



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board

Wednesday, June 12, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co Chair; David Elliott Lewis, Ph D, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Marlene Flores; Sgt. Kelly Kruger; and Errol Wishom.

BOARD MEMBERS ON LEAVE: Melody Daniel, MFT; Terence Patterson, EdD, ABPP; and Alphonse Vinh, MS; and Lena Miller, MSW.

BOARD MEMBERS ABSENT:

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Cary Martin, San Joaquin County Mental Health Board Member, President, California Association of Local Mental Health Boards and Commissions; Donna Martin, Vanae Tran; Wendy Yu; Martha Stein; Derrick Williams and two members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:45 PM.

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 highlighted the following items which are included in the June Director's report.

The final budget for the FY 2013-2014 was approved with Mayor Ed Lee restoring and/or backfilling most of the DPH (Department of Public Health) cuts. His actions mean there will not be any loss in services to clients or loss of jobs.

The Mayor would like to RFP (request for proposals) out as much as possible on non-revenue generating services, since subsidies for these services must be met with the City's General Funds.

DPH is moving forward with the 2014 Affordable Care Act (ACA), also known as the Obama Care Act. CBHS is consulting with HMA (Health Management Associates) and five committees were established to plan for the ACA implementation.

San Francisco Health is the new healthcare delivery system with new classifications and procedural changes. Mental health and substance abuse will be categorized as ambulatory care. Jail health services will be known as outpatient and special care services. Laguna Honda Hospital and the SFGH (San Francisco General Hospital) will be known as institutional care. This new healthcare delivery system will penalize the City if an individual is re-hospitalized within 30 days of a previous hospital discharge.

For example, the initial critical care is patient stabilization. Then recovery and supportive care is done through ambulatory care or a residential care.

She suggested the board should have an ACA presentation. Barbara Garcia has been planning several stake holder meetings to address changes resulting from the ACA.

Mental health and substance abuse are still being carved out. The services are funded by special financial resources from the State of California and mental health plans rather than through the City's General Funds.

She believed behavioral health will move towards managed care, integrating with mental health, substance abuse and primary care. The next three months is a serious planning period. This coming October is the start of the health insurance renewal process, and San Francisco's healthcare delivery must be up and running by January 2014. The department anticipates the initial transition period to be challenging; but they hope clients/patients will get used to the new system quickly.

Ms. Virginia Lewis asked how health insurance exchanges of the ACA works.

Ms. Robinson explained that consumers can just think of ACA's health insurance exchanges as a State or Federal online marketplace offering private insurance -- just as travelers can choose their travel itinerary through online travel companies like Kayak, Priceline or Travelocity.

Mr. Joseph asked about specialized healthcare homes for home-bound clients with severe mental health needs.

Ms. Robinson said that for mentally ill people who are uncomfortable at going to their primary doctor for care, they can get their care at more than 30 Medical Homes, most of which are clinics.

Dr. David Elliott Lewis asked if money will be saved under the Mayor's Office requirement to RFP out services.

Ms. Robinson said money will be saved. The Mayor's Office wants DPH to reduce the amount of these financial contracts. If the current rate is allowed to continue, then in five years DPH would be running a \$1.5 billion in deficit.

Ms. Virginia Lewis asked for clarification on revenue generating services.

Ms. Robinson said MediCal reimbursements are revenue generating services. But healthcare services in ADUs (Acute Diversion Units) are reimbursed at lower rates by MediCal.

A way to save money is for MediCal patients/clients in non-acute beds to be transferred to lower services so they would be no longer considered non-acute by MediCal. MediCal does not reimburse the following services: acute diversion, out-patient care, substance abuse residential care, group services and board and care services

Under the ACA, immigration status and income will determine a client/patient qualification. Since San Francisco is a sanctuary city, ineligible ACA consumers will continue to receive care, even though the City cannot bill for reimbursement. In essence, San Francisco has great services but also most costly based on our data and outcomes.

Monthly Director's Report June 2013

1. A new Suicide Attempt Survivor Support Group in San Francisco

The Mental Health Association of San Francisco (www.mentalhealthsf.org) and the San Francisco Suicide Prevention Center (www.sfsuicide.org) have created a customized group specifically for individuals who are suicide attempt survivors. This group will be clinically guided by supervised peer leaders, will utilize the Wellness Recovery Action Plan (WRAP) curriculum and will occur weekly for 12 weeks. For full details contact Jennifer Awa at the Mental Health Association of San Francisco at (415) 341-9507 or jenn@mentalhealthsf.org.

