



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board
Wednesday, [January 08, 2014](#)
1380 Howard Street
5th Floor, Room 515
San Francisco, CA

BOARD MEMBERS PRESENT: David Elliott Lewis, Ph D, Co Chair; Ellis Joseph, MBA, Co Chair; Wendy James, Vice Chair; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Lena Miller, MSW; Andre Moore; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS; Bailey Wendzel; and Errol Wishom.

BOARD MEMBERS ON LEAVE: Virginia S. Lewis, MA, LCSW, Secretary; Melody Daniel, MFT; and Sgt. Kelly Kruger.

BOARD MEMBERS ABSENT: None

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Toni Parks, Victor Gresser, Peer-to-Peer and Vocational Services; Dan W. Lee and 13 members of the public.

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:38 PM.

He introduced Ms. Bailey Wendzel, a newly appointed board member. She is the Program Coordinator at the National Alliance on Mental Illness (NAMI-SF) in San Francisco. She was recently appointed by District 2's Supervisor Mark Farrell to a family member seat on the board. She shared that she wanted to join the board because she is passionate about mental illness which she started to learn more about it as a child because she wanted to help her family. In addition to her work with NAMI, she works closely with the Veterans Administration (VA) in San Francisco to help recently returning veterans with PTSD, including their families.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

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

Ms. Robinson, Director of CBHS, gave the January 2014 director's report.

She shared the latest updates that she learned about a few hours before coming into the meeting. These last minute updates were not incorporated in her January 2014 report. The current California governor Jerry Brown just received the proposed budget for the State, and she hoped the governor will continue to support social services.

On January 2, 2014 a meeting included the non-specialty mental health topic. The State of California asked CBHS to take on the out-patient mental health challenge. One of the 10 essential benefits in the Affordable Care Act (ACA) is non-specialty care, which is recognized in the Diagnostic Statistical Manual (DSM) V manual, which was completed in May 2013, as a medical necessity with symptoms ranging from mild to moderate but symptoms are not disabling enough to seriously interfere with a person's life functions.

We know that about 11% of the general American population at some point in their lives will seek mental health care. In San Francisco, about 42,000 people will utilize non-specialty care services. The initial allocation is \$2.13 per member per month. But that allocation can increase higher to an average of \$16 to \$21, depending on the pathology. The funding just pays non-specialty care with licensed clinicians but not with psychiatrists.

We will tap into our Providers Network of licensed clinicians to provide non-specialty mental health services. These services are individual and group therapy, assessment, out-patient services, laboratory services for drug therapy, medication management and psychiatric consultation. However, relational therapy such as couple counseling and family therapy are excluded. CBHS is trying to make access to non-specialty care, which requires a physician referral, as friendly as possible for clients.

Behavioral Health Access Center (BHAC) clinicians can perform assessment and do referrals. The key feature of non-specialty care coverage is the inclusion of substance abuse. There is not an exclusion clause on the number of sessions, and treatment continues until the underlying diagnosis no longer meets medical necessity. We have identified several groups in CBHS to train staff and peer specialists to engage clients in mental health and substance disorder care.

The second news is in the spring, the 2014 Peer Specialist Certificate program will be offered by Richmond Area Multi-Services, Inc. (RAMS) which is a private, non-profit comprehensive mental health agency.

Dr. David Elliott Lewis asked what constitutes non-specialty mental health services.

Ms. Robinson explained that mental health issues diagnosed and recognized in the DSM V manual as medical necessity with mild to moderate symptoms. Prevention and early intervention of severe mental illness (SMI) costs a lot less than a full-blown hospitalization or psychiatric emergency, not to mention the expense to public safety.

Dr. Patterson asked for clarification of the definition of medical necessity.

Ms. Robinson explained that the definition of medical necessity is highly technical and medically specific in term of covered benefits as defined by medical insurance plans. But mental health professionals have recognized that different situations meet a different definition because no definition adequately specifies the precise boundary.

Because of the medical definition of what constitutes a medical necessity and from the perspective of coverage determination guideline, any coverage for behavioral health assessment and treatment for V-Code conditions may not be recognized in the medical DSM V manual. Therefore, a V-code suffer may not be entitled to health insurance benefits. For example, combat PTSD is a covered benefit but community violence PTSD is a non-covered benefit.

Something of interest to the board is the State mandated adult-client satisfaction survey from various community programs. Historically the survey was not publicly available, but it is now in the public domain. It used to be that program providers, themselves, did not even know the survey's results. Now, providers can see feedback and make changes.

