co-workers came down from Sacramento, CA to hear the presentation. She works with Bridge Network. She currently has a couple of cases. Sacramento is the number two county in California that prosecutes youth as adults. For example, a boy 17 years of age with childhood trauma. This young man is now facing attempted murder charge with 50 years behind bars. A woman 27 years of age with childhood trauma when she was exploited at 16 years of age.

**Ms. Roma Guy** thanked the board for the meeting tonight and inviting the two guests to speak. She is representing Tax Payers for Public Safety and would like to see more presentations like this because of the invisibility of the incarcerated population, especially at youth guidance and in the jails. These are the pipelines to prison. She feels we need to be in touch with Health Commissioners and members of the Board of Supervisors, because we need policies. The reason we have the most unpopulated jail in the state of California is because of our community services, but there is still something bothering her about incarceration in San Francisco. There is stigma not only of the mentally ill, but people of color , especially She said there is a strong need for San Franciscans to be more in touch with their supervisors and policy makers, and San Francisco needs to take risks and do more things and more innovative programs. We need the leadership to back this up. She has two citations to share, the Burns Institute Study showing where the racial bias is in the San Francisco system. So it doesn't matter if other people are doing worse than us because we are not doing so good, in fact badly, especially with African Americans. So they looked at five decision points from arrest to release and there is racial bias in every one of them. So this needs to be studied and there need to be community discussions about it, because there are many African Americans who have mental health issues and many areas where African Americans live where there is trauma that leads to problems. She appreciated that trauma was talked about too. The second one is Elise Riley about women, who focused on San Francisco. She was looking at the question of what are the risk factors for women in San Francisco. This is a population that is at risk for HIV and homelessness and what she learned

which wasn't an expected outcome was that the highest risk for HIV and homelessness was one experience in our jail. It is a systemic problem. What are we doing about it?

**Mr. Jacob Savage** is new to mental health advocacy. He volunteers in the Tenderloin District His primary focus is creating a human connection. He shared his discomfort with his own racial bias when he first walked through the Tenderloin District five years ago. Now he feels it is a wonderful, authentic place, when you make eye contact with people and connect with them. He talked about a person recovered from 20 years on drugs eight years ago and now is leading Tenderloin Walking Tours. He encouraged everyone to sign up for the tours.

**Ms. Walker** also works with Bridge Network in Sacramento. She asked what Dr. Kupers feels is the correlation between slavery and the effects it has on our inmates and the intergenerational stigma the African American community has? How do we support our mothers who are coming out of the prison system? They have to raise their children with that stigma along with being incarcerated. She knows mothers who are battling disability, depression and stress. How do we receive funding because she finds that society seems willing to fund projects that take care of animals before taking care of mothers.

**Dr. Kupers** recommended reading the New Jim Crow: Mass Incarceration in the Age of Colorblindness by Michelle Alexander. It is a consolidation of what we know about racial discrimination through slavery, Jim Crow and the present. The new Jim Crow is the criminal justice system. He stated African Americans make up 13% of the U.S. population but the criminal justice system is disproportionately made up 50% of African Americans. There is something very deep, very structural. It is about race. There is a continuity between slavery and the prisons. The prison system just perpetuates slavery in America. Before the Civil War, only whites were incarcerated, as blacks were punished by the slave owners, including whipping them to death, so there was no need to put them in prison. When Civil War ended, the prisons were empty because everyone had been let out to fight in the war. After the war, the prisons loaded up with black people, freed slaves who were then leased back to plantation owners, ex slave owners They even got a lot of the same people they had before the war and they did the same work, such as picking cotton, that they were doing before the war. Actually their situation deteriorated because before the Civil War, they were slaves and the plantation owner owned them. Now if the plantation owner wanted to beat someone up or maim them or kill them, they could go back to the prison and say that the worker released to them wasn't any good, so they want a replacement. So the actual health plight of the African Americans went down.

But jumping ahead to now, there are many commonalities between the prison system and Jim Crow and slavery. We have to do something. You walk into a prison and you see the racial politics of our country. First in the mental health treatment units, the best vocational training slots are disproportionately occupied by white prisoners. The solitary confinement units like the SHU in California are disproportionately occupied by blacks and Latinos in the prison system. What is that about? If you ask a deputy about any particular individual he will answer that he disobeyed an order. But a lot of others disobeyed an order too but the black individual was singled out and put into segregation.

