

FY 2013 - 2014 ANNUAL REPORT



SAN FRANCISCO MENTAL HEALTH BOARD

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INTRODUCTION

The San Francisco Mental Health Board (MHB), established in 1983 in San Francisco, as mandated by the Bronzan-McCorquodale Act within the Welfare and Institutions Code, Section 5600, is responsible for the following:

- Review and evaluate the community's mental health needs, services, facilities and special problems;
- Review County agreements entered into pursuant to Section 5650;
- Advise the Board of Supervisors and the Director of Community Behavioral Health Services (CBHS) as to any aspect of the local mental health system;
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process;
- Submit an Annual Report to the Board of Supervisors on the needs and performance of the mental health system;
- Review and make recommendations on applicants for the appointment of the director of mental health services prior to the vote by the Board of Supervisors; and
- Review and comment of the County's/City's performance outcome data and communicate findings to the California Mental Health Planning Council.

MISSION

The Mental Health Board of San Francisco represents and ensures the inclusion of the diverse voices of consumers, citizens, and stakeholders

MENTAL HEALTH BOARD MEMBERSHIP

Seat 1: Christine “Wendy” James, Vice-Chair	Appointed by Supervisor Avalos
Seat 2: Alphonse Vinh, MS	Appointed by Supervisor Yee
Seat 3: Kara Ka Wah Chien, JD	Appointed by Supervisor Kim
Seat 4: Terezia “Terry” Bohrer, RN, MSW, CLNC	Appointed by Supervisor Chiu
Seat 5: Virginia S. Lewis, LCSW, Co-Secretary	Appointed by Supervisor Tang
Seat 6: Andre Moore	Appointed by Supervisor Cohen
Seat 7: David Elliot Lewis, Ph.D., Co-Chair	Appointed by Supervisor Breed
Seat 8: Terence Patterson, Ed.D., ABPP	Appointed by Supervisor Campos
Seat 9: Vanae Tran, MS	Appointed by Supervisor Mar

Seat 10: Harriette Stevens, Ed.D.	Appointed by Supervisor Farrell
Seat 11: Sgt. Kelly Kruger	Appointed by Supervisor Wiener
Seat 12: Errol Steven Wishom, Co-Secretary	Appointed by Board of Supervisors
Seat 13: Melody Daniel, MFT	Appointed by Board of Supervisors
Seat 14: Ellis C. Joseph, MBA, Co-Chair	Appointed by Board of Supervisors
Seat 15: Lena Miller, MSW	Appointed by Board of Supervisors
Seat 16: Idell Wilson	Appointed by Board of Supervisors
Seat 17: (vacant Supervisor Seat)	Appointed by Board of Supervisors

Staff: Helynna L. Brooke, Executive Director
Loy Proffitt, MBA, Administrative Manager

A Word from the Co-Chairs

If the Mental Health Board of San Francisco were a country, I would call it a promising but developing democracy whose government is still learning its way. This analogy is meant to suggest that while we have made some progress in fulfilling our mission, we have a ways yet to go.

We can and should do better. Areas in need of further work include completing more program reviews, passing more resolutions and engaging more of the community to attend our meetings.

Regarding our meetings, we have suffered too many where quorum has not been met. We need to do much better in engaging our own board members as well as in recruiting new ones to fill the remaining open seats.

I see all of these areas as opportunities for improvement and challenges to be met.

When I look beyond our own board to our city's mental health system, I also see many areas in need of improvement. Our clinics often hide anonymously without signage – simple signs that could inform the neighborhoods they resides in of the services they offer.

I don't accept the argument that people seeking treatment would be harmed if the buildings they entered displayed street facing signs indicating the services provided within. If anything, such practices promote shame and stigma. Furthermore, whatever possibility might exist for harm is far outweighed by the positive benefits of informing the community and especially those in need of the mental health services freely available in their community.

Our city can also do much better in terms of decreasing the time it takes to connect clients with regular weekly treatment services.

While intakes and initial assessments occur quickly, everything that should follow doesn't. Over the last decade, the waiting period to start weekly treatment with a mental health professional has increased as has the time needed to setup a client with case management. From my own observations, it appears to have increased from weeks to months. This is not acceptable. We can and must do better.

I believe our city will also be better served by creating and annually updating a master mental health plan that specifies areas of need, resources available and planned improvements. It would also be useful if such a document contained flow charts that illustrated how people entered and flowed through our system of care. Such a plan should be made as widely available as possible. This should be done by publishing this plan on both our city's website and also on the main social media sites as well including facebook and Google Plus.

On a personal note, I feel that it has been an honor to serve on this board. I plan to work both harder and smarter to help our board better realize its potential.

Sincerely,
David Elliott Lewis, Ph.D.
Co-Chair, Mental Health Board of the City and County of San Francisco

SFMHB ACCOMPLISHMENTS/RESOLUTIONS

In FY 2014, the MHB met 11 times, including an all-day MHB retreat held in December 2013. Meetings are held in City Hall, in Room 278, from 6:30 to 8:30 P.M. Public participation is and at all meetings public representatives were in attendance. Meeting planning is carried out by the Executive Committee, which consists of the officers, Subcommittee chairpersons and staff. Public representatives have also attended Executive Committee meetings. All meetings are in conformance with the Sunshine Laws.

This year 4 MHB Resolutions were proposed and approved.

- **RESOLUTION (MHB 2014-01):** BE IT RESOLVED that the Mental Health Board commends the work of the San Francisco Night Ministry on its 50th year.
- **RESOLUTION (MHB 2014-02)** BE IT RESOLVED that the Mental Health Board commends Ms. Terry Byrne for her work with the Mental Health Association with the *“Do Send a Card”* program to send get well cards to psychiatric inpatients at San Francisco General Hospital and the stigma reducing SOLVE program (Sharing Our Lives, Voices and Experiences)
- **RESOLUTION (MHB 2014-03)** BE IT RESOLVED that the Mental Health Board commends Ms. Adrian Williams, for the founding of the Village Project which provides public and co-operative housing residents with positive activities and events for the "Village Kids" and their families.
- **RESOLUTION (MHB 2014-04)** BE IT RESOLVED that the Mental Health Board of San Francisco urges the Golden Gate Bridge Highway and Transportation Board and the Metropolitan Transportation Commission to immediately allocate funds for the Golden Gate Bridge barrier net in 2014 and assure immediate construction.

MHB AD HOC COMMITTEES:

MHB Bylaws allow the Chair of the MHB to establish ad hoc committees to address specific issues. The committee can determine its own membership and selection of officers and must report the committee’s activities to the Executive Committee and the full MHB at monthly meetings.

In FY 2014, a Laura’s Law (AB1421)/Assisted Outpatient Treatment (AOT) committee was formed to develop a Resolution for the MHB in the event legislation is proposed for San Francisco. Four members of the MHB and five members of the public met over two months to

discuss this controversial issue. A proposed Resolution was drafted; however, consensus could not be reached and the issue was tabled. The committee was discontinued in May.

MENTAL HEALTH BOARD PRESENTATIONS:

July 7, 2013

“Mental Health Services Act Updates: Mental Health Services Act (MHSA) Annual Update,” presented by Marlo Simmons, Director

Summary: Ms. Simmons gave the annual report to the board as required by State law that requires the Mental Health Board review the Annual Update. San Francisco suffered in the original allocations of MHSA funding because it was not permitted to include the number of people who were homeless in the number of people with mental illnesses. MHSA funding includes a provision for Full Service Partnerships (FSP) services. The essence of FSP for recovery is “whatever it takes” to support adults with severe mental illnesses and support children with severe emotional disorders. For example, FSP coordinates emergency and permanent housing and works on transitioning clients to lower levels of care. Clients in FSP include people who are homeless, clients with co-occurring diagnoses, elderly, immigrants and disenfranchised people.

September 11, 2013

“Overview of Quality Management and Outcomes Measurement for Community Behavioral Health Services.” by Deborah Sherwood, Ph.D. Director, Office of Quality Management Community Programs San Francisco Department of Public Health

Summary: The Quality Management Department measures how programs meet their outcomes, analyzes the Client Satisfaction Surveys and has the role of Risk Management. They also manage data on the assessment tools, the Child and Adolescent Needs and Strengths tool for children and youth, and the Adult Needs and Strengths Assessment for adults.

October 9, 2013

“Overview of CBHS Peer-To-Peer And Vocational Programs,” presented by Charlie Mayer, LCSW, Peer-To-Peer And Vocational Programs Manager, Community Behavioral Health Services

“Peer Respite in the Bay Area,” presented by Michael Gause, Deputy Director Mental Health Association of San Francisco

Summary: There is collaboration between CBHS and DOR (the CA Department of Rehabilitation) to provide support for the Vocational Co-Op program. CBHS matches funding from the State. Vocational Co-Op partners up with the Caminar Jobs Plus, Citywide Employment Program, Richmond Area Multi-Services (RAMS) Hire-Ability and Positive Resource Center.

Mr. Gause described peer respite care models. The Peer-run model has at least 51 percent of peers on the board of directors, with peer staff in charge of daily operation. He advocated for the Peer-run model be implemented in San Francisco

November 13, 2013 **“Crisis Services After Dark on the Streets of San Francisco: Night Ministry,” presented by Rev. Lyle J. Beckman; and Rev. Diana Wheeler, Deacon Assigned to Night Ministry**

Summary: Night ministers provide counseling, referral and crisis services to anyone in distress during the hours between 10 PM – 4 AM every day. The ministers are ordained clergies working the streets of San Francisco to provide crisis intervention services to all persons regardless of age, gender, ethnicity, sexual orientation, life style, social or economic status, religion or no religion. Night clergies walk the streets of San Francisco to engage people in serious conversations on issues like anxiety and depression, isolation, loneliness and grief and the most recent trend, aging and disability. Whenever the street is too uncomfortable for any one in distress, ministers will meet people anywhere in San Francisco. For example, ministers have met with people in coffee shops, private homes, bars, transportation centers, hotel lobbies, and hospitals.

