San Francisco Health Network
Behavioral Health Services

San Francisco
Mental Health Services Act (MHSA)

FY2020-2023 Three-Year Program and Expenditure Integrated Plan

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

Maestrapeace Mural at The Women's Building in San Francisco's Mission District

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Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date, as well as our planning efforts for programs moving forward.

The report includes an **introductory section**, which provides an overview of the Mental Health Services Act, the general landscape of San Francisco, our department's Community Program Planning (CPP) activities, MHSA program highlights in the past year, and the report's formal review process.

The SF DPH **MHSA seven service categories** are outlined in the remainder of the report, each with its own section describe the overarching purpose of each service category and the programs within the category. Each section includes an overview and description, the target population, highlights and successes. The seven service categories include: 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; and 7. Capital Facilities & Information Technology.

MHSA staff and consumers at the SF Transgender Health Fair

MHSA County Compliance Certification

County: San Francisco

Local Mental Health Director	Program Lead
Name: Marlo Simmons, MPH Telephone Number: 415-255-3915 Email: marlo.simmons@sfdph.org	Name: Jessica Brown, MPH Telephone Number: 415-255-3963 Email: jessica.n.brown@sfdph.org
County Mental Health Mailing Address: Behavioral Health Services 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 MHSA Three-Year Plan, including stakeholder participation and non-supplantation requirements.

This MHSA Three-Year Plan 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 MHSA Three-Year Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment. A public hearing was held by the local Behavioral Health Commission. All input has been considered with adjustments made, as appropriate. The MHSA Three- Year Plan, attached hereto, was adopted by the County Board of Supervisors on September 22, 2020.

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 MHSA Three-Year Plan are true and correct.

10/14/20

Signature | Date

Marlo Simmons, MPH
Local Mental Health Director/Designee

County: San Francisco County

Date: 10/14/2020

MHSA County Fiscal Accountability Certification[1]

County/City: San Francisco

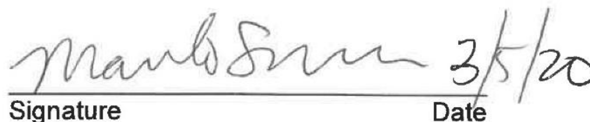
- [x] Three-Year Program and Expenditure Plan
- [ ] Annual Update
- [ ] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: Marlo Simmons, MPH	Name: Ben Rosenfield
Telephone Number: (415) 255-3915	Telephone Number: (415) 554-7500
E-mail: marlo.simmons@sfdph.org	E-mail: ben.rosenfield@sfgov.org
Local Mental Health Mailing Address: 1380 Howard Street 4th Floor San Francisco, CA	

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.

Marlo Simmons, MPH
Local Mental Health Director (PRINT)



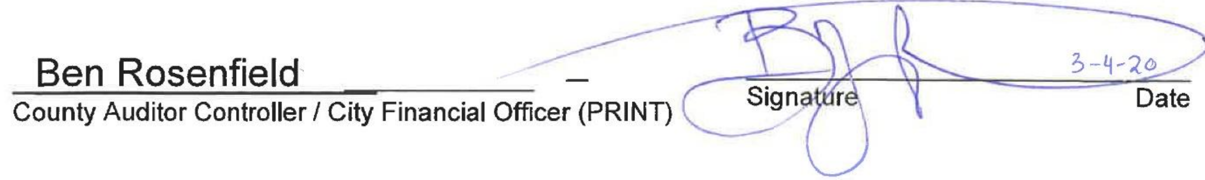
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

MHSA County Fiscal Accountability Certification

I hereby certify that for the fiscal year ended June 30, 2019, 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 12/30/2019 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2019, 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 3-4-20 Date

Director's Message

The Mental Health Services Act (MHSA) has funded innovative and traditional mental health programs and services across San Francisco since its introduction in 2004 and, in recent years, our focus has turned to increasing equitable access to high-quality mental health care for all. The principles that guide the MHSA program include community collaboration, recovery & wellness, health equity, client & family member involvement, and integrated client-driven services.

This FY2020-2023 Three-Year Program and Expenditure Integrated Plan showcases MHSA program outcomes achieved in Fiscal Year 2018-19 and gives an overview of future program plans for the coming three years. In developing this plan, the SFDPH MHSA team prioritized collecting community input and feedback - from consumers, providers, peers, family members, and other stakeholders – to guide program improvements, implementation, and evaluation.

Improving the quality of life for individuals with mental illness, as well as their friends and families, is a challenge that is compounded by other issues that can appear overwhelming, including physical health, economic, housing, and other social issues. To address these issues through a comprehensive strategy, the SFDPH MHSA team is dedicated to working across systems, both public and private, to accomplish our goals of increasing awareness, reducing stigma, increasing equitable access, promoting prevention and early identification and intervention of mental health symptoms, and improving quality of care. The San Francisco Behavioral Health Services (SFBHS) recently announced the creation of the Office of Equity, Social Justice, and Multicultural Education (SFBHS OESM) to "advocate for policies and practices that promote diversity, equity, and inclusion in collaboration with all San Francisco communities." SFDPH MHSA is in direct partnership with the SFBHS OESM in our efforts to increase equitable access to high-quality mental health care for all. Examples of our recent collaborative efforts include: enhanced community outreach, strengthened program outcomes data collection, a BHS Equity Learning Series and Equity Training Plan, and the implementation of a BHS 5 Year Workforce Development Plan focused on promoting equity in the SF BHS workforce.

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.

Jessica Brown, MPH
Director, San Francisco Mental Health Services Act

Remembering Our Beloved Peers

The San Francisco Department of Public Health Mental Health Services Act team is dedicated to supporting our clients and consumers – through direct mental health services and workforce training – so that they can achieve wellness and live independent, productive, and meaningful lives. We have learned that by designing our programs so that they offer direct employment to MHSA clients/consumers, we can better assist the individuals we serve in reaching these outcomes. These peer employment positions can be found at all levels in our programs, including peer mentors, health promoters, community advocates, workgroup leaders, and managers. Not only do these peer employees find meaningful employment opportunities through our programs, they develop meaningful connections with our clients and offer them a valuable and unique perspectives on the journey to wellness. Each of our peers create a lasting impression and make a difference in the lives of our clients, as well as our staff. This past year, we are remembering three of our peers who passed away as we honor their memory.

Ruby Yee

Ruby Yee was a well-loved and important member of the Hire-Ability Clerical team. Moving from our IT vocational program into the Forms Department, she was immediately a well-equipped and welcome addition to our close-knit family. She came into her role and immediately captivated the team with her bubbly personality and kindness. She would gush over her dog and her family and fiercely root for the Warriors while creating strong connections with the variety of individuals she came in contact with at BHS. Her passing was devastating to the team but more so than the pain of her untimely death. The memory of her smile and laugh resonates in our hearts.

> "Ruby had a heart of gold."
>
> - Peer/Friend

Joi Kendricks

Joi Kendricks was an incredibly independent individual who was well-known throughout the Behavioral Health network. Not afraid to be outspoken, she would quickly find herself as the life of every party she would partake. Yet despite her social and outgoing personality, she could just as easily draw you in and truly make you feel that you are the only person in the room. Emanating warmth and love, Joi would never hesitate to ensure that you, as an individual, were in a safe and happy environment. Joi will be missed by her coworkers and, most importantly, by the variety of clients she touched.

> "Joi had a green thumb. She loved to be surrounded by plants."
>
> - Peer/Friend

Zane Burton

Zane Burton was very loved by his co-workers and friends at the SF-FIRST FSP program. He always reminded us to, "Suit up, boot up and show up". He would always say, "Let's give him a round of applause" to keep the team motivated, and cheer for team and co-worker accomplishments. He was our cheerleader. He always encouraged us to keep going and feel pride in the work we do, and to see the positive impact we have on SF-FIRST enrolled clients. He truly was a team player with a huge heart. He was able to engage with clients that other people had a hard time connecting with. He always said "failure to plan is planning to fail" to stress the importance of having a strong, solid plan to meet the needs of our clients. Zane was such a dedicated worker that he was able to secure a position as a County SFDPH employee. Zane will be missed by many people in the San Francisco community.

> "Zane was welcoming, warm, and had a wonderful laugh."
>
> - Former Supervisor/Friend

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.

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 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 and community members 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.

Mental Health Matters Day in Sacramento 2019 with MHA-SF Peers

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.

MHSA Community Program Planning Meeting at City Hall, September 2019

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 most densely populated large city in California (with a population density of 17,352 residents per square mile) and the second most densely populated major city in the United States, after New York City. Between 2011 and 2018, the San Francisco population grew by almost 8% to 888,817, outpacing California's population growth of 6% during this same time period. By 2030, San Francisco's population is expected to grow to more than 980,000.

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 20% 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, population growth is expected for all races and ethnicities except for Black/African American populations. Asian and White populations are expected to remain the most populous groups and will grow as a percentage of the overall population. Population growth is expected to be lower for Latinx and Pacific Islanders.

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 9,784 homeless individuals reside in San Francisco due to a count taking place in 2019. 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 has a relatively small proportion of households with children (19%) compared to the state overall (34%), the number of school-aged children is expected to grow by 24% by 2030. However, In addition, it is estimated that the population of individuals over the age of 65 will increase – from 17% in 2018 to 21% in 2030 and persons 75 and older will make up approximately 11% of the population. During the same time, it is estimated that the population of working age residents (ages 25 to 64 years) will decrease from 61% in 2018 to 56% in 2030. This shift could have implications for the provision of social services.

For additional background information on population demographics, health disparities, and inequalities, see the 2019 San Francisco Community Health Needs Assessment located at https://www.sfdph.org/dph/files/hc/HCAgen/HCAgen2016/May%2017/2016CHNA-2.pdf.

Mental Health San Francisco Legislation

On December 12, 2019, the City and County of San Francisco passed new legislation to establish Mental Health SF, a mental health program designed to provide access to mental health services, substance use treatment, and psychiatric medications to all adult residents of San Francisco with mental illness and/or substance use disorders who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. This legislation also calls to establish an Office of Private Health Insurance Accountability to advocate on behalf of privately insured individuals not receiving timely and appropriate mental health care under their private health insurance. Lastly, the legislation must establish the Mental Health SF Implementation Working Group to advise the Mental Health Board, the Department of Public Health, the Health Commission, the San Francisco Health Authority, and the Board of Supervisors on the design and implementation of Mental Health SF.

While this legislation was born out of a growing concern about San Francisco clients experiencing homelessness, we feel that the legislation outlines a vision that will benefit all of our staff and clients. This legislation was heavily informed by leaders and countless stakeholders that have been digging deep to understand our system's challenges and to identify solutions. We feel this legislation references the real challenges we all see in our system and those that our staff and clients face every day. We also believe the stated values and principles resonate with San Francisco Mental Health Services Act.

The implementation of this legislation and determining how to allocate new funding will be a top priority for San Francisco leadership over the next few years. We look forward to learning more about Mental Health SF and how SF-MHSA can contribute to its successful implementation. We will have more information to report as this program unfolds and we will provide updates in subsequent MHSA Annual Update reports.

San Francisco Behavioral Health Services Office of Equity, Social Justice, and Multicultural Education

In early 2019, Behavioral Health Services (BHS) announced the creation of the Office of Equity, Social Justice, and Multicultural Education (OESM).

Vision of OESM

"All communities within San Francisco will have equitable access to high-quality mental health care and substance use treatment, delivered by a highly skilled and empowered workforce reflective of the communities served."

This new office now supports the operations of the following BHS programs: Cultural Competency, Workforce Development and Wellness, BHS Training, Communications, and Community Outreach. Collectively, these programs work with our community and stakeholders to advance equity and promote diversity and inclusion for all - including BHS consumers, service providers, and staff. The OESM works towards developing and providing high-quality culturally and linguistically appropriate services.

As the SFDPH MHSA department is now partnered directly with the OESM, the SFDPH MHSA team is working to ensure that our goals and priorities listed in the 2020-2023 Program and Expenditure Plan align with the mission and vision of OESM. In November 2019, the SFDPH MHSA team met to develop and refine our departmental goals for the coming year, with a keen lens on aligning these efforts with the overarching vision and mission of the OESM. Some of the priority goals included: enhancing our programmatic data tracking in effort to better identify and understand the needs of our underserved populations; provide training and technical assistance to our service providers in cultural competency and ongoing data tracking efforts; continue to leverage our Community Program Planning efforts – from conducting focus groups and other community outreach to increasing transparency of how community feedback is incorporated into future program planning and program improvement efforts. Another priority area identified by the SFDPH MHSA team was to improve our Innovations programming, from incorporating community feedback into new Innovations program proposals through a robust and transparent process, to assisting interested applicants through the Innovations proposal process, and developing transition plans for Innovations programs whose funding is sunsetting. Other examples of SFDPH MHSA's collaboration with OESM includes the BHS Workforce Plan, behavioral health analysis and education pertaining to diagnosis by race and age groups, and the Online Learning Management System. Please see below for more details about these exciting projects.

Mission of OESM

"Advocate for policies and practices that promote diversity, equity and inclusion in collaboration with all San Francisco communities."

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 ongoing CPP activities listed in Exhibit 1, MHSA hosts 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 8, 2019, as lime green is recognized as the official color of mental health awareness. Stigma Busters is a consumer-led committee that meets regularly to plan and promote stigma reduction activities throughout the San Francisco community.

The SF DPH BHS Stigma Busters also campaigned in honor of Suicide Awareness Month in September, Stigma Busters disseminated Each Mind Matters' "Know the Signs" campaign materials to providers, cafes, businesses, and community members. The materials were shared to promote awareness and inform the public on how to identify the signs of suicide and what resources are available to those in crisis.

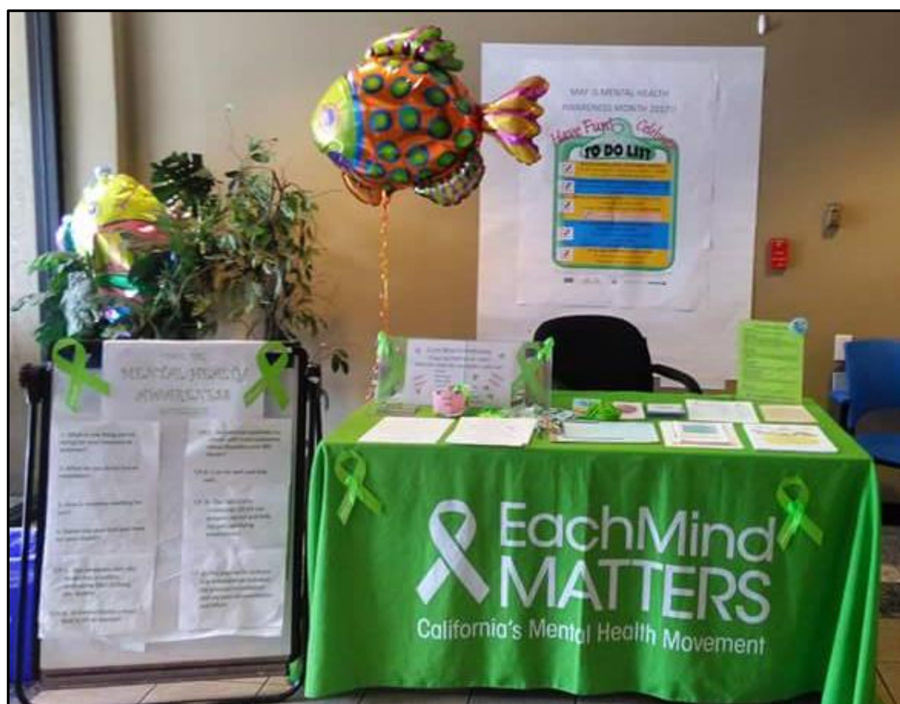
These events help spark conversations about mental health needs and increase awareness of wellness and recovery services in our community.

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 provides up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The webpage is now hosted through the San Francisco Department of Public Health website.

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.



SF DPH MHSA Table at the Each Mind Matters event in 2019

MHSA Advisory Committee & Our Commitment to Consumer Engagement

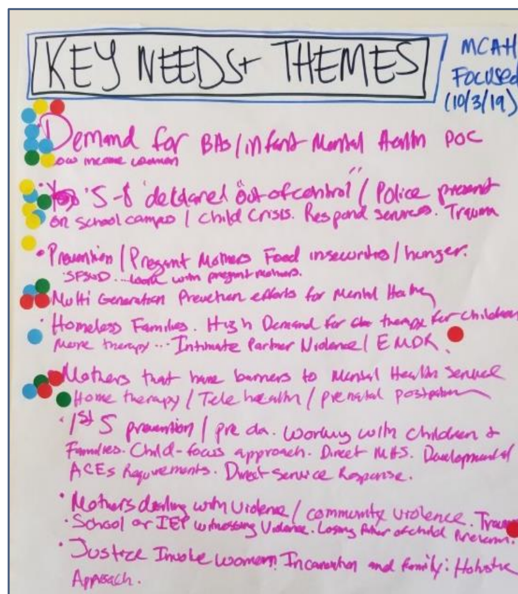
MHSA Advisory Committee

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 2019, the MHSA Advisory Committee meeting schedule was as follows: 3/13/19, 6/12/19, 9/11/19 and 12/11/19. 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 FY2020-23 Three-Year Integrated Plan
- Innovation planning for potential new learning projects
- The new Innovation Project Proposal Process
- 2019 Vocational Summit planning
- Transition Age Youth System of Care activities
- New MHSA Legislation
- Full-Service Partnership (FSP) planning
- MHSA Program Implementation
- MHSA Budgeting
- Provider and Community Networking
- Request for Qualification (RFQs) planning
- Annual Consumer, Peer and Family Conference
- Annual MHSA Awards Ceremony
- PEI and INN regulations and reporting protocol
- MHSA Mid-Year and Year-End Reporting
- Highlights and Spotlight programs
- No Place Like Home initiative
- MHSA evaluation efforts and performance objectives
- PEI and INN regulations and reporting protocol



Increasing Consumer Engagement with the SF BHS Client Council

MHSA has been working to foster a stronger collaboration with the San Francisco Behavioral Health Services 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 2019, the Client Council has continued providing program planning input and feedback to the SF Behavioral Health system, including advising on the implementation of the MHSA Innovation Tech Suite project, as well as the transition of ending the MHSA First Impressions program as an Innovations-funded program and moving forward to preserve the program under a more permanent stream of MHSA funding. The Client Council has also provided advocacy support to keep Adult Residential Facilities open, has provided feedback on materials, including designing improvements for client educational materials on alcohol use for a system-wide improvement project.

Strengthening Relationships

MHSA engages with various oversight bodies, including the SF Behavioral Health Commission 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 Behavioral Health Commission in order to gather valuable feedback regarding MHSA strategies, including policy development, program development, implementation, budgeting and evaluation. The SF Behavioral Health Commission has been closely involved since the initial development of MHSA in San Francisco. The Commission 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 Commission at every monthly board meeting in order to keep them abreast of new developments and activities. The Commission includes special active members as well as members with personal lived experience with the mental health system. The SF Behavioral Health Commission 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 2020-2023 Plan

As part of the 2020-2023 MHSA Program and Expenditure Integrated 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. As a result of direct stakeholder feedback, we expanded our CPP outreach efforts in 2019 and we standardized processes for better prioritizing community needs. 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. SFDPH 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.

The SFDPH MHSA team has placed a sharp focus on engaging with the community through CPP efforts in recent years and in 2019 the team has demonstrated organization and efficiency in meeting the needs of our community members so that their feedback is captured and integrated into our program improvement efforts through a transparent process. Meeting announcements, participant registration, open communication, thorough note-taking, and follow-up efforts lead to successful and meaningful community participation in our program planning efforts. As a result of this success, the SFDPH MHSA team met with a more diverse group of stakeholders and community members than in previous years, including individuals from: the SFDPH Population Health Division; The SFDPH Maternal, Child, and Adolescent Public Health Nurses; the SF Black/African American Health Initiative; the SF Black Employee Alliance; the SFDPH Office of Equity, Social Justice, and Multicultural Education; the SF Police Department; the SF Department of Public Works; the SF Municipal Transpiration Agency; SF Probation and Reentry Services team; the SF Department of Technology; SF General Hospital; UCSF Pre-term Birth team; SF Mental Health Patients' Rights Advocates; and many other members of our community. Another new addition in 2019 included a new focus on our Prevention and Early Intervention (PEI) programming so that our community can better understand the unique purpose and requirements of PEI programming within MHSA.

MHSA staff presents at 2019 CPP meeting on SF Housing Needs

Community and Stakeholder Involvement

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

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 2019, **MHSA hosted 19 community engagement meetings across the City** to collect community member feedback on existing MHSA programming and better understand the needs of the community and to develop this MHSA Three-Year Plan. 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 stakeholder groups, including local veterans, Transition Age Youth, vocational program participants, the Older Adult community, the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) community, primary care and medical staff, employees of municipal agencies and law enforcement.

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 2019 CPP meetings are listed in the following table.

2019 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group**
March 13, 2019	MHSA Advisory Committee Meeting SF Public Library,100 Larkin Street, San Francisco CA 94102
April 3, 2019	BHS Workforce Development Programs City College of San Francisco, 50 Frida Kahlo Way, San Francisco, CA 94112
April 8, 2019	Provider staff from Roadmap to Peace Instituto Familiar de la Raza and Bay Area Community Resources 2929 19th Street, San Francisco, CA 94110
April 22, 2019	Asian & Pacific Islander Mental Health Collaborative Samoan Community Development Center 2055 Sunnydale Ave, San Francisco CA 94134
June 12, 2019	MHSA Advisory Committee Meeting 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102
September 11, 2019	MHSA Advisory Committee Meeting 1380 Howard Street, San Francisco, CA 94103

2019 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group**
September 19, 2019	Mo'MAGIC Meeting African American Arts & Culture Complex 762 Fulton Street, San Francisco, CA 94102
October, 3, 2019	City & County Workforce Meeting 6th Floor Conference Room 25 Van Ness, San Francisco, CA, 94102
October 4, 2019	SF Behavioral Health Services Providers Meeting Atrium Conference Room 1 South Van Ness, San Francisco, CA 94103
October 11, 2019	Trans Women of Color San Francisco Community Health Center 730 Polk St, San Francisco, CA 94109
October 15, 2019	B'MAGIC Meeting Joseph Lee Recreation Center 1395 Mendell Street, San Francisco, CA, 94124
October 30, 2019	Individuals with history of criminal justice system-involvement Community Assessment and Services Center (CASC) 564 6th Street, San Francisco, CA 94103
November 5, 2019	MHSA consumers and family members (Spanish-speaking) Excelsior Family Connections 5016 Mission Street, San Francisco, CA 94112
November 7, 2019	African American/Black, Latino/x men who have sex with men 25 Van Ness, Rm 330A, San Francisco, CA 94102
November 14, 2019	SF State University and City College San Francisco students Towers Conference Center 798 Font Blvd, San Francisco, CA, 94132
November 19, 2019	SF BHS Client Council and MHSA consumers Peer Program Planning and RFQ Implementation 1380 Howard Street, San Francisco, CA 94103
November 23, 2019	MHSA consumers, family members, and community members from the Chinese community Kaiser Permanente, 4131 Geary Blvd., San Francisco, CA 94118
December 2, 2019	Individuals experiencing homelessness Including veterans and the trans community SF Main Library, 100 Larkin St, San Francisco, CA 94102
December 11, 2019	MHSA Advisory Committee 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 2020-2023 Program and Expenditure Plan and inform future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the MHSA 2020-2023 Program and Expenditure Plan.

Community and Stakeholder Feedback

> ***"An ounce of prevention is worth more than a pound of cure."***
>
> **- Community Member**

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.

Community and stakeholder feedback in 2019 was scheduled around existing community meetings with service providers, the MHSA Advisory Committee, and other community partners. Community feedback collected in recent years continues to frame MHSA outreach and engagement efforts. For example, as noted in the FY19-20 MHSA Annual Update report, San Franciscans continue to express a desire for diverse service providers and more intentional efforts to address systemic barriers related to housing, workforce development, and education. Given the importance of these social determinants of health for the mental health of our communities, the key findings below focus on some of the main systemic barriers to economic stability and mental well-being, particularly around housing, incarceration, and the workforce. MHSA community outreach and engagement in 2019 also focused on the needs of specific populations who had previously reported substantial additional barriers affecting mental health. These include certain racial and ethnic populations (Asian and Pacific Islanders, Black and African Americans, and Latinx), gender and sexual minorities, individuals affected by homelessness and/or incarceration, populations related to age and the life-course (transition age youth and maternal, child and adolescent health).

The below feedback was collected from service providers, SFDPH consumers, community members, and other stakeholders in 2019. As described above, the conversations that solicited this feedback were designed based on feedback collected in recent years. 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. Additionally, many strategies for improving mental health that arose from these meetings addressed specific populations or facets of the life course (e.g., aging, education). For this reason, the feedback below is organized into different categories based on the setting in which the feedback was solicited and the cross-cutting social determinants of health identified at these meetings. 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 Certain Racial and Ethnic Populations

Asian and Pacific Islanders

- Data collection can be challenging if trust isn't built with clients during initial meetings. Some community members prefer to visit traditional/cultural temples for blessings and at times simply do not want to visit mental health resource centers.
- Continuing barriers for these community groups relate to language barriers, lack of trust with government systems, and fear of losing immigration status.

- Clients prefer appointments with a community member, advocate, or translator who speaks and understands their language and culture. Language barriers persist especially for the Vietnamese and Laotian communities.
- Community groups recommend the increase of funds to add program staff and especially to improve activities directed to youth.
- Chinese community members expressed that housing and intensive care management for individuals with mental illness (especially adult children) is difficult. A livable wage and housing cost reduction would allow at least one adult to stay alongside the child.
- Other innovative solutions included home visits by social workers and quality drop-in services (day care) to gain skills (personal hygiene; communication; exercise) and basic support (medical compliance; nutrition; coping with stress).

Black/African Americans

- The greatest need is for mental health providers and diversity in the mental health workforce. Community members brainstormed about the need to incentivize people of color working in the mental health sector.
- In particular, beyond recruitment, the community advocated for funding projects to resolve retention issues at all position levels.
- Providers need to deliver culturally-responsive services, especially in neighborhoods with deep cultural vibrancy (e.g., Bayview-Hunters Point).
- Community members voted to prioritize innovative ideas and mentorship programs received the most votes and support from the group.
- Additionally, training school staff and teachers about restorative justice might open the opportunity to discuss trauma-informed methods that particularly affect the Black/African American communities.

> ***"I'd like to see programs that address racism. Programs are impacted by racism as well as providers."***
>
> **- Community Member**

Latinx Communities

- Latinx parents express the need for more intentional services, care, and education for members experiencing a disability, co-morbidity, and economic distress.
- Women who experience physical and emotional abuse require a higher level of care.
- Language barriers, concerns about legal status, clarity about how to access necessary services and cultural stigma were discussed as the key barriers to addressing mental health in the Latinx community.
- The participants agreed that specialized outreach services may be necessary to improve mental health in this community. In particular, women, undocumented youth, and new migrants need to be brought into contact with potential service providers.

Needs of Gender and Sexual Minorities

- Trans women expressed the need for more intentional providers who are aware of their life circumstances and challenges. Their approach should be intersectional and recognize complexity of identities.
- An innovative idea put forth by the group was a resource guide that provides information on all available services. Additionally, they would like to see the continuation of peer groups and chats.
- Members of the transgender community stated the importance of streamlined services (eliminate paperwork and gatekeepers; increase safety measures) and added services (educational and job entry programs) to advance mental health.
- One huge problem identified relates to fatal interactions with police - especially with trans women of color. Accountability of the San Francisco Police Department (SFPD) is

required and intentional sensitivity trainings for police could improve future interactions.

- Black+Latinx men-who-have-sex-with-men (MSM) presented innovative ideas to bring health support into community-trusted environments such as the Barber shop, wellness center, and the Boys and Girls Club. Another major point of emphasis included the importance of messaging and campaigning to further conversations about mental health.
- MSM of color also identified how city and country practices have played into creating worse health outcomes for black men, especially black gay men. To address these systemic barriers, the group brainstormed how changes to funding-streams, services, education pathways, career-focused opportunities, and partnerships could better support Black/African American and Latinx sexual minorities.

Needs of Individuals Affected by Homelessness and Incarceration

- Supportive housing programs need more intensive support (peer-based; mobile/street medicine; readiness for independent living; housing and moving support; intervention services with on-site case managers who have capacity to see patients) and modifications (allow for immediate access, remove black listing; support case managers) to the shelter system.

> ***"We should have resources available and provide support on a regular basis around life skills. This helps clients be healthier and more capable."***
>
> **- MHSA Stakeholder**

- For people experiencing homelessness, better access to mobile psychological and medical services and immediate access to mental health services and respite care can end vicious cycles of emergency department visits.
- Not all veterans are eligible for VA hospital benefits, so veterans need to be better targeted for connections to housing services.
- Due to the high turn-over of staff addressing the high-need population of people experiencing homelessness, recruitment and retention policies should be re-evaluated along with adequate training and salary.
- Relatedly, peer-mentorship would be helpful for getting people ready to access services. Hire more people who have been through mental health programs and have experienced homelessness. Staff should represent members from the community.
- San Franciscans with housing struggles expressed that services need to be more flexible with rules. Paperwork can be overwhelming. Special attention needs to be put on folks experiencing transition into or out of homelessness.
- For individuals involved in the Justice System, specialized pathways to vocations post-release were identified as most rewarding. Programs could be structured around certificate programs/apprenticeships. They could provide educational certificates and job coaching to eventually lead to long term employment.
- Individuals negatively impacted by incarceration highlight access to services including therapy, peer programs, and early intervention groups as the biggest mental health needs.
- This group also emphasized the importance of early intervention for youth prior to incarceration.
- Other major needs identified included the necessity for counseling, proper medication, and professional

> ***"We need more people who have walked-the-walk and can talk-the-talk to give back to those younger offenders still caught up in the system."***
>
> **- Community Member**

vocational programs.

Needs of Age and Life-course Populations

Students and Transition Age Youth (TAY)

- For students and youth, relatable mental health services and resources must address depression, anxiety, social anxiety, and stress. These programs should be accessible for the lifestyles of youth (e.g., evening, online, crisis-hotline).
- Food and housing insecurity exacerbates mental health needs and interferes with academic goals for students. Better dissemination of services, support, and knowledge of DPH could ameliorate these stressors.
- Trauma-informed and supportive care can address longstanding trauma needs. Care needs to flexible to address situational context (e.g., immigrant, or youth experience).
- TAY that suffer from substance abuse need more affordable resources. Providers should also consider how TAY struggles cause consequential damage to parents.
- Inter-generational efforts should be considered to end the cycle of poverty and provide additional supports to the younger generations.

> ***"How do we talk [to youth] about a way to cultivate healthy relationships when it's so fast-paced and confusing?"***
>
> **- Service Provider**

Maternal, Child, and Adolescent Health (MCAH)

- Mothers in need of psychiatric services are not able to afford therapy.
- Many young mothers also experience language barriers for services due to the lack of diverse mental health specialists.
- In addition to the need for consistent, affordable mental health services, new mothers would benefit from educational programs related to life-skills and workforce development.
- Facilities and programs should to be innovative in ways they reach pregnant women and new mothers. One potentially beneficial strategy would be greater investments to support home visits.
- The community group discussing MCAH issues identified an opportunity to collaborate with the San Francisco Unified School District (SFUSD) and programs like Our Children Our Family and First 5.

Needs Related to Workforce and Educational Development

- Employment pathways are particularly beneficial for individuals experiencing homelessness and those recently released from prison. Job readiness and job retention support should be key considerations for these communities.
- Rapid response funds can make vocational engagement/workforce development more effective by reducing clients' wait time to receive employment services.
- Teaching clients basic life-skills (by integrating this aspect into existing programs) can help clients be more capable and independent. This will improve both self-sufficiency and well-being.
- The Educational Entertainment project provides an opportunity for workforce development via stipends/internships. Community members stressed that the project should aim to destigmatize mental health; partner with Community Based Organizations and schools and utilize social media for mental health messaging and project promotion. It should also utilize language, characters, and mediums that are representative of the Black/African American experience that all audiences, especially youth, can relate to.

- Topics in this project can address: what it's like to be a young person now; how to think differently about mental health; how to navigate relationships with family, peers, and between different generations; share lived experience and stories of wellness and recovery; address sexual & gender based violence; and consider how mental health intersects with gender, health, and class.
- Outreach around the project can entail: providing therapeutic services for those affected by violence, organizing pop-up shops (services) in the community, integrating mental health services into existing community spaces (like clubs or churches), meeting people where they are, and having a wellness in the streets program for youth.

Feedback that was Consistent in Previous Years

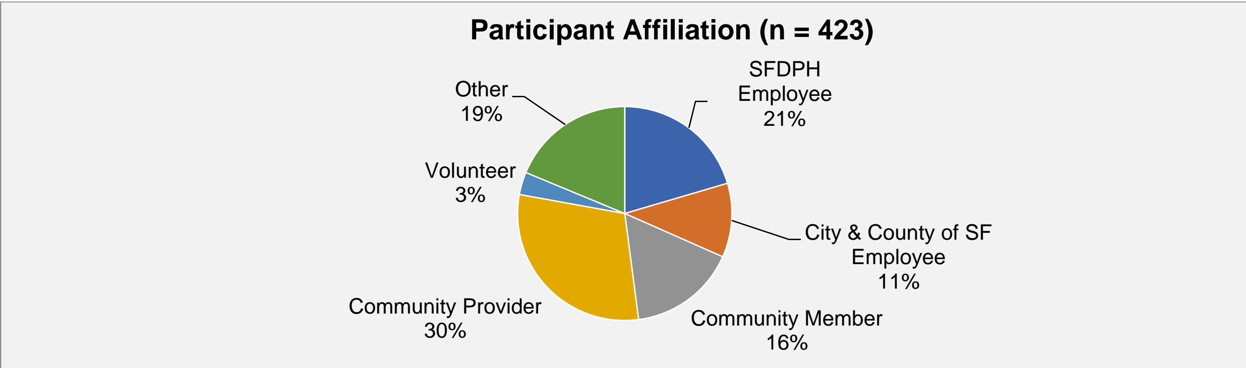
While most of the community feedback was new and innovative, we did find common themes in comparison to the CPP feedback provided in previous years. We find it important to analyze input provided in the past to determine our progress of meeting the needs of the community and to determine a plan for addressing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

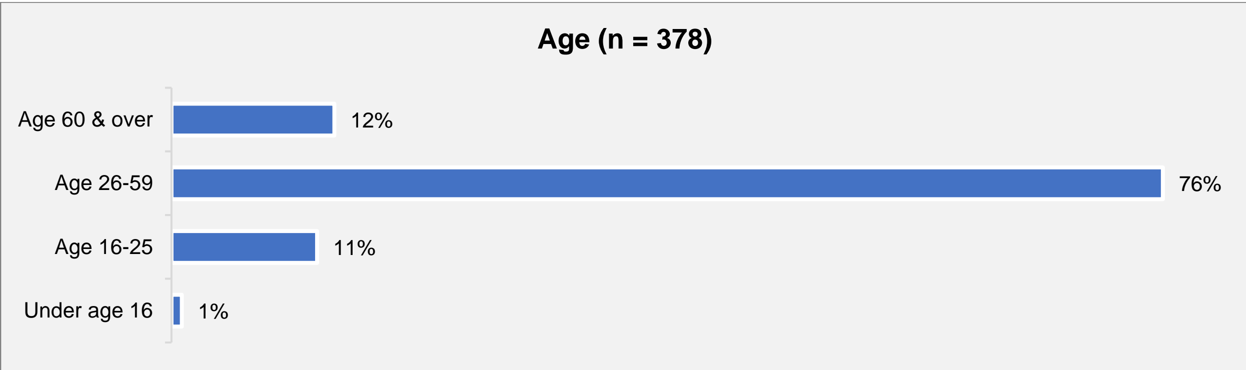
- Community members from all different cultures and backgrounds expressed a need for a more diverse workforce addressing mental health needs. This would address existing language barriers and provide more culturally responsive care for diverse San Franciscans.
- TAY and the adults who love and support them continue to express a need for positive adult role models and mentors.
- Service providers need to understand where trainings are available for the LGBTQ+ (lesbian, gay, bi-sexual, transgender, queer, questioning, and more) community. Both service providers and clients want a better understanding of navigating referral and service linkage.
- Just as in previous Annual Update reports, community members continue to ask service providers where they can get housing supports and providers have limited resources to share.
- The need for community education and stigma reduction around behavioral/mental health is important, particularly regarding cultural and linguistic needs.
- The need for a clear understanding of what behavioral/mental health (MHSA-funded) programs and services already exist and improved methods for navigating these resources.
- More intentional collaboration is needed across different city departments to make it easier for clients to access necessary services, especially for people experiencing homelessness.

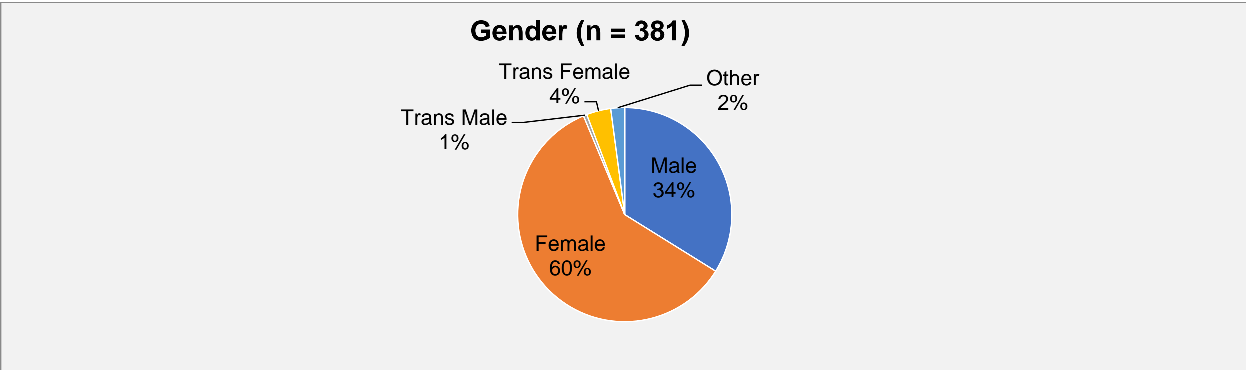
CPP Focused on the Needs of Trans Women of Color

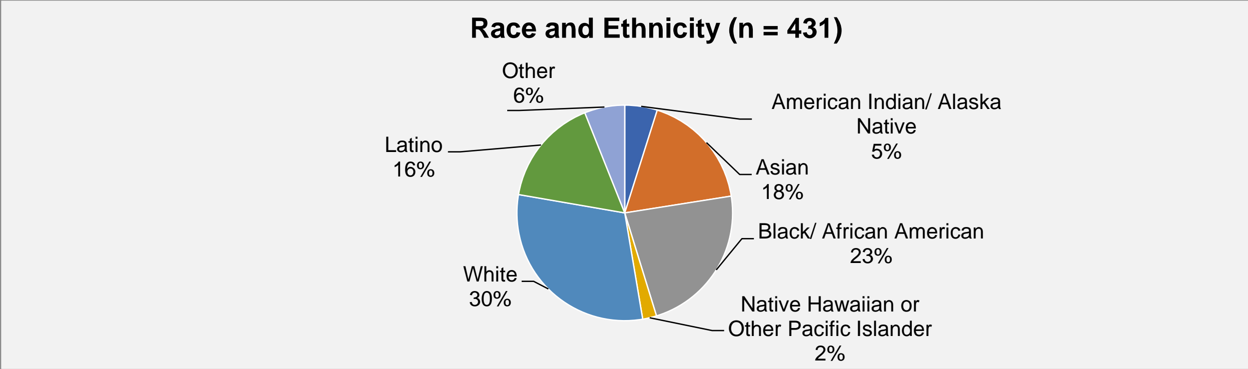
CPP Meeting Participation

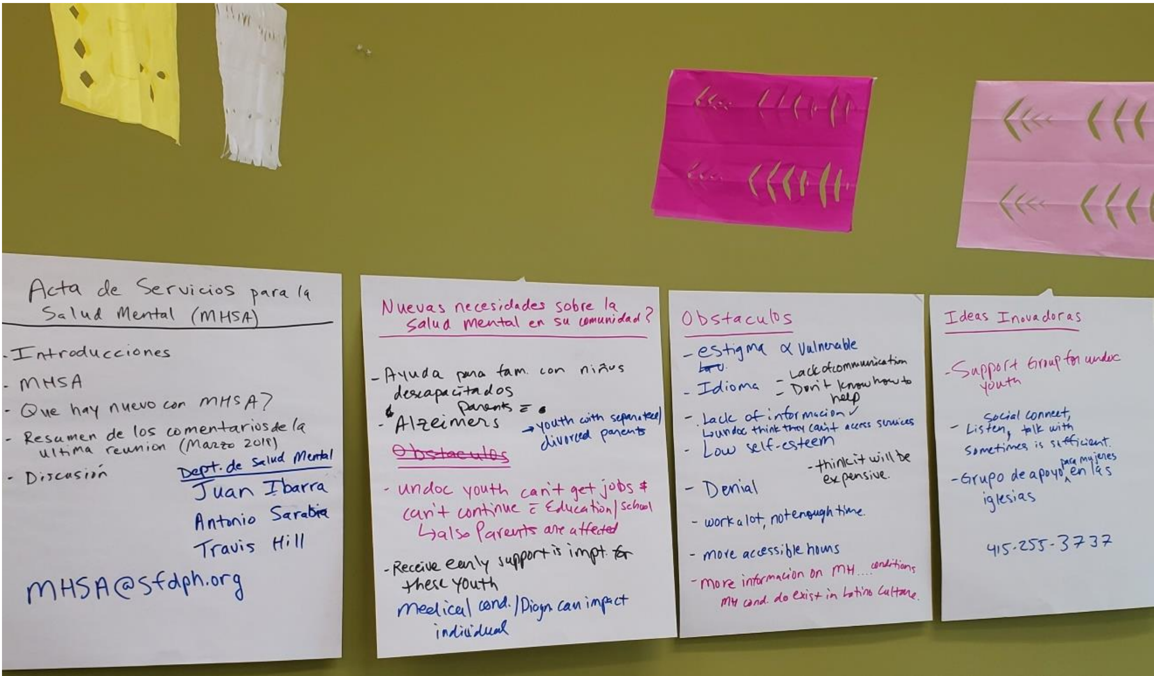
Over 430 people participated in the MHSA community meetings held in 2019.
Of those attendees, MHSA staff collected demographic data on 431 individuals and those data are reflected in the charts below. Please see participant demographics for 2019 below.











Example flip chart notes from a CPP meeting

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.

- Building Maintenance, Construction and Remodeling Vocational Program
- Wellness in the Streets

- Culturally Relevant Mental Health Promotion and Early Intervention (PEI) Services for Filipino, Samoan and Southeast Asian Communities
- Online Learning Management System

SF BHS and MHSA intend to collect stakeholder and community input to develop and issue the following RFQs in the coming year:

- Peer-to-Peer Behavioral Health Services
- Full-Service Partnership (FSP) SPARK
- Vocational Rehabilitation Services (7 vocational programs)
- Faces for the Future
- Peer-to-Peer Employment Services & Peer Specialist Mental Health Certificate program
- Mental Health Certificate Program
- Black/African American Wellness and Peer Leaders (BAAWPL)

In addition to these specific programs for which the SFDPH MHSA team is soliciting feedback, we also included some discussions on how contracting with service providers invites opportunity for community and stakeholder feedback in program design and improvements through our CPP meetings. These conversations focused more generally on contracting with SFDPH MHSA, as well as our enhanced data collection and evaluation, and service provider training initiatives. We presented this information to increase awareness among the community of these contracting opportunities and how our contracts are developed in collaboration with service providers, peers, service navigators, individuals with lived experience and family members.