2. Strengthening Families Program

Strengthening Families Program for Parents & Teens

Ages 12-14

For more information contact: julia.barboza@bayviewci.org

(See attachment 1)

3. Transgender Wellness and Recovery RAP Group

R is for Respect, A is for Answers, and P is for Positive Journeys

Starting Dates: June 11th and June 25th / and every 2nd and 4th Tuesday of every Month

Time: 12:45pm – 1:45pm

Where: BHAC Conference Room on the first floor of 1380 Howard Street

Facilitators: Jamie Armstrong / Annette Quiett

4. New Binge Drinking Intervention Available

(See attachment 2)

5. CDC Issues Comprehensive Report on Children's Mental Health

A new Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) Supplement finds that between 13% and 20% of American children live with depression, anxiety, ADHD, autism spectrum disorders, Tourette syndrome, and a host of other mental health issues. (ADHD is the most common diagnosis, followed by behavioral and conduct problems). The total annual cost of this prevalence of mental illness is about \$247 billion a year. Compiling information from various data sources covering 2005-2011, the MMWR Supplement is the first-ever report to describe federal efforts to monitor mental disorders, as well as to offer estimates of the number of children aged 3-17 years with specific mental disorders. According to the report, up to one in five U.S. children experiences a mental disorder each year. Attention-deficit/hyperactivity disorder (AD/HD) is the most prevalent diagnosis, and suicide, which can result from the interaction of mental disorders and other factors, was the second-leading cause of death among adolescents in 2010. "This report is an important step to better understand children's mental disorders, identify gaps in data, and develop public health strategies to protect and promote children's mental health, so children can reach their full potential in life," according to a CDC news release.

6. Hepatitis C Management Presentation

Date: Thursday, June 20, 2013

Time: 8:30am – 12:00pm

For more information or to register, go to <http://tinyurl.com/HepCJune2013>

(See attachment 3)

7. Save the Date – Clinical Care for Transgender People

Beyond the Basics: Clinical Care for Transgender People

Date: October 1, 2013

Time: 9:00am - 5:00pm

For more information contact: julie.graham@sfdph.org

(See attachment 4)

8. Diane Prentiss to Serve as an Expert

Our own Diane Prentiss has been invited by the California Institute for Mental Health to join a panel of national experts that will guide and inform changes. These changes will be pursued in a learning collaborative designed to improve recovery outcomes of individuals with serious mental illness. The collaborative will help mental health programs to make fundamental changes that promote recovery for individuals with serious mental illness. The program changes will help people to develop meaningful, self-directed lives in their communities with a focus on improved health, housing, purpose in daily life, and relationships in their community. Thank you Diane for all the work that

you do that helps promote recovery for individuals with serious mental illness. We are honored to have you represent San Francisco.

9. A New State of Mind: Ending the Stigma of Mental Illness

A New State of Mind: Ending the Stigma of Mental Illness is a documentary that aired on PBS May 30, 2013. Narrated by Glenn Close, this film tells the stories of everyday people through their struggles, recovery and resilience in the face of mental health challenges. It shines a light on the far-reaching effects of stigma related to mental illness. This documentary can be viewed at EachMindMatters.org.

10. Katie A. – San Francisco’s Plan

On March 4th and 5th a San Francisco Stakeholders group was assembled for a two-day summit, which involved system of care partners, community based organizations and peer families. Specific gaps were identified by the stakeholders with respect to: the availability of timely services for all foster-care youth; the capacity of the assessment process to reach all youth particularly those placed out of county; the quality and consistency of the services provided; and the involvement of youth and family at the policy and decision making level.

The group agreed on an AIM for Katie A. redesign:

Design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency and well-being of children, youth and families that have been involved in or at risk of involvement in Foster Care, Probation, Special Education and are struggling with the complications of behavioral health issues. The goal is to design a system that will serve the Katie A. and non-Katie A. children and families alike.

San Francisco plans to make significant enhancements to our current system of care. We will incorporate CPM, CFT, ICC, and IHB processes into all aspects of our service delivery system focusing on engaging children, youth and families from their first contact with the system and involving them in all aspects of their care. The SF plan involves building on our existing system by increasing our capacity to screen and assess, improve our quality and increase our coordinated care and in home capacity. We will work with providers and civil service clinics to develop and measure effective models to deliver these services.

