



## SAN FRANCISCO MENTAL HEALTH BOARD

**Mayor Edwin Lee**

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Gene Porfido  
Richard Slota, MA  
Harriette Stallworth Stevens, EdD  
Marylyn L. Tesconi  
Njon Weinroth  
Idell Wilson  
Benny Wong, LCSW

### **ADOPTED MINUTES**

Mental Health Board Meeting  
Wednesday, **June 15**, 2016  
City Hall, 2<sup>nd</sup> Floor, Room 278  
One Carlton B. Goodlett Place  
San Francisco, CA  
6:30 PM – 8:30 PM

**BOARD MEMBERS PRESENT:** Kara Chien, JD, Chair; David Elliott Lewis, PhD, Secretary; Terry Bohrer, RN, MSW, CLNC; Wendy James; Angela Pon; Gene Porfido; Richard Slota, MA; Harriette Stevens, EdD; Marylyn Tesconi; Njon Weinroth; and Idell Wilson.

**BOARD MEMBERS ON LEAVE:** Ulash Thakore-Dunlap, MFT, Vice Chair; Virginia S. Lewis, MA, LCSW; Toni Parks; and Benny Wong, LCSW.

**BOARD MEMBERS ABSENT:** Supervisor Mark Farrell.

**OTHERS PRESENT:** Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Edwin Batongbacal, LCSW, Adult & Older-Adult Director; Denise Carver, Health Right 360; Judy Drummond; Susan Page, YMAP; Sharon Scottkish, MHA-SF; Michael Lukso; Dan Lee; and **six** additional members of the public.

### **CALL TO ORDER**

**Ms. Chien** called the meeting of the Mental Health Board to order at 6:40 PM.

In the aftermath of the June 12, 2016 Orlando massacre, she requested the board to have a moment of silence to voice solidarity with the grieving families and communities.

## **ROLL CALL**

**Ms. Brooke** called the roll.

**Ms. Chien** welcomed Marylyn Tesconi, appointed to a Family Member seat by the Board of Supervisors and Richard Slota, also appointed to a Family Member seat, but by Supervisor Eric Mar. She asked the new board members to share a little about themselves later in the meeting.

## **AGENDA CHANGES**

No changes.

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

**Ms. Chien** said “As you know, Jo Robinson has retired as the Director of Behavioral Health Services. The board will be involved in hiring her replacement.”

In the meantime, members of the Executive Team will take turns providing the Director’s Report to the board. I would like to introduce Edwin Batongbacal. He is the Director of Adults and Older Adults for Behavioral Health Services. He will give the report this month.

*The full director’s report (Attachment A) can be viewed at the end of the minutes or on the Internet*

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

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

**Mr. Batongbacal** highlighted the following items.

- The hiring of the new BHS director has been extended. The executive team wanted to broaden the pool of applicants, since there are only 11 applicants who have applied for the position.
- He shared that the San Francisco Department of Public Health (DPH) is very responsive to the kind of events like the 2016 Orlando nightclub shooting that killed 49 people and wounded 53 others in a terrorist attack. In less than 24 hours, DPH director Barbara Garcia swiftly responded to the hate crime with an urgent meeting on Monday to coordinate services and mobilize resources. Deploying trauma supportive services and safety programs, DPH has reached out to San Francisco’s communities, and the LGBTIQ community has been impacted the most.
- There were about 115 Assisted Outreach Treatment (AOT) engagements and 50% of clients were referred for AOT services and care.
- Medication Use Improvement Committee (MUIC) flyers in threshold languages were distributed to educate and empower patients to speak to their providers about medication side effects.

- He shared some performance objectives in behavioral health. For example, recent hospital discharged clients should not be readmitted within 30 days. Clients should link up to vocational services, because people with mental illness should live a meaningful quality of life.

**Ms. Chien** shared that she has seen improvement in crisis care and services in her court cases at the Public Defender's Office. When she has represented clients at the Behavioral Health Court (BHC). She has noticed that community providers and case managers are getting the message of a warm hand off transfer for clients transitioning to other services, to reduce further traumatizing clients.

**Dr. Stevens** asked about capacity of the AOT program.

**Mr. Batongbacal** said the capacity is fluid. On the AOT team, there are two peer outreach workers, a case manager and a citywide team to assist voluntary AOT clients.

