San Francisco Mental Health Services Act

2015-2016 Annual Report

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
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Email: jo.robinson@sfdph.org	Email: marlo.simmons@sfdph.org
County Mental Health Mailing Address: Behavioral Health Services 1380 Howard Street 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 March 8, 2016.

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)

Signature

Date 10-21-15

County: San Francisco

Date: October 2015

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MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Francisco

☐ Three-Year Program and Expenditure Plan
☑ Annual Report
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	Program Lead
Name: JD Robinson, MFT	Name: Marlo Simmons
Telephone Number: 415-255-3440	Telephone Number: 415-255-3915
Email: jd.robinson@sfdph.org	Email: marlo.simmons@sfdph.org
County Mental Health Mailing Address: 1380 Howard Street, 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 the 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 other counties in future years.

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

JD Robinson, MFT
Local Mental Health Director/Designee (PRINT)

Signature 10/21/15
Date

I hereby certify that for the fiscal year ended June 30, 2015, 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 11/23/2015 for the fiscal year ended June 30, 2015. I further certify that for the fiscal year ended June 30, 2015, 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 the attached update/report is true and correct to the best of my knowledge.

BEN ROSENFIELD
County Auditor Controller/City Financial Officer (PRINT)

Signature 3-17-16
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 2015-16 Annual Report 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 2013-14, 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 the integration of MHSA funded programs in San Francisco's public mental health system, Community Behavioral Health Services (BHS), in both the Child, Youth and Families System of Care as well as the Adult/Older Adult System of Care. We used MHSA funding to increase services to better meet the behavioral health needs of youth involved with the Juvenile Justice System and to expand wellness and recovery practices in all clinical settings. In addition, we strengthened our evaluation practices and we will 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 implement and evaluate best practices and for their valuable participation in all levels in 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
San Francisco MHSA

Marlo Simmons, MPH
Director, SF Mental Health Services

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 SF 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.

Community Program Planning (CPP) and Stakeholder Engagement Activities

Exhibit 1 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 1. Key Components of the SF MHSA Program Planning Process

MHSA Communication Strategies	• Make information available on MHSA website • Provide regular updates to stakeholders • Share implementation highlights in monthly BHS Director's Report
MHSA Advisory Committee	• Identify priorities • Monitor implementation • Provide feedback
Program Planning and RFP Selection Committees	• Assess needs and develop service models • Review program proposals and interview applicants • Select most qualified providers
Program Implementation	• Collaborate with participants to establish goals • Promote peer and family employment • Promote the engagement of peers in program governance
Evaluation	• Promote peer and family engagement in evaluation efforts • Collect data on participant satisfaction

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 (BHS) 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.

The **monthly BHS 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 and a Commitment to 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. In 2014-2015, SF MHSA Advisory Committee held a membership drive to recruit members from the mental health community, with a focus on the following underrepresented community members: expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Current Advisory members were instrumental in outreaching to these communities to fill gaps. Our Advisory group now consists of twenty-five active members, and our membership drive was successful in recruiting targeted community folks. A two hour long New Member Orientation was held in October 2014.

In early 2014, SF MHSA partnered with the Mental Health Association of San Francisco (MHA-SF), with the goal of increasing consumer representation and participation in Advisory meetings. MHA–SF assists with the following objectives:

- Supporting the consumer Co-Chair of the MHSA Advisory Committee to participate in developing meeting agendas and presentations for each meeting
- Identifying strategic objectives, including policy issues related to stigma/awareness and developing partnerships with community-based organizations/business leaders to advance stigma change efforts

SF MHSA has also been working to foster a stronger collaboration with the BHS 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 BHS 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.

In FY 2014-2015, SF MHSA held a total of Seven (7) Advisory meetings, and one (1) new member Orientation.

Advisory meetings occurred on the following dates: 6/18/14, 8/20/14, 10/15/14, 12/17/14, 2/25/15, 4/15//15, 6/17/15. Topics for these meetings included, but were not limited to the following:

- Wellness and Recovery
- Stigma
- Innovation
- Peer Respite
- Celebrating Recovery
- Funding cycles and RFQ/RFP discussion
- DPH Privacy Policy and Implications on Stigma/Recovery
- Transgender community and mental Health needs

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 BHS 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
- Holds meetings every two months (meetings alternate between meetings at MHSA and our partnering community-based organizations)
- Encourages community participation at meetings

FY14-15 Advisory Committee Member Demographic Profile

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 described below.

- Members include eight service providers (47 percent), twelve consumers (71 percent), and five family members (29 percent)
- The majority of participants work with Peer-to-Peer support programs (41 percent), followed by Recovery-Oriented Treatment Services (29 percent), Prevention & Early Intervention programs (24 percent), Behavioral Health Workforce Development (12 percent), Vocational Services (12 percent), Housing Services (6 percent), and Innovations (6 percent)

Committee members are diverse and represent a variety of communities and identities:

- Majority (47 percent) of participants identify as female, while 7 (41 percent) identify as male, and 2 (12 percent) identify as trans female
- 9 (53 percent) identify as straight and 6 (35 percent) identify as gay/queer
- 6 (35 percent) identify as white/Caucasian, 4 (24 percent) identify as Asian, 5 (29 percent) identify as black/African American, 2 (12 percent) identify as Hispanic/Latino, 2 (12 percent) identify as American Indian/Alaskan Native
- Several members also speak languages other than English; 2 (12 percent) speak Spanish, while other members speak Vietnamese (1), Mandarin (1), Chata (Choctow American Indian dialect) (1), and Punjabi and Hindi (1)

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 or planning groups 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.

- The 0-5 Full Service Partnership was borne out of a need for MHSA to expand the reach of our most intensive mental health services. In order to assess and determine the service gaps, the MHSA Program Manager spoke to a wide variety of stakeholders including, the current FSP providers, FSP clients, the BHS Client Council, the Mental Health, the MHSA advisory board, and other community-based mental health providers. It was determined by way of this process that there was a dearth in intensive case management services for very young

children (aged 0-5) and their families. Many families with young children living in poverty in San Francisco experience trauma, violence, substance abuse and many others factors that place them at risk for adverse mental health outcomes. To date, there hadn't existed a wrap-around program that could address the needs of the entire family. The 0-5 FSP program established to do just that. Once the needs assessment identified, the core service gap, and RFQ was written to elicit the most qualified community-based agency to provide such services. A review panel that represented the cultural diversity of the future program participants was brought together to read and score all the proposals, interview the applicants, and determine the most qualified applicant. The candidate that was successful is currently working closely with DPH, other City Departments and community stakeholders to develop the program model and scope of work. The official program will launch in January 2016.

- In FY14-15, the Vocational Services department conducted three consumer and family member focus groups, one stakeholder focus group, and one consumer survey assessing the needs of over 120 community members in order to design new and re-design existing vocational programming. In addition the Peer-to-Peer Services department conducted six peer, consumer and family member focus groups to assess the needs of the community in order to re-design and better integrate the BHS peer-to-peer programs. These focus groups are in addition to the extensive CPP efforts that are embedded into the ongoing work within these programs. Consumers, family members and advocates consistently participate in manager meetings, staff meetings and decision-making meetings to provide valuable input in all areas of policy development, program development, implementation, budgeting, and evaluation. In FY 15-16, BHS Vocational and Peer-to-Peer Services plan to continue conducting focus groups to engage the community and plans to reach a broader audience including law enforcement and educational stakeholders.

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 14-15, over half of all grantees/contracts indicated that their program employs consumers or participants through MHSA funding, totaling over 110 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

Evaluation

In any given year, there are between 75-85 actively funded MHSA programs. MHSA funded staff within the BHS 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 BHS 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 FY14-15, the Quality Management team worked with the Population Focused Mental health Promotion (PFMHP) programs in a way that was both innovative and collaborative to help create meaningful prevention and early intervention (PEI) outcomes. The 18 PFMHP programs are designed to benefit oppressed and marginalized communities by honoring their histories of collective trauma, cultural and spiritual beliefs around health and mental health, and their community defined practices toward wellness. When these programs work well, they draw isolated members into community activities and connect them to supportive social/cultural activities and behavioral health services, if needed.

In order to evaluate the impact of these culturally specific programs, the PFMHP program staff and the MHSA Evaluation Team convened seven 'Learning Circles' to collectively identify and agree on service modalities, activities and common outcomes. Based on common process and outcome objectives, the programs developed their own individual program-specific objectives in the S.M.A.R.T. format recommended by BHS. In addition, the Office of Quality Management (OQM) hosted monthly "Impact" meetings for MHSA programs to provide collaborative, evaluation technical assistance in a group format, and OQM also offered individual program technical support to work through evaluation related details, such as questionnaire design, data collection planning and analysis. It was expected that by year-end, each of the 18 PFMHP programs would be better able to summarize the impact of program activities on participant and target population experience of wellness, as evidenced by stronger outcomes reporting to MHSA and to BHS. The team has made a deep commitment to a culturally competent and inclusive process, paying careful attention to the target populations, the programs' culturally relevant practices, and the programs' goals. Staff has already learned so much from the providers. Additionally, staff has seen tremendous growth in their interest in and ability to measure their outcomes. A central principle in this endeavor has been collaboration on all levels: between MHSA, OQM and the PFMHP contracted programs, as well as internally within the county.

Statewide Evaluation Efforts

MHSA funded staff within the BHS Office of Quality Management also play an active role in supporting statewide evaluation efforts and activities for MHSA, providing another opportunity to actively engage a broader range of stakeholders. Notable activities in 2014-15 are listed below.

- Serving on the MHSOAC Evaluation Committee, representing San Francisco DPH, for a two-year term
- Serving on an advisory group for an evaluation contracted by the MHSOAC to UC San Diego of the Recovery Orientation of MHSA programs across California
- Serving on an advisory group for an evaluation contracted by the MHSOAC to design and pilot and new system to replace the existing DCR and CSS data collection systems
- Serving on the CalMHSA Statewide Evaluation Expert (SEE) Team to provide research and evaluation guidance and consultation to CalMHSA programs and RAND.
- Participating in a Latino stakeholders' focus group as part of the CA Reducing Disparities Project's Strategic Plan for Reducing Mental Health Disparities

Moving Forward in FY15-16 with CPP

Strengthening SF MHSA's Advisory Committee

For FY15-16, SF MHSA has established a goal to strengthen the Advisory Committee by focusing on structure and guidelines for governance. Efforts will also include addressing gaps in member recruitment and collaborating together to build a calendar of meeting topics for the upcoming year. A member demographic survey will also be administered annually to inform member recruitment and engagement.

African American Healing Alliance: Trauma Recovery Services in District 10

The African American Healing Alliance (AAHA) is a consortium of community members, service providers and community based organizations that are located in San Francisco's District 10, which is also referred to as the City's Southeast sector. This sector encompasses the neighborhoods of Alice Griffith, Bayview, Double Rock, Hunter's Point, Hunter's View, Potrero Hill, Sunnydale and Visitacion Valley. The focus of the AAHA is to help youth and families – who are and continue to be traumatized by the violence in District 10's neighborhoods – to heal, recover and thrive. The AAHA is constructing a community-driven plan that seeks to ease the suffering of District 10 residents by designing and delivering a suite of Southeast sector trauma recovery services that are rooted in best practices that the community has defined for themselves.

San Francisco's Integrated MHSA Service Categories

As outlined in the 2014 – 2017 Integrated Plan, SF MHSA continues to organize our work around the following service categories:

- Recovery-Oriented Treatment Services
- Mental Health Promotion & Early Intervention (PEI) Services
- Peer-to-Peer Support Services
- Vocational Services

- Housing
- Behavioral Health Workforce Development
- Capital Facilities/Information Technology

This has 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 2. 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

Local Review Process

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 2015-16 Annual Report was posted for a period of 30 days from 10/19/15 to 11/18/19. Members of the public were requested to submit their comments either by email or by regular mail. There were no public comments during the

posting. Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board on 11/18/15. The Annual Report was also presented before the Public Safety and Neighborhood Services Committee on 2/25/16. There were no public comments.

Public Hearing & Board of Supervisors Resolution

FILE NO. 151166 RESOLUTION NO. 81-16

[Mental Health Services Act Annual Report - FY2015-2016]

Resolution authorizing adoption of the Mental Health Services Act Annual Report FY2015-2016.

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, The MHSA specifies five major program components for which funds may be used and the percentage of funds to be devoted to each component; and

WHEREAS, 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, In order to access MHSA funding, counties are required to develop Three-Year Program and Expenditure Plans, and Annual Updates, in collaboration with stakeholders; post the plans for a 30-day public comment period; and hold a public hearing on the plan with the County Mental Health Board; 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 on file with the Clerk of the Board of Supervisors in File No. 140759; and

WHEREAS, The FY2015-2016 MHSA Annual Report provides an overview on progress implementing the various component plans in San Francisco; and

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

Department of Public Health
BOARD OF SUPERVISORS Page 1

WHEREAS, The San Francisco Department of Public Health's Behavioral Health Services section has developed an Annual Report in compliance with AB 1467, 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 approval of the Mental Health Services Act Contract No. 07-77338-000 and the designation of the Community Behavioral Health Director as the signatory of this agreement is on file with the Clerk of the Board of Supervisors in File No. 080122, which is hereby declared to be a part of this resolution as if set forth fully herein; now, therefore, be it

RESOLVED, That the FY2015-2016 MHSA Annual Report is adopted by the Board of Supervisors; and, be it

FURTHER RESOLVED, That the Board of Supervisors authorizes the modification of the MHSA Agreement to include the FY2015-2016 Annual Report.

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: 151166 **Date Passed:** March 08, 2016

Resolution authorizing adoption of the Mental Health Services Act Annual Report FY2015-2016.

February 25, 2016 Public Safety and Neighborhood Services Committee - RECOMMENDED

March 08, 2016 Board of Supervisors - ADOPTED

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

File No. 151166

I hereby certify that the foregoing Resolution was ADOPTED on 3/8/2016 by the Board of Supervisors of the City and County of San Francisco.

Angela Calvillo
Clerk of the Board

Mayor

3/11/2016
Date Approved

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 an overview and description, the target population, highlights and successes, as well as efforts moving forward in FY15-16 for the following seven categories:

- Recovery-Oriented Treatment Services
- Mental Health Promotion & Early Intervention (PEI) Services
- Peer-to-Peer Support Services
- Vocational Services
- Housing
- Behavioral Health Workforce Development
- Capital Facilities/Information Technology

2. Recovery-Oriented Treatment Services

Service Category Overview

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 Prevention and Recovery in Early Psychosis Program, (2) Trauma Recovery Programs, (3) the Behavioral Health and Juvenile Justice Integration, (4) Dual Diagnosis Residential Treatment, (5) the Behavioral Health Access Center, and (6) Behavioral Health and Primary Care Integration. INN funding also supports several programs in this MHSA service category.

Program Overview and Target Population

Full Service Partnership (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 SMI or SED to lead independent, meaningful, and productive lives. Nine FSP programs served a diverse group of clients in terms of age, race/ethnicity, and stage of recovery (see Exhibit 4). In 2014-15, FSP programs served 910 clients. The majority of clients served were adults (59%), followed by children, youth, and families (27%), and TAY (8%) and older adults (6%).

Exhibit 3. Summary of Full Service Partnership Programs

Target Population	Lead Agency	Services
Children 0 – 5 & Families	Instituto Familiar de la Raza	Provides intensive case management and wraparound services to the 0 – 5 population.
Children & Adolescents	Seneca SF Connections	Offers wraparound services to help children and their families achieve stability and increase access to community resources
	Family Mosaic Project	Provides intensive case management and wraparound services in the Bayview, Mission, and Chinatown neighborhoods
TAY	Family Service Agency	Provides physical health care, mental health treatment, medication management, employment assistance, housing support, and peer support
	Community Behavioral Health Services - TAY	Conducts intensive services (e.g., training on independent living skills, mental health and substance abuse counseling) with youth transitioning out of foster care and the child welfare system

Adults	Family Service Agency	Conducts wellness and creative arts workshops, holds community cultural events, offers support groups, and organizes healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods

Exhibit 3. Summary of Full Service Partnership Programs (continued)

Target Population	Lead Agency	Services
Adults	Hyde Street Community Services	Implements mental health promotion efforts to homeless individuals in the Tenderloin who have not successfully engaged with outpatient services and frequently experience multiple co-occurring disorders
	SF Fully Integrated Recovery Service Team	Provides services (e.g., individual or group therapy, medication management) to individuals with SMI who have been homeless for an extended time
	UCSF Citywide Case Management Forensics	Provides consultation, services, screening and assessment, and other mental health services to adults who are engaged with the Behavioral Health Court
	Assisted Outpatient Treatment (AOT) Program	Provides intensive outpatient services to adults with severe mental illness who have poor treatment compliance in an effort to improve their quality of life
Older Adults	Family Service Agency	Serves older adults ages 60 and above who need specialized geriatric services related to mental health and aging

FY14-15 Highlights and Successes

FSP Outcomes

The Data Collection and Reporting (DCR) system tracks outcome indicators for all FSP clients across the state of California. Outcomes for FSP clients can include time spent in different residential settings and the occurrence of emergency events requiring intervention. These data are entered into the DCR using Key Event Tracking (KET) Assessments, ideally *as they occur.* Days in residential settings are automatically calculated in the DCR based on the start of each KET that registers a changed living situation. Specific outcomes reported here include the number of days clients spent in a residential setting and the rate of emergency events (measured by the number of events per person-year).

In 2014-15, all emergency events showed event rate declines for all event categories, across all age groups

In describing outcomes related to residential settings, the following charts compare the total number of days for each setting, for all clients between the baseline year (the 12 months immediately preceding entry into the FSP) and the first year enrolled in the FSP. Clients may have spent days in more than one setting over the course of each year. Included in residential outcomes reporting are all clients who were active for at least one continuous year in the FSP at any time from the inception of the DCR through June 2015.

Each residential setting is then highlighted by the percent change from baseline to the first year in the FSP. In general, the residential settings are displayed from more desirable to less desirable, but this is

highly variable by age group as well as for individuals. In other words, while a supervised placement may represent a setback for one client, for another client this may be a sign of progress, depending on the circumstances of their recovery.