With this large systems change goal in mind, San Francisco is well positioned to meet the specific needs of the class of children included in the Katie A. lawsuit. In 1996 San Francisco Community Behavioral Health and the Department of Human Services collaborated to create Foster Care Mental Health (FCMH). For seventeen years this program has assessed for medical necessity, authorized services and served the mental health needs of dependent children, youth and their families.

The service plan outlined below builds on this successful program by augmenting the assessment, treatment, quality and the available network for services. This redesign will increase coordination between mental health, social services and other agencies needed for individual children/youth and their families. It will assure comprehensive services are provided on a timely basis, and support

community-based delivery of those services. Improving the reach and effectiveness of FCMH will insure that the entire Katie A. class is served, as well as increase our focus on reaching foster care and at risk youth earlier in their involvement with social services with effective and comprehensive services. The Katie A. has been identified effectively in the context of a multiagency triage process referred as the Multi Agency Service Team (MAST), which began in 2009. Specific gaps were identified by the stakeholders with respect to; the availability of timely services for all foster-care youth; the capacity of the assessment process to reach all youth particularly those placed out of county; the quality and consistency of the services provided; and the involvement of youth and family at the policy, training and decision making level.

11. Substance Use Disorder

Two trainings related to opioid use and opioid use disorders were held in May. Both courses were star-studded with DPH faculty across disciplines and departments. On May 2nd was 'Pain Day', which drew over 300 participants from primary care and mental health clinics. This training, sponsored by the San Francisco Health Plan, focused on safety in use of opiates for chronic pain, and included speakers who addressed how to choose safe dose levels for patients who have pain, how to evaluate progress in treatment, how to taper off opioids, how to address addictive behaviors in patients who have pain, and included practice in motivational interview techniques. The day ended with clinic groups choosing improvement projects related to their pain treatment panels.

On May 15th, CBHS held an 8 - hour training on use of buprenorphine in office-based treatment of opioid dependence open to all DPH physicians. Out of those who attended, 27 physicians sent in notification of intent to prescribe buprenorphine, qualifying them for the federal waiver that enables buprenorphine use for addiction. Nurse practitioners also attended this training. Drug counseling, pharmacy and nursing were represented on the faculty, and Ramon Lacayo and Norman Aleman were in charge of logistics. One of the highlights of this course was a consumer advocate speaker, who was eloquent on how buprenorphine treatment at CBHS OBIC had helped her with her pain and her addiction.

12. Problem-Solving Courts

The San Francisco Superior Court has operated problem-solving courts (also known as collaborative courts) for almost two decades. Along with governmental (the Department of Public Health has been an active partner) and community-based partners, the courts strive to increase public safety by providing high quality, evidence-based services. Over the past 20 years, thousands of court-involved community members have participated in our programs and turned their lives around. To chronicle San Francisco's problem-solving courts, emerging trends in collaborative justice, and relevant news and research, the Court created a blog: [Moving Justice Forward](#).

We invite you to follow [Moving Justice Forward](#) and learn more about the problem-solving courts currently operating at the San Francisco Superior Court. Submit your email address by using the "Follow By Email" feature (upper right-hand corner of the homepage) to receive email updates whenever a new post is added to the blog. Please contact Lisa Lightman, Director of Collaborative Courts, if you have any questions.

13. Call for State Action – Andrea Shilton, CiMH

As some of you may have read, Senator Darrell Steinberg has released a “Call for State Action” regarding an increased investment in mental health services. I am attaching the proposal to this email. Late last week, more details of the proposal were released (see the attachment entitled “SBFR Handout for Investment in Mental Health Wellness”) but budget trailer bill language is not yet available. Consequently, the Pro Tem has additional time to finalize actual legislative language to implement the program. We do know the stated key objectives of the proposal are as follows:

- Add 25 Mobile Crisis Support Teams and at least 2,000 Crisis Stabilization and Crisis Residential Treatment beds over the next two years to expand community-based resources and capacity. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders.
- Add at least 600 triage personnel over the next two years to specifically assist several thousand high-need individuals to access medical, specialty mental health care, alcohol and drug treatment, social, educational and other services.
- Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and access to timely assistance.
- Reduce recidivism and mitigate unnecessary expenditures for local law enforcement.
- Emphasize early intervention and treatment to achieve recovery and reduce costs.
- Maximize federal funding opportunities, local realignment dollars, Proposition 63 Mental Health Services Act Funds (MHSA), foundation grant funds, and State General Fund monies.