November 2019 CPP Meeting and Cultural Celebration

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 352 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 the 2020-23 Program & Expenditure Plan

The SF DPH MHSA 2020-2023 Program and Expenditure Plan was developed in collaboration with MHSA consumers, peers, family members, service providers, local residents, and other stakeholders. The SF DPH MHSA community outreach and program planning efforts were coordinated by a core team of MHSA staff, which included the MHSA Director and Program Managers. Independent consulting firms, Hatchuel Tabernik & Associates and Harder + Company Community Research, provided assistance with program outcome data analysis and reporting.

In the planning work conducted for the 2020-23 Plan, the MHSA team incorporated the stated goals of the Mental Health Services Act, the mission of the San Francisco Department of Public Health, and revisited our local MHSA priorities and needs identified in our 2017-2020 Program and Expenditure Plan and subsequent Annual Update Reports. Most importantly, the Community Program Planning (CPP) strategies outlined in the previous section of this report enabled the MHSA team to identify and integrate direct program feedback from the individuals we serve, and the greater community, in planning for future MHSA programming. In addition to incorporating community feedback into our planning process, the MHSA team relied on several other strategies to inform future program improvements, including:

- Reviewing the previous three-year Program and Expenditure Plan (2017-2020) and the subsequent MHSA Annual Update Reports submitted for each MHSA component. This was done to understand how well priorities identified in those plans have been addressed and determine if all programs had been implemented as originally intended.
- Reviewing MHSA regulations, laws and guidelines released by the State (e.g., Department of Mental Health, Mental Health Services Oversight and Accountability Commission, California Housing Finance Agency, and new IMHSA Innovations and Prevention and Early Intervention regulations) to ensure all required reporting information is incorporated in this plan.
- Reviewing informational materials produced by California Mental Health Services Authority, California Mental Health Director's Association, and Office of Statewide Health Planning and Development.
- Reviewing MHSA Annual Year-End Program Reports and demographic data submitted by SF DPH contractors and civil service providers.
- Conducting program planning with service providers and consumers through robust contracting efforts throughout the Department.

Local Review Process

Our Community Program Planning process offers a number opportunities for consumers, peers, family members, service providers, community members, and other stakeholders to share their input in the development of our planning efforts, learn about the process of our MHSA-funded programs, including the role of the MHSA Advisory Committee, BHS Client Council, and other community engagement meetings. Please see the components on MHSA Communication Strategies and MHSA Advisory Committee for a specific list of meeting dates and topics in above sections.

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 2020-23 Program and Expenditure Plan was posted on the MHSA website at www.sfdph.org/dph. **The FY2020-23 Program and Expenditure Integrated Plan was posted for a period of 30 days from February 6, 2020 to March 9, 2020.** 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 FY2020-23 Program and Expenditure Integrated Plan		
Community Member	**Summary of Comments**	**DPH Response**
Joe Ramirez-Forcier, Positive Resource Center	Stakeholder reported that it would be great to see more programming specific to the HIV positive and older adult communities who live with mental health challenges, and those that are homeless and live with mental health challenges.	DPH was thankful for the feedback and let the stakeholder know that this feedback will be used in the community program planning process moving forward.
Isaac Teckie, Community Member	Community member requested an extension of the 30-day posting.	DPH thanked the community member for the feedback and request, however, the request was denied as SF-MHSA has a tight timeline to obtain BOS approval and submit the final Three-Year Plan to the State by 6/30/20.
Isaac Teckie, Community Member	Community member provided a follow-up question asking to review previous Innovations Proposal Applications.	DPH informed the community member that this was the first time SF-MHSA requested Innovations Proposal Applications so, unfortunately, there are not any previous applications to review.

Summary of Public Comments on the FY2020-23 Program and Expenditure Integrated Plan		
Community Member	**Summary of Comments**	**DPH Response**
Isaac Teckie, Community Member	Community member asked another follow-up question to inquire about the Innovations Proposal Applications and see if they are available for review by the public. Community member also asked where and how the public could access MHSA related documents.	DPH informed the community member on where/how to make a public records request with the San Francisco Department of Public Health. DPH also provided community member with the MHSA website to locate MHSA documents.
Monique LeSarre, Rafiki Coalition for Health and Wellness	Stakeholder inquired about MHSA efforts to provide training to teachers to redirect discipline actions and recognize behavioral issues as manifestations of trauma, especially involving students of color. Stakeholder also inquired about cultural sensitivity in MHSA trainings. Stakeholder also inquired about graduate level programs to try and recruit more clinicians into the BHS workforce.	DPH thanked stakeholder for her inquiries and feedback. Detailed information was provided to answer questions and provide more insight into MHSA programming.
Colleen Devine, OTTP-SF	Stakeholder noted that the Three-Year Plan addresses the unmet needs of underserved populations. Stakeholder also requested for more services that support TAY in obtaining long-term community employment.	DPH was thankful for the feedback and let the stakeholder know that this feedback will be used in the community program planning process moving forward.
Terezie S. Bohrer, Stakeholder	Stakeholder requested more information on Comprehensive Crisis Services and recommended revisions on how the relationship between SF-MHSA and the Behavioral Health Commission is described in the report. Stakeholder also recommended more specificity on the plans regarding the aging population.	DPH was thankful for the feedback. DPH let the stakeholder know that revisions will be made to the Final Three-Year Plan and this feedback will be used in the community program planning process moving forward.
Wynship Hiller	Stakeholder notified DPH after the close of the public comment period stating that he was not notified of the 30-day public comment period and requested that SF-MHSA post for another 30-day comment period.	DPH apologized for the fact that Mr. Hiller did not receive notification. DPH added Mr. Hiller to the email distribution list for future correspondence and offered Mr. Hiller an opportunity to provide public comment via email. Mr. Hiller declined this offer.

Following the 30-day public comment and review period, **a public hearing was conducted by the Behavioral Health Commission of San Francisco on May 20, 2020.** as the initial date for our public hearing on March 18, 2020 was cancelled due to COVID-19. The FY2020-23 Program and Expenditure Integrated Plan was also presented before the **Board of Supervisors Budget and Finance Subcommittee on September 16, 2020** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted the FY2020-23 Program and Expenditure Integrated Plan on September 22, 2020.**

FILE NO. 200669 RESOLUTION NO. 414-20

1 [Mental Health Services Act - Three-Year Program and Expenditure Plan - FYs 2020-2023]
2
3 **Resolution authorizing adoption of the San Francisco Mental Health Services Act**
4 **Three-Year Program and Expenditure (Integrated Plan) for FYs 2020-2023.**
5
6 WHEREAS, The Mental Health Services Act (MHSA) was passed through a ballot
7 initiative (Proposition 63) in 2004 that provides funding to support new and expanded county
8 mental health programs; and
9 WHEREAS, The MHSA specifies five major program components (Community
10 Services and Supports; Capital Facilities and Technological Needs; Workforce, Education and
11 Training; Prevention and Early Interventions; and Innovation) for which funds may be used
12 and the percentage of funds to be devoted to each component; and
13 WHEREAS, In order to access MHSA funding from the State, counties are required to
14 1) develop Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates,
15 in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and
16 3) hold a public hearing on the plan with the County Behavioral Health Commission; and
17 WHEREAS, The San Francisco Department of Public Health has submitted and
18 received approval for Three-Year Program and Expenditure Plan (Integrated Plan) for FYs
19 2017-2020 on file with the Clerk of the Board of Supervisors in File No. 170904; and
20 WHEREAS, The San Francisco Mental Health Services Act Three-Year Program and
21 Expenditure Plan FYs 2020-2023, a copy of which is on file with the Clerk of the Board of
22 Supervisors in File No. 200669, which is hereby declared to be a part of this resolution as
23 if set forth fully herein, complies with the MHSA requirements above, and provides an
24 overview of progress implementing the various component plans in San Francisco for
25 FY2018-2019 and identifies new investments planned for FYs 2020-2023; and

WHEREAS, Recently enacted legislation, AB 1467, adds the requirement that MHSA Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of Supervisors prior to submission to the State; now, therefore, be it

RESOLVED, That the San Francisco Mental Health Services Act Three-Year Program and Expenditure Plan FYs 2020-2023 is adopted by the Board of Supervisors.

City and County of San Francisco
Tails
Resolution

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

File Number: 200669 **Date Passed:** September 22, 2020

Resolution authorizing adoption of the San Francisco Mental Health Services Act Three-Year Program and Expenditure (Integrated Plan) for Fiscal Years 2020-2023.

September 16, 2020 Budget and Finance Committee - RECOMMENDED

September 22, 2020 Board of Supervisors - ADOPTED

Ayes: 11 - Fewer, Haney, Mandelman, Mar, Peskin, Preston, Ronen, Safai, Stefani, Walton and Yee

File No. 200669

I hereby certify that the foregoing Resolution was ADOPTED on 9/22/2020 by the Board of Supervisors of the City and County of San Francisco.

Angela Calvillo
Clerk of the Board

London N. Breed
Mayor

10·2·20
Date Approved

Highlights of MHSA

In FY18-19, **MHSA served a total of 50,315 individuals** through our outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic services; and service linkage efforts.

New Regulations for MHSA
SFDPH MHSA intends to adhere to all new regulations and legislation. For example, Senate Bill 389 was recently approved by Governor Gavin Newsom on August 30, 2019. This bill amends the Mental Health Services Act to authorize the counties to use MHSA moneys to provide services to persons who are participating in a pre-sentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision, or mandatory supervision.

SFDPH MHSA is in compliance with this new Senate Bill with the implementation of our MHSA-funded Assisted Outreach Treatment (AOT) program. Please see the Recovery-Oriented Treatment section below for more details on this program.

9th Annual MHSA Awards Ceremony
On September 24th at the San Francisco Scottish Rite Masonic Center, around 300 of our SFDPH MHSA Peers were acknowledged for their achievements in recovery. The theme of this year's awards ceremony was "Puzzling Our Pieces," which reflects the many elements of our peers' wellness and recovery journeys.

MHSA Achievement in Recovery award recipients are nominated by their fellow peers or SFDPH MHSA service providers to acknowledge their efforts in advocacy, employment, independent living, pursuit of educational goals, financial independence, reducing the impact of substances, addressing legal issues, and/or improving their physical health. Each awardee is welcomed onstage, gifted a medal and certificate, and treated to a live comedy & music performance, as well as a community-building lunch.

The 2019 MHSA Peer of the Year, Nancy Esteva, was awarded for her outstanding efforts in the previously mentioned areas. Ms. Esteva provides services to monolingual immigrants. The 2019 MHSA Peer Impact Award went to Demetria Gigante for her dedication to serving other peers who are seeking wellness.

Staff Updates
In FY18-19, a number of staffing changes occurred in the MHSA division, including:

- SFDPH MHSA welcomed the new MHSA Director, Jessica Brown, MPH in September 2019. Previously, Ms. Brown served as the manager of Training and Workforce Development for the SFDPH Population Health Division, Center for Learning and Innovation, managing and coordinating the Center's internal capacity-building program and activities. She also served as the Director of the Center's Summer HIV/AIDS Research Program. Prior to her arrival at SFDPH, she worked in various capacities at the California Department of Public Health. She earned her Master's degree in Public Health from San Jose State University.
- Juan Ibarra, Epidemiologist and MHSA Evaluator, served as Interim MHSA Director prior to Ms. Brown's arrival in September.
- Anthony Sarabia began working as the RAMS Vocational Intern in February 2019.
- SFDPH BHS/MHSA recently filled the Training Position as of January 2020.
- SFDPH MHSA has a vacant Vocational Specialist position as of February 2019.

SFDPH MHSA Innovations Projects

Innovations (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 six INN Learning Projects integrated throughout the seven MHSA Service Categories. These include:

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

New Innovations Projects

The SFDPH MHSA team designed streamlined Innovations proposal forms that were created to outline the process for the selection of new Innovation project ideas and simplify the proposal submission of “innovative” project ideas from the community. The MHSA Advisory Committee Meeting held a Community Program Planning meeting on June 12, 2019 to design the new Innovation Project Process document and an Innovation Project Idea Form. These documents, which include the state regulation criteria for Innovation programs and steps for local and state approval, were also emailed to MHSA Stakeholders to collect additional feedback. As a result of the feedback collected, a Frequently Asked Questions document was created to provide clarification on the Innovation idea, application, and project approval processes. A request for the submission of project ideas using the Innovation Project Idea Form was distributed to MHSA Stakeholders on October 7, 2019. The ideas received will be the basis for possible new Innovation programs in the coming years.

A total of 27 Innovations Proposal forms were received in December of 2019 and reviewed by a BHS/MHSA selection committee in consultation with BHS leadership. The selection committee is proposing a new Innovations project that would use components of several Innovations Proposal forms submitted by the community. The proposed project is a five-year project that would focus on increasing culturally congruent interventions for the Black/African American communities of San Francisco. This project would have four main learning goals:

1. Increase recruitment and retention of Black/African American staff in the mental health system.
2. Increase outreach and engagement of Black/African American clients in the county mental health system including those who are currently underserved by the mental health plan.
3. Through a Needs Assessment, determine a list of innovative and culturally congruent practices for these communities.
4. Test culturally relevant practices to increase consumer satisfaction at the test sites.

The three identified pilot sites for this project may be South of Market Mental Health (SOMMH), Mission Mental Health Clinic, and OMI Family Center. SF-MHSA/BHS would begin the process of hiring and/or identifying key staff people to work with the Black/African American Care Team and a program manager will be hired to manage this project. The learning project can provide an expanded research and testing of culturally congruent interventions specifically designed for the Black/African American populations in San Francisco. A small component of this project may include engagement and outreach with San Francisco's churches to provide education and mental health promotion for these communities, as integrating spirituality may be important. We may also evaluate subgroups including Adults, Older Adults, Transition Age Youth (TAY), Parents, Women, LGBTQ+, etc. Lastly, we will collaborate with the DPH Office of Equity, Social Justice and Multicultural Education (OESM) to ensure that equity is a key component in the development of services and how we engage the communities.

Evaluation will be a critical component to this new Innovations project. As a result of implementing this project, we anticipate the following client outcomes:

- ✓ Increasing feelings of personal value or self-worth
- ✓ Increasing quality (i.e. on patient-reported outcome measures)
- ✓ Reducing utilization (i.e. emergency department visits, hospitalization, frequency of in-person visits)
- ✓ Increasing community engagement
- ✓ Satisfaction with intervention strategies
- ✓ Satisfaction with outreach/engagement strategies

Innovations Projects Sunsetting in 2020

Two of the Innovation projects listed above will be sunsetting on July 30, 2020 – The Transgender Pilot Project and Addressing the Needs of Socially Isolated Older Adults. The SFDPH MHSA team has leveraged our ongoing Community Program Planning (CPP) efforts to collect input from diverse community groups that will inform the ending phase of these projects and any future plans for continuing the successful components of these program through alternate funding streams.

The Transgender Pilot Project Support Group and other program participants provided direct feedback on the program's Innovation funding ending and how future efforts should be focused in preserving the program. Stakeholders at our recent CPP meeting that focused on the housing crisis in San Francisco, as well as our BHS Client Council, provided feedback on the sunsetting of Innovation funding for the Needs of Socially Isolated Older Adults program. Stakeholder feedback will also guide the final Learning Reports for these projects, which will begin in early 2020.

The First Impressions Innovation project's Innovation funding ended June 30, 2019 and the Learning Report was submitted to the California Mental Health Services Act Oversight and Accountability Commission in December 2019. Based on overwhelmingly positive community and stakeholder feedback, this project has continued with alternate funding sources. Please see the

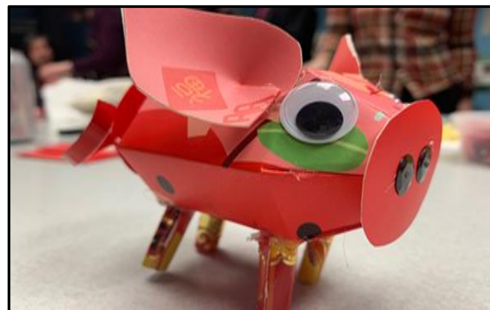
"Vocational Services" section below for more details.

MHSA Programs Awarded Extensions of Innovation Funding
The Transgender Pilot Project and Addressing the Needs of Socially Isolated Older Adults Innovations Programs received a funding increase from the California Mental Health Services Oversight and Accountability Commission in October 2019 to increase the funding for both of these programs through June 30, 2020.

The Transgender Pilot Program focuses on prevention through the creation of social support networks, and addresses mental health issues by engaging Transgender women of color into services that are culturally responsive. The funding extension provided $182,850 for the period of July 1, 2019 to June 30, 2020. Funds will be used to expand outreach in Spanish and after hours, staff development, evaluation and strategic planning.

The Addressing the Needs of Socially Isolated Older Adults program provides peer-based outreach and engagement services to socially isolated older adults with mental health concerns living in the central neighborhoods of San Francisco. The funding extension provided $195,787 for the period of July 1, 2019 to June 30, 2020 and will allow this program to enhance program evaluation and program sustainability efforts, peer workforce development, and outreach to seniors, with a new focus on reaching isolated Transgender seniors.

SFDPH MHSA's Innovations Intensive Case Management/Full Service Partnership to Outpatient Transition Support Project
SFDPH MHSA applied to and received funding from the California Mental Health Services Oversight and Accountability Commission in Fiscal Year 2017-18 for a five-year project to support our clients' transitions from Intensive Case Management/Full Service Partnership programs to Outpatient Treatment Services.



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

The Intensive Case Management/Full Service Partnership programs to Outpatient (ICM/FSP-OP) Transition Support project offers an autonomous peer linkage team, which provides both wraparound services and a warm hand off from ICM to OP. When clients no longer need the intensive level of care and service provided by ICM and FSP programs and they are discharged, many individuals do not link successfully to medically necessary and regular OP services. In a 3-year analysis at BHS, only 16% of discharged ICM/FSP clients had follow-up care at outpatient clinics, and half of those clients remained in the outpatient program for a year or more. Furthermore, 38% of discharged ICM/FSP clients had no identified new episodes, suggesting that they are most likely disengaged from the mental health system of care. The more recent analysis of engagement at outpatient programs showed that only 18.3% in FY15/16 and 18.9% in FY16/17 of discharged ICM/FSP clients who were eligible for outpatient services successfully linked to outpatient services. The major goals of this project are to increase client engagement in behavioral health outpatient services among those stepping down from ICM/FSP services, improve the overall client experience for those in transition, and support and further develop a peer-driven model of care. 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 mental health outpatient services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

On July 6, 2018, MHSA published RFQ 22-2018 for the project, which has been renamed the Peer Transition Team (PTT). For this RFQ, the selected service provider will be required to select, employ, train and support five peer specialists to perform the peer duties described in this document. At least one of these five peers must be a peer who is a Transition Age Youth (16-24 years of age) and at least one of these five peers must be either a bilingual Spanish-speaking peer or a bilingual Chinese-speaking peer. The selection team reviewed proposals and awarded the contract to the Richmond Area Multi Services agency (RAMS), based on agency qualifications. RAMS launched the program start-up on January 1, 2019. This start up period included the hiring of peer staff, the purchasing of items for the program, introductions to all the relevant program sites, and development of forms and brochures needed by the programs. Full operations of the programming has become available starting July 2019.

Innovations Technology-Assisted Mental Health Solutions Project
The Innovation Technology is being administered by CalMHSA on behalf of participating member counties. This is a three-year demonstration project which is funded and directed by participating counties. The primary purpose of this INN Tech Suite Project is to increase access to mental health care and support and to promote early detection of mental health symptoms. Through the utilization of multiform-factor devices, such as smart phones, tablets and laptops, as a mode of connection and treatment to reach people who are likely to go either unserved or underserved by traditional mental health care, project services will focus on prevention, early intervention, family and social support to decrease the need for psychiatric hospital and emergency care service. The Innovations Technology-Assisted Mental Health Solutions project (Tech Suite) has been preparing for multi-county marketing efforts. With input from all counties, a brand, logo, and outreach materials are being created. A formal name for the Tech Suite has been adopted, which is Help@Hand. Help@Hand is being envisioned as a multi-city and county collaborative whose vision is to improve the well-being of Californians by integrating promising technologies and lived experiences.

Testing of the initial two apps that the project started with and gathering stakeholder feedback resulted in a decision to move forward with the original plan of creating a suite of apps to be available to counties to meet their varied needs and focus populations as an intimal priority. A selection process of vendors is under way and the first county pilots are planned for the end of 2019. After these 3-month pilots, apps will become available for any county to use.

Realizing the importance for community stakeholders to develop tools to support informed decisions and better engage with future digital mental health solutions, the CalMHSA Peer & Community Engagement Manager, with the CalMHSA team, facilitated community discussions around the state to support this goal. Feedback collected included needs and concerns around engaging with technology.

One of these community discussions was held with San Francisco's Transgender population, one of the groups being focused on for our local Help@Hand Project. In collaboration with digital mental health literacy experts, CalMHSA will look at the results and identify county specific needs. A digital literacy educational curriculum will be developed and trainings will be held so that counties can help potential participants in the project better utilize digital tools for their mental health and wellness. SFDPH MHSA will roll this program out to all San Francisco residents, with a focus on the transition age youth (ages 16 – 24) and the socially isolated transgender adult populations. We hope to launch in the spring of 2020.

Spotlight on Wellness in the Streets

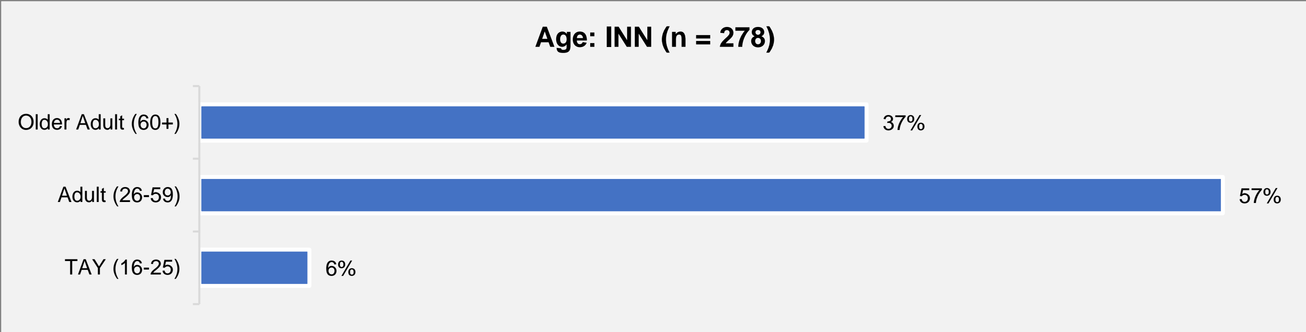
The San Francisco Bay Area is amidst a housing crisis that disproportionately impacts low income individuals who are experiencing or at-risk of severe mental illness. With shelters full to capacity each night, individuals and organizations are facing the reality that services must meet people "where they are at" – in new and innovative ways. SFDPH MHSA's Wellness in the Streets is a peer-led, peer-run project that operates a support team of formerly homeless individuals to provide peer counseling and service referrals to homeless San Franciscans.

Wellness in the Streets is a new Innovations project, which received approval from the California Mental Health Services Act Oversight and Accountability Commission (MHSAOAC) on September 22, 2018 for 5 years of funding at $350,000 per year. Once approved, SF BHS published a Request for Qualifications in February 2019 and selected the Richmond Area Multi Services (RAMS) as the service provider, based on their agency qualifications. The program launched October 2019.

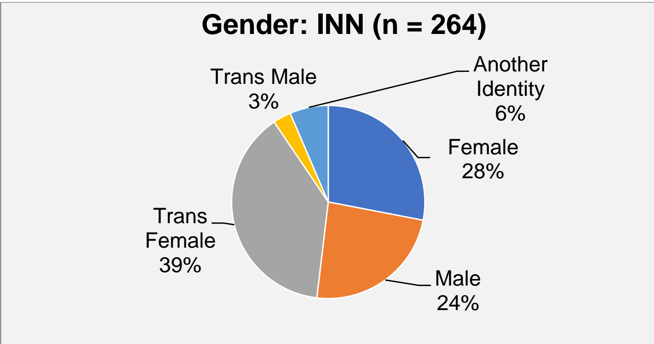
Wellness in the Streets aims to increase feelings of social connectedness, promote awareness of mental health resources, and enhance overall wellness among homeless individuals. In achieving these outcomes, the program is testing new and innovative ways of engaging with homeless San Francisco residents. This means conducting outreach in outdoor and public settings – on street corners, in encampments, and at public parks. Peers will engage interested individuals in activities such as one-on-one one peer counseling and support, crisis planning, service linkage, and support groups. The ultimate goal of the WITS is to move participants along the stages of change until they are able to engage in services. Peers will evaluate outreach efforts and client interactions through short surveys and feedback tools, to be completed while in the field, to understand how program elements can be further customized in order to improve the quality and delivery of services.

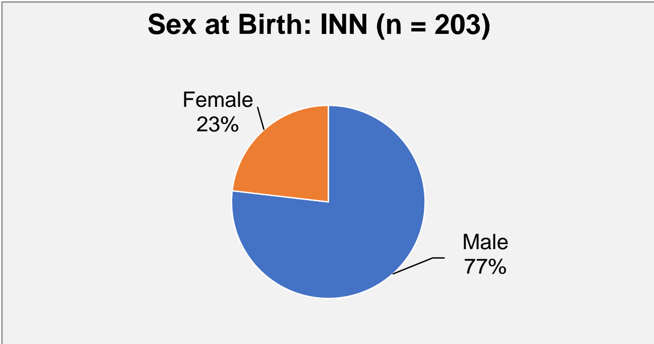
Participant Demographics for all INN Programs

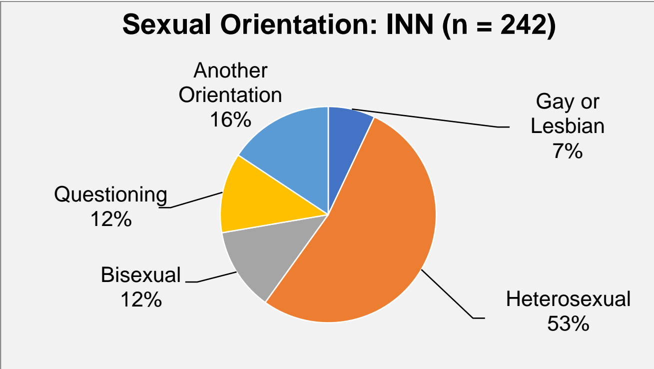
Total Served = 1,705
Total Unduplicated = 543

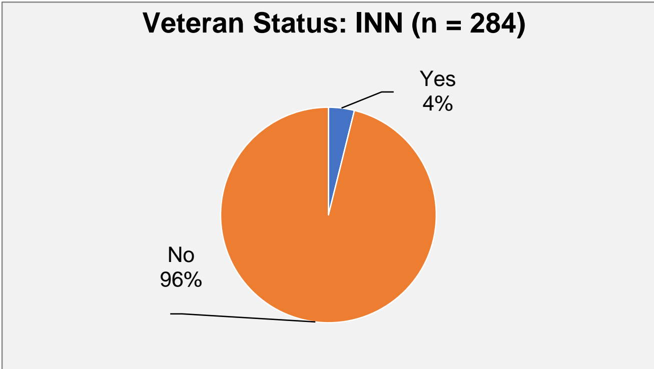


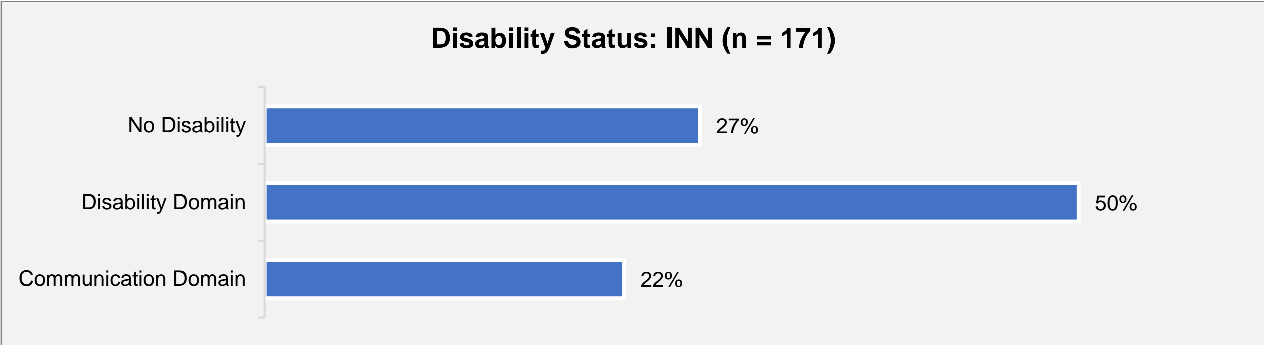
*< 1 percent of participants reported data for CYF (0-15)











*< 1 percent of participants reported data for Another Disability

Race/Ethnicity	n	%
Black/African American	69	24%
American Indian or Alaska Native	6	2%
Asian	8	3%
Native Hawaiian or Pacific Islander	1	0%
White	75	26%
Other Race	18	6%
Hispanic/Latino	26	9%
Non-Hispanic/Non-Latino	64	22%
More than one Ethnicity	22	8%
Total	**289**	**100%**

Primary Language	n	%
Chinese	4	2%
English	175	80%
Russian	1	0%
Spanish	32	15%
Tagalog	4	2%
Vietnamese	0	0%
Another Language	3	1%
Total	219	100%

Service Indicator Outcomes for all INN Programs

Service Indicator Type	Program Results
Total family members served	203 individuals
Potential responders for outreach activities	Outreach specialists and program managers
Total individuals with severe mental illness referred to treatment	47 individuals
Types of treatment referred	Medical, mental health, substance use, and case management
Individuals who followed through on referral	47 (100%) for reporting programs.
Average duration of untreated mental illness after referral	No INN programs were able to report these data. SF-MHSA will provide technical assistance to providers to better capture these data in the future.
Average interval between referral and treatment	No INN programs were able to report these data. SF-MHSA will provide technical assistance to providers to better capture these data in the future.
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	No INN programs were able to report these data. SF-MHSA will provide technical assistance to providers to better capture these data in the future.
Types of underserved populations referred to prevention program services	Homeless, immigrant, communities of color, isolated older adults, LGBTQ+, low-income
Individuals who followed through on referral	47 (100%) for reporting programs.
Average interval between referral and treatment	No INN programs were able to report these data. SF-MHSA will provide technical assistance to providers to better capture these data in the future.
How programs encourage access to services and follow-through on referrals	Peers remind clients to contact their providers as need arises

SFDPH MHSA Prevention and Early Intervention Programs

Prevention and Early Intervention (PEI) Reporting Requirements

The Mental Health Services Act requires that all Counties receiving MHSA funds submit annual reports that provide data on 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. PEI 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.

MHSA successfully integrated new PEI regulated demographic data into online reporting templates for our service providers in FY 2017-18. The MHSA team is also working to engage its PEI service providers 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. MHSA's evaluators are working directly with our service providers to offer ongoing trainings and provide technical assistance to ensure accurate reporting and adherence to the PEI regulations.

San Francisco's Stigma Reduction Programming

SFDPH MHSA places a high value on reducing stigma throughout the San Francisco community and the importance of mental health education. For several years, our peer-based Stigma Reduction Program, SOLVE, has been a leader in our community working towards these efforts. SOLVE recently merged with other peer programs with similar goals to become a new program titled, "Peer Outreach and Education Services. This program collaborates with other projects to provide education and help reduce stigma associated with mental health. Please see the "Peer-to-Peer Support Programs and Services" section below for more details. In addition, we also provide robust stigma reduction outreach and educational activities throughout the year at various tabling events.

Implementation of the Prevention and Early Intervention Program Planning

This section is in response to the Information Notice from the MHSOAC dated January 27, 2020. SF-MHSA is compliant with all items listed in the Welfare and Institutions Code Section 5840.7. Most of the priority activities listed on the Information Notice are funded by PEI, however, a few programs are funded by other sources allowing SF-MHSA to focus on additional prevention and early intervention needs. Please see a brief summary below regarding SF-MHSA's implementation of these priority activities. For additional information regarding these PEI activities described below and/or all PEI-funded programs, please refer to the "Mental Health Promotion and Early Intervention Programs" section of this report.

Childhood Trauma Prevention and Early Intervention

Several of SF-MHSA's PEI funded programs target childhood trauma prevention and early intervention, however, several programs in particular have a strong emphasis on addressing this need. The Trauma and Recovery Services program works with children and their families to prevent or reduce trauma-related symptoms. The Population-Focused Transition Age Youth programs all address the prevention and early detection of childhood trauma.

In addition, we have several other MHSA-funded programs (other than PEI) that address this need including the FSP SPARK program, FUERTE and our Trauma Informed Systems program.

Early Psychosis Disorder Detection and Intervention

The ReMind Program (formerly known as PREP) is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This program is funded by MHSA CSS. Another program with Behavioral Health Services, called Beam-Up, also addresses intervention treatment of early psychosis. Beam-up, however,

works with individuals who may be identified as clinical high-risk. Beam-Up is funded by a State SAMHSA Grant.

Mood Disorder Detection and Intervention

All of our PEI funded programs provide early detection and initial support to clients who may be experiencing a mood disorder. If a mood disorder is suspected, all PEI funded programs will then provide direct linkage to the appropriate Behavioral Health Services System of Care for proper intervention services.

Suicide Prevention Programming

SF-MHSA does not implement a formal PEI funded Suicide Prevention Program, however, in order to meet MHSA regulations, Behavioral Health Services funds a Suicide Prevention Program with the contractor, San Francisco Suicide Prevention which is funded by General Fund dollars.

In addition, the SFDPH MHSA PEI programs currently implement suicide prevention activities in their programming and we intend to strengthen these activities in FY20/21. We will work with community members and providers to develop a robust plan to better streamline the education and implementation of all suicide prevention activities for PEI programs. We also provide robust suicide prevention outreach and educational activities throughout the year at various tabling events.

Youth Outreach and Engagement Strategies

Most of SF-MHSA's PEI funded youth programs have a strong focus on outreach and engagement activities, however, the programs that prioritize these strategies include our School-Based Programs, Child Crisis and our Population-Focused Programming for Transition Age Youth.

Culturally Competent and Linguistically Appropriate Prevention and Early Intervention

We are pleased to say that all of our PEI funded programs emphasize the need to provide culturally competent and linguistically appropriate services to every consumer. The Population-Focused Programming takes this priority to another level by offering specialized services for underserved populations including, but not limited to, the following:

- Socially Isolated Older Adults
- Black/African Americans
- Asians and Pacific Islanders
- Latinx including the Indigenous Mayan communities
- Native Americans
- Adults and TAY who are homeless or at-risk of homelessness
- TAY who are justice involved
- TAY who are LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and more)

The Population-Focused Programming also uses multi-intervention strategies and social connection strategies in order to support prevention and early intervention best practices.

Strategies Targeting the Mental Health Needs of Older Adults

Several of our Population-Focused Programs work with the older adult community, however, one PEI funded program in particular specializes with this population. The Senior Drop-In Center is a multi-service center that provides drop-in peer-led wellness-based services, including primary and behavioral health care, case management services, and socialization opportunities. The Mobile Crisis and Crisis Response Team programs also work with the older adult population.

Early Identification Programming of Mental Health Symptoms

Several PEI funded programs emphasize the need for early identification of emerging mental health symptoms. One program, the San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI), specializes in early identification and intervention services. These services are designed to capitalize on the important role of early identification and intervention in enhancing the success of children and families facing early developmental challenges. In addition, all of our Population-Focused Programming and School-Based Programs provide early identification services.

Other Local PEI Efforts

SF-MHSA is pleased to report that we have other PEI-funded initiatives based on the CPP input we collected over the years. For more details regarding these activities, please refer to the "Mental Health Promotion and Early Intervention Programs" and the "Recent Community Program Planning Efforts" sections of this report.

Metrics Related to the Assessment of Program Efficacy

SF-MHSA partners with the SFDPH Quality Management team and behavioral health consumers in order to develop comprehensive evaluation plans for PEI funded programs. The evaluation plans often include the following:

1) S.M.A.R.T. objectives, (i.e. those that are **S**pecific **M**easurable, **A**chievable, **R**elevant and **T**ime-Bound);
2) Strong methods of achieving objectives; and
3) Evaluation efforts that include a program logic model, goals, objectives, timelines, indicators of success, defined benchmarks and expected outcomes and deliverables.

We develop evaluation tools for PEI-funded programs assess mental health consumers' progress and solicit their feedback. With these findings, we can regularly make immediate adjustments to the program as needed. Data collection tools may include, but are not limited to:

Administrative Data:

- Wellness activity attendance log
- Case Management Plans (including wellness goals)
- Service Plans
- Referral log for behavioral health services

Participant Measures:

- Measure of community participant's knowledge of mental health
- Measure of community participant's level of stigma toward mental health
- Measure of social connectedness and connection with community

- Measure of mental wellness, such as the PHQ-2, GAD-2, or other assessment
- Community participants' feedback (e.g. satisfaction surveys and recommendations for program improvements)

Staff Measures:

- Measure of peer staff confidence/skills
- Measure of peer staff perception of support for their wellness

<u>Estimate of the Share of PEI Funding</u>

Below you will find a table that provides an estimate of the share of PEI funding and other funding sources allocated to each of the priorities listed above.

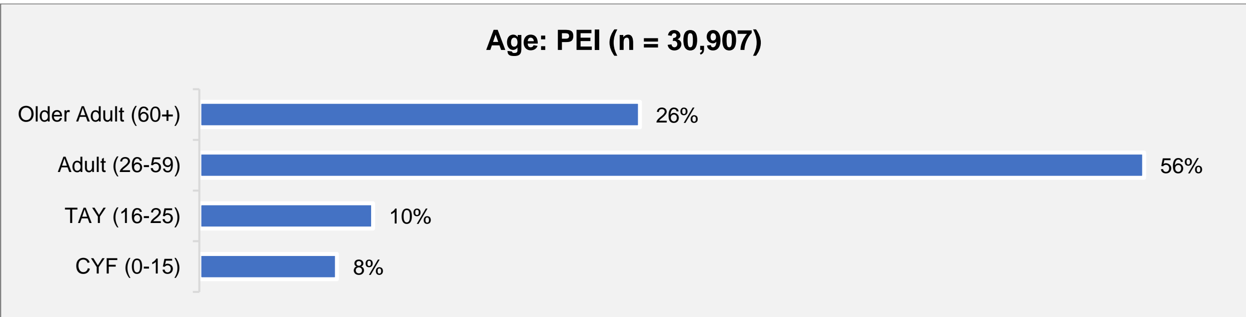
Program Name	Childhood Trauma Prevention and Early Intervention	Early Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	Competent and Linguistically Appropriate Prevention and Early Intervention	Strategies Targeting the Mental Health Needs of Older Adults	Early Identification Programming of Mental Health Symptoms	Fiscal Year 2020/21 Estimated MHSA Funds	Fiscal Year 2021/22 Estimated MHSA Funds	Fiscal Year 2022/23 Estimated MHSA Funds
PEI 1. Stigma Reduction	√	√	√	√	√	√	√	$ 185,107	$ 185,107	$ 185,107
PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	√	√	√	√			√	$ 1,077,490	$ 1,080,686	$ 1,083,977
PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventio	√	√	√	√	√	√	√	$ 4,089,226	$ 4,090,073	$ 4,090,945
PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	√	√	√	√	√		√	$ 639,671	$ 639,671	$ 639,671
PEI 6. Comprehensive Crisis Services (10% Prevention)	√	√	√	√			√	$ 368,380	$ 379,431	$ 390,814
PEI 7. CalMHSA Statewide Programs	√	√	√	√	√	√	√	$ 68,635	$ 68,635	$ 68,635

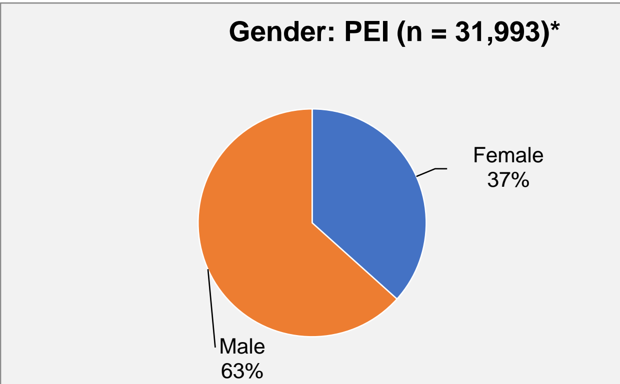
For additional budget information, please see the budget documents listed at the end of this 3-Year Plan.

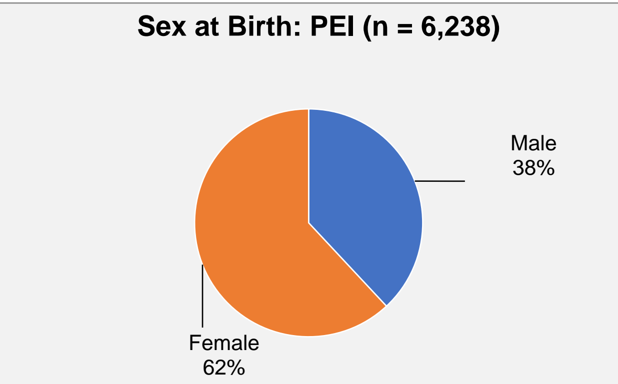
MHSA Evaluation Team

Participant Demographics for all PEI Programs[2]

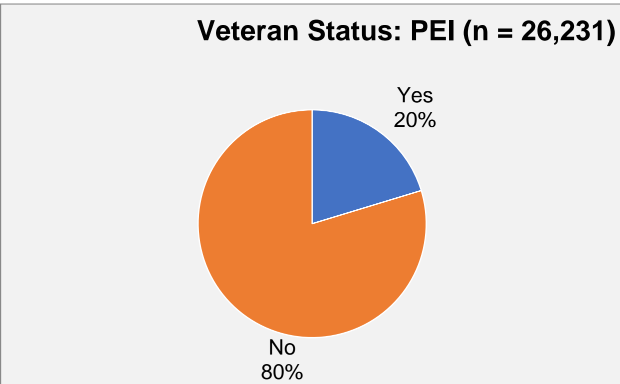
Total Served = 121,370
Total Unduplicated = 35,092
Served for Early Intervention = 1,444
Served for Mental Illness Prevention = 3,278

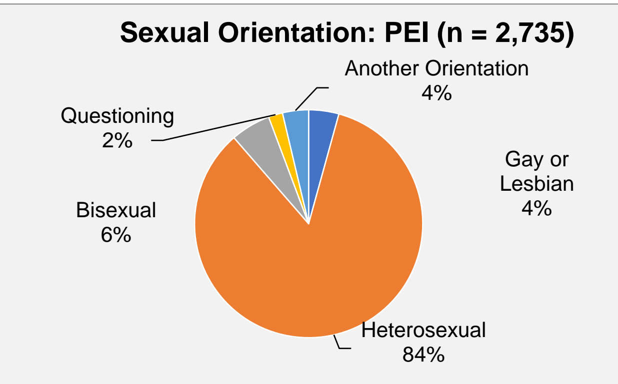




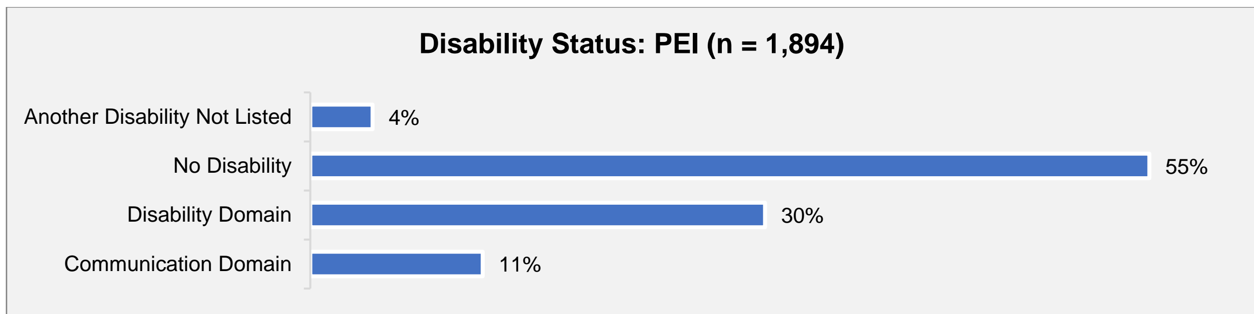


*< 1 percent report data on Trans Female, Trans Male, and Another Identity





[2] N values in demographic reporting vary depending on the availability of data in each category.



