

SAN FRANCISCO MENTAL HEALTH BOARD



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Judith Klain, MPH
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Susan Page
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Richard Slota, MA
Marylyn Tesconi
Benny Wong, LCSW

ADOPTED MINUTES

Mental Health Board Meeting
Wednesday, September 19, 2018
25 Van Ness Avenue
6th Floor, Room 610
6:00 PM – 8:00 PM

BOARD MEMBERS PRESENT: Harriette Stevens, EdD; Co-Chair; Ulash Thakore-Dunlap, MFT, Co-Chair; Judy Z. Drummond, MA; Carletta Jackson-Lane, JD; Gregory Ledbetter; Susan Page; Richard Slota, MA; Njon Weinroth; and Benny Wong, LCSW.

BOARD MEMBERS ON LEAVE: Terry Bohrer, RN, MSW, CLNC; Judith Klain, MPH; Toni Parks; and Marylyn Tesconi.

BOARD MEMBERS ABSENT

OTHERS PRESENT: Helynna Brooke, Executive Director; Kavoos Ghane Bassiri, LMFT, LPCC, CGP, Behavioral Health Services (BHS) Director; Cathy Spensley, MSW, LCSW, Senior Division Director, Family Service Agency (FSA) of San Francisco – Felton Institute; Jordan Pont, Felton FSA; Alison Livingston Citywide AOT/UCSF; Paul Hickman, Felton FSA; Virginia Braski; Mary Louise Roberson; Rachel Rodriguez and 1 public members.

Ms. Thakore-Dunlap called the meeting to order at 6:07 PM.

Roll Call

Ms. Brooke called the roll.

Agenda Changes

No changes

ITEM 1.0 REPORT FROM BEHAVIORAL HEALTH SERVICES DIRECTOR (See Attachment A)

The full director's report can be viewed at the end of the minutes or on the internet.

The Behavioral Health Services Update & Review of BOS Performance Audit presentation at the end of the minutes.

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

Mr. Ghane Bassiri highlighted the following items in the Director's Report and MHSA.

Within the adult and older adult system of care, BHS is trying to streamline the transition from Intensive Case Management (ICM) to outpatient care. Some of the support services can continue such as a representative payee if needed. The transition is for people who have been in ICM for a long time (able to make it to clinic based appointment) but don't need as much intensive care at this time. New ICM slots would open as a result, as some of these longer term and/or "stabilized" consumers transition. There is MHSA Innovative funding to help with the transition from ICM to outpatient care by services through Peer providers who can provide support and warm handoff on move from ICM to outpatient. Current ICM providers are USCF Citywide, Mission Mental Health, Westside Community Services, South of Market Mental Health, Felton Institute/FSA, and Hyde Street Community Services.

Dr. Ritchie Rubio has joined BHS as the Director of Practice Improvement and Analytics within the Children, Youth and Families Services division.

The Law Enforcement Assisted Diversion Program (LEAP) is nearing its first year anniversary and showing significant successes in diverting individuals with low level drug offenses into social services rather than jails. People who have been in and out of jail for years are engaging in services effectively.

BHS is intensifying its work with programs to determine what is working using the Logic Model which determines for example, "IF we do THIS, then THIS will happen, and then THAT will change for the better". Programs are being trained to use the model too.

Dr. Jeanette Cavano, the BH Drug Information/Academic Detailing pharmacist will be producing a newsletter called Details which summarizes internal medication use information and initiatives as well as behavioral health medication news updates, recent literature, and responses to pertinent drug information questions. The BHS Pharmacy staff also hosted a table on National Overdose Awareness Day on August 31st in the lobby of the building.

BHS has formed an Eligibility Unit to work with providers to help people enroll and stay on Medi-Cal for benefits, as eligible.

Mr. Ghane Bassiri reported on the following items not in the Director's Report, related to personnel.

- Barbara Garcia, Director of the Department of Public Health has resigned and Greg Wagner is serving as the Acting Director. There will be a search for the new director and a job

description & announcement will be posted soon. The Health Commission held a hearing for people to provide input as to what they would like in a director. The Health Commission will review the applications, conduct interviews, and identify the top candidates to present to the Mayor in order to review and select to hire.

- Dr. Ken Epstein has resigned from his position (effective September 28th) and Max Rocha will be serving as the Acting Director of Children, Youth and Families Services, while there will be a search to fill the position. Dr. Epstein had provided leadership at the department on the training and implementation of trauma informed care.
- Dr. Ayanna Bennett will oversee the Department's Trauma Informed Systems initiative and Lisa Reyes will be the manager. Dr. Bennett is the Director of Interdivisional Initiatives at SFDPH. She was formerly the director of the 3rd Street Youth Center & Clinic.
- BHS is nearing the end of the hiring process for & selection of BHS Director of Equity, Social Justice, and Multi-Cultural Education position (formerly titled BHS Director of Cultural Competency).

1.2 Public Comment

No Public comments

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the [Mental Health Services Act](#) or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

Mr. Ghane Bassiri Although not MHSA funding, there is new one-time funding from the State, from January 2019 through June 2020, as a result of the Governor's Budget Act for California Counties, from Department of Health Care Services (DHCS) for local activities involving individuals with serious mental illness and who are homeless or at risk of homelessness. SFDPH BHS is working with the Mayor's Office on the planning and currently exploring various options and ideas/proposal for using these funds for urgent levels of care management such as transition from Psychiatric Emergency Services (PES), street outreach & engagement, linkage services, intensive case management, Peer based services, and having some clinics open later into the evening as well as to provide for more intake support and increasing placements. SFDPH will also be working with the Department of Homelessness & Supportive Housing towards this end.

2.2 Public Comment

Ms. Mary Ann asked if anyone can apply for the position of Director of Public Health or is it for City employees/Civil Service staff only.

Mr. Ghane Bassiri replied that the position is open to the public and anyone can apply for the position (meeting the minimum qualifications).

ITEM 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment

No public comments.

3.2 Proposed Resolution: Be it resolved that the minutes for the Mental Health Board meeting of August 1, 2018 be approved as submitted.

Unanimously approved.

3.3 Resolution (MHB-2018-01): Be it resolved that the Mental Health Board held a public hearing and reviewed the Mental Health Services Act FY 2018-2019 Annual Update.

Tabled

3.4 Resolution: Proposed Resolution: Be it resolved that the Mental Health Board commends Angela Pon for her contribution to the board.

