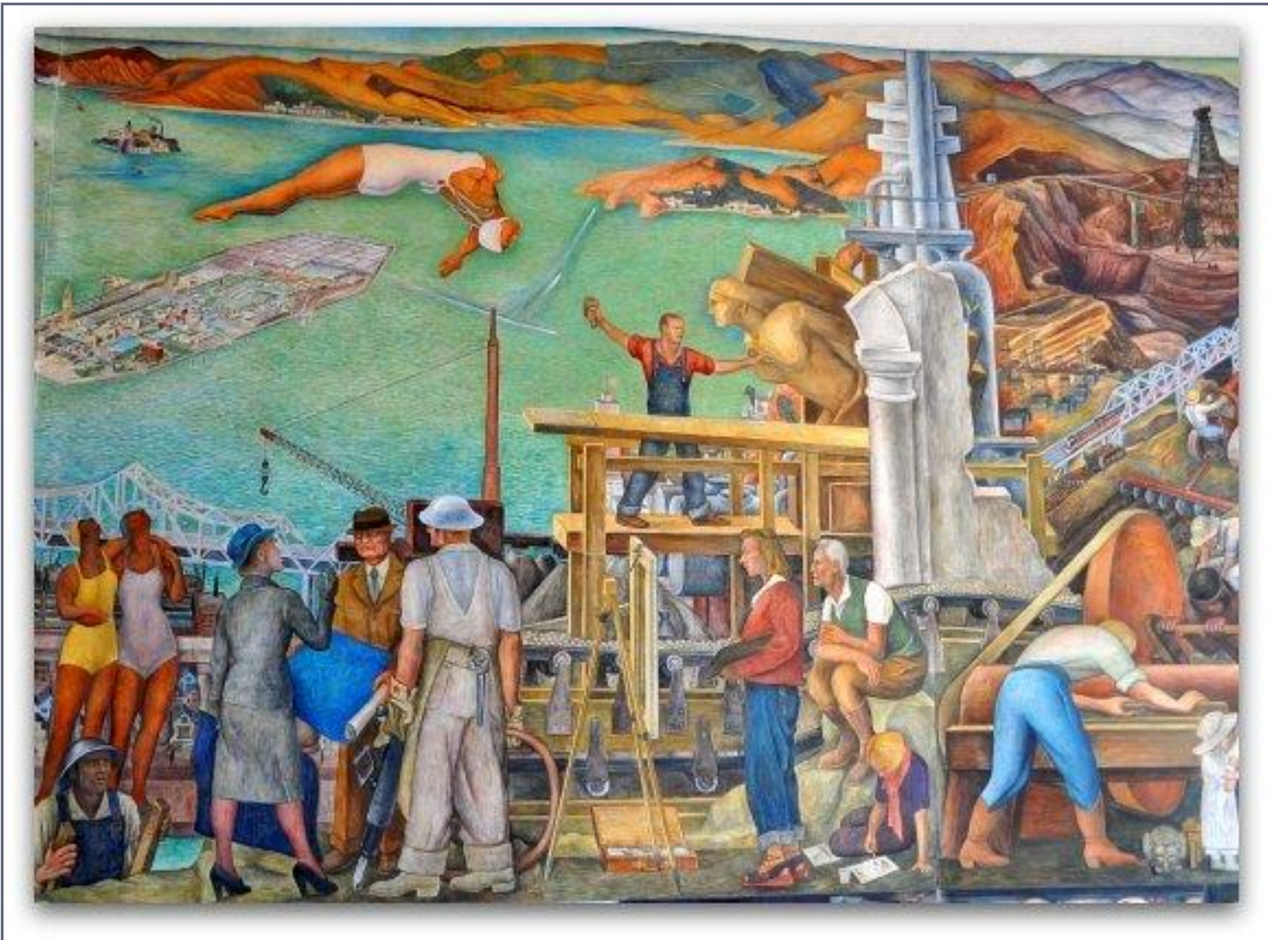
San Francisco Health Network
Behavioral Health Services

Mental Health Services Act (MHSA) 2019-20 Annual Update

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



"Pan American Unity" by Diego Rivera, City College of San Francisco Diego Rivera Theater.

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MHSA County Compliance Certification

County: **San Francisco County**

Local Mental Health Director	Program Lead
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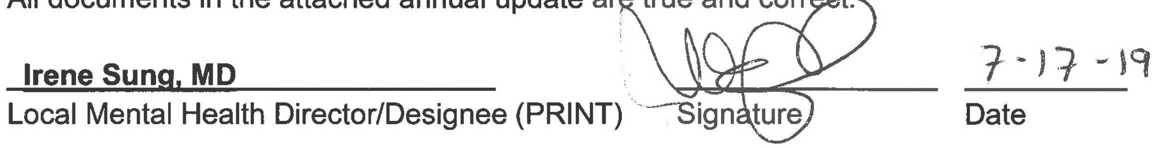
County Mental Health Mailing Address: 1380 Howard Street 5th Floor San Francisco, CA 94103	

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 **July 16, 2019**.

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.



Irene Sung, MD — 7-17-19
Local Mental Health Director/Designee (PRINT) Signature Date

County: **San Francisco County**

Date: 07-17-2019

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Francisco

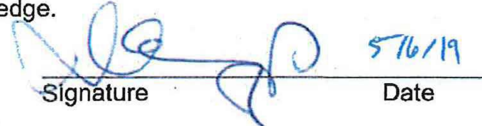
☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Irene Sung, MD	Name: Ben Rosenfield
Telephone Number: (415) 255-3742	Telephone Number: (415) 554-7500
E-mail: irene.sung@sfdph.org	E-mail: ben.rosenfield@sfgov.org
Local Mental Health Mailing Address: 1380 Howard Street 5th Floor San Francisco, CA 94103	

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

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

Irene Sung, MD
Local Mental Health Director (PRINT)

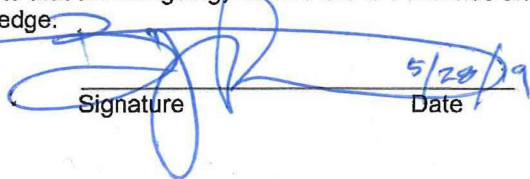


Signature   Date: 5/6/19

I hereby certify that for the fiscal year ended June 30, 2018, 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 3/25/2019 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2018, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Ben Rosenfield
County Auditor Controller / City Financial Officer (PRINT)



Signature   Date: 5/28/19

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

Director's Message

The Mental Health Services Act (MHSA) program in San Francisco continues to foster healthy communities through programs that increase mental health awareness, decrease stigma associated with mental illness and increase access to care. The principles that guide the MHSA program includes community collaboration, recovery & wellness, health equity, client & family member involvement, and integrated services promoting whole-person care.

This year's Annual Update outlines outcomes achieved in Fiscal Year (FY) 17-18 and highlights program plans for FY 19-20. In developing this report, the MHSA program held an array of stakeholder engagement meetings to ensure community involvement in program evaluation, planning and implementation.

A common theme with the stakeholder feedback we received revolves around the San Francisco Housing Crisis. This economic issue is a source of stress that impacts the wellbeing and health of parents, families and service providers. We recognize that this crisis should be at the core of the work being implemented by the Public Health Department. The innovative and dedicated staff in MHSA are working to address this issue and we believe you will find evidence of this throughout this report.

The MHSA program continues to provide services in various wellness categories including prevention, early intervention, vocational, housing, peer-to-peer, workforce development, information technology, and intensive case management services.

In support of the San Francisco Department of Public Health's (SF DPH) mission, the MHSA program is committed to protecting and promoting the health of all San Franciscans.

We look forward to the years ahead in partnership with our stakeholders and residents of San Francisco.

Dr. Irene Sung
Acting Director
SF Behavioral Health Services

Juan Ibarra, DrPH, MPH, MSW
Acting Director
SF Mental Health Services Act

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 percent of the vote statewide, San Francisco voted 74 percent in favor of the act. MHSA funding, revenue from a 1 percent 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.

WELLNESS • RECOVERY • RESILIENCE

As dictated by the law, the majority of MHSA funding that San Francisco receives is 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 percent of whom 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.

Proposition 63 also stipulates that 20 percent 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.

San Francisco MHSA has worked diligently to expand its programming. The following examples illustrate some of the many ways in which MHSA contributes to the wellness of the San Francisco community.

- MHSA created a Program Manager position to bridge the gap between SF-MHSA and the new Department of Homelessness and Supporting Housing (HSH). This position will monitor MHSA-funded housing programs and ensure that all MHSA regulations and principles are implemented appropriately.
- MHSA will work very closely with the San Francisco Department of Public Health (SFDPH) Behavioral Health Services (BHS)'s new Office of Equity, Social Justice and Multicultural Education in order to share resources and collaborate with programming.

- MHSA invests in the training, support, and deployment of peer providers throughout SFDPH. MHSA partners with local service providers, including the Richmond Area Multi-Services to brainstorm ways to better support the peer provider community.
- MHSA regularly conducts outreach to many different cultures and communities throughout San Francisco in effort to engage outreach workers, identify mental health-related needs in these communities, and provide information on population-specific services available in the City.

SF MHSA strongly promotes 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 ('the City') is a seven-by-seven square mile coastal, metropolitan city and county, located on the northern end of a peninsula that separates the San Francisco Bay from the Pacific Ocean. It is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. Though it is geographically small, it is the second most densely populated large city in the nation and fourth most populous city in the state at 884,363 people in 2017. Between 2010 and 2017, the San Francisco population grew by 10%, outpacing California's population growth of 6% during this same time period. By 2030, San Francisco's population is expected to grow to nearly 1,000,000.

A proud, prominent feature of San Francisco is its culturally diverse neighborhoods, where 112 different languages are spoken. Currently, over one-third of the City's population is foreign-born and 44% of residents speak a language other than English at home. However, over the past 50 years, there have been notable ethnic shifts, including a steep increase in the Asian/Pacific Islander population and decrease in the Black/African American population. Over the next decade, the number of multi-ethnic and Latino residents is expected to rise, while the number of Black/African American residents is expected to continue to decline.

Housing in San Francisco is in increasingly high demand due to the recent tech industry boom. At the same time, due to geographic and zoning constraints, supply for housing is severely limited. These and other factors led to San Francisco becoming the most expensive rental housing market in the nation in 2019. This housing crisis, as it is commonly referred to today, is compounded by extremely high costs of living (at nearly 80% higher than the national average). Approximately 7,500 homeless individuals reside in San Francisco. High costs of living have contributed to huge demographic shifts in the City's population over the past decade, including a dramatic reduction in Black/African American populations and in the number of families with young children.

Although San Francisco was once considered to have a relatively young population, it has recently experienced a decrease of children and families with young children. Today it has the lowest percentage of children among all large cities in the nation. The high cost of living, prohibitive housing costs, and the young, often childless, composition of tech industry workers are assumed to be the leading causes of this population flight. In addition, it is estimated that the population of individuals over the age of 65 will increase to 20% by 2030 (from 14% in 2010). 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 2016 San Francisco Community Health Needs Assessment located at https://www.sfdph.org/dph/files/hc/HCAgen/HCAgen2016/May%2017/2016CHNA-2.pdf.

Community Program Planning (CPP) & 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

The San Francisco MHSA planning process began in 2005 with then-Mayor Gavin Newsom's creation of a 40-member, citywide Behavioral Health Innovation (BHI) Task Force, which was headed by the San Francisco Deputy Director of Health.

The BHI Task Force was responsible for identifying and prioritizing the greatest mental health needs of the community and developing a Three-Year Program and Expenditure Plan to address these needs. 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, social support 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 California Department of Mental Health in November 2005 and approved in March 2006.

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

- **Workforce Development, Education, and Training (WDET)** planning meetings were held for eight months from April to December 2007. The Plan was submitted in March 2008 and approved in September 2008.

- **Prevention and Early Intervention (PEI)** planning meetings were held for six months from January 2008 to July 2008. The Plan was submitted to both the Department of Mental Health and the Mental Health Services Oversight and Accountability Commission (MHSOAC) for their review and approval in February 2009. The plan was approved in April 2009.

- **Capital Facilities and Information Technology** planning processes were held separately. The Plan for the Capital Facilities component was submitted in April 2009, after a series of three community planning meetings held in February 2009. The Information Technology component CPP involved two informational meetings and six community planning meetings from November 2008 to April 2009. The Plan was submitted in March 2010 and was approved in August 2010.

- **Innovation (INN)** community meetings were held from April through August 2009. The Plan was submitted in March 2010 and approved in May 2010.

Community Program Planning (CPP) & Stakeholder Engagement Activities

Exhibit 1 provides an overview of San Francisco's ongoing CPP activities. San Francisco 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 process provides a number of opportunities for stakeholders to participate in the development of our three-year plans and annual updates, and stay informed of our progress in implementing MHSA-funded programs.

Exhibit 1. Key Components of MHSA CPP

Component	Activities
Communication Strategies	• SF BHS DPH MHSA website • Monthly BHS Director's Report • Stakeholder updates
Advisory Committee	• Identify priorities • Monitor implementation • Provide ongoing feedback
Program Planning and Contractor Selection	• Assess needs and develop service models • Review program proposals and interview applicants • Select most qualified providers
Program Implementation	• Collaborate with participants to establish goals • Peer and family employment • Peer and family engagement in program governance
Evaluation	• Peer and family engagement in evaluation efforts • Collect and review data on participant satisfaction • Technical assistance with Office of Quality Management

In addition to the CPP activities listed in Exhibit 1, MHSA host a number of activities and events throughout the year to promote mental health awareness.

In honor of "May is Mental Health Awareness Month," SF DPH BHS' Stigma Busters worked with the City of San Francisco to light up San Francisco City Hall green on May 10, 2018, as lime green is recognized as the official color of mental health awareness. Also in honor of Mental Health Awareness Month, MHSA sponsored the *Peer Panel Forum: A discussion with RAMS, Mental Health Association of San Francisco, and National Alliance on Mental Illness* at the San Francisco Main Public Library in May 2018.

The SF DPH BHS Stigma Busters also campaigned in honor of Suicide Prevention Week (September 9-15, 2018) and World Suicide Day (September 10, 2018). Stigma Busters disseminated Each Mind Matters' "Know the Signs" campaign materials to providers and community members. The materials educated the public about how to identify the signs of suicide and what resources are available to those in crisis. For the first time, local businesses, such as The Market, Cumaica, and Gallery Café partnered with BHS' Stigma Busters and distributed a total of 800

“Know the Signs” coffee sleeves and drink coasters to spread the word. Slice of Life Café at 1380 Howard also supported the campaign again this year.

These events help spark conversations about mental health needs and increase awareness of wellness and recovery services in our community.

MHSA Communication Strategies

San Francisco Department of Public Health seeks to keep stakeholders and the broader community informed about MHSA through a variety of communication strategies, including the SF BHS MHSA website, regular communication with community groups, contributing content to the monthly Community BHS Director’s Report, and providing regular updates to stakeholders.

The San Francisco MHSA webpage on the SFDPH website, https://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp, 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 webpage hosted now through the San Francisco Department of Public Health 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 program materials presented at the SFDPH Transitional Age Youth 2018 Launch Event

MHSA Advisory Committee & Our Commitment to Consumer Engagement

MHSA Advisory Committee

The 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
- Hold meetings every two months
- Encourage community participation at meetings

The MHSA Advisory Committee's robust recruitment efforts focuses on engaging members from the mental health community, with an emphasis on the following underrepresented community members: those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of over 25 active members.

For FY18-19, the MHSA Advisory Committee meeting schedule is as follows: 8/15/18; 10/17/18; 12/19/18; 3/13/19; and 6/12/19. The purpose of these meetings is to gather Committee member feedback on MHSA programming and the needs of priority populations. Topics for these meetings include, but are not limited to, the following:

- CPP for MHSA activities and the FY18-19 Annual Update
- INN planning for potential new learning projects
- 2018 Vocational Summit planning
- Transition Age Youth System of Care activities
- Intensive Case Management to Outpatient Flow INN Project
- Full Service Partnership (FSP) planning
- Hummingbird Place Peer Respite INN learning project
- Request for Proposals (RFPs) planning
- Annual Consumer, Peer and Family Conference
- Annual MHSA Awards Ceremony
- PEI and INN regulations and reporting protocol
- New SF-MHSA Electronic Reporting System
- Highlights and Spotlight programs
- No Place Like Home initiative
- MHSA evaluation efforts

Increasing Consumer Engagement

MHSA has been working to foster a stronger collaboration with the BHS Client Council. The Client Council is a 100 percent 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, advocate their issues, and ensure their participation in 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.

In FY18-19, the Client Council expanded its membership, provided input to MHSA on the development and implementation of several INN projects, provided feedback on the BHS Electronic Patient Health portal design, and advocated to make the Electronic Patient Health portal more responsive to consumers' needs. In addition, The Client Council decided to incorporate Stigma Busters as a standing committee of the Council to ensure that the group's vital work engaging the community in anti-stigma and mental health awareness activities remains strong even with the transition of some key members.

Strengthening Relationships

MHSA engages with various oversight bodies, including the SF Mental Health Board and the Health Commission, to gather feedback and guidance. Support from these groups helps facilitate MHSA programming and ensures that these services fit into the MHSA System of Care. The relationship between MHSA and these groups provide an ongoing channel of communication and support.

MHSA partners with the SF Mental Health Board in order to gather valuable feedback regarding all MHSA strategies, including policy development, program development, implementation, budgeting and evaluation. The SF Mental Health Board has been closely involved since the initial development of MHSA in San Francisco. They have been an instrumental component of our Community Planning Process over the years. The Board works as an oversight body to provide education to MHSA leadership teams and to ensure that the needs of the community are met. MHSA provides updates to the Board at every monthly board meeting in order to keep them abreast of new developments and activities. The Board includes special active members as well as members with personal lived experience with the mental health system. The SF Mental Health Board members are strong advocates for Full-Service Partnership programs and their consumers and they help to safeguard against duplicated activities and services.

MHSA has also recently increased collaborative efforts with the Health Commission by presenting new MHSA strategies and collecting feedback from this valuable oversight body. MHSA has also started presenting before the Integration Steering Committee to collect additional input on MHSA activities before presenting to the full Health Commission.

Recent Community Program Planning Efforts

Community Program Planning (CPP) in the MHSA 2017-2020 Plan

As part of the 2017-2020 MHSA Program and Expenditure Plan, SF DPH conducted extensive community outreach and engagement activities across the City and County. These community outreach and engagement efforts were critical in guiding MHSA program improvements and planning for future programming.

In addition to including the community input and program feedback in the 2017-2020 MHSA Program and Expenditure Plan, MHSA published a separate 2017 Community Program Planning Report. This report provides a comprehensive summary of our community outreach and engagement efforts, as well as our plans to integrate community feedback into MHSA programming. The report was circulated to the eleven San Francisco neighborhoods and settings in which we hosted engagement meetings, the greater San Francisco community, and other local collaborative partners and stakeholders. This report can also be found on the SF DPH MHSA website at https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/MHSA-CPP-Report-2017.pdf

SF DPH remains committed to conducting community outreach and engagement to ensure consumers have the appropriate wellness tools and resources to support them in their recovery journey.

2018 CPP Meeting in the SF Bayview District.

Community and Stakeholder Involvement

SF DPH has strengthened its' MHSA program planning by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In Fiscal Year 2018-19, **MHSA hosted 23 community engagement meetings across the City** to collect community member feedback on existing MHSA programming and better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders. In recent years, the MHSA team identified certain groups that had not been involved in previous CPP. We are happy to report that we have since increased our outreach efforts to include more involvement with certain stake holder groups, including local veterans, Transition Age Youth, vocational program participants, the Older Adult community, the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) community, and law enforcement.

> *"Let's help people connect to family members and support clients in strengthening relationships to loved ones."*
>
> \- Community Member

All meetings were advertised on the SFDPH website and via word-of-mouth and email notifications to providers in the SF BHS, MHSA, and San Francisco Health Network distribution networks. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed.

The FY18-19 CPP meetings are listed in the following table.

FY2018-19 Community Program Planning (CPP) Meetings	
Date	**CPP Location**
June 13, 2018	Combined SF-MHSA Provider and Advisory Meeting 1380 Howard Street, San Francisco, CA, 94103
July 17, 2018	Full Service Partnership (FSP) Outcomes & Evaluations Meeting Child, Youth and Families FSP Program Directors and/or Staff 1380 Howard Street, San Francisco, CA, 94103
July 30, 2018	Roadmap To Peace (RTP) Meeting on Workforce Development for RTP Youth & TAY 5128 Mission-First Floor-Room, San Francisco, CA 94112
August 2, 2018	Impact Meeting - MHSA Providers (Non-FSP) 1380 Howard Street, San Francisco, CA, 94103
August 15, 2018	SF-MHSA Advisory Meeting 1380 Howard Street, San Francisco, CA, 94103
August 16, 2018	Roadmap To Peace (RTP) Meeting on Workforce Development for RTP Youth & TAY 1380 Howard Street, San Francisco, 94103
August 24, 2018	Full Service Partnership (FSP) Outcomes & Evaluations Meeting FSP Program Directors and/or Staff 1380 Howard Street, San Francisco, CA, 94103

FY2018-19 Community Program Planning (CPP) Meetings	
Date	**CPP Location**
September 12, 2018	Mental Health Services Act (MHSA) Provider Meeting Contracted & Civil services Providers of MHSA Services 25 Van Ness, San Francisco, CA, 94102
September 21, 2018	Impact Meeting MHSA Providers (Non-FSP) 1380 Howard Street, San Francisco, CA, 94103
October 16, 2018	CPP Presentation at BHS Client Council Meeting Client/Consumer Advisory Board 1380 Howard Street, San Francisco, CA, 94103
October 17, 2018	SF-MHSA Advisory Meeting 1380 Howard Street, San Francisco, CA, 94103
November 9, 2018	Full Service Partnership (FSP) Outcomes & Evaluations Meeting FSP Program Directors and/or Staff 1380 Howard Street, San Francisco, CA, 94103
November 30, 2018	San Francisco Community Health Center Meeting Transgender Women of Color 730 Polk St, San Francisco, CA 94109
December 10, 2018	Department of Rehabilitation (DOR) Cooperative Meeting Co-op Partners 455 Golden Gate Avenue, San Francisco, 94102
December 12, 2018	YMCA Bayview's Black/African American Wellness & Peer Leadership (BAAWPL) Meeting YMCA Bayview BAAWPL Staff 1601 Lane Street, San Francisco, CA, 94124
December 13, 2018	Tenderloin Neighborhood Development Corporation (TNDC) & Kelly Cullen Community Property Management & Operations Meetings 145 Taylor Street, San Francisco, CA, 94102
December 14, 2018	Full Service Partnership (FSP) Outcomes & Evaluations Meeting FSP Program Directors and/or Staff 1380 Howard Street, San Francisco, CA, 94103
December 19, 2018	Combined SF-MHSA Provider and Advisory Meeting 1380 Howard Street, San Francisco, CA, 94103
January 7, 2019	Curry Senior Center CAP Meeting Curry's Consumer Advisory Panel (CAP) 315 Turk Street, San Francisco, CA, 94102
February 19, 2019	Children Youth and Families System of Care Providers Meeting 25 Van Ness, San Francisco CA 94103
February 22, 2019	Richmond Area Multi-Services (RAMS) Leadership Academy Peers (Consumers of Mental Health Services)
March 5, 2019	Excelsior Family Connections Spanish Speaking Families & Staff Meeting 60 Ocean Avenue, San Francisco, CA 94112
March 5, 2019	Asian & Pacific Islander Mental Health Collaborative Community Program Planning Meeting 1380 Howard Street, San Francisco, CA, 94103

In each of the community meetings, MHSA staff presented an overview of the Mental Health Services Act, including its core components, guiding principles, and highlights of existing programs and services. Staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health needs and strategies to address these needs. These discussions also addressed how DPH can improve existing MHSA programming. Feedback from community members at the meetings were captured live, on flip charts and via transcription, in effort to maintain a high-level of transparency. MHSA staff addressed how the feedback would be incorporated into the MHSA 2019-2020 Annual Update and inform future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the MHSA 2019-2020 Annual Update.

Community and Stakeholder Feedback

The feedback and input shared by our community stakeholders is under careful review and consideration by MHSA leaders and staff. This valuable feedback will be used to guide and refine MHSA-funded programming.

> *"San Franciscans need jobs that pay a living-wage. People should not have to work multiple jobs and neglect their children in order to just barely scrape by."*
>
> -MHSA Stakeholder

Community and stakeholder feedback in FY18-19 was scheduled around existing community meetings with service providers, the MHSA Advisory Committee, and other partners. Community feedback collected in recent years continues to frame MHSA outreach and engagement efforts. For example, as noted in the MHSA 2017-20 Three Year Plan, and in the MHSA FY18-19 Annual Update Report, housing and homelessness is one of the greatest issues facing San Franciscans. Since housing and homelessness is a key influence of public health and so greatly affects one's mental health, MHSA remains committed to collaborating with the community on how we can address these overwhelming issues. As such, the key findings below focus on housing as a need in San Francisco. Similarly, MHSA community outreach and engagement in FY18-19 focused on the needs of socially isolated senior citizens, Transition Age Youth, Black/African American communities, and LGBTQ+ populations.

As the issue of affordable housing in San Francisco is ongoing and relentless, service providers are sharing more about how difficult it is to staff mental health service provider positions. Service providers are expected to "move mountains" with regard to addressing housing instability, gentrification, substance abuse, and compounded mental health issues. And it is becoming increasingly difficult for the providers themselves to be able to afford to live and work in San Francisco and the surrounding Bay Area. Furthermore, even traveling to work is becoming increasingly dangerous for some who work with vulnerable populations, as community violence and other health hazards pose threats. These are issues felt by the San Francisco community in general, but it is evident the public workers, educators, and health workers are particularly challenged due to the stress involved in working with vulnerable populations who are facing insurmountable obstacles and the limited funding that is available to support this type of work.

> *"It is difficult to fill vacant mental health professional positions and even more difficult to find folks who are from diverse communities."*
>
> -Community Member

The below feedback was collected from service providers, SFDPH consumers, community members, and other stakeholders in FY18-19. As described above, the conversations that solicited this feedback was designed on feedback collected in recent years and MHSA went directly to service providers, consumers, and stakeholders who work with these specific populations to ask for their perspective and suggestions on MHSA programming and the needs of our community. For this reason, the feedback below is organized into different categories based on the setting in which the feedback was solicited, however, many of these points could be and are considered at a higher, more general, level by the SFDPH BHS MHSA leadership and program staff.

Needs of Socially-Isolated Senior Citizens

- Seniors need transportation supports as they cannot walk the hills of San Francisco and, more and more, public transportation poses health and safety risks.
- Community members continue to see a need for support for socially isolated seniors in SROs and have seen how the "Addressing the Needs of Socially Isolated Older Adults" program has been effectively meeting important needs in the community. Stakeholders advocated that this project continue.

Needs of Transition-Age Youth (TAY)

- Students need transportation supports – MUNI and BART passes – and assistance or waivers to purchase school supplies
- TAY need positive adult role models and mentors.
- TAY housing needs more trained, clinical staff.

Needs of LGBTQQ Populations

- There are not enough services for Trans women. Women and gay men are always lumped into categories with Trans women.
- There are not enough drop-in hours at service centers. There should be more groups and services offered later in the day.
- Services for LGBTQ+ are focused on HIV, not on life skill development.
- Service providers need training on serving transgender communities. Service providers need to understand where and when trainings are available to them.
- There is a continued gap and need for programs specifically focused upon the specific needs of the Transgender community, like the Transgender Pilot Project (TPP). Community members advocated that this project continue.

Needs of Black/African American Communities

- There is a need for more culturally-relevant ways of healing.
- There is a need for rapid response service to African American communities, specifically for mental health-related issues so that issues to not escalate to violence. This is especially true when the police have to be called.
- SF Housing Authority discriminate against African American families through policy.
- A lack of employment opportunities for Black men affects their families.
- We need cultural (not clinical) healers. A lot of African Americans have Native Ancestry too. There are not a lot of mental health services in the African American or Indigenous realm of healing practices.

Needs of Homeless Populations and Needs Related to Permanent Supportive Housing (PSH)

- There needs to be more agencies doing outreach with homeless populations. The majority of agencies that are supposed to be doing outreach with homeless populations are just moving people from one place to another.
- Homelessness is increasing everywhere! Everyone is asking service providers where they can get housing supports and providers have no resources to share.
- Some of the policies around public and affordable housing are unnecessarily restrictive and create a more stressful living environment. Public Housing policies that hurt families include:
    - policies that dictate the number of visitors allowed
    - policies that dictate how many times a visitor may visit
    - policies that dictate how many days a visitor can stay in the unit
    - restrictions on hanging up holiday lights
- Gentrification causes stress and exacerbates mental health issues.
- PSH buildings should have medical staff on-site.
- PSH residents need to be connected to Intensive Case Management services.
- Substance use and mental health issues affect people's housing stability.
- Program staff need training on how to handle all the issues that are facing FSP clients who don't know how to get along with others or follow the rules.
- "We are here fighting over crumbs. The people in power don't care about the homeless - so they just move them to some other corner of the city and the budget goes elsewhere."
- Eviction from supportive housing is not addressed as much as it should be. MHSA works hard to get clients into supportive housing but not hard enough to keep them there and keep them successful. Intersectionality of services can help with this. The collaboration of on-site housing staff and FSP providers works well to help people retain housing.
- With Coordinated Entry System, there will be another case manager to deal with clients' housing stabilization. That means one person could have three case managers - it is important to clarify roles and responsibilities,

> *"We need to address the larger issues of income inequality and poverty within the issue of homelessness."*
>
> -Community Member

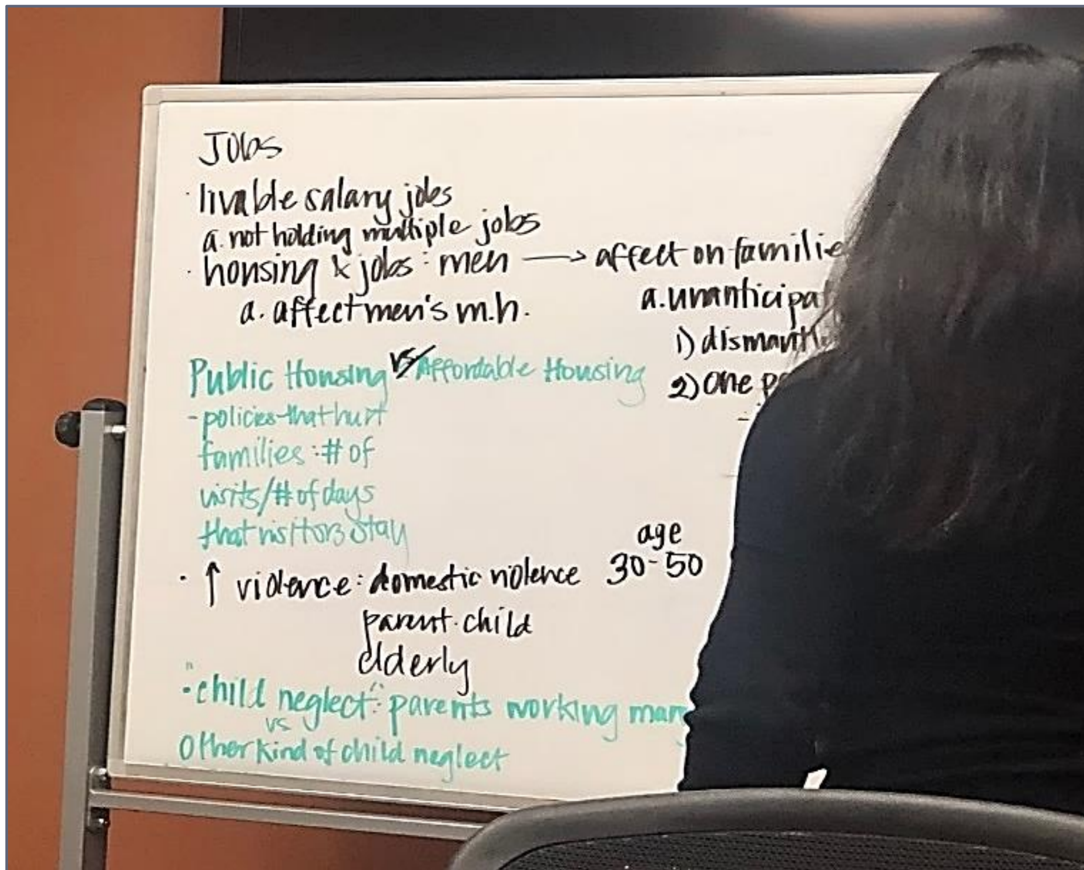
Other Mental Health-Related Needs of San Franciscans

- Service providers advocated for continued support for the Community Health/Mental Health Worker Program at San Francisco City College to provide opportunities for youth who are (1) interested in working in health and (2) interested in working with SFDPH.
- Community feedback from the Client Council and other stakeholders noted that the First Impressions program (an MHSA-funded vocational rehabilitation program for clients interested in building maintenance, construction, and remodeling) "could be beneficial for people who want to go into building maintenance, basic construction, or remodeling" and it could also "help people develop soft skills." Stakeholders advocated that this project continue in some form or another.
- Many stakeholders noted the value of an Online Learning System that could be available as a training tool for the BHS workforce. They recommended a tool that could assist with the onboarding of new staff, provide Continuing Education Units for licensed staff, and help increase access to valuable training materials. Several stakeholders expressed that it would be useful to have an online learning system since there are many barriers to holding live trainings (i.e. limited availability and access issues).

Feedback that was Consistent in Previous Years

While most of the community feedback was new and innovative, we did find common themes in comparison to the CPP feedback provided in previous years. We find it important to analyze input provided in the past to determine our progress of meeting the needs of the community and to determine a plan for addressing unmet needs. The feedback below includes themes similar to the previous year.

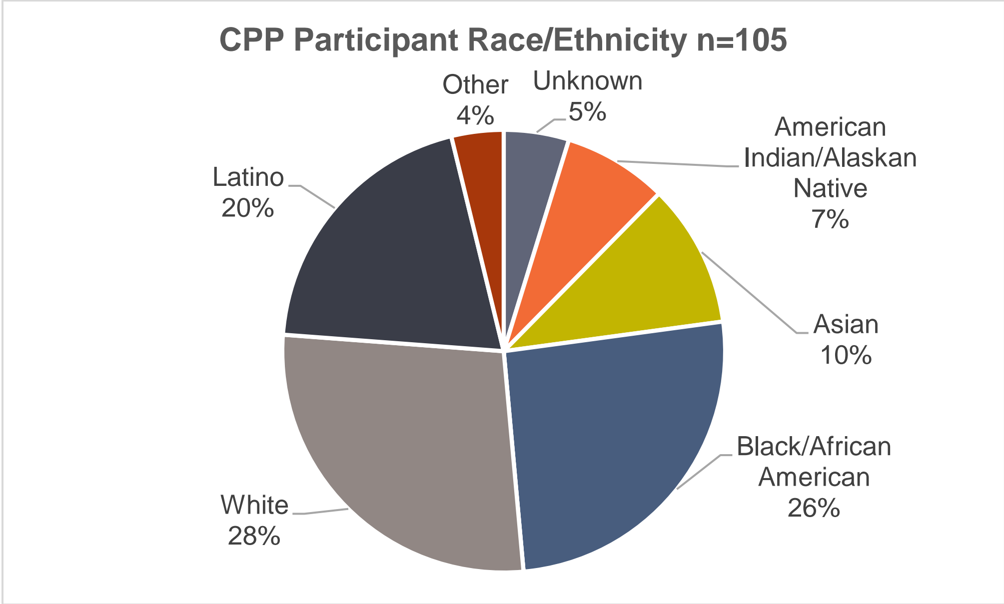
- The need for safe and stable (affordable) housing, particularly for those with serious mental illness, TAY, and older adults.
- The need for community education and stigma reduction around behavioral/mental health needs, particularly cultural and linguistic needs.
- The need for a clear understanding of what behavioral/mental health (MHSA-funded) programs and services already exist.
    - The DPH website is difficult to navigate and should include a Directory of Service Providers that is routinely updated so that consumers and service providers can understand what services are currently offered/where they are available.

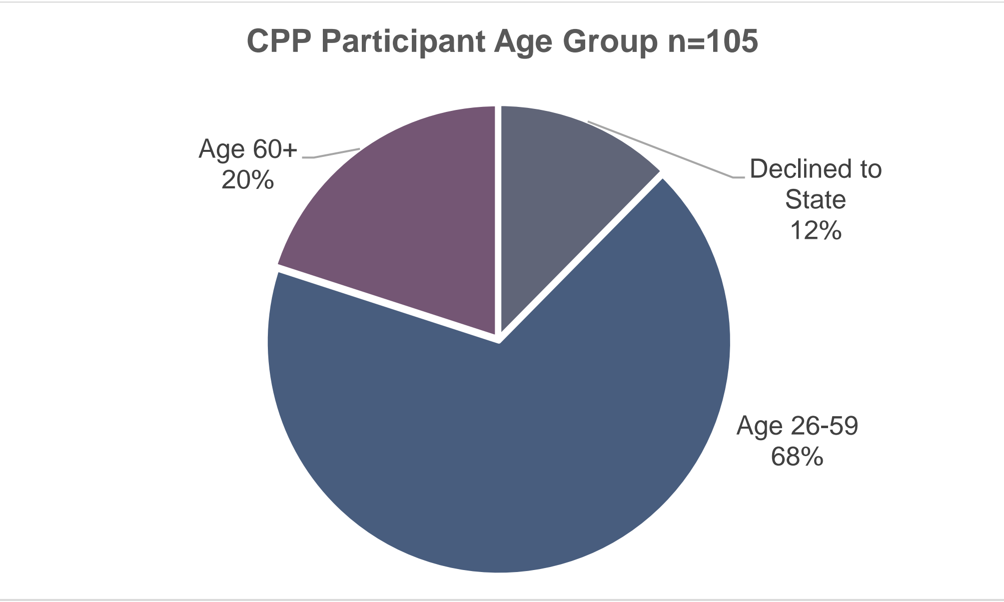


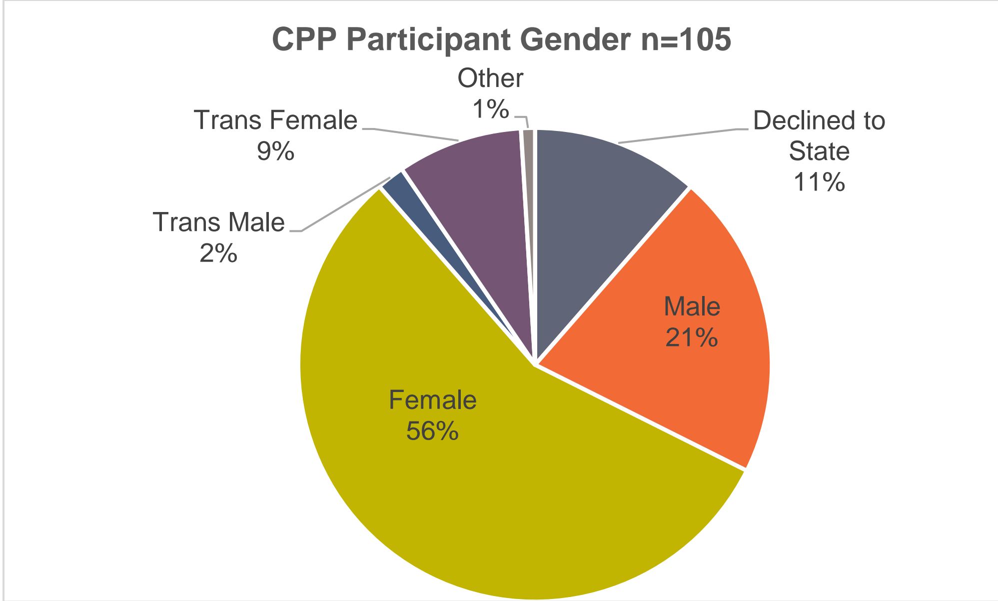
SFDPH MHSA staff hosts CPP meeting

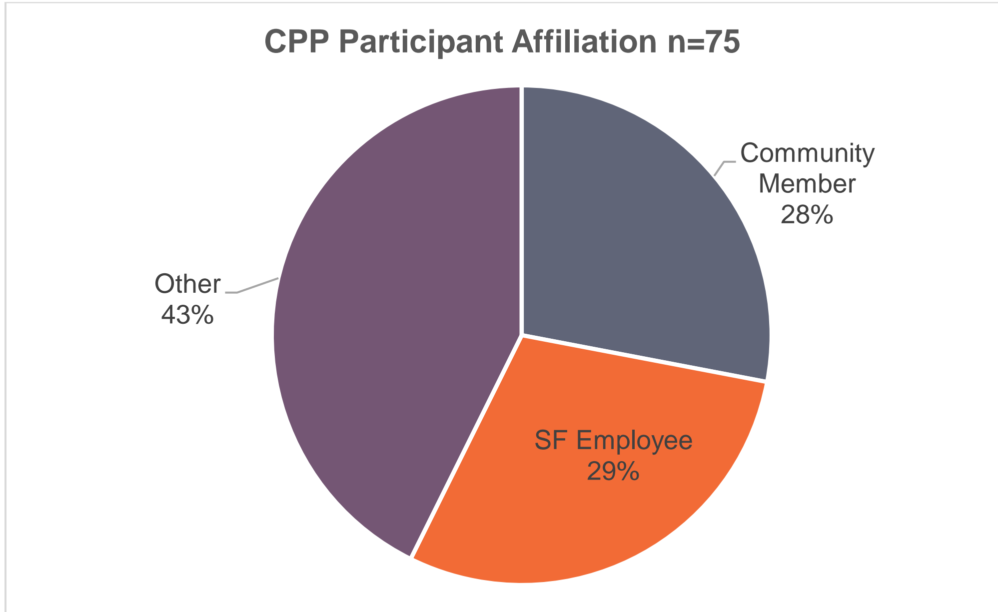
CPP Meeting Participation

Over 200 people participated in the MHSA community meetings held in Fiscal Year 2018-2019. Of those attendees, MHSA staff collected demographic data on 105 individuals and those data are reflected in the charts below. Please see participant demographics for FY18-19 below.









CPP with Service Provider Selection

MHSA includes elements of the CPP in developing and refining each of our 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 examples of recent CPP efforts that took place in developing Request for Proposals (RFP) or Request for Qualifications (RFQ) and contracting with service providers.

- ICM/FSP to Outpatient Transition Support RFQ
- Wellness in the Streets RFP
- Building Maintenance, Construction and Remodeling RFQ

CPP with the Client Council

As mentioned above, SF-MHSA has also been working to foster a stronger collaboration with the BHS Client Council. The Client Council is a 100 percent consumer/client driven and operated advisory body that meets monthly. 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 collaborative effort, MHSA has gathered feedback from the Client Council on numerous MHSA funded initiatives throughout FY17-18.

Program Implementation

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

- Providers from MHSA-funded agencies meet on a regular basis to discuss local MHSA program activities and to provide feedback.
- Providers participate in the regularly scheduled Impact Meetings that are facilitated by MHSA and leaders from our DPH Quality Management team. Providers are able to provide input regarding programming, data collection efforts, strategies to best meet program objectives, client satisfaction requirements, and other various topics.
- Consumers and peers are involved in all areas of the program life-cycle. Consumers and peers participate in Request for Qualifications and Request for Proposals (RFQ/P) review panels, provide input as a vital stakeholder during the program planning and contract negotiation phase, and support with technical assistance during implementation to ensure the program is meeting the appropriate deliverables.

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Proposition 63, an emphasis was placed on the importance of consumer participation 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. BHS currently employs over 300 peers throughout our behavioral health system. Consumers can be found working in almost all levels and types of positions, including: peer counselors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management.

San Francisco’s Integrated MHSA Service Categories

Exhibit 2. MHSA Service Categories	
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 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	• Trains and supports consumers and family members 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 • Increases client access to personal health information

As discussed in the introduction to this report, San Francisco’s initial MHSA planning and implementation efforts were organized around MHSA funding components (e.g., Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN)). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components. The Mental Health Services Act, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, MHSA realized that developing an Integrated Plan with a common vision and shared priorities is difficult when funding streams were used as the framework. In partnership with our stakeholders, MHSA simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 2 below).

These MHSA Service Categories have allowed us to plan programs and services for specific populations and to expand our continuum of services with clear outcomes – including integration

of peers into service delivery, promoting culturally competent care, increasing access to housing and employment, and developing high quality recovery-oriented treatment services.

It is important to note that the majority of our 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.

Developing this Annual Update

This Annual Update was developed in collaboration with various consumers, peers and other stakeholders. Our Annual Update Planning effort was coordinated by a planning group comprised of the MHSA Director and Program Managers, with independent consulting firms (Hatchuel Tabernik & Associates and Harder + Company Community Research) providing data analysis, program planning and report writing services.

In these planning efforts, MHSA incorporated the stated goals of MHSA and revisited the local priorities and needs identified in previous planning efforts. All of the CPP strategies outlined in the previous section were employed in developing this plan. Additional strategies in this process are listed below.

- Reviewed the previous three-year Program and Expenditure Plan and the most recent MHSA Annual Update submitted for each MHSA component. This was done to understand how well priorities identified in those plans have been addressed, as well as to determine if all programs had been implemented as originally intended.
- Reviewed MHSA regulations, laws and guidelines released by the State (e.g., Department of Mental Health (DMH), Mental Health Services Oversight and Accountability Commission (MHSOAC), California Housing Finance Agency (CalHFA), new INN and PEI regulations) to ensure all mandated information would be incorporated in this plan.
- Reviewed informational materials produced by California Mental Health Services Authority (CalMHSA), California Mental Health Director's Association (CMHDA), and Office of Statewide Health Planning and Development (OSHPD).
- Reviewed Annual Year-End Program Reports and demographic data submitted by contractors and civil service programs.
- Conducted program planning with providers and consumers through robust RFQ, program negotiation and contracting efforts throughout the Department.

Much of this Annual Update is made up of programs implemented through the 2017-2020 Three-Year Program and Expenditure Plan (Integrated Plan). Most of our CPP activities over the last year have been focused on the development of this Annual Update.

Local Review Process

Our CPP involved various opportunities for community members and stakeholders to share input in the development of our Annual Update planning efforts and learn about the process of our MHSA-funded programs, including MHSA Advisory Committee meetings, BHS client council

meetings, and community engagement meetings. Please see the components on MHSA Communication Strategies and MHSA Advisory Committee for a specific list of meeting dates and topics.

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 was posted on the MHSA website at www.sfdph.org/dph and www.sfmhsa.org. **Our 2019-20 Annual Update was posted for a period of 30 days from 4/1/19 to 5/1/19**. Members of the public were requested to submit their comments either by email or by regular mail. The following is a summary of the public comments during the 30-day posting:

Summary of Public Comments on the FY19-20 MHSA Annual Update		
Community Member	**Summary of Comments**	**DPH Response**
Wynship W. Hillier, M.S. – Community Member	Mr. Hiller noted that the FY19/20 Annual Update did not include data required by the Foreign Intelligence Surveillance Act of 1978, 50 U.S.C. §§ 1801-1885c.	SF-MHSA was appreciative of the comments. Including data regarding the Foreign Intelligence Act is not required for the Annual Update, per MHSA laws and regulations, therefore SF-MHSA will not be reporting on these data.
James W. Dilley, MD - Emeritus Professor of Clinical Psychiatry, UCSF Department of Psychiatry	Dr. Dilley suggested that the UCSF Psychiatry projects be reported as one program, suggested additional outcomes, and inquired about the total client count for the entire "Psychiatry Residency and Fellowships" sub-section.	SF-MHSA was appreciative of the comments and spoke with Dr. Dilley. SF-MHSA explained the history of reporting this program as "two projects" since one takes place at a hospital and the other in outpatient clinics with different outcomes. SF-MHSA included more outcomes, as suggested, and welcomed additional data to ensure accuracy with reporting on the number of clients served.
Ryan Reichel - Epidemiologist/MHSA Program Evaluator, San Francisco Department of Public Health	Minor updates/revisions to the FSP Section were provided and recommended.	SF-MHSA was appreciative of the updates and noted that all applicable revisions would be included. SF-MHSA included revisions in the final version that was sent to the SF Board of Supervisors and the state.
Dara Papo, LCSW - Care Coordination Services Manager, Department of Homelessness and Supportive Housing	Minor updates/revisions to the Housing Section were provided and recommended.	SF-MHSA was appreciative of the updates and noted that all applicable revisions would be included. SF-MHSA included revisions in the final version that was sent to the SF Board of Supervisors and the state.

Following the 30-day public comment and review period, **a public hearing was conducted by the Mental Health Board of San Francisco on 5/15/19**. The Annual Update was also presented before the **Board of Supervisors Budget and Finance Subcommittee on 07/10/2019** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted the Annual Update on 07/16/2019.**

FILE NO. 190601 RESOLUTION NO. 329-19

[Mental Health Services Act Annual Update - FY2019-2020]

Resolution authorizing adoption of the San Francisco Mental Health Services Act Annual Update FY2019-2020.

WHEREAS, The Mental Health Services Act (MHSA) was passed 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 (Community Services and Supports; Capital Facilities and Technological Needs; Workforce, Education and Training; Prevention and Early Interventions; and Innovation) for which funds may be used and the percentage of funds to be devoted to each component; and

WHEREAS, In order to access MHSA funding from the State, counties are required to 1) develop Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates, in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and 3) 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 Plan (Integrated Plan) for FY2017-2020 on file with the Clerk of the Board of Supervisors in File No. 170904; and

WHEREAS, The San Francisco Mental Health Services Act Annual Update FY2019-2020, a copy of which is on file with the Clerk of the Board of Supervisors in File No. 190601, which is hereby declared to be a part of this resolution as if set forth fully herein, complies with the MHSA requirements above, and provides an overview of progress implementing the various component plans in San Francisco and identifies new investments planned for FY2019-2020; and

1 WHEREAS, Recently enacted legislation, AB 1467, adds the requirement that MHSA
2 Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of
3 Supervisors prior to submission to the State; now, therefore, be it
4 RESOLVED, That the FY2019-2020 MHSA Annual Update is adopted by the Board of
5 Supervisors.
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City and County of San Francisco
Tails
Resolution

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

File Number: 190601 **Date Passed:** July 16, 2019

Resolution authorizing adoption of the San Francisco Mental Health Services Act Annual Update FY2019-2020.