Race/Ethnicity	n	%
Black/African American	11,251	34%
American Indian or Alaska Native	613	2%
Asian	7,100	21%
Native Hawaiian or Pacific Islander	387	1%
White	7,969	24%
Other Race	1,131	3%
Hispanic/Latino	2,956	9%
Non-Hispanic/Non-Latino	1,533	5%
More than one Ethnicity	368	1%
Total	**33,308**	**100%**

Primary Language	n	%
Chinese	2,476	8%
English	25,682	84%
Russian	8	0%
Spanish	1,626	5%
Tagalog	91	0%

Primary Language	n	%
Vietnamese	184	1%
Another Language	389	1%
Total	**30,456**	**100%**

Service Indicator Outcomes for all PEI Programs – FY18/19

PEI Data Requirement	Program Summary
Total family members served	1,408 family members; average 108.31 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: (Listed in order of prevalence) educators and other school staff, social workers and case managers, therapists and psychiatric service workers, childcare workers and pediatricians, parole and probation officers, and community referral/linkage service workers.
Total individuals identified as needing a higher level of care for mental illness who were referred to treatment	57 individuals; average 9.5 across 6 reporting programs.
Types of treatment referred	Responses include: • Assessment for either Case Management Services, Substance use counseling or mental health therapy • Parent child therapy • Substance abuse treatment/support services, medical services/health care, and Mental Health Support • Child Crisis - assessment and stabilization • Psychiatric, Mobile Crisis, employment, housing • Orientation to therapy, Monk blessing, Internal referral (agency workshops) • Parent-child playgroup at Infant-Parent Program
Individuals identified as needing a higher level of care who followed through on referral	63/71 or approximately 89% across six 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: - 1 week - 2-3 weeks - 3 months - 1 year
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include

PEI Data Requirement	Program Summary
	- 1 week - 2 days contact, 12 days intake - 7-10 days, - 24 days
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	646 individuals; average 49.7 individuals across 13 reporting programs.
Types of underserved populations referred to prevention program services	Responses include: Homeless, families at risk of homelessness, families in public housing, low income, those living below the poverty line, older adult, LGTBQ, queer, and communities of color, African Americans, American Indian and Alaskan Native, Latinx, Chicanx, TAY from communities of Color (Black, Asian, Hispanic) living in Bayview Hunters Point, Filipinx, Somoan, Laotian, Cambodian, Vietnamese, Vietnamese youth, immigrants (elders, newcomers, and unaccompanied youth), In-custody, gang affiliated, young children and their families, systems-involved (legal, foster, etc), children in foster care, inner city teens, youth experiencing academic truancy, limited English speakers, families impacted by substance use and dependency, isolated older adults. Ethnic/racial groups: communities of color, Black/African Americans, American Indian and Alaskan Native, Latinx, Chicanx, Maya, Filipinx, Somoan, Laotian, Cambodian, Vietnamese Age Groups: TAY from communities of color, youth In-custody, gang affiliated, youth experiencing academic truancy, children in foster care, children and families, isolated older adults Social Minorities/Resource-limited: Homeless, families at risk of homelessness, families in public housing, low income, those living below the poverty line, LGTBQ, queer, immigrants (elders, newcomers, and unaccompanied youth), systems-involved (legal, foster, etc), limited English speakers, families impacted by substance use and dependency.
Individuals from underserved populations who followed through on referral to any prevention service	284/383 or approximately 74% across 13 reporting programs.

PEI Data Requirement	Program Summary
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses: - 1 week (mentioned three times) - 1-3 weeks - 4-6 weeks
How programs encourage access to services and follow-through on referrals	Responses include: • The Peer Outreach Specialists are available to program participants every day. The Mental Health Association of SF presents monthly to participants which includes Mental Health resources in the community. • Engaging and encouraging to follow through on referrals, sometimes escorting to referrals. • Consultants prefer doing a warm handoff for mental health referrals. When possible, they accompany the family to the initial appointment. Otherwise, having a clear contact person and calling the referral agency ask the best way to link families is also done. Maintaining relationships with community partners is also key • Case Manager and Therapist facilitate a warm hand off to the service provider of the program referred. • Provides navigations services to the clients to make the referral process less stressful. We also follow up all referrals with 2 calls to the client to ensure service connections. • Services provided on-site, decreasing barriers to access • TAY referred agency, need to follow-up with referral agency and TAY within two days of the referral to identify if a point of contact had been made. • The community health worker tracks linkages and referrals in case management notes. For non-case management members that receive a referral, the Administrative Assistant conducts follow-up 72 hours afar the referral. • Community members are encouraged by community leaders to access services so that they turn help their families and other community members access the same services and resources. • Consultants follow up either with the family liaison at the sites, or with the specific clinic or programs to ensure engagement. • Our Service Navigator follows up on referrals with individuals. Our Mental Health Specialist also tracks the number of clients seen who have been referred internally. • Mental Health Consultants are placed at early learning centers and residential programs serving

PEI Data Requirement	Program Summary
	families with young children in SF and are regularly present at these sites, building relationships with families and staff; these relationships enable the consultant to be embedded in trusted settings where families are served. • We encourage access to services by conducting outreach to underserved populations, conduct workshops on common mental health disorders, including signs and symptoms. We follow through on internal referrals by following up with the client within two days. • When identified, the client is referred and verified by sign -in sheet participation, phone contact with referral agency, or follow up directly with client for participation. • Case manager accompanies clients to appointments within the community (by driving them in agency van specifically for this purpose to remove any barriers to transportation), works around the client's schedule to assure they can access needed services.

Per PEI Regulations, we provide 3-Year comparison evaluation data for FY16/17, FY17/18 and FY18/19 on outcomes and demographics. These comparison data sets provide a high-level overview and a summary to compare progress. For an extensive review of these data, please also refer to our FY19/20 MHSA Annual Update, our FY18/19 MHSA Annual Update and our Mental Health Promotion and Early Intervention Programs section below for additional PEI data.

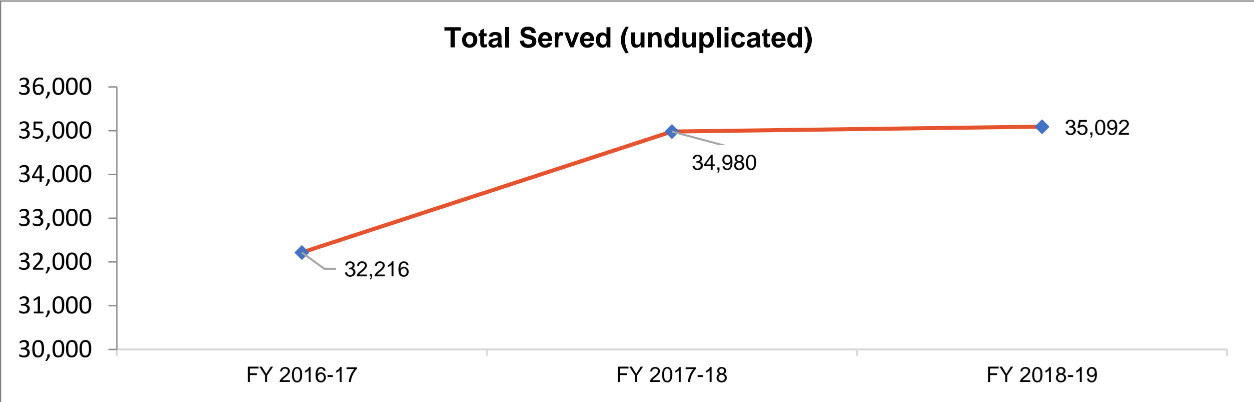
3-Year Comparison of MHSA PEI Evaluation Data

Reporting Year	Select Numeric Outcomes
FY 2016-2017	• 36 Peer Educators participated in the SOLVE Program in FY16-17, 12 individuals entered the new Peer Educator training series, and 3 previously inactive Peer Educators returned to the program. (Stigma Reduction: Sharing Our Lives, Voices and Experiences (SOLVE) – Mental Health Association of San Francisco) • Behavior Coaching served 26 different students on an individual and/or small group basis, provided social skills support for five classes, and ran a total of five social skills groups by grade level (for grades 1, 3, and 4), ranging in size from 4-7 students. (School Based Mental Health Services- Edgewood Center for Children and Families) • 1,044 hours of individual therapeutic services were provided to 247 students in FY16-17.(Wellness Centers - Richmond Area Multi-Services, Inc.(RAMS)) • Staff provided individual and group academic career development services to 184 students (approximately 36% of all MCP students) in FY16-17, exceeding their goal by 142%. (Masters in Counseling Psychology Project - California Institute of Integral Studies (CIIS))

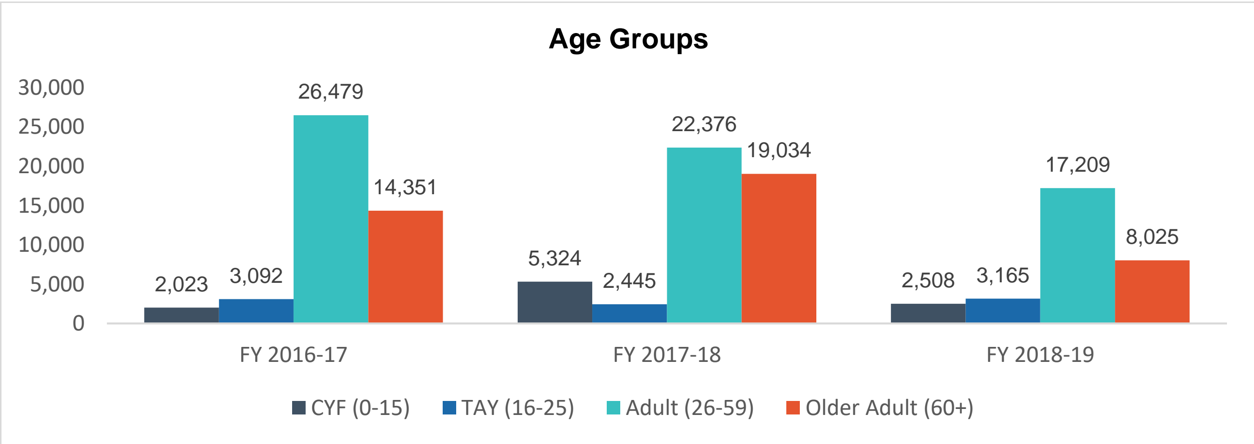
Reporting Year	Select Numeric Outcomes
	• Staff provided 450 adults age 55+ first-level "Gating" screening, identifying symptom domains of depression, anxiety, social isolation, chronic pain, substance abuse, sleep quality, and cognition. (Older Adult BH Screening Program - Institute on Aging) • Rafiki Coalition provided 161 stress reduction sessions, promoting and providing a minimum of movement options that reduce stress (e.g. physical activity, exercise, dance classes). (Black/African American Wellness and Peer Leadership Program – SFDPH Interdivisional Initiative with YMCA Bayview and the Rafiki Coalition) • Staff screened and assessed 225 unduplicated individuals, helping the program to better understand what types of services the community needed. (Indígena Health and Wellness Collaborative –Instituto Familiar de la Raza (IFR)) • 139 TAY and/or their families had a written plan of care, and 87 TAY and/or their families achieved at least one care plan goal. (TAY Multi-Service Center – Huckleberry Youth Programs) • The Crisis Response Team served 181 individuals, providing 24/7 mobile response to homicides, critical shootings, stabbings, suicides and pedestrian fatalities. (Comprehensive Crisis Services).
FY 2017-2018	• 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. (Behavioral Health Services at Balboa Teen Health Center (BTHC) *Bayview Hunter's Point Foundation*) • 88% (23 of 26) of participants who attended 5 or more activities reported an increase in socialization, as measured by client surveys. (Senior Drop-In Center *Curry Senior Center*) • 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. (Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional Initiative with YMCA Bayview and the Rafiki Coalition*) • 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 (A&PI) Youth and Family Community Support Services *Community Youth Center*) • 46 of the 85 (54%) isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services. (South of Market/6th Street Self-Help Center *Central City Hospitality House*) • 91% of Harm Reduction Support Group participants (126 out of 139) demonstrated reduced risk behaviors. (Tenderloin Self-Help Center *Central City Hospitality House*) • 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. (ROUTZ TAY Wellness *Larkin Street Youth Services*)

Reporting Year	Select Numeric Outcomes
	• 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. (Early Childhood Mental Health Consultation Initiative) • The Child Crisis Team served 1,561 individuals and the Crisis Response Team served 231 individuals (Comprehensive Crisis Services)
FY 2018-2019	• Of 26 clients enrolled for at least 12 months, 19 (73%) engaged in new employment or education activities.(Prevention and Recovery in Early Psychosis (PREP) – Felton Institute) • Nurse practitioners referred 65 patients to case managers. The goal was to reach 50 patients.(Integration of Behavioral Health and Primary Care – Curry Senior Center) • At James Lick Middle School and Hillcrest Elementary, 18 of 24 (75%) staff members expressed that the consultant helped them to respond more effectively to children's behavior. (Youth Early Intervention – Instituto Familiar de la Raza) • Enrolled and monitored successful completion in equivalency exams in 16 out of 24 (67%) clients. (Trauma and Recovery Services – YMCA Urban Services) • 70 out of 79 (92%) San Francisco community residents reported an increase knowledge in accessing mental health services. (Ajani Program – Westside Community Services) • 93 unduplicated participants attended Harm Reduction support groups conducted by the Harm Reduction Therapy Center. 86 (92%) out of 93 of Harm Reduction support group participants demonstrated reduced risk behaviors. (South of Market Self-Help Center – Central City Hospitality House) • 119 (96%) out of 124 API youth participants with identified mental health diagnoses were referred to mental health services. (Population Specific TAY Engagement and Treatment – Asian/Pacific Islander – Community Youth Center) • 110 TAY and/or their families developed a written plan of care, and 104 TAY (95%) and/or their families achieved at least one case/care plan goal. (Population Specific TAY Engagement and Treatment – All –Huckleberry Youth Programs) • Served 800 people by providing 24/7 mobile response to homicides, critical shootings, stabbings, suicides and pedestrian fatalities, and providing clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents. (Comprehensive Crisis Services).

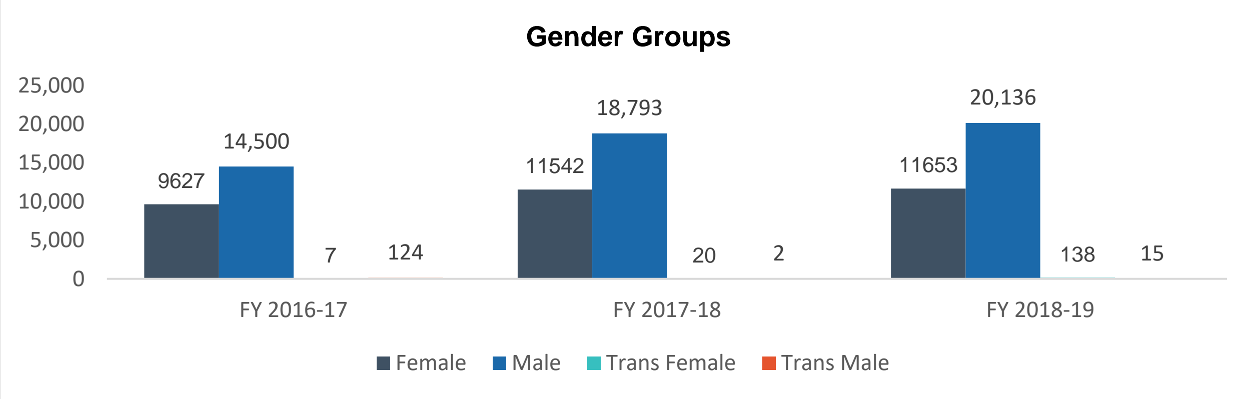
3-Year Comparison of Demographic Data



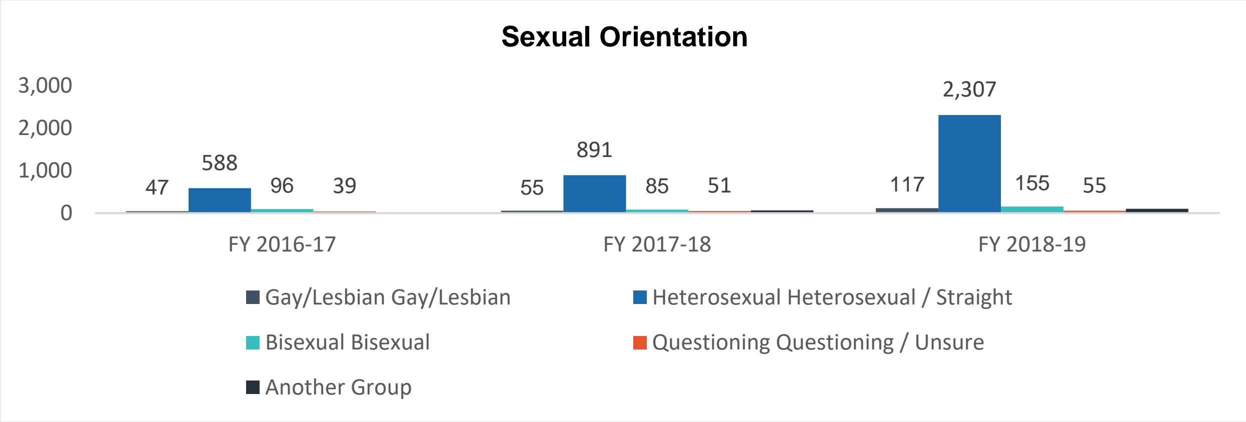
Across a 3-Year span from 2016 to 2019, demographic data reports show an increase in unduplicated participants in MHSA programs from 32,216 to 35,092.



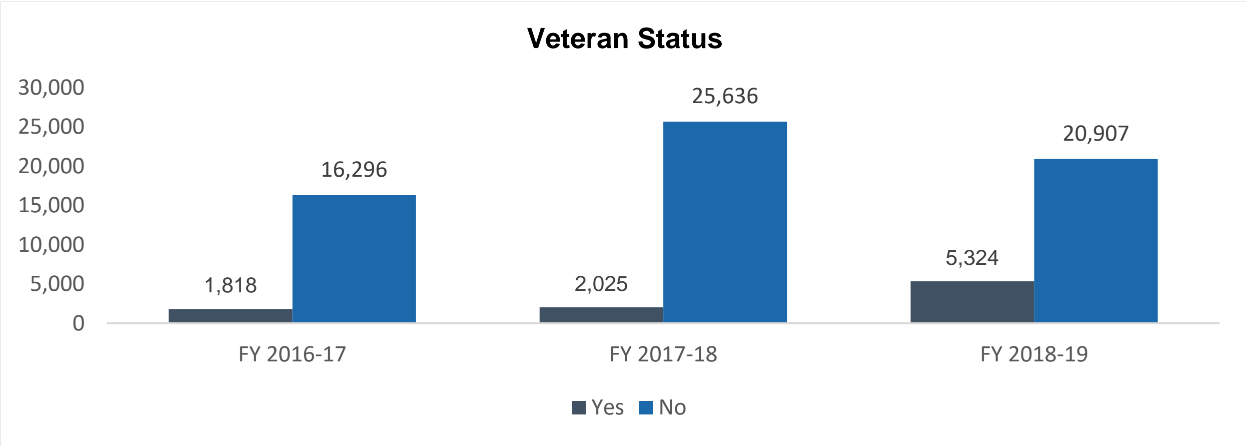
The total number of individuals who reported data for age increased between FY 2016-17 and FY 2017-18 from 47,767 to 52,979 and decreased between FY 2017-18 and FY 2018-19 to 30,907.



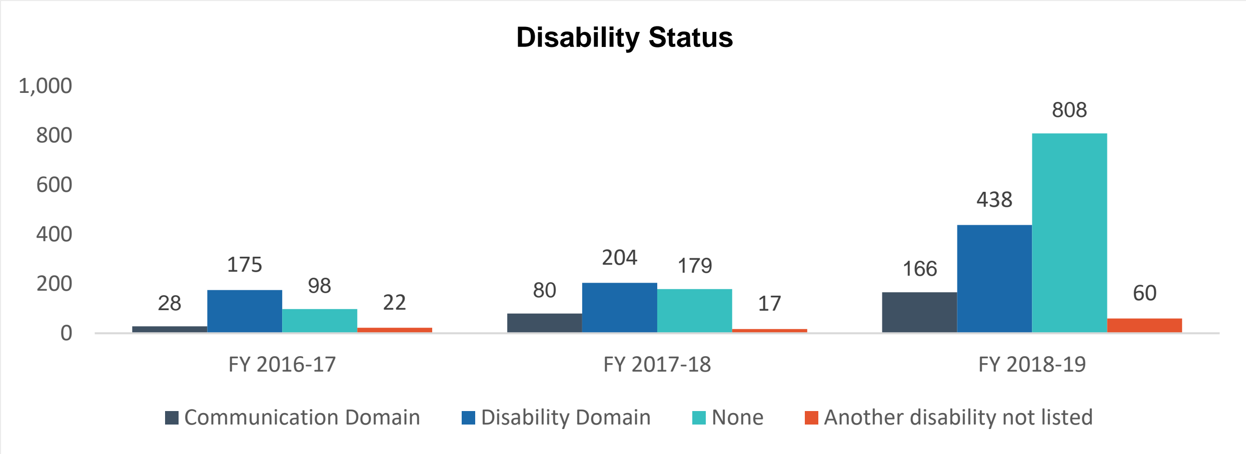
The total number of individuals who reported data for gender increased between FY 2016-17 and FY 2017-18 from 26,923 to 34,274 and decreased between FY 2017-18 and FY 2018-19 to 31,993. FY 2016-17 n=26,923; FY 2017-18 n=34,274; FY 2018-19 n=31,993;The following gender categories are noted here due to their relatively small portion in the above graphic: FY 2016-17: 7 Trans females, 124 trans males; FY 2017-18: 20 trans females, 2 trans males; FY 2018-19: 138 trans females, 15 trans males.



The total number of individuals who reported data for sexual orientation decreased between FY 2016-17 and FY 2017-18 from 1,463 to 1,372 and increased between FY 2017-18 and FY 2018-19 to 2,735.



The total number of individuals who reported data for veteran status increased each year from FY 2016-17 (N= 19,192) to FY 2017-18 (N=23,113) to FY 2018-19 (N=26,231).



The total number of individuals who reported data for veteran status increased each year from FY 2016-17 (N= 560) to FY 2017-18 (N=1,068) to FY 2018-19 (N=1,472).

Race/Ethnicity	FY 2016-17	FY 2017-18	FY 2018-19
Black/African American	6,752	10,295	11,251
American Indian or Alaska Native	346	518	613
Asian	3,040	9,435	7,100
Native Hawaiian or Pacific Islander	1,001	568	387
White	4,399	6,052	7,969
More than one Ethnicity	386	929	368
Other Race		1,756	1,131
Hispanic		4,116	2,956
Non-Hispanic		5,616	1,533
Total	15,924	39,285	33,308

Primary Language	FY 2016-17	FY 2017-18	FY 2018-19
Chinese	762	2,681	2,476
English	3,630	4,160	25,682
Russian	8	1	8
Spanish	900	1,505	1,626
Tagalog	268	36	91
Vietnamese	1,654	196	184
Another Language	64	559	389
Total	7,286	9,138	30,456

SF DPH MHSA 2020-23 Program and Expenditure Plan

As a result of the feedback we received during our MHSA CPP efforts, and due to our successful evaluation outcomes, the following programs/projects will operate as approved in the previous Three-Year Plan and subsequent Annual Update Reports. Note: the Full Service Partnership (FSP), Innovations (INN), and Stigma Reduction programs are denoted.

- **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 Seneca **(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)**
  - AIIM Higher
  - Community Assessment and Resource Center (CARC)
  - Behavioral Health Access Center (BHAC)
  - Behavioral Health Services in Primary Care for Older Adults
  - PREP - TAY Early Psychosis Intervention and Recovery (also known as Re-MIND)
- **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 (Latinx including indigenous Mayan communities)
  - Living in Balance
  - 6th Street Self-Help Center
  - Tenderloin Self-Help Center
  - Community Building Program
  - Population Specific TAY Engagement and Treatment – Latino/Mayan
  - Population Specific TAY Engagement and Treatment - Asian/Pacific Islander
  - Population Specific TAY Engagement and Treatment - Juvenile Justice/others
  - Population Specific TAY Engagement and Treatment – LGBTQ+

MHSA Funded

        - 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 Outreach and Engagement Services **(Stigma Reduction Program)**
    - Addressing the Needs of Socially Isolated Adults Program
    - 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
    - Wellness in the Streets **(INN)**
    - Technology-Assisted Mental Health Solutions **(INN)**
    - Intensive Case Management/Full-Service Partnership to Outpatient Transition Support **(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
    - Community Mental Health Academy
    - Faces for the Future Program
    - DPH Online Learning System
    - Trauma Informed Systems Initiative
    - TAY System of Care Capacity Building – Clinician's Academy
    - TAY System of Care Capacity Building – TAY Advisory Board

MHSA Funded

- Fellowship for Public Psychiatry in the Adult/Older Adult System of Care
- Public Psychiatry Fellowship at SF General
- BHS Graduate Level Internship Program
- Child and Adolescent Community Psychiatry Training Program (CACPTP)

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

2019 MHSA CPP Meeting and Cultural Event

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.

- 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
- Intensive Case Management/Full-Service Partnership to Outpatient Transition Support **(INNOVATIONS)**

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*	
	TAY FSP *Seneca Center*	
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.
	SF Fully Integrated Recovery Services (SF FIRST) *SFDPH*	Provides FSP services to highly vulnerable individuals with multiple medical, psychiatric, substance abuse, and psychosocial difficulties, including chronic homelessness.

FSP Programs		
Target Population	**Program Name** *Provider*	**Additional Program Characteristics**
	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 at Turk *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.

FSP Participant Demographics, Outcomes, & Cost per Client

Demographics

San Francisco's eleven Full Service Partnership programs in operation during the fiscal year 2018-19 enrolled a total of nearly 1,000 client episodes (n=976), experienced by 961 unduplicated FSP clients.

The demographics tables and graphs below represent an expansion of reporting from past years. Sex, Gender Identity, Race/Ethnicity, and Primary Language are reported in tables by FSP Program and by Client Age Group. Stacked bar charts show the percentage distribution across Client Age Groups. Also displayed is a matrix count of Client Age by FSP Age Category.

Demographic data are pulled from the Behavioral Health Services electronic health record system, Avatar, for all client episodes active in any FSP program, for any length of time between July 1, 2018 and June 30, 2019.

Client age is calculated from date of birth to July 1, 2018. A small number of clients (n=24) were opened in two different FSPs during the fiscal year, due to "aging up" or transferring programs for other reasons. For age reporting, clients are represented only once. Where demographics are displayed by FSP, all clients served in the FSP in the fiscal year are represented.

Client Sex, Gender Identity and Sexual Orientation
The eleven FSPs in San Francisco served nearly twice as many males (62%) as females (38%), especially in the adult programs.

Client Sex by FSP Program

FSP Program	Female	Male	Total
BHS TAY FSP	20	34	54
Citywide AOT	11	19	30
Citywide Forensics	69	216	285
Family Mosaic Project (FMP)	35	65	100
FSA Adult FSP	25	37	62
FSA Older Adult FSP	29	29	58
FSA TAY FSP	20	21	41
Hyde Street FSP	31	27	58
IFR SPARK FSP	9	9	18
Seneca Connections	81	82	163
SF FIRST FSP	37	70	107
Total	**367**	**609**	**976**

Client Sex by Client Age Group

Client Age Group	Female	Male	Total
1 CYF (0-5)	5	10	15
2 CYF (6-15)	78	102	180
3 TAY (16-24)	84	106	190
4 Adult (25-59)	134	299	433
5 Older Adult (60+)	60	83	143
Total	**361**	**600**	**961**

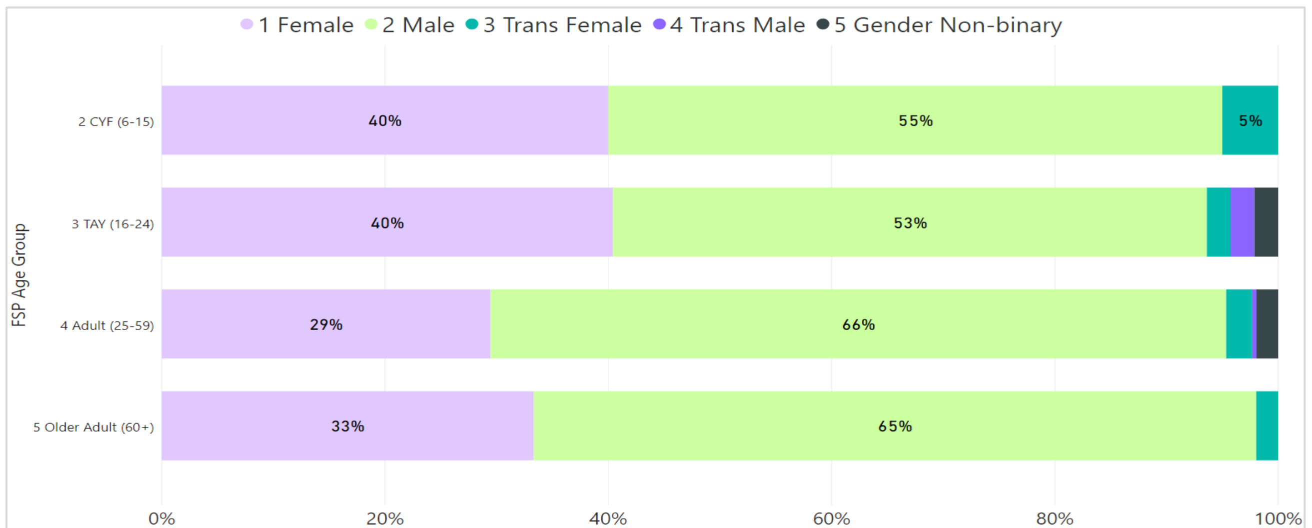
San Francisco recently initiated expanded data collection in Avatar for Sexual Orientation and Gender Identity (SOGI), however missing data are still prevalent (reported below as "No Data").

Client Gender by Client Age Group

Client Age	1-Female	2-Male	3-Trans Female	4-Trans Male	5-Gender Non-binary	6-No Data	Total
1 CYF (0-5)		2				13	15
2 CYF (6-15)	8	11	1			160	180
3 TAY (16-24)	36	46	2	2	2	102	190
4 Adult (25-59)	74	168	6	1	5	179	433
5 Older Adult (60+)	16	32	1			94	143
Total	**134**	**259**	**10**	**3**	**7**	**548**	**961**

Of those clients for whom Gender Identity data were available, 2-8% client identified as Trans Female, Trans Male or Genderqueer/Non-binary.

Client Gender by Client Age Group (excludes "No Data")



Similarly, as the SOGI data collection policies and practices continued to be adopted, data on client Sexual Identity (SI) were still underreported. Approximately 50%-70% of clients had missing SI, depending on client age group. Available data show 84-85% of clients as Straight/Heterosexual, 5-11% identifying as Gay or Lesbian, and 5-9% Bisexual, Questionning or Unsure, depending on age (no graph).

Client Age and FSP Program Focus

FSP programs in San Francisco typically orient their services according to target age group. Clients can "age up" or "age out" of age-focused programs when developmentally appropriate and the client is ready. For example, TAY-aged clients were seen in CYF, TAY and Adult FSPs, depending on their age and readiness to transition.
Increasingly, adult clients advancing into older age do not necessarily "age up" to the one Older Adult FSP, but instead stay with the Adult program they know, needing more older age-related services such as transportation, medical care and attention to cognitive impairment. In fact more clients over 60 years old are served by the four adult FSPs (n=87, 60%) than by the single Older Adult FSP (n=58, 40%).

The grid below shows where clients of different ages are seen across the FSP age spectrum:

- Children, Youth and Families serving clients 0-5 years old and their siblings (CYF0-5);
- Children, Youth and Families serving clients 6-15 years old (CYF6-15);
- Transitional Age Youth (TAY) serving clients 16-24 years old (TAY)
- Adult FSPs serving clients 25-59 years old (Adult)
- Older Adult FSPs serving clients 60 years and older (OA)

FSP Target Age Category by Client Age Group

	FSP Age Category					
Client Age	1 CYF0-5 FSP (IFR)	2 CYF6-15 FSPs (FMP, Seneca)	3 TAY FSPs (BHS, FSA)	4 Adult FSPs (Forensics, AOT, FSA, SFF, Hyde)	5 OA FSP (FSA)	**Total**
1 CYF (0-5)	5	10				**15**
2 CYF (6-15)	13	167				**180**
3 TAY (16-24)		86	93	17		**196**
4 Adult (25-59)			2	438		**440**
5 Older Adult (60+)				87	58	**145**
Total	**18**	**263**	**95**	**542**	**58**	**976**

Race/Ethnicity

Race and Ethnicity data are captured in Avatar and recoded into seven categories: African America/Black, Asian, Latinx, Multi-ethnic, Native American, Native Hawaiian and Other Pacific Islander (NHOPI), White and Other. African American/Black and Latinx clients are over-represented compared to the general population of San Francisco. Asians are under-represented, and whites are extremely under-represented in the younger client populations.

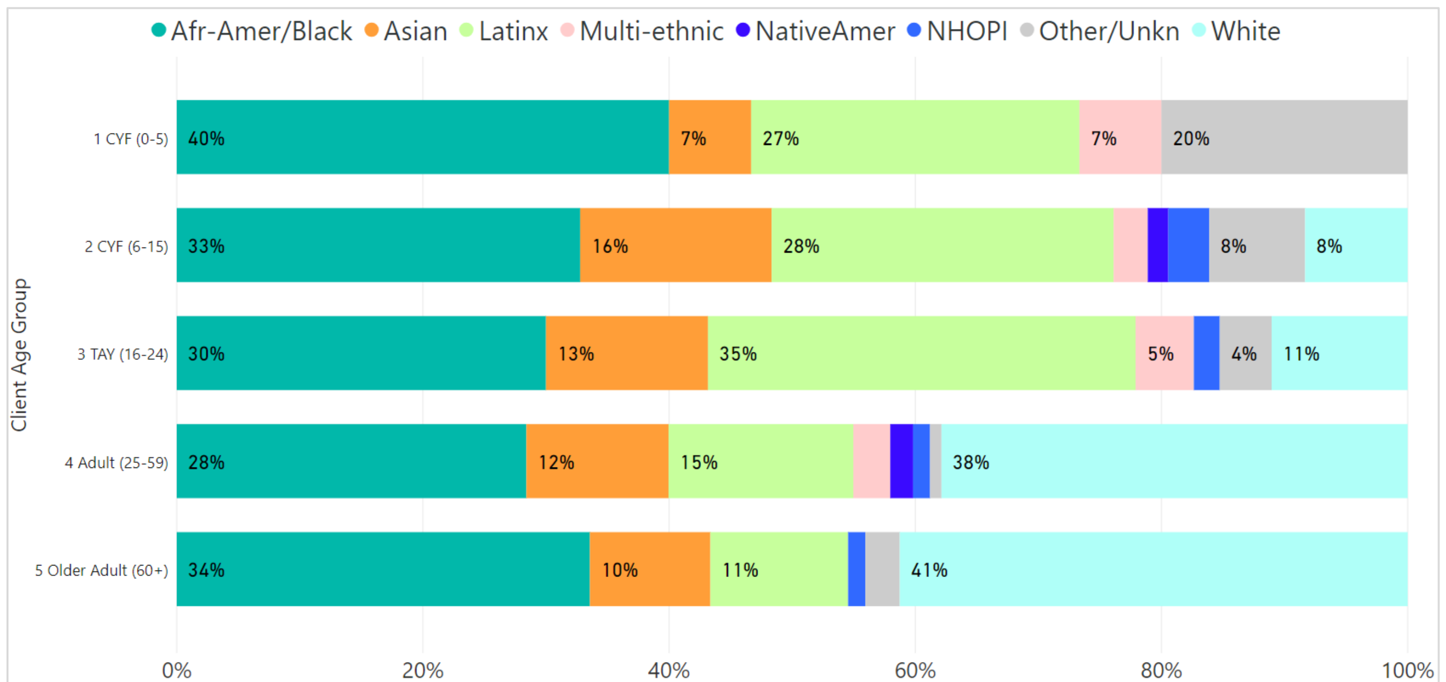
Client Race/Ethnicity by FSP Program

	Afr-Amer/Black	Asian	Latinx	Multi-ethnic	Native Amer	NHOPI	Other/ Unkn	White	**Total**
BHS TAY FSP	14	4	25	1		3	2	5	**54**
Citywide AOT	4	2	4	2	1	1		16	**30**
Citywide Forensics	94	36	38	6	6	3	4	98	**285**
Family Mosaic Project (FMP)	23	22	31	4	2	4	5	9	**100**
FSA Adult FSP	16	11	12	2	1	1		19	**62**
FSA Older Adult FSP	16	7	6			1	3	25	**58**
FSA TAY FSP	12	9	10	5				5	**41**
Hyde Street FSP	23	5	6	1	1	2		20	**58**
IFR SPARK FSP	4	3	5			1	4	1	**18**
Seneca Connections	67	13	49	4	1	1	14	14	**163**
SF FIRST FSP	24	7	19	3		1	1	52	**107**
Total	**297**	**119**	**205**	**28**	**12**	**18**	**33**	**264**	**976**

Client Race/Ethnicity by Client Age Group

	Afr-Amer/Black	Asian	Latinx	Multi-ethnic	Native Amer	NHOPI	Other/ Unkn	White	**Total**
1 CYF (0-5)	6	1	4	1			3		**15**
2 CYF (6-15)	59	28	50	5	3	6	14	15	**180**
3 TAY (16-24)	57	25	66	9		4	8	21	**190**
4 Adult (25-59)	123	50	65	13	8	6	4	164	**433**
5 Older Adult (60+)	48	14	16			2	4	59	**143**
Total	**293**	**118**	**201**	**28**	**11**	**18**	**33**	**259**	**961**

Client Race/Ethnicity by Client Age Group



Client Primary Language

Client Primary Language is collected at FSP intake, and updated by case managers, as part of the Client Services Information (CSI) admission and treatment planning processes required by Medi-Cal. FSP clients indicate their primary language as English (85%).

Client Primary Language by FSP Program

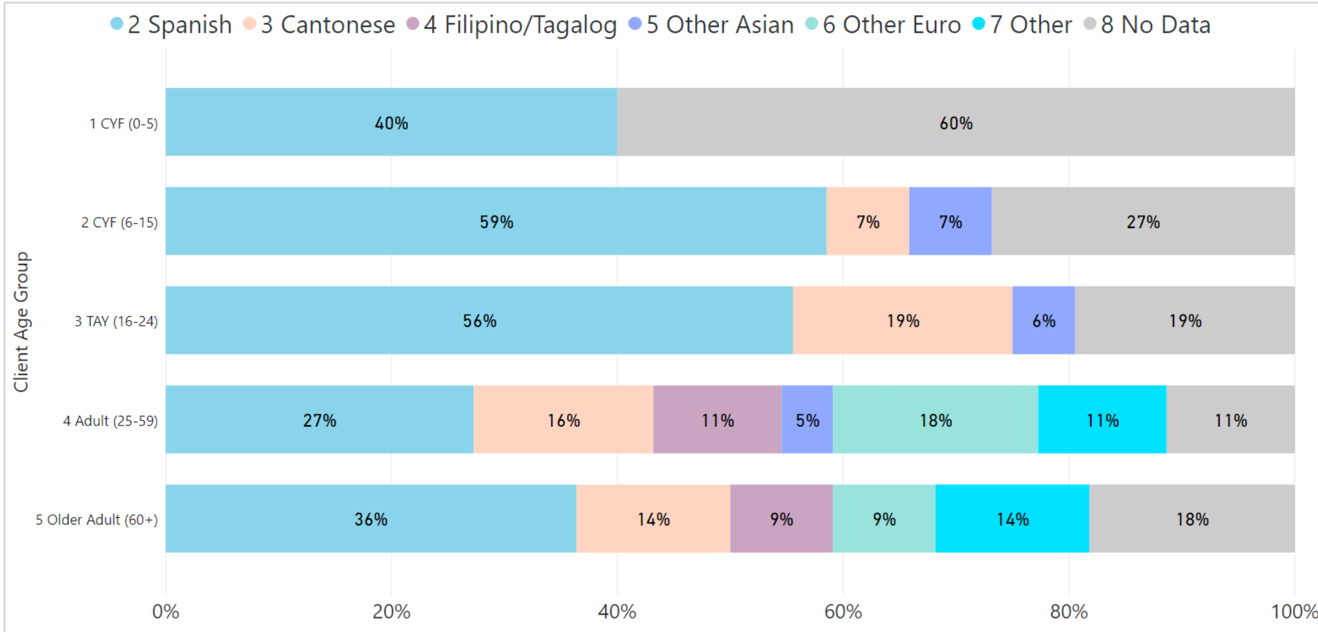
	1 English	2 Spanish	3 Cantonese	4 Filipino/ Tagalog	5 Other Asian	6 Other Euro	7 Other	8 No Data	**Total**
BHS TAY FSP	47	6	1						**54**
Citywide AOT	26	1	1			1	1		**30**
Citywide Forensics	264	3	2	4	3	4	2	3	**285**
Family Mosaic Project (FMP)	73	15	5		2			5	**100**
FSA Adult FSP	54		4			2	1	1	**62**
FSA Older Adult FSP	48	2	2	1		1	2	2	**58**
FSA TAY FSP	33		4		1			3	**41**
Hyde Street FSP	55	1					1	1	**58**
IFR SPARK FSP	9	5						4	**18**
Seneca Connections	133	20			1			9	**163**
SF FIRST FSP	84	14	1	2		3	1	2	**107**
Total	**826**	**67**	**20**	**7**	**7**	**11**	**8**	**30**	**976**

Client Primary Language by Client Age Group

	1 English	2 Spanish	3 Cantonese	4 Filipino/ Tagalog	5 Other Asian	6 Other Euro	7 Other	8 No Data	**Total**
1 CYF (0-5)	10	2						3	**15**
2 CYF (6-15)	139	24	3		3			11	**180**
3 TAY (16-24)	154	20	7		2			7	**190**
4 Adult (25-59)	389	12	7	5	2	8	5	5	**433**
5 Older Adult (60+)	121	8	3	2		2	3	4	**143**
Total	**813**	**66**	**20**	**7**	**7**	**10**	**8**	**30**	**961**

Of those clients not reporting English as a primary language for whom data were available (n=118), Spanish (7%), Cantonese (2%) and Filipino and Tagalog (0.7%) were most common. Other Asian languages included: Vietnamese, Japanese, and Mandarin. Other European languages included: Russian, French, German and Portuguese. Arabic and Samoan were reported under Other.

Client Primary Language by Client Age Group



FY18-19 Key Outcomes and Highlights

The MHSA Data Collection and Reporting (DCR) system tracks outcome indicators for all Full Service Partnership (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 DHCS server into a San Francisco County SQL server data warehouse. From this, we generate datasets using SQL and ACCESS and reports, sharing them regularly with FSP programs. These tools were used 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. Data were entered into the DCR system using the Partnership Assessment Forms (PAFs) and Key Event Tracking (KET) Assessments, ideally as they occurred. Residential and Emergency outcomes are reported here by FSP program age group.

FSP Residential Outcomes

Data Collection. 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.

Reporting Methodology. Residential Settings graphs include all **clients** active in the FSP during FY18-19 with a completed PAF, who have served **in the FSP partnership for at least one continuous year and up to four years**. These graphs exclude clients who have been active in the FSP for less than one year or more than four.

Charts Explained. The following charts compare active clients' **baseline year** (the 12 months immediately preceding entry into the FSP) to the **most recent year** enrolled in the FSP. As clients have entered the FSP in different years, the baseline year is are not the same years for all currently active clients. Typically, clients spend time in more than one setting in each year.