Funding for the proposal would include \$142.5 million one-time state general funds; \$38.9 million MHSA state administration funds (largely from raising the current 3.5% administration cap back to its original 5%); and \$24.8 million federal funds.

Please pay particular attention to the line item in the Senate Budget and Fiscal Review attachment regarding *Peer Support Crisis Training*. The proposal would provide \$2 million in the area of training on topics such as crisis management, suicide prevention, recovery planning, targeted case management and related functions, and to facilitate employment of peer support classifications. The Office of Statewide Health Planning and Development (OSHPD) staff reported on this proposal to their Board of Trustees today, and indicated that they potentially would be administering these funds.

As more detail becomes available about this particular piece of the proposal, I will provide all of you with the statutory language and information (which could be as early as next week).

(See attachments 5 & 6).

14. California State University Launches On-Campus Programs for Veterans

The California State University system has launched a series of programs that serve veterans and help them achieve their new mission: obtaining a degree. Each campus has established a Veterans Resource Center to support veteran students. Trainings improve recognition of emotional distress

among veterans, and promote suicide prevention strategies for this population. Contact Ana Aguayo-Bryant at aaguayo@calstate.edu for more information.

15. Mental Health Loan Assumption Program

Receive up to \$10,000 in educational loan repayments.

Application deadline: October 1, 2013

For more information go to www.healthprofessions.ca.gov

(See attachment 7)

16. Collaborative Documentation – a Tool that Benefits Both Client and Staff

“When you write what I say, I feel heard, and I like knowing what goes in my chart.”

Several counties and states have been changing the way in which they document the session’s content; it is called Collaborative Documentation. This type of documentation is a joint effort between a client and the service provider. The documentation is done in real time in the presence of the client and with the participation of the client. As clinical tool, it offers clients the opportunity to provide input and perspective on services and progress. It allows both the clinician and the client to clarify their understanding of important issues and goals. This process involves incorporating an active discussion at the end of the encounter and documenting the information into the EMR.

When the client’s hand touches the door to leave the session, the documentation is complete. Collaborative Documentation is an appropriate extension of the therapeutic interaction that serves to focus the client on what just occurred in the session as well as their next steps in the process of their treatment/recovery. This type of documentation is reported to save an average of 6 – 9 hours per week in post-session documentation time.

A recent survey of clients showed that 81% (national average) found Collaborative Documentation to be helpful. They reported feeling validated -- what they say is “important”.

Community Behavioral Health Services is beginning to look at Collaborative Documentation. We will be asking for a few voluntary clinics that will learn with us as we begin this exploration. If you are interested, please contact Diane Prentiss (Diane.Prentiss@sfdph.org).

17. Transitioning to Primary Care

OMI Family Center has identified patient transitions to primary care as an important goal in a patient’s wellness and recovery. To do this, we must focus on the possibility for the client to “graduate” from CBHS from the beginning of their treatment. However, transitioning our stabilized clients to primary care is a challenge for CBHS clinics. Barriers that are often faced by our CBHS providers are: clients without linkage to a primary care physician, a client’s attachment to their CBHS clinic, the provider’s attachment to their clients, and finally, the primary care provider’s; hesitation, uneasiness with our client population, and fear of a client’s decompensation, just to name a few. Regardless of these barriers, we don’t want our clients to only identify themselves as mental health patients, instead we want them to focus on their strengths and road to recovery. To address some of these barriers, OMI Family Center has modified some of its clinic procedures.

OMI is currently changing its intake procedure for new clients to incorporate recovery as a goal for all patients. As a result, linkage to primary care will be a focus during the initial treatment sessions, rather than focused at the end stages of their treatment. This allows for both client and primary care provider to learn about one another, and to develop a comfortable relationship.

OMI's clinical pharmacist, Betsy Yuan PharmD, has developed a transition letter to send to primary care physicians that include pertinent information, such as: the client's DSM diagnosis, frequency of medication management appointments, frequency of therapy appointments, medication regimen, and recommended medication monitoring. The letter also indicates that the client has reached their treatment goals, extra refills of medications will be provided for a few months, and that the client's case will be left open for a year, in case the client needs to be seen again at OMI or the primary care provider needs to speak to the client's former specialist.