Tabled

ITEM 4.0 PRESENTATION: OLDER ADULT SERVICES AND GAPS, CATHY SPENSLEY, MSW, LCSW, SENIOR DIVISION DIRECTOR, FAMILY SERVICE AGENCY OF SAN FRANCISCO – FELTON INSTITUTE.

4.1 Presentation: Older Adult Services and Gaps, Cathy Spensley, MSW, LCSW, Senior Division Director, Family Service Agency of San Francisco – Felton Institute.

Ms. Thakore-Dunlap shared that Cathy Spensley, LCSW, is the Senior Division Director at Felton/Family Service Agency of San Francisco, overseeing programs that serve over 5000 older adults a year. Her areas of specialization include mental health, senior services, workforce development, and advocacy. She is active on many committees and advisory boards, including the Mayor's Long Term Care Coordinating Council, the Dignity Fund Coalition, and the San Francisco Tech Council. She presents at annual conferences on policy and service level needs of older adults. Cathy has a BA in Communications from American University and a MSW from UC Berkeley.

Ms. Spensley took care of her elderly mother for years which inspired her to choose the field of elderly services. Felton (FSA), a community based organization, serves all ages and has been around for 130 years.

MHSA changed the system of care by bringing in Peers (people with lived experience with mental illness and/or substance use). At Felton, peers are full participants of the clinical team. Paul Hickman leads the Peer Division for FSA. Peers meet with clients, do home visits and escort them to appointments. Many elderly folks tend to isolate themselves so peers encourage them to participate in programs. Peers visit people in homeless shelters too. The seniors have expressed that they would like someone to come by on weekends too.

FSA specials in geriatrics for people on MediCal who are severely mentally ill people, may have cognitive impairment, and may be homeless. They are funded by MHSA, as well as State and Federal grants. They were the first intergenerational program in the state. They have a long term care ombudsman program to connect people to board and care homes for adults and older adults. They provide case management, workforce development and meaningful activities. They are

wanting to work more together within their different departments. They work with people from different cultures and who speak many different languages.

Ms. Spensley shared that there is a need for more education about aging. Services are somewhat fragmented. Older adults have specialized needs. Some people think people with dementia need to be 5150'd. There is a need for more communication.

The Dignity Fund, Proposition I from two years ago provides for services for older adults up to \$44 million. It includes adults with disabilities. They are not seeing many from the mental health side yet. There are a lot of people growing older and living longer. 25% of the population of the United States have some sort of disability.

A lot of older adults in San Francisco are living in poverty. Evictions have increased as have the referrals to Felton. People are living longer but increased co-morbidity, and a certain per cent are getting dementia and Alzheimer's. In Oakland the fastest population of people who are homeless are elderly. There is also an increase in substance use such as opiate use. It looks different than in the past as the new group with substance use disorders causing functional impairment but not serious mental illness. If treated the problems disappear.

There was flat funding for so many mental health programs for years, with no cost of living adjustments. It has made it difficult to recruit staff because of the lower pay and losing people to higher paid jobs in civil service. Ms. Spensley raised the question of why can't programs get more funding if doing well? She felt we need to look at ways to increase capacity. Felton has a strong full service partnership program that is keeping people out of hospitals.

Ms. Spensley suggested that we need to have a conversation about how we can track data more effectively and use the data. There is fragmentation of services and silos. We need to meet the growing needs and look for additional funding so successful programs are rewarded for their work. More effective collaboration is needed among multiple programs such as Aging, Mental Health and Workforce Development.

She suggested that when the City interviews people for positions that folks they don't choose might be shared with CBO's.

Mr. Ledbetter is chair of the Older Adult Committee and he works with several clients. He has one client who was released from Dore Urgent Care to go back to Felton. Felton sent him to San Bruno for detox and he returned traumatized.

Ms. Spensley replied that they need to take those cases and find out what they should do to find out what went wrong.

Mr. Ledbetter asked about how to reach people who are not aware of their programs.

Ms. Spensley replied that they need to do more outreach. For example, Paul who has escorted clients to programs as well as doing a lot of outreach work with clients.

Ms. Spensley added that Felton has an open door policy. She will call Paul and he will figure out where to send the client.

Ms. Jackson-Lane stressed the need for additional clinical staff suggesting that they might get folks from San Francisco State University or UC Berkeley. They should be able to work for a CBO for a year or two.

Mr. Weinroth asked for an explanation of the difference between peers and staff.

Ms. Spensey explained that the number one transformation of the system since the passage of the Mental Health Services Act was the use of peers. Sometimes clinical staff doesn't treat peers as equals but they are working on that.

Mr. Wong said that a couple of years ago the Department of Aging created a resource for aging.

Ms. Spensley said they have a resource for family members and about MediCal.

4.2 Public Comment

Ms. Mary Ann shared that it is depressing to hear that there are services people don't find out about. She felt that there is not enough printed material. Most is sent to websites which are not good for those who are blind or hard of hearing. There are natural and artificial barriers.

Mr. Hillier said that he went to Felton for services and they asked for his social security number and when he wouldn't give it to them so he was refused services.

ITEM 5.0 REPORTS

For discussion

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 invited additional board members to attend the **She the People** conference.

5.2 Report from Chair of the Board and the Executive Committee. Discussion regarding Chair's meetings with Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance use.

The meeting of the Older Adult Committee, chaired by Gregory Ledbetter, met not meet in August and may change the time of the regular meeting beginning in September.

The Substance Use Committee, chaired by Njon Weinroth, will meet from 9:00 AM to 10:00 AM Tuesday on September 25th, 2018 just before the Executive Committee meeting.

The Executive Director (ED) Succession Committee chaired by Marylyn Tesconi needs to schedule its next meeting as Marylyn just had surgery last week.

5.3 Committee Reports

Mr. Weinroth reported that he met with Dr. Judith Martin, Director of Substance Use Services for BHS.

Mr. Ledbetter shared that the committee is working on the issue of more outreach to seniors, especially in the south of Market and Tenderloin areas.

Ms. Thakore-Dunlap called for volunteers to be on the Mental Health Board retreat committee and Idell Wilson and Gregory Ledbetter volunteered.

5.4 Commendations.

Mr. Slota and **Ms. Bohrer** did a program review of the Medical Respite and Sobering Center and he suggested they receive a commendation for their work.

Ms. Jackson-Lane suggested a commendation for Westside.