January 8, 2014 **“National Alliance for Mental Illness (NAMI),” presented by Bailey Wendzel.**

Summary: NAMI is the largest grass roots mental health organization in the U.S. In the U.S. population, statistically, about 25 percent of people live with some form of mental illness, and the mission of NAMI is to improve the quality of life for people with mental illnesses. Fundraising from the annual NAMI walk, other fundraising events and grants support NAMI training programs, i.e., Family-to-Family, Peer-to-Peer, In Our Own Voice, Parents and Teachers as Allies, Ending the Silence to Provider Education programs. Ending Silence educates high school youth about mental illness, and teaches coping skills to offer hope and dreams, so high school students can support and find resources for their friends and families. The program also contacts parent to give them information. In Our Own Voice are speaking presentations for organizations and corporations like Genentech and Deloitte Consulting Services. Speaking presentations are therapeutic for NAMI speakers because talking about their own experiences validates their recovery.

February 12, 2014 **“Behavioral Health Access Center (BHAC), Mental Health Access, Treatment Access and the Offender Treatment Program,” presented by Craig Murdock and Steve Benoit**

Summary: BHAC started four years ago with the purpose of creating a single portal with a low

entry barrier for clients/patients in crisis to enter CBHS services. BHAC is in a co-location with three other programs: Treatment Access Program, Mental Health Access Program and the Offender Treatment Program. For most clients, it is not conducive to their recovery when the system is based on “survival of the fittest” mentality. Clients want less bureaucracy, fewer barriers and hurdles, fewer forms, and shorter wait times for access to services. At BHAC, there is language capability for seven languages on site. The center is walk-in and sees clients with severe mental illnesses, substance abuse disorders and primary care issues.

March 12, 2014 **“Jail Behavioral Health Services/Jail Reentry Services,” presented by Joan Cairns and Carrie Gustafson**

Summary: Behavioral Health Services (BHS) has 22 clinicians, 1.75 psychiatrists, and 4 mental health counselors to address the behavioral health needs of approximately 1,400 inmates. Monthly, clinicians conduct over 600 mental status evaluations, approximately 400 5150’s, 3,400 treatment sessions, 600 collateral contacts, 280 discharge planning contacts, and 830 case management contacts. In 2013, BHS saw 5,326 individuals. BHS provides inmate evaluation within 24-48 hours, crisis intervention, individual and group therapy, medication management, substance abuse assessment, and training for the Sheriff’s Department and Jail Mental Health Services.

April 9 2014 **“Mental Health Issues and Services in the Juvenile Justice System,” presented by Dr. Hagop Hajian and Ms. Tahsini**

Summary: Special Programs for Youth works closely with juvenile youth experiencing psychological distress to perform assessment, intervention, treatment and services, including medication if medically necessary. For example, the program assesses depression to determine whether it is situational or clinical. A part of treatment includes therapeutic sessions to educate youth who were exposed to adverse childhood experiences on psychophysical education and crisis management. Incarceration of the juvenile population with mental illnesses is increasing; though it is less pronounced than adults. Nevertheless, youth with mental illnesses are being incarcerated at a higher rate than before. Diagnoses most commonly seen in youth are depression, ADHD, PTSD, trauma related symptoms, and other psychotic disorders.

May 14, 2014 **“Aging and Mental Health,” presented by Patrick Arbore, Ed.D., Founder and Director of Center for Elderly Suicide Prevention**

Summary: Since 1973, the Friendship Line has never gone unanswered, and there are volunteers to staff 24/7. The Line acts both as a hotline and Warmline for older people living independently but in extreme isolation and for the younger disabled population. The Line is accredited by the American Suicide Accreditation. Besides providing crisis intervention and ongoing

connection for callers, the Institute on Aging staff, working on the hotline tries to proactively anticipate or assess vulnerable people who are at-risk for suicide to prevent them from getting to that point. This includes follow-up calls and engaging in conversations during challenging times such as grieving, loneliness and depression. On the Warmline, volunteers provide emotional support to callers living alone who are susceptible to falls and who feel vulnerable that people might not find them. Volunteers provide reassurance with a pre-arrangement for either a call-in or check-in for well-being checks. In a few situations, volunteers make courtesy calls to clients to remind them to take their medications.

June 18, 2014

“Mental Health Services Act Annual Update” presented by Marlo Simmons, Director, San Francisco Mental Health Services Act Programs

Summary: Ms. Simmons gave the annual report to the board as required by State law that requires the Mental Health Board review the Annual Update.

MENTAL HEALTH SYSTEM CHANGES

The Director of Community Behavioral Health Systems, Jo Robinson, or her designee attend and report at each MHB meeting. Written and oral reports are presented at the start of each meeting, followed by MHB member comments and questions and the public in attendance is also given the opportunity to speak.

The following summarizes the Director’s reports and discusses system strengths and salient issues of concern to the MHB:

- CBHS **mental health disaster team** responded to the Asiana jet liner crash, providing bi-lingual staff along with other Department of Public Health staff.
- Funding was provided to the **Arab Cultural and Community Center** of San Francisco to provide culturally sensitive mental health services to support the increase in Iraqi refugee women struggling with depression, anxiety and isolation.

- Katie A. lawsuit: new program designed and initiated to improve care for children/families in the **Foster Care Mental Health system**.
- **Trauma informed training** initiative established.
- **Wellness and Recovery** strengths assessment utilized.
- **DSM-V** utilized throughout the mental health system.
- CBHS developed **Conflict of Interest Policy** for interactions with the **Pharmaceutical** Industry.
- CBHS presented an update to the Health Commission and Public Health Committee on **outcomes and practice improvement** activities.
- **Behavioral Health Court** celebrated its tenth anniversary.
- Federal Department of Justice “**Supervised Visitation**” **grant** award received to provide assistance to families with a history of domestic violence.
- San Francisco Suicide Prevention Center launched a new **Spanish Language Crisis Line**.
- Numerous meetings/workshops on the **Affordable Care Act**. Under the Affordable Care Act (ACA), many CBHS clients are now eligible for healthcare coverage. This includes folks who previously did not qualify for healthcare coverage, such as clients who applied for Medi-Cal and were previously denied.
- The **Seeking Safety Program**, an evidenced based practice, initiated in 2011 continued to provide system wide training for trauma and substance abuse.
- The **Chinatown Child Development Center** was recognized by the Health Commission as an outstanding program.
- A **Woman’s Place Behavioral Mental Health Program**, Community Awareness and Treatment Services were established and are located at two sites. The program is aimed at women who are chronically homeless, have co-occurring mental illnesses and substance abuse problems.
- CBHS was recognized by the **California Department of Rehabilitation** for its efforts at promoting employment opportunities for individuals with disabilities.

- The **Comprehensive Crisis Services team** responded to numerous adult and child crisis calls and as a result of a new grant expanded its community outreach programs.
- In January, the **Parent Training Institute (PTI)** received funds from First 5 San Francisco to support three new Triple P training and implementation initiatives in spring 2014: Triple P Group Stepping Stones which is a parent training program for caregivers with children who have developmental disabilities - groups will be run by staff from Support for Families of Children with Disabilities; Teen Group Triple P which is for caregivers of teens; Primary Care Triple P which will be piloted in five primary care clinics with Dr. Jamal Harris, M.D., heading up the initiative and the PTI providing training and implementation support.
- The **Trauma Informed Systems (TIS) Training** initiative was been approved by the San Francisco Director of Health. Beginning in February, the TIS team started half-day training for all staff on universal and culturally specific aspects of trauma with the goal of developing foundational understanding of trauma and shared language across all sectors of the workforce.
- **Jail Health and Behavioral Health Services:** The health disparities that exist in our communities are concentrated in the population that cycle in and out of our jails and prisons. Jails, in particular, represent one of the largest catchment areas for people with substance use and mental health conditions, infectious diseases and other chronic health problems. Compared to the general population, the jail population has disproportionately high rates of chronic medical conditions, substance use disorders, serious mental illness, and co-occurring substance use and mental health disorders. Inmate health problems have significant impacts on the communities from which they come and to which, in nearly all cases, they will return. In the San Francisco County Jail, Jail Health offers extensive mental health, substance abuse and medical treatment. However, if these services do not continue in the community due to a lack of health insurance, we will not see a significant, long term impact on individual and public health. Two studies done in the San Francisco County Jail have shown that treatment and services provided to inmates has a direct effect on public health. In the first, Impact of Chlamydia Screening at County Jail on Community Prevalence of Chlamydia in Females: A Comparison of the Jail Screening Program with Chlamydia Positivity at Two Health Centers San Francisco, 1997 - 2001, it was found that chlamydia screening in the San Francisco County Jail from 1997 to 2001 appears to be responsible for a significant decrease in chlamydia rates among young women tested at Southeast Health Center. The second, Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail, 2008, found that inmates who received discharge planning—namely, inmates who were HIV positive—were more likely to have a regular source of care after release from custody than were inmates who did not receive this service. The vast majority of jail detainees have no private or public health insurance. Under the ACA, estimates suggest that up to 90 percent of men and women in county jails are now eligible for healthcare coverage. Should continuous, integrated healthcare services become widely available for jail populations, a reduction in criminal behavior and repeated incarcerations associated with chronic health conditions is expected. Jail Health anticipates that including healthcare enrollment services in our reentry planning efforts has the potential to significantly increase the likelihood that formerly incarcerated individuals will access and continue treatment in the community, which in turn will positively affect public health and recidivism rates.

Washington State studied the impact of extending chemical dependence treatment to low-income individuals, a group that was frequently involved with the criminal justice, and found: Average medical cost savings of \$2,500 annually per person treated and reductions in arrest rates ranging from 17 percent to 33 percent. Additional estimated savings of \$5,000 to \$10,000 per person treated for local law enforcement, jails, courts, and state corrections agencies, all from reductions in crime. An increase of \$2,000 in average annual income for people who received substance use disorder treatment. In addition, according to the National Institute on Drug Abuse (NIDA), for every dollar spent on addiction treatment programs, there is an estimated \$4 to \$7 reduction in the cost of drug-related crimes. With outpatient programs, total savings can exceed costs by a ratio of 12:1. Thus far Jail Health Services has successfully enrolled 22 individuals in healthcare and assisted upwards of 60 individuals with beginning the healthcare enrollment process. It is anticipated those numbers will grow significantly once the DPH enrollment specialist becomes certified and is able to do enrollment in the intake jail.