Ms. Bohrer was impressed with the survey. She also suggested future surveys should include a number showing the total of participating patients versus the total of actual responses.

Dr. David Elliott Lewis wondered if the next round of request for proposals (RFP) would be more focused on ACA services in terms of a holistic approach to both mind and body.

Ms. Robinson explained that holistic care is very important in the health home concept. She suggested the board should include Mission Health in its program reviews in the fiscal year 2013-2014. She said Dr. Ryan Shackelford is both a family care and a psychiatric internist at Mission Health.

1.2 Public Comment

Mr. Fofide is with the Tom Waddell program and asked how the ACA affects clients who are already receiving services.

Ms. Robinson explained it depends on classification. There is no change for people with severe mental illness (SMI). But for people with mild to moderate mental illness, she will try to make it possible for them to get help.

Mr. Gresser asked for clarity on the number 41,000.

Ms. Robinson explained that 41,000 is the initial number from Medi-Cal, meaning San Francisco has about 41,000 clients with Medi-Cal coverage. Starting in 2014, San Francisco will have two health plans for people without private health insurance. So far, the Anthem plan has 800 participants and the San Francisco Health plan has 11,000 participants. The \$2.13 per person is just the initial allocation amount that could increase to \$15 -- \$20 per member.

She also mentioned the Victor Gresser is a CBHS peer intern and works a few doors from her office, and at his desk he has an empowering sign that reads

QUESTION 1:

A person with a history of mental illness or substance abuse can live a happy life which includes satisfying employment that meets the standards of the employer and the community.

True

False

Monthly Director's Report January 2014

1. Youth Leadership Institute's Tobacco Use Reduction Force (TURF)

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. For TURF leaders this development exceeded their expectations. Luisa Sicarios, TURF member and YLI Board member, shared that for the first time she 'felt heard' by AAGA. Youth leader Malaysia Sanders explained that it felt good to be "on the same page" with an ally like AAGA.

At the first meeting between TURF and AAGA leaders, both groups were able to quickly find common ground. TURF leaders carefully and effectively talked about the impact of a disproportionate number of tobacco retailers in their communities, in comparison to other more affluent parts of San Francisco, and crafted a message about why AAGA should stand with them on this issue. The message resonated with AAGA leadership and captured their full attention. TURF leaders spoke from the heart, which cemented the newly formed relationship.

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 SF. 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.

San Francisco has more than one thousand stores that sell cigarettes and other tobacco products, most of which are concentrated in low-income communities of color. While the city is divided into 12 supervisorial districts with relatively equal total populations, some districts like the Tenderloin have more than 270 outlets, while others, like the Marina, have 50 outlets. 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.

2. Consumer's Guide to Addiction Treatment

CASA Columbia just released a consumer's guide to finding high quality addiction treatment. The link is

<http://www.casacolumbia.org/addiction-treatment>

3. Seeking Safety in CBHS

Two years ago, the CBHS Groupwork Committee launched a system-wide implementation of Seeking Safety, and organized the training of a hundred clinicians from over thirty CBHS programs – who all agreed to implement Seeking Safety groups for at least a year at their agencies.

This initiative was part of promoting group-work – instead of just individual counseling – as a pathway of treatment for clients presenting with common problems for which group intervention

is effective at addressing – one of which is Seeking Safety for trauma and substance abuse. Gabriela Grant provided the Seeking Safety training for the CBHS clinicians.

The newly-trained Seeking Safety counselors met quarterly during the first year in 2012 to support each other in the launching of their groups, and to problem-solve implementation barriers with CBHS central administration. Follow-up trainings and implementation manuals, along with evaluation support through Quality Management, were provided by CBHS. An email list-serve allowed the clinicians to share experiences with each other, and regular feedback solicited by CBHS allowed them to give input about support they needed from central administration.

The result two years ongoing is the sustained interest in, and continued implementation of, Seeking Safety at CBHS programs. Each of the twenty-nine participating CBHS programs delivered an average of 41 Seeking Safety sessions at each site, which engaged the active participation of a total of 806 CBHS clients. These 806 clients received an average of 9 Seeking Safety group sessions each, which resulted in significant improvements over time (as measured over three time periods in the evaluation study) in self-reported drug and alcohol use, and in the ability to attain safety in their relationships, thinking, behavior, and emotions.

