

San Francisco Mental Health Services Act

2014-2017 Integrated Plan

The Mental Health Services Act of San Francisco is a program of the Department of Public Health – Community Behavioral Health Services



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MHSA COUNTY COMPLIANCE CERTIFICATION

County: ___San Francisco_

Local Mental Health Director	Program Lead
Name: **Jo Robinson, MFT**	Name: **Marlo Simmons**
Telephone Number: **415-255-3440**	Telephone Number: **415-255-3915**
Email: **jo.robinson@sfdph.org**	Email: **marlo.simmons@sfdph.org**
County Mental Health Mailing Address: **1380 Howard St., Room 210B** **San Francisco, CA 94103**	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

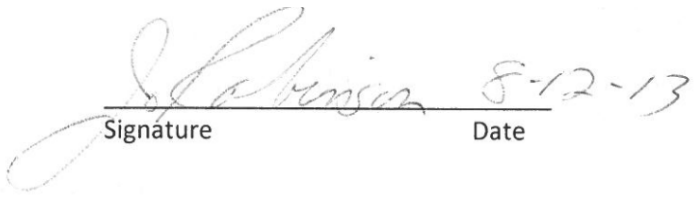
Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Jo Robinson, MFT

_____

Local Mental Health Director/Designee (PRINT)



_____ 8-12-13

Signature Date

County:__San Francisco_____

Date:_ August 2013_____

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Francisco

- [x] Three-Year Program and Expenditure Plan
- [ ] Annual Update
- [ ] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jo Robinson	Name: Monique Zmuda
Telephone Number: (415) 255-3440	Telephone Number: 415-554-7500
E-mail: jo.robinson@sfdph.org	E-mail: Monique.Zmuda@sfgov.org
Local Mental Health Mailing Address: 1380 Howard Street, 5th Floor, room 518 San Francisco, CA 94103	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Jo Robinson — Local Mental Health Director (PRINT)

Jo Robinson — Signature — 8/18/14 — Date

I hereby certify that for the fiscal year ended June 30, 2014, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/27/2013 for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2014, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

MONIQUE ZMUDA — County Auditor Controller / City Financial Officer (PRINT)

Signature — 8/27/14 — Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Directors' Message

In San Francisco, as in all counties throughout California, the success of the Mental Health Services Act (MHSA) is measured by how effectively it transforms local mental health systems. This 2014-17 Integrated Plan reflects our commitment to the principles outlined in the MHSA and the progress we are making to actively engage clients, consumers, and families; to promote wellness, recovery, and resilience; and to implement integrated models of care.

In 2012-13, we continued to make significant strides in meeting the priorities and goals identified in our previous community-wide MHSA planning efforts. The MHSA has enabled us to further build a service approach that is culturally and linguistically responsive to the needs of children, transition age youth, adults, and older adults. Our treatment services are being enhanced through a focus on recovery and a greater recognition of the central role that consumers, clients, and family members play in self-directing care. We strengthened our dedication to prevention and early intervention by promoting resilience, expanding interpersonal connections, and raising individuals' general level of health and well-being before serious mental health issues develop. We continued to learn from innovative strategies that encouraged creativity and aimed to improve outcomes. Moreover, we encouraged entry into and retention in our behavioral health workforce through trainings and professional development opportunities to help us meet the increasing demands on our system. In the years ahead, we will also continue to improve our monitoring and evaluation activities in order to effectively meet the outcome and performance objectives of our MHSA-funded programs.

Our progress is deeply rooted in the integral contributions of a broad, diverse network of stakeholders that includes consumers, family members, behavioral health service providers, MHSA-funded community contractors, MHSA staff, representatives from other systems of care (e.g., education, human services), and San Francisco MHSA Advisory Committee members. We appreciate and respect the hard work and commitment of our partners to best practices and for their valuable participation at various levels of the MHSA process.

We will continue to reflect on all that we have learned thus far and continue promoting a culture of recovery, resiliency, and wellness. Alongside our community partners and stakeholders, MHSA will continue to play a critical role in strengthening and expanding the public mental health system in San Francisco.

We look forward to the years ahead.

Jo Robinson, MFT
Director, Community Behavioral Health Services

Marlo Simmons, MPH
Director, San Francisco MHSA

1. Introduction

In November 2004, California voters approved Proposition 63, now known as the Mental Health Services Act (MHSA), intended to expand and transform community mental health services throughout California. While the proposition passed with 54% of the vote statewide, San Francisco voted 74% in favor of the act. MHSA funding, revenue from a 1% tax on any personal income in excess of $1 million, is distributed to respective county mental health systems under regulations developed by the State.

The MHSA called upon local counties to transform their public mental health systems to achieve the goals of raising awareness, promoting the early identification of mental health problems, making access to treatment easier, improving the effectiveness of services, reducing the use of out-of-home and institutional care, and eliminating stigma toward those with severe mental illness or serious emotional disturbance. Counties were also required to collaborate with diverse community stakeholders in order to realize the MHSA's vision of recovery and wellness. This vision was based on the belief in the strengths and resiliency of each person with mental illness and has been fundamental to the development of more comprehensive, innovative, culturally responsive services for individuals and families served by local mental health systems.

As dictated by the law, the majority of MHSA funding that San Francisco receives are dedicated to the development and delivery of treatment services. In San Francisco, MHSA funding has allowed for expanded access to intensive treatment services, housing, employment services and peer support services for thousands of individuals with mental illness, 50% of who are homeless or at-risk of becoming homeless. Promising outcomes from MHSA investments include declines in arrests, mental and physical health emergencies, school suspensions and expulsions, and the number of days in residential treatment.

Prop 63 also stipulates that 20% of the funds support programs "effective in preventing mental illnesses from becoming severe" and "reducing the duration of untreated severe mental illnesses." This commitment to prevention and early intervention is historic and moves the mental health system towards a "help-first" instead of a "fail first" strategy.

It will not be money alone that transforms the public mental health system. The greatest promise of the Mental Health Services Act: it is a vision of outreach and engagement, a philosophy of recovery and wellness, a belief in the strength and resiliency of each person with mental illness, and recognition that they are to be embraced as equal members of our community. Recovery from mental illness is not only possible, it is to be expected.

MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

1. **Cultural Competence**. Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.

2. **Community Collaboration**. Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.

3. **Client, Consumer, and Family Involvement**. Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.

4. **Integrated Service Delivery**. Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.

5. **Wellness and Recovery**. Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

General Characteristics of San Francisco

San Francisco is a seven by seven square mile, coastal, metropolitan city and county. Though geographically small, it is the second most densely populated major city in the country and fourth most populous city in California (17,179 people per square mile). The city is known for its culturally diverse neighborhoods where over twelve different languages are spoken. The most recent U.S. Census found that San Francisco has a population of 805,235 people and experienced mild growth since the last census (four percent). Although San Francisco was once considered to have a relatively young population, it has experienced a decrease among children and families with young children; there are more people moving out of San Francisco than moving in. The high cost of living and increasing rents (both residential and commercial) are several causes of the flight. Approximately 6,500 homeless individuals and 670 homeless families with children reside in San Francisco. Twelve percent of residents live under the poverty level. In addition, over the next two decades, it is estimated that 55 percent of the population will be over the age of 45, and the population over age 75 will increase from seven percent to 11 percent. The projected growth in San Francisco's aging population has implications on the need for more long-term care options moving forward. For additional background information on population demographics, health disparities, and inequalities, see the 2012 Community Health Status Report for the City and County of San Francisco located at http://www.cdph.ca.gov/data/informatics/Documents/San%20Francisco%20CHSA_10%2016%2012.pdf.

Community Program Planning (CPP) and Stakeholder Engagement

The MHSA reflects a new and unique process of implementing public policy through collaboration with multiple stakeholders and advocates with a range of knowledge and experience.

From the Beginning

In San Francisco, the MHSA planning process commenced in 2005 with the creation by the Mayor of a 40 member citywide Behavioral Health Innovation (BHI) Task Force, headed by the Deputy Director of Health. The BHI Task Force was responsible for identifying and prioritizing mental health needs in the community and developing a Three Year Program and Expenditure Plan. The BHI Task Force held over 70 meetings over a five month period with consumers, their families, behavioral health service providers, representatives from the criminal justice system, educational professionals, human services providers and administrators, and members of the community. Information was collected through provider surveys, peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, as well as 80 position papers received from various constituents. This process resulted in the development of a Three Year Program and Expenditure Plan for the Community Services and Supports component. The plan was submitted to the Department of Mental Health in November 2005 and was approved in March 2006.

The planning process continued for the other MHSA funding components, following the successive releases of each component's Plan guidelines. Each of these planning processes built upon the recommendations of the respective committees and workgroups established during the 2005 community-wide planning meetings.

- **Workforce Development, Education, and Training (WDET)** planning meetings were held for eight months from April to December 2007. The Plan was submitted in March 2008 and approved in September 2008.
- **Prevention and Early Intervention (PEI)** planning meetings were held for six months from January 2008 to July 2008. The Plan was submitted to both the Department of Mental Health and the Oversight and Accountability Commission for their review and approval in February 2009. The plan was approved in April 2009.
- **Capital Facilities and Information Technology** planning processes were held separately. The Plan for the Capital Facilities component was submitted in April 2009, after a series of three community planning meetings held in February 2009. The Information Technology component CPP involved two informational meetings and six community planning meetings from November 2008 to April 2009. The Plan was submitted in March 2010 and was approved in August 2010.
- **Innovation** community meetings were held from April through August 2009. The Plan was submitted in March 2010 and approved in May 2010.

Priority Populations

Exhibit 1 highlights the priority populations identified through a variety of community program planning activities for the following MHSA funding components.

Exhibit 1. SF MHSA Priority Populations

Priority Populations	Not Age Specific	Children	Transitional Age Youth	Adults	Older Adults
CSS Plan	▪ LQBTQ communities	▪ CPS/Foster Care ▪ Juvenile justice involvement ▪ Homeless ▪ Mental illness co-occurring with autism ▪ Undocumented ▪ Suicide ▪ Trauma resulting from witnessing or being a victim of violence	▪ Violence ▪ Youth aging out of foster care ▪ Juvenile Justice involvement ▪ Lack of employment or inability to work ▪ Trauma resulting from witnessing or being a victim of violence ▪ First break prevention management ▪ Homeless	▪ Homeless ▪ Hospitali-zation ▪ Suicide ▪ Inability to work ▪ Trauma resulting from witnessing or being a victim of violence ▪ Incarceration	▪ Hospita-lized in high levels of care ▪ Homeless ▪ Dementia ▪ Suicide ▪ Isolation
PEI	▪ Trauma exposed individuals and families ▪ LGBTQ populations ▪ Stigma and discrimination reduction ▪ Suicide prevention ▪ Underserved ethnic communities (e.g., Mayan, Filipino, Vietnamese) ▪ Underserved language communities (e.g., Russian, Tagalog, Spanish, Cantonese) ▪ Faith-based organizations and groups	▪ Children at risk of or experiencing juvenile justice involvement ▪ Children at risk for school failure ▪ Children in stressed families	▪ Individuals experiencing onset of serious psychiatric illness		▪ Older adults with unidenti-fied mental health concerns

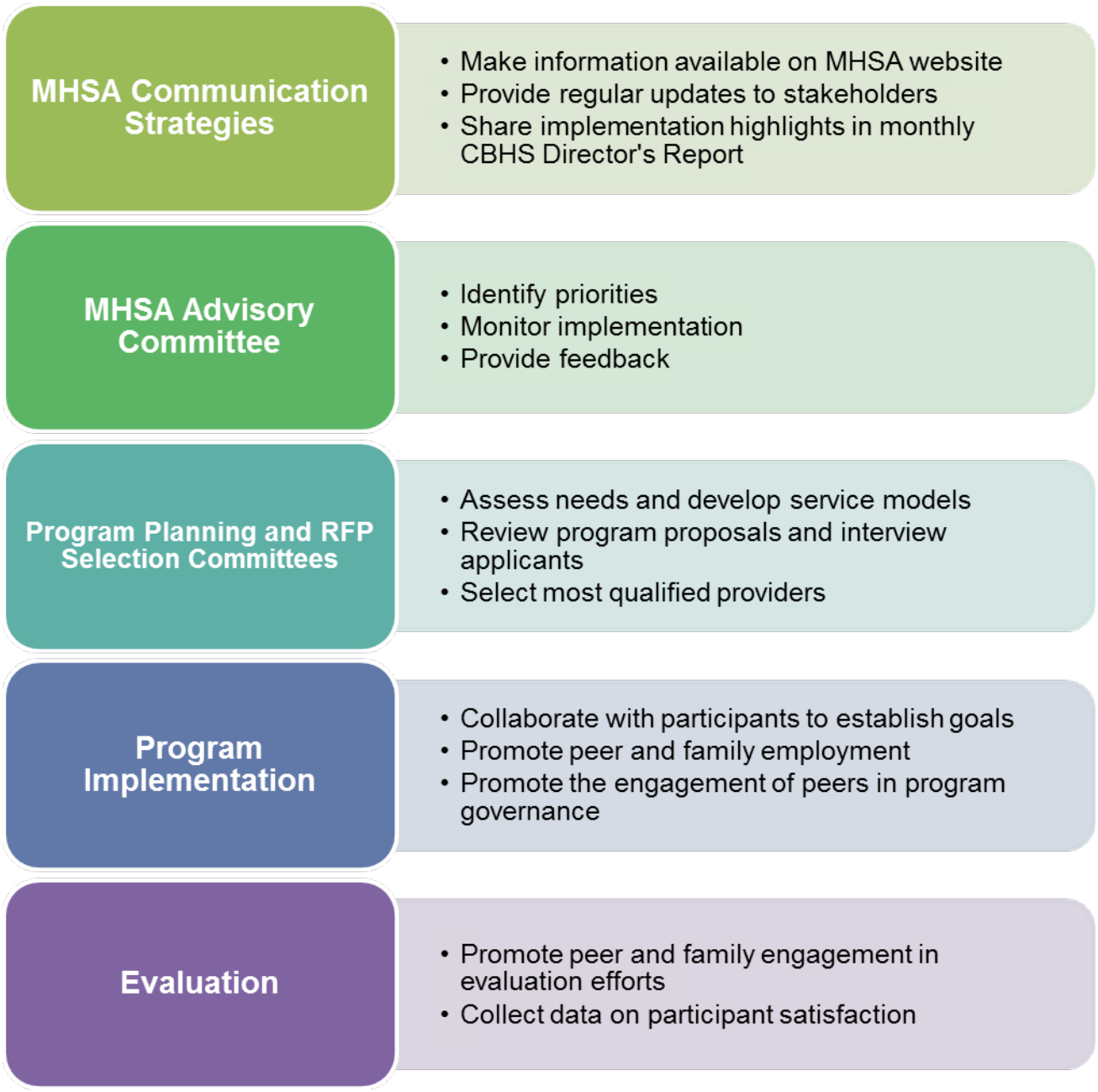
Exhibit 1. SF MHSA Priority Populations

Priority Populations	Not Age Specific	Children	Transitional Age Youth	Adults	Older Adults
WDET	▪ Promote hiring of underserved cultural populations ▪ Promote hiring of consumers and family members to deliver peer services				
INN	▪ Hoarding ▪ Vocational Services ▪ Peer Services ▪ Transgender ▪ Complimentary wellness/healing practices (e.g. mindfulness, drumming) ▪ Bayview/Visitacion Valley ▪ Churches				▪ Socially isolated

Community Program Planning (CPP) and Stakeholder Engagement Activities

Exhibit 2 provides a visual overview of San Francisco's ongoing community program planning activities. SF MHSA employs a range of strategies focused on upholding the MHSA principles and engaging stakeholders in various ways at all levels of planning and implementation. Our CPP provides various opportunities for stakeholders to participate in the development of our three-year plans and annual updates and to stay informed on our progress implementing MHSA-funded programs. This section provides a description of our general CPP activities. In addition to the broad strategies described below, each section in this report includes highlights of program-specific CPP activities.

Exhibit 2. Key Components of the SF MHSA Program Planning Process



MHSA Communication Strategies

Through a variety of communication strategies, we seek to keep stakeholders and the broader community informed about MHSA. We do this through our website and regular communication with other groups, contributing content to the monthly Community Behavioral Health Services (CBHS) Director's Report and providing regular updates to stakeholders.

The **San Francisco MHSA website, www.sfmhsa.org**, is in the process of being updated to incorporate a more user-friendly design, up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The redesigned website, hosted now through the SF DPH website, will showcase frequent program highlights and successes.

MHSA Annual Implementation Updates

The following provides examples of partner presentations conducted by MHSA staff over the last year. These presentations are intended to provide information as well as collect input:

- Community Behavioral Health Services Adult System of Care Providers – June 7, 2013
- Community Behavioral Health Services Adult System of Care Leadership – June 11, 2013
- Community Behavioral Health Services Children System of Care Providers – July 16, 2013
- Community Behavioral Health Services Children System of Care Leadership – July 8, 2013
- San Francisco Mental Health Board – July 10, 2013
- San Francisco Health Commission, Community and Public Health Committee – August 20, 2013
- Combined MHSA Advisory Committee and Provider Meeting – October 16, 2013
- San Francisco Sentencing Commission – March 26, 2014

The **monthly CBHS Director's Report** provides another forum for sharing information about the implementation of MHSA with a broad group of stakeholders. Each month, MHSA provides updates about program implementation, upcoming meetings and other MHSA news.

MHSA Advisory Committee

The SF MHSA Advisory Committee is an integral component of community engagement because it provides guidance in the planning, implementation, and oversight of the MHSA in San Francisco. In order to build on the previous and ongoing participation of local stakeholders, the purpose of the MHSA Advisory Committee includes the following:

- Work collaboratively with CBHS to support broad community participation in the development and implementation of MHSA initiatives
- Guide MHSA resources to target priority populations as identified in existing MHSA plans
- Ensure that San Francisco's mental health system adheres to the MHSA core principles

The MHSA Advisory Committee Meetings for FY 13-14 were as follows. Example agenda items are also included.

- June 19, 2013 – Ongoing evaluation activities, 12N, and improving the CP process
- August 21, 2013 – Structure of MHSA Advisory Committee, school-based programs and Full-Service Partnership (FSP) programs
- October 16, 2013 – Combined MHSA Advisory Committee and Provider Meeting
- February 19, 2014 – Housing, FSP, and Capital Facilities proposals for Integrated Plan
- April 16, 2014 – WDET proposals for Integrated Plan

Advisory Committee Structure and Membership

- Consists of up to 25 members who are consumers, family members, and providers
- Includes consumers and family members of at least 51% of total membership
- Reflects MHSA priority populations and areas of mental health expertise
- Has no term limits for membership
- Consists of two co-chairs (the MHSA Director and one consumer) who develop Advisory Committee agendas and facilitate meetings
- Convenes an Executive Committee of members who are nominated by the larger group to review membership every year
- Holds meetings every two months (meetings alternate between meetings at MHSA and our partnering community-based organizations)
- Encourages community participation at meetings

Composition of FY13-14 SF MHSA Advisory Committee

In addition to including representatives from education, social services, drug and alcohol service providers, and various health care providers, the Advisory Committee includes representation from diverse populations and priority groups as listed below.

- Thirteen service providers (59 percent), 12 consumers (55 percent), and seven family members (32 percent)
- Six service providers worked with PEI-funded programs, four service providers each worked with WET- and CSS-funded programs, and three service providers worked with INN-funded programs
- Whites (37 percent), African Americans/Blacks (17 percent), Native Americans (13 percent), Latinos (13 percent), Asians (13 percent), and Native Hawaiians/Pacific Islanders (7 percent)
- Gay, lesbian, or queer (11 percent), questioning (5 percent), and bisexual (5 percent) individuals
- Twelve females (55 percent), seven males (32 percent), two individuals of another gender (9 percent), and one transgender female (5 percent)
- Members' ages ranged from 30 to 72 and the average age was 43 years old
- Two members (9 percent) speak Spanish and one member (5 percent) speaks Cantonese

SF MHSA has identified specific gaps in membership, and is actively working to recruit stakeholders representing transitional age youth, law enforcement, and veterans.

Improving Consumer Engagement

SF MHSA has had many successes engaging consumers and family members at every level of the CPP process and in the implementation of the vast majority of programs. Over the last year, it has been a challenge to achieve our goal of having 51% consumer representation in all MHSA Advisory Committee meetings. We are pursuing two strategies to address this trend.

SF MHSA has recently formalized a partnership with the Mental Health Association of San Francisco (MHA-SF), with the goal of increasing consumer representation and participation in Advisory meetings. MHA–SF will assist with the following objectives:

- Developing a Consumer Training Institute with the goal of increasing parity, inclusion, and representation of consumer members

- Supporting the consumer Co-Chair of the MHSA Advisory Committee to participate in developing meeting agendas and presentations for each meeting
- Recruiting at least eight new consumers/individuals with lived experience of mental health conditions to serve as standing members of the committee.
- Identifying strategic objectives, including policy issues related to stigma/awareness and developing partnerships with community-based organizations/business leaders to advance stigma change efforts as part of the MHSA Advisory Committee's focus

SF MHSA has also been working to foster a stronger collaboration with the CBHS Client Council. The Client Council is a 100% consumer/client driven and operated advisory body. The mission of the Client Council is to advance the cause of the San Francisco mental health consumer/client to protect their rights, to advocate their issues, and ensure their participation on all phases of systematic changes in services, implementation of programs, and treatment development. The goal of the Client Council is to advise CBHS regarding policies and practices that directly influence consumers/clients in mental health and substance abuse services. As a result of this new collaboration, the Client Council and MHSA Advisory committee share some members. SF MHSA also plans to have bi-annual joint meetings of these two advisory bodies.

Program and Populations Planning and RFP Selection Committees

In addition to the MHSA Advisory Committee, SF MHSA includes elements of community program planning (CPP) when developing each of our new programs. Frequently, this takes the form of an ad hoc committee made of various stakeholders, including people with expertise or lived experience of specific populations. The MHSA principle of engaging consumers and family members is applied to all programs. The following are two examples of the work of these committees.

Socially Isolated Older Adults Planning Committee (INN)

In 2011-12, the MHSA Advisory Committee identified Socially Isolated Older Adults as a priority population. SF MHSA convened a group of stakeholder to develop an innovative service model designed to improve outcomes for this community. The planning process spanned the course of two months between October and December of 2011. Consumers and other stakeholders were involved in developing an innovative peer-to-peer service model and later, through the request for proposal (RFP) selection process.

First Impressions (INN)

Prior to the development of the First Impressions RFP, several stakeholder committee meetings were held to gather feedback and recommendations on areas of program development, policies, implementation and budgeting. Stakeholders included consumers, family members of consumers, vocational providers and leaders in the community. Committee meetings were held on 8/15/12, 8/13/12, 9/12/12, 9/19/12 and 10/24/12. Consumers were heavily involved in the review process and consisted of one-third of the voting panel. Consumers scored the proposals and also scored the program interviewees to ensure this stakeholder voice was well heard.

Program Implementation

The active engagement of stakeholders in planning continues into implementation. Providers and consumers are partnering with stakeholder groups to ensure programs are collaborating with other initiatives. Examples of our stakeholder engagement in implementation include the following:

- Providers from MHSA-funded agencies meet on a regular basis to discuss local MHSA program activities and to provide feedback.
- Population Focused Mental Health Promotion Contractors Learning Circles: In order to promote a culturally competent and inclusive process, SFMHSA is holding a series of meetings called 'Learning Circles' with population-focused programs to collectively discuss and agree on service types, activities and outcomes. These shared performance objectives will then be measured and reported on for the next fiscal year. The Learning Circles also provide an opportunity for programs to share their progress on implementation, goals and strategies for evaluation.

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Prop 63, an emphasis was placed on the importance of consumers in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. In FY 12-13, thirty-two (32) grantees/contracts indicated that their program employs consumers or participants through MHSA funding, totaling over 167 peers as employees. Consumers could be found working in almost all levels and types of positions, including: peer mentors, health promoters, community advocate, workgroup leaders, teaching assistants, and management. Several programs have positions created specifically for clients and consumers, including mentoring, advocacy, and peer facilitators.

Additionally, some programs reported that – while they do not offer employment – they are able to pay a small stipend, award a scholarship, or offer seasonal employment. In addition to those who hire consumers, three additional grantees indicated that they offer volunteer opportunities for consumers to be involved in the program. Activities for volunteer and stipend workers vary and include supporting summer programs, teaching workshops, providing peer mentoring, and data collection. In some instances, clients who have graduated or finished participating in the program have come back to work or volunteer within the organization. In one example, two former participants returned to assist with peer groups. In another, previous graduates returned as mentors and senior mentors to lead summer programming.

Evaluation

In any given year, there are between 75-85 actively funded MHSA programs. MHSA funded staff within the CBHS Office of Quality Management plays an active role in supporting evaluation activities for MHSA, providing another opportunity to actively engage stakeholders. One highlight of this work, the MHSA Evaluation Impact Group, is detailed below.

The MHSA Evaluation Workgroup, recently renamed to the MHSA Impact Group, provides technical assistance (TA) on evaluation and program improvement activities for non-full service partnership MHSA-funded programs in a group setting. Specifically, the Impact Group is a workshop where programs come to design evaluations, develop measurement tools and learn how to carry out evaluation activities. As needed, MHSA evaluators also follow-up with programs on a one-on-one basis to increase a program's capacity in carrying out specific evaluations. The evaluators also conduct workshops to enhance communication, reporting and dissemination of outcomes and program impact, particularly to the client community.

The Impact Group has created a collaborative, supportive forum for CBHS to facilitate high quality evaluation activities in a peer discussion format. The program representatives have expressed their appreciation for technical training that is delivered in a conversational, understandable format, as well as the peer-to-peer support and engagement between programs.

MHSA Impact Group activities have included:

- Training in evaluation techniques, such as focus groups, logic models, survey design, PDSA model for improvement
- Individual TA with programs to develop evaluation goals, tools and reports
- Presentations from MHSA programs
- Guidance on defining MHSA contract objectives
- Guidance on submitting program reports for the MHSA Annual Report
- Guidance on DPH data collection policies and strategies

In April 2014, the MHSA Impact Group has begun to work more closely with the Population-focused Mental Health Prevention and Wellness Promotion PEI programs. Guided by each program's objectives and activities, the Impact Group is helping to identify appropriate measurement tools and provide direction on methods for effective data collection to support outcomes reporting.

San Francisco's Integrated MHSA Service Categories

As discussed in the introduction to this report, San Francisco's initial MHSA planning and implementation efforts were organized around MHSA funding components (e.g., Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN)). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components.

The MHSA, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, SF MHSA realized that developing an Integrated Plan with a common vision and shared priorities is difficult when funding streams were used as the framework. In partnership with our stakeholders, SF MHSA simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 3 below).

These MHSA Service Categories have allowed us to plan programs and services for specific populations and to expand our continuum of services with clear outcomes – including integration of peers into service delivery, promoting culturally competent care, increasing access to housing and employment, and developing high quality recovery-oriented treatment services.

It is important to note that the majority of our MHSA Service Categories include services funded by INN. INN funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes.

Exhibit 3. SF MHSA Service Categories

SF MHSA Service Category	Description
Recovery-Oriented Treatment Services	▪ Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment) ▪ Uses strengths-based recovery approaches
Mental Health Promotion & Early Intervention (PEI) Services	▪ Raises awareness about mental health and reduces stigma ▪ Identifies early signs of mental illness and increase access to services
Peer-to-Peer Support Services	▪ Consumers and family members are trained and supported to offer recovery and other support services to their peers
Vocational Services	▪ Helps consumers secure employment (e.g., training, job search assistance and retention services)
Housing	▪ Helps individuals with serious mental illness who are homeless or at risk of homelessness secure or retain permanent housing ▪ Facilitates access to short-term stabilization housing
Behavioral Health Workforce Development	▪ Recruits members from unrepresented and under-represented communities ▪ Develops skills to work effectively providing recovery oriented services in the mental health field
Capital Facilities/ Information Technology	▪ Improves facilities and IT infrastructure ▪ Increase client access to personal health information

Developing this Integrated Plan

Our Integrated Planning effort was coordinated by a planning group comprised of the SF MHSA Director and Program Managers of specific MHSA initiatives (e.g., WDET, INN, PEI) with independent consulting firm Harder+Company Community Research providing planning and facilitation services. The group met for five two-hour planning retreats from October 2011 to January 2012. We incorporated the stated priority populations and goals in the MHSA, as well as revisited the local priorities and needs identified in previous planning efforts. All of the CPP strategies discussed in the previous section were employed in developing this plan. Additional strategies employed in this process are listed below.

- Reviewed previous three year Program and Expenditure plans submitted for each MHSA component. This was done to understand how well priorities identified in those plan have been addressed, as well as to determine if all programs had been implemented as originally intended.
- Reviewed MHSA regulations, laws and guidelines released by the State (e.g. DMH, OAC, CalHFA) to ensure all mandated information would be incorporated in this plan.
- Reviewed informational materials produced by CalMHSA, CMHDA, and OSHPD
- Reviewed Annual Program Reports and demographic data submitted by contractors and civil service programs.