The Department of Public Health's Office-Based Induction Clinic (OBIC) and the Jail: It is estimated that 12-15 percent of the inmate population has a history of heroin addiction, most of whom do not receive drug abuse treatment, either during incarceration or upon release. As a consequence, re-addiction to heroin typically occurs within one month of release from incarceration, increasing the likelihood of death from overdose; HIV infection; hepatitis B and C infections; increased criminal activity; and re-incarceration. Buprenorphine, an opioid agonist has been found to be highly effective in reducing heroin use in the community and retaining patients in treatment and is being increasingly used in place of methadone. Jail Health Services began prescribing Buprenorphine to inmates for opiate maintenance approximately 6 months ago. To ensure continuity of care upon release from custody, it established a linkage to community treatment for these patients through the Department of Public Health's Office-Based Induction Clinic (OBIC). All patients started on Buprenorphine in jail are provided information about and referred to OBIC for follow up care. Jail Health Services then tracks these patient's court dates so that they can notify OBIC when the individual is released from custody. Thus far, approximately 50 percent of patients prescribed Buprenorphine in jail have connected with OBIC upon release from custody at least once for continued care.

- **Behavioral Health “No-Shows” by Month FY 12-13:** One of the Timely Access indicators CBHS are required to track for the Department of Health Care Services (DHCS) is our rate of “no-shows.” No-shows are defined as appointments for those clients who do not show for their appointment at their scheduled appointment time, and do not call to cancel or reschedule. While the ultimate goal will be to reduce the number of no-shows so that clinic time is being maximally utilized, CBHS must also work on increasing accurate documentation of all no-shows so that they can determine an accurate baseline for improvement. Target rates for no-shows for primary and behavioral health care are typically around ten percent. However, our no-show rates documented in Avatar falls far below that. The data below represent the no-shows documented in Avatar for all outpatient mental health services provided in Fiscal Year 2012-2013. The no-show rates are separated for psychiatrists’ appointments with children (those under 18 years old) or adults, and clinicians’ (all non-psychiatrists) appointments with children or adults. All no-show rates increased over the course of the year, with a notable increase in adult psychiatry no shows from 8.77 percent per month in July of 2012 to 12.07 percent in June of 2013. This increase in psychiatry no-shows followed a focused effort on the part of psychiatrists to regularly use the no-show service code in Avatar; therefore this increase is seen as a positive step toward improving data quality.

- C.A.R.E Task Force:** In his 2014 State of the City Address, Mayor Edwin M. Lee observed that, “While we have the strongest social safety net in the nation, we still have far too many people unable to make the choices they need to save their own lives because of severe mental health and substance abuse problems.” In an effort to ensure recovery and success for this population, Mayor Lee tasked the San Francisco Department of Public Health (DPH) with convening a community process to determine how to engage and maintain in appropriate behavioral health treatment severely mentally ill, and often dually diagnosed, individuals that current programs have failed to successfully treat or adequately engage. Mayor Lee tasked DPH with convening a community process to determine how to engage and maintain in appropriate behavioral health treatment dually diagnosed individuals that current programs have failed to successfully treat or adequately engage. This process, driven by the C.A.R.E (Contact ▪ Assess ▪ Recover ▪ Ensure Success) Task Force, took place between March 2014 and May 2014 with a final report issued in May that outlined a range of policy and programmatic recommendations for Mayor Lee’s consideration. A broad range of community stakeholders (including the Co-chair of the MHB) comprised the C.A.R.E Task Force, co-chaired by Jo Robinson, DPH Director of Community Behavioral Health Services, and Lani Kent, Office of Mayor Lee. All four meetings of the C.A.R.E Task Force were open to the public, and public comment was encouraged.
- Time to First Offered Appointment FY 2012-13:** One of the Timely Access indicators CBHS is required to track by the Department of Health Care Services (DHCS) is the time between “initial contact” and the first offered appointment. All initial contacts by consumers, whether via phone or in person, are to be documented in the Timely Access Log in Avatar. This is a requirement for both mental health and substance abuse providers. The State requirement is appointments for non-urgent conditions be made available within ten days.

The data in the table below indicate that CBHS was in compliance approximately 89 percent of the records entered into the Timely Access Log during FY12-13. While CBHS is doing well, there is room for improvement to ensure all clients are offered appointments in a timely manner, and all initial contacts are recorded in the log.

FY 2012-13	All Providers	Adults	Children
Average length of time from first request for service to first <i>offered appointment</i>	4.72 days	4.25 days	6.70 days
State (DMHC) standard or goal	10 days	10 days	10 days
Percent of <i>offered</i> appointments that meet this standard	89.3%	91.5%	79.7%

- California Institute for Mental Health and Alcohol and Other Drugs Policy Institute Boards met March 20 - 21 and unanimously voted to merge the organizations as of July 1, 2014. On that date their name will change to **California Institute for Behavioral Health Solutions**.

- A four-year, \$16.8 million Mental Health Services Act (MHSA) **Crisis Triage grant** has been awarded to the Child, Youth and Family System of Care to both enhance child and youth crisis triage services and to establish a peer operated crisis and triage warm line serving children and adults. When in crisis, San Francisco children and youth have been assessed and treated in inappropriate settings, including adult crisis and emergency rooms, or transported to hospitals away from their family and community. In addition, there is a shortage of hospital beds. The MHSA Crisis Triage grant will help improve and enhance the capacity to divert and prevent hospitalization and to create more flexible, culturally reflective and available mobile crisis capacity to reach children, youth and families within the context of their family, community and school. The grant will be implemented in three components. Component one will be a 24 hour warm-line for youth and adults. The staffing will include peers and volunteers and the focus will be on prevention and resource navigation. Component two will be the establishment of a child, youth and family friendly triage space for children and youth experiencing acute psychiatric issues. This will give San Francisco County an alternative to evaluating youth in emergency rooms and adult facilities. In addition we will be able to increase our capacity to divert youth from being hospitalized in out of county facilities. The third component will be the development of four community based teams that will provide focused treatment to children, youth and family members who are experiencing trauma due to community violence and/or experiencing psychiatric and behavioral issues in their homes, after-school programs, schools or other community settings. The teams will be staffed with clinical, behavioral and peer staff. CBHS looks forward to implementing the grant beginning in the summer of 2014.
- Final outcome measures for Fiscal Year 2012-2013 demonstrate continued need for early **childhood mental health consultation** in San Francisco. Major findings include: 97 percent of child care staff surveyed reported that the mental health consultant helped increase their understanding of children's emotional needs; 96 percent of child care staff surveyed reported that the mental health consultant increased their understanding of children's development; 96 percent of child care staff surveyed reported that working with the mental health consultant helped them respond more effectively to children's behavior; 96 percent of child care staff surveyed reported that the mental health consultant helped them communicate more effectively with parents of children who have challenging behaviors; 97 percent of child care staff surveyed were satisfied with the services overall of the mental health consultant.
- **Quality Management conducted a survey** of youth and family engagement and satisfaction between May 21st and June 1st, 2013. The survey contained 20 items covering satisfaction and client-therapist engagement. It also included a section with questions asking whether the youth is doing better in school, home, or in public as a result of therapy. A total of 1,763 forms were returned representing responses on 1,212 unique youth, 680 from youth age 12 through 17, 1,028 from caregivers of youth age six through 17, and 55 from caregivers of children birth through five years. Item responses were "Strongly Disagree," to "Strongly Agree." Surveys with 70 percent or more items marked "Agree" or "Strongly Agree" were considered satisfied. Overall, Child Youth & Family Program responses indicated high satisfaction (88.4%). Reports were provided to individual programs with information about the response rate and feedback on overall satisfaction, and whether the program differed significantly from others. Detail was provided at the item level through tables and charts showing the proportion of "Strongly Disagree" to "Strongly Agree" satisfaction responses.

- The Children Youth and Families (CYF) and Adult/Older-Adult CBHS Systems-of-Care are initiating a planning process to redesign the **Program Utilization Review and Quality Committee (PURQC)** process within CBHS mental health outpatient programs. PURQCs meet weekly in order to authorize requested levels-of-service utilization for clients, review charts for compliance with regulations and standards for documentation set by Medi-Cal and CBHS, and review charts for quality-of-care. The redesign will work on the following concerns and issues that have been identified in the current PURQC process: (1) There is limited amount of time to review a high volume of charts coming in weekly into PURQC for renewal of utilization authorization, which may be leading to a poor quality of review across the three areas of review – utilization authorization, compliance and quality. (2) What is an alternative protocol to determine what charts are required to be PURQCd that will result in a lesser number of charts having to be PURQCd weekly, but with the opportunity to have more time to review each chart, and therefore more quality in the chart reviews? (3) There is no monitoring to find out if the level of intensity/frequency of services authorized by the PURQC is actually implemented. (4) It is not certain whether the results of the reviews of their charts by the PURQC are adequately brought to the attention of clinicians, and that adequate follow-up on compliance or quality-of-care issues, to foster improvement in areas of weaknesses, are done with clinicians. (5) The results of the PURQC review of charts in the area of compliance need to be followed up, and necessary improvement in the clinician’s practice monitored and ensured. (6) Quality-of-Care chart reviews and discussions with the clinicians may be lacking in the PURQC weekly chart audits. (7) A quality-oriented chart review looks for indicators of a Wellness-Recovery approach to providing care. (8) How can the Quality of Care aspect of the PURQC chart review be strengthened within the weekly PURQC meetings? Or should there be a separate arena instead for Quality of Care chart reviews, via other case conference venues or strengths-based group supervision, taking it totally outside of the weekly PURQC meetings which can then focus solely on Utilization Authorization and Compliance? The PURQC redesign teams will start meeting and expect to complete their work and recommendations by September 2014.