Over the past couple of years OMI's clinical pharmacist has had successful case transfers to primary care without any resistance from the primary care office or provider. As a result, OMI intends to formally integrate the clinical pharmacist into the final stages of a client's treatment. During this stage before "graduation", the clinical pharmacist also has the opportunity to fine tune and simplify a patient's medication regimen and empower the client with tools to improve their own treatment. Just one example, the pharmacist will review with clients the different methods to ensure they have medication refills in advance and ways to improve medication adherence. These final steps help to further prepare the client as they simultaneously step-up to a higher stage of recovery and step down to a lower intensity of mental health care. Thus, the services provided by the clinical pharmacist at OMI are an essential part to the patient's wellness, recovery and successful reintegration back into the community.

18. Journal of Public Health Devotes Entire May Issue to Mental Health Stigma - Pat Ryan, CMHDA

For the first time, the prestigious *American Journal of Public Health* (AJPH) devoted an entire issue in to the problem of mental illness stigma, framing it as a public health problem. The journal's May issue was several years in the making, thanks to hard work not only by the authors of the published papers and the *AJPH* staff, but by staff at the Carter Center and the Centers for Disease Control and Prevention (CDC). Several of the people involved in the effort, as well as those who have made great strides fighting stigma, celebrated the issue's launching at the Carter Center in Atlanta April 18. They included former First Lady Rosalynn Carter; Thomas Bornemann, Ed.D., director of the Carter Center Mental Health Program; Wayne Giles, M.D., director of the Division of Population Health at the CDC; Benjamin Druss, M.D., Rosalynn Carter, Chair of Mental Health at Emory University; Wayne Clark, PhD and Stephanie Welch, MSW, from the California Mental Health Services Authority (*CalMHSA*); and former member of Congress Tony Coelho, a major sponsor of the 1990 Americans With Disabilities Act. Stigma is scrutinized from many different vantage points in the new issue. One project entails identifying and eliminating existing laws, policies, and practices that result in discrimination against the mentally ill. Another project focuses on educating elementary school children about mental illness. Yet a third tries to remove scurrilous messages about people with mental illness from Spanish-language media. Of special note, CalMHSA's Stephanie Welch, MSW and Wayne Clark, PhD report in their article that California's 2004 Mental

Health Services Act (MHSA) is not only funding mental illness prevention and early-intervention strategies, but projects aimed at reducing mental illness stigma as well.

The special stigma issue received funding from the Carter Center, the CDC, and the Substance Abuse and Mental Health Services Administration. The issue can be accessed at <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1695389>.

19. Obama, Biden Headline White House-sponsored Conference on Mental Health- Pat Ryan, CMHDA

On Monday, National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) Executive Director Ron Manderscheid was among those invited to the White House for the invitational National Conference on Mental Health hosted by President Obama and Vice President Biden. The event brought together people from across the country, including Capitol Hill leaders, mental health advocates, healthcare providers, representatives from state and local governments, educators, faith leaders, and individuals who have struggled with mental health problems “to discuss how we can all work together to reduce stigma and help the millions of Americans struggling with mental health problems recognize the importance of reaching out for assistance,” according to the White House. The president provided extensive remarks about the importance of bringing mental health issues out of the shadows, and eliminating the stigma that too often discourages people from seeking help. “The main goal of this conference is not to start a conversation -- so many of you have spent decades waging long and lonely battles to be heard. Instead, it’s about elevating that conversation to a national level and bringing mental illness out of the shadows. We want to let people living with mental health challenges know that they are not alone, and we’ve got to be making sure that we’re committed to support those fellow Americans, because struggling with a mental illness or caring for someone who does can be isolating. And I think everybody here who’s experienced the issue in one way or another understands that. It begins to feel as if not only are you alone, but that you shouldn’t burden others with the challenge and the darkness, day in, day out -- what some call a cloud that you just can’t seem to escape -- begins to close in.”

The national “Call to Action to Create Community Solutions on Mental Health” will include an ongoing national dialogue to be co-chaired by Health and Human Services Secretary Kathleen Sebelius and Education Secretary Arne Duncan. The Administration has launched a website at www.mentalhealth.gov to provide a single portal for information and resources for the national dialogue. With the tag line of “Let’s Talk About It,” the site includes information for consumers, educators, and others. The Department of Veterans Affairs has also announced plans to convene local mental health summits with community partners to help address the needs of veterans and their families. Finally, a California “Call to Action” forum has been scheduled for Saturday, July 20, from 9:30 am to 3:30 pm in Sacramento at the Sacramento Convention Center (1400 J Street). To register, go to www.creatingcommunitysolutions.org and click on the Sacramento button on the map.