A survey conducted last month with Seeking Safety clinicians showed continued interest in CBHS trainings and support for Seeking Safety implementation. Seeking Safety is an evidence-based practice that makes use of twenty-five session-modules, and a present-focused therapy approach, to help people attain safety from trauma/PTSD and substance abuse. Seeking Safety consists of 25 topics that can be conducted in any order: Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding), Life Choices, and Termination.

4. Westside Community Services Hires New Director of Child, Youth and Family

Dr. Monique LeSarre is the new Director of our Child, Youth and Family division. Dr. LeSarre most recently directed the San Francisco Mental Health Services Act Project where she worked with the San Francisco Department of Public Health to recruit and train a culturally competent workforce for community mental health settings. She has an impressive background in teaching, research and clinical service delivery and has trained at Oakland Children's Hospital, Iris Center, Haight Ashbury Psychological Services and the Center for Youth Wellness with Dr. Nadine Burke.

Dr. LeSarre continues to serve as adjunct faculty at the California Institute of Integral Studies, teaching in the Master's in Counseling programs and the Bachelors of Arts Completion Program. She regularly consults and provides trainings and curriculum development with Bay Area clinics, community based organizations, and Public Health agencies including Glide Memorial Church, Larkin Street, Californians for Safety and Justice, and Insight Prison Project.

Dr. LeSarre has worked extensively with youth and adults serving life sentences at San Quentin Prison. Her past clinical work involved early intervention with mothers in residential drug treatment, as well as with children zero to five with developmental delays. Her areas of clinical focus include institutional violence, trauma across the lifespan, community trauma and indigenous healing practices in urban communities. She is passionate about providing multiple levels of intervention from direct services, training, family and community support and wellness modalities. Dr. LeSarre's teaching, training and service delivery model relies upon utilizing and recognizing our children, youth and families strengths and resiliencies and engaging the community from a strong culture based supportive approach.

5. Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS)

Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) is 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.

AAIMS continues to evolve. Peer leaders have begun to play a larger role in community outreach and recruitment/retention of new members. Peer leaders, in addition to teaching/supporting the 20 week AAIMS nutrition and cooking classes, they also assist in:

- (1) Developing and offering a menu of tailored trainings to the community (e.g., SROs, community agencies, mental health providers) on healthy cooking and eating/for wellness & recovery
- (2) Planning to collaborate with a local organization to create co-facilitator positions for AAIMS Peer Advocates in their healthy cooking workshops in SRO buildings in the Tenderloin
- (3) Increasing participation in local community organizing and advocacy efforts as food justice leaders and spokespeople
- (4) Conducting outreach/cooking demonstrations at community events. And,
- (5) Helping to develop and publish a healthy eating cookbook for the Tenderloin SRO resident community.

The AAIMS project has been incredibly innovative and successful. At this point, it is morphing into a peer vocational training program in nutrition and cooking. But most importantly, it has been powerfully healing to participants involved. One participant/peer leader confided: "I go to my therapist, to support groups, to my doctor...but nothing has helped me more than being part of this group. This is the best therapy for me, hands down!"

6. New Research: Alcohol, Tobacco, Drug Use Much Higher among those with Mental Illness

Rates of smoking, drinking and drug use are significantly higher among those with psychotic disorders than the general population, U.S. researchers say. The article, “Comorbidity of Severe Psychotic Disorders With Measures of Substance Use,” recently published in the journal *JAMA Psychiatry*, found that:

- 30% of those with severe psychiatric illness engaged in binge drinking, compared to 8% in the general population.
- Among those with mental illness, more than 75% were regular smokers, compared to 33% in the control group.
- Half of those with mental illness also used other illicit drugs, compared to 12% in the general population.

A link to the abstract can be found here:

<http://archpsyc.jamanetwork.com/article.aspx?articleid=1790914>

7. Chinatown Child Development Center Recognized by Health Commission

At its December 17, 2013 meeting, the San Francisco Health Commission recognized the entire Chinatown Child Development Center (CCDC) staff with one of its Health Commission Employee Recognition awards. During its 40-year history, the CCDC staff have strongly believed that it “takes a community” to provide the needed services to the unserved and underserved Chinese and Southeast Asian populations in our City. Their efforts have exemplified best practices, resulting in improved outcomes for our clients. Staff have consistently entrenched themselves in the Chinatown community and beyond, developing relationships and partnerships with different community-based agencies and individuals.