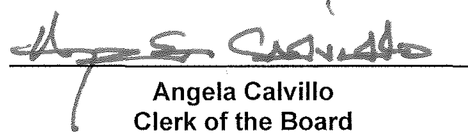
July 10, 2019 Budget and Finance Sub-Committee - RECOMMENDED

July 16, 2019 Board of Supervisors - ADOPTED

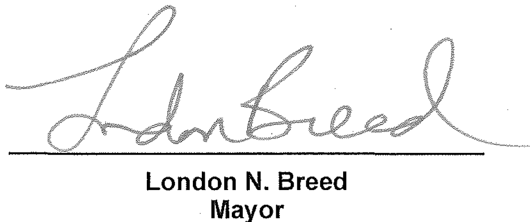
Ayes: 10 - Brown, Fewer, Haney, Mandelman, Peskin, Ronen, Safai, Stefani, Walton and Yee
Excused: 1 - Mar

File No. 190601

I hereby certify that the foregoing Resolution was ADOPTED on 7/16/2019 by the Board of Supervisors of the City and County of San Francisco.



Angela Calvillo
Clerk of the Board



London N. Breed
Mayor

Date Approved

MHSA Fiscal Year 2019-2020 Annual Update

As a result of the feedback we received during our MHSA efforts and due to our successful evaluation outcomes, the following programs/projects will operate as approved in the previous 3-Year Program and Expenditure Plan:

- **Recovery-Oriented Treatment Services**
  - Strong Parents and Resilient Kids (SPARK) **(FSP Program)**
  - SF Connections **(FSP Program)**
  - Family Mosaic Project **(FSP Program)**
  - TAY Full-Service Partnership at Felton **(FSP Program)**
  - SF Transition Age Youth Clinic **(FSP Program)**
  - TAY Full-Service Partnership at Edgewood **(FSP Program)**
  - Adult Full-Service Partnership at Felton **(FSP Program)**
  - Adult Full-Service Partnership at Hyde Street **(FSP Program)**
  - Assisted Outreach Treatment (AOT) **(FSP Program)**
  - SF First **(FSP Program)**
  - Forensics at UCSF Citywide **(FSP Program)**
  - Older Adult FSP at Turk **(FSP Program)**
  - Intensive Case Management/Full-Service Partnership to Outpatient Transition Support **(INN)**
  - AIIM Higher
  - Community Assessment and Resource Center (CARC)
  - Behavioral Health Access Center (BHAC)
  - Behavioral Health Services in Primary Care for Older Adults
  - Technology-Assisted Mental Health Solutions **(INN)**
- **Mental Health Promotion and Early Intervention**
  - Behavioral Health Services at Balboa Teen Health Center
  - School Based Mental Health Services
  - School Based Youth Early Intervention
  - School Based Wellness Centers
  - Trauma and Recovery Services
  - FUERTE School-Based Prevention Groups project **(INN)**
  - Senior Drop-In Center
  - Ajani Program
  - Black/African American Wellness and Peer Leaders (BAAWPL)
  - API Mental Health Collaborative
  - Indigena Health and Wellness Collaborative
  - Living in Balance
  - 6th Street Self-Help Center
  - Tenderloin Self-Help Center
  - Community Building Program
  - PREP - TAY Early Psychosis Intervention and Recovery
  - Population Specific TAY Engagement and Treatment - Latino
  - Population Specific TAY Engagement and Treatment - Asian/Pacific Islander
  - Population Specific TAY Engagement and Treatment - Juvenile Justice
  - Population Specific TAY Engagement and Treatment – LGBTQ+

    - Population Specific TAY Engagement and Treatment - Black/African American
    - TAY Homeless Treatment Team Pilot
    - ECMHCI Infant Parent Program/Day Care Consultants
    - ECMHCI Edgewood Center for Children and Families
    - ECMHCI Richmond Area Multi-Services
    - ECMHCI Homeless Children's Network
    - ECMHCI Instituto Familiar de la Raza
    - Mobile Crisis
    - Child Crisis
    - Crisis Response
- **Peer-to-Peer Support Programs and Services**
    - Peer Engagement Services
    - Addressing the Needs of Socially Isolated Adults Program **(INN)**
    - LEGACY
    - Peer to Peer, Family to Family
    - Peer Specialist Certificate, Leadership Academy and Counseling
    - Gender Health SF
    - Peer to Peer Employment
    - Peer Wellness Center
    - Transgender Pilot Project **(INN)**
    - Reducing Stigma in the South East (RSSE)
    - Wellness in the Streets **(INN)**
- **Vocational Services**
    - Department of Rehabilitation Vocational Co-op
    - i-Ability Vocational Information Technology (IT) Program
    - First Impressions (Building Maintenance, Construction and Remodeling) Program
    - SF First Vocational Project
    - Janitorial Services
    - Café and Catering Services
    - Clerical and Mailroom Services
    - Growing Recovery and Opportunities for Work Through Horticulture (GROWTH)
    - TAY Vocational Program
- **Housing**
    - Emergency Stabilization Housing
    - FSP Permanent Supportive Housing
    - Housing Placement and Support
    - TAY Transitional Housing
- **Behavioral Health Workforce Development**
    - Community Mental Health Worker Certificate
    - Faces for the Future Program
    - DPH Online Learning System
    - Trauma Informed Systems Initiative
    - TAY System of Care Capacity Building
    - Fellowship for Public Psychiatry in the Adult/Older Adult System of Care
    - Public Psychiatry Fellowship at SF General
    - BHS Graduate Level Internship Program

- **Capital Facilities and Information Technology (IT)**
  - Recent Renovations – Capital Facilities
  - Consumer Portal - IT
  - Consumer Employment – IT
  - System Enhancements – IT

MHSA 2018 Consumer, Peer, and Family Conference

Highlights of MHSA

In FY17-18, **MHSA served a total of 52,699 individuals** through our outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic services; and service linkage efforts.

Award recipients at the 2018 MHSA Award Ceremony

New Regulations for MHSA
MHSA has been working in collaboration with DPH Quality Management to strengthen data-collection efforts and strategies in order to be in compliance with new regulations.

In addition, Senate Bill 192 was approved by Governor Jerry Brown on September 10, 2018. MHSA intends to fully comply with this amendment of Sections 5892 and 5892.1 of the Welfare and Institutions Code, relating to mental health. This bill clarifies that the value of a prudent reserve for a Local Mental Health Services Fund shall not exceed 33% of the average community services and support revenue received for the fund, in the preceding 5 years. The bill requires the county to reassess the maximum amount of the prudent reserve every 5 years and to certify the reassessment as part of its 3-year program and expenditure plan required by the MHSA. Please see Appendix A for more details.

This bill also establishes the Reversion Account within the fund, and requires that MHSA funds reverting from the counties, and the interest accrued on those funds, be placed in that account. This bill requires counties to submit the plans to expend the reallocated funds to the commission. The bill requires the reallocated funds to revert to the state if a county has not submitted a plan for the expenditure of the reallocated funds by January 1, 2019. Additionally, this bill requires the reallocated funds in the plan that have not been spent or encumbered by July 1, 2020, to revert to the state.

MHSA publically posted an INN Reversion plan in July of 2018 and received Board of Supervisor's Adoption of this plan on October 30, 2018 with Mayor London Breed's approval on November 9, 2018. This final plan was sent to the state in November of 2018. MHSA also intends to comply with this new law moving forward.

Noteworthy Accomplishments for MHSA in FY17-18
This year marked many special accomplishments for MHSA, including the launch of an online reporting platform for MHSA program Year-End Reports, the integration of PEI and INN regulations for demographic data integrated into our service provider reporting templates, and a number of other accomplishments detailed below.

Online Learning System
In 2015, the Department of Public Health sent out a Staff Engagement survey to create a baseline understanding of the experience of its employees. One of the key findings was that 68% of

staff reported not having the tools to do their job; with this information BHS leadership sent out a subsequent workforce survey to determine the current status of staff's job satisfaction, experience with training and wellness resources, and professional development activities. The feedback informed BHS leadership that 75% of its staff would find an online training system either useful or very useful; this is consistent with data that shows agencies that support their staff with an online system experience less staff turnover and improved staff engagement due to its flexibility for staff to complete trainings at their convenience. It also allows leaders the ability to tailor training plans to meet their local needs.

With this feedback from staff, a community planning process was conducted on February 19, 2019 at the Children's Youth & Family provider meeting to gather further feedback from our community partners about the project. Participants who currently have access to an online training system shared that, "it is helpful to track training information", "it provides consistent training material to all of the staff", and that "the system is convenient and easily accessible." Some challenges/concerns noted was that, "some topics are better covered at a live training", and "live trainings provide the opportunity for staff to dialogue about the topic with other participants, rather than completing a training in isolation". Overall, the attendees were positive and supportive of the resource. **As a result of this stakeholder feedback, MHSA plans to implement an Online Learning System for the Behavioral Health Services workforce.**

This project is intended to implement a 24/7 online learning system; the goal is to implement this resource to all civil service and contracted agency staff within behavioral health services. The staff will be able to access this online learning system through a website link that is distributed to all staff members.

The planning process will require the development of a RFQ to identify qualified contractors who can meet this training need. We will also organize a work group of stakeholders that includes both civil service and contracted behavioral health staff, IT team members, the learning platform's implementation staff, and community members who will work collaboratively to advance this project. **The timeline for the project implementation is flexible, but the projected plan may begin July 2020** with the release of an RFQ and the identification of workgroup members. **The funding for the project will be MHSA dollars with an estimated cost of $70,000 annually.** This price includes: a specified number of users, annual subscription per user, and a one-time set up fee.

One organization that provides an online training platform is Relias Learning; they are a national provider of behavioral health focused learning resources. They provide 24/7 access to the platform from work or home, which allows tremendous flexibility to the staff who desire to engage in training modules outside of the work setting. Along with the benefits of increasing the knowledge and skills of the workforce staff, effective online systems support improved compliance and staff engagement, quality improvement, and increased staff efficiencies.

Some examples of training topics include: Addiction, Evidence Based Practices, DSM 5, Integrated Care, Co-Occurring Disorders, Children's Youth and Family/Adult Older Adult specific topics, Employee Wellness, and Workforce Skills (i.e. effective communication, working with difficult people, and conflict management.) The project will also provide continuing education credits for licensed behavioral health staff (Ph.D/Psy.D, MFT, LCSW, LPCC, LEP's) in order to support these staff with their bi-annual license renewals.

Behavioral Health Services leadership has always been committed to ensuring that its staff are equipped with the tools necessary to do their jobs, therefore, we are excited to announce this project plan.

8th Annual MHSA Awards Ceremony
On October 24, 2018, the Mental Health Association of San Francisco (MHASF) hosted the 8th Annual MHSA Awards Ceremony at the Scottish Rite Masonic Center, the ceremony's home for the past 4 years. This year's theme was 'We Are Legends,' which emphasized San Francisco peers' connection to the legacy of Mental Health Recovery Movement advocates and activists, as well as the impact those peers have on their communities today. The event's MC, MGM Grande, is a member of San Francisco's mental health community and shared her experiences with recovery during the ceremony. Over 185 awardees were honored for their achievements in mental health recovery using MHSA-funded services in San Francisco, including one Peer of the Year and one Peer Impact Award. SVIP (Street Violence Intervention Program) and SOLVE (Sharing Our Lives, Voices, and Experiences) were recognized as Teams of the Year. The ceremony also took time to honor two members of the peer community who were lost to acts of violence over the past year, Joseph Taeotui of SVIP and Norman Tanner of San Francisco AIDS Foundation.

The ceremony was the culmination of months of hard work by the peer-led MHSA Awards Organizing Committee, who met with MHASF Staff bi-weekly between July and October to coordinate every aspect of the ceremony, from nominations to entertainment to catering. In addition to the experience of helping to organize a memorable event, peers participating on the committee received professional development support throughout the process and had the opportunity to co-MC portions of the event as well.

Staff Updates
In Fiscal Year 2018-19, a number of staffing changes occurred in the MHSA division, including:

- The MHSA Director, Imo Momoh, received a promotion to the SF Behavioral Health Services Director of Equity, Social Justice, and Multicultural Education. Before joining SFDPH, Imo was the Cultural Competency Officer for the San Bernardino County, Department of Behavioral Health. Before his time in San Bernardino County, Imo was the Ethnic Services and Workforce Education; Training Manager for Contra Costa County Behavioral Health. Throughout this work, Imo has demonstrated his steadfast commitment to promoting access and advancing equity in the community and workforce. With his leadership, several programs have been recognized/awarded, locally and nationally, for its innovation, effectiveness and successful outcomes.
- Dr. Grant Colfax was selected as the new Director of the Department of Public Health. Dr. Colfax is a national leader on HIV Prevention and was trained at UCSF. He most recently served as Director of Marin County Health and Human Services. He previously worked at SFDPH as Director of HIV Prevention and Research before leaving to join the Obama White House as the Director of National AIDS Policy. He will start as San Francisco Health Director on February 19, 2019.
- Two new Peer Interns joined the SF MHSA team to support the work of the Vocational Service Department

2018 TAY System of Care Launch Event

and provide administrative support for the Client Council and for Outreach and Awareness activities.
- One of our new MHSA Program Managers has been working closely on the Black and African American Wellness and Peer Leadership (BAAWPL) project, providing oversight and support to the MHSA-funded housing programs and supporting the MHSA-funded FSP programs.
- The MHSA Staff Wellness Coordinator expanded her duties to support work on the Sexual Orientation/Gender Identity (SOGI) initiative at BHS.
- The Transition Age Youth (TAY) Manager has been working to further develop and launch the new TAY System of Care for BHS.

MHSA Innovations Executive Summary

INN Reporting Requirements

The Mental Health Services Act requires that all Counties receiving MHSA funds submit annual reports that detail individual Innovation program outcomes, total dollar amounts expended on each INN program, program referral and treatment data, and other reporting requirements by June 30th of each year. INN program outcome and demographic data, as well as the extensive community outreach and planning efforts conducted through our MHSA Community Program Planning processes, as outlined in this report, are designed to meet and exceed these reporting requirements.

This Innovations (INN) Executive Summary is intended to be a high-level overview of MHSA's INN programming, highlights and analyzed data of all INN projects. For information about specific INN programs, please refer to the INN programs mentioned later in this report.

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. INN funding provides up to five years of funding to pilot projects. There are currently seven INN Learning Projects integrated throughout the seven MHSA Service Categories. These include:

1. First Impressions
2. Transgender Pilot Project
3. Addressing the Needs of Socially Isolated Older Adults
4. Intensive Case Management/Full-Service Partnership to Outpatient Transition Support
5. Wellness in the Streets
6. Technology-Assisted Mental Health Solutions
7. Family Unification and Emotional Resiliency Training (FUERTE)

INN Projects Wrapping-Up and CPP

Three of the Innovation projects listed above will be wrapping up in the next two years, and our CPP process has begun to collect input from diverse community groups that will inform the ending phase of these projects and any future plans for continuing these programs through alternate funding streams. These programs include: 1. First Impressions, 2. Addressing the Needs of Socially Isolated Older Adults, and the 3. Transgender Pilot Project.

Community Feedback Regarding the INN Programs Ending

Feedback received from the Transgender community, including a Transgender Pilot Project Support Group, has been that there is a continued gap and need for programs specifically focused upon the specific needs of the Transgender community, like the Transgender Pilot Project. Participants shared that when women's programs and transgender programs and are combined, they are not adequately serving the needs of the latter group. It was stated that many programs, such as drop-in centers, close early and are not open when there is a need for them. In regards to the Addressing the Needs of Socially Isolated Older Adults, groups such as the Consumer Advisory Panel at the Curry Senior Center, continue to see a need for support for socially isolated seniors in SROs and have seen how this project has been effectively meeting important needs in the community. Lastly, we received community feedback from the Client Council and other stakeholders that the First Impressions program "could be beneficial for people who want to go into building maintenance, basic construction, or remodeling" and it could also "help people develop soft skills." Community members and stakeholders advocated that all three of these projects continue in some form.

First Impressions Vocational Program will be ending on June 30, 2019. This unique program has received widespread support at several community planning sessions that have taken place at community meetings, such as The BHS Client Council and the MHSA Advisory Board. During this period, MHSA has also been working with University of California San Francisco Citywide to prepare a robust evaluation of the *First Impressions Vocational Program.* First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, job coaching, training and job placement. MHSA recently received approval from the MHSOAC for a one-year extension for First Impressions to extend both the time and budget of this project. This one year extension from July 1, 2018 to June 30, 2019 is helping to accomplish two goals: better analyze transferable work skills and analyze the longevity of impact. During this last year, First Impressions has created an additional internship with the DPH Facilities to better prepare participants for continued employment in the field with higher levels of sector competency, and experience for their resumes, and provide valuable data in a formal employment setting for the evaluation of this program. Due to this exciting expansion, the program is now also known as the Building Maintenance, Construction, and Renovations Vocational Program, a name which encompasses the additional professional training component of the project.

As a result of community feedback, MHSA issued a Request for Qualifications for the Building Maintenance, Construction, and Renovations Vocational Program. The successful components of this project will continue with other funding sources other than INN.

The *Transgender Pilot Project (TPP)* is designed to increase evaluation planning in order to better collect data on the strategies that best support Transgender women of color with engaging in behavioral health services. TPP entered the pilot year of operations in FY15-16 as a INN Project. The two primary goals involve increasing social connectedness and providing wellness and recovery based groups. The ultimate goal of the groups is to support clients with linkage into the mental health system and services. MHSA also submitted a request and was awarded a one-year extension and additional funding for the *Transgender Pilot Program* by the MHSOAC. The INN funding for this program will end on June 30, 2020.

2019 Cultural and Wellness Event – Chinese New Year Arts and Crafts

As a result of community feedback, the successful components of this project will continue with other funding sources other than INN after June 30, 2020. The lessons learned and program activities that are proven to be effective based on evaluation efforts, will continue in some form. This may take place by leveraging funding, collaborating and bridging activities with other similar MHSA programs, or continuing funding with CSS or other county funds.

The *Addressing the Needs of Socially Isolated Older Adults* program provides peer outreach and engagement services along with screening and assessment services to reduce isolation among the older adult population. MHSA also submitted a request and was awarded a one-year extension and additional funding for this project by the MHSOAC. The INN funding for this program will end on June 30, 2020.

As a result of community feedback, the successful components of this project will continue with other funding sources other than INN after June 30, 2020. The lessons learned and program activities that are proven to be effective based on evaluation efforts, will continue in some form. This may take place by leveraging funding, collaborating and bridging activities with other similar MHSA programs, or continuing funding with CSS or other county funds.

Update on Four new INN Initiatives

As a result from our CPP efforts, we will introduce four new and innovative initiatives in programming in the next year. These four INN initiatives represent the only additional expenditures planned for the MHSA budget.

In March 2018, the MHSOAC approved our INN proposal titled *Intensive Case Management/Full-Service Partnership to Outpatient Transition Support*. An RFQ was released to the community in July 2018. Richmond Area Multi-Services, Inc. (RAMS) was awarded a contract for this program, which began on January 1, 2019. The total INN program is a five-year project. This project involves an autonomous peer linkage team providing both wraparound services and a warm hand off when transitioning from intensive case management services or full-service partnership services to outpatient treatment. The team will consist of five culturally and linguistically diverse peers and one clinician. Peers will serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow-up, and communicate with providers. The team will outreach to transitional clients in order to support them to

have successful linkages to outpatient services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

RAMS Mental Health Peer Specialist Certificate Graduation

In the fall of 2018, two additional new INN proposals were approved by the MHSOAC. The *Wellness in the Streets INN* project, which was approved on October 25, 2018, will help increase access to underserved populations – specifically, San Francisco residents who are homeless that do not typically access mental health services despite experiencing behavioral health needs. The proposed project would involve a roving support team of formerly homeless peer counselors that would engage this population in peer counseling directly on the streets of San Francisco in areas where individuals are unhoused. The primary objectives of the project will be to increase feelings of social connectedness, increase awareness of mental health resources and increase wellness.

The *Technology-Assisted Mental Health Solutions* INN project will be a collaborative effort with other counties. Along with 10 other counties, San Francisco received MHSOAC approval for this project on September 27, 2018. This project will utilize innovative technology approaches to overall public mental health service delivery in order to increase access to mental health care and support for San Francisco residents. The components of this project will include Peer-to-Peer Chat Interventions and Virtual Evidence-Based Support Utilizing an Avatar that will be accessible from a computer, cell phone or tablet. The primary goals will be to provide alternate modes of engagement, support and intervention and to increase access to peer-to-peer interventions.

The *Family Unification and Emotional Resiliency Training (FUERTE)* program was approved by the MHSOAC on January 24, 2019 – funding the program for five years at $1.5 million. FUERTE is an innovative project that would be an expansion of an existing program that uses an evidence-based model. It would provide a robust evaluation for the program, allowing it be successfully adapted to other populations. FUERTE is one of the few existing interventions culturally tailored to address the needs of Latino newcomer adolescents with Limited-English proficiency and health literacy. FUERTE is a school-based group prevention program which uses a sociocultural, ecological lens and an Attachment Regulation and Competency (ARC) framework with the aim of engaging Latino newcomer adolescents.

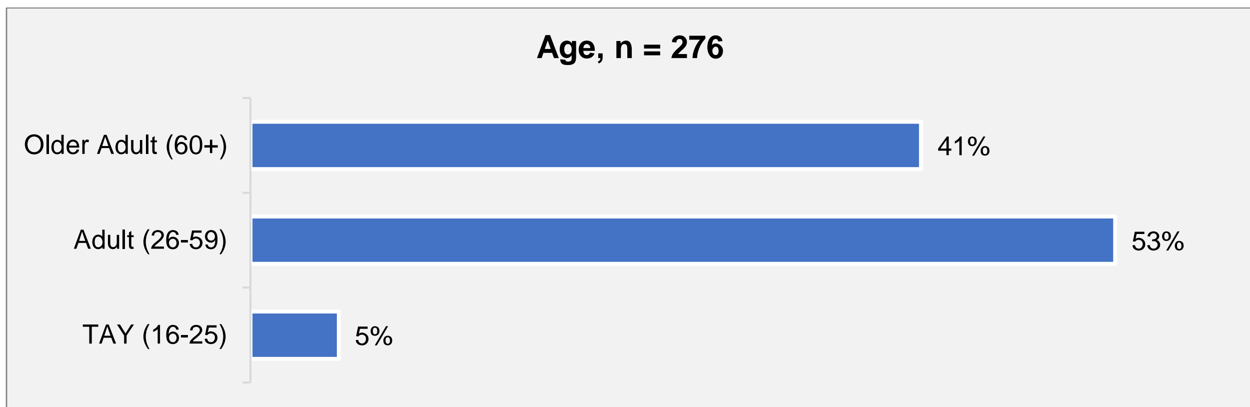
Latino newcomer adolescents (foreign born youth with five years or less post migration to the U.S.) are a rapidly growing youth population nationwide and remain the leading growing demographic in California urban centers such as San Francisco. These youth are at high risk of marginalization and poor societal outcomes, in part due to a range of health disparities including poverty, language barriers, and documentation status. Although the FUERTE curriculum is built on evidence-based concepts, FUERTE's delivery model is innovative and to our knowledge does not exist elsewhere. Our FUERTE model would be expanded to also include parent and caregiver interventions, which would consist of 2 hours of evening activities including education

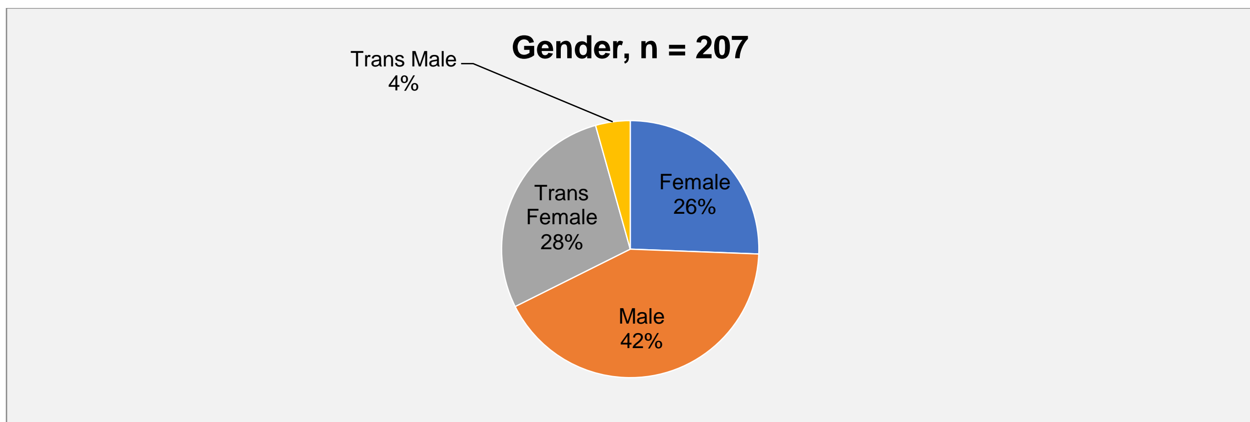
and the provision of supplemental materials. Our FUERTE model would also build out its peer development model, where former group members would be trained to provide peer-to-peer services as peer recovery support coordinators integrated into the new model.

In order to rigorously evaluate the modified FUERTE program, the program expansion would be paired with a delayed intervention model randomized controlled trial. Annually, new participants will be randomized to participate in the fall or spring semester FUERTE groups at each school. We will employ a combination of quantitative and qualitative methods as part of our evaluation. A final aim of our new project is to develop a framework on the cultural adaptation of FUERTE to different groups of newcomer Latino adolescents, as well as newcomers from other ethnic groups with similar concerns and needs (e.g., youth from Arabic-speaking countries). The framework will allow us to develop a "playbook" that will be used alongside the FUERTE manual to guide clinicians and community partners on how to adapt the main components of FUERTE to be used with different populations of newcomer immigrant youth.

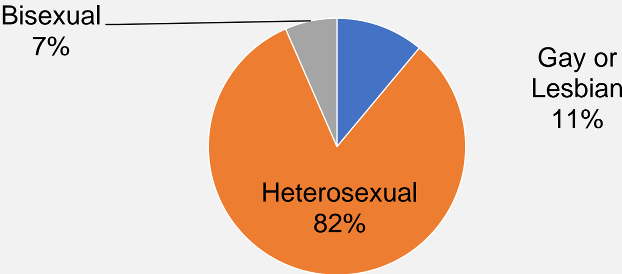
Participant Demographics for all INN Programs

Total Served = 1,349
Total Unduplicated = 300

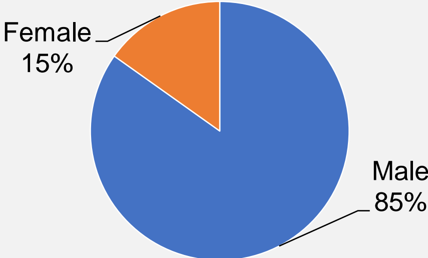




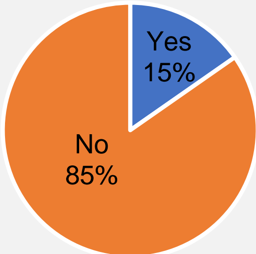
Sexual Orientation, n = 199



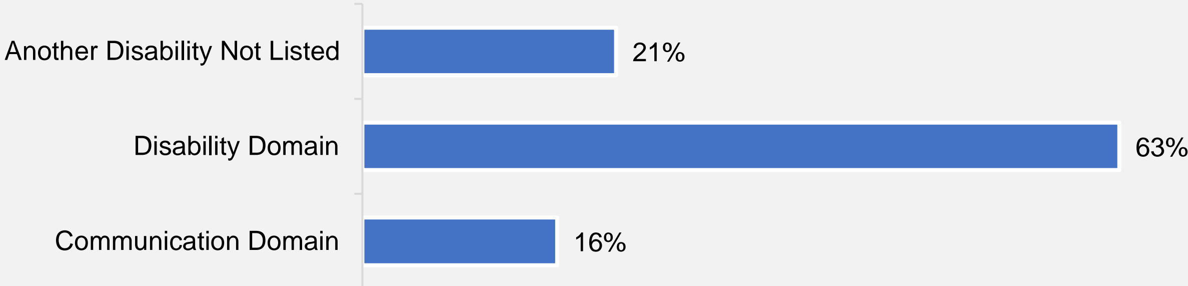
Sex at Birth, n = 224



Veteran Status, n = 98



Disability Status, n = 266



Race/Ethnicity	n	%
Black / African-American	65	17%
American Indian / Alaska	8	2%
Asian	16	4%
Native Hawaiian Islander	6	2%
White	71	19%
Other Race	21	6%
Unknown	33	9%
Hispanic	44	12%
Non-Hispanic	82	22%
More than one ethnicity	8	2%
Total	**377**	**100%**

Primary Language	n	%
English	168	72%
Spanish	25	11%
Tagalog	11	5%
Unknown	27	12%
Total	**232**	**100%**

For INN programs, 0% of participants reported data for the Russian language. Additionally, the following languages were not included since they rounded to 0%: Chinese, Vietnamese, and Another Language.

MHSA Prevention and Early Intervention Executive Summary

PEI Reporting Requirements

The Mental Health Services Act requires that all Counties receiving MHSA funds submit annual reports that detail individual Prevention and Early Intervention (PEI) program outcomes, total dollar amounts expended on each PEI program, program referral and treatment data, and other reporting requirements by June 30th of each year. INN program outcome and demographic data, as well as the extensive community outreach and planning efforts conducted through our MHSA Community Program Planning processes, as outlined in this report, are designed to meet and exceed these reporting requirements.

This Prevention and Early Intervention (PEI) Executive Summary is intended to be a high-level overview of MHSA's PEI programming, highlights and analyzed data of all PEI projects. For information about specific PEI programs, please refer to the Mental Health Promotion and Early Intervention section mentioned later in this report.

The focus of all PEI programs is to: (1) raise awareness about mental health conditions; (2) address the stigma tied to mental health; and (3) increase individuals' access to quality mental health care. MHSA investments build the service delivery capacity of programs and grassroots

organizations that typically don't provide mental health services (e.g. schools, cultural celebrations, and cultural epicenters).

Population-Focused Programs Receives Award

The MHSA *Population-Focused: Mental Health Promotion and Early Intervention programs* were awarded the National Association of Counties 2018 Achievement Award. Our Population-Focused programs were recognized as pioneers in their efforts to support oppressed and marginalized communities by honoring their histories, cultural and spiritual beliefs around physical and mental health. These programs have helped to transform San Francisco's landscape of public mental health PEI service provision in ways that have defied conventional practices.

PEI Regulations

To standardize the monitoring of all California MHSA PEI and INN programs, the MHSOAC crafted regulations with respect to counties' data collection and reporting. Key areas of attention are given to the number of people served by a program; the demographic background of program participants [e.g. age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)]; and the interval of time passed from an initiated referral to when the client first participates in referred services. The MHSOAC calls this "referral-to-first participation in referred services period" a *successful linkage*; and successful linkages are one indicator among many that signifies clients' timely access to care.

Given the need for the MHSOAC to know and better understand the communities being served by MHSA resources, it is extremely important for MHSA to develop processes and instruments that will afford programs the ability to capture regulated data in a manner that is respectful and does not offend, discourage or alienate individuals who are seeking help. All counties are required to include their regulated demographic data in their Annual PEI Report to the MHSOAC, which is part of a county's Annual Update or 3-Year Program and Expenditure Plan.

In Fiscal Year 2017-18, MHSA successfully integrated new PEI regulated demographic data into online reporting templates for our service providers. The MHSA team is also working to engage its PEI programs to learn more about their efforts to track internal and external referrals they make for their clients, as well as how they document "successful linkages," which can serve as indicators that clients are participating in at least one session with the referred service provider. Because these programs vary so greatly, MHSA staff are attentive to the gentle nuances of how successful linkage services are carried out and recorded by each program.

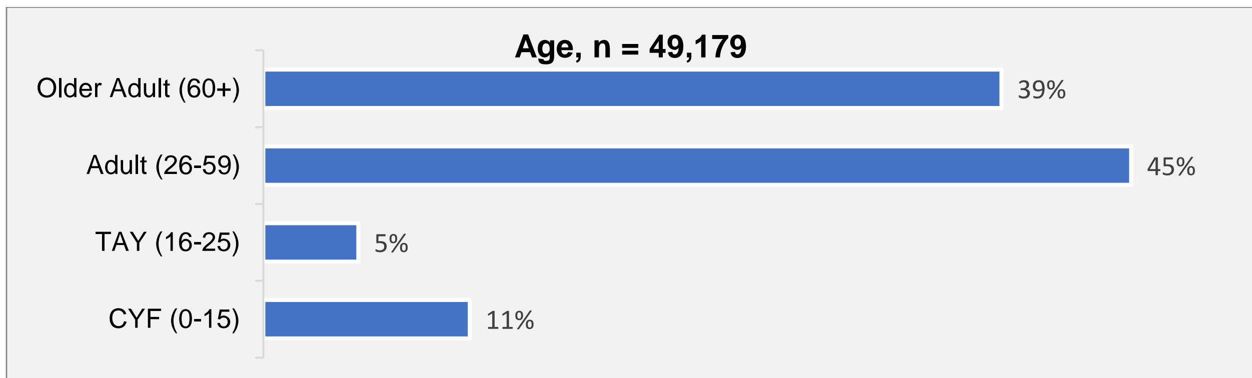
Service Indicator Outcomes for all PEI Programs

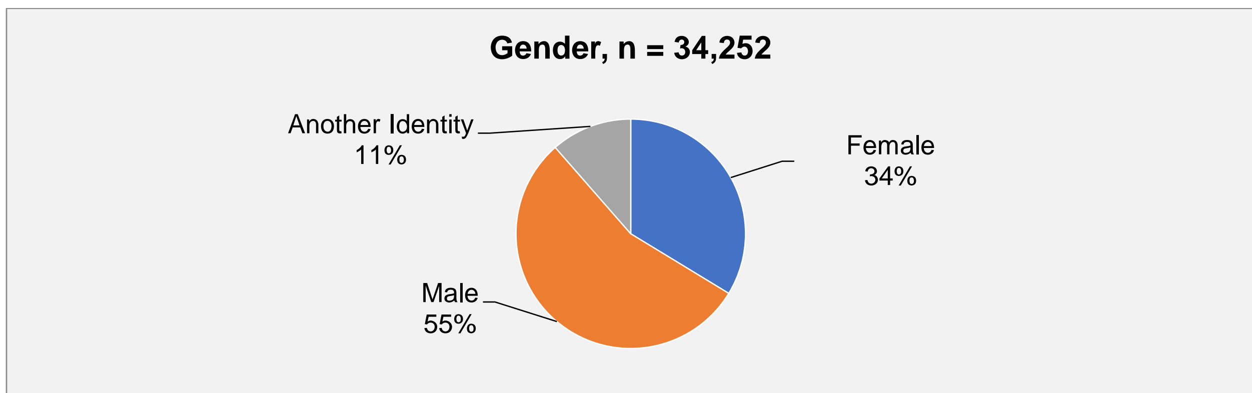
Service Indicator Type	Program Results
Total family members served	2,220 family members; average 317.14 family members across 7 reporting programs.
Potential responders for outreach activities	Education personnel, child care and shelter workers, substance use experts, medical personnel, behavioral health workers, peer advocates, case managers, social workers, criminal justice personnel, community organization staff, parents, and lawyers.
Total individuals with severe mental illness referred to treatment	163 individuals; average 27.17 across 6 reporting programs.
Types of treatment referred	Medication evaluation and adherence, community hospitals, parent-infant pair services, individual and family therapy, suicide prevention, boarding schools, and group homes.
Individuals who followed through on referral	Approximately 100% for reporting programs.
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report this data. Example responses include a range of: - 6 months - One year - Since childhood (many years)
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses all within 1-2 weeks.
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	1,267 individuals; average 126.7 individuals across 10 reporting programs.
Types of underserved populations referred to prevention program services	People of color, immigrants, system-involved (legal, foster care), gender/sexual minorities, pregnant women, Spanish speakers, transitional age you, mentally ill youth; and people experiencing or impacted by: homelessness, domestic violence, substance use, and trauma.
Individuals who followed through on referral	97% for reporting programs.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses: - 1 week - 2-4 weeks - 1-3 months
How programs encourage access to services and follow-through on referrals	Parent education groups, support groups, community resource sharing, sensitivity to cultural differences, community liaisons, warm hand offs, follow-up check-ins, advertise in targeted areas, in-person outreach, navigation assistance, community meeting presentations, staff training goals, and family support services.

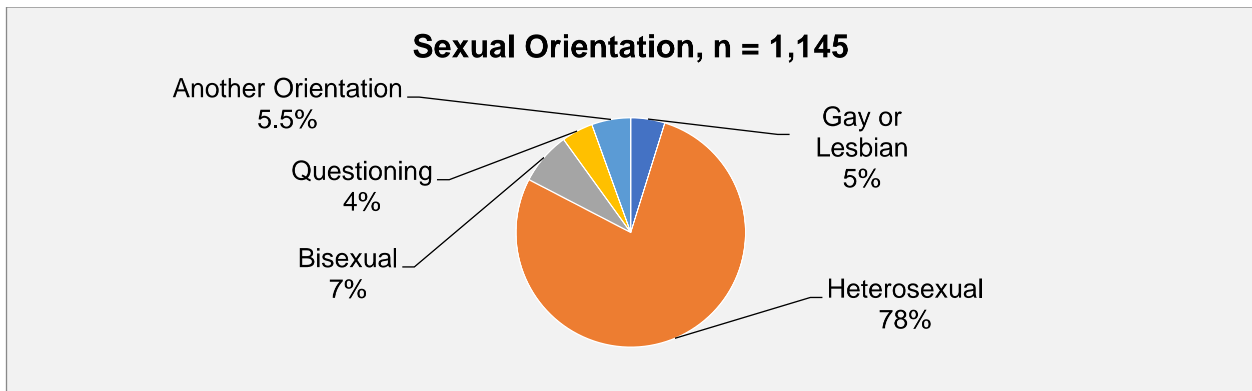
Demographics

Participant Demographics for all PEI Programs

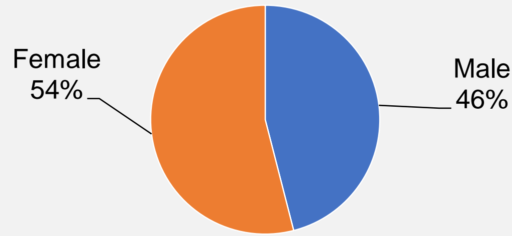
Total Served = 100,426
Total Unduplicated = 39,953
Served for Early Intervention = 802
Served for Mental Illness Prevention = 6,185



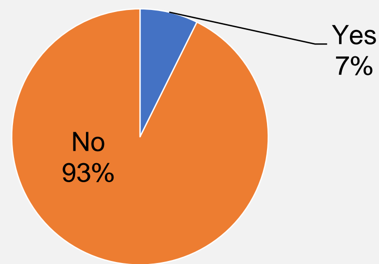




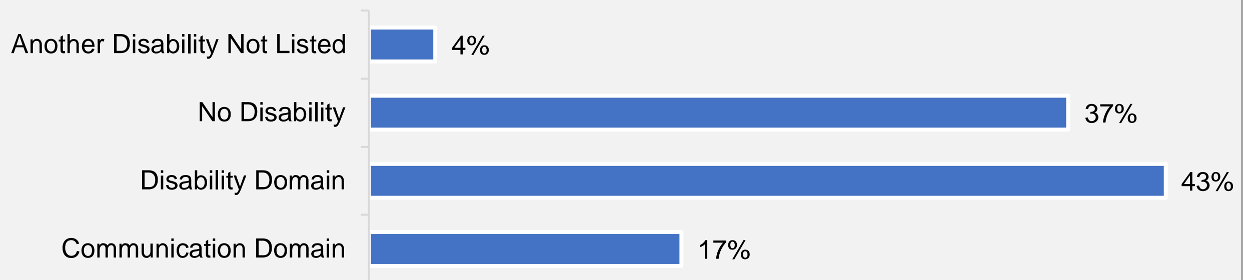
Sex at Birth, n = 7,273



Veteran Status, n = 27,661



Disability Status, n = 480



Race/Ethnicity	n	%
Black/ African-American	2	24%
American Indian/Alaska	518	1%
Asian	9,435	22%
Native Hawaiian Islander	568	1%
White	6,052	14%
Other Race	1,756	4%
Unknown	2,852	7%
Hispanic	4,116	10%
Non-Hispanic	5,616	13%
More than one ethnicity	929	2%
Total	**42,388**	**100%**

Primary Language	n	%
Chinese	2,681	8%
English	4,160	13%
Russian	1	0%
Spanish	1,505	5%
Tagalog	36	0%
Vietnamese	196	1%
Unknown	22,900	71%
Another language not listed	559	2%
Total	**32,163**	**100%**

For PEI less than 1% of participants reported data for Trans Male and Trans Female so these demographics were not included.

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 for the following seven categories:

1. **Recovery-Oriented Treatment Services**
2. **Mental Health Prevention & Early Intervention Services**
3. **Peer-to-Peer Support Programs and Services**
4. **Vocational Services**
5. **Housing Services**
6. **Behavioral Health Workforce Development**
7. **Capital Facilities & Information Technology**

MHSA staff at the 2018 Consumer, Peer, and Family Conference 2018

1. Recovery-Oriented Treatment Services

Service Category Overview

Recovery-Oriented Treatment Services include services traditionally provided in the mental health system, such as screening and assessment, clinical case management, individual and group therapy, and medication management.

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 programs and initiatives.

- Trauma Recovery Programs
- Behavioral Health and Juvenile Justice Integration
- The Prevention and Recovery in Early Psychosis Program
- The Behavioral Health Access Center
- Integration of Behavioral Health and Primary Care

FSP Programs

Program Collection Overview

FSP programs reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing “whatever it takes” to assist individuals diagnosed with serious mental illness (SMI) or, for children with serious emotional disturbance (SED), to lead independent, meaningful, and productive lives.

FSP services at all programs consist of the following:

- Intensive case management
- Wraparound services
- Medication management
- Housing support
- Employment assistance and vocational training
- Substance use harm reduction and treatment
- Individual and group therapy and support groups
- Peer support
- Flex Funds for non-Medi-Cal needs

Target Populations

Nine FSP programs have served a diverse group of clients, in terms of age, race/ethnicity, and stage of recovery, since 2006. In 2015-16, two new programs began to enroll clients: Instituto Familiar de la Raza (IFR) created the Strong Parents and Resilient Kids (SPARK) program to serve families with a child or children aged 0-5 with attachment disorders; and Citywide Case Management now provides services through the Assisted Outpatient Treatment (AOT) program to clients with serious mental illness who have not previously engaged effectively with Behavioral Health Services but remain at great risk to themselves or others.

FSP Programs		
Target Population	**Program Name** ***Provider***	**Additional Program Characteristics**
Children 0-5 & Families	Strong Parents and Resilient Kids (SPARK) *Instituto Familiar de la Raza*	Provides trauma focused dyadic therapy, intensive case management, and wraparound services to the population of 0-5 year olds and their caregivers.
Children & Adolescents	SF Connections *Seneca Center*	Through close partnerships with Social Services, Mental Health, Juvenile Probation, and other organizations, Seneca and FMP provide trauma informed, unconditional, family-centered, strengths-based, and outcome-oriented alternatives to group care placements, for children and youth ages 5-18 with complex and enduring needs at risk of out of home placement.
	Family Mosaic Project (FMP) *SFDPH*	
Transitional Age Youth (TAY)	TAY FSP *Felton Institute*	Supporting youth, ages 16-25, with serious and persistent mental illness, substance abuse, homelessness, HIV/AIDS, and/or foster care experience, to help them stabilize, link to needed services, set and achieve treatment goals, improve functioning in daily life, and engage in meaningful socialization, vocational, volunteer, and school activities. The programs also work with family members, significant others, and support-persons in the clients' lives.
	SF TAY Clinic *SFDPH*	
Adults	Adult FSP (Bayview, Oceanview, and Western Addition neighborhoods) *Felton Institute*	Offers an integrated recovery and treatment approach for individuals with serious and persistent mental illness, homelessness, substance use disorder, and/or HIV/AIDS by centering care with the individual and involving family members, significant others, and support persons in the clients' lives.
	Adult FSP (Tenderloin neighborhood) *Hyde Street Community Services*	Provides culturally relevant services to the diverse ethnic and racial populations residing in the Tenderloin, especially Arab-speaking, Southeast Asian, African American, and Latinx individuals living with co-occurring disorders.
Adults/Older Adults	Assisted Outpatient Treatment (AOT) *SFDPH & UCSF Citywide Case Management*	Outreaches to and engages individuals with known mental illness, not engaged in care, who are on a downward spiral. AOT is a court process that uses peer counselors to facilitate individuals' access to essential mental health care.

FSP Programs		
Target Population	**Program Name** *Provider*	**Additional Program Characteristics**
	SF Fully Integrated Recovery Service Team (SF FIRST) *SFDPH*	Provides FSP services to highly vulnerable individuals with multiple medical, psychiatric, substance abuse, and psychosocial difficulties, including chronic homelessness. *See additional information in the 'Spotlight' feature below.*
	Forensics *UCSF Citywide Case Management*	Provides compassionate, respectful, culturally and clinically competent, comprehensive psychiatric services to individuals with severe and persistent mental illness (often co-existing with substance abuse) involved in the criminal justice system.
	Older Adult FSP *Felton Institute*	Serves older adults age 60 and older with severe functional impairments and complex needs, by providing specialized geriatric services related to mental health and aging.

Participants at the MHSA Transitional Age Youth 2018 Launch Event

Spotlight on SF Fully-Integrated Recovery Services FSP and Vocational Program

San Francisco Fully-Integrated Recovery Services (SF FIRST) is a multi-disciplinary behavioral health program serving adult residents of San Francisco. SF FIRST works with a diverse group of highly-vulnerable individuals who have multiple medical, psychiatric, substance abuse and psychosocial difficulties. SF FIRST uses principles of wellness and recovery and a trauma-informed approach to meet the needs of clients who have typically experienced difficulty engaging in traditional systems of care. At the time of enrollment, SF FIRST clients are often experiencing homelessness or are marginally housed and are among the highest users of San Francisco's emergency medical and psychiatric services.

The SF FIRST FSP program is an intensive case management program that supports people in reaching their treatment and recovery goals. The SF FIRST FSP program works with a variety of service providers and stakeholders to coordinate and increase the efficiency of the service provision. SF FIRST services include: behavioral health, integrated primary care, intensive case management, psychiatric services, crisis intervention services, linkages to housing, after-hours on-call services, harm reduction, community integration, peer support, vocational services, and payee services. The SF FIRST FSP supports clients in attaining wellness by supporting them in mitigating medical, psychiatric, substance use disorder, and chronic homelessness challenges. The SF FIRST programs have achieved many successes including supporting 81% of all enrolled SF FIRST clients in getting permanently housed and 30% participating in vocational programs.

One of the many services provided to clients is a specialized job-training program - the SF FIRST Vocational Program. The SF FIRST Vocational Program assists SF FIRST FSP clients with job readiness and training. In developing their wellness and recovery plan, SF FIRST vocational program participants express a desire to develop job readiness skills around organization, time management, communication, and goal-setting, among others. SF FIRST Vocational Program connects clients to stipended employment positions (1-5 hours per week) across different industries, with a wide range of experience and opportunity. Position and placements have been as an assembly and packing worker, barista, donation deliverer, food preparation worker, building greeter, and laundry assistant. In addition to stipends and training, the program provides clients with vocational counseling 1-3 times per month in effort to help mitigate any job retention barriers.

In FY17-18, the SF Vocational Program achieved the following program goals, including:

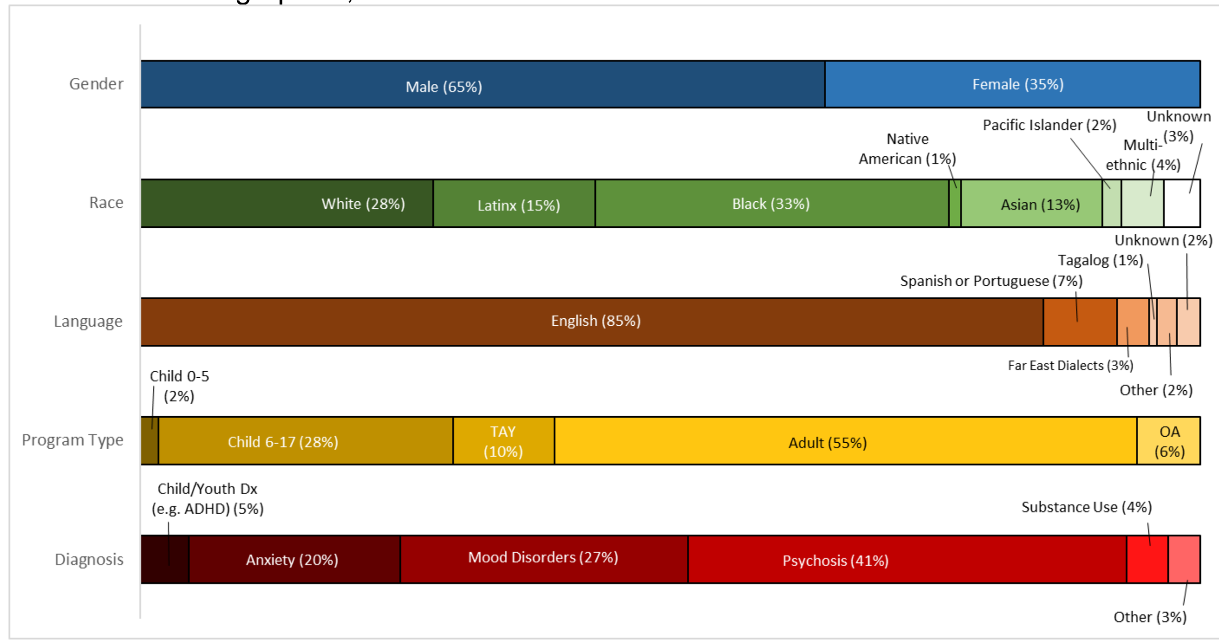
- Served 22 of the 110 clients enrolled in the SF FIRST FSP Program (exceeding goal of 20 clients).
- 82% of clients (18 of 22) self-reported improvements in their coping abilities at the 9-month program completion date (exceeding goal of 75%).
- 10 clients completed the entire 9-month program (meeting goal of 10 clients).