**Ms. Chien** said that AOT provides transparent reporting on its internet site.

**Ms. Brooke** said she was reporting on behalf of Ms. Toni Parks who was unable to attend tonight's meeting. Ms. Parks mentioned that she was very impressed with AOT when she recently referred a person to AOT.

**Mr. Slota** thanked the leadership in DPH for their quick and thoughtful response to the Orlando massacre.

**Dr. David Elliott Lewis** asked about having a 24 hour crisis service for adults.

**Mr. Batongbacal** responded that the FY 2016-2017 budget submitted to the Mayor for approval included funding to support a 24 hours crisis program for adults.

## **1.2 Public Comment**

No public comments.

## **ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS**

### **2.1 Mental Health Services Act Updates:**

**Ms. Chien** said the search for the new MHSA director is still continuing.

**Mr. Batongbacal** said he had no updates.

### **2.2 Public Comment**

No public comments.

## **ITEM 3.0 ACTION ITEMS**

### **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 18, 2016 be approved as submitted.

[Unanimously approved.](#)

**3.3 Proposed Resolution:** Be it resolved the Mental Health Board of San Francisco advocates increased funding to provide 24-hour/7 days a week comprehensive mobile crisis intervention services for the people of San Francisco, commencing in Fiscal Year 2016-2017.

**Ms. Brooke** informed the board that Supervisor London Breed is completing the FY 2016-2017 budget and has included a 24x7 crisis response for adults. The supervisor requested the Mental Health Board to send her tonight's resolution.

**RESOLUTION (MHB 2016-04):** Be It Resolved the Mental Health Board of San Francisco advocates increased funding to provide 24-hour/7 days a week comprehensive mobile crisis intervention services for the people of San Francisco, commencing in Fiscal Year 2016-2017.

WHEREAS, the San Francisco Department of Public Health Behavioral Health Services has Comprehensive Crisis Services which consists of three teams, including the Crisis Response Team, the Child Crisis Team and the Mobile Crisis Treatment Team, and;

WHEREAS, in response to, and in following up with communities and families affected by homicides and critical shootings, the Crisis Response Team may go to the scene and/or hospitals to provide de-briefing and linkage care. After a homicide, the team may be involved in making funeral arrangements, including attending burial services, and;

WHEREAS, the Child Crisis Team performs assessments and intervention for children under the age of eighteen in homes, at police stations and in emergency departments, and is able to provide case management services for up to 30 days;

WHEREAS, the Mobile Crisis Treatment Team serves adults over the age of eighteen and provides response six days a week, Monday through Friday from 8:00 AM to 11:00 PM, Saturday and holidays from 12:00 noon to 8:00 PM, and;

WHEREAS, services are needed 24 hours a day, seven days a week to provide efficient and effective crisis intervention and crisis stabilization services thereby decreasing unnecessary use of Emergency Departments and admissions to hospitals, offering assistance to individuals who are homeless with behavioral health issues and providing immediate counselling to families in crisis, and;

WHEREAS, with increased Mobile Crisis Team staffing, the behavioral health personnel would be able to coordinate and collaborate more effectively with public safety personnel such as the Fire Department, Police Department, Sheriff's Department and BART officers, and;

WHEREAS, there is a need for 24 hour, seven days a week, Mobile Treatment Teams to provide effective community intervention, increasing diversion from jails and hospitals, and;

THEREFORE, BE IT RESOLVED that the Mental Health Board of San Francisco urges the Mayor and Board of Supervisors to allocate funds for the Department of Public Health, Behavioral Health Services for Crisis Mobile Treatment Teams 24 hours a day, seven days a week commencing in Fiscal Year 2016-2017.

[Unanimously approved.](#)

**ITEM 4.0 PRESENTATION: CHALLENGES AND BARRIERS TO CRISIS SERVICES, CECILE O’CONNOR, RN, FOUNDER AND FORMER DIRECTOR DORE URGENT CARE.**

**4.1 Presentation: Challenges And Barriers To Crisis Services, Cecile O’Connor, RN, Founder And Former Director Dore Urgent Care.**

**Ms. Chien** introduced Cecile O’Connor, formerly the founder and director of Dore Urgent Care and a presenter and leader in the new Crisis Intervention Training with the San Francisco Police Department. She will share from her years of experience working with our most vulnerable clients.