CCDC partnered with the Chinatown Public Health Center to provide two successful programs to the community in 2012, both focusing on obesity prevention. Chinatown Public Health Center has been CCDC’s primary care partner for close to 30 years. This partnership is a perfect example of the movement towards primary care/mental health integration which our SF Dept. of Public Health has been encouraging.

Due to the consistent good work that CCDC staff do, whenever Community Behavioral Health Services has a new idea or initiative that needs to be piloted, CCDC staff are often called upon to help. Regardless of how busy CCDC staff may be, they always stand ready to help out.

8. Media Toolkit available for Mental Health Stakeholders

The new resource, "Working with the Media to Tell Your Story," produced by the Entertainment Industries Council, Inc. is a toolkit to help mental health community organizations and individuals connect with the media around accurate and positive mental health stories. The toolkit is currently available in both English and Spanish. Contact: Nedra Weinreich at nweinreich@eiconline.org or (818) 861-7782.

9. Save the Date For Mental Health and Substance Use Disorder Awareness Day

On May 13th, 2014, California's mental health community will come together for Mental Health and Substance Use Disorder Awareness Day in Sacramento, CA. The event is being coordinated through the California Coalition for Mental Health and Each Mind Matters to raise awareness of mental health and substance use disorder treatment. Additional details on this exciting event are coming soon. Contact: Joseph Robinson at Joseph.Robinson@calmhsa.org

10. Quality Improvement in Civil Service Programs

Beginning in October 2012, CBHS Executive Leadership began meeting with the program directors and medical directors of the 20 civil service mental health and substance abuse treatment programs with the goal of identifying and addressing quality of care. Two initial meetings were held during which improving clinic flow and successful treatment completion were identified as key areas for improvement. After an introduction to the Plan-Do-Study-Act model for process change, each clinic was asked to identify something they could try within the next two months that would result in improvements in these areas. Ideas were collected at the meeting, and were compiled and emailed back to the attendees as reminders of their plans.

A follow-up meeting was held on February 8, 2013, during which each clinic presented what they tried, what they learned, and next steps. In this way, the group learned about Rapid Tests of Change and PDSAs in a way that was experiential and meaningful. Program teams refined their focus to address flow into and out of their programs to create more service capacity. For the remainder of FY 2012-13, programs began testing small changes and reported progress during quarterly meetings and via on-line surveys from administration. Initially the goal was to simply practice using the PDSA model, and gain interest and buy-in from staff in using this approach. The majority of the tests conducted in this period were related to clinic flow; however, it was clear that more effort needed to be put into identifying clear project aims, goals, objectives and measures. The decision was made to bring in a quality improvement trainer to conduct a full day "ABC's of QI" with the civil services teams, to provide a stronger foundation in the Model for Improvement and the use of the PDSA model. This training was held at the Ferry Building on July 17th, 2013 and was conducted by Hunter Gatewood of Signal Key Consulting. In addition to the civil service Program Director and Medical Director, each clinic was asked to add a Clinical Psychologist and Senior Clinician to their team. During this training, teams spent considerable time developing AIM statements, drafting measurable goals and objectives, and thinking through measures that could be used to monitor progress.

Based on contacts with each civil service clinic in which clinic progress and motivation was assessed, three cohorts of clinics were formed: Early Innovators (7 clinics), Developing a Plan (5 clinics), and Getting Started (8 clinics). Each of these cohorts was convened for a half-day follow up training in October 2013 with Hunter Gatewood and CBHS Executive Leadership to bolster the understanding of the Model for Improvement and PDSAs, and to refine the focus of the QI projects for the next year. Through these discussions, the issue of "flow out" of our programs was selected by nearly all of the programs.

Beginning in February 2014, Quality Improvement staff will be setting up individualized coaching meetings and monthly group calls to support the ongoing QI efforts, including providing data to support both PDSA evaluation and progress on the project AIM. The goal of

the QI coaching is to support the clinics in the use of QI tools as they test their own creative solutions to addressing clinic outflow to enhance overall clinic capacity.

11. Family Mosaic Project

In mid-2013, all of FMP staff were trained in the Wraparound Model and its principles. Since that time, FMP has been focused on redeveloping its infrastructure, program planning and implementation. FMP staff spent a huge amount of time in program planning meetings, trainings and retreats. One of the many new additions to FMP is our Wrap team that consists of one care coordinator, two behavioral support staff, clinical psychologist, nurse and a psychiatrist. While each team member holds a specific role, the team works together to provide an array of services to a maximum of 7 families. Family Mosaic Project will continue to use this year in developing its service delivery of the Wrap team and intensive case management program.