Much of this Integrated Plan is made up of programs implemented through previous plans. Most of our CPP activities over the last year have been focused on the development of this plan.

Local Review Process

In addition, our stakeholder process involved various opportunities (e.g. advisory committee meetings, client council meetings) to share input in the development of our Integrated Planning effort and to learn about the process of our MHSA-funded programs. Please see the components on MHSA Communication Strategies and MHSA Advisory Committee for a specific list of meeting dates and topics.

- Community Behavioral Health Services Executive Committee – June 25, 2013 to plan for the Integrated Plan
- MHSA Advisory Committee meetings focused on the Integrated Plan include:
  - February 19, 2014 – Housing, FSP, and Capital Facilities proposals for Integrated Plan
  - April 16, 2014 – WDET proposals for Integrated Plan
- San Francisco Chapter, National Alliance on Mental Illness (NAMI) – February 19, 2014 to present and discuss the Integrated Plan
- San Francisco Client Council meetings:
  - November 19, 2013 – Vocational Services
  - December 17, 2013 – FSP expansion proposal
  - February 18, 2014 –Peer-to-Peer services
  - May 20, 2014 – Integrated Plan overview

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Annual Update Report was posted on the SF MHSA website at http://www.sfdph.org/dph and http://sfmhsa.org. Our MHSA Integrated Plan was posted for a period of 30 days from **May 16, 2014** to **June 18, 2014.** The Plan was also emailed to over 90 community members, many of whom are leaders to large distribution lists. Members of the public were requested to submit their comments either by email or by regular mail. In addition, the Integrated Plan was presented at the following meetings to gather stakeholder input for the public comment and review process:

- CBHS Adult and Older Adult System of Care Provider meeting – June 6, 2014
- CBHS Children and Families System of Care Provider meeting – June 17, 2014
- Client Council – June 17, 2014
- Department of Public Health, Director Garcia's Integrated Steering Committee meeting – June 18, 2014
- MHSA Advisory Committee meeting – June 18, 2014
- San Francisco Mental Health Board Hearing – June 18, 2014

Public Hearing

Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board on **June 18, 2014**.

Comments Received

Comments received from the public hearing include the following:

Community Member	Content of Comment	Response
Terezie Bohrer	Ms. Bohrer asked for clarification about adult full service partnership program cost per clients, who most likely be participated in the MediCal program – indicated it was unclear if the cost per client includes Medi-Cal and expressed concern that it is misleading as currently presented.	The cost per client calculations include only MHSA funding. A note to this effect will be added to the cost per clients sections for all programs that generate MediCal revenue. – FSP, and PREP
Michael Gause	Mr. Gause expressed an interest in having more public discourse on the plan and local implementation of MHSA.	MHSA staff welcomes the offer from the MHA-SF to host additional community forums and to increase the number of individuals involved in the community planning process.

The table below summarizes additional comments from stakeholders during the 30-day public comment period:

Community Member	Content of Comment	Response
Terri Bryne, S.O.L.V.E. Program Coordinator	Mental Health Association of San Francisco (MHA-SF) Staff submitted letters outlining similar comments.	• In FY 14/15, SF MHSA is planning to develop and launch a Peer Leadership Academy to train and support peers to be more engaged in the MHSA Community Planning Process.

Michael Gause, Deputy Director **Stephen Marks, Training and Evaluation Director**	• Increased funding and support for Consumer Leadership and Training • Support for Peer Crisis Respite • Increased Support for Consumer Outreach and Engagement	MHSA is also planning to expand the Peer MH Certificate Program to include an advanced training curriculum for emerging Peer Leaders and Supervisors. In addition, our Peer-to-Peer Employment Services are being restructured and part of that work includes a focus on skill building and professional development of Peer Staff. • The recently released Mayor's CARE Task Force recommendations include a call for a Peer Respite Center at SFGH. MHSA has committed Peer staff and resources from the Peer-to-Peer budget to the Respite Center. • Many MHSA programs include elements of outreach and engagement. MHSA welcomes partnerships with MHA-SF staff to ensure Peers are as involved in this work as possible.
Julian Plumadore* Community Advocate for the Mental Health Association of San Francisco (MHASF) ***Julian also serves as a Co-Chair for the SF MHSA Advisory Committee.**	Recommendations for developing a Consumer Training Program for peer employees in San Francisco include: • Begin with a survey targeted to peers currently employed by MHSA-funded programs in San Francisco. • Discuss the foundation of peer roles. • Provide Essential Skills training.	Peers are included in the development of all new programs developed and funded by MHSA. These elements will be presented for consideration to the Planning/Advisory Committees tasked with developing the Leadership Academy and the Advanced Peer Certificate.

Eduardo Vega, Executive Director, MHA-SF	The following are themes from a letter submitted by Mr. Vega two days prior to the close of the 30-day public comment period. • The plan contains substantially positive and important directions for utilizing San Francisco county Mental Health Services Act (MHSA) dollars in the upcoming three years. • I am concerned that San Francisco community members were not adequately engaged with the MHSA planning process as required by MHSA State regulations. • He proposes to delay the public hearing and extend the public comment period to allow for 1) public forums, 2) additional outreach by his organization, 3) to consolidate public comment/discussion in a separately distributed document.	The following are themes from a response letter from SF MHSA Director, Marlo Simmons: • The Integrated Plan is the product of an extensive Community Planning Process that began in February 2012. • The plan provides a detailed overview of the CPP and how SF MHSA actively involves stakeholders on all levels of MHSA planning and implementation. • We were not able to extend the comment period, as doing so would have resulted in a delay submitting the plan to the SF Board of Supervisors until after they return from their summer break. • The work of SF MHSA is constantly evolving and includes countless opportunities for you and your agency to get more involved in ongoing SF MHSA work. • For FY 14/15, our CPP plans include: 1) working to strengthen ties between the MHSA Advisory Committee and the CBHS Client Council, 2) including funding for a Peer Leadership Academy in a soon-to-be-released RFQ, and 3) working with the Advisory Committee to develop a more formal structure, including clearer roles and responsibilities, and new recruitment strategies.

Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date, as well as efforts moving forward. The following seven sections describe the overarching purpose of each of San Francisco's MHSA Service Categories. Each program section includes information on the background and community need, a program overview, the target population and numbers served, projected outcomes, as well as the participant engagement and community program planning (CPP) process. The outcomes listed for each section are the outcomes SF MHSA intends to report in annual updates. Plans to expand certain service categories or develop new programs are highlighted and discussed at the end of each section.

The program sections also include estimates of budget expenditures for FY14-15, as well as costs per client based on projected annual goals for clients and individuals to be served. These numbers are an approximation only. Consequently, these amounts should be regarded with caution and utilized for informational purposes only.

Board of Supervisors Resolution

FILE NO. 140759 RESOLUTION NO. 390-14

[Mental Health Services Act 2014-2017 Integrated Plan]

Resolution adopting the Mental Health Services Act 2014-2017 Integrated Plan.

WHEREAS, The Mental Health Services Act (MHSA) was enacted through a ballot initiative (Proposition 63) in 2004 that provides funding to support new and expanded county mental health programs; and

WHEREAS, In order to access MHSA funding, counties are required to 1) develop Three-Year Program and Expenditure Plans, and Annual Updates, in collaboration with stakeholders; 2) post the plans for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Mental Health Board; and

WHEREAS, Recently enacted legislation, Assembly Bill 1467 (AB 1467), adds the requirement that stakeholder-developed plans be adopted by County Boards of Supervisors prior to submission to the State; and

WHEREAS, The MHSA specifies five major program components for which funds may be used and the percentage of funds to be devoted to each component. These components are: Community Services and Supports (CSS); Capital Facilities and Technological Needs (CFTN); Workforce Development, Education and Training (WDET), Prevention and Early Interventions (PEI); and Innovation (INN); and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for three-year program and expenditure plans for each MHSA component; and

Department of Public Health
BOARD OF SUPERVISORS Page 1

WHEREAS, In compliance with MHSA regulations, the San Francisco Department of Public Health's Community Behavioral Health Services section has developed an MHSA Integrated Plan, having worked with stakeholders to develop the plan, posted the plan for public comment, and held a public hearing with the San Francisco Mental Health Board; and

WHEREAS, The San Francisco Mental Health Services Act 2014-2017 Integrated Plan, a single plan that brings together all MHSA components, provides an overview of progress implementing the various component plans in San Francisco and Identifies new investments planned for fiscal year 2014-15; and

WHEREAS, San Francisco County is projected to receive MHSA revenue of $30,973,615 for Fiscal Year 2014-2015 and this projection has been submitted to be included in the FY 14-15 Annual Appropriations Ordinance; now, therefore, be it

RESOLVED, That the San Francisco Mental Health Services Act 2014-2017 Integrated Plan is adopted by the Board of Supervisors.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

City and County of San Francisco
Tails
Resolution

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

File Number: 140759 **Date Passed:** October 21, 2014

Resolution adopting the Mental Health Services Act 2014-2017 Integrated Plan.

October 08, 2014 Budget and Finance Committee - RECOMMENDED

October 21, 2014 Board of Supervisors - ADOPTED

Ayes: 11 - Avalos, Breed, Campos, Chiu, Cohen, Farrell, Kim, Mar, Tang, Wiener and Yee

File No. 140759

I hereby certify that the foregoing Resolution was ADOPTED on 10/21/2014 by the Board of Supervisors of the City and County of San Francisco.

Angela Calvillo
Clerk of the Board

Mayor

10/29/2014
Date Approved

2. Recovery-Oriented Treatment Services

Recovery-Oriented Treatment Services include services traditionally provided in the mental health system including screening and assessment, clinical case management, individual or group therapy and medication management. These services support the MHSA's philosophy that mental health needs are not defined by symptoms but rather by a focus on achieving, maintaining, and promoting the overall health and well-being of the individual and family. The MHSA's philosophy recognizes and builds upon the areas of life in which individuals are successful by promoting strengths-based approaches, emphasizing the recovery process, and encouraging resilience to help individuals live with a sense of mastery and competence.

The majority of MHSA funding for Recovery-Oriented Treatment Services is allocated to Full Service Partnership (FSP) Programs. The remaining funds are distributed to the following: (1) the Behavioral Health Access Center, (2) the Prevention and Recovery in Early Psychosis Program, (3) Trauma Recovery Programs, (4) the Integration of Behavioral Health and Juvenile Justice, (5) the Integration of Behavioral Health and Primary Care, (6) Dual Diagnosis Residential Care and (7) Expanding Outpatient Clinic Capacity. INN funding also supports several programs in this MHSA service category.

Full Service Partnership Programs

Background and Community Need

Full Service Partnership (FSP) programs were designed to serve Californians in all phases of life who experience the most severe mental health challenges because of illness or circumstance. This population has been historically underserved and has substantial opportunity for benefits from improved access and participation in quality mental health treatment and support.

The FSP model is grounded in earlier efforts, namely Assembly Bill 2034 (AB 2034) and its predecessors. AB 2034 was unique in its focus on serving homeless individuals with serious mental illness, the "housing first" mandate, flexible funding, and the collection and reporting of client and systems outcomes in "real time". The final analysis of ABV 2034 reported substantial quality of life improvements, as well as marked cost savings for our systems of care. Accordingly, the primary purpose of Proposition 63 was to expand this proven model to everyone who needed that level of care. Counties are mandated by MHSA to spend 51% of MHSA funds on FSP.

Program Overview

FSP programs reflect an intensive and comprehensive model of case management based on a client and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) to lead independent, meaningful, and

productive lives. Full Service Partnerships embrace client driven services and supports with each client choosing services based on individual needs. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers. FSP programs are capable of providing an array of services well beyond the scope of traditional outpatient services. FSP programs address emotional, housing, physical health, transportation, and other needs that will help them function independently in the community.

Nine FSP programs served a diverse group of clients in terms of age, race/ethnicity, and stage of recovery. This plan includes an expansion of FSP services for TAY and adults and the creation of FSP programs for children 0-5 and their families.

Exhibit 4. Summary of Full Service Partnership Programs

Target Population	Lead Agency	Services
Children, Youth & Their Families	Seneca SF Connections	▪ Provide SB 163 Wrap Around services so adolescents stay in family settings within the community and achieve permanency and stability. ▪ Access community resources to address the needs of the youth. ▪ Facilitate transition to TAY services as they age out of CYF services. ▪ Empower the caregiver to care for the child.
	Family Mosaic Project	▪ Provide intensive case management and wrap around services to children and their families to enable the child to remain at home and progress in a natural environment. ▪ Provide or arrange for mental health services, therapeutic services, mentoring, respite care, and other services as individually developed through the development of a comprehensive plan.
Transitional Age Youth (TAY) ages 16-25	Family Service Agency	▪ Provide physical health care, mental health treatment, medication management, substance abuse treatment, employment assistance, post-employment support, benefits assistance and advocacy, and peer support integrated into single service teams. ▪ Work closely with housing services to help secure housing for the target population. ▪ Utilize flexible funding to purchase specialized services and supports.
	Community Behavioral Health Services - TAY	▪ Develop comprehensive assessment and treatment care plans. ▪ Provide intensive services that include mental health treatment and substance abuse counseling. ▪ Link clients to employment/job coaching/placement, education training on independent living skills, referrals to legal assistance, recreation and social activities, and coordinate with HSP for transitional and supportive housing.

Exhibit 4. Summary of Full Service Partnership Programs

Adults ages 26-59	Family Service Agency	▪ Conduct outreach to homeless encampments, parks homeless shelters, and food programs, and other service locations. ▪ Address immediate needs of potential clients such as food, shelter, clothing, and other amenities. ▪ Provide health screening and first aid, dispense medications, prescribe psychotropic medications with supervision from a psychiatrist and arrange for medical treatment. ▪ Provide mental health and substance abuse treatment and case management. ▪ Assist with initial application for benefits such as food stamps, Medi-Cal, SSI, and other benefits.
	Hyde Street Community Services	▪ Provide services to adult residents of the Tenderloin neighborhood of San Francisco ▪ A multi-disciplinary staff works together to address the often complex problems of the client population. ▪ Adhering to a philosophy of providing integrated services, the program welcomes individuals with co-morbid substance abuse problems and addresses those issues in both individual and group treatment.
	SF Fully Integrated Recovery Service Team	▪ Provide services (e.g., individual or group therapy, medication management) to individuals with SMI who have been homeless for an extended time. Additional MHSA funded supports include payee services and vocational training.
	UCSF Citywide Case Management Forensics	▪ Promote wellness and recovery. ▪ Stabilize mental health symptoms and improve and sustain quality of life. ▪ Provide wrap around services adhering to a Recovery Model, including: intensive case management, individual and group therapy, medication support services, peer support, and crisis intervention. ▪ Provide integrated services including employment services, recreational and community integration activities, benefits advocacy, money management, linkage to primary care, and stable housing.
	CBHS Transitions	▪ Small pilot focusing on care coordination from hospital discharge to successful engagement with an outpatient clinic
Older Adults ages 60+	Family Service Agency	▪ Meet clients where most often found: non-office settings such as streets, shelters and SROs ▪ Conduct assessment and evaluation ▪ Offer mental health treatment, including dual disorder services both individual and group ▪ Provide case management services and crisis intervention ▪ Engage clients in vocational assessment and rehabilitation services. ▪ Link clients to housing and follow-up in-home services.

Target Population

The target population for FSP programs include low-income adults (18-60 years old), with histories of serious and persistent challenges and often homelessness, in need of intensive case management and other intervention. The programs are especially designed to anticipate problems before they become emergencies.

Budget and Costs per Client

FSP expenditures for fiscal year 2014-15 are projected to be $9,491,468. The projected per-client costs are detailed below.

Exhibit 5: Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Full Service Partnership: CYF (0-5)	40 clients	$400,000	$10,000
Full Service Partnership: CYF (6-18)	270 clients	$1,415,000	$5,241
Full Service Partnership: TAY (18-24)	90 clients	$1,076,468	$11,961
Full Service Partnership: Adults (18-59)	537 clients	$5,850,000	$10,894
Full Service Partnership: Older Adults (60+)	87 clients	$750,000	$8,621

Projected Outcomes

Since the inception of MHSA, the Full Service Partnership programs have demonstrated improved outcomes in client functioning. During time spent in FSP treatment, clients register improvements in **residential settings** reflected in the shift in days away from shelter/temporary housing, homeless, criminal justice, and hospital settings to more stable settings. Rates of **emergency events**, such as arrests, mental health or psychiatric emergencies (which include substance use related events) and physical health emergencies, as well as school suspensions and expulsions for young children and TAY, also show dramatic reductions for clients enrolled in the FSPs.

In addition, a DCR Workgroup is convened monthly. The committee continues to monitor the quality of DCR data for FSP outcomes reporting. The committee is working closely with programs providing online support, training and data coding technical assistance. In the coming year, the Workgroup plans to develop a “DCR Case Management” report. This new report will display client data for each FSP program, by case manager, on domains not previously reported on for San Francisco FSPs, such as: Legal

(payee status), Financial Benefits, Connection to Primary Care, Education and Employment/Vocational Training.

Graduation: The Ultimate FSP Outcome

A team of FSP staff, DPH evaluators and MHSA staff joined the California Institute for Mental Health (CiMH) 15-county Learning Collaborative focusing on "Advancing Recovery Practices (ARP)" that ran for 14 months ending March 2013. The SF MHSA team extended the work an additional year, completing in March 2014.

The primary goals included:

- Increase client and provider discussions of recovery
- Implement tools and protocols that support client graduations into the community
- Increase client graduations into the community

CiMH provided an intensive structured curriculum to build capacity for recovery-oriented, strengths-based mental health care, as well as change management under the Institute for Healthcare Improvement's well-established Model for Improvement. Through the iterative testing process and discussions, the team developed a Recovery Checklist that has been adapted and adopted by other programs.

Clients who Met Treatment Goals (Graduated)

The percentage of FSP clients discharged who met goals improved, albeit modestly. Before discussions began on the graduation criteria, zero (0) clients were discharged having "met goals". With participation in the ARP Learning Collaborative, increased emphasis on facilitating "graduations", and implementation of the Recovery Checklist, the rate of overall discharges declined, but the percentage who discharged having met treatment goals increased on average.

Program Specific Community Program Planning (CPP) Activities

Full Service Partnership programs engage a diverse cadre of stakeholders to assist in the planning and development of appropriate programming to meet the needs of the target population. Most of the FSP programs have an advisory committee made up of clients, family members, staff and other concerned citizens that meets regularly to discuss the current workings of the program, successes, as well as opportunities for improvement. Together, the committee members strategize on how to expand and capitalize on what is working well and the changes needed to make the program better able to support the clients as they move towards wellness and recovery.

The programs also employ individuals with lived experience navigating the mental health system. These individuals not only play a key role in supporting the clientele, but these peers are also instrumental in

informing the program planning process. Because they have also received, and are still receiving, mental health support services, they fully understand what clients are going through and what might help them.

Expanding Access to FSP Services

The Full Service Partnership funding expansion planning process spanned from July 2013 to April 2014 and involved engaging and eliciting feedback from hundreds of stakeholders who have a vested interest and knowledge of the populations serviced by these programs.

All of the Full Service Partnership (FSP) programs were engaged in the planning process, as were the various ongoing planning bodies that help to inform the work of CBHS, such as the MHSA Advisory Committee and the CBHS Client Council. The leadership staff at CBHS also had a chance to voice their suggestions.

The following outlines the proposed expansions for FSP services:

TAY and Adult FSP programs each have significant waitlists of individuals in need of intensive, wrap-around services. In order to help address that need for individuals with severe mental illness, it has been proposed that additional funding be allocated to create additional FSP capacity by adding more clinical staff. The proposal would allow for two of the most impacted adult FSP programs to receive funding to hire additional staff. Specifically, the additional funding would hire two clinicians at one of the FSPs and a Cantonese-speaking case manager. Further, an additional clinical staff person is desired to help serve the increasing TAY population that is in need of FSP services. With additional capacity, we can keep the client/clinician caseload ratios in line with best practice. Proposed are the following program specifics:

- Cantonese speaking clinician

Children aged 0-5 are not being adequately served in our system of care. This is particularly true for youngest children who are in foster care or who have otherwise experienced trauma and are in need of intensive mental health services. The family as a unit, as opposed to just the young child, would be the target of the intervention. The idea is that MHSA could contract with a mental health agency to provide FSP services to the 0-5 population and their families, with the following program specifics:

- Serve approximately 16 young children and their families who are experiencing stressors and traumas, such as violence, abuse, and out-of-home placement.
- Low caseload (approximately six to eight families per clinician)
- Staffing: one Clinical Supervisor; two Licensed Clinicians; two Health Worker II with substance abuse expertise; two Resource Specialist to assist families obtain housing and other basic needs; one Parent Peer, and one Youth Peer. All members of the staff will have expertise in early childhood development.

Behavioral Health Access Center

Background and Community Need

Designed in 2008 to promote more timely access to behavioral health services and to better coordinate the intake and referral process for individuals seeking services, the Behavioral Health Access Center (BHAC) was one of the first projects funded by MHSA. The BHAC is a portal of entry into San Francisco's overall system of care and co-locates the following five behavioral health programs: 1) Mental Health Access for authorizations into the Private Provider Network, 2) the Treatment Access Program for assessment and placement into addiction and dual diagnosis treatment, 3) the Offender Treatment Program (formerly SACPA Prop 36) to place mandated clients into addiction and dual diagnosis treatment, 4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy, and 5) the CBHS Pharmacy that provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol detoxification medications for Treatment Access Program clients, specialty behavioral health medication packaging and serves as a pharmacy safety net for all CBHS clients.

Program Overview

As a program that serves clients on both a drop-in and appointment basis, BHAC seeks to provide the necessary care coordination for all San Franciscans in need of behavioral health care. BHAC has relied on MHSA resources to increase the depth of clinical care and other services. Through the provision of additional staff, clients receive a higher quality of care and are linked to services within a meaningful period of time. This helps increase positive client outcomes and improves access to care. BHAC programs are supported by an expanded team of MHSA-funded staff, including:

- A Psychiatric Nurse Practitioner who provides expertise in treatment planning, identification of primary care concerns, and stabilization of behavioral health issues
- Two Eligibility Workers who help increase client access to entitlements (e.g., Medi-Cal, Healthy SF, and SFPATH) and to care through linkages with the Private Provider Network
- Two clinical pharmacists who provide expertise in client medication management services (e.g., drug specific monitoring) and lead client medication groups. A full-time pharmacy technician who assists the CBHS Pharmacists to provide Substance Use Disorder Treatment medications, clinical tracking and support to prescribers.

Target Population

The BHAC target population includes multiple underserved populations including the chronic and persistently seriously mentally ill, substance use disorder and dual diagnosis clients. A substantial number of clients are indigent, homeless, non-English speaking, and/or in minority populations

One of the pharmacists is bilingual and provides direct client treatment for medication management, medication review, and smoking reduction services to the Cantonese-speaking population at Chinatown North Beach Clinic and Sunset Mental Health Center.

Budget and Costs per Client

Behavioral Health Access Center expenditures for fiscal year 2014-15 are projected to be $803,751. The projected per-client costs are detailed below.

Exhibit 6: Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Behavioral Health Access Center	1857 clients	$803,751	$433

Projected Outcomes

BHAC seeks to achieve the following outcomes:

- Provide timely access to behavioral health and physical health care
- Increase access to public benefits programs
- Improve system medication use:
  - Improve prescribing for Substance Use Disorder by all prescribers at CBHS
  - Reduce polypharmacy of psychiatric medications
  - Improve safe and appropriate prescribing of benzodiazepines

Program Specific Community Program Planning (CPP) Activities

BHAC employs both peer navigators and peer specialists. Clinical pharmacists engage clients and their caregivers in the community and clinic by providing bilingual drug information and pharmacy education at meetings such as those held by the Family Alliance and CTNB Schizophrenia support group, as well as at clinical pharmacist Q & A sessions. Clinical pharmacists also engage with stakeholders and clients who are employed by CBHS in the planning and development of smoking reduction and healthy living programs.

Prevention and Recovery in Early Psychosis (PREP)

Background and Community Need

Roughly half of all lifetime mental disorders have been shown to start by the mid-teens and three-fourths by the mid-20s. Severe disorders like schizophrenia are typically preceded by earlier behavioral, social and emotional signs and symptoms that seldom receive clinical attention. Research shows that

intervening during the early stages of psychosis improves outcomes. However, treatment is often not accessed until a number of years later. Missing this critical window for early intervention can lead to greater suffering, trauma and functional deterioration.

Program Overview

PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs internationally in Australia and the United Kingdom, and nationally in the state of Maine, among other sites. PREP treatment services include the following: algorithm-based medication management, cognitive rehabilitation, cognitive behavioral therapy for early psychosis, multi-family groups (MFG), strengths-based care management, and neuropsychiatric and other advanced diagnostic services. PREP has a significant outreach component that obtains referrals of appropriate clients into the program, and that is designed to reduce the stigma of schizophrenia and psychosis in general and promote awareness that psychosis is treatable.

Since its launch in 2010, the PREP program has demonstrated positive outcomes with participants demonstrating reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services. The program has also significantly reduced hospitalizations among participants.

Target Population

PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years. Due to the nature of psychosis – which strikes without regard to income or socioeconomic status – the distribution of cases is expected to approximate the demographic distribution of youth and young adults in San Francisco, but with a somewhat greater proportion of low-income youth and families. PREP partner organizations Larkin Street Youth Services and the Sojourner Truth Foster Care Agency work with special populations of at-risk youth (i.e. foster care and homeless youth).

PREP operates citywide and offers services at the PREP San Francisco office. However, when requested, therapists and staff meet with clients at offsite locations (e.g. client's home, school, etc.) throughout the city. PREP also conducts outreach throughout San Francisco and recently began conducting additional outreach to the Bayview Hunters Point neighborhood (zip code: 94124).

Budget and Costs per Client

PREP expenditures for fiscal year 2014-15 are projected to be $931,770. The projected per-client costs are detailed below.

Exhibit 7. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Prevention and Recovery in Early Psychosis (PREP)	110 clients	$931,770	$8471

Projected Outcomes

The PREP program seeks to achieve the following outcomes:

- Participants will have reduced symptoms of depression, anxiety and psychosis
- Participants will have reduced number of acute psychiatric inpatient hospital episodes
- Participants will develop and use resources to function more effectively and independently, and build capacity to cope with challenges they encounter
- Participants with goals of obtaining positions in competitive employment will engage in new employment or education
- Participants will report high levels of satisfaction and engagement.

Program-Specific Community Program Planning (CPP) Activities

PREP promotes participant involvement in program outreach through the PREP Youth Advisory Council (PYAC). PYAC conducts youth professional development training and provides them with skills to conduct outreach to their peers. In FY 12-13, MHA-SF screened, interviewed and hired eight PYAC members, including two current PREP clients and one PREP Alumnus.

Trauma Recovery Program

Background and Community Need

Children and youth impacted by trauma, including community violence, face serious risk for multiple health and social problems including physical injury, post-traumatic stress syndrome, incarceration, and social isolation. Cultural, linguistic and socially relevant services serve as vehicles in the engagement, assessment, differential diagnosis and recidivism of youth and their families. Services that integrate various interventions – e.g. crisis intervention, family support, case management and behavioral change -- within the context of values, beliefs and norms rooted in the community being served have been well documented and underscore the importance of providing culturally proficient models of service.

The Trauma and Recovery project was selected during the original CSS planning process to address the need for community-based, client-driven prevention and early intervention for individuals, families and communities impacted by violence.

Program Overview

The Trauma and Recovery Program aids youth and families through comprehensive services that aim to reduce psychiatric symptoms, increase functioning and increase coping skills and lessen the likelihood for further intervention in the future. Crisis response and mental health assessment services for students occur on select public school campuses, and services emphasize collaboration with students' parents/caregivers. In addition, one-time and on-going mental health support of teachers, staff and parents/caregivers are available on an individual and group basis.

The original Trauma Recovery Program involved two MHSA-funded lead agencies partnering with a web of community based organizations. The organizations center on frontline violence prevention and intervention responder programs that deliver outreach, assessment, crisis and short-term counseling, and case management. Additionally, these lead agencies provide mental health consultation to this web of organizations, where the treatment's focus is recovery from traumatic response and the symptoms that stem from chronic and/or complex trauma.

Beginning in FY 13-14, the program was expanded to include funding for another agency to implement a pilot to address the unmet mental health needs of Latino youth and families who are traditionally unwilling to pursue treatment from the mental health system, and whose resistance is further exacerbated by geographical/ gang boundaries that preclude youth from accessing scarce mental health resources due to their location in danger zones. With a focus on addressing the pervasive trauma experienced by this community, the pilot program includes a treatment model that combines culturally informed, evidence-based substance abuse and mental health practices. The pilot also includes mental health training and consultation for agency staff.