FSP Participant Demographics, Outcomes, & Cost per Client

Demographics

San Francisco runs eleven FSP programs annually with a client total of nearly 1,000 clients (n=995) active during the fiscal year 17-18. The graph below shows the percentages of clients for each gender, race/ethnicity, primary language, age group (program type) and primary diagnosis prevalent among FSP clients.

FSP Client Demographics, overall



FY17-18 Key Outcomes and Highlights

FSP Data Collection and Reporting (DCR) Outcomes

The MHSA DCR system tracks outcome indicators for all FSP clients across the state of California using a web-based portal managed by the Department of Health Care Services (DHCS). Providers enter client data into the portal throughout the duration of a client's partnership. On a weekly basis, San Francisco downloads this data from the state server into a county SQL server data warehouse. From this we generate datasets and reports, share them with FSP programs and use these tools to create the exhibits below.

Key outcomes reported here for FSP clients include time spent in different residential settings and the occurrence of emergency events requiring intervention. These data are entered into the DCR system using Partnership Assessment Forms (PAFs) and Key Event Tracking (KET) Assessments, ideally as they occur. Residential and Emergency outcomes are reported here by age group.

Residential Settings

Residential settings are first recorded in the PAF by the case manager at the time of a client's enrollment in the FSP. Any changes to this initial residential setting are logged in a KET, along with the date the change occurred. This date starts the clock in a calculation of the number of days a client spends in each living situation until the next change in setting.

Who is being reported? Residential Settings graphs include all clients active in the FSP during FY17-18 with a completed PAF, who have been in the FSP partnership for at least one continuous year. These graphs exclude clients who have been active in the FSP for less than one year.

Specific outcomes reported here include the **number of clients** who spent days in each residential setting and the **percent of total days** all clients spent in a residential setting.

The following charts compare active clients' baseline year (the 12 months immediately preceding entry into the FSP) to the first complete year enrolled in the FSP. As clients have entered the FSP in different years, the baseline and first years are not the same years for all currently active clients. Also displayed is the percentage change in time spent in each setting for the baseline year as compared to the first year in FSP. Typically, clients spend time in more than one setting over the course of each year.

Residential settings are displayed from more desirable (generally more independent, less restrictive) to less desirable, but this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for one client, for another the move could be an indication of getting into much needed care for the first time. Because residential settings differ greatly between children and all other age groups, the following graphs (Exhibits CYF-1 – OA-1) show each age group separately.

Emergency Events

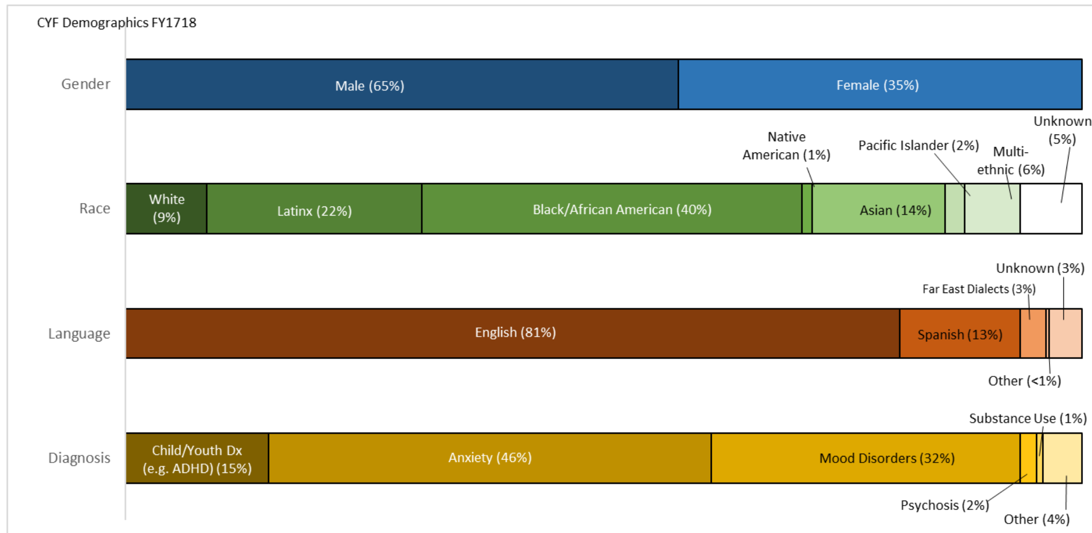
Emergency events include arrests, mental health or psychiatric emergencies (which include substance use related events), and physical health emergencies, as well as school suspensions and expulsions for children and TAY. Physical health emergencies are those which require emergency medical care (usually a visit to the hospital emergency department), not those of a psychiatric nature. The KET is designed for case managers to enter these events as they occur, or the first opportunity thereafter.

Who is being reported? The graphs below compare emergency events for **all FSP clients active any time in the fiscal year 2017-18** from the one-year baseline (Immediately preceding enrollment in the FSP) to an **average of emergency events over all years in the FSP**. Event rates are reported here, for simplicity, as number of emergency events per 100 clients.

Note that the numbers of active clients reported for emergency events below, in each age group, are larger than for residential events. Unlike the residential data, the emergency events graphs include all active clients, even if they have been in the FSP for less than one year.

Children, Youth and Families (CYF)

Exhibit CYF-1. CYF Client Demographics, n=294



Child, youth, and family (CYF) client data show movement from restrictive settings into more home-based settings during FSP treatment. Child clients are typically more stable in their residences than older clients, especially once in FSP, and show more modest changes across settings. The biggest change was seen in the reduction of child clients who experienced Residential Treatment once in FSP (-10). Interestingly, although fewer clients were living With Other Family (Exhibit CYF-2) after one year in FSP, the amount of time (days) clients spent in this setting increased slightly (Exhibit CYF-3). So too, youth who remained in FSPs for at least one year increased the number of days they recorded living in foster homes or in places they rented (Exhibit CYF-3). This suggests that perhaps FSPs were helpful in assisting some clients with finding and staying in more stable housing within the first year of service.

Exhibit CYF-2. Change in Residential Settings for CYF Clients (1 of 2)

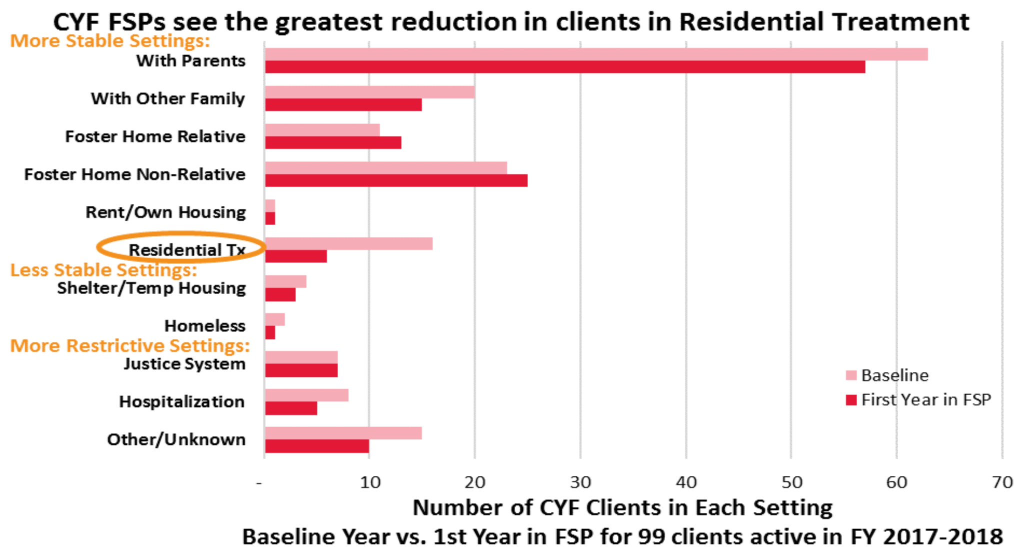
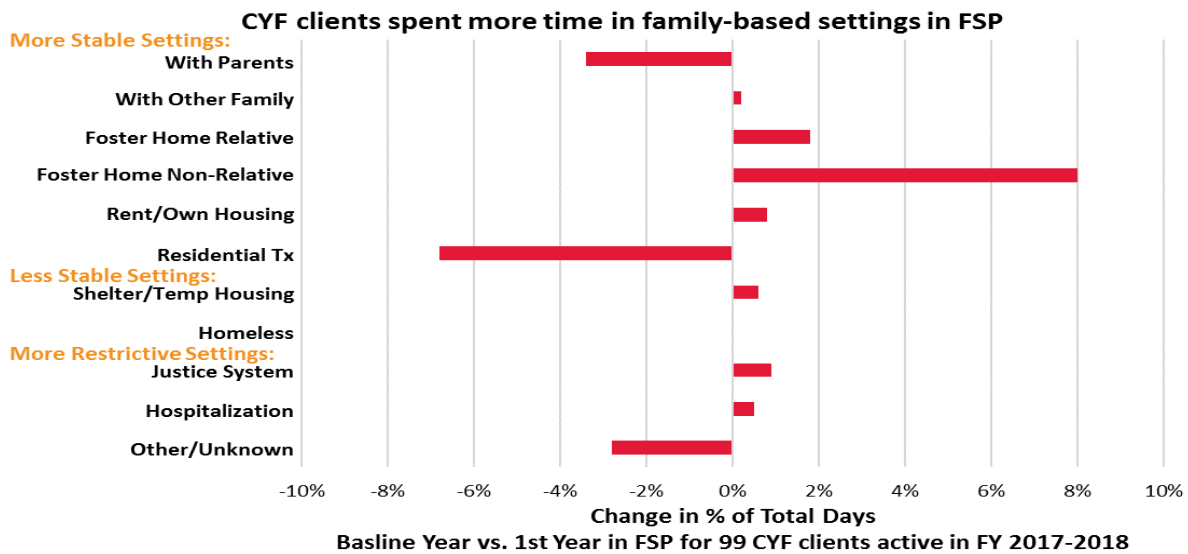


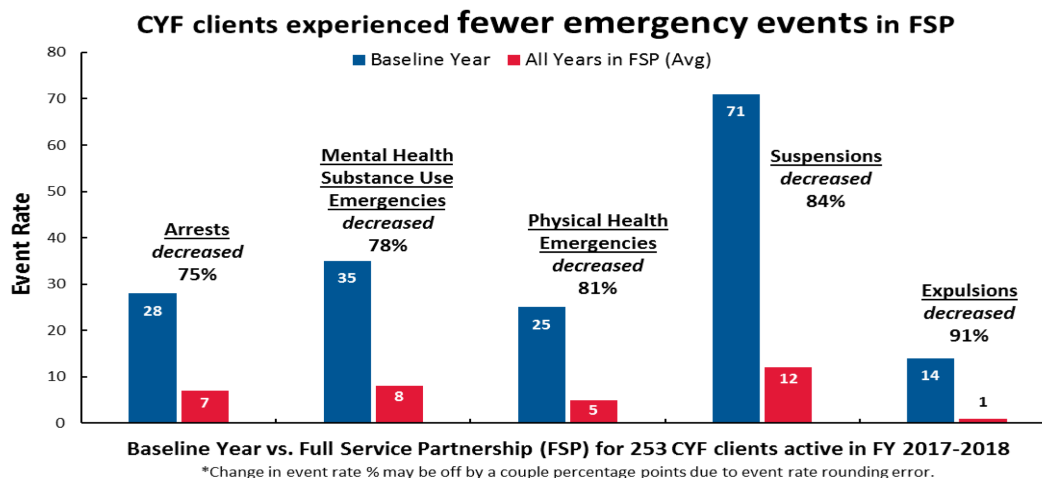
Exhibit CYF-3. Change in Residential Settings for CYF Clients (2 of 2)



Among child clients, fewer emergency events were reported after entering FSP (Exhibit CYF-4)**.** Compared to baseline trends, there were marked declines across all types of emergency events reported for child clients. One contributing factor to reduced expulsions is that the San Francisco Unified School District (SFUSD) recently initiated a policy that disallows expulsions. Because some clients' baseline and follow up years were prior to this policy change, or they are students outside the SFUSD, expulsions do still appear in the graph, albeit at a much lower rate.

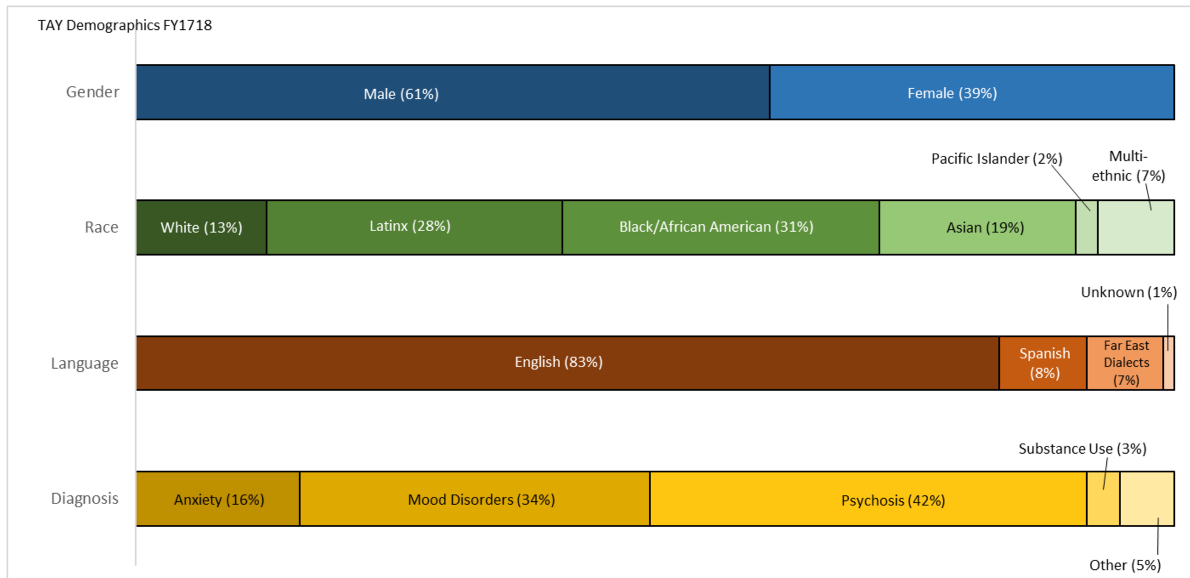
The Child cohort trends for emergency events highlight two contrasting possibilities: Either the data is complete and FSPs are drastically reducing emergency events for clients following engagement in FSP, or the Key Events data is not complete and these decreases are artifacts of a bigger systems documentation issue. Data Quality reports suggest that there is some missing DCR data for CYF clients, and thus, these trends should be interpreted with caution.

Exhibit CYF-4. Emergency Events for Child Clients



Transition Age Youth (TAY)

Exhibit TAY-1. TAY Client Demographics, n=95



TAY clients accessed more stabilizing settings in FSP treatment (Exhibit TAY-2). More TAY moved out of Justice and Hospital settings in their first year in FSP and spent less time (days) in each of these settings than they did prior to enrolling in FSP services (Exhibit TAY-3). TAY spent 6.8% more total time in SRO with Lease and 4.9% more in Supervised Placement during their first year in FSP, suggesting some TAY clients are gaining access to housing and/or stabilizing enough to maintain more stable housing. The positive changes in residential settings are further reflected by TAY having spent 4.5% fewer days in Justice System settings and 4.0% fewer days Hospitalized.

Exhibit TAY-2. Change in Residential Settings for TAY Clients (1 of 2)

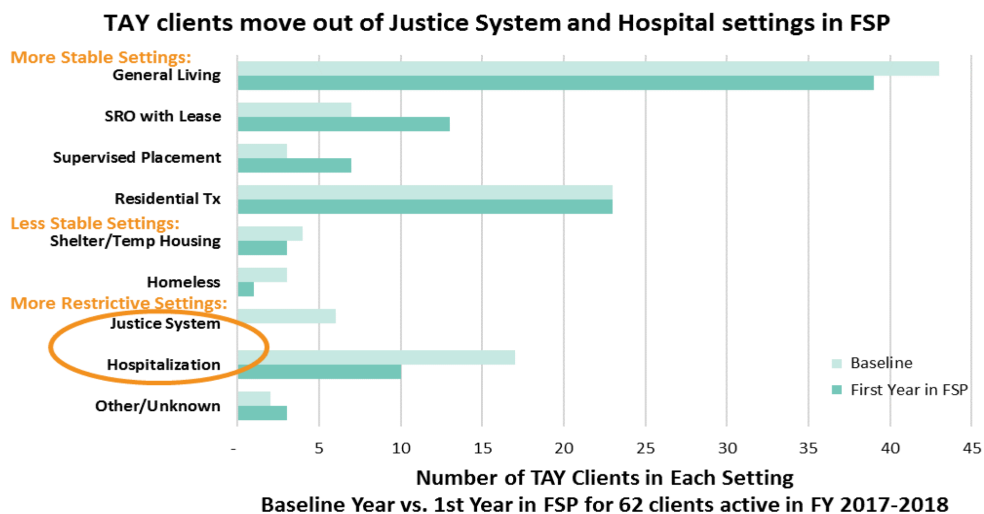
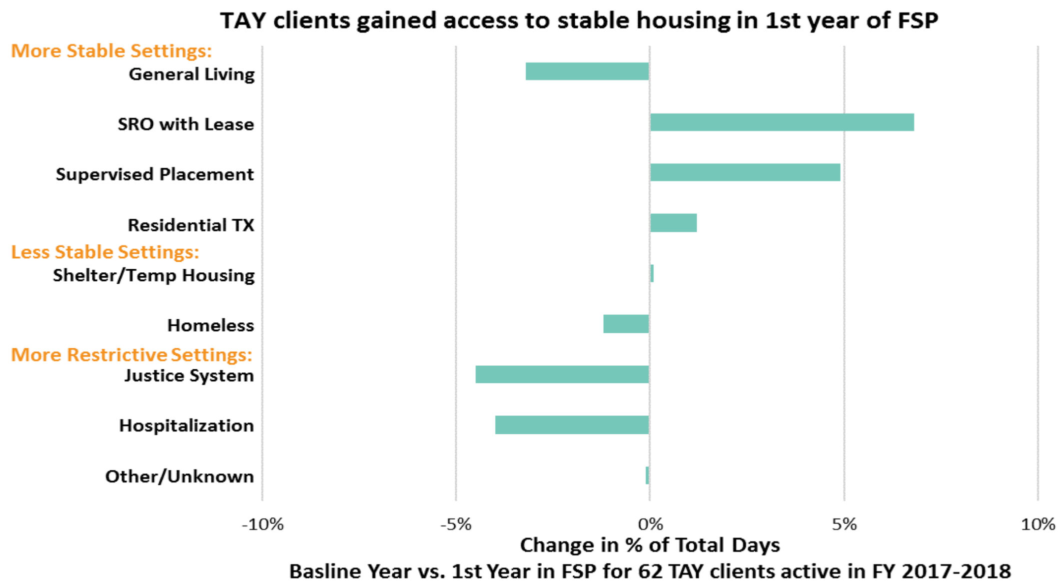


Exhibit TAY-3. Change in Residential Settings for TAY Clients (2 of 2)

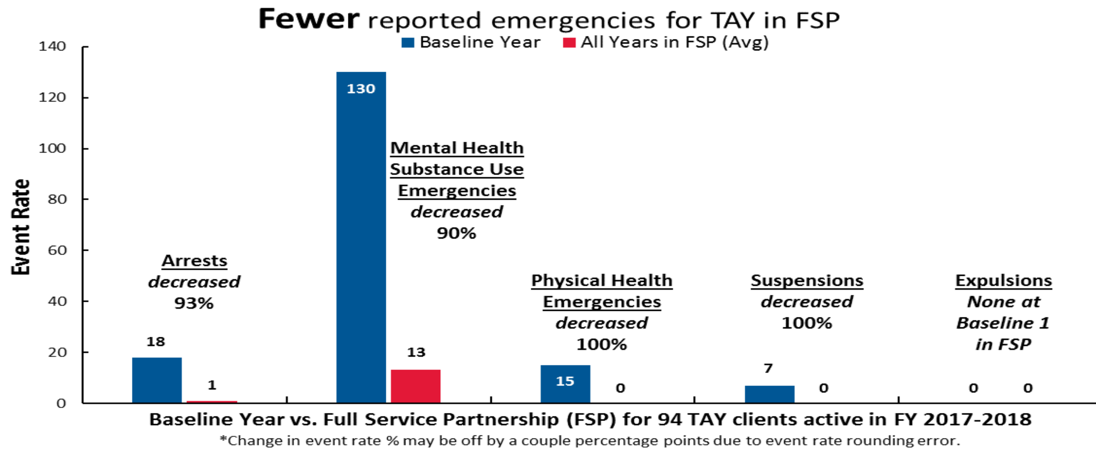


For TAY clients, fewer emergency events were reported (Exhibit TAY-4)**.** Marked declines appear across all emergency events experienced by TAY clients. Most noticeably, physical health emergencies decreased 97% and arrests decreased 93%, from 15 events per 100 clients to 0 and 18 events to 1, respectively. Mental Health Substance Use emergencies dropped from 130 events per 100 clients in the baseline year, to 13 events per 100 clients in the FSP years.

Based on discharge data that suggest engaging with TAY is a major challenge (see Exhibit 11 that shows 14% “Unable to Locate” and 36% “Partner Left Program”), many TAY clients are likely to leave the FSP within year one. This suggests that some TAY clients with high distress are under-represented in the follow-up FSP rate. School Suspensions (reduced from 7 to 0 per 100 clients) also show significant improvement. No School Expulsions were reported in the baseline or FSP years for TAY active in 2017-18. Either expulsions are under-reported, or this decrease reflects a recent policy change in the school district, as mentioned for Exhibit CYF-4, which strongly discourages student expulsions.

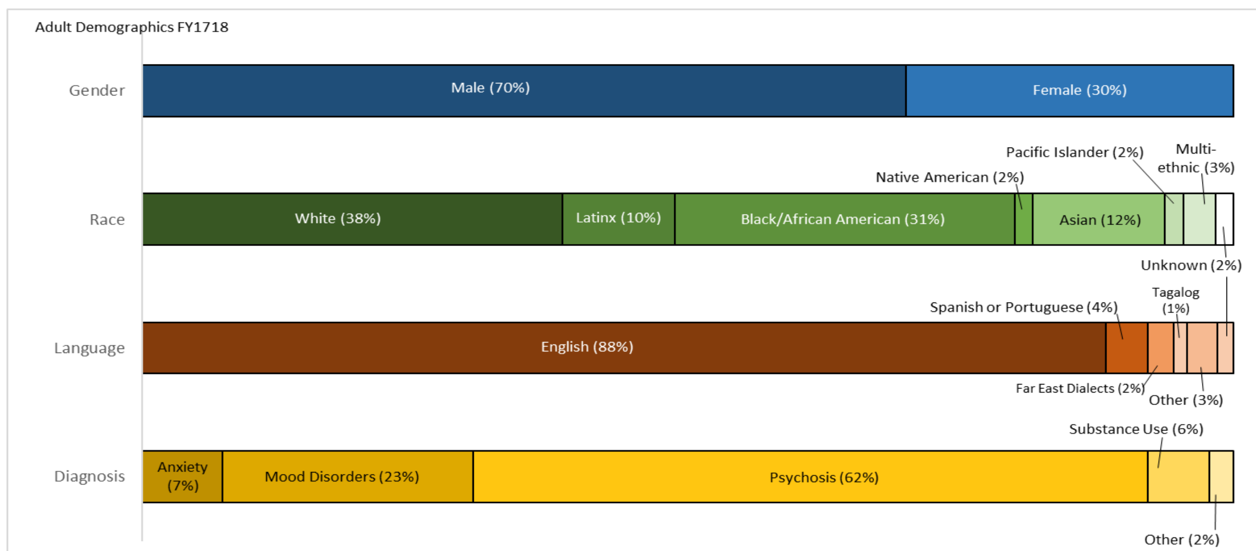
2018 TAY System of Care Launch Event

Exhibit TAY-4 Emergency Events for TAY Clients



<u>Adults</u>

Exhibit AD-1. Adult Client Demographics, n=545



Adult clients saw a reduction in both number of clients (Exhibit AD-2) and amount of time spent (Exhibit AD-3) in Homeless, Justice System, and Hospital settings after the first year in FSP services. From baseline to first year in FSP during FY17-18, there were fewer adults and less time spent Homeless (-43 people, -6.9% days), in the Justice System (-54 people, -9.2% days), and Hospitalized (-49 people, -1.4% days). There was an increase in the number of clients (+10) and in the percentage of days spent in General Living arrangements (+0.6%), SRO with Lease (+53, +6.7%), MHSA Stabilization (+31 people, +2.6% days), and Supervised Placement (+11 people, +2.5% days). Fewer clients spent time in Residential Treatment (-3), but there was an increase in the percentage of days spent in this setting (+5.8%), which may represent an advancement in recovery for FSP clients who have not previously accessed care.

Exhibit AD-2. Change in Residential Settings for Adult Clients (1 of 2)

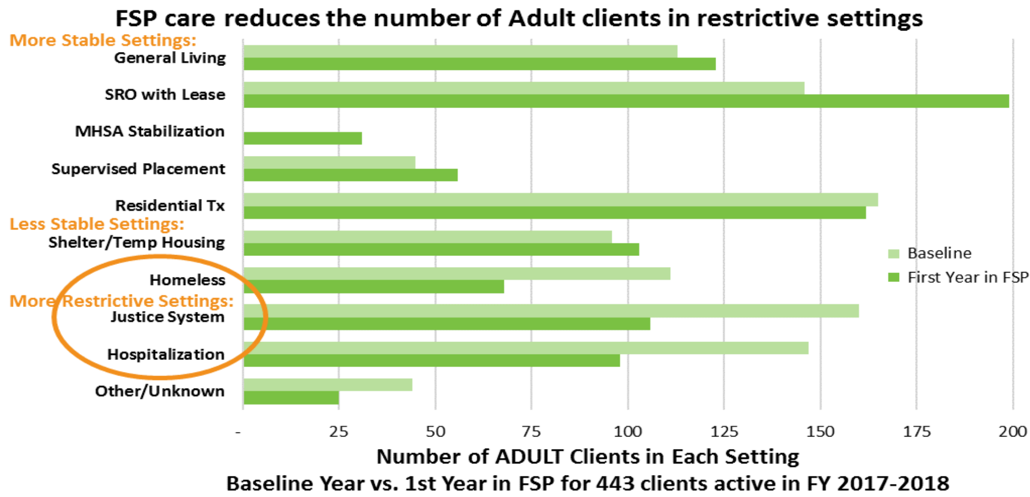
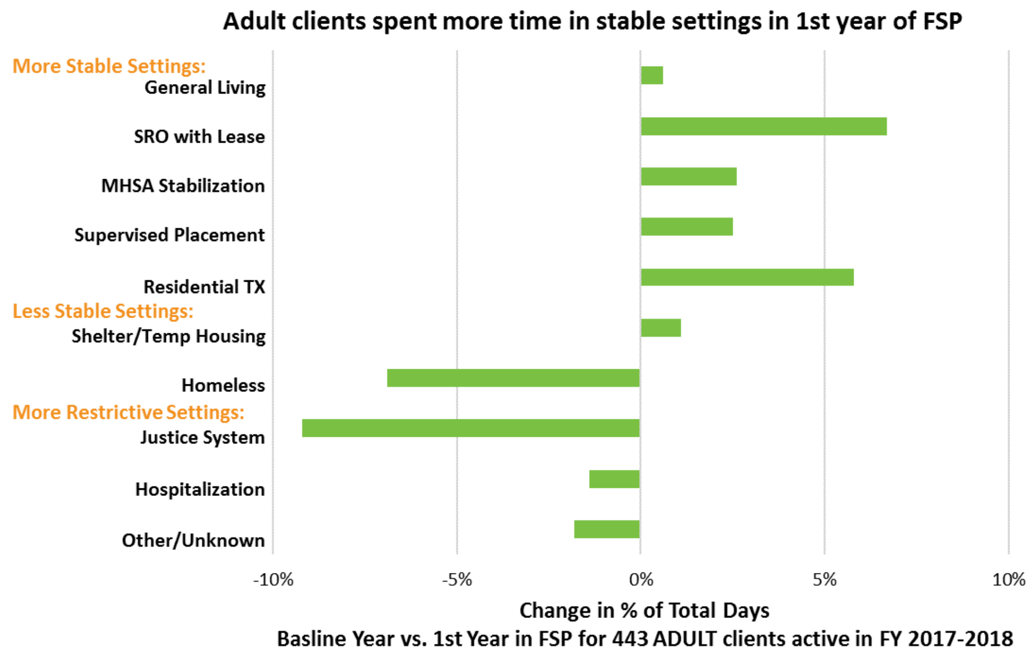
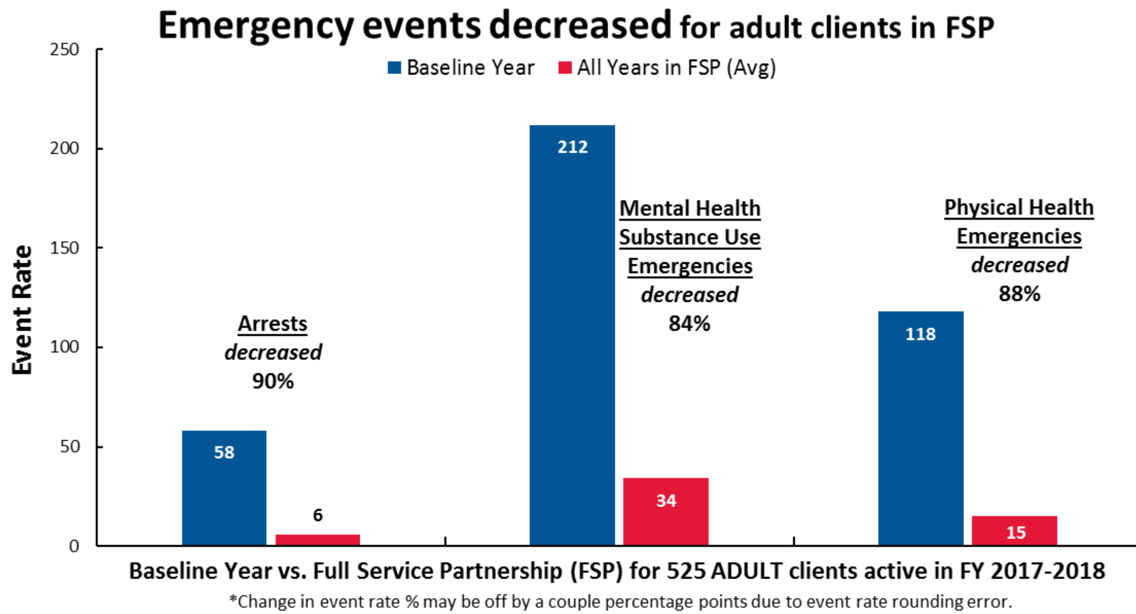


Exhibit AD-3. Change in Residential Settings for Adult Clients (2 of 2)



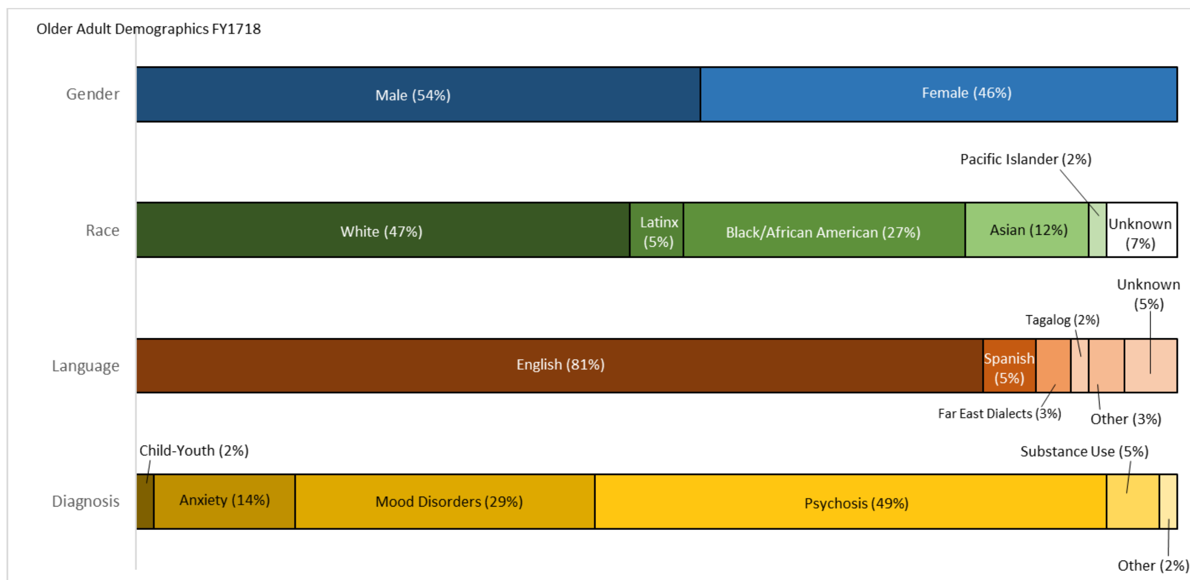
Adult clients show fewer emergency events since enrollment in FSP programs (Exhibit AD-4)**.** As depicted, there were declines reported across all emergency events. Arrests dropped 90%, from 58 per 100 clients in the baseline year, to 6 events per 100 clients in the FSP years. Reports of Mental Health Substance Use Emergencies declined 84% from 212 per 100 clients in the baseline year, to 34 events per 100 clients in FSP. Physical Health Emergencies declined 88% from 118 per 100 clients in the baseline year, to 15 in 100 in the FSP years.

Exhibit AD-4. Emergency Events for Adult Clients



Older Adults

Exhibit OA-1. Older Adult Client Demographics, n=59



Older Adult FSP clients show significant decreases in time spent in unstable settings. Data indicate fewer (-9) older adult clients (Exhibit OA-2) spent a lower percentage of total days (-3.8%) (Exhibit OA-3) during their first year in FSP in Hospitalization settings and in the Justice System (-1 person, -2.8% days). While the number of people Homeless stayed the same in the first year of FSP (5 people), the amount of time clients spent Homeless decreased (-5.9% days).

Similarly, the number of clients in General Living arrangements stayed the same, but the amount of time spent in General Living increased by 2.4%, suggesting that FSP helps clients stay in stable settings longer.

Exhibit OA-2. Change in Residential Settings for Older Adult Clients (1 of 2)

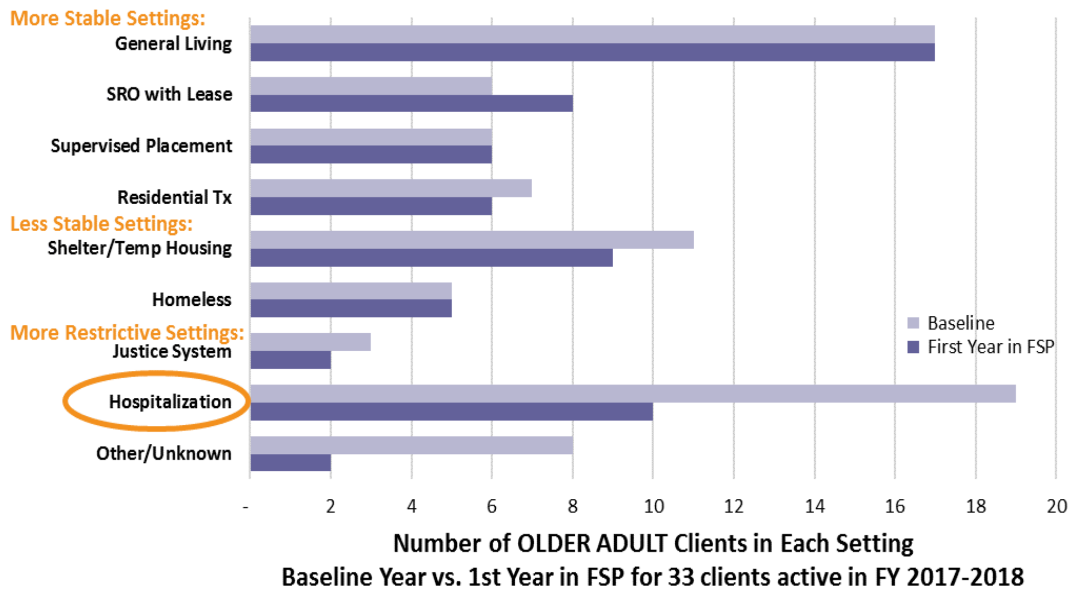
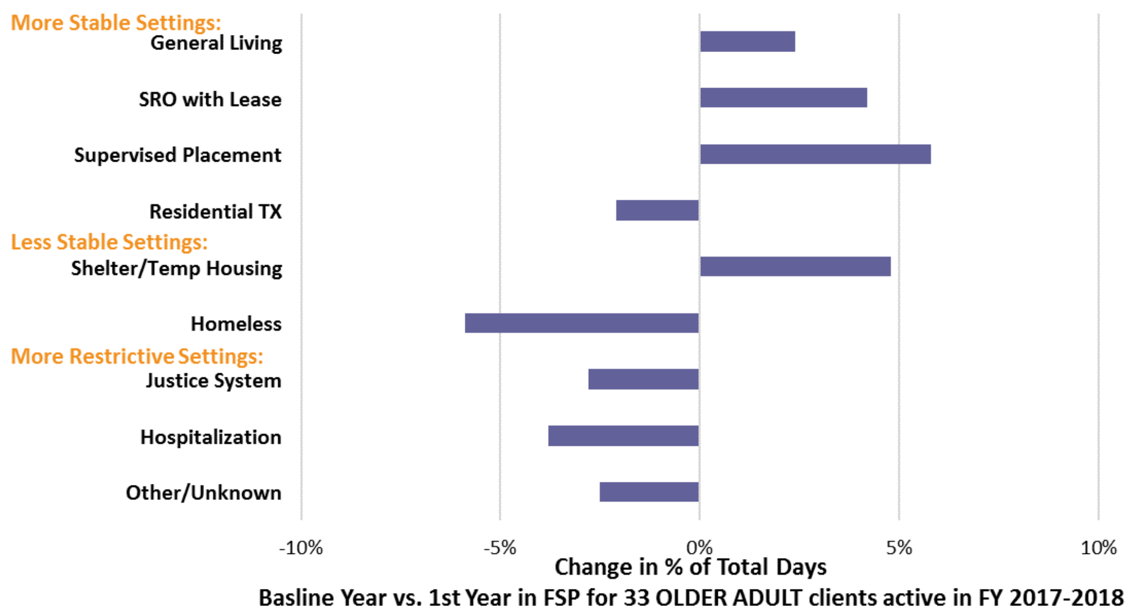


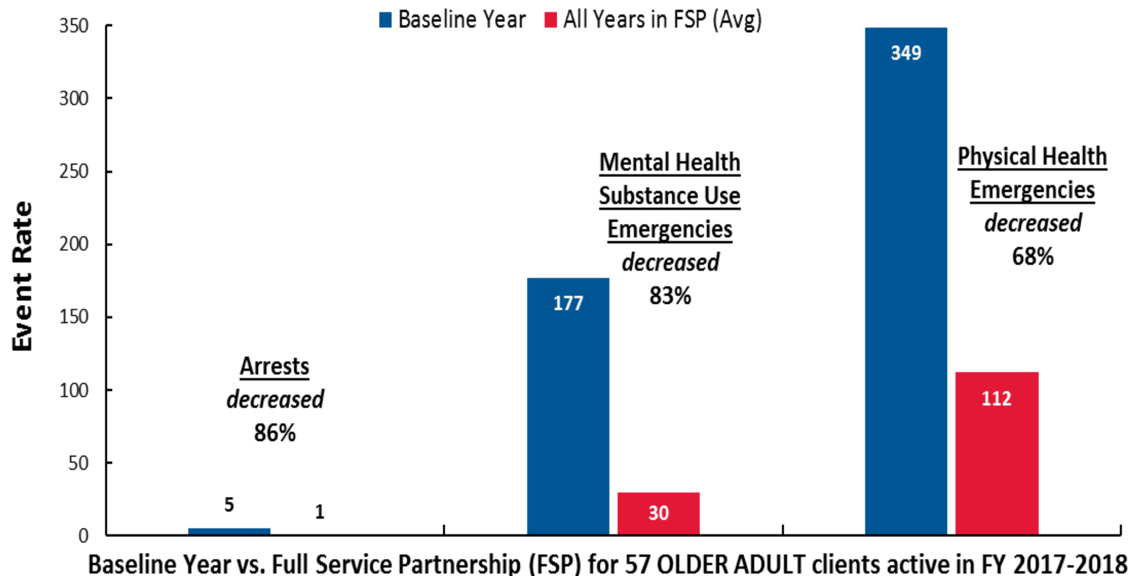
Exhibit OA-3. Change in Residential Settings for Older Adult Clients (2 of 2)



Despite high levels of physical health emergencies among older adult clients at baseline, data reveal improvements after the first year in FSPs (Exhibit OA-4)**.** Arrest rates reduced 86% from 5 to 1. The rates of mental and physical health emergencies also dropped 83% and

68% respectively. Physical health emergencies are commonly reported for older adults, as many as 112 per 100 clients even while in FSP treatment. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

Exhibit OA-4. Emergency Events for Older Adult Clients

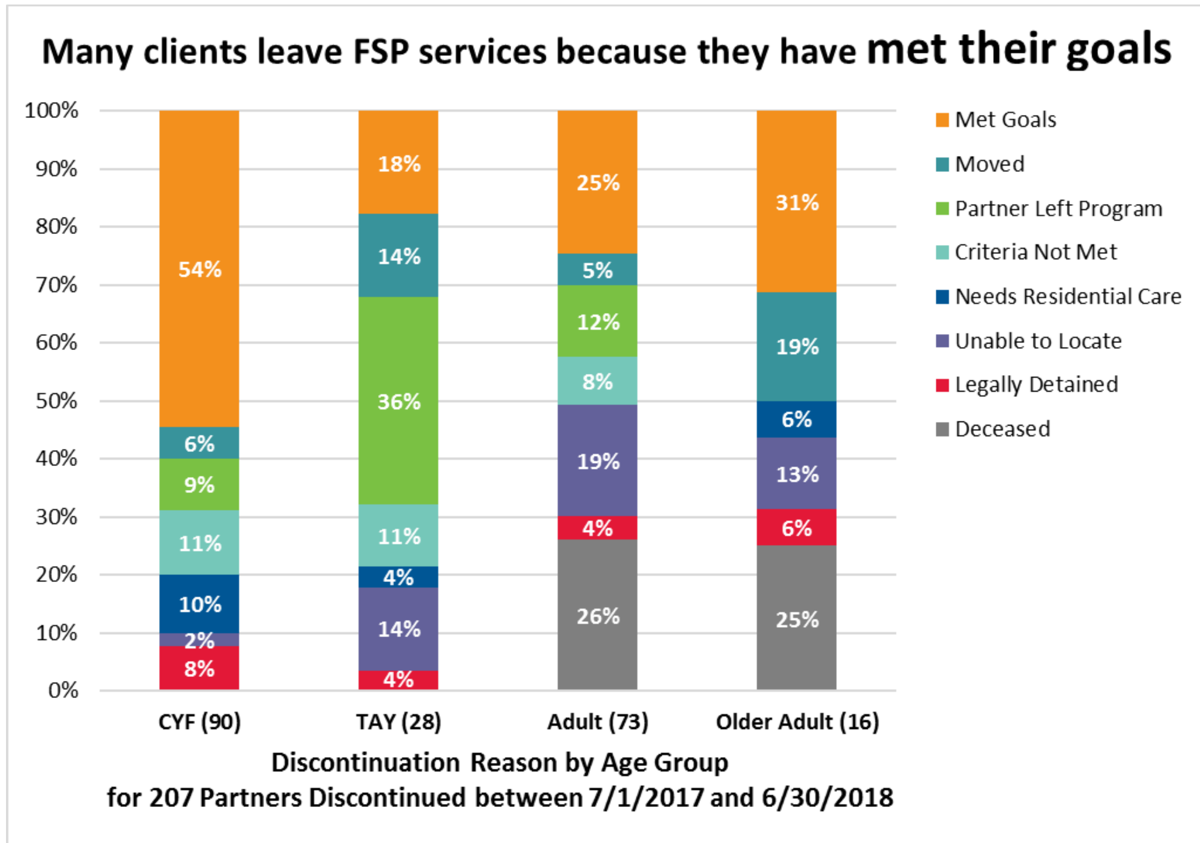


Reason for Discontinuation

Reason for Discontinuation is logged by the case manager as a Key Event when a client is discharged from the FSP. Clients may leave the program when their treatment goals are met, however, many leave for other reasons, some of which suggest the level of care is no longer appropriate or the client is not engaging in treatment.

Reasons for Discontinuation varied widely in FY17-18. “Met Goals” was the most reported reason for discontinuation for CYF and Older Adult FSP clients, and represented 37% of discharges overall. TAY clients left FSP services (Partner Left Program) most often across the four age groups. Most concerning in this display is that, that among adults, 26% of discontinuations were due to death, most likely premature, caused by long-term substance overuse, chronic medical conditions, homelessness, and poor access to medical care.

Exhibit RFD. Reason for Discontinuation for All Clients, by Age Group



The high rate of TAY departures from FSP is an ongoing challenge of appropriate engagement and availability of TAY centered behavioral health services, among other things. San Francisco County is addressing this challenge with the launch of a TAY system of care described elsewhere in this report.

Improving DCR Data Quality

Since the inception of the DCR, ensuring high quality KET data to capture 100% of residential changes, emergency events and other life events has proven a formidable challenge.

San Francisco formed the DCR Workgroup, comprised of two MHSA evaluators and one IT staff person to work with FSP programs to support accurate and timely client data entry into the DCR. The Workgroup developed several data quality and data outcome reports that are shared monthly with the FSP programs in an effort to help monitor and increase the level of completion for KETs.

The Workgroup has also shared a KET tracking template as a tool to help case managers record KETs as the events occur and remember to enter them in the DCR at a later time. Data quality and completion appear to be impacted or enhanced, depending on the staffing capacity of the program to support data entry as a priority.

Beginning in FY15-16, BHS established 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. One objective monitors the percentage of clients with open FSP episodes in the Avatar EHR who are enrolled in the DCR. A second objective sets an expectation that programs should have 100% of expected Quarterly Assessments completed for all clients. For FY17-18, 2,920 Quarterly assessments were due for 929 active clients in the DCR. Among these, 72% of the assessments were completed. QM technical assistance and support, including coaching on assessment completion, are in place to increase compliance and the accuracy of outcomes data.

2018 Consumer, Peer and Family Conference

The DCR Workgroup also provides in person trainings in the DCR and visits individual programs as needed. In FY17-18, the DCR Workgroup conducted five DCR user trainings and provided ongoing daily support in both data entry and reporting over email and phone. Based on these trends, more communication and support is needed to increase the completion rate of DCR data.

DCR Security Update

The California Behavioral Health Information Systems (BHIS) under the Department of Health Care Services (DHCS) conducted a DCR security upgrade from October to November 2017. This process involved taking the DCR offline and migrating it to a new web address and then recreating all preexisting DCR accounts in the new system. All DCR users were required to re-establish their user accounts to gain entry into the new DCR system.

Changes in the way the new DCR portal functioned created challenges for FSPs. Three challenges, in particular, stand out. First, County Administrator status is necessary for entering new users into the DCR. DHCS implemented a limitation on the number of County Administrators to two in the new DCR, when previously there was no restriction. San Francisco County, for example, had as many as six County Administrators who could provide technical assistance to users. The considerable reduction in the number of County Administrators for San Francisco significantly impacted the process of adding over 150 users back into the DCR. The approval of a new, second County Administrator took several months. These limitations caused significant delays and a loss of data entry which we are still trying to correct.

Second, the new DCR required all users provide an organizational email address in order to re-establish their DCR account. Several of our FSP utilized email addresses that did not have or-

ganizational names. One small FSP program, and interns at several others, used generic accounts, such as @gmail, @yahoo, etc., for conducting business. Requiring these FSP's to use email addresses hosted by their organization created an added burden on programs that were required to change their email practices in order to regain access to the DCR.

Third, a feature of the new DCR is that account passwords expire very quickly, every 75 days. If a password expires, it must be reset by BHIS. Providers have reported the new DCR protocol has locked them out more frequently than before the security upgrade.

DCR data entry was delayed for up to four months for all FSPs as a result of restricted access during the DCR migration period and subsequent transition planning to work with the new system. Extra emphasis was made on entering FSP outcomes data for the months the DCR was unavailable, but we expect some data are still missing.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[2]**
FSP Children	294 Clients	$1,362,289	$4,634
FSP TAY	95 Clients	$1,207,223	$12,708
FSP Adult	545 Clients	$4,218,561	$7,740
FSP Older Adult	59 Clients	$988,074	$16,747

Trauma Recovery Programs

Program Collection 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.