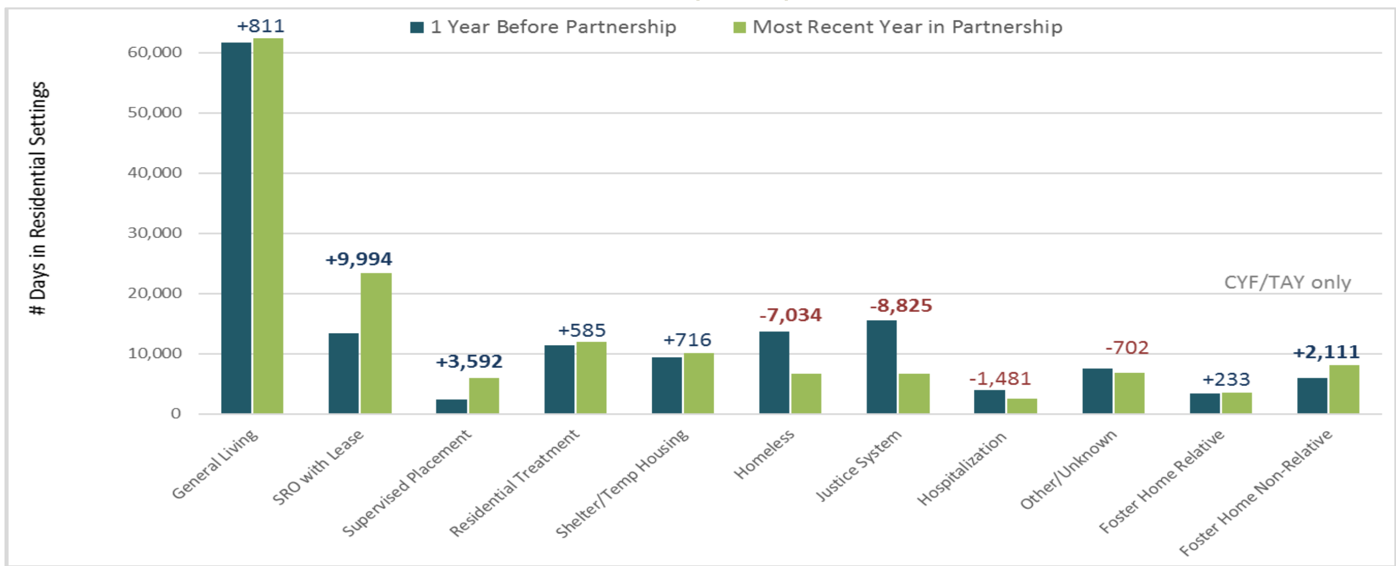
Residential settings are displayed from more desirable, i.e. generally more independent, less restrictive, to less desirable, but this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for one client, for many the move indicates getting into much needed care. Because residential settings differ greatly between children and all other age groups, the graphs following "All FSP Clients" show each FSP program age group separately. For older adults, a hospitalization may address an age-related medical need, not necessarily an acute psychiatric event.

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.

Clients in All FSPs

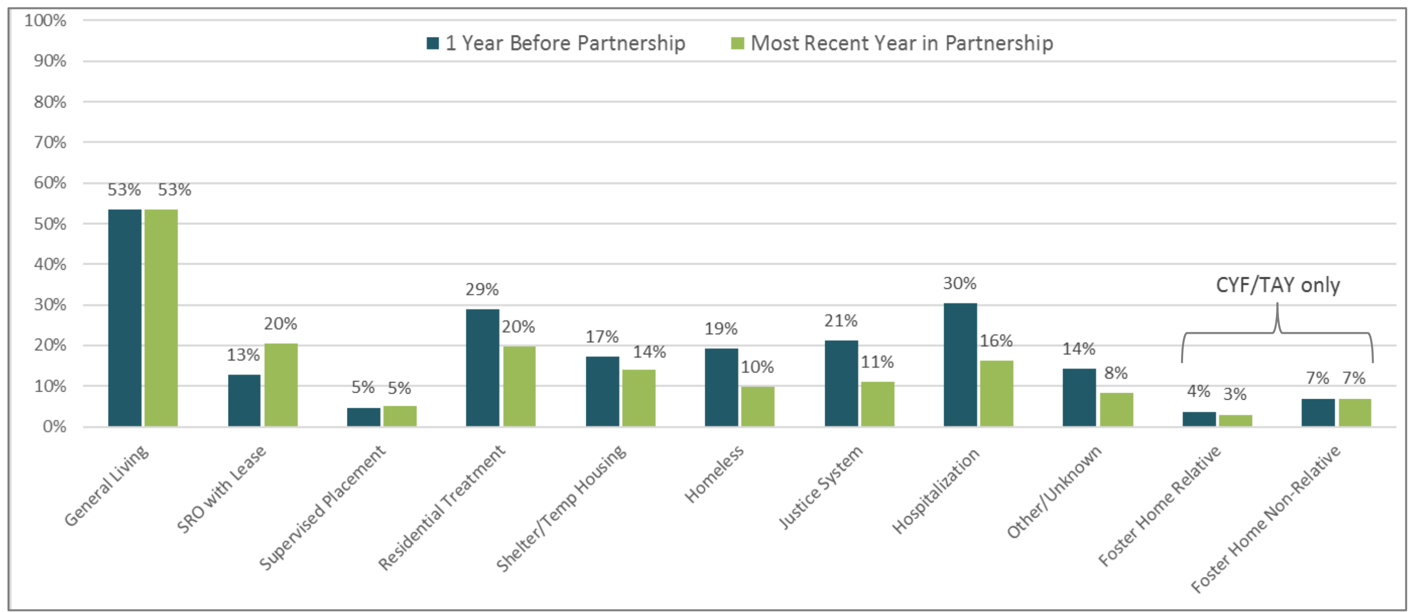
Over all age groups, the residential outcomes below (Exhibit RES-All-1) show reductions in the number of days that all clients enrolled between 1-4 years in an FSP program experienced homelessness, justice system, and hospital settings in their baseline year (pre-FSP) compared to the most current year in FSP. The most considerable increases were in Single Room Occupancy (SRO with Lease, i.e. tenants' rights) and supervised placement, as well as Foster Care Settings, applicable only to CYF and TAY clients.

Exhibit RES-All-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=406)



While time spent in stable settings increased, and simultaneously decreased for less stable or more restrictive settings, the numbers of clients experiencing these residential settings dropped or remained steady for most unstable or restrictive settings (Exhibit RES-All-2). Looking at the above and below graphs together, it's helpful to notice the direction of days spent and the direction of percentage of clients experiencing that setting. For example, a smaller percentage of clients experienced Residential Treatment and Shelter/Temp Housing in the most recent year (20% down from 29%, and 14% down from 17%, respectively). However, those fewer clients spent more days in Residential and Shelter/Temp Housing in the most current year, compared to the baseline year (up 585 and 716 days, respectively).

Exhibit RES-All-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=406)



Child, Youth and Family Clients (CYF)

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.

In most categories, when the number of clients experiencing a residential setting increases (Exhibit RES-CYF-2), the total time reported in that category also increases (Exhibit RES-CYF-2). For Foster Home with Relative, however, fewer clients logged more time than for the baseline.

Exhibit RES-CYF-1. **Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, CYF only (n=139)**

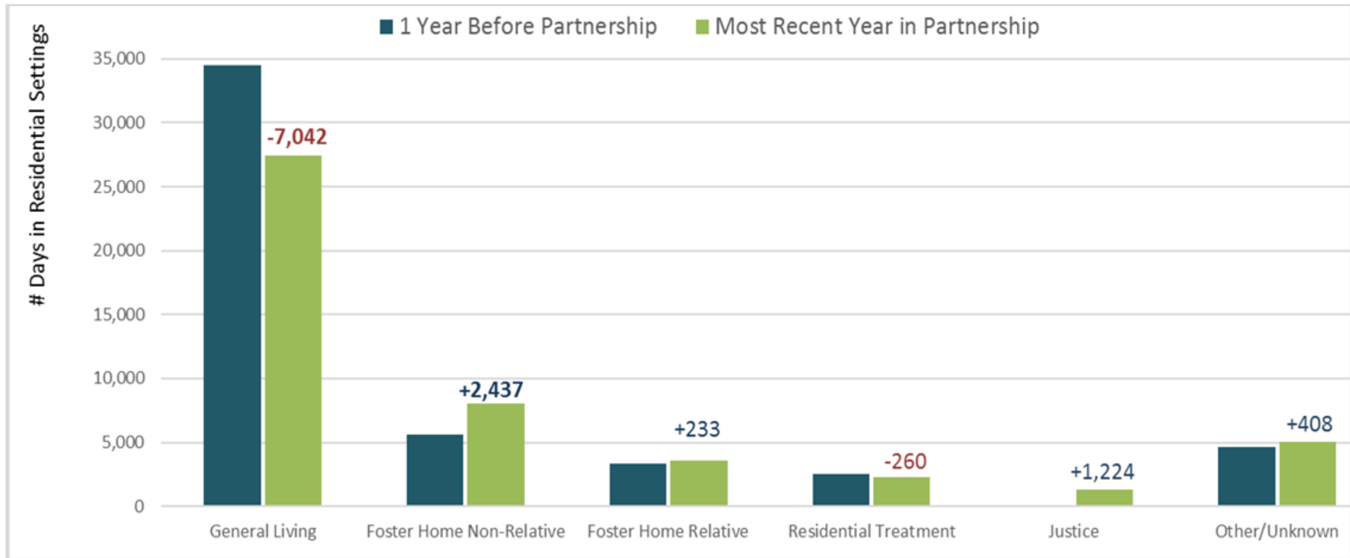
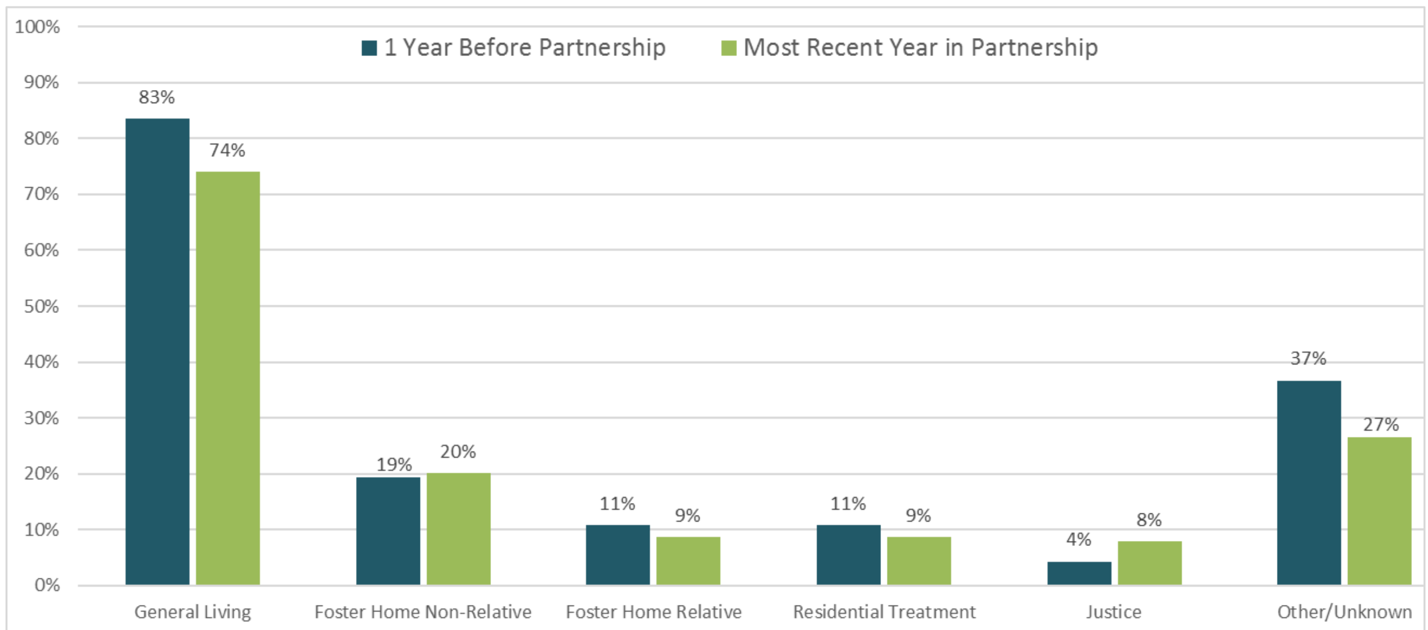
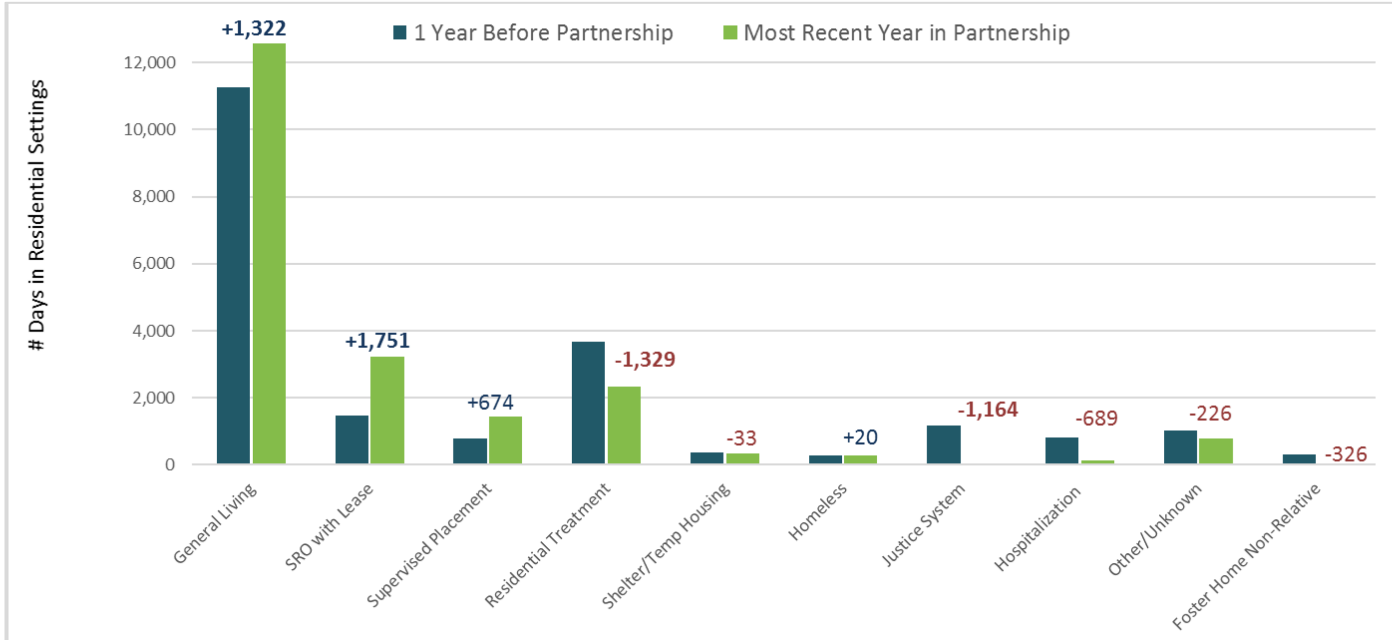


Exhibit RES-CYF-2. **Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, CYF only (n=139)**



Transition Age Youth (TAY)
From the baseline year to the most current year in FSP, TAY clients spent more time in stabilizing settings like General Living, SRO with Lease and Supervised Placement (Exhibit RES-TAY-1).

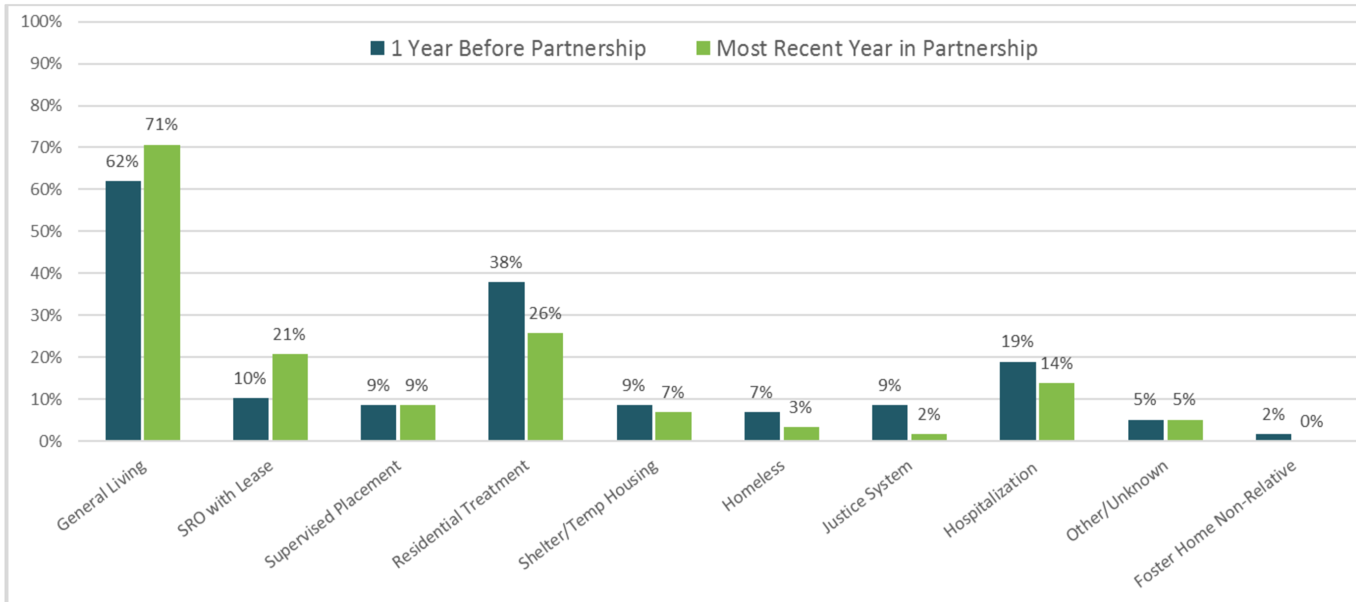
Exhibit RES-TAY-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, TAY only (n=58)



For more unstable or restrictive settings, TAY logged fewer days and fewer of these settings (Exhibit RES-TAY-2) than in their baseline year. This suggests that TAY clients are gaining access to housing or stabilizing enough to maintain more stable housing.
While the days spent experiencing Homelessness increased by 20, the number of clients in Homeless settings dropped 4%.

MHSA Staff preparing for a CPP Meeting

Exhibit RES-TAY-2. **Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, TAY only (n=58)**



Adult Clients

Adult clients saw a reduction in both amount of time spent (Exhibit RES-A-1) and the number of clients (Exhibit RES-A-2) experiencing Homeless, Justice System, and Hospital settings, from the baseline to the most current year in FSP.

Dramatic increases are evident in the number of clients and in the percentage of days spent in General Living arrangements, SRO with Lease, MHSA Stabilization, and Supervised Place-ment. Fewer clients spent time in Residential Treatment (-13%), but those few clients spent more days (2,091) days in this setting, which may represent an advancement in recovery for FSP clients who have not previously accessed care.

Exhibit RES-A-1. **Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Adult Clients only (n=172)**

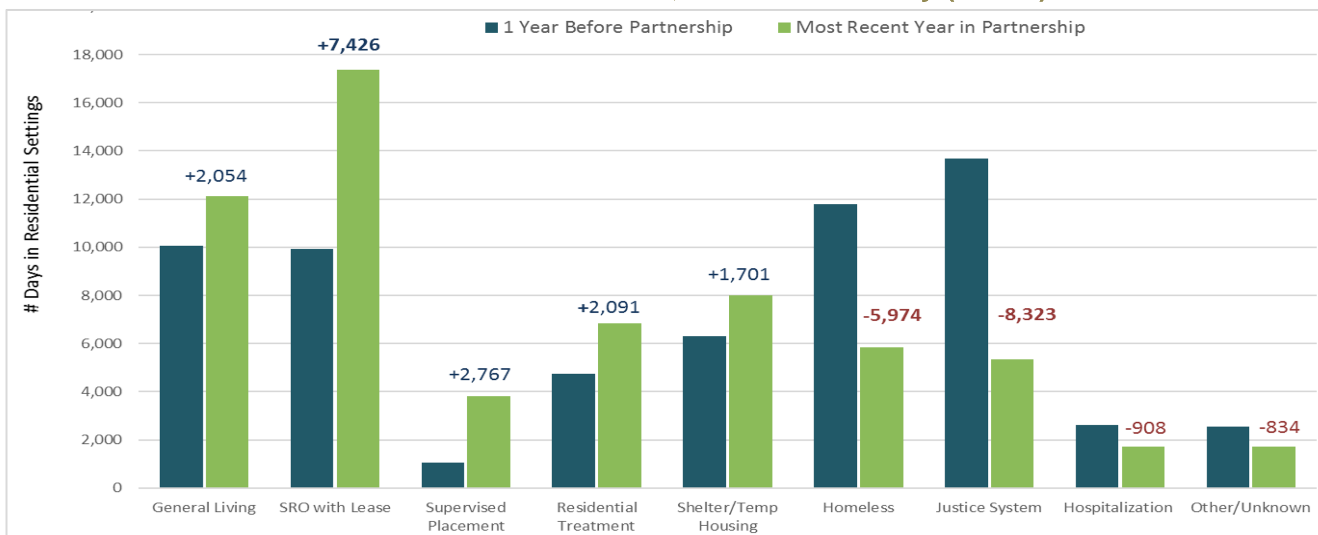
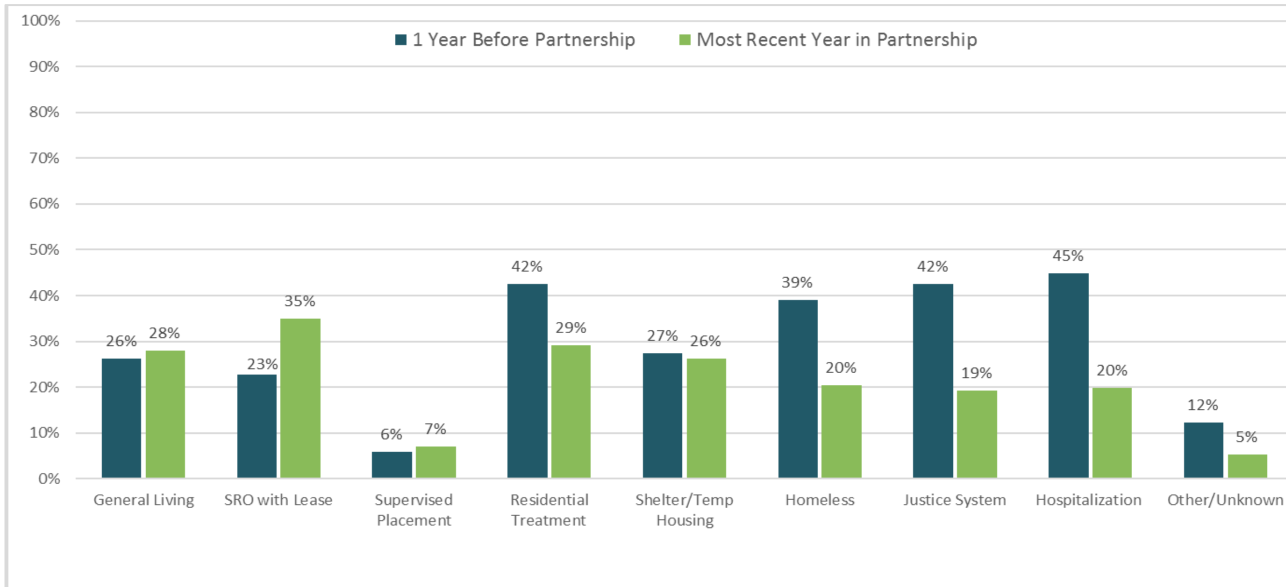


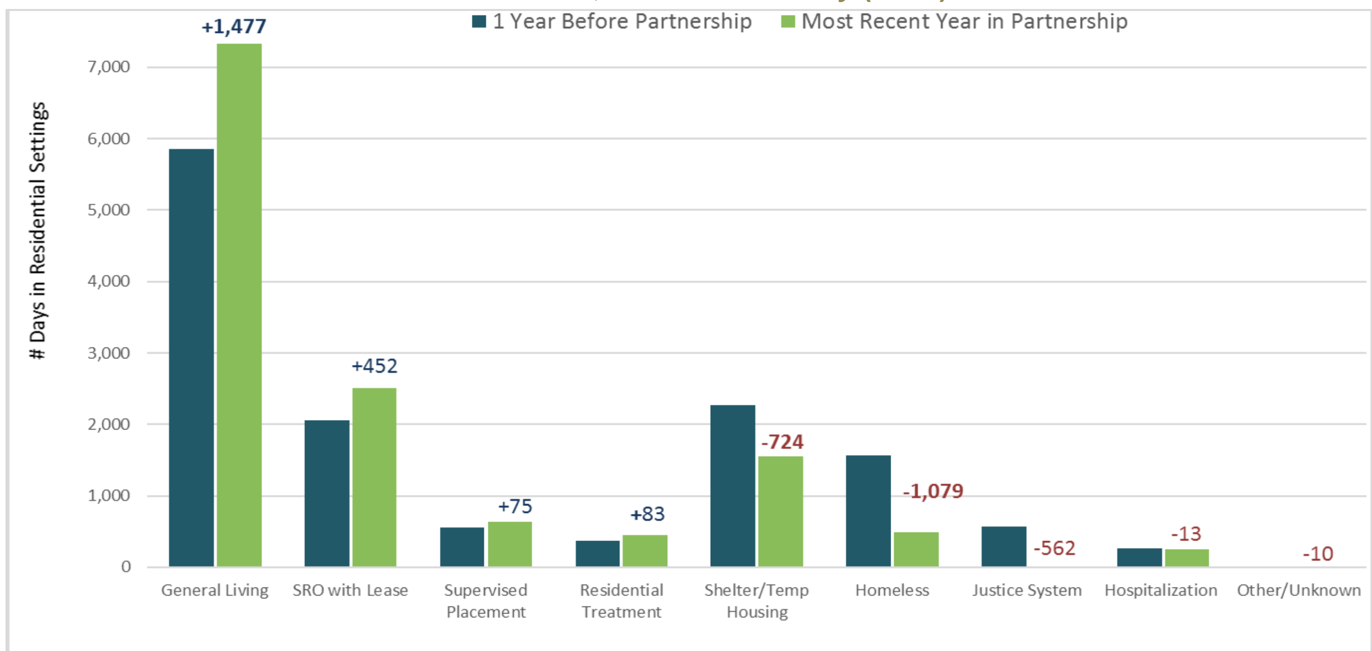
Exhibit RES-A-2. **Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Adult Clients only (n=172)**



Older Adult Clients

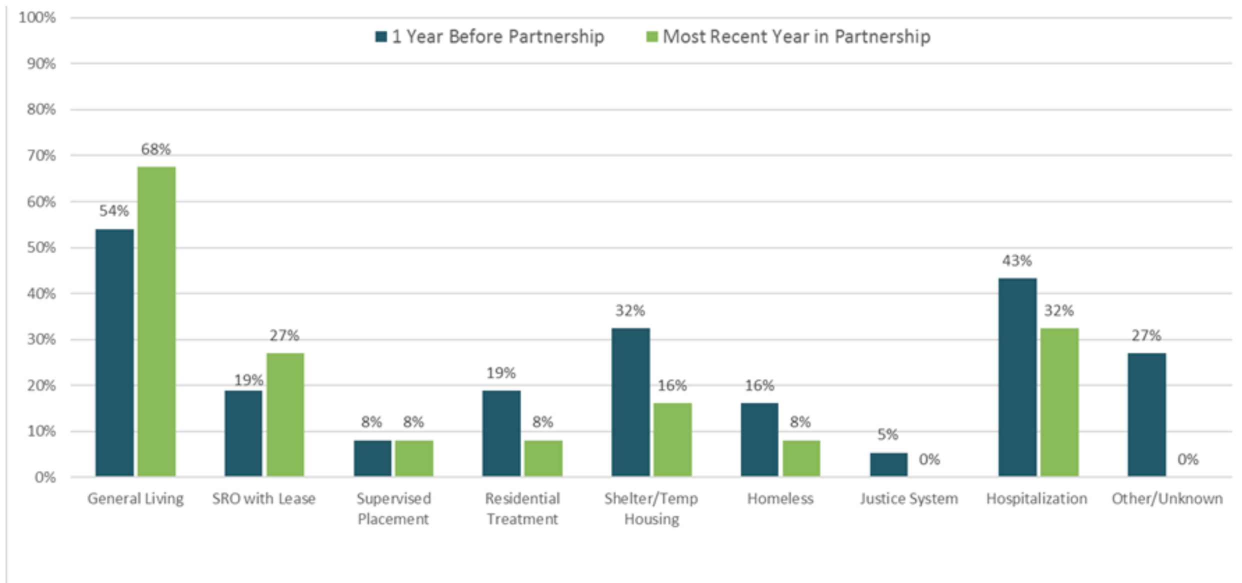
Compared to the year prior to entering FSP programs, Older Adult FSP clients spent less time overall in unstable settings (Exhibit RES-OA-2), and more time in stable housing settings. For example, the number of days spent in General Living arrangements (+1,477 days), SRO with Lease (+452), Supervised Placement (+75), and Residential Treatment (+83) were all higher compared to the year prior to entering FSP programs.

Exhibit RES-OA-1. **Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Older Adults only (n=37)**



It is important to note that while the *number of days* in Residential Treatment increased across all Older Adult FSP clients compared to the year prior to entering the FSP, proportionally *fewer clients* spent time in Residential Treatment (-13%), which may represent an advancement in recovery for FSP clients who have not previously accessed care (Exhibit RES-OA-2).

Exhibit RES-OA-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Older Adults only (n=37)



Emergency Events

Data Collection. 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.

Report Methodology. The graphs below compare Emergency Events for **all FSP clients active any time in the fiscal year 2018-19** from the one-year baseline to an **average of emergency events over all years while in the FSP**. Event rates are reported here, for simplicity, as number of Emergency Events per 100 clients for each one year period.

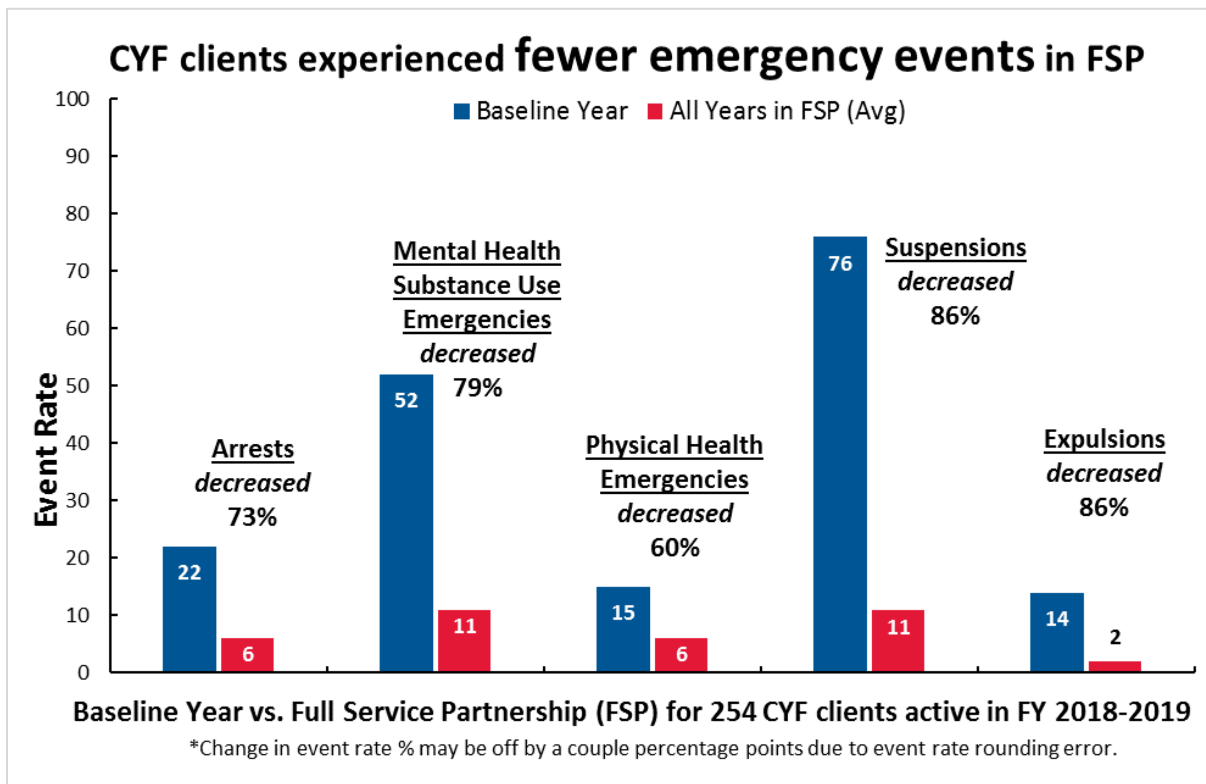
Charts Explained. Note that the numbers below of active clients reported for emergency events, in each age group, are larger than for residential events. Unlike the residential data, the emergency events graphs include all active clients, even if they have been in the FSP for less than one year or more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

Among child clients, fewer emergency events were reported after entering FSP (Exhibit EE-CYF)**.** 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 documentation issue in the system of care. Data Quality reports suggest that there are some missing DCR data for CYF clients; thus, these trends should be interpreted with caution.

Exhibit EE-CYF. Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, CYF only (n=254)

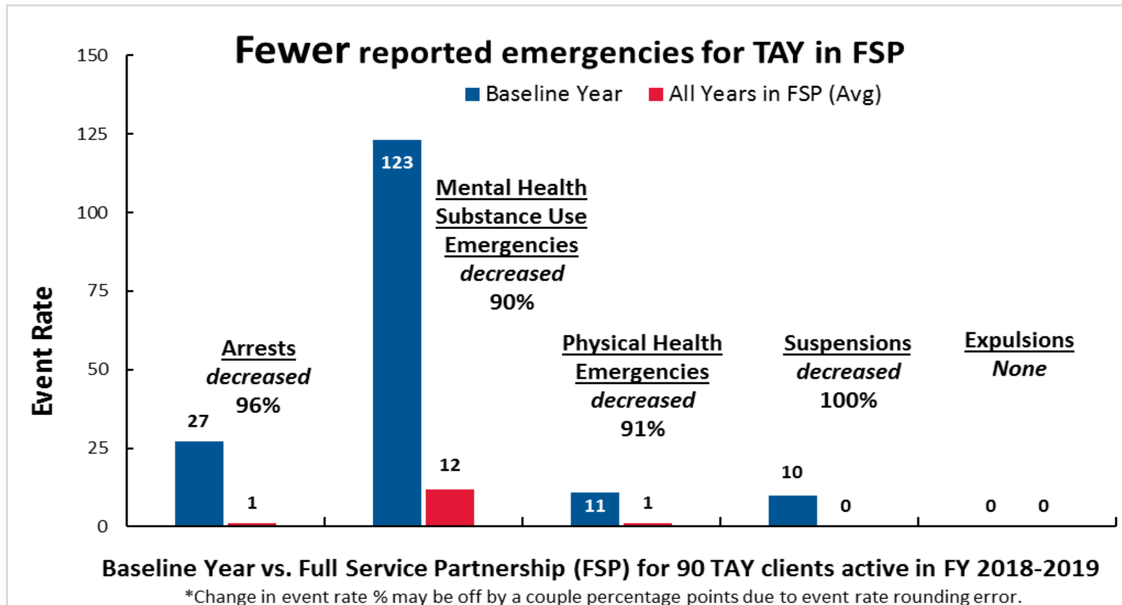


Among TAY clients, fewer emergency events were reported (Exhibit EE-TAY). Marked declines appear across all emergency events experienced by TAY clients. For example, mental health substance use emergencies, physical health emergencies, and arrests all decreased by 90% or more.

Discharge data also suggest that TAY engagement may be a major challenge (see Exhibit RFD). Between 11% and 20% of TAY clients are “Unable to Locate” or “Partner Left Program.” Data suggest that TAY clients may leave the FSP programs within the first year of service. It is possible that due to loss to follow up, the full sample of TAY clients served may be under-represented in the follow-up rates displayed here for our FSP programs.

School Suspensions declined from 10 to 0 per 100 clients, and there were no School Expulsions reported across all TAY clients who were active in 2017-18. Either expulsions are under-reported, or this decrease reflects a policy in the school district, as mentioned for Exhibit EE-CYF, which strongly discourages student expulsions.

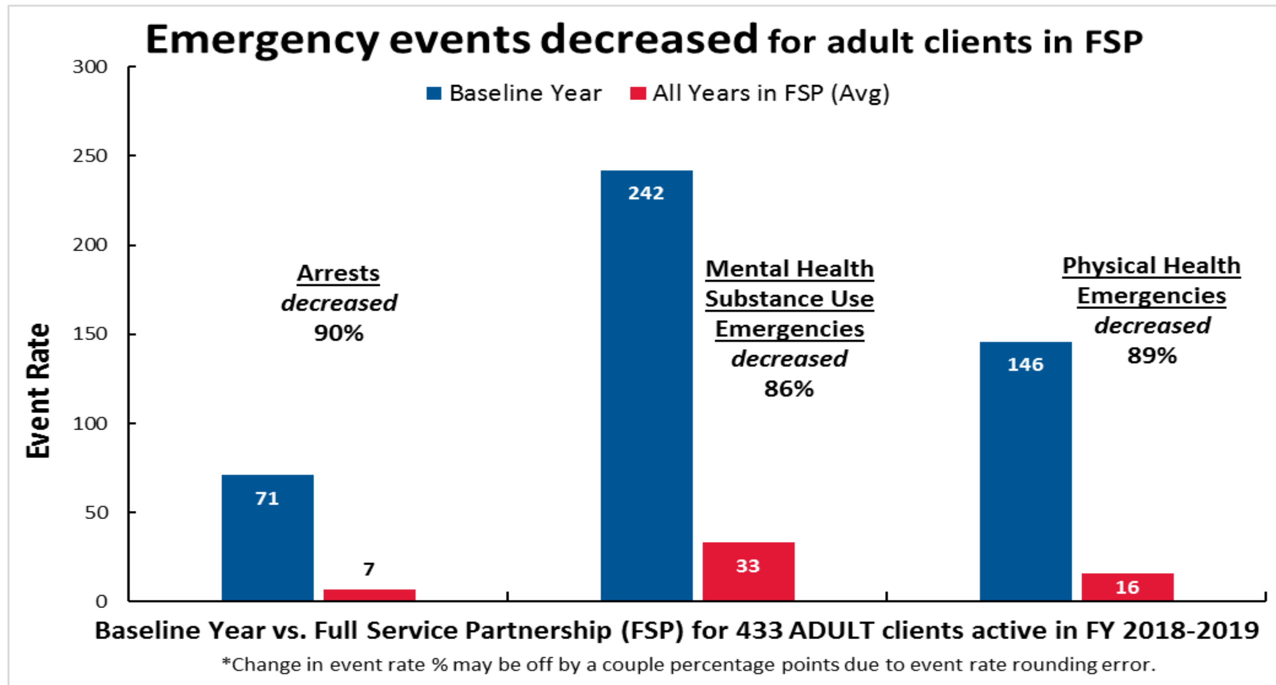
Exhibit EE-TAY. **Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, TAY only (n=90)**



Among Adult clients, fewer emergency events were reported compared to baseline FSP data (Exhibit EE-A)**.** Marked declines appear across all emergency events experienced by Adult FSP clients. For example, mental health substance use emergencies, physical health emergencies, and arrests all decreased by over 85%.

Workforce Development CPP Planning Session

Exhibit EE-A. **Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Adult Clients only (n=433)**

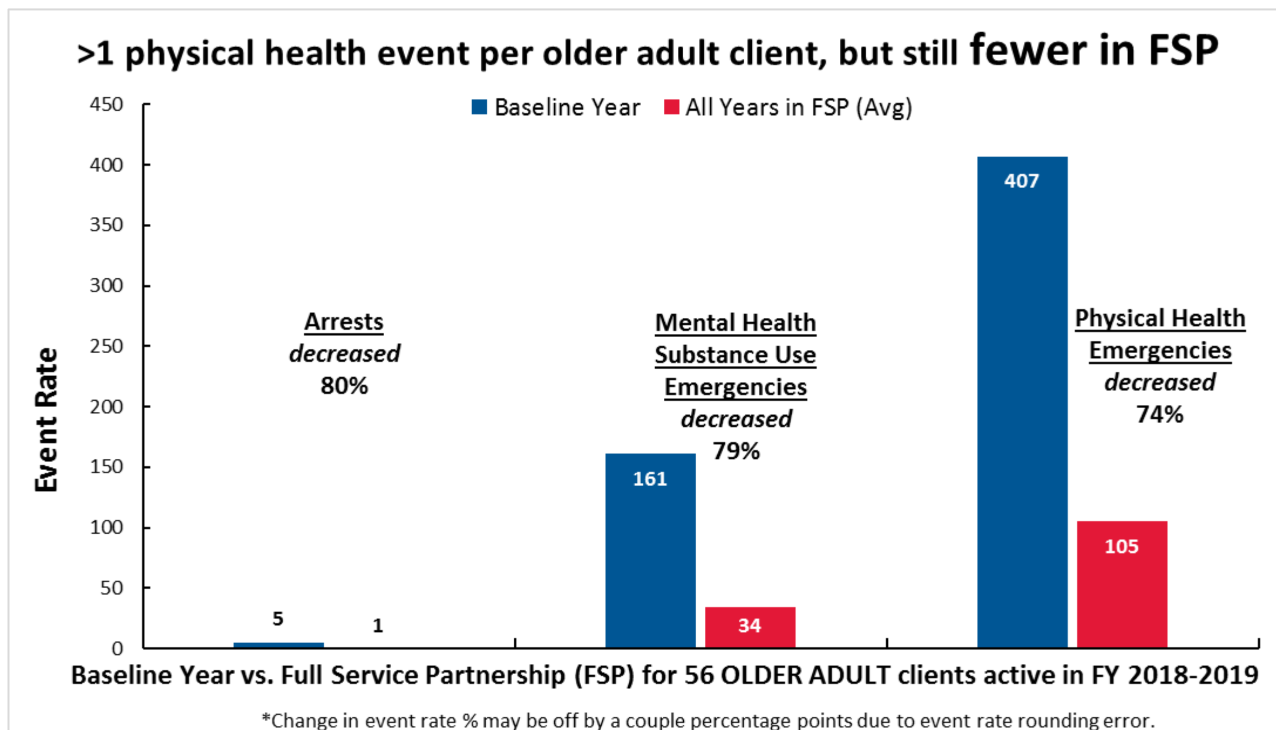


Despite high levels of physical health emergencies among older adult clients at baseline, data reveal improvements after the first year in FSPs (Exhibit EE-OA)**.** Marked declines appear across the emergency events experienced by Older Adult FSP clients. For example, mental health substance use emergencies, physical health emergencies, and arrests all improved by over 74%.