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

Mr. Slota shared that he did a program review of the Medical Respite and Sobering Center. In general they are doing a great job with a very challenging population. They need lockers for clients, more clinical staff, more nurses and social workers, more money for food as they are spending only \$5 per day per person. They need housing for discharged clients. For older adults, they need training in dementia and better end of life care. They need clothes for large people..

5.6 Refer to Executive Committee.

Non specialty mental health programs like Beacon.

5.7 Public comment.

A **public member** wanted to know more about the AOT program and MHSA.

6.0 Public Comment

Mr. Hillier stated that BHS is too aggressive about getting new clients and involuntarily medicating people.

Adjournment

The meeting was adjourned at 7:52 PM.



Behavioral Health Services Monthly Director's Report August & September 2018

1. MENTAL HEALTH SERVICES ACT (MHSA)

Mental Health Suicide Prevention Week

Suicide Prevention Week is September 9- 15, 2018, and World Suicide Day is September 10, 2018. In recognition, Behavioral Health Services (BHS) will be disseminating Each Mind Matters, "Know the Signs," materials to providers and community members, as well as hosting an educational activity in the lobby of 1380 Howard. For the first time, local businesses, such as The Market and Cumaica are partnering with BHS and distributing, "Know the Signs," coffee sleeves and drink coasters to spread the word. Slice of Life Café at 1380 Howard is also supporting the campaign again this year.



For more information about the signs of suicide and the Each Mind Matters campaign, please visit:

<https://www.suicideispreventable.org/>

<https://emmresourcecenter.org/resources/2018-suicide-prevention-week-toolkit>

National Suicide Prevention Lifeline: (800) 273-8255, Crisis Text Line: TEXT "Home" to 741-741.

2. ADULT & OLDER-ADULT (AOA) SYSTEM OF CARE

ICM-OP Step-Down Client-Flow Task Force follows-up on recommendations

Since June 2018, when a collaboration of BHS mental health outpatient (MH OP) and Intensive Case Management (ICM) programs concluded its year-long work, a small task force in BHS has been busy implementing the collaboration's recommendations toward ensuring the successful step-down of clients from intensive case management to regular outpatient services.

- A contract solicitation was successfully concluded, and a provider selected, to start the MHSA innovation program that will employ a team of peers to provide support to clients stepping down from ICM to MH OP level-of-care. Negotiations with the selected provider will take place soon, in order for services to begin.
- Learning for Action (LFA), which facilitated the months-long deliberations of the collaboration, has started drafting a new BHS policy on promoting successful transition of clients from ICM down to MH OP level-of-care. The new policy will incorporate all of the collaboration's recommendations regarding a standardized procedure to refer ICM clients to OP, including the following:
 - i. Director-to-director referrals (or designees)
 - ii. Use of standardized ICM Referral Form and Readiness Questionnaire
 - iii. Facilitation of client choice of provider, and prior client visit to the OP program
 - iv. Dual episodes open in ICM and OP until step-down is deemed successful
 - v. Maintenance of OP client registry to monitor clients continued success in OP treatment
 - vi. Adoption by OP programs of flexible ways to serve stepped-down clients in order to ensure successful integration of clients into care – including: provision of outreach, flexibility in medication support services, accommodation of client drop-ins, continuity of some ICM services into OP for clients stepping down into co-located OP services, and purchase of wrap-around supports and services
 - vii. Continued centralized tracking of all step-down referrals to monitor and ensure overall system-of-care success.
- \$5,000 annually for each mental health outpatient program has been budgeted for purchase of any needed miscellaneous supports for stepping-down clients.
- A couple of meetings with Conard House Rep Payee Services firmed up the availability of rep payee slots to clients who will need that continued money management support as they transfer to regular OP care. BHS will issue reminder information about the steps to access Conard rep payee services.
- BHS Quality Management continues to receive notice from ICMs, of the clients they are referring to MH OP, to track the continued overall success of the system of care in these referrals.

3. CHILDREN, YOUTH AND FAMILIES (CYF) SYSTEM OF CARE

BHS is very pleased to announce that **Dr. Ritchie Rubio** has joined SFDPH at BHS with CYF System of Care, as the Director of Practice Improvement & Analytics. Dr. Rubio will oversee various efforts related to best clinical practices, data/outcomes, and workforce development.

Dr. Rubio has worked as a clinical child psychologist, play and expressive arts therapist, researcher, program evaluator, statistical consultant, and associate professor/lecturer in a variety of clinical and academic settings including universities, pediatric hospitals, community mental health settings, schools, and research institutes in three countries: Philippines, U.S.A., and New Zealand. He was born and raised in the Philippines and immigrated to the U.S. 15 years ago to pursue his doctorate through the Ford Foundation International Fellowships Program (IFP). He completed his Ph.D. in Clinical Psychology with a Child and Family emphasis from the California School of Professional Psychology (CSPP) at Alliant International University, San Francisco.

His clinical work was/is primarily with immigrant and multicultural children/youth and their families. In working with clients and their families, he mostly integrates psychodynamic, attachment, family systems, multicultural, expressive arts, narrative, and CBT orientations. As for research interests, Dr. Rubio explores global gender roles, therapy strategies that blend Eastern and Western paradigms, culture-specific worldviews, and diversity initiatives. His research work has been published in peer-reviewed journals and he has presented at annual conventions of the American Psychological Association and the American Family Therapy Academy.

As a former Lead Evaluator for the San Francisco Department of Public Health he has helped develop and implement a Data Reflection to Innovate and Vitalize Effectiveness (DRIVE) initiative that encourages clinicians to routinely reflect on data outcomes of their clients as a means to improve their clinical effectiveness. He is also a Research Faculty and fellow at the Rockway Institute working on projects related to the psychosocial functioning of gay fathers and their children born through surrogacy; and mental health outcomes of same-sex couples following legal recognition of their relationships. Dr. Rubio, most recently, was an Associate Professor at the Counseling Psychology program of the Wright Institute in Berkeley. He has taught and facilitated courses like Child and Adolescent Counseling; Research-Based Practice; Clinical Assessment and Measures; Crisis, Disaster, and Trauma Counseling; Family Violence and Protection; Common Therapeutic Factors; Psychopharmacology; and a Professional Development Seminar.

