Mental Health SF Implementation Working Group
Meeting Minutes DRAFT

February 28, 2023 │ 9:00 AM – 1:00 PM

This meeting was held by WebEx pursuant to the Governor's Executive Orders and Mayoral Emergency Proclamations suspending and modifying requirements for in-person meetings. During the Coronavirus Disease (COVID-19) emergency, the Mental Health San Francisco Implementation Working Group will convene remotely until it is legally authorized to meet in person.

Note: The agenda, meeting materials, and video recording will be posted at the Mental Health SF https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

1. Call to Order/Roll Call

The meeting was called to order at 9:06a by Chair Monique LaSarre. Facilitator Ashlyn Dadkhah completed roll call.

Committee Members Present: Vitka Eisen, M.S.W., Ed.D (late), Steve Fields, M.P.A. (late), Ana Gonzalez, D.O., Hali Hammer, M.D., Monique LeSarre, Psy. D., Steve Lipton, James McGuigan, Jameel Patterson, Andrea Salinas, L.M.F.T., Sara Shortt, M.S.W., Amy Wong

Committee Members Excused Absent: None.

Committee Members Unexcused Absent: None.

2. Vote to Excuse Absent Member(s)

Facilitator Dadkhah reviewed the process for excusing absent members. This vote was bypassed because there were no excused/unexcused absent members.

3. Welcome and Review of Agenda/Meeting Goals

Chair LaSarre reviewed the goals for the February 2023 meeting. She reminded IWG that the chat function is disabled for panelists and the public. Chair LaSarre briefly introduced the speakers for this meeting. She also reviewed the Mental Health San Francisco (MHSF) domains and reminded the IWG that the charge of this work group is to advise on the design, outcomes, and effectiveness of MHSF to ensure its successful implementation of the ordinance domains.

4. Discussion Item #1: Remote Meeting Update

Facilitator Jen James reviewed the required findings for State and Local Requirements regarding IWG meeting virtually (Emergency Order will terminate on February 28th, 2023). She reviewed the two key resolutions to be voted on by the IWG and reminded the IWG that this meeting is the last virtual meeting.

5. Public Comment for Discussion Item #1

No public comment.

6. **Vote on Discussion Item #1**

Chair LaSarre motioned to approve the Remote Meeting Findings; Member Hali Hammer seconded the motion. The IWG voted and approved the Remote Meeting Findings.

- Vitka Eisen, M.S.W., Ed.D - Yes
- Steve Fields, M.P.A. - Not present for vote
- Ana Gonzalez, D.O. - Yes
- Hali Hammer, M.D. - Yes
- Monique LeSarre, Psy. D. - Yes
- Steve Lipton - Yes
- James McGuigan - Yes
- Jameel Patterson – Yes
- Andrea Salinas, L.M.F.T. - Yes
- Sara Shortt, M.S.W. - Yes
- Amy Wong – Yes

7. **Discussion Item #2: Approve Meeting Minutes**

Chair LaSarre opened discussion for the IWG to make changes to the January 2023 meeting minutes. IWG members did not have changes to the meeting minutes.

8. **Public Comment for Discussion Item #2**

No public comment.

9. **Vote on Discussion Item #2**

Member Hammer motioned to approve the January 2023 meeting minutes; Member Steve Lipton seconded the motion. January 2023 meeting minutes were voted on and approved by the IWG.

- Vitka Eisen, M.S.W., Ed.D – Abstain (absent from January 2023 meeting)
- Steve Fields, M.P.A. – Not present for vote
- Ana Gonzalez, D.O. - Yes
- Hali Hammer, M.D. - Yes
- Monique LeSarre, Psy. D. - Yes
- Steve Lipton - Yes
- James McGuigan - Yes
- Jameel Patterson - Yes
- Andrea Salinas, L.M.F.T. - Yes
- Sara Shortt, M.S.W. - Yes
- Amy Wong – Yes

10. **Discussion Item #3: MHSF Director's Update**

Director Hillary Kunins announced the formation of a new Board of Supervisors Committee on Homelessness and Behavioral Health. Supervisor Hillary Ronen will be the Chair of this committee, and the Committee has not yet met. Director Kunins mentioned that all behavioral health contracts will go through this committee. She explained that San Francisco Department of Public Health (DPH) is waiting for more updates.