Target Population

The programs described above provide individual and family centered intervention to the following target populations.

- **Youth ages 14 to 25 and their families who reside in the Mission District and Latinos citywide with trauma recovery services.** The target population is youth and their families affected by street and community violence. This program primarily focuses on the 94110, 94112, 94102 and 94103 zip codes. Individuals and/or families suffering from or at-risk of trauma will receive face-to-face assessments and treatment with Clinical Case Managers, with individuals receiving an average of three to nine months of sessions. The focus of treatment is recovery from traumatic response and the symptoms that stem from chronic and/or complex trauma.

- **School-aged public school students who reside in communities that struggle with violence (Bayview Hunter's Point, Potrero Hill and Western Addition).** Clients represent a diverse mix of race/ethnic groups including African American, Latino, Asian & Pacific Islander and Caucasian. Youth are assessed and linked to services via crisis response and mental health assessments delivered at public school campuses. Students served are either referred or identified by school staff as in need of help but do not qualify for specific mental health programs offered on campus.

Budget and Costs per Client

The expenditures for Trauma Recovery Services for fiscal year 2014-15 are projected to be $547,000, the majority of which are allocated to direct services. The expenditures for specific service modalities are listed in Exhibit 8 below.

Exhibit 8. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Direct Service	83 clients	$351,174	$4,231
Consultation Services	461 participants	$195,826	$425

Projected Outcomes

The recovery and trauma programs seek to achieve the following outcomes:

- Participants will experience improvements in symptoms of depression, anxiety, self-concept and/or behavior
- Participants, including youth, parents, and community violence response staff, will have increased understanding of trauma related conditions and appropriate interventions
- Participants will report fewer trauma-related emotional and psychological symptoms (e.g., irritability, feelings of hopelessness, avoidant behaviors)

Program-Specific Community Program Planning (CPP) Activities

Participants are engaged throughout the program design and implementation phases through the following activities:

- **Consumer participation in Program Design**: Peace Dialogues' participants are instrumental in the design of the program and lead the implementation and facilitation of efforts with the support from program staff.
- **Consumer participation in evaluation of Mental Health Interventions**: program participants take pre- and post-test surveys that inform the impact and design of the program's efforts. Clients are asked to self-report on the benefits of mental health services and provide the mental health specialist with feedback for when therapy is not working for them during their treatment time.

Expanding Trauma Recovery Services in District 10

For over three decades, community violence has had a devastating impact on of communities within San Francisco's Southeast Sector or "District 10". Today, trauma affects many young people and their families, with damaging long-term physical and emotional impacts. According to data from the City and County of San Francisco's Community Behavioral Health System, 64% of children and youth in District 10 have been exposed to at least one type of trauma and more than one third of all child and youth clients have been exposed to multiple types of traumatic events (38% and 36%, respectively).

While community violence and the resulting trauma have been identified by community members, public health representatives, and the City as one of the most important issues impacting District 10, not enough has been done to provide systematic and sustainable healing and treatment service. On November 13, 2012, approximately fifty providers, experts and members of the City and County of San Francisco convened for the Southeast Trauma Summit, partially funded by MHSA, to create a practical plan to effectively address the healing needs of residents impacted by community violence and trauma within District 10. The purpose of the summit was to:

- Identify best practices for trauma related to community violence in the Southeast.
- Identify service providers within the Southeast Sector to provide healing and treatment for youth and families impacted by trauma related to community violence.
- Develop strategies to shift City funding to culturally competent providers within the Southeast sector to provide treatment and healing services for trauma related to community violence.

The summit emphasized a new approach to community violence and resulted in recommendations to meet the needs of the residents of District 10 in a coordinated fashion. MHSA is currently working with community representatives and organizers of the Trauma Summit to develop and implement a Treatment and Response Approach that incorporates recommendations outlined in the D-10 Trauma Summit Report. While details of a program and expenditure plan need to be developed and a competitive bidding process is pending, $200,000 has been allocated to this effort.

Integration of Behavioral Health into the Juvenile Justice System

Background and Community Need

Both nationally and locally in San Francisco, over 70% of youth involved in the juvenile justice system have behavioral health problems. Detention offers a critical window to link youth to appropriate mental health services. However, alarmingly high numbers of youth in juvenile justice systems nationwide have untreated mental health needs that may be the basis of their delinquent and risk-taking behaviors and pose obstacles to rehabilitation, thus contributing to increased recidivism.

With different roles to play, probation and community mental health can be at odds about how to best address the needs of youth who have committed crimes and have had difficulty engaging in treatment. In the absence of objective information, especially at a time of crisis, these differences can undermine collaboration, breakdown communication and result in uncoordinated and opinion-driven plans that lead to the wrong door or no services, and ultimately, poor outcomes for youth.

Program Overview

AIIM (Assess, Identify Needs, Integrate Information, and Match to Services) Higher takes a collaborative path that eliminates subjectivity and puts standardized identification of youth needs and strengths with the Child Adolescent Needs and Strengths (CANS) assessment at the center of a structured decision-making, service planning and treatment engagement process. AIIM Higher is a probation-behavioral health assessment and planning program that connects and supports the engagement of youth and families in appropriate and effective services. AIIM provides a continuum of services including: behavioral health screening within the juvenile justice system; consultation with probation, courts, and other legal stakeholders and community providers; resource referral and information; standardized assessment; and linkage and engagement services for youth and families; and family-driven care planning. AIIM provides services through a multidisciplinary team that includes a psychologist, social workers, a psychiatrist, and an occupational therapist.

In addition to the core services described above, AIIM Higher oversees three therapeutic court programs, the Juvenile Wellness Court, the Juvenile Drug Court, “SF-ACT” and the Competency

Attainment Program. The **SF-ACT Intensive Outpatient Treatment program based at Civic Center Secondary** is an unprecedented collaboration among the Superior Court, Juvenile Probation, Department of Children, Youth & Families, SFUSD, the Department of Public Health, Richmond Area Multi-services, Inc., and Catholic Charities, it is also supported in part by MHSA funding and will serve 40 youth during this pilot year.

MHSA also provides funding to support a half-time **Psychiatrist at the Juvenile Justice Center** to provide medication management and support services to incarcerated youth in an effort to improve outcomes after discharge.

Target Population

The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11-21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. AIIM Higher operates citywide and serves youth and their families wherever they feel most comfortable whether it is at home, school or in the community. Services are also offered at the Juvenile Justice Center, 375 Woodside Ave, Room 225 and 606 Portola Avenue.

Budget and Costs per Client

Program expenditures for Integration of Behavioral Health and Juvenile Justice for fiscal year 2014-15 are projected to be $470,189. The projected per-client costs are detailed below.

Exhibit 9. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Integration of Behavioral Health Into the Juvenile Justice System	512 clients	$470,189	$918

Projected Outcomes

- Youth and their families are engaged in services
- Youth participants who transition back into the community are successfully linked to behavioral health services
- Recidivism rates among AIIM youth will be decreased
- Participants will report a decrease in their needs and risks and improvement in life functioning on their most recent Child and Adolescent Needs and Strengths (CANS) assessment

- Probation and providers are collaborating more in the management and delivery of enhanced services

Integration of Behavioral Health and Primary Care

Background and Community Need

Too many people go without their mental health needs being adequately identified and addressed. Of equal concern is the substantial physical suffering and premature death for individuals with serious mental illness. To address these concerns, the Department of Public Health has been making great strides to integrate physical and behavioral healthcare. In 2009, after an extensive community planning process, DPH decided to implement the Primary Care Behavioral Health Model in DPH primary care clinics. In this model, behavioral health clinicians work as a member of a primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based and practical interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management services (e.g., class and group medical visits). MHSA has provided resources to support this initiative.

Program Overview

MHSA supports behavioral health staff stationed at the following Primary Care Clinics:

- Chinatown Public Health Clinic – Disability Clinic
- Cole Street Clinic
- Larkin Street Youth Clinic
- Curry Senior Center Primary Care Clinic
- Southeast Health Center

MHSA also supports primary care staff stationed at the following mental health clinics:

- South of Market Mental Health
- Behavioral Health Access Center
- Chinatown Child Development Center

Target Population

The target populations for these services are individuals and families served in primary care clinics with unidentified behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

Building Bridges: Linking Clinic Integration Activities with School-Based Services (INN-Funded)

Building Bridges, now in its second year, was designed to test a staffing model to promote **interagency collaboration** between DPH Community Health Programs for Youth (CHPY) clinics and San Francisco Unified School District. Youth living in neighborhoods like Hunter's Point, Sunnydale, and other neighborhoods in the Southeast section of San Francisco, are at significant risk for exposure to community violence, family upheaval and other factors that may cause and exacerbate behavioral health problems. Reaching many of these youth in the community is often difficult due to (1) stigma associated with accessing mental health services, (2) youth not knowing where to go if they are interested in services, and (3) fears around consent and confidentiality. Additionally, many youth with mental health issues go to primary care services with physiological complaints that are actually psychological in nature. For these youth, an **interagency collaborative** approach between schools where youth should be daily, community behavioral health providers and primary clinics potentially supports increased access for youth and a streamlined system for professional linkages and referrals for care.

The addition of an INN-funded position enabled the **Balboa Teen Health Center (BTHC)** to increase individual behavioral health services from 2,280 to 2,605 individual encounters, and overall groups by approximately 10%. Moreover, as this position was filled by a Cantonese-speaking therapist, service utilization by this population of youth, many of whom tend to present with anxiety and depressive disorders, increased by 17%. MHSA funds have allowed the **3rd Street Youth Center and Clinic** to build significant school-linked services in the southeast sector of the city and attempting to better address the significant overall health needs of the youth in this community. The MHSA-funded psychologist allowed deeper connection with more youth, to build rapport, and eventually support stronger connections to other services that are clinic-based in their community. The MHSA-funded position of a social worker at **Hawkins Clinic,** located in Visitacion Valley has created major inroads in working more effectively with youth, particularly males, from the that southeastern neighborhood. These youth are highly likely to have experienced significant trauma in their lives which affects both their positive development and attachment to school.

Budget and Costs per Client

Program expenditures for Integration of Behavioral Health and Primary Care for fiscal year 2014-15 are projected to be $1,179,270. The projected per-client costs are detailed below.

Exhibit 10. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Integration of Behavioral Health and Primary Care	2000 clients	$1,179,270	$590

Projected Outcomes

Programs seek to achieve the following outcomes:

- Increase the provision of behavioral health screening and intervention in primary care settings
- Increase the provision of evidence-based short-term treatment interventions at DPH primary Care Clinics
- Decrease in symptom levels from baseline
- Increase number of referrals to specialty mental health clinics
- Increase the number of individuals with behavioral health concern that are successfully managed in a primary care setting

Enhancing Integration with Behavioral Health Homes

MHSA is supporting the implementation of a novel model of integrated care called the Behavioral Health Homes (BHH) by funding the Chief Medical Officer for the BHH Initiative. In his role, Dr. James Ryan Shackelford will be responsible for the strategic planning, oversight, and implementation of the initiative. Within a BHH, clients will receive an increased level of team-based care related to their physical conditions including primary care services for acute and chronic conditions, coordination with medical and surgical specialists as well as with social service and community agencies, system navigation, and enhanced service integration through team-based care, quality improvement and population management principles. Dr. Shackelford will work closely with SF Health Network executive leaders in Primary Care, Behavioral Health and Ambulatory Care to create the training structure that will sustain this Model of Integrated Care uniformly across SFHN Behavioral Health Clinics.

Dual Diagnosis Residential Treatment

Background and Community Need

Residential treatment was identified as a priority by the MHSA planning task force in San Francisco. Specifically, the original CSS plan called for additional beds to offer an opportunity for consumers undergoing acute crisis to receive support towards stabilization, and engage in a partnership with the system towards recovery.

Program Overview and Target Population

Dual diagnosis residential treatment services are provided to individuals who do not have Medi-Cal coverage and who would otherwise not be eligible for services. As a result of the Affordable Care Act (ACA), more individuals are now eligible to enroll in MediCal than ever before. SF MHSA intends to partner with the service provider and other stakeholders to evaluate how ACA may impact the target population for this program.

Budget and Costs per Client

HealthRight 360 expenditures for fiscal year 2014-15 are projected to be $85,309. The projected per-client costs are detailed below.

Exhibit 11. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Dual Diagnosis Residential Treatment	25 clients	$85,309	$3,412

Projected Outcomes

The dual diagnosis residential treatment and support programs seek to achieve the following outcomes:

- Clients are linked to an appropriate level of continuing care and support
- Clients are linked to a primary care home
- Clients will avoid hospitalization for mental health reasons for the duration of their stay
- Clients will report increased quality of life (versus self-report at intake)

Program Specific Community Program Planning (CPP) Activities

Peer staff conducts outreach to the provider community, criminal justice system, homeless shelters, medical providers and other substance abuse treatment programs through regular presentations, participation in community meetings, and public health meetings.

Expanding Outpatient Mental Health Clinic Capacity

Program Overview and Target Population

In recognition of disparities in access to behavioral health treatment for certain populations, this program has expanded the staffing capacity at outpatient mental health clinics to better meet the treatment needs of underserved communities. Funding through this initiative has allowed for expanded capacity at the following clinics to serve the populations noted.

- South of Market Mental Health Clinic – homeless individuals with dual diagnosis
- South East Mission Geriatrics – older adults
- Mission Mental Health – monolingual Spanish speaking adults

New Position: MHSA Wellness and Recovery Program Manager

The FY 13-14 MHSA budget includes an additional position for a MHSA Wellness and Recovery Program Manager. Once hired, this Program Manager will work collaboratively with CBHS staff, consumers and other community stakeholders to develop, implement and evaluate projects to promote the principles and practices of wellness and recovery across the CBHS systems of care. The position will also entail identifying and supporting the implementation of evidence-based and promising practices, designing and conducting research and planning activities, and developing and conducting training, as well as providing technical assistance.

Projected Outcomes

Programs seek to achieve the following outcomes:

- Increase access to care for underserved communities
- Improve the capacity of clinics to provide culturally competent care

Budget and Costs per Client

Expanding outpatient mental health capacity expenditures for fiscal year 2014-15 are projected to be $338,323. The projected per-client costs are detailed below.

Exhibit 12. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Expanding Outpatient Mental Health Clinic Capacity	150 clients	$338,323	$2,255

3. Mental Health Promotion and Early Intervention (PEI) Services

In half of the lifetime cases of mental health disorders, symptoms are present in adolescence (by age 14); in three-quarters of cases, symptoms are present in early adulthood (by age 24). There are often long delays between onset of mental health symptoms and treatment. Untreated mental disorders can become more severe, more difficult to treat, and cause co-occurring mental illnesses to develop. Currently, the majority of individuals served by CBHS enter our system when a mental illness is well-established and has already done considerable harm (e.g. prison, hospitalization or placement in foster care) despite the fact that many mental health disorders are preventable and early intervention has been proven to be effective.

With a focus on underserved communities, the primary goals of Mental Health Promotion and Early Intervention (PEI) Services are to raise awareness about mental health, address mental health stigma, and increase access to services. PEI builds capacity for the provision of early intervention services in community-based settings where mental health services are not traditionally provided (e.g. community-based organizations, schools, ethnic specific cultural centers and health providers).

The PEI service category is comprised of the following: (1) Stigma Reduction (2) School-Based Mental Health Promotion (K-12), (3) School-Based Mental Health Promotion (Higher Ed) (4) Population-Focused Mental Health Promotion, (5) Mental Health Consultation and Capacity Building, and (6) Comprehensive Crisis Services. INN funding also supports several programs in this MHSA service category.

Statewide PEI Projects

MHSA included funding for three Statewide Prevention and Early Intervention Projects: Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction. In 2009, San Francisco received an annual allocation for Prevention and Early Intervention Statewide Projects of $755,100 for a period of four years. San Francisco allocated this funding to the Joint Powers Authority known as the California Mental Health Services Authority (CalMHSA). CalMHSA was founded by member counties to jointly develop, fund, and implement mental health services projects and educational programs at the State, regional, and local levels.

Since the adoption and implementation of the existing CalMHSA PEI Statewide Implementation Plan in 2011, the investment by counties and the impact of the statewide PEI Projects resulted in CalMHSA Board actions to continue to find a funding solution for continuing PEI Statewide Projects. In support of this plan to sustain statewide PEI work, San Francisco, has proposed making a contribution of $100,000 in FY 14-15, or 2% of its local PEI allocation to CalMHSA.

Stigma Reduction

Program Background

Sharing Our Lives, Voices and Experiences

(SOLVE) is a stigma elimination program. SOLVE trains people in the community who have been living with mental health challenges to share their personal experiences. By telling their stories, these peer educators help to reduce the social barriers that prevent people from obtaining treatment. The SOLVE Speakers Bureau consists of an array of people who have had challenges in their lives with mental health conditions and who come forward to talk openly about these experiences by sharing their stories of struggle, hope and triumph with others. SOLVE's mission aims to decrease the fear, shame and isolation of those with mental health challenges and conditions through peer education.

Target Population

SOLVE speakers reach individuals including community members, public policy makers, health care providers, corporate and community leaders, students and school employees, law enforcement and emergency service providers, and behavioral health providers. Geographically, SOLVE will target individuals 18 years or older within communities that are severely under-served and less likely to access or obtain support for prevention, wellness, and recovery. These areas include the Tenderloin, Mission, Bayview/Hunter's Point, Excelsior, Chinatown, and Visitacion Valley neighborhoods in San Francisco. SOLVE will work with community centers, religious institutions, and schools in each of these areas to deliver culturally-specific neighborhood-based presentations and provide linguistically appropriate referral materials. SOLVE will also leverage community and partnership resources in order to provide interpretation for presentations to monolingual Chinese, Russian, Spanish, and Tagalog-speaking audiences. In addition, SOLVE will target more of the diverse gender-variant community within San Francisco.

Budget and Costs per Client

SOLVE expenditures for fiscal year 2014-15 are projected to be $175,000. The projected per-client costs are detailed below.

Exhibit 13. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
SOLVE Stigma Reduction	1600 participants	$175,000	$109

Projected Outcomes

The SOLVE program seeks to achieve the following outcomes:

- Presentation attendees will:
  - Demonstrate a better understanding of the effects of stigma on people with mental health challenges and conditions

    - Demonstrate a better understanding of mental health challenges and conditions,
    - Express less fear/more acceptance of people with mental health challenges
- Peer Educators will report experiencing reduced self-stigma, reduced risk factors, improved mental health, improved resilience and protective factors, increased access to care and empowerment

Program Specific Community Program Planning (CPP) Activities

The 25-30 consumers trained and supported to be SOLVE speakers are engaged in all elements of program implementation and evaluation. Experienced SOLVE speakers are involved in the training of new speakers.

School-based Mental Health Promotion (K-12)

Program Overview

School-Based Mental Health Promotion – a collaboration of community-based organizations and San Francisco K-12 campuses – applies school-based best practices that address non-academic barriers to learning. These programs support student success by combining the full spectrum of prevention, early intervention, and linkages to behavioral health services (e.g., wellness promotion workshops, family engagement and support, career planning, mentoring, crisis intervention, case management) with existing resources already housed in school settings. Presently, these services are provided at the following schools:

- Burton High School
- Balboa High School Teen Health Center
- Charles Drew Preparatory Elementary School
- Hillcrest Elementary School
- James Lick Middle School
- June Jordan High School
- San Francisco School of the Arts High School

Target Population

The target population for these programs is low-performing students who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction.

Budget and Costs per Client

School-based Mental Health Promotion (K-12) expenditures for fiscal year 2014-15 are projected to be $991,000. The projected per-client costs are detailed below.

Exhibit 14. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
School-Based Mental Health Promotion (K-12) – Prevention Activities	3009 clients	$495,500	$165
School-Based Mental Health Promotion (K-12) – Early Intervention Activities	700 clients	$495,500	$708

Projected Outcomes

The School-Based programs endeavor to increase the capacity of school staff to address the behavioral health needs of the children in their care, as well as empower the youth themselves to seek and engage in supportive services. Specifically, they seek to achieve the following outcomes:

- Teachers will report that they can respond more effectively to student's behavior.
- Students will show a marked reduction in the frequency of behavioral or emotional outbursts in the classroom,
- Students will be able to identify services they can access for support and will rate their comfort level in accessing these services as moderately comfortable or better.
- Students will be able to identify skills they can successfully utilize to reduce stress or other related symptoms.

Spotlight on K-12 Programs' Evaluation Efforts

K-12 programs' evaluation efforts are centered on five providers – three in high school settings and two in elementary school settings. All five programs identified a common outcome. Elementary providers chose to focus on teacher self-efficacy, while the high school providers focused on school connectedness, with an emphasis on positive relationships with adults in school. Elementary programs used the Teacher Opinion Survey, while high school programs used a slightly adapted section of the California Healthy Kids Survey.

Programs have currently completed the collection of pre-survey data from providers working in elementary schools, and have 36 teacher surveys. The high school providers work with students on a rolling basis and anticipate collecting more pre and post-surveys. Surveys from 70 students have been collected so far.

Programs will also collect qualitative data in the form of feedback from teacher focus groups at elementary sites, student interviews at high school sites, and interviews with providers to document lessons learned for future MHSA evaluation efforts.

Program Specific Community Program Planning (CPP) Activities

The School-Based programs will continue to engage school-based staff in the development and implementation of the interventions provided on-site. Programs based in high school recruit and train peers to conduct outreach, psycho-social education and peer support. In addition, staff, as well as youth, will continue to take part in the robust program evaluation that is currently being conducted in partnership with all the school-based programs and lead by consulting firm Learning for Action.

School-based Mental Health Promotion (Higher Education)

Program Overview

School-based programs focused on higher education include partnerships with California Institute of Integral Studies (CIIS) and the Student Success Program at San Francisco State University. The CIIS MHSA project expands student support services within CIIS's School of Professional Psychology (SPP) program to increase recruitment and retention of students from underrepresented groups through a variety of activities (e.g. trainings, individualized educational plans, workshops on the management, referrals). An innovative program on the San Francisco State University (SFSU) campus, the Student Success Program – located in the College of Health and Social Sciences – is designed to increase university access and enrollment, enhance retention and maximize graduation rates among consumers, family members of consumers and members of underserved and underrepresented communities who are preparing for careers in the public behavioral health field.

Target Population

Target populations are behavioral health consumers, family members of consumers and members of communities that are underserved and underrepresented in the public behavioral health workforce – e.g. African Americans, Latinos, Native Americans, Asian Pacific Islanders and students who identify as LGBTQQI. The program is designed to support transitional age youth and adults who have experienced bio psychosocial and environmental stressors that have negatively impacted their academic performance (e.g. mental/physical health issues, poverty, substance abuse, incarceration).

Budget and Costs per Client

School-based Mental Health Promotion (Higher Education) expenditures for fiscal year 2014-15 are projected to be $417,226. The projected per-client costs are detailed below.

Exhibit 15. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
School-Based Mental Health Promotion (Higher Education) – Prevention Activities	14,901 individuals	$208,613	$14
School-Based Mental Health Promotion (Higher Education) – Early Intervention Activities	470 individuals	$208,613	$444

Projected Outcomes

School-based programs focused on higher education seek to achieve the following outcomes:

- Increase university access and enrollment
- Enhance retention and maximize graduation rates among individuals and family members with lived experience
- Expand student support services including initial assessment, individual planning, academic and peer counseling

Program Specific Community Program Planning (CPP) Activities

Student Success Program services are student-driven and include counseling, coaching, advising, crisis intervention, career planning and professional development, peer mentorship, community building and social activities. Both school programs actively engage student in the development, implementation and evaluation of programming.

Population-Focused Mental Health Promotion and Early Intervention

Background and Community Need

San Francisco's original PEI plan included a Holistic Wellness Initiative that was adapted from a model of best practices developed for San Francisco's Native American population (i.e., the Holistic System of Care for Native Americans in an Urban Environment). The Holistic Wellness Initiative, designed to meet the cultural and linguistic needs of other underserved populations focused on increasing: 1) participants' problem-solving capacity and accountability for personal wellness; 2) knowledge about the early symptoms of potentially severe and disabling mental illness; and 3) inter-dependence and social connections within families and communities. San Francisco's holistic wellness work has not only been influential in reaching underserved communities, but has also helped reduce barriers to access.

Program Overview

Our community planning efforts have prompted us to utilize available MHSA resources more effectively to further reduce disparities to service access. By broadening the Holistic Wellness Initiative to the Population-Focused Mental Health Promotion service category, we are more intentional about San Francisco's focus on underserved and priority populations, including: 1) racial/ethnic populations; 2) gay, lesbian, transgender and questioning individuals; 3) socially isolated older adults; and 4) homeless individuals. This service category has allowed us to assess MHSA services more comprehensively, avoid duplication, and promote cultural congruency and competence. In addition, population-focused mental health promotion services are centered on acknowledging the healing practices, ceremonies and rituals of diverse communities, with an emphasis on understanding the cultural context first and working in partnership with programs to design culturally relevant and appropriate services. Programs also honor participants' cultural backgrounds and practices of mental health while also making available a variety of services centered on non-clinical support.

Like other PEI programs, this service area centers on raising awareness about mental health, reducing stigma, intervening early, and increasing access to services. And what differentiates this cohort of programs from other PEI programs is that it concentrates its efforts on very specific groups, based upon ethnicity, culture, age, sexual orientation, and homelessness.

These Population Focus programs benefit the African American, Asian and Pacific Islander, Native American, Latino/Mayan, Arab, Homeless Adults, Homeless/System Involved Transitional Age Youth, and LGBTQ communities by honoring their histories, cultural and spiritual beliefs around health and mental health, and their community defined practices toward wellness.

Programs funded in this service category provide the following:

- **OUTREACH AND ENGAGEMENT:** Activities intended to establish/maintain relationships with individuals and introduce them to available services; raise awareness about mental health.
- **WELLNESS PROMOTION:** Activities for individuals or groups intended to enhance protective factors, reduce risk-factors and/or support individuals in their recovery; promote healthy behaviors (e.g. mindfulness, physical activity)
- **SCREENING AND ASSESSMENT:** Activities intended to identify individual strengths and needs; result in a better understanding of the health and social concerns impacting individuals, families and communities, with a focus on behavioral health issues.
- **SERVICE LINKAGE:** case management, service coordination with family members; facilitate referrals and successful linkages to health and social services, including specialty mental health services.
- **INDIVIDUAL AND GROUP THERAPEUTIC SERVICES:** Short-term (less than 18 months) therapeutic activities with the goal of addressing an identified behavioral health concern or barrier to wellness.

Exhibit 16. Population-Focused Programs

Target Population	Program	Services
Socially Isolated Older Adults	Older Adult Peer-to-Peer Services Network* (INN)	New INN funded pilot program (FY14-15) to develop and implement peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors.
	Older Adult Behavioral Health Screening and Response Project	Home-based behavioral health screening, brief interventions and service linkage.
	Curry Senior Drop-in Center	Wellness activities, health care, housing support services and service linkage to older adults in the Tenderloin neighborhood.
Asian & Pacific Islander	Asian & Pacific Islander Youth & Family Community Support Services	Outreach and therapeutic services tailored to A&PI youth.
	Asian & Pacific Islander Health Parity Mental Health Colaborative	New initiative convened workgroups consisting of at least ten community-based organizations and at least 50 community members from three API communities (Southeast Asians, Filipino, Samoan) that reflect the greatest disparity in mental health access. Implementing work plans each workgroup created to provide culturally competent and holistic mental health promotion and early intervention services and to develop capacity of partner organizations to understand and address mental health.
African American	Collaboration with the Faith-Community (INN)	Engages faith-based organizations and families in Bayview/Hunter's Point and Visitaction Valley in order to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers.
	African American Holistic Wellness Program	Wellness workshops, community cultural events, support groups, and healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods
	Ajani African American Outreach and Engagement	Outreach activities to engage individual, family, and group therapy to African American families who live in low-income communities, are affected by mental illness, and/or are impacted by racism.
Mayan/Indigenous Latino	Indigena Health & Wellness Collaborative	Workshops that focus on different health topics and cultural activities, community forums on trauma and spiritual and cultural Mayan/Indigenous ceremonies, self-risk and needs assessments, individual therapeutic services, training, and outreach.