Spotlight on Chinatown Child Development Center, L.E.G.A.C.Y., Project 500, and Southeast Child & Family Therapy Center

Southeast Child & Family Therapy Center provides different group sessions/activities as part of its array of services. One of the groups is the Drumming Group, which utilizes a culture-based healing modality. The approach draws from Afro-Caribbean music traditions and restorative practices that promote wellness. Group members engage in learning, playing, and leading rhythms that encourage connection and cohesion through increasing awareness, attunement, and empathy between members. The parents and caregivers play the drums alongside their children, which provides connection and positive role modeling for socialization and reflection. Southeast Child/Family Therapy Center's Roleplaying and Storytelling Adventure Game is a group intervention that utilizes role-play, improvisation, theory of mind, embodiment,

and teamwork to support wellness. Group members are encouraged to work together as a team to problem solve as their created fictional identities. The consistency provided by the game's rules and the imagined setting provide a safe space for members to take safe, growth oriented risks to explore their identity, relationships, and sense of agency. Clients learn to manage stress by guiding their characters through challenging situations, reflecting on the similarities between their own personal real-world challenges and the imagined challenges of their characters, and identify in-game solutions that may provide insight to how to manage stress in non-game situations.

Navigating Uncharted Stories group, supports newcomers and San Francisco natives who are having difficulty managing their experiences of isolation, invisibility, exclusion, and discrimination. The group includes 4 outings, once per week, where members visit parks, beaches, and different recreational locations in the city and engage in activities that foster dialogue about our identities, histories, homes, and communities. Activities include mindfulness, expressive arts, discussion, psycho-education, exercise, and prosocial activities that foster inclusivity and connection. BHS appreciate the therapists' commitment, passion, and creativity in developing these exciting and culturally-relevant groups!

Project 500 clinicians are in the process of enrolling mothers in another round of Attachment Vitamins, which is a 10-week intervention to help parents and caregivers of children aged birth-5 years old to learn about child development and the impact of stress and trauma, reflect on the child's experiences and the possible meanings of the child's behaviors, as well as promote secure attachment and safe socialization practices.

In addition to providing psycho-educational groups, dyadic treatments such as Child Parent Psychotherapy, and mental health consultation and conferences to P500 mobility mentors within HSA and home visiting nurses within Maternal Child Adolescent Health, P500 clinicians continue to provide opportunity for engagement of families through informal socialization groups. Interested P500 parents/family and children are currently engaged in a 6-week playgroup. This gathering is sometimes joined by extended family members and partners as well. Caregivers share stories/ tips, resources and sometimes outgrown baby clothes. Most notably, despite the different languages spoken- Cantonese, Lao, Spanish and English mothers communicate and have a lot of fun in the process.

In August, LEGACY staff became certified in Mental Health First Aide, with a focus on the youth population. Mental Health First Aid goes over common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help youth during both crisis and non-crisis situations. LEGACY staff participated in community outreach at the B-Magic's Backpack Giveaway in the Bayview neighborhood of the City. Also, LEGACY hosted another successful Family Support Night and families were able to participate in an interactive discussion around community. All present school-aged youth were able to receive a backpack filled with school supplies.

Chinatown Child Development Center staff and consumers participated in an all-weekend day gardening activity at the Presidio nursery. Participants learned to identify native plants in the Presidio gardens and helped to beautify the area by pulling out weeds. Additional activities included creating colorful leaf collages from various plants. All activities and lessons were conducted in Chinese (Cantonese dialect) by park volunteers. Lunch and snacks were also provided by the park staff, with fresh vegetables and fruits picked from their organic gardens. This event was organized by the Golden Gate National Parks

Conservancy. The Golden Gate National Parks volunteer program is a partnership of the Golden Gate National Parks Conservancy, National Park Service, and the Presidio Trust.

4. FORENSIC/JUSTICE INVOLVED BEHAVIORAL HEALTH SERVICES

Law Enforcement Assisted Diversion Program (LEAD) and Drug Court Treatment Center Updates

As the Law Enforcement Assisted Diversion (LEAD) program nears its one year implementation anniversary, we have been able to reflect on some of the successes of our services. While the explicit function of LEAD is to divert individuals with low level drug offenses into social services and away from jail, the byproducts of continuous engagement by skilled outreach workers and case managers can be truly life changing. The biggest successes of the LEAD program are due to the hard work of the clients, and the persistent nature of LEAD's harm reduction strategy. DPH quickly provides clinical assessments to connect participants referred from the Mission and Tenderloin Districts to Felton Institute or Glide Foundation for services. Given the Harm Reduction Principles, clients are not pushed into immediate action or change, but are allowed to proceed at the pace that they are most comfortable with.

The program is working with many individuals who have been experiencing homelessness for years, and even decades, and have been previously labeled as, "service resistant"; however, we have found that these individuals just haven't found the right fit for them yet. By taking the time to get to know each client and their unique needs, Glide and Felton have been able to engage participants in a powerful way. This includes interventions such as taking steps towards housing, medication assisted treatment, and entering residential programs.

Some examples of successes include clients reconnecting with family, a client successfully completing probation for the first time in their adult life, and another who showed up to court (out of custody) for the first time. These service coordination plans are further supported by a strong multi-disciplinary team, including legal partners who assist participants in addressing any outstanding legal cases both within and outside of San Francisco County. We have learned that these seemingly small achievements build confidence that pave the way for more success. Clients have expressed that since they haven't felt judged by their service providers through LEAD, they are able to shed some of their shame, and address bigger life obstacles. Congratulations to the LEAD program for all of their success!

Every year, the Drug Court Treatment Center holds 4-graduations for participants who complete the Drug Court program requirements. In order to graduate, participants must have six-months of sobriety, consistent attendance in programming, engagement with treatment providers and case managers, and have completed a Recovery Aftercare Plan with established support systems. Successful completion of Drug Court may result in early termination of probation, reduced charges, or case dismissal.

Thus far in 2018, Drug Court has held three graduations (January, April, and July). Prior to participating in the program 81% of graduates had used drugs daily and 13% had used drugs multiple times per week. At the time of graduation *all* graduates were drug free. Similarly, 63% of graduates had no income at time of entry, and 88% are now employed with 100% having legal sources of income. Currently all graduates are safely housed (a 50% increase from program entry), 19% are enrolled in school or vocational training, and 44% are planning to enroll in the future. Finally, 25% of graduates have been reconnected with their children and one baby has been born drug-free!