Per the previous requests from the IWG to be informed of upcoming hearings related to behavioral health, Director Kunins shared that DPH will be presenting at a hearing on evictions on March 20th, 2023. Additionally, DPH will also be presenting on April 13th, 2023 at a hearing for the implementation of CARE Court.

Director Kunins spoke about the recently issued health alert for Xylazine (aka 'tranq'). She explained that Xylazine is a veterinary sedative that has affected the drug supply on the east coast. The San Francisco Office of the Chief Medical Examiner has now officially detected Xylazine in a minimum of six individuals who had died from overdose. Director Kunins noted that all positive tests for Xylazine were found in the presence of Fentanyl. Xylazine is associated with skin wounds so clinicians must be advised to administer the appropriate treatment.

Buprenorphine Naloxone and Methadone are most effective in treating opioid addiction. Director Kunins explained that one challenge in prescribing these medications included the need for a clinician to obtain a "Special" or "X" waiver from the Drug Enforcement Administration (DEA). Director Kunins announced that

as of December 29th, 2022, through a federal omnibus bill, obtaining a waiver is no longer needed to prescribe Buprenorphine Naloxone for the use of opioid use disorder. Specifically, all prescribers with a valid DEA registration to prescribe controlled substances may prescribe Buprenorphine Naloxone. Director Kunins informed the IWG that over 3,000 people in San Francisco are treated with Buprenorphine Naloxone per year.

The Substance Abuse and Mental Health Service Administration (SAMHSA) has provided updated rules for opioid treatment programs. These rules plan to increase the flexibility of using Methadone, in hopes of encouraging more people to try Methadone treatment. DPH supports this proposal with scientific research in mind.

Director Kunins shared two updates on hiring and staffing. (1) At the city-level, the Civil Service Commission has approved a proposal spearheaded by Mayor Breed, to speed up the City hiring process. These procedures should give Human Resources (HR) greater administrative authorities and the capacity to make hiring processes consistent. This proposal suggests that the City's hiring time will be reduced by up to 40% for certain positions. Director Kunins shared that it currently takes 250 days on average for the City to fill a permanent position. (2) DPH is taking on a project to incorporate lived experience into desired qualifications for notice inquires used for hiring. This pilot is a collaboration between DPH, Human Resources and the Behavioral Health Office of Justice, Equity, Diversity, and Inclusion and will trial from February 2023 to August 2023. The goal of this pilot is to increase the number of clinicians who culturally represent clients served and clients with the largest health disparities. This pilot also intends to diversify clinical and director management roles.

Discussion

Member Vitka Eisen asked Director Kunins to confirm if Naloxone can reverse an overdose despite the presence of Xylazine and Director Kunins answered yes. She highlighted that Xylazine is not an opioid and causes sedation. While Naloxone reverses the effects of an opioid overdose, the presence of Xylazine may make an individual still appear sluggish after surviving an overdose. Member Eisen followed up by asking if smoking opioids would be considered as a harm reduction practice, considering that Xylazine affects soft tissue. Director Kunins answered that there is still an uncertainty to whether smoking is suggested over injecting opioids.

Member Steve Lipton asked for Director Kunins to comment on her being quoted in The San Francisco Chronicle. He highlighted a message from the article that suggests there are limited resources, including beds. She commented that the new beds and facilities domain under MHSF is intended to alleviate bed shortages. As well, the Treatment on Demand Report details that wait times for residential substance use disorders (SUD) treatment are short. Director Kunins expressed that DPH shares resource concerns and will continue to work towards a larger capacity for beds and resources.

Member Steve Fields asked Dr. Kunins why she did not mention the closing of acute diversion programs that include dual diagnosis residential treatment programs. Director Kunins thanked member Fields for raising his comment and explained that she was speaking without notes.

Vice Chair Jameel Patterson asked what the plan is to bridge the gaps in health disparities particular to Black communities. Director Kunins answered that diversifying the civil workforce improves health outcomes, so this is one strategy. Launching culturally competent care is another strategy.

11. Public Comment for Discussion Item #3

No public comment.