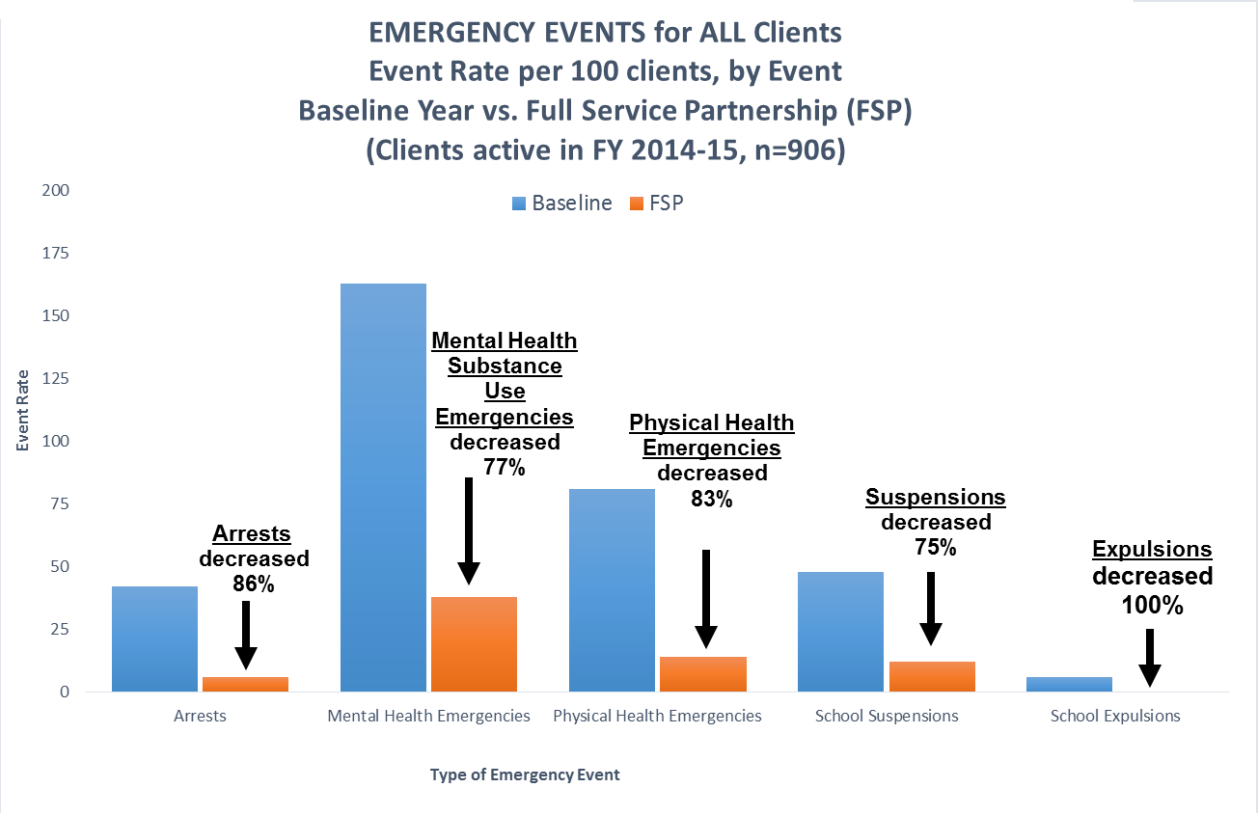
Of note, one of the residential settings unique to San Francisco is MHSA stabilization housing. This option is available for TAY, adult, and older adult clients. MHSA stabilization allows a formerly homeless client to stay a maximum of 60 days in a single-room occupancy (SRO) unit while s/he accumulates tenant history and completes the application process for more permanent housing. As a result, a client's opportunities to qualify for and transition to more permanent housing are improved.

Outcomes for Emergency Events

Emergency events include Arrests, Mental Health or Psychiatric Emergencies (which includes substance use related events) and Physical Health Emergencies, as well as School Suspensions and Expulsions for young children and TAY, for FSP clients active as of June 2015. The rate at which emergency events occur for clients in the baseline (pre-FSP) year is compared to the rate while in the FSP. Unlike the Residential Settings measure, which looks only at the first year in FSP for all clients, the emergency events FSP measure averages the annual event rate over all years in FSP. Event rates are reported here as number of emergency events per 100 clients.

In 2014-15, over all age groups, Arrests dropped 86% from 42 per 100 clients in the baseline year to 6 arrests during FSP years. Mental Health/Substance Use Emergencies, which are concentrated among TAY, decreased 77% across all age groups from 163 events per 100 clients to 38 emergencies during FSP years. Physical Health Emergency events, most common among Older Adults, registered 81 events per 100 clients at baseline and decreased to 14 events per 100 clients during FSP years, an 83% reduction. For younger children and TAY, School Suspensions were reduced a combined 75% from 48 suspensions per 100 youth at baseline to 12 during FSP years. School Expulsions, which occur much less often (6 expulsions per 100 students at baseline) reduced to zero during FSP years.

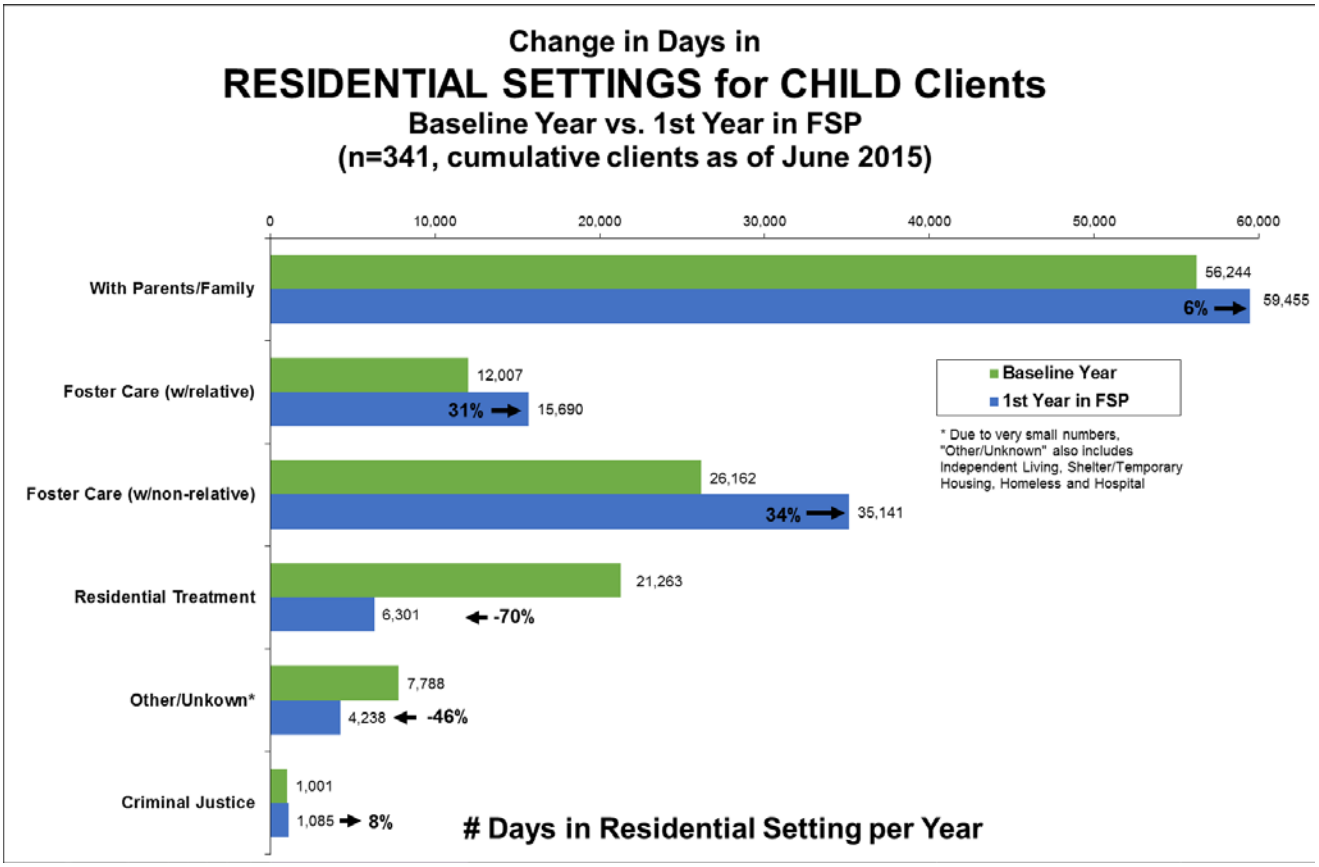
Exhibit 4. Emergency Events for All Clients: Baseline Year vs. Full Service Partnership (FSP)



Outcomes for Child, Youth, and Family (CYF) Clients

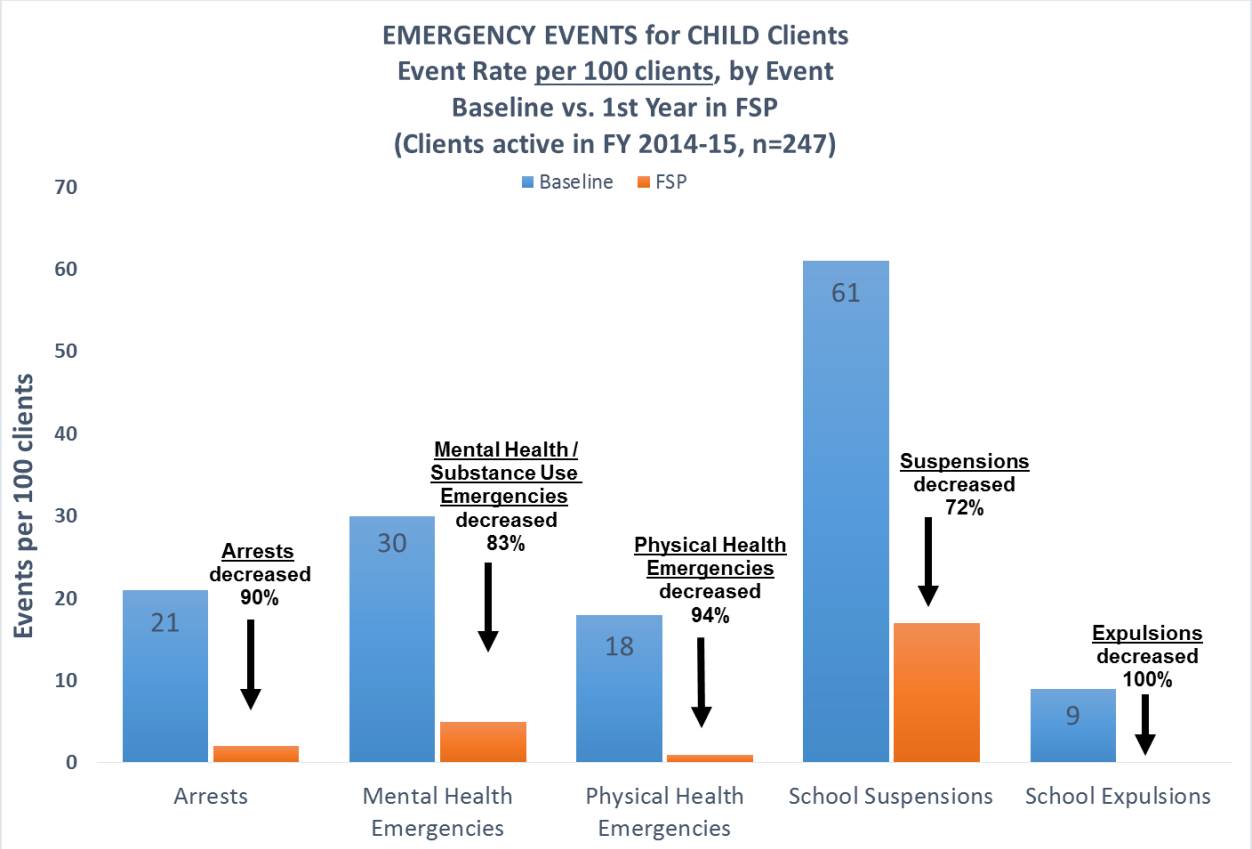
Child, youth, and family clients (i.e., child) data show movement from restrictive settings (e.g., residential treatment) into more family-based settings during FSP treatment. Most significantly, days in Residential Treatment dropped 70%, and increases from 6% to 34% appear in settings with parents or in foster care (see Exhibit 6). While days in hospital and homeless settings are overall relatively low, and therefore grouped in the Other/Unknown category, the decline was from 355 to 186 days in the hospital (-48%), and an increase from 300 to 365 (+22%) was reported in homeless days for child clients. Other /Unknown overall decreased 46%, and Criminal Justice days were increased 8%.

Exhibit 5. Change in Days in Residential Settings for Child Clients



Emergency events occurred less often among child clients. There were marked declines across all types of emergency events experienced by child clients as depicted in Exhibit 7, particularly in the rate of School Expulsions (100% reduction) and Mental Health / Substance Use emergencies (83% reduction).

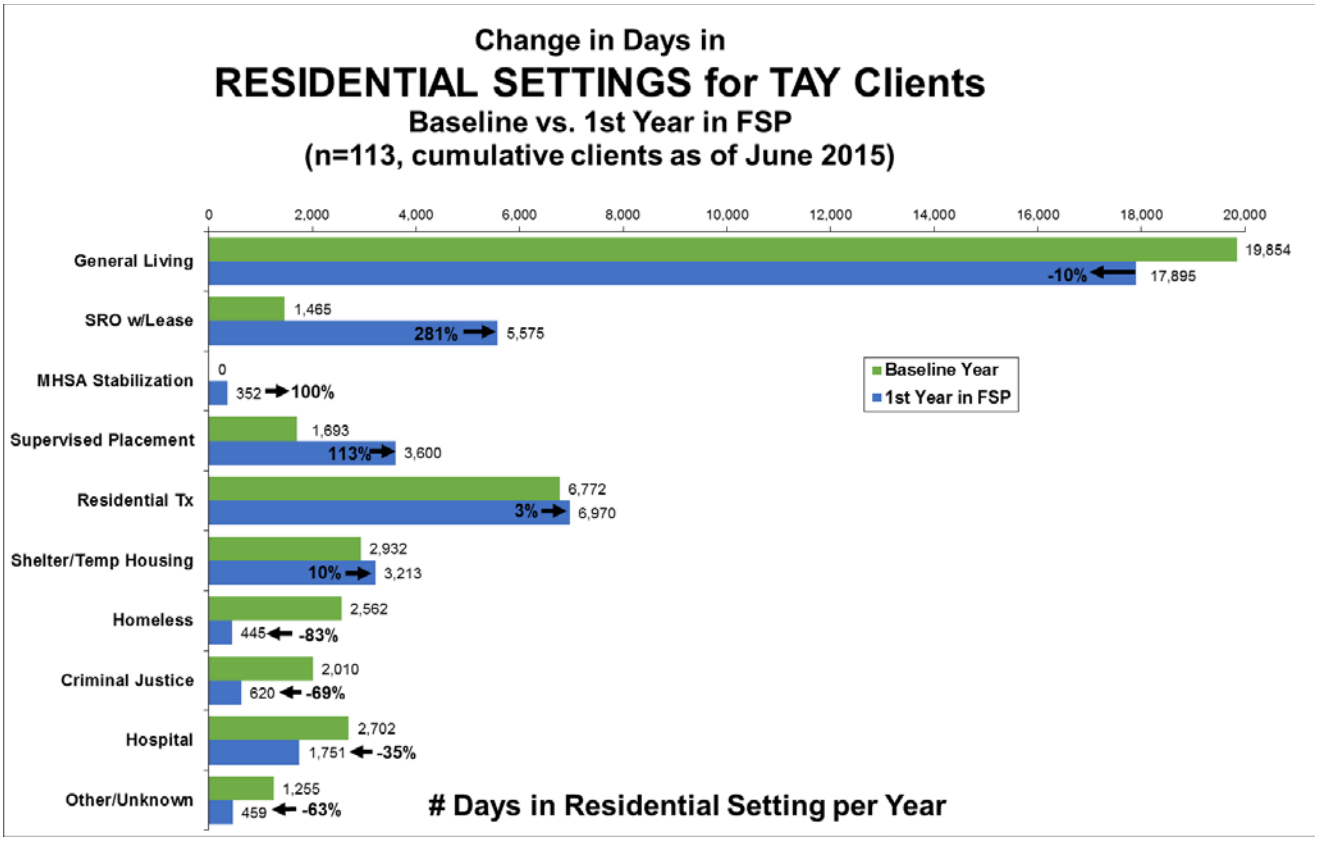
Exhibit 6. Emergency Events for Child Clients



Outcomes for TAY Clients

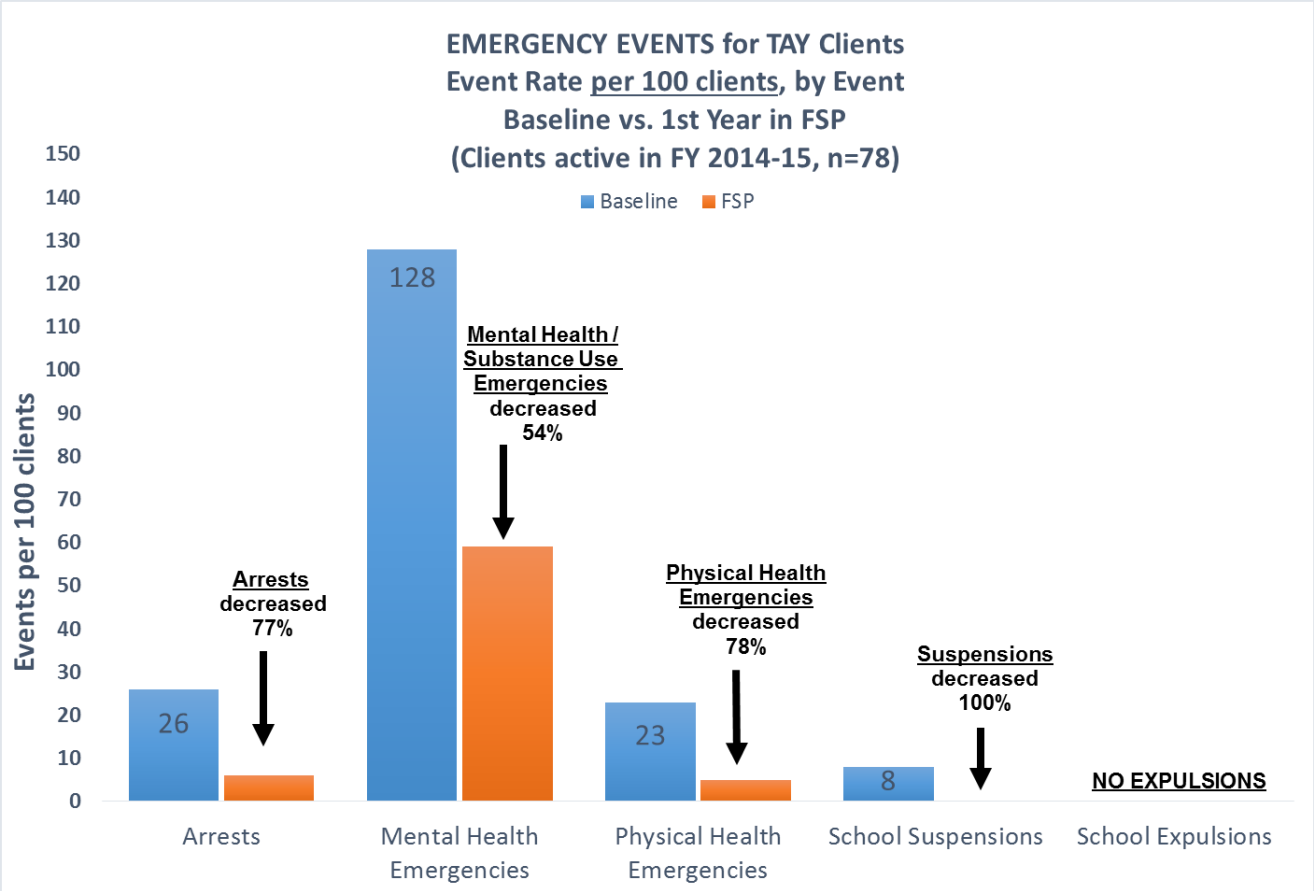
For TAY clients, several settings shift from baseline to FSP treatment. Positive signs are evident in Exhibit 8 from TAY having moved out of homelessness (83% reduction), justice (69% reduction) and hospital settings (35% reduction) and into MHSA Stabilization units for the first time, supervised placement (113% increase), or permanent housing (SRO with Lease, 281% increase).

Exhibit 7. Change in Days in Residential Settings for TAY Clients



TAY clients experienced fewer emergency events. As shown in Exhibit 9, there were marked declines across all types of emergency events experienced by TAY clients. Most dramatically, Mental Health Emergencies dropped from 128 events per 100 clients in the baseline year, to 59 events per 100 clients) in the FSP years. It is noteworthy that TAY clients are likely to leave the FSP within one year, suggesting that some TAY clients with highest distress are under-represented in the follow-up FSP rate. Arrests (77% reduction) and School Suspensions (100% reduction) also showed significant improvement. No school expulsions were reported in the baseline or FSP years for TAY active in 2014-15.