20. Wellness and Recovery – Gloria Frederico, MFT

Opportunities for Wellness and Recovery can happen at any time. It is often these unexpected moments of kindness that can have the greatest impact on our clients. I would like to share with you one such moment that I learned about while attending the OMI Family Center Staff Retreat.

The purpose of the retreat was to introduce the strengths based treatment and wellness and recovery best practices that were learned during Team OMI's participation in the Advancing Recovery Practices learning collaborative sponsored by California Institute of Mental Health.

The Staff Meetings at OMI Family Center start with the leadership team asking staff to share any recent client successes or even recent successes in their own life. Each and every success reported is met with enthusiastic applause. Success stories were shared by clinical staff, medical staff and even one from the Deputy Sheriff. It is Deputy OT Cotton's which I will share with you now.

Deputy Cotton has been stationed at OMI Family Center for fourteen years. His desk is located next to the waiting area where children and teenagers wait until they are seen by their treating clinician. Deputy Cotton observed a 12 year old boy who often sat with his face covered and ignored any attempts at engagement by clerical or clinical staff. Deputy Cotton observed this behavior for many weeks until finally he asked the boy to please sit up straight and to answer questions when addressed by staff.

Deputy Cotton then began to ask the boy how he was doing in school and if he liked video games. A conversation ensued and a relationship was formed. It eventually came out that this youth was at risk of not graduating from the eighth grade. After checking with the boy's father, Deputy Cotton made the boy a deal: If he could get a grade "C" or better in all of his classes then Deputy Cotton would bring him in a video game at the end of the year.

Many months passed and the changes that were occurring within the boy could be seen by all. The young boy was sitting up straight, with no hoodie covering his face, and was engaging in conversation with Deputy Cotton and other staff who sat nearby. The transformation was slow but steady.

In early June this young man came to the clinic with his diploma in hand. He asked if Deputy Cotton could please make a copy of his Diploma. A copy was made and then the young boy said, "You forgot a very important person." Deputy Cotton said, "I did. Who?" The young man responded, "You."

When Deputy Cotton shared this story there was not a dry eye in the room.

21. NAMI California is looking for Ending the Silence Presenters

NAMI California is seeking presenters to participate in an educational program designed for high school audiences. Through a PowerPoint, short videos, and personal testimony, students learn symptoms and indicators of mental illness, as well as how to help themselves or others who may be in need of support. Young adults (18-29) with lived experience are particularly encouraged to apply. Upcoming two-hour webinar trainings will be offered on June 12th and June 27th. If you are interested, please contact Beth Larkins at beth.larkins@namicalifornia.org.

22. MHSA Annual Report

San Francisco Mental Health Services Act Annual Report for FY 2012/2013 is now available to review and comment on the SF DPH website at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/mnu30-DayNotice.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 Fiscal Year 2012-2013 Annual Report for a period of 30 days from June 11, 2013 to July 10, 2012. This 30-day stakeholder review and comment is in fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848.

Please email your comments to Marlo.Simmons@sfdph.org or send by mail to:

Community Behavioral Health Services Mental Health Services Act
1380 Howard Street, Room 210b
San Francisco, CA 94103

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

1.2 Public Comment

No public comment.

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

Ms. Robinson said the MHSA annual report is posted for a 30 day review prior to the Health commission meeting and the review by the Mental Health Board.

2.2 Public comment

Ms. Crystal wanted to know about health home care and services for San Francisco

Ms. Robinson said they are still researching right now.

ITEM 3.0 ACTION ITEMS

Mr. Joseph said, in addition to approval of minutes for the May Board Meeting, the board will be voting on a Budget Resolution proposed by the Executive Committee.

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of May 8, 2013 be approved as submitted.

Unanimously approved

3.3 PROPOSED RESOLUTION (MBH 2013 –03)

That the Mental Health Board thanks the Mayor and Board of Supervisors for supporting and recognizing the importance and value of mental health and substance abuse services in the 2013-14 Budget Allocations.

Unanimously approved

ITEM 4.0 PRESENTATION: MENTAL HEALTH BOARD ROLES AND RESPONSIBILITIES, CARY MARTIN, PRESIDENT, CALIFORNIA ASSOCIATION OF LOCAL MENTAL HEALTH BOARDS AND COMMISSIONS (CALMHBC)

Mr. Joseph introduced Cary Martin, President of the California Association of Local Mental Health Boards and Commissions for the State of California to give an overview of the roles and responsibilities of board members.