12. Discussion Item #4: DPH Implementation Report Update

Presenter Kelly Kirkpatrick shared an update on the DPH MHSF Implementation report, which had been

shared with the Mayor and the Board of Supervisors. She overviewed the contents of the summary report and reviewed MHSF key accomplishments from 2022. Presenter Kirkpatrick highlighted that over 160 new beds were added in 2022, as reported in the DPH Behavioral Health Residential Treatment Expansion Dashboard. She reviewed program goals for MHSF in 2023, as well as MHSF systemwide goals for 2023.

Discussion

Member Fields suggested there should be a study on community-based organization (CBOs) salaries, to close the gap between CBOs salary and city/county salaries. In addition to his suggestion, he asked for more information on the transition of contracted beds to City-owned facilities. Presenter Kirkpatrick referred to her presentation to answer that the MHSF Staffing Analysis (expected to be completed mid-2023) from the Controller's Office will address CBO pay equity issues. To answer Member Fields' question, she responded that through Prop C, the City is aiming to acquire buildings to expand the capacity for beds, and the services for these facilities would most likely be contracted to CBOs or through a request for proposal (RFP).

13. **Public Comment for Discussion Item #4**

No public comment.

14. **Discussion Item #5: Street Crisis Response Team Reconfiguration**

Director Mary Ellen Carroll introduced herself as the Director of the Department of Emergency Management (DEM) and shared some of her background in working for the City. She clarified that the main role for the DEM is to provide coordination and support for street response teams. Presenter Carroll overviewed the upcoming consolidation of the Street Crisis Response Team (SCRT) and Street Wellness Team into an expanded SCRT. Further, she explained one reason for the consolidation being that the street crisis and street wellness teams shared almost identical outcomes in terms of the population they interacted with.

Director Kunins reviewed DPH operational changes under MHSF. Included in these changes are a deployment of neighborhood-based teams of clinicians and peer health workers to work closely with the reconfigured SCRT.

Discussion

Member Andrea Salinas asked if the operational updates include an expansion of the Office of Coordinated Care (OCC) Team in relation to working with SCRT. Director Kunins clarified that DPH is still contemplating specific workflows. She further explained that neighborhood-based clinicians will be working with the former OCC SCRT team on more complex cases as a part of an effort towards longitudinal care to get people settled into the appropriate routine care based on their needs. Member Salinas then asked why a behavioral health clinician has been removed from street teams. Presenter Carroll answered that behavioral health clinicians' time were not being utilized efficiently on the street teams and it allows for more SCRT teams. Presenter Carroll also mentioned that paramedics and paramedic captains are available for 5150 calls.

Considering that there will not be a clinician on the SCRT team to write a 5150, Member Lipton asked how the SCRT team will arrange a 5150. Presenter Carroll answered that department rescue captains will be made immediately available for 5150s, and because 5150s are not the main priority for SCRT, she feels the capacity for these calls will be met with current staffing. Member Lipton followed up by asking what the time frame would be to respond to a 5150. Presenter Carroll answered that they anticipate a rescue captain would arrive within minutes of a call. Member Lipton asked that DPH update IWG on the reconfiguration of SCRT with previous IWG recommendations in mind. Director Kunins followed up Presenter Carroll's responses by sharing that only about 5% of SCRT calls result in a 5150 to date. She also clarified that a potential tradeoff for the reconfigured SCRT would allow for more clinicians to be available for in-depth follow up. Member Lipton agreed that more personnel on the ground is a good thing but expressed

concern for the capacity for 5150 calls. Presenter Carroll responded that this reconfiguration will be monitored closely, and DEM will consider training paramedics how to do 5150s, if necessary.