[2] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Target Populations

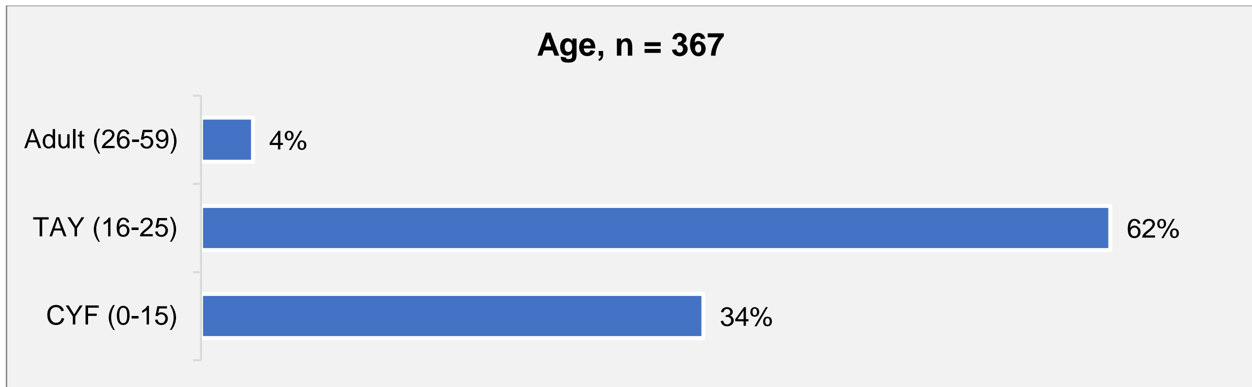
The Trauma Recovery programs serve youth ages 12 to 25, as well as their families, with a focus on youth of color, particularly Latinos who reside in the Mission District, and youth who come from low-income and/or immigrant families. Program participants are typically individuals who have been affected by violence. Most often, these youth are faced with a number of additional risk factors, including lack of educational success/withdrawal from school, familial mental health and substance use disorders, multi-generational family involvement in crime, community violence, and extreme poverty.

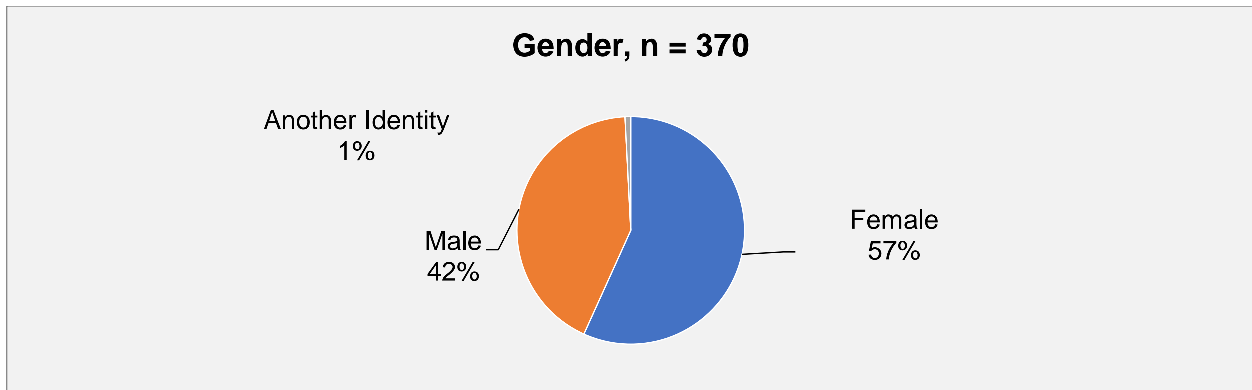
MHSA TAY 2018 Launch Event

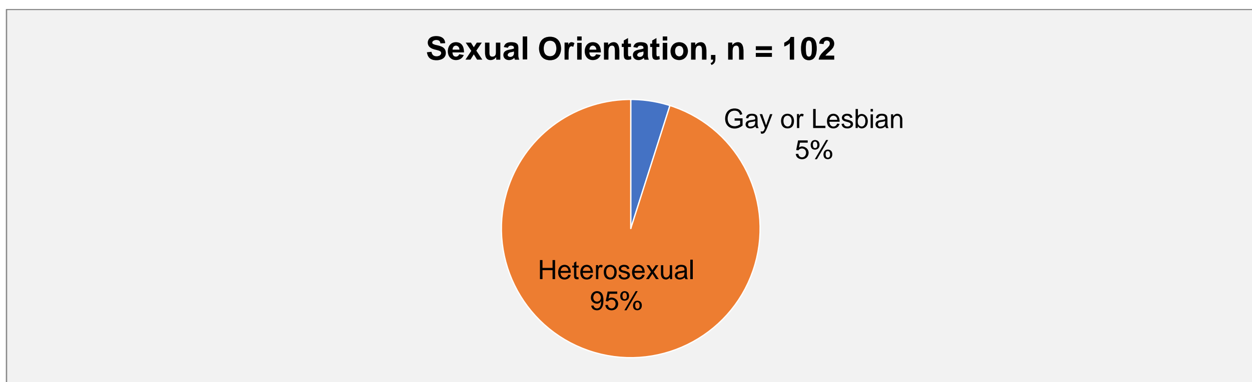
Trauma Recovery Programs	
Program Name *Provider*	**Services Description**
La Cultura Cura/Trauma Recovery and Healing Services *Instituto Familiar de la Raza (IFR)*	Instituto Familiar de la Raza provides trauma recovery and healing services through its Cultura Cura Program to individuals ages 12 to 25 and their families, with an emphasis upon Mission District youth and Latinos citywide. Services include prevention and intervention modalities to individuals, agencies and the community.
Emic Behavioral Health Services *Horizons Unlimited*	Horizon Unlimited's Emic Behavioral Health Services (EBHS) program provides services to meet the unmet mental health needs of youth and families whose problems place them at significant risk, and impede adequate functioning within their family, school, community and mainstream society. The EBHS treatment model combines culturally informed, evidence based substance abuse and mental health principles and practices that are linguistically sensitive, strength based, family focused and bio-psychosocially-oriented.

Participant Demographics, Outcomes, and Cost per Client

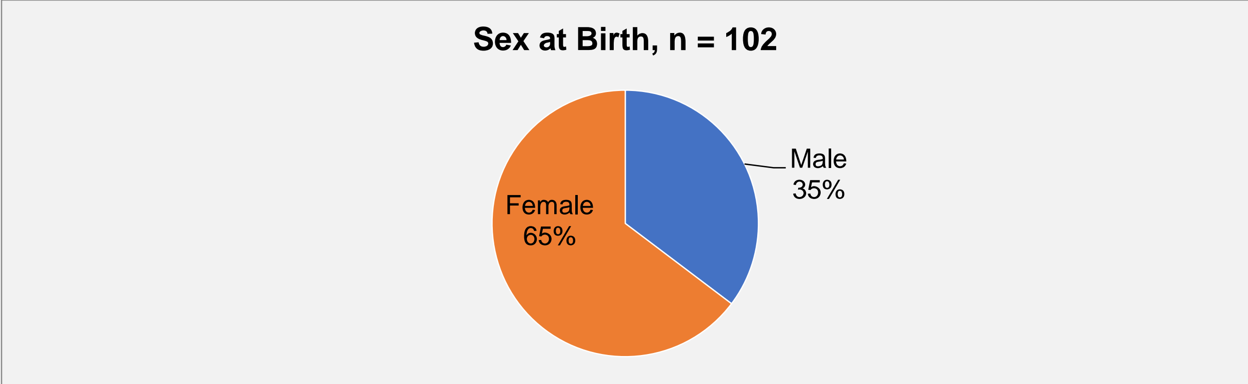
Demographics: Trauma Recovery Program Participants[3]

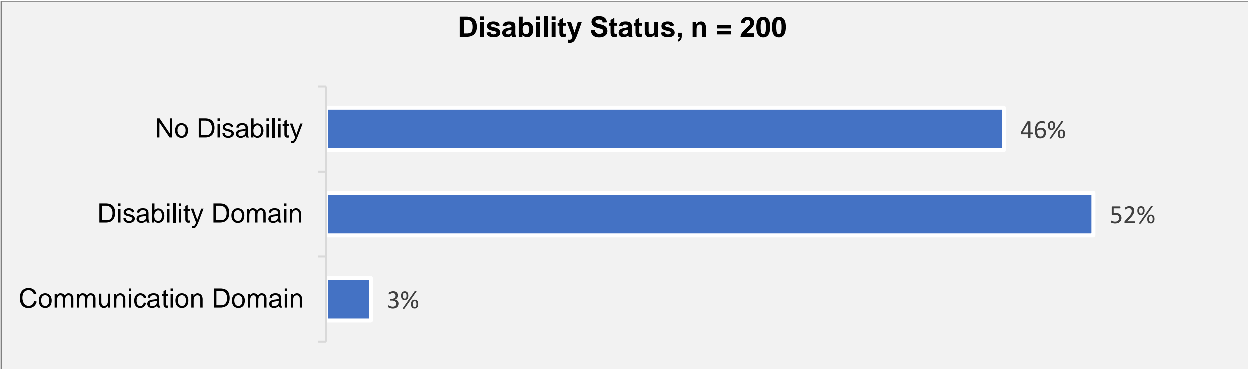






[3] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).





Race/Ethnicity	n	%
Black/African-American	8	2%
Native Hawaiian Islander	1	0%
White	174	33%
Hispanic	336	64%
Non-Hispanic	4	1%
More than one ethnicity	2	0%
Total	**525**	**100%**

Primary Language	n	%
English	74	20%
Spanish	293	80%
Total	**367**	**100%**

For Trauma Recovery programs, 0% of participants reported data for the following languages: Chinese, Another Language, Russian, Tagalog, and Vietnamese. Also, 100% of participants reported non-veteran status and 0% of participants reported data for American Indian/Alaskan, Asian, and Other Race.

Program *Provider*	FY17-18 Key Outcomes and Highlights
La Cultura Cura (LCC) *Instituto Familiar de la Raza (IFR)*	• LCC served 269 unduplicated youth and families through its array of interventions, including referral follow-up, assessment and treatment, capacity building sessions, crisis response and debriefing, and drumming circles. • 100% of youth and families referred to LCC received follow-up services (exceeding goal of 85%). • LCC conducted a Drumming for Peace session and co-sponsored 9 indigenous ceremonies (including Mayahuel, Tonantzin, Cuahtemoc, Fiesta de Primavera, Native American Water Walk, EHECATL and Xilonen, and two for Día de los Muertos). The total estimated number of participants for these ceremonies is 1,700. • 82% of youth receiving mental health treatment (23 out of 28) improved on their symptoms as measured by CANS assessment scores, self-reporting, or clinician observations. • An LCC clinician piloted a monthly drumming group for three months for 5 youth at Balboa High School to increase their capacity to deal with stress and express their frustration, anger and sadness in a transformative way. Clinician introduced the youth to traditional drumming rhythms and medicinal herbs, such as sage and lavender to decrease stress. We feel the pilot was successful with youth reporting, "I was able to release bad energy" and "I feel so much better after this."
Emic Behavioral Health Services *Horizons Unlimited*	• Staff conducted outreach to 495 individuals in the community to raise awareness of available services • 102 clients were screened and assessed for behavioral health concerns. • 69% (70 of 102) were referred to an array of services. • 102 clients received non-clinical case management services and were linked to appropriate services based on their needs. • 41 TAY participated in wellness promotion activities through support groups or medicinal drumming sessions • 35 of the 41 TAY reported that they learned coping skills to help them manage stressful situations • 48 participants received individual &/or family therapeutic services.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[4]**
Trauma Recovery Programs	371 Clients	$469,309	$1,265

Behavioral Health and Juvenile Justice System Integration

Program Collection Overview

MHSA Consumer, Peer, and Family Conference 2018

The Behavioral Health and Juvenile Justice System Integration programs serve as a single point of entry for youth involved in the San Francisco Probation System to get connected to community-based behavioral health services. These programs work in partnership with the San Francisco Juvenile Probation Department and several other agencies to provide youth with community-based alternatives to detention and formal probation including case management, linkage to resources and other behavioral health services.

Target Populations

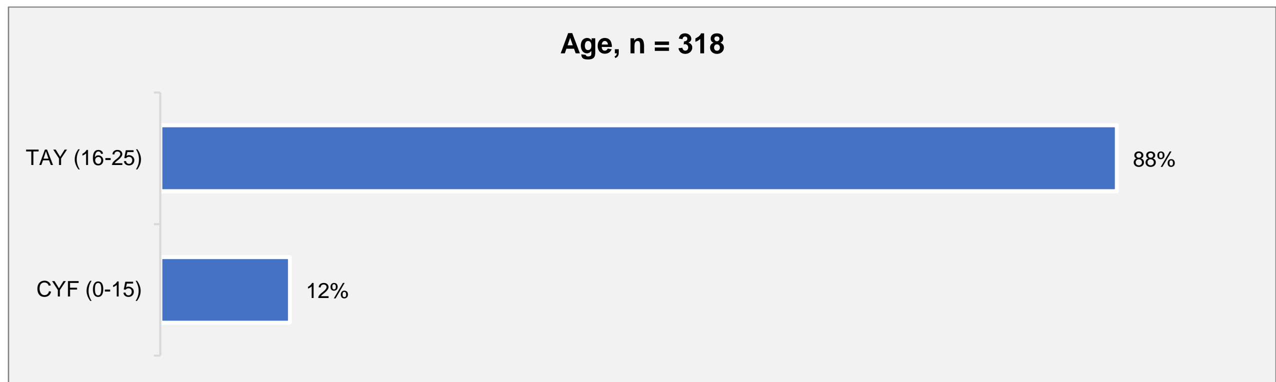
The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11- 21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. These programs and their affiliated programs operate 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 and in Juvenile Hall.

[4] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Behavioral Health and Juvenile Justice System Integration Programs	
Program Name ***Provider***	**Services Description**
Assess, Identify Needs, Integrate Information & Match to Services (AIIM) Higher *Seneca Center and SFDPH*	AIIM Higher is a partnership among the San Francisco Juvenile Probation Department, the Child, Youth and Family System of Care, and Seneca Center. The AIIM Higher team is comprised of mental health clinicians who conduct clinical assessments and facilitate community behavioral health linkages for probation-involved youth in San Francisco.
Community Assessment and Resource Center (CARC) *Huckleberry Youth Programs*	CARC is a partnership among Huckleberry Youth Programs (the managing provider), Juvenile Probation, San Francisco Sheriff's Department, San Francisco Police Department, Community Youth Center and Instituto Familiar de la Raza. A valuable service is the availability of MHSA supported on-site therapists who provide mental health consultation to case managers, family mediation, and individual and family therapy. Mental health consultation is provided through weekly client review meetings and during individual case conferences.

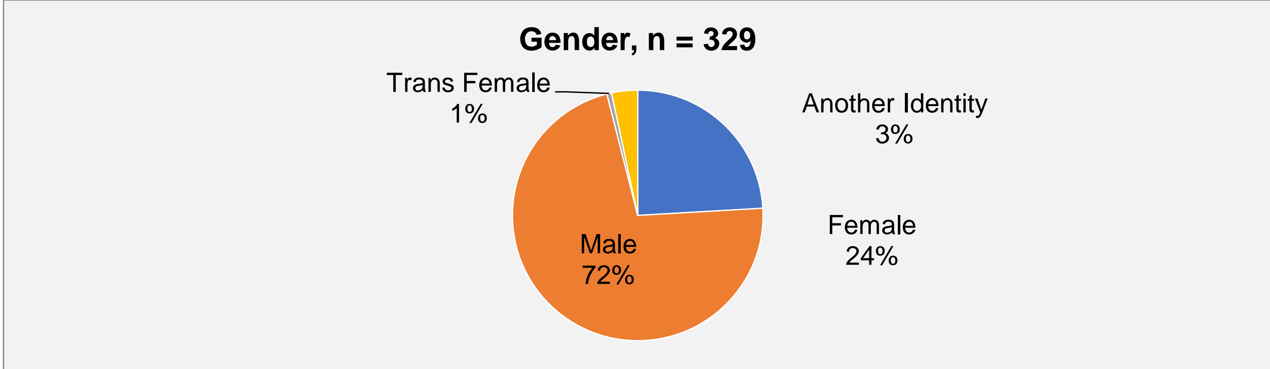
Participant Demographics, Outcomes, and Cost per Client

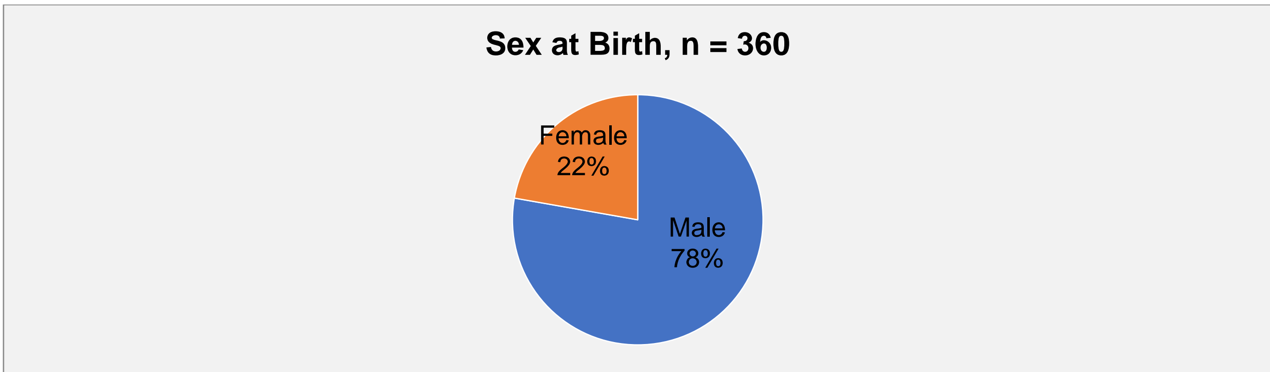
Demographics: Behavioral Health and Juvenile Justice Integration[5]



[5] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).

Recovery-Oriented Treatment Services





Race/Ethnicity	n	%
Black/African-American	136	44%
Asian	3	1%
Native Hawaiian Islander	25	8%
White	12	4%
Other Race	17	6%
Hispanic	76	25%
More than one ethnicity	37	12%
Total	**329**	**100%**

Primary Language	n	%
English	294	89%
Spanish	35	11%
Total	**329**	**100%**

For Behavioral Health and Juvenile Justice Integration, 0% of participants reported data for the following languages: Chinese, Russian, Tagalog, Vietnamese, and Another Language. Also, 100% of participants reported no disability, non-veteran, and unknown sexual orientation. Also, 0% of participants reported data for Non-Hispanic. Additionally, data for American Indian/Alaska were not included since rounded to 0%.

Program *Provider*	FY17-18 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to Services (AIIM Higher) *SFDPH and Seneca Center*	• Of the 329 youth screened for behavioral health needs, 290 received consultation, information and referral or linkage services. • Of the 329 youth screened for behavioral health needs, 39 received the full scope of AIIM Higher services, including assessment, planning, linkage and engagement services) • Of the 39 clients that AIIM Higher served in with the full scope of services, all 39 clients (100%) were linked to appropriate community based services. • Of the youth who received CANS assessments and were successfully linked to services, 100% (39 of 39) participated in warm handoff meetings facilitated by AIIM Higher staff and additional face-to-face services with the identified long-term provider, indicating successful linkage and engagement.
Community Assessment and Resource Center (CARC) *Huckleberry Youth Programs*	• 7,836 duplicated TAY were engaged in outreach and utilized drop-in centers. • 3798 duplicated TAY participated in group activities including health fairs, conferences, and workshops. • 438 TAY were screened for behavioral/mental health concerns. • 100% (438) of TAY who were screened and or assessed were referred or received on-site behavioral health services. • 89% (110 of 124) TAY with written case/care plans (and/or their families) achieved at least one case / care plan goal.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[6]**
Behavioral Health & Juvenile Justice Integration	682 Clients	$330,488	$485

Prevention and Recovery in Early Psychosis (PREP) – Felton Institute

Program Overview

PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full

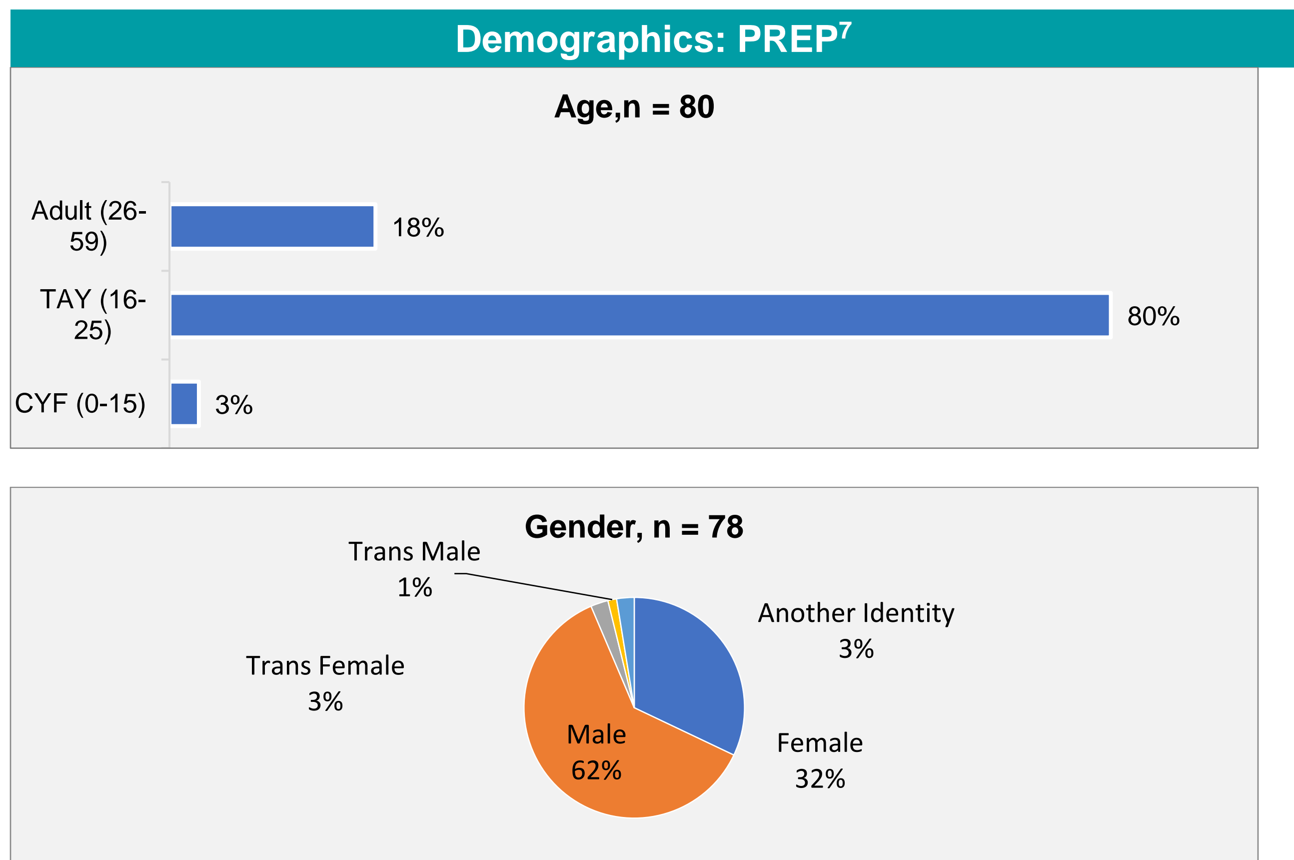
[6] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

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, and 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.

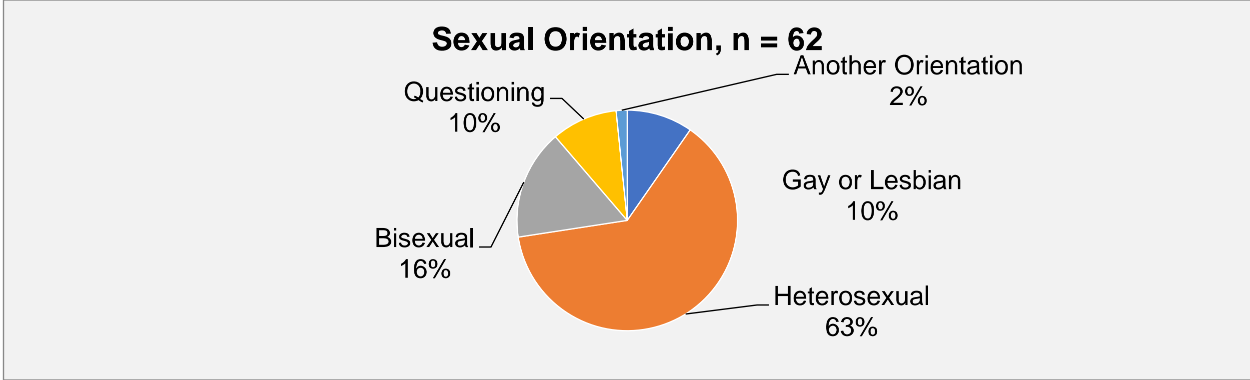
Target Populations

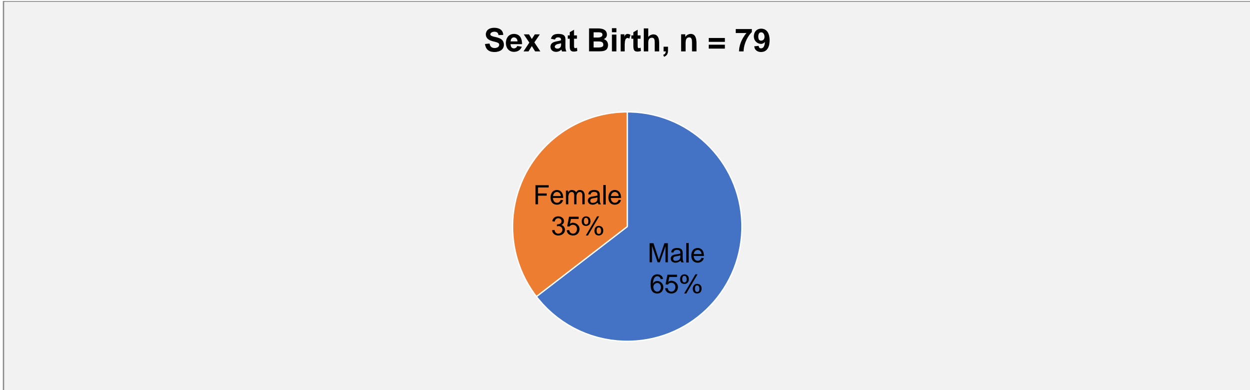
PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years.

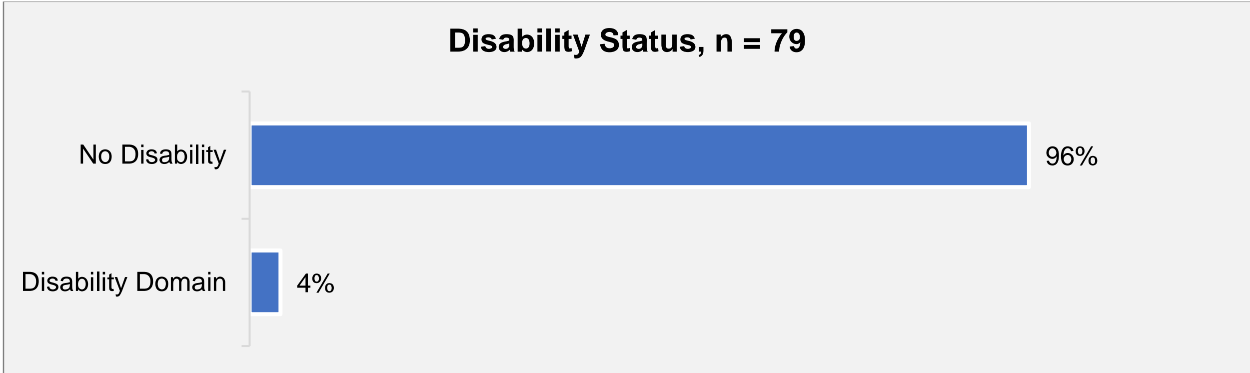
Participant Demographics, Outcomes, and Cost per Client



[7] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).







Race/Ethnicity	n	%
Black/African-American	14	9%
Asian	18	11%
White	20	13%
Other Race	28	18%
Hispanic	17	11%
Non-Hispanic	52	33%
More than one ethnicity	11	7%
Total	**160**	**100%**

Primary Language	n	%
Chinese	3	4%
English	66	84%
Spanish	6	8%
Tagalog	2	3%
Vietnamese	2	3%
Total	**79**	**100%**

For PREP programs, 0% of participants reported data for the Another Language and the Russian language. Also, 100% of participants reported non-veteran status and 0% of participants reported data for American Indian/Alaska and Native Hawaiian Islander.

Program *Provider*	FY17-18 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP) *Felton Institute*	• 61% of clients (21 out of 34) enrolled for at least 12 months, 21 clients (61%) engaged in new employment or education. • 71% of clients (24 out of 34) enrolled for at least 12 months showed an increase in ability to cope with challenges they encounter, as assessed by clinicians. • PREP provided 2,617 hours of direct treatment services and 754 hours of indirect treatment services. • PREP enrolled 2 new cohorts of families in a 12-month Psychoeducational Multi-Family Group (MFG) to develop knowledge about early psychosis and problem-solving skills for individuals and families in a therapeutic group setting. • PREP conducted 130 phone screens to determine need for comprehensive diagnostic assessment and 38 diagnostic assessments (SCID or SIPS) to determine need for early psychosis treatment services.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[8]**
Prevention and Recovery in Early Psychosis (PREP)	80 Clients	$919,962	$11,500

[8] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Behavioral Health Access Center (BHAC) - DPH

Program Overview

Designed and implemented in 2008, with the goal of ensuring more timely access to behavioral health services and better coordinating intake, placement authorization, and referral processes for individuals seeking care, BHAC was one of the first projects funded by MHSA. The BHAC is a portal of entry into San Francisco's overall adult and older adult 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, authorization, and placement into residential 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
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

2018 Consumer, Peer and Family Conference

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 continues to prepare for the implementation of the Drug Medi-Cal – Organized Delivery System (DMC-ODS) in San Francisco. San Francisco County's Implementation Plan was one of the first approved by the California Department of Health Care Services and part of the plan appoints and empowers BHAC to act as the portal of entry into the organized delivery system for those seeking care for substance use disorders. Through the provision of high-quality provision of services and best practices, BHAC will engage with vulnerable populations while provision Medi-Cal beneficiaries with appropriately matched interventions using proven placement criteria.

The establishment of the ODS in San Francisco marks a huge change to the way that services are provided and how reimbursement is provided for an array of treatment interventions not previously covered. As part of preparations for DMC-ODS implementation, BHAC has created a beneficiary enrollment process through a cooperative agreement with Richmond Area Multi Services, Inc. The goal of this effort is to ensure that any person seeking care is enrolled in Medi-Cal. Onsite enrollment occurs five days per week, and an addition to enrollment, the program provides information, inter–county transfer assistance and access to other entitlements.

BHAC has also been instrumental in in the implementation of Proposition 47 in San Francisco County. Proposition 47 will allow certain eligible and suitable ex-offenders to access community-based care funded through an allocated grant from DHCS. Proposition 47 funding has allowed San Francisco County to increase the amount of residential treatment capacity in the community and interrupt potential re-incarceration or continued criminal behaviors, therefore reducing recidivism. BHAC will provide treatment matching and placement authorization to participants in this program.

Target Populations

The BHAC target population includes multiple underserved and vulnerable populations including those with serious, chronic, and persistent mental illness, 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. One of the Eligibility Workers is tri-lingual and able to serve clients speaking English, Spanish, and Tagalog.

Program Outcomes, Highlights and Cost per Client

Program ***Provider***	**FY17-18 Key Outcomes and Highlights**
Behavioral Health Access Center *SFDPH*	• BHAC became a constituent program of the Health Streets Operations Center (HSOC), a city-wide effort to address the needs of homeless persons in San Francisco. Working in collaboration with other City departments and principals, especially within public safety, BHAC is bridging an increasing number of clients who are homeless and/or marginally housed. • Phased implementation of the DMC-ODS waiver across the SUD system of care with the establishment of an authorization and reauthorization process for residential treatment; enhanced after hours services to beneficiary callers. • Made 2,087 face-to-face contacts with individuals seeking access to care. • Conducted 19,011 telephone interventions through the Access Call Center. • Enrolled 109 new Medi-Cal beneficiaries. • Served 3,087 duplicated clients.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[9]**
Behavioral Health Access Center	3,087 Clients	$860,324	$279

Integration of Behavioral Health and Primary Care

Program Collection Overview

DPH has worked toward fully integrated care in various forms for the last two decades. In 2009, after an extensive community planning process, DPH implemented the Primary Care Behavioral Health (PCBH) model in the majority of DPH 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. (e.g., class and group medical visits).

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

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

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

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

In addition, MHSA has made investments to bridge Behavioral Health Services and Primary Care in other ways. We have supported BHS to create Behavioral Health Clinics that act as a “one-stop clinic” so clients can receive selective primary care services. We also fund specialized integrated services throughout the community. The following are examples of other projects taking place throughout the system:

- The SPY Project
- Disability Clinic
- Hawkins Village Clinic
- Cole Street Youth Clinic
- Balboa High School Health Center

Curry Senior Center’s Behavioral Health Services in Primary Care program provides wrap-around services including outreach, primary care, and comprehensive case management as

[9] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

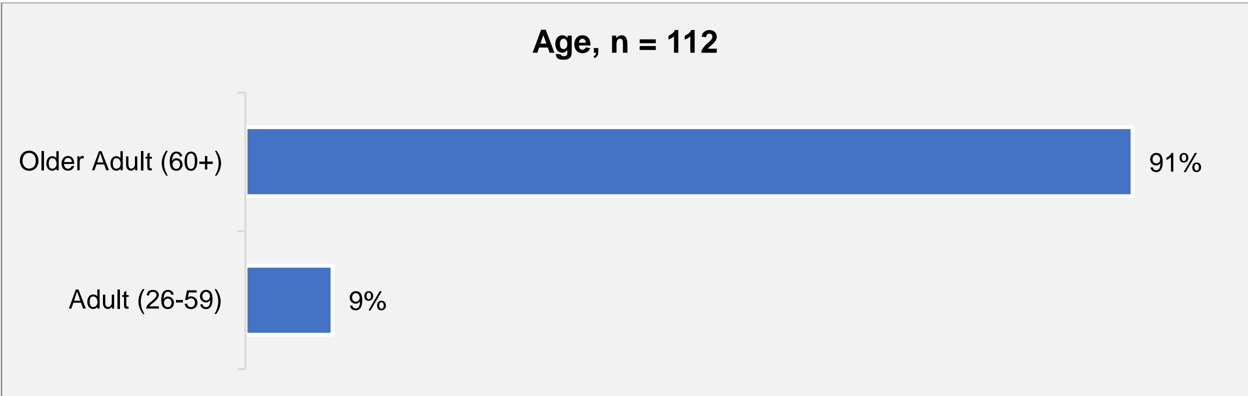
stabilizing strategies to engage isolated older adults in mental health services. The Nurse Practitioners within this program provide individual screening encounters for mental health, substance abuse and cognitive disorders in various locations.

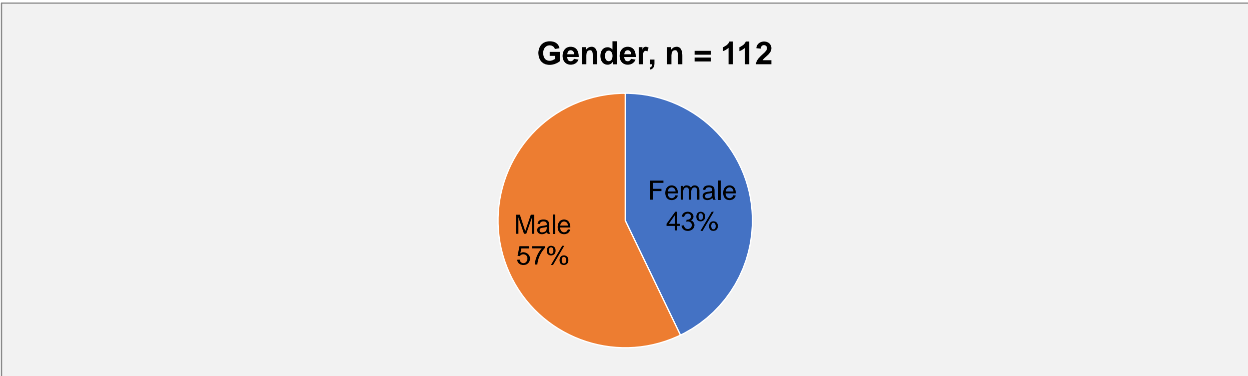
Target Populations

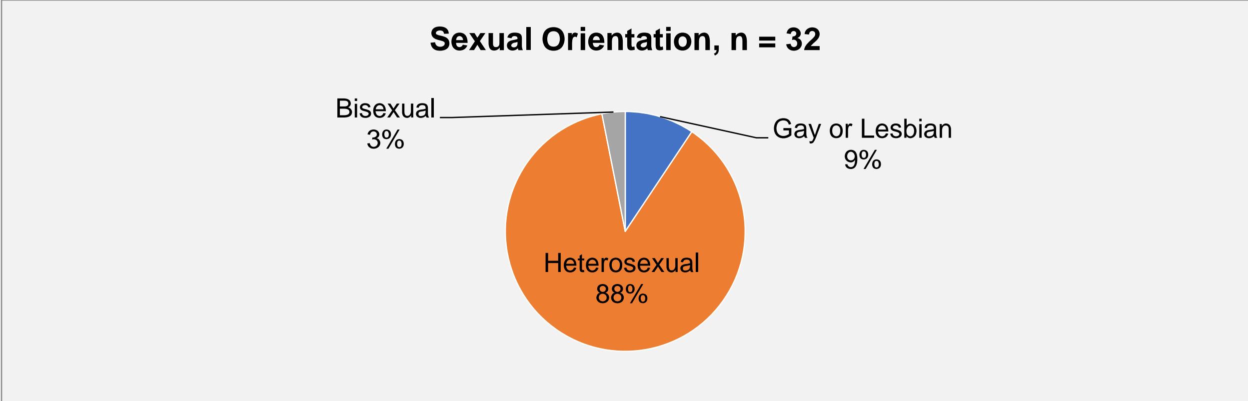
The target populations for these services are individuals and families served in primary care clinics with unidentified behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

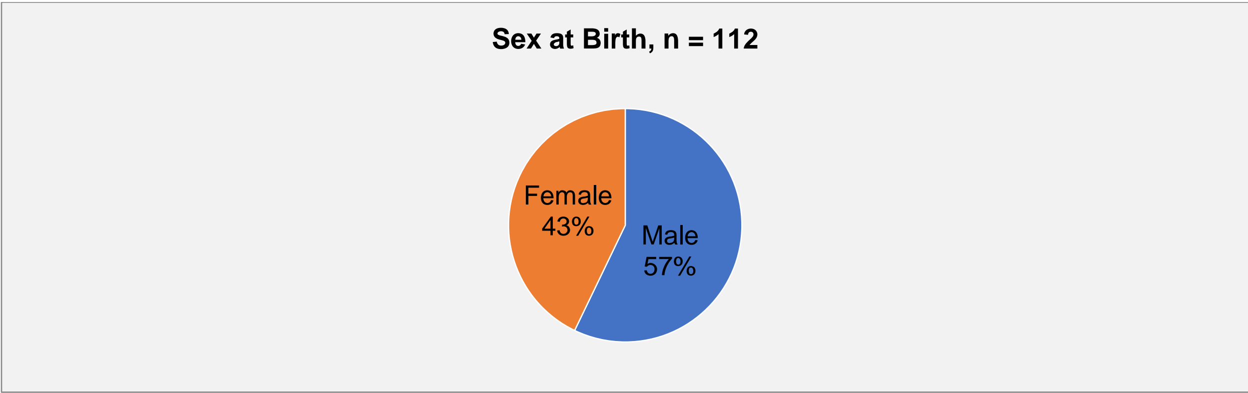
Participant Demographics, Outcomes, and Cost per Client

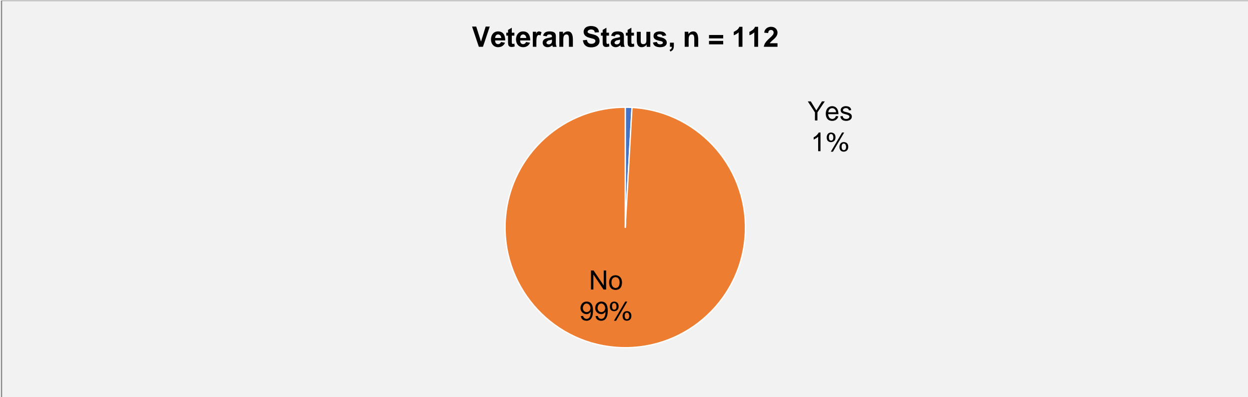
Demographics: Primary Care Integration











Race/Ethnicity	n	%
Black/African-American	27	12%
American Indian/Alaska	4	2%
Asian	30	14%
Other Race	9	4%
White	41	19%
Non-Hispanic	100	45%
Hispanic	11	5%
Total	**221**	**100%**

Primary Language	n	%
Chinese	10	9%
English	80	71%
Another language not listed	5	4%
Vietnamese	12	11%
Spanish	5	4%
Total	**112**	**100%**

For Behavioral Health and Primary Care programs, 0% of participants reported data for the Russian or Tagalog. Also, 100% of participants reported disability domain and 0% of participants reported data for Native Hawaiian Islander and more than one ethnicity.

Program *Provider*	FY17-18 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care *Curry Senior Center*	• 112 unduplicated seniors were screened and assessed by Curry Senior Center's Nurse Practitioners for mental health and cognitive disorders. • The Curry Senior Center Case Manager completed 45 assessments, including referring 22 new clients to case management services. • The Curry Senior Center provided 282 face-to-face case management services to 51 seniors with mental health issues and in need of housing, primary care, mental health care, substance abuse treatment, and other supportive services. • The Curry Senior Center Nurse Practitioner provided primary care services to older adults with mental health issues with a total number of 185 encounters. • 90% of the case management program participants (55 out of 61) were linked to substance abuse and/ or mental health services.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[10]**
Integration of Behavioral Health and Primary Care	326 Clients	$1,605,184	$4,924

Moving Forward in Recovery-Oriented Treatment Services

Full-Service Partnership Programs

[10] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

24/7 Coverage Requirement for FSP Programs

Effective July 17, 2018, BHS implemented a policy to define the 24/7 coverage requirement for FSP programs, and describe the responsibilities of FSP providers in ensuring that 24 hours a day, 7 days a week, FSP providers are available to respond to the client/family to provide after-hour intervention.

The 24/7 coverage policy, which applies to all providers of FSP services, assures that integrated, wraparound services are available 24 hours a day, 7 days a week for FSP clients, and when appropriate, the client's family. The internal policy reiterated requirements mandated by statewide MHSA legislation. Finally, the BHS policy recommended that all FSP programs document internal guidelines or policies for ensuring that an FSP provider is available 24 hours a day, 7 days a week, to respond to the client/family to provide after-hour intervention. The 24/7 policy was disseminated to all FSP programs via email.

Referral and Discharge Procedures for Emergency Stabilization Unit (ESU)

In the 2018 calendar year, the MHSA Program Manager for housing programs collaborated with the MHSA Liaison on the Transitions team to develop referral and discharge procedures for MHSA-funded emergency stabilization units. The goal of the procedures was to clarify processes for FSP program staff in effort to:

- Clarify the expected communication between FSP program staff, FSP clients, the MHSA Liaison, and property management staff in buildings with ESUs,
- Ensure that all FSP providers knew how to access ESUs for their clients, as some programs utilize the resource more than others, and
- Clarify expectations of clients, FSP providers, and other staff to maximize the efficiency in filling vacancies, and transitioning clients to other housing options once they have exhausted the time that can be spent in an ESU.

The new referral and discharge procedures were disseminated to all FSP programs via the standing FSP Outcomes and Evaluation meeting, as well as via email.

FSP Flex Funds

Flex funds are monies that are set aside specifically to address children, youth, adults, older adults, and their families' needs and to provide support services that are outside the scope of traditional specialty mental health services. Flex funds are designed to build collaborative service plans with children, youth, adults, and older adults and their families, focused on healing, wellness, and recovery. MHSA uses these flex funds to support the philosophy of doing "whatever it takes" for those who experience symptoms related to Severe Mental Illness or Severe Emotional Disturbance and intended to help them lead healthy, connected, family-centered, independent, meaningful, and engaged lives.

<u>Assisted Outpatient Treatment Program</u>

In July 2014, San Francisco's Board of Supervisors authorized Assisted Outpatient Treatment as a response to Mayor Ed Lee's 2014 Care Task Force. Implemented November 2, 2015, the San Francisco Assisted Outpatient Treatment Model is utilized as an intervention and engagement tool designed to assist and support individuals with serious mental illness. The program has been constructed to employ principles of recovery and wellness, and has a particular focus on community-based services and multiple opportunities for an individual to engage in voluntary treatment. The ultimate goal of the program is to improve the quality of life of participants and support them on their path to recovery and wellness, as well as prevent decompensation and cycling through acute services (e.g., psychiatric hospitalization) and incarceration.

Our FUERTE INN Proposal was approved by the MHSOAC on 1/24/19.

As the Assisted Outpatient Treatment (AOT) program continues to grow, program evaluation will build on current findings and will be expanded to include the following: (1) input and perspective from additional stakeholder groups, and (2) analysis of the program's cost and financial impact. Moving forward, AOT staff will utilize the findings of future evaluations to inform program implementation and the provision of effective services to clients.

<u>Behavioral Health Access Center (BHAC)</u>

BHAC engages with vulnerable populations who seek access to care in San Francisco. BHAC has served thousands of people since 2009 and continues to be a high-profile portal of entry into the system of care.

In FY18-19, BHAC will recruit a complement of licensed and certified staff, bringing increased clinical depth to the program, and readying the program for the anticipated volume increase of clients seeking care under Drug Medi-Cal. These six new staff will be oriented to our system of care, and assist in reducing barriers to accessing care. These recruitment efforts will be part of the Drug Medi-Cal – Organized Delivery System

2. Mental Health Promotion and Early Intervention

Service Category Overview

San Francisco's MHSA has shaped its PEI programs into an extended canopy of Mental Health Promotion and Early Intervention programs that cover four major categories:

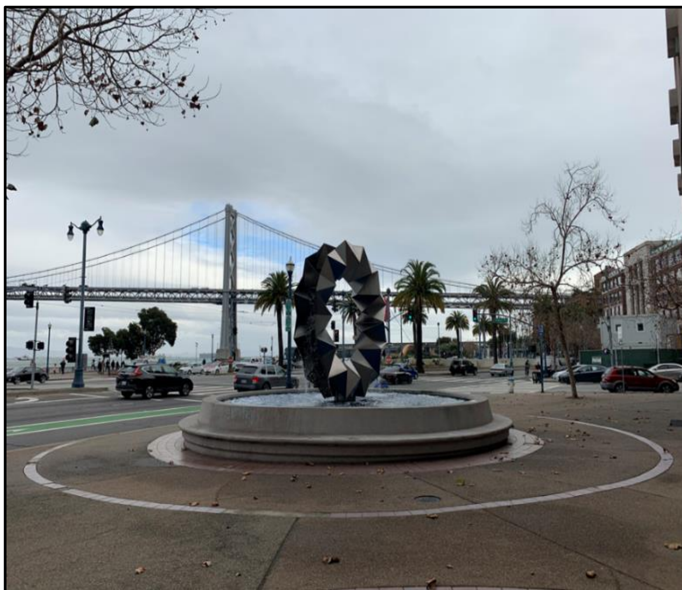
1. School-Based Mental Health Promotion;
2. Population-focused: Mental Health Promotion;
3. Mental Health Consultation and Capacity Building; and
4. Comprehensive Crisis Services

PEI

The focus of all PEI programs is to raise people's awareness about mental health conditions; address the stigma tied to mental health; and increase individuals' access to quality mental health care. MHSA investments build the service delivery capacity of programs and grassroots organizations that typically don't provide mental health services (e.g. schools, cultural celebrations, and cultural epicenters).

Regulations for Statewide PEI Programs and Innovation (INN) Projects

To standardize the monitoring of all California PEI and INN programs, the MHSOAC crafted regulations with respect to counties' data collection and reporting. Key areas of attention are given to the number of people served by a program; the demographic background of program participants [e.g. age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)]; and the interval of time passed from an initiated referral to when the client first participates in referred services. The MHSOAC calls this "referral-to-first participation in referred services period" a successful linkage; and successful linkages are one indicator among many that signifies clients' timely access to care.



Given the need for the MHSOAC to know and better understand the communities being served by MHSA resources, it is extremely important for MHSA to develop processes and instruments that will afford programs the ability to capture regulated data in a manner that is respectful and does not offend, discourage or alienate individuals who are seeking help. All counties are required to include their regulated demographic data in their Annual PEI Report to the MHSOAC, which is part of a county's Annual Update or 3-Year Program and Expenditure Plan.

School-Based Mental Health and Wellness Centers (K-12)

Program Collection Overview

School-Based Mental Health Services and Wellness Centers (K-12) programming – a collaboration of community-based organizations and San Francisco Unified School District (SFUSD) K-12 school campuses – applies best practices that address non-academic barriers to learning. These programs offer students and their families a range of support services, which are offered on-campus during and after the school day so that they are accessible to students and their families. This coordinated, collaborative approach supports students' academic and personal successes by providing a full spectrum of PEI behavioral health services, as well as linkages to additional support services. These programs build on the strengths of community partners and existing school support services to incorporate a wide variety of philosophies, which are rooted in a prevention or resiliency model, such as youth development, peer education, cultural or ritual-based healing, and wraparound family supports.