**Dr. David Elliott Lewis** said that he met Cecile O’Connor a few years ago at two MHB program reviews at Dore Urgent Care center, which is one of Progress Foundation’s many program.. During the program review process, he learned that Cecile O’Connor was the founder of Dore, which is a unique program in San Francisco for sub-acute care. When she left Dore recently in April 2016 which meant she is no longer contractually obligated to the San Francisco Behavioral Health System, he thought she would be a good presenter for board members to learn more about San Francisco behavioral health concerns, so board members may advocate about the issues.

**Ms. O’Connor** briefly shared her background. She has been a registered nurse for 40 years. She began her nursing in oncology and palliative care in Toronto, Canada. She then moved into behavioral healthcare about 27 years ago.

In 1990, she worked in the children and adolescent department of Ross Hospital in Marin; which was a private hospital that is now closed. After the hospital closure, she went on to work in Marin County jail as a nursing supervisor. There she met a police officer Joel Fay, who later became a psychologist to work with law enforcement personnel. When they realized the number of persons with behavioral health issues in the Marin jails, they collaborated, along with many others, to advocate for structural changes. Their disciplinary team came up with a revolutionary idea. The idea was to bring mental health services into Marin County jails. Unfortunately, like most other California counties during this period, there was a shortage in funding. Therefore, she began seeking new opportunities in behavioral healthcare.

She joined San Francisco Psychiatric Emergency Services (PES) at the San Francisco General Hospital. While spending four years as a night charge nurse, she felt disheartened when she saw how people with mental illness were being treated according to the medical system’s medical model.

Progress Foundation executives saw her passion and commitment in behavioral healthcare. She felt she could make a greater impact in the social rehabilitation model of Dore Urgent Care. The social rehabilitation model was revolutionary at the time and is still as of today. Social rehabilitation philosophy is wellness and recovery is a partnership between individuals and their providers. After seeing how much positive impact social rehabilitation has had on Dore clients, she felt the model could be replicated in other places, so she recently left Dore to become a social rehabilitation consultant in Oakland.

One of her main concerns is that psychiatric crisis care should not be based on the medical model, because the burden of proof for how bad a psychiatric crisis is often onerously placed on a client before a provider of the medical model would consider treatment. As a nurse she

understands the medical model very well; but approaching a crisis care with the medical model is ineffective.

The medical model does not recognize that psychiatric prevention is, itself, a treatment. She shared that after working at SFGH for about 15 years, the ER does not treat or approach a person in crisis emergency in a partnership way. ER nurses tend to be paralyzed and don't know what to do for the person in crisis. She emphasized that she is not anti hospital per se but she is anti the system.

She believes that there needs to be a different approach to help people in crisis when they arrive at the hospital. Statistically everyone at some point in their life has a high probability for experiencing a crisis. Since psychiatric crisis is self-defined, the partnership approach should be a common practice.

She suggested having a multi-disciplinarian team deploy in a recreational vehicle (RV) that offers mobile crisis care. Since prevention is treatment, clients can drop into an RV crisis clinic to talk about their concerns.

She suggested that crisis prevention should include normalizing mental health care. People need to be able to talk about mental health without the fear of shame and stigma. Emergency room doctors and nurses ought to be more familiar with crisis treatment, just as they would instinctively know to order blood, EKG tests for an ER patient with shortness of breath and chest pain, which are most likely symptoms of a heart attack or myocardial infarction.

At the state level, she suggested that the Center for MediCal and Medicare Services (CMS) needs to recognize the social rehabilitation model. This means medical coding needs to change for crisis care. For example, redefining the meaning for "what constitutes treatment." When a person in crisis is in a hospital, hospital admission should be not classified as observation status according to CMS.