While, physical health emergencies may be common among older adults, particularly those served by FSP programs, our data reveal that compared to the first year in an FSP, the rate of physical health emergencies (407 per 100 clients at baseline) dropped 74% to 105 events per 100 clients after at least one year of FSP service. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

CPP Meeting 2019

Exhibit EE-OA. **Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Older Adults only (n=56)**

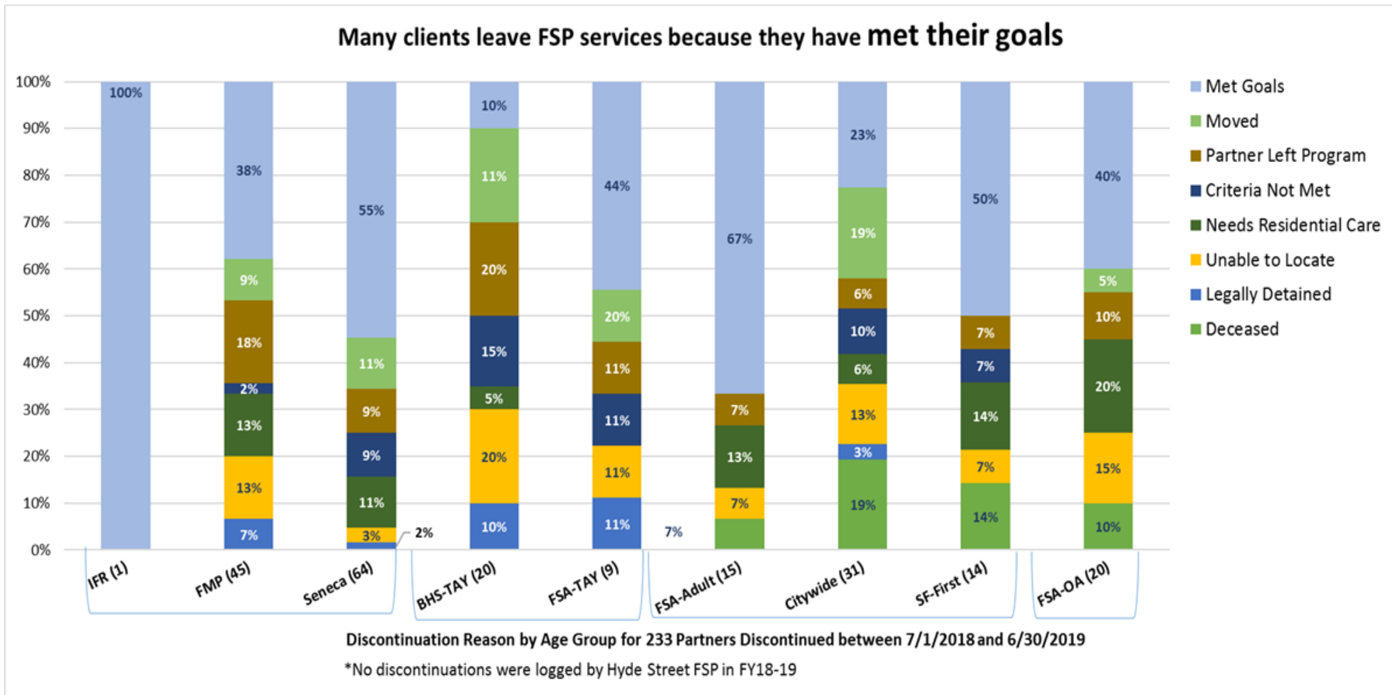


Reason for Discontinuation

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 FY 2018-19. Client reasons for discontinuation most often as “Met Goals” across all age groups, and represented 37% of discharges across the whole FSP system of care. Discontinued TAY clients were more often reported as “Partner left program.” Most concerning in this display is that, among Adults, on average 26% of discontinuations were due to death, often premature and complicated 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



As mentioned previously, the high rate of TAY departures from FSPs prior to meeting treatment goals is an ongoing engagement challenge. San Francisco County is actively addressing this challenge with the launch of a dedicated TAY System of Care.

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 continues to manage DCR activity through the DCR Workgroup, comprised of one MHSA evaluator, the MHSA director and one IT staff person. The Workgroup works with FSP programs to support accurate and timely client data entry into the DCR, in part by generating several data quality and data outcome reports that are shared monthly with the FSP programs. These reports and data discussions about them help monitor and increase the level of completion for KETs and Quarterly Assessments.

The Workgroup also provides 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 DCR data entry as a priority.

Additionally, for FY19-20, BHS has set 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.

QM technical assistance and support, including coaching on assessment completion, are in place to increase compliance and the accuracy of outcomes data.

The DCR Workgroup also provides in person trainings in the DCR and visits individual programs as needed. In FY18-19, the DCR Workgroup conducted several 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.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[3]**
Full Service Partnership (Children)	195 Clients	$1,327,485	$6,808
Full Service Partnership (TAY)	196 Clients	$1,115,746	$5,693
Full Service Partnership (Adult)	440 Clients	$4,277,975	$9,723
Full Service Partnership (Older Adult)	145 Clients	$497,943	$3,434

Behavioral Health and Juvenile Justice System Integration

Program Collection Overview

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.

[3] 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.

Mo' Magic CPP Meeting 2019

Spotlight on AIIM Higher

AIIM Higher (Assess Identify needs Integrate information Match to services) is a partnership between the SFDPH and the San Francisco Juvenile Probation Department (JPD) to align and improve services for youth who are involved in the juvenile justice system, and their families. AIIM Higher plays a central role in connecting SFDPH and JPD and program staff serve as liaisons between probation officers and behavioral health service providers.

AIIM Higher staff work onsite at Juvenile Justice Center (JJC) since the program launched in 2009. In this role, staff provide JJC youth and families with the following services: (1) screening and comprehensive needs assessment, (2) clinically-informed behavioral health consultation, and (3) linkage and transition to the most appropriate community-based services.

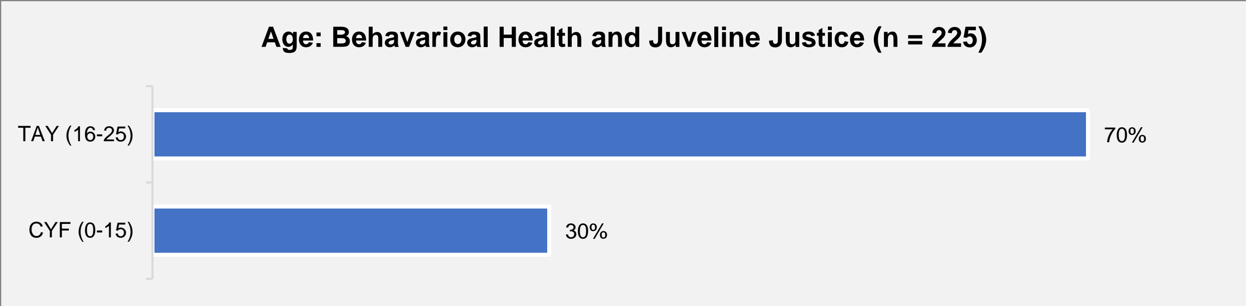
Building upon its collaborative relationship with JPD and a growing understanding of the needs of probation-involved youth in San Francisco, AIIM Higher has expanded its juvenile justice services to engage youth as they transition through critical juvenile justice intervention windows, providing a comprehensive array of individual and group interventions at JJC, including: (1) substance use treatment coordination, consultation and training through our Treatment to Recovery through Accountability, Collaboration and Knowledge program (TRACK); (2) juvenile justice re-entry services through Family Intervention, Reentry and Supportive Transitions (FIRST); (3) intensive case management through Youth Transitional Services (YTS); (4) evidence-based classes in Aggression Replacement Training (ART); (5) Competency Attainment Program (CAP) a legal education program for youth that have found to be incompetent by the court; and (6) probation-focused Wraparound.

AIIM Higher staff complete a brief, standardized assessment for every youth presented for referral to understand their needs and determine eligibility and level of services to be provided. Results of the assessment are reviewed directly with the Probation Officer in order to determine next steps and type of service provided. This past fiscal year, AIIM Higher staff provided the full scope of AIIM Higher services (assessment planning, and Linkage and engagement services) to 40 youth. Consultation, information and referral or Linkage services were provided to 225 youth, with a total of 373 youth screened for behavioral health needs, exceeding our goal of 150. After a CANS Screen assessment is completed by an AIIM Higher clinician, referrals to services are made in conjunction with the client, family and probation officer.

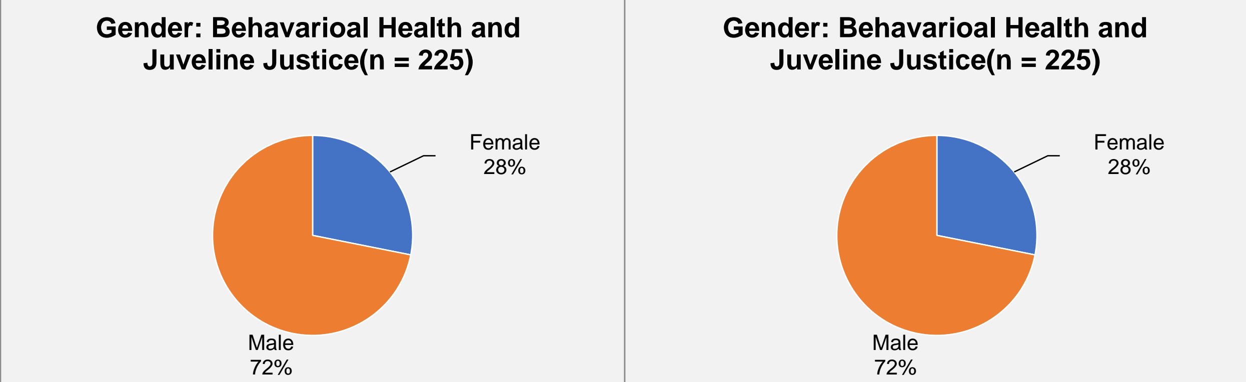
AIIM Higher staff have built strong collaborative relationships with community providers and continue to work with youth and families during the initial referral and linkage process to ensure that clients are engaged in these services. When the youth and family have at least three face-to-face sessions with the new primary provider, this is an indication that it is time to prepare the family for discharge from AIIM Higher. This allows AIIM Higher clinicians to address any barriers to engagement and ensure that the youth and family are successfully linked to longer-term community-based services before AIIM Higher discharges them from our program.

Participant Demographics, Outcomes, and Cost per Client

Demographics: Behavioral Health and Juvenile Justice Integration[4]



*< 1 percent of participants reported Adult (26-59), Older Adults (60+)



*< 1 percent of participants reported data for Trans Female, Trans Male, Another Identity

Sexual orientation = all unknown/ non response
Veterans = *< 1 percent of participants reported data for Yes
Disability = NO DATA

Race/Ethnicity	n	%
Black/African American	131	59%
American Indian or Alaska Native	2	1%
Asian	9	4%
Native Hawaiian or Pacific Islander	8	4%
White	12	5%
Other Race	1	0%
Hispanic/Latino	50	22%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	10	4%
Total	**223**	**100%**

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

Primary Language	n	%
Chinese	0	0%
English	37	93%
Russian	0	0%
Spanish	3	8%
Tagalog	0	0%
Vietnamese	0	0%
Unknown	0	0%
Another Language	0	0%
Total	**40**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher – *Seneca Center and DPH*	• Screened 373 youth for behavioral health needs, exceeding the goal of 150. • Consulted, provided information, or referred to linkage service to 225 youth. • 100% of the 40 clients that AIIM Higher served with the full scope of services (assessment, planning, and linkage & engagement services), were linked to culturally appropriate community based services.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[5]**
Behavioral Health & Juvenile Justice Integration	225 Clients	$314,414	$1,397

Prevention and Recovery in Early Psychosis (PREP)

Program Overview

PREP also known as (re)MIND is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs internationally in Australia and the United Kingdom, and nationally in the state of Maine, among other sites. PREP treatment services include the following: algorithm-based medication management, cognitive rehabilitation, 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

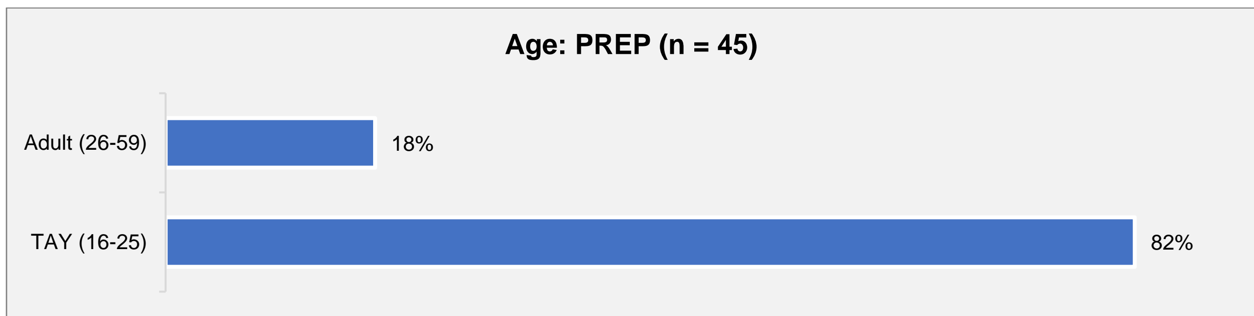
[5] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

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.

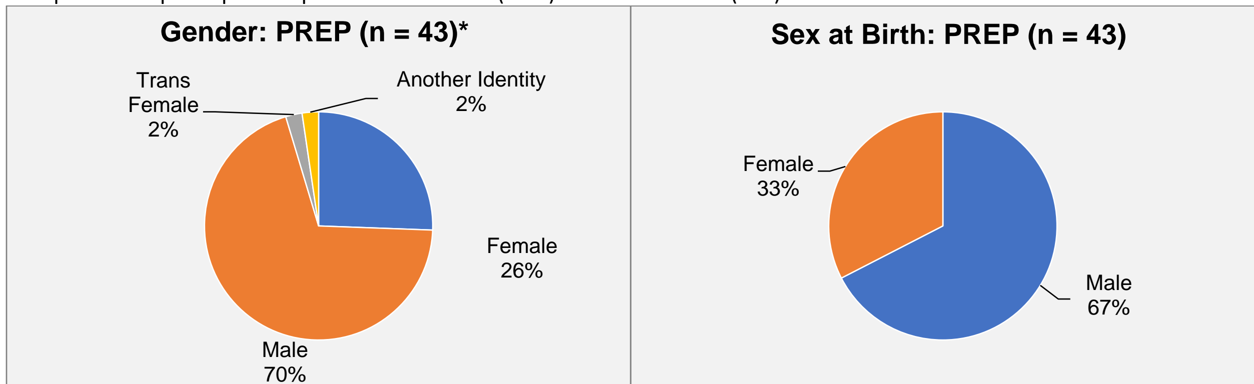
Target Populations

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.

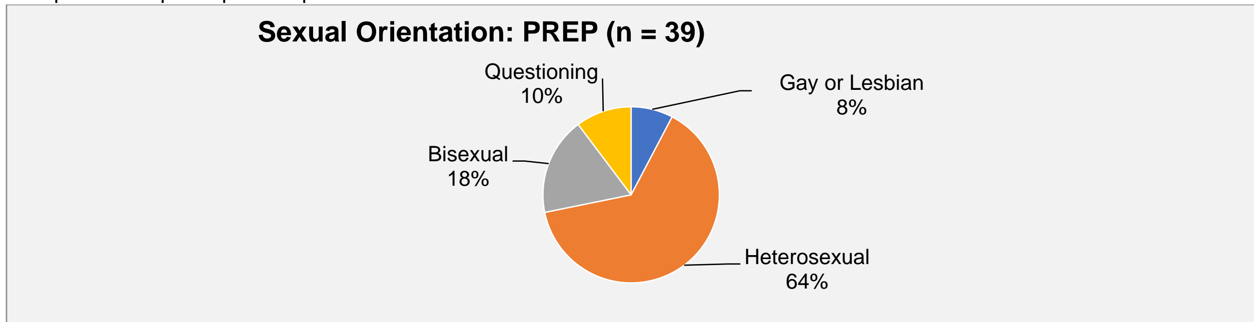
Participant Demographics, Outcomes, and Cost per Client



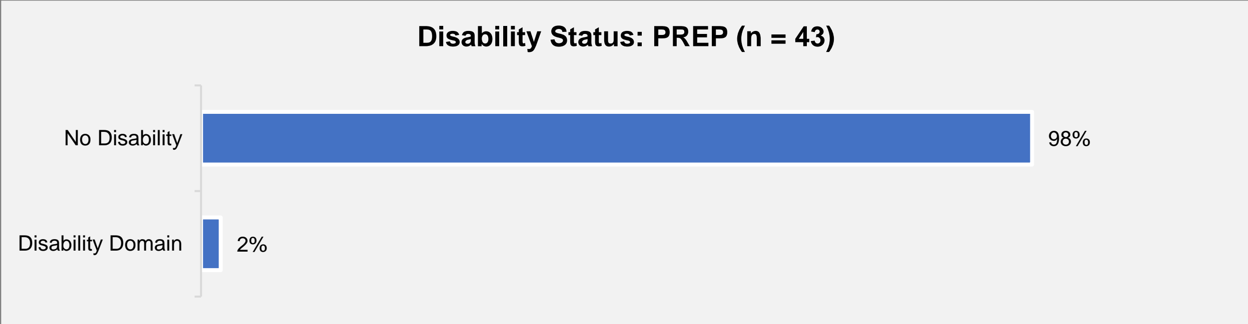
*< 1 percent of participants reported data for CYF (0-15) and Older Adults (60+)



*< 1 percent of participants reported data for Trans Male



Veteran: *< 1 percent of participants reported data for Yes



*< 1 percent of participants reported data for Communication Domain, and Another Disability

Race/Ethnicity	n	%
Black/African American	7	8%
American Indian or Alaska Native	0	0%
Asian	8	9%
Native Hawaiian or Pacific Islander	1	1%
White	10	11%
Other Race	19	21%
Hispanic/Latino	13	14%
Non-Hispanic/Non-Latino	32	36%
More than one Ethnicity	0	0%
Total	**90**	**100%**

Primary Language	n	%
Chinese	0	0%
English	38	84%
Russian	0	0%
Spanish	3	7%
Tagalog	1	2%
Vietnamese	2	4%
Another Language	1	2%
Total	**45**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP) – *Felton Institute*	• Outreached 50 programs and/or community stakeholder groups to establish and maintain referral relationships with regards to early psychosis services and PREP as a local resource. • Conducted 72 phone screens and/or consultations to determine need for comprehensive diagnostic assessment, and diagnostic assessments. • Of 26 clients enrolled for at least 12 months, 19 (73%) engaged in new employment or education activities. • Of 26 clients enrolled for at least 12 months, 12 (46%) had no acute inpatient setting episode within 12 months prior to their enrollment. Out of these 12 clients, 11 (92%) continued to have no acute inpatient setting episodes. • Of 26 clients enrolled for at least 12 months, 18 (69%) showed an increase in ability to cope with challenges they encounter, as assessed by clinicians.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[6]**
Prevention and Recovery in Early Psychosis (PREP)	45 Clients	$600,000	$13,333

MHSA CPP Meeting

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

Recovery-Oriented Treatment Services

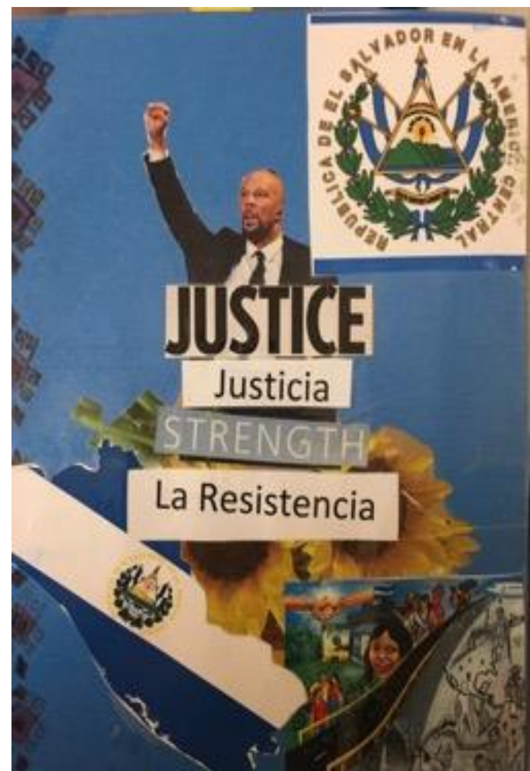
Behavioral Health Access Center (BHAC) - SFDPH

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

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*	FY18-19 Key Outcomes and Highlights
Behavioral Health Access Center - *SFDPH*	• Staff received 18,560 calls from residents of San Francisco seeking access to mental health services. • Staff conducted 819 face-to-face contacts with clients accessing behavioral health care and in need of concurrent primary care services. • Beginning in 2019, BHAC implemented stakeholder meetings to plan for an expansion of the BHAC program to include increased clinical depth, provision of ancillary services, and the availability of screening, assessment, and treatment placement 24/7. This expansion will add 22 new positions (non-MHSA funded).

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[7]**
Behavioral Health Access Center	2,006 Clients	$898,806	$448

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

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

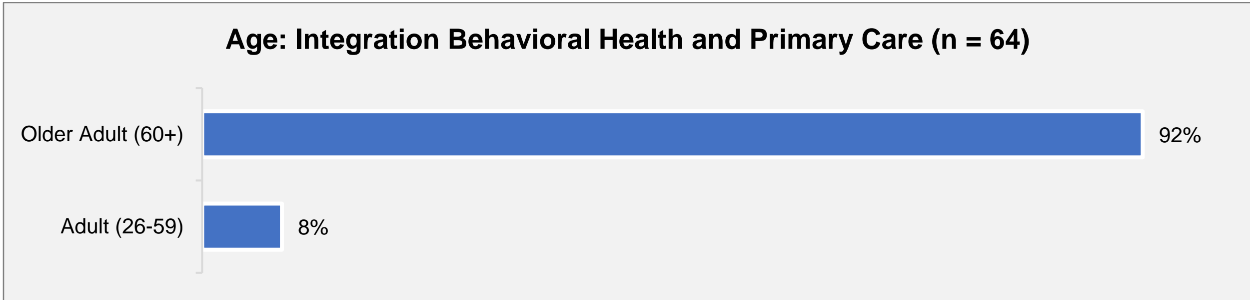
In addition, the Curry Senior Center's Behavioral Health Services in Primary Care program provides wrap-around services including outreach, primary care, and comprehensive case management as stabilizing strategies to engage isolated older adults in mental health services. The Nurse Practitioners within this program provide individual screening encounters for mental health, substance abuse and cognitive disorders in various locations.

Target Populations

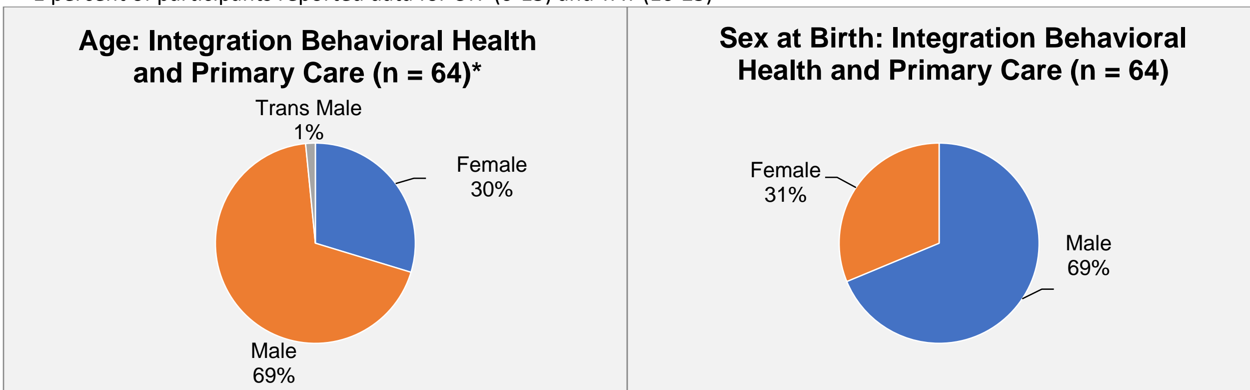
The target populations for these services are individuals and families served in primary care clinics with unidentified behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

Participant Demographics, Outcomes, and Cost per Client

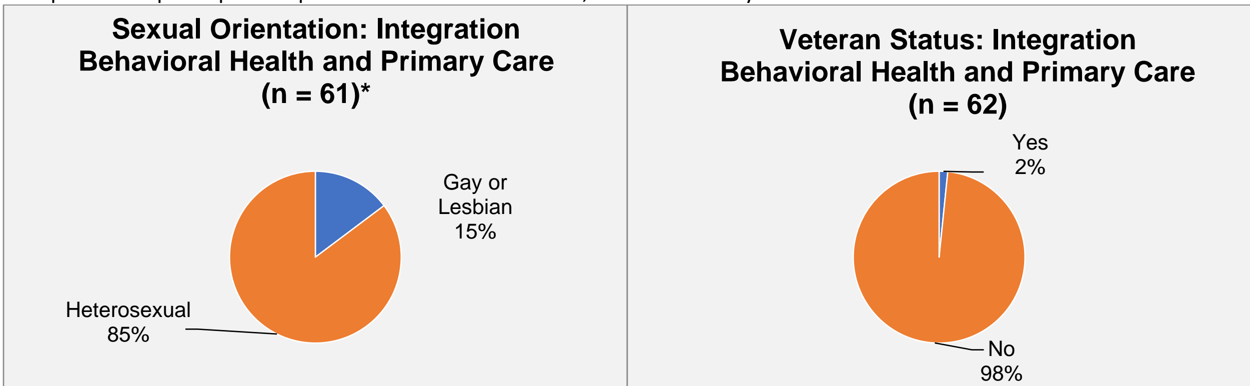
Demographics: Integration of Behavioral Health and Primary Care



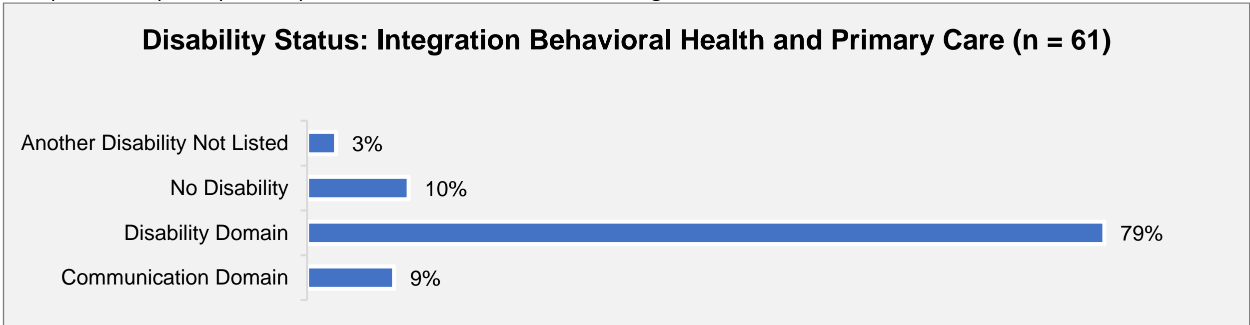
*< 1 percent of participants reported data for CYF (0-15) and TAY (16-25)



*< 1 percent of participants reported data for Trans Female, Another Identity



*< 1 percent of participants reported data for Bisexual, Questioning, Another Orientation



Race/Ethnicity	n	%
Black/African American	17	14%
American Indian or Alaska Native	1	1%
Asian	3	2%
Native Hawaiian or Pacific Islander	0	0%
White	32	26%
Other Race	7	6%
Hispanic/Latino	4	3%
Non-Hispanic/Non-Latino	56	46%
More than one Ethnicity	1	1%
Total	**121**	**100%**

Primary Language	n	%
Chinese	0	0%
English	58	95%
Russian	0	0%
Spanish	3	5%
Tagalog	0	0%
Vietnamese	0	0%
Another Language	0	0%
Total	**61**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – *Curry Senior Center*	• Behavioral navigators completed 413 face to face encounters. The goal was to reach 450 patient encounters. • Nurse practitioners completed mental health screenings using PHQ-9 across 203 patients. The goal was to screen 100 patients. • Nurse practitioners referred 65 patients to case managers. The goal was to reach 50 patients. • Only 3 patients completed the survey to demonstrate an increased ability to manage medication. The goal was to reach 6 patients.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[8]**
Integration of Behavioral Health and Primary Care	580 Clients	$1,641,118	$2,830

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

Intensive Case Management/Full-Service Partnership to Outpatient Transition Support (INN) - RAMS

Program Overview

SFDPH MHSA applied to and received funding from the California Mental Health Services Oversight and Accountability Commission in Fiscal Year 2017-18 for a five-year project to support our clients' transitions from Intensive Case Management/Full Service Partnership programs to Outpatient Treatment Services.

The Intensive Case Management/Full Service Partnership programs to Outpatient (ICM/FSP-OP) Transition Support project offers an autonomous peer linkage team, which provides both wraparound services and a warm hand off from ICM to OP. When clients no longer need the intensive level of care and service provided by ICM and FSP programs and they are discharged, many individuals do not link successfully to medically necessary and regular OP services.

The major goals of this project are to increase client engagement in behavioral health outpatient services among those stepping down from ICM/FSP services, improve the overall client experience for those in transition, and support and further develop a peer-driven model of care. 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 mental health outpatient services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

On July 6, 2018, MHSA published RFQ 22-2018 for the project, which has been renamed the Peer Transition Team (PTT). For this RFQ, the selected service provider will be required to select, employ, train and support five peer specialists to perform the peer duties described in this document. At least one of these five peers must be a peer who is a Transition Age Youth (16-24 years of age) and at least one of these five peers must be either a bilingual Spanish-speaking peer or a bilingual Chinese-speaking peer.

The selection team reviewed proposals and awarded the contract to the Richmond Area Multi Services agency (RAMS), based on agency qualifications. RAMS launched the program start-up on January 1, 2019. This start up period included the hiring of peer staff, the purchasing of items for the program, introductions to all the relevant program sites, and development of forms and brochures needed by the programs. Full operations of the programming began July 2019. Program outcomes and participant demographics will be available for FY19-20 in next year's Annual Update Report.

Moving Forward in Recovery-Oriented Treatment Services

Full-Service Partnership Programs

Refining Program Practices to Support Staff and BHS System Needs

FSP programs adopt a client-centered approach when addressing difficult situations, such as violation of safety protocols, which ensures that our clients are involved in problem-solving discussions. Our team also continuously reviews FSP client progress to ensure they are receiving

the correct level of care. In an effort to achieve this, FSP programs have created a step-down transition program to ease the transition from our more intensive levels of care to our less intensive outpatient programs and many programs have been stepping-down clients who are ready for a lower level of care. In preparation for stepping down, programs offer clients linkages to meaningful vocational, educational, and socialization activities. FSP service providers also collaborate with the Innovation Peer Transitions Team from RAMS to host peer-led socialization groups, which further support our clients in ensuring they receive the proper care.

Barriers such as retaining program staff, maintaining a diverse workforce, and operating in the midst of the homeless crisis, have significantly impacted the work of FSP programs. However, due to extensive recruitment and outreach to the general public, some of the program have been able to remain fully staffed. In addition, with the increase in shared leadership practices, there have been more capacity building opportunities for FSP program staff.

In addressing staff retention and staff shortages, SFDPH MHSA and FSP service providers have created a clinical internship program with a Marriage and Family Therapist (MFT) to assist in providing therapy and intensive case management (ICM) services for a small case load. There has also been integration of peer staff in FSP programs. Peer interns and staff have assisted in events, group rehabilitation, welcome events, and leading skill building activities. Through this integration, some of the peer interns and staff advanced to full time positions.

Strong Commitment to Hiring & Training a Culturally-Responsive Workforce

In the past year, FSP program directors and staff have demonstrated their commitment to providing services that are culturally-responsive. To ensure culturally-responsive care, FSP program providers have participated in a series of culturally-sensitive trainings on the following topic areas:

- Geriatric mental health
- Sexual Orientation & Gender Identify (SOGI)
- Trauma informed care

Multidisciplinary Collaboration to Meet Client Needs

FSP housing programs have collaborated on MHSA housing program meetings, improving the communication between FSP case managers and other stakeholders. This in turn has improved care coordination such as on-site support services, property management, and payers' services. Some housing programs began referring clients to a Coordinated Entry System that help clients in receiving housing assistance.

Commitment to Equity

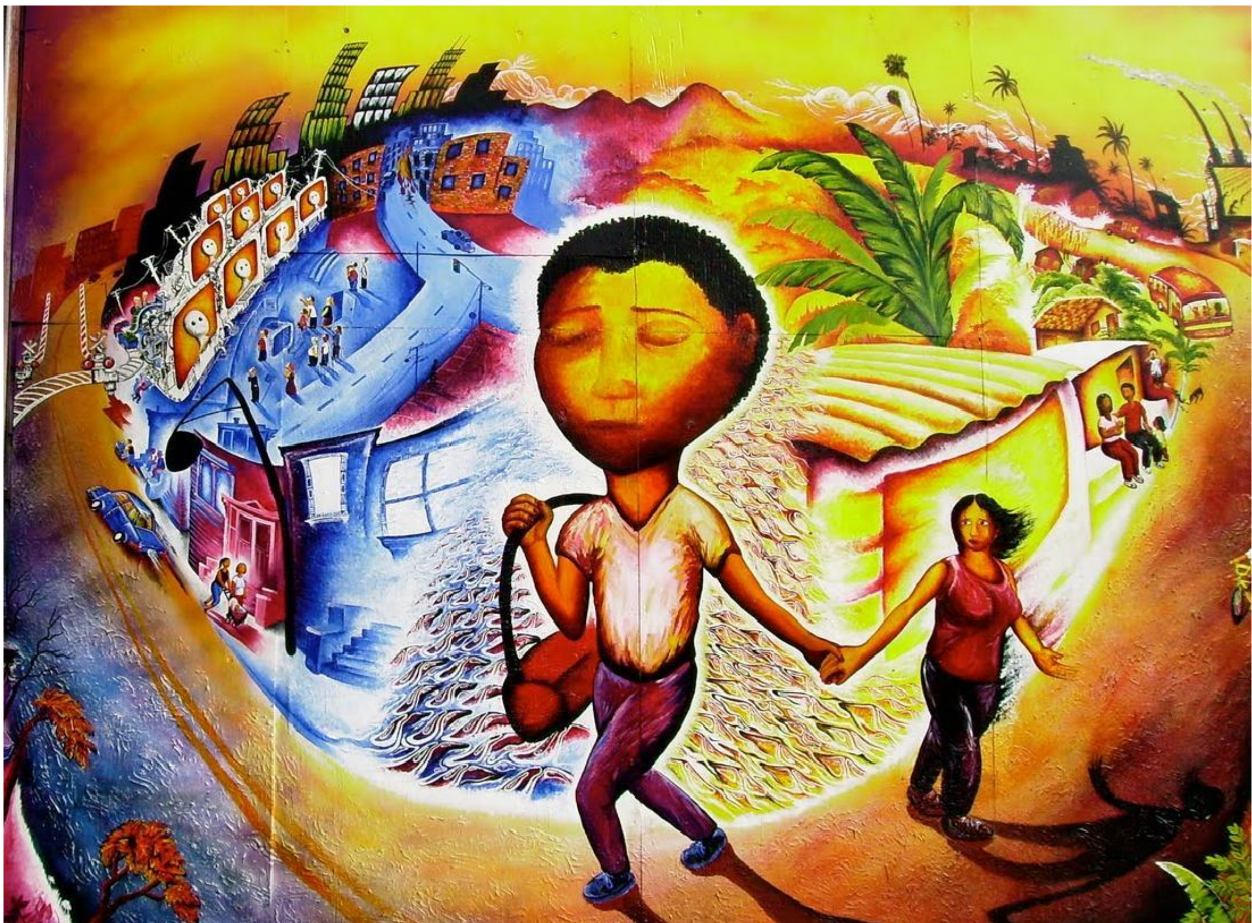
Our FSP leadership teams plan to better collaborate with the Office of Equity, Social Justice and Multi-Cultural Education (OESM) over the coming year in order to revisit FSP program implementation and ensure that we are looking through an equity lens. We want to renew our commitment to equity and feel it is important to identify FSP service and outcome disparities. Then we intend to create concrete and measureable plans to address these disparities to ultimately improve FSP outcomes for our clients.

Behavioral Health Services in Primary Care

In 2018, the Behavioral Health Services in Primary Care program added a new position to its care team, the Behavioral Health Navigator. This position, which has fulfilled an essential need

in the continuum of care, assists socially isolated seniors enhance their mental health stability and wellness. Services provided by this position include, but are not limited to;

- Helping with paperwork and applications
- Accompanying the client to appointments and the pharmacy to in accessing their medication
- Assistance with medication management



El Inmigrante. Street Mural at Shotwell St. and 23rd St., La Mision, San Francisco, CA. Copyright Joel Bergner (2005).

2. Mental Health Promotion and Early Intervention Programs

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 Promotion (K-12)

Program Overview

School-Based Mental Health Promotion (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.

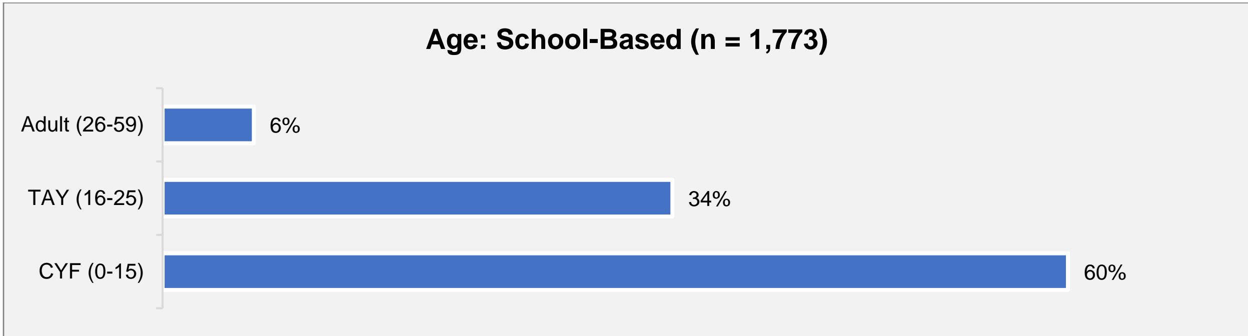
Target Populations

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.

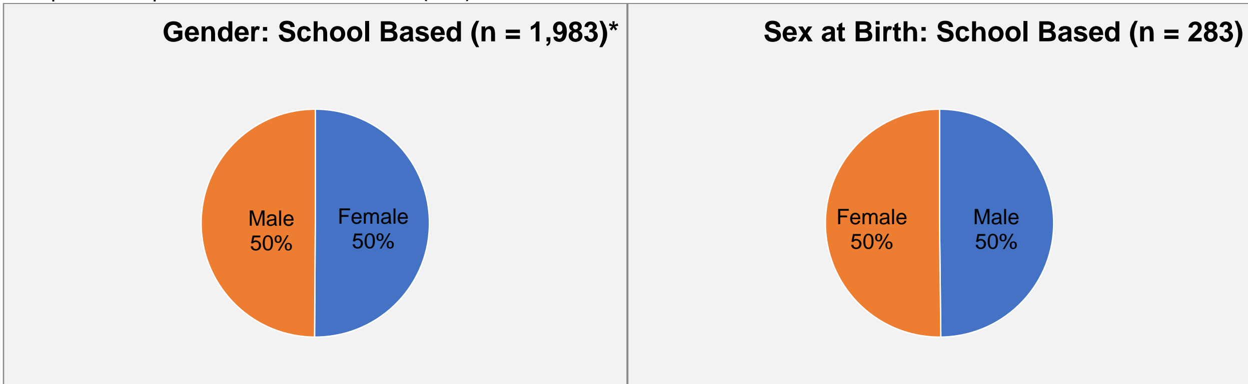
FUERTE Program Staff 2019

Participant Demographics, Outcomes, and Cost per Client

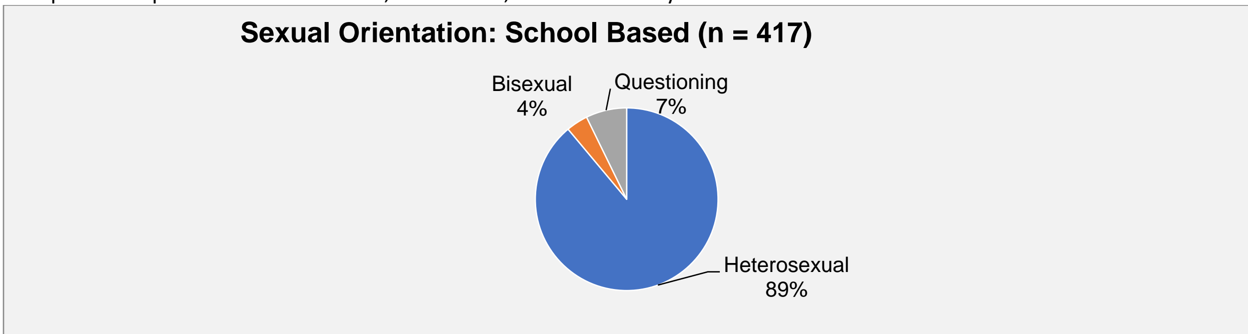
Demographics: School Based Prevention (K-12)[9]



*< 1 percent reported data on Older Adult (60+)



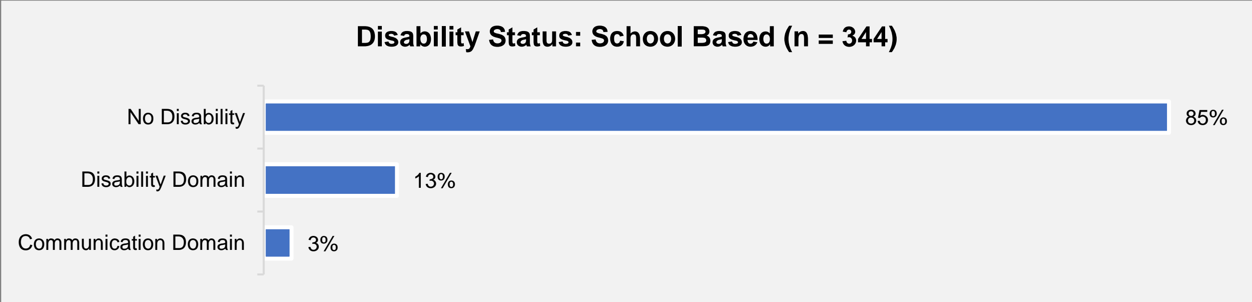
*< 1 percent reported on Trans Female, Trans Male, Another Identity



*< 1 percent of participants reported data on Gay or Lesbian, Another Identity

Veterans: *< 1 percent of participants reported data for Yes

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



*< 1 percent of participants reported data on Another Disability

Race/Ethnicity	n	%
Black/African American	264	10%
American Indian or Alaska Native	1	0%
Asian	571	21%
Native Hawaiian or Pacific Islander	41	2%
White	81	3%
Other Race	721	27%
Hispanic/Latino	805	30%
Non-Hispanic/Non-Latino	32	1%
More than one Ethnicity	159	6%
Total	**2,675**	**100%**

Primary Language	n	%
Chinese	117	6%
English	1,134	61%
Russian	6	0%
Spanish	562	30%
Tagalog	4	0%

Primary Language	n	%
Vietnamese	5	0%
Another Language	31	2%
Total	**1,859**	**100%**

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

PEI

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

Program	FY18-19 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center – *Bayview Hunter's Point Foundation*	• Of the 590 participants, 271 participants completed the pre-survey and 109 participated completed the post-survey. • Of the 109 who completed the post-survey, 57 (52%) agreed with the statement "I am comfortable using services at my school's health center." • Of the 19 Balboa Teen Health Center participants who completed the BHS Consumer Satisfaction Survey, 18 (95%) of participants agreed with the statement "Staff treated me with respect." • Given short staffing and departure of long-term lead therapist, Balboa Teen Health Center did not administer post session tests for youth accessing early intervention services.
School-Based Mental Health Services – *Edgewood Center for Children and Families*	• 12 total classroom teachers participated in the Edgewood's Year-end Client (School Staff) Satisfaction Survey. The statements in the survey had a rating of 1 (strongly disagree) to 10 (strongly agree). • Teacher participants reported being able to handle challenges of teaching with a mean score of 8.5. • Teacher participants reported feeling the desire to continue working as a teacher in the school with a mean score of 8.8. • Teacher participants reported feeling more successful in

Program	FY18-19 Key Outcomes and Highlights
	dealing with challenging student behaviors since the beginning of the school year with a mean score of 8.3.
Youth Early Intervention – *Instituto Familiar de la Raza*	• At James Lick Middle School and Hillcrest Elementary, 116 out of 118 (98%) received at least one consultation from the Mental Health Consultant to support them to respond to stressors in their classroom. • At James Lick Middle School and Hillcrest Elementary, 19 of 24 (79%) staff members expressed satisfaction with the consultation services. • At James Lick Middle School and Hillcrest Elementary, 18 of 24 (75%) staff members expressed that the consultant helped them to respond more effectively to children's behavior.
Wellness Centers – *Richmond Areas Multi-Services (RAMS)*	• Outreached and promoted services to 2,738 youth. • Offered services to 804 individuals by the Mental Health Consultant. • Offered individual services to 154 individuals. • Offered group services to 88 individuals. • Provided 270 hours for screening and assessments.
Trauma and Recovery Services – *YMCA Urban Services*	• Reduced chronic absenteeism by at least 50% in 20 out of 24 (83%) clients. • Enrolled and monitored successful completion in equivalency exams in 16 out of 24 (67%) clients. • Offered Family Needs Assessments to 24 out of 24 clients, which all participants completed.