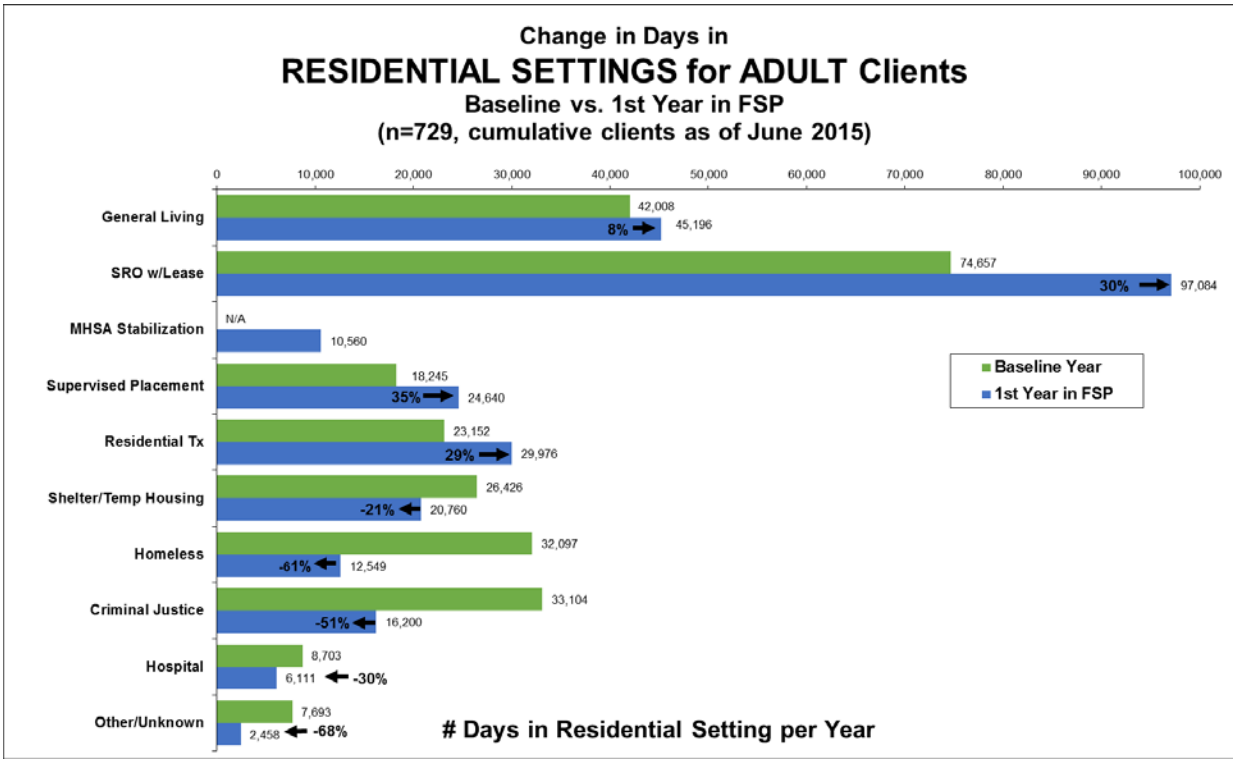
Exhibit 9. Emergency Events for TAY Clients



Outcomes for Adult Clients

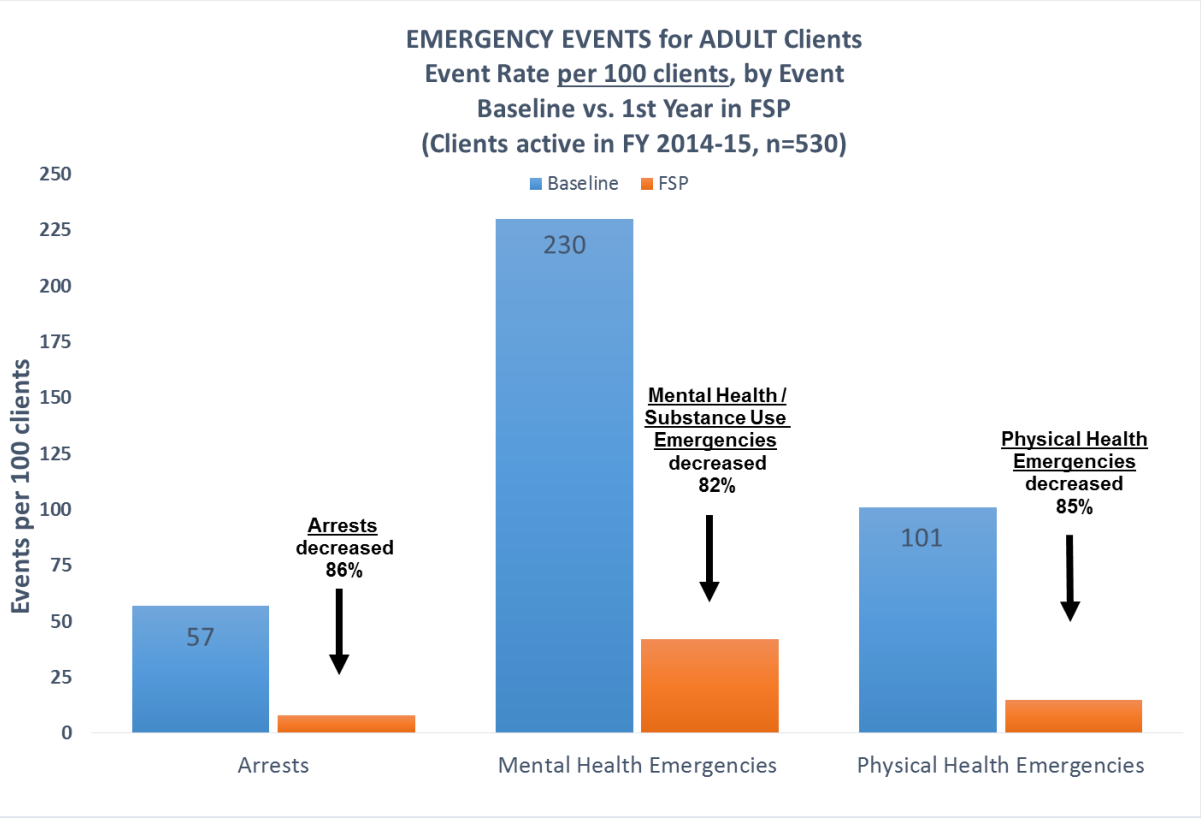
Among adult clients reported in Exhibit 10, improvements are reflected in the shift in days away from Shelter/Temporary Housing, Homeless, Criminal Justice, and Hospital settings to more stable settings. These stable settings include General Living, SRO with Lease, MHSA stabilization, Supervised Placement, and Residential Treatment. In previous years, General Living has decreased from baseline to FSP, so the uptick shown this year (8%) is a positive result. While Supervised and Residential Placements are relatively restrictive settings, they may represent advancement in recovery for FSP clients who have not previously accessed stabilizing care.

Exhibit 10. Change in Days in Residential Settings for Adult Clients



Adult clients show fewer emergency events since enrollment in FSP programs. As depicted in Exhibit 11, there were substantial declines across all types of emergency events, particularly in the rate of arrests (86% reduction). Adults' Mental Health Emergencies dropped from 43 per 100 clients in the baseline year, to just below 8 events per 100 clients in the FSP years. Arrests declined from 5 per 100 clients in the baseline year to 3 in 100 in the FSP years (85% decrease).

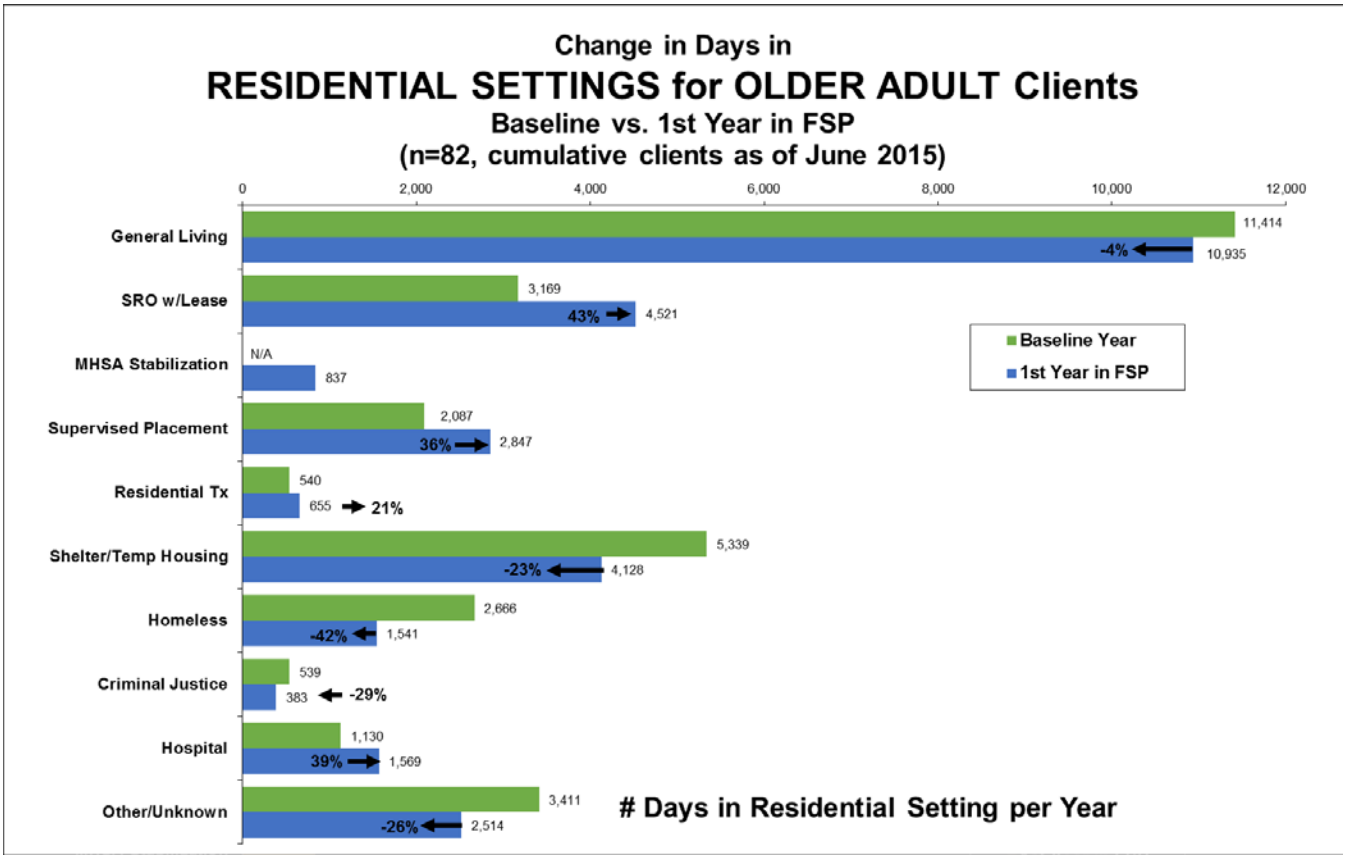
Exhibit 11. Emergency Events for Adult Clients



Outcomes for Older Adult Clients

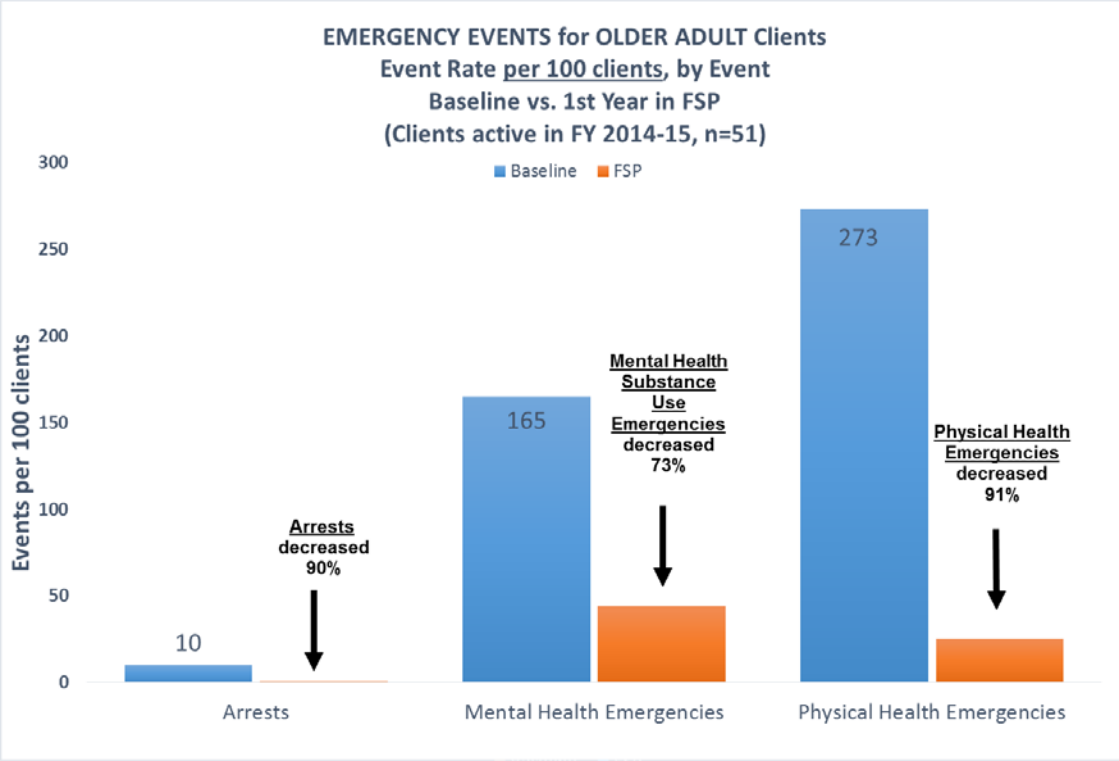
Like TAY clients, Older Adults experienced a decrease in General Living (4% reduction), but had an increase in Hospital days (39%). For some older clients, the first year in FSP treatment may include access to long-overdue medical care due to previously untreated conditions, combined with advancing age. Similar to the other age groups, increases appear for SRO with Lease, MHSA Stabilization, Supervised Placement, and Residential Treatment, suggesting positive outcomes, especially as days in shelter/temporary housing, homelessness, and criminal justice (-29%) all decline in FSP treatment. Older adults are often relocating either into special care settings or permanent housing, which reflects improved stability and care for their needs.

Exhibit 12. Change in Days in Residential Settings for Older Adult Clients



Older adult clients show fewer emergency events after enrollment in FSP programs. Similar to other age groups, older adult clients experienced major decreases across all emergency event types, particularly in the rate of Arrests (90% reduction; see Exhibit 13), although the rates of Mental and Physical Health Emergencies also dropped dramatically. The numbers of events reduced is encouraging, from 165 Mental Health emergencies at baseline to 44 during FSP, and from 273 Physical Health events to 25 in the FSP years.

Exhibit 13. Emergency Events for Older Adults Clients



Improving DCR Data Quality

Since the inception of the DCR, ensuring high quality of KET data to capture 100% of residential changes, emergency events and other life events has proven a formidable challenge. The San Francisco DCR Workgroup developed several data quality and data outcome reports to help monitor and increase the level of completion for KETs. These reports are shared monthly with the FSP programs and discussed, with the expectation that they are used to identify gaps in KETs and have them addressed. The DCR Workgroup has also created and shared a KET tracking sheet for case managers to use to record KETs on paper as the events occur, as a tool for remembering to enter them in the DCR database when they next login. Data quality and completion appear to be impacted or enhanced, depending on the capacity of the program to make DCR data entry a priority.

As of July 1, 2015, BHS is adopting new contract performance objectives based on DCR compliance, in an effort to increase the visibility of the DCR and underscore the importance of the functional outcomes for FSP clients. Expectations are that all programs will have 100% of their Quarterly Assessments completed within 30 days of the due date. For CYF programs, an additional performance objective will require that 100% clients with episodes opened in Avatar will also be enrolled in the DCR. Reports are already in place to share with the programs to assist them in monitoring their progress toward these data improvement goals.

FSP/DCR Meetings: These monthly meetings provided an opportunity for FSP program directors and clinical supervisors to share best practices and challenges in DCR data collection and program goals.

DCR data quality and outcomes were shared regularly and discussed, generating innovative suggestions on improving client recovery and program performance. Of particular interest in 2014-15 was the creation of a Caseload Report (by program and PSC) from the DCR data, and the creation of a draft DCR data dashboard that will be further developed in 15-16.

Moving Forward in FY15-16

0 – 5 FSP Program

In the summer of 2014, a thorough community needs assessment was conducted to determine the gaps in service for our city's most vulnerable populations-those with Serious Mental Illness or Disorders, those that are homeless, or have experienced excessive trauma. San Francisco's Full Service Partnership Programs currently serve that population, but there are certain populations whose needs still go unmet. The needs assessment found that there was a dearth in services and support for young children, aged 0-5, and their families who are living with the effects of trauma, substance abuse, and mental illness. The needs are particularly great for young children who are in foster care or who have otherwise experienced trauma and are in need of intensive mental health services.

SF MHSA is choosing to focus on the 0-5 population because it is widely known that the first five years of a child's life are critical to healthy development and growth. Recent advances in brain science have supported key tenets of attachment theory regarding the needs for babies and toddlers grow and develop in the context of supportive and nurturing caregivers. Young children who have nurturing, healthy and supportive attachments to the adults in their lives are much more likely to development in a typical fashion and to thrive both socially and emotional. The psychological benefits of secure attachments in early childhood can last well into adulthood.

Pervasive and ongoing trauma, coupled with poverty, and neglect can have detrimental effects on all individuals, however the effects can be most devastating for very young children whose brains are still very much in development. The FSP is unique and innovative in that it focuses on the child in the context of their family and/or caregiver(s). Holistic interventions will incorporate the needs and resources of the child, family, extended family as well as the community within a culturally and linguistically reflective model. Wrap-around services focused on family engagement and participation will be practiced within a flexible delivery system ensuring the family/caregivers greatest possibility of participating and benefiting from the services in order to address the adults challenges that impact attachment and increase risk to their children at risk such as substance abuse, domestic and community violence, and history of mental illness and psychiatric hospitalizations.

As a result of this RFQ, a new Full Service Partnership (FSP) program will be developed to support the stabilization and recovery of families in crisis who are also caring for children under the age of 5. An RFQ was issued in April 2015 for the provision of intensive-level case management and mental health

services to families with children aged 0-5. Most of the program participants will be residents of one of the four HOPE SF public housing sites. Seven RFQ proposals were submitted. A review panel reviewed each of the proposals and chose three applicants to interview. On May 13, 2015, the review panel met again to interview the finalists and one agency was chosen to contract with. On July 1st, CYF leadership and staff will meet with the selected agency to begin the process of developing a scope of work and contract deliverables.

Adult FSP Expansion

In FY14-15, adult FSP funding increased; this was reflected in all funding notifications for FY14-15 and will be reflected in the FSP contracts. SF MHSA anticipates approximately 120 new FSP slots for adults. New staff positions include the following:

- Citywide Forensics case manager
- FSA TAY FSP case manager
- FSA OA FSP Cantonese-speaking case-manager
- FSA Adult FSP to recruit a Cantonese-speaking case manager

Assisted Outpatient Treatment (AOT) Law

California's Assisted Outpatient Treatment (AOT) Law, most commonly referred to as Laura's Law, was passed by the California Legislature in 2002 as Assembly Bill 1421. San Francisco's Board of Supervisors subsequently adopted the law in July 2014. In San Francisco AOT will be utilized as an intervention tool with strict eligibility criteria that can be used to engage adults with severe mental illness who have poor treatment compliance. While the program does allow for court ordered treatment, San Francisco's implementation has a particular focus on community-based services that allow multiple opportunities for the individual to engage in voluntary treatment. The ultimate goal of this program is to provide intensive outpatient services to these individuals in an effort to improve their quality of life, as well as prevent decompensation and cycling through acute services and incarceration.