Exhibit 16. Population-Focused Programs

Target Population	Program	Services
Native American	Native Wellness Center: Living in Balance	Outreach and engagement, wellness promotion, individual and group therapeutic services, pro-social community building events, direct services, and service linkage.
Homeless Adults	Holistic Violence Prevention & Wellness Promotion Project	Prevention activities that address safety in the community through the Healing, Organizing, & Leadership Development Program, completes mental health screenings, and holds community violence prevention events
	Tenderloin Self-Help Center	Low-threshold services (peer counseling, case management, peer-led support groups, employment resource center) for those who do not otherwise utilize traditional service delivery models
	Sixth Street Self-Help Center	Counseling and case management support, holistic behavioral health services and primary care triage, support groups, and socialization activities for residents of the Sixth Street/South of Market neighborhood
Homeless or System Involved TAY	ROUTZ TAY Wellness Services	Drop-in programming (e.g., group and individual counseling, psychiatric consultation, medication management, crisis planning, and psychoeducation)
	TAY Multi-Service Center	Community outreach and education, delivers coordinated clinical case management services, and screens TAY for development leadership services
	SF4TAY.com	*S*F4TAY.org is a TAY-specific website to improve outreach to transitional age youth. This comprehensive, searchable resource directory allows young adults to easily access information in order to connect with the range of services available to them. Services in health, workforce, education, and housing are listed on one central site.
LGBTQ	Transgender Wellness* (INN)	Peer staff conduct outreach, facilitate wellness/ recovery groups, peer counseling and system navigation and linkage for transgender clients. This program is described in the Peer-to-Peer services category, but is also considered an important component of the Population Focused work.
Arab Refugees	Arab Refugee Support Group	Focused on planning that will provide culturally responsive mental health support.

*Both the Transgender Wellness and Older Adult Peer Support programs are 'locally approved' INN projects. Due to changes to the budget and scope of each project, this plan includes revised INN Proposals to be submitted to the MHSOAC (see Appendices A and B).

Target Population

Exhibit 17 details each target population's approximate size, risk factors, target neighborhoods, and population-specific strategies.

Exhibit 17. Profiles of Target Populations

Target Population	Size of population	Risk Factors	Target Neighborhoods	Population Specific Strategies
Socially Isolated Older Adults	136,000 at least 60 years of age*	Social isolation, poverty, language barrier	Citywide	In-home partnership with food services, warm Line, behavioral health screening in primary care settings
Asian Pacific Islander	271,274*	Linguistic isolation, immigration, economic instability	South of Market (94103), Tenderloin (94102, 94109), Bayview Hunters Point (94124), Potrero Hill (94108) and Visitacion Valley (94134)	API Health Parity Coalition (to address health disparities), holistic and culturally relevant health promotion, community building
African American	48,780*	Trauma, poverty, incarceration, stressed families	Bayview (94124), Oceanview (94112) and Western Addition (94115) areas	Partnerships with churches, Healing Circles, wellness promotion activities (e.g. Mindfulness workshops, community cultural events), training and coaching sessions (e.g. healthy eating workshops, positive self-esteem for girls, Triple P parenting group), group therapy (e.g. , Grief & Loss group) and individual therapy
Mayan and Latino	Latino: 121,774* Mayan: >10,000	Poverty, cultural and linguistic barriers, unstable housing and homelessness, stressed families (related to cultural and racial discrimination and immigration), violence and trauma, recent immigration	Mission (94110, 94103) and Tenderloin (94102) Districts, Richmond (94115)	Culturally relevant and linguistically appropriate services, culturally informed model

Exhibit 17. Profiles of Target Populations

Target Population	Size of population	Risk Factors	Target Neighborhoods	Population Specific Strategies
Native American	4,024*	Trauma, stressed families, school failure, incarceration, isolation	Mission District (94110) and Citywide	Holistic approaches incorporating Native American values and traditions, community building events, wellness promotion, Talking Circles
Homeless Adults	6,514**	Unemployment, poverty, substance use, incarceration, domestic violence, trauma	Citywide	Wrap around services, peer-based self-help model, harm reduction model, community building
System Involved TAY and Homeless TAY (ages 16-24)	2200 on probation**** Over 1000 receive either General Assistance or support from CalWorks**** Over 200 age out of foster care each year**** 4500-6800 homeless annually**	Unemployment, homelessness, criminal justice involvement, poverty, trauma	Citywide	Multi-service centers, community outreach, prevention and early intervention services, peer-based services
LGBTQ	94,027*****	Discrimination, homophobia, transphobia, isolation, housing and economic instability	Citywide	Providing anti-stigma training, wellness & recovery services for Transgender community

** 2010 U.S. Census Bureau*

***San Francisco Homeless Count Report*

****San Francisco Mayor's Office of Housing and Office of Economic & Workforce Development 2010-14 Five-Year Consolidated Plan*

*****The Mayor's Task Force on Transitional Youth Report: Disconnected Youth in San Francisco*

****** http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-Same-Sex-Couples-GLB-Pop-ACS-Oct-2006.pdf*

Budget and Costs per Client

Population-focused mental health promotion expenditures for fiscal year 2014-15 are projected to be $2,751,970. The projected per-client costs are detailed below.

Exhibit 18. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Population-Focused Mental Health Promotion – Prevention Activities	25,687 individuals	$1,375,985	$54
Population-Focused Mental Health Promotion – Early Intervention Activities	4,578 individuals	$1,375,985	$301

Projected Outcomes

Population-Focused Mental Health Promotion objectives will focus on five service types: outreach and engagement, screening and assessment, individual and group therapeutic services, wellness promotion and service linkage. Programs seek to achieve the following shared objectives:

- Individuals will be identified with a need referred to mental health and other social services.
- Individuals will be screened and identified as needing mental health/behavioral health services
- Individual case/care plan goals will be achieved.
- Participants will report increased social connectedness, quality of life, harm reduction and help seeking behavior.
- Individuals will receive one-on-one therapeutic services.
- Individuals will participate in wellness promotion activities.
- Individuals and families will be successfully linked to mental health and/or other social services.

Program-Specific Community Program Planning (CPP) Activities

Participant involvement plays an integral role in the planning process for population-focused mental health promotion programs. In preparation for new PEI regulations and the FY14-15 contract cycle, SFMHSA is partnering with all seventeen population-focused programs to create shared performance objectives that will measure common service types, such as outreach and engagement, screening and assessment, and individual and group therapeutic services. Because population-focused programs specifically target underserved communities, it is especially critical to partner with these organizations

to spread awareness around mental health. In addition, this involves a level of translation between the communities and the mental health system, as the term and concept do not exist in certain languages and/or are stigmatized.

In order to bridge these barriers and promote a culturally competent and inclusive process, SFMHSA is holding a series of meetings called 'Learning Circles' with population-focused programs to collectively discuss and agree on service types, activities and outcomes. These shared performance objectives will then be measured and reported on for the next fiscal year. The Learning Circles also provide an opportunity for programs to share their progress on implementation, goals and strategies for evaluation.

Mental Health Consultation and Capacity Building

Background and Community Need

Mental health consultation builds upon the understanding that the social and emotional well-being of a child is squarely linked to the relationships that child has with the adults/caretakers in their lives. Mental health consultation services are built upon an approach that involves mental health professionals working with non-clinical staff to enhance their provision of mental health services to clients. Specifically, the consultation model is built on the relationships of a trained consultant with mental health expertise working collaboratively with staff, programs, and families of children (from birth to school-aged) to improve their ability to prevent, identify, treat, and reduce the impact of mental health challenges. Ultimately, the consultative relationship seeks to achieve positive outcomes for children and youth in their community-based settings (such as school and neighborhood hubs) by using an indirect approach to foster their social and emotional well-being.

Consultation services differs from many other approaches or evidence-based practices in that they are not scripted (i.e., there is no curriculum to follow). The services are characterized by adherence to a core set of principles (e.g., relationship-based) as opposed to delivery of specific activities in a prescribed sequence. Accordingly, consultation services encourage customized service delivery to meet the diverse needs of various children, families, and school and/or community programs.

Program Overview

The San Francisco **Early Childhood Mental Health Consultation Initiative (ECMHCI)** is grounded in the work of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and are delivered in the following settings: center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. The Initiative is made possible through a partnership between four county agencies: San Francisco's Department of Public Health/Community Behavioral Health Services; Human Services Agency; Department of Children, Youth, and Their Families;

and First 5 San Francisco. Funding for the Initiative is contributed by all four county agencies, and it also includes funds provided by Mental Health Services Act (MHSA). Services may include case consultation, program consultation, training and support for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic playgroups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families.

The **Youth Mental Health Consultation Program** seeks to improve the lives of in and at-risk youth by providing direct service (crisis intervention and short-term therapy) and facilitating a sustainable change process within the systems through which youth receive services. Specifically, the program provides consultation to community-based agencies that serve low-income, at-risk youth. The target agencies have limited access to mental health resources and may include but are not limited to community centers, violence prevention programs, juvenile justice programs, afterschool programs, and cultural centers. The staff and youth from these agencies represent a diverse spectrum of cultural backgrounds including male, female, inter-generational, LGBTQ, Latino, African-American, Caucasian, and Asian.

The goal of the **Spring Project** is to support high risk pregnant women and new parents struggling with the stress of poverty, often in combination with mental health and/or substance abuse problems and issues associated with traumatic immigration, through the transition from pregnancy to parenthood in order to help ensure healthy outcomes for their infants and toddlers. This is achieved through the provision of mental health consultation and related direct mental health services to constituents within pre and postnatal primary care clinics at San Francisco General Hospital through the SPRING Project. The primary consultation site is the High Risk Obstetrics Clinic. Consultation will also be provided, when requested, to the Labor and Delivery, Nursery and the Kempe Pediatric Clinic staff.

Target Population

The primary target population is at-risk children who by virtue of poverty, trauma, immigration stress, and family dysfunction are at-risk for social, emotional and cognitive delays that can have lasting negative repercussions to the quality of their future lives.

Consultation services focuses the intervention not necessarily on the children themselves, but rather on the adults in their lives – teachers, parents, child care providers, doctors, and other caretakers. Consultation services seek to build the adults' capacity to understand and address the behavioral health needs of the children for which they provide care.

Budget and Costs per Client

Mental health consultation and capacity building expenditures for fiscal year 2014-15 are projected to be $831,855. The projected per-client costs are detailed below.

Exhibit 19. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Mental Health Consultation and Capacity Building	8596 clients	$831,855	$97

Projected Outcomes

These consultation programs endeavor to increase the capacity of school staff and caregivers to address the behavioral health needs of the children in their care, as well as provide direct treatment services to those children and families with more complex behavioral health needs. Specifically, they seek to achieve the following outcomes:

- Staff will report that consultation services increased their understanding of children/youth needs and development and helped them communicate more effectively with parents of children who have challenging behaviors.
- Staff receiving consultation services will report that they were satisfied with the services received from their mental health consultant.
- Staff receiving consultation services will report an improvement in job skills as it relates to addressing the behavioral needs of the children and youth in their care.
- Pregnant women identified as high risk for serious psychiatric difficulties who are typically lost to treatment will be retained.
- Pregnancy outcomes will improve for infants born to mothers with significant psychiatric concerns.
- Obstetric and pediatric providers will demonstrate increased awareness regarding the risks associated with maternal depression for women and infants, effective strategies for intervention, and the critical role of cultural competence in service delivery.

Program-Specific Community Program Planning (CPP) Activities

Child care providers, staff and parents are intimately involved in all aspects of the program design of all three programs. Furthermore, community members and stakeholders are involved in the ECMHCI funding proposal review process and selection of grantees. The Youth Agency Mental Health Consultation engage the youth they serve to assess what is working well and what programmatic improvements need to be made.

Comprehensive Crisis Services

Background and Community Need

Comprehensive crisis response and stabilization services have long been considered a crucial element of public behavioral health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. Crisis response to incidents of violence can reduce the long-term impact of complex trauma exposure. Due to the pressing need for services to address the needs of children, youth, adults and families impacted by violence and mental health crisis – a need that has been highlighted through various MHSA Community Program Planning efforts – MHSA PEI funding supported a significant expansion of crisis response services in 2009.

Program Overview

Comprehensive Crisis Services (CCS) is a mobile, multidisciplinary, multi-linguistic agency that provides acute mental health and crisis response services. CCS is comprised of four different teams (see Exhibit 20). These teams provide caring and culturally competent assistance throughout the San Francisco community. Services include: follow up contact within a 24-48 hour period of the initial crisis/incident; short term case management; and therapy to individuals and families that have been exposed to trauma. MHSA funds four members of the crisis response team.

Exhibit 20. Summary of San Francisco Comprehensive Crisis Services

Team	Services and Target Populations
Mobile Crisis Treatment	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older.
Child Crisis	Offers 5150 assessments & crisis intervention for suicidal, homicidal, gravely disabled and out of control children and adolescents regardless of health insurance status. Clients with publically funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response	Provides mobile response to homicides, critical shootings, stabbings, and suicides; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.
Crisis Wrap	Delivers up to 18-month intensive mental health wraparound services including education support, respite, mentoring, placement stabilization, and family support to youth who are under the age of 18 and are either wards of the court through the Department of Human Services or Juvenile Justice System.
Multi-Systemic Therapy	Delivers an intensive family-based treatment that focuses on multiple systems (home, school, community, peers) that affect juvenile offenders between the ages of 12 and 17.5. Provides parents/caregivers with the skills and resources to address chronic, violent, or delinquent behaviors and serious mental health problems.

Budget and Costs per Client

Comprehensive crisis services expenditures for fiscal year 2014-15 are projected to be $494,988. The projected per-client costs are detailed below.

Exhibit 21. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Comprehensive Crisis Services	306 clients	$494,988	$1,618

Projected Outcomes

Individual

- Participants will learn and use effective coping strategies to address an acute mental health crisis, grief, loss, and trauma exposure
- Participants will access mental health services within a 30 day period from being exposed to a traumatic event or an acute mental health crisis

Program

- CRT staff will provide more community base services to assist individuals that are trauma exposed
- After being notified of a trauma exposed individual by San Francisco Police and/or San Francisco General Hospital, CRT will outreach to those individuals within a 24 hour period of being notified.

System

- Individuals in need of mental health services related to trauma exposure are identified and referred by the San Francisco Police Department and San Francisco General Hospital. This early identification and referral leads to timely intervention and a reduction in the burden of suffering caused by delay in or lack of access to services.

As a result of this intervention, communities in San Francisco that are most affected by violence and trauma-exposure will have better access to effective and timely crisis and case management services, which will reduce disparities in access to care and prevent the development of more chronic and severe impairment in trauma-exposed individuals. Beginning in 2014, Crisis Services is collaborating with Quality Management to articulate clear outcome objects and assess areas for program improvement based on evaluation data.

Program-Specific Community Program Planning (CPP) Activities

The Crisis Response Team has developed a partnership with the Mayor's Office and the Street Violence Intervention Program (SVIP) and meets weekly to coordinate client care, monitor outcomes and to improve client quality of care. Focus groups which involve clients and providers assist with program planning and the evaluation of the program.

4. Peer-to-Peer Supports: Clinic and Community-Based

Background and Community Need

Peer support is an integral element of a recovery-oriented behavioral health system, and provision of behavioral health support by persons who have had experience with these issues innately brings empathy and empowerment that can inspire recovery in others. MHSA funding for Peer-to-Peer Support Services gives peer providers, who have significantly recovered from their illnesses, the opportunity to assist others by teaching how to build the skills necessary that lead to meaningful lives. The programs that provide Peer-to-Peer Support Services are described below. INN funding also supports several programs in this MHSA service category.

Program Overviews

Peer Response Team (INN)

Only a small proportion of the 12,000 - 15,000 San Franciscans with serious hoarding and cluttering issues receive any form of treatment. Unfortunately, most interventions occur after eviction proceedings are underway or after the individual is homeless. The Peer Response Team (PRT) was created to provide peer support and assistance navigating the community and systems of care for individuals dealing with hoarding and cluttering challenges. PRT is dedicated to educating the public and service providers to reduce public stigma and to help break down the isolation and self-stigma of their peers and encourage them with positive role models of coming out, recovery, and participation in peer community.

NAMI Pilot

The National Alliance for Mental Illness (NAMI) offers outstanding peer-directed programs in education and support. In partnership with NAMI-SF, three core NAMI programs are now being offered in primary care and mental health clinics in San Francisco. NAMI Family-to-Family Education is a 12-week curriculum that offers a wide range of information about mental illness and assists caregivers in

understanding how the experience of mental illness affects their family member. NAMI Peer-to-Peer Recovery Education is a nine-week program that combines lectures, interactive exercises, and structured group process to promote awareness about the impact of mental illness. This program will be translated to Spanish. In *Our Own Voice: Living with Mental Illness* is an interactive, multi-media consumer presentation designed to educate the general public and to change attitudes. Trained consumers, some of whom speak Spanish, share personal experiences of living with mental illness and convey messages of treatment, access and recovery.

Peer Specialist Mental Health Certificate

While all peer programs provide ongoing training and support, there is a growing need to provide comprehensive training for consumers interested in a career path in peer counseling. Every year the number of employment opportunities increase for individuals interested in providing culturally congruent peer counseling and support, resource linkage, and skill building trainings to clients of outpatient clinics or other wellness and recovery programs. The Peer Specialist Mental Health Certificate provides a standardized certification based on nationally adopted ethics and principles and helps to prepare individuals for various peer positions throughout the San Francisco community. The Peer Specialist Mental Health Certificate is a 12-week program designed to prepare consumers and/or family members with the basic skills and knowledge for entry-level employment in the behavioral/mental health system of care and with academic/career planning that supports success in institutions of higher learning. This program gives participants the opportunity to meet and network with behavioral health professionals through a career and resource fair and facilitates the possibility of future vocational or employment opportunities.

Office of Self Help (OSH)

The Office of Self Help is a consumer-staffed self-help program providing counseling, groups, activities, social support, education, information referral and Oasis drop-in center. Initial healthcare is available from a nurse practitioner. Dual diagnosis self-help groups are available on-site. Shuttle service is available to transport friends and family members to visit patients in out-of-county facilities. MHSA funds three different parts of the Office of Self Help: obtaining and stabilizing increased cultural staff and language capacity, additional shuttle services for families to visit out of county locked facilities, and a Warm Line.

Transgender Wellness Program (INN)

The MHSA program will provide on-site wellness and recovery groups and system navigation for clients. Clients can be seen for peer to peer counseling in individual and group settings. The target population for these groups will continue in FY14-15 to be transgender individuals living in San Francisco. While the focus of the groups is primarily trans women of color, all trans clients are welcome. Consumers are also given the opportunity to be paid stipends to work and organize the Transgender Health and Wellness Fair. MHSA peer staff is also involved in creating a safe space for HIV+ trans women of color as part of a collaboration with SFPDH Tom Waddell clinic and API Wellness/Trans Thrive Program. This locally

approved INN-funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see Appendix A).

CBHS Consumer Employment Services

The program improves the care for consumers accessing services by including those that have had lived experience within multi-disciplinary treatment teams. The Consumer Employment Program provides well-trained staff able to fill the need for peer employees at various clinics. This program has helped consumers find appropriate, much-needed services and provided hope to program participants while continuing to work on the staff's own health and wellness. The Consumer Employment Services provide support and basic training for entry level employment in a behavioral health setting. There are 43 MHSA-funded peers employed in this program.

For peer employees, the basic objective is to provide peer-to-peer training and practice that includes 1) learning and applying Wellness and Recovery principles to peer-to-peer support practice, 2) developing basic job skills and 3) receiving on-the-job practice in clerical/administrative support, general peer support in system navigation and/or basic wellness and recovery group facilitation. Job coaching and skills development training are provided to support skills development. Central to these objectives are providing a recovery and wellness based consumer employment program that integrates empowerment, hope, a process for using one's personal lived experience to create a safe place for relationship and community building for peers in the community. The Consumer Employment Services are designed and delivered by individuals who have lived experienced as a mental health consumer, or a family member or significant other of a consumer.

For consumers receiving support from their peers, the goal of this program is to help consumers and/or family members become and stay engaged in the recovery process, learn and develop new skills and develop a positive support system that maintains their wellness and recovery. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Peer-to-Peer Counseling Services to support consumers in their recovery include one-on-one peer counseling support, navigation support through various systems of care, drop-in support, and group support that includes art groups, socialization groups, skill-building groups, WRAP groups, exercise groups, and many more.

Specifically, the consumer employment services utilize two practices, which are the wellness and recovery model and the supported employment model. The model encourages consumer and behavioral health to collaborate to educate consumers about recovery strategies, illness information, coping with stress and navigating the behavioral health system of care, as well as other public health services. The supported employment model uses employment as a key element in recovery from mental illness and co-occurring disorders (and the related issues of homelessness). The model asserts

that programs providing employment services in concert with practical and social supports are a valuable resource for people with behavioral health & Recovery and Wellness issues.

LEGACY

LEGACY has the opportunity to try out new approaches by working with families and youth to combat the stigma of those suffering from mental health issues.

Family Programming

Family specialists and a family coordinator, with system experience, helps guide and empower families whose children are being served in the behavioral health and other child serving systems. The family specialists help caregivers navigate the comprehensive network of services available to children, youth and their families. In addition to the one-on-one peer support, the family specialists facilitate three innovative and family-driven initiatives that promote family-driven care and support the wellness and recovery goals of families served in the behavioral health system. These include: 1) the Family Advisory Network; 2) the Incredible Years & Positive Parenting Program training; and 3) the Sista Circle. MHSA funds 3.5 FTE peer staff to coordinate the family programs. In addition, “the drumming circle” will be a wellness approach that engages families, individuals and the community in a shared, participatory and collaborative activity intended to generate a sense of well-being, relaxation, community support and cultural revitalization. The circle will integrate various modalities; creating and maintaining a safe space, establishing community, sharing conversation and story about wellness, collective drumming, song and culturally based wellness tools.

Youth Programming

The overall goal of the youth mentoring program is to hire peer mentors who are former consumers of the various systems (juvenile justice, mental health, foster care and special education) who have achieved stability and have the ability to assist other young mental health consumers achieve resiliency and recovery as defined by the individual consumer. The youth mentoring program interventions and specific activities include: physical activities for health and fitness, education on nutrition and exercising, journal writing, conferences with teachers to discuss behavior/grades, explore academic challenges and solutions, tutoring and support with school projects, practice/review of English language with Spanish speaking mentee, provide psycho- education on the importance of therapy and medication management, introduce mentees to new activities and encourage social engagement, Boys and Girls club memberships, support on individuation development, time management skill building, create and implement responsibility action plan (chore chart), and decrease isolation by taking mentee out of the house for activities.

Target Population

The Peer-to-Peer Supports Services' target population will include underserved and underrepresented San Francisco mental health consumers and their family members who: have experience in the community behavioral health systems, may be interested in a mental health career path, may benefit from additional educational training, and may benefit from learning new skills within a wellness and recovery peer program. The underserved and underrepresented San Francisco mental health consumers and their family members may include African Americans, Asian & Pacific Islanders, Latinos/as, Native Americans, and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQQ) individuals. The target population includes individuals who have accessed the system of care as a consumer, former consumer or a family member.

Budget and Costs per Client

Peer-to-Peer expenditures for fiscal year 2014-15 are projected to be $2,210,000. The projected per-client costs are detailed below.

Exhibit 22. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Peer-to-Peer Supports: Clinic and Community-Based	2550 clients	$2,210,000	$867

Projected Outcomes

The Peer-to-Peer Programs seek to achieve the following outcomes:

- Participants will report an increased ability to manage hoarding and cluttering behaviors.
- Participants will report an increased problem solving capacity and responsibility and accountability for their wellness.
- Participate who indicated at enrollment that their housing at risk will report a decreased risk.
- Participants will complete the program (i.e. graduate) thus increasing readiness for entry-level employment/internship/volunteerism in the behavioral health system.
- Course graduates will indicate higher-level of engagement within the health and human services.
- Consumers will have enhanced problem solving skills, and responsibility and accountability for their wellness.
- Clients will report an increased quality of life.
- Consumers will have improved social norms, attitudes.
- Transgender Wellness consumers will report an increase in quality of life.
- Youth program participants will report an increase in improvement at school.
- Participants will report an increase in socialization and a feeling of an increased sense of community.

- Consumers receiving peer-to-peer services will report an increase in their overall quality of life.
- Consumers receiving peer-to-peer services will report a decrease in social isolation and an increase in community integration.

Program Specific Community Program Planning (CPP) Activities

The Peer-to-Peer Programs are committed to consumer involvement, and the programs will demonstrate a partnership with consumers of mental health and their families, and various stakeholders. All of the Peer-to-Peer Programs are staffed by consumers, former consumers and/or family members of consumers. These consumer staff has been involved in all areas of mental health policy, program planning, implementation, monitoring, quality improvement, evaluation and budget allocations. Per the report of the peer staff themselves, "we have been consistent in coming up with new ideas on how to better work with the CBHS consumer population" and "we come together to form a united front for peer education and hiring". The Peer-to-Peer Programs will continue to give consumers a voice in their care and assist them with identifying their own goals. Before new programs are launched, consumers are actively involved in the program planning and provider selection process.

Celebrating Successes in Recovery and Wellness

MHSA Awards Ceremony: The MHSA Awards Ceremony is an Innovations project that publicly honors current and former clients in MHSA-funded programs in San Francisco. Consumers/peers are recognized for their personal achievements in wellness and recovery in a formal celebration that includes a delicious sit-down meal, entertainment, and awards.

In 2012, the awards ceremony was an Olympics themed event. At this event, 120 individuals and teams were honored for their achievements in recovery.

On October 11, 2014, the Third Annual MHSA Awards Ceremony was held, and it has been our largest ceremony thus far. The event's theme was "Bay to Breaking Stigma". At this highly anticipated event:

- 23 agencies referred individuals for awards
- 225 consumer nominations were awarded
- 33 nominators attended the Awards Ceremony
- 400 individuals attended the event

Unique to this project, the awards ceremony and all of the activities prior to the event are planned and coordinated by a 15-20 consumer planning body, with the assistance of the Mental Health Association of San Francisco and SF MHSA. The planning process for this event usually takes six months and included outreach, choosing an event theme, selecting award criteria, logistics, presenting awards, and entertainment.

Request for Proposal (RFP) Planned for CBHS Consumer Employment Services

San Francisco began integrating Peer Specialists into the mental health service delivery system by hiring six Peer Navigators in 2008. Today, CBHS employs 85 peers in a variety Peer-to-Peer Programs. To better coordinate the recruitment, training, placement, support and supervision of peer staff within the CBHS System of Care and community settings, CBHS has recommended the selection of a single service provider to oversee and support the CBHS Peer-to-Peer Programs. Through a competitive bidding process, CBHS will identify a service provider to provide management of these programs. The provider selected will use input from peers regarding program development, implementation, evaluation and long-term strategic planning. CBHS is requesting that the service provider hire all peer staff currently employed by CBHS. This model will help peers to be a part of a larger infrastructure to better utilize resources, opportunities for advancement and find strength in a larger support system. This model can create a stronger program that promotes program expansion and streamlines services.

Expanding Peer-to-Peer Services to Reach Socially Isolated Older Adults

Through a stakeholder process that involved older adult service providers and peers, social isolation was identified as one of the key concerns for older adults living in San Francisco. The goals for this new INN-funded program will be to: (1) produce programming (e.g., culturally-informed training curriculum, supervision/support plan, engagement tools) that will improve our system of support for socially isolated adults, (2) build effective partnerships between individuals and organizations who provide peer support services and programs for socially isolated adults, and (3) develop a more coordinated system of care for socially isolated adults. This locally approved INN funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see Appendix B).

Expanding Peer-to-Peer Services in Mental Health Clinics

The FY 14-15 MHSA budget includes five new Health Worker positions. These positions will provide an opportunity to hire peers that have developed advanced skills in providing peer support and integrating these new staff into clinic-based teams.

5. Vocational Services

Background and Community Need

Since mental health issues can be a barrier to employment, it is imperative that vocational services be incorporated into mental health treatment. Treatment programs must be ready to serve the many consumers with serious mental illness who must find and maintain employment in a very short time period.

MHSA funding for vocational services assists consumers and family members in securing and maintaining meaningful employment. According to SAMHSA, "Work as a productive activity seems to meet a basic human need to be a contributing part of a group. It is critical that the meaning of work be understood in the context of each individual's personal values, beliefs, and abilities; cultural identity; psychological characteristics; and other sociopolitical realities and challenges." In collaboration with The California Department of Rehabilitation, the San Francisco Department of Public Health has identified a need for various training and employment support programs to meet the current trends and employment skill-sets necessary to be successful in the competitive workforce. Many mental health consumers have identified interest in various career paths but lacked support and skills training to secure an employment opportunity.

Program Overviews

Department of Rehabilitation Vocational Co-op Program

The San Francisco District of the Department of Rehabilitation (DOR) and the City and County of San Francisco's Community Behavioral Health Services (CBHS) will combine staff and resources to provide vocational rehabilitation services to mutual consumers of mental health. DOR and CBHS will determine eligibility and functional capacities, assist a consumer to develop an Individualized Plan for Employment (IPE), provide vocational counseling, as well as provide services and service coordination that will lead to a successful employment outcome. DOR and CBHS will partner with a service provider to meet the various and diverse needs of the community; UCSF Citywide Employment Program – FSP Program. CBHS will oversee the program and the provider will implement the following services: Vocational Assessment Services; Employment Services; and Retention Services. All clients served under this MHSA funded portion of the program will be clients already receiving services in the UCSF Citywide's FSP Intensive

Case Management Program. All clients will meet criteria for severe mental illness and have current or history of criminal justice involvement.