One graduate’s success took two attempts at Drug Court. This participant initially entered a residential treatment program where she stayed for a year and attended outpatient for a few months, but then relapsed and failed to appear in court. This participant returned for a second try at Drug Court, entered an outpatient program, and although had some challenges and triggers, developed increased coping skills and graduated within eight months.

Many thanks to all the community partners in Collaborative courts for allowing our participants the opportunities to engage in and successfully find paths to recovery.

5. BHS QUALITY MANAGEMENT REPORT

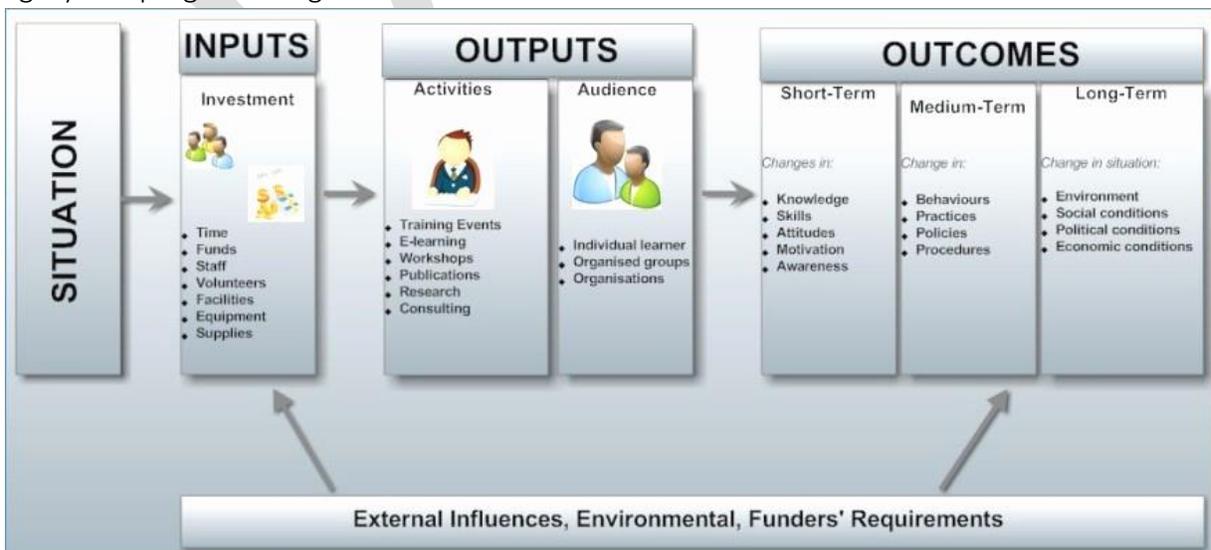
How Do You Know that your Program is Working? Quality Management conducts Logic Model Workshops for Program Managers.

Programs are often design to serve clients or participants by focusing on delivering services. But how does one know the programs, no matter how long-standing or innovative, are actually driving the positive change that was intended?

Program planners and evaluators use a tool called a Logic Model to outline the implementation of a program and to evaluate its effectiveness through clarifying intended outcomes.

The Quality Management (QM) team in BHS assists program planners in mapping out program designs to the desired objectives. This fiscal year, the QM team, led by Diane Prentiss, conducted a logic modeling workshop for program managers for the Mental Health Services Act (MHSA) programs. The hands-on workshop helped managers articulate the sections of a Logic Model: Resources available, Strategies or Activities planned, Outputs expected (such as, number of trainings, number of clients served, etc.) as well as Intermediate and Long-term Outcomes, and the Indicators they might use to measure these outcomes.

Following the logic of Theory of Change (for example, “IF we do THIS, then THIS will happen, and then THAT will change for the better”), breaking down the program in this manner helps to clarify assumptions so that the end can map back to what was intended in the first place. A well-constructed logic model will facilitate the integrity of a program design.



In August, a second workshop focused on **using program outcomes** from a logic model **to construct appropriate evaluation tools**, going straight from the logic model into evaluating outcomes.

For example, several MHSA Prevention and Early Intervention programs convene activities centered on building social connection, such as drumming or talking circles, among a specific population of residents, like indigenous/native peoples, as a way of strengthening community and preventing the onset or worsening of mental health conditions. We will create items for a brief questionnaire that focus on social connectedness in these activities and discuss the best language and method for collecting this information from participants. This helps administrators know whether or not the programs are having an actual (hopefully measurable) impact on participants' social connectedness and well-being.

Logic Modelers:



Left to Right: Teresa Yu (MHSA) , Kim Ganade (MHSA), Heather Weisbrod (TAY System of Care), Diane Prentiss (Quality Management, facilitator), Sarah Parajito (QM), Jennie Hua (BHS System of Care), Photo by Ryan Reichel (QM), Missing from photo: Tracey Helton (MHSA) and Charlie Mayer (RDA Consultants).

6. BHS PHARMACY

Dr. Jeanette Cavano is the BH Drug Information/Academic Detailing pharmacist. BHS Pharmacy is happy to report she will be producing a newsletter called **Details** which summarizes internal medication use information and initiatives as well as behavioral health medication news updates, recent literature, and

responses to pertinent drug information questions. Please feel free to submit questions or ideas for topics to Jeanette.Cavano@sfdph.org.

The Drug Information Consultation Service responds to drug information requests regarding behavioral health drug therapy. This service is available Monday through Friday 9:00am to 4:30pm and is free of charge to all BHS clinicians. Questions and requests for consultation may be submitted by calling 415-255-3705 or emailing Jeanette.cavano@sfdph.org.

Details Volume One (See Attachment) will be posted to the SFDPH - CBHS Webpage under Medication Resources.

International Overdose Awareness day

Back by popular demand, BHS Pharmacy hosted a table in the 1380 Howard lobby on August 31st to recognize International Overdose Awareness day.

- 1) Informational table in the lobby from 9:00 AM-4:00 PM included the following:
 - a) Opioid Overdose Awareness poster board about opioid safety education, treatment access information, how to respond to an opioid OD using naloxone
 - b) Educational handouts: naloxone fact sheet, SF safe medicine disposal, TAP brochure, Good Samaritan law handout
 - c) Naloxone/Opioid Use Trivia board
- 2) Naloxone furnishing for any and all interested people (providers, patients, community members, etc.). BHS Pharmacy offered training on opioid reversals in the lobby area + provided free naloxone from the pharmacy.
- 3) Pharmacy Staff wore purple (National Drug Overdose Awareness color)



The Pharmacy team pictured includes pharmacy interns, technicians and pharmacists. From left to right: Jason Y. Wong, Jose Manzano, Arnold Estrada, Nerissa Zamora, Evelyn Suson-Lee, Jennifer Behan, Theresa Maranon, Elizabeth Preciado, Stephanie Pang, Jeanette Cavano and Gloria Wilder.