Services offered at the schools include leadership development, outreach and engagement, screening and assessment, crisis intervention, training and coaching, mental health consultation, and individual and group therapeutic services. Current school-based mental health programs include School-Based Wellness Promotion services at high schools, and Early Intervention Program Consultation at elementary and middle schools.

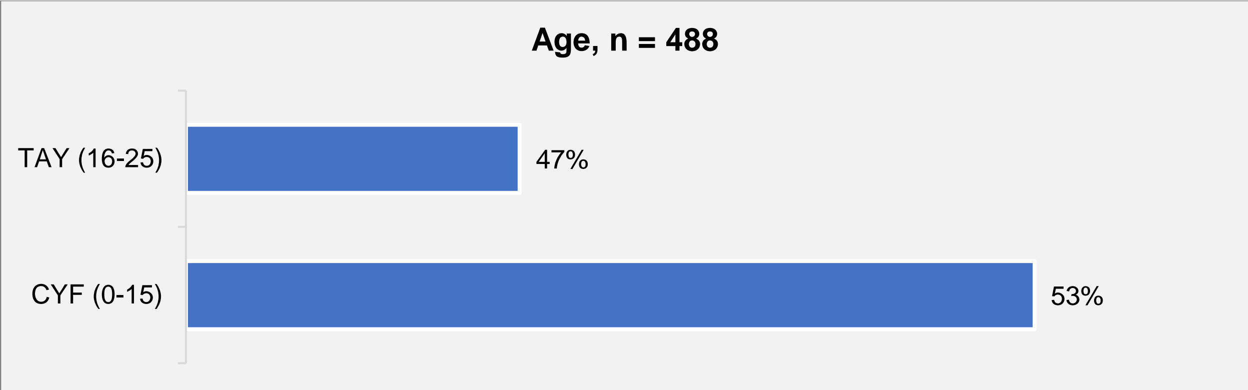
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To this end, these programs provide direct services to students and their families/caregivers, such as screening and assessment, community outreach and engagement to raise awareness about behavioral health topics and resources, support service resource linkages, wraparound case management, behavior coaching, crisis intervention, individual and group therapeutic services, school climate and wellness promotion workshops and activities, and family engagement and education. These programs also provide regular mental health consultation to teachers, support staff, and administrators, with particular focus on teachers and staff who are challenged by students' emerging mental health and behavioral needs.

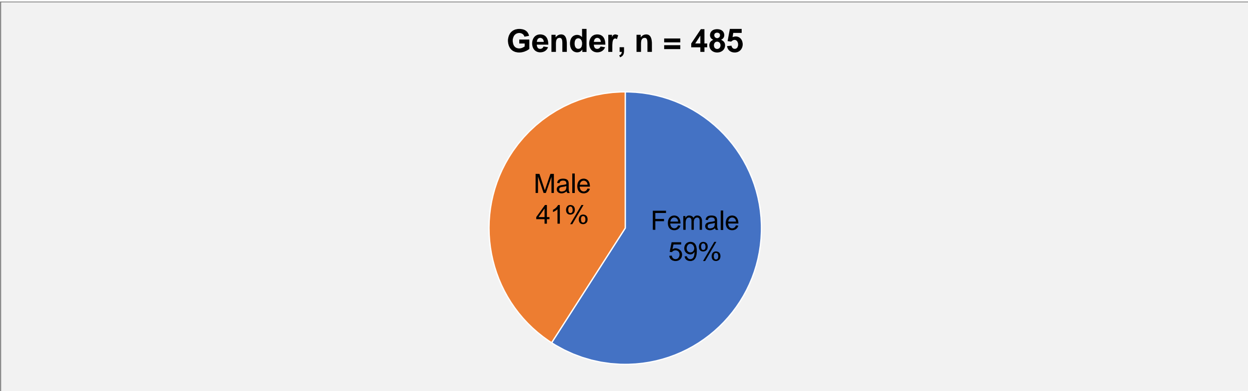
Target Populations

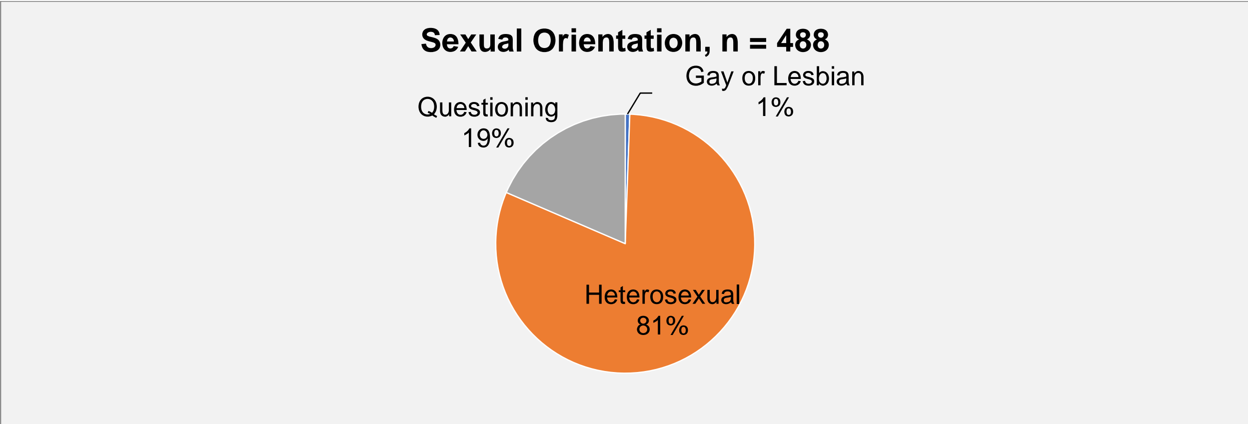
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers. School-Based Mental Health Promotion programs also provide mental health consultation to school personnel.

Participant Demographics, Outcomes, and Cost per Client

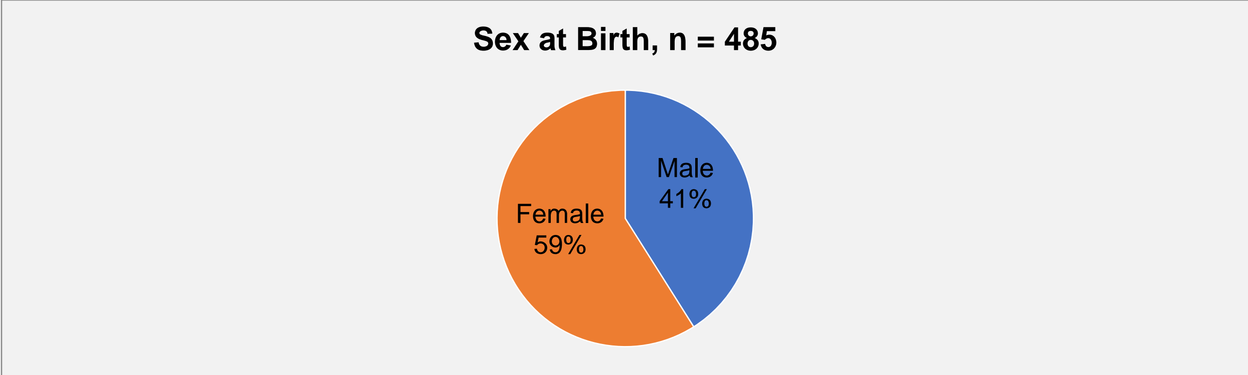
Demographics: School Based Prevention (K-12)[11]

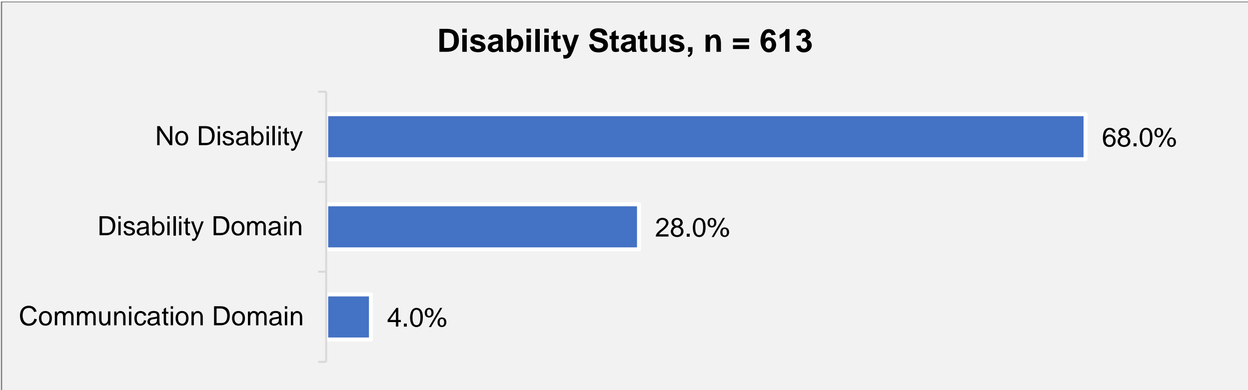






[11] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).





Race/Ethnicity	n	%
Black/African-American	63	13%
Asian	43	9%
Native Hawaiian Islander	9	2%
White	52	11%
Hispanic	275	58%
More than one ethnicity	32	7%
Total	**503**	**100%**

Primary Language	n	%
English	335	69%
Spanish	152	31%
Total	**488**	**100%**

For School-Based Mental Health Promotion (K-12), 0% of participants reported data for the following languages: Chinese, Russian, Tagalog and Vietnamese. Additionally, the data for Another Language were not included since they rounded to 0%. Also, less than 1% of participants reported data for Trans Male so these demographics were not included. Also, 0% of participants reported data for Non-Hispanic. Additionally, the data for American Indian / Pacific Islander were not included since they rounded to 0%. Also, 100% of participants reported non-veteran status.

Program Provider	FY17-18 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center (BTHC) *Bayview Hunter's Point Foundation*	• 489 Balboa students participated in classroom presentations that were led by BTHC Youth Advisory Board Members or Health Educators. • 105 youth were seen at BTHC for 3 or more counseling visits. Of those counseling clients, in post session tests, 73 (68.5%) identified one or more skills they have successfully utilized to reduce stress or other related symptoms, and at least one positive goal they were currently actively working on.
School Based Mental Health Services *Edgewood Center for Children and Families*	• 62.5% of students showed an increase in Teacher-Preferred, Peer- Preferred, and Classroom Adjustment Behaviors score from pre to post-services, with these students increasing by a mean of 9.4%, as measured by teacher-completed pre and post-services WMS surveys. • 15 teachers received School Climate Consultation services. When asked if they agreed or disagreed with the following statement, "The slump period and other wellness supports gave me a greater capacity to manage the challenges of teaching/being a teacher"; respondents averaged 7.8/10 (1=disagree and 10=strongly agree) and 80% rated 6 or higher.
School Based Youth Early Intervention *Instituto Familiar de la Raza*	• The Early Intervention Program provided classroom supports, teacher trainings, kindergarten transition supports, service referral/linkages, parent and teacher/staff trainings, school climate and culture work, afterschool program consultation, and a multi-disciplinary Mental Health Collaborative team to coordinate resources and build a referral network for students, families, and teachers at Hillcrest Elementary and James Lick Middle Schools. • 84% of teachers surveyed (n=17) felt that working with the Mental Health Consultant moderately-substantially increased their understanding in responding to students' social emotional and developmental needs. • At James Lick Middle School, the program met their annual goal of building capacity of teachers by providing more opportunities for reflection and safe space for discussion.
Wellness Centers *Richmond Area Multi-Services, Inc. (RAMS)*	• 100% of youth have reported meeting or somewhat meeting their goals in therapy. • 76% of students report improvements in relationships with family and friends. • 98% of students receiving services reported improvement in stress levels.

Program Provider	FY17-18 Key Outcomes and Highlights
	• 4% of students report "liking" therapy. 89% would recommend that a friend go to therapy.
Trauma and Recovery Services *YMCA Urban Services*	• (68%) of severely truant clients in the PASS program (13 out of 19) reduced their chronic absenteeism by at least 50%. • (68%) of enrolled youth (13 out of 19) re-engaged with school and/or successfully completed equivalency exams and/or linked to vocational programs. • 94.7% of clients (18 out of 19) had a family needs assessment completed. The one client that was not was closed within the first 60 days due to lack of engagement and inability to connect with case manager. The 18 assessed clients were each linked to appropriate supports and services, including higher levels of care, new school placements, and vocational programs.

FY17-18 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[12]
School-Based Mental Health Promotion (K-12)	3,414 Clients	$1,131,958	$332

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

MHSA Population-Focused Mental Health Programs provide the following services:

- Outreach and engagement: Activities intended to establish/maintain relationships with individuals and introduce them to available services; and 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

[12] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

- 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

MHSA continues to strengthen its specialized cohort of 16 Population-focused: Mental Health PEI programs that serve distinct groups based on ethnic and cultural heritage, age and housing status.

Target Populations

As a component of the PEI program planning processes, a number of underserved populations were identified, including, but not limited to, the following:

- Socially Isolated Older Adults
- Black/African Americans
- Asians and Pacific Islanders
- Mayan/Indigenous
- Native Americans
- Adults and TAY who are homeless or at-risk of homelessness

Many of these populations experience extremely challenging barriers to service, including but not limited to: language, culture, poverty, stigma, exposure to trauma, homelessness and substance abuse. As a result, the MHSA planning process called for proposals from a wide variety of qualified organizations in order to break down barriers and improve the accessibility of services through culturally tailored outreach and services. These population-focused services acknowledge and incorporate participants' cultural backgrounds, including healing practices, rituals and ceremonies, in order to honor the cultural context and provide non-clinical services that incorporate these practices. These population-focused programs focus on raising awareness about mental health needs and available services, reducing stigma, the importance of early intervention, and increasing access to services. As a result, all of the programs emphasize outreach and engagement to a very specific population group.

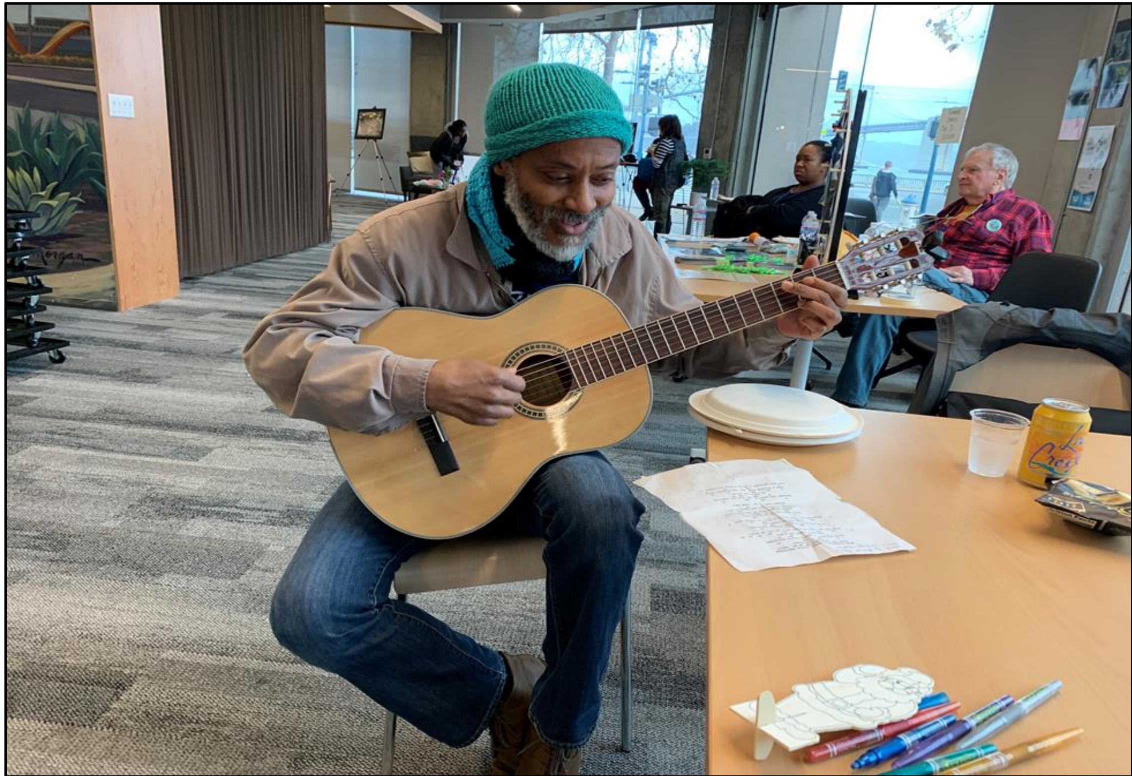
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Socially Isolated Older Adults	Senior Drop-In Center *Curry Senior Center*	The Curry Senior Drop-in Center is a multi-service center located in the Tenderloin neighborhood. It provides drop-in peer-led wellness-based services, including primary and behavioral health care, case management services, and socialization opportunities. *See additional information in the 'Spotlight' feature below.*
Blacks/African Americans	Ajani Program *Westside Community Services*	The Ajani program helps to build strong families by providing an understanding how healthy families function and by encouraging them to develop leadership, collective responsibility and mentoring skills.

Population-Focused Mental Health Promotion Programs

Target Population	Program Name *Provider*	Services
	Black/African American Wellness and Peer Leader-ship Program *SFDPH Interdivisional Initiative*	The Black/African American Wellness & Peer Leadership (BAAWPL) initiative takes a collective impact approach where the City, community, and two lead community-based organizations – the YMCA Bayview and the Rafiki Coalition – that are intent on decreasing the physical and mental health disparities of San Francisco's Black/African American populations.
Asians/Pacific Islanders (API)	API Youth Family Community Support Services *Community Youth Center*	The program primarily serves Asian/Pacific Is-lander and Lesbian, Gay, Bi-sexual, Transgender, and Questioning youth ages 11-18 and their fami-lies. The program provides screening and assess-ment, case management and referral to mental health services.
	API Mental Health Collaborative *Richmond Area Multi-Services (RAMS)*	The program serves Filipino, Samoan and South East Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight cul-turally and linguistically congruent agencies; and the Collaborative as a whole has engaged in sub-stantial outreach and community education.
Mayans/Indigena	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	The program serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social ser-vices, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance *Native American Health Center*	The program serves American Indian/Alaska Na-tive adults and older adults who have been ex-posed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involve-ment or involved with the juvenile justice system. The program included extensive outreach and en-gagement through cultural events such as Tradi-tional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also in-clude NextGen Assessments, individual counsel-ing, and traditional healers.

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Adults who are Homeless or At-Risk of Homelessness	South of Market Self-Help Center *Central City Hospital House*	The program serves adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs. *See additional information in the 'Spotlight' feature below.*
	Tenderloin Self-Help Center *Central City Hospital House*	The program serves adult residents facing behavioral health challenges and homelessness in the Tenderloin neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs. *See additional information in the 'Spotlight' feature below.*
	Community Building Program *Central City Hospital House*	The program serves traumatized, homeless and dual-diagnosed adults in the Tenderloin neighborhood. The program conducts outreach, screening, assessment, and referral to mental health services. It also conducts wellness promotion and includes an 18-week peer internship training program. *See additional information in the 'Spotlight' feature below.*
TAY who are Homeless or At-Risk of Homelessness	TAY Multi-Service Center *Huckleberry Youth Programs*	The program serves low-income African American, Latino or Asian Pacific Islander TAY (ages 16-24) who have been exposed to trauma, are involved or at-risk of entering the justice system and may have physical and behavioral health needs. Program participants may be involved with the City's Community Assessment and Resource Center (CARC) which focuses on 16 and17 year old youth. The program conducts street outreach, mental health assessments and support, case management and positive youth development services.

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
	ROUTZ TAY Wellness *Larkin Street Youth Services*	The program serves TAY youth with serious mental illness from all of San Francisco. This high intensity, longer term program includes supportive services, including wraparound case management, mental health intervention and counseling, peer-based counseling, and life skills development.



MHSA Consumer, Peer and Family Conference 2018

Spotlight on Curry Senior Drop-In Center

The Curry Senior Drop-in Center at Curry Senior Center engages socially isolated seniors, 55 years of age and older, in Wellness and Recovery activities in a supportive, peer-based environment. This program, which is located at a multi-service senior center in the Tenderloin, refers and links seniors to wrap-around services including primary care, behavioral health, and case management services, as well as socialization opportunities.
A Consumer Advisory Panel meets monthly to review issues in service delivery and to provide feedback to the Center's leadership team to ensure that consumers are engaged in the development, implementation, and evaluation of program.
In FY17-18, significant changes were made to the program including: increasing drop- in program days from 6 to 7 days per week, expanding program hours from 6 to 8 hours per day, and increasing wellness group programming. Seven new groups were started in 2018. Programs offered at the Drop-In include: Harm Reduction Support Group, Transgender Support Group, The Men's Group, Music in the Streets, Open Mic, Stress Busters, and Documentary Series.

FY17-18 Client Outcomes

- 139 seniors attended peer-led, wellness-based activities. 88% of those surveyed who attended 5 programs or more reported an increase in socialization.
- 58 seniors were assessed and referred to various social services and supports.
- 88% of surveyed participants attending 5 programs or more selected "strongly agree" or "agree" for the statement: "My culture and lifestyle are respected in the Drop-In Center".

A Day at Curry Senior Drop-In Center

One client who has greatly benefited from the Senior Drop-in Center Program is Mr. C, who shows up to the Drop-in Center most days of the week. Earlier this year, he lost his job and became homeless. Mr. C, who has a 6-month wait until retirement benefits begin, is currently staying in a nearby shelter, receiving GA benefits, and eating his meals at the Curry Senior Center Dining Room.

After eating breakfast at the dining room, he regularly joins the News and Discussion group. He has met a number of men attending these discussions, which are very lively, politically fueled, and community focused. Mr. C also attends the Men's Group at the Drop-In where he has found support around being homeless, low-income, a senior, and African American. These groups have not only offered him support but have been a place where Mr. C has also cultivated meaningful friendships.

At the Drop-in, Mr. C often checks in with staff, and receives assistance filling out housing applications, and has received referrals for food, clothing, and medical attention. Mr. C reports feeling safe and supported in the Drop-In. He explains: "There are few places in the neighborhood I can go and feel the support and safety I feel here."

Spotlight on Pop-Focus Programming for Adults who are Homeless or At-Risk of Homelessness by Central City Hospitality House

Hospitality House operates three Population-Focused programs that serve San Francisco adults who are homeless or at-risk of homelessness. These programs include the Community Building Program in the Tenderloin neighborhood and two self-help centers (in the Tenderloin and South of Market Area). These programs serve adults who are homeless, facing homelessness, and/or have histories of homelessness. These individuals often face behavioral health challenges, are dually diagnosed, and have experienced trauma.

Community Building Program

The Community Building Program (CBP) empowers Tenderloin denizens to address the negative impact they and their neighbors experience as a result of being exposed to trauma. The program conducts outreach, screening, assessment, and referral to mental health services. It also conducts wellness promotion and includes an 18-week peer internship training program. A wellness promotion branch of the CBP includes a specialized component - the Heal, Organizing & Leadership Development (HOLD) program. Each 18-week HOLD program cycle, 8 interns are selected and trained to promote wellness through various community activities. These activities are designed to enhance people's protective factors, reduce risk factors, promote healthy behaviors, and provide support for individuals in their recovery. The objective of the HOLD program is for interns to increase their social connectedness with others and directly apply their newly-acquired skills in community organizing. All HOLD program interns are trained in (1) the impact of trauma, (2) oppression & healing, and (3) community organizing.

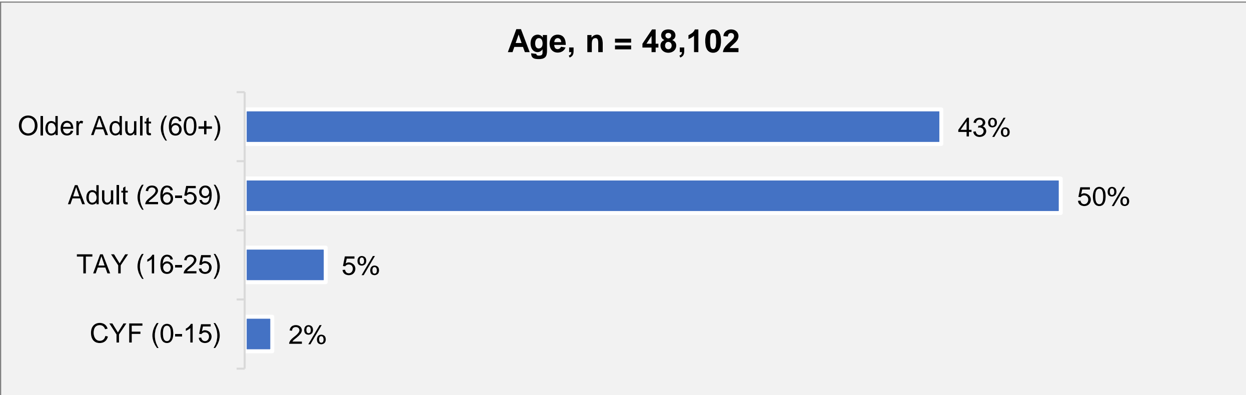
6th Street and Tenderloin Self-Help Centers

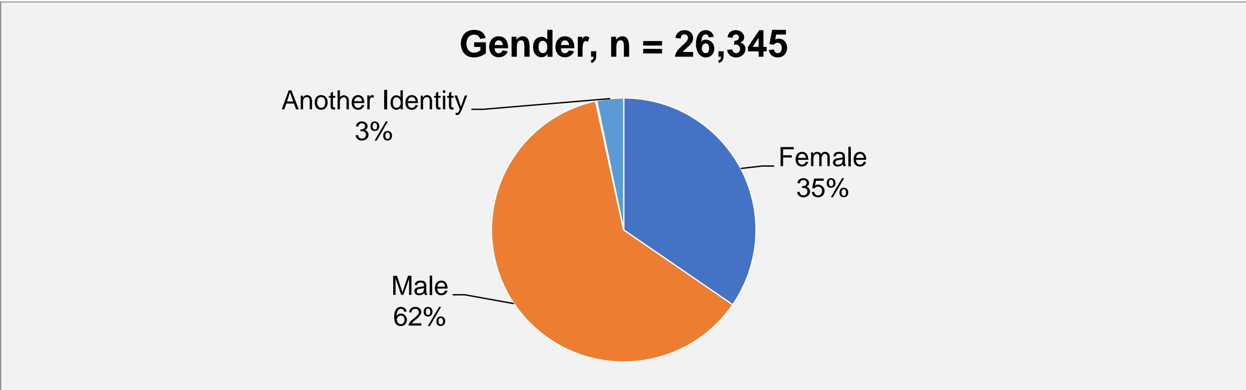
The Central City Hospitality House 6th Street Self-Help Center and Tenderloin Self-Help Center are low-threshold programs that serve adults/older adults of the 6th Street Corridor of SOMA (South of Market Area) and the Tenderloin neighborhoods. The goal of the Self-Help Centers is to reduce the trauma of persons adversely affected by homelessness and poverty by providing: 1) mental health services; 2) substance abuse treatment; 3) connection to housing; 4) search for employment; and 5) stabilization and socialization services.

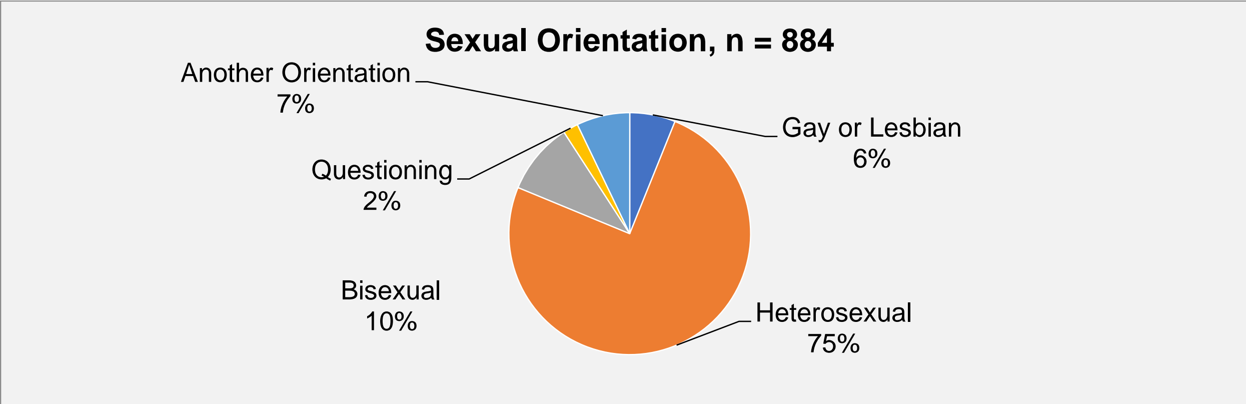
The majority of clients often face a number of barriers in accessing traditional mental health services, including but not limited to: disenfranchisement, homelessness, immigration status concerns, disabilities, or ex-offender status. Both Self-Help Centers subscribe to a peer-based, harm-reduction, self-help model, where peers who may have experienced similar circumstances - and have participated in helping/recovery services and would like to help others - reach out to difficult-to-reach populations and encourage them to engage in offered services (e.g., help finding housing/employment, or connect with a therapist).

Participant Demographics, Outcomes, and Cost per Client

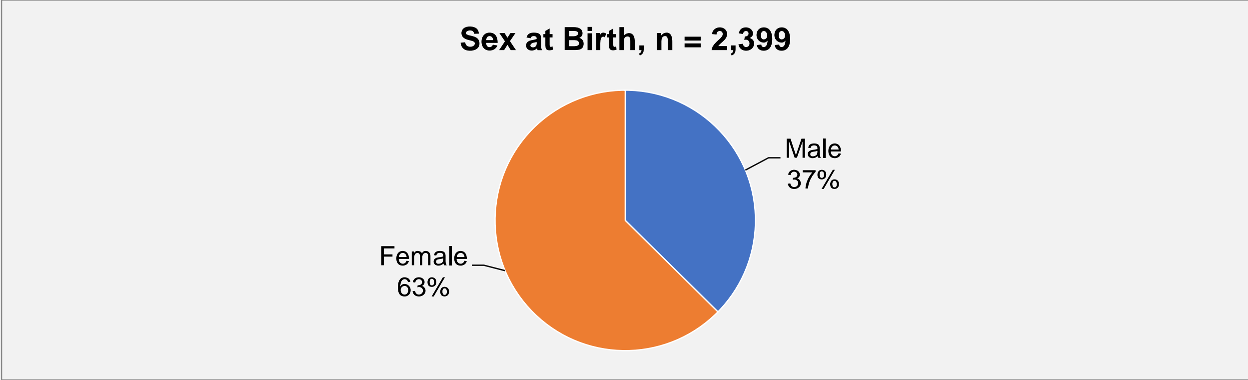
Demographics: Population Focused Mental Health[13]

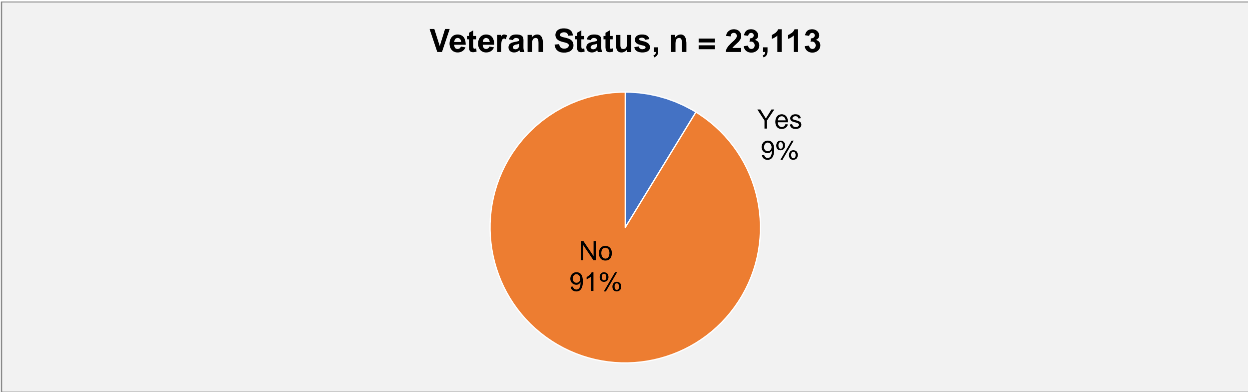


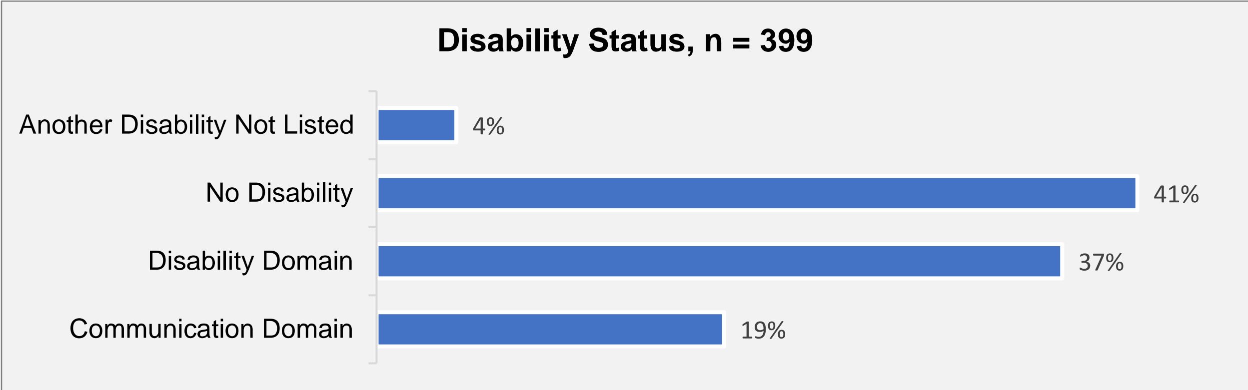




[13] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).







Race/Ethnicity	n	%
Black/African-American	9,137	35%
American Indian/Alaska	501	2%
Asian	5,984	23%
Native Hawaiian Islander	436	2%
White	5,268	20%
Other Race	1,756	7%
Hispanic	2,592	10%
More than one ethnicity	229	1%
Total	**26,016**	**100%**

PEI

Primary Language	n	%
Chinese	41	2%
English	1,251	72%
Spanish	243	14%
Tagalog	36	2%
Vietnamese	63	4%
Another language not listed	103	6%
Total	**1,737**	**100%**

For Population-Focused Mental Health Promotion, 0% of participants reported data for the Russian language. Also, less than 1% of participants reported data for Trans Female so these demographics were not included. Also, data for Non-Hispanic were not included since they rounded to 0%.

Socially Isolated Older Adults	FY17-18 Key Outcomes and Highlights
Senior Drop-In Center *Curry Senior Center*	• 139 seniors will attend wellness-based activities offered by Peer staff. • 88% (23 of 26) of participants who attended 5 or more activities reported an increase in socialization, as measured by client surveys. • 58 seniors were informally assessed for non-behavioral health services.
Black/ African-American	**FY17-18 Key Outcomes and Highlights**
Ajani Program *Westside Community Services*	• 220 African Americans received health care promotional information and linkages to culturally appropriate services. • The Westside Community Counselor and Program manager conducted outreach to African Americans living in housing projects in the Western Addition and Southeast Corridor to make residents aware of the benefits of ACA and connect them with enrollment information and assistance. This included speaking with residents and property managers, as well as, handing out program brochures and referral forms. • Westside staff attended 12 community based events focused on underserved communities.

Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional Initiative with YMCA Bayview and the Rafiki Coalition*	• The BAAWPL Program held an Annual Black Health and Healing Summit on June 1 and 2, 2018, with over 500+ participants over the 2 days. • Completed 8 L.I.F.T Multiple group sessions with an additional 47 participants • Held a Kwanzaa celebration on December 27, 2017 with 100 participants in effort to engage the community to increase awareness of cultural practices and reduce isolation. • Held 8 Community Voices Forums with a total of 396 participants. • 147 individuals were screened and assessed for physical wellness (i.e. blood pressure, weight and self-declared physical activity) and referred to internal services, programs and/or external services or programs.
Asian/ Pacific Islander	**FY17-18 Key Outcomes and Highlights**
Asian/Pacific Islander (A&PI) Youth and Family Community Support Services *Community Youth Center*	• 167 A&PI youth will be screened for behavioral health concerns. • 99 of 122 (80%) workshop participants will demonstrate increase quality of life. • 122 A&PI youth and families enrolled in case management service have successfully attained at least one of their treatment goals, as reported in progress notes and treatment closing forms.
Asian/Pacific Islander Mental Health Collaborative *Richmond Area Multi-Services Center (RAMS)*	• Contacted 45,724 Asian American and Pacific Islander (AA & PI) individuals through community-specific events (such as cultural specific or community gatherings, celebrations, festivals, workgroup meetings), with direct contact to 11,125 individuals. • 112 AA & PI individuals were screened and/or assessed for behavioral health needs and/or basic / holistic needs using an AA-PI specific assessment tool developed by RAMS and community partners. • All 112 (100%) of individuals screened and assessed were referred, plus an additional 290 individuals intakes and referrals were made without a completed screening and assessment form. • 3,464 AA & PI individuals participated in culturally-relevant psycho-education workshops. • 560 participants reported an increase in their knowledge about mental health. • 101 AA & PI individuals will receive case management for behavioral health and/or basic/holistic services.

Mayan/Indígena	FY17-18 Key Outcomes and Highlights
Indígena Health and Wellness Collaborative *Instituto Familiar de la Raza (IFR)*	• 65% of participants expressed that participation in the Psychosocial Peer Support Groups/Talleres helped them increase their social connectedness. • 961 individuals participated in 6 group activities (Vaqueria, Carnaval, Health Fairs, powwows). • Contacted 151 individuals through outreach activities (street outreach and phone calls. • 80 individuals were screened and/or assessed for practical, emotional and mental health concerns using the "Information & Referral Form" administered by staff. • 100 clients participated in small psychosocial peer support group/Talleres.
Native American	**FY17-18 Key Outcomes and Highlights**
Living in Balance *Native American Health Center (NAHC)*	• Staff conducted outreach and engagement services to 104 participants. • Staff held 114 Wellness Promotion group sessions, reaching 144 UDC. Wellness Promotion group session topics included Basket Making, Beading Circles, Drum Group, and Talking Circle Group. • 40 participants were successfully assessed and linked to mental health services; 20 participants were linked to other Native American Health Center departments/services.
Adults who are Homeless or At-Risk for Homelessness	**FY17-18 Key Outcomes and Highlights**
South of Market/6th Street Self-Help Center *Central City Hospitality House*	• 86% of Harm Reduction support group participants (97 out of 133) demonstrated reduced risk behaviors. • The Self-Help Center expanded from the Tenderloin/Civic Center neighborhoods to include the Western Addition, South of Market, Nob Hill, and Polk Gulch. Curry's intention was to hire 2 new staff and collaborate with another senior center in one of the new neighborhoods in hopes of creating opportunity to conduct outreach and facilitate social events. 85 socially-isolated older adults will be screened for behavioral health needs using a preclinical behavioral health screening tool, administered by Peer Outreach Workers. • 46 of the 85 (54%) isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services.

Community Building Program *Central City Hospitality House*	• 15,198 unduplicated participants participated in a range of socialization and wellness services. • 81 unduplicated participants were screened and or assessed for behavioral health concerns as measured by the Case Management Assessment conducted by TSHC case managers. • 69 unduplicated participants were screened and/or assessed, and were referred to behavioral health services as measured by creation of a harm reduction plan.
Tenderloin Self-Help Center *Central City Hospitality House*	• 15,198 unduplicated participants participated in a range of socialization and wellness services. • 91% of Harm Reduction Support Group participants (126 out of 139) demonstrated reduced risk behaviors. • 81 unduplicated participants were screened and or assessed for behavioral health concerns as measured by the Case Management Assessment conducted by TSHC case managers.
Homeless or System Involved Transition Age Youth (TAY)	**FY17-18 Key Outcomes and Highlights**
TAY Multi-Service Center *Huckleberry Youth Programs*	• 7,836 (duplicated) TAY were engaged in outreach and utilized drop-in centers. • 3,798 (duplicated) TAY participated in group activities including health fairs, conferences, and workshops. • 438 unduplicated TAY were screened for behavioral/mental health concerns. 100% of TAY who were screened and/or assessed were referred or received on-site behavioral health services.
ROUTZ TAY Wellness *Larkin Street Youth Services*	• 76% (39 of 51) of youth housed were linked to mental health services. It should be noted 4 youth exited the program before a linkage was made and an additional 9 youth have not yet been linked to individual or group mental health services. • 100% (51 of 51, 133% of goal) youth were retained in housing or exited to other stable housing. • 92% of youth who responded to a client satisfaction survey rated their overall satisfaction as high.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[14]**
Population-Focused Mental Health Promotion	23,361 Clients	$1,814,238	$78

Early Childhood Mental Health Consultation Initiative

Program Collection Overview

Mental health consultation and capacity building services include case consultation, program consultation, training and support/capacity building for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, and psychotherapy), therapeutic play groups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families. These services are designed to capitalize on the important role of early intervention in enhancing the success of children and families facing early developmental challenges.

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the evidence-based work[15] 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: DPH/BHS; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco. Funding for the Initiative is contributed by all four county departments, as well as funds provided by the MHSA.

Services may include case consultation, program consultation, training and support for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic play groups, 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.

[14] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.
[15] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91

The five (5) providers for the San Francisco Early Childhood Mental Health Consultation Initiative include:

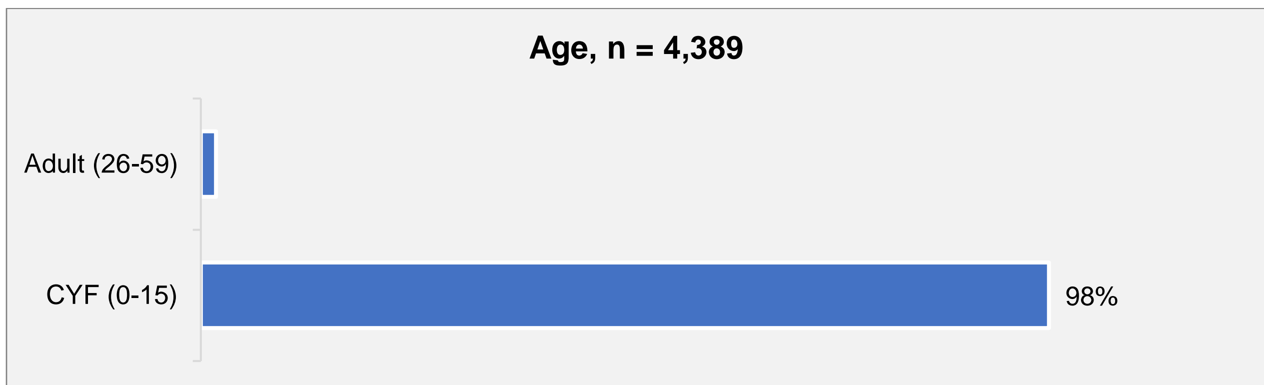
- Infant Parent Program - Day Care Consultants
- Edgewood Center for Children and Families
- Richmond Area Multi-Services
- Homeless Children's Network
- Instituto Familiar de la Raza

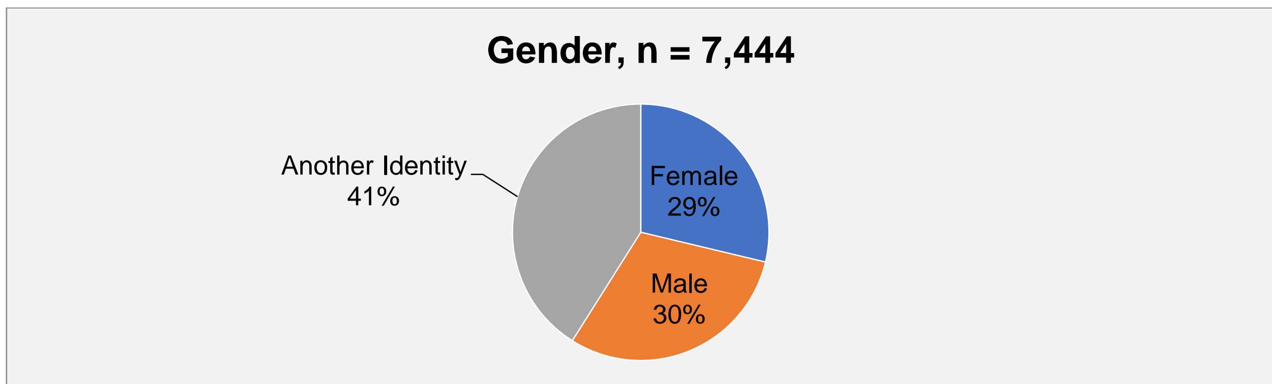
Target Populations

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients who experienced trauma, substance abuse, homelessness, and other challenges. The program works with children and families facing early developmental challenges.

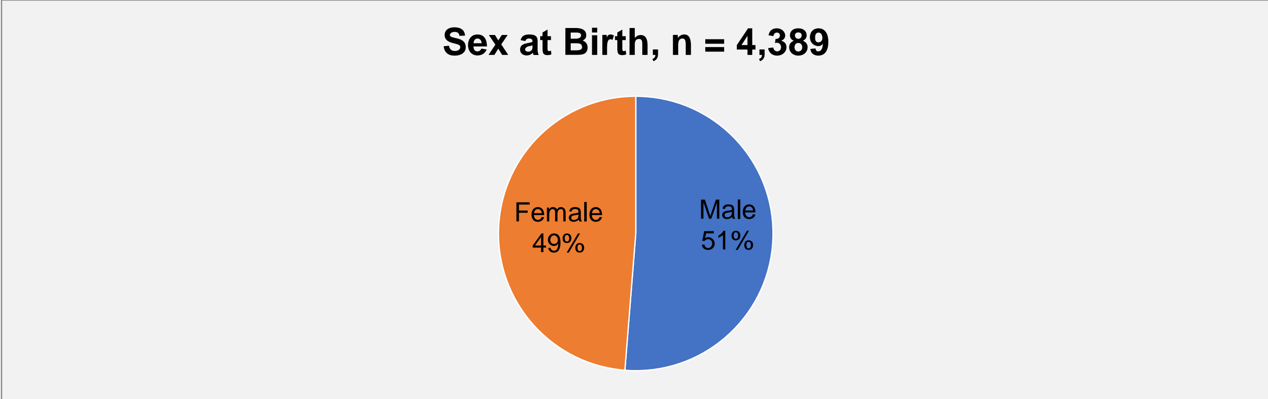
Participant Demographics, Outcomes, and Cost per Client

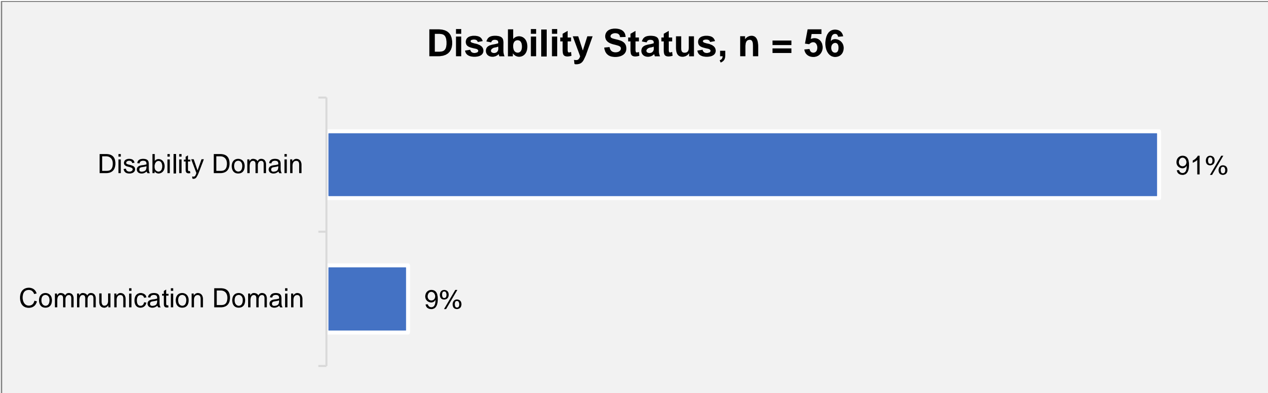
Demographics: Early Childhood Mental Health Consultation Initiative[16]





[16] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).





Race/Ethnicity	n	%
Black/African-American	1,095	9%
Asian	3,408	27%
Native Hawaiian Islander	123	1%
White	732	6%
Hispanic	1,249	10%
Non-Hispanic	5,503	43%
More than one ethnicity	668	5%
Total	**12,778**	**100%**

Primary Language	n	%
Chinese	2,640	38%
English	2,574	37%
Spanish	1,110	16%
Vietnamese	133	2%
Total	**6,912**	**100%**

For Early Childhood Mental Health Consultation Initiative, 0% of participants reported data for Tagalog. Additionally, data for Russian were not included since they rounded to 0%. Also, less than 1% of participants reported data for Older Adult (60+), TAY (16-26) so these demographics were not included. Also,

data for American Indian/Pacific Islander were not included since they rounded to 0%. Also, 100% of participants reported heterosexual orientation and non-veteran status.

Program	FY17-18 Key Outcomes and Highlights
Early Childhood Mental Health Consultation Initiative	• 97% of the parents (81 out of 83) who received weekly mental health services from a perinatal mental health specialist saw a decrease in their levels of depression, anxiety, and/or PTSD. • 96% of the women (80 out of 83) who received direct perinatal psychotherapy services reported positive attachment with their newborn and enhanced ability to accurately interpret the emotional and physical cues of their babies at 2 months of age.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[17]**
Mental Health Consultation and Capacity Building	9,239 Clients	$719,956	$78

Comprehensive Crisis Services

Background and Community Need

Comprehensive crisis response and stabilization services are 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 efforts – PEI funding supported a significant expansion of crisis response services in 2009.