12. Parent Training Institute

In December, the PTI's Steering Committee received feedback from a team of researchers from the Centers for Disease Control (CDC), which had conducted focus groups with Triple P practitioners in June to learn more about cultural and other adaptations made to better meet the needs of diverse families. The research team was impressed by the work of our local Triple P practitioners and reported that they hope to expand the study and collect more data in the spring.

The PTI was invited to participate in a national webinar on January 28, 2014 focusing on the quality improvement framework used by the PTI with the evidence-based parenting programs for families involved with child welfare. The webinar is hosted by the National Child Welfare Resource Center for Organization Improvement (www.nrcoi.org), which is a service of the Children's Bureau. The presenters from San Francisco will be Sylvia Deporto (Deputy Director of Family and Children Services, Human Services Agency), Stephanie Romney (Director of the PTI), and Judith Baker (Former Director of South of Market Family Resource Center and Triple P practitioner).

13. TBS

As a result of the 2013 RFP, there was a reduction in contractors. I'd like to commend Edgewood, RAMS Fu Yau Project, Homeless Children's Network, Infant Parent Program's Daycare Consultants, and Instituto Familiar de la Raza for taking on additional child care sites and clients while doing their very best to ensure continuity of care. Hundreds of clients were associated with the RFP's transition phase, and each agency is doing an amazing job during this critical time. Also, through a participatory process, the ECMHCI's CBHS program manager and the five contractor program directors are currently identifying core issues to resolve in order to further evolve the work and standardize core components of service delivery.

14. AIIM Higher

Since 2009, in partnership with SF JPD, the AIIM Higher (AH) Team has worked with over 500 probation-involved youth and their families to identify, understand, and translate their needs and strengths into recommendations for case planning.

AIIM uses the Child and Adolescent Needs and Strengths (CANS) Assessment to increase mutual understanding and good decision-making, target treatment recommendations and coordinate steps.

This “collaborative care cycle” mobilizes youth and their families to engage in services and sets them up to succeed (Fig 1.). Since the CANS is used by all System of Care providers, cross-system planning and communication about progress aligns supervision and treatment goals to support youth as they transition back to their families and communities.

A recent evaluation of AIIM clients (N=164) from 2010-13 demonstrated that this process works. Probation officers and AH agreed on treatment decisions for a majority (82%) of youth (Fig. 2).

In addition, we found that AIIM clients who engaged in community treatment had a significant decrease in needs and risks and improvement in life functioning on their most recent CANS (Fig 3).

As a next step, we are working together to increase probation and provider collaboration in the management and delivery of enhanced services so that youth receive the right type of care in the right amount to support their health, safety and well-being.

15. Katie A.

The IASC (Katie A.) implementation is moving along. We have a dedicated team from CBHS and HSA who are willing to participate in a PSA. The PSA will focus on assigning a care coordinator from CBHS to follow foster care youth throughout their time in HSA. We are hoping that this will provide more effective and consistent mental health service delivery to this vulnerable population and their families.

16. California Statewide Conference on "Keeping Kids in School and Out of Courts Summit"

On December 4th, 2013, CBHS Children, Youth & Families System of Care participated in the California Statewide Conference on "Keeping Kids in School and Out of Courts Summit" at Anaheim. The Summit brought together judicial officers, educators, juvenile justice and child welfare professionals, and community leaders to:

- Spotlight the problem of truancy and school discipline policies that put California’s children at greater risk of juvenile and criminal justice system involvement;
- Highlight some successful solutions to the problem; and
- Engage local teams to return to their home counties with a strategy to keep kids in school and out of court.

The City of San Francisco's panel included key staff and leadership from DPH, JPD, HSA, DA's Office, Public Defender, SFUSD, and TARC. The day was highlighted by Chief Justice Tani Cantil-Sakauye signing a resolution declaring Dec 4, 2013, "Keeping Kids in School and Out of Court Day."

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

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

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

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

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

2.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update

Ms. Robinson announced that the Board of Supervisors (BOS) already requested the proposed MHSA budget, because the BOS wants to start soliciting public discussion at budget hearings.

2.2 Public comment

Mr. Lee pointed out that there are San Franciscans with mental illness whose income level exclude them from receiving Medi-Cal services, but believed that they should be allowed to still receive a subsidy to participate in the Covered California program.