7. ANNOUNCEMENTS:

Behavioral Health Services has formed an Eligibility Unit to assist programs in verifying clients' eligibility. The team has introduced several new projects to assist programs in eligibility-related matters:

- An eligibility hotline, where staff can ask general eligibility questions, receive information regarding a client's coverage status, or gain clarity regarding eligibility policy. The hotline number is **(415) 255-3744** and all calls will be returned within 24 hours.
- A monthly report that identifies clients within a program who have lost Medi-Cal coverage. The report also provides the date of lost coverage and instructions on submitting a redetermination.
- Weekly hours at the Behavioral Health Access Center where clients can receive assistance in applying to Medi-Cal. Eligibility workers will be available Mondays, Wednesdays, and Fridays from 1:00pm - 4:00pm. Please note that the eligibility workers will not be able to determine eligibility or authorize benefits.

If your program is interested in receiving the monthly Lost Medi-Cal report, please email jena.jenson@sfdph.org. Please let us know if you have any questions or comments.

List of Presentations by SFDPH-BHS:

Ong, W., & Rubio, R. J. (2018, August). *Crisis among ethnically diverse youth: Grounded theory and implications for clinical practice*. Presentation at APA Division 37 - Child and Family Policy and Practice.

Martinez, A. R., & Rubio, R. J. (2018, August). *Unaccompanied immigrant Latino youth: A cultural perspective to engagement in mental health services*. Presentation at APA Division 45 - Psychological Study of Culture, Ethnicity and Race.

Rubio, R. J. (2018, August). *Boys in psychiatric crisis episodes: Clinical correlates, risk factors, and narratives*. Presentation at APA Division 51 - Men and Masculinity.

Rubio, R. J., Farahmand, F. K., Maddox, J., & Epstein, K. (2018, August). *Reflective, relational, and skillful clinical supervision in a public behavioral health system*. Presentation at APA Division 12 - Clinical Psychology.

The National Alliance on Mental Illness (NAMI) California invited SFDPH-BHS to present on its Transgender Pilot Project (TPP) at their Northern California Regional Multicultural Symposium, to be held in October 2018, in Redwood City.

Grindr for Equality has invited Jenna J. Rapues, MPH (Director of Gender Health SF) to participate in the first ever Grindr HIV Data Privacy Summit, to be held in October 2018, in Los Angeles, California.

In October, BHS will present on the Data Reflection Initiative, at the 14th Annual TCOM (Transformational Collaborative Outcomes Management) Conference, jointly hosted by Chapin Hall at the University of Chicago and The Praed Foundation. This year's conference theme is, Evidence Based Practice: Taking Person Centered Care to Scale.

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

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

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Details

Pharmacy Report



San Francisco
Health Network



BHS Medication-Use Resources and Initiatives

New Sedative-Hypnotic Guidelines Approved by MUIC

The Behavioral Health Services Medication Use Improvement Committee has updated the Safer Prescribing of Sedative-Hypnotics Guideline (available at the link below). This guideline acknowledges the significant risks for misuse, abuse, diversion and adverse effects of these agents. Organizationally, we have made significant efforts to reduce prescribing of these agents whenever possible.

The previous sedative-hypnotic guideline was developed and distributed in 2014. At that time, approximately 15% of the BHS population over 18 was prescribed a sedative-hypnotic. High risk populations of patients also prescribed methadone maintenance and older adults were also evaluated. Over a two year period, prescribing of sedative-hypnotics declined in all populations.

MUIC continues to monitor sedative-hypnotic use in BHS, and prescribing of benzodiazepines has remained fairly steady over the last two years, particularly in the older adult population. MUIC identified older adults as a population in need of further deprescribing due to the higher prescribing rate and greater risk for harm in this population.

Percent of Population with Chronic Prescription for Sedative-Hypnotic

| Population | Oct 2013 | Mar 2015 |
|-------------------------------|----------|----------|
| >18 years old | 15.89% | 12.21% |
| Older Adults (> 60 years old) | 15.83% | 13.27% |
| On methadone maintenance | 26.37% | 16.49% |

Medication updates to the guideline include:

- Updated risk assessment for new and ongoing sedative-hypnotic prescriptions
- Considerations in special populations such as older adults, pediatrics, pregnancy and lactation
- Dose adjustments in renal/hepatic impairment
- Information about Suvorexant
- Alternative/Herbal treatments for insomnia and anxiety disorders

In addition to medication information about sedative-hypnotics, the guideline contains links to support materials for reducing or avoiding sedative-hypnotics for insomnia. Tools include:

- Sleep diaries and educational handouts
- Information on CBT for Insomnia
- Information on sleep clinic referral

1. Safer Prescribing of Sedative-Hypnotics Guide
<https://www.sfdph.org/dph/files/CBHSdocs/Sedative-Hypnotic-Guideline.pdf>

Details

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New Drugs and Dose Forms

New Modified-PK Dose Form for Long-Acting Aripiprazole

Aripiprazole Lauroxil ER (Aristada Initio®) was approved by the FDA on 6/29/18. This dose form is a modified-PK-profile form of aripiprazole lauroxil ER (Aristada) that enters the systemic circulation much more quickly. It is intended to be given as a bridge to aripiprazole lauroxil ER from oral aripiprazole therapy or to be used to return to long-acting aripiprazole lauroxil after missed doses.

Aripiprazole Lauroxil ER is not to be used in aripiprazole-naïve patients due to concerns regarding tolerability. This new dose form prevents the need for oral bridging to ongoing aripiprazole lauroxil long-acting injections. Tolerability of aripiprazole should be established with oral dosing for at least two weeks before using the long-acting injectable formulation. A single injection of Aristada Initio 675 mg should then be given along with a single oral dose of aripiprazole 30 mg. This first dose of ongoing Aripiprazole lauroxil monthly injections may be given on the same day as the Aristada Initio dose or up to 10 days later. Giving these three different dose forms together resulted in aripiprazole concentrations equivalent to Aripiprazole lauroxil ER given with 21 days of oral aripiprazole overlap. Concentrations reach relevant levels within 4 days of this combined dosing.