- **MHSA Integrated Plan At-A-Glance**

The San Francisco Mental Health Services Act (MHSA) Integrated Plan is now available to review and comment on the SFDPH website at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp>

The Community Behavioral Health Services (CBHS) unit of the Department of Public Health is inviting all stakeholders to review and comment on the San Francisco Mental Health Services Act Integrated Plan for a period of 30 days from May 16, 2014 to June 16, 2014. Attached is the Integrated Plan At-A-Glance.

This 30-day stakeholder review and comment is in fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848.

- **O.M.I. Family Center’s Wellness and Recovery Rollout**

It has been a year since OMI Family Center launched its three-phase wellness and recovery treatment model. The three phases are: Phase I – Welcoming / Engagement and Early Treatment; Phase II – Strengths Based Treatment; and Phase III – Late Treatment Consolidation and Grad-

uation. The program was also designed to align with the Affordable Care Act Triple Aim of improving healthcare, improving population health and reducing costs.

Dr. Michael Marcin and Gloria Frederico, MFT, OMI Medical Director and Program Director, respectively, provided preliminary outcomes data to the CBHS Executive Committee, which showed that the program redesign resulted in improvements in OMI's client retention rates, including OMI surpassing National Institute of Health national average retention rates reported for mental health clinics.

The redesign involved the introduction of a Welcome Class for all clients, and a Medication Orientation Class for those referred for medication services. The Welcome Class resulted in a 22% increase in the percent of clients keeping their subsequent appointments with OMI clinicians. Staff reported increased feelings of effectiveness.

The implementation of the Medication Orientation Class serves to educate and engage patients, as well as effectively match patient commitment to available psychiatric services. The class resulted in a 37% reduction in wait-time to see a psychiatrist. There was also a 62% reduction in wait-time to see O.M.I.'s nurse, who plays an active role in psychiatric evaluations. This was because less of the psychiatrists' time was wasted on no shows, resulting in more open appointments utilized by those clients most likely to benefit from and engage medication treatment. The no-show rate for initial medication evaluation appointments was reduced by 53%. Interestingly, the proportion of people who chose to call to cancel or change appointments versus simply not showing up nearly doubled, which is believed to be a marker for a more fruitful treatment engagement. The data analysis shows that these changes are both statistically significant and clinically effective.

- **Nancy Lim-Yee, Director of Chinatown Child Development Center to Retire**

Ken Epstein and Max Rocha want to express our thanks and gratitude for the quality of Nancy's 39-year tenure at Chinatown Child Development Center. It is an incredible honor to have gotten to know Nancy over the last few years. She is a gifted leader whose vision has helped build a true community based program. She has managed to navigate in three important areas as a representative to SFDPH. She has built a quality program and hired and trained excellent staff, she has contributed to CCDC being a true community clinic embedded in the community it serves and she has been an advocate for access for a community that has been underserved, poorly served and/or unserved in the past. She has accomplished these three goals with grace and humility while never backing down and always pushing for excellence and equity. San Francisco Public Health, CYF Behavioral Health and the community have been blessed to benefit from all the Nancy has done and she will be missed. However, we know that the legacy she has built lives well and strong in CCDC and in the community and I believe this will drive the system to continue to advance her vision and for her staff to continue to improve the services to the community.

- **Comprehensive Child Crisis Services (CCCS)**

The Comprehensive Child Crisis Services (CCCS) team continued to be busy in May 2014, helping to stabilize individuals and families in crises and to do our due diligence to keep children, adolescents, adults and the community safe. Our teams remained dedicated, flexible, and creative while providing out of the box solutions mental health care to protect the well-being of difficult to place youth that needed around the clock care for over 48 hours due to a shortage of child crisis beds within our system of care. And our teams provided this seamless mental health services while dealing with a broken internal air system, with at times, unbearably warm office conditions. We are very grateful for our team member's patience and resolve to provide excellent care under stressful circumstances and in difficult working conditions.

Two of our clinical interns completed their internship here at CCCS and went onto to accept great positions. Jenny Ireland, MFTi, was hired as a residential counselor at Fred Finch Youth Center, which provides housing and counseling services to at-risk youth and adolescents in the East and South San Francisco Bay Area. Nicholas Grant, PhD Candidate, was hired at Tulane University in New Orleans, LA as a Pre-doctoral Intern in their medical and school counseling clinics. We were fortunate to have had them work with us for the past nine months and are very proud of their achievements!

- **LEGACY (Formerly CSOC)**

In May, CSOC/ L.E.G.A.C.Y. saw two of its Youth Development Team staff graduated from certification programs. Victor Damian graduated from San Francisco State University with a Core Strengths Coaching Certificate. This will further his work with youth and young adults in empowering them to thrive, flourish, set goals, get results, flow, and obtain a better sense of well-being. Inez Love graduated from Community College of San Francisco with a certificate in Trauma Prevention and Recovery. This certificate will enhance the current work she does with youth and young adults who have been effected by and are healing from violence.

Our Family Involvement Team (FIT) has been busy doing outreach in the Southeast community. On May 23rd, the FIT team participated in the Walgreens Health Fair on 3rd and Williams Street. On Friday June 6th, they will be assisting families in the Sunnydale area at the SF Families Connect Day.

- **Therapeutic Behavioral Services (TBS)**

We are pleased to report that the Department of Health Care Services commended our policy and procedures during the triennial audit regarding the issuance of EPSDT/TBS Notices to Medi-Cal beneficiaries as required by state mandate. The audit team praised the organization and levels of detail that were included in the binder that was presented to them by Chris Lovoy, TBS Coordinator, and they even took the binder back to Sacramento as a model for other counties state-wide. TBS continues to go strong with a regular influx of referrals, and the positive feedback about TBS from our system of care's mental health providers has been very much appreciated.

- **Family Mosaic Project** is now accepting referrals. The referrals must come through one of 3 ways: A.I.I.M Higher, M.A.S.T. or Level II Risk.

Family Mosaic Project is a part of San Francisco's Department of Mental Health - Children, Youth and Family Services that provides intensive care coordination within the wraparound model to children, youth and their families.

Since 1998, Family Mosaic Project has provided wraparound services to children, youth and families in an effort to avoid out-of-home placement or a higher level of care.

Our mission is to support children and families in their communities by providing extraordinary outreach and innovative approaches to mental health services. We bring the services to you and your family at home, school and/or the community.

- **Foster Care Mental Health**

In May, Foster Care Mental Health (FCMH) welcomed two new 2930 Psychiatric Social Workers, Niki Smith and Emily Meneses. They will be conducting CANS screens and assessments for children and youth, and working closely with the Child Advocacy Center to ensure timely mental health assessment and linkage to services when needed. Also, FCMH is pleased to announce that Dr. Karen Finch will be joining our team in early September. Dr. Finch is currently completing her child psychiatry fellowship at UCSF and will be a wonderful addition to our team of child psychiatrists at FCMH.

- **Mission Family Center**

As of May 27th Mission Family Center has filled all of our vacant positions! We are very pleased to welcome Eleana Arizaga, Psychiatric Social Worker, who comes to us from the Human Services Agency and with experience as therapist in her native Peru. Maureen Gammon is a Health Worker III, with an exemplary tenure at Family Mosaic and experience as a professional coach. Gilma Cruz-Montes, ASW who began at the end of April, comes to MFC from CSOC-Legacy where she was a renowned Parent Advocate. MFC is thrilled to have these three amazing therapists on board with us! With these vacancies filled we will be able to better serve our community and further decrease our waitlist which has already been reduced by 52% since January 2014. We are also proud to share our efforts in piloting new clinical flow processes, including planning for a parent psycho-educational orientation group this summer.

- **School Based Mental Health**

DPH & SFUSD embarked on a series of planning meetings with goals of identifying concrete ways in which DPH's Children, Youth & Families System of Care, and SFUSD's Special Education (SPED) and Students, Families & Community Support Services (SFCSS) can work together to effectively support the highest need students. Examples of upcoming collaboration plans for mental health services amongst the three groups include prioritizing pre-referral support for teachers and schools so that they have the skills to support African American, Latina/o, English Learners, and socio-economically disadvantaged students; mapping and analyzing mental health resources across school sites; and aligning common evaluation and services outcomes. This plan will coordinate efforts for the next two to three academic years.

- **Southeast Child/Family Therapy Center**

In May we have been saying good-bye to our fabulous interns and have been planning an African American Parent support group and a summer community activity group for teens. We also wrapped up our Adventure-based Psychotherapy group which was featured on the front page of the Chronicle. One of the members said he always wanted to be famous and now he is. We are also planning to say good-bye to Shirley Leong who has worked for us for almost 14 years. She will be retiring on June 21st, 2014. We wish her a happy retirement.

- **Alternative Family Services (AFS)**

AFS is a mental health and foster care agency. We strive to provide coordinated, integrated and individualized care to children and families involved in the foster care system.

AFS works with CBHS to deliver a range of services including "Therapeutic Visitation Services" (TVS), an innovative strengths-based, family-focused therapeutic program for children and youth who are recently removed from their families. TVS is a time-limited program that utilizes intensive community based or in-home family therapy and parent-child interventions to increase the support and skills families need to safely reunify and

maintain family attachment. These services are intended to promote safety, well-being, and permanency for children and families. TVS also helps to integrate key players from Child Welfare, Family Courts, Panel Attorneys, CASA Workers, etc.

Recently, AFS participated in CBHS' Katie A Planning Workgroup to develop implementation recommendations. Currently, we are beginning to support Foster Care Mental Health's efforts to conduct "front-end" CANS assessments for children who are removed from their home.

Internally, AFS is looking to working to improve the effectiveness and efficiency of our services through an "integrated model of care" (i.e., integrated foster care and mental health care). We are focusing on the Intensive Treatment Foster Care (ITFC) program, where coordinated EPSDT services and social services reduce both mental health problems and the need for higher-level care. This is an amazing time to be working with child-welfare involved families—there are many changes at the federal and state levels that should help expand access and involvement for clients.