In FY14-15, the AOT Director was hired in a Clinical Psychological (2574) classification and started on March 30, 2015. The Director has been responsible for program development and offering trainings to stakeholders regarding AOT. In FY15-16, two positions (a peer and a family liaison) will be hired into newly funded Health Worker II (2586) positions. These positions are required by the San Francisco Health Code and will complete the AOT Care Team. In FY14-15, the treatment portion of AOT was contracted out to UCSF's Citywide program and they have identified a supervising clinician who will be leading the program for their department. Additionally, an RFQ panel was convened to score applications for organization that will be used to provide an external annual evaluation to the State Department of Mental Health, as well as a three year comprehensive evaluation to the Board of Supervisors.

Behavioral Health Access Center

Program Overview

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 to place justice 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 BHS 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, naloxone for opiate overdose prevention, specialty behavioral health medication packaging and serves as a pharmacy safety net for all BHS clients.

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 and smoking cessation groups. A full-time pharmacy technician who assists the BHS 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.

FY13-14 Highlights and Successes

- Provided 1,814 unduplicated care episodes with access to behavioral health and physical health care
- BHAC staff received 760 calls from residents of San Francisco seeking access to mental health services within the clinic system of care or in the Private Provider Network (PPN).
- BHAC conducted 712 face to face contacts with clients accessing care and in need of concurrent primary care services.
- RAMS peer staff/enrollers were brought onsite to assist in enrolling clients not already receiving benefits for Medi-Cal and Drug Medi-Cal. 78 applications were brought to completion.
- For buprenorphine, there were 2903 encounters at BHS Pharmacy, with an average of 107 active clients each month.
- For methadone, there were 242 encounters at BHS Pharmacy
- In FY14-15, 253 clients were served in the clinic as part of the Substance Use Disorder Treatment programs

Moving Forward in FY15-16

In FY15-16, BHAC will provide funding to San Francisco Suicide Prevention for off hour coverage for the
Behavioral Health Services (BHS) Adult System of Care (SOC) line.

Prevention and Recovery in Early Psychosis (PREP)

Program Overview

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.
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 shown positive outcomes with participants demonstrating reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services.

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).

FY13-14 Highlights and Successes

After enrollment in PREP, consumers showed reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services from baseline to 12 months, as measured from consumer and clinician perspectives. Based on findings from the Patient Health Questionnaire Depression Scale (PHQ9), for example, 77% of consumers reported a reduction in symptoms related to depression. Another notable finding is that at least 70% of new clients maintained engagement in the program for at least 60 days so that clients and families are aware of resources and have developed support and safety plans.

Exhibit 14. FY13-14 Key Outcomes

- At least 72% of clients enrolled in the program for 12 months or more demonstrated improvement in at least one ANSA domain.
- At least 45% of clients engaged in the program for 12 months or more were enrolled in new educational and vocational activities. Placements included Starbucks, a bike shop, a catering company, and an internship with a stockbroker.
- Ninety-two percent (92%) of clients enrolled in the program for 12 months or more reported high levels of satisfaction and engagement with services as measured via the Service Satisfaction Scale and Working Alliance Inventory, which are assessed in semi-annual consumer evaluations.

In addition, providers reported that participation in the Multi-Family Group (MFG) contributed to improvements in family members' knowledge about schizophrenia, consumers' and family members' use of positive problem solving approaches, and family relationships.

Moving forward, SF MHSA aims to partner with Adult System of Care (SOC) leadership to support PREP to have stronger linkages and referral relationships with SOC clinics and SFGH psych services.

Trauma Recovery Program

Program Overview

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. The 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 12 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. The goals of this trauma recovery and healing services program is to (a) reduce the incidence and prevalence of trauma related conditions in children, youth and families, including risk for retaliation among youth engaged in negative street activity; (b) increase violation prevention providers' understanding of mental health issues in the context of violence; (c) mitigate risk factors associated with vicarious trauma among violence prevention providers; and (d) decrease stigma among youth and families in accessing public health services.

- **School-aged public school students who reside in communities that struggle with violence (Bayview Hunter's Point, Potrero Hill and Western Addition).** Youth and families receive effective and comprehensive mental health services that aim to (a) reduce individuals' psychiatric symptoms; (b) increase functioning; and (c) increase coping skills that likelihood of further intervention in the future is lessened. Persons touched by this program have suffered traumatic events in their lives or who are facing emotional, physical or behavioral effects of trauma exposure in their environments.
- **Latino and other youth of color, ages 12 to 25, and/or their family members, who reside in the Mission District and throughout the city, who face multiple and persistent risk factors.** The program's treatment model combines culturally informed, evidence based substance abuse and mental health principles and practices that are linguistically sensitive, strength based, family focused approaches – with the aim of addressing the unmet mental health needs of youth and families who are traditionally unwilling to purse behavioral health care.

Integration of Behavioral Health into the Juvenile Justice System

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 behavioral 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. To develop plans that mitigate risk and support therapeutic progress, San Francisco Juvenile Probation and the CYF System of Care have partnered to establish a collaborative planning and shared decision-making approach with youth, families and caregivers. This approach is a critical foundation for making good decisions and doable plans with youth and families about the support and care to address needs, and bolster strengths for safe, productive and healthy lives.

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 and its affiliated programs operate citywide and serve 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, 606 Portola Avenue and in Juvenile Hall.

Program Overview

AIIM (Assess, Identify Needs, Integrate Information, and Match to Services) Higher
In 2014-15, AIIM provided services to a total of 316 youth (78% male; 62% under age 17; and 79% SF residents). AIIM 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 began in 2008 with a small grant from the Criminal Justice and Mental Health Collaboration program, US Department of Justice and thee services were expanded and sustained in 2010 with MHSA and Medi-Cal funding. AIIM is a multidisciplinary and cross agency team (from Occupational Therapy and Training Program, Seneca Family of Agencies, and SF City and County) that includes a psychologist, social workers, and a psychiatrist that provide standardized assessment and planning that supports the engagement of youth and families in appropriate and effective services. Our continuum of core services include: behavioral health screening; 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.

MHSA also provides funding to support a half-time Psychiatrist at our sister program Special Programs for Youth at the Juvenile Justice Center to provide medication management and support services to incarcerated youth in an effort to improve outcomes after discharge.

From 7/1/2014 to 6/30/2015, 95 youth received psychiatric medication support services through the MHSA program. A total number of 521 contacts were provided to these youth by the psychiatrists at the Juvenile Justice Center, with total number of 334 hours during this past fiscal year.

The youth served through the MHSA program often had psychiatric conditions related to trauma, and community violence; mood disorders like depression; and severe psychiatric conditions like schizophrenia. Many youth had co-existing substance use disorders. Several youth also had intellectual disabilities. Worries, nightmares, sadness, anger problems, and sleeping problems were very common presenting complaints for these youth. Some of the youth also had suicidal thoughts and few experienced severe symptoms like hearing voices and having confused, disorganized thinking.

The medication services provided to these youth included psychiatric diagnostic assessments and education about psychiatric condition and treatment options. When indicated and after discussion of risks and benefits of medication and consent from the youth and parent / guardian, medication treatment was initiated for these youth. In addition to medication treatment, these youth were provided with psychotherapy and case management services by their in-house behavioral health clinicians / therapists. There was also coordination with the in-house primary care team.

AIIM also monitors prevalence rates and serves as a barometer for treatment access and gaps in needed community services for probation-involved youth, families and caregivers. AIIMs has used this information to guide the expansion of our continuum of care with therapeutic court programs and targeted community-based interventions (Aggression Replacement Training (ART), Family Intervention, Reentry and Supportive Transitions (FIRST), and SF Youth Back on TRACK (Treatment to Recovery Through Accountability, Collaboration and Knowledge).

Court Programs. Our three court programs include: the Juvenile Wellness Court for youth experiencing significant impairment such as, traumatic brain injury, psychosis and so on; the Juvenile Drug Court, "SF-ACT" for youth with moderate to severe substance use disorders; and the Competency Attainment Program for youth who have been found incompetent due to developmental immaturity, disability, or behavioral health problems.

The **SF-ACT Intensive Outpatient Treatment (IOT) 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. (RAMS), and Catholic Charities, it is also supported in part by MHSA funding. SF-ACT provides comprehensive care for youth with co-occurring substance use and other behavioral health problems.

In 2014-15, SF-ACT provided 700 hours of services (individual, recovery group and family therapy) to 17 clients. Consistent with the SF Juvenile Justice population, a majority of clients were male (71%). Of those served, 52% were successful: 18% were still in SF-ACT services; 29% graduated from the program and were off probation, and 12% were in after care. Another 24% were back in custody and 18% required a higher level of care. This was the 2nd year of the SF-ACT program at Civic Center High School. Year 2 was focused primarily on: Strengthening systemic support & relationship with school to support overall student resiliency; providing increased outreach to and collaboration with Superior Court and the Probation Department; and finally, ongoing discussion on how to increase overall census in program.

In May, due to the low census a decision was made to reassign the RAMS Team to the TRACK program.

Targeted Interventions. AIIM launched the **ART** program in 2013. All our staff are trained and facilitate ART groups. ART is a 10-week, 30-hour intervention administered to groups of 8 to 12 youth two to three times per week. Youth are eligible for ART if it is determined—from the results of a formal risk assessment tool youth have a moderate to high risk for re-offense and problems with aggression or lacks skills in pro-social functioning. Using repetitive learning techniques, offenders develop skills to control anger and use more appropriate behaviors. In addition, role-plays and guided group discussion is used to correct thinking that can get youth into trouble.

Initially funded with $1M in US DOJ grants, **FIRST** and **TRACK** are recently launched programs that provide portable services throughout the City and State (for youth in placement). Both programs are evidence-informed and have a built-in a training, supervision and coaching infrastructure for high quality implementation and sustainability. Like AIIM, these programs are multi-disciplinary, cross agency teams designed to leverage local expertise. Agencies involved include: Instituto Familiar de la

Raza (IFR), OTTP, Seneca, UCSF Young Adult and Family Center, and YMCA Urban Services). Blended teams also insures that we have the cultural and linguistic competence needed to meet the needs and support the strengths of our youth and families.

FIRST engages youth and families at the point of referral to placement and supports them with case management and Intensive Family Therapy (an adaption of Brief Strategic Family Therapy) while youth are away and as they reenter for a successful return to family and community. In 2014-15, 25 youth and families have received these services.

TRACK provides intensive outpatient treatment out in the community and at our milieu (606 Portola) across form the Juvenile Justice Center to youth and their families with co-occurring substance use and other behavioral health disorders. TRACK clinicians provide individual, group and family therapy within a collaborative treatment framework to insure that probation supervision and recovery practices work in sync to support youth progress. In 2014-15, 26 youth and their families were served in this program.

FY14-15 Successes and Highlights

- From 7/1/2014 to 6/30/2015, 95 youth received psychiatric medication support services through the MHSA program. A t total number of 521 contacts were provided to these youth by the psychiatrists at the Juvenile Justice Center, with total number of 334 hours during this past fiscal year.
- In 2014-15, SF-ACT provided 700 hours of services (individual, recovery group and family therapy) to 17 clients.
- In 2014-15, 25 youth and families have received FIRST services.
- In 2014-15, 26 youth and their families were served in the TRACK program.

Integration of Behavioral Health and Primary Care

Program Overview

The interactions between mental and physical health have been known through the ages, and in recent years has been more embraced in healthcare. Many people go without their mental health needs being adequately identified and addressed in medical settings. Of equal concern is the substantial untreated chronic medical disease, physical suffering as well as premature death for individuals with serious mental illness. To address these concerns, the San Francisco Department of Public Health has been making great strides to integrate physical and behavioral healthcare. In 2009, after an extensive community planning process, SFDPH implemented the Primary Care Behavioral Health Model in the majority of SFDPH primary care clinics. In this model, behavioral health clinicians work as members of the primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based therapeutic 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.

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 (contract)
- 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.

FY13-14 Highlights and Successes

In an effort to understand how behavioral health is currently managed in our primary care clinics, depression screening and interventions were examined at seven of our fourteen non-hospital primary care clinics. The aim of these efforts was to determine the proportion of patients diagnosed with depression and, of those diagnosed with depression, the proportion that interacted with a Behavioral Health Clinician during the fiscal year. The seven clinics selected for inclusion serve 39% of our non-hospital primary care clinic population (20,356 of 52,000 patients) and were all on electronic health records at the beginning of the fiscal year. Figures reported below reflect patients at the following primary care health centers: Castro-Mission, Chinatown Public, Maxine Hall, Ocean Park, Potrero Hill, Silver Avenue, and Southeast.

- Increase the provision of behavioral health screening in primary care settings
  - As of March 31, 2015, 17.6% of primary care patients at the seven studied health centers had a depression diagnosis

- Increase the provision of evidence-based short-term treatment interventions at SFDPH Primary Care Clinics

- As of May 31, 2015, of the above 17.6% of patients diagnosed with depression, 53% of these patients had a note related to a telephone or face-to-face encounter with a Behavioral Health Clinician

Moving Forward in FY15-16

Programs seek to achieve the following outcomes:

- Over the next eighteen months (July 2015 – December 2016) a plan will be developed to implement universal depression screening in our Primary Care Clinics. Our approach will include rolling out the PHQ-9 and PHQ-2 (with PHQ-9 follow up) screening tools across the network of our primary care clinics.
- Part of the planning process for universal depression screening will include identifying workflows and interventions for those patients who screen positive for depression and other behavioral health concerns.

MHSA is also 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. The Chief Medical Officer 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. Solis 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

Program Overview and Target Population

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. 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.

FY13-14 Highlights and Successes

- 24 unduplicated clients were linked to an appropriate level of continuing care and support

- Units of service included 683 bed days

Moving Forward in FY15-16

Advancing Wellness and Recovery Practices

In November of 2014, a full-time Wellness and Recovery Coordinator was hired to join the MHSA team. The Coordinator was selected for this position and brings 22 years of clinical experience. She has most recently worked as a civil service outpatient clinic director where she successfully worked with staff in transforming the clinic to a Wellness and Recovery Clinic. She has also served as faculty for the California Institute of Behavioral Health Services sponsored statewide Advancing Recovery Collaborative.

In January of 2015, a year-long Wellness & Recovery Collaborative was launched. The collaborative consists of five outpatient mental health clinics. The clinics are diverse in their focus serving child, youth and families; adults; and older adults. Each clinic is comprised of a multi-disciplinary team. The teams are learning the P.D.S.A. (Plan-Do-Study-Act) approach from the Model for Improvement quality improvement framework with the goal of improving Wellness and Recovery practices at the five participating clinics.

Each of the teams has completed a Team Development Measure and are using the results to formulate strategies to increase team cohesiveness. The teams are also learning new solution focused skills such as the Strengths Assessment tool and Strengths Based Group Supervision approach. By using these new solution focused skills the hope is that clinicians will be able to work collaboratively with their clients to develop more meaningful goals and that goal completion will increase for those clients who are working within the strengths-focused model.

A similar approach has begun with teams comprised of members from our community partners. These are multi-disciplinary teams who work within the Full Service Partnership and Intensive Case Management framework. The MHSA staff will be working with each team closely and will be traveling to clinic sites to provide on-site coaching. Baseline data has been collected. The Wellness and Recovery Collaborative also generated new energy for the ICM/FSP Recovery Initiative described below.

ICM/FSP Recovery Initiative: After teaming up with UCSF Citywide Forensics and participating in the Advancing Recovery Practices (ARP) Learning Collaborative sponsored by CIMH from 2011-13, BHS launched a recovery initiative with the TAY, Adult and Older Adult ICM and FSP programs to share learning from the Collaborative across the intensive case management system of care.
Each month through 2014-15, staff invited presentations by teams that benefitted from two rounds of the learning collaboratives (Citywide, OMI Family Center, Mission ACT and Sunset Mental Health). Facilitated discussions about increasing staff optimism for the clients and creating more welcoming,

client centered programs with a focus on recovery, allowed us to plan PDSAs toward improved care. Examples of these PDSAs include:

- Making time at weekly meetings for staff to share client success stories
- Testing use of the Kansas University Strengths Assessment
- Introducing recovery theme-based discussion to staff meetings
- Redirecting client sessions to focus on client-defined goals

Starting in May 2015, the ICM/FSP Recovery Initiative began to align with Wellness and Recovery Collaborative focusing PDSA work on: 1) building team cohesiveness and strength, and 2) increasing the use of the strengths tools. Three adult civil service teams belong to both efforts. Because clinicians are reporting that the Strengths Assessment provides a new perspective on the client and fosters hope for the client's recovery. Most clinicians who have tested it, report that they appreciate the tool as it is helpful in preparing Treatment Plans of Care. In FY14-15 SF MHSA expects to see an increase in the use of the Strengths Assessment tools and Strengths-base Group Supervision which centers on the Strengths Assessment and team collaboration.

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

Service Category Overview

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 BHS 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 Overview

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.

Exhibit 15. FY13-14 Key Outcomes

- One-hundred percent (100%) of Peer Educators reported experiencing reduced self-stigma, reduced risk factors, improved mental health, improved resilience and increased access to care and empowerment
- Ninety-seven percent (97%) of service providers and professionals who attended anti-stigma presentations delivered by Peer Educators demonstrated a better understanding of the effects of stigma on people with mental health challenges and conditions

FY13-14 Highlights and Successes

Peer Educators from SOLVE assisted in co-facilitation of all peer orientation trainings with MHA-SF staff and the further development of training curricula. In addition, 13 new Peer Educators were accepted into the SOLVE program this past year. SOLVE also conducted 62 community presentations, each featuring anti-stigma messaging with an emphasis on prevention and early intervention, recovery, services within the community and challenging to

misconceptions of mental illness. SOLVE provided featured presentations to the San Francisco Policy Department's specialized Crisis Intervention Team (CIT) Training on a quarterly basis.

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

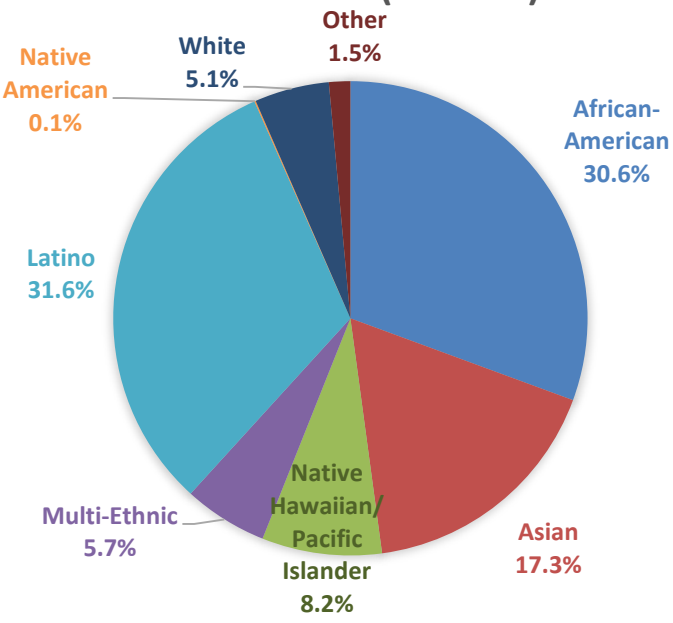
Target Population

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

FY13-14 Highlights and Successes

The School-Based programs endeavored 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. Notable accomplishments during 2013-14 include the following:

EXHIBIT 16. ETHNICITIES SERVED IN FY13-14 SCHOOL-BASED PROGRAMS (N=1101)



- At least eighty-five percent (85%) of students in academic and intensive case management showed increased ability to skillfully deal with difficulties in their lives, exceeding the baseline by 20%
- Ninety percent (90%) of youth case managed experienced an increase in social connection, exceeding the baseline by 20%
- Upon case closure, ninety-three percent (93%) of students stated that they saw improvements in their relationships with family and school
- Upon case closure, at least seventy-five percent (75%) of youth reported improvement in their overall coping skills and confidence in themselves
- Seventy percent (70%) of teachers agreed or strongly agreed that they felt more successful (than at the beginning of the school year) in intervening effectively with challenging student behaviors

Moving Forward in FY15-16

The BHS Child Youth and Family System of Care has been actively engaging SFUSD to streamline and coordinate mental health services, both in community and school based settings. A Senior Marriage, Family and Child Counselor will be hired to oversee DPH's coordination activities and will help to triage cases presented by the school district, provide clinical consultation, link clients to DPH system of care, and follow through and monitor on case plans discussed during systems coordination meetings. This position is funded by a redirection of contractual services funding and MHSA funding. This improved partnership is now allowing high level SFUSD administrators and CYF's Deputy Director to directly address high risk cases that require systemic solutions, so it is critical that the Department has the staffing to sustain the effort.