CBHS will also provide a Vocational Coordinator who will assist in planning, coordinating services between DOR and CBHS and providing overall administrative support to the CBHS contract. The Vocational Coordinator will also provide outreach to CBHS consumers and CBHS staff to inform them about this cooperative program and its services.

i-Ability Vocational IT Program

I-Ability provides culturally competent, consumer-driven and strengths-based vocational services meeting the needs of consumers. The program prepares consumers to provide information technology (IT) support services (e.g. desktop, help desk) at the CBHS IT Department through its Vocational Information Technology Training Program. The i-Ability Vocational IT program will have three components:

- Avatar Helpdesk, a single point of contact for end users of the CBHS electronic health record system ("Avatar") to receive support.
- Desktop, a single point of contact for end users of CBHS computers/hardware to receive support and maintenance within CBHS computing environment.
- Advanced Avatar Helpdesk, a single point of contact for end users of the CBHS electronic health record system ("Avatar") to receive support.

The program design will include providing vocational services including but not limited to: vocational assessments, job skills training, on-site work experience, vocational counseling and job coaching, and classes/workshops aimed at skills development and building strengths towards employment readiness.

First Impressions (INN)

First Impressions (FI) is a basic construction and remodeling vocational program that will assist mental health consumers in learning marketable skills, receive on-the-job training and mentoring, and secure competitive employment in the community. The program is based on the MHSA's Recovery Model which is founded on the belief that all individuals – including those living with the challenges caused by mental illness – are capable of living satisfying, hopeful, and contributing lives. First Impressions will provide three months of classroom education/training, six months of paid fieldwork experience, vocational assessment, coaching, and job placement support and retention services each year. The ultimate goal is for consumers to learn marketable skills while being a part of the transformation of the CBHS Mental Health Care System by creating a welcoming environment in the wait rooms of DPH/CBHS clinics.

The FI program is a collaboration of the UCSF Citywide Employment Program, Asian Neighborhood Design and CBHS. Citywide Employment Program staff conducts extensive job development activities to create relationships with businesses and employers. Citywide Employment Program staff provides support and coaching into the workforce and connect participants to additional resources as needed

(e.g. Department of Rehabilitation, educational/training resources, housing, benefits, and clothing & transportation resources.)

Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) (INN)

Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) is led by the Housing and Urban Health Clinic. This pilot program adapted an existing nutrition and exercise protocol into a community mental health setting and integrated shopping and cooking skills training. This program will educate consumers on 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.

Participants were recruited from SFDPH clinics serving residents of supportive housing sites and directly from single room occupancy hotels (SROs), primarily in the Tenderloin, Mission, and South of Market neighborhoods. These neighborhoods provide little to no access to cooking facilities and have a dearth of outlets for affordable fresh foods.

SF First Vocational Training Program

The SF FIRST Vocational Training Program is designed to offer each trainee a one to five hour per week stipend position to learn necessary skills for successful employment. Some of the positions will be located at South of Market Mental Health Services, home base for the FSP SF FIRST Intensive Case Management (ICM) team. Other trainee positions will be located in the community.

The SF FIRST Vocational Training Program will offer training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a donations clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitation, etc. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal-setting and hygiene maintenance for the workplace.

Target Population

The target populations for vocational services are San Francisco residents including transitional age youth, adults and older adults, who are consumers of mental health. Many clients will be living in single resident occupancy unit (SROs) or will report a pending legal charge or history of criminal justice involvement. A portion of the vocational services will strive to improve the health and well-being of underserved homeless persons while primarily serving individuals who experience severe mental illness, chronic and severe medical conditions and/or substance abuse related issues.

Over 70% of the consumers receiving vocational services through these MHSA-funded programs will be FSP clients participating in an intensive case management program identified as needing additional support to help consumers reach their wellness goals. Particular outreach will be to consumers who are interested in vocational assessment, training and/or competitive employment and may benefit from a structured vocational program. Most consumers, if not all, will be receiving behavioral health services through CBHS.

Budget and Costs per Client

Vocational services expenditures for fiscal year 2014-15 are projected to be $762,155. The projected per-client costs are detailed below.

Exhibit 23. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Vocational Services	204 clients	$762,155	$3,736

Projected Outcomes

The vocational services programs seek to achieve the following outcomes:

- Consumers will utilize their new skills and secure employment in the competitive workforce and also retain this employment for at least 90 days.
- Consumers will receive intake and support with finding employment.
- Trainee graduates will have met their vocational goals.
- Enrolled trainees will successfully complete both the classroom and internship training, for applicable programs.
- Trainee graduates will indicate improvements to their coping abilities.
- Peer leaders will be provided an opportunity to learn new leadership, group facilitation and mentoring skills.
- Participants will be provided education on wellness and nutrition.

Program-Specific Community Program Planning (CPP) Activities

The vocational services programs demonstrate a partnership with consumers of mental health and their families, and various stakeholders in mental health policy, program planning, implementation, quality improvement and evaluation. These programs will be committed to consumer involvement and community input in all elements of program operations. Consumers will continue to design and lead the outreach planning efforts to help increase participation in programming. Marketing such as flyers, brochures and job fair promotion will continue to be designed by consumers currently or previously

receiving services in vocational services. Consumers will continue to participate in quarterly meetings to provide insight, recommendations and input on policies, program planning and quality assurance.

Some programs will continue to have post-cohort focus groups to solicit similar feedback regarding the curriculum of the program, recruitment process, accessibility, and effectiveness. Vocational services will continue to give consumers a voice in their care and assist them with identifying their own wellness goals while taking into consideration the needs of the community. The Peer Leader role and expansion of the programming was a direct result of consumer feedback and involvement in program planning.

6. Housing

The Housing service category helps address the need for a continuum of accessible and safe supportive housing to help formerly homeless clients with serious mental illness or severe emotional disorders maintain their housing. This service category includes Emergency Stabilization Housing, FSP Permanent Housing, ROUTZ Transitional Housing for TAY and other MHSA Housing Placement and Supportive Services.

Emergency Stabilization Housing

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The twenty-five ESUs are located within three single room occupancy (SRO) hotels in San Francisco. The units are available to Full Service Partnership clients, Intensive Case Management clients and Central City Hospitality House.

FSP Permanent Housing

In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million. In addition, San Francisco added $2.16 million from CSS to housing in 2007-08. There are a total of 57 MHSA-funded housing units developed with capital funding. These units help those who are homeless or at risk of homelessness and are located in various neighborhoods in San Francisco including the Tenderloin, Rincon Hill, and Ingleside (see Exhibit 24). An additional nine units will be open next year (1100 Ocean and Rosa Parks). Summaries of these developments are provided below. SF MHSA also has a contract with Tenderloin Neighborhood Development Corporation for 21 units of permanent housing at three of their affordable housing sites, as well as a small contract with Community Housing Partnership for a few units of permanent housing at Cambridge, another non-DAH supportive housing site.

MHSA-funded housing units are developed within larger mixed-population buildings with on-site supportive services coordinated with and linked to the larger infrastructure of supports provided by Full Service Partnership programs. San Francisco is the only county in California to use its MHSA dollars beyond the housing allotment for permanent units. Because of that addition, San Francisco has accrued approximately $300,000 in interest, and is working with the Mayor's Office of Housing and Community Development to allocate these funds for three additional units at the Rosa Parks development described below that will require a new application.

Exhibit 24. Summary of MHSA Permanent Supported Housing Units *

Target Population	Development	Developers	MHSA-Funded Units (N=63)
Older Adults	*Rosa Parks*		3
	Polk Senior Housing 990 Polk St.	Tenderloin Neighborhood Development Corporation & Citizens Housing Corporation	10
Adults	*Drs. Julian & Raye Richardson Apartments* 365 Fulton St.	Community Housing Partnership & Mercy Housing California	12
	Kelly Cullen Community 220 Golden Gate Ave.	Tenderloin Neighborhood Development Corporation	17
	Rene Cazenave Apartments 530 Folsom St.	Community Housing Partnership & BRIDGE Housing	10
Veterans	*Veterans Commons* 150 Otis St.	Swords to Plowshares & Chinatown Community Development Center	8
TAY	*Ocean Avenue Affordable Housing Project* 110 Ocean Ave.	Bernal Heights Neighborhood Center & Mercy Housing California	6 **

*Developed with one-time capital housing funds
** Under construction in 2014

Tenderloin Neighborhood Development Corporation: Polk and Geary Senior Housing

Polk Senior Housing

The **Polk and Geary** senior building, built in partnership with Citizens Housing Corporation, represents an innovative approach to address homelessness by combining services-rich supportive housing units within a larger low-income population. Ten of the units are fully accessible, and the remaining units are adaptable for individuals with disabilities. Fifty units are set aside for formerly homeless seniors; the rents and services for residents of these units are subsidized by the City of San Francisco.

Community Housing Partnership: Richardson Apartments

Drs. Julian and Raye Richardson Apartments, opened in 2011, is a five-story development including 120 studio units of housing for extremely low income, formerly chronically homeless individuals. Located at the corner of Fulton & Gough streets, the building also includes ground floor retail commercial space, common space and social service program space. Twelve units are designated for the MHSA Housing Program. The University of California-San Francisco Citywide Case Management team works with SFDPH's Housing and Urban Health Clinic (HUHC) and three adult Full Service Partnerships (FSPs) to provide the 12 MHSA residents with integrated recovery and treatment services appropriate for severely mentally ill adults to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. Community Housing Partnership manages the property.

Swords to Plowshares: Veterans Commons

Veterans Commons, opened in 2012, is an adaptive re-use of a nine-story steel-frame and concrete structure at 150 Otis Street in San Francisco. The building was originally constructed in 1916 as the City's first Juvenile Court and Detention Home, but now consists of permanent, affordable rental housing with on-site supportive services for homeless veterans. The project houses 76 U.S. veterans, eight of whom qualify for the MHSA Housing Program.

The development includes space for intensive supportive services, including space for counseling, group meetings, case management, and social activities. Swords to Plowshares manages the property.

Tenderloin Neighborhood Development Corporation: Kelly Cullen Community

Photo by Mark Luthringer Photography

Kelly Cullen Community is a $95 million renovation of the former Central YMCA at 220 Golden Gate and provides 172 efficiency studio units for chronically homeless individuals, including 17 MHSA units. Completed in 2012, the project includes a ground floor SFDPH-managed health and wellness clinic and a corner commercial retail space.

Community Housing Partnership: René Cazenave Apartments

The recently completed **Rene Cazenave** Apartments were developed in cooperation between Community Housing Partnership and BRIDGE Housing, and designed by Leddy Maytum Stacy Architects. The project was selected by the San Francisco Redevelopment Agency (SFRA), to develop affordable housing in the new Transbay Redevelopment Area. Rene Cazenave Apartments is the first

of several development sites that will serve as a gateway to the SFRA's vision of a new "main street" along Folsom Street. Following completion of the project, Community Housing Partnership remains the owner and property manager of the site.

Rene Cazenave Apartments is a mid-rise, eight-story building that includes a total of 120 apartments. Twelve of these apartments are 1-bedroom units, while 108 are studios. Overall, 10% of the units are handicap accessible and all other units are adaptable for handicap use. All tenants are formerly homeless individuals and are being referred through the San Francisco Department of Public Health.

FSP Permanent Housing Still in Development

Mercy Housing: 1100 Ocean Avenue

The **Ocean Avenue** development is a new construction project that will include 70 units of housing for families and transitional aged youth (TAY) and one property manager unit. The building will consist of a mix of studios, one, two and three-bedroom units available to residents making no more than 50% of the area median income. Twenty-five units will be restricted at 20% of the area median income. It is anticipated that this project will start construction in mid-2013, with a seventeen-month construction period.

Six of the project's 25 TAY units will be reserved for the MHSA Housing Program. An integrated services team will provide the youth community with a full range of on-site and off-site resources, including community-building events, educational opportunities, information and referrals to local social services, case management and crisis prevention and intervention. In addition, Community Behavioral Health Services, will work with property management and two TAY Full Service Partnerships to provide the 25 TAY residents with integrated recovery and treatment services appropriate for severely mentally ill youths to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. Mercy Housing Management Group, an affiliate of Mercy Housing California, will manage the property.

Rosa Parks II Senior Housing

San Francisco has accrued approximately $300,000 in interest, and is working with the Mayor's Office of Housing and Community Development to allocate these funds for three additional units at the Rosa Parks development described below that will require a new application.

Rosa Parks II Senior Housing (RPII) is a proposed 98-unit, five-story affordable senior housing development. The project is located at the corner of Turk and Webster streets in the Western Addition neighborhood of San Francisco, California. RPII will be constructed on the parking lot of an existing public housing facility, Rosa Parks, an eleven-story, 198-unit building owned and operated by the Housing Authority of the City and County of San Francisco since 1959. Site control is held by Rosa Parks II, L.P. through a pre-paid 75-year ground lease with the Housing Authority of the City and County of San Francisco as ground lessor. Rosa Parks II, L.P., a limited partnership of which a Tenderloin Neighborhood Development Corporation (TNDC) affiliate serves as the general partner, has owned the RPII site since fall 2009 when Citizens Housing transferred ownership to TNDC before it disbanded. Citizens Housing was awarded site control of RPII in 2006 through a competitive RFP process. In 2011, TNDC received HUD 202 capital advance funding and project rental assistance for 100% of the units.

ROUTZ Transitional Housing for Transition-Aged Youth (TAY)

Larkin Street Youth Services: Aarti Hotel

Youth with mental health and substance abuse issues have unique and complex needs for housing. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transition aged youth with Larkin Street Youth Services. The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the **Aarti Hotel** (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites. In fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, like skills training, wraparound case management, mental health interventions, and peer based counseling.

Housing Placement and Supportive Services

Established by the San Francisco Department of Public Health in 1998, the Direct Access to Housing (DAH) is a permanent supportive housing program targeting low-income San Francisco residents who are homeless and have special needs. A "low threshold" program that accepts adults into permanent housing directly from the streets, shelters, hospitals and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance abuse problems, and/or complex medical conditions. MHSA has allowed for Direct Access to Housing to expand capacity to serve MHSA clients with the addition of an Intake Coordinator and a Nurse Practitioner. The Intake Coordinator works to place clients in the setting most appropriate to their needs. DAH's varied portfolio of housing sites and individual referral prioritization system allows for tailored placement based on clinical needs of the population based on their:

- Level of medical acuity
- Substance use severity
- Homeless situation
- Match between clients' needs and available on-site services
- Availability and match of a DAH unit

The Nurse Practitioner (currently vacant) will allow DAH to better meet the needs of clients placed in their 1500 units, all of which have a history of homelessness and the majority with mental health challenges.

Budget and Costs per Client

Housing expenditures for fiscal year 2014-15 are projected to be $2,393,610. The projected per-client costs are detailed below.

Exhibit 25. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Emergency Stabilization Housing (50% FSP)	181 individuals	$393,637	$2,175
Full-Service Partnership Permanent Housing (Capital Units and Master Lease)	91 individuals	$650,000	$7,143
ROUTZ TAY Transitional Housing (50% FSP)	74 individuals	$1,089,465	$14,723
Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	500 individuals	$260,508	$521

Evaluation of Housing

MHSA and CBHS Quality Management staff are currently collaborating with Abbott Consulting to carry out an outcomes analysis for MHSA-funded housing interventions that will produce reports that address eligibility process, services and outcomes for all MHSA Housing activities described above. The compilation will be carried out in 2014-15 and shared with a variety of stakeholders in San Francisco to provide a basis for decision-making regarding future program improvements and new initiatives.

MHSA Housing Evaluation Plan

Consultants will work with SFDPH to prepare and implement an analysis of housing activities administered by SFDPH with MHSA funding. The report will describe a logic model to reflect San Francisco's MHSA Housing theory of change. Evaluators will consult with DPH, the funder representatives, housing developers, program service providers, and clients and their families to clarify the goals and objectives for the program, and will contact respected intermediary experts on health and housing goals and outcomes to offer a broad perspective.

Process questions will be developed based on the programs' stated principles, the funding guidelines, and a client impact process analysis. Outcome questions will study:

- Housing and homelessness outcome measures
- Health and wellness measures
- Individual factors associated with outcomes
- Placement permanency

- Program and contextual factors

Data collection will be based on detailed records on housing retention, income changes, health data, and other indicators. Evaluators also expect to conduct interviews and surveys of client participants and provider staff.

Additional information will be gathered through focus groups, interviews with treatment providers and direct program staff, and with clients and their families. Evaluators will consult with the following stakeholder groups:

- Funders
- Advisory Board
- Stabilization program staff
- FSP Staff
- Clients in stabilization program
- Clients in permanent housing
- Family members

The evaluators will create an initial report after three months. This report will focus on permanent housing placements and will preview initial findings. A final, comprehensive report will then be prepared, demonstrating the data trends, outcomes, and any program concerns. The report will include process and program recommendations and submitted to DPH staff for distribution.

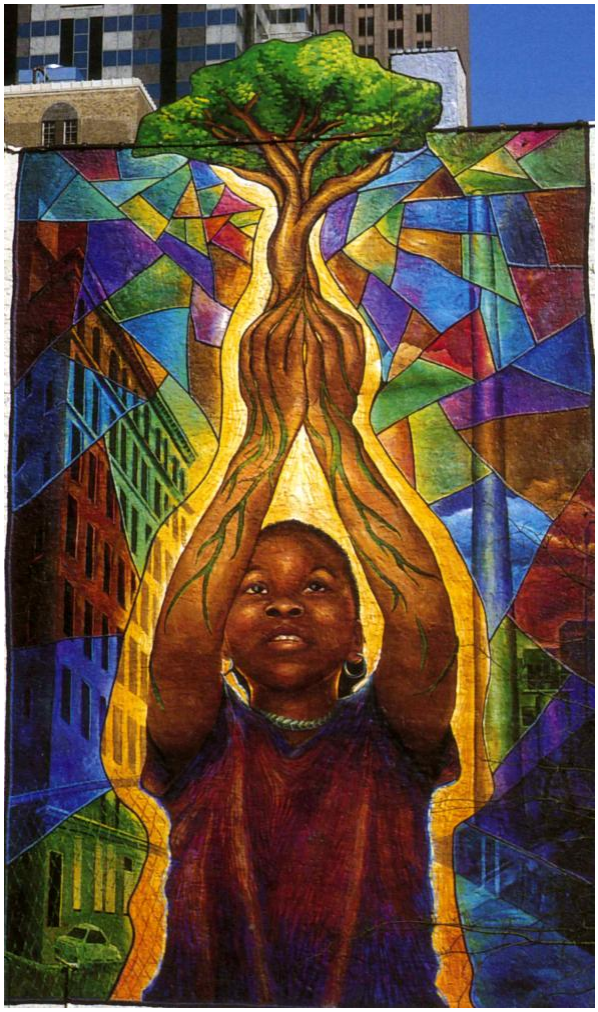
Meeting Unmet Housing Needs: Next Steps for MHSA

Feasibility Study for Additional Housing

The housing sites developed with MHSA funding provide homes to those who have struggled with the brutal combination of mental illness and homelessness. San Francisco recognizes that many more homes are needed and is currently looking to identify its best options for new housing opportunities for MHSA consumers. MHSA has embarked on a project to look into the feasibility of expanding various housing models to meet the needs of families and individuals served by MHSA Full Service Partnerships (FSPs). This report to DPH, when completed, will present different housing models, such as rapid rehousing with short/medium term subsidies; long term subsidized scattered site housing, and site-based permanent supportive housing like the projects already developed. The report will also consider the short and long-term costs associated with each housing model, and the development and service capacity within DPH to deliver each model. This will include costing out additional capital in comparison to scattered site leasing. SF MHSA has not ruled out an additional set-aside, but does not have any certain allocations either.

7. Behavioral Health Workforce Development

The Behavioral Health Workforce Development service category addresses the shortage of qualified individuals who provide services in San Francisco's public mental health system. This includes developing and maintaining a culturally competent workforce that includes individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency. This service category includes 1) the Mental Health Career Pathways Program, 2) Training and Technical Assistance, 3) Residency and Internship Programs, and 4) (state-funded) Financial Incentive Programs.



In 2009, MHSA received an initial $4.6 million allocation of MHSA funding to support Workforce, Development, Education and Training (WDET) activities. San Francisco has developed a strong collection of activities san programs designed to achieve WDET goals. Through CPP activities, the decision was made to sustain MHSA WDET activities, described below, with CSS funds.

Training and Technical Assistance

MHSA funding for Training and Technical Assistance seeks to increase local capacity to 1) deliver mental health interventions that reflect MHSA vision and values, 2) develop expertise necessary to effectively plan, implement and evaluate MHSA programs, 3) teach, learn and share information, best practices and "lessons-learned" with each other, participants and stakeholders 4) develop capacity for traditional and non-traditional mental health partners, agencies or systems to participate and help lead the transformation of the mental health system through the MHSA.

CBHS Trainings

The MHSA supports additional capacity in the CBHS Training Unit to: support and coordinate training and technical assistance efforts for CBHS clinicians, providers, consumers, and family members, and support CBO training efforts that address and adhere to the principles of MHSA. Training topics include wellness and recovery, evidenced based practices, cultural competence, intensive case management, and the integration of primary care and mental health services.

Identifying Workforce Development Priorities: CBHS Workforce Disparities Analysis

Consulting firm Learning for Action (LFA) conducted an analysis of a sample of medical (MD/NP) and masters level clinical (MSW/MFT) providers in the San Francisco public mental health system of DPH Community Behavioral Health Services (CBHS) civil service staff and contractors. The analysis provides a description of the demographics and language capacity in this workforce, and a comparison of these characteristics with those of the MediCal-eligible population in San Francisco. The sample includes 251 civil service providers (73 medical providers and 178 clinical providers) and 281 contractor providers (51 medical providers and 230 clinical providers). **Key takeaways of the analysis include the following:**

- Male providers are significantly less likely than female providers to serve in masters level clinical positions.
- Some ethnic disparities are apparent based on type of position held by providers. This is especially true for MDs/NPs, with 52% (civil service) and 76% (contractor) positions being held by white staff. African Americans represent 5% of staff and only 3% (1 individual) of medical providers. Additionally, there are no Native American clinical or medical staff providers in either the civil service or contractor workforce samples, and only three Latino medical providers. The extremely small number of African American and Latino medical providers, and complete absence of Native American medical providers, in this workforce sample indicates both a considerable mismatch in the ethnic makeup of providers when compared to the population in need of public behavioral health care and a need for increased ethnic diversity in this job tier.
- Limited additional data on San Francisco's civil service behavioral health workforce suggest that the paraprofessional workforce is more ethnically diverse than that of masters-level providers. In particular, while African Americans are underrepresented among medical and clinical behavioral health care positions, they are more than twice as likely as white staff to be in paraprofessional civil service positions, and make up more than a third of the paraprofessional civil service workforce.
- Overall, 66% of civil service providers and 58% of contractor providers report fluency in at least one additional language other than English. Twenty-five languages—the most common of which are Spanish, Cantonese and Mandarin—are represented among the 328 providers who speak an additional language. A notable exception in the match between provider language capacity and need is in the case of Cantonese speakers, where the proportion of providers speaking Cantonese is only half that of the population in need.

While this data has been helpful in developing preliminary priorities for MHSA funded workforce development activities in FY 14-15, additional data analysis and CPP are needed to finalize a set of priorities. The CPP work in this area is ongoing and includes an effort underway to more systematically collect demographic data and linguistic capabilities of all civil services and contract staff.

Developing Expertise in Group Treatment

As a pathway of treatment for clients presenting with complex mental health and substance abuse issues, CBHS leadership identified the need for providers to offer group treatment models of care. The result is the implementation of Seeking Safety and Illness Management and Recovery (IMR) both being evidenced based practices under SAMHSA.

Seeking Safety

Two years ago, the CBHS Group work 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, one of which is Seeking Safety for trauma and substance abuse.

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. A survey conducted last month with Seeking Safety clinicians showed continued interest in CBHS trainings and support for Seeking Safety implementation.

Illness Management and Recovery (IMR)

The Illness Management and Recovery Model (IMR) is an evidence based program, developed and supported by SAMHSA. The model is comprised of a series of weekly sessions in which facilitators help people who have experienced psychiatric symptoms to develop personalized strategies for managing their mental illness and moving forward in their lives.

In 2013, San Francisco trained more than 50 providers in IMR facilitation. In 2014, CBHS adopted and renamed IMR as “Wellness Management and Recovery” (WMR) and is carrying out a pilot of WMR, in the group format, in eight behavioral health care sites. The groups at each site are expected to last between three and ten months. In the sessions, practitioners work collaboratively with participants, offering a variety of information, strategies, and skills that they can use to further their own recovery. There is a strong emphasis on helping participants set and pursue personal goals, as well as put strategies into action in their everyday lives.

Evaluation of the Wellness Management and Recovery (WMR) Pilot

CBHS and Quality Management are working with Learning for Action (LFA) to evaluate the Wellness Management and Recovery (WMR) pilot, which was previously known as the Illness Management and Recovery (IMR) model. The evaluation will last two years and center on how WMR is being implemented and outcomes for clients, participating clinics and clinicians, and the system of care as a whole. The primary evaluation goals are to:

- Understand whether WMR is being implemented as intended, and/or how it is being adapted to best meet the needs of consumers in each group
- Identify barriers to implementing WMR to help improve future processes
- Assess early changes participating consumers experience toward recovery and wellness
- Impact of WMR on clinic capacity, access, and productivity (year two only)

Evaluation data will be collected in several ways. Clinical data will be derived from Avatar, the electronic health record system, with support from Quality Management. Weekly check-in forms will be completed by facilitators and participants as a therapeutic intervention more than an assessment tool; however, they will be reviewed to support measures such as goal setting and involvement of learning partners and/or significant others, as well as for indicators of any outcomes that surface. LFA will provide brief surveys to be completed by WMR consumers at the beginning of WMR and at the second-to-last WMR group. LFA will also conduct interviews with a sample of consumers participating in WMR to understand their experiences and gather feedback. Finally, LFA will interview WMR providers to learn more about how WMR was implemented, barriers to implementation and outcomes from facilitators' perspectives.

Medicinal Drumming: A Culturally Affirming Group Practice

The availability of culturally congruent services is insufficient to meet the needs of San Francisco's diverse communities. Historically, western-based therapeutic services focus on the individual, while culturally diverse communities are generally group oriented. The American Psychological Association contends that new and alternative methods are needed to address the needs of the masses. Through research and applied practice, Dr. Sal Núñez and the community- defined evidence project have demonstrated that the Medicinal Drumming praxis engages large groups of diverse populations through an interconnected journey of wellness and recovery. To promote knowledge about and expand access to Medicinal Drumming, SF MHSA launched a pilot apprenticeship program last year that recruited and trained staff from health and social service providers. Participants attended trainings, received supervision and consultation during the integration of the drumming praxis into their agency and community. As a result of this pilot, the Medicinal Drumming method has been incorporated as a wellness and recovery model at several local clinics and campuses, such as Hospitality House, Instituto Familiar De La Raza, California Institute of Integral Studies, and City College of San Francisco. While the formal evaluation report is still being developed, feedback from the trainees, as well as the over 200

drumming group participants from the partner organizations, has been very positive. As a result, we plan to support the project for an additional year.

Adolescent/TAY Provider Capacity Building

The purpose of adolescent/TAY provider capacity building is to improve communication and coordination of health related activities and services among youth/young adult providers across service sectors – including CBOs, DPH, UCSF, SFUSD, Juvenile Justice, workforce development and housing – while also building provider capacity and support systems. The target population includes providers throughout the city with attention to those serving under-served populations and subgroups of youth and young adults such as TAY, LGBTQ, ethnic/racial minorities, and homeless youth. Many of the providers served are located in the Southeast Sector, Mission District, and Ingleside-Excelsior-Crocker Amazon.

12N LGBTQ Sensitivity Training for Providers (INN)

Chapter 12N of the San Francisco Administrative Code requires all City departments to provide training that will increase sensitivity and reduce stigma against lesbian, gay, bisexual, transgender youth. All staff who work with or whose work directly impacts youth are required to complete the 12N training. Agencies receiving $50,000 annually from the city must also ensure training of their staff. The 12N ordinance specifies that the following content must be included:

- Sensitivity training to LGBT youth with disabilities
- Mental health issues
- HIV
- Immigration challenges
- Diverse ethnic backgrounds
- Sexual abuse histories
- Homeless and runaway backgrounds
- Non-accepting households.