- **A Better Way**

A Better Way provides mental health, parent training, foster care, adoption and housing services to children and youth throughout the Bay Area. In San Francisco County we offer specialty mental health services to clients aged birth to 21 and their families. In addition to standard outpatient mental health care, we provide two specialized services: Therapeutic Visitation (for families pursuing reunification) and early childhood mental health care (for children aged birth to five and their caregivers). Therapeutic Visitation consists of family therapy, parent training and clinical case management specifically aimed at: (a) developing stronger parent/child connections; (b) helping children heal from past trauma; (c) helping parents understand and address Child Welfare concerns; & (d) helping families develop and demonstrate improved protective factors in progressively "real-life" settings. Our Early Childhood mental health program offers screening/assessment/dyadic therapy, Parent Child Interaction Therapy (PCIT), and infant massage training to parents and caregivers of infants and young children. Our treatment teams include Mental Health professionals and Family Partners and Child & Family Team Facilitators.

MENTAL HEALTH SYSTEM STRENGTHS/NEEDS/RECOMMENDATIONS

STRENGTHS:

The San Francisco Community Behavioral Health System (CBHS) offers a diverse array of services of which approximately half are operated by private community based organizations (CBO). It is a system dedicated to providing high quality, culturally and age appropriate services, trauma informed, in the least restrictive environment. For the past few years CBHS has been in the process of shifting to a "recovery oriented" system and increasing the utilization of peers in their programs. Intensive efforts are made to hire and contract with diverse staff to meet the cultural needs of the population. The proposed budget for FY 2014-15 is \$32,724,000.

The San Francisco Mental Health Services Act (MHSA) Integrated Plan FY 14/15, developed through a community planning process, addresses recovery oriented treatment services, early intervention, peer-to-peer, vocation services, housing, workforce development and information technology. The projected budget for FY 14/15 is over \$34.6 million. MHSA staff are highly dedicated to providing quality services and have developed an impressive array of innovative services.

NEEDS AND RECOMMENDATIONS:

Several members of the MHB participated in the development of the 31 recommendations of the C.A.R.E Task Force. Several are critical to a comprehensive mental health system and need to be implemented as soon as possible. The mental health system needs of specific concern to the MHB, based on knowledge gained through educational presentations, quality assurance reports, site visits, client interviews, and lived experience, are the following:¹

- Enhance family member participation whenever possible in the care and treatment of their family members.
- Develop a psychiatric respite care program utilizing peer specialists and mental health professionals.
- Increase the use of peer specialists in client engagement and all aspects of treatment.
- Increase reimbursements for a wider range of substance abuse services including harm reduction housing for people who are chronic alcoholics and include a medical component in residential substance abuse treatment.
- Increase the intensive case management/full service partnership program.
- Support the Crisis Intervention Team in the San Francisco Police Department.
- Expand the Homeless Outreach Team.
- Expand housing options that provide safe, stable housing for people with behavioral health issues.
- Increase residential treatment programs.
- Increase opportunities for vocational training and meaningful employment.
- Increase access to wellness and recovery centers.
- Include the faith based community in outreach and treatment.
- Promote the utilization of psychiatric advance directives.
- Promote sharing of information and better coordination between programs to ensure continuity of care.
- Build a new City jail to house men with behavioral health issues or place them in a facility with an appropriate milieu for behavioral health care and treatment.
- Explore other telephone options for inmates in SAN FRANCISCO jail facilities—current cost of making phone calls is outrageous.
- Explore reducing or instituting free court costs for people with behavioral health issues to decrease the inmates time in jail due to not having sufficient (or any) funds to pay court costs.
- Increase crisis mobile treatment to 24 hours/7 days a week.
- Advocate for hiring minority mental health professionals, consistent with client populations served.

¹ Note: Items on this list are not in priority order.

- An array of transitional and permanent, safe housing with appropriate support services for people with mental illnesses remains inadequate.

MHB PROGRAM REVIEWS/SITE VISITS

Site visits were made to six programs during FY 2014. The purpose of these program reviews is to supplement the reviews of programs by CBHS by in-person interviews by Mental Health Board members to help identify a range of experiences and feelings by consumers, providing a unique perspective about how clients feel about their treatment. Interviews with consumers and staff help identify mental health program and system needs and concerns. The program visit is set up in advance by MHB staff. MHB members, either alone or in a group, visit the site, talk to key personnel and interview clients served by the program. Upon completion of a review, a summary report, describing strengths and needs, is completed and sent to the CBHS Director and the director of the program reviewed. This year the MHB decided to report program reviews to the entire MHB during a regularly scheduled meeting. The following Program Reviews were completed in FY 2014:

- **Chinatown Community Mental Health Clinic:** This CMHC offers an array of outpatient behavioral health services including assessments, individual therapy, case management, family therapy, acupuncture, medications, crisis outreach, education and information, socialization and group activities. Multidisciplinary staff is multilingual (Chinese, Lao, Vietnamese, Cambodian, Thai, Italian and English) and provide culturally appropriate services. Plans are underway to provide on-site somatic care through the services of a nurse practitioner from a local medical clinic. There were no patients on the waiting list for services. Suggestions/recommendations by the MHB site review included offering WRAP training, utilizing Psychiatric Advance Directives, consider utilization of trained volunteers and provide listing of resources/activities outside the CMHC to enhance client socialization skills and provide recreational activities.
- **Jail Psychiatric Services and Jail Health Services, San Francisco Jail:** Inmate population with mental illnesses has increased; inmates are currently sicker and more complicated to work with; increase in older inmates with behavioral health problems; new jail for women offers appropriate behavioral health services; old jail in the Justice Center is not adequate for inmates with behavioral health issues. Behavioral Health Services (BHS) has 22 clinicians, 1.75 psychiatrists, and 4 mental health counselors to address the behavioral health needs of approximately 1,400 inmates. Monthly, clinicians conduct over 600 mental status evaluations, approximately 400 5150's, 3,400 treatment sessions, 600 collateral contacts, 280 discharge planning contacts, and 830 case management contacts. In 2013, BHS saw 5,326 individuals. BHS provides inmate evaluation within 24-48 hours, crisis intervention, individual and group therapy, medication management, substance abuse assessment, and training for the Sheriff's Department and Jail Mental Health Services. Suggestions by MHB site reviewers included: Increase shuttle buses for families to visit inmates at San Bruno jail; install free or nominal cost phones; waive court costs for inmates with behavioral health problems; design programs for older inmates; examine how inmates can get some fresh air during their stay; establish garden and dog programs at San Bruno; offer ac-

cess to computers and computer training for inmates on long stays (some inmates stay in SAN FRANCISCO Jail up to three years); and market opportunities for volunteers to participate in the jail, e.g., bring library books, NAMI Peer-to-Peer training, etc.

- **Horizons Unlimited**
- **Progress Foundation, Dore Urgent Care Clinic**
- **Progress Foundations, Crisis Residential Program**

San Francisco: Data Notebook 2014

FOR CALIFORNIA MENTAL HEALTH BOARDS AND COMMISSIONS



Prepared by California Mental Health Planning Council, in collaboration with: California Association of Mental Health Boards/Commissions, and APS Healthcare/EQRO

San Francisco County: Data Notebook 2014 for California

The Mental Health Board utilized the format of the California Data Notebook as a guide for providing information and data about Community Behavioral Health Services. The board will also be submitting the responses to questions raised in the Data Report to the State of California.

MENTAL HEALTH BOARDS AND COMMISSIONS

County Name: San Francisco Population (2013): 831,156

Website for County Department of Mental Health (MH) or Behavioral Health: <http://www.sfdph.org>

Website for Local County MH Data and Reports: <http://www.sfdph.org>

Website for local MH Board/Commission Meeting Announcements and Reports: http://www.sfgov.org/mental_health and <http://www.mhbsf.org>

Specialty MH Data from review Year 2013-2014: <http://caegro.com/webx/.ee85675>

Total number of persons receiving Medi-Cal in San Francisco (2012): 166,789

Average number Medi-Cal eligible persons per month: 142,626

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 27.8 %

Adults, ages 18-59: 39.4 %

Adults, Ages 60 and Over: 32.8 %

Total persons with SMI² or SED³ who received Specialty MH services (2012): 14,443

Percent of Specialty MH service recipients who were:

Children 0-17: 20.3 %

Adults 18-59: 57.6 %

Adults 60 and Over: 22.1 %

² Serious Mental Disorder, term used for adults 18 and older.

³ Severe Emotional Disorder, term used for children 17 and under.

INTRODUCTION: Purpose, Goals, and Data Resources

This Data Notebook has been developed for the use by the local mental health (MH) boards and commissions by a yearlong workgroup comprised of members from:

- *California Mental Health Planning Council (CMHPC)*
- *California Association of Local Mental Health Boards and Commissions (CALMHB/C)*
- *APS Healthcare/EQRO (External Quality Review Organization)*

Our plan is for the Data Notebook to meet these goals:

- *Assist local boards to meet their mandates to review the local county mental health systems, identify unmet needs, and recommend improvements.*
- *Provide a professional format for submitting reports to their local Board of Supervisors, and/or their county Director of Mental Health Services.*
- *Function as an educational tool for local boards, whose members have varying levels of skills, frequent turnover, and need ‘refresher’ training about using data.*
- *Help the CMHPC fulfill its mandates to review and report on the public mental health system in California, which also helps provide evidence for advocacy.*

Data reporting drives policy, and policy drives funding for programs. But the data must be both recent and available to the public, or else it is not useful. So, the CMHPC will provide examples of local data from current public reports. We focus on two broad areas: (1) evaluation of program performance, and (2) indicators of client outcomes.