Aristada Initio may also be used to supplement after missed doses of Aristada if too much time has elapsed since the last dose. For details of when to administer Aristada Initio in this situation, refer to LexiComp or the manufacturer's labeling.

Aristada Initio is **not** interchangeable with Aristada and should not be used for repeat dosing. Unfortunately, with such similar names (the generic names are exactly the same), the risk for mixing these products up is high.

1. Aristada Initio PI: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/209830lbl.pdf accessed 8/7/18.

Non-Opioid Treatment for Management of Opioid Withdrawal Symptoms

On May 16, 2018, the FDA approved **Lofexidine** (brand name **Lucemyra®**) for mitigation of withdrawal symptoms to facilitate abrupt discontinuation of opioids in adults. Lofexidine is an oral, selective alpha-2 receptor agonist that reduces the release of norepinephrine. It was shown safe and effective in reducing withdrawal symptoms in two large trials, measured using an objective patient-reporting scoring instrument.

Lofexidine is dosed 0.54 mg tablet four times a day during peak withdrawal symptoms; it may be increased to 0.72 mg per dose (up to 2.88 mg per day) and continued up to 14 days. It should be tapered down as withdrawal symptoms wane. Dose reduction is indicated for mild to severe renal or hepatic impairment. Common adverse effects include orthostatic hypotension, bradycardia, hypotension, insomnia, dizziness, sedation and dry mouth. There is a risk of rebound hypertension if the drug is stopped abruptly.

This drug was given fast-track status for approval by the FDA. "As part of our commitment to support patients struggling with addiction, we're dedicated to encouraging innovative approaches to help mitigate the physiological challenges presented when patients discontinue opioids," said FDA Commissioner Scott Gottlieb, M.D.

Although this new approval does add to our armamentarium of treatments for opioid withdrawal symptoms, it does not really offer a novel approach. Clonidine, an agent with similar pharmacology and adverse effects, has been used for years to treat symptoms associated with opioid withdrawal. It remains to be seen how this new agent will offer any true advantages over current treatments.

1. Lucemyra PI: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/209229s000lbl.pdf accessed 7/26/18.
2. FDA approved the first non-opioid treatment for management of opioid withdrawal symptoms in adults. FDA press release. May 16, 2018. <https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm607884.htm> accessed 7/26/18.

Cannabis Product to Treat Rare Forms of Epilepsy

Cannabidiol (brand name **Epidiolex**[®]) oral solution was approved by the FDA on 6/25/2018 for treatment of seizures associated with Lennox-Gastaut syndrome and Dravet syndrome in patients 2 years of age and older. Cannabidiol, a pure cannabinoid derived from the *Cannabis sativa L* plant (aka marijuana), does not appear to have the psychoactive effects seen from tetrahydrocannabinol (THC), the other cannabinoid in marijuana. Other commercial products such as Dronabinol and Nabilone contain synthetic versions of THC. The precise mechanism of action of Cannabidiol in its anticonvulsant effects remains unknown, but it does not appear to produce this effect through interaction with cannabinoid receptors.

Cannabidiol dosing starts at 2.5 mg/kg/day and can be titrated up to a maximum dose of 20 mg/kg/day. Somnolence and sedation were reported commonly in clinical trials (approximately 3X more commonly with active treatment than placebo); these effects were dose-related. Cannabidiol is metabolized by and an inhibitor of CYP450 enzymes 3A4 and 2C19, and as such, can interact with many other medications.

Cannabidiol is currently classified by the DEA as a Schedule I controlled substance, but this classification is under review. This product will not be available commercially until its scheduling is changed.

1. Epidiolex PI: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/210365lbl.pdf accessed 8/4/18.

Substance Use Disorders and Treatment

CDC Warns About Risk in Overdose Deaths Linked to Fentanyl Analogs

Fentanyl and fentanyl analogs are increasingly involved in opioid overdose deaths, and new analogs continue to be identified. Carfentanil, the most potent analog found in the U.S., is intended for sedation of large animals, and is estimated to have 10,000 times the potency of morphine.

From July 2016-June 2017, according to data analyzed from the CDC's tracking system, fentanyl analogs were detected in approximately 20% of opioid overdose deaths, with over 11% testing positive for carfentanil. The proportion of deaths with fentanyl analogs present nearly doubled during the time period analyzed.

The CDC recommends raising public awareness of the highly variable content of fentanyl present in illicit opioids and the potential lethality of this drug. They also recommend expanding the availability of naloxone and facilitating access to Medication-Assisted Treatment for opioid use disorder. Overdoses with these highly potent fentanyl analogs may require multiple doses and prolonged administration of naloxone to reverse the effects.

1. Morbidity and Mortality Weekly Report, July 13, 2018. <https://www.cdc.gov/mmwr/volumes/67/wr/mm6727a4.htm>
2. CDC Health Alert Network, July 11, 2018. <https://emergency.cdc.gov/han/han00413.asp>

Medication Assisted Therapy After Nonfatal Opioid Overdose Reduces Mortality

The good news is that people who survive an opioid overdose and receive medication treatment for their opioid use disorder (MOUD) are less likely to die in the following year. According to a study published in the Annals of Internal Medicine in June, in a cohort of over 17,000 people who had a nonfatal opioid overdose between 2012 and 2014 in Massachusetts, all-cause mortality at 12 months was 4.7 deaths per 100 person-years. Less than a third of participants received MOUD in the 12 months following a non-fatal overdose, but for those who received treatment with buprenorphine/naloxone or methadone, all-cause and opioid-related mortality were lower than for those who did not receive treatment.

1. Laroche MR, Bernson D, et al. Medication for Opioid Use Disorder after Nonfatal Opioid Overdose and Association with Mortality. *Ann Int Med* 2018; 169: 137-145.

Psychiatric Medications

New Treatments for Tardive Dyskinesia Not Cost Effective

Tardive Dyskinesia (TD) has been a challenge since the introduction of antipsychotics in the 1950s. Rates of TD are 5% per year for conventional antipsychotics and 3% per year with atypicals. Discontinuing antipsychotics may not reverse, and may temporarily exacerbate TD symptoms. After decades with little guidance or effective treatment, the first two agents with FDA-approval to treat TD, **valbenazine (Ingrezza®)** and **deutetrabenazine (Austedo®)** were introduced in 2017.