Ms. Robinson stated that any person can get a qualification determination under the ACA.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of November 13, 2013 be approved as submitted.

Unanimously approved

3.3 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board Retreat on December 7, 2013 be approved as submitted.

Unanimously approved

3.4 PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends the work of the San Francisco Night Ministry on its 50th year.

Unanimously approved

ITEM 4.0 PRESENTATION: NATIONAL ALLIANCE FOR MENTAL ILLNESS (NAMI), BAILEY WENZDEL

4.0 Presentation: National Alliance for Mental Illness (NAMI), Bailey Wendzel.

Ms. Wendzel's NAMI-SF presentation handout is at the end of the minutes.

Ms. Wendzel is Program Coordinator at the National Alliance on Mental Illness (NAMI-SF) and is a new board member. She said NAMI is the largest grass roots mental health organization in the US. In the US general population, statistically, about 25% live with some form of mental illness, and a mission of NAMI is to improve the quality of life for people with mental illness.

In San Francisco, NAMI reaches out to Bayview and Visitacion Valley areas. Expanding educational training programs in mental health and substance use disorder to peers, family and providers, NAMI just started four months ago with language capability in Cantonese and Spanish. NAMI training programs are always conducted in pair of presenters. Mental Health Board member Virginia Lewis has led therapeutic sessions for NAMI.

Fundraising from the annual NAMI walk, other fundraising events and grants support NAMI training programs from Family-to-Family, Peer-to-Peer, In Our Own Voice (IOOV), Parents & Teachers as Allies, Ending the Silence to Provider Education programs.

In a five week course offering cultural perspectives from family members, consumers, for example, Provider Education targets doctors, nurses and healthcare providers. Parents & Teachers as Allies is training in two hours for teachers and parents to better understand early warning signs of mental illness in children & adolescents.

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.

She introduced Dr. David Elliott Lewis to talk about In Our Own Voice (IOOV).

Dr. David Elliott Lewis explained that In Your Own Voice is a two-speaker presentation. He believed the program provides self-empowerment and self-validation in recovery, because presenters speak about personal challenges and struggles and put a human face to the illness. IOOV is an opportunity for personal growth, because participants reflect back their dark periods without reliving the trauma, appreciate support from the community in their personal progress of recovery and can feel hopeful about their future for themselves, their families and friends.

He recounted that in his childhood years he grew up with a stay-at-home mother and perceived that people with mental illness could just simply “snap out of it.” But, in actuality, as an adult in his 40’s his debilitating depression and panic attacks were triggered by several tragic events that happened over a short time span -- his grief over the loss of his parents in a relatively short period of time, the ending of his long-term marriage, and the bankruptcy of his business.

But, he shared that his recovery has been a multi-faceted one. He received therapeutic help in San Francisco’s community based behavioral services and programs. In his early recovery process, he got weekly therapy. For him, the path to recovery has been progressively getting better.

In Your Own Voice is very therapeutic because he has been able to pull himself out of his own inner dark world. He believes that many people under-appreciate the therapeutic value of recovery, resiliency and perseverance. He joined the board as a mental health advocate to change social attitudes and to help eliminate the stigma of mental illness and the discrimination of people with mental illness.

Ms. Wendzel said the Peer-to-Peer program teaches coping skills and people living with mental illness relate well to peers, because peers get it without further explanations. The mentorship helps people transition into the workforce and to live a productive life. Participants in the training get a binder of materials and leave with an Advanced Care Directive for Mental Health and a relapse prevention plan. After completing the program, there is also follow up with students. There is also assessment before and after completing the training. NAMI currently runs four trainings to June 2014 at several CBHS clinics.

The Family to Family program is a great one when a family member can get family training simultaneously as a loved one receives peer training to learn about coping skills and self-care. When family is involved in their love one’s treatment, the outcome is better for the whole family. About two-thirds of graduates of both trainings go on to become teachers themselves. The programs are recognized and listed on national evidence based lists of best practices.

Mr. Wishom commented that the San Francisco NAMI is a great program. He has participated in NAMI annual fundraising walks for several years. He is NAMI-SF certified and for two years, he

did about 15 In Your Own Voice speaking engagements at high schools, San Francisco General Hospital and other organizations.

Dr. Patterson wondered if there is range of trainings in surrounding communities.