Spotlight on K-12 Programs' Evaluation Efforts

BHS and School-Based Mental Health Promotion worked with Learning for Action (LFA) to conduct a cross-site evaluation with a group of MHSA-funded school-based mental health providers. While the overall purpose of the evaluation was to understand how, and to what extent, school-based mental health services contribute to positive student outcomes, specific outcomes were developed for elementary and high school MHSA-funded programs. Elementary school outcomes included teachers' sense of self-efficacy in supporting students' mental health and well-being, while high school outcomes included student perceptions of school connectedness and supportive relationships with adults at school. Evaluation activities included:

- Administration of the Teacher Opinion Survey to elementary school teachers receiving services from MHSA-funded programs
- Administration of an abbreviated version of the California Healthy Kids Survey to high school students pre-and post-intervention
- Focus groups with elementary school teachers, support staff, & administrators
- Interviews with high school students who were recipients of MHSA services
- Interviews with MHSA providers

Main findings demonstrated the following:

- School-based MHSA providers equip teachers with the knowledge and tools to address students' social and emotional needs
- MHSA providers provide new information and skills to teachers to help improve interactions with students
- High school students receiving services indicated increases in school connectedness (e.g., motivation to stay in school)
- The High School Student Survey revealed that 75% of students agree or strongly agree with statements indicating that they are doing better in school since participating in their school's MHSA program

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).

FY13-14 Highlights and Successes

Notable accomplishments during 2013-14 for school-based programs focused on higher education include the following:

- At least 600 unduplicated students received drop-in wellness promotion services
- At least 130 students received in-depth counseling, including intake, assessment, educational and wellness planning and follow-up services
- Eighty-two percent (82%) of students who utilized individual counseling exhibited significant progress in advancing the goal of enhancing their health and well-being and reducing the impact of health related challenges
- Seventy-seven percent (77%) of students exhibited significant progress in advancing the goal of enhancing social connections and reducing a sense of isolation and loneliness
- Eight-one percent (81%) of students exhibited significant progress in advancing the goal of increasing their confidence and reducing anxiety, shame, hopelessness and a sense of being overwhelmed by the demands related to academic performance

Population-Focused Mental Health Promotion and Early Intervention

Program Overview

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.

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, SF MHSA is 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 responsive 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, gender identity/sexual orientation, and the under-housed. SF MHSA has supported this network of grassroots Mental Health Promotion and Early Intervention programs reaching 25,000 people each year from underserved communities.

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 Community Youth Center (CYC)	Outreach and therapeutic services tailored to A&PI youth.
	Asian & Pacific Islander Health Parity Mental Health Collaborative	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	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.

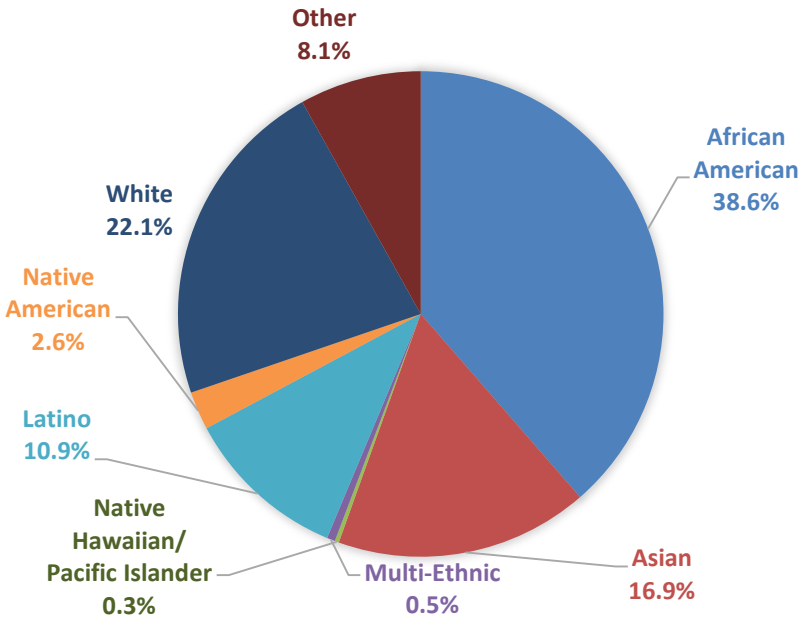
Target Population	Program	Services
	Horizons Unlimited of San Francisco, Inc. EMIC Behavioral Health	A family focused treatment model that is culturally informed, linguistically sensitive and geared for Latino and other youth of color (ages 12 to 25) and their family members who may not seek traditional mental health care and/or substance abuse/use treatment. Goals include helping youth and their family members address mental health and/or substance abuse issues and training Horizons Unlimited staff to recognize mental health and/or substance abuse/use symptoms in youth, who frequent their agency for youth development programs, and make referrals to the EMIC Behavioral Health Services project when appropriate.
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.

Target Population	Program	Services
Arab Refugees	Arab Refugee Support Group	The Arab Cultural and Community Center (ACCC) has performed landmark work for San Francisco's Arab and Muslim community from 2013 through 2015, by providing support groups and individual therapy for women who have been traumatized by war in their home counties and who are experiencing present trauma due to stressors related to immigration. Because of the ACCC's pioneering work, the San Francisco Mental Health Services Act (SF MHSA) has garnered a better understanding of how to approach, outreach to, communicate with and support individuals from our Arab and Muslim communities; and SF MHSA looks forward to future partnerships with the ACCC. Some of our lessons learned include (a) teaching program participants how to navigate the city through public transportation is empowering; (b) having support groups for the ACCC women, who come from countries that are historically at religious war with each other, is extremely healing; and (c) each program participant's cultural background has been a protective factor that has allowed them to recover.

Target Population

Population-focused programs serve multiple underserved groups, specifically African American, Asian and Pacific Islander, Native American, Latino/Mayan, Arab, older adults, homeless adults, Homeless/System Involved Transitional Age Youth, and LGBTQ communities. Target neighborhoods include the South of Market, Tenderloin, Bayview Hunters Point, Oceanview, Mission, Potrero Hill, Visitacion Valley, and Western Addition for various population groups, such as Asian and Pacific Islanders, African Americans, Mayan and Latinos, and Native Americans. Citywide efforts are also focused on LGBTQ, homeless adults, TAY and older adult communities.

EXHIBIT 17. ETHNICITIES SERVED IN FY13-14 POPULATION-FOCUSED PROGRAMS (N=26,087)

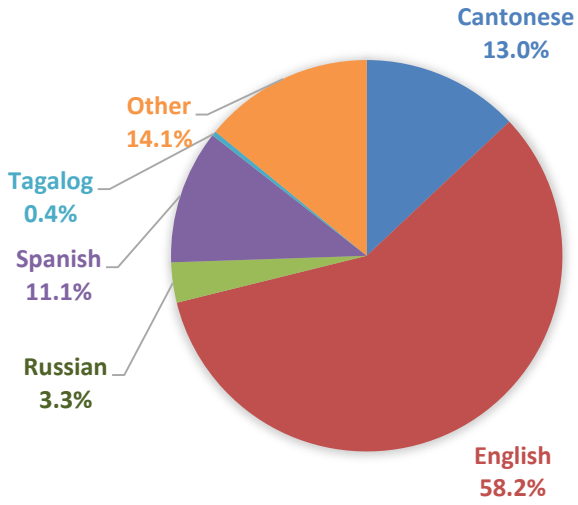


FY13-14 Highlights and Successes

Notable accomplishments across the PEI component in 2013-14 include the following:

- One hundred percent (100%) of YMCA Bayview African American Holistic Wellness program participants reported increased understanding of the need for interdependent relations and social connectedness
- Ninety-six percent (96%) of Huckleberry Youth Services workshop attendees reported increasing their knowledge of healthy behaviors as measured by post-test evaluations
- At least eighty-five percent (85%) of Burton High School students in academic and intensive case management showed increased ability to skillfully deal with difficulties in their lives, exceeding the baseline by 20%
- Ninety percent (90%) of Burton High School youth case managed experienced an increase in social connection, exceeding the baseline by 20%
- At least seventy-five percent (75%) of teachers receiving consultation services reported that the consultant helped them to respond more effectively to children's behavior
- Upon case closure, ninety-three percent (93%) of students served by the RAMS Wellness Center stated that they saw improvements in their relationships with family and school
- Upon case closure, at least seventy-five percent (75%) of youth served by the RAMS Wellness Center reported improvement in their overall coping skills and confidence in themselves
- Seventy-two percent (72%) of wellness coaching participants at the Curry Senior Drop-in Center followed through with at least one identified action step, exceeding the performance goal by 32%.
- Seventy-five percent (75%) of TAY and families who engaged in therapy through Huckleberry Youth Services achieved clinically significant improvement in symptoms during the first eight sessions

EXHIBIT 18. LANGUAGES SPOKEN BY THOSE SERVED IN FY13-14 POPULATION-FOCUSED PROGRAMS (N=2,048)



Improving Contractor Capacity to Measure Impact

Over the past year, eighteen San Francisco Mental Health Service Act-funded Population Focused: Mental Health Promotion & Early Intervention (PFMHPEI) programs met with MHSA staff and SF DPH Office of Quality Management (OQM) evaluators to develop contract Process & Outcome Objectives for FY2014-15. The process began with defining universal program activities (e.g. outreach activities intended to establish/maintain relationships with individuals), service types (e.g. Outreach & Engagement; Screening & Assessment; Wellness Promotion), process objectives (e.g. X number of individuals will participate in Wellness Promotion activities), and outcome objectives (e.g. X number of individuals will achieve at least one case/care plan goal) that would apply to all PFMHPEI Programs. From these established universal constructs, each PFMHPEI program tailored their respective program-specific Process and Outcome objectives. Because population-focused programs specifically target underserved communities, it was especially critical to partner with these organizations to spread awareness around mental health. In addition, the planning process involved a level of translation between the communities and the mental health system, as the "mental health" term and concept do not exist in certain languages and/or are stigmatized.

Mental Health Consultation and Capacity Building

Program Overview

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.

SF MHSA funds a portion of San Francisco's Early Childhood Mental Health Consultation Initiative (ECMHCI), which 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 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. These services are meant to underscore the importance of early intervention and enhance the child's success. Information collected from MHSA funded sites revealed that 100% of programs felt that mental health consultation was helpful in retaining children in their program who were at risk of expulsion. Additionally, 77% of parents surveyed reported that mental health consultation increased their awareness of the connection between their child's environment and behavior.

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.

The **Parent Training Institute** (PTI) seeks to improve child and family outcomes by providing evidence-based parenting (EBP) interventions to caregivers of young children with emotional or behavioral problems, or who are at risk of developing such problems due to socio-economic and other risk factors. Established in 2009, PTI has supported the training of over 125 EBP practitioners who have

delivered EBP interventions to over 2,000 parents and caregivers. These interventions have increased the use of effective, non-punitive parenting strategies by parents and decreased child behavior problems.

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.

FY13-14 Highlights and Successes

Mental health consultations 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. Notable accomplishments during 2013-14 include the following:

- At least seventy-five percent (75%) of teachers receiving consultation services reported that the consultant helped them to respond more effectively to children's behavior
- Ninety-five percent (95%) of infants born to mothers with significant psychiatric concerns displayed normal neonatal functioning. 100% of these infants had normal birth weights and normal Apgar scores.
- Seventy-two percent (72%) of wellness coaching participants followed through with at least one identified action step, exceeding the performance goal by 32%.
- Seventy-five percent (75%) of TAY and families who engaged in therapy achieved clinically significant improvement in symptoms during the first eight sessions

Comprehensive Crisis Services

Program Overview

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.

SF MHSA funds a portion of Comprehensive Crisis Services (CCS), which 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 19. 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.

FY13-14 Highlights and Successes

Individual

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

Program

- CRT staff provided 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 conducted outreach to those individuals within a 24 hour period of being notified.

System

- Individuals in need of mental health services related to trauma exposure were 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 had 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 collaborated with Quality Management to articulate clear outcome objects and assess areas for program improvement based on evaluation data.

MHSA Triage Grant

San Francisco County was awarded approximately 4 million dollars over four years to develop programs to decrease the use of hospital emergency rooms, psychiatric emergency rooms and inpatient stays for people who were experiencing psychiatric crises. In response to this SF County established the following programs:

Warm Line: A 24 hour warm line staffed by peers. People in psychiatric crises can call and speak with a peer to get support, families can also call to to get support. Staff is trained to redirect calls if the caller needs additional help or services.

Mobile Treatment Teams: Teams consisting of a clinician, case manager, and peer who will work in the community to help stabilize children and families who have been difficult to engage, have had a psychiatric crises or having experienced trauma. The intervention is designed to be short term and intensive. To stabilize families and connect them to less intensive services.

Crises Stabilization Unit: A 23 hour stabilization unit located in the community. The goal is to try to stabilize youth who are experiencing a psychiatric crisis in a family friendly setting and avoid Psychiatric Hospitalization.

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

Service Category Overview

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 Overview

Peer Response Team (INN)

The Peer Response Team is an ethnically and culturally diverse team of four Peer Responders with lived experience of hoarding challenges that are trained and supported in responding to requests for individual peer support in San Francisco. Peer support can include phone calls, office visits, and home visits. Peer Responders model recovery and encourage connection to a broader community through involvement in mutual support groups housed at the Mental Health Association of San Francisco. In addition to working with individuals with hoarding challenges, the PRT team also has been a unique resource for local agencies, such as Adult Protective Services, landlords, lawyers, eviction defense, case managers, therapists, and families and friends. PRT has also been in the forefront on anti-stigma education and messaging around hoarding.

PRT began in 2011, and wrapped up its final year as an Innovation project in July 2015. Because the PRT work has been transformative not only to recipients of services, but to the peers themselves, MHSA will continue to fund PRT Peer positions at MHA SF. Within our BHS system, MHSA is exploring

and committed to increasing clinician and peer staff training on hoarding, as well as working with local agencies/service providers in assisting individuals with hoarding challenges.

NAMI Peer-to-Peer Training

The National Alliance for Mental Illness (NAMI) offers peer-directed programs the education to support individuals living with mental health challenges and their families. 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. Both of these programs are also offered in Spanish.

NAMI-SF also delivers an anti-stigma program entitled, In Our Own Voice: Living with Mental Illness, which is an interactive, multi-media consumer presentation designed to educate the general public and to change attitudes about mental health. 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.

Transgender Pilot Project (INN)

Approved by the MHSOAC in FY14-15, the purpose of the Transgender Pilot Program (TPP) is to increase linkages to services and improve client engagement in services. The focus will be on transgender women of color 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. This group identified as the hardest to engage.

This project will employ three strategies: support groups, outreach, and an annual Transgender Health Fair as a one stop shop for linkages to services. Each strategy will be evaluated in order to learn the positives and drawbacks of each form of access. These methods will be compared individually and against each other. The Learning Question for this project is: What are effective peer support strategies and practices for Transgender women of color that will improve their engagement in mental health services, encourage social inclusion, and encourage community engagement?

LEGACY (Lifting and Empowering Generations of Adults Children and Youth)

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) Positive Parenting Program training; and 3) Therapeutic drumming. Therapeutic drumming is 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. MHSA funds 3.5 FTE peer staff to coordinate the family programs.

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.

Addressing the Needs of Socially Isolated Older Adults (INN)

Approved by the MHSOAC in FY14-15, the purpose of this project is to 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 with the Curry Senior Drop-in Center 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.

The Learning Questions for this program are:

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.
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.

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.

FY13-14 Highlights and Successes

Outcome objectives for Peer-to-Peer Support Services were guided by MHSA's principle to engage consumers and families in all aspects of the behavioral system, including planning, policy development, service delivery, and evaluation. Programs reported successes in increasing access to peer counseling and family support services and expanded neighborhood outreach and health promotion and referrals to mental health services. Other outcomes specified by programs as a result of participation in peer-led programs included greater engagement in treatment services and increased knowledge of the recovery process. Peer-related outcomes included decreased self-stigma and increased knowledge and awareness of mental health behaviors among Peer Responders, Counselors, and Educators.

Exhibit 20. FY13-14 Key Outcomes

- Ninety-one percent (91%) of participants who received support from Peer Responders with lived experience reported an increased ability to manage hoarding and cluttering behaviors
- Ninety-eight percent (98%) of participants who received support from Peer Responders with lived experience reported an increase in responsibility and accountability for their own wellness

Moving Forward in FY15-16

Request for Qualifications (RFQ) published for the Peer-to-Peer Employment Program

San Francisco began integrating Peer Specialists into the mental health service delivery system by hiring six Peer Navigators in 2008. Today, BHS 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 BHS System of Care and community settings, BHS has published a RFQ calling for the selection of a single service provider to oversee and support the BHS Peer-to-Peer Programs. Through a competitive bidding process, Richmond Area Multi-Services (RAMS) was selected as the service provider to provide management of these programs. The programs include the former MHSA Consumer Employment Program, The Office of Self Help, the Pathways to Discovery program and the Peer Support Internship Program. This new integrated model, currently called the Peer-to-Peer Employment Program, will begin on July 1, 2015. RAMS and BHS has started gathering input from peers regarding program development, implementation, evaluation and long-term strategic planning. Twelve hours of focus groups have been conducted to gather information from peers, consumers, family members and stakeholders about what the community would like to see within this new integrated program. Several more focus groups are scheduled to take place in August to continue building upon the strong foundation of ideas and suggestions from the consumer community. BHS requested that RAMS hire all peer staff currently employed by BHS. 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 will create a stronger program that promotes program expansion and streamlines services.

One goal of the Peer-to-Peer Employment Program is to provide coordinated, collaborative employment-related support for the peer employees. This support will be provided by RAMS, BHS and by leveraging resources through the Department of Rehabilitation. The peer employee support services will include, but not limited to; increased training, increased supervision, consultation support, job coaching and retention services, and peer-based support groups.

Hummingbird Place

The Hummingbird Place is a peer-designed and managed Respite. The Respite launched in May of 2015 providing a safe space that offers connection and breathing room to those in need of healing and new direction on their path toward wellness. Hummingbird Place provides a less restrictive setting for those needing alternatives to hospitalization. Under this peer model, staff with lived experience will work with service providers in the community to divert eligible participants from emergency settings. In addition, the Respite can take in individuals exiting the hospital that may need extra support rejoining the community.

The Peer Respite is located on the grounds of San Francisco General Hospital on the first floor of the three-story Behavioral Health Center (BHC). The second and third floors of the BHC house two residential programs. Although located a few buildings over from Psychiatric Emergency Services and Inpatient Units, the space has a non-institutional home like environment where guests are welcome to have a respite from the stressors that overwhelm their daily lives. The space has a large open layout with a dedicated backyard space, lots of natural light, a large living room, homey bedding, and art created by peers. The space has the capacity to serve up to 20 individuals (depending on staffing ratios and acuity of those needing services).