We recognize that each county has a unique population, resources, strengths, and needs. Thus, there is no single perfect data source to answer all the important questions one might ask about mental health services. However, the following data resources will help board members answer questions in this Data Notebook:

- *experience and opinions of the local mental health board members*
- *recent reports about county MH programs from APS Healthcare/EQRO*
- *data you request from your county QI Coordinator and/or Mental Health Director (because CMHPC does not have that data, and it’s not in other public reports)*
- *client outcomes data provided by California Institute of Mental Health (CiMH) in their analysis of the most recent Consumer Perception Survey.*

Some of our data comes from APS Healthcare/EQRO, which kindly gave permission to use their figures and tables, prepared for review of each county’s Medi-Cal Specialty Mental Health services. Those reviews are at: www.CAEQRO.com. You may find the full-length EQRO reports helpful because they summarize key programs and quality improvement efforts for each county. They also describe strengths, opportunities for improvement, and changes in mental health programs since the last year.

Understanding changes in local programs can help consumers because of the massive re-organization of mental health services statewide. Some changes have been confusing to clients. The old state Department of Mental Health was eliminated in 2012 and many functions were moved to the De-

partment of Health Care Services. Other changes due to federal health care reform and the Affordable Care Act affect how mental health services are provided, funded, and linked to primary health care or substance use treatment. Also, local counties have adjusted to major challenges. Remember, this report is about your community, and what you and your stakeholders choose to discuss. Examining the data can indeed “Tell a Human Story.” But quantitative data (numbers) provides only part of the picture, for example:

- measures of whether the quality of program services improve over time
- whether more people from different groups are receiving services
- how many clients got physical healthcare or needed substance use treatment.

The other part of the story gives human context to the numbers. Such qualitative data (narrative, descriptions, or stories) tells more of the story, because we can:

- describe special programs targeted for outreach to specific groups
- examine how the programs are actually implementing their goals
- list concrete steps that are taken to improve services, and
- tell what is being done to increase client engagement with continued treatment.

We hope this project contributes to ongoing quality improvement (QI) in mental health services. We seek constant improvement in our approach to quality because:

- needs change over time,
- all human endeavors are by nature imperfect,
- creativity gives rise to new ideas, and
- we can share examples of successful programs to help other communities.

TREATING THE WHOLE PERSON:

Integrating Behavioral and Physical Health Care:

Studies have shown that individuals with serious mental illness die, on average, 25 years earlier than the general population. This information makes improving the physical health of clients of great importance and should be a goal of county mental health departments along with providing effective and appropriate mental health services. Coordination of care for mental health, substance abuse and physical health is one way of accomplishing the goal.

The California Mental Health Planning Council does not have any data to provide to show how your county’s programs connect clients of mental health services with necessary physical health care. We ask that the local mental health board request information from your county mental health depart-

ment for any data on numbers (or percent) of total mental health clients who are referred to, or connected with, physical health providers to assess, treat and monitor physical health issues.

County efforts to improve the physical health of clients.

CBHS recognizes the importance of integrating mental health and physical health care and have developed plans to have somatic health care delivered by co-locating a nurse practitioner at four mental health clinic sites this year.

The Office-Based Opiate Treatment (OBOT) program celebrated ten years of service in San Francisco. The Novel OBOT program, which served as a pilot program for the State of California, provided a licensed narcotic treatment program with methadone fully integrated into three San Francisco Department of Public Health Primary Care clinics - Tom Waddell Urban Health Clinic, Potrero Hill Health Center and San Francisco General Hospital Ward 86.

The program allows individuals who are addicted to opiates like heroin to receive treatment from their primary care provider- treating all their health conditions in a holistic way. This is important because many drug users have co-occurring medical conditions that can be complex and dangerous if their medical provider lacks knowledge of their drug use or participation in drug treatment. The OBOT clients have built positive relationships with the pharmacy staff and also with substance abuse counselors, nurses and physicians at their primary care homes.

Community Behavioral Health Services in collaboration with Rally Family Visitation Services, Saint Francis Memorial Hospital, was awarded a three year grant from the Office on Violence Against Women for the Safe Havens: Supervised Visitation and Safe Exchange Grant Program.

CBHS PHARMACY & OUTPATIENT MONITORING

Subutex (Buprenorphine) programs are on-going for treatment of addiction

SAN FRANCISCO Dept. of Public Health DRUG OVERDOSE EDUCATION PROJECT Narcan is co-prescribed for opioid patients at DPH Clinics (Data indicates 1,000 lives saved over the 10 years)

Primary Behavioral Health Care Integration grant at the California Innovations Summit on May 22, 2013, panel presentation with CBHS Director Jo Robinson and Dr. Deborah Borne. The Summit highlighted San Francisco's model of integrating health care into a behavioral health program at South of Market Mental Health.

The San Francisco Hep C Task Force held a meeting August 8, 2013 with pharmaceutical reps to explore strategies to use innovations to reduce hepatitis related health outcome disparities.

Wellness programs to engage and motivate clients to take charge of improving their physical health

- a) Managing chronic disease/addiction: Patients who are just starting on buprenorphine at OBIC or who require more intensive monitoring can receive their medication from the CBHS Pharmacy. CBHS pharmacists work closely with patients and prescribers to coordinate care, monitor for changes in psychiatric symptoms, assess substance use, and support adherence. Patients interested in treatment of opioid addiction are referred to OBIC
- b) Stress Management/Social connectedness Linea de Crisis - The San Francisco Suicide Prevention Partnership launched its new Spanish Language Crisis Hotline "Linea de Crisis" that provides Spanish language crisis support in the Bay Area.
- c) Mission Family Center is located in the heart of the Mission and focuses on serving children, youth and families that live in the district and/or the bicultural/bilingual Spanish speaking community.
- d) Smoking cessation Youth Leadership Institute's (YLI's) Tobacco Use Reduction Force (TURF) is a group of San Francisco youth leaders working to reduce the impact of tobacco on their city's low-income neighborhoods. In a significant new development, TURF has built an unlikely partnership with the powerful Arab American Grocers Association (AAGA), the City's largest association of small independent markets with more than 400 separate retailers. Though most Association members sell Tobacco, AAGA is now supporting TURF's efforts to reduce tobacco retailer density and improve community health. In their second meeting, AAGA took this partnership a step forward, asking TURF to help them in their efforts to pass an ordinance to help sustain small independent retailers in SAN FRANCISCO. Given that TURF has secured more than 600 individual and organizational supporters for its ordinance, AAGA realized TURF could be an important ally to them as well. With support from AAGA, TURF is now working draft a policy that will cap the number of tobacco retail permits per district to 45 and create a mechanism to reduce permits over time without taking permits directly from existing merchants. TURF estimates that this mechanism will significantly reduce the number of stores selling tobacco over the next ten years.
- e) Nutrition Alleviating Atypical Antipsychotic Induced Metabolic Syndrome is a MHSA-Innovations pilot program led by the Housing and Urban Health Clinic. This program adapted an existing nutrition and exercise protocol into a community mental health setting and integrated shopping and cooking skills training. This program educates consumers prescribed atypical antipsychotics about the connection between diet and health, how to shop based on what is locally available, healthy cooking, and how to exercise to improve fitness and health.
- f) Consumer and Family Conference: Food, Mood & Move July 19, 2013 St. Mary's Cathedral Conference Center. The workshop training was on healthy eating, assisting clients in assessing their overall diet quality, tips and resources on how to eat on a

budget and how to reduce intake of foods and beverages of low nutritional value. Also discussed, low cost ways to promote physical activity to clients as a way to improve their physical and mental health.

NEW CLIENTS: One Measure of Access

Definition of 'new' clients

Behavioral health clients are considered new when they open a new episode of care within a fiscal year.

County data on the number of 'new' clients last year.

New children/youth (0-17 yrs) 3,425

Of these, how many (or %) are 'brand new' clients 2,149 (63 %)

New adults (18-59 yrs) 14,826

Of these, how many (or %) are 'brand new' clients 8,147 (55%)

New older adults (60+ yrs) 1,714

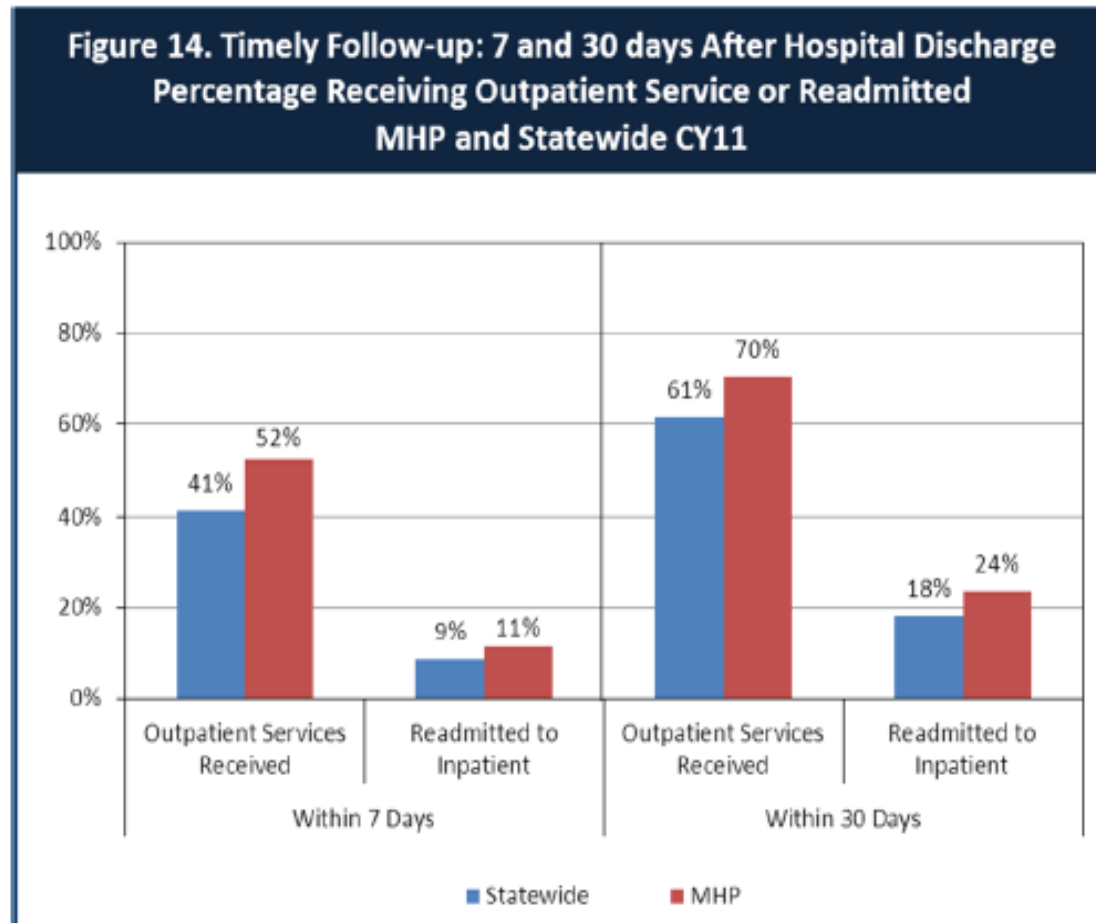
Of these, how many (or %) are 'brand new' clients 848 (49%)

REDUCING RE-HOSPITALIZATION: Access to Follow-up Care

Sometimes, an individual experiences acute symptoms of mental illness or substance abuse which can result in a brief stay in an acute care hospital. Receiving follow-up services after discharge from a short-term (3-14 day) hospitalization can be critical to preventing a return to the hospital.