Ms. Wendzel said Family to Family and Peer to Peer trainings are generally offered in many local NAMI chapters. But other trainings like In Your Own Voice, Parents & Teachers as Allies, Ending the Silence and Provider Education programs are not so common elsewhere.

Ms. James shared that she felt validated in her recovery because she does not feel that she is going through the recovery alone. She felt that a mindfulness practice has helped her grow personally.

Dr. David Elliott Lewis said that NAMI collaborates with other community programs as training partners.

Ms. Wendzel said Peer-to-Peer training takes place inside a clinic. Family-to-Family trainings are done outside of a clinic, after business hours and on weekends. The participating clinics are the Ocean Mission Ingleside (OMI), the Sunset, Mission and South of Market.

Ms. Robinson commented that NAMI San Francisco received some MHSA funding.

Mr. Vinh asked the time duration for the Peer to Peer program.

Ms. Wendzel said the program is 10 weeks long with meetings once a week on the same weekday at same time.

Dr. David Elliott Lewis remarked that it is great to see that family and consumers have aligned themselves on the same side, which has not always been the case before.

4.2 Public Comment

Mr. Gresser participates in Peer-to-Peer and Vocational Services and asked about class size.

Ms. Wendzel said the average size is 15-20 participants with a pair of instructors. The small setting with low instructor-to-student ratio is very conducive.

A public member asked about the choice of word of “illness” in the NAMI acronym, rather than the word “health” which sounds less stigmatizing.

Ms. Wendzel said the acronym was founded during the 1970’s and the terminology of “illness” itself can be very stigmatizing in the 21st Century. She believed the word “health” should replace the word “illness” since health is a lot more positive.

Ms. Bohrer shared that she came from Maryland and has been a member of NAMI since 1976. She explained that since the early founders of NAMI were made up of concerned parents who were

seeking care for their children, they felt the word “illness” best characterized their children’s symptoms. Thus the word “illness” was adopted into the acronym.

ITEM 5.0 REPORTS

For discussion

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

Ms. Brooke made the following announcements

- January 22nd and 29th, 2014 are Constant Contact’s social media trainings at the San Francisco Library in the Civic Center.
- January 23rd, 2014 is Understanding Trauma, and Attachment Theory and Trauma training at the California Endowment Conference Center in Oakland.
- February 6th, 2014 is Psychophysiology of Trauma training at the California Endowment Conference Center in Oakland.
- February 20th, 2014 is Trauma Informed Care training at the California Endowment Conference Center in Oakland.
- Board members who need to seek re-appointment to the board received their application packet in their envelope, except for Kara Chien who has already submitted hers.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Dr. David Elliott Lewis announced that the Executive Committee has changed its meeting time to the daytime. The next meeting is Thursday, January 16th, 2014 at 11:00 AM at 1380 Howard Street, Room 424. All board members as well as members of the public are welcome to attend.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Ms. Bohrer suggested recognition of Terry Byrne at MHA-SF for her Send a Card [to a hospitalized person with mental illness] project.

Dr. Patterson suggested Ms. Adrienne Williams from the Western Addition for her involvement in the Village project, which helps children traumatized by violence.

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

Mr. Vinh will attend the second workshop next week on crisis counseling for seniors who have a higher suicide rate than other age groups.

Dr. David Elliott Lewis announced that he plans to attend Health Commission meetings next week. He also wanted to attend a BOS meeting to address a 24/7 mobile mental health crisis outreach system for San Francisco.

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

Ms. James would like a presentation on senior suicides.

Mr. Wishom would like a presentation about wheel-chair bound people with mental illness trying to access services.

Ms. Chien suggested FSA's PREP program which is an early intervention and prevention of psychosis.

Dr. David Elliott Lewis would like a presentation from Behavioral Health Access Center (BHAC).

Ms. Bohrer suggested a workshop meeting processing data from the 2013 retreat.

Ms. Robinson suggested a presentation on Juvenile Justice Mental Health.

5.6 Public comment.

Public member wondered if a 24/7 mobile mental health crisis outreach is like having the former program in San Francisco called Spirit menders.

Public member would like discussion or a presentation in the new business section to include children and teenagers with mental illness. She was very disappointed when UCSF did not build a psychiatric care unit specifically for hospitalized children and teens.

Ms. Robinson said CBHS has a Child Family division for children and teens.

ITEM 6.0 PUBLIC COMMENT

No public comments.

ADJOURNMENT

Meeting adjourned at 8:25 PM.