Member McGuigan asked for clarification on the assessment for psychiatric holds, as well as a numeric translation of the 5% of 5150 holds to date. Kathleen Silk (DPH) answered that since November 2020, out of approximately 15,000 calls to SCRT, 8,400 encounters with people have been reported and 5% of those encounters have resulted in 5150s (less than one per day). Ms. Silk explained that every SCRT encounter uses an assessment for a psychiatric hold. This assessment includes collateral history that is available in charts, EPIC, or previous encounters, including criteria for danger to self/others and/or grave disability. Member McGuigan asked how SCRT determines danger to self and grave disability. Ms. Silk answered that SCRT determines these based on what is outlined in the 5150 law and acknowledged that the law may be narrower than what the public may deem disturbing. The legislation defines the criteria for a 5150 hold as a person being an eminent danger to themselves, or having the inability to feed, clothe, or house oneself based on a mental health disorder. It was also clarified that continued grave disability is a criterion for conservatorship. Director Kunins highlighted that the upcoming transitions will afford the ability for SCRT to continually work with people through follow ups, regardless of whether an encounter results in a 5150 hold. She also raised that 5150 holds do not necessarily ensure desirable health outcomes without the appropriate connections to acute care.

Member Eisen offered her opinion that it is difficult to determine a grave disability in a one-time encounter. She asked the following questions: (1) why pull the clinician from the SCRT rig? (2) why not consider rotating a clinician on and off the SCRT rig? (3) has DPH factored in staffing issues in recruiting master level clinicians for street outreach work? (4) should master level clinicians do outreach work? (5) should staff include clinicians under the master level? (6) how do we confront the lack of services for people? and (7) why has IWG not been consulted before decisions were made? Further, Member Eisen shared her opinion that the lack of communication between DPH and IWG suggests that the IWG is irrelevant in decision-making. Director Kunins offered that DPH seeks the depth and diversity in experience within IWG and acknowledged that the IWG were not notified in a timely matter on the reconfiguration of SCRT. Director Kunins assured that the IWG is not a 'box-checking' group; she suggested a future adjustment in aligning timelines, so that there is better communication to the IWG. Director Kunins concurred that for outreach and encounter purposes, a master's degree does not confer a greater ability to do vital work, but a master's degree does provide a clinician with a high level of skill and evidence-based strategies during interventions. Further, she clarified that by staffing clinicians that do not have a master's degree, this should increase the capacity to deliver interventions. Director Kunins shared that DPH is working on the consistency of resources and shared that Member Eisen's idea of rotating clinicians on/off rigs will be taken back to the DPH team. Member Eisen highlighted that the IWG has monthly meetings have timely brainstorms with DPH in comparison to other entities.

Member Sara Shortt stated that taking behavioral health professionals away from SCRT teams is problematic. She said that clinicians do much more than write 5150 holds. Further, she is concerned that without a clinician, SCRT would fall out of the purview of MHSF and mislead the public. In addition to these concerns, she echoed the importance of the SCRT team consisting of multidisciplinary elements. Member Shortt stated that she feels disrespected because this is not the first instance where DPH has consulted IWG after decisions were already made for MHSF. Member Shortt also asked where the clinicians hired for SCRT will be going. She requested this reconfiguration halt until stakeholders directly interact with IWG. Presenter Carroll responded by stating her willingness to collaborate further. She said that DEM has done enormous work to support initiatives with the goal of less police interaction and briefly explained some of the types of training 911 dispatchers have done.

Member Fields stated that the SCRT was implemented without the guidance of the IWG and reviewing the comments from the IWG's Implementation Report would hold IWG and DPH in a better working relationship. Further, he expressed the importance of reviewing mental health intervention follow ups, specifically 5150s, to gain a better understanding of efficacy.

Member Salinas shared a concern regarding the 5150 plan in which her team has had to wait a long time for the paramedics to arrive on scene, especially if no congruent medical issue is present for the person being held for 5150. She asked Presenter Carroll how the response times for all 5150s can improve. She also highlighted that the definition for 5150 and 5250 holds has changed over time, and that change needs to be taken further into consideration.

Chair LaSarre noted that she is inviting Presenter Carroll to the March IWG Retreat to answer the questions presented in this portion of the meeting.

Member Hammer raised a concern that too many questions were being deferred to the March Retreat and requested that the March 2023 IWG meeting agenda be amended to accommodate Presenter Carroll answering questions.

Director Carroll requested to have the IWG collect questions directed to DEM, so that DEM and other departments can collaborate to respond to questions at a later IWG meeting.