After an initial phase of being open only during day-time hours (10am-6pm), Hummingbird Place is expected to be open 24/7 with beds for four overnight guests for stays of up to 14 days. Programming run by Peer Counselors will be available daily from 11:00am to 9:00pm. Certified Nursing Assistants will be on site to supervise overnight stays. The Respite is not designed as a housing alternative but will be used on a temporary basis for guests requiring additional support to avoid hospitalization or facilitate their successful return to the community.

Both individual and group counseling will be available. The groups held at the Peer Respite are launching points for education and engagement in community services. By participating in WRAP, Stress reduction, One to One counseling, art therapy, music, yoga, gardening and/or food preparation, guests learn new tools for living outside a controlled environment. In addition, the Peer Respite has plenty of space for quiet time, one to one counseling, and/or positive social interaction.

Peer staff will work closely with case managers and other service providers to identify those that would benefit from the Respite as an alternative to crisis or PES. Potential guests are identified by staff at partnering sites including Intensive Case Management, Full Service Partnerships, Inpatient

Psychiatry and Psychiatric Emergency Services. Peer Counselors screen guests for a good fit with Peer Respite criteria and requirements. The Peer Respite is a voluntary program with minimal paperwork. The primary outcomes are:

- The development of a successful Psychiatric Peer Respite in San Francisco.
- A decrease in utilization of crisis and psychiatric emergency services.
- An increase in client engagement in alternatives to hospitalizations.

BHS is currently applying for MHSA Innovations funding to further test and learn what are the most successful peer modalities within a peer respite model.

Advanced Level Training

BHS recently published a RFQ to identify a service provider to continue the Peer Specialist Mental Health Certificate program and also develop 2 advanced level training programs. Richmond Area Multi-Services (RAMS) was awarded the contract which starts in FY15/16. RAMS, with BHS and consumer input, will be responsible for the development and implementation of the advanced level training programs to further support and educate peers working with consumers of behavioral health services. RAMS will conduct a needs assessment and gather community input regarding specific needs in the area of peer training. The advanced level programs will work in collaboration with the new Peer-to-Peer Employment Program to share resources, best practices and educational curriculum. The proposed model for the advanced level training programs may include, but not limited to, the following:

1. *Advanced Level Peer Specialist Mental Health Certificate Program* – This certificate training program will teach peers and consumers advanced skills as a peer specialist and provide at least 8 weeks of classroom training. Peers will be further trained in facilitating multiple evidenced-based peer groups commonly used when working as a peer specialist. Peers will be trained in best practices when working with consumers with acute needs that may be hard to engage. Peers will be trained in a leadership and supervisory capacity in areas such as; peer project oversight; supervision of peer staff; facilitation of peer manager meetings; peer recruitment, selection and onboarding; peer consultation/support; peer job coaching, etc. This program should have a component in which peers are mentored by other peer leaders from the Peer-to-Peer Employment Program and a component in which peers may be provided education about the Civil Service application and testing process, congruent with DPH policies.

2. *Leadership Academy* – The Leadership Academy will provide short-term training (2-3 hour course) in specific topics and offer courses frequently throughout the year (monthly) at various days/times to reach a broad audience. There shall be no requirement of peers/consumers to complete multiple courses or adhere to time restrictions, which will allow for program flexibility to work around the needs of many. This training program will teach

peers and consumers basic education in the areas of, but not limited to, budgeting, policy development, program development, program implementation, quality assurance, evaluation, RFP/RFQ review process, etc. This program will provide unbiased information to peers and consumers to develop a basic understanding of certain programmatic areas while empowering peers/consumers to develop and advocate for their own beliefs. These training courses will help peers and consumers develop skills to feel better equipped when participating in activities that request consumer input. Activities may include the MHSA Advisory Committee, the Client Council, BHS RFQ/RFP Review Panel Process and the MHSA Community Planning Process (CPP).

BHS Peer to Peer Program Manager

Both MHSA and the Affordable Care Act (ACA) mandate that peers be recruited, trained and supported to be active members of the service delivery system. The MHSA Peer-to-Peer Program Manager will be responsible for planning, designing, implementing and evaluating various projects outlined in the Integrated Plan designed to promote and increase the use of peer programs and practices. This position will also be responsible for the management of a new Peer Respite program located at the SFGH Behavioral Health Center.

Working Well Together - State Peer Certificate Project

Working Well Together (WWT) serves the county mental health system staff involved in designing, implementing, evaluating, and/or sustaining the consumer, family member, and parent/caregiver workforce within the local public mental health system. WWT was given the task of collecting feedback through monthly stakeholder calls to create a set of policy recommendations for peer certification. The MHSA Consumer Employment staff provided their insight and opinions to WWT. Staff also provided historical information related to the similar process that requiring Substance Abuse Counselors In addition, a staff member educated the group on the culturally specific WRAP groups for the Trans community that are being held in San Francisco county. California State Senator Mark Leno put forth a bill to create the state certification guidelines based on the WWT recommendations.

Transgender Health Services

BHS will also be hiring a Transgender Health Services coordinator (1-2 years 2593) and lead evaluator (FI at HR 360).

5. Vocational Services

Service Category Overview

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 Overview

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 (BHS) will combine staff and resources to provide vocational rehabilitation services to mutual consumers of mental health. DOR and BHS 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 BHS will partner with a service provider to meet the various and diverse needs of the community; UCSF Citywide Employment Program – FSP Program. BHS 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.

These services are supported by a Vocational Coordinator who will be hired to assist in planning, coordinating services between DOR and BHS and providing overall administrative support to the BHS contract. The Vocational Coordinator will also provide outreach to BHS consumers and BHS 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 BHS 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 BHS electronic health record system ("Avatar") to receive support.
- Desktop, a single point of contact for end users of BHS computers/hardware to receive support and maintenance within BHS computing environment.
- Advanced Avatar Helpdesk, a single point of contact for end users of the BHS 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. BHS recently launched a pilot supported employment component to this program to provide a time-limited employment opportunity for successful graduates of the training program(s). This pilot provides advanced level skills in the areas noted above and has proven to be successful. BHS plans to further grow this pilot throughout FY15/16.

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 BHS Mental Health Care System by creating a welcoming environment in the wait rooms of DPH/BHS clinics.

The FI program is a collaboration of the UCSF Citywide Employment Program, Asian Neighborhood Design and BHS. 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)

Now in its fourth year of implementation, Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) has adapted an existing nutrition and exercise protocol into a community mental health setting and integrated shopping/cooking skills and peer leader training. This program educates 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 are primarily recruited from SFDPH mental health 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. Many graduates of AAIMS cooking classes have emerged as peer leaders. Currently, AAIMS has a total of eighteen peer leaders who assist in a myriad of responsibilities, including, but not limited to: teaching classes on nutrition and cooking, managing and keeping inventory of kitchen supplies, cooking for meetings and events, and neighborhood food advocacy issues. Most AAIMS project participant report a decrease in metabolic syndrome issues and a sharp increase in social connectedness.

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.

Assisted Independent Living (Baker Places)

The Baker Places vocational consumer employment project will support consumer employees (2.5 FTE) to develop skills in the workforce areas of clerical/administrative support and mail distribution. This supported employment project will be located on-site at Baker Places and will provide training, supervision and advanced support to a team of consumers with an emphasis on professional development. This project will help consumer employees to identify professional development goals and breakdown barriers to reaching their goals. This project will also assist consumer employees to advance to the competitive workforce by linking consumers to the Department of Rehabilitation's job placement services and/or linking to other vocational programs within the BHS system.

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 BHS.

FY13-14 Highlights and Successes

Notable accomplishments in Vocational Services in 2013-14 include the following:

- One hundred percent (100%) of I-Ability trainee graduates met vocational goals
- One hundred percent (100%) of I-Ability trainee graduates reported improvements to their coping abilities with stress
- Over eighty-five percent (85%) of I-Ability trainees successfully completed the training or exited the program early due to obtaining gainful employment

- One hundred percent (100%) of First Impressions trainees expressed overall satisfaction with the program in post-program satisfaction surveys
- At program completion, one hundred percent (100%) of First Impressions trainee graduates met their vocational goals, which are collaboratively developed between the FI Employment Specialist and trainee, as evidenced by Vocational Plan summary reports.

Moving Forward in FY15-16

Request for Qualifications (RFQ) published for the Vocational Rehabilitation Employment and Training Programs

Recently BHS published a RFQ to call for the selection of one or several service providers to manage multiple vocational and employment programs, while working in collaboration with one another. The MHSA funded programs included in the RFQ include the Information Technology Program (i-Ability Vocational IT Program named above) and two new programs; TAY Vocational Services and Landscaping and Horticulture Services. Once the service providers are selected, the programs are projected to launch in January of 2016.

The overall goal of TAY Vocational Services is to provide time-limited paid internships to transitional age youth, ages 15 to 25, in order to provide healthy activities, provide entry-level work experience and help behavioral health TAY consumers achieve resiliency and maximize recovery. This project should launch as a pilot program and the selected service provider will be responsible for conducting a Needs Assessment and work in collaboration with a broad range of stakeholders including TAY consumers, family members, BHS, MHSA, and consultants to design and implement this novel vocational training program. The objective of the Needs Assessment would be to further determine the vocational needs/interests of the TAY community, the workforce sector interests of this community, and also to work with BHS to determine placement sites and positions that match the needs of the consumers. In a recent BHS focus group, feedback identified the need for more TAY representation and TAY vocational services within the community.

Landscaping and Horticultural Services is a vocational program that utilizes horticultural and gardening activities to promote mental health recovery. The aim is to enhance the self-esteem and emotional well-being of consumers receiving behavioral health services through BHS. The program should engage consumers in developing practical skills in the landscaping and horticultural industry by using hands-on activities to improve one's workforce skills and allow consumers to connect more deeply with their environment.

A recent BHS vocational program survey yielded a 22% response in the landscaping/horticultural gardening field. The selected service provider will be responsible for continuing to assess the needs of the community and design this program accordingly. The provider is expected to follow and develop a curriculum based on the State Water Resources Control Board's requirement on a 25% reduction of

water use and the San Francisco Public Works Water Efficient Irrigation Ordinance with recommendations on water efficient landscaping and drought tolerant plants.

Under this RFQ, BHS is also organizing the BHS Vocational Services by workforce sectors and each sector will have supportive services including, but not limited to; a vocational assessment, training, supported employment, job coaching, supervision, and case management services working towards a consumer-driven goal. Goals may include; working towards competitive employment, working to develop new skills, working to advance in the field and/or working to find meaningful activities to further enhance one's wellness. BHS has collected extensive information from consumers, family members and other vocational stakeholders to determine the current needs of the community. BHS conducted three consumer and family member focus groups, one stakeholder focus group, and one consumer survey assessing the needs of over 120 community members in order to design the programs proposed in the RFQ. Consumers reaffirmed the importance of work as a means to gain the routine, responsibilities and skills necessary to their health and overall self-worth. Research has shown that employment provides a meaningful activity which often helps individuals with disabilities reclaim their social role and rebuild their self-management skills. Training and employment promotes health and wellness and may help individuals to pave the way for a more fulfilling quality of life. The opportunity to work should be recognized as an integral part of recovery working towards optimal health.

Department of Rehabilitation Vocational Co-op Program

In FY15-16, two new Department of Rehabilitation/BHS programs will launch to further expand the vocational assessment and employment development services. Occupational Therapy Training Program (OTTP) will provide employment support services for the Transitional Age Youth (TAY) and mental health population. Toolworks will provide similar services for the Deaf and Hard of Hearing and mental health population.

6. Housing

Service Category Overview

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 ESUs are located within several 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's housing support staff.

FSP Permanent Housing

Program Overview

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 63 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). Six units for Transition-aged youth opened in 2015. An additional three units will be open next year at Rosa Parks II, a development for seniors. 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 contract with Community Housing Partnership for a eight units of permanent housing at the Cambridge Hotel, another non-DAH supportive housing site.

Target Population

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.

Exhibit 21. Summary of MHSA Permanent Supported Housing Units *

Target Population	Development	Developers	MHSA-Funded Units (N=63)
Older Adults	*Rosa Parks*	Tenderloin Neighborhood Development Corporation	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* 1100 Ocean Ave.	Bernal Heights Neighborhood Center & Mercy Housing California	6

*Developed with one-time capital housing funds

FY13-14 Highlights and Successes

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. Of the 11 MHSA referrals housed at this senior residence, one-hundred percent (100%) were able to maintain housing for at least three years.

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. Eighty-six percent (86%) of MHSA referrals maintained housing for at least 12 months at this site.

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. Swords to Plowshares manages the

property. The development includes space for intensive supportive services, including space for counseling, group meetings, case management, and social activities. Seventy-eight percent (78%) of MHSA placements at Veteran Commons have maintained housing over the past year.

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. Eighty-six percent (86%) of MHSA placements at Kelly Cullen have maintained housing after one year.

Community Housing Partnership: René Cazenave Apartments

The **Rene Cazenave** Apartments were developed by 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. Since the property has been opened last year, one-hundred percent (100%) of MHSA placements maintained housing.

Mercy Housing: 1100 Ocean Avenue

The **Ocean Avenue** development, completed in 2015, is a new construction project that includes 70 units of housing for families and transitional aged youth (TAY) and one property manager unit. The building has 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 are restricted at 20% of the area median income.

Six of the project's 25 TAY units are reserved for the MHSA Housing Program. An integrated services team provides 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, manages the property.

Moving Forward in FY15-16

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 planned 98-unit, five-story affordable senior housing development, with three units set aside for older adults under MHSA. 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. The project will be developed by the Tenderloin Neighborhood Development Corporation and is scheduled for completion in summer 2016.

Community Housing Partnership Expansion

At this time, BHS has the opportunity to reserve 43 units in non-profit housing with services coordination staff through a contract expansion with the Community Housing Partnership. The cost per unit for operating subsidies is proposed at $5,110 per unit per year. The cost of on-site services is $3,578 per client, per year. The agency also charges 15% indirect expenses. The total annual cost, after ramp-up, would be $429,618. This program plans to target single adults with serious mental illnesses who are currently homeless. Staffing would include two FTE Services staff to assist with on-site services, activities and groups, and to work directly with FSP providers on individual service plans. The sites to be used for housing placement are owned and operated by CHP and CCDC. They have been remodeled and are regularly inspected to monitor housing quality standards. Buildings include the Cambridge, Hamlin, San Cristina, and other CHP sites as vacancies become available. Placements will begin when the expenditure is approved. One services staff position will be put in place immediately

when expenditure is approved, and a second when placements will soon surpass 50%. DAH administers a current contract with CHP for seven units with CHP. This would be replaced with a sole source contract for 43 units, including services.

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. Eighty-eight percent (88%) of placements in this program maintained housing or had a stable exit after one year, exceeding the performance goal.

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:

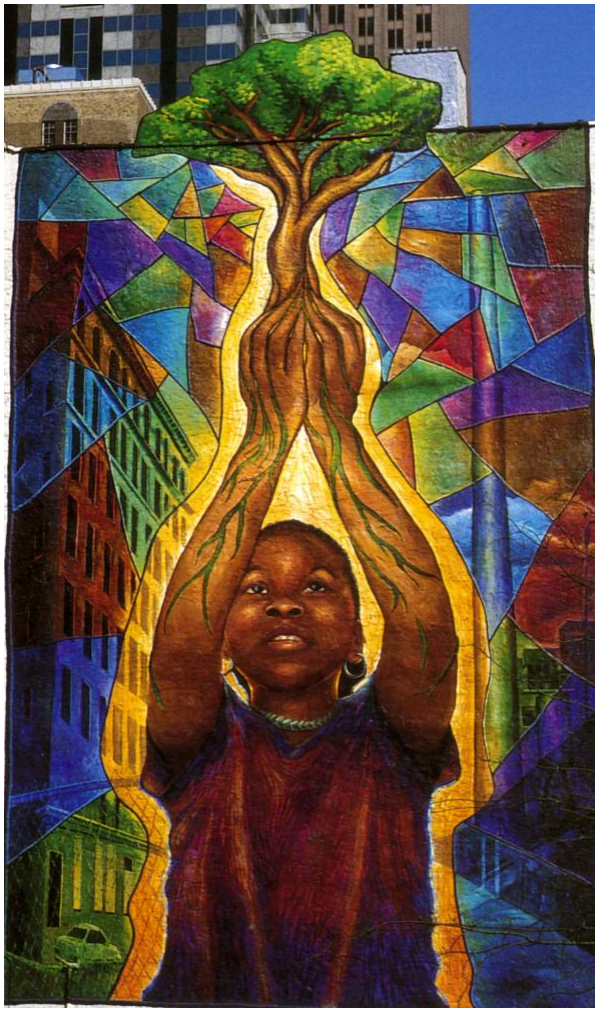
- Level of medical acuity
- Substance use severity
- Homeless situation
- Match between clients' needs and available on-site services
- Availability and match of a DAH unit

The Nurse Practitioner 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.

7. Behavioral Health Workforce Development

Service Category Overview

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 humble and 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 and programs designed to achieve WDET goals. Through Career Pathway Program (CPP) activities, the decision was made to sustain MHSA WDET activities, described below, with CSS funds. SF MHSA's goal is to develop a behavioral health pipeline to increase the number of individuals that are informed about, choose to prepare for, and are successful in entering and/or completing behavioral health training programs. This work involves collaboration between MHSA, BHS, SFUSD, City College of San Francisco, San Francisco State University, and CIIS.

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.

Behavioral Health Services (BHS) Trainings

Program Overview

The MHSA supports additional capacity in the BHS Training Unit to: support and coordinate training and technical assistance efforts for BHS 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.

FY 14-15 Highlights & Successes

The BHS Training Unit provided 95 trainings during FY14-15 covering a wide range of topics. Nineteen trainings on Transforming Stress and Trauma were conducted, involving over 1400 attendees. Twenty-four trainings focusing on Cultural Competency and Cultural Humility were conducted throughout the year, reaching over 700 attendees. Nine trainings on the new edition of the clinical diagnosis manual, DSM-V, were conducted, involving over 700 attendees. Four trainings on Motivational Interviewing provided information and support to over 100 attendees. A range of other trainings, covering topics such as Disaster Mental Health, Harm Reduction, Substance Use, and Ethics were also provided throughout the year.

Identifying Workforce Development Priorities: BHS Workforce Disparities Analysis

Consulting firm Learning for Action (LFA) conducted an analysis of a sample of medical (Medical Doctors and Nurse Practitioners (MD/NP) and masters level clinical – Masters in Social Work and Marriage and Family Therapy (MSW/MFT) providers in the San Francisco public mental health system of DPH Behavioral Health Services (BHS) 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, BHS leadership identified the need for providers to offer group treatment models of care. The result is the implementation of Seeking Safety and Wellness Management and Recovery (WMR) both being evidenced-based practices under SAMHSA.

Wellness Management and Recovery (WMR)

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 2014, BHS 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

BHS and Quality Management are working with Learning for Action (LFA) to evaluate the Wellness Management and Recovery (WMR) pilot, which is based on a SAMHSA developed model called Illness Management and Recovery (IMR). 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. The evaluation report of the pilot is expected to be released October 2015.

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

Program Overview

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.

Target Population

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.

FY13-14 Highlights and Successes

The AHWG Coordinator and its Steering Committee (including Subcommittees) provided over 400 hours of service of capacity building among youth and young adult provider networks, including coordinating meetings, an annual provider gathering, and ongoing individual meetings with providers. The Youth and Young Adult Behavioral Health Working Group (YYABHWG) also provided over 200 service hours focused on improving referrals and wrap-around services for TAY with significant behavioral and mental health needs. The AHWG Coordinator, in partnership with steering, subcommittee, and other stakeholder groups provided 400 service hours of planning and coordination that specifically addressed training and coaching needs for providers in order to improve young adult and adolescent health services.