4.1: Presentation: Mental Health Board Roles and Responsibilities, Cary Martin, President, California Association of Local Mental Health Boards and Commissions (CALMHB/C)

Mr. Martin is currently Chair of the California Association of Local Mental Health Boards. In the 1960's, he lived in San Francisco and worked at Langley Porter, where he actively piloted several behavioral health programs.

He briefly talked about the history of mental health in California under Governor Ronald Reagan. During this time period, there were a couple of important tsunami changes in psychiatry. Not wanting to continue the mental hygiene movement, Governor Ronald Reagan vetoed important but necessary mental healthcare services and programs, and many Californians were adversely affected by these changes. Additionally, people with mental illness were de-institutionalized from hospitals without any care safety net. Suddenly, communities were seeing a big wave of people with mental illness in their communities. Also, homelessness became a huge problem. But Republican Senator

Milton Marx tried to stem the hemorrhage in mental health services and programs. He changed his votes to turn the tide and saved some behavioral health programs.

He said that prior to Governor Reagan the words hobos, winos and homelessness were not viewed with derision as they are today. Before the 1950's, these words elicited compassion. [*Probably, 1920's Depression Era, the Dust Bowl of the 1930s and the two World Wars, just about every family in America were personally touched either by tragedies, hardship and/or destitution.*]

He talked about mental health board duties and responsibilities. In the §5604.2 of the California Welfare and Institutional Codes (WICs), He said “the local mental health board shall do ...” review of the community's mental health needs, services, facilities and special problems.

Dr. David Elliott Lewis paraphrased that §5604.2 has a mandate for the Mental Health Board of San Francisco to perform program reviews annually.

Ms. Robinson stated that she found the board's summaries of program reviews to be very important and helpful.

Mr. Martin emphasized the importance of prevention as stated in the §5608 (e). He believed that if a client/patient received a mental health diagnosis then prevention has already failed. He personally believed that not enough is being done around prevention in many counties in California. MHSA would provide resources to meet unmet needs.

His second emphasis was § 5650. Local mental health boards are obligated to review contracts for services and programs as stated in §5650 (3) before the Board of Supervisors (BOS).

He believed that the board needs to advise directors about any aspect of mental health programs. For example, in January 2005 he traveled throughout the State of California to have dialogues with county leaders. He encouraged board members to look for ways to do outreach and keep constituents abreast of mental health related issues.

Ms. Bohrer asked about interaction among different counties' mental health boards.

Mr. Martin said there is some collaboration but not as much as he expected.

Ms. Bohrer asked if the majority of counties merged substance abuse and mental health boards together.

Mr. Martin replied that there has always been a division between mental health and substance abuse. He personally does not like the term behavioral health.

Dr. David Elliott Lewis asked why Mr. Martin does not like the words behavioral health

Mr. Martin explained the term behavioral health does not really capture the essence of mental health and substance abuse.

4.2 Public Comment

No public comments.

ITEM 5.0 REPORTS

For discussion

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

Ms. Brooke made the following announcements:

1. Beilenson Hearing on Tuesday, June 18th, 2013 at 3:00 pm at City Hall, Board of Supervisors chamber.
2. Very successful first forum on May 22nd, 2013 titled “Path To Wellness” with LaVaughn Kellum King facilitating the panel of Dr. Charles Wibbelsman, Chief of Adolescent Medicine for Kaiser, Dr. Emily De La Rosa, Clinical Social Worker for Kaiser, Jeff Steinberg, Founder of Sojourn to the Past, and Laurie Marshall of the Create Peace Project. The food was great and presentations fabulous. Virginia Lewis was there from the board. The next forum is July 17th, 2013.
3. Attachment Theory and Trauma Conference Thursday June 27th, 2013 in Oakland
4. Presentation of the Health Care Services Master Plan on Thursday, July 11th 2013 at 101 Grove, Room 300, at 4:00 pm
5. July 18, 2013 is Mental Health in the SF Bay Area by KTVU TV at 2 Jack London Square 1:15-4:00. Lunch will be served.
6. Consumer and Family Conference Friday, July 19th, 2013. Lunch will be served.
7. Issues to Action July 20th, 2013 6:15 – 8:30 pm

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

Mr. Joseph shared that Alyssa Landy is resigning her seat on the board due to conflicts with scheduling from her job.