Crisis Intervention Training (CIT) has three parts: law enforcement, advocacy and mental health. CIT training is based on the mental health partnership model. This model needs to expand to encourage early intervention. An opportunity for crisis engagement is necessary. For example, when she was at Dore, the number one concern for many clients in crisis was they just wanted someone to listen for some time; but "talk therapy" is not promoted in county healthcare clinics and programs. She believes talk therapy is not only important, but there should be more clinics and programs to provide talk therapy services. Sub-acute situations should not escalate into an emergency crisis that requires expensive emergency care.

She concluded her presentation by suggesting a two-prong approach. She would like to see alternatives to hospitalization include changing the general public attitude by normalizing mental health. For example, there is a lot of outpouring of support for a person who was diagnosed with cancer; but people seem not to know what to do for a kid going through an acute crisis. Or, when a person is hospitalized for a medical issue, sympathy cards are sent, but when a person is hospitalized for psychiatric care no get well cards are received.

Removing stigmatizing words such as "treatment resistance", "malingering" from the lexicon and treating people with respect and dignity are important. Furthermore, she believes there should be a systemic "curiosity" for what a person in crisis is experiencing rather than their crisis

pathology. Providers need to ask such thoughtful question as “How are you?”, “What do you need?” and/or “What would make you feel better?”

For example, there was a Dore client who went to PES at SFGH 37 times, and none of the PES clinicians ever asked the client “why she was in PES so many times?” Her philosophy is treating everyone well, meeting people where they are at, understanding what triggered the crisis, and stop labeling and judging them for their illness.

**Ms. Chien** shared that she has noticed the Department of Public Health is making positive changes. DPH has implemented AOT since November 2015 and Stigma Buster in the last few years.

She advocated that when patients go to a general practitioner for an annual checkup, doctors should do a wellbeing check as part of integrative healthcare services.

**Ms. O’Connor** shared that she is not against medications per se, but has seen clinicians rely on medications too much. She believes pharmaceutical companies should provide rehabilitative care to people who became addicted to their opioids.

**Dr. Stevens** asked what PES is.

**Ms. O’Connor** said PES is the Psychiatric Emergency Services department at SFGH. The department is licensed to have up to 18 clients; but frequently PES has as many as 30 people and must send people to an acute diversion unit (ADU) like Dore Urgent Care.

**Dr. Stevens** is concerned about situations where patient’s treatment history and medications become unavailable to them from another clinic, because there seemed to be no comprehensive approach and no one seems to know what is going on for this patient.

**Ms. O’Connor** shared that there is no one comprehensible record keeping system. In this fragmented record keeping system, there is no designated primary doctor that oversees a person’s care. There was a Dore client who was seen by five different doctors for different services like housing, transgender reassignment care, mental healthcare, physical care and methadone care.

Part of the problem is credentialing. We can streamline the process by having one designated system that provides a one-stop shop for crisis treatment so clients don’t have to go to different providers for services. Another part is payment for care should not require a psychiatric diagnosis, since a psychiatric diagnosis can be stigmatizing.

For example, when a young client became hysterical in a court proceeding because she did not understand what was happening to her, the police brought that client to Dore Urgent Care; Dore did intervention with talk therapy, and after three hours she calmed down and voluntarily left. That intervention should be constituted as treatment in the social rehabilitation model.

**Mr. Porfido** agreed that early intervention is good. He wanted to understand the process to get to PES and Dore.

**Ms. O’Connor** said since PES is overflows with capacity and must send patients to a diversion unit. Progress Foundation offers many programs with one diversion unit called Acute Diversion Unit (ADU) that can handle medical evaluation for PES. But an ADU can also accept clients referred by Dore Urgent Care. An ADU is allowed to bill the State up to 20 hours of services.

Dore's social rehabilitation offers multi-disciplinary teams of clinicians, nurses, nurse practitioners (NP) psychiatric technicians, and counselors. Although Dore is a residential treatment program, the environment of Dore is a non-hospital setting where medications can be given if the client wants them or if the client brought in their own medication. Dore staff do not wear uniforms. Rather than receiving care in a hospital formal environment, receiving care in a non-formal setting is very conducive to recovery and is less stigmatizing for people in crisis. Clients feel they are treated with respect for who they are rather than being treated based on their psychiatric diagnosis.