[17] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Program Collection Overview

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

Target Populations

The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and in need of support.

Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	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 Team	Offers 24/7 mobile 5150 assessments & crisis intervention for suicidal, homicidal and gravely disabled children and adolescents regardless of health insurance status. Clients with publicly-funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response Team	Provides 24/7 mobile response to homicides, critical shootings, stabbings, suicides and pedestrian fatalities; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

Program Outcomes, Highlights and Cost per Client

Program	FY17-18 Key Outcomes and Highlights
Comprehensive Crisis Services	• The Mobile Crisis Team served 1,997 individuals • The Child Crisis Team served 1,561 individuals • The Crisis Response Team served 231 individuals • The Crisis Intervention Specialist served 150 individuals

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[18]**
Comprehensive Crisis Services	3,939 Clients	$344,003	$87

Moving Forward in Mental Health Promotion and Early Intervention

School-Based Mental Health Promotion

School based mental health services remain steady this first six-months of the fiscal year (FY18-19), with a focus on maintaining or updating services at specific sites:

- Redirected Edgewood's shared staffing resources between Hillcrest Elementary School and Charles Drew Elementary School to focus on the latter;
- Maintaining the following services:
  - Bayview Hunters Point Foundation's at Balboa High School (Balboa Teen Health Services);
  - IFR's mental health consultation at Hillcrest Elementary School & James Lick Middle School;
  - RAMS Wellness trauma based programming across various high schools; and
  - Urban YMCA's Trauma & Recovery Services across various schools.

The Wellness Initiative overall coverage across various high schools was discussed amongst the initiative funders: San Francisco Unified School District (SFUSD), Department of Children, Youth and Families (DCYF) & SFDPH. All three entities have agreed that there is a need to support and maintain this program's 20+ clinicians, as this program faces staff turn-over while the staff contends with the high cost of living in the Bay Area. SFDPH & DCYF agreed to jointly increase the investment in the overall Wellness Initiative by $220k in FY18-19 to increase staffing salaries. MHSA also agreed to work in tandem with this effort.

In order to maintain steady with programming, it is recommended to further review how the 5% funding reduction to PEI-funded school based services has impacted staffing patterns and programming; and identify in what ways MHSA can sustain a plan to address the diverse needs in San Francisco.

[18] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

African American Healing Alliance

The African American Healing Alliance concluded on 6/30/17. The community decided that it was a natural end date based on a recent assessment of the project. MHSA introduced the practice to the point that the investment was made. Many providers were able to embed the practices into their internal systems so these services will continue throughout Behavioral Health Services. We are pleased to report that this project was a success and provided education on practices that will continue throughout DPH.

Practicing Wellness Activities at the Consumer, Peer and Family Conference

3. Peer-to-Peer Support Programs and Services: Clinic and Community Based

Service Category Overview

Peer-to-Peer Support Services are an integral part of a wellness and recovery-oriented mental health system, as individuals who have participated in mental health services, either as a consumer or as a family member, bring unique skills, knowledge, and lived experience to consumers who are struggling to navigate the mental health system. Peers also support consumers in dealing with stigma and facing economic and social barriers to wellness and recovery. These MHSA-funded services are largely supported through the Community Services and Supports and INN funding streams.

The scope of peer-to-peer support services includes:

- Peer training and certificate programs that provide various levels and intensity of trainings for consumers
- Peer outreach to underrepresented and underserved populations who typically face challenges in accessing services due to stigma, lack of linguistic or cultural representation, economic pressures, substance abuse, and age- or gender-related barriers
- Peer support for a variety of demographic groups, such as children and youth, non-English speakers, underrepresented ethnic groups, transgender individuals, and people with collecting challenges
- Supports for consumers who are facing legal, housing, employment, child support and other challenges
- Serving as a role model and beacon of hope to inspire consumers that wellness and recovery are attainable

There is also a key role for peer-based strategies in the ongoing work of educating the public on stigma reduction. Peer-to-Peer Support Service programs reach out to a wide range of public venues, such as health fairs, senior centers, and youth service centers, in order to demonstrate that consumers can recover and make positive contributions to the community. Through presentations and dialogue with community residents, consumers can offer a vision for wellness, especially to communities that

RAMS Peer Wellness Center

Peer-to-Peer

are facing stigma and hopelessness about the possibility of recovery. The stigma of mental illness is often culturally influenced, which makes it that much more essential that peers reflect the gender, language, age groups and culture of the City and County of San Francisco.

In addition, SFDPH-MHSA continues to make investments with the employment of peer providers in Civil Service positions throughout the system. We currently fund civil service peer providers at Mission Mental Health, Southeast Child Family Center, Community Justice Center, and Southeast Mission Geriatrics. MHSA is working with these providers to expand outpatient Mental Health Clinic capacity.

Target Populations

"Peers" are defined as individuals with personal lived experiences who are consumers of behavioral health services, former consumers, or family members or significant others of consumers. Peers utilize their lived experience in peer-to-peer settings, when appropriate, to benefit the wellness and recovery of the clients and communities being served.

Population Served by Peers: Peers will conduct culturally and linguistically congruent outreach, education and peer support to consumers of residential, community, mental health care and primary care settings within the Department of Public Health.

Peer-to-Peer Support Programs	
Program Name ***Provider***	**Services Description**
Addressing the Needs of Socially Isolated Older Adults (MHSA INN) *Curry Senior Center*	The Curry Senior Center's Addressing the Needs of Socially Isolated Older Adults program provides peer outreach and engagement services along with screening and assessment services to reduce isolation among the older adult population.
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) *SFDPH*	LEGACY program offers family and youth navigation services and education with a focus on stigma reduction.
National Alliance on Mental Illness *(NAMI)*	NAMI Peer-to-Peer, Family-to-Family program utilizes trained peers to provide outreach, engagement, navigation in the community. Peer mentors meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the participant by meeting weekly for 1 hour and assisting the participant with their wellness and recovery journey. Mentors also act as a community resource for helping a participant direct their own path to wellness and recovery.

Peer-to-Peer Support Programs	
Program Name ***Provider***	**Services Description**
Peer Specialist Mental Health Certificate and Leadership Academy *Richmond Area Multi-Services (RAMS)*	The Certificate Program (Entry and Advanced courses) prepares BHS consumers and/or family members with skills & knowledge for peer specialist/counseling roles in the systems-of-care. In addition, the program offers the Leadership Academy which is a monthly training series designed to support and educate peer providers in the behavioral health field. Trainings will also focus on building skills for participation in a variety of activities that request peer provider/consumer input (e.g., boards and advisory committees, review panels, policy development, advocacy efforts, etc.).
Gender Health SF (formerly known as Transgender Health Services) *SFDPH*	Gender Health SF program provides access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. MHSA began funding the peer counselor positions only, to support this program as a supplemental enhancement. Peer counselors ensure proper coordination of behavioral health services and ensure all behavioral health needs are addressed.
Peer-to-Peer Employment Program *Richmond Area Multi-Services (RAMS)*	The Peer Counseling & Outreach facilitates wellness activities and enhances treatment services by providing peer counseling and supportive case management & resource linkage to clients of BHS clinics/programs. The services, offered by individuals with lived experience, aim to improve the level of engagement with clients, foster feelings of hope, and promote recovery & wellness. The Peer Internship offers entry-level placements in peer direct services and administrative support roles. In a collaborative learning and supported environment, peer interns work with other peer providers in a variety of DPH programs. The paid internships are nine months (20 hours/week) in duration.
Peer Wellness Center *Richmond Area Multi-Services (RAMS)*	The Peer Wellness Center is for adult/older adult consumers of BHS in need of additional support, with services provided by peer counselors and wellness staff who have lived experience. Consumers gain empowerment skills, engage in mindfulness practices, and participate in whole health wellness within a safe environment that utilizes empathy & peer support to help promote and inspire recovery. Also, the Center offers information for supportive services and linkages to a variety of behavioral health and primary health care resources in San Francisco.
Transgender Pilot Project (MHSA INN) *SFDPH*	The Transgender Pilot Project is designed to increase evaluation planning in order to better collect data on the strategies that best support Trans women of color with engaging in behavioral health services. TPP entered the pilot year of operations in FY15-16 as a MHSA INN Project. The two primary goals involve increasing social connectedness and providing well-ness and recovery based

Peer-to-Peer Support Programs	
Program Name ***Provider***	**Services Description**
	groups. The ultimate goal of the groups is to support clients with link-age into the mental health system and services.
Reducing Stigma in the Southeast (RSSE) *SFDPH*	Reducing Stigma in the Southeast program engages faith-based organizations and families in the housing community referred to as “The Village” in order to increase mental health awareness, de-crease stigma, and provide community support by linking commu-nity members with vital resources (e.g. helping community mem-bers to connect with housing and food assistance programs).
Peer Outreach and Engagement Services *Mental Health Association of SF*	For most of FY17-18, the Peer Outreach and Engagement Ser-vices program was broken into the following three programs: • SOLVE aims to reduce stigma (including self-stigma, structural stigma, and societal stigma) discrimination and bias, related to mental illness/mental health conditions as well as to empower those affected by stigma to advocate for their communities’ needs. • SUPPORT (previously known as Peer Response Team) aims to improve outcomes for mental health consumers by providing individual and group interventions that focus on increasing peer wellness, recovery, and resiliency. • NURTURE aims to empower mental health consumers by teaching basic nutrition, fitness, and mindfulness-based skills, and by encouraging participants to apply and practice these new skills.

RAMS Peer Wellness Center Holiday Art Project

Spotlight on the Richmond Area Multi-Services Peer Wellness Center

In the fall of 2015, RAMS Division of Peer-Based Services, Peer Wellness Center program began providing services to a small but growing group of clients accessing Behavioral Health Services. Today, located in the Civic Center/Mid-Market neighborhood of San Francisco, the RAMS Peer Wellness Center has accomplished significant outcomes.

- 1,200 active client members.
- Over 5,000 support, psycho-educational and recreational groups.
- Over 32,000 individuals access our services.
- The program is staffed by approximately 20 Peer Counselors, all of whom identify as having mental health and/or substance use as lived experience.
- The Peer Wellness Center is 100% peer-staffed, including the direct supervisors.

The program operation hours are Monday, Wednesday, and Fridays, from 9:00am-5:00pm, Tuesday and Thursdays from 9:00am-7:00pm, and Saturdays from 10:00am-3:00pm. The Center is closed on Sundays.

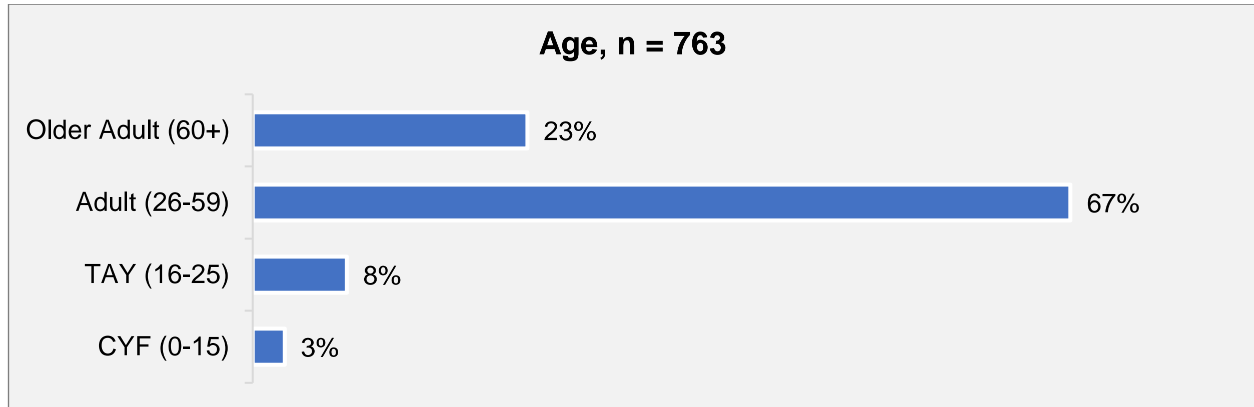
RAMS Peer Wellness Center provides a respite and a safe space for its members to participate and engage with their peers as part of their healing and recovery journey. Based on the principles of Wellness and Recovery, the Peer Wellness Center promotes a milieu that encourages healthy living activities, establishing strong social network supports, accessing resources to increase stabilization with housing and healthcare as well as establishing more structure in their daily lives. The peer counselors offer an invaluable dimension to support as having shared lived experiences and can listen to and provide hope to members and clients who are struggling in their recovery.

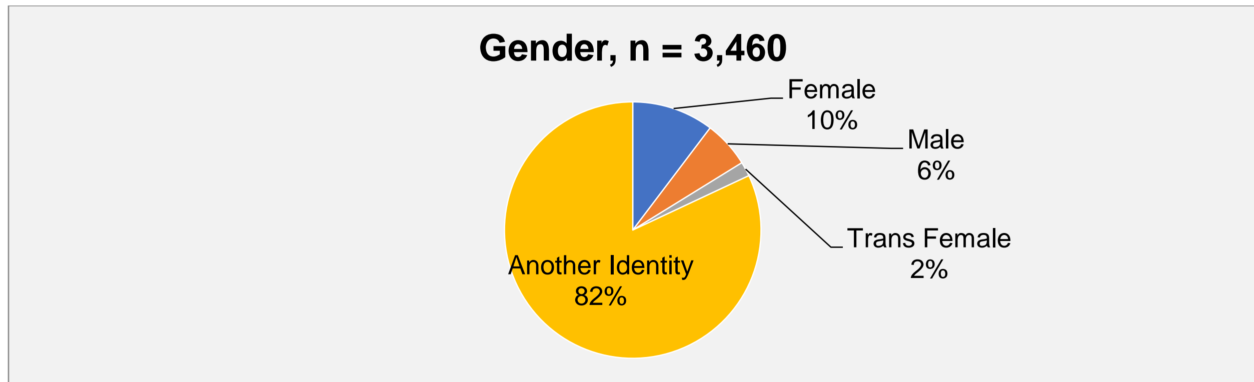
A Client Success Story

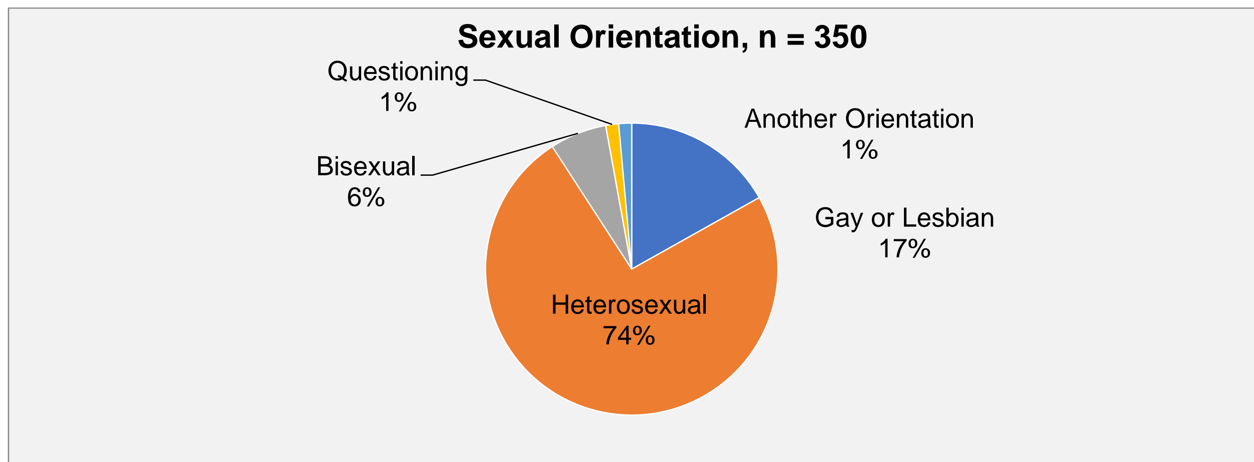
A long-time client of the Peer Wellness Center, Bob, struggled with Substance Use Disorder. Bob would come to the Peer Wellness Center, often feeling unwell. Peer counselors would sit with him to encourage him to enter into active treatment, even accompanying him to the drop-in clinic at the Behavioral Health Services building, only for Bob to change his mind once he got there. After several months, Bob suddenly stopped showing up to the program. Our counselors tried contacting him, but the efforts were to no avail. Six months later, Bob showed up to the Peer Wellness Center looking healthy, bright eyed, and confident. Everyone was so happy to see him! Bob told the counselors that he hit rock bottom one evening and decided he could not continue living this way. He said the one thing that gave him the courage to seek out treatment was the caring support and hope he received from the Peer Wellness Center staff. He said he was inspired by the people at the Center who took their first step to recovery, got better, and eventually contributed back to the community. With this inspiration, Bob felt there was hope for him. Bob admitted himself into a residential treatment program and has been in recovery ever since. Today he is more than one year clean. Bob doesn't come to the Peer Wellness Center as often as he used to, now that he has expanded his social network. When he does visit, he seems healthy and happy. In turn, our peer staff are now inspired by Bob and the true testament to the success of peer support.

Participant Demographics, Outcomes, and Cost per Client

Demographics: Peer to Peer Support Programs[19]



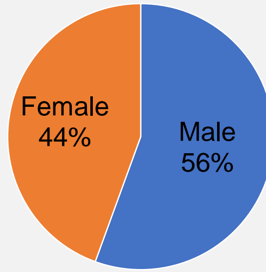




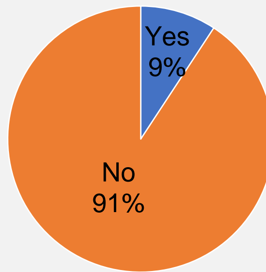
Peer-to-Peer

[19] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).

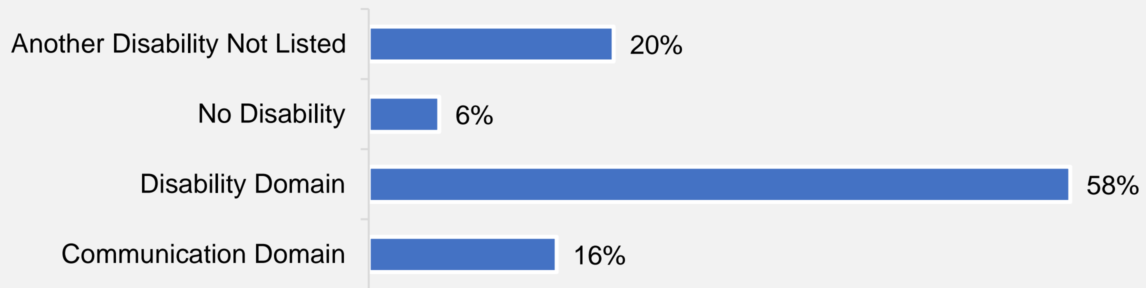
Sex at Birth, n = 657



Veteran Status, n = 216



Disability Status, n = 359



Peer-to-Peer

Race/Ethnicity	n	%
Black/African-American	175	15%
American Indian/Alaska	16	1%
Asian	118	10%
Native Hawaiian Islander	13	1%
White	186	16%
Other Race	66	6%
Hispanic	183	16%
Non-Hispanic	359	31%
More than one ethnicity	31	3%
Total	**1,147**	**100%**

Primary Language	n	%
Chinese	69	2%
English	3,249	94%
Spanish	133	4%
Tagalog	13	0%
Total	**3,470**	**100%**

For Peer-to-Peer Support Programs and Services, data for the following languages were not included since they rounded to 0%: Russian, Vietnamese, and Another Language. Also, less than 1% of participants reported data for Trans Male so these demographics were not included.

Program ***Provider***	**FY17-18 Key Outcomes and Highlights**
Addressing the Needs of Socially Isolated Older Adults (MHSA INN) *Curry Senior Center*	• 85 isolated older adults were screened for behavioral health needs using a preclinical behavioral health screening tool, administered by Peer Outreach Workers. • 46 isolated older adults were screened and identified as having a behavioral health need will be referred to appropriate behavioral health services. • 18 isolated older adults attended at least 5 group activities. • 76 isolated older adults were screened for non-behavioral health needs. • 70 isolated older adults who indicate the need for non-behavioral health services were referred to the appropriate service.
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) *SFDPH*	• LEGACY staff hosted 8 trainings on the following topics: Self-Empowerment, Medicinal Drumming, Financial Responsibility, Girl's Empowerment, Getting Educated on Your Child Education and Parenting Skills (Spanish and Cantonese).

Program *Provider*	FY17-18 Key Outcomes and Highlights
	• Five staff members attended 26 case management meetings at 4 different four Children Youth and Family outpatient clinics – Collaborate and consulted with Child, Youth & Family outpatient clinics during case management meetings to offer a peer perspective and increase the number of referrals to LEGACY program.
National Alliance on Mental Illness (*NAMI)*	• 90% (35 of 39) of participants reported an increased understanding of their mental illness as a diagnostic medical condition and felt better about their ability to recognize signs and symptoms, as evidenced by the completion of a relapse prevention plan. • 82% (32 of 39) of participants reported an increased awareness and skills to better practice self-care. • 85% (41 of 48) family member participants reported feeling more prepared to solve future problems with their loved one who is living with a mental health condition, and better connected to the community and available resources.
Peer Specialist Mental Health Certificate and Leadership Academy *Richmond Area Multi-Services (RAMS)*	• 96% of Entry Level Certificate graduates (25 out of 26) said they planned on pursuing a career in the field of health and human services. • 100% of graduates surveyed reported that they had been engaged with the health and human services field through employment, volunteer positions, and/or further education within 6 months of graduation.
Gender Health SF (formerly known as Transgender Health Services) *SFDPH*	• GHSF staff worked with a minor to seek and acquire chest surgery. The GHSF had never worked with a minor before. • Through advocacy and relationship building, GHSF succeeded in adding two in-network facial feminization surgeons at ZSFG. • GHSF successfully referred a patient for body feminization (body contouring) through the SF Health Plan.

Program *Provider*	FY17-18 Key Outcomes and Highlights
Peer-to-Peer Employment Program *Richmond Area Multi-Services (RAMS)*	• 100% (7 of 7) of intern graduates reported improvements in managing their own wellness and recovery and coping with stress in the workplace. • 87% of clients/participants surveyed (138 of 159) reported improvement in their overall quality of life. • 86% of clients surveyed (137 out of 159) expressed overall satisfaction with services received by the program. • Our Peer Counseling staff continues to grow and change, as we offered employment at RAMS to three of the graduates from the FY17-18 Peer Internship Program (two of the other graduates accepted employment at other community agencies, one has been accepted into a master's program for school counseling in Fall 2018, and the final graduate is pursuing volunteer opportunities in the field).
Peer Wellness Center *Richmond Area Multi-Services (RAMS)*	• 83% of clients/participants of group services and/or Wellness Center services (132 of 159) reported that they have maintained or increased feelings of social connectedness. • 87% (138 of 159) clients/participants surveyed reported improvement in their overall quality of life as evidenced by satisfaction survey results. • 100% (50 of 50) of program employees (working 16+ hours/week) will participate in at least four or more skills development and/or wellness trainings/sessions (e.g. enrolling in the certificate or advanced degree program; participating in trainings on counseling and engagement skills, community resources, stress management/coping, etc.).
Transgender Pilot Project (MHSA INN) *SFDPH*	• A total of 88% of participants reported an increase in their feelings of social connectedness. • A total of 86% of participants reported improvements to health, wellness and recovery.
Peer Outreach and Engagement Services *Mental Health Association of SF*	• SOLVE delivered 12 anti-stigma presentations, reaching a total of 307 individual audience members. 94% of audience members who filled out the post-presentation survey (289 out of 307) reported decreased stigma regarding mental health conditions • SUPPORT delivered 1:1 support to 35 consumers of behavioral health. 93% of individuals who received 1:1 support and responded to a follow-up survey (13 of 14 individuals) reported decreased feelings of isolation.

Program *Provider*	FY17-18 Key Outcomes and Highlights
	• Peer Coaches offered 7 community-building trainings and 4 NURTURE orientations focused on nutrition, physical activity, and mind-body awareness, reaching 49 participants. 96% of participants (44 out of 46) reported that their understanding of wellness and/or nutrition has improved after the training.
Reducing Stigma in the Southeast (RSSE) *SFDPH*	• Staff facilitated bi-monthly groups to bring community participants together and address the concerns of the community. • Staff worked to increase knowledge and awareness of resources, by discussing topics such as health, nutrition, advocacy, recovery, education, violence prevention and wellness. • Staff provided peer and family support, as well as resources and referrals. • Staff conducted extensive outreach and professional networking activities by spreading awareness of mental health resources at community fairs and events.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[20]**
Peer-to-Peer Programs	3,709 Clients	$5,285,150	$1,425

Moving Forward in Peer-to-Peer Support Programs

Gender Health SF (GHSF)
In June 2017, GHSF moved to its current home at the Zuckerberg San Francisco General Hospital campus. The previous program space at 50 Ivy Street was small and did not allow for staff to meet with patients or offer additional programming to address a wide array of needs. Our new space has accommodated for growth in staffing and additional programming such as wellness classes, support groups, educational workshops and training.

The program's name was changed from Transgender Health Services to Gender Health SF. The name change signifies an inclusive and intentional framework for serving all people who identify as transgender, transsexual, and gender non-binary while advancing health and wellness for the population.

A core component contributing to the success of GHSF is the Peer Patient Access Navigator program. Patient access navigators, many of whom are peers, have received services through

[20] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

GHSF and have been recipients of mental health services monitor the care of patients from the point of enrollment through a year after their surgery.

Update on Peer Outreach and Engagement Program

In 2018, MHASF's successful SOLVE (Sharing Our Lives, Voices, and Experiences) speaker's bureau and the Peer Response Team merged to become Peer Outreach and Engagement Services. The new program takes the best aspects of both original programs and combines them to better reduce mental health stigma and meet the needs of San Francisco peers. With 12 Objectives, 6 Peer Coaches, and over 20 Peer Educators in the field sharing their lived experiences, the Peer Outreach and Engagement Services program is a large and complex program. It is on track to meet program deliverables as it fine-tunes elements to meet consumer and contract needs. For example, the Support/Nurture component of the program has seen a 100% increase in participation as individuals decrease isolation and increase their social skills.

The Peer Outreach and Engagement Services Program seeks to blur the lines between different elements of the program so participants just see Wellness: a holistic approach to developing resiliency. With the distractions that life offers, wellness is not a state of mind or a static goal but a journey. Whether participants are developing tools to find focus and balance through mindfulness; learning tips and techniques for healthy eating; sharing personal stories to eliminate public and self-stigma; or reclaiming living space from clutter, Peer Coaches and Peer Educators are there as guides along the way.

8th Annual Transgender Health and Wellness Fair

On December 10th, 2018, SF-MHSA held the 8th Annual Transgender Health and Wellness Fair. This fair consisted of exciting presentations, educational training opportunities, resource information, award distribution and networking.

RAMS Peer Specialist Mental Health Certificate

In December 2018, the RAMS Division of Peer-Based Services celebrated the graduation of the 12 students of Cohort #17, who successfully completed the 12-week, 100-hour RAMS/SF State University Peer Specialist Mental Health Certificate Entry Course. We teach students to focus on their individual wellness and recovery to build resilience and enhance capacity to provide strengths-based, person-centered care to individuals and groups throughout San Francisco.

RAMS Peer Specialist Mental Health Certificate Graduation 2018

The graduates are in the process of interviewing for positions at various sites throughout San Francisco, and multiple students from this cohort are already providing services at different organizations, including Mentoring and Peer Support (MAPS), Curry Senior Center, HealthRight360, San Francisco AIDS Foundation, Institute on Aging, and RAMS, among others. The Peer Certificate program looks forward to these graduates empowering individuals in the community to achieve their wellness goals!

4. Vocational Services

Service Category Overview

The San Francisco Department of Public Health incorporates vocational services within its mental health programming through MHSA funding. These vocational services ensure that individuals with serious mental illness and co-occurring disorders are able to secure meaningful, long-term employment. Research shows that supported employment programs help individuals with mental illness achieve and sustain recovery.

In collaboration with The California Department of Rehabilitation, DPH has identified a need for various training and employment support programs to meet the current labor market trends and employment skill-sets necessary to succeed in the competitive workforce. These vocational programs and services includes vocational skill development and training, career/situational assessments, vocational planning and counseling, service coordination, direct job placement, ongoing job coaching, and job retention services. These MHSA-funded services are largely supported through the Community Services and Supports and INN funding streams.

Target Population

The target population consists of BHS clients. Particular outreach is made to underserved populations and those interested in job readiness programs, on-the-job training, internships, competitive employment and meaningful activities leading to work.

Vocational

Vocational Services	
Program Name ***Provider***	**Services Description**
Department of Rehabilitation Vocational Co-op (The Co-op) *SFDPH and State of California*	The San Francisco Department of Rehabilitation (DOR) and BHS collaborate to provide vocational rehabilitation services to consumers of mental health services. Services offered by this program include vocational assessments, the development of an Individualized Plan for Employment, vocational planning and job coaching, vocational training, sheltered workshops, job placement, and job retention services.

Vocational Services	
Program Name ***Provider***	**Services Description**
i-Ability Vocational IT Program *Richmond Area Multi-Services (RAMS)*	The i-Ability Vocational Information Technology training program prepares consumers to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at the BHS IT Department. The program includes three components: • Desktop: Learn new skills in the deployment and support of office equipment including; desktops, laptops, servers, printer, etc. Skills learned include the installation of software, application testing, break/fix, presentation skills, resume writing, etc. • Advanced Desktop: Participants continue to expand their knowledge in the area of desktop support services. Additionally, participants serve as mentors for participants of the Desktop program. • Help Desk: Participants learn customer and application support skills through the staffing Avatar Electronic Health Record (EHR) help desk, a call center. Skills learned include application support, customer service skills, working in a collaborative environment, resume writing, documentation development, etc. • Advanced Help Desk: Participants continue to expand their knowledge in the area of application support gained through their successful graduation from the Help Desk program. Additionally, participants serve as mentors for participants of the Help Desk program. • Employment: Graduates of the IT vocational training program are provided with the opportunity to apply for a full-time position with the IT department. Services offered by the program include vocational assessments, vocational counseling, job coaching, skill development and training.
First Impressions (MHSA INN) *UCSF Citywide Employment Program*	First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls, ceilings, and doors; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, vocational planning, job coaching, vocational training, workshops, job placement, and job retention services.
Alleviating Atypical	The Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) program provides nutrition, exercise, and health education and training. The program educates program participants on the

Vocational

Vocational Services	
Program Name ***Provider***	**Services Description**
Antipsychotic Induced Metabolic Syndrome (AAIMS) *API Wellness Center*	connection between diet and health, provides healthy cooking and exercise classes, information on shopping for healthy food based on local availability with the goal of decreasing participant's metabolic syndrome issues and increasing their social connectedness. AAIMS peer leaders also advocate for neighborhood food access.
SF Fully Integrated Recovery Services Team (SF FIRST) *SFDPH*	The SF FIRST Vocational Training Program offers 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 clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitator, as well as other positions. 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. *See additional information in the "Spotlight" featured above.*
Assisted Independent Living Vocational Program *Baker Places*	The Assisted Independent Living Vocational Program supports consumer employees in building skills related to clerical/administrative support and mail distribution. This supported employment project is located on-site at Baker Places and provides training, supervision and advanced support to a team of consumers with an emphasis on professional development. The Assisted Independent Living project aims to help consumers to identify professional development goals and breakdown barriers in reaching their goals. The project also links consumers to the Department of Rehabilitation's job placement services and other vocational programs within the BHS system.
Janitorial Services – *Richmond Area Multi-Services (RAMS)*	The Janitorial Services program provides janitorial and custodial vocational training to behavioral health consumers.
Café and Catering Services *UCSF Citywide Employment Program*	The Café and Catering Services program provides café, barista, catering and customer service vocational training to behavioral health consumers.
TAY Vocational Program *Richmond Area Multi-Services (RAMS)*	The TAY Vocational Program offers training and paid work opportunities to TAY with various vocational interests.

Slice of Life Catering Vocational Program

Spotlight on i-Ability Vocational IT Training Program

The RAMS' i-Ability Vocational Information Technology (IT) Training Program prepares clients to provide IT support services (e.g., Help Desk, Desktop support) in the SF Behavioral Health Services internal IT Department. The program includes 2-4 week unpaid classroom instructional period, followed by a paid work training period.

- Desktop: Clients learn new skills in the deployment and support of office equipment (computers, servers, printers, other hardware). These skills include the installation of software, application testing, break/fix, and soft skills (resume building, presentation).
- Advanced Desktop: Clients expand their knowledge in the area of desktop support services following graduation from the Desktop program. Clients serve as mentors for participants of the Desktop program.
- Help Desk: Clients learn customer and application support skills for the SF BHS staffing Avatar Electronic Health Record Help Desk (call center). These skills include application support, customer service and communication skills, and others.
- Advanced Help Desk: Clients expand their knowledge in the area of customer and application support following graduation from the Help Desk program. Clients serve as mentors for participants of the Help Desk program.
- Consumer Portal Help Desk: Clients learn customer service skills and application support through the BHS Consumer Electronic Health Record Help Desk. These skills include application support, customer service skills, and others. This is a new component that started in FY17-18.

Graduates of the IT vocational training program are provided with the opportunity to apply for a full-position with the IT department.

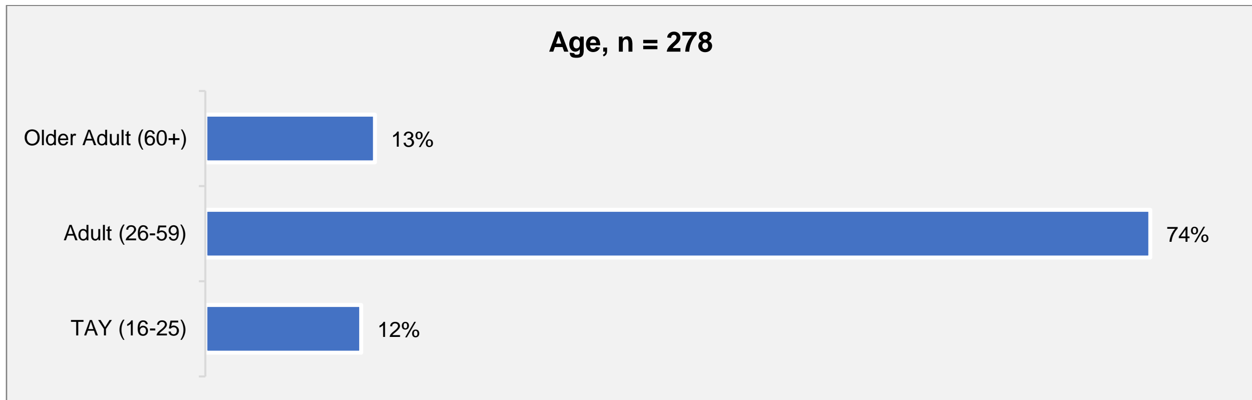
The i-Ability Vocational IT Training Program services adhere to the Wellness and Recovery Model, which helps consumers improve their mental health and wellness. These services are intended to provide meaningful activities that foster a client's independence and increase their ability to participate in society in a meaningful way.

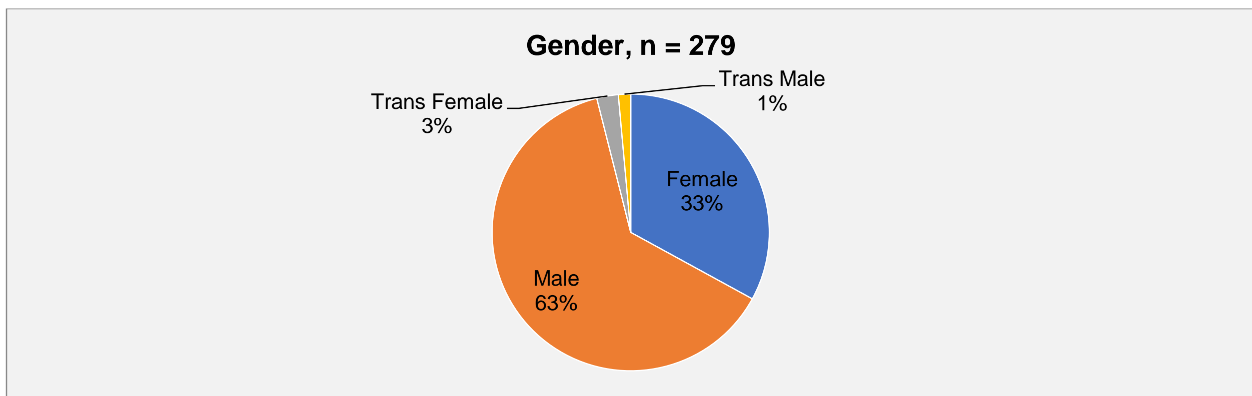
In FY17-18, the i-Ability Vocational IT Training Program achieved the following:

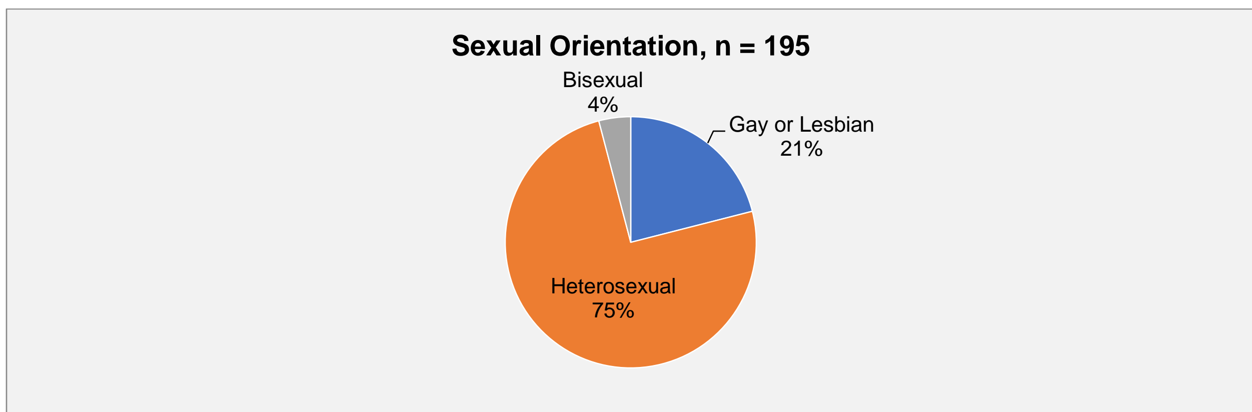
- **100%** of graduates (37/37) met their individualized vocational goals.
- **95%** of graduates (35/37) indicated improvements to their coping abilities
- **95%** of enrollees (37/39) successfully completed the training or exited the program early due to obtaining employment related to this field

Participant Demographics, Outcomes, and Cost per Client

Demographics: Vocational Services[21]



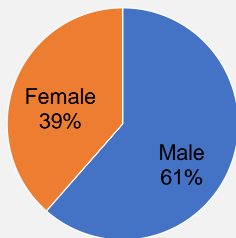




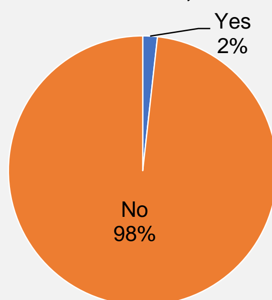
Vocational

[21] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).

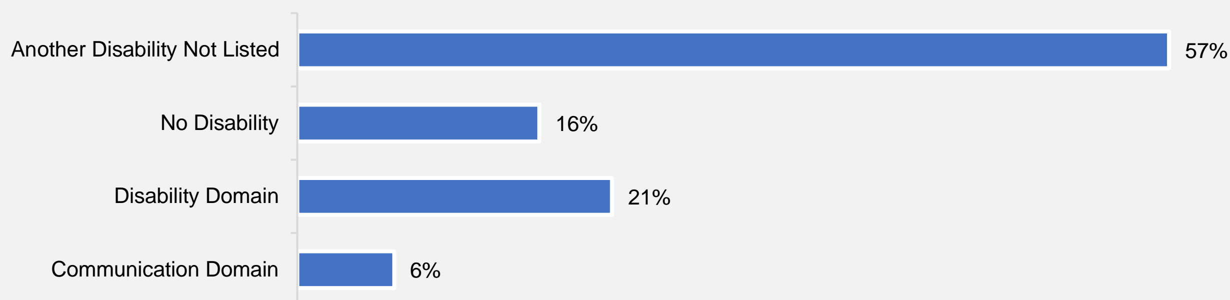
Sex at Birth, n = 135



Veteran Status, n = 228



Disability Status, n = 126



Vocational

Race/Ethnicity	n	%
Black/African American	76	26%
American Indian/Alaska	6	2%
Asian	22	8%
Native Hawaiian Islander	4	1%
White	111	39%
Other Race	15	5%
Hispanic	36	13%
Non-Hispanic	2	1%
More than one ethnicity	15	5%
Total	**287**	**100%**

Primary Language	n	%
English	268	97%
Another language not listed	3	1%
Spanish	4	1%
Total	**276**	**100%**

For Vocational Services, data for Chinese and Tagalog were not included since they rounded to 0%. Also, less than 1% of participants reported data for CYF (0-15) so these demographics were not included.

Program *Provider*	FY17-18 Key Outcomes and Highlights
Department of Rehabilitation Vocational Co-op (The Co-op) *SFDPH and State of California*	• Served a total of 509 clients. • 274 clients were placed in competitive employment. Of these, 54% (148 out of 274) remained employed after 3 months. • Partnered with the BHS Vocational team to organize a job fair where over 20 employment agencies shared information with over 100 consumer participants. • Held the 3rd Annual Vocational Summit with over 70 attendees including peer consumers and clinical service providers.
i-Ability Vocational IT Program *Richmond Area Multi-Services (RAMS)*	• 100% of trainee graduates have met their vocational goals. • 95% trainee graduates agreed/indicated improvements to their coping abilities, as reflected by post-program evaluations and satisfaction surveys. • 95% of i-Ability trainees successfully completed the training or exited the program early due to obtaining gainful employment or finding volunteering that is related to their vocational interests.

Program *Provider*	FY17-18 Key Outcomes and Highlights
First Impressions (MHSA INN) *UCSF Citywide Employment Program*	• 100% of graduates reported an improvement in development of work readiness skills (such as work/education/volunteering). • 100% of graduates reported an improvement in confidence to use the new skills learned. • First Impressions piloted a collaboration with Facilities to create two part-time positions for program graduates. These positions allowed participants to work 20 hours per week, apprenticing directly with the DPH Facilities Team.
Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) *API Wellness Center*	• Among participants in Nutrition and Wellness Activities who completed both pre and post surveys, 92% (11 of 12) reported sustained or improved health status. • 78% (45 of 58) of Tenderloin residents who received a hot meal prepared by wellness and nutritional support vocational participants reported an immediate increase in overall wellness. • 80% (12 of 15) wellness and nutritional support vocational participants who completed a survey reported an increase in vocational/employment readiness after participating in the program.
SF Fully Integrated Recovery Services Team (SF FIRST) Vocational Project *SFDPH*	• 82% of trainees (18 out of 22) indicated improvements in coping abilities as evidenced by post-program evaluations. • 10 consumers completed the entire 9-month program. • Served 22 consumers through the Stipended Training Program.
Assisted Independent Living Vocational Program *Baker Places*	• Program staff provided clinical case management supervised by a licensed mental health clinician to 95% of program participants (59 out of 62).
Janitorial Services *Richmond Area Multi-Services (RAMS)*	• 100% (4/4) of program participants eligible to complete the internship. • 67% (2/3) of survey responders reported an increased ability to manage symptoms in the workplace, not achieving our goal of 75%. The 3rd responder stated "neutral" in regards to this indicator. • 100% (3/3) of survey responders reported an increased readiness for additional vocational activity.
Café and Catering Services *UCSF Citywide Employment Program*	• Enrolled 33 BHS consumers. • Graduated 13 BHS consumers. • All 13 graduates (100%) reported an improvement in development of work readiness skills to use toward future opportunities.

Program *Provider*	FY17-18 Key Outcomes and Highlights
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) *UCSF Citywide Employment Program*	• Enrolled 19 and graduated 8 consumers. • 100% of graduates reported an improvement in development of work readiness skills and an improvement in confidence to use the new skills learned.
TAY Vocational Program *Richmond Area Multi-Services (RAMS)*	• Enrolled 15 youth in the program. • 100% (5 out of 5) participants in cohort 1 and 100% (5 out of 5) participants in cohort 2 indicated feeling confident using the skills they have learned in the program. • 90% (9 out of 10 surveyed) indicated on the post-experience survey that the overall services at Career Connections was "excellent" or "very helpful." • 10 participants are pursuing goals identified while attending Career Connections, including higher education, competitive work and additional vocational training.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[22]**
Vocational Programs	1,002 Clients	$1,916,300	$1,912

Vocational

Moving Forward in Vocational Services

The Alleviating Atypical Antipsychotic Induced Metabolic Syndrome Program

The Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) program ended in its current form on 6/30/18. The SFDPH Tom Waddell Urban Health Clinic was awarded INN funding for this five-year pilot project and began offering services in October 2011. After INN funding ended, it became a project of the Asian & Pacific Islander Wellness Center, starting in July 2016, and continued as an MHSA Peer-to-Peer Services program.

After a thorough assessment of the needs of the community, MHSA has decided to merge the Peer Outreach and Engagement Services program with the AAIMS nutritional vocational project since there is substantial overlap with the two programs. After gathering input from the community and other stakeholders, it appeared most sensible to streamline these activities and combine funding, resources and best practices. The promotion of all practices from these two projects will continue with this positive system transformation.

The AAIMS program provides nutrition, exercise, and health education and training. The program educates program participants on the connection between diet and health, provides healthy cooking and exercise classes, information on shopping for healthy food based on local

[22] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

availability with the goal of decreasing participants' metabolic syndrome issues and increasing their social connectedness. AAIMS peer leaders also advocate for neighborhood food access.

AAIMS has learned how to translate a successful nutrition and exercise training into a Tenderloin community mental health setting; combining it with skills training and shopping and cooking using the limited resources available to a low-income population. It also showed some impact on metabolic markers, like weight loss, for seriously mentally ill consumers, many who are prescribed atypical antipsychotic medications, despite tremendous challenges and barriers. AAIMS has learned how to successfully improve self-confidence and nutrition- related skills in target consumers – first in an intensive group setting, then as reinforced via peer leadership and vocational opportunities, advocacy, and peer-to-peer support and through community outreach in diverse settings. Most strikingly, the project has learned that efforts to improve this population's nutrition and wellness is most effective within a context of food justice work, sensitive to social-economic-cultural realities as well as through real opportunities for meaningful and paid work in the community for peers.

Some key highlights and learnings from the AAIMS program have included:

- The power of food to bring people together for positive social interactions, to lessen isolation and for improved mental health outcomes.
- Food as self: participants connect to culture and memories, past and current relationships through cooking, gardening, recipes, and meals.
- The importance of leveraging resources, making connections, and community collaborations.
- Behaviors and attitudes towards healthy eating and healthy foods take time, exposure, and support. Tastings, hands-on experiences, and experiential trips and tours of community sites – like healthier places to shop and community gardens - have a great impact. Every small change in behavior or awareness counts, and builds towards greater change. Clients are most successful when they define their own goals.
- When barriers are removed, patients prefer delicious, healthy and nourishing foods. Success requires access to information, tools, experience, connection and support for change.
- Consumers/peers desire to give back and to have a positive impact on the community – to reach and teach others, and to do meaningful work.
- Improved nutrition seems to contribute positively to mental health recovery. More research in this area is needed and desired.

<u>The Slice of Life Café and Catering Program</u>

The Slice of Life program graduated its 5th cohort, in November 2018, at the San Francisco Behavioral Health Center located next to the Zuckerberg San Francisco General Hospital. Under the expert tutelage of the Chef, the Program Coordinator and the Peer Mentor, the graduates prepared an elegant and delicious 3-course luncheon for family, friends and staff. The luncheon was a culinary culmination of the skills the graduates learned over their 6-month, paid-work experience. The CEO at Zuckerberg San Francisco General Hospital, who attended the graduation, wrote,
"The program increases integration into the community and feelings of self-worth. It's all about better lives and hope for the people it serves; that was clear from the wonderful graduation celebration!"

Other Vocational Programming

In Fiscal Year 18-19 and beyond, the SF DOR Vocational Co-op Program will focus on serving marginalized groups, including TAY, transgender, and homeless clients. Also, the SF-MHSA team intends to work in collaboration with SFDPH Quality Manangement to develop a Final INN Learning Report for the Citywide First Impressions Program and submit to the MHSOAC.

The Slice of Life Vocational Program Graduation

5. Housing Services

Service Category Overview

MHSA-funded housing helps address the need for accessible and safe supportive housing to help clients with serious mental illness or severe emotional disorders obtain and maintain housing. This service category includes Emergency Stabilization Housing, FSP Permanent Supportive Housing, Housing Placement and Support, ROUTZ Transitional Housing for TAY, and other MHSA Housing Services.

No Place Like Home (AB 1618)

On July 1, 2016, California Governor Jerry Brown signed legislation enacting the No Place Like Home (NPLH) Program to dedicate $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are living with a severe mental illness (SMI) and are in need of mental health and/or substance use services and are experiencing chronic homelessness, or are at-risk of chronic homelessness, or homelessness. The bonds are repaid by funding from the MHSA Fund. Some key features of this program include: (1) counties are eligible applicants (either solely or with housing development sponsor); (2) utilization of low-barrier tenant selection; and (3) counties must commit to provide mental health services and coordinate access to other supportive services.

State funding for NPLH was delayed by the passage of Proposition 2 during the November 6, 2018 California General Election. In San Francisco, NPLH has inspired an immense amount of cross-departmental collaboration to create permanent supportive housing for people with SMI/SED. The Department of Homelessness and Supportive Housing (HSH), Mayor's Office of Housing and Community Development (MOHCD), DPH, and other agencies are working in partnership to facilitate this program. Collaborating stakeholders meet monthly to discuss the integration of new NPLH units into San Francisco's pipeline of permanent support housing. MOHCD and HSH, will be taking the lead on this project. DPH will work in partnership with MOHCD and HSH, to develop and implement the supportive services portion of the NPLH program.