Member Lipton echoed Member McGuigan's question about defining 5150 holds. He commented that there was not an accurate 5150 hold definition provided during this meeting and stated that the terms '5150' and 'assessment' were being used too ambiguously. He also suggested to revisit this topic during the IWG March Retreat.

15. Break

11:27am-11:40am

16. Public Comment for Discussion Item #5

- Caller #1 (Fatima): Fatima expressed her support to keep mental health clinicians on SCRT teams. She explained that they are better equipped than paramedics to handle SCRT interventions, evaluate psychiatric holds, as well as are more likely to build rapport. Fatima also raised a concern that key stakeholders were not informed prior to the decision of clinicians being removed form SCRT teams. She shared a fear that SCRT is becoming numbers and outcome-focused and may unnecessarily place community members under a psychiatric hold, which would cause harm and trauma. Fatima urged keeping clinicians on SCRT rigs and suggested soliciting feedback from communities that use SCRT services to improve service delivery, in addition to using comprehensive and continuous training.

- Caller #2 (Brandon): Brandon shared that raising his hand via WebEx was easier to access than calling in for a public comment. He shared that the call system for public comment was not user friendly.

Facilitator James apologized for the technical difficulties and reminded the IWG and public that all questions, comments, and concerns can be submitted via email mentalhealthsf@iwg.sfgov.org.

17. Discussion Item #6: Mapping Discussion Group Report Out

Member Salinas shared the Mapping Discussion Group's conversation. The group discussed two types of mapping- creating a mapping/directory of providers and understanding both the ideal and actual experience of those who access MHSF services and the larger system of care. For creating a directory of providers- she noted that under the new CalAIM requirements, all counties are required to create a mapping/directory for services. DPH is currently working on a full directory of all behavioral health services in the city, as well as upgrading the website to be more user friendly. She is hopeful that the pathways to behavioral health services will also be included in the updated mapping in addition to indications of self-referrals or interdepartmental referrals. For creating the ideal and actual experience of those accessing MHSF services and the larger system of care, Member Salinas explained that this component is a task that BHS and DPH are taking on. They will develop three distinct "flows" of the ideal way a person enters the system and accesses needed care. These maps will include (1) dual diagnosis, (2) gender, family, TAY, non-English speaking, undocumented and (3) complicated comorbidity. Once the maps of the ideal flow are developed, they will be used for community engagement purposes, to provide focused way for community providers to provide feedback on programs facilitating this flow and identifying gaps. Facilitator James emphasized the connection between mapping and community engagement.

To the first mapping consideration- a directory of providers that is easily accessed and understood by the community- Presenter Ashley Vaughn reviewed issues in community access and the understanding of services. She stated that the Behavioral Health webpage, provider directory, and communication materials are all being updated to become more user-friendly. DPH is working to centralize access information and update each program's function. She also mentioned that the provider directory is currently posted online.

Facilitator James asked for timelines for improvements to the website mapping overall. Presenter Vaughn responded that there is no confirmation of a deadline, but mapping remains a high priority.

Discussion

Member Eisen asked, that given that case management responsibilities fall across different entities in the continuum of care, if it is possible to develop an inventory of case management care coordination for client interface. Member Salinas supported her request and responded that if more care coordination was a goal of the BHS, then this type of inventory would be appropriate to address in the mapping project.

Member Fields addressed the intersection between what mapping is and what mapping should be. He emphasized that the term 'map' should reflect the current services in place that are available. He suggested referring to a map that describes services that should be available/are in planning as a 'blueprint'. Additionally, he suggested a multi-sector approach to develop blueprints and maps that enhance the continuum of care by focusing on recovery, stability, and thriving in the community.

Facilitator James asked for clarification if Member Fields was describing this mapping project, which is a client level path that describes optimal movement through services. Chair LaSarre explained that the term 'navigation' describes the physical travel throughout the system. Further, and per the legislation, the most pressing mapping design involves the vision landscape of the continuum of care. Chair LaSarre noted that this type of map also needs to include prevention and early intervention from an anti-racist lens.

Heather Weisbrod offered the assurance that the OCC has been focusing on mapping as currently described by the IWG and will continue to engage IWG about mapping.