MHSA CPP Meeting 2019

Spotlight on Family Unification and Emotional Resiliency Training (FUERTE)

SFDPH MHSA's new Family Unification and Emotional Resiliency Training (FUERTE) program is a new prevention program with a goal of reducing behavioral health disparities among Latinx newcomer youth. FUERTE is an Innovations project that was recently approved by the California Mental Health Services Act Oversight and Accountability Commission. This school-based, preventative programming will serve as the frontline for reducing disparities in behavioral health access. The FUERTE program promotes interagency and community collaboration with the explicit goals of increasing mental health literacy and service access, as it has been largely enacted through a unique collaboration between the San Francisco Unified School District (SFUSD), the San Francisco Department of Public Health, and the Departments of Psychiatry and Pediatrics at the University of California, San Francisco.

Much of the curriculum of FUERTE was developed and adapted through feedback from newcomer immigrant youth and their families, as well as service providers. In addition, we have created a system of care for these youth in which FUERTE helps to facilitate the transition to services for these youth to improve their overall functioning including behavioral health care, medical care, educational, legal, and other social services. The FUERTE program is designed for youth ages 12 to 18 in SFUSD.

FUERTE is laying the foundation for its services and will begin providing groups to its target population of recently immigrated Latinx youth. It is working towards being fully staffed with a team which includes a project coordinator, training coordinator, and research coordinators. It is building relationships with SFUSD high schools in order to establish program sites. In addition, group facilitators will receive training in the updated FUERTE curriculum and clinical framework. FUERTE groups will begin at school sites by the end of FY19/20. Mental health screening will be conducted and any participating students identified being at risk for behavioral health issues will be referred and linked to specialty mental health services.

FUERTE also plans to integrate the following new components:

- A robust program evaluation that will allow us to ascertain the current efficacy and feasibility of the program.
- The FUERTE curriculum, available in English and Spanish, will be made broadly available to schools and providers across California for free use and adaptation.
- A network of trained FUERTE facilitators will be available to lead "train the trainer" sessions for other providers that are interested in undertaking this model
- A framework on the adaptation and tailoring of FUERTE to different groups of newcomer immigrant populations will be innovatively developed based on examining how current clinicians make decisions on tailoring the FUERTE curricula.

FY18-19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[11]**
School-Based Mental Health Promotion (K-12)	797 Clients	$1,070,132	$1,343

Population-Focused Mental Health Promotion & Early Intervention

PEI

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
- 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
- Latinx including the Indigenous Mayan communities
- Native Americans
- Adults and TAY who are homeless or at-risk of homelessness
- TAY who are LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and more)

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

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.
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.
	Black/African American Wellness and Peer Leadership 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.

Population-Focused Mental Health Promotion Programs		
Target **Population**	**Program Name** ***Provider***	**Services**
Asians/Pacific Islanders (API)	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 culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Latinx including Indigenous Mayan communities	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 services, 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 Native adults and older adults who have been exposed 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 involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, 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 (6th Street) 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.
	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.
	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.
Latinx/Mayan TAY	Population Specific TAY Engagement and Treatment – Latinx/Mayan *Instituto Familiar de la Raza*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Latino/Mayan community.

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Asian/Pacific Islander TAY	Population Specific TAY Engagement and Treatment – Asian/Pacific Islander *Community Youth Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Asian/Pacific Islander community.
Black/African American TAY	Population Specific TAY Engagement and Treatment – Black/African American *Third Street Youth Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Black/African American community.
TAY who are LGBTQ+	Population Specific TAY Engagement and Treatment – LGBTQ+ *SF LGBT Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and more) community.

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
TAY who are Homeless or At-Risk of Homelessness or Justice Involved	Population Specific TAY Engagement and Treatment *Huckleberry Youth Programs*	The program serves low-income African American, Latino, Asian Pacific Islander, or LGBTQ 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.

Peer Wellness Center

PEI

Spotlight on NACo Awards

In 2018, the National Association of Counties (NACo) awarded the SFDPH BHS MHSA Prevention and Early Intervention (PEI) programs in the area of health for their pioneering approaches to mental wellness with oppressed and marginalized communities throughout the city. These PEI programs:

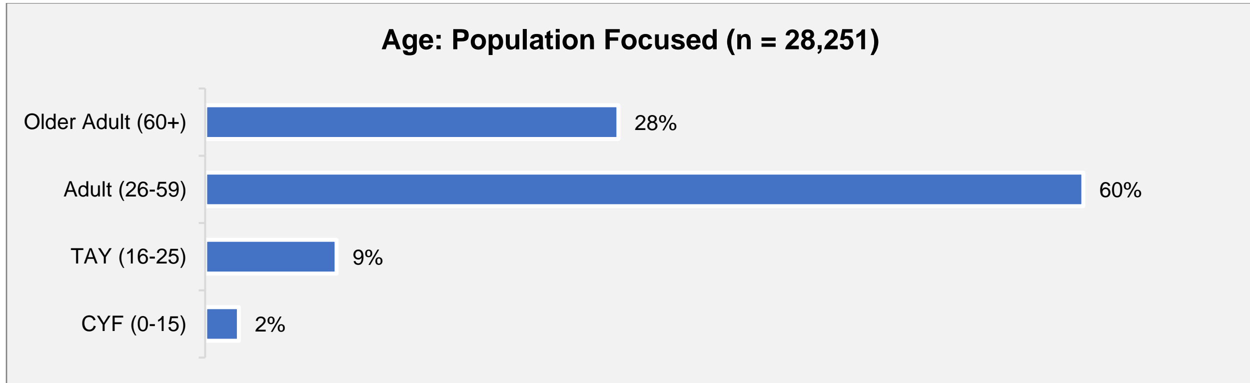
- vary widely based upon ethnic/cultural heritage, age, and housing status (e.g. Samoan community, isolated older adults, homeless transitional age youth);
- are crafted to be culturally affirming and linguistically responsive by honoring communities' histories, cultural and spiritual beliefs around health and mental health and community defined practices that lead to wellness; and
- are known as Population-focused: Mental Health Promotion and Early Intervention (Pop Focus) programs.

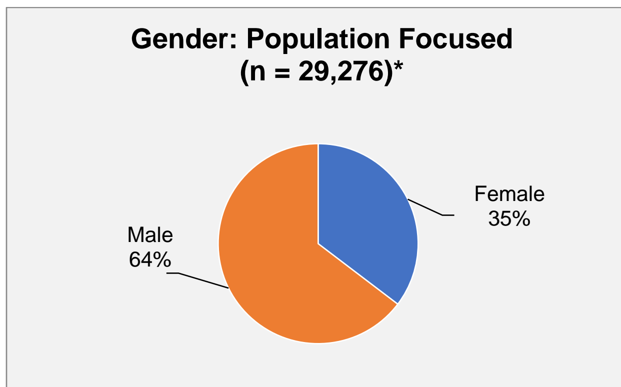
Pop Focus programs are unified by a universal service model that they co-created with SFDPH's MHSA and Quality Management staff. The service model is comprised of five key modalities - outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic service; and service linkage – with each modality having its own corresponding process and outcome objectives.

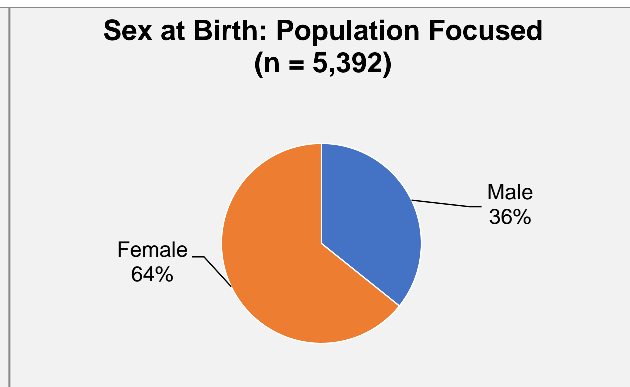
These PEI programs are well-received in communities because they a) have built relationships and trust the staff of the PEI programs delivering services; b) are offered choices of clinical and/or non-clinical services to care for their wellness; and c) SFDPH has learned that culture frames communities' interactions with mental health services.

Participant Demographics, Outcomes, and Cost per Client

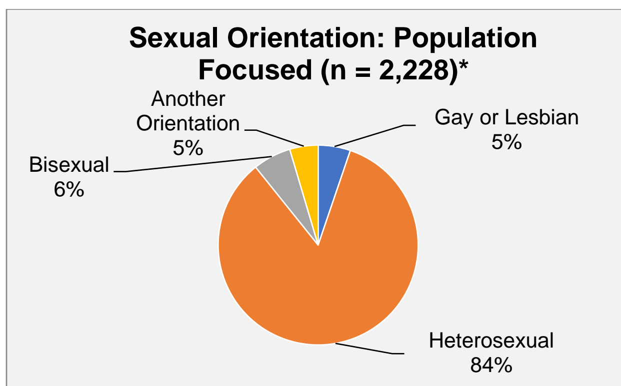
Demographics: Population Focused Mental Health[12]

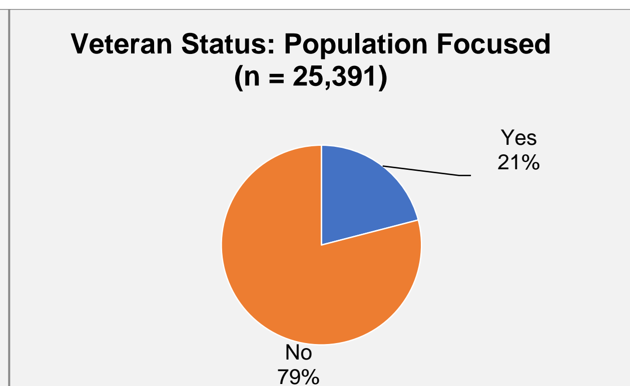






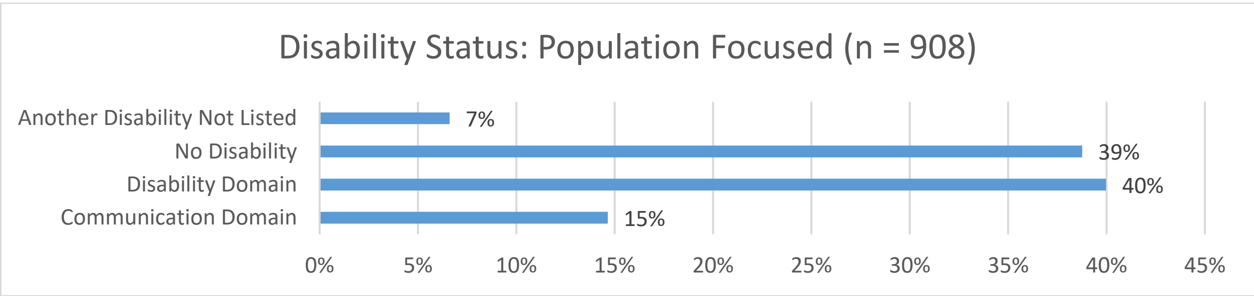
*< 1 percent of participants reported data for Trans Female, Trans Male, and Another Identity





*< 1 percent of participants reported data for Questioning

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



PEI

Race/Ethnicity	n	%
Black/African American	10,816	37%
American Indian or Alaska Native	612	2%
Asian	6,209	21%
Native Hawaiian or Pacific Islander		
White	7,714	26%
Other Race	319	1%
Hispanic/Latino	1,865	6%
Non-Hispanic/Non-Latino	1,501	5%
More than one Ethnicity	162	1%
Total	**29,498**	**100%**

Primary Language	n	%
Chinese	2,150	8%
English	23,962	87%
Russian	2	0%
Spanish	920	3%
Tagalog	79	0%

Vietnamese	177	1%
Another Language	355	1%
Total	**27,645**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Senior Drop-In Center – *Curry Senior Center*	• 397 seniors attended wellness-based activities offered by peer staff. • 216 attended 5 activities or more. • 140 seniors reported an increase in socialization. • 71 seniors who were informally assessed for non-behavioral health needs were referred to services.
Ajani Program – ***Westside*** *Community Services*	• Outreached 405 African American residents in San Francisco through large community events. • 31 out of 34 (91%) individuals outreached via group presentations reported an increased willingness to seek mental health services. • 70 out of 79 (92%) San Francisco community residents reported an increase knowledge in accessing mental health services.
Black/African American Wellness and Peer Leadership Program – *DPH Inter-Divisional Initiative (collaborative of AA Holistic Wellness and SF Live D10 Wellness)*	• 107 out of 107 (100%) of participants reported an increase in their feelings of social connection related to participation and attendance at programs and services. • 150 out of 200 participants (75%) reported an improvement of overall physical health/mobility or increased awareness of their mental health. • 53 participants were linked to a wellness coach and participants received a one on one wellness coaching session.
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	• Outreached and engaged with 54,976 individuals from direct and social media contact. • Screened and assessed 87 individuals, who were referred to additional services. • 2335 individuals participated in culturally-relevant mental health promotional activities. • Offered case management services to 81 individuals who also completed basic written case/care service plans.
Indigena Health and Wellness Collaborative (Latinx including indigenous	• Outreached and contacted 100 individuals through outreach activities (street outreach and phone calls). • Screened and/or assessed 57 unduplicated participants for

Mayan Communities) – *Instituto Familiar de la Raza*	practical, emotional and mental health concerns. All participants were referred to further internal or external programs. • 61 participants participated in Psychosocial Peer Support Groups/Talleres. 90% of survey respondents expressed that participation in the Psychosocial Peer Support Groups/Talleres helped them increase their social connectedness.
Living in Balance – *Native American Health Center*	• Reached 341 unduplicated participants through outreach and engagement. • Offered 180 Wellness Promotion group sessions, reaching 194 unduplicated clients. • Offered 189 units of individual therapeutic sessions reaching 88 unduplicated clients
South of Market Self-Help Center – *Central City Hospitality House*	• 8,183 unduplicated individuals participated in a range of socialization and wellness services offered by the Hospitality House. • 93 unduplicated participants attended Harm Reduction support groups conducted by the Harm Reduction Therapy Center. 86 (92%) out of 93 of Harm Reduction support group participants demonstrated reduced risk behaviors. • Case Managers screened and/or assessed 82 unduplicated participants for behavioral health concerns. 65 (79%) of these participants were referred to behavioral health services.
Tenderloin Self-Help Center - *Central City Hospitality House*	• 11,679 unduplicated individuals participated in a range of socialization and wellness services offered by the Hospitality House. • 182 unduplicated participants attended a Harm Reduction support Group conducted by the Harm Reduction Therapy Center. 166 (91%) out of 182 participants demonstrated reduced risk behaviors. • Case Managers screened and/or assessed 159 unduplicated participants for behavioral health concerns. All 159 participants were referred to behavioral health services.
Community Building Program - *Central City Hospitality House*	• Held 12 community events to establish and maintain relationships, promote services, and raise awareness about mental health, reaching 150 community members. • Case Managers screened and/or assessed 85 unduplicated participants for behavioral health concerns.
Population Specific TAY Engagement and Treatment – Latino – *Instituto Familiar de la Raza*	• Referred 125 youth and families to La Cultura Cura (LCC) and assessed eligibility for TAY programming and treatments services at LCC. • Organized community ceremony including Drumming for Peace which was attended by 75 community participants attended. • 57 (95%) out of 60 service delivery participants who participated in the multi-session capacity building workshops identified signs of vicarious trauma in their practice when working with TAY youth.

	• Outreached at 4 events and engaged with 575 individuals to raise awareness of MHSA services available. • Screened 59 TAY who attended one of the outreach events and referred 28 TAY (47%) who identified with a mental health need to services.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander – *Community Youth Center*	• Screened 124 Asian & Pacific Islander (API) youth for behavioral health concerns. • 124 API youth and families enrolled in case management services developed and attained at least one of their treatment goals. • 119 (96%) out of 124 API youth participants with identified mental health diagnoses were referred to mental health services. • 98 (82%) out of 119 API youth receiving case management and/or therapeutic services reported an increased quality of life by end of year.
Population Specific TAY Engagement and Treatment – LGBTQ+ – *SF LGBT Center*	• Served 214 unduplicated participants • Referred 11 identified by Navigation Services as needing health services to services. • 12 (52%) of the 23 survey participants responded to having a strong sense of belonging to a community. • Launched the Youth Leadership Council and hosted the kick-off retreat.
Population Specific TAY Engagement and Treatment – Black/African American – *Third Street Youth Center; Larkin Street Youth Services*	• Social workers helped and assessed the behavioral health needs of 54 TAY. • Offered 2,274 mental health sessions to 627 youth, and provided youth development groups to 40 youth • Of the 54 screened and assessed TAY, 54 TAY (100%) were referred to mental health services. • Posted 29 health-related messages across social media platforms to raise awareness on all programming services and impact.
Population Specific TAY Engagement and Treatment – All *–Huckleberry Youth Programs*	• Screened and/or assessed 120 unduplicated TAY for behavioral/mental health concerns. 80 (66%) TAY of those 120 screened were referred for behavioral health services. • 110 TAY and/or their families developed a written plan of care, and 104 TAY (95%) and/or their families achieved at least one case/care plan goal. • 30 TAY received individual therapeutic services. • Hosted and facilitated 12 TAY Frontline Worker Meetings to provide program updates, discuss trends, policy issues, facilitate referrals, and provide training.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[13]**
Population-Focused Mental Health Promotion	30,085 Clients	$2,521,075	$84

PEI

Early Childhood Mental Health Consultation Initiative

Program 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[14] 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. The cycle of this initiative began on January 1st, 2019. As a result, the five providers became flexible in administering their services, given the small timeframe of January to June 2019.

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. Due to the short timeframe, data is limited at this time.

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

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

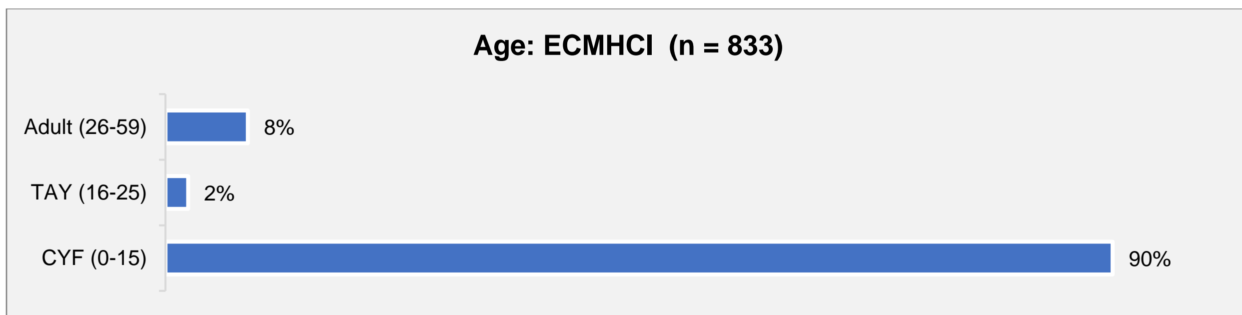
- Homeless Children's Network
- Instituto Familiar de la Raza

Target Populations

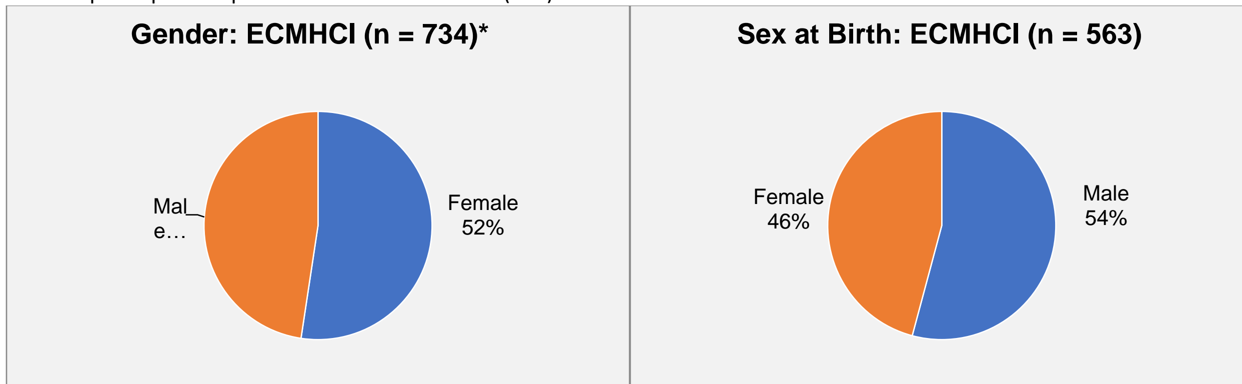
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients who experienced trauma, substance abuse, homelessness, and other challenges. The program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

Participant Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative[15]

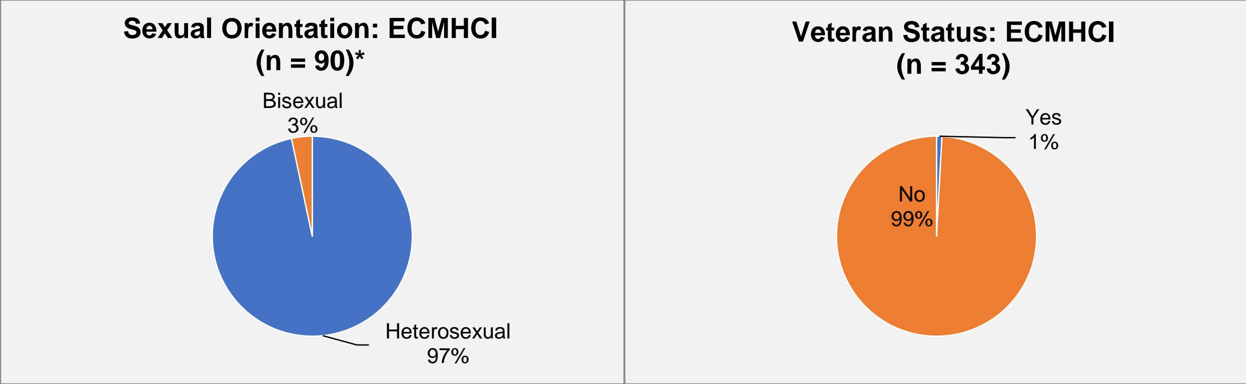


< 1 % of participants reported data for Older Adult (60+)

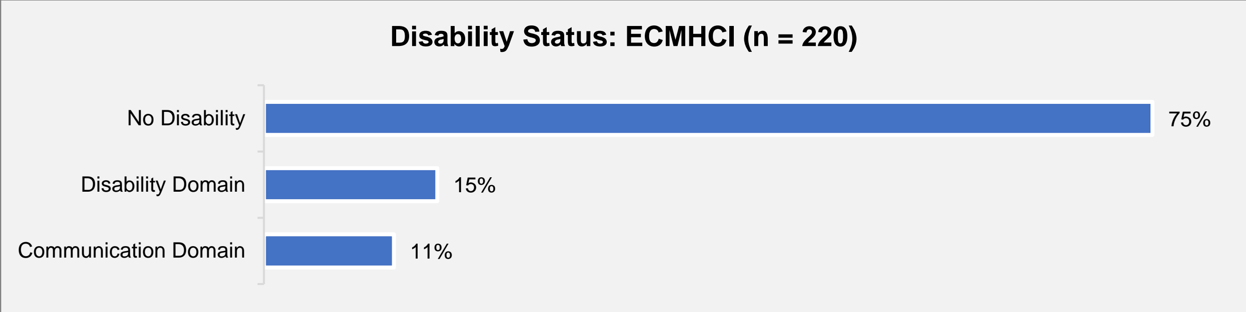


*< 1% of participants reported data for Trans Female, Trans Male, Another Identity

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



*< 1% of participants reported data for Bisexual, Questioning, Another Orientation



*< 1% of participants reported data for Another Disability

Race/Ethnicity	n	%
Black/African American	171	15%
American Indian or Alaska Native	0	0%
Asian	320	28%
Native Hawaiian or Pacific Islander	46	4%
White	174	15%
Other Race	91	8%
Hispanic/Latino	286	25%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	47	4%
Total	**1,135**	**100%**

Primary Language	n	%
Chinese	209	22%
English	586	62%
Russian	0	0%
Spanish	144	15%
Tagalog	8	1%
Vietnamese	2	0%
Another Language	3	0%
Total	**952**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Early Childhood Mental Health Consultation Initiative	• In the midst of receiving funding in the middle of the fiscal year, the majority of providers managed to adjust successfully to the changes in funding. • The majority of providers were able to maintain strong relationships with the local community and enhance their capacity to administer services.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[16]**
Mental Health Consultation and Capacity Building	719 Clients	$639,671	$890

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

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.

Program Overview

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

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	FY18-19 Key Outcomes and Highlights
Comprehensive Crisis Services	• The Mobile Crisis Team served 1,794 individuals • The Child Crisis Team served 1,260 individuals • The Crisis Response Team served 800 individuals • The Crisis Intervention Specialist served 75 individuals

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[17]**
Comprehensive Crisis Services	3,929 Clients	$342,912	$87

Moving Forward in Mental Health Promotion and Early Intervention

Early Childhood Mental Health Consultation Initiative (ECMHCI)
The ECMHCI issued a Request for Qualifications (RFQ) for program service providers, which offered an opportunity to revise our program contracts and open the contracting opportunity to new service providers in the community. The RFQ was developed with input from our clients and staff and was then published and distributed among the community to invite a number of qualified applicants. In the end, the same set of service providers were selected due to their qualifications and the new contracts were awarded to initiate January 1, 2020.

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

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 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.
Peer to Peer, Family-to-Family *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 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 Support Programs	
Program Name ***Provider***	**Services Description**
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 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, decrease stigma, and provide community support by linking community members with vital resources (e.g. helping community members to connect with housing and food assistance programs).

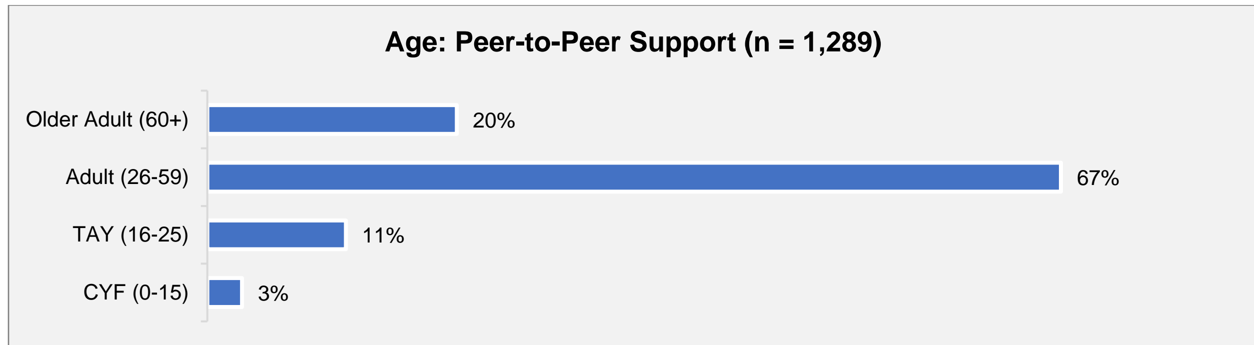
Peer-to-Peer Support Programs	
Program Name *Provider*	**Services Description**
Peer Outreach and Engagement Services *Mental Health Association of SF* (STIGMA REDUCTION PROGRAM)	For most of FY17-18, the Peer Outreach and Engagement Services program was broken into the following three programs: • SOLVE 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.

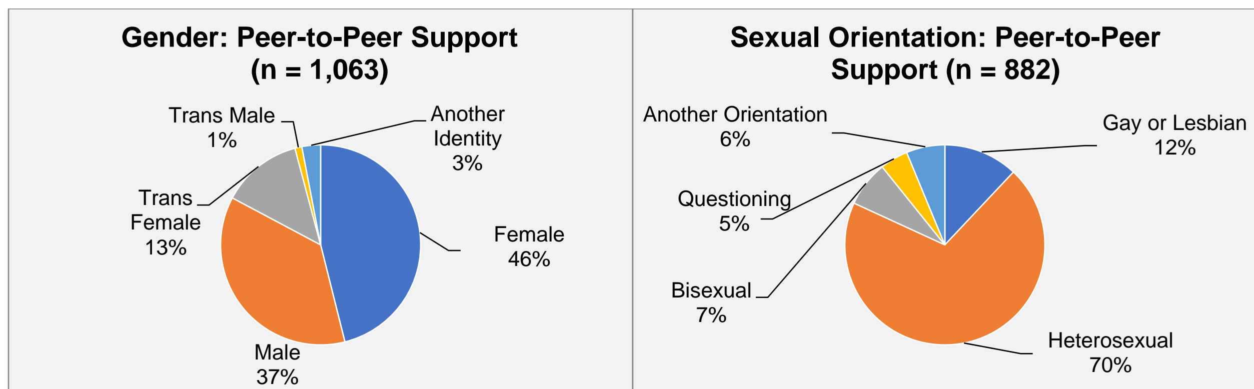
Peer-to-Peer

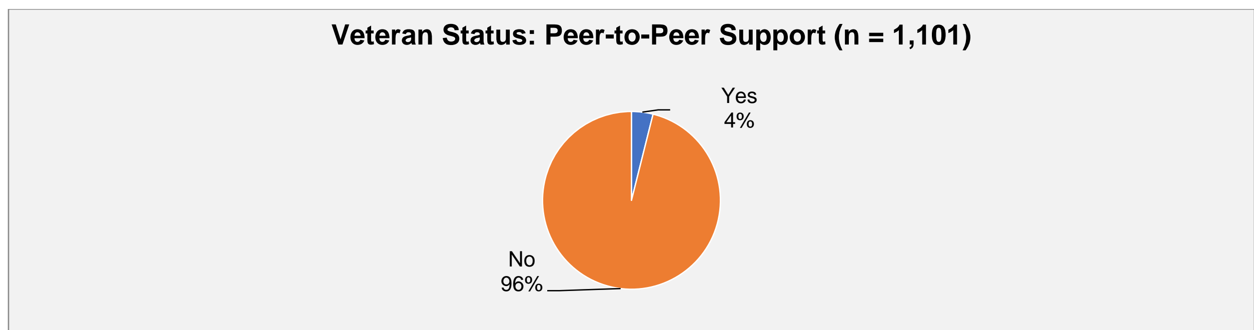
Peer Wellness Center

Participant Demographics, Outcomes, and Cost per Client

Demographics: Peer to Peer Support Programs[18]

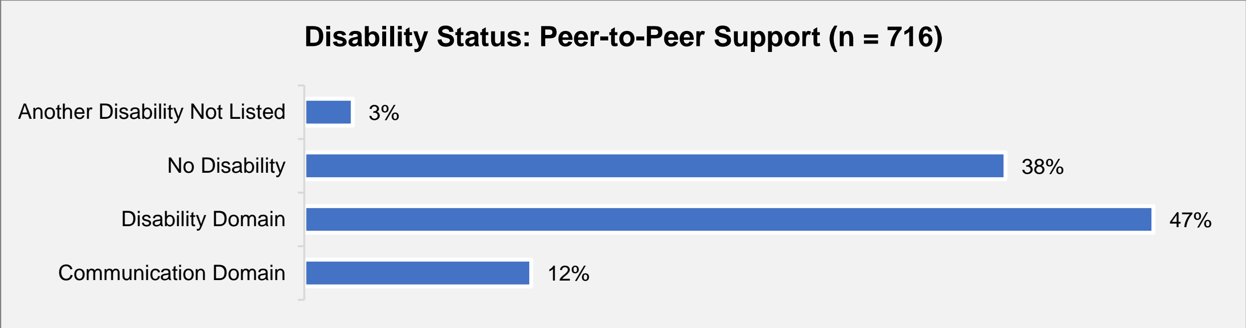






Peer-to-Peer

[18] 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	231	6%
American Indian or Alaska Native	32	1%
Asian	157	4%
Native Hawaiian or Pacific Islander	18	0%
White	439	11%
Other Race	124	3%
Hispanic/Latino	328	8%
Non-Hispanic/Non-Latino	2614	65%
More than one Ethnicity	51	1%
Total	**3994**	**100%**

Primary Language	n	%
Chinese	46	1%
English	958	28%
Russian	15	0%
Spanish	205	6%
Tagalog	13	0%
Vietnamese	1	0%
Unknown	2229	64%
Another Language	13	0%
Total	**3480**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Addressing the Needs of Socially Isolated Older Adults (INNOVATIONS) – *Curry Senior Center*	• Reached 355 older adults and screened 107 isolated older adults using a preclinical behavioral health screening tool. • Screened 22 isolated older adults for non-behavioral health needs, and all 22 older adults were referred to the appropriate service. • 30 isolated older adults attended at least 5 group activities or more, and 12 (40%) of those 30 reported increased level of social connectedness.
Lifting and Empowering Generations of Adults, Children and Youth (LEGACY) - *SFDPH*	• Participated and outreached in 7 community health fairs. • Screened 96 individuals to offer culturally and linguistically appropriate services through individual peer-to-peer support to address mental health needs. 70 individuals (73%) enrolled into services. • Peer specialists screened 96 individuals and conducted support groups, providing wellness promotion and linkage to services. • 67 individuals completed at least one self-identified behavioral health service goal. • Offered support groups to 92 parents/caretakers and 220 children under the Family Support Night program. 48 (86%) out of 56 consumers who completed a survey of the Family Support Night program noted feeling more connected to their community as a result of the program.
Peer to Peer, Family to Family - *NAMI*	• 90% of participants reported an increased understanding of their mental illness as a diagnostic medical condition, and felt better able to recognize signs and symptoms. • 43 (92%) out of 47 Family to Family participants reported feeling more prepared to solve future problems with their loved one living with a mental health condition and better connected to the community and available resources. • 20 (85%) out of 24 Peer to Peer participants will understand what action steps to take when symptoms reoccur.
Peer Specialist Certificate, Leadership Academy and Counseling – *Richmond Area Multi-Services (RAMS)*	• Of the 53 program participants enrolled, 49 (92%) graduated from the Entry and/or Advanced Certificate Program. • 45 (98%) out of 46 participants in the post-program evaluation indicated plans to pursue and/or continue a career in the health and human services field. 46 out of 46 reported an increase in skills and knowledge due to participation in the program. • Coordinated and held a total of 5 social networking events to connect and link program alumni with current participants.
Gender Health SF – *SFDPH*	• Served and educated a total of 145 unduplicated clients. All participants noted that the program was satisfactory.

Program	FY18-19 Key Outcomes and Highlights
Peer to Peer Employment - *Richmond Area Multi-Services (RAMS)*	• 44 out of 44 program employees (100%) completed at least four trainings in skills development and/or wellness. • 251 (88%) out of 285 clients surveyed reported improvement in their overall quality of life. • 9 (90%) out of 10 enrolled interns successfully completed training or have existed early due to obtaining employment in the field. 7 out 7 intern graduates (100%) who completed the indicated improvements in their abilities to cope and manage symptoms in the workplace.
Transgender Pilot Project (INNOVATIONS) - *SFDPH*	• 45 (97%) out of 47 program participants who completed the survey reported an increase in social connectedness. • 49 (94%) out of 52 Trans Health and Wellness Fair participants reported improvements to health, wellness and recovery as a direct result their participation.
Reducing Stigma in the South East (RSSE) – *SFDPH*	• Staff worked to increase knowledge and awareness of resources, by discussing topics such as breast cancer, bullying prevention, advocacy, mental health, nutrition, and wellness. • Staff provided peer and family support, as well as resources and referrals. • Increased collaboration and expanded programming with local organizations including 66 Raymond, the Village, RAMS, and Healing Circle.
Peer Outreach and Engagement Services – *Mental Health Association of San Francisco* **(STIGMA REDUCTION PROGRAM)**	• SOLVE delivered 25 anti-stigma presentations, reaching a total of 500 individual audience members. 269 (91%) of the 285 audience members who filled out the post-presentation survey reported decreased stigma regarding mental health conditions • SUPPORT delivered 1:1 support to 41 consumers of behavioral health. 11 (85%) of the 13 individuals who received 1:1 support and responded to a follow-up survey reported decreased feelings of isolation. • Peer Coaches offered 8 community-building trainings and 7 NURTURE orientations focused on nutrition, physical activity, and mind-body awareness, reaching 51 participants. 43 (86%) of 50 participants reported that their understanding of wellness and/or nutrition has improved after the training.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[19]**
Peer-to-Peer Programs	4,018 Clients	$5,459,041	$1,359

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

Moving Forward in Peer-to-Peer Support Programs

Reducing Stigma in the Southeast Sector

In FY18-19, the Reducing Stigma in the Southeast Sector (RSSE) programming ended. The long-time RSSE staff person and founder LaVaughn King made the decision to retire. With other initiatives such as HOPE SF filling service gaps in the area, it was determined that similar programming in the Southeast Sector of San Francisco would continue. The SFDPH MHSA will ensure that the best practices and successful components of RSSE are integrated into other peer programming in this area.

At the same time, peer services at Gender Health San Francisco increased to address the navigation needs of patients seeking gender affirming services. Gender Health SF is a one of kind program in the nation. The peer support component is an important part of the patient care experience and we are excited to be a part of such an innovative program.

MHSA Consumer, Peer and Family Conference

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 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.

Vocational Services	
Program Name ***Provider***	**Services Description**
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.
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. Consumers learn café and catering related skills while working towards competitive employment.
Clerical and Mailroom Services *Richmond Area Multi-Services (RAMS)*	The Clerical and Mailroom Vocational Programs provides both time-limited paid internships and long-term supported employment opportunities to participants of BHS. Participants learn important skills in the area of administrative support, mailroom distribution and basic clerical services. Participants also receive soft skills training, retention support services, coaching and linkage to services to obtain employment in the competitive workforce, if desired.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) *UCSF Citywide Employment Program*	The GROWTH Project provides training for individuals looking to establish careers in the horticulture and landscaping field. Consumers are taught skills in the field while focusing on draught-resistant landscaping.
TAY Vocational Program *Richmond Area Multi-Services (RAMS)*	The TAY Vocational Program offers training and paid work opportunities to TAY with various vocational interests. Consumers learn work-readiness skills while working towards competitive employment.

Spotlight on GROWTH Vocational Program

SFDPH MHSA's GROWTH program is a nine-month employment training program that prepares MHSA consumers for competitive employment in the fields of landscaping and horticulture. Each trainee in the program receives three months of classroom instruction, followed by a six month paid work experience at SFDPH clinics. By providing these work opportunities at the clinics, the program promotes wellness and recovery by beautifying clinic space, which offers an improved experience for our clients.

In FY 18-19, The GROWTH Project achieved the following outcomes:

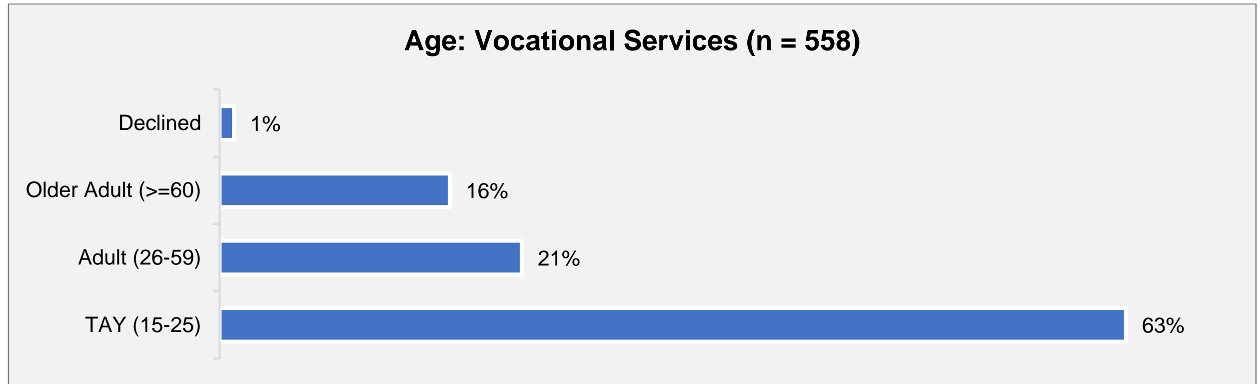
- The GROWTH Project graduated 5 trainees
- 100% of graduates (5/5) reported an improvement in development of work readiness skills
- 100% graduates (5/5) reported an improvement in confidence to use new skills learned

A GROWTH Success Story

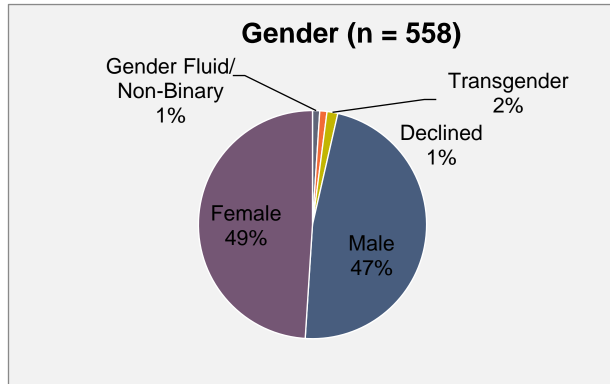
"James" is a 47-year-old Caucasian male who is diagnosed with schizophrenia and polysubstance abuse. For most of his adult life, his mental illness went untreated, he was deep in his substance addiction, and he was homeless. However, in the last five years, James has worked hard to achieve and maintain sobriety and stable housing, and has followed through with his recovery goals. He hadn't worked in over 20 years but employment was one of his goals in recovery. Initially skeptical, he applied and was accepted into the GROWTH program. James immediately stood out as a leader, but expressed that he was neither confident nor comfortable being a leader. Throughout his time in the GROWTH program, he learned how to lead and follow within a team and build his confidence presenting in front of a group of people. James worked extra hard to prepare himself to apply for jobs and interview. He had his first interview in 20 years at a local nursery. He exuded confidence during the interview due to the knowledge he learned from GROWTH. He was offered a part-time job and within two weeks was offered a full-time position. He is currently working full-time and working his way up the seniority ladder to train the next employee. James reports now feeling fulfilled, accomplished, and most of all, happy.