Exhibit 22. FY13-14 Key Outcomes

- The AHWG Coordinator and its Steering Committee (including Subcommittees) provided over 400 hours of service of capacity building among youth and young adult provider networks.
- The Youth and Young Adult Behavioral Health Working Group (YYABHWG) provided over 200 service hours with the focus on improving referrals and wrap-around services for TAY with significant behavioral and mental health needs.
- For the FY 2013/2014 AHWG provided 200 service hours to research and promote best practices and policies for youth and young adults.

AHWG succeeded in distributing and disseminating the Trauma and Resilience Toolkit widely to several agencies in San Francisco and other Bay Area counties. More than 10 agencies within SF were given hard copies of the toolkit, and also disseminated educational resources through the web aimed at providers, adolescents, and parents/caregivers. They increased the usage and traffic to the agency website (www.ahwg.net), with 31 resources available via the website. Overall, the AHWG provided over 200 service hours committed to promoting existing and new resources and tools for providers.

12N LGBTQ Sensitivity Training for Providers (INN)

Program Overview

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.

Target Population

The 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 12N training was offered in two formats: 1) an in-person, group format with a facilitated discussion session, and 2) an online format for employees. Group discussions took place at program staff meetings or DPH-wide trainings (13 total sessions). Online participants accessed the training individually via the DPH training website. Six hundred and fifty-four (654) DPH staff members attended the group discussion training sessions, while 1,078 staff completed the online version.

FY13-14 Highlights and Successes

Survey results demonstrated an overall improvement in employees' sensitivity, knowledge and awareness to LGBTQ youth. In spite of high pre-test scores (above 70% for most questions), participants in both training formats increased their post-test scores by 4.2 percent points and showed improvement in 14 out of 17 total survey questions. Online participants had consistently higher average test scores than group participants. A possible reason for this difference may be that the online participants were able to control the video (i.e., replay the video), whereas the group participants viewed the video one time from start to finish.

The training also received overall high satisfaction scores, with online participants rating it lower than group participants. The majority of all participants (above 75 percent) rated the training as "excellent" or "good". However, the level of satisfaction for group participants was higher than for online participants. A possible reason for the lower level of satisfaction for online participants may be attributable to technical difficulties (i.e.,

Exhibit 23. FY13-14 Key Outcomes

- Developed a youth-inspired training video and materials on LGBTQ sensitivity issues
- Trained 1,732 city employees via group or online formats
- The majority of all participants (above 75 percent) rated the training as "good" or "excellent."

links to video/tests were not working properly and, as a result, some participants had to redo portions of the training).

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.

Trauma Informed Systems Initiative: Expanding Training and Technical Assistance

Program Overview

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.

FY 14-15 Highlights & Successes

The Trauma informed Systems initiative has produced over 45 live trainings for the DPH workforce, training just over 2,000 employees in the basics of trauma. Workforce trainings are offered twice a month to a cross section of DPH employees. 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

Moving Forward in FY15-16

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.

Street Violence Intervention and Prevention (SVIP) Program

On June 2, 2015, the SFDPH-funded Street Violence Intervention & Prevention (SVIP) Academy celebrated the graduation of its first cohort of 17 street outreach workers, coordinators and directors. Participants completed a nine-month long training program that focused on community mental health, trauma, vicarious trauma and trauma recovery; and this Academy's unique learning and application setting allowed the SVIP staff to build upon their already existing talents for working with and alongside of communities. The SVIP Professional Development Academy is built upon the core curriculum of the MHSA-funded Community Mental Health Certificate Program and has additional emphases on trauma, vicarious trauma and trauma recovery.

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.

Summer Bridge

Program Overview

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/BHS, 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.

Target Population

The program targets youth to receive Wellness promotion and education on topics such as Mindfulness, mental health/illness and the recovery model, identity/self-image, addiction (substance and gambling), and self-care. The program is a didactic and experiential introduction to these topics over the course of an 8-week program.

Exhibit 24. FY13-14 Key Outcomes

- After participating in the program, the majority of graduates agreed or strongly agreed with the statement, "I know how to refer family and/or friends for mental health support and/or services."
- 83 percent of Summer Bridge 2013 graduates indicated that they agreed or strongly agreed with the statement, "I have found role models in the health & human services field" at the end of year program evaluation.
- 78 percent of Summer Bridge 2013 graduates indicated that they agreed or strongly agreed with the statement, "I have people in my life whom I trust and can confide in" at the end of year program evaluation.

FY13-14 Highlights and Successes

A total of 48 youth received workforce development skills through participating in the Summer Bridge program. An additional 23 youth received workforce development skills in summer 2013 (July to August 2013) and 25 youth received workforce development skills in summer 2014 (June 2014) in the Summer Bridge program. As a result of the opportunities in Summer Bridge and Youth Council, participants and peer mentors have contacted the program coordinator throughout the year for letters of recommendation and referrals for job internships and positions.

Summer Bridge provided 3 hours of overview and 3 hours of reflection on topics of mental health/illness, mindfulness, self-care, identity, and addiction for a total of 36 hours of Wellness promotion activities over the course of the program. Additionally, the group participated in six field trips to explore these topics, resulting in another 18 hours of wellness promotion activities.

Community Mental Health Worker Certificate (CMHC)

Program Overview

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 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

Target Population

The program focuses on engaging people with lived experience with mental health services and their family members as mental health care workers.

FY13-14Highlights and Successes

During FY 13-14, CMHC recruited 76 students into the introductory course Health 91D - Introduction to Recovery and Wellness in Mental Health, exposing them to the wellness and recovery model in behavioral health and evaluating them for academic readiness. CMHC also conducted outreach and engaged communities and service delivery agencies to raise awareness about the wellness and recovery model in behavioral health and to educate employers about the contributions that individuals with lived experience bring to the workforce.

Supportive services, systems navigation and linkage to on and off campus service were provided to students and candidate students, which assisted with enrollment and registration, retention, success, and completion of course work, and graduation. The CMHC faculty and staff outreached and engaged community agencies to create new placement sites for students and developed partnerships with three new internship preceptors/community stakeholders. The program Director and Associate Director also initiated the production of four new films on the CMHC and wellness and recovery model in mental health. These will be used to outreach via electronic media as well as educational tools.

Exhibit 25. FY13-14 Key Outcomes

- During FY 13-14, 23 out of 25 students in cohort-3 graduated from the program, indicating a 92% rate of retention and success of program completion.
- Seventy of the 76 students enrolled in the Health 91D successfully completed the course, resulting in 92% rate of retention and success.
- Five out of the six participating agencies continue offering therapeutic drumming to their communities with reported success from each agency. As a result of the training, the participating service providers developed relationships which have influenced interagency collaboration and support.

During FY 13-14, as part of their internship, the Peer Career Mentors received weekly supervision and training from Dr. Sal Núñez. In turn the team provided wellness groups screening, assessment, action and educational planning, systems navigation, linkage, individual peer based counseling, group facilitation, trauma recovery informed education, and coaching to students in the Health Education Department. These services assisted in graduating 92% of the cohort-3 class, and successfully supported new students in socializing into the academic setting. Additionally, the PCM behavioral health specialist, and MFTI supervised by Dr. Núñez provided wellness and recovery based psychotherapy to over 15 students across the academic year.

The CMHC students, Peer Career Mentors, and faculty offered a series of workshops to the community, these included presentations at the SFDPH systems of care meetings with both, adult and older adult service providers and children, youth and families providers; at a CASRA conference, a trauma recovery conference, veterans group at Fort Maley, consumer groups, and preceptor sites. According to the data, the information and presentations assisted in shedding more light onto the wellness and recovery model in mental health, academic pathways in behavioral health, and the need of consumers in the field of professional behavioral health.

CMHC also offered two culturally affirming drumming circles were offered to the community at large, one in the Fall of 2013 and another in the Spring of 2014. Additionally, two groups were offered by the Peer Career Mentors, one group focused on wellness and recovery principles for family members (of consumers of mental health services), and another group focused on wellness and recovery principles for students in general.

Moving Forward in FY15-16

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.

Coordinator for BHS Staff Wellness

BHS clinical staff is subjected to immensely challenging life situations of the individuals who seek behavioral health services. Stories compounded by grief, loss, sadness, anger, anxiety, depression and turmoil are not foreign to BHS clinicians. Therefore, BHS is committed to providing the proper care for frontline staff who are at increased risk for burnout, compassion fatigue, depression, and other stress-related problems. In accordance with the Ambulatory Care goal to improve staff satisfaction, the DPH goal to develop a trauma informed system and the MHSA goal to promote wellness and recovery principles and practices, the position will help create peer support groups for clinical staff and develop training and education materials on self-care. The Coordinator will also promote prevention and protective practices among staff and link staff with needed resources.

Residency and Internship Programs

Psychiatry Fellowships

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. The goal of the UCSF Langley Porter Psychiatric Institute's Child and Adolescent Psychiatry Fellowship Program is 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.

Through this MHSA funded program, a partnership between the UCSF Child and Adolescent Psychiatry Training Program and San Francisco Health Network's Behavioral Health System allows Child and Adolescent Psychiatry Fellows to have a longitudinal clinical experience in Community Psychiatry. The fellows are placed in civil service clinics and intensive programs throughout San Francisco. They are closely supervised by San Francisco Health Network (SFHN) BHS Child and Adolescent Psychiatrists in providing psychiatric evaluations and treatment to children, adolescents and families. In FY13-14, a total of 45 clients were served by five fellows. Additionally, the fellows learn about the larger Children, Youth and Family, System of Care. The fellows work with a multilingual, multicultural, multidisciplinary team of providers in our clinics, and gain important skills working with diverse populations. Over the past five years, at least seven graduates have chosen to come and work for SFDPH, and many other fellows have pursued careers in Community Psychiatry in other California Counties.

Internship Program

The FY 13-14 MHSA budget includes a new BHS Internship Coordinator position, which is yet to be hired. As highlighted in the FY 13-14 Update, the new Coordinator will work with BHS 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 [BHS] clinics and its program sites. Duties for the position include the following:

- Plan a program design that will coordinate DPH-BHS internship opportunities and placements,
- Outreach to potential clinical supervisors throughout BHS
- Work with university/college graduate programs to develop and execute standardized-contracts between DPH-BHS clinics and program sites & the respective universities/colleges
- Work with DPH-BHS 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-BHS 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

Service Category Overview

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.

The 2014 – 17 Integrated 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. The plan also called for an annual investment of $500,000 in capital improvements, beginning in FY 14-15 with the South of Market Mental Health Center. The majority of the work for this project began in FY15-16.

Program Overview

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. The Integrated Plan called 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. Meetings have focused on gathering feedback and input on the decision-making in areas of planning and implementation, monitoring, quality improvement, evaluation and budget allocation.

Information Technology

As the 2014 – 2017 Integrated Plan discussed, 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. BHS has accomplished much of what was outlined in the initial plan. However, the BHS IT landscape has changed considerably the last five 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 BHS IT department has been integrated with the overall Department of Public Heath (DPH) wide IT department. The consolidation of the two departments has assisted with the coordination of projects and resources that will lead to better coordination in the delivery of services to clients. Clients have seen 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**: BHS 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. BHS 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. BHS is currently actively evaluating the timing for MU attestation with California State.

Implementation Update

The following provides highlights on three primary IT 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

DPH decided to move forward with the NetSmart Consumer Portal, which plans to launch in FY16-17. Current efforts include a scheduler that will be the primary source of collecting relevant data for clients. Roll-out efforts are pending and may include the implementation of kiosks.

The DPH Client Portal Project has also 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 department has postponed 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 **Consumer IT Support: Desktop and Help Desk** 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 BHS Administration Building. Accomplishments for this successful program include the following:

- Consumer employment programs have been a huge success for BHS. 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 BHS in the competitive job market.

Expanding Consumer Employment

SF MHSA has focused on further efforts to enhance basic IT infrastructure by hiring five graduates of BHS 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

An **MHSA Consumer Advocate** was hired in 2013 within the IT applications department. The advocate participates in the following activities: 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 BHS.

The department has also implemented **ePrescribing access** to additional licenses to ensure that all BHS prescribers use a single mode of prescription maintenance. There are currently one hundred prescribers and 202 non-prescribers.

eSignature pads were purchased that allow electronic signature capabilities to provide ready access to signed notices, consents and treatment plans for consumers and care providers. SF MHSA is planning a later deployment than had initially been anticipated.

IT Community Program Planning (CPP) Activities

BHS has provided 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 BHS IT Department has actively incorporated consumer input to continue to make improvements to the Vocational Program. The BHS IT Department conducted group exit interviews of graduates from the vocational program. These interviews provided 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.

Moving Forward in FY15-16

BHS will be hiring two front-line civil-service clinicians to assist SFHN-BHS central administration in implementing Avatar Scheduler at mental health outpatient programs (civil service and CBOs). Under the supervision of the Deputy Director of SFHN-BHS, the Implementation Coordinator will include the following job duties:

- Work as a member of the SFHN-BHS team (which includes BHS IT staff, BHS Administration and the MU Steering Committee members) to develop a plan and manage the end-to-end implementation process for the Avatar Scheduler.
- Work with clinic leadership to develop a realistic plan for each clinic to successfully adopt the use of the Scheduler that takes into account clinic culture and staff skill levels, and makes the transition as easy as possible with minimal complications.
- Coordinate the development and support implementation of staff training.
- Support clinic staff to ensure implementation is achieved on schedule.
- Manage communication with BHS administration and clinic staff.

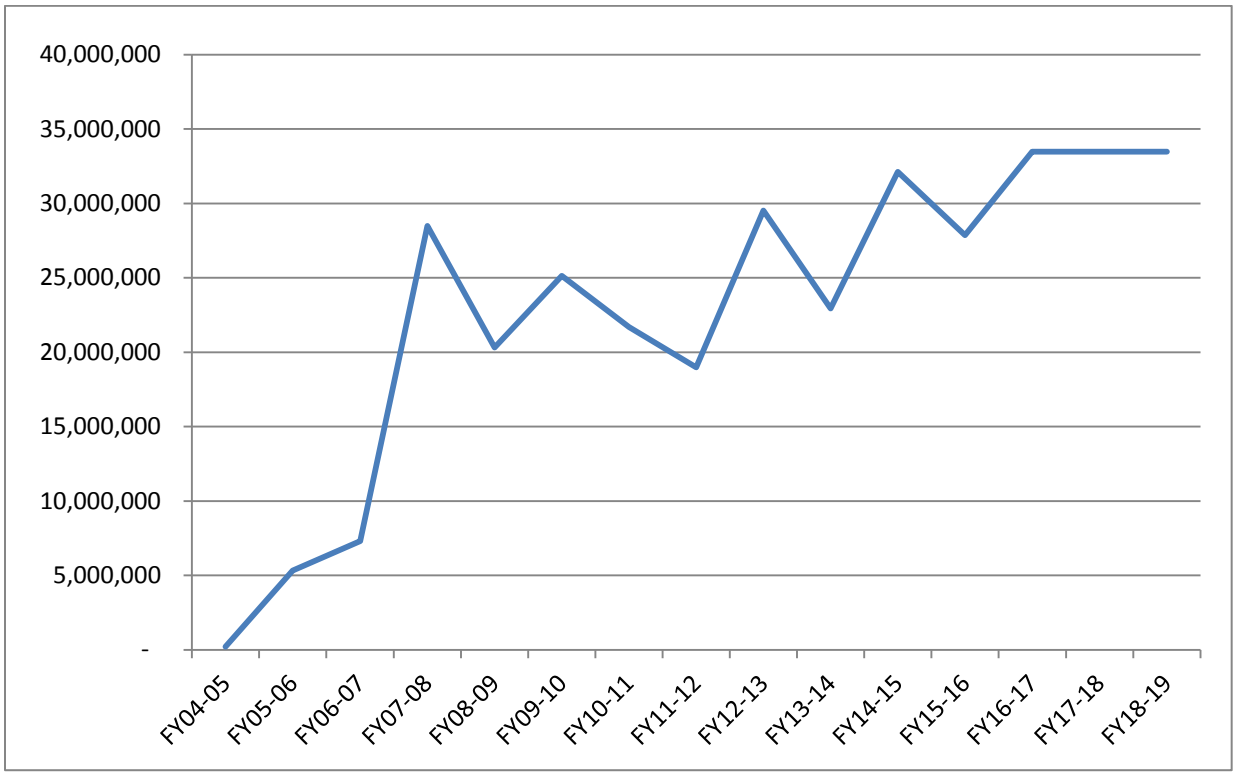
- Provide feedback to IT staff on technical and/or other implementation challenges to ensure that needs and concerns of affected clinic staff are addressed.
- Develop evaluation and feedback loop from BHS staff re: EHR use and planning.
- Support other planning and implementation activities related to the effective use of electronic health records

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 2018-19 suggest that MHSA revenue will level off (see Exhibit 26 below).

Exhibit 26. San Francisco MHSA Revenue by Fiscal Year

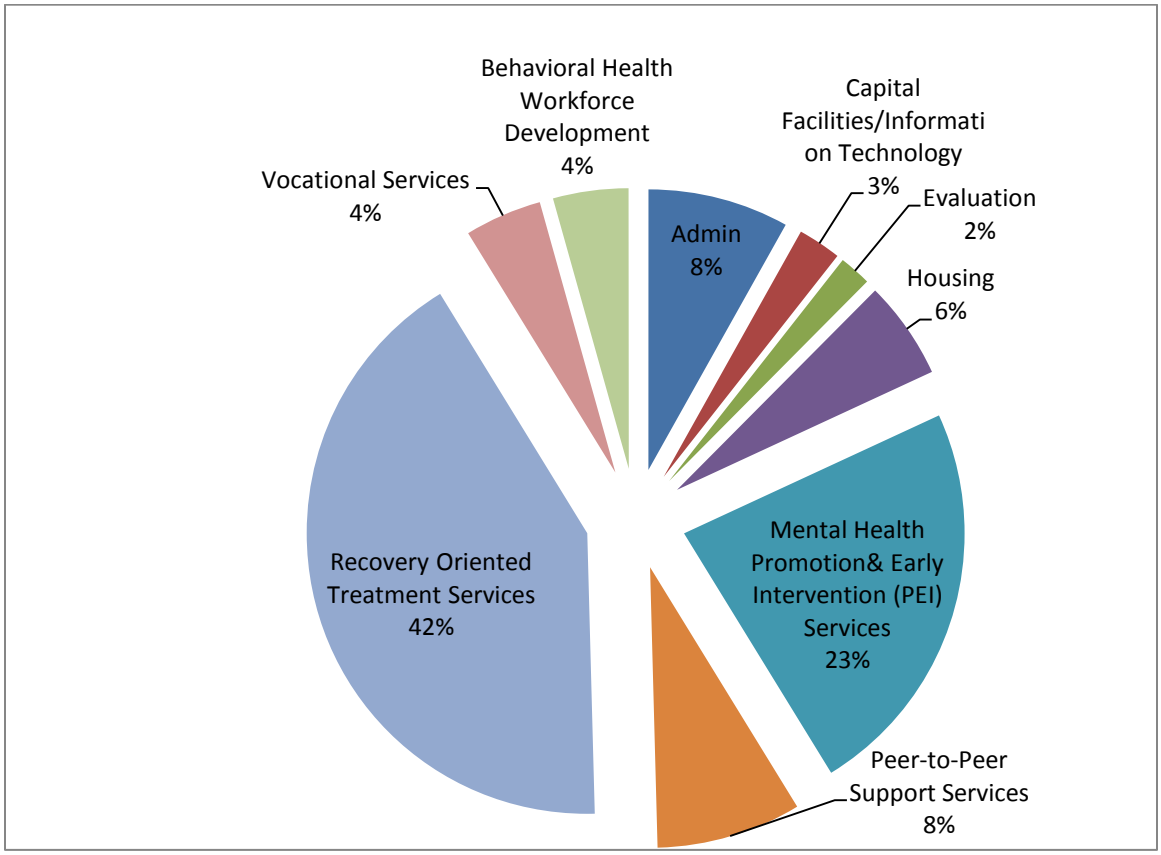
FY 15-16 and beyond are estimates based on State projection.