Since NPLH requires the provision of supportive services for people housed in NPLH units, a needs assessment is being conducted by HSH and will be finalized in April 2019. This assessment will explore the supportive services needed, best practices for providing supportive services in permanent supportive housing for people with SMI/SED, and gaps in existing supportive services. A diversity of stakeholders will give input on supporting people living with mental illness to retain their housing, including those working in mental health, permanent supportive housing, and homelessness.

Coordinated Entry Systems

The NPLH program mandates that to qualify to live in a NPLH unit, people must have been assessed with a standard assessment tool that ensures people with the greatest need for and

most barriers to housing are prioritized. Starting in 2017 and continuing in 2018, HSH launched three Coordinated Entry Systems (CES) to centralize the housing referral and placement process throughout the county. There are now Adult (18+), Family, and Youth (18-24) CES to evaluate and prioritize the needs of people experiencing homelessness. Launching each of these systems are iterative processes, so CES will continue to be developed as older systems of housing assessment and placement are discontinued.

The CES aims to reduce barriers for clients and providers by streamlining and standardizing the intake process for housing. CES will prioritize the most marginalized people experiencing homelessness for housing, while supporting other unsheltered people with problem solving and linkage to available resources. Each person (or family) who encounters the CES will complete a primary assessment to determine if they will be prioritized for a vacancy within the housing system, or referred to problem-solving resources. This assessment will ensure that people are prioritized for housing based on their barriers to housing, vulnerability (including mental health illness, substance use disorder, and medical conditions), and amount of time homeless (scaled for equity across age groups) to determine priority status.

To ensure that the primary assessment tool was relative, equitable, and prioritized the most underserved communities, the CES team of HSH conducted an Assessment Blitz. The goal was to assess a significant portion (20%) of the population experiencing homelessness. Through collaboration with providers like FSP, Intensive Case Management, and outpatient programs, the CES team exceeded the goal of assessing at least 2,000 people.

The implementation of the CES is an exciting change that will impact housing programs managed by MHSA, while simultaneously expanding housing access to clients who are otherwise not served in MHSA-funding housing programs. MHSA program will continue to monitor the development of the NPLH program and its impact on the County's Annual MHSA Revenue Allocation due to the bond repayment.

Housing

Emergency Stabilization Units

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. MHSA-funded ESUs are managed by a DPH team called Transitions. The twenty-five ESUs are located within several single room occupancy (SRO) hotels in San Francisco. The units are available to FSP clients. In the 2018-2019 Fiscal Year, referral and discharge procedures were created for MHSA-funded stabilization units, to refine the efficiency of the program operations. Procedures for the use of MHSA-funded ESUs were shared and discussed with all FSP Programs on November 9, 2018. In recent years, the amount of ESUs being contracted with SFDPH have decreased. This is due in part to buildings leasing out individual units or entire buildings for higher amounts, comparable with the expensive rental market in San Francisco. Though interim housing options for MHSA clients are increasingly limited, the Transitions team has worked to increase the ESU inventory for MHSA by five units in the past fiscal year.

FSP Permanent Supportive Housing (PSH)

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 by creating many units of housing for MHSA clients that are still being operated within the provision of the MHSA. In addition, San Francisco added $2.16 million from Community Services and Supports (CSS) to hous-

ing in 2007-08. MHSA-capital-funded housing units were developed within larger mixed-population buildings with on-site supportive services, and linked to the larger infrastructure of intensive case management services provided by FSPs.

Through referral from FSP providers and with confirmation of eligibility by BHS, all MHSA-funded PSH units are reserved for clients experiencing or at risk of imminent homelessness, who are also living with mental illness. TAY-specific housing is intended for TAY with varying levels of mental health challenges, while MHSA-funded housing for adults and older adults is intended FSP participants living with serious mental illness. Currently, there are a total of 192 MHSA-funded permanent supportive housing (PSH) units dedicated to people with mental health challenges. Of these 192 PSH units, 152 units are earmarked for FSP participants from the TAY, Adult, and Older Adult Systems of Care. MHSA-funded housing units include a mix of units developed with capital funding, and acquired through a number of older affordable housing sites. Such units are located throughout San Francisco.

Through partnership with HSH, MHSA-funded PSH sites are managed by the Adult Housing Team, (which includes staff who specialized in TAY-specific housing and services). MHSA-funded units are available to transition-aged youth, adults, and seniors.

Housing Placement Services

With the launch of the Adult, Youth, and Family CES, assessment and placement into all supportive housing are now standardized. The goal of streamlining processes is to ensure that people are prioritized for housing based on their barriers to housing, vulnerability (including disabling and medical conditions), and amount of time homeless (scaled for equity across age groups). HSH developed San Francisco's CES and an integrated database (called the ONE System) with ongoing input from a diversity of stakeholders.

MHSA-funded PSH units will continue to be reserved for FSP clients at adult housing sites, and TAY experiencing mental health challenges at TAY housing sites. Over time, prioritization for MHSA-funded units will be conducted through the Coordinated Entry System. Beyond the MHSA inventory of 192 units, clients served by MHSA programs can be accessed and prioritized for housing in the general pools of housing for homeless youth, adults, and families. HSH has valuable experience that will continue to be an asset in providing permanent housing to people experiencing homelessness with serious behavioral health and/or complex physical health needs.

Supportive Services

Supportive services are designed to be flexible in order to meet the special needs of an individual participating in the housing programs. Services may include, but are not limited to; case-management support, transportation assistance and needs-related payments that are necessary to enable an individual to remain stable in their housing.

The MHSA team in San Francisco collaborates with HSH to coordinate the provision of supportive services at properties with MHSA-funded PSH units. HSH contracts with several supportive housing stakeholders to support people living with mental health illness in retaining their housing. Tenderloin Neighborhood Development Corporation (TNDC), Community Housing Partnership (CHP), and Delivering Innovation in Supportive Housing (DISH) provide supportive services for 137 MHSA-funded PSH units for FSP clients. Swords to Plowshares manages the on-site support service needs for 9 adult PSH units reserved for FSP participants who are Veterans. Finally, the 46 PSH units for TAY experiencing mental health challenges receive on-site supportive services from Larkin Street Youth Services and Mercy Housing California. Lastly, Northern

California Homes and Services provides services for the 3 units owned by TNDC at Willie. B. Kennedy.

Supportive service providers are an essential complement to primary case managers/personal service coordinators working with clients in the FSP programs. In collaboration with the MHSA Program Manager for Housing Programs, HSH Manager for MHSA-funded housing, FSP program staff, property management, and payee providers, the support service providers help resolve issues that compromise housing retention through ongoing communication and cooperation. With TNDC and CHP specifically, the supportive service providers facilitate monthly property management and operations with the aforementioned stakeholders.

MHSA-Funded Housing for TAY

While TAY served by MHSA who are age 18 can up can access adult housing, they can also be placed at youth-center housing sites. 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 transitional- aged youth with Larkin Street Youth Services (LSYS). The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street). 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, life skills training, wrap-around case management, mental health interventions, and peer-based counseling.

Supportive Services

Supportive services are designed to be flexible in order to meet the special needs of an individual participating in the housing programs. Services may include, but are not limited to; case-management support, transportation assistance and needs-related payments that are necessary to enable an individual to remain stable in their housing.

MHSA-Funded Housing: FY17-18						
MHSA Housing Site	**Owner/ Operator**	**MHSA Units**	**Target Population**	**Services**	**Type of Project**	**Referral Source**
Cambridge	**CHP**	9	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**
Hamlin	**CHP**	0	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**
Iroquois	**CHP**	2	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**
Rene Cazaneve	**CHP**	10	Adults	**Citywide + FSP**	MHSA Capital	**CES**
Richardson	**CHP**	12	Adults	**Citywide + FSP**	MHSA Capital	**CES**
San Cristina	**CHP**	15	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**
Senator	**CHP**	3	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**
Camelot	**DISH**	11	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**
Empress	**DISH**	7	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**
LeNain	**DISH**	3	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**
Pacific Bay Inn	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**
Star	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**
Windsor Hotel	**DISH**	6	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**
Aarti/Routz	**Larkin St.**	40	TAY	**Larkin - All**	MHSA GF - TH	**BHS Placement**
1100 Ocean	**Mercy**	6	TAY	**FPFY + FSP**	MHSA Capital	**BHS Placement**
Veterans Commons	**Swords**	8	Veterans	**Swords/VA + FSP**	MHSA Capital	**BHS Placement**
Ambassador	**TNDC**	9	Adults	**TNDC + FSP**	HSH Supportive Housing	**CES**
Dalt	**TNDC**	10	Adults	**TNDC + FSP**	HSH Supportive Housing	**CES**
Kelly Cullen	**TNDC**	17	Adults	**TNDC + FSP**	MHSA Capital	**CES**
Polk Senior	**TNDC**	10	Seniors	**LSS + FSP**	MHSA Capital	**CES**
Ritz	**TNDC**	2	Adults	**TNDC + FSP**	HSH Supportive Housing	**CES**
Willie B. Kennedy	**TNDC**	3	Seniors	**NCHS + FSP**	MHSA Capital	**CES**
TOTAL UNITS		**191**				

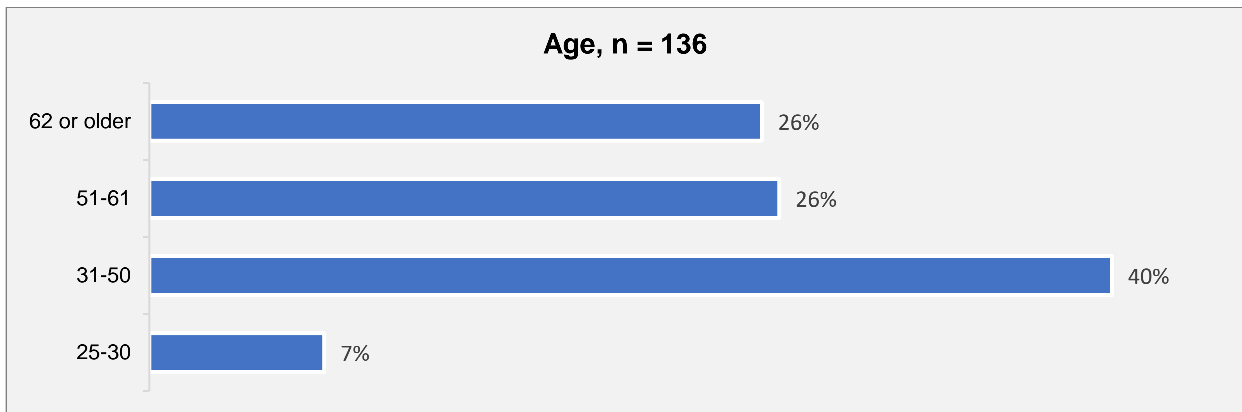
UNITS BY SUPPORTIVE SERVICE PROVIDER	
Total Units Supported by Community Housing Partnership (CHP)	51
Total Units Supported by Delivering Innovative Supportive Housing (DISH)	35
Total Units Supported by Mercy Housing	6
Total Units Supported by Larkin Street Youth Services (LSYS)	40
Total Units Supported by Swords to Plowshares	8
Total Units Supported by Tenderloin Neighborhood Development Corporation (TNDC)	51

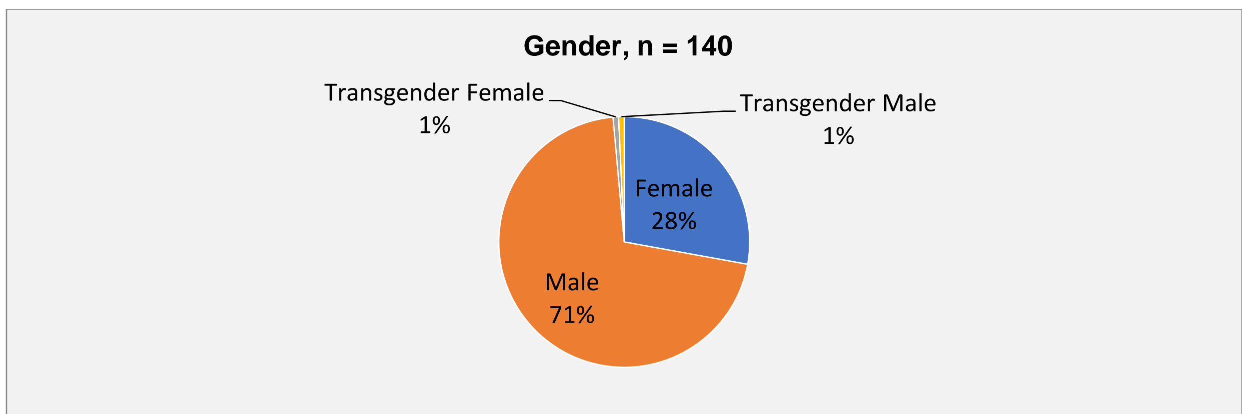
Program Outcomes and Highlights

Demographics: Housing Programs[23]

<u>Note:</u> The Housing Demographics are highlighting specific housing programs explained below. Not all housing programs collect demographics data.

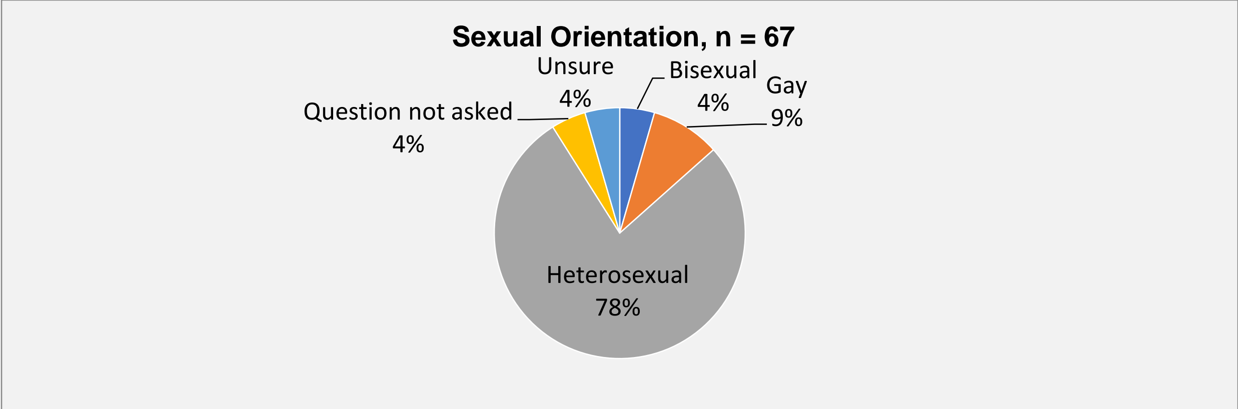
<u>Adult Programs</u>
These demographics encompass the population in MHSA units on 6/30/2018 at the adult sites listed in the table above.





Housing

[23] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).



Race/Ethnicity	n	%
Black/African-American	50	37%
Asian	2	1%
Asian / Pacific Islander	10	7%
Filipino/ a	1	1%
Latino/ a	17	13%
Other	3	2%
White	53	39%
Total	**142**	**100%**

New Placements
The number of new housing placements in FY17-18: 29

Number of Exists
The number of housing exits is 14. This is lower than the number of new placements due to the new units coming online at the Cambridge, Senator, Iroquois, and San Cristina.

Exit Reason	Count
Death	6
Eviction	3
Move in with Family/Friend	1
Moving On Initiative	1
Voluntary Surrender to Avoid Eviction	3
Grand Total	**14**

Client Stabilization Efforts
This chart describes the number and percent of clients who have been stabilized in housing for 12 months, and for 24 months (depending on housing term). This list is also representative of clients in MHSA units on the last day of FY17-18:

Length of stay	Count	Percentage
Under 12 months	27	20.1%
1 year	25	18.7%
2 years	13	9.7%
3 years	11	8.2%
4 years	10	7.5%
5 years or more	48	35.8%
Grand Total	**134**	**100.0%**

Program *Provider*	FY17-18 Key Outcomes and Highlights
ROUTZ Transitional Housing for TAY	• Of 51 youth housed one or more months, 3 youth averaged 3 case management sessions per month at the end of this report period. However, an additional 17 youth received an average of 2 case management sessions per month, and 25 youth averaged 1 case management session per month. An additional 6 youth were housed less than a month, of those 1 received 3 case management sessions, 1 received 7, 1 received 12, 2 have not received any case management sessions. • 76% (39 of 51) of youth housed were linked to mental health services. • 100% (51 of 51, 133% of goal) youth were retained in housing or exited to other stable housing.

Note: The Housing Outcomes are highlighting the ROUTZ Transitional Housing for TAY.

Housing

Moving Forward in Housing Services

In January 2018, the MHSA team welcomed a new MHSA Program Manager who has a programmatic focus on MHSA housing programs, among other MHSA-related duties. Filling the vacant MHSA Housing Program Manager position supports the department's goals to work in collaboration with a variety of stakeholders to get MHSA clients housed. The MHSA Program Manager continues to facilitate cross-department communication between HSH, Mayor's Office of Housing and Community Development, BHS, and MHSA to maximize the effectiveness and success of MHSA housing efforts.

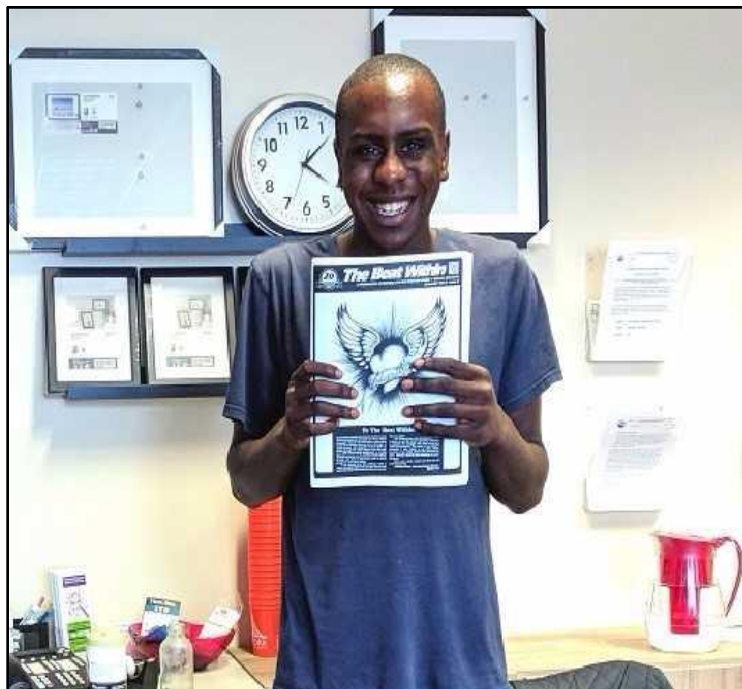
As stated in our previous Annual Update, HSH now centralizes the county's efforts to address homelessness issues. HSH oversees the Housing Placement Services for MHSA-funded units. HSH also leads the provision of Supportive Services with ongoing support from FSP providers, MHSA, and the larger BHS System of Care. MHSA and HSH continue to strategize, plan and discuss ways to best meet the housing retention and housing needs for all clients. This collaborative team has a strong focus to improve the housing program by maximizing the use of existing resources and collaborative problem-solving for FSP and other housing clients. Moving forward, this collaborative group will work to improve housing stability for DPH clients served by MHSA – funded programs by prioritizing the following:

San Francisco Mural in the Mission District

- Enhancement of the inter-agency communication for problem-solving
- Establishment of clear problem-solving pathways/protocols for common housing issues
- Leverage the DPH network to increase linkage to Substance Use Disorder resources

Regarding No Place Like Home, the City and County of San Francisco applied to two Notice of Funding Availability (NOFA)'s, one for a Noncompetitive Allocation and the other to be an Alternative Process County. Total requested funds from both sources is $27.7 million. Counties will be notified of awards in June of 2019.

Lastly, MHSA will continue to provide funding and support for hoarding and cluttering services for clients with severe mental illness. These funds allotted to cluttering is an effort to support wellness and housing retention. The program will be administered by the Adult Protective Services unit within the Human Service Agency for the benefit of adults with mental health disabilities and older adults that are experiencing self-neglect, abuse, or that are at risk of eviction. In the FY18-19, MHSA allocated additional funds to support cleaning, hoarding, and cluttering services for emergency stabilization units, to ensure that ESUs continue.



6. 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 competent workforce that includes individuals who have experiences being service recipients, family members of service recipients and practitioners who are well versed in providing client- and family-driven services that promote wellness and resiliency. This service category includes 1) the Mental Health Career Pathways Program, 2) Training and Technical Assistance, and 3) Residency and Internship 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. MHSA's goal is to develop a behavioral health workforce development 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, San Francisco Unified School District (SFUSD), City College of San Francisco, San Francisco State University, and California Institute of Integral Studies.

Target Populations

These programs work with college students with populations who are currently underrepresented in licensed mental health professions,: high school students who express career interests in the health care/behavioral health care industries; and mental health consumers, family members and individuals who come from ethnic groups that are not well represented in the mental health/behavioral professions (e.g., African American; Latino; Native American; Asian; Pacific Islander; Lesbian, Gay, Bisexual, Transgender, and Questioning communities).

Mental Health Career Pathway Programs	
Program Name ***Provider***	**Services Description**
Community Mental Health Worker Certificate *City College of San Francisco*	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 educates and trains culturally and linguistically diverse consumers of mental health, family members of consumers and mental health community allies to enter the workforce as front-line behavioral health workers who are able to deliver culturally congruent mental health care to underrepresented

Mental Health Career Pathway Programs	
Program Name *Provider*	**Services Description**
	populations (e.g., African American; Asian; Pacific Islander; Latino; Native American; Lesbian, Gay, Bisexual, Transgender, Questioning; and immigrant communities).
FACES for the Future Program *Public Health Institute*	Faces for the Future program (FACES) is nationally recognized for healthcare career preparation work with high school students. The FACES program introduces John O'Connell High School students to career pathways in healthcare, public health and mental and behavioral health while supporting them with academic interventions, coordination of wellness services, referrals to outside agencies when needed and youth leadership development opportunities.

Spotlight on FACES for the Future

The FACES for the Future program began in 2000 in Oakland as a direct response to two significant problems facing diverse communities:
A lack of support and opportunity for youth who are seeking to improve their lives through education, career training, and healthy choices, and
A lack of diversity reflected in the health professions that directly contributes to worsening health disparities in diverse communities.

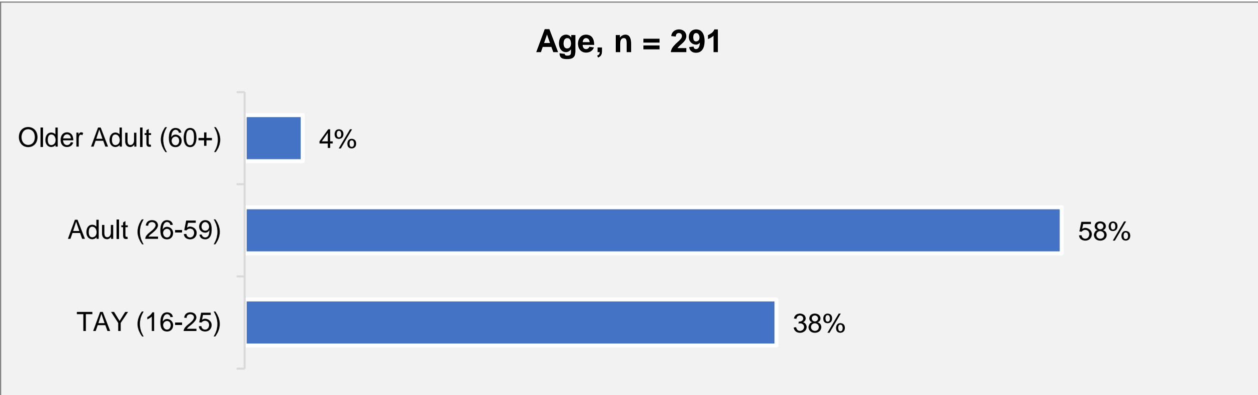
FACES for the Future addresses these goals by connecting local schools, health professionals, and community benefit organizations to support a cohesive system of support for youth to ensure we have highly qualified, multilingual and multicultural health care professionals to meet the growing workforce demand of the industry. The program was quickly identified as a best practice model and FACES for the Future programs were replicated in other regions of California and nationally.

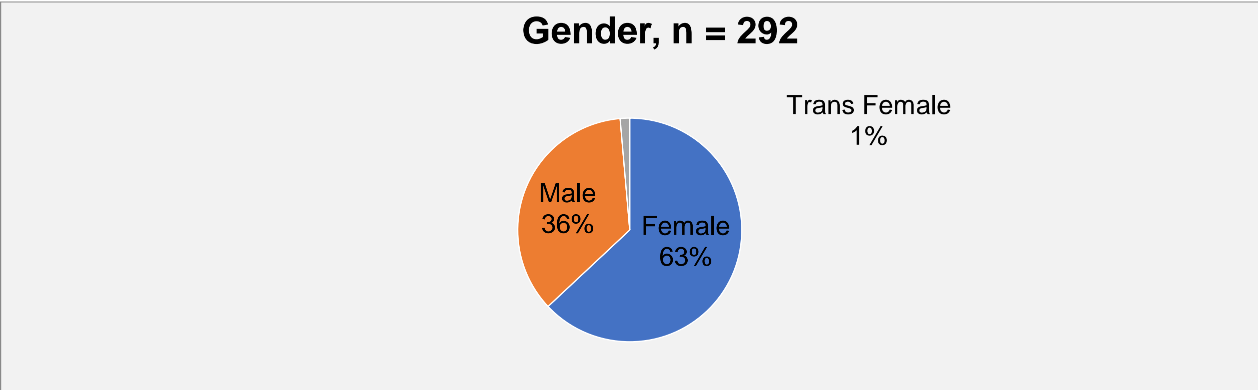
All FACES programs provide Four Core Components:

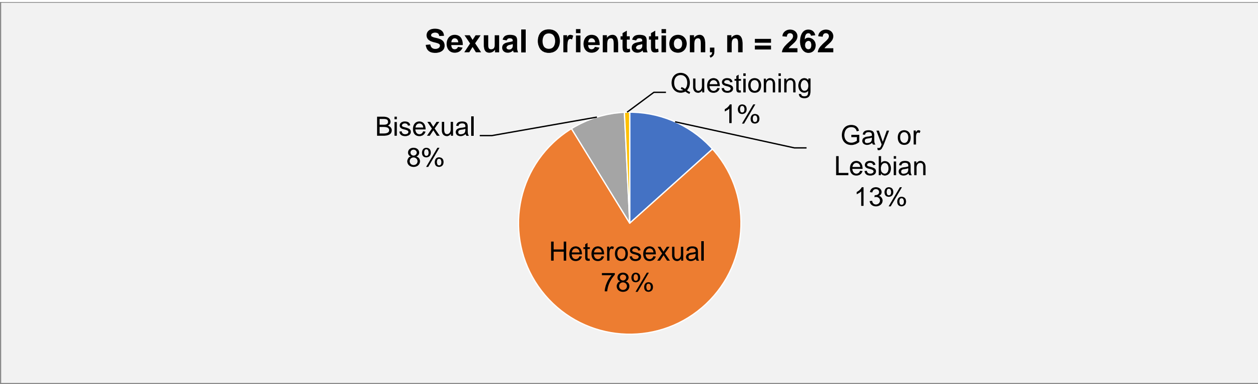
- Health Career Training and Work-based Learning: Offers internships in hospitals, community clinics, mental and behavioral health agencies, public health departments, and health-focused community-based organizations.
- Academic Support: Provides youth with tutoring, college application preparation and financial aid and scholarship application support.
- Wellness Services: Offers student assessments for environmental stresses that may be negatively impacting the achievement of academic goals. Students are then connected with outside resources as needed, including, for example, counseling, medical homes, housing and food resources. In addition, programs provide wellness trainings on topics such as mindfulness, healthy relationships, and self-advocacy.
- Youth Leadership Development: Provides peer health education, opportunities to participate in public health conversations about issues impacting their communities, and activism on issues surrounding health disparities.

Participant Demographics, Outcomes, and Cost per Client

Demographics: Career Pathways Programs[24]

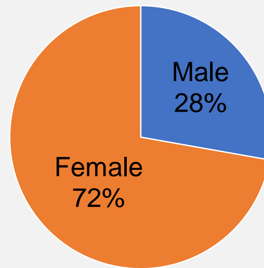




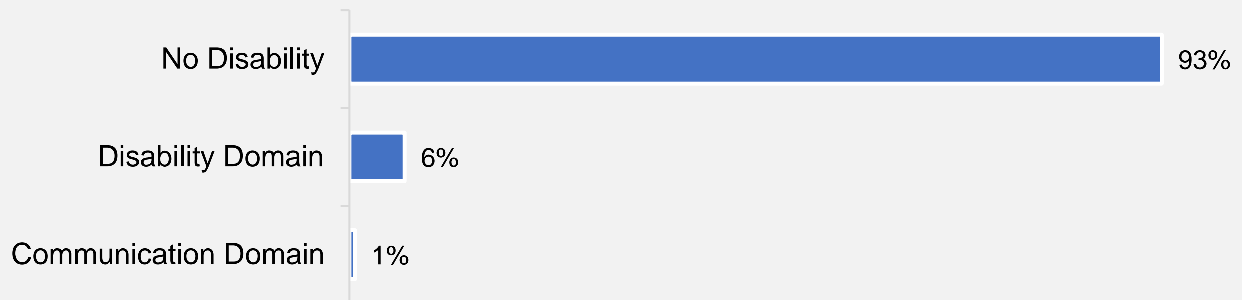


[24] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).

Sex at Birth, n = 90



Disability Status, n = 158



Race/Ethnicity	n	%
Black/African-American	35	17%
American Indian/Alaska	3	1%
Asian	29	14%
Native Hawaiian Islander	5	2%
White	48	23%
Other Race	6	3%
Hispanic	75	36%
More than one ethnicity	7	3%
Total	**208**	**100%**

Primary Language	n	%
Chinese	16	6%
English	185	65%
Russian	4	1%
Spanish	63	22%
Tagalog	8	3%
Unknown	6	2%
Another language not listed	10	3%
Total	**294**	**100%**

For Mental Health Career Pathways Programs, 0% of participants reported data for the Vietnamese language. Additionally, data for Russian were not included since they rounded to 0%. Also, less than 1% of participants reported data for Trans Male so these demographics were not included. Also, 0% of participants reported data for Non-Hispanic. Also, 100% of participants reported non-veteran status.

Program Name ***Provider***	**FY17-18 Key Outcomes and Highlights**
Community Mental Health Worker Certificate *City College of San Francisco*	• 95% of students (21 out of 22) graduated from the Community Mental Health Certificate program. 100% of students who graduated expressed interest in pursuing a health-related career. • 88% of students (43 out of 49) enrolled in HLTH 91D passed and graduated. • 100% of students (22 out of 22) successfully completed their internship, which involved 120 hours of field placement over the semester.
Faces for the Future Program *Public Health Institute*	• 90 students applied and were enrolled in the program. • 76% of students enrolled (68 out of 90) participated in off-site internships. • 100% of FACES seniors (33 out of 33) graduated from high school, and 97% these students (32 out of 33) enrolled into post-secondary education following graduation. 97% of FACES seniors enrolled into post-secondary education.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[25]**
Mental Health Career Pathways	294 Served	$741,929	$2,524

[25] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Training and Technical Assistance Programs	
Program Name ***Provider***	**Services Description**
Trauma-Informed Systems (TIS) Initiative *SFDPH*	The TIS 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.
Adolescent Health Issues *Adolescent Health Working Group*	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, SFDPH , UCSF, SFUSD, Juvenile Justice, workforce development and housing – while also building provider capacity and support systems.
Street Violence Intervention and Prevention (SVIP) *HealthRIGHT 360 (Fiscal Intermediary)*	The nine-month SVIP Professional Development Academy builds upon the existing skills and talents of San Francisco’s brave and courageous street outreach workers/crisis responders and educates them in the areas of community mental health, trauma, vicarious trauma and trauma recovery within the frameworks of cultural sensitivity, responsiveness and humility. Participants complete a nine-month long training program, and this Academy’s unique learning and application setting allows 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.

Program Outcomes, Highlights and Cost per Client

Program Name ***Provider***	**FY17-18 Key Outcomes and Highlights**
Trauma Informed Systems Initiative *SFDPH*	• 1,629 participants were trained in the last year. • Organized weekly training at ZSFGH, averaging 45 participants per week. Over 9 months, the percentage of staff trained has increased from 3% to 15%. • 2 TIS staff members began the process of becoming certified in "Search Inside Yourself," a yearlong learning and practice venture in emotional intelligence, neuroscience, mindfulness and leadership.
Adolescent Health Issues *Adolescent Health Working Group*	• 80% of participants reported knowledge increase in serving adolescents and TAY through Trauma informed lens, • 70% of participants reported an increase understanding of the connection between toxic masculinity and barriers to behavioral health service access. • 85% of attendees who completed an event evaluation reported increases in knowledge in serving boys and young men of color.
Street Violence Intervention and Prevention (SVIP) *HealthRIGHT 360 (Fiscal Intermediary)*	• 12 SVIP staff trainers were given "train-the-trainer" technical assistance. • 10 SVIP staff were enrolled in the CCSF adult associate program at the time of reporting. 3 are slated to graduate in May 2019. 2 SVIP staff expressed interest in furthering their education in the mental/behavioral health fields. • 90% of the SVIP staff were satisfied with the academy, and the train-the-trainer technical assistance. 90% reported integrating the frames, protocols, and procedures learned in the academy into their practice.

FY17-18 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[26]**
Training and Technical Assistance	1,841 Served	$800,829	$435

Workforce Dev.

[26] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Residency and Internship Programs	
Program Name ***Provider***	**Services Description**
Fellowship Program for Public Psychiatry in the Adult System of Care - *UCSF*	The goal of the Fellowship Program for Public Psychiatry in the Adult System of Care is to train the next generation of public mental health care leaders who will provide patient-centered care to vulnerable populations with severe mental illness through: 1) understanding and implementing relevant, evidence-based psychosocial rehabilitation and psychopharmacological treatments, 2) promoting recovery, and 3) developing rewarding public-academic partnerships to examine their work. The Public Psychiatry Fellowship has developed a strong curriculum, which promotes leadership opportunities, a sense of community, and mentoring.
Public Psychiatry Fellowship at Zuckerberg SF General Hospital – *UCSF*	The mission of the Public Psychiatry Fellowship is to train the next generation of public mental health care leaders who will provide patient-centered care to vulnerable populations with severe mental illness through: 1) understanding and implementing relevant, evidence-based psychosocial rehabilitation and psychopharmacological treatments, 2) promoting recovery, and 3) developing rewarding public-academic partnerships to examine their work. The Public Psychiatry Fellowship has developed a strong curriculum, which promotes leadership opportunities, a sense of community, and mentoring.
Behavioral Health Services Graduate Level Internship Program - *SFDPH*	The BHS Graduate Level Internship Program provides training opportunities for psychology interns, masters-level trainees, peer interns, nursing and nurse practitioner students. SF County BHS Civil Service Clinics only accept trainees (a student who is actively enrolled in a graduate program (MSW, MFT, LPCC, Ph.D./Psy.D., etc. as defined by their academic institution) into its training program. Students are provided with weekly didactic training seminars at their local placements and several students attend the training seminars that are provided within our system of care.

Program	FY17-18 Key Outcomes and Highlights
Fellowship Program for Public Psychiatry in the Adult System of Care - *UCSF*	• Four second-year fellows were placed in BHS Community Psychiatry Programs for FY17-18. All four fellows successfully completed the rotation and had positive feedback about their experience. One of the fellows joined SFDPH as an employee and is now working at Family Mosaic Project and Comprehensive Crisis Services.
Public Psychiatry Fellowship at	• Due to her other competing work responsibilities, research supervisor Dr. Melanie Thomas decided to step down in August of this

Program	FY17-18 Key Outcomes and Highlights
Zuckerberg SF General Hospital - *UCSF*	year. She is replaced by a new supervisor, Dr. Marina Tolou-Shams. This has been beneficial to the program as Dr. Tolou-Shams is both an NIH-funded scientist and the Chief of the Division of Infant, Child and Adolescent Psychiatry. These skills serve our MHSA-funded child psychiatrists well on their capstone project. • There is a severe shortage of psychiatrists in the US and a particular shortage working in the public sector. To date, our Fellowship has been very helpful in addressing these needs in San Francisco and the Bay Area. As of 2019, a total of 15 of our graduates are employed in public psychiatry positions in SF and the Bay Area. Seven work in outpatient settings within the San Francisco Health Network's Behavioral Health Services, with two occupying senior leadership roles. In addition, three of the eight inpatient psychiatrists at our SFHN County Hospital (ZSFG) are graduates of the fellowship, and five work for other Bay Area counties.
Behavioral Health Services Graduate Level Internship Program - *SFDPH*	• More than 75 trainees were placed in graduate placements. These trainees were able to provide a range of behavioral health services: individual/family therapy, case management, and crisis and wraparound services. • The multi-cultural student stipend program (MSSP) supported 20 MSSP students with stipends that totaled $75,000. MSSP provided support to students interested in public sector work, working with populations with health disparities and addressing shortages of culturally and linguistically competent staff.

FY17-18 Cost per Client			
Program	**Total Served**	**Annual Cost**	**Cost per Client[27]**
Psychiatry Residency and Fellowships	131 Served	$470,132	$3,589

Workforce Dev.

Moving Forward in Behavioral Health Workforce Development

Behavioral Health Services Training Committee

BHS will continue convening the BHS Training Committee to inform and support the BHS training program in order to enhance professional development, improve workforce practices, and increase workplace experience. The Training Committee is comprised of BHS system of care staff including civil service & contracting agencies including administrative support staff, program supervisors, managers, peers and interns/trainees. The Committee is led by the BHS Training Coordinator and be empaneled by a diverse group of stakeholders who embody the full range of racial, cultural, and educational backgrounds that represent our diverse workforce. The

[27] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

committee will evaluate the training needs of the workforce, make recommendations to inform the training plan, and identify resources that will support the training program. The committee convenes quarterly. In the past year, the BHS Training Committee has accomplished several objectives. This committee supported the implementation of the BHS training plan that was developed from stakeholder feedback from a workforce survey that was administered in April 2018. The committee has been working to implement this plan while focusing on increasing racial and cultural awareness and understanding for all staff members. In addition, a Substance Use Disorder (SUD) Training Officer was hired in January to help train staff members. A survey was also conducted for the SUD system and, as a result of stakeholder feedback received, the team has been implementing training on evidence-based practices including harm reduction, the opioid crisis, opioid management, etc. We are happy to announce that the SUD training calendar has increased its training efforts over the past year.

Street Violence Intervention and Prevention (SVIP)
The SVIP program concluded on 6/30/18 due to the lessons learned and the workforce department's system transformation. Based on feedback, the community decided that it was a natural end date based on a recent assessment of the project. MHSA introduced the practice to the point that the investment was made. Many providers were able to embed the practices into their internal systems so these services will continue throughout Behavioral Health Services. We are pleased to report that this project was a success and provided education on practices that will continue throughout DPH.

Adolescent Health Working Group
The Adolescent Health Working Group program was integrated into the newly formed Transition Age Youth (TAY) System of Care (SOC) and merged with other programming to become the TAY SOC Capacity Building program.

Workforce Development Efforts
For over six years, SF-MHSA has worked with and funded local education programs to increase and diversify San Francisco's public mental health workforce so that it better reflects the communities it serves. Our partners are:
- Richmond Area Multi-Services (RAMS): Summer Bridge program for high school students
- FACES for the Future for high school students of San Francisco Unified School District's (SFUSD) John O'Connell High School
- RAMS: Peer Specialist Mental Health Certificate program for people with lived experience who are interested in careers in public mental health field
- City College of San Francisco: Community Mental Health Worker Certificate program for people with lived experience who are interested in careers in public mental health field
- San Francisco State University (SFSU): Student Success Program for college students
- California Institute of Integral Studies (CIIS): Student Support Services for college students

Workforce Development Planning
With the sunsetting of statewide Workforce Development, Education and Training (WDET) funds for California counties, BHS developed a 5-year strategic plan that streamlined its workforce development efforts through four discrete goals with accompanying objectives.

GOAL 1: Transform our workforce so it better reflects our service populations
GOAL 2: Ensure that our workforce has the training, skills & tools to deliver quality care
GOAL 3: Support & empower staff to be engaged at work & grow professionally
GOAL 4: Successfully integrate peers across the workforce

In addition, BHS's new Office of Equity, Social Justice and Multicultural Education will now house all BHS workforce development, education and training efforts.

7. Capital Facilities and 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 2017-20 Integrated Plan included projects to renovate various buildings depending upon available funding – with the Southeast Health Center Expansion taking priority.

MHSA funding for Information Technology (IT) supports upgrades to clinical and administrative information systems as well as improvements to consumers' and family members' access to personal health information within various public and private settings.

Capital Facilities	
Renovations	**Services Description**
Recent Renovations	The Southeast Health Center is a DPH primary care clinic located at 2401 Keith Street serving San Francisco's historically underserved Bayview-Hunters Point neighborhood. The Southeast Health Center Expansion and Behavioral Health Integration Project was included in the FY16-17 Annual Update and the FY17-20 Integrated Three Year Plan. With the goal of better and more holistically meeting the needs of Bayview-Hunters Point patients and their families, this priority DPH project renovates and expands upon the existing facility, bringing a fuller and more integrated complement of DPH's healthcare resources and programs to one convenient campus.
Ongoing Renovations	The Mobile Crisis Program is located in the Bayview Hunter's Point Neighborhood and serves the City and County of San Francisco. With the addition of Crisis intervention Specialist Teams, the physical space at 3801 Third Street is receiving design and development changes to improve community based health service available in this 24hour x 7 day a week program. Interior rooms, IT infrastructure and telephony are being thoughtfully planned to support the collaborative efforts between DPH and SFPD to support individuals affected by a crisis. Planning began in July 2018 with execution ongoing through the March 2019. The Chinatown / North Beach Mental Health Services program is also in queue. Pending a lease renewal for this program, interior remodels of the Pharmacy to increase client safety and privacy are

Capital Facilities	
Renovations	**Services Description**
	planned. Additional interior improvements will be to the common areas and group spaces. This will continue the program's work to impact socialization for clients. Planning for these renovations began in July 2018 and will be scheduled during the Spring of 2019.

Information Technology	
Program Name	**Services Description**
Consumer Portal	The Consumer Portal went live in May of 2017 and continues to provide support for consumers who have registered for the portal. In addition to providing first line support for consumers, portal staff work on marketing, hold walk-in hours to help consumers register for the portal and provide portal navigation training. Staff also conduct site visits to assist to encourage MH Clinics to issue registration PINS to consumers. The Consumer Portal project expected outcomes include: • Increase consumer participation in care • Help keep consumer information up-to-date • Promote continuity of care with other providers • Providing coverage and training support for the Help Desk • Perform outreach efforts to promote the Consumer Portal
Help Desk/Advanced Help Desk	The Help Desk and Advanced Help Desk programs continue to provide excellent customer service to the mental health clinics by assisting clinical staff regarding issues with Avatar (Electronic Health Record). An important goal of this vocational program has been to prepare consumers for re-entry into the workplace. The Avatar Help Desk recruited fewer trainees to staff the Help Desk since the funding for consumer wages has not been increased to account for the past two minimum wage increases. Important contributions of consumers in this program include: • Help Desk caller resolution rate of 90% • Liaison between clinical staff and Avatar support staff • Escalate issues that impact the functioning of Avatar
Desktop/Advanced Desktop	The Desktop and Advanced Desktop programs work in partnership with BHS (Field Services) technical staff in supporting various de-

Information Technology	
Program Name	**Services Description**
	ployments and projects. This vocational program provides consumers with the basic technical knowledge and skill to pursue entry level work in this field. Important contributions of this program include: • Imaging and setup of nearly 1000 individual computers for the Field Services team • Participate in the deployment of new computers for all floors of 1380 Howard • Provide technical supporting to Project Homeless Connect
Consumer Employment	The collaboration between BHS Ambulatory Applications and RAMS has resulted in significant opportunities for consumers to attain gainful employment this past fiscal year. Five IT training program graduates were hired for peer positions within the BHS Ambulatory Applications team. The RAMS i-Ability IT training staff's trainers/supervisors now includes graduates of the training program. Furthermore, two graduates of the Avatar Help Desk were hired for full-time positions with the City. Other graduates attained full-time employment outside of SFDPH this past fiscal year. The Avatar Accounts team is comprised of several consumers in the role of Onboarding/Offboarding the various administrative and clinical staff at the various mental health clinics that utilize Avatar as their Electronic Health Record system. The consumers working on this team will be critical to the transition from Avatar to Epic as the new Electronic Health Record system. Important contributions of these employed consumers include: • Processed 828 new Avatar account requests • Collaborate with Server and Compliance Departments • Monitor and Maintain Avatar access and security
System Enhancements	The System Enhancements project provides vital program planning support for IT system enhancements. Responsibilities include the following: • Ensuring that timelines and benchmarks are met by the entire EHR team • Manage dependencies by helping to ensure that equipment, personnel and other resources are deployed efficiently and according to timeline • Managing EHR-related professional development for all BHS staff in an effective and timely manner to ensure smooth implementation across the Division. • Conduct data analysis related to the projects

Information Technology	
Program Name	**Services Description**
	• Three civil service Business Analyst positions funded by MHRS. These positions are dedicated to supporting the Avatar application and related projects that include the MHSA database. • Preparation for the transition to the Epic system (Electronic Health Record) in 2021.

Moving Forward in Capital Facilities

The DPH Capital Facilities Plan will address seismic upgrades to several facilities to mitigate damage to buildings. This increases the resiliency of the services offered by the city and protects staff and clients. DPH is pursuing funding for Potrero Avenue, Sunset Mental Health and the Southeast Health Center. Additionally, Behavioral Health Services may need to relocate programs to address changing client needs. Capital Facilities funding will support buildout of new facilities in FY19-20.

MHSA CPP Meeting in 2019

Program Evaluation for All MHSA Programs

System Change: ICM/FSP to Outpatient MH Client Flow

A Celebration of Collaborative Improvement Work!
In the behavioral health system, transitioning clients from ICM programs, which includes FSP programs, to standard mental health outpatient clinics (OP) has met with many challenges, often resulting in clients not connecting successfully to outpatient services.

Between December 2017 and June 2018, over 40 stakeholders from outpatient mental health, ICM/FSP programs, behavioral health consumer advocates, and BHS administrative staff from the system-of-care (SOC), Quality Management (QM), and MHSA, met twice monthly in three cross-modality, multidisciplinary workgroups to improve the success and experience of clients as they transition from ICMs to lower intensity behavioral health care.

Each of the three workgroups focused on a different area of the ICM-to-OP flow then conducted small tests of change (PDSAs), such as identifying client readiness to transition out of ICM, introducing a new administrative referral process and an ICM-OP Referral Form, involving ICM and OP directors in all referrals, tracking ICM-OP referrals centrally and inviting peers to support clients through the transition. Through testing, the workgroups generated important data and learning and formulated priority recommendations.

On June 26th, workgroup members and other interested stakeholders convened at the SF Public Library to showcase new tools, celebrate discoveries, share key learning, and formalize the presentation of their recommendations to the larger group.

A few of the key recommendations put forth by the groups are now action items for the task force and emerging policies, to be implemented across TAY, Adult and Older Adult ICM (including FSPs) and appointment based OP services.
The recommendations are:

Stakeholders at the SF Public Library

- *Nurture a culture in all ICM and OP clinics that normalizes and prepares clients for transitioning*
- *Use the Recovery Questionnaire to assess ICM client readiness and identity the areas of development to help prepare a client for transition*
- *Utilize a standardized procedure to refer ICM clients to OP*
- *Communicate referrals between ICM to OP director to director (or to a designated point person)*
- *Use the ICM-OP Referral Form to ensure OP has the information they need*

- *Track referrals centrally (BHS) so that improvement can be measured and challenges logged and addressed*
- *Conduct a warm hand-off in person when an ICM client is transitioning to OP*
- *Provide monetary resources to OP clinics for tokens, food, and other supports for incoming ICM clients on a time-limited basis*
- *Provide rep payee/public guardian office services to recently transitioning clients in OP with a greater emphasis on customer service, including working with case managers*
- *Provide more flexible ways to dispense medications in OP settings; and co-located ICM-OP programs should consider implementing continuity of clients prescriber across levels of care*
- *Track progress and retention of clients arriving at OP from ICMs through a clinic based client registry*

<u>ICM-OP Task Force</u>
From July through December, the SOC convened an ICM-OP Task Force on at least four occasions to move the workgroups' recommendations forward. The task force is designed to ensure accountability to progress and complete key tasks:

1) Finalize a BHS policy and procedure document that standardizes referrals from ICM to OP across the system of care and ensures clients' continuity of care
2) Ensure implementation of the ICM-OP Referral policy and procedures
3) Continue to collect referral data centrally and evaluate the impact of the changes; also explore incorporating the referral form(s) into the BHS electronic health record (Avatar)
4) Continue to support expansion of outreach and supportive services at the OP level to ensure appropriate and adequate support for incoming ICM clients
5) Communicate with providers on a monthly basis any updates on implementation of the task force's recommendations.

<u>ICM to Outpatient Referral Tracking</u>
Prior to 2018, BHS had no systematic way to track client referrals from ICM to OP. In February 2018 BHS attempted to collect referral data from ICM programs via email submissions to QM, with limited success, i.e. incomplete data. QM staff follow up as needed to obtain episode data directly from Avatar and/or with directors or clients' case managers for additional narrative to help explain dates and notes recorded in Avatar.
The following data summarizes the ICM to OP referrals received by QM between February and October 2018.