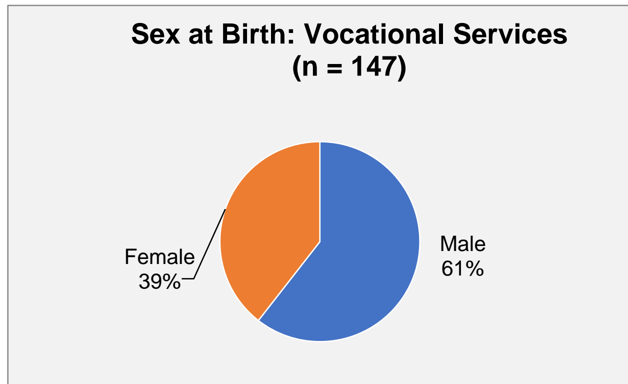
Participant Demographics, Outcomes, and Cost per Client

Demographics: Vocational Services[20]

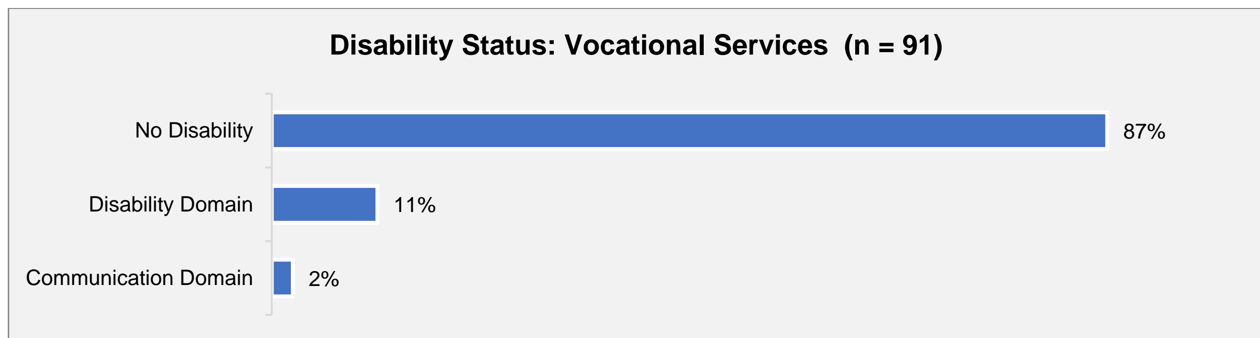


*< 1 percent of participants reported data for CYF (0-15)





*< 1 percent of participants reported data for Trans Male, Another Identity
*< 1 percent of participants reported data for Questioning, Another Orientation



*< 1 percent of participants reported data for Another Disability

[20] 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	34	16%
American Indian or Alaska Native	1	0%
Asian	31	15%
Native Hawaiian or Pacific Islander	4	2%
White	53	25%
Other Race	19	9%
Hispanic/Latino	23	11%
Non-Hispanic/Non-Latino	41	20%
More than one Ethnicity	4	2%
Total	**210**	**100%**

Primary Language	n	%
Chinese	3	2%
English	116	92%
Russian	0	0%
Spanish	5	4%
Tagalog	0	0%
Vietnamese	2	2%
Another Language	0	0%
Total	**126**	**100%**

Vocational

Program	FY18-19 Key Outcomes and Highlights
Department of Rehabilitation Co-op – *DPH and California State*	• Served a total of 426 clients. • 280 clients were placed in competitive employment. Of these, 182 (65%) remained employed after 3 months.
i-Ability Vocational IT Program - *Richmond Area Multi-Services (RAMS)*	• 16 (80%) out of 20 enrolled trainees graduated from the program • 16 out of 16 of trainee graduates (100%) who completed the program feedback tool indicated improvements to their coping abilities. • 16 out of 16 of trainee graduates (100%) who completed a satisfaction survey indicated that they felt an increase in readiness for additional meaningful activities related to vocational services. • 16 (80%) out of 20 trainee participants completed an exit interview in the form of a focus group or individual interview.

Program	FY18-19 Key Outcomes and Highlights
First Impressions (INNOVATIONS) – *UCSF Citywide Employment Program*	• 6 (46%) of the enrolled 13 BHS users successfully graduated from the pilot program. • 100% of trainee graduates reported improvement in both confidence to use the new skills learned and development of work readiness skills to use toward future opportunities (such as work/education/volunteering.
SF Fully Integrated Recovery Services (SF First) Vocational Project - *SFDPH*	• A total of 26 consumers were served through the training program. • 85% of trainees (22 out of 26) indicated improvements in coping abilities as evidenced by post-program evaluations. • 15 consumers completed the entire 9-month program.
Janitorial Services - *Richmond Area Multi-Services (RAMS)*	• 4 out of 4 clients who received services for at least three months successfully completed the program. • 2 out of the 2 survey respondents indicated improvements in their coping abilities in the workplace and reported an increase in readiness for additional meaningful activities related to vocational services. • All 4 graduates were either referred to or participating in the RAMS Hire-Ability Employment Services Program at the time of case closure.
Café and Catering Services - *UCSF Citywide Employment Program*	• The Slice of Life Café and Catering Program enrolled 30 BHS consumers. • 15 participants graduated from the program, and 100% reported an improvement in development of work readiness skills to use toward future opportunities, and an improvement in confidence to use the new skills they learned.
Clerical and Mailroom Services - *Richmond Area Multi-Services (RAMS)*	• 100% (12/12) of intern graduates indicated improvement in their coping abilities in the workplace. • 100% (12/12) of intern graduates indicated an increase in readiness for additional meaningful activities related to vocational services (e.g. educational program, advanced internship, advanced training programs, employment, volunteer work, etc.). • 91% (10/11) graduates expressed motivation in being engaged in vocational related activities. Of these graduates, 3 completed the program early due to obtaining employment.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) - *UCSF Citywide Employment Program*	• 5 (25%) of the 20 BHS consumers enrolled in the GROWTH Project graduated from the program. • All 5 graduates reported an improvement in development of work readiness skills and an improvement in confidence in these new skills.
Transitional Age Youth Vocational Program -	• 15 (88%) of the 17 participants who received services for at least three months enrolled and completed the

Vocational

Program	FY18-19 Key Outcomes and Highlights
Richmond Area Multi-Services (RAMS)	program. • 14 (93%) of those 15 surveyed indicated improvement in their coping abilities in the workplace and reported an increase in readiness for additional meaningful activities related to vocational services.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[21]**
Vocational Programs	635 Clients	$1,890,467	$2,977

Moving Forward in Vocational Services

Behavioral Health Services - Fourth Annual Vocational Summit

One of the many events hosted by Behavioral Health Services Division (BHS) for Mental Health Awareness Month, the Fourth Annual Vocational Summit was held at the San Francisco Public Library on May 15, 2019. Over 60 individuals attended the event, included staff, consumers, peer leaders, representatives from BHS, Vocational Programs, California Department of Rehabilitation (DOR), and members of the general SF community. William "Travis" Hill, BHS vocational outreach coordinator, served as the Master of Ceremony.

Community Awareness Treatment Services

The Summit highlighted the success of Vocational Co-op graduates, representing all five of our SFDPH MHSA Vocational programs, including the Richmond Area Multi-Services (RAMS), Inc. Hire Ability; UCSF Citywide Employment Services; Caminar Jobs Plus; Occupational Training and Therapy Program; and PRC. Each of these programs presented an overview of their vocational services, target population, and client success stories. Twelve vocational providers from San Francisco provided networking and one-on-one discussions about vocational opportunities to Summit attendees. The engaging activity, Vocational Trivia, was greatly received by Summit attendees in which participants who answered questions correctly each received an Each Mind Matters prize. The next Vocational Summit is scheduled for May 2020.

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

Vocational

Vocational Services Updates
SFDPH MHSA issued a Request for Qualifications for a building maintenance, construction, and remodeling program in 2019. The five-year contract was awarded to UCSF Citywide's First Impressions program, to begin July 2019.

The Vocational Specialist position (2585 Health Worker 3) was filled in October 2019 and a Vocational Intern was brought on in February 2019. This intern assisted the BHS Vocational Team with referrals, data reports, and meeting logistics. This intern also assisted the larger MHSA team during the "May is Each Mind Matters Awareness Month" and the Community Planning Process Meetings.

Vocational Services is currently exploring a partnership with the Human Service Agency (HSA). HSA is interested in the First Impressions and GROWTH services and has expressed having funding available. BHS plans on meeting with HSA and will continue internal discussions on how to add HSA to Vocational program contracts.

Outreach Update
Outreach efforts have continued building connections throughout the various agencies in the mental health community. All of the vocational programs averaged 15 outreach presentations per month. The outreach efforts have focused the following underserved populations:

- TAY (transitional age youth)
- Homeless/Unstably Housed populations
- Women and Trans Gender Community

The outreach efforts will continue to focus on "planting a seed" for clients not yet receiving mental health services through BHS. New areas and places of focus have been at the following:

- Navigation Centers
- CASC Community Assessment Service Center
- LGBT Center
- Restorative Justice/re-entry resource fair
- San Francisco Jails psychiatric units via Jail Health Service

Slice of Life Vocational Catering Program

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.

<u>No Place Like Home (AB 1618)</u>

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.

<u>Coordinated Entry</u>

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 (CE) processes to centralize the housing referral and placement process throughout the county. There are now CE processes for Adult (18+), Family, and Youth (18-24) to evaluate and prioritize the needs of people experiencing homelessness. Launching CE of each population is an iterative process and will continue to develop as older systems of housing assessment and placement are discontinued.

CE aims to reduce barriers for clients and providers by streamlining and standardizing the intake process for housing. CE will support the most marginalized people experiencing homelessness for housing, while also supporting other unsheltered people with problem solving and linkage to available resources. Each person (or family) who encounters CE 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 evaluated 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 ensure that the primary assessment tool was relative, equitable, and prioritized the most underserved communities, the Access Points (AP) funded by 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 APs exceeded the goal of assessing at least 2,000 people.

The implementation of CE 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. The 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.

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 addi-

tion, San Francisco added $2.16 million from Community Services and Supports (CSS) to housing 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 for FSP participants living with serious mental illness. Currently, there are a total of 191 MHSA-funded permanent supportive housing (PSH) units dedicated to people with mental health challenges. Of these 191 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 HSH Supportive Housing Programs Team. MHSA-funded units are available to transition-aged youth, adults, and seniors.

Housing Placement Services

With the launch of the Adult, Youth, and Family CE processes, 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 CE and an integrated database (called the Online Navigation and Entry [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. Prioritization for MHSA-funded units are conducted through the Coordinated Entry process. Beyond the MHSA inventory of 191 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), Lutheran Social Services (LSS) and the HSH Support Services team provide supportive services for 137 MHSA-funded PSH units for FSP clients. Swords to Plowshares manages the on-site support service needs for 8 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.

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 Program 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 co-operation. With TNDC and CHP specifically, the supportive service providers facilitate monthly property management and operations meetings with the aforementioned stakeholders.

MHSA-Funded Housing for TAY

While TAY served by MHSA who are age 18 and 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 PSH Housing: FY18-19

MHSA Housing Site	Operator	MHSA Units	Target Population	Services	Type of Project	Referral Source	% of FSP Clients
Cambridge	**CHP**	9	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**	111%
Hamlin	**CHP**	0	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**	0%
Iroquois	**CHP**	2	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**	0%
Rene Cazenave	**CHP**	10	Adults	**Citywide + FSP**	MHSA Capital	**CES**	110%
Richardson	**CHP**	12	Adults	**Citywide + FSP**	MHSA Capital	**CES**	125%
San Cristina	**CHP**	15	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**	100%
Senator	**CHP**	3	Adults	**CHP + FSP**	HSH Supportive Housing	**CES**	0%
Camelot	**DISH**	11	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**	109%
Empress	**DISH**	7	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**	100%
LeNain	**DISH**	3	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**	100%
Pacific Bay Inn	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**	100%
Star	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**	150%
Windsor Hotel	**DISH**	6	Adults	**HSH + FSP**	HSH Supportive Housing	**CES**	133%
Aarti/Routz	**Larkin St.**	40	TAY	**Larkin - All**	MHSA GF - TH	**BHS Placement**	8%
1100 Ocean	**Mercy**	6	TAY	**FPFY + FSP**	MHSA Capital	**BHS Placement**	100%
Veterans Commons	**Swords**	8	Veterans	**Swords/VA + FSP**	MHSA Capital	**BHS Placement**	100%
Ambassador	**TNDC**	9	Adults	**TNDC + FSP**	HSH Supportive Housing	**CES**	89%
Dalt	**TNDC**	10	Adults	**TNDC + FSP**	HSH Supportive Housing	**CES**	110%
Kelly Cullen	**TNDC**	17	Adults	**TNDC + FSP**	MHSA Capital	**CES**	100%
Polk Senior	**TNDC**	10	Seniors	**LSS + FSP**	MHSA Capital	**CES**	90%
Ritz	**TNDC**	2	Adults	**TNDC + FSP**	HSH Supportive Housing	**CES**	100%
Willie B. Kennedy	**TNDC**	3	Seniors	**Sequoia + FSP**	MHSA Capital	**CES**	33%
TOTAL UNITS		**191**					**81%**

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

Spotlight: Helping to Address the Needs of the Homeless Population

What Is the Program: The Mental Health Services Act Housing Program consists of 191 permanent supportive housing (PSH) units supported by MHSA capital funds, MHSA general funds, and subsidies procured and managed by the Department of Homelessness and Supportive Housing (HSH). MHSA funds PSH units, on-site support services to complete BHS case management, and a Program Manager on the HSH team who collaborates with an MHSA Program Manager to direct the MHSA Housing Program.

Who Is Eligible: The MHSA Housing Program is for transitional aged youth (TAY), adult, and older adult Full Service Partnership (FSP) clients, (less 40 PSH units for any TAY with mental health challenges). Most people housed in MHSA-funded housing experienced homelessness prior to placement in a PSH unit.

How it Works: The MHSA Housing Program involves wraparound services and multidisciplinary coordination to support behavioral health wellness and housing retention. The program involves ongoing care coordination, collaboration, and problem-solving with BHS FSP case managers, on-site support service staff, property management staff, and money management professionals. MHSA and HSH program management staff monitor programs and provide technical assistance to their respective providers.

Thanks to Our Providers and Partners! MHSA San Francisco is deeply appreciative of the ongoing efforts of the many stakeholders that make the MHSA Housing Program possible. Special thanks to the FSP program clinicians, on-site support service staff, property management teams, and money management professionals! Thank you for your consistent efforts to promote a living environment that fosters wellness and recovery while working to resolving behavioral, payment, and cleanliness issues as they arise. We look forward to continuing our partnership with HSH on this program.

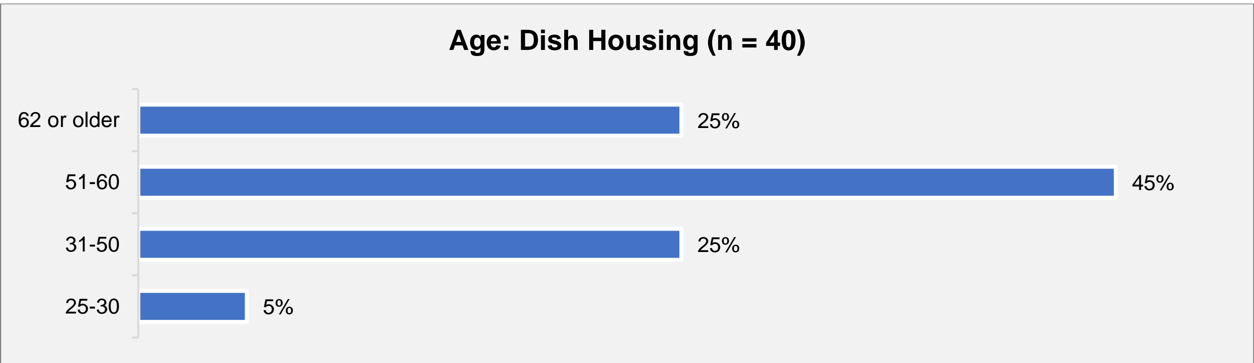
Other Outcomes of MHSA Housing Collaborations: Due to cross-county roles as the San Francisco No Place Like Home (NPLH) representative and experience with MHSA Housing Program, the MHSA Program Manager led an effort in collaboration with the Transition Age Youth and Adult/Older Adult Systems of Care to get BHS clients 811 Housing Choice Vouchers (HCV). HSH led a multi-departmental project with the SF Housing Authority, and several county and community stakeholders, in which the BHS Division participated. MHSA and SOC Managers provided ongoing technical assistance for ICM and FSP clients which resulted in six BHS clients getting access to a potentially permanent housing subsidy. The effort is one of the many ways the MHSA San Francisco team has collaborated to understand and address homelessness among behavioral health clients.

MHSA-Funded ESU Housing: FY18/19			
Name of Housing Site	**Address of Housing Site**	**Property Management Provider**	**Count of MHSA Units in FY 18-19**
16th Street Hotel	3161 16th Street San Francisco, CA 94103	Danny and Alisha Patel	13
Crystal Hotel	2766 Mission St. San Francisco, CA 94110	Manager-Peter Morari Nisheet Shah-Owner	3
Eddy Hotel	640 Eddy St. San Francisco, CA 94109	Asmin "Bibi" Bibi	6
Oak Tree Hotel	45 6th Street San Francisco, CA 94103	Jay Devdhara	3
TOTALS			**25**

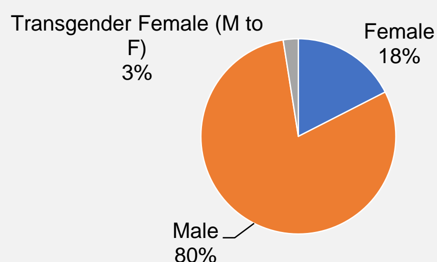
Participant Demographics and Outcomes

Demographics: Housing Programs[22]

Delivering Innovative Supportive Housing (DISH) Housing

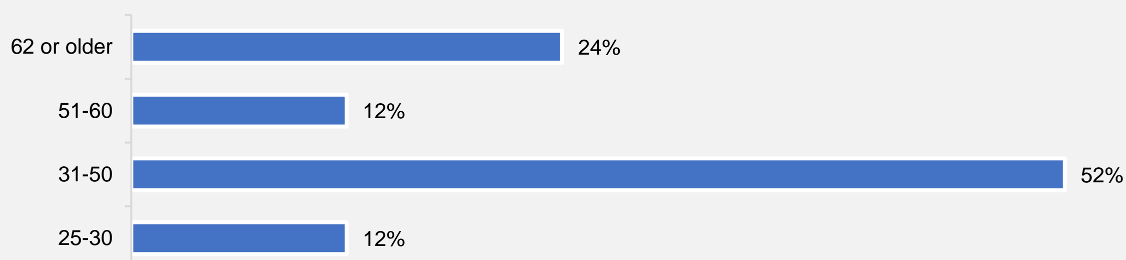


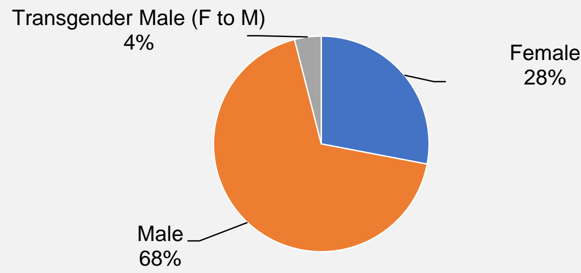
[22] In the following demographic charts, “n” sizes vary if data was not fully available for any individual variable(s).



Race/Ethnicity	n	%
African American / Black	9	23%
Asian / Pacific Islander	4	10%
Latino/a	7	18%
Other	3	8%
White	17	43%
Total	**40**	**100%**

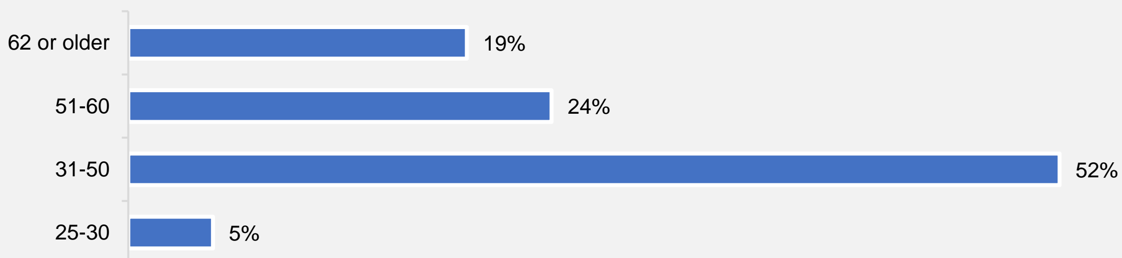
<u>Community Housing Partnership (CHP) Housing</u>



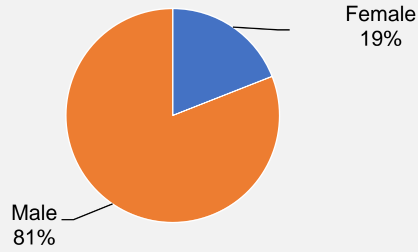


Race/Ethnicity	n	%
African American / Black	8	32%
Declined / not stated	2	8%
Filipino/a	1	4%
Latino/a	2	8%
White	12	48%
Total	**25**	**100%**

Tenderloin Neighborhood Development Corporation (TNDC) Housing



Gender: TNDC Housing (n = 21)

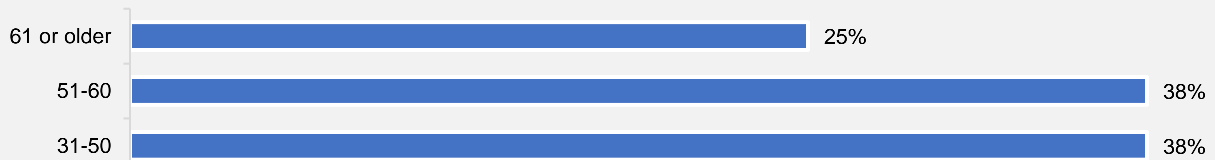


Race/Ethnicity	n	%
African American / Black	9	42%
Asian	1	5%
Asian / Pacific Islander	2	10%
Latino/a	3	14%
White	6	29%
Total	**21**	**100%**

Housing

<u>Swords to Plowshares Housing</u>

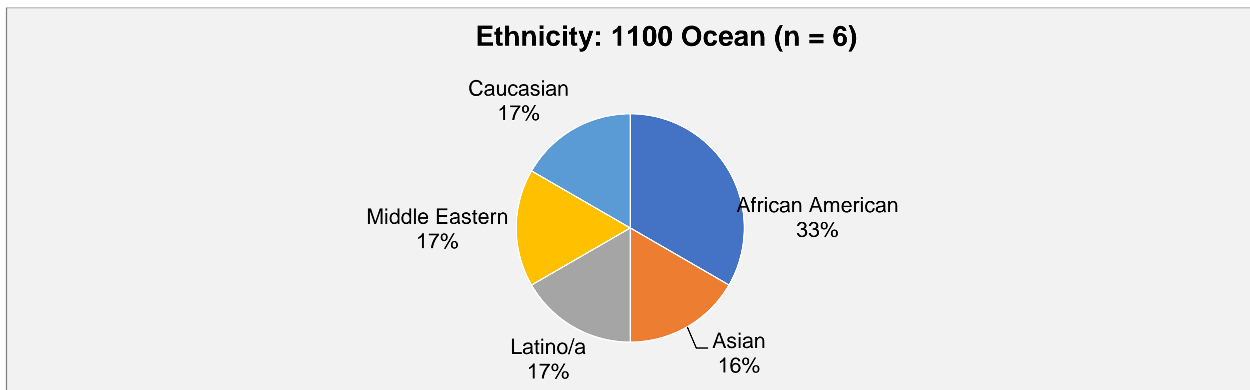
Age: Swords to Plowshare Housing (n = 8)

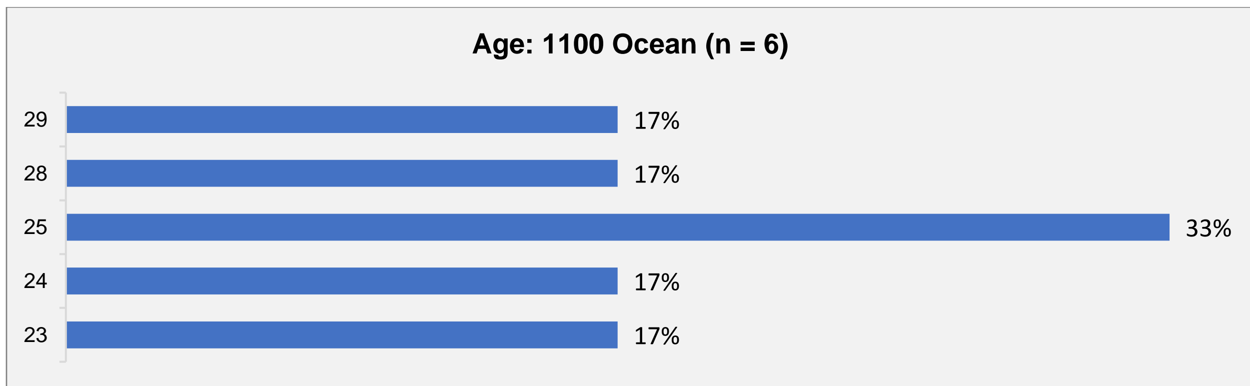


Ethnicity: Swords to Plowshare Housing (n = 8)

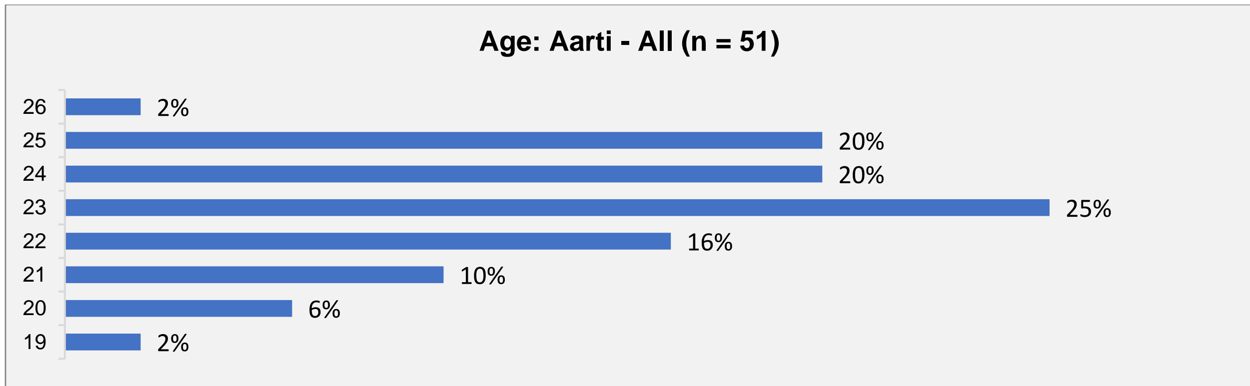
Race/Ethnicity	n	%
African American / Non-Hispanic	4	50%
White / Non-Hispanic	4	50%
Total	**8**	**100%**

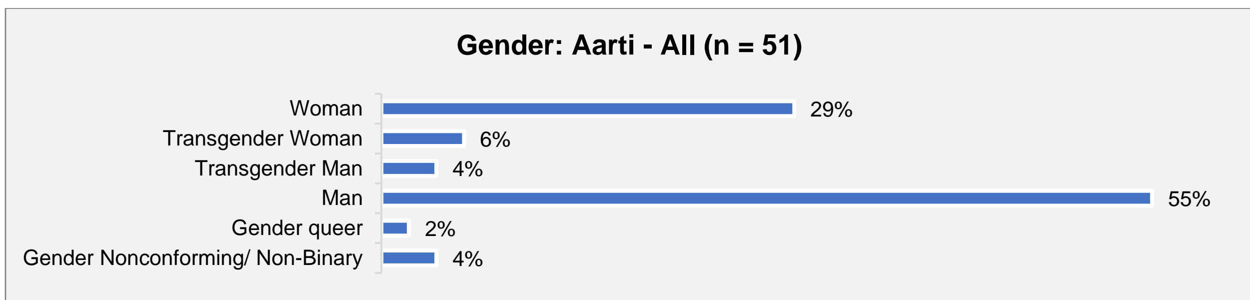
1100 Ocean - TAY Housing

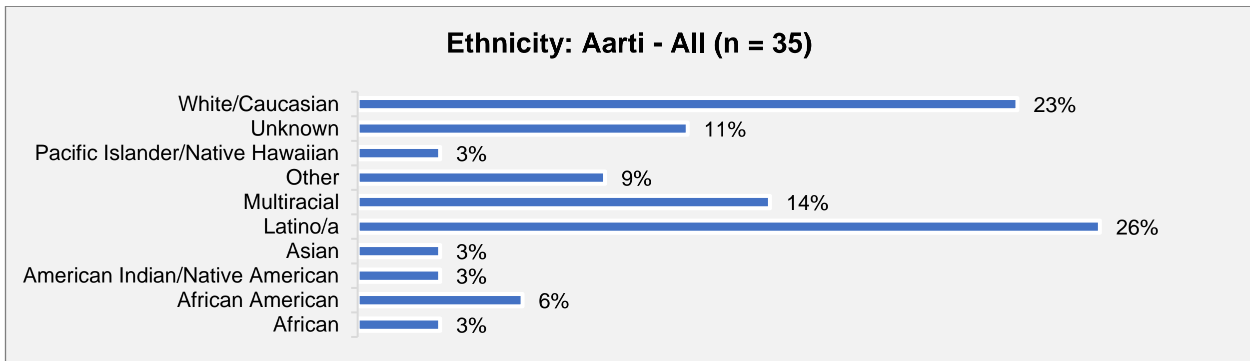


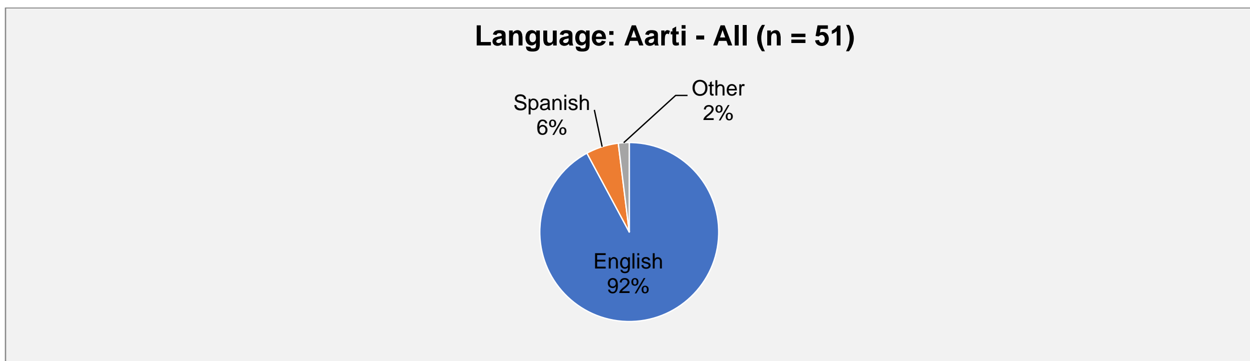


Aarti Housing

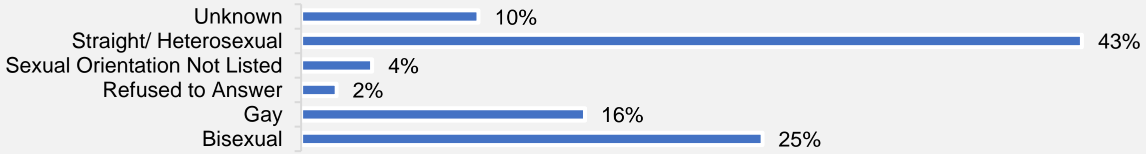




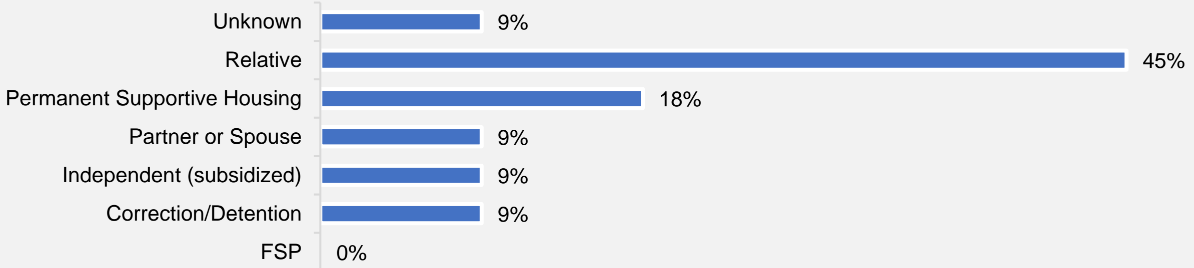




Sexual Orientation: Aarti - All (n = 51)

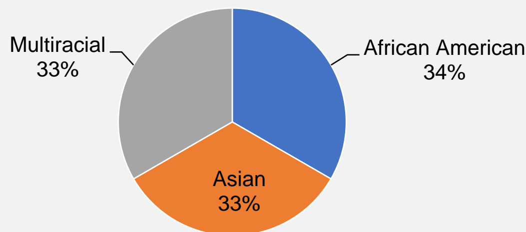


Client Exits: Aarti - FSP Clients Only (n = 11)



Gender: Aarti - FSP Clients Only (n = 3)

Ethnicity: Aarti - FSP Clients Only (n = 3)



Outcomes: Housing Programs[23]

Emergency Stabilization Units (ESUs)

These MHSA-funded ESU rooms are only available to community providers of intensive case management (ICM) or Full Service Partnership (FSP). Clients must be referred from the following agencies:

- Hyde Street (FSP)
- BHS TAY (FSP)
- Felton Adult (FSP)
- Felton Older Adult (FSP)
- SF First (FSP and ICM)
- UCSF Citywide Forensics (ICM)
- UCSF Citywide Linkage (ICM)
- UCSF Citywide Probation (ICM)
- UCSF Citywide Focus (ICM)
- UCSF Citywide AOT (ICM)

Count of Stay	MHSA Rooms
Other	1
SF General Emergency Dept.	2
SF General Inpatient	2
CLEAD/CASC/ Probation	10
ICM/FSP	79
Grand Total	**94**

For FY 8-19, 94 clients stayed a total of 4,330 days in ESUs. Out of these 94 clients, 45 (47.87%) clients were FSP clients.

DISH Housing

Length of Stay	Clients	# Exits
1 year	10	
2 years	5	
3 years	5	
4 years	4	
5 years or more	13	
Under 12 months	3	
Grand Total	**40**	**10**

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

CHP Housing

Length of Stay	Clients	# Exits
1 year	9	
2 years	7	
3 years	2	
4 years	2	
5 years or more	5	
Grand Total	**25**	**2**

TNDC Housing

Length of Stay	Clients	# Exits
1 year	6	
2 years	4	
4 years	3	
5 years or more	8	
Grand Total	**21**	**3**

Swords to Plowshare Housing

Length of Stay	Clients	# Exits
1 year	0	
2 years	1	
3 years	1	
4 years	1	
5 years or more	5	
Under 12 months	0	
Grand Total	**8**	**0**

1100 Ocean – TAY Housing

Length of Stay	Clients	# Exits
over 24 months	6	
Grand Total	**6**	**0**

Aarti Housing

# of tenants housed in MHSA funded units	Count
New	16
FSP	3
Total	**19**

# of Client Exits	Count	Percent
FSP	0	0%
Correction/Detention	1	9%
Independent (subsidized)	1	9%
Partner or Spouse	1	9%
Permanent Supportive Housing	2	18%
Relative	5	45%
Unknown	1	9%
Total	**11**	**100%**

% of Clients who maintained housing between 12-24 months	Percent
FSP	100%
All Tenants	92%

Moving Forward in Housing Services

'No Place Like Home' Planning Efforts
The SFDPH MHSA is planning to receive funding allocations from the California No Place Like Home initiative. Our first funding allocation, estimated at $27.7 million, will be used to build 127 adults and senior units at 1064-1068 Mission Street. SFDPH MHSA is projecting these projects to be completed in the fall/winter of 2021. SFDPH MHSA will request a second funding allocation of $36.4 million over the next two fiscal years. The NPLH requires the provision of supportive services for people housed in NPLH units and to better identify and understand the needs of the individuals to be housed in the proposed units, the Department of Homelessness and Supportive Housing is planning to conduct a needs assessment. This assessment will explore the supportive services needed, best practices for providing supportive services in permanent supportive housing for people with severe mental illness and severe emotional disorders, 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. SFDPH MHSA will utilize the data collected in the NPLH needs assessment and BHS provider conversations about mental health, housing, and eviction prevention needs of people experiencing homelessness to plan for our program improvements.

Data Sharing & Systems Changes
Over the next three years, EPIC will be the new electronic health record system for all of BHS. This system change will have implications for the way we use the Data Collection and Records (DCR) and the ONE System to optimize health and housing outcomes. Therefore, the MHSA Program Manager will be a ONE System liaison for people served through MHSA housing programs and BHS clients in general to support division needs for housing assessment, navigation, and care coordination in partnership with BHS leadership and providers

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 Certificate Program *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).
Community Mental Health Academy *Crossing Edge Consulting*	SFDPH BHS partnered with the City College of San Francisco's Community Mental Health Worker Certificate Program to create a 16-week mental health seminar series called the Community Mental Health Academy (Academy) that is designed to equip community based organizations' frontline staff with foundational knowledge about community mental health; culturally affirming techniques on how to approach and address someone who is in need of mental health support; and efficient ways to link someone with mental health care.
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.

San Francisco Mural

Workforce Dev.

Spotlight on Community Mental Health Academy

16-week mental health seminar series for community based organizations' frontline staff

Empowering Community Based Organizations:
San Francisco's Department of Public Health (SFDPH): Behavioral Health Services (BHS) division learned that there are frontline staff of local non-mental health related community based organizations (e.g. after school programs) who are witnessing an uptick of children and parents/caregivers who may be experiencing mental health distress. In response to this citywide need, SFDPH BHS partnered with Dr. Sal Nunez of City College of San Francisco's Community Mental Health Worker Certificate Program and Crossing Edge Consulting to create a 16-week mental health seminar series called the Community Mental Health Academy (Academy) that is designed to equip community based organizations' frontline staff with foundational knowledge about community mental health; culturally affirming techniques on how to approach and address someone who is in need of mental health support; and efficient ways to link someone with mental health care. Below are some core learning modules of the Academy curricula:

- Self-care
- Mental health first aid
- Assessment & referrals
- Basic counseling skills
- Crisis intervention
- Trauma-informed care

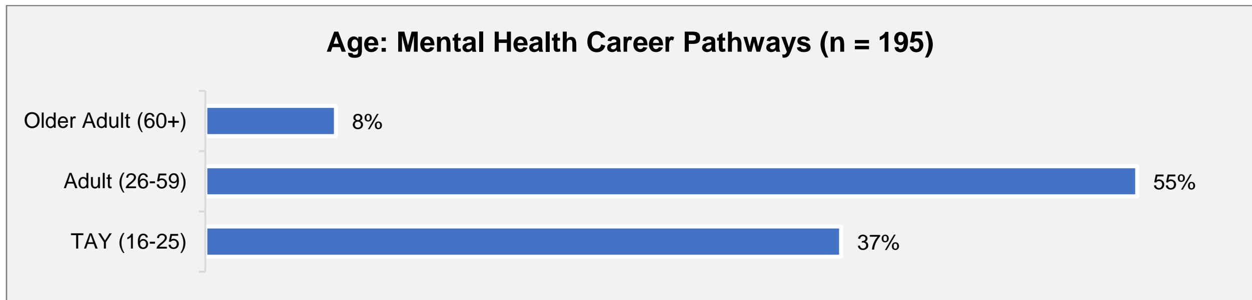
This successful workforce development project:

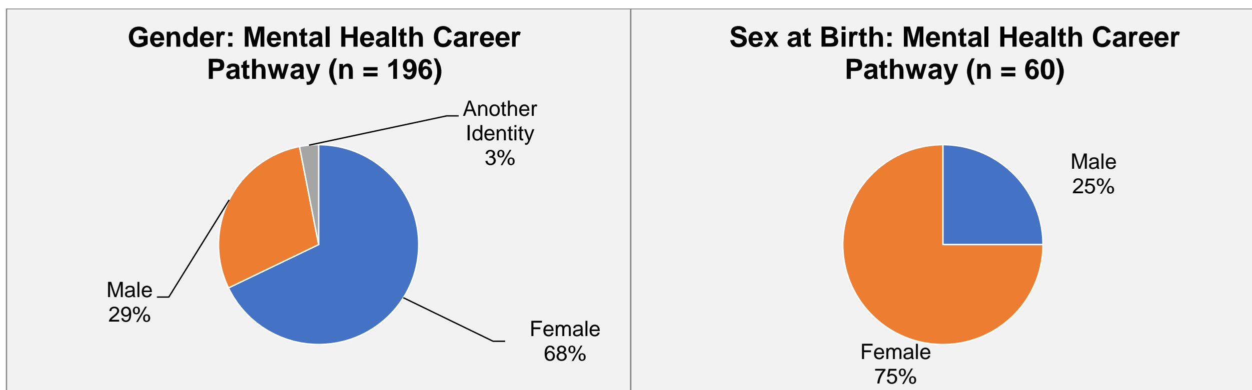
- launched in FY17-18, implementing the Academy with San Francisco's SOMA (South Of Market) Youth Collaborative and the Peer Health Leaders of Hope SF (a city initiative to revitalize San Francisco's severely distressed public housing sites by creating thriving and mixed-income communities); and
- trained case managers of the city's Roadmap To Peace initiative – a rapid response network of programs that works with some of San Francisco's most at-risk/in-risk Latinx transitional age youth – in FY18-19.

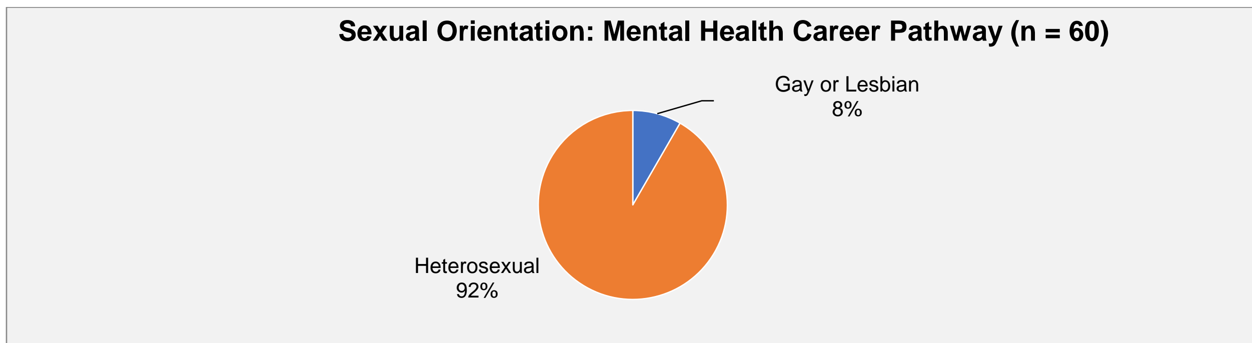
Within the short span of two fiscal years, this pioneering mental health workforce development program has educated, trained and educationally inspired sixty (60) Community Mental Health Academy graduates, with an estimated twenty (20) who have begun or resumed their post-secondary education path.