I have mentioned that the main intervention that correlates with lowering the recidivism rate is family visits throughout the jail or prison term. The other one is education. There are studies that now show that the recidivism rate now runs at 60 – 70%, so they are going to go back to prison. If they have had significant education while they are behind bars, or quality contact visits, their

recidivism rate is going to go down to 15%. That is a stunning difference in results. So we need to focus on education and family visits to significantly increase the opportunity for people to go straight after release. It raises the question of the prisoner industrial complex. There are many things that are done that are foolhardy in the criminal justice system, such as violating people for dirty urines. The response should be substance abuse treatment or some kind of meaningful work. Instead we put them behind bars which will increase the likelihood they will do further substance abuse and crime. Who wants to sentence someone who is 18 years old to 80 years in prison? People who make money, or gain power or have some kind of an investment interest in swelling the prison population. The reason education was discontinued in prisons is that several senators said they have to pay for their own kids to go to college so they are not going to support education of prisoners. We actually should be supporting education in prison because it is one of the best correlates to going straight after release. It is because there are vested interests by people who want to swell the prison population, including private prison management companies. They make a profit when more people spend a longer time in prison.

From our perspective in the mental health service community the damage that is done to people with mental illness who get trapped in that system is to come out in worse shape and then we have trouble treating them. On the race issue, I have one simple suggestion. Let's talk about it. What was it like being one of the 50% black people in prison? What kind of society do I live in that all the brothers are here in prison? And when people start understanding the social meaning of that and make some sense of that, including someone with a serious mental illness, they can understand that the reason they were treated differently by the white guards than the white inmates. It has something to do with what Michelle Alexander was writing about and then that makes sense and they can figure out a strategy to deal with it.

I really appreciate you having this meeting and listening to people in the community and having this discussion.

**Ms. Chien** said there is so much more work that we have to do. She thanked Kalima for his courageous sharing and being an inspiration to many of us, and Dr. Kupers for an informative, insightful and inspiring presentation. We talked elephants in the room, the racial issues, the disproportionate use of resources or the lack of resources. Thank you so much. I am also very inspired by the audience working in programs.

**Dr. Kupers**: I neglected to mention and I want to finish with. I am very opposed to a mental health jail. Jail is not a good place to do mental health treatment. Every sheriff I have spoken with has said that the most serious mental illness, the more likely they are going to put them in a cell by themselves, and leave them there because there is no other way to maintain order in the jail. I am concerned that if you build a jail that is a mental health jail, maybe there will be a budget for mental health treatment the first year, but the budget is going to get cut in successive years. There will be another priority. People are going to be warehoused on psychotropic medications and the only thing you can do if people act out is increase the dose, so you will really be re-creating the asylum in a mental health jail. Diversions and programs in the community are much less expensive and much more productive in terms of all the outcome studies. Thank you so much for having me here and I really appreciate your work.

## ITEM 5.0 REPORTS

**5.1 Report from the Executive Director of the Mental Health Board. Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects**

**Ms**. **Brooke** shared the following:

- Ms. Brooke will be on the east coast October 3rd through October 13th visiting her grandson and attending the memorial service for her stepmother.
- Young Women's Open Mic
- CIBHS Regional Training on October 24, 2015.
- 10/6 Accommodations for People with Disabilities training.

**5.2 Report of the Chair of the Board and the Executive Committee.**

**Ms. Chien** said the next Executive Committee meeting is on Tuesday, September 22nd, 2015 in room 226 at 1380 Howard Street. All board members are welcome as well as members of the public.

She appointed Dr. Stevens chair of the Retreat Committee. David Elliott Lewis, Benny Wong and Idell Wilson are on the committee. She asked board members to let Ms. Brooke know if they would also like to participate on the Retreat Committee. The committee has had one meeting and has allocated specific roles for every board member. Dr. Stevens will be in touch with each of you about your role.

**5.3 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.**

*Item tabled until the October meeting.*

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

*Item tabled until the October meeting.*

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

*Item tabled until the October meeting.*

**5.6 PUBLIC COMMENT**

No public comments.

**6.0 PUBLIC COMMENT**

No public comments.

**Adjournment**

Adjourned at: 9:15 PM