Goals of 12N Project were to develop a youth-inspired training video on LGBTQ sensitivity issues, supporting documents, a training format and conduct pre/post evaluation to bring the City into compliance with the ordinance. Members from several organizations/commissions carried out the project training implementation and evaluation:

- San Francisco Youth Commission
- San Francisco Community Programs for Youth
- San Francisco Human Rights Commission
- San Francisco Community Behavioral Health Services, including Quality Management, Cultural Competence and MHSA staff.

The collaborative effort produced a powerful, informative video that was widely viewed, generated discussion among City employees and began to affect changes in practice at some work sites that serve

youth. DPH is integrating this video into ongoing mandated trainings for staff and contractors. Many other City Departments have requested to also use the training. While INN funding was expected to be used for ongoing implementation and evaluation, other sources of funding have been identified and INN funding is no longer needed. SF MHSA is currently working to develop a learning report for this project.

Budget and Costs per Client

Training and Technical Assistance expenditures for fiscal year 2014-15 are projected to be $386,000. The projected per-client costs are detailed below.

Exhibit 26. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Training and Technical Assistance	4,727 participants	$386,000	$82

Projected Outcomes

Training and Technical Assistance programs seek to achieve the following outcomes:

- Increase knowledge and skills delivering recovery oriented services
- Promotes culturally competent service delivery
- Promotes meaningful inclusion of clients/family members
- Promotes an integrated service experience for clients and their family members
- Promotes community collaboration

Expanding Training and Technical Assistance

Mental Health Outreach Workers (MHOW) Training Program (INN – proposed)

This plan includes a proposal for a new INN project (see Appendix C). The Mental Health Outreach Workers (MHOW) Training program aims to train San Francisco street outreach workers, exposed to constant community trauma, on how to best meet the mental health needs of the clients that they encounter in the field, and also how to best deal with one's own experience with trauma. Three sub-communities of outreach workers have been identified by local CPP as frontline programs coming in contact with high rates of trauma. These are: Homeless Youth Outreach Workers Programs and Street Violence Outreach workers, and Asian Community Outreach workers. In total, a cohort of 60 outreach workers will be trained (20 per sub-community).

Trauma Informed Systems Initiative

The Trauma Informed Systems Initiative focuses on the system-wide training of a workforce that will develop a foundational understanding and shared language, and that can begin to transform the system from one that asks "What is wrong with you?" to one that asks "What happened to you?". The initiative strives to develop a new lens with which to see interactions that reflect an understanding of how trauma is experienced in both shared and unique ways.

To date, the vetting process for the Trauma Informed Systems Initiative has included over 400 people within the DPH system including providers, non-providers, primary care and various peer and advocacy groups. Feedback, suggestions and observations from these meetings have guided the development process from the beginning. Developed materials include a full, interactive curriculum designed to support our workforce in understanding essential aspects of trauma and to create shared language with which to begin responding in a trauma informed way in their work environments. Live trainings will be offered on a rolling basis, system-wide for open, online registration through the training department. Trainings will begin in March 2014 and continue twice monthly until June 2014 when trainings will become weekly. Outcomes for the initiative include the following:

- Practitioners receive coordinated training and coaching in order to disseminate change
- Regular process and outcome evaluations associating the training initiative with concrete changes in service delivery, service excellence and staff satisfaction.
- Focus on equity and disparity includes fully involving communities, families, youth and consumers in the development and evaluation of the initiative
- Evident leadership support to provide the infrastructure necessary for sustainability including policy development, timely training, skillful supervision and coaching

The Trauma-Informed System of Care (TIS) project evaluation design will include key components of a comprehensive quality improvement performance management system that will capture relevant process and outcome data. This will include the following:

- Development of a well-articulated theory of change
- Development and implementation of a Provider Survey and interviews with partners and providers to assess systems change outcomes
- Development of a systems change tracking tool that will capture measures such as staff days on the job (reduced absenteeism), increased client engagement (reduced no-shows/dropouts), reduced personnel actions, and client satisfaction
- Assessment of youth outcomes through the administration of the CMHS Child Outcome Measures for Discretionary Programs, which collects performance measure data in areas such as mental illness symptomatology, employment/education, stability in housing, etc.

Mental Health Career Pathways Program

The Mental Health Career Pathways Program focuses on developing a workforce pipeline that will usher in the next generation of mental health and behavioral health practitioners and include members of

underserved and underrepresented communities. The agencies and programs involved in this program are described below.

Community Mental Health Worker Certificate (CMHC)

The Community Mental Health Worker Certificate (CMHC) program at City College of San Francisco (CCSF) is a 16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through consumer-directed goal setting and collaboration between mental health service consumers and mental health providers. The program trains a diverse group of front-line health workers to provide culturally responsive mental health and recovery services to the client population in San Francisco. The program focuses on engaging people with lived experience with mental health services and their family members as mental health care workers. The curriculum promotes the workforce skills needed to be gainfully employed as a mental health worker, and to enhance the knowledge base of existing mental health employees. In addition, students have access to critical supports designed to facilitate student retention and success in the program, including the following:

- Peer Care Manager who helps students navigate the college system, make linkages with other services, develop a personalized and comprehensive wellness and recovery action plans to support their academic participation and success
- Behavioral Health Specialist Intern who helps manage any mental health related needs
- Financial Aid Counselor who is available to students at the beginning and end of each semester to streamline processing of CMHC students' financial aid needs
- CCSF's Disabled Students Programs and Services (DSPS), which dedicates one DSPS counselor to CMHC so that students have expedited access to appointments
- A Career Development and Placement Center counselor, who helps students develop their resume, interview skills, and a professional portfolio, as well as provides assistance with internship placement

Summer Bridge

Summer Bridge is an eight-week summer mentoring program for current and recently graduated San Francisco public high school students age 16-20 who are interested in psychology and want to explore career opportunities in the field. The Summer Bridge Program goals and outcomes are to: 1) promote awareness of psychological well-being and 2) foster interest in health and human services as career options. The program participants meet 12 hours a week at our partner location, Horizons Unlimited in the Mission. Attendees hear presentations by guest speakers on topics ranging from identity, self-expression, mental health and stigma, LGBTQQ issues among adolescents and their families, body image and self-esteem, and personal stories from professionals in the field of mental health. The participants have also gone on various field trips: a RAMS staff training on racism and mental health, a visit to SFDPH/CBHS, a tour of San Francisco State University and meetings with undergraduate and graduate faculty members, and an introduction to the RAMS Child, Youth and Families Outpatient Clinic to learn about psychotherapy and the youth-oriented services provided by the agency.

Budget and Costs per Client

Career Pathways expenditures for fiscal year 2014-15 are projected to be $269,365. The projected per-client costs are detailed below.

Exhibit 27. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Career Pathways	98 individuals	$269,365	$2,749

Projected Outcomes

Mental Health Career Pathways programs developed outcome objectives that address the following MHSA goals specifically related to creating a workforce pipeline for mental health and behavioral health practitioners. These programs aim to increase:

- Interest in behavioral health careers for targeted populations
- Enrollment in post-secondary behavioral health training programs for targeted populations
- Building of a diverse workforce that reflects communities' ethnic, cultural, linguistic, sexual orientation, and religious/spiritual backgrounds
- Optimization of expertise that mental health consumers and their families bring to the public mental health labor market
- Imbue current public mental health workforce with relevant knowledge of cultural congruency and community defined practices, research and evaluation

Expanding (High School) Career Pathways

Given the need to recruit a more diverse behavioral health workforce – especially individuals from African American and Latino communities, San Francisco is exploring a strategy to begin this work in the high schools. Faces for the Future program (FACES) is nationally recognized for work in healthcare career preparation work with high school students. San Francisco Unified School District's (SFUSD) John O'Connell High School has begun planning to implement programming focused on behavioral health professions.

O'Connell High School's FACES's signature work based model will be coupled with psychosocial components imbued throughout the program. The four cornerstones of the school's lab design will be 1) career exposure, 2) academic support, 3) wellness and 4) youth leadership development. In addition, FACES will provide wrap around services to its students, addressing basic needs of food, health, safe transportation and mental/emotional support. For their internships, O'Connell High School students will be placed with community partners, where they will learn about public health practice, how mental health and behavioral health is interwoven into that practice and how to deliver culturally responsive

care. Although the details of this partnership are still being finalized, the FY 14-15 MHSA budget includes an allocation of $100,000 for this project.

Residency and Internship Programs

The goal of the Fellowship Program for Public Psychiatry in the Adult System of Care is to further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asian Pacific Islanders, health care utilization by LGBTQ individuals) and services for adults diagnosed with severe mental illness. In order to address San Francisco's behavioral health workforce shortages and supplement its existing workforce, the MHSA funds psychiatric residency and internship programs leading to licensure (see Exhibit 28 below).

Exhibit 28. Summary of Residency and Internship Programs

Lead Agency	Program	Focus
San Francisco Department of Public Health	Fellowship Program for Public Psychiatry in the Adult System of Care	To further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asians, health care utilization by LGBTQ individuals) and services for adults diagnosed with severe mental illness
UCSF Langley Porter Psychiatric Institute	Child & Adolescent Psychiatry Fellowship Program	To further develop fellows' knowledge and skills in psychiatric evaluations and services for children ages 4 to 18, the Community Behavioral Health system, and working with diverse populations

Budget and Costs per Client

Residency and internship expenditures for fiscal year 2014-15 are projected to be $364,000. The projected per-client costs are detailed below.

Exhibit 29. Cost per Client

Program	Annual Goal	Annual Cost	Cost per Client
Residency and Internships	804 individuals	$364,000	$453

Projected Outcomes

The Fellowship program seeks to achieve the following outcomes:

- Promote psychiatrists' continued work in the public mental health system.
- Expand the availability of psychiatric services using the fellows.

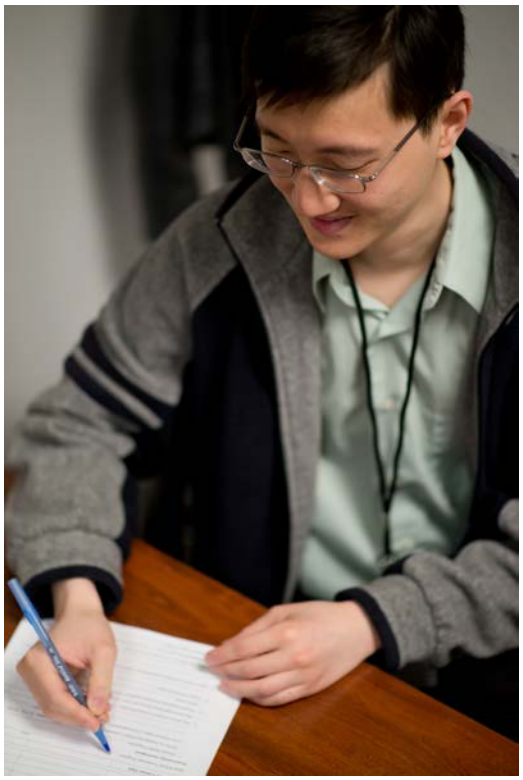
Expanding Internship Opportunities

The FY 13-14 MHSA budget includes a new CBHS Internship Coordinator position, which is yet to be hired. As highlighted in the FY 13-14 Update, the new Coordinator will work with CBHS staff, university and college graduate level (Master's level and PhD level) programs and graduate student interns to develop, implement and evaluate a centralized and coordinated public mental health internship/practicum program with the City & County of San Francisco's Department of Public Health [DPH] – Community Behavioral Health Services [CBHS] clinics and its program sites. Duties for the position include the following:

- Plan a program design that will coordinate DPH-CBHS internship opportunities and placements,
- Outreach to potential clinical supervisors throughout CBHS
- Work with university/college graduate programs to develop and execute standardized-contracts between DPH-CBHS clinics and program sites & the respective universities/colleges
- Work with DPH-CBHS clinics and program sites to ensure that in-service/in-house trainings are scheduled and carried out in compliance with the respective graduate level programs
- Work with DPH-CBHS clinics and program sites to develop standardized forms, policies and procedures to document graduate students' internship/practicum

State-funded Financial Incentive Programs

MHSA funding from the State, administered by OSHPD, supports stipends, scholarships, and loan forgiveness programs that serve as financial incentives to recruit and retain both prospective and current mental health employees. While we do not administer these funds locally, MHSA staff does help with outreach for the program described below.



The **Mental Health Loan Assumption Program (MHLAP)** is one resource that encourages mental health providers to practice in underserved locations in California by authorizing a plan for repayment of some or all of their educational loans in exchange for their service in a designated hard-to-fill/retain position in the public mental health system. The Mental Health Loan Assumption Program (MHLAP) awards recipients up to $10,000 with a required 12-month service obligation.

The Licensed Mental Health Service Provider Education Program (LMHSPEP) -- for Department of Public Health (DPH) civil service and DPH-contractor employees who are working in mental health service settings. The Licensed Mental Health Service Provider Education Program (LMHSPEP) awards recipients up to $15,000 with a required 24-month service obligation.

This year all applications were done online at

www.calreach.oshpd.ca.gov. If an individual qualifies, he or she can apply for both programs – but can only accept one award. For full details, visit www.healthprofessions.ca.gov

8. Capital Facilities/Information Technology

MHSA funding for Capital Facilities allows counties to acquire, develop, or renovate buildings to support the delivery of MHSA programs. Funds may also be used to develop community-based, less restrictive settings that will reduce the need for institutionalization or incarceration. MHSA funding for Information Technology (IT) supports upgrades to clinical and administrative information systems as well as improvements to consumers' and family members' access to personal health information within various public and private settings.

Capital Facilities

The original MHSA Capital Facility Program and Expenditure Plan included projects to renovate three buildings – Silver Avenue Health Center, Redwood Center and Sunset Mental Health. Subsequent proposals were approved to support renovation projects at Southeast Health Center and a new integrated clinic at 220 Golden Gate. This plan also calls for an annual investment of $500,000 in capital improvements, beginning in FY 14-15 with the South of Market Mental Health Center.

Silver Avenue Family Health Center (SAFHC) was the first capital project to be completed, facilitating the co-location of mental health professionals in primary healthcare settings by adding six new private counseling rooms, a large group room, waiting and reception area, and administrative space.

The Redwood Center was identified in the original MHSA plan for capital projects as a potentially appropriate site as a dual diagnosis-ready residential treatment facility. The Redwood Center is located on property owned by the Public Utilities Commission (PUC) in San Mateo County. SFDPH was forced to terminate the renovation process in early fiscal year 2012-13 because of financial and operational challenges and limitations posed by the site's designation as "historical." In fiscal year 2014-15, we will reassign an estimated $1.4 million that was originally slated for the Redwood Center. These unspent capital dollars will be used to augment renovations of the Southeast Health Center.

The Sunset Mental Health Services included an expansion of office space (e.g. new kitchen, meeting room) to accommodate growth in staff size. In addition, there were updates to the waiting room, such as an addition of digital media broadcasting mental health message and improvements to the interior design. The site also underwent increases in security to protect clients and staff, as well as in accessibility (e.g. meet current guidelines for the American with Disabilities Act). A new ventilation and heating system was installed.

Tom Waddell Urban Health Clinic In addition to MHSA-funded housing units, Kelly Cullen Community included a new 12,000-square-foot Integrated Housing and Urban Health Clinic (IHHC). Two federally qualified health centers, the Housing and Urban Health Clinic and Tom Waddell Clinic, were relocating to this site which will serve 25,000 people annually. The new IHHC includes offices for IHHC staff, 17 exam rooms, one group behaviorist office, two nursing/vitals offices, seven counseling spaces, three intake/benefits stations, a pharmacy, a phlebotomy lab, a large group meeting room and a waiting area with reception desk that can accommodate approximately 30 patients. The new clinic provides integrated physical, mental, and substance abuse services onsite with an emphasis on holistic services, wellness, and permanence.

Southeast Health Center Expansion/Integration Project

The enhancement of the Southeast Health Center (SEHC), which is partially funded by MHSA, will allow for the integration of behavioral health services, substance abuse services, crisis intervention and specialty services, and citywide behavioral health services. This **Southeast Health Campus** will bring together the expertise of existing children's behavioral health services and primary care. This growth is expected to increase SEHC's capacity to serve an estimated 1,250 additional children and families. SEHC will also be able to operate on evenings and weekends and better meet the schedules of working parents.

The project focuses on the renovation and expansion of an existing one-story 18,000 square feet primary care neighborhood health clinic in the Bayview Hunters Point neighborhood of San Francisco, located at 2401 Keith Street. It will be implemented in two distinct phases: 1) renovation of the existing 18,000 sq. ft. facility by 2016 and 2) construction of a two-story, approximately 23,000 square feet

addition by 2019. The intent of both the renovation and expansion is to facilitate the delivery of a more integrated and efficient neighborhood based health care system. Specific project goals include:

- Redesigning for enhanced patient/work flow
- Redesigning to facilitate patient-centered team-based care
- Integrating behavioral health into Primary Care teams
- Creating an inviting and family friendly environment for patients
- Co-locating new clinical and ancillary specialty services, including behavioral health, urgent care, radiology, and laboratory
- Providing space for community-oriented health and wellness programs and services.

Expanding Capital Improvements to Mental Health Clinics

Most mental health clinics in San Francisco have serious need for capital improvements. This plan calls for an annual investment of $500,000 in capital improvements, beginning in FY 14-15 with an allocation of $300,000 for capital improvements at the South of Market Mental Health Center. The balance of the annual capital investment will be made available pending additional CPP activities.

The enhancement of the South of Market Mental Health (SOMMH) clinic will support the creation of a Wellness Center and a more welcoming environment for MHSA consumers in the underserved South of Market area of San Francisco. SOMMH currently serves over 1300 consumers.

The South of Market Mental Health clinic was identified as a project site because of the need to upgrade this outpatient mental health clinic facility to provide a more accessible, welcoming and clinically effective facility for clients with serious mental illness. Renovations will upgrade the facility to promote maximum consumer empowerment and engagement within a wellness center environment. Renovation will result in an expansion of the capacity and access to existing services as well as the provision of new wellness services. The renovations will coincide with a change in the service delivery modality from a traditional medical model to a low-threshold environment providing multiple avenues for consumers to engage in services at their own pace.

A planning committee has been formed and includes local stakeholders such as adults and seniors with severe mental illness, families of consumers, providers, law enforcement, education, social service providers and providers of alcohol and substance abuse treatment. Future meetings will focus on gathering feedback and input on the decision-making in areas of planning and implementation, monitoring, quality improvement, evaluation and budget allocation.

Information Technology

The initial SF MHSA Information Technology (IT) Plan, approved in 2010, was developed through an extensive community planning process led by an MHSA-IT Planning Committee. The plan included three program areas: 1) Consumer Portal, 2) Consumer Employment and 3) System Enhancements. CBHS has accomplished much of what was outlined in the initial plan. However, the CBHS IT landscape has

changed considerably the last four years since the planning process, thus resulting in the need to adapt the plan. Additional expenditures in the System Enhancements program area have been and will be needed to make basic IT infrastructure improvements required to respond to the changing landscape. In addition, as Avatar has been implemented and input has been collected from staff and consumers about IT infrastructure, a need has emerged for more basic improvements than originally planned.

Changing Landscape

In response to the changes in the health care arena, the CBHS IT department has been integrated with the overall Department of Public Heath (DPH) wide IT department. The consolidation of the two departments will assist with the coordination of projects and resources that will lead to better coordination in the delivery of services to clients. Clients will see the benefits through the implementation of enterprise wide solutions that will facilitate their ability to coordinate their care between behavioral health and primary care clinics.

- **Implementation of Avatar**: In 2008, Netsmart of New York was funded to acquire and implement the Avatar suite of products (a.k.a. the "SF Avatar" project). SF Avatar is designed to drive the Behavioral Health Information System (BHIS) from point of entry through registration, eligibility determination, clinical record keeping, billing, revenue collection, accounting, reporting, administrative and clinical decision support, quality management, and research and outcomes reporting.
- **Affordable Care Act**: CBHS actively pursued enrollment of Eligible Providers (EPs) in the Federal and California State Meaningful Use (MU) program since the end of 2012. In the first quarter of 2013, 47 EPs from the civil services programs have signed the Incentive Assignment Form and 40 EPs have further been registered with CMS. CBHS postponed attesting for MU in response to the larger IT re-organization as enterprise solutions were being explored. In the meantime, the System of Care has developed Team-Based Care model, emphasized role-definition of each profession, and strengthened Care Coordination centered on a particular client, all of which will facilitate implementation of MU-required practices. CBHS is currently actively evaluating the timing for MU attestation with California State.

Implementation Update

The following provides highlights of the original IT Plan's three program areas: 1) Consumer Portal, 2) Consumer Employment and 3) System Enhancements with updates on implementation and how elements of the project have been adapted in response to the changing environment.

Consumer Portal

- ✓ The original IT Plan proposed **purchasing *Consumer Connect* by NetSmart**, assistive language technology and voice recognition software.

Update: The Consumer Portal solution provided by NetSmart through the Avatar application will not be used. San Francisco Department of Public Health (DPH) decided in 2013 to pursue an Enterprise Client

Portal solution, enabling consumers to view their health records and communicate with providers via a web-based system that is accessible to them at anytime, from any computer. Funding for the enterprise portal has been allocated within the larger DPH IT Department. As such, the funds that were provided by MHSA for the NetSmart Consumer Portal have been re-allocated to fund professional services related to System Enhancements. This includes efforts dedicated to the on-going improvement and support of the Avatar application (Electronic Health Record used by mental health).

✓ The original IT Plan proposed **making computing resources and internet access available to consumers** at forty provider sites.

Update: Given the status of the enterprise Consumer Portal implementation, this project is on hold at this time. The DPH Client Portal Project has designated a Client Engagement Workgroup to develop work plans, identify personnel and material resources, and recruit and educate clients for the use of Portal. One of the important functions of this Workgroup is to ensure that suggestions from clients and client advocacy groups are integrated in the planning and implementation of the Client Portal and its enrollment process.

The Consumer Portal project outcomes remain the same:

- Increase consumer participation in care
- Improve communication between consumers and/or family members and their care team
- Reduce medication errors
- Improve appointment attendance
- Help keep consumer information up-to-date
- Promote continuity of care with other providers

Consumer Employment

✓ The original IT Plan proposed a **Document Imaging project** to hire consumers to convert paper health records in batch format as well as on-going service document scanning into the electronic health record.

Update: The department decided to postpone implementation of document imaging that would have scanned all existing client paper charts into Avatar. The funds that were slated for this project are currently being used to provide additional structure, specificity and support to the Help Desk Vocational Training Program. Initially, Avatar Help Desk and Desktop programs were combined. The funds were used to separate these programs into two distinct tracks; one more focused on desktop support and the other more dedicated to application support. The department plans to implement the document imaging of some documents, such as those that may be presented by clients (social security card, identification cards, etc.). The utility and scope of this project are still under review.

✓ The original IT Plan proposed a **Consumer IT Support: Desktop and Help Desk** to provide a single point of contact for consumer and family member end users to receive IT support accessing the consumer portal, including answering, triaging and responding to calls from

consumers/family members. Desktop Support services include installing, diagnosing, repairing, maintaining, and upgrading PC hardware and equipment to ensure optimal performance.

Update: This project was modified to focus on desktop support in order to provide participants with a more specialized and targeted vocational experience. Participants learned skills related to the steps required to deploy new workstations, including imaging, logistics of deployment, removal of old hardware, break-fix and equipment tracking. Participants also worked on special projects such as the implementation of new desktop rooms. They also assisted in supporting the desktop needs for the department's Project Homeless Connect, in which workstations are stood up in an offsite location for the purposes of providing on-site registration into mental health and substance use disorder services. A new desktop support workshop was recently built out on the main floor of the CBHS Administration Building. Accomplishments for this successful program include the following:

- Consumer employment programs have been a huge success for CBHS. Participants have successfully graduated from the program with only one out of approximately 40 participants choosing to drop out for personal reasons. The growth, leadership and initiative of the participants are apparent in a number of projects where the participants have identified a need and taken initiative to complete a task, such as documenting a particular procedure or creating an Access database for tracking tickets.
- Reviewers from a site visit by the California External Quality Review Organization (EQRO) were impressed by the IT vocational programs and asked to utilize these programs as a model for other counties throughout the state.
- Two graduates of the vocational programs were hired on as full-time employees in IT. They work side-by-side with other IT staff and have been a valuable addition to our team.
- The program is in the process of hiring four part-time staff to assist in the deployment of desktops.
- Many of the graduates have gone to obtain employment outside of CBHS in the competitive job market.

Expanding Consumer Employment

SF MHSA will focus on further efforts to enhance basic IT infrastructure by hiring five graduates of CBHS vocational programs to assist in the deployment of desktops to behavioral health programs. Graduates hired will receive on the job training which will help expand their knowledge base and make them more competitive in the job market.

System Enhancements

✓ The original IT Plan proposed hiring staff to **implement the plan, specifically an MHSA Consumer Advocate** to facilitate consumer involvement and participation in planning and implementation and an **IT Engineer** to support the infrastructure of increased broadband, extranet servers and a large number of consumer users to the system.

Update: The Consumer Advocate was hired in 2013 within the IT applications department. Some of the activities that individuals are involved include the following: attending the Client Council to keep them informed about developments (especially around a consumer portal), developing video training

materials for users of the Avatar application as well as for the trainees in the Avatar Help Desk, participating in planning meetings regarding consumer engagement in the department wide consumer portal, participating in the Clinical Leadership Workgroup and working with Avatar Help Desk trainers to continue to develop the program.
The IT Engineer was hired in 2013. Some of the activities that individual is involved include the following: improving the connectivity at behavioral health sites and supporting servers that host the Avatar application and other applications that support the activities of CBHS.

- ✓ The original IT Plan proposed **ePrescribing access** to additional licenses to ensure that all CBHS prescribers use a single mode of prescription maintenance.

Update: The department purchased the following licenses: There are currently one hundred prescribers and 202 non-prescribers.

- ✓ The original IT Plan proposed **Point of Service (POS) document imaging** to provide for printing and scanning back into the Avatar client record the forms and treatment plans necessary to complete the electronic record for each client.

Update: This project is on hold at this time. The project has been modified from the original proposal. Initially the intention was to scan all paper charts into Avatar. This part of the project has been postponed.

- ✓ The original IT Plan proposed **eSignature,** specifically electronic signature capabilities to provide ready access to signed notices, consents and treatment plans for consumers and care providers.

Update: Signature pads were purchased, and SF MHSA is planning a later deployment than had initially been anticipated.

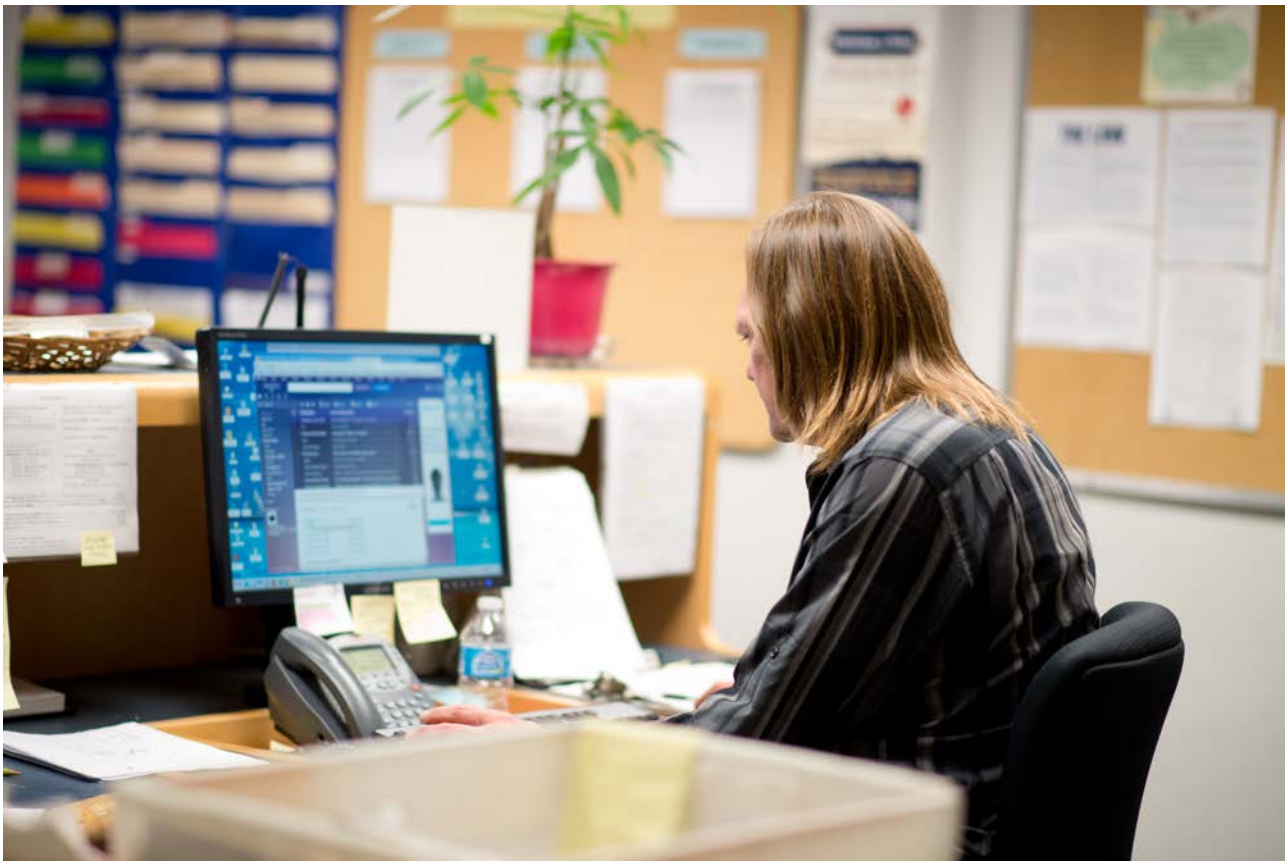
IT Community Program Planning (CPP) Activities

CBHS is committed to providing regular updates to the Client Council. During initial planning for the Consumer Portal, a survey was developed with Client Council input to find out consumers' level and use of technology, interest in using technology and to gather which features would be most important to consumers.