Also, he invited board members to attend the next Executive Committee meeting on Thursday, June 20th at 6:30 at 1380 Howard Street, Room 515. All board members are welcome to attend the meeting as well as members of the public.

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.

Sgt Kruger nominated Cecile O’Connor and Dr. Melissa Nau at PES (Psychiatric Emergency Services.)

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

Ms. Virginia Lewis along with several other members from the Physicians Organizing Committee and San Francisco Cares visited Senator Leland Yee's office to discuss Sutter CPMC's breach of contract to provide psychiatric beds for San Francisco.

Dr. David Elliott Lewis also visited Senator Yee's office. He said that San Francisco Housing and Health Care Justice has been lobbying for Sutter CPMC to keep its promise. He believed that Sutter CPMC needs oversight transparency and penalties for any non-compliance.

Sgt Kruger mentioned that the next CIT (Crisis Intervention Training) training will be from June 17th to 20st, 2013 starting at 8 AM at the County Fair Building at 9th and Lincoln. She welcomed observation from board members, but requested board member to have no interaction with presenters.

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

Mr. Joseph announced that most board members attended the December 2013 Board Retreat and gave direction to the Executive Committee, but this item is a place where they can suggest things to the Executive Committee for future Mental Health Board meetings. He asked if there any members of the board who have any suggestions for the Executive Committee for future agenda items. He also reminded everyone that a brief statement describing the item is all that can be said, and there can be no board discussion on the new item, since it has not been noticed to the public yet.

Dr. David Elliott Lewis would like Colleen Chawla who is the Deputy Director of Health and Director of Policy and Planning of San Francisco Department of Public Health to come and talk about the Affordable Care Act.

5.6 Public comment.

Ms. Crystal talked about Family Service Agencies and a few others that are funded by MHSA. She proposed hearing about the Prevention & Recovery in Early Psychosis (PREP) program for adolescents.

Mr. Martin suggested a presentation with data to be interpreted to the Board of Supervisors.

ITEM 6.0 PUBLIC COMMENT

No public comments.

ADJOURNMENT

Meeting adjourned at 8:34 PM.

Cary Martin WIC document

5601. As used in this part:

(a) "Governing body" means the county board of supervisors or

boards of supervisors in the case of counties acting jointly; and in the case of a city, the city council or city councils acting jointly.

5602. The board of supervisors of every county,..... shall establish a community mental health service to cover the entire area of the county

5604. (a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members

Nothing in this section shall be construed to limit the ability of the governing body to increase the number of members above 15. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.

(2) Fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(b) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

(d) No member of the board or his or her spouse shall be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(e) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(g) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

5604.2. (a) The **local mental health board shall** do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director

as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients *and on the local community*.

5604.3. The board of supervisors may pay... necessary expenses...of their official duties and functions.-- include travel, lodging, child care, and meals.. approved by the director of local mental health program.

5604.5. The local mental health board shall develop bylaws to be approved by the governing body which shall:

(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.

(b) Ensure that the composition of the mental health board represents the demographics of the county as a whole, to the extent feasible.

(c) Establish that a quorum be one person more than one-half of the appointed members.

(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.

(e) Establish that there may be an executive committee of the mental health board.

5607. The local mental health services.. director.. appointed by.. governing body

5608. The local director of mental health services.. shall..

(c) Recommend to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable in accomplishing the purposes of this division.

(e) **Carry on studies** appropriate for the discharge of his or her **duties, including the control and prevention of mental disorders.**

(f) Possess authority to **enter into negotiations for contracts** or agreements for the purpose of providing mental health services in the county.

What are State Mental Health Planning and Advisory Councils?

In 1986, a [Federal law](#) was passed that required states to do mental health planning as a condition of receiving federal mental health funds. It further required that the planning process include various stakeholder groups-consumers of mental health services, parents of children with emotional disturbances, family members of adults with serious mental illness, representatives from State agencies: mental health, education, vocational rehabilitation, criminal justice, housing, social services and the state Medicaid agency as well as public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. U.S. States and Territories then formed these councils which now exist in every state.

What do these councils do?

The purpose of the planning councils in each State and Territory is to meaningfully involve concerned citizens in planning and evaluating the mental health service delivery in their states. Defined by Federal law, these councils:

- Review community mental health block grant plans and make recommendations to the State administration.
- Monitor, review and evaluate all mental health services throughout the State or Territory.
- Serve as advocates for adults with serious mental illnesses, children with severe emotional disturbances, and others with mental health needs.