Rather than discharging crisis recovered clients right back into an environment that put them in crisis in the first place, the idea behind Dore is partnership giving clients some time in a safe space to help them find their own resolutions, instead of telling a client in crisis what to do. This means a Dore clinician would elicit information from a client in order to better understand the crisis through talk therapy. Then the Dore clinician helps the client figure out what services or program would meet the client's needs. For example, a client with a short trigger for PTSD may want help developing self-management skills to avoid triggers. So, having self reflection and learning to plan things that set a person to "win" are necessary skills. She feels the treatment modality should be 24 hours by 7 days and be comprehensive not just 50 minutes of talk therapy, because the essence of crisis de-escalation is management of oneself or behavioral health management.

**Dr. David Elliot Lewis** felt there is a lack of treatment in hospital settings and wanted to know more about best practices.

**Ms. O'Connor** said the in-patient therapy model has been around for over 50 years ago. The in-patient therapy model worked very well then because services were comprehensive and long enough in time duration. But CMS has shortened treatment time and treatment modalities. Another issue is financial concern which separates mental illness and substance abuse care.

**Mr. Batongbacal** shared that involuntary treatment is really a systemic oppression. So DPH believes that the wrap-around model is much more conducive for a person in crisis to engage fully in wellness and recovery.

**Ms. O'Connor** said nursing schools are not teaching students about asking for a patient's permission before making any examination. For example, someone in crisis may be very uncomfortable with unsolicited touching and probing, since the patient may already be in a fearful state and not feel safe and may interpret the clinical examination as an inappropriate act of crossing personal boundaries.

#### **4.2 Public comment**

**A Member of the Public** wondered about the economics for Dore's social rehabilitation model whether it is replicated in other places.

**Ms. O'Connor** said the problem is private hospitals won't share hard data. It is difficult to analyze for the economic efficiency.

#### **ITEM 5.0 REPORTS**

### **5.1 Report from the Executive Director of the Mental Health Board. Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects**

**Ms. Brooke** shared the following:

- Shared letter to Toni Parks and the advocacy she did regarding smoking in residential treatment programs as well as connecting with UCSF to provide smoke cessation workshops for residents.
- She arranged a meeting with the police officer from Seattle who created the Safe Place program for LGBT folks with police commissioner Sonia Melara, Lt. Peter Shields, Director of the Hate Crime unit for SFPD and Teresa Spark from the Human Rights Commission. David Elliott Lewis attended the meeting as well.

### **5.2 Report of the Chair of the Board and the Executive Committee.**

**Ms. Chien** mentioned that the next Executive Committee meeting is Tuesday, June 28th at 10:00 AM at 1380 Howard Street, Room 226. All board members as well as members of the public are welcome to attend.

The Annual Report will be presented at the meeting. Ms. Brooke has received my letter and a letter from Ms. Thakore-Dunlap for inclusion in the report. She suggested board members who want a letter from them to be included in the annual report, email it tonight when they get home. Otherwise it will not be included.

Toni Parks wanted to form the MHB Grievance Committee. This committee was formed at the May 2016 executive committee meeting.

She invited the new board members to share about themselves and their goals for being on the board.

**Ms. Tesconi** said she was interested in being appointed when she attended the Alliance for Girls event and saw a flyer. When her daughter was 17, she became suicidal and involved with substance abuse. To try to understand more about mental illness and substance use, she received her masters in mental health. She would like to see innovative treatments.

**Mr. Slota** said his 22 year old African American son is homeless. He joined the board so he can advocate better services for people who are homeless with mental illness.

He is also a Vietnam era vet. He has worked in mental health in Solano County to help people find and keep a job. He is a licensed career development counselor. He retired in 2015. He is a playwright. He has an MA from SFSU. His daughters live in Nigeria and Ghana.

### **5.3 People or Issues Highlighted by MHB: Suggestions of people and/or programs that the board believes should be acknowledged or highlighted by the Mental Health Board.**

[None recommended](#)

### **5.4 Report by members of the Board on their activities on behalf of the Board**

**Ms. Bohrer** did training in Berkeley. She will go to Ontario, Ca for further training.

**Dr. David Elliott Lewis** shared he went to the jail re-imagined project meeting. He and Ms. Bohrer attended the Crisis Intervention Training (CIT) Award Ceremony on Jun 2, 2016 which honored 15 SFPD officers.