With the decision to implement an enterprise consumer portal, the DPH Client Portal Steering Committee appointed a Patient Engagement Workgroup to focus on engaging and provisioning clients into the portal as well as the HIE. This workgroup is comprised of members who have extensive experience in working with client advocacy, vocational training, and peer support groups. One of the accomplishments of this workgroup was to engage clients to participate in the DPH Client Portal Naming Contest in January 2014. Clients submitted their recommendations for naming the Portal. After several rounds of voting, "my SFHealth" was chosen to be the DPH Portal Name. Future client involvement will

include designing the Portal Access Webpage and planning and facilitating peer groups to register and access the Client Portal.

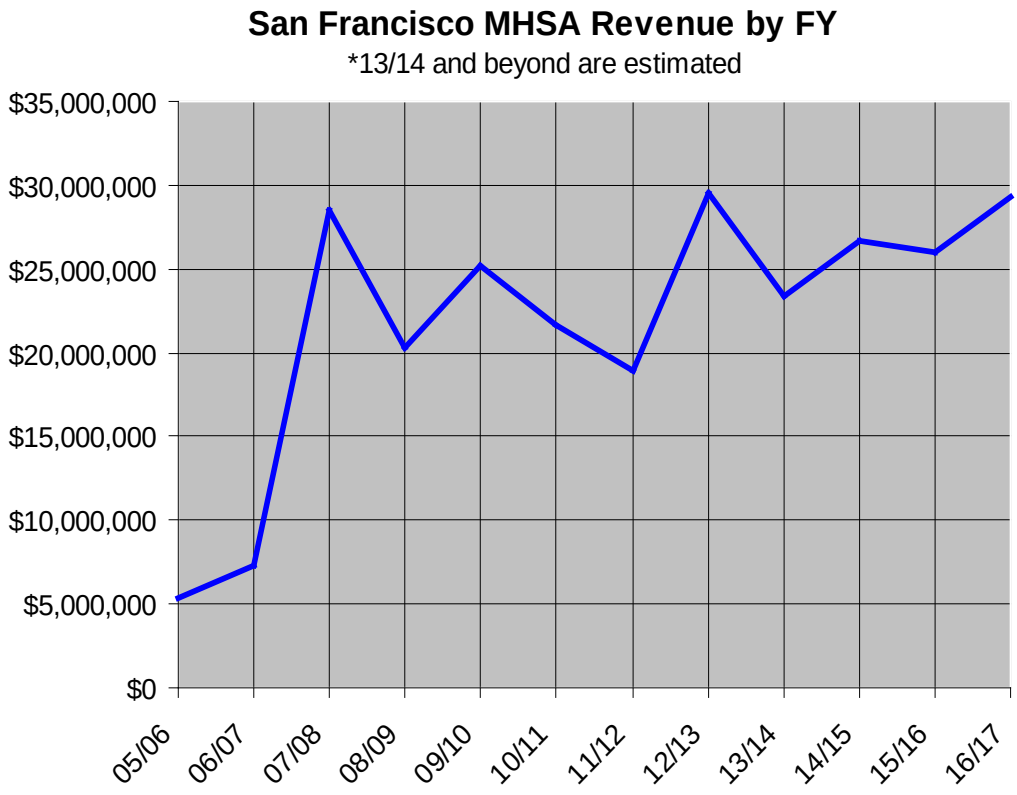
Finally, the CBHS IT Department actively seeks consumer input to continue to make improvements to the Vocational Program. The CBHS IT Department conducts group exit interviews of graduates from the vocational program. These interviews provide an unbiased means of sharing thoughts and feelings about the program because they are conducted without the RAMS Trainers /Supervisors. Some of the changes and improvements that have been a direct result of feedback from these exit interviews include: 1) changing the program from six months to 12 months, 2) creating an Advanced Help Desk track that offers leadership opportunities for graduates as well as chances to learn more skills, and 3) some specific curriculum changes.



9. MHSA Budget

Declines in San Francisco's MHSA revenue occurred in fiscal years 2010-11 and 2011-12 due to the budget downturn that affected California. Revenues for FY 12-13 showed growth. Projections through FY 2016-17 suggest that MHSA revenue will level off (see Exhibit 30 below).

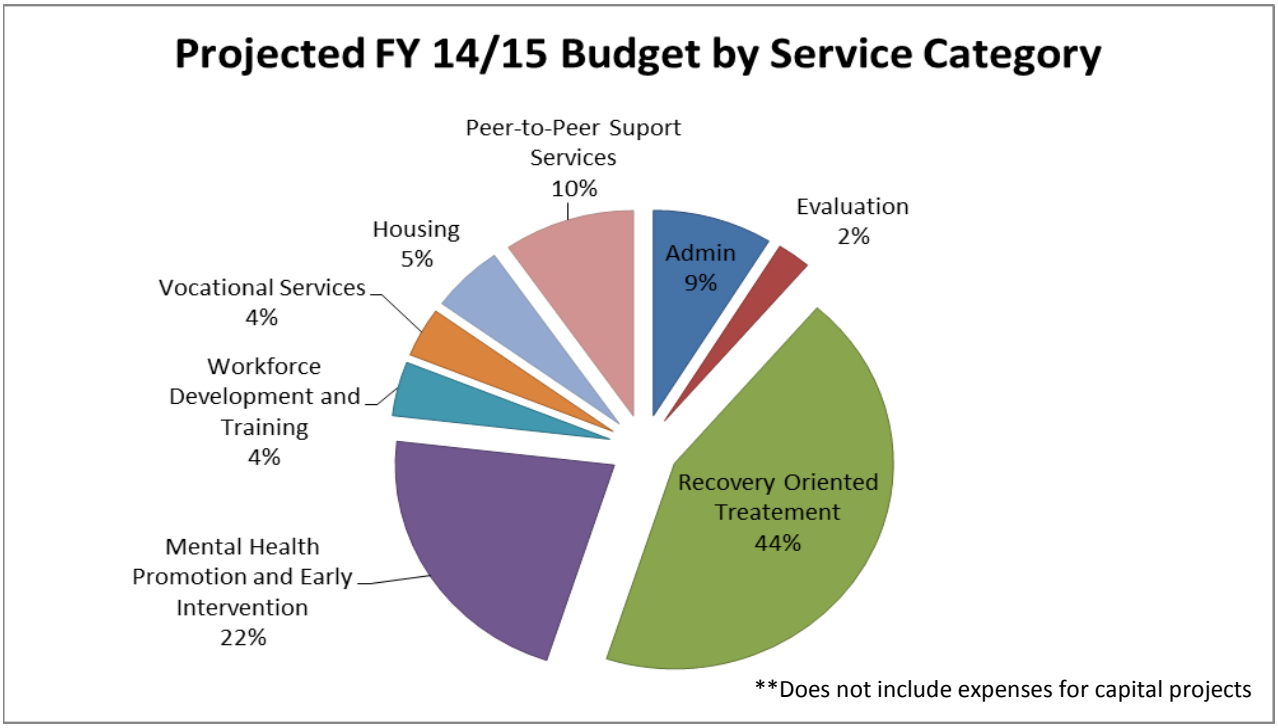
Exhibit 30. San Francisco MHSA Revenue by Fiscal Year



MHSA expenditures for FY 14-15 are estimated to be $30,973,615. Expenditures included one hundred FTE personnel (civil service) and 70 contracted programs with 46 organizations.

As shown in Exhibit 31, the majority of MHSA funds (44%) supported Recovery-Oriented Treatment Services followed by Mental Health Promotion and Early Intervention services (22%). MHSA funding was distributed to other service categories including Housing (5%), Peer-to-Peer Support services (10%), Behavioral Health Workforce Development and Training (4%), and Vocational Services (4%). All service categories included funding for INN-related projects.

Exhibit 31. Projected FY 14-15 Budget by Service Category



The MHSA FY-14-15 budget breakdown of programs by funding component is located in Appendix D. FY15-16 and FY17-18 projected budgets are expected to be comparable to the FY14-15 budget. Final budgets for future years will be provided in Annual Update reports.

10. Moving Forward

The Future of the MHSA in San Francisco

In the years ahead, we will continue to transform San Francisco's public mental health system. Within the constraints of the resources available, the MHSA will play an important role in strengthening and expanding the transformation of public mental health services locally and throughout California. Our future efforts will include the dissemination of our 2014-17 Integrated Plan that brings together all of the MHSA components. We will also continue to improve our monitoring and evaluation activities in order to effectively meet the outcome and performance objectives of our MSHA-funded programs.

11. Appendix A: Transgender INN Proposal

Date: 4/9/14

County: San Francisco County

Work Plan #: 16

Work Plan Name: Transgender Pilot Program (TPP)

Purpose of Proposed Innovation Project (check all that apply):

☒ **Increase access to underserved groups**

☐ Increase the quality of services, including better outcomes

☐ **Promote interagency collaboration**

☐ Increase access to services

ADAPTED* INN Program – REVISED submission as this project was approved through our local process*

Briefly explain the reason for selecting the above purpose

Years of budget cuts to HIV prevention programs have significantly reduced services to the transgender community. Multiple programs closed in a three year period including Tenderloin Health, Ark House, Restoration House, Transcending, and T-lish. At the MHSA community advisory meetings and recent peer events, individuals spoke to the need of the creation of a program that would help address the Wellness and Recovery of the transgender community.

According to a 2011 study published the National Center for Trans Equality, here is the outlook for transgendered people:

- 41% have attempted suicide
- 50% of the respondents reported having to educate their provider on trans care
- 26% reported worsened health conditions because they postponed care
- Trans clients experience high of violence and harassment leading to PTSD and other mental health conditions

These statistics are even higher when translated into issues faces by Trans women of color. In San Francisco, we come in contact with large sections of the consumer populations that are not linked into any services. The consumers identify stigma, discrimination, and lack of cultural relevant outreach as reasons why they do not access the mental health system.

The Transgender Pilot Program (TPP) hopes to increase linkages to services and improve client engagement in services. The focus will be on Trans Women of color, a group identified as the hardest to engage.

Specifically, the new program will learn how to do the following:

- Produce programming – including a culturally-informed training curriculum, supervision/support plan, and engagement strategies and tools that will improve the system of support for Trans Women of color.
- Build effective partnerships between individuals and organizations who provide peer support services and programs for Trans Women of color
- Discover engagement strategies for Trans Women of Color considering Gender Reassignment Surgery
- Engage clients into services and re-engage those that have fallen out over time.

There simply is no existing practice that has been studied that shows the best way to engage this population, despite the risk factors and high rates of untreated mental health issues.

Project Description

The Program will employ three strategies and evaluate each one. One involves support groups. The second is outreach. The third is an annual Transgender Health Fair as a one stop shop for linkages to services. The ways will be tested so we can learn the positives and drawbacks of each form of access. These methods will be compared individually and against each other.

The Transgender Pilot Program will consist of four weekly peer-led support groups and community outreach activities. Each of the four support groups will have a different focus. They will all be strength-based and resiliency-focused with the overarching goal of supporting consumers to engage in services. 1) The first group will be focused on pre-treatment/pre-placement services. The group will provide linkages to services in the community as well as resource development. 2) The second group will be a Wellness and Recovery Focused group that targets clients that are more engaged in the community, yet require support. 3) The third group will be in cooperation with Tom Waddell Health Center. They have identified a need for a group focused on building resilience and wellness for their HIV positive clients enrolled in services. TPP will not be providing these direct services, however, TPP will host the site with the goal of creating a collaborative process in which to learn from one another and also to increase engagement in care sites outside of the group. 4) The final group will be one that covers issues related to transgender health. The group will also sponsor a monthly testing site for HIV, STIs, and Hepatitis C.

In regards to outreach, the peer counselors will perform three types of activities. 1) The first will be street outreach. The peer counselors will hand out flyers for groups, invite clients to participate, and provide information about available services relevant for the transgender community. 2) The second type of outreach will be patient education. The peer counselors will be providing patient education for clients who are contemplating Gender Reassignment Surgery through the program provided by the San

Francisco Department of Health. 3) The final type of outreach will be the peer-organized, peer-led Transgender Health Fair. The Health Fair will be an opportunity to directly link clients into county services. The event will involve tabling by service providers, health screeners, peer counselors and will have presentations that impact Health and Wellness.

Target Population

The target populations will include socially isolated Trans women of Color individuals living in San Francisco who are living with mental illness or are at risk for developing such issues, with particular emphasis on those who are low-income. We want to learn to improve access to our county system to know how to prioritize resources.

Expected Outcomes/Positive Change: If this project is successful, the primary outcomes would be:

- An increase in consumer engagement in clinic and clinical services
- An increase in client satisfaction with level of connection and engagement
- A decrease in social isolation
- An increase in consumers who have engaged in health and wellness programs provided by the community

Program Goals Include:

The peer counselors will help build trusting relationships with transgender individuals, advocate for and model recovery and wellness, and create linkages to community resources, treatment services, and social activities. The County will get a jump start on how to allocate resources as more and more Trans Women are seeking services.

The groups will be launching points for education and engagement in community services. The consumers will be provided the opportunity for service providers to directly come to them, in order to increase access to services. In addition, consumers will be given a forum to share ideas regarding services that are available in the broader community at large. This project will then evaluate utilization of those linkages.

In the education and preparation course for gender reassignment surgery, the small peer counseling groups will allow the consumers to obtain detailed, first hand information about the potential benefits and risks involved. The peer counselors will conduct panel presentations for potential clients and the community at large. The goal will be to have a pool of potential clients matched to peer counselors who can help them navigate the healthcare system while minimizing the stress involved with the process, therefore improving clinical outcomes.

Examples of community collaborations include targeting:

- Community-based organizations who serve transgender consumers
- Clinics that currently serve transgender individuals
- Community settings where transgender people socialize

- Medical providers that specialize in transgender care
- Peer counselors working in the community

Title 9 General Standards: *TPP will apply the following general standards.*

- **Community Collaboration:** TPP will work in partnership with mental health clinic staff, the CBHS executive and operation teams, SF mental health clinic staff, building contractors, and clients/consumers from SF mental health clinics.
- **Cultural Competence:** The hiring of Trans for TPP will have a deep involvement that reflects the clients that they serve. Trans consumer specifically report a sense of connection with a place where they see staff that "look like them". Peers will be part of the hiring process.
- **Client Driven:** TPP is an empowerment driven approach in which the clients receiving services and running activities such as the Transgender Health Fair
- **Wellness, Recovery and Resilience focus:** By empowering consumers in the program development of the services they desire, we anticipate that this process will strengthen their individual wellness and recovery and improve other areas of their life.
- **Integrated Service Experience:** TPP is a service integration model in its very nature. TPP consumers will be provided direct access by bringing the service providers to them, within an environment where they feel comfortable.
- **Family-driven:** TPP will be a client, family, and community-driven program. This program will understand and embrace the notion that families should be involved and are often an integral component of the health and wellness of consumers. TPP will have an evening group one time per month in which partners and friends can also access services along with their loved ones, the consumers.

Contracted Activities may include, but are not limited to the following:

- Identify community partner organizations
- Identify traditional and non-traditional venues where transgender individuals access services
- Develop outreach and engagement strategies to address the needs of the target population
- Create culturally specific programming for transgender clients
- Provide ongoing training and professional development support for the peer counselors

Contribution to Learning

Learning Question: What are effective peer support strategies and practices for Trans women of color that will improve their engagement in mental health services, encourage social inclusion, and encourage community engagement?

Specifically targeting Trans women of color from a peer wellness framework is an approach that has not yet been tried at a county level. Moreover, using the peer-to-peer support model to address the needs of this population is also a new and innovative approach. Transgender individuals are chronically under-employed due to stigma and other barriers. While peers are mobilized to provide linkages in community agencies, this program seeks to learn about direct connections into county programs.

The program would be new for this area and an adapted practice on a broader level. We hope to learn from the consumers receiving services and from the peers providing support, to further continue to develop a successful model that other counties may follow.

We predict that our overall system of care will be improved in the following ways: 1) strengthen the network of peer support services; 2) increase linkages between mental health, transgender individuals and the community; and 3) increase engagement in overall peer-based wellness and recovery services. This project will engage consumers in the process of how they want services to look. It will reduce stigma as it increases access to services. The consumers will have investment and ownership.

What we will learn is whether our three selected strategies are effective. Next, we can determine is one stands out above the others. We will have some evidence and ability to make policy recommendations based on our learnings.

Project Measurement

As we roll out the program, we will be continually monitoring whether or not the three types of program are creating increased access and levels of engagement.

First we will evaluate each type of program individual, measuring it's efficacy with engagement and linkage. Then, we will do comparative analysis. What are the effective elements of each program? How does the program increase linkages? What are the effective strategies to get clients to services? We also want to find a way to measure if participation was a one time event or did they actually engage in the service.

Timeline

Phase I- Start Up and planning (7/2014-12/2014)

Program staff and consumers will spend the first six months of this project selecting methods of program evaluation. We will be looking for community input as a big piece of setting up the evaluation. Staff will be hired and become trained in the importance of evaluation.

Phase II- Implementation (1/2015-12/2015)

In this phase of the project, the program will be fully operational identifying a transgender population who is experiencing mental illness, assessing their social and behavioral health needs, and establishing a mutually-agreed upon relationships. We will collect baseline data for program participants and track changes over time. We will measure participant satisfaction and capture linkages.

Phase III – Reflection, evaluation, and dissemination (1/2016-6/2016)

In this phase, the qualitative evaluation gathered in implementation will be analyzed to determine the overall affect that using a peer-to peer support model had on the engagement and overall wellbeing of

the program participants. We will also assess the success of the peer support staff, the community partnerships and the added value of their collaborations. We will get feedback on their take on the program. We will draft our recommendations for the county leadership team and the State.

Leveraging Resources

The Project anticipates $20,000 in matching funds from another SFDPH department. The funds will be added to the overall budget to increase the capacity of the Friday Night Transgender Wellness Group.

Budget

YEAR ONE BUDGET

	County Mental Health Department	**Other Governmental Agencies**	**Community Mental Health Contract Providers**	**Total**
A. Expenditures				
1. Personnel Expenditures	**$206,461**			
2. Operating Expenditures	**$8,000**			
3. Non-recurring expenditures				
4. Training Consultant contracts				
5. Work plan management	**$25,735**			
6. Evaluation	**$8, 000**			
7. Total proposed work plan-Year 1 expenditures				
B. Revenues				
1. Existing revenues				
2. Additional revenues a. b.				

3. Total New Revenue				
4. Total Revenues				
C. Total funding requirements	**$248,196**			

YEAR TWO BUDGET

	County Mental Health Department	**Other Governmental Agencies**	**Community Mental Health Contract Providers**	**Total**
D. Expenditures				
8. Personnel Expenditures	**$206,461**			
9. Operating Expenditures	**$8,000**			
10. Non-recurring expenditures				
11. Training Consultant contracts				
12. Work plan management	**$25,495**			
13. Evaluation	**$8,000**			
14. Total proposed work plan-Year 1 expenditures				
E. Revenues				
3. Existing revenues				
4. Additional revenues a. b.				
3. Total New Revenue				

4. Total Revenues				
F. Total funding requirements	**$248,196**			

12. Appendix B: Older Adult INN Proposal

Date: 06/20/14

County: San Francisco County

Work Plan #: 15

Work Plan Name: Addressing the Needs of Socially Isolated Older Adults

Purpose of Proposed Innovation Project (check all that apply)

☐ **Increase access to underserved groups**

☐ Increase the quality of services, including better outcomes

☐ **Promote interagency collaboration**

☒ **Increase access to services**

ADAPTED* INN Program – REVISED submission as this project was approved through our local process*

Briefly explain the reason for selecting the above purpose

Social isolation has been identified as one of the key concerns for older adults living in San Francisco. Older adults, particularly those who do not have many community connections are one of the most *underserved* populations in the city of San Francisco. Though City Departments and CBO contractors currently provide high quality services to San Francisco's older adults, a smaller number of older adult subpopulations, particularly those that are isolated, have not had their mental health needs fully addressed. Further complicating outreach efforts to these sub-populations is the isolation itself, making it difficult to target services given the limited availability of reliable data on this population. However, it is known that certain factors put older adults at greater risk for isolation, including, but not limited to, the following: low-income, cultural and linguistic barriers, LGBT, lack of awareness of services, lack of appreciate interventions, stigma, lack of housing options, residence in SROs, and physical and/or cognitive impairments.

According to numerous studies, one of which published by the National Institutes on Health, found there to be a potentially strong correlation between perceived isolation and mental health problems, especially depression. Loneliness is a key predictor of depression among older adults, in particular. Similarly, perceived social support is more important for mental health outcomes than indicators of social connectedness, such as received support and network size. To the extent that mental health problems put individuals at risk for physical health problems, perceived isolation may also affect physical health through its impact on mental health.

One of the key tenets by which the Mental Health Services Act is grounded is wellness and recovery. We fully expect that those living with mental illness can have full lives filled with meaningful roles and strong relationships. One of the ways in which our programs and services embody the wellness and recovery philosophy is through the use of peers in service and support delivery. Peer-to-peer support uses other people with lived experience as a mental health services consumer or family member to engage, educate, and support others in the same circumstance. Research has shown this approach to be highly effective and empowering.

Therefore, the goal of this program is to decrease social isolation among older adults living Tenderloin neighborhood in San Francisco, and increase their access to services and supports through the use of peers. The Tenderloin is a highly depressed neighborhood with high rates of drug abuse, violence and prostitution.

In looking at similar models for service delivery, we found similar programs such as PATH and Philadelphia and Senior Reach in Colorado. These programs engage members from the community to help identify those that might be needed services for mental health issues in the community. In the Case of Senior Reach, workers are sent to engage socially isolated older adults in their homes. However, none of these programs adequate address our question as to how this program design would work in an area primarily made up of Single Room Occupancy Hotel rooms as the majority of the senior housing. In our community settings, the senior residents can be geographically be twenty feet from numerous people, yet still be completely isolated. By evaluating the program in this setting, the city could then decide is a similar program would work in other densely packed areas of the city serving others with mental health challenges.

Based on the national research mentioned above, approaching this challenge through a wellness and recovery lens to target such a high-need and marginalized population has not been previously. Here in San Francisco, we want to employ this innovative approach in a way that is consistent with the recovery lens through which develop all of our interventions. Specifically, the goal is to develop effective peer support strategies and practices for low-income socially isolated older adults that will *improve their engagement* in mental health services, encourage social inclusion, and decrease stigma and discrimination. A secondary goal is to develop a training curriculum and system of support for the "peer supporters" that will be employed by the program. We want to ensure that the peers who will "on the front lines" are well equipped to address the recovery needs of their clients, as well as attend to their own self-care needs so that they may continue of their wellness journey.

Project Description

The purpose of the funding endeavor is learn how to engage and connect socially isolated adults with social networks and behavioral health services through the use of the peer-to-peer model. Peer support services are defined as services provided by consumers, family members, and other individuals who are on their own recovery journey and have received training in how to be helpful to others who participate in mental health services. Peer support services are customized to the needs of individuals with and at-

risk for mental illness and include opportunities to advocate for themselves, meet their goals for recovery, make connections inside and outside of the mental health system, get a job, find better housing, and learn skills to live well and have a meaningful role in the community.

Specifically, the new program will endeavor to do the following:

- To produce programming – culturally-informed training curriculum, supervision/support plan, and engagement strategies and tools – that will improve our system of support for socially isolated older adults
- To build effective partnerships between individuals and organizations that provide peer support services and programs for socially isolated older adults
- To develop a more coordinated system of care for socially isolated older adults. The funded program should promote seamless collaboration between programs that are currently serving this population.

From the client/partner perspective, we expect that the funded program(s) will increase social connectedness, strengthen support for recovery and wellness, increase access to mental health services, and increase use of mental health services and support.

MHSA also seeks to make advances to our overall system of system of care. There is an expectation that this work will strengthen the network of peer support services, increase linkages between mental health, older adult systems of care, and the community, and increase cadre of peer supporters focused on the needs of socially isolated older adults. Moreover, as previously mentioned, we will test the effectiveness of developing a network of peer supporters that are highly training and supported in their role as helpers. We want to test how that support and professional development will maintain or increase their own feelings of recovery and wellness as it pertains to their mental health.

Lastly, from the beginning, the program will institute a plan for evaluating the effectiveness of the intervention. Evaluation outcomes should include an assessment of the impact of the outreach and engagement strategies used and the effectiveness of the peer curricula and training. The results from these evaluations must be well documented and reported.

C. Target Population

Socially isolated older adults living in San Francisco who are living with mental health challenges or are at risk for developing such issues, with particular emphasis on low-income older adults living in the Tenderloin neighborhood of San Francisco, a low-income area that is prone to violence. There is a growing body of research that has found that individuals living in poverty, and particularly those exposed to violence, have significant adverse mental health outcomes such as depression and risk for suicide, post-traumatic stress disorder (PTSD), aggressive and/or violent behavior disorders. We will attempt to learn whether our peer-based approach will help to mitigate some of these effects for socially isolated older adults.

D. Program Goals Include:

As mentioned above, this program will use peer supporters as its foundation. We will look at the best approaches for how peer supporters can build trusting relationships with socially isolated older adults, advocate for and model recovery and wellness, and create linkages to community resources, treatment services, and social activities.

One of the key goals of this effort is to build and/or strengthen a network of peer support services focused on engaging social isolated older adults. Integration and partnership amongst established community organizations will be a strong tenet of the program.

Potential traditional and non-traditional community partners will include:

- Community-based organizations who serve older adults;
- Educational and cultural institutions;
- Faith-based and spiritual organizations;
- Provider and professional organizations;
- Civic organizations;
- Business; and
- Individual content experts

E. Contracted Activities may include:

Contracted activities may include, but are not limited to the following:

- Identify selection criteria for peer supporters, and the best qualities that one should embody in order to effective serve in this capacity.
- Identify traditional and non-traditional venues where socially isolated older adults may be reached.
- Develop outreach and engagement strategies to address the needs of the target population.
- Conduct behavioral health assessments of the individuals identified.
- Develop a curriculum and training plan that emphasizes a strengths-based perspective.
- Create a supervision plan for the peer supporters.
- Provide ongoing training and professional development support for the peer supporters.

Contribution to Learning

Learning Question #1: Whether and how using a peer-to-peer system will effectively engage, empower, and instill protective factors for adverse mental health outcomes for socially isolated older adults living in the highly depressed neighborhood of the Tenderloin in San Francisco. Moreover, using the peer-to-peer support recovery-based model to address the needs of this population is a new and innovative approach-one that has not been attempted with our population. We can anticipate that through this effort socially isolated older adults will increase social connectedness, strengthen support for recovery

and wellness, increase their access to mental health services, and increase their use of mental health services. We also predict that our overall system of care will be improved in the following ways: 1) strengthen the network of peer support services; 2) increase linkages between mental health, older adult systems of care, and the community; and 3) increase cadre of peer supporters focused on the needs of socially isolated older adults.

Learning Question #2: How best to support the peer supporters in their learning as mental health professionals, as well as in their recovery journey from mental health challenges. We will learn from the peer supporters whether the work provides protective factors for them, the frequency and type of supervision and support they need, caseload capacity, as well as what is realistic regarding scope of work expectations.

Timeline

Phase I- Start Up and planning (7/2014-12/2014)

Program staff and consumers will spend the first six months of this project selecting community partners that employ peers that can engage and serve the older adult population. The program will also fine-tune their scope of work, hire needed staff, and establish the need infrastructure to run the program. Peers will hired and engaged in the planning process.

Phase II- Implementation (1/2015-12/2015)

In this phase of the project, the program will be fully operational identifying socially isolated adults, assessing their social and behavioral health needs, and establishing a mutually-agreed upon relationship/plan of care.