The chart below shows the percentage of people discharged in your county who received at least one service within 7 days of discharge. Also shown is the percentage of those same people who were readmitted to the hospital. The chart also shows the same information for receiving services and being readmitted to the hospital within 30 days. Red indicates the numbers for your county and the blue indicates the percentage for the State of California. (MHP = county mental health plan, CY = calendar year).

San Francisco:



How San Francisco County compares to state outcomes.

San Francisco had 52% outpatient services within 7 days versus 41% for CA and 11% readmitted to inpatient versus 9% for CA. San Francisco had 70% outpatient services within 30 days versus 61% for CA and 24% readmitted to inpatient versus 18% for CA. San Francisco County has provided more Outpatient Services versus the State within 7 and 30 days; therefore, the County is doing better in terms of timely follow-up. Slightly more San Francisco County patients are readmitted to Inpatient hospitalization versus the State in these two time frames.

The County hospital works closely with Community Programs and families of patients to assure a warm handoff to programs. There are also 400 clients served by Assertive Community Treatment programs. These clients have 24/7 access to a case manager which has resulted in a reduction of hospitalizations over the years.

Ways San Francisco can improve follow-up and reduce re-hospitalizations.

We need to take a closer look at connections to community services. Patients are sometimes referred to family members' care, even though the family may not be obliged to take in an older (non-minor) adult patient. The family's inability to provide for such patients could result in an increase in readmissions. Therefore, we need to ensure that follow-up programs are consistent and available throughout the system.

CBHS was awarded a four year grant from MHSA to augment crisis response services and volunteers. The focus will be on prevention and resource navigation. Component two will be the establishment of a child, youth and family friendly triage space for children and youth experiencing acute psychiatric issues. This will give San Francisco County an alternative to evaluating youth in emergency rooms and adult facilities. In addition we will be able to increase our capacity to divert youth from being hospitalized in out of county facilities. The third component will be the development of four community based teams that will provide focused treatment to children, youth and family members who are experiencing trauma due to community violence and/or experiencing psychiatric and behavioral issues in their homes, after-school programs, schools or other community settings. The teams will be staffed with clinical, behavioral and peer staff starting in Summer 2014

CHART REVIEWS for Quality Improvement:

The CYF and Adult/Older-Adult CBHS Systems-of-Care are initiating a planning process to redesign the PURQC process within CBHS mental health outpatient programs. PURQC (Program Utilization Review and Quality Committee). PURQCs meet weekly in order to authorize requested levels-of-service utilization for clients, review charts for compliance with regulations and standards for documentation set by Medi-Cal and CBHS, and review charts for quality-of-care.

It is not certain whether the results of the reviews of their charts by the PURQC are adequately brought to the attention of clinicians, and that adequate follow-up on compliance or quality-of-care issues, to foster improvement in areas of weaknesses, are done with clinicians.

The results of the PURQC review of charts in the area of compliance need to be followed up, and necessary improvement in the clinician's practice monitored and ensured. Quality-of-Care chart reviews and discussions with the clinicians may be lacking in the PURQC weekly chart audits. A quality-oriented chart review looks for indicators of a Wellness-Recovery approach to providing care.

Three most significant barriers to service access

- 1) Cultural, i.e., reluctance to obtain services because of the stigma of needing mental health services in these communities;
- 2) Lack of psychiatrists which limits the number of patients that can be seen; and
- 3) Numbers of therapists.

ACCESS BY UNSERVED AND UNDER-SERVED COMMUNITIES

Figure 6a. MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY11

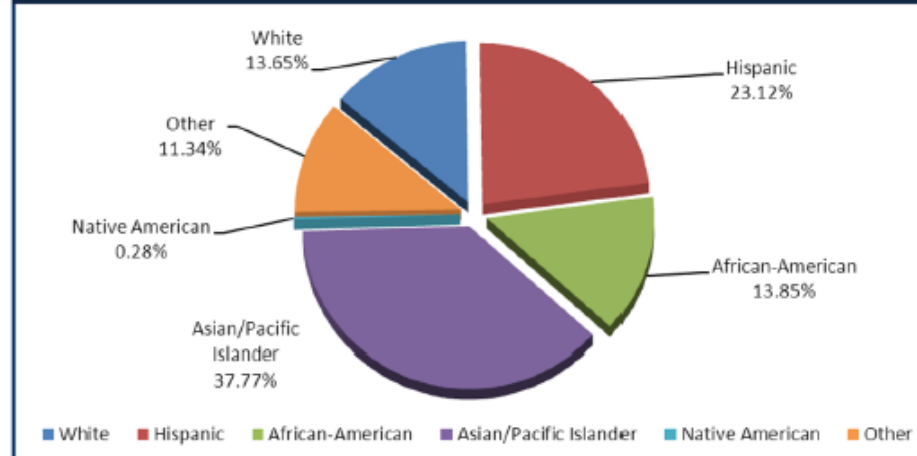
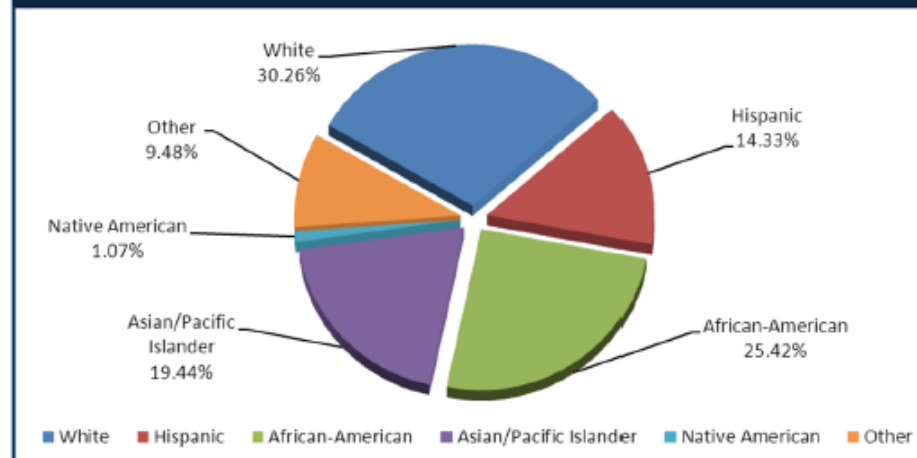


Figure 6b. MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity CY11



Assessment of the percentage of Medi-Cal eligible that have an actual need for mental health services.

Community Programs serve nearly 40,000 people. The Data Notebook suggests that It would be good to assess the percentage of Medi-Cal eligible that have an actual need for mental health services. The planned integration of primary care with mental health and substance

abuse is expected to increase the number of people eligible for Medi-Cal who will be treated for mental health and substance as they enter the system through primary care and are referred for services. It appears there is a higher percentage of White and African Americans served by Medi-Cal (30.2 and 25.4%) vs. Asian/Pacific and Hispanic (19.4 and 14.3). Large numbers of eligible Asians are not receiving services, as the percentage served is half of those eligible (19% vs. 37% of eligible). There may be some cultural factors to account for a reluctance to receive mental health services. A similar drop-off is seen with Hispanics (14% vs. 23% of eligible.) It is not known as this point if all of those who are eligible for mental health or substance abuse services through Medi-Cal are actually in need of those services.

		Asian/Pacific	African-Amer.	Hispanic	White	Other	Native
Medi- Cal Eligible	37.7%	13.8	23.1	13.6	11.3	0.28	
Medi-Cal Served		19.4	25.4	14.3	30.2	9.5	1.1

Outreach efforts being made to reach minority groups in San Francisco

- Linea de Crisis - The San Francisco Suicide Prevention Partnership launched its new Spanish Language Crisis Hotline “Linea de Crisis” that provides Spanish language crisis support to the Bay Area.
- CalMHSA Stigma and Discrimination Reduction contractor, Runyon Saltzman & Einhorn, recently released two Spanish-language videos at www.EachMindMatters.org. Counties, community-based organizations and CalMHSA grantees can use these short videos to help reduce stigma and discrimination among community members and decision makers.
- Two clinicians at the Chinatown Child Development Center, Dr. Hang L. Ngo and Grace Fung, were recently awarded a small grant from the Chinese Community Health Care Association (CCHCA) for a grant proposal entitled "Linguistically and Culturally Appropriate Group Therapy Treatment for Chinese Children with ADHD and Their Caregivers Based on a Modified Version of the Family STARS Program.
- Iraqi Refugees Support Group: MHSA has begun funding the Arab Cultural and Community Center of San Francisco (www.arabculturalcenter.org) to provide culturally sensitive mental health support to Iraqi refugee females struggling with depression, anxiety and isolation. Since the start of the war in Iraq, 14,000 settled in California. The Bay Area has seen a dramatic influx of refugees these past five years, mainly from Iraq and more recently a few from Syria. Many of these refugees are suffering from extreme symptoms associated with the traumas of war, relocation to dangerous neighborhoods, loneliness, lack of community, etc. The support group aims to provide a space where refugee women can receive mental health support within a culturally acceptable channel without the worry of acquiring the stigma associated with going to see a therapist. The support group is a safe place for the women to bond with each other, share with each other, cook together, and learn essential life skills together. It provides a place where they can learn about topics such as depression, PTSD, health and wellness in a supportive environment. This support group is also a safe space where women can seek help confidentially about mental health services and other needed health referrals.
- Children’s System of Care (CSOC) works with families impacted by the gun violence that claims the lives of San Francisco youth, the developed a five-day “healing from community violence” workshop for transitional age youth who have lost friends and family to gun violence. In this

workshop, youth learn to identify their personal symptoms from trauma, how to seek treatment, and receive coping/healing tools that will help them begin the process of healing and maintaining a healthy mental well-being.