**Ms. James** attended the MHSA Advisory meeting which tries to engage people into mental health care.

**Dr. Stevens** met with the Executive Director of the Senior & Disability Network (SDN) and would like to see a presentation from SDN.

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

None mentioned

#### **5.6 Public Comment**

No comments.

#### **6.0 PUBLIC COMMENT**

No comments.

#### **Adjournment**

Adjourned at: 8:45 PM

## **ATTACHMENT A**

### **MONTHLY DIRECTOR'S REPORT**

**June 2016**

#### **1. AOT FIRST ANNUAL REPORT**

Assisted Outpatient Treatment (AOT) was implemented November 2015. Our first annual report was submitted to the State Department of Mental Health and is now available to review on our webpage ([www.sfdph.org/aot](http://www.sfdph.org/aot)) under "Annual Report."

Of note, 48% of individuals outreached during the reporting cycle accepted voluntary services and 61% were successfully housed. As part of the review process, participants were asked to complete a confidential questionnaire. All of the participants indicated feeling "hopeful" about their future and the majority indicated positive perspectives on the approach to engagement from the AOT Care Team. Further, most family/support persons that completed an interview with the evaluation team reported feeling supported by staff and noted that they have an increased awareness of and access to effective resources in and out of California.

We look forward to continuing the program and providing updated information to the system of care. If you would like to learn more about AOT, please visit our webpage or call 415-255-3936.

#### **2. NEWS FROM THE PHARMACY – MUIC DEVELOPS FLYERS TO EDUCATE CLIENTS**

Over the past months, the Medication Use Improvement Committee (MUIC) developed several patient flyers aimed at educating clients about various MUIC initiatives. The flyers include information about anticholinergic medications, sedative-hypnotic medications and drug interactions. Early versions of the flyers were brought to client council meetings, after which they were modified based on the feedback received in those meetings. Pictured below, the aim of the flyers are to empower patients to speak to their providers about these medication concerns. They have been translated into the threshold languages- Chinese, Spanish, Tagalog, Vietnamese (Russian pending) and posted to the Community Behavioral Health Services public website.

We suggest posting the flyers in waiting rooms and patient care areas within the Behavioral Health Services clinics.

Links to the flyers:

<https://www.sfdph.org/dph/files/CBHSdocs/Anticholinergics-English.pdf>

<https://www.sfdph.org/dph/files/CBHSdocs/Sedative-Hypnotics-English.pdf>

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YOU MAY BE AT RISK FOR **MEMORY PROBLEMS** AND **INVOLUNTARY MOVEMENTS**

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**DO YOU TAKE ANY OF THESE MEDICATIONS**

Ativan (Lorazepam)	Restoril (Temazepam)
Ambien (Zolpidem)	Valium (Diazepam)
Klonopin (Clonazepam)	Xanax (Alprazolam)

YOU MAY BE AT RISK FOR SERIOUS HEALTH SIDE EFFECTS INCLUDING **FALLS** AND **MEMORY LOSS**

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### BUPRENORPHINE SAVES LIVES!



**BUT *NOT* IF YOU TAKE ANY OF THESE:**

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Klonopin (Clonazepam)	Restoril (Temazepam)
Valium (Diazepam)	Xanax (Alprazolam)

YOU MAY BE AT RISK FOR SERIOUS HEALTH SIDE EFFECTS INCLUDING **ACCIDENTAL DEATH**

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Talk to your medical provider or pharmacist today!



### METHADONE SAVES LIVES!



**BUT *NOT* IF YOU TAKE ANY OF THESE:**

Ativan (Lorazepam)	Ambien (Zolpidem)
Klonopin (Clonazepam)	Restoril (Temazepam)
Valium (Diazepam)	Xanax (Alprazolam)

YOU MAY BE AT RISK FOR SERIOUS HEALTH SIDE EFFECTS INCLUDING **ACCIDENTAL DEATH**

[Learn More](#)

Don't become a statistic  
Talk to your medical provider or pharmacist today!