Phase III – Reflection, evaluation, and dissemination (1/2016-6/2016)

In this phase, the qualitative evaluation gathered in implementation will be analyzed to determine the overall affect that using a peer-to peer support model had on the engagement and overall wellbeing of the program participants. We will also assess the success of the community partnerships and the added value of their collaborations.

Project Measurement

These will be developed by agency that is awarded the grant to lead this project.

Leveraging Resources (if applicable)

YEAR ONE BUDGET

	County	**Other**	**Community**	**Total**

	Mental Health Department	Governmental Agencies	Mental Health Contract Providers	
G. Expenditures				
15. Personnel Expenditures				
16. Operating Expenditures				
17. Non-recurring expenditures				
18. Training Consultant contracts				
19. Work plan management				
20. Evaluation				
21. Total proposed work plan-Year 1 expenditures				
H. Revenues				
5. Existing revenues				
6. Additional revenues a. b.				
3. Total New Revenue				
4. Total Revenues				
I. Total funding requirements				

YEAR TWO BUDGET

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures				
2. Operating Expenditures				
3. Non-recurring expenditures				
4. Training Consultant contracts				
5. Work plan management 6. Evaluation				
7. **Total proposed work plan- Year 2 expenditures**				
B. Revenues				
1. Existing revenues				
2. Additional revenues a. b.				
3. Total New Revenue				

4. Total Revenues				
C. Total funding requirements				

13. Appendix C: Mental Health Outreach Worker INN Proposal

Date: 5/2/14

County: San Francisco County

Work Plan #: INN # 16

Work Plan Name: Mental Health Outreach Workers (MHOW) Training Program

Purpose of Proposed Innovation Project (check all that apply)

☐ Increase access to underserved groups

☒ **Increase the quality of services, including better outcomes**

☐ Promote interagency collaboration

☐ Increase access to services

MHOW will increase the quality of services, including better outcomes in two unique ways. First, by training community outreach workers in mental health trauma so they may better serve their clients, and secondly, by helping outreach workers deal and heal with their own vicarious trauma, thus allowing them to be more present and empathetic to the communities that they serve.

Although that we anticipate that MHOW will increase access to underserved groups, promote interagency collaboration, and increase access to services for mental health consumers, we will not measure them in this initial pilot innovation project.

Project Description

The Mental Health Outreach Workers (MHOW) Training program aims to train San Francisco street outreach workers, exposed to constant community trauma, on how to best meet the mental health needs of the clients that they encounter in the field, and also how to best deal with one's own experience with trauma.

Three sub communities of outreach workers have been identified by our local CPP as frontline programs coming in contact with high rates of trauma. These are: Homeless Youth Outreach Workers Programs and Street Violence Outreach workers, and Asian Community Outreach workers. In total, a cohort of 60 outreach workers will be trained (20 per sub community).

The MHOW curriculum has been developed according to standards articulated by the Mayor's Office Violence Prevention Services and the Department of Public Health. Additionally, it will be informed by contemporary research findings and key geographic communities throughout the city. The training will

be conducted over the course of twelve months, with three hours per week of class time (e.g. Wednesday, 11am to 2pm) and at least two hours per week of homework. This project is unique in that the curriculum has not been piloted with its targeted audience- street violence workers and additionally it will be piloted with 2 unintended target audiences: homeless youth outreach worker and outreach workers working with the Asian Pacific Islander communities.

Additionally, MHOW is unique in that that outreach workders currently only receive limited or no mental health focused training. A recent pilot to enroll a few of outreach workers our Community Mental Health Certificate Program was unsuccessful. Lastly, there is currently no training/intervention of this kind in San Francisco.

The ultimate goal of this program is to develop advanced mental health outreach workers on how to work with individuals who have experienced trauma. Additional goals include:

- Stigma and discrimination reduction- because staff will have increased knowledge and practice skills in the realm of community mental health and mental health care, their perceived stigma of mental health and mental health care will be reduced.
- Trauma recovery- staff will have an increased knowledge and practice skills surrounding trauma recovery and will be applying these new skills through their street outreach, school outreach, and general outreach within their community.

Expected Outcomes/Positive Change: If this project is successful, the primary outcomes would be:

- An increase in consumer engagement with outreach services
- An increase in client satisfaction with services
- An increase in outreach worker morale
- An increase in appropriate referrals to mental health/substance use/housing services.
- Increase in awareness and recovery of one's own trauma symptoms
- Improved linkages with mental health services and supports for communities with high rates of trauma
- Increased staff knowledge and skills around community mental health with a broader understanding of violence, trauma caused by violence, vicarious trauma, and trauma recovery.

Title 9 General Standards: MHOW will apply the following general standards.

- **Community Collaboration:** MHOW will work in collaboration with the Mayor's Office Violence Prevention Services, Department of Public Health, community-based organizations, and outreach workers in order to share information and fulfill their common vision and goal. San Francisco MHSA (SF MHSA) is working in close collaboration with the Mayor's Office of Violence Prevention, the Department of Public Health's Crisis Response Team, local community based organizations and community stakeholders in the development, testing, implementation and evaluation of this training program. SF MHSA staff will be keeping all involved parties abreast –

via phone calls, emails, face-to-face meetings and quarterly updates -- of the program's development, testing/further testing, improvement/further improvement, and evaluation phases – including findings and recommendations.

- **Cultural Competence:** The MHOW framework has cultural humility content and culturally affirming practices embedded throughout its curriculum , which will support the mental health outreach workers' professional development in providing culturally responsive care in the community (e.g. Chapter 7: Practicing Cultural Humility of the textbook "Foundations for Community Health Workers"). Additionally, sub-communities of outreach workers (such as homeless youth, etc) are the focus of this pilot to ensure successful integration into the community.

- **Client Driven:** MHOW is inherently client driven in that the services take place where the client is at physically (street-based) and also emotionally.

- **Wellness, Recovery and Resilience focus: Integrated Service Experience:** The MHOW framework and curriculum will be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers. It will promote concepts key to the recovery for mental illness and trauma, such as: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

Contribution to Learning

MHOW is an **ADAPTED** mental health program, specific to outreach workers with vicarious trauma. MHOW is the first academy of its kind in San Francisco. The County of Los Angeles has a similar established learning institution for its street violence intervention and prevention workers, and key concepts and curriculum themes have been considered in the development of the MHOW Training Academy. Moreover, the successful SF MHSA-funded Community Mental Health Certificate Program's curriculum serves as the MHOW's core curriculum, with additional emphases in violence, trauma caused by violence, vicarious trauma and trauma recovery.

While there are other mental health outreach worker training curricula in the field, this MHOW curricula stands apart because it is (1) solidly based upon the SF MHSA-funded Community Mental Health Certificate program curriculum delivered by City College of San Francisco; (2) this community mental health program curriculum is elevated with the additional emphases on violence, trauma due to violence, vicarious trauma and trauma recovery; and (3) this curriculum will be tested with individuals who deliver non-licensed mental health care.

MHOW's learning goals are to learn how to staff and clients are affected by providing and delivering standardized community mental health trainings for critical street violence intervention and prevention staff; and (2) How does training a workforce in community mental health with additional emphases in violence, trauma caused by violence, vicarious trauma and trauma recovery, help them in their own trauma and vicarious trauma.

Additional MHOW Learning Goals:

1. Was the curriculum appropriate and relevant to the mental health outreach workers and their work in the community?

2. Was the curriculum appropriate for this particular staff? If no, why? What part(s) were inappropriate? If yes, how was it appropriate for this particular staff?

3. What part(s) of the curriculum were efficacious? (e.g. curriculum content, curriculum delivery such as manner of instruction, physical environment/setting for learning)

4. Was the testing of this adapted curriculum successful? Of the testing process, what was learned? What resonated for the mental health outreach workers? What didn't resonate for them? What curricula components were received, understood and practiced well? What curricula components were not received, understood and practiced well?

5. Did the curriculum increase consumer engagement? Are supervisors observing changed attitudes and behaviors of the mental health outreach workers?

Timeline

Phase I- Start Up and planning (6/2014-9/2014)

The 1st three months of planning will be dedicated to recruiting outreach workers to participate in the MNHOW training from the 2 targeted communities: street violence workers, homeless youth outreach workers, and API community outreach workers. Additionally, interviews and focus groups will be held; and data will be collected from the community and its evaluators, stakeholders, service providers, and consumers and family members of consumers to develop the evaluation plan for the MHOW project.

Phase II- Implementation (9/2014-8/2015)

This phase will be when the classroom instruction will occur. During this phase, evaluation will take place to track qualitatively how this process is affecting those who are involved.

Phase III – Reflection, evaluation, and dissemination (9/2015-11/2015)

Phase III will include the complete analysis of evaluation efforts of MHW. The learning report will be written and shared. Additionally, a public report back will also take place. If the approach proves successful CBHS/MHSA will consider expanding this program to all outreach workers in San Francisco.

Project Measurement:

Is the MHOW curriculum relevant to the outreach worker segment of the mental health workforce?

Measurement: mental health outreach workers can respond to a short questionnaire via survey monkey to report if the curriculum and its delivery was relevant to them and their community work.

Was the intended audience of this curriculum delivery the appropriate audience?

Measurement: mental health outreach workers can respond to a short questionnaire via survey monkey to report if the curriculum and its delivery was relevant to them and their community work.

What are the contributions of this adapted curriculum? – the areas that have been affected/changed

Determine how to measure MHOW are learning

What part(s) of the curriculum and its delivery worked? What part(s) of the curriculum and its delivery did not work?

Overall Program Outcomes:

- If MHOW is successful, MHSA San Francisco will use this model to fund additional training for outreach workers.
- If MHOW is successful, its innovative model will be adopted by other clinics in San Francisco, as well as other local and state mental health clinics.

Leveraging Resources (if applicable)

$12,500 matching planning grant (matching the Mayor's Office of Violence Prevention investment of $12,500)

N/A

Budget

	County Mental Health Department	**Other Governmental Agencies**	**Community Mental Health Contract Providers**	**Total**
A. Expenditures				
1. Personnel Expenditures	**$125,000**			
2. Operating Expenditures	**$80,000**			
3. Non-recurring expenditures	**$70,000**			
4. Training Consultant	**$10,000**			

contracts				
5. Work plan management	**$10,000**			
6. Evaluation	**$5,000**			
7. Total proposed work plan expenditures	**$300,000**			
B. Revenues				
1. Existing revenues	$12,500 matching planning grant (matching the Mayor's Office of Violence Prevention investment of $12,500)			
2. Additional revenues a				
3. Total New Revenue				
4. Total Revenues				
C. Total funding requirements				**$300,000**

14. Appendix D: MHSA Budget of Programs by Funding Component

The table below details the MHSA FY14-15 budget breakdown of programs by funding component. FY15-16 and FY17-18 projected budgets are expected to be comparable to the FY14-15 budget. Final budgets for future years will be provided in Annual Update reports.

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 14/15 Projected Budget
	Community, Services and Supports (CSS) 80% of total MHSA revenue (after INN calculated) Per MHSA, 51% is allocated to serve FSP clients	
RTS	CSS Full Service Partnership 1. CYF (0-5)	$ 400,000
RTS	CSS Full Service Partnership 2. CYF (6-18)	$ 1,415,000
RTS	CSS Full Service Partnership 3. TAY (18-24)	$ 1,076,468
RTS	CSS Full Service Partnership 4. Adults (18-59)	$ 5,850,000
RTS	CSS Full Service Partnership 5. Older Adults (60+)	$ 750,000
H	CSS FSP Permanent Housing (capital units and master lease)	$ 650,000
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	$ 803,751
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	$ 931,770
RTS	CSS Other Non-FSP 3. Trauma Recovery	$ 547,000
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	$ 1,179,270
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	$ 470,189
RTS	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	$ 85,309
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP)	$ 2,210,000
VS	CSS Other Non-FSP 8. Vocational Services (30% FSP)	$ 228,252
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	$ 393,637
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	$ 260,508
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	$ 1,089,465
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	$ 338,323
	CSS Admin	$ 1,668,577
	CSS Evaluation	$ 528,857
	SUBTOTAL Community Services and Support (CCS)	**$ 20,876,376**
	Workforce, Development Education and Training (WDET) $1.6 million per year of CSS transferred to WDET	
WD	WDET 1. Training and TA	$ 386,000
WD	WDET 2. Career Pathways	$ 269,365
WD	WDET 3. Residency and Internships	$ 364,000
	WDET Admin	$ 115,000
	WDET Evaluation	$ 37,150
	TOTAL	**$ 1,171,515**

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 14/15 Projected Budget
	Capital Facilities/IT **O**ne-time allocation and $500k per year of CSS funds transferred to CF	
CF/IT	Cap 1. Southeast Health Center	TBD
CF/IT	Cap 2. South of Market Mental Health	$ 300,000
CF/IT	Cap 3. *TBD through CPP*	TBD
CF/IT	IT 1. Consumer Portal	$ 225,000
VS	IT 2. Vocational IT (part of Vocational Services)	TBD
CF/IT	IT 3. System Enhancements	$ 225,000
	IT Admin	$ 163,658
	TOTAL	**$ 913,658**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**$ 22,961,549**
	Prevention and Early Intervention (PEI) 20% of MHSA revenue (after INN calculated)	
PEI	PEI 1. Stigma Reduction	$ 175,000
PEI	PEI 2. School-Based Mental Health Promotion (K-12)	$ 991,000
PEI	PEI 3. School-Based Mental Health Promotion (Higher Ed)	$ 417,226
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention	$ 2,751,970
PEI	PEI 5. Mental Health Consultation and Capacity Building	$ 831,855
PEI	PEI 6. Comprehensive Crisis Services	$ 494,988
	PEI Admin	$ 141,261
	PEI Evaluation	$ 143,401
	TOTAL	**$ 5,946,701**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 7. Peer-Led Hoarding and Cluttering Support Team (part of Peer-to-Peer Support Services - P2P)	$ 215,735
PEI	INN 8. Collaboration with the Faith Community (part of Mental Health Promotion and Early Intervention - PEI)	$ 150,000
TBD based on specific projects	INN 9. Mini Grants	TBD
VS	INN 11. Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) (part of Vocational Services - VS)	$ 233,903
RTS	INN 12. Building Bridges Clinic/School of Linking Project (part of Recovery Oriented Treatment Services - RTS)	$ 405,361
VS	INN 14. First Impressions (part of Vocational Services - VS)	$ 300,000
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults (part of Mental Health Promotion and Early Intervention - PEI)	$ 200,000
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals (part of Mental Health Promotion and Early Intervention - PEI)	$ 159,087
WD	INN 17. MH Certificate for Outreach Paraprofessionals (part of Workforce Development)	$ 200,000

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 14/15 Projected Budget
	INN Admin	$ 201,279
	TOTAL	**$ 2,065,365**
	TOTAL PROJECTED FY 14/15 MHSA Budget * * FY 15/16 and 17/18 expected to be comparable to FY 14/15. Final budgets for future years will be provided in Annual Updates.	**$ 30,973,615**
	MHSA Integrated Service Categories	
	Recovery Oriented Treatment Services	**RTS**
	Mental Health Promotion and Early Intervention Services	**PEI**
	Peer-to-Peer Support Services	**P2P**
	Vocational Services	**VS**
	Workforce Development	**WD**
	Capital Facilities/IT	**CF/IT**
	Housing	**H**

15. Appendix E: Approved FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Francisco — Date: 12/23/14

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	9,586,238	3,880,236	3,643,223	0	2,529,296	
2. Estimated New FY2014/15 Funding	23,285,878	5,821,469	1,531,966			
3. Transfer in FY2014/15[a/]	(2,000,000)			1,500,000	500,000	
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	30,872,116	9,701,705	5,175,189	1,500,000	3,029,296	
B. Estimated FY2014/15 MHSA Expenditures	20,876,376	6,046,701	2,065,365	1,171,515	913,658	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	9,995,740	3,655,004	3,109,824	328,485	2,115,638	
2. Estimated New FY2015/16 Funding	20,713,453	5,178,363	1,362,727			
3. Transfer in FY2015/16[a/]	(1,171,515)			1,171,515		
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	29,537,678	8,833,367	4,472,551	1,500,000	2,115,638	
D. Estimated FY2015/16 Expenditures	20,876,376	6,046,701	2,065,365	1,171,515	913,658	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	8,661,301	2,786,666	2,407,186	328,485	1,201,980	
2. Estimated New FY2016/17 Funding	23,091,147	5,772,787	1,519,154			
3. Transfer in FY2016/17[a/]	(843,030)			843,030		
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	30,909,418	8,559,453	3,926,340	1,171,515	1,201,980	
F. Estimated FY2016/17 Expenditures	20,876,376	6,046,701	2,065,365	1,171,515	913,658	
G. Estimated FY2016/17 Unspent Fund Balance	10,033,042	2,512,752	1,860,975	0	288,322	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	1,000,000
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	1,000,000
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	1,000,000
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	1,000,000

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Community Services and Supports (CSS) Component

County: San Francisco Date: 12/23/14

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	CSS Full Service Partnership 1. CYF (0-5)	400,000	$ 400,000				
2.	CSS Full Service Partnership 2. CYF (6-18)	1,415,000	$ 1,415,000				
3.	CSS Full Service Partnership 3. TAY (18-24)	1,076,468	$ 1,076,468				
4.	CSS Full Service Partnership 4. Adults (18-59)	5,850,000	$ 5,850,000				
5.	CSS Full Service Partnership 5. Older Adults (60+)	750,000	$ 750,000				
6.	CSS FSP Permanent Housing (capital units and master lease)	650,000	$ 650,000				
7.	Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP)	442,000	442,000				
8.	Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (30% FSP)	68,476	68,476				
9.	Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	236,182	236,182				
10.	Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP	78,152	78,152				
11.	Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	653,679	653,679				
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
Non-FSP Programs							
1.	CSS Other Non-FSP 1. Behavioral Health Access Center	803,751	803,751				
2.	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	931,770	931,770				
3.	CSS Other Non-FSP 3. Trauma Recovery	547,000	547,000				
4.	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,179,270	1,179,270				
5.	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	470,189	470,189				
6.	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	85,309	85,309				
7.	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP)	1,768,000	1,768,000				
8.	CSS Other Non-FSP 8. Vocational Services (30% FSP)	159,776	159,776				
9.	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	157,455	157,455				
10.	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	182,356	182,356				
11.	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	435,786	435,786				
12.	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	338,323	338,323				
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
CSS Administration		1,668,577	1,668,577				
CSS Evaluation		528,857	528,857				
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		20,876,376	20,876,376	0	0	0	0
FSP Programs as Percent of Total		55.7%					

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	400,000	$ 400,000				
2. CSS Full Service Partnership 2. CYF (6-18)	1,415,000	$ 1,415,000				
3. CSS Full Service Partnership 3. TAY (18-24)	1,076,468	$ 1,076,468				
4. CSS Full Service Partnership 4. Adults (18-59)	5,850,000	$ 5,850,000				
5. CSS Full Service Partnership 5. Older Adults (60+)	750,000	$ 750,000				
6. CSS FSP Permanent Housing (capital units and master lease)	650,000	$ 650,000				
7. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP)	442,000	442,000				
8. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (30% FSP)	68,476	68,476				
9. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	236,182	236,182				
10. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP	78,152	78,152				
11. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	653,679	653,679				
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	803,751	803,751				
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	931,770	931,770				
3. CSS Other Non-FSP 3. Trauma Recovery	547,000	547,000				
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,179,270	1,179,270				
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	470,189	470,189				
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	85,309	85,309				
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based	1,768,000	1,768,000				
8. CSS Other Non-FSP 8. Vocational Services	159,776	159,776				
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	157,455	157,455				
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	182,356	182,356				
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	435,786	435,786				
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	338,323	338,323				
CSS Administration	1,668,577	1,668,577				
CSS Evaluation	528,857	528,857				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	20,876,376	20,876,376	0	0	0	0
FSP Programs as Percent of Total	55.7%					

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	400,000	$ 400,000				
2. CSS Full Service Partnership 2. CYF (6-18)	1,415,000	$ 1,415,000				
3. CSS Full Service Partnership 3. TAY (18-24)	1,076,468	$ 1,076,468				
4. CSS Full Service Partnership 4. Adults (18-59)	5,850,000	$ 5,850,000				
5. CSS Full Service Partnership 5. Older Adults (60+)	750,000	$ 750,000				
6. CSS FSP Permanent Housing (capital units and master lease)	650,000	$ 650,000				
7. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP)	442,000	442,000				
8. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (30% FSP)	68,476	68,476				
9. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	236,182	236,182				
10. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP	78,152	78,152				
11. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	653,679	653,679				
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	803,751	803,751				
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	931,770	931,770				
3. CSS Other Non-FSP 3. Trauma Recovery	547,000	547,000				
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,179,270	1,179,270				
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	470,189	470,189				
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	85,309	85,309				
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based	1,768,000	1,768,000				
8. CSS Other Non-FSP 8. Vocational Services	159,776	159,776				
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	157,455	157,455				
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	182,356	182,356				
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	435,786	435,786				
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	338,323	338,323				
CSS Administration	1,668,577	1,668,577				
CSS Evaluation	528,857	528,857				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	20,876,376	20,876,376	0	0	0	0
FSP Programs as Percent of Total	55.7%					

Prevention and Early Intervention (PEI) Component

County: San Francisco Date: 12/23/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	175,000	175,000				
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	495,500	495,500				
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	208,613	208,613				
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	1,375,985	1,375,985				
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	623,891	623,891				
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	49,499	49,499				
7. PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention						
11. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Intervention)	495,500	495,500				
12. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Intervention)	208,613	208,613				
13. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Interver	1,375,985	1,375,985				
14. PEI 5. Mental Health Consultation and Capacity Building (25% Intervention)	207,964	207,964				
15. PEI 6. Comprehensive Crisis Services (90% Intervention)	445,489	445,489				
PEI Administration	141,261	141,261				
PEI Evaluation	143,401	143,401				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,046,701	6,046,701	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	175,000	175,000				
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	495,500	495,500				
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	208,613	208,613				
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	1,375,985	1,375,985				
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	623,891	623,891				
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	49,499	49,499				
7. PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention						
11. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Intervention)	495,500	495,500				
12. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Intervention)	208,613	208,613				
13. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Interver	1,375,985	1,375,985				
14. PEI 5. Mental Health Consultation and Capacity Building (25% Intervention)	207,964	207,964				
15. PEI 6. Comprehensive Crisis Services (90% Intervention)	445,489	445,489				
PEI Administration	141,261	141,261				
PEI Evaluation	143,401	143,401				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,046,701	6,046,701	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	175,000	175,000				
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	495,500	495,500				
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	208,613	208,613				
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevent	1,375,985	1,375,985				
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	623,891	623,891				
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	49,499	49,499				
7. PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention						
11. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Intervention)	495,500	495,500				
12. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Intervention)	208,613	208,613				
13. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Interver	1,375,985	1,375,985				
14. PEI 5. Mental Health Consultation and Capacity Building (25% Intervention)	207,964	207,964				
15. PEI 6. Comprehensive Crisis Services (90% Intervention)	445,489	445,489				
PEI Administration	141,261	141,261				
PEI Evaluation	143,401	143,401				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,046,701	6,046,701	0	0	0	0

Innovations (INN) Component

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 7. Peer-Led Hoarding and Cluttering Support Team	215,735	215,735				
2. INN 8. Collaboration with the Faith Community	150,000	150,000				
3. INN 9. Mini Grants	0					
4. INN 11. WAIST Nutrition Project	233,903	233,903				
5. INN 12. Building Bridges Clinic/School of Linking Project	405,361	405,361				
6. INN 14. First Impressions	300,000	300,000				
7. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Ad	200,000	200,000				
8. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	159,087	159,087				
9. INN 17. MH Certificate for Outreach Paraprofessionals	200,000	200,000				
INN Administration	201,279	201,279				
Total INN Program Estimated Expenditures	2,065,365	2,065,365	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 7. Peer-Led Hoarding and Cluttering Support Team	215,735	215,735				
2. INN 8. Collaboration with the Faith Community	150,000	150,000				
3. INN 9. Mini Grants	0					
4. INN 11. WAIST Nutrition Project	233,903	233,903				
5. INN 12. Building Bridges Clinic/School of Linking Project	405,361	405,361				
6. INN 14. First Impressions	300,000	300,000				
7. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Ad	200,000	200,000				
8. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	159,087	159,087				
9. INN 17. MH Certificate for Outreach Paraprofessionals	200,000	200,000				
INN Administration	201,279	201,279				
Total INN Program Estimated Expenditures	2,065,365	2,065,365	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 7. Peer-Led Hoarding and Cluttering Support Team	215,735	215,735				
2. INN 8. Collaboration with the Faith Community	150,000	150,000				
3. INN 9. Mini Grants	0					
4. INN 11. WAIST Nutrition Project	233,903	233,903				
5. INN 12. Building Bridges Clinic/School of Linking Project	405,361	405,361				
6. INN 14. First Impressions	300,000	300,000				
7. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Ad	200,000	200,000				
8. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	159,087	159,087				
9. INN 17. MH Certificate for Outreach Paraprofessionals	200,000	200,000				
INN Administration	201,279	201,279				
Total INN Program Estimated Expenditures	2,065,365	2,065,365	0	0	0	0

Workforce, Education and Training (WET) Component

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WDET 1. Training and TA	386,000	386,000				
2. WDET 2. Career Pathways	269,365	269,365				
3. WDET 3. Residency and Internships	364,000	364,000				
WET Administration	115,000	115,000				
WET Evaluation	37,150	37,150				
Total WET Program Estimated Expenditures	1,171,515	1,171,515	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WDET 1. Training and TA	386,000	386,000				
2. WDET 2. Career Pathways	269,365	269,365				
3. WDET 3. Residency and Internships	364,000	364,000				
WET Administration	115,000	115,000				
WET Evaluation	37,150	37,150				
Total WET Program Estimated Expenditures	1,171,515	1,171,515	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WDET 1. Training and TA	386,000	386,000				
2. WDET 2. Career Pathways	269,365	269,365				
3. WDET 3. Residency and Internships	364,000	364,000				
WET Administration	115,000	115,000				
WET Evaluation	37,150	37,150				
Total WET Program Estimated Expenditures	1,171,515	1,171,515	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Component

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 1. Silver Avenue FHC/South East Child & Family Therapy Center	0					
2. Cap 2. Redwood Center Renovation	0					
3. Cap 3. Sunset Mental Health	0					
4. Cap 4. IHHC at Central YMCA (Tom Waddell)	0					
5. Cap 5. Southeast Health Center	0					
6. Cap 6. South of Market Mental Health	300,000	300,000				
7. Cap 7. TBD through CPP	0					
CFTN Programs - Technological Needs Projects						
11. IT 1. Consumer Portal	225,000	225,000				
12. IT 2. Vocational IT	0					
13. IT 3. System Enhancements	225,000	225,000				
CFTN Administration	163,658	163,658				
Total CFTN Program Estimated Expenditures	913,658	913,658	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 1. Silver Avenue FHC/South East Child & Family Therapy Center	0					
2. Cap 2. Redwood Center Renovation	0					
3. Cap 3. Sunset Mental Health	0					
4. Cap 4. IHHC at Central YMCA (Tom Waddell)	0					
5. Cap 5. Southeast Health Center	0					
6. Cap 6. South of Market Mental Health	300,000	300,000				
7. Cap 7. TBD through CPP	0					
CFTN Programs - Technological Needs Projects						
11. IT 1. Consumer Portal	225,000	225,000				
12. IT 2. Vocational IT	0					
13. IT 3. System Enhancements	225,000	225,000				
CFTN Administration	163,658	163,658				
Total CFTN Program Estimated Expenditures	913,658	913,658	0	0	0	0

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 1. Silver Avenue FHC/South East Child & Family Therapy Center	0					
2. Cap 2. Redwood Center Renovation	0					
3. Cap 3. Sunset Mental Health	0					
4. Cap 4. IHHC at Central YMCA (Tom Waddell)	0					
5. Cap 5. Southeast Health Center	0					
6. Cap 6. South of Market Mental Health	300,000	300,000				
7. Cap 7. TBD through CPP	0					
CFTN Programs - Technological Needs Projects						
11. IT 1. Consumer Portal	225,000	225,000				
12. IT 2. Vocational IT	0					
13. IT 3. System Enhancements	225,000	225,000				
CFTN Administration	163,658	163,658				
Total CFTN Program Estimated Expenditures	913,658	913,658	0	0	0	0

In San Francisco, MHSA-funded programs are administered by Community Behavioral Health Services, under the Community Programs division of the San Francisco Department of Public Health. We utilize existing networks within the Department of Public Health and in other civil services agencies, to provide high quality behavioral health services to children, transitional age youth, their families, adults and older adults. These services are provided in partnerships with clients, families, other agencies and community providers.

http://sfmhsa.org/about_us.html