Director Kunins highlighted considering how case management functions in Intensive Case Management (ICM) and stated that DPH has been struggling to meet the mapping requests of the IWG as one of DPH's stakeholder groups. She said that DPH aims to be responsive and requested IWG to remain concrete and sequential in their definition of mapping, so that the process can move forward. Chair LaSarre said that IWG is concrete in what mapping is being requested.

Vice Chair Patterson suggested to begin mapping by looking at one geographic section at a time. By looking at one neighborhood at a time, IWG and DPH can record what services are present and what services are not present in that location. Chair LaSarre agreed with Vice Chair Patterson and supported looking at the neighborhoods for a concrete map. Director Kunins stated that she hears the urgency for the need for mapping.

Chair LaSarre highlighted that importance of community engagement and invited the public to participate in services mapping through the communication working groups noted by DPH.

18. Public Comment for Discussion Item #6

- Caller #1 (Ruben): Ruben asked what the City is doing to incentivize new mental health professionals and to keep social workers and caseworkers on board. He also asked what the plan is to address clients' broken trust due to the high turnover of mental health professionals.

19. Discussion Item #7: March Retreat Discussion Report Out

Chair LaSarre stated that a discussion group previously met to discuss the IWG March Retreat. This group included Member Amy Wong, Member Lipton, Member McGuigan, Member Fields, and Chair LaSarre.

Member Lipton reviewed the three initial goals of the retreat, which considered including a discussion about the December Implementation Report and what IWG needs from DPH. Chair LaSarre mentioned that the IWG could email comments about this section of the meeting.

Member Hammer reiterated the idea that the retreat will be a good setting to explore how IWG interacts with other departments; exploring this will allow the IWG to provide meaningful input about programmatic development.

Member Eisen echoed the importance of interacting with departments in real time, as well as brainstorming on how to have a dynamic relationship in implementing the MHSF legislation.

Member Salinas asked for clarification of the second listed goal (explore how the IWG can facilitate the evolution of MHSF to a system of care as envisioned by the MHSF Ordinance). Member Eisen offered her understanding that this goal explains looking at portions of MHSF that have already been implemented, exploring the process of looking at the system, brainstorming solutions, and envisioning work moving forward. Member Fields stated that Member Eisen's explanation was correct. Further, he supported the call to help all San Franciscans, and not just the people in crisis. It is important to have partnership with DPH to envision which elements are needed so that the system is not only in a constant response to crisis systems.

Vice Chair Patterson stated that number crunching must be avoided. He suggested a ladder system, where someone explores steps they can take for recovery. Further, he said that numbers do not necessarily reflect the experiences of the community.

20. Public comment for Discussion Item #7

- Caller #1 (Kat): Kat shared that she is a formal licensed SCRT clinician. Referring to Discussion Item 6, she explained that SCRT clinicians utilized creative interventions aside from writing 5150 holds. She mentioned that the decision to remove clinicians from SCRT threatens violence to community members and feels like a setback.

21. Discussion Item #8: Office of Coordinated Care and Case Management Expansion Update

Discussion item #8 will be moved to a later MHSF IWG Meeting agenda.

22. Discussion Item #9: Update on New Beds & Facilities

Discussion item #9 will be moved to a later MHSF IWG Meeting agenda.

23. Discussion Item #10: Voting in Chair and Vice Chair

Discussion item #10 will be moved to a later MHSF IWG Meeting agenda.

24. Public Comment for any other matter within the jurisdiction of the Committee not on the agenda

No public comment.

25. Draft Planning & Sequencing for 2023 and Housekeeping

Facilitator James overviewed the planning and sequencing for 2023 IWG meetings. She mentioned that in March, there will not be a formal IWG meeting due to the Retreat, and formal meetings will reconvene in April 2023. Facilitator James also noted that starting in March 2023, IWG meetings will be held in person.

The next meeting (IWG Retreat) will be on Tuesday, March 28, 2023 at 9:00am-1:00pm at San Francisco City Hall. The April 2023 IWG meeting will be held on April 25, 2023 9:00a-1:00p at the DPH building.

Information about the meeting room locations will be posted on the IWG website.

26. Adjourn

Chair LaSarre motioned to adjourn the meeting; Member Eisen seconded. Meeting adjourned at 12:58 pm.