### **3. MEDICINAL DRUMMING: AN ANCIENT AND MODERN DAY HEALING APPROACH**

Since 2013 Dr. Sal Nunez of City College of San Francisco has been implementing and evaluating an SFPD Mental Health Services Act-funded pilot project called the Medicinal Drumming Praxis project, where staff from San Francisco community based behavioral health agencies are trained in a culturally affirming wellness and recovery therapeutic methodology of *group drumming*. Staff learn and practice the skills needed to facilitate group drumming (at their own respective agencies), a therapeutic milieu that has demonstrated profound benefits for numbers of San Franciscans.

Dr. Sal Nunez's Medicinal Drumming Praxis project - along with his extensive experience in delivering medicinal drumming to communities – are highlighted in this month's (June 2016) NeuroQuantology under the title of Medicinal Drumming: An Ancient and Modern Day Healing Approach.

For more details, visit <http://www.neuroquantology.com/index.php/journal/article/view/939>.

### **4. CHILDREN, YOUTH AND FAMILIES (CYF)**

#### **Chinatown Child Development Center**

The Chinatown Child Development Center staff, former program director and community partner, Diana L. Wong, PsyD, LMFT, Nancy Lim-Yee, LCSW and Peter Ng, MD, respectively; met the clients and families at the festival family event and continue to annually support the Cameron House Carnival. Marking its 68th year, this year's 30 lucky CCDC participants (grandparents, parents and young children) enjoyed homemade sweets from the Cameron Bakery, watching Supervisor Aaron Peskin being "dunked" in their famous Dunko water game and also enjoyed complimentary relaxing therapeutic massages after a long day of fun! The carnival was started in the 1950's as a way for youth and young adults to develop a sense of service to the community. All proceeds from the festive event benefit the Donaldina Cameron House Youth Programs. The Chinatown Child Development Center has been supporting this wonderful cause for the past 10 years. Annually held on the 1st Saturday of May, rain or shine, volunteers are always welcome!

The Chinatown Child Development Center continues to be an integral component member of the steering committee for the API Health Parity Coalition. Agenda items of discussion from the most recent monthly meeting included reviewing the Community Health Improvement Plan (CHIP) and further discussing the Health Improvement Partnership (SF HIP). In addition, 7 health need areas were identified; with psychological health, healthy eating and safety/violence prevention cited as the top 3 areas of need/concern. CCDC continues to support identified needs of the community by engaging consumers to participate in structured focus groups as

needed. The API Health Parity Coalition general meeting is scheduled for June 23, 2016 at the Chinatown Child Development Center.

### **Mission Family Center**

May was a busy month for Mission Family Center (MFC). The month's highlight was our clinic's participation in CARNAVAL with a booth in the Health Pavilion. We outreached to 200+ children and parents providing resources and a beautiful butterfly project.

The staff organized to make T-shirts for TEAM MFC with the butterfly logo "Migration is Beautiful," from the work of artist, Favianna Rodriguez, who uses her art to celebrate the resiliency, courage, and determination of migrants who come in search of their dreams.

We participated in the Client Satisfaction Survey week and are anxiously awaiting our results. MFC is now on board with the AVATAR Scheduler, with a positive response, thus for especially with regard to tracking progress notes through the scheduler. We had a spike in referrals during the month of April and May, so our summer will be busy matching clients to clinicians. We continue to host the Unaccompanied Minors Work Group and the CYF Spanish Speaking Providers Work Group toward the goal of improved access for our families. On the college front two additional clients were accepted to college for this fall! Their families and MFC are very proud of them!

### **Southeast Child & Family Therapy Center**

We would like to welcome Alex Quintanilla, ASW to our clinic. He is a Spanish speaking clinician who will be working with us for 16 hours a week on an as needed basis to serve the many referrals we receive for the Spanish speaking community.

We also would like to thank Dr. Dawn Sung, our public psychiatry fellow, for her excellent work with our clients. She completed a year in the Children Youth and Families System of Care, working both at Southeast Child/Family Therapy Center and Family Mosaic Program. Next, she will be going to work at UCSF Benioff Children's Hospital in Oakland. We wish her all the best.

### **LEGACY**

In honor of Mental Health Awareness Month, L.E.G.A.C.Y received an award of commendation from the Executive Committee of the San Francisco Mental Health Board for its commitment, dedication and services it provides to the community.

**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>

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