**Advocates
for Change**
From Dialogue to Action



**2014
NATIONAL
CONVENTION**



NAMI
National Alliance on Mental Illness

San Francisco

Peer and Family Programs



- NAMI San Francisco offers an array of peer-education and support programs to help individuals living with mental illness and their families
- Our knowledge of mental health from the individual and the family member perspective plays a key role in the effectiveness of our programs

Program List

- Family-to-Family
- Peer-to-Peer
- In Our Own Voice
- Parents & Teachers as Allies
- Ending the Silence
- Provider Education

- Aim: presents a subjective view of family and consumer experiences with mental illness to providers
- 5-week course
- Teaching team consists of: 2 Family-to-Family teachers, 2 consumers, & a mental health professional who is also a family member or consumer



- Aim: educate school professionals to help them better understand early warning signs of mental illness in children & adolescents
- 2 hour in-service program
- Components:
 - Introduction (education professional/parent)
 - Early warning signs (facilitator)
 - Family response (parent)
 - Living with mental illness (consumer)



- Aim: give students the opportunity to learn about mental illness and how to seek help
- 50 minute presentation
- Delivered by two trained speakers
- Students are given resource card, information about youth support services, and parents are contacted

- Presentation about mental illness given by trained individuals living with mental illness
- Why peers?
 - Personal expertise
 - Sharing of journeys
 - Role models of hope
 - Stigma reduction
 - Personal growth



- Format:
 - 2 speakers
 - 5 part video (currently being remade)
 - 1 hour presentation
- Audiences:
 - Healthcare providers, staff, students, hospitals
 - Corporations, organizations
 - General public, NAMI meetings, Family-to-Family classes



- Designed for individuals living with mental illness
- Ten, 2 hour classes
- Taught by 2 trained Peer Mentors living in recovery themselves
- Offers comprehensive information on:
 - Biological bases of mental illness
 - Personal and interpersonal awareness
 - Coping skills
 - Self care
 - Recovery- current treatment strategies
 - Community resources

- Provides participants with two tangible products related to preventing and accommodating relapse:
 - Relapse Prevention Plan
 - Personalized Advance Directive for Mental Health Care Decision Making
- Studies have shown other positive outcomes:
 - Improved psychological and social adjustment
 - Increased security and self-esteem
 - Enhanced knowledge of early warning signs
 - Improved coping skills



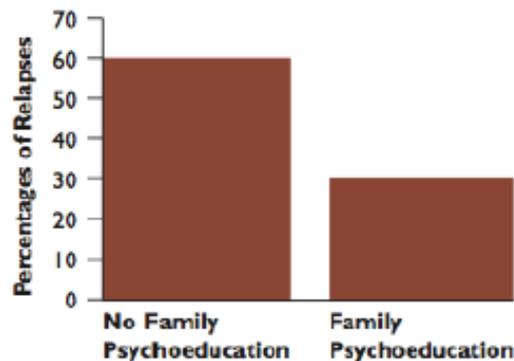
NAMI Family-to-Family

National Alliance on Mental Illness

- Designed for families, partners and friends of individuals living with mental illness
- Twelve, 2-3 hour classes
- Taught by 2 family members
- Provides concrete tools to improve coping and problem-solving skills
- Helps participants to better understand and support their loved one while maintaining their own well being

- Listed on the National Registry of Evidence-Based Programs and Practices
- Studies show when families participate in psychoeducation programs, their ill relatives experience fewer relapses and improved symptoms.

Relapse Rates for Patients with Schizophrenia



In a study of 895 patients, the average relapse rate is cut in half after families completed a Family psychoeducation course.

- Topics
 - Schizophrenia, Major Depression, Mania, Schizoaffective Disorder
 - Mood and Anxiety Disorders
 - Functions of key brain areas
 - Problem solving skills workshop
 - Medication review
 - Communication skills workshop
 - Resources
 - Advocacy

 **nAMI** On Campus 

National Alliance on Mental Illness

 **nAMI** Basics 
National Alliance on Mental Illness

 **nAMI** Walks 
National Alliance on Mental Illness

IT'S TIME. 

 **nAMI** Bikes 
National Alliance on Mental Illness *Fight Stigma & Ride!*

 **nAMI** Connection 
National Alliance on Mental Illness **RECOVERY SUPPORT GROUP**

 **nAMI** Hearts & Minds 
National Alliance on Mental Illness