MHSA expenditures for FY 13-14 are estimated to be $27,513,825. Expenditures included one hundred FTE personnel (civil service) and 70 contracted programs with 46 organizations.

As shown in Exhibit 27, the majority of MHSA funds (42%) supported Recovery-Oriented Treatment Services followed by Mental Health Promotion and Early Intervention services (23%). MHSA funding was distributed to other service categories including Housing (6%), Peer-to-Peer Support services (8%), Behavioral Health Workforce Development and Training (4%), Vocational Services (4%), Admin (8%), and Evaluation (2%). All service categories included funding for INN-related projects.

Exhibit 27. FY 13-14 MHSA Expenditures by Service Category



The MHSA FY 13-14 expenditures breakdown of programs by funding component is located in Appendix A.

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, Community Behavioral Health Services (BHS). 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 2015-16 Annual Report that brings together all of the MHSA components.

We will continue to strengthen the integration of MHSA funded programs in San Francisco's public mental health system and further build a service approach that is culturally and linguistically responsive to the needs of children, transition age youth, adults, and older adults. We plan to better integrate our Trauma and Recovery Services for youth into our entire Child Youth and Families System of Care. We plan to expand the number of peers and family members working in our system by strengthening our Youth-to-Youth and Family-to-Family services. We also intend to better partner with stakeholders and consumers to create stronger linkages and referral relationships within our Recovery-Oriented Treatment Services. We will continue to increase the depth of clinical care and other services provided through our behavioral health clinics/programs and we will continue to strengthen the integration of Primary Care and Behavioral Health services. Lastly, we will continue to improve our monitoring and evaluation activities in order to effectively meet the outcome and performance objectives of our MHSA-funded programs.

Recently, the MHSA Director advanced into a role as the Deputy Director for Community Behavioral Health Services. In FY15/16, we plan to recruit and select a new MHSA Director that will continue to promote 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.

We will continue to reflect on all that we have learned thus far and continue to promote the principles of MHSA. 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.

11. Appendix A: MHSA Programs Expenditures by Funding Component

The table below details the MHSA FY 13-14 expenditures breakdown of programs by funding component.

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 13/14 Expenditures
	Community, Services and Supports (CSS) 80% of total MHSA revenue (after INN calculated) In FY 13-14, 57% was allocated to serve FSP clients	
RTS	CSS Full Service Partnership 1. CYF (0-5)	0
RTS	CSS Full Service Partnership 2. CYF (6-18)	$ 800,170
RTS	CSS Full Service Partnership 3. TAY (18-24)	$ 1,501,092
RTS	CSS Full Service Partnership 4. Adults (18-59)	$ 3,907,082
RTS	CSS Full Service Partnership 5. Older Adults (60+)	$ 686,427
RTS	CSS Full Service Partnership 6. AOT	0
H	CSS FSP Permanent Housing (capital units and master lease)	$ 583,468
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	$ 987,978
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	$ 931,770
RTS	CSS Other Non-FSP 3. Trauma Recovery	$ 442,982
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	$ 1,087,152
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	$ 362,802
RTS	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	$ 78,626
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (20% FSP)	$ 2,076,231
VS	CSS Other Non-FSP 8. Vocational Services (30% FSP)	$ 235,902
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	$ 272,824
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	$ 45,894
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	$ 649,320
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	$ 316,339
	CSS Admin	$ 1,583,728
	CSS Evaluation	$ 346,822
	SUBTOTAL Community Services and Support (CCS)	**$ 16,896,609**
	Workforce, Development Education and Training (WDET) $1.6 million of CSS transferred to WDET	
WD	WDET 1. Training and TA	$ 445,329
WD	WDET 2. Career Pathways	$ 482,415
WD	WDET 3. Residency and Internships	$ 268,868
	WDET Admin	$ 134,316
	WDET Evaluation	$ 25,465

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 13/14 Expenditures
	TOTAL	**$ 1,356,393**
	Capital Facilities/IT	
CF/IT	Cap 1. Silver Avenue FHC	$ 6,392
CF/IT	Cap 3. Sunset Mental Health	$ 157,124
CF/IT	Cap 4. IHHC at Central YMCA (Tom Waddell)	$ 91,180
CF/IT	IT 1. Consumer Portal	$ 84,753
VS	IT 2. Vocational IT (part of Vocational Services)	$ 511,530
CF/IT	IT 3. System Enhancements	$ 342,600
	IT Admin	$ 180,308
	TOTAL	**$ 1,373,887**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**$ 19,626,889**
	Prevention and Early Intervention (PEI) 20% of MHSA revenue (after INN calculated)	
PEI	PEI 1. Stigma Reduction	$ 179,057
PEI	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	$ 1,018,282
PEI	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	$ 302,235
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	$ 3,130,195
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	$ 1,105,086
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	$ 632,815
	PEI Admin	$ 142,812
	PEI Evaluation	$ 136,835
	TOTAL	**$ 6,647,317**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 7. Peer-Led Hoarding and Cluttering Support Team	$ 215,735
VS	INN 11. Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) (part of Vocational Services - VS)	$ 224,773
RTS	INN 12. Building Bridges Clinic/School of Linking Project	$ 358,942
VS	INN 14. First Impressions	$ 246,869
	INN Admin	$ 193,299
	TOTAL	**$ 1,239,619**
	TOTAL FY 13-14 MHSA Gross Expenditures.	**$ 27,513,825**
	MHSA Integrated Service Categories	

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 13/14 Expenditures
	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**

12. Appendix B: FY2014-15 through FY2016-17 Three-Year Mental Health Services Act Expenditure Plan

	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	15,873,900	3,235,186	3,884,261	0	2,572,119	
2. Estimated New FY2014/15 Funding	24,409,077	6,102,269	1,605,861			
3. Transfer in FY2014/15[a/]	(1,579,709)			1,579,709		
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	38,703,268	9,337,455	5,490,122	1,579,709	2,572,119	
B. Estimated FY2014/15 MHSA Expenditures	17,088,817	7,180,634	1,576,833	1,579,709	1,137,214	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	21,614,451	2,156,821	3,913,289	0	1,434,905	
2. Estimated New FY2015/16 Funding	21,172,059	5,293,015	1,392,899			
3. Transfer in FY2015/16[a/]	(1,875,265)			1,552,668	322,597	
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	40,911,244	7,449,835	5,306,187	1,552,668	1,757,502	
D. Estimated FY2015/16 Expenditures	19,055,865	7,180,634	1,876,069	1,552,668	1,757,502	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	21,855,379	269,201	3,430,119	0	0	
2. Estimated New FY2016/17 Funding	25,436,385	6,359,096	1,673,446			
3. Transfer in FY2016/17[a/]	(2,942,170)			1,552,668	1,389,502	
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	44,349,595	6,628,297	5,103,565	1,552,668	1,389,502	
F. Estimated FY2016/17 Expenditures	19,055,865	6,580,635	1,876,069	1,552,668	1,389,502	
G. Estimated FY2016/17 Unspent Fund Balance	25,293,730	47,663	3,227,496	0	0	

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)

		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)	0	$ -				
2.	CSS Full Service Partnership 2. CYF (6-18)	1,215,369	950,740	60,291			204,338
3.	CSS Full Service Partnership 3. TAY (18-24)	1,042,267	899,930	127,480			14,858
4.	CSS Full Service Partnership 4. Adults (18-59)	11,422,753	3,415,215	2,637,013	2,122,416	44,589	3,203,520
5.	CSS Full Service Partnership 5. Older Adults (60+)	1,020,610	772,656	225,150	7,404		15,400
6.	CSS FSP Permanent Housing (capital units and master lease)	574,252	574,252				
7.	Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,146,990	1,146,990				
8.	Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	149,643	149,643				
9.	Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	182,487	182,487				
10.	Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	39,856	39,856				
11.	Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	553,705	553,705				
Non-FSP Programs							
1.	CSS Other Non-FSP 1. Behavioral Health Access Center	889,746	713,023	176,723			
2.	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,220,448	1,145,676	64,615			10,157
3.	CSS Other Non-FSP 3. Trauma Recovery	461,940	437,317	13,467	113	11,043	
4.	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,099,384	945,731	153,652			
5.	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,489,868	541,048	1,262			947,558
6.	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	65,820	62,050				3,770

7.	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,351,903	1,233,392	3,504	244,235		870,773
8.	CSS Other Non-FSP 8. Vocational Services (45% FSP)	182,896	182,896				
9.	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	121,658	121,658				
10.	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	92,997	92,997				
11.	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	369,137	369,137				
12.	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	442,882	301,260	141,622			
CSS Administration		1,915,906	1,834,929				80,977
CSS Evaluation		422,228	422,228				
CSS MHSA Housing Program Assigned Funds		307,316					
Total CSS Program Estimated Expenditures		28,782,062	17,088,817	3,604,778	2,374,168	55,632	5,351,351
FSP Programs as Percent of Total		50.8%	estimated CSS funding over total CSS expenditures				

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS)

		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)	1,215,369	950,740	60,291			204,338
3.	CSS Full Service Partnership 3. TAY (18-24)	1,042,267	899,930	127,480			14,858
4.	CSS Full Service Partnership 4. Adults (18-59)	11,422,753	3,415,215	2,637,013	2,122,416	44,589	3,203,520
5.	CSS Full Service Partnership 5. Older Adults (60+)	1,020,610	772,656	225,150	7,404		15,400
6.	CSS Full Service Partnership 6. AOT	440,683	440,683				
7.	CSS FSP Permanent Housing (capital units and master lease)	924,248	924,248				
8.	Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,146,990	1,146,990				
9.	Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	312,793	312,793				
10.	Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	182,487	182,487				
11.	Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	39,856	39,856				
12.	Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	553,705	553,705				
Non-FSP Programs							
1.	CSS Other Non-FSP 1. Behavioral Health Access Center	1,071,239	894,516	176,723			

2.	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,220,448	1,145,676	64,615			10,157
3.	CSS Other Non-FSP 3. Trauma Recovery	471,940	447,317	13,467	113	11,043	
4.	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,364,899	1,199,946	164,952			
5.	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,489,868	541,048	1,262			947,558
6.	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	65,820	62,050				3,770
7.	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,287,508	1,168,997	3,503	244,235		870,773
8.	CSS Other Non-FSP 8. Vocational Services (45% FSP)	327,302	327,302				
9.	CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	121,658	121,658				
10.	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	92,997	92,997				
11.	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	369,137	369,137				
12.	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	442,882	301,260	141,622			
CSS Administration		2,003,406	1,922,429				80,977
CSS Evaluation		422,228	422,228				
CSS MHSA Housing Program Assigned Funds		307,316					
Total CSS Program Estimated Expenditures		30,760,410	19,055,865	3,616,078	2,374,168	55,632	5,351,351
FSP Programs as Percent of Total		52.7%	estimated CSS funding over total CSS expenditures				

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS)

		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)	1,215,369	950,740	60,291			204,338
3.	CSS Full Service Partnership 3. TAY (18-24)	1,042,267	899,930	127,480			14,858
4.	CSS Full Service Partnership 4. Adults (18-59)	11,422,753	3,415,215	2,637,013	2,122,416	44,589	3,203,520
5.	CSS Full Service Partnership 5. Older Adults (60+)	1,020,610	772,656	225,150	7,404		15,400
6.	CSS Full Service Partnership 6. AOT	440,683	440,683				
7.	CSS FSP Permanent Housing (capital units and master lease)	924,248	924,248				
8.	Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,146,990	1,146,990				
9.	Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	312,793	312,793				
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11.	Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	39,856	39,856				
12.	Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	553,705	553,705				
Non-FSP Programs							
1.	CSS Other Non-FSP 1. Behavioral Health Access Center	1,071,239	894,516	176,723			
2.	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,220,448	1,145,676	64,615			10,157
3.	CSS Other Non-FSP 3. Trauma Recovery	471,940	447,317	13,467	113	11,043	
4.	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,364,899	1,199,946	164,952			
5.	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,489,868	541,048	1,262			947,558

6.	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	65,820	62,050				3,770
7.	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,287,508	1,168,997	3,503	244,235		870,773
8.	CSS Other Non-FSP 8. Vocational Services (45% FSP)	327,302	327,302				
9.	CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	121,658	121,658				
10.	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	92,997	92,997				
11.	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	369,137	369,137				
12.	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	442,882	301,260	141,622			
CSS Administration		2,003,406	1,922,429				80,977
CSS Evaluation		422,228	422,228				
CSS MHSA Housing Program Assigned Funds		307,316					
Total CSS Program Estimated Expenditures		30,760,410	19,055,865	3,616,078	2,374,168	55,632	5,351,351
FSP Programs as Percent of Total		52.7%	estimated CSS funding over total CSS expenditures				

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI)

		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	190,338	190,338				
2.	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	612,138	612,138				
3.	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	192,855	192,855				
4.	PEI 4. Population Focused Mental Health Promotion & Early Intervention (50% Prevention)	2,488,090	1,742,158				745,932
5.	PEI 5.Mental Health Consultation & Capacity Building (75% Prevention)	2,792,285	770,084				2,022,201
6.	PEI 6. Comprehensive Crisis Services (10% Prevention)	63,253	63,253				
7.	PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention							
8.	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	612,138	612,138				
9.	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	192,855	192,855				
10.	PEI 4. Population Focused Mental Health Promotion & Early Intervention (50% Prevention)	2,488,090	1,742,158				745,932
11.	PEI 5.Mental Health Consultation & Capacity Building (75% Prevention)	930,762	256,695				674,067
12.	PEI 6. Comprehensive Crisis Services (10% Prevention)	569,277	556,140	13,137			
PEI Administration		149,823	149,823				
PEI Evaluation		0					
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		11,381,902	7,180,634	13,137	0	0	4,188,131

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI)

		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	190,338	190,338				
2.	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	612,138	612,138				
3.	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	192,855	192,855				
4.	PEI 4. Population Focused Mental Health Promotion & Early Intervention (50% Prevention)	2,488,090	1,742,158				745,932
5.	PEI 5.Mental Health Consultation & Capacity Building (75% Prevention)	2,792,285	770,084				2,022,201
6.	PEI 6. Comprehensive Crisis Services (10% Prevention)	63,253	63,253				
7.	PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention							
8.	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	612,138	612,138				
9.	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	192,855	192,855				
10.	PEI 4. Population Focused Mental Health Promotion & Early Intervention (50% Prevention)	2,488,090	1,742,158				745,932
11.	PEI 5.Mental Health Consultation & Capacity Building (75% Prevention)	930,762	256,695				674,067
12.	PEI 6. Comprehensive Crisis Services (10% Prevention)	569,277	556,140	13,137			
PEI Administration		149,823	149,823				
PEI Evaluation		0					
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		11,381,902	7,180,634	13,137	0	0	4,188,131

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI)

		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	190,338	190,338				
2.	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	512,138	512,138				
3.	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	92,855	92,855				
4.	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,488,090	1,742,158				745,932
5.	PEI 5.Mental Health Consultation & Capacity Building (75% Prevention)	2,692,285	670,084				2,022,201
6.	PEI 6. Comprehensive Crisis Services (10% Prevention)	63,253	63,253				
7.	PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention							
8.	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	512,138	512,138				
9.	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	92,855	92,855				
10.	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,488,090	1,742,158				745,932
11.	PEI 5.Mental Health Consultation & Capacity Building (75% Prevention)	830,762	156,695				674,067
12.	PEI 6. Comprehensive Crisis Services (10% Prevention)	569,277	556,140	13,137			
PEI Administration		149,823	149,823				
PEI Evaluation		0					
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		10,781,902	6,580,635	13,137	0	0	4,188,131

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN)

		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 11. WAIST Nutrition Project	277,338	277,338				
2.	INN 12. Building Bridges Clinic/School of Linking Project	265,515	254,215	11,300			
3.	INN 14. First Impressions	231,394	231,394				
4.	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	143,254	143,254				
5.	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	323,761	323,761				
INN Administration		202,663	202,663				
INN Evaluation		144,209	144,209				
Total INN Program Estimated Expenditures		1,588,134	1,576,833	11,300	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 11. WAIST Nutrition Project	277,338	277,338				
2.	INN 14. First Impressions	231,394	231,394				
3.	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	143,254	143,254				
4.	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	566,894	566,894				
5.	INN 17. Hummingbird Place - Peer Respite	297,817	297,817				
INN Administration		215,163	215,163				
INN Evaluation		144,209	144,209				
Total INN Program Estimated Expenditures		1,876,069	1,876,069	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN)

		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 11. WAIST Nutrition Project	277,338	277,338				
2.	INN 14. First Impressions	231,394	231,394				
3.	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	143,254	143,254				
4.	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	566,894	566,894				
5.	INN 17. Hummingbird Place - Peer Respite	297,817	297,817				
INN Administration		215,163	215,163				
INN Evaluation		144,209	144,209				
Total INN Program Estimated Expenditures		1,876,069	1,876,069	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET)

		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.	Training and TA	921,935	655,179	4,750			262,006
2.	Career Pathways	291,463	291,463				
3.	Residency and Internships	458,035	458,035				
WET Administration		145,203	145,203				
WET Evaluation		29,829	29,829				
Total WET Program Estimated Expenditures		1,846,465	1,579,709	4,750	0	0	262,006
		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
1.	Training and TA	821,747	554,991	4,750			262,006
2.	Career Pathways	364,610	364,610				
3.	Residency and Internships	458,035	458,035				
WET Administration		145,203	145,203				
WET Evaluation		29,829	29,829				
Total WET Program Estimated Expenditures		1,819,424	1,552,668	4,750	0	0	262,006
		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
1.	Training and TA	821,747	554,991	4,750			262,006
2.	Career Pathways	364,610	364,610				
3.	Residency and Internships	458,035	458,035				
WET Administration		145,203	145,203				
WET Evaluation		29,829	29,829				
Total WET Program Estimated Expenditures		1,819,424	1,552,668	4,750	0	0	262,006

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN)

		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.	Silver Avenue FHC/South East Child & Family Therapy Center	10,769	10,769				
2.	Redwood Center Renovation	157	157				
3.	Sunset Mental Health	57,202	57,202				
4.	IHHC at Central YMCA (Tom Waddell)	12,667	12,667				
5.	Southeast Health Center	0					
6.	South of Market Mental Health	0					
CFTN Programs - Technological Needs Projects							
11.	Consumer Portal	110,165	110,165				
12.	Vocational IT	577,581	577,581				
13.	System Enhancements	179,401	179,401				
CFTN Administration		189,273	189,273				
Total CFTN Program Estimated Expenditures		**1,137,214**	**1,137,214**	**0**	**0**	**0**	**0**

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN)

		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.	Silver Avenue FHC/South East Child & Family Therapy Center	0					
2.	Redwood Center Renovation	0					
3.	Sunset Mental Health	0					
4.	IHHC at Central YMCA (Tom Waddell)	0					
5.	Southeast Health Center	0					
6.	South of Market Mental Health	368,000	368,000				
CFTN Programs - Technological Needs Projects							
11.	Consumer Portal	110,165	110,165				
12.	Vocational IT	577,581	577,581				
13.	System Enhancements	512,483	512,483				
CFTN Administration		189,273	189,273				
Total CFTN Program Estimated Expenditures		1,757,502	1,757,502	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN)

		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.	Silver Avenue FHC/South East Child & Family Therapy Center	0					
2.	Redwood Center Renovation	0					
3.	Sunset Mental Health	0					
4.	IHHC at Central YMCA (Tom Waddell)	0					
5.	Southeast Health Center	0					
6.	South of Market Mental Health	0					
CFTN Programs - Technological Needs Projects							
11.	Consumer Portal	110,165	110,165				
12.	Vocational IT	577,581	577,581				
13.	System Enhancements	512,483	512,483				
CFTN Administration		189,273	189,273				
Total CFTN Program Estimated Expenditures		1,389,502	1,389,502	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