The Institute for Clinical and Economic Review (ICER) recently published an analysis of the clinical effectiveness, cost effectiveness and potential budget impact for these agents, known as Vesicular Monoamine Transporter 2 (VAMT2) Inhibitors. Both agents have been shown to produce significantly greater improvement in AIMS scores relative to placebo. Approximately a third of patients receiving either agent in these studies achieved a $\geq 50\%$ reduction in AIMS scores (defined as “responders”).

Despite demonstrated clinical effectiveness in short-term trials, with average wholesale prices ranging from \$4,150/mo-\$12,500/mo (\$50,000-\$150,000/yr) and the potential need for lifetime treatment, the analysis suggests that the cost of these agents far outweighs their benefits. Incremental cost effectiveness ratios over a lifetime horizon were \sim \$752,000 and \$1.101 million per Quality-Adjusted Life Year (QALY) for valbenazine and deutetrabenazine respectively. This far exceeds the generally accepted ratio of \$150,000 per QALY. Moreover, ICER estimates a potential 5-year budget impact of over \$22 billion for these agents.

Adverse effects of these agents include drowsiness, fatigue, headache and akathisia. Both agents are only available through limited distribution networks, requiring registration with the distribution program. The introduction of treatments for TD raised hopes for addressing a long-standing challenge in psychiatry. However, with limited availability, high cost and modest benefits, it is unlikely we will see these two agents in widespread use any time soon.

1. Atlas SJ, Agboola F, Curfman G. Effectiveness and value to 2 novel treatments for tardive dyskinesia. *JAMA Int Med* 2018; 178: 1110-1112.



Crossroads between Psychiatry and Medicine

Antidepressant Treatment Improves Cardiac Outcomes in ACS

Depression has been associated with poorer outcomes after acute coronary syndromes (ACS). In a recently published clinical trial, 300 patients with ACS and depression (screened by Beck Depression Inventory and diagnosed based on psychiatric interview) were randomized to receive escitalopram in flexible doses or matched placebo for 24 weeks. Over 8 years of follow up, 40% of patients who received escitalopram and 54% of patients receiving placebo experienced major adverse cardiac events (MACE, a composite of all-cause mortality, MI and percutaneous coronary intervention), resulting in a Hazard Ratio of 0.69 ($p=0.03$). These results are somewhat in contrast to other studies of the impact of antidepressants on MACE (SADHART,² MIND-IT³), which found no difference between groups receiving antidepressant vs. placebo. Further research is needed to assess the generalizability of the findings of this new study.

1. Kim J-M, Stewart R, et al. Effect of Escitalopram vs Placebo Treatment for Depression on Long-term Cardiac Outcomes in patients with Acute Coronary Syndrome. *JAMA* 2018; 320: 350-357.
2. Van Melle JP, de Jonge P, Honig A, et al; MIND-IT Investigators. Effects of antidepressant treatment following MI. *Br J Psychiatry* 2007; 190: 460-466.
3. Glassman AH, Bigger JT Jr, Gaffney M. Psychiatric characteristics associated with long-term mortality among 361 patients having an acute coronary syndrome and major depression: seven-year follow up of SADHART participants. *Arch Gen Psychiatry* 2009; 66: 1022-1029.

Cumulative Incidence of Hypertension Much Higher in Blacks than Whites

A longitudinal study assessing the incident risk for hypertension in blacks and whites from ages 18-55 was published in the Journal of the American Heart Association. Nearly 4000 participants aged 18-30 without hypertension at baseline were followed to the age of 55 and assessed for hypertension (defined according to the 2017 American College of Cardiology/American Heart Association blood pressure definition of SBP≥130, DBP≥80 or self-reported use of antihypertensive medication). By age 55, cumulative incidence of hypertension was approximately 75% in black men and women, significantly higher than the 54% seen in white men and 40% seen in white women.

After full multivariate adjustment, blacks had a 1.5 to 2 times higher risk for hypertension compared with whites in any baseline BP category. Further, blacks were more likely to develop hypertension at a younger age, with 20% of black women and 30% of black men developing hypertension by the age of 35.

In this study, a higher DASH diet adherence score and lower BMI were associated with lower risk for developing hypertension in both blacks and whites. In a previous study (the Jackson Heart Study³), authors found a strong effect of concordance with the American Heart Association's Life's Simple 7 (LS7: nutrition, physical activity, cigarette smoking, body mass index, BP, cholesterol and glucose) and incident hypertension in blacks. Authors and editorialists recommend focusing on these modifiable risk factors to reduce the risk for hypertension in Black/African-Americans.

In light of added risks for metabolic complications of atypical antipsychotics in the behavioral health client population, focused efforts to ensure we support our Black/African-American clients in healthy lifestyle choices are essential. See references below for information about the AHA LS7 and the DASH diet.

1. Thomas SJ, Booth III JN, Dai C, et al. Cumulative incidence of hypertension by 55 years of age in blacks and whites: the CARDIA study. J Am Heart Assoc 2018; 7. doi: 10.1161/JAHA.117.007988.
2. Egan B. Defining hypertension by blood pressure 130/80 mm Hg leads to an impressive burden of hypertension in young and middle-aged black adults: follow-up in the CARDIA study. J Am Heart Assoc 2018; 7: e009971. doi: 10.1161/JAHA.118.009971.
3. Diaz KM, Booth JN III, Seals SR, et al. Physical activity and incident hypertension in African Americans: The Jackson Heart Study. Hypertension 2018; 68: 421-427.
4. Your Guide To Lowering Blood Pressure. National Institutes of Health. National Heart, Lung, and Blood Institute (includes info on DASH diet) https://www.nhlbi.nih.gov/files/docs/public/heart/hbp_low.pdf accessed 8/8/18.
5. My Life Check—Life's Simple 7. American Heart Association. <http://www.heart.org/en/healthy-living/healthy-lifestyle/my-life-check--lifes-simple-7> accessed 8/8/18.

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Details is produced by the Behavioral Health Drug Information Service. It summarizes internal medication use information and initiatives as well as behavioral health medication news updates, recent literature and responses to pertinent drug information questions. Please feel free to submit questions or ideas for topics to Jeanette.Cavano@sfdph.org.

The Drug Information Consultation Service responds to drug information requests regarding behavioral health drug therapy. This service is available Monday through Friday 9:00am to 4:30pm and is free of charge to all BHS clinicians. Questions and requests for consultation may be submitted by calling 415-255-3705 or emailing Jeanette.cavano@sfdph.org.