- f. Expanded health coverage screening: The Human Services Agency is providing help to those who are low income but not eligible to Medi-Cal to purchase affordable private health insurance offered by Covered California.

Mental Health Board suggestions for improving outreach to and/or programs for underserved groups

- Add street signage to all community mental health clinics to inform their neighborhoods and those travelling through of the free mental health services available.
- Run a public education campaign to inform all of the availability of free community mental health services. This should occur through multiple ways. These can include advertising on billboards, flyers handed out at street fairs and outdoor public events as well as radio spots. All flyers should include a phone number and a website to learn more.
- Expand and improve mobile outreach by including multi-disciplinary teams with peers. Have them canvas areas of high need such as the Tenderloin, Western Addition and South East sectors of the city.
- Decrease the wait time to be connected to mental health treatment after initial intake, assessment or triage.
- Each community mental health clinic should have a mobile outreach team that canvases the surrounding neighborhood to inform and engage residents. Each team of at least 3 should include a peer.
- Create a citywide mental health resource list made available through a website, phone number and an Android and iPhone app.

CLIENT ENGAGEMENT IN SERVICES

One MHS goal is to connect individuals to services they need. Clients who stop services too soon may not achieve much improvement, nor is it likely to last. So it is important to measure not only who comes in for treatment, but also how long they stay in services. Here we are considering individuals with high service needs, not someone who just needs a ‘tune-up.’ Although not every individual needs the same amount of services, research shows that when someone with severe mental illness continues to receive services over time, their chances of recovery increase.

Engagement in services, also called ‘retention rate’, is important to review. If individuals come in, receive only one or two services and never come back, it may mean the services were not appropriate, or that the individual did not feel welcome, or some other reason that should be explored. Again, we recognize that some individuals only need minimal services, but here we are looking at those with severe mental illness. Ultimately, the goal is to ensure they are getting needed services and are on the road to recovery. But we would not know that unless we look at how many services individuals received over time.

The chart below shows the number of Medi-Cal beneficiaries in our county who received 1, or 2, or 3, or 4, or 5, or more than 15 mental health services during the year. For individuals experiencing severe mental illness, the more engaged they are in services, the greater the chance for lasting improvements in mental health.

SAN FRANCISCO County MHP Medi-Cal Services Retention Rates CY12

Number of Services Approved per Beneficiary Served	SAN FRANCISCO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	1,088	7.53	7.53	9.38	9.38	4.90	18.87
2 services	766	5.30	12.84	6.29	15.67	0.00	12.84
3 services	646	4.47	17.31	5.38	21.06	2.94	11.11
4 services	565	3.91	21.22	4.93	25.98	1.93	9.40
5 - 15 services	4,531	31.37	52.59	32.38	58.36	21.24	40.93
> 15 services	6,847	47.41	100.00	41.64	100.00	23.68	60.46

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

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San Francisco County is doing well with retention rates.

According to the chart of San Francisco County MHP Medi-Cal Services Retention Rates, San Francisco is somewhere in the middle versus the statewide averages for Retention. Based on an assumption that more services could mean long-term engagement of the clients, San Francisco is closer to the highest retention rates statewide for those beneficiaries receiving 5-15 (31.4% vs 40% maximum statewide) or >15 services per year (47.4% vs. 60.4% maximum statewide). This could reflect a greater number of individuals with severe mental illness or higher service needs in San Francisco County, requiring more services, and could also represent better retention.

For those clients receiving less than 5 services, San Francisco is in the process of developing plans to re-engage those individuals for further mental health services.

Mayor Lee tasked the San Francisco Department of Public Health (DPH) with convening a community process to determine how to engage and maintain in appropriate behavioral health treatment severely mentally ill, and often dually diagnosed, individuals that current programs have failed to successfully treat or adequately engage. The website for this task force is:
<http://www.SanFranciscodph.org/dph/comupg/knowlcol/CARE/default.asp>

Engagement of underserved communities

Recognition by San Francisco Health Plan Tom Waddell Urban Health was given the Excellence in Member Services and Cultural Awareness award in recognition of their excellent service to special populations/transgender population, (higher rates of mental health diagnoses, psychiatric medications, higher rate of physical health problems, meth use, according to UCSAN FRANCISCO studies, greater HIV testing rates, greater needle use, but no difference in service utilization, indicating a possible need to treat a greater percentage of these patients for substance abuse).

Southeast Health Center was recognized with the Commitment to Health Improvement award for making dramatic improvements in patient access to care.

Culturally sensitive programs and recruitment of experienced ethnic professionals will help. In many cultures, receiving mental health services often carries a negative stigma for the client. Many clients are afraid of seeking mental health services as they will be stigmatized by their community as being crazy. Some clients worry this could affect their chances of marriage and/or chances of marriage for their children as it may be construed that the therapist is dealing with a problem that might be genetic and thus can be inherited.

The Comprehensive Crisis Services team crisis calls have surged, teams continued to work diligently to provide culturally competent, responsive services to help support the safety and wellness of the children, adults, and families experiencing acute behavioral health crises in San Francisco.

Support services were provided to the staff at the new Sunnydale Wellness Center as the staff reached out to the community.

San Francisco Foster Care Mental Health: They are developing child and family teams working with a specific clinician for co-ordination of care, to support the health of youth and families in foster care, special education, and probation, and including plans for culturally modified treatments. This group is composed of high number of various ethnicities.

CLIENT OUTCOMES: Consumer Perception Survey (August 2013)

Ultimately, the reason we provide mental health services is to help individuals manage their mental illness and to lead productive lives. We have selected two questions from the Consumer Perception Survey which capture this intention. One question is geared toward adults of any age, and the other is for children and youth under 18.

Below are the data for responses by clients in your county to these two questions.

*The total numbers of surveys completed for Adults or Children/Youth in your county are shown separately in the tables below, under the heading "**Total."***

Q1. Adults. As a direct result of the services I received, I deal more effectively with daily problems.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Number of Responses	4	4	43	101	116	268
Percent of Responses	1.5 %	1.5 %	16.0 %	37.7 %	43.3 %	100.0 %

Q2. Children/Youth. As a result of services my child and/or family received, my child is better at handling daily life.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Number of Responses	1	1	21	59	34	116
Percent of Responses	0.9 %	0.9 %	18.1 %	50.9 %	29.3 %	100.0 %

Ideas regarding county's engagement of underserved

Health Fairs: For example LEGACY group (Lifting, Empowering Generations of Adults, Children, and Youth) Peer support through fairs at Housing Developments, Middle Schools.

New Mental Health Resources for Asian Pacific Community Prop 63 Funding. Documentation now in Hmong, Lao, Khmer, and Mien with vocabulary index of common mental health terms and cultural myths fact sheets (www.speakourminds.org/resource-categories/to-say/)

Effectiveness of mental health services in our county

81% of adult clients agreed or strongly agreed (101 + 116/268 surveyed) that they dealt more effectively with daily problems as a result of receiving county mental health services. 80.2% of families agreed or strongly agreed (59+34/116) that youth were handling daily life better.

Recommendations for improving effectiveness of services

Continued/expanded professional training programs such as:

- a. TRAUMA INFORMED TRAINING SESSIONS, including community programs and education for health care workers
- b. SUPERIOR COURT Behavioral Health Programs: Directing those incarcerated for untreated mental health issues to community programs instead, therefore reducing the harm that comes to these prisoners for lack of treatment
- c. DPH School Programs Training of Workforce: Special Coordinator helps to develop curriculums for training.
- d. College programs: UCSF Pharmacy school is incorporating Mental Health Awareness training for students.
- e. NAMI National Alliance on Mental Illness, S.F. Peer Outreach program to high schools, and promotion of Art and Video student projects promoting awareness.
- f. Group Intervention programs for patients with common problems to expand reach beyond individual sessions.
- g. Outreach and information to multiple SRO hotels (single room) residents. Many elderly and isolated clients in need of services

Suggestions to increase the response rate for questionnaires.

Increase the methods in which the survey is implemented. Social Media (i.e. Facebook page), telephone questionnaires, email to clients, return postcard, etc.

Suggestions regarding:

- a. **Specific unmet needs or gaps in services**
- b. **Improvements to, or better coordination of, existing services**
- c. **New programs that need to be implemented to serve individuals in your county**

Medi-Cal Patients: Incorporate medication reviews for senior patients, particularly those psychiatric prescription clients who may need to avoid Antihistamines, Anti-Parkinson (Cogentin), Tricyclics (Elavil, Doxepin), and avoid Benzodiazepines for insomnia (Valium, Ativan, Restoril, Klonopin).

Encourage “Brown Bag Review” sessions with clinicians or clinics/pharmacies to reduce the above medications as well as over-the-counter interactions.

Use BEERS LIST for psychiatric prescribing (especially, reduction in doses for the elderly).
Caution in doses of Antidepressants and Antipsychotics