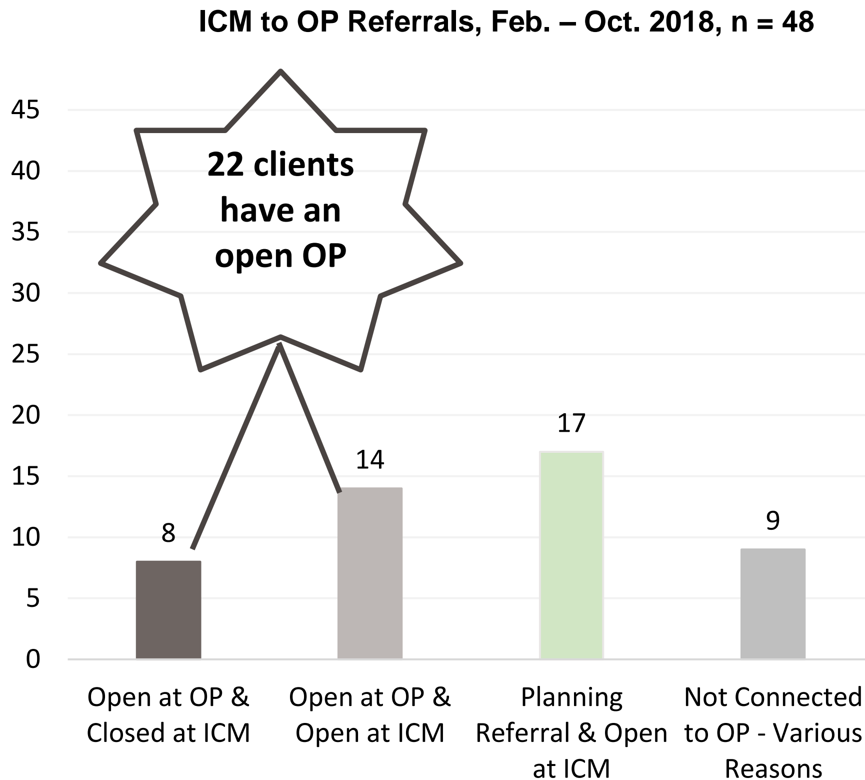
Almost half of clients (n=22, 46%) have an open episode in an outpatient clinic.

- 8 clients (17%) have documented successful transitions to OP and been closed in ICM.
- 14 clients (29%) have open episodes in OP while remaining open in the ICM to allow time for successful linkages.
- 17 clients (35%) are still open in ICM and are preparing for their transition to OP.
- 2 clients (4%) started the referral process but then postponed their transitions when issues arose that needed to be addressed at the ICM level.
- 2 clients (4%) arrived at OP and were bounced back to their referring ICM programs.
- 2 clients (4%) did not meet the criteria for OP. One was immediately referred to a new ICM, and the other, after being referred to OP, was declined for not being willing to comply with the OP program's rules. This client is now being seen at another program in the community.

- 2 clients (4%) identified as being referred to OP were closed at ICM but no data were available in either Avatar or CCMS to indicate any service usage at all. They have been designated “Status Unknown.”

Note that these data represent only those clients who were identified to QM as being referred to outpatient care. There may be other ICM clients who left ICM services for destinations other than OP or whose data were not submitted to the QM team and therefore are not included in this summary.

ICM to OP Referrals, Feb. – Oct. 2018, n = 48



In November 2018, BHS initiated a systematic, referral summary report to be submitted monthly by ICM directors or staff, including those from FSP, via email, fax, or phone, to BHS by the 7th of each month following. Even those ICM programs without new referrals are directed to submit a report stating “zero new referrals”, in order to account for all programs. This new strategy is expected to improve the quality and completion of referral data. The resulting data will be used to monitor the quality of clients’ transitions to outpatient care.

Gender Health San Francisco

MHSA-funded staff within the QM unit play an active role in supporting evaluation activities for MHSA. The Gender Health SF (GHSF) project is another opportunity to actively engage stakeholders in the process to better understand and improve MHSA’s impact in the community.

Why Gender Health? Why now?
According to several reports issued in the past decade by the Institute of Medicine (IOM), National Center for Transgender Equality (NCTE), and the National Gay and Lesbian Task Force (NGLTF), transgender and gender nonbinary individuals face disproportionately high rates of poverty, suicide, homelessness, isolation, food insecurity, substance abuse, and violence. For example, trans people experience unemployment at two to three times the rate of the general population, and nearly all persons surveyed (90%) reported experiencing some form of harassment and discrimination. Some key lessons learned from these surveys in 2011 and again in 2015 include:

- 19% were refused health care services due to their transgender or gender nonconforming status;
- 28% postponed needed health care due to discrimination experienced in health care settings;
- 48% postponed needed health care because they couldn't afford it;
- Rates of serious psychological distress were approximately five times higher than rates reported in the general population; and
- Rates of suicide attempts were nearly nine times higher than rates in the general US population.

Research on resilience demonstrates that when offered access to culturally competent and medically necessary services, trans and gender nonbinary individuals experience improved psychosocial and quality of life outcomes. Therefore, based on the evidence available in the literature, in August 2013, DPH established Transgender Health Services, renamed Gender Health SF (GHSF), to provide access to gender affirming surgeries and related education and preparation services to eligible uninsured transgender or gender nonbinary adult residents. Currently, DPH provides a range of health services to transgender and gender nonbinary residents such as primary care, prevention, behavioral health, hormone therapy, chest and breast surgeries, and specialty and inpatient care. GHSF also serves to strengthen transgender health care competency among all DPH staff at all access points and among community partners. Together, GHSF, MHSA, and all of DPH are working hard to increase access excellent mental health care, to reduce the known health disparities, and to increase quality of life among trans and gender nonbinary persons.

GHSF is Evolving!
Program evaluation planning for GHSF began in January 2016, and evaluation data collection began in April 2016. A majority of the GHSF program staff are also peers in the community, which makes the program a unique work environment that values community lived experiences and professional development of trans and gender non-binary people. For many of our peer navigators, this would be their first professional work experience, so GHSF has built in a peer training component in their program. This year, GHSF has grown! They added two new peer navigators, a clinical supervisor for the peer navigator team, and a full-time trainer. The program also said hello to a new Program Director. Prior to this role, the Program Director served as the Interim Director of the UCSF Transgender Center of Excellence, and had worked for the Department of Public Health

Population Health Division for many years directing both provider and community-based transgender HIV and health promotion efforts within DPH.

In total, the program now consists of one Director, a part time medical team lead, a part time nurse practitioner, a patient care coordinator, two behavioral health team members, a lead patient navigator, three additional peer patient navigators, a trainer, and a part time program evaluator. Since the program inception in 2013, GHSF has served over 500 unduplicated individuals and averages nearly 150 client referrals per calendar year; in total, GHSF has received over 850 referrals since 2013. Since the program evaluation began in 2016, the number of annual client referrals to GHSF has doubled.

The **four key indicators** of the GHSF program evaluation include:

- monitoring annual relative improvements in client readiness,
- timely access to services,
- program satisfaction, and the
- role of peer navigators in assuring three client quality of life indicators (quality of life, psychosocial functioning, and dealing with gender dysphoria).

GHSF program activities towards ensuring client readiness and timely access to care include regular peer-led Client Education & Preparation Programs (EPPs) and various peer-led support groups (e.g., smoking cessation, weight and healthy nutrition, dealing with gender dysphoria). Also, whenever requested, peer navigators accompany clients to their surgical consultation appointments to assist with client advocacy and surgery preparation. Within the San Francisco Health Network, peer navigators also conduct regular provider and staff in-service trainings to increase the Department's capacity in building background knowledge and LGBTQ cultural sensitivity amongst Behavioral Health, Primary Care, and various hospital staff throughout the San Francisco Health Network.

Since the program evaluation began in 2016, participant satisfaction evaluations were completed for attendees at capacity building community orientations for our partner programs in the city and county of San Francisco, Education and Surgery Preparation Programs (EPPs) for clients, wellness groups for clients, and SFDPH provider education (in-service) sessions. In this past fiscal year, GHSF hosted over 100 training and education sessions for clients, including over 50 wellness and support groups, nearly 150 drop-in client hours, 19 advocacy clinics, and over 50 pre and post-operative client education sessions. Similar to last year, evaluation data revealed that a majority of clients "agreed" or "strongly agreed" that the GHSF education programming was "valuable" and "worthwhile," and helped clients feel "very" or "completely" ready for surgery, even when clients had to wait, on average, as long as 27 months before their surgery date. In addition, clients rated the GHSF wellness program activities as "extremely" good and that they liked the activities "a lot." In the wellness groups and EPPs, clients learned about the importance of good sleep and nutrition, smoking cessation, stress reduction strategies, possible surgical complications and how to best navigate through them, how to have realistic post-operative expectations. Participants also learned about best practices when working with one's assigned peer navigator to maximize wellness and recover following a gender affirmation surgery. Participants also learned strategies for how to plan ahead of their surgeries to have social support structures in place, and how to manage stress before, during, and after surgery.

What is the Client Feedback?

Over 200 providers participated in GHSF in-service trainings since 2016, a majority of providers reported that they "agreed" or "strongly agreed" that they felt better able to take care of their transgender patients. In particular, providers noted that they "feel better prepared" to speak with clients about their upcoming surgeries. Many providers also indicated in their qualitative responses that they "want more" of these in-person types of provider education and training sessions. When asked for qualitative feedback about how they hoped to change their clinical practices as a result of the trainings, many providers wrote that they hoped to "create a safe space" for their clients and to "use what [they] learned" in the training to "be more sensitive" and "more competent" when serving their transgender and gender nonbinary clients. Some providers noted that while the information provided in the in-service trainings wasn't particularly new to them, they felt "so grateful" that their other clinical team members received the training.

"The [GHSF] staff were all excellent; they helped me with paperwork."

"I was satisfied with the experience because everyone kept checking-in on me."

"[GHSF] played a really helpful role in letting me know I had this option and doing a lot of work for me like helping me with paperwork, scheduling peer navigation and communication and liaising with my providers."

- **GHSF Clients**

The GHSF peer navigators work hard to ensure that clients remained engaged with their health care providers, which is one of the key standard of care requirements for assessing surgical readiness and achieving health plan approval for accessing gender affirmation surgery. Using standard scales as measurements (e.g., World Health Organization Brief Quality of Life Scale, Kessler-6 scale of psychological distress), outcome evaluation data revealed that client psychosocial well-being indicators improved after clients were able to access gender affirming surgeries.

Qualitative interviews with 23 clients were conducted approximately 6-12 months after their surgeries during FY17-18 (for a program total of 56 since 2016), to learn more about the role of the peer navigators in improving client outcomes and health care experiences. Clients often reflected on how important it was to have a peer advocate checking in on them and helping with the administrative paperwork for such an important and meaningful surgery. For example:

Clients also reflected on how important it was to have someone, especially an in-community peer, to walk them through this complex process so that clients both had a "better understanding of the process," from someone that they trust, and that they had someone there to "help them through all the changes." The peers at GHSF truly understand their clients and see them in their true identities.

GHSF is also excited to share that in February 2018, GHSF's Lead Patient Navigator was recognized by the San Francisco General Hospital Foundation as one of two annual Heroes & Hearts Recipients. The Heroes & Hearts Award recognizes extraordinary community members who exemplify the "go above and beyond" spirit of San Francisco General Hospital Foundation

and Zuckerberg San Francisco General – making a difference in the lives of all San Franciscans. Nearly half of GHSF patients are monolingual Spanish speakers; in addition to the language barriers, these patients struggle with poverty, homelessness, complex health problems, and a range of psychosocial challenges related to discrimination and stigma. As a Spanish-speaker, GHSF's Lead Patient Navigator works primarily with these patients to navigate them through the SFDPH health system to access medically necessary gender affirming services.

In summary, through GHSF's ongoing peer-led community outreach activities throughout the BHS clinic network, GHSF is regularly asking and learning from the trans and gender nonbinary community members, as well as BHS staff, what the current needs of these communities are. From these outreach activities, GHSF is able to add or modify their ongoing programming to meet the current needs of community members and the clients that they serve.

In addition, The GHSF evaluation plan is being expanded this coming year to assess the impact of the peer navigation team on client surgical and behavioral health outcomes, as well as satisfaction with the GHSF program.

"Calls from [from my peer navigator] made me feel I had someone on my side before surgery. It's different talking to somebody versus reading a form. [GHSF] advocated for my identity as a gender queer."

"My experience was difficult. People changed and moved, but the [GHSF] care team was there for me through all of the changes."

"Having my navigator there with me to translate everything meant so much to me."

- **GHSF Clients**

GHSF Beyond San Francisco
The QM unit assisted GHSF in preparing for a number of local, national and international presentations, including at the United States Professional Association for Transgender Health (USPATH) in Los Angeles in 2017, at NAMI Northern California Multicultural Symposium in 2018, and at the World Professional Association for Transgender Health (WPATH) International Conference in Buenos Aires, Argentina in 2018. The presentations focused on the program evaluation outcomes and program lessons learned of the MHSA-funded Gender Health SF program, and effective peer patient navigation services.

Summary of Peer-Focused Programs

BHS is committed to providing behavioral health programs that support, train, and hire peers. Toward this aim, BHS funded three new and unique programs in recent years to provide both peer-to-peer and vocational services for peers. These efforts focused on employing and using peers as part of their own wellness and to enhance the services offered to consumers within the BHS system through the unique skillsets and perspectives they bring to their work.

This summary consolidates "lessons learned" for the benefit of improving peer focused programs already in place and in development for next year.

Evaluators for the three programs sought feedback from peer employees via surveys and interviews. Below is a description of the peer employment programs, a summary of lessons learned, and recommendations for future peer programming based off the findings from each.

Mentoring and Peer Support (MAPS) Program
The Mentoring and Peer Support (MAPS) program, supported by a 3 year grant from the Substance Abuse Mental Health Services Agency, offered peer services from 2015 through 2017. DPH's Jail Health Services program partnered with San Francisco Collaborative Courts, HealthRight 360, and the San Francisco Veteran's Administration Medical Center. The program

sought to improve behavioral health and wellness outcomes while reducing criminal justice recidivism among substance using adults under Court jurisdiction.

MAPS employed a diverse team of peers, including 1 full-time lead peer mentor and 5 half-time peer mentors. They used evidence-based practices to encourage, support, and foster treatment success among clients recently referred from Behavioral Health Court, Drug Court, and the newly created Veterans Justice Court. The guiding principle of the MAPS program was that, by their example, a peer can show the client a path to social re-integration.

<u>Hummingbird Place Peer Respite</u>
Open from 2015-2017, Hummingbird Place Peer Respite operated as a peer-led, safe space offering connection and breathing room to those in need of a new direction on their path towards wellness. It was a voluntary low-threshold program alternative to Psychiatric Emergency Services (PES) located on the grounds of Zuckerberg San Francisco General Hospital, but in a separate building. Hummingbird Place was 100% peer-run, including all staff and the DPH program manager. For a time, a certified nursing assistant who identified as a peer was allocated to the program for 16 hours per week. Hummingbird Place was firmly grounded in the principles of Wellness and Recovery. Open Monday-Saturday, guests were allowed the freedom to engage or not engage with staff. For those who wished to engage, peer staff worked with them on their individual wellness and strengths-based goals.

<u>Richmond Area Multi-Services, Inc. (RAMS) Peer Employment</u>
Established in 1974, Richmond Area Multi-Services (RAMS) offers over 30 community-based programs and is one of several MHSA-funded programs that aims to deliver a highly supportive employment experience to peers. RAMS seeks to give peers employment experiences that help them feel integrated into a team, offers professional development and career advancement opportunities, and provides them with support in their wellness and recovery.

<u>Lessons Learned</u>
Across the three peer employment programs from which peer feedback was obtained, the following observations and perspectives were shared by peers:

- Clients valued having peer mentors who shared experiences similar to their own.
- Peers were very satisfied with their positions and saw their work as a step towards healing both for their clients and themselves.
- Peers were valued for their tenacity and unwillingness to give up on themselves or others.
- Stability with peer employees is challenging but necessary to program success, especially for peers in lead peer or coordinator positions.
- Some situations with clients were triggering to peers, impacting their recovery and occasionally resulted

Stakeholders at the SF Public Library

in a peer mentor who left the program. These peer relapse events distressed both clients and other peers.

- Peer staff reported feeling challenged in their recovery by triggering events, but also felt strengthened through interaction with other peers and remembering how much better their lives are now.
- Peers have a great need for supportive self-care strategies and training around counseling skills, setting boundaries with clients, harm reduction, CPR/First Aid, and protocols for handling medical and psychiatric emergencies, biohazards, and contentious clients.
- Peers desired greater communication and clarity around their roles and responsibilities.
- Peers reported the need to better understand the relationship of their work earnings to SSI and SSDI and other benefits, as earning beyond the eligible limit can cause some benefits to be discontinued.
- More peers are needed to meet demand and reduce burnout!

Recommendations for Future Programming

Based on the lessons learned, it is recommended that future peer employment programs enhance the following programmatic offerings for their peer staff:

1. Emphasize focus on staff wellness through promoting more activities for self-care, trainings as mentioned above, and hiring enough peers for the amount of work.
2. Increase staff coverage to relieve lapses in staffing due to sick days and staff dropout/turnover.
3. Strengthen and document onboarding practices, including trainings appropriate to work and increased communication around responsibilities and protocols for handling crises.
4. Greater infrastructure – including access to office/work space and computers – at programs that operate primarily in the field would increase peer productivity and give clients a fixed site at which to meet their mentors off of the streets.
5. For peers working in a non-peer-to-peer setting, enhance interpersonal skills training, as these skills were valued above all others, and continue to make peers feel appreciated in the workplace.
6. Guidance on how increased working hours and pay can impact their benefits. Given the complexity of navigating benefits, it might be necessary to have a system expert to assist peers on this topic, with the goal of finding ways for peers to work more hours without losing their benefits.

MHSA Mid-Year and Year-End Reporting

QM supported the staff in MHSA Administration with program Mid-Year and Year-End reporting. At a MHSA Providers meeting in late summer QM introduced IT staff who presented on How-To to access the online reporting screen and walk the programs through it. QM staff provided guidance on collection and reporting of demographics data, referrals and participant feedback to the program.

INN Project Evaluations

QM is routinely consulted for the development of evaluation plans for new MSHA programs. SF-MHSA generated four new INN proposals in FY17-18 (all of which were approved!), and QM was integral to the design of the evaluation plans from the inception of each proposal. The INN plans are described in the INN section of this Annual Update above.

QM will be instrumental in the evaluation of the ICM-OP Peer Transition Team as it gets implemented by RAMS, the awarded provider. Data collection needs will be discussed and tools will

be developed collaboratively. RAMS staff will collect the data with support and oversight from QM.

Program Development and Evaluation Support

Contract Objectives SMART for TAY

Throughout the development of the new TAY System of Care, Quality Management has supported the program manager(s) in identifying outcome goals, building a logic model and defining SMART objectives for the more than 17 new TAY programs as they come online in 2018-2019.

Improved Program Objectives for other MHSA programs

Beyond supporting the TAY SOC and collaborating in previous intensive learning circles with the Population Focused Mental Health Promotion (PFMHP) programs, QM reviewed all MHSA programs' contract process and outcome objectives for FY19-20 in an effort to make them stronger. The careful review of objectives helped identify programs that still needed support on creating SMART objectives. With SMARTer objectives, SF MHSA can report more meaningful and accurate outcomes and impacts. Nearly 100% of the MSHA programs had both process and outcomes and were in SMART format, more than in any year since the inception of MHSA.

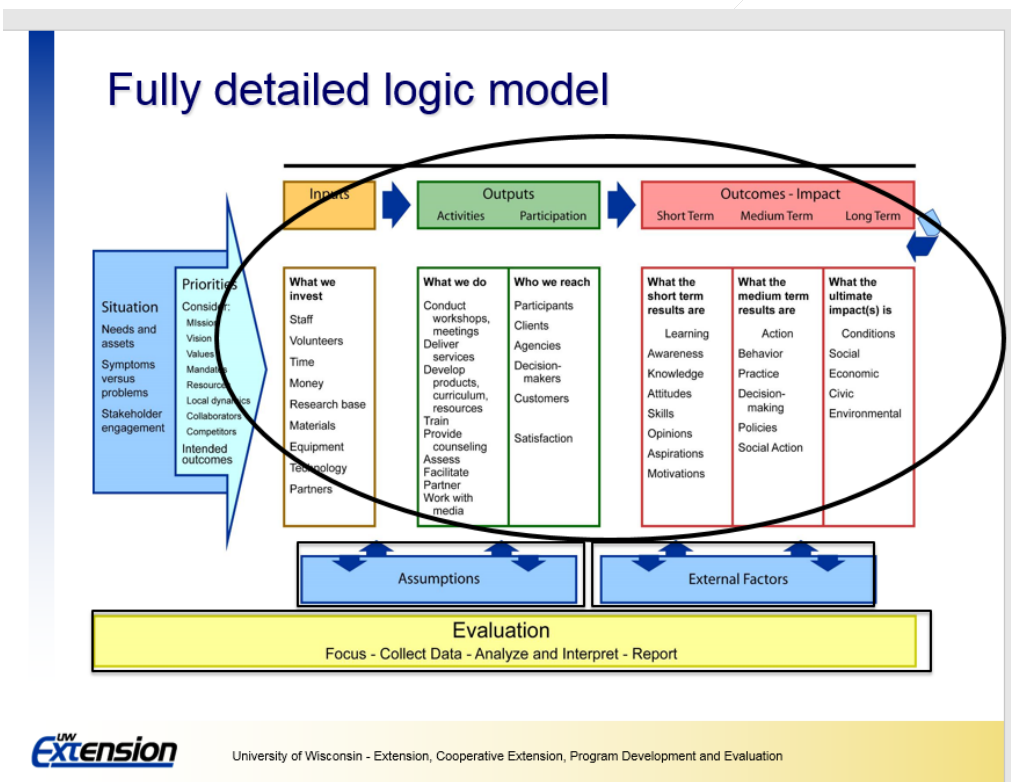
Evaluation Frameworks for new RFQs and RFPs

As new programs are conceptualized, or INN funding gets approved, the County creates Requests for Qualifications (RFQs) and Requests for Proposals (RFPs) that give community based providers the opportunity to apply for funding to implement the services proposed. In recent years, MHSA has brought QM into the RFQ/RFP development process earlier in order to ensure that clear goals are articulated from the start and that evaluation expectations are well defined. Applicants are encouraged to design logic models for their proposals and articulate how they plan to measure their outcomes.

Training for MHSA Staff on Logic Models and Theory of Change

QM initiated a new effort this year to enhance MHSA administrative capacity to use logic models and identify Theory of Change mechanisms for MHSA funded programs. QM lead two workshops with MHSA staff to layout the building blocks of logic models (goals, activities, resources, short and long term objectives and measurements). Creating a visual of each program helps identify how to measure its impact and can assist in program development and improvement. The second workshop emphasize outcomes and ways to collect data to measure intended outcomes.

SFDPH MHSA Team - Logic Model Workshop



Sample slide from the workshop, created by University of Wisconsin Extension program

Overall, the MHSA Evaluation Team under QM integrates within the MHSA Administrative team, attending staff meetings regularly and collaborating on a daily basis, from the conceptualization of new programs to the annual reporting of outcomes internally, to the State and to other interested stakeholders.

“Looking Ahead for SF-MHSA”

In the years ahead, we will continue in our mission of transforming San Francisco’s public mental health system. The MHSA will play an important role in strengthening and expanding the provision of mental health services locally, and throughout the state of California. Our future efforts will include the dissemination of the 2019/20 Annual Update, which brings together a vision for implementation of all the MHSA components.

In the coming year, MHSA will work to implement and enhance the programming described in detail in this report. We will also strive to integrate all of the valuable feedback received in CPP meetings and other stakeholder engagements. We are committed to weaving this feedback into the core of MHSA programming. Over the next year, we will also focus efforts in a number of key areas. These areas of focus are detailed below:

- **We will take measures to respond to the upcoming No Place Like Home (NPLH) bond.** NPLH re-purposes statewide MHSA funds, and will provide $2 billion for the construction and rehabilitation of permanent supportive housing for homeless individuals with severe and persistent mental illness. In the coming months, we will monitor the roll-out of this legislation, as we have already prepared to participate in the competitive funding process. In the years ahead, we will work to implement effective NPLH programming.

- **We will place a strong emphasis on program evaluation across the MHSA components.** In the year ahead, we will work to enhance our monitoring and evaluation activities, in order to effectively meet the performance objectives of our MHSA-funded programs. We will continue to gather stakeholder feedback and make improvements to our new and streamlined electronic data-collection and reporting tool that allows programs to submit mid-year and year-end reports online that include demographics data, measurable outcomes, client success stories and more. This electronic system is HIPAA compliant.

- **We will place a strong emphasis on expanding our collaborative efforts with multiple counties.** In the year ahead, we will continue to enhance our relationships and networking capabilities with multiple counties in order to effectively work together, share common goals, exchange best practices and lessons learned and leverage resources. We began partnering with multiple counties on our Technology-Assisted Mental Health Solutions INN project. We also started a regular convening with neighboring counties to share ideas and strategize more effectively.

- **We will implement our new INN projects.** As stated above, we have four (4) new INN projects that were approved by the MHSOAC over the past year.
  - ICM/FSP to OP Transition Support
  - Wellness in the Streets
  - Technology-Assisted Mental Health Solutions
  - Family Unification and Emotional Resiliency Training (FUERTE)

  MHSA has started the planning/implementation phases of these projects working with community members and stakeholders in order to have a successful program launch.

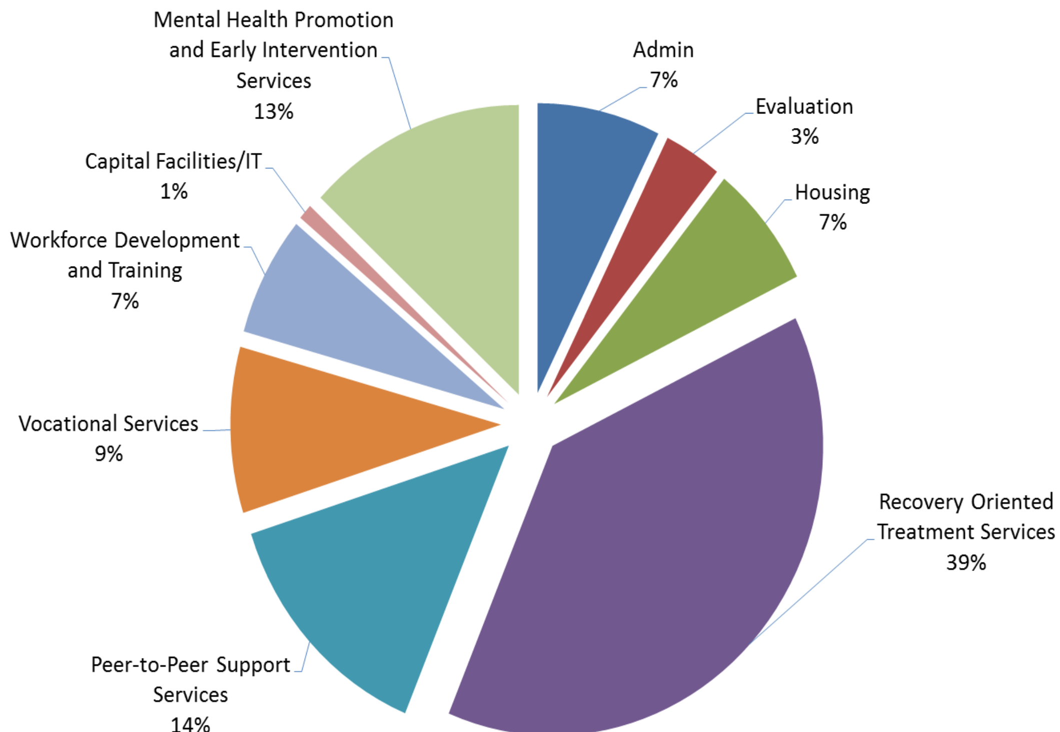
- **We will create a new Online Learning System.** As stated above, we received stakeholder feedback calling for the implementation of a new Online Learning System. This system will be a training tool in order to increase access to training activities, increase capacity for the professional development of staff, provide Continuing Education (CE) credits for licensure, and provide online training seminars covering an array of topics.

MHSA Budget

MHSA Integrated Service Categories

MHSA Integrated Service Categories	Abbreviation	FY 17/18 Expenditure Amount	Percentage
Admin	Admin	2,397,205.83	7%
Evaluation	Evaluation	1,127,414.75	3%
Housing	H	2,255,893.41	7%
Recovery Oriented Treatment Services	RTS	12,550,748.32	39%
Peer-to-Peer Support Services	P2P	4,498,917.14	14%
Vocational Services	VS	3,015,581.08	9%
Workforce Development and Training	WD	2,185,170.06	7%
Capital Facilities/IT	CF/IT	281,932.03	1%
Mental Health Promotion and Early Intervention Services	PEI	4,268,199.14	13%
TOTAL		**32,581,061.77**	**100%**

FY17/18 MHSA Actual Expenditures



SF MHSA Integrated Services Categori	Programs by Funding Component	FY 17-18 Expenditure
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 17-18, 52% was allocated to serve FSP clients	
Admin	CSS Admin	1,967,042.03
Evaluation	CSS Evaluation	1,028,061.29
H	CSS FSP Permanent Housing (capital units and master lease)	821,952.32
RTS	CSS Full Service Partnership 1. CYF (0-5)	399,375.98
RTS	CSS Full Service Partnership 2. CYF (6-18)	962,912.93
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,207,223.18
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,495,353.66
RTS	CSS Full Service Partnership 5. Older Adults (60+)	988,073.69
RTS	CSS Full Service Partnership 6. AOT	723,206.67
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	860,324.34
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	919,961.50
RTS	CSS Other Non-FSP 3. Trauma Recovery	469,309.31
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,605,184.43
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	330,488.41
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,087,326.60
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,663,652.50
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	310,003.97
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	171,435.12
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	952,502.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	160,880.84
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	428,453.39
	SUBTOTAL Community Services and Support (CSS)	**23,552,724.15**
	Workforce, Development Education and Training (WDET) **$2.2M transferred from CSS to fund WDET activities in FY 17-18**	
WD	WDET 1. Training and TA	800,828.58
WD	WDET 2. Career Pathways	741,928.51
WD	WDET 3. Residency and Internships	470,132.27
Admin	WDET Admin	75,779.25
Evaluation	WDET Evaluation	99,353.46
	SUBTOTAL Workforce, Development Education and Training (WDET)	**2,188,022.07**
	Capital Facilities/IT **$1.5M transferred from CSS to fund Capital Facilities/IT activities in FY 17-18**	
CF/IT	IT 1. Consumer Portal	122,624.40
VS	IT 2. Vocational IT	1,099,281.58
CF/IT	IT 3. System Enhancements	159,307.63
Admin	IT Admin	136,327.72
	SUBTOTAL Capital Facilities/IT	**1,517,541.33**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**27,258,287.56**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	185,500.00
PEI	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	1,131,957.80
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	1,814,237.78
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	719,956.21
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	344,003.35
PEI	PEI 7. CalMHSA Statewide Programs	72,544.00
Admin	PEI Admin	75,779.27
	SUBTOTAL Prevention and Early Intervention (PEI)	**4,343,978.41**

	Innovation (INN) 5% of total MHSA revenue	
VS	INN 14. First Impressions	252,647.00
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	240,936.30
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	170,654.24
WD	INN 17. Hummingbird Place - Peer Respite	172,280.70
Admin	INN Admin	142,277.56
	SUBTOTAL Innovation (INN)	**978,795.80**
	TOTAL FY 17-18 MHSA Expenditures	**32,581,061.77**

FY17/18 through FY19/20 Three-Year MHSA Expenditure Plan

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. Estimated FY 2017/18 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	12,161,592	1,368,880	4,375,469	-	-		17,905,941
1a. Adjustments posted in FY 17/18	(227,292)	140,570	1,152	(1,806)	(7,312)		(94,688)
2. Estimated New FY2017/18 Funding	28,703,280	7,175,820	1,888,374				37,767,473
3. Transfer in FY2017/18a/	(5,420,772)			2,189,828	2,274,853	956,090	-
4. Access Local Prudent Reserve in FY2017/18						-	-
5. Estimated Available Funding for FY2017/18	35,216,808	8,685,269	6,264,995	2,188,022	2,267,541		54,622,635
B. Estimated FY2017/18 MHSA Expenditures	23,552,724	4,343,978	978,796	2,188,022	1,517,541		32,581,062
C. Estimated FY2018/19 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	11,664,084	4,341,291	5,286,199	-	750,000		22,041,574
2. Estimated New FY2018/19 Funding	25,080,000	6,270,000	1,650,000				33,000,000
3. Transfer in FY2018/19a/	(4,405,885)			2,073,031	2,332,854	-	-
4. Access Local Prudent Reserve in FY2018/19						-	-
5. Estimated Available Funding for FY2018/19	32,338,199	10,611,291	6,936,199	2,073,031	3,082,854		55,041,574
D. Estimated FY2018/19 Expenditures	22,834,020	4,922,034	1,542,538	2,073,031	2,332,854		33,704,477
E. Estimated FY2019/20 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	9,504,179	5,689,257	5,393,661	-	750,000		21,337,097
2. Estimated New FY2019/20 Funding	25,080,000	6,270,000	1,650,000				33,000,000
3. Transfer in FY2019/20a/	(4,777,242)			2,330,238	2,447,004	-	-
4. Access Local Prudent Reserve in FY2019/20						-	-
5. Estimated Available Funding for FY2019/20	29,806,937	11,959,257	7,043,661	2,330,238	3,197,004		54,337,097
F. Estimated FY2019/20 Expenditures	22,777,336	4,994,930	2,811,147	2,330,238	2,447,004		35,360,655
G. Estimated FY2019/20 Unspent Fund Balance	7,029,601	6,964,327	4,232,514	-	750,000		18,976,443

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	6,303,480
2. Contributions to the Local Prudent Reserve in FY 2017/18	956,090
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	7,259,570
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	7,259,570
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	7,259,570

Community Services and Supports (CSS) Estimated Budget – FY17/18 through FY19/20

	Fiscal Year 2017/18					
	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)	552,342	399,375.98	-	-	-	152,966
2. CSS Full Service Partnership 2. CYF (6-18)	4,122,859	962,913	52,931	180,976	1,661,725	1,264,314
3. CSS Full Service Partnership 3. TAY (18-24)	1,608,368	1,207,223	337,329	3,506	58,235	2,075
4. CSS Full Service Partnership 4. Adults (18-59)	12,349,749	3,495,354	1,754,334	2,417,692	245	4,682,124
5. CSS Full Service Partnership 5. Older Adults (60+)	1,425,618	988,074	322,093	93,125	-	22,326
6. CSS Full Service Partnership 6. AOT	723,207	723,207	-	-	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	821,952	821,952	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,924,421	2,043,663	-	110,936	-	769,822
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,765,941	748,644	7,626	283,471	-	726,200
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	186,002	186,002	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement & Supportive Services (DAH) (30% FSP)	51,431	51,431	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	571,501	571,501	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,018,458	860,324	133,133	-	-	25,000
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,303,482	919,962	62,859	13,599	63,035	244,027
3. CSS Other Non-FSP 3. Trauma Recovery	501,062	469,309	-	662	27,074	4,017
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,772,273	1,605,184	167,089	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,539,268	330,488	-	-	-	1,208,780
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,924,421	2,043,663	-	110,936	-	769,822
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,158,372	915,009	9,321	346,464	-	887,578
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	124,002	124,002	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement & Supportive Services (Direct Access to Housing) (30% FSP)	120,005	120,005	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	381,001	381,001	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	469,123	160,881	308,242	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	428,453	428,453	-	-	-	-
CSS Administration	1,967,042	1,967,042	-	-	-	-
CSS Evaluation	1,028,061	1,028,061	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	42,838,413	23,552,724	3,154,958	3,561,366	1,810,314	10,759,051
FSP Programs as Percent of Total	52%	estimated CSS funding over total CSS expenditures				

	Fiscal Year 2018/19					
	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)	798,129	399,376	-	398,753	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	1,735,739	908,095	369,653.23	278,957	57,129	121,904
3. CSS Full Service Partnership 3. TAY (18-24)	3,389,610	1,671,288	611,740	755,708	346,903	3,971
4. CSS Full Service Partnership 4. Adults (18-59)	9,386,667	3,621,578	1,139,611	1,510,246	1,282,360	1,832,872
5. CSS Full Service Partnership 5. Older Adults (60+)	2,376,347	999,668	392,581	568,369	325,160	90,569
6. CSS Full Service Partnership 6. AOT	1,116,385	737,520	157,120	221,745	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	1,345,912	752,314	-	593,598	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,736,404	1,990,884	227,561	1,425,392	2,840	89,727
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,525,196	701,773	49,214	543,675	6,040	224,495
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	329,724	188,268	60,119	81,337	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement & Supportive Services (DAH) (30% FSP)	100,955	53,576	-	47,379	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	618,990	325,277	-	293,713	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,817,500	880,125	587,737	157,139	192,499	-
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	967,024	505,587	-	426,030	29,110	6,298
3. CSS Other Non-FSP 3. Trauma Recovery	278,336	139,579	-	138,561	-	195
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	3,786,674	1,882,178	1,244,926	446,841	212,730	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	438,021	276,981	-	161,040	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,736,404	1,990,884	227,561	1,425,392	2,840	89,727
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,864,129	857,722	60,150	664,492	7,382	274,383
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	219,816	125,512	40,079	54,224	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	235,562	125,011	-	110,552	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	412,660	216,851	-	195,809	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	242,214	167,475	30,349	-	44,389	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	530,060	355,183	174,877	-	-	-
CSS Administration	3,405,233	1,936,406	1,084,481	384,345	-	-
CSS Evaluation	1,808,880	1,001,325	773,603	33,952	-	-
CSS MHSA Housing Program Assigned Funds	23,583	23,583	-	-	-	-
Total CSS Program Estimated Expenditures	46,226,154	22,834,020	7,231,363	10,917,249	2,509,382	2,734,140
FSP Programs as Percent of Total	54%	estimated CSS funding over total CSS expenditures				

	Fiscal Year 2019/20					
	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)	798,129	399,376	-	398,753	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	791,578	414,134	168,579.09	127,217	26,054	55,594
3. CSS Full Service Partnership 3. TAY (18-24)	3,421,391	1,686,958	617,475.44	762,794	350,155	4,009
4. CSS Full Service Partnership 4. Adults (18-59)	9,437,802	3,641,307	1,145,819	1,518,473	1,289,346	1,842,857
5. CSS Full Service Partnership 5. Older Adults (60+)	2,409,218	1,013,496	398,012	576,232	329,657	91,821
6. CSS Full Service Partnership 6. AOT	1,132,225	747,984	159,350	224,891	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	1,345,912	752,314	-	593,598	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,754,586	2,000,572	228,668	1,432,328	2,854	90,163
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,738,311	799,831	56,090	619,643	6,884	255,863
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	334,467	190,976	60,984	82,506	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement & Supportive Services (DAH) (30% FSP)	100,955	53,576	-	47,379	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	618,990	325,277	-	293,713	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,865,542	903,389	603,273	161,293	197,587	-
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	967,024	505,587	-	426,030	29,110	6,298
3. CSS Other Non-FSP 3. Trauma Recovery	278,336	139,579	-	138,561	-	195
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	3,884,368	1,930,737	1,277,044	458,369	218,218	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	438,021	276,981	-	161,040	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,754,586	2,000,572	228,668	1,432,328	2,854	90,163
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,124,602	977,571	68,555	757,341	8,413	312,722
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	222,978	127,318	40,656	55,004	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	235,562	125,011	-	110,552	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	412,660	216,851	-	195,809	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	250,279	173,052	31,360	-	45,867	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	547,726	367,021	180,705	-	-	-
CSS Administration	3,525,190	2,004,621	1,122,685	397,885	-	-
CSS Evaluation	1,812,350	1,003,245	775,087	34,018	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	46,202,787	22,777,336	7,163,010	11,005,755	2,507,001	2,749,686
FSP Programs as Percent of Total	60.8%	estimated CSS funding over total CSS expenditures				

Prevention and Early Intervention (PEI) Estimated Budget – FY17/18 through FY19/20

	Fiscal Year 2017/18					
	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	185,500	185,500	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	602,924	565,979	-	-	-	36,945
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health PEI (50% Prevention)	972,150	907,119	-	-	-	65,032
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,139,479	539,967	-	-	-	2,599,512
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	34,789	34,400	388	-	-	-
7. PEI 7. CalMHSA Statewide Programs	72,544	72,544	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	602,924	565,979	-	-	-	36,945
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health PEI (50% Prevention)	972,150	907,119	-	-	-	65,032
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,046,493	179,989	-	-	-	866,504
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	313,097	309,603	3,494	-	-	-
PEI Administration	75,779	75,779	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	8,017,829	4,343,978	3,882	-	-	3,669,969

	Fiscal Year 2018/19					
	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	185,500	185,500.00	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	634,000	595,150	-	-	-	38,849
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health PEI (50% Prevention)	1,222,007	1,140,261	-	-	-	81,746
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,175,504	546,163	-	-	-	2,629,341
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	39,136	38,699	437	-	-	-
7. PEI 7. CalMHSA Statewide Programs	72,544	72,544	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	634,000	595,150	-	-	-	38,849
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health PEI (50% Prevention)	1,222,007	1,140,261	-	-	-	81,746
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,058,501	182,054	-	-	-	876,447
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	352,220	348,290	3,930	-	-	-
PEI Administration	77,961	77,961	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	8,673,378	4,922,034	4,367	-	-	3,746,977

	Fiscal Year 2019/20					
	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	185,500	185,500	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	636,074	597,098	-	-	-	38,976
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health PEI (50% Prevention)	1,249,104	1,165,545	-	-	-	83,558
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,188,366	548,375	-	-	-	2,639,990
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	40,439	39,988	451	-	-	-
7. PEI 7. CalMHSA Statewide Programs	72,544	72,544	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	636,074	597,098	-	-	-	38,976
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health PEI (50% Prevention)	1,249,104	1,165,545	-	-	-	83,558
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,062,789	182,792	-	-	-	879,997
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	363,949	359,888	4,061	-	-	-
PEI Administration	80,557	80,557	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	8,764,498	4,994,930	4,512	-	-	3,765,056

Innovations (INN) Estimated Budget – FY17/18 through FY19/20

	Fiscal Year 2017/18					
	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 14. First Impressions	252,647	252,647	-	-	-	-
2. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adu	240,936	240,936	-	-	-	-
3. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	170,654	170,654	-	-	-	-
4. INN 17. Hummingbird Place - Peer Respite	172,281	172,281	-	-	-	-
5. INN 18. Intensive Case Management Flow	-	-	-	-	-	-
6. INN 20. Technology-assisted Mental Health Solutions	-	-	-	-	-	-
7. INN 21. Wellness in the Streets (WITS)	-	-	-	-	-	-
8. INN 22. FUERTE						
INN Administration	142,278	142,278	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	978,796	978,796	-	-	-	-

	Fiscal Year 2018/19					
	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 14. First Impressions	202,500	202,500	-	-	-	-
2. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adu	256,250	256,250	-	-	-	-
3. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	259,536	259,536	-	-	-	-
4. INN 17. Hummingbird Place - Peer Respite	-	-	-	-	-	-
5. INN 18. Intensive Case Management Flow	542,871	542,871	-	-	-	-
6. INN 20. Technology-assisted Mental Health Solutions	-	-	-	-	-	-
7. INN 21. Wellness in the Streets (WITS)	-	-	-	-	-	-
8. INN 22. FUERTE	50,000	50,000	-	-	-	-
INN Administration	231,381	231,381	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	1,542,538	1,542,538	-	-	-	-

	Fiscal Year 2019/20					
	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 14. First Impressions	-	-	-	-	-	-
2. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adu	175,692	175,692	-	-	-	-
3. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	124,771	124,771	-	-	-	-
4. INN 17. Hummingbird Place - Peer Respite	-	-	-	-	-	-
5. INN 18. Intensive Case Management Flow	681,345	681,345	-	-	-	-
6. INN 20. Technology-assisted Mental Health Solutions	757,667	757,667	-	-	-	-
7. INN 21. Wellness in the Streets (WITS)	350,000	350,000	-	-	-	-
8. INN 22. FUERTE	300,000	300,000	-	-	-	-
INN Administration	421,672	421,672				
INN Evaluation	-	-				
Total INN Program Estimated Expenditures	3,232,819	3,232,819				

Workforce, Education and Training (WET) Estimated Budget – FY17/18 through FY19/20

	Fiscal Year 2017/18					
	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	1,256,182	800,829	-	79,396	-	375,957
2. Career Pathways	741,929	741,929	-	-	-	-
3. Residency and Internships	470,132	470,132	-	-	-	-
WET Administration	75,779	75,779	-	-	-	-
WET Evaluation	99,353	99,353	-	-	-	-
Total WET Program Estimated Expenditures	2,643,375	2,188,022	-	79,396	-	375,957

	Fiscal Year 2018/19					
	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	1,228,397	783,116	-	77,640	-	367,642
2. Career Pathways	635,870	635,870	-	-	-	-
3. Residency and Internships	474,596	474,596	-	-	-	-
WET Administration	77,961	77,961	-	-	-	-
WET Evaluation	101,489	101,489	-	-	-	-
Total WET Program Estimated Expenditures	2,518,312	2,073,031	-	77,640	-	367,642

	Fiscal Year 2019/20					
	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	1,475,583	940,699	-	93,263	-	441,621
2. Career Pathways	646,398	646,398	-	-	-	-
3. Residency and Internships	558,548	558,548	-	-	-	-
WET Administration	80,557	80,557	-	-	-	-
WET Evaluation	104,036	104,036	-	-	-	-
Total WET Program Estimated Expenditures	2,865,122	2,330,238	-	93,263	-	441,621

Capital Facilities/Technological Needs (CFTN) Estimated Budget – FY17/18 through FY19/20

	Fiscal Year 2017/18					
	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	-	-	-	-	-	-
2. Redwood Center Renovation	-	-	-	-	-	-
3. Sunset Mental Health	-	-	-	-	-	-
4. IHHC at Central YMCA (Tom Waddell)	-	-	-	-	-	-
5. Southeast Health Center	-	-	-	-	-	-
6. South of Market Mental Health	-	-	-	-	-	-
7. First Impressions	-	-	-	-	-	-
8. Chinatown/Northbeach Exam Room	-	-	-	-	-	-
9. Comprehensive Crisis Services/CTT Team Build Out	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	122,624	122,624	-	-	-	-
9. Vocational IT	1,099,282	1,099,282	-	-	-	-
10. System Enhancements	159,308	159,308	-	-	-	-
CFTN Administration	136,328	136,328	-	-	-	-
Total CFTN Program Estimated Expenditures	1,517,541	1,517,541				

	Fiscal Year 2018/19					
	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	-	-	-	-	-	-
2. Redwood Center Renovation	-	-	-	-	-	-
3. Sunset Mental Health	-	-	-	-	-	-
4. IHHC at Central YMCA (Tom Waddell)	-	-	-	-	-	-
5. Southeast Health Center	750,000	750,000	-	-	-	-
6. South of Market Mental Health	-	-	-	-	-	-
7. First Impressions	50,147	50,147	-	-	-	-
8. Chinatown/Northbeach Exam Room		-				
9. Comprehensive Crisis Services/CTT Team Build Out		-				
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	126,129	126,129	-	-	-	-
9. Vocational IT	1,103,390	1,103,390	-	-	-	-
10. System Enhancements	164,213	164,213	-	-	-	-
CFTN Administration	138,975	138,975	-	-	-	-
Total CFTN Program Estimated Expenditures	2,332,854	2,332,854				

	Fiscal Year 2019/20					
	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	-	-	-	-	-	-
2. Redwood Center Renovation	-	-	-	-	-	-
3. Sunset Mental Health	-	-	-	-	-	-
4. IHHC at Central YMCA (Tom Waddell)	-	-	-	-	-	-
5. Southeast Health Center	750,000	750,000	-	-	-	-
6. South of Market Mental Health	-	-	-	-	-	-
7. First Impressions	-	-	-	-	-	-
8. Chinatown/Northbeach Exam Room		30,000				
9. Comprehensive Crisis Services/CTT Team Build Out		120,000				
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	130,329	130,329	-	-	-	-
9. Vocational IT	1,103,390	1,103,390	-	-	-	-
10. System Enhancements	169,681	169,681	-	-	-	-
CFTN Administration	143,602	143,602	-	-	-	-
Total CFTN Program Estimated Expenditures	2,297,004	2,447,004				

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: San Francisco

Fiscal Year: FY 2019-20

Local Mental Health Director

Name: Irene Sung, M.D.

Telephone: (415) 255-3742

Email: irene.sung@sfdph.org

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Irene Sung, M.D.
Local Mental Health Director (PRINT NAME)

Signature

6-17-19
Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

Maximum Allowable Prudent Reserve

California Senate Bill 192 clarifies that the value of a prudent reserve for a Local Mental Health Services Fund shall not exceed 33% of the average community services and support (CSS) revenue received for the fund in the preceding 5 years. Accordingly, amendments were made to Section 5892 and 5892.1 of the Welfare and Institutions Code to adopt this new regulation.

Specific instructions for calculating a county's maximum allowable prudent reserve were provided by MHSUDS Information Notice 19-017, which states that all California counties "must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS component in FY 2013-14, FY 2014-15, FY 2015-16, FY 2016-17, and FY 2017-18."

Per the Fiscal Year 2017-18 MHSA Revenue and Expenditure Report, the prudent reserve balance for the City & County of San Francisco is $7,259,570. This amount is below the maximum allowable prudent reserve level enforced by Senate Bill 192 and MHSUDS Information Notice 19-017.

Calculation of the Maximum Allowable MHSA Prudent Reserve (PR) Funding Amount for the City & County of San Francisco

Fiscal Year	Distribution to CSS Component
FY 2013-14	$ 17,197,536
FY 2014-15	$ 23,960,215
FY 2015-16	$ 19,887,523
FY 2016-17	$ 25,831,276
FY 2017-18	$ 27,956,023
5- year CSS Average Revenue:	$ 22,966,515
Maximum PR Amount at 33% of CSS Average Revenue	**$ 7,578,950**

In San Francisco, MHSA-funded programs are administered by Behavioral Health Services, under 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. www.sfmhsa.org/about_us.html