Participant Demographics, Outcomes, and Cost per Client

Demographics: Career Pathways Programs[24]

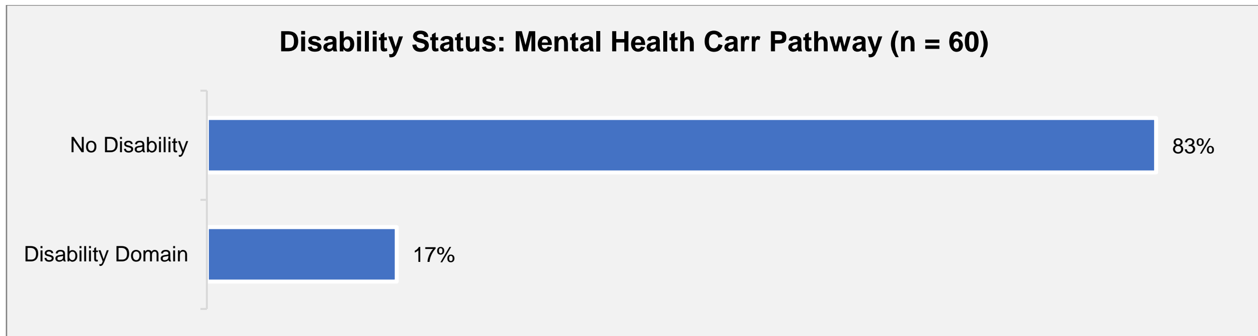






*< 1% of participants reported data for Yes; Veteran Status

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



*< 1% of participants reported data for Communication Domain; Another Disability Not Listed

Race/Ethnicity	n	%
Black/African American	30	19%
American Indian or Alaska Native	2	1%
Asian	26	16%
Native Hawaiian or Pacific Islander	2	1%
White	44	28%
Other Race	1	1%
Hispanic/Latino	52	33%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	3	2%
Total	**160**	**100%**

Primary Language	n	%
Chinese	14	7%
English	115	57%
Russian	2	1%
Spanish	53	26%
Tagalog	8	4%
Vietnamese	0	0%
Another Language	9	4%
Total	**201**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Community Mental Health Worker Certificate – *City College of San Francisco*	• 18 (95%) out of 19 students graduated from the Community Mental Health Certificate program. Of the 18 students surveyed, 100% of students who graduated expressed interest in pursuing a health-related career. • 48 (80%) out of 60 students enrolled in HLTH 91D passed and graduated. • 18 (95%) out of 19 students successfully completed their internship, which involved 120 hours of field placement over the semester.
Community Mental Health Academy – *Crossing Edge Consulting*	• This program recently launched and a Guided/Protocol Manual consisting of eight core modules focused on evidence based and best practices to working with behavioral and mental health challenges in community settings was developed with stakeholders. • Curricula modules were developed including lecture, group activities, vignettes, and other training tools. In addition to meeting the needs of the current workforce, the curricula was designed to match the cultural epistemology of the group.
Faces for the Future Program – *Public Health Institute*	• 60 students applied and were enrolled in FACES. • The FACES Program Coordinator participated in 54 on-site collaborative meetings with John O'Connell HS partners; taught 8 two-hour internship training preparatory workshops; and facilitated 50 hours of work-based learning opportunities for students to connect with health professionals. • 56 (93%) out of 60 students enrolled participated in off-site internships. • 100% of FACES seniors graduated from high school and enrolled into post-secondary education following graduation.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[25]**
Mental Health Career Pathways	238 Clients	$694,139	$2,917

[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.
TAY System of Care Capacity Building – Clinician's Academy *Felton Institute*	The TAY System of Care Capacity Building trains providers such as SFUSD teachers and staff in assisting TAY students to address substance use through harm reduction methods. This program also trains providers on improving TAY access to services and service delivery.
TAY System of Care Capacity Building - Advisory Board *Mental Health Association San Francisco*	The TAY System of Care Advisory Board, also known as Youth Eliminating Stigma (YES) Speaker's Bureau, works to convene an advisory board comprised of TAY. This program also provides a total of 24 hours of training on a range of mental health recovery-focused topics, including but not limited to recovery language and history of the recovery movement. This program works to educate youth to increase understanding of the mental health challenges facing TAY and increase confidence in their ability to express their ideas as part of a team.

Program Outcomes, Highlights and Cost per Client

Program	FY18-19 Key Outcomes and Highlights
Trauma Informed Systems Initiative - *SFDPH*	• 2,700 participants were trained in the last year. • 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. This program is offered on a monthly basis.
TAY System of Care Capacity Building – Clinician's Academy – *Felton Institute*	• 11 out of 11 participants who participated in the pre and post survey reported higher usage of skills/ therapeutic practices with consumers following participation in the Academy as compared with prior to the Academy during which 9 (82%) out of 11 achieved this goal. • 11 out of 11 participants who participated in the pre and post survey reported increases in knowledge of the development needs of TAY consumers following the in the Academy as compared with prior to the Academy during which 6 (55%) out

Workforce Dev.

	of 11 achieved this goal. • 36 respondents expressed strong interest in and commitment to attending Year 2 of the Training Academy.
TAY System of Care Capacity Building – Advisory Board – *Mental Health Association San Francisco*	• 100% of all advisory members reported an increased knowledge about the mental health recovery model. • 100% of TAY Advisory Board members reported increased confidence in their ability to express their ideas as part of a team. • By June 30, 2019, MHASF recruited a total of six advisory members.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[26]**
Training and Technical Assistance	2,743 Served	$852,337	$311

Peer Wellness Center

[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.
Child and Adolescent Community Psychiatry Training Program - *CACPTP*	The Child and Adolescent Community Psychiatry Training Program works to train the next generation of public mental health care leaders who will provide children and adolescent-centered care to vulnerable populations with severe mental illness. This program provides fellowships throughout BHS' Child, Youth and Families System of Care.
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 Outcomes, Highlights and Cost per Client

Program	FY18-19 Key Outcomes and Highlights
Fellowship for Public Psychiatry in the Adult/Older Adult System of Care and SF General Hospital – *UCSF*	• Added two new clinical sites" SFHN-BHS Comprehensive Crisis Services and Richard Fine People's Clinic (RFPC) at Zuckerberg San Francisco General Hospital. • Added two fellows who will complete a capstone project and submitted to the annual meeting of American Psychiatric Association in 2019. The fellows attended additional external trainings: (1) Mental Health Advocacy training at the Steinberg Institute and (2) a Leadership Training by Dr. Irene Sung.
BHS Graduate Level Internship Program – *SFDPH*	• Conducted a total of 50 training activities for 2,716 participants. The trainings focused on providing clinically-relevant treatment to marginalized populations; increase trauma-informed care; increase in racial equity in behavioral health care; improve the leadership skills of the workforce with 2,716 participants. • Established monthly webinar series for substance use treatment provider. • Added accreditation status for CME (physicians) and drug abuse counselors • Conducted year-long training academy for clinical supervisors.
Child and Adolescent Community Psychiatry Training Program (CACPTP) – *UCSF*	• Added 4 fellows to the clinical sites • Started a 4-month rotation at Juvenile Hall, where three Child and Adolescent Psychiatry Fellows rotate.

FY18/19 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[27]**
Psychiatry Residency and Fellowships	2,850 Served	$378,141	$133

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

Moving Forward in Behavioral Health Workforce Development

BHS Training Unit
The BHS Training Unit recently led a Workforce Development Advisory Committee to achieve the following objectives:

- improve workforce clinical and administrative skills
- advance workforce equity and diversity
- increase employee satisfaction and wellbeing

The training unit also conducted trainings for administrators of the Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF). BHS staff also organized a Peer and Family Conference for people with lived experience and their families. To assist older adults, staff members also participated in the Performance Improvement Project to improve the process of prescribing medications for alcohol use and to un-prescribe benzodiazepines in older adults.

The BHS Training Unit also published an RFQ for an Online Learning Management System that can be accessed by staff 24/7 at any location. This system is intended to offer multiple behavioral health courses, including courses that provide continuing education units to licensed and registered staff. These trainings will cover a myriad of topics designed to increase knowledge, skills, and expertise for providers at all levels of the organization. This contract will begin with the selected provider on January 1st, 2020.

For FY 19/20, the BHS Training Unit intends to focus on expanding the Workforce Development Advisory Committee, increasing focus on equity in behavioral health and within the workforce, and to work on contracting & implementation of the new Online Learning Management System.

Child and Adolescent Community Psychiatry BHA Program (CACPTP)

In FY 18/19 CACPTP have four program fellows see clients in the following sites:

- Chinatown Child Development Center
- Family Mosaic Project
- Mission Family Center
- Southeast Child Family Therapy Center

Although none of the fellows joined the health department after graduating, one did go on to work in Community Psychiatry in another county. They also held a course in Community Psychiatry which met for four sessions on the following topic areas:

- SFDPH BHS in CYF an Overview
- Working in SFUSD

- Behavioral Health Case Discussions
- CYF Intensive Services

All of these sessions were rated highly among program fellows, which included first & second year Child Psychiatry Fellows and a medical student, for a total of ten participants. As for FY 20/21 they anticipate to have five fellows at their different sites.

Bryant Street Navigation Center

UCSF Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital and BHS Adult/Older Adult System of Care

In FY 19/20, fellowship staff added two new clinical sites; the SFHN-BHS Comprehensive Crisis Services and the Richard Fine People's Clinic (RFPC) at Zuckerberg SFGH. The staff have also formed a new partnership with Turning Point Mental Health Urgent Care Clinic based in Sacramento, CA. This partnership will consist of urgent care clinic to serve as a clinic site for a fourth-year resident from UC Davis. It has been noted that with the current funding, four fellows have graduated from the program. This year, the programs reach has extended beyond San Francisco County, with two new Fellows from San Mateo County and one from Turning Point of Sacramento.

Future Plans

There are two new MHSA-funded fellows this academic year. Dr. Matthew Goldman, is a fellow working in both the SFHN-BHS Mission Mental Health Clinic and the SFHN-BHS Comprehensive Crisis Services unit. Dr. Tamara Bendahan is a fourth-year resident at UCSF who is working with the Behavioral Health Team within Zuckerberg SFGH's RFPC. These two will attend trainings on Mental Health Advocacy at the Steinberg Institute. To expand the reach of the fellow's capstone projects, program staff will emphasize collaboration with and dissemination to mental health services consumers from each clinical site. Specifically, each fellow will identify a consumer partner from their sites' Community Advisory Board and work with them throughout the year, as well as disseminate their results to a broad group of stakeholders (i.e. consumers, clinic staff, leadership). Their final project will be submitted to the annual American Psychiatric Association meeting held in Philadelphia in Spring 2020. For FY 20/21, program staff have already begun recruiting and have received several applicants and already have interviews scheduled with two potential fellows.

Additional Updates

BHS and SFDPH MHSA are in the process of updating their 2017-2021 Behavioral Health Services Five-Year Workforce Assessment/Plan. It was determined that additional workforce staffing and client-level data is now available and should be integrated into the report. The Assessment/Plan will also be updated using information from the MHSA 2019-2020 Annual Update and from qualitative data collected during interviews with the SFDPH Workforce Program Management team and staff. The Five-Year Workforce Assessment/Plan will be ready for dissemination by Spring 2020.

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.

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

Information Technology	
Program Name	**Services Description**
	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
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

Chinatown North Beach Clinic- 729 Filbert Street
The project entails:

- Remodel and tenant Improvements of Chinatown North Beach clinic.
- Reconfigure space to create a Primary Care examination room.
- Remodel the lobby and pharmacy area to provide greater access and security for the clients and staff.
- Improve floor surfaces to increase safety and sanitary nature of the clinic.

FY18-19 update – SFDPH has removed and replaced the common area flooring on all three floors to a modern, non-permeable surface. The scope of work included all three floors, hallways, the community kitchen and group spaces, and the intake room.

FY19-20 update - Pending project work for the Pharmacy remodel is in the quoting stage and awaiting approval to proceed.

Child Crisis and Comprehensive Mobile Crisis – 3801 Third Street -
The Mobile Crisis Team is based in this location for outreach and home visits during a mental health crisis for adults (18 years and older). Additionally, Child Crisis operations are held here to support outreach visits during a mental health crisis for children (younger than 18 years).

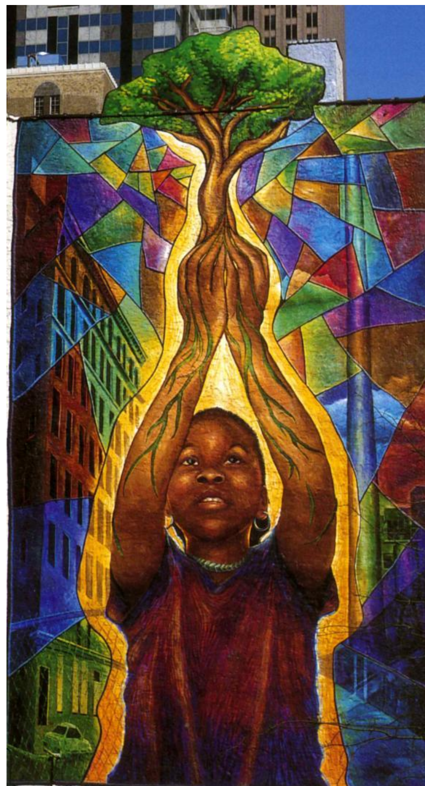
FY18-19 update - Replaced 3 City vehicles that support the Comprehensive Crisis Response and City's Intervention Team that provides 24 hour x 7 day a week collaborative work with the CCSF Emergency Medical Sections and Public Safety Departments.

FY19-20 update - Pending project to reconfigure and build out client meeting spaces for the Comprehensive Crisis Services and Foster Care Mental Health Team. Specifically, we will build out a client phone center and client meeting space transforming the open office space into an appropriate space for client engagement and call center activities.

Moving Forward in Information Technology

Consumer Portal
The Consumer Portal provides support for consumers interested in/or 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 and encourage mental health clinics to issue registration PINS to consumers.



The Consumer Portal project expected outcomes include:

- Increase consumer participation in care
- Promote continuity of care with other providers
- Provide 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 deployments 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
- Assist Field Services with service tickets
- Provide technical support 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. 90% of IT training programs graduates have gained employment as peer staff while others have been employed by RAMS or other community programs/private organizations.

IT employment of peer staff include:

- The Avatar Consumer Portal
- Avatar Accounts
- Avatar Help Desk Trainers

System Implementation, Support, Maintenance and Reporting
System implementation, support, maintenance and reporting provides vital program planning and support for projects. Three civil service Business Analysts positions are funded by MHSA. These positions are dedicated to supporting MHSA IT initiatives and IT systems including the Avatar EHR application.
Responsibilities include the following:

- Implementation of MHSA projects
- Manage connectivity for our BHS contract providers to the Avatar EHR system
- Coordinate with the System of Care on BHS/MHSA IT related projects
- Conduct data analysis related to projects
- Ensure the Avatar EHR system is compliant with State mandates
- Support the Avatar EHR system for BHS providers
- Preparation for the transition to the Epic system (Electronic
- Health Record) in 2022
- Participate in the IT strategic goals for the Department of Public Health, including MHSA and BHS
- Maintenance of MHSA reporting databases, including DCR

First Impressions Vocational Construction Program

Capital Facilities & IT

Program Evaluation for All MHSA Programs

System Change: Integrating MHSA principles into the larger BHS System of Care

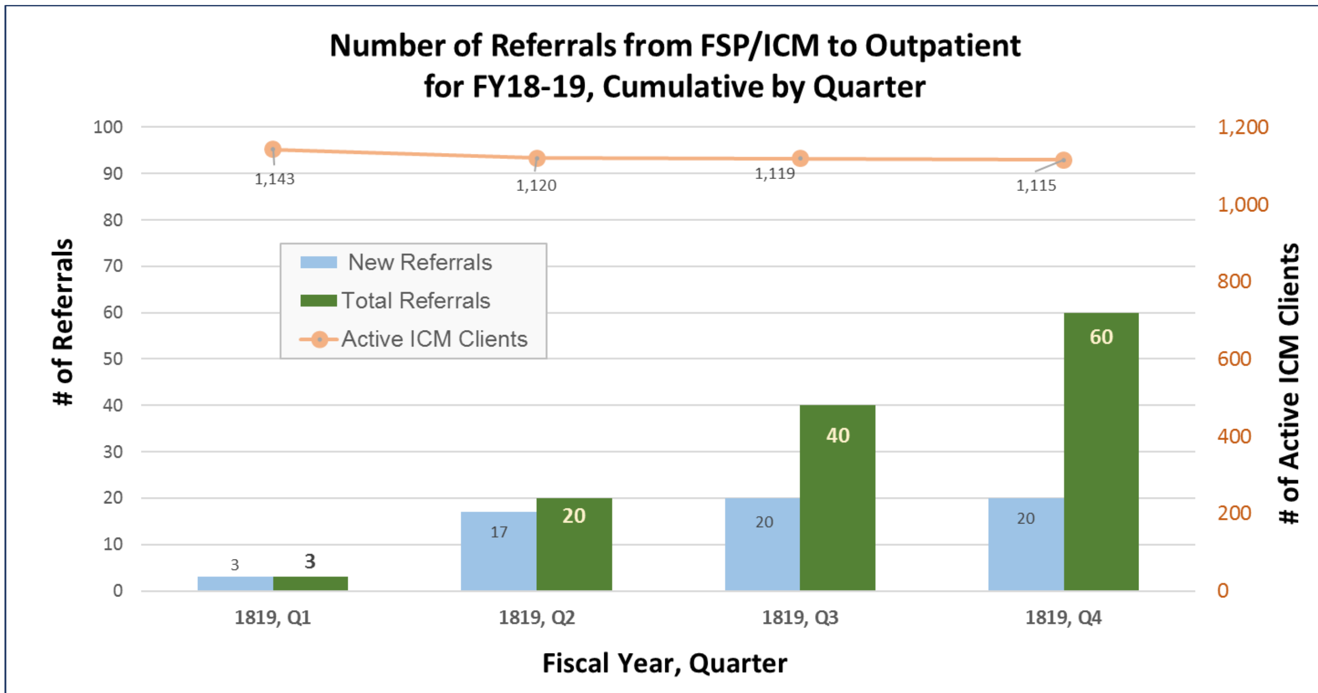
Intensive Case Management (ICM) programs, which include Full Service Partnership (FSP) programs, welcome higher acuity clients and provide "whatever it takes" to improve clients' wellbeing and recovery. Transitioning clients to appointment based mental health outpatient clinics (OP), when they no longer need the intensity of ICM/FSP care, continues to present many challenges for clients and the Behavioral Health System of Care. However, with the implementation of new standards of work and supports for clients, we are better able to assess clients' transitions to OP care.

For six months prior to July 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, and MHSA, met twice a month and built a collaborative that produced solutions to improve client transition to Outpatient. Several key initiatives, borne from the workgroup collaborative, were implemented in FY18-19, which strongly reflect the goals of integrating client care more seamlessly, and supporting and encouraging client wellness and recovery.

ICM to Outpatient Referral Tracking
Previously, BHS had no systematic way to track ICM/FSP client referrals to Outpatient (OP) clinics. As part of the collaborative, in early 2018, BHS piloted referral reporting by ICM/FSP programs, then in BHS instituted a required list of client referrals to OP, to be submitted monthly by ICM directors or staff, including those from Full Service Partnerships (FSPs). This new strategy has allowed BHS to monitor the frequency of client transitions to outpatient care.
The following is a summary of ICM/FSP to OP referrals from July 1, 2018 through June 30, 2019.

MHSA Awards Ceremony

Evaluation



As of December 1, 2019, more than 73 referrals have been submitted to OP, with 51 (70%) clients having met criteria for a "successful linkage" to Outpatient care. That is, 51 clients have met all the following:

1. Evidence of a **referral made** from ICM/FSP to OP
2. New outpatient episode **open for at least 60 days**
3. The referred ICM/FSP client attends at least **3 OP services**
4. **The ICM/FSP episode** generating the referral **is closed**

Lengths of stay at OP suggest that clients are connecting for longer than the criteria of 60 days:

Length of Stay at OP	# Clts	%
60 days - 90 days	5	9%
3 – 6 months	17	31%
6 – 9 months	11	20%
9 – 12 months	12	22%
More than 12 months	10	18%
Totals	**55**	100%

ICM-OP Task Force

Throughout FY18-19, the SOC convened an ICM-OP Task Force, meeting monthly, to move the collaborative workgroups' recommendations forward. The task force is designed to ensure continuity and accountability on progress and complete key tasks:

1) Finalized a BHS communication that standardized an ICM/FSP to OP referral process across the system of care and ensures clients' continuity of care

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2) Ensures implementation of the ICM-OP Referral process requirements
3) Continues to collect referral data centrally and evaluate the impact of the changes; also exploring the incorporation of the referral form(s) into the BHS electronic health record (Avatar)
4) Continues to work toward expansion of outreach and supportive services at the OP level to better engage and retain incoming ICM and FSP clients
5) Communicate regularly with ICM/FSP and OP providers updates and challenges on implementation of the task force's recommendations.

The ICM-OP Task Force will continue its work throughout FY19/20.

Innovations Project Evaluations

MHSA-funded staff within the BHS Quality Management unit play an active role in supporting evaluation activities for MHSA. Quality Management is routinely consulted for the development of evaluation plans for new MSHA programs. Four new approved Innovations projects were in development in FY18-19, and QM was integral to the design of the evaluation plans from the inception of each proposal and through early implementation. The Innovations plans are described elsewhere in this report

QM is particularly involved with the ICM-OP Peer Transition Team implemented by RAMS as it aligns well with, and in fact came out of, the ICM-OP Collaborative. RAMS staff will collect the data with technical support and oversight from QM. With the addition of a PsyD intern from the California School of Professional Psychology, and in collaboration with RAMS, QM created an evaluation plan and drafted data collection tools to assess multiple perspectives of the Peer Transition project:

1. Client experience
2. Peer Specialist experience
3. FSP/ICM assessment
4. Outpatient assessment

Data collection will capture from each: effectiveness of client support, communication between the PTT and the programs, support of the peer team, among other priorities. Implementation of the evaluation data collection tools will begin in 2020, after collaborative revisions and pilot testing by RAMS.

QM also supported Innovations program development, defining objectives and preliminary evaluation planning for Wellness in the Streets (WITS) and FUERTE, and offered input on the Tech Suite project still in development. QM will play a major role in evaluating the WITS for its duration. However, the FUERTE program will have primary evaluation support from UCSF, with QM oversight.

Finally, QM supports MHSA in advising on and assistance in writing Innovations Final Leaning Reports, such as the UCSF First Impressions Final Report, recently submitted, and the Transgender Pilot Project report in development.

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 came 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 FY 19-20 in an effort to make them stronger. The careful review of objectives helped identify programs that still needed support in creating SMART objectives. With SMARTer objectives, SF MHSA can report more meaningful and accurate outcomes and impacts in MHSA Annual Update reports. 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 Innovations 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.

PEI Regulations for Referrals: Access and Linkage to Treatment

In response to recently added regulations for PEI and INNOVATIONS programs to capture Access and Linkage to Treatment for previously unserved and underserved individuals in the population, Quality Management partnered with MHSA administrative staff to provide technical assistance to programs. QM convened two MHSA Impact meetings, in May and June 2019, to explain the enhanced regulations in depth and the impact on their data gathering. QM also offered follow up TA, one on one, with visits to the programs. QM visited two programs to date, RAMS Asian Pacific Island Mental Health Collaborative (APIMHC) and Native American Health Center. We reviewed their current data collection tools and collaboratively identified adjustments that would incorporate referral data and follow up information in a culturally effective manner.

Gender Health San Francisco

Established in August 2013 as Transgender Health Services, Gender Health SF (GHSF), as it is now known, is a first-of-its-kind peer-based program whose mission is to increase access to quality gender affirming health care for underserved transgender and non-binary residents in San Francisco, regardless of immigration status and/or lack of income. GHSF also provides staff cultural humility trainings across all SFDPH service access points.

The GHSF project actively engages stakeholders in the evaluation process to better understand and improve MHSA's impact in the community. Quality Management plays an active role in GHSF's evaluation activities.

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 national 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 tells us that when offered access to culturally competent and medically necessary services, trans and gender non-binary individuals experience improved psychosocial and quality of life outcomes.

GHSF is a Nationally-Recognized Award Winning Program!

This past April 2019, GHSF was invited to present 9 workshops at the 2019 National Transgender Health Summit (NTHS) in Oakland, CA. NTHS is the premiere national conference in transgender health offering cutting-edge research, evidence-based educational sessions, and training opportunities across many disciplines.

In addition, two GHSF peer staff were recognized for their outstanding work and leadership in gender health. For their outstanding service to support the health and well-being of the trans and gender non-binary communities, Project AFFIRM awarded Tố Như (Lotus) Đào, GHSF Behavioral Health Clinician, the Health Provider of the Year award. And, for her outstanding service and advocacy work with the local trans community, Project AFFIRM awarded Karen Aguilar the Education and Advocacy Achievement Award.

Gender Health SF Celebrates PRIDE 2019

This past June marked the 16th annual San Francisco Trans March, where SF residents, community leaders, and allies joined together and marched to show support for the transgender and gender non-binary communities. In honor of the City and County's long standing advocacy for

Evaluation

trans and gender non-binary communities, Mayor Breed proclaimed June 28, 2019 Trans March Day in San Francisco. From her proclamation, “San Francisco has a long history of being a place where the transgender community and its allies work tirelessly to advance the national dialogue around civil rights and social justice for marginalized and underserved communities, and has often served as the place where resiliency is fostered and community policies are advanced.”

Gender Health SF (GHSF) celebrated PRIDE month by being out at the Trans March to host a community resource table where we promoted wellness and health education resources. In being present, we honored all LGBTQ+ people who are living their truth, power and visibility toward inclusiveness and liberation.

In the spirit of Pride celebrations, San Francisco General Hospital Women's Health Center hosted a Pride lunch celebration in honor of the GHSF team. GHSF and the Women's Health Center are building a coalition to create inclusive programming and services for trans and non-binary patients who need gender affirming health care and social support.

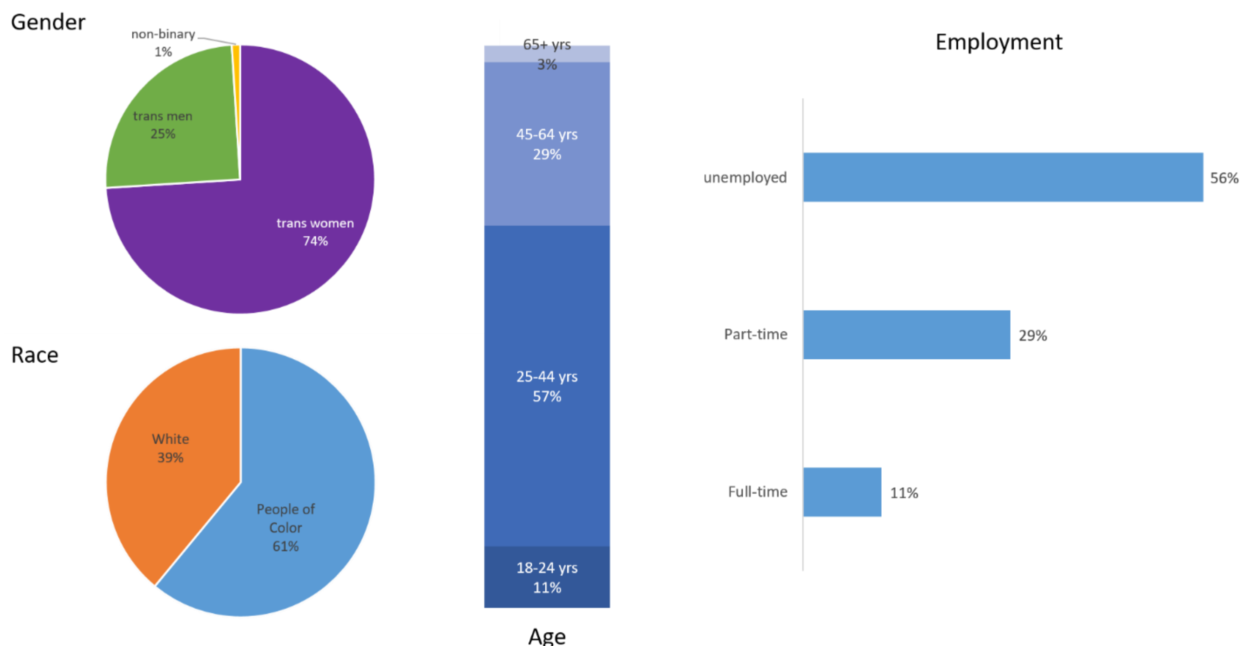
In June 2019, GHSF presented its annual update to the San Francisco Health Commission.

Program highlights included that GHSF now offers:

- Expanded wrap-around peer navigation with access to integrated, interdisciplinary care coordination between BHS, Primary Care, and the identified surgery team;
- Weekly peer-run drop-in services and education activities that increase surgical preparation and social connectedness for clients awaiting or recovering from gender-affirming surgeries; and
- Client-centered advocacy that increased access to body hair reduction services for uninsured clients.

Partners served by GHSF are predominantly adults who identify as trans women of color. Partners reported more unstable housing (25%) and more unemployment (56%) than the national average surveyed by the US Trans Survey in 2015 (15% and 32%, respectively).

Gender Health SF Demographics



The San Francisco Health Commissioners recognized GHSF as "one of the most necessary and important programs that the City sponsors." The program evaluation showed that people who receive peer-navigation from GHSF throughout their surgery preparation and recovery processes reported better overall health, less serious psychological distress, and less alcohol use. The program evaluation also showed that peer navigated gender affirming surgery access resulted in reduced body discomfort and lower gender dysphoria and improved psychosocial quality of life.

Since the program's inception in 2013, GHSF has served over 550 unduplicated individuals. The program averages nearly 150 client referrals per calendar year. In total, GHSF has received over 1,000 referrals since 2013. Since the program evaluation began in 2016, we have documented that the number of annual client referrals to GHSF has doubled.

A core component to the success of GHSF is the Peer Patient Access Navigator program. Patient Access Navigators, all of whom are peers and who identify as part of transgender and gender non-binary communities, hold caseloads and navigate wrap around care for all referred partners from the point of enrollment in GHSF through surgery access and for at least one year after gender affirming surgery. The Patient Access Navigators are the partners' primary points of contact with GHSF and maintain a caseload of clients in various stages of transition-related support services. As GHSF's best partner advocates, they center the lived experiences of community members in expanding the field of gender health. All of GHSF's programming is driven and informed by the peer staff.

The program learned from participant feedback that providers want more trainings and our patient partners really appreciated learning ahead of time about possible surgery complications and how to prepare both emotionally and socially for their upcoming surgeries.

As a result of the partner feedback gathered from this past year's education and preparation sessions, we added more Spanish-language groups, we now review the more common complications in advance, and we share resources for pre- *and* post-operative social support earlier in the navigation process. We also developed more trainings to meet the current education needs of the providers in the BHS system of care

Spotlight on a Client Success Story

An African American woman of trans experience in her early 60's approached our program after experiencing difficulty with accessing gender affirming care. She is a Veteran with a complex medical history including a history of complex trauma. She receives her care through the Veteran Affairs and has been attempting to access gender affirming care throughout her life, but was largely unsuccessful due to numerous barriers and life circumstances. Because we understood the unique needs of transgender veterans, we were able to provide a high level of peer-coordinated care and health care engagement support. Together, this Patient and her Patient Access Navigator were able to coordinate complete referrals for surgery with the VA as well as provide the needed surgery education and preparation, accompany the patient to her consultation and post-operative appointments, and provide gender affirming assessments for additional surgeries. To date, this Patient has successfully obtained and recovered from her first surgery and is now preparing for her next steps. Gender Health SF is also now working closely with the SFVA to support them in building capacity to support transgender veterans.

In summary, through GHSF's ongoing peer-led community outreach, educational, and engagement activities throughout the BHS care network, trans and gender non-binary residents in San Francisco who are served by the program experience on average better overall health, better quality of life, and less psychosocial distress than those who participated in a national survey in 2015. While there is still a long way to go to bring full health equity to the trans and gender non-binary communities, Gender Health SF is leading the way with innovative, peer-led interventions to elevate these communities to increased wellness and recovery.

Trans Day of Remembrance Night in San Francisco, November 2019

“Looking Ahead for SFDPH 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 2020-2023 Three-Year Integrative Plan, 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 continue to take measures to respond to the No Place Like Home (NPLH) bond and requests.** NPLH re-purposes statewide MHSA funds, and will provide $2 billion Statewide for the construction and rehabilitation of permanent supportive housing for homeless individuals with severe and persistent mental illness. In the coming year, we will work to implement effective NPLH programming as outlined by the State.

- **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 reporting tools that allow programs to submit mid-year and year-end reports that include demographics data, measurable outcomes, client success stories and more.

- **We will implement new Innovations (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 also started collecting community input regarding current community needs and possible new INN programs. We recently implemented a new community/stakeholder proposal process and INN proposals are currently being review by a committee.

- **We will implement a new Online Learning System.** As stated in the FY19/20 Annual Update, we received stakeholder feedback calling for the implementation of a new Online Learning System. A RFQ was issued and we plan to start a contract with a selected provider on January 1, 2020. 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.

Projected MHSA Expenditures

MHSA Integrated Service Categories

MHSA Integrated Service Categories	Abbreviation	FY 18/19 Expenditure Amount	Percentage
Admin	Admin	2,588,422.62	8%
Evaluation	Evaluation	950,276.15	3%
Housing	H	1,995,130.83	6%
Recovery Oriented Treatment Services	RTS	12,119,583.90	37%
Peer-to-Peer Support Services	P2P	4,989,055.36	15%
Vocational Services	VS	2,959,715.26	9%
Workforce Development and Training	WD	1,924,616.16	6%
Capital Facilities/IT	CF/IT	256,966.62	1%
Mental Health Promotion and Early Intervention Services	PEI	5,059,798.06	15%
TOTAL		**32,843,564.95**	**100%**

FY18/19 MHSA Actual Expenditures

SF MHSA Integrated Services Categori	Programs by Funding Component	FY 18-19 Expenditure
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 18-19, 53% was allocated to serve FSP clients	
Admin	CSS Admin	2,063,640.04
Evaluation	CSS Evaluation	892,458.82
H	CSS FSP Permanent Housing (capital units and master lease)	904,615.63
RTS	CSS Full Service Partnership 1. CYF (0-5)	395,804.22
RTS	CSS Full Service Partnership 2. CYF (6-18)	931,681.18
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,115,745.79
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,780,031.64
RTS	CSS Full Service Partnership 5. Older Adults (60+)	1,026,926.03
RTS	CSS Full Service Partnership 6. AOT	497,943.00
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	898,806.02
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	600,000.00
RTS	CSS Other Non-FSP 3. Trauma Recovery	140,604.00
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,641,117.92
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	314,413.61
RTS	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	-
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,232,469.16
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,687,966.88
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	397,405.94
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	92,720.26
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	600,389.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	326,334.78
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	450,175.71
	SUBTOTAL Community Services and Support (CSS)	**22,991,249.63**

	Workforce, Development Education and Training (WDET) **$2.3M transferred from CSS to fund WDET activities in FY 18-19**	
WD	WDET 1. Training and TA	852,336.97
WD	WDET 2. Career Pathways	694,138.63
WD	WDET 3. Residency and Internships	378,140.56
Admin	WDET Admin	78,207.96
Evaluation	WDET Evaluation	57,817.33
	SUBTOTAL Workforce, Development Education and Training (WDET)	**2,060,641.45**
	Capital Facilities/IT **$3.0M transferred from CSS to fund Capital Facilities/IT activities in FY 18-19**	
CF/IT	Cap 3. Sunset Mental Health	-
CF/IT	IT 1. Consumer Portal	140,310.65
VS	IT 2. Vocational IT	1,069,248.38
CF/IT	IT 3. System Enhancements	116,655.97
Admin	IT Admin	139,718.83
	SUBTOTAL Capital Facilities/IT	**1,465,933.83**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**26,517,824.91**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	185,106.69
PEI	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	1,070,131.86
PEI	PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,521,075.42
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	639,671.47
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	342,912.24
PEI	PEI 7. CalMHSA Statewide Programs	68,634.97
Admin	PEI Admin	78,207.95
	SUBTOTAL Prevention and Early Intervention (PEI)	**4,905,740.60**
	Innovation (INN) 5% of total MHSA revenue	
VS	INN 14. First Impressions	202,500.00
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	406,250.00
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	185,039.61
WD	INN 17. Hummingbird Place - Peer Respite	-
P2P	INN 18. Intensive Case Management Flow	147,963.55
P2P	INN 20. Technology-assisted Mental Health Solutions	17,333.04
PEI	INN 22. FUERTE	232,265.41
Admin	INN Admin	228,647.84
Evaluation	INN Evaluation	-
	SUBTOTAL Innovation (INN)	**1,419,999.45**
	TOTAL FY 18-19 MHSA Expenditures	**32,843,564.95**

FY20/21 through FY22/23 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 2020/21 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	12,874,914	8,853,904	5,027,109	150,000	2,274,332		29,180,259
2. Estimated New FY2020/21 Funding	25,232,000	6,308,000	1,660,000				33,200,000
3. Transfer in FY2020/21	(3,559,225)			2,189,828	1,369,396	-	-
4. Access Local Prudent Reserve in FY2020/21						-	-
5. Estimated Available Funding for FY2020/21	34,547,689	15,161,904	6,687,109	2,339,828	3,643,728		62,380,259
B. Estimated FY2020/21 MHSA Expenditures	24,310,955	6,512,503	3,244,528	2,307,957	3,619,396		39,995,339
C. Estimated FY2021/22 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	10,236,735	8,649,401	3,442,581	31,871	24,332		22,384,920
2. Estimated New FY2021/22 Funding	25,232,000	6,308,000	1,660,000				33,200,000
3. Transfer in FY2021/22	(3,947,091)			2,334,910	1,612,181	-	-
4. Access Local Prudent Reserve in FY2021/22						-	-
5. Estimated Available Funding for FY2021/22	31,521,644	14,957,401	5,102,581	2,366,781	1,636,513		55,584,920
D. Estimated FY2021/22 Expenditures	24,642,672	6,530,117	3,247,513	2,334,910	1,612,181		38,367,392
E. Estimated FY2022/23 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	6,878,972	8,427,284	1,855,068	31,871	24,332		17,217,528
2. Estimated New FY2022/23 Funding	25,232,000	6,308,000	1,660,000				33,200,000
3. Transfer in FY2022/23	(3,987,386)			2,362,037	1,625,349	-	-
4. Access Local Prudent Reserve in FY2022/23						-	-
5. Estimated Available Funding for FY2022/23	28,123,586	14,735,284	3,515,068	2,393,908	1,649,681		50,417,528
F. Estimated FY2022/23 Expenditures	24,983,939	6,548,259	3,250,588	2,362,037	1,625,349		38,770,171
G. Estimated FY2022/23 Unspent Fund Balance	3,139,648	8,187,025	264,480	31,871	24,332		11,647,356

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	7,259,571
2. Contributions to the Local Prudent Reserve in FY 2020/21	0
3. Distributions from the Local Prudent Reserve in FY 2020/21	0
4. Estimated Local Prudent Reserve Balance on June 30, 2021	7,259,571
5. Contributions to the Local Prudent Reserve in FY 2021/22	0
6. Distributions from the Local Prudent Reserve in FY 2021/22	0
7. Estimated Local Prudent Reserve Balance on June 30, 2022	7,259,571
8. Contributions to the Local Prudent Reserve in FY 2022/23	0
9. Distributions from the Local Prudent Reserve in FY 2022/23	0
10. Estimated Local Prudent Reserve Balance on June 30, 2023	7,259,571

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

Community Services and Supports (CSS) Estimated Budget – FY20/21 through FY22/23

	Fiscal Year 2020/21					
	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)	548,736	395,804.22	-	-	-	152,932
2. CSS Full Service Partnership 2. CYF (6-18)	1,177,417	969,185	46,353	-	-	161,879
3. CSS Full Service Partnership 3. TAY (18-24)	1,380,644	1,036,481	329,559	-	-	14,604
4. CSS Full Service Partnership 4. Adults (18-59)	9,849,232	3,923,711	1,872,072	1,335,770	2,798	2,714,880
5. CSS Full Service Partnership 5. Older Adults (60+)	1,549,094	1,060,096	411,795	-	-	77,204
6. CSS Full Service Partnership 6. AOT	478,352	478,352	-	-	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	904,616	904,616	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,517,446	2,141,348	-	112,252	-	263,846
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,026,955	846,380	7,624	289,447	-	883,503
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	243,453	243,453	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	30,698	30,698	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,062,556	925,692	111,116	-	-	25,748
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,127,941	638,956	255,607	-	-	233,379
3. CSS Other Non-FSP 3. Trauma Recovery	190,938	140,604	39,461	-	-	10,873
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,935,334	1,737,109	198,226	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,594,999	314,414	3,774	1,129	50,610	1,225,073
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,517,446	2,141,348	-	112,252	-	263,846
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,477,389	1,034,464	9,319	353,769	-	1,079,837
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	162,302	162,302	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	71,628	71,628	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	240,156	240,156	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	663,792	373,732	290,060	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	768,871	768,871	-	-	-	-
CSS Administration	2,321,031	2,321,031	-	-	-	-
CSS Evaluation	1,050,292	1,050,292	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	37,251,551	24,310,955	3,574,965	2,204,619	53,408	7,107,604
FSP Programs as Percent of Total	51%					

	Fiscal Year 2021/22					
	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)	787,457	395,804	-	391,652	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	1,745,395	985,572	395,955.56	329,186	34,681	-
3. CSS Full Service Partnership 3. TAY (18-24)	2,024,866	1,054,468	419,539	316,748	234,110	-
4. CSS Full Service Partnership 4. Adults (18-59)	9,432,624	3,979,362	1,358,342	1,641,990	1,431,512	1,021,419
5. CSS Full Service Partnership 5. Older Adults (60+)	2,494,723	1,074,495	445,063	577,824	397,341	-
6. CSS Full Service Partnership 6. AOT	651,921	485,274	83,775	82,872	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	1,762,883	904,616	-	858,267	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,150,488	2,152,268	304,052	1,594,636	-	99,531
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,898,181	849,079	85,633	690,909	6,995	265,564
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	482,484	245,625	66,939	169,919	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	44,792	30,698	-	14,095	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	720,467	360,233	-	360,233	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,838,813	948,018	634,730	160,598	95,467	-
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,533,519	638,956	-	638,956	255,607	-
3. CSS Other Non-FSP 3. Trauma Recovery	320,669	140,604	-	140,604	39,461	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	3,308,985	1,779,237	1,094,603	278,462	156,684	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	525,157	314,414	-	207,508	2,491	745
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,150,488	2,152,268	304,052	1,594,636	-	99,531
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,319,999	1,037,764	104,663	844,445	8,550	324,579
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	321,656	163,750	44,626	113,279	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	104,515	71,628	-	32,887	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	480,311	240,156	-	240,156	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	636,312	384,944	141,527	-	109,841	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,275,337	792,339	482,998	-	-	-
CSS Administration	4,311,268	2,379,298	1,577,368	354,602	-	-
CSS Evaluation	1,826,710	1,081,800	744,910	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	49,150,021	24,642,672	8,288,774	11,634,466	2,772,739	1,811,370
FSP Programs as Percent of Total	51%					

	Fiscal Year 2022/23					
	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)	787,457	395,804	-	391,652	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	1,775,286	1,002,451	402,736.63	334,824	35,275	-
3. CSS Full Service Partnership 3. TAY (18-24)	2,060,443	1,072,996	426,910.72	322,313	238,223	-
4. CSS Full Service Partnership 4. Adults (18-59)	9,568,495	4,036,682	1,377,908	1,665,642	1,452,132	1,036,132
5. CSS Full Service Partnership 5. Older Adults (60+)	2,529,158	1,089,327	451,206	585,800	402,826	-
6. CSS Full Service Partnership 6. AOT	661,499	492,404	85,006	84,090	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	1,762,883	904,616	-	858,267	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,172,178	2,163,516	305,641	1,602,970	-	100,052
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,904,398	851,860	85,914	693,172	7,018	266,434
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	486,878	247,862	67,549	171,467	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	44,792	30,698	-	14,095	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	720,467	360,233	-	360,233	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,883,417	971,014	650,126	164,494	97,783	-
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,533,519	638,956	-	638,956	255,607	-
3. CSS Other Non-FSP 3. Trauma Recovery	320,669	140,604	-	140,604	39,461	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	3,389,685	1,822,629	1,121,298	285,253	160,505	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	525,157	314,414	-	207,508	2,491	745
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,172,178	2,163,516	305,641	1,602,970	-	100,052
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,327,597	1,041,162	105,006	847,210	8,578	325,642
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	324,585	165,242	45,033	114,311	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	104,515	71,628	-	32,887	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	480,311	240,156	-	240,156	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	655,401	396,492	145,772	-	113,136	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,313,597	816,110	497,488	-	-	-
CSS Administration	4,420,016	2,439,314	1,617,156	363,546	-	-
CSS Evaluation	1,881,511	1,114,254	767,257	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	49,806,095	24,983,939	8,457,646	11,722,420	2,813,034	1,829,056
FSP Programs as Percent of Total	51%					

Prevention and Early Intervention (PEI) Estimated Budget – FY20/21 through FY22/23

	Fiscal Year 2020/21					
	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	185,107	185,107	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	575,944	538,745	-	-	-	37,199
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,150,095	2,044,613	-	-	-	105,482
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,079,266	479,754	-	-	-	2,599,512
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	37,255	36,838	417	-	-	-
7. PEI 7. CalMHSA Statewide Programs	68,635	68,635	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	575,944	538,745	-	-	-	37,199
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,150,095	2,044,613	-	-	-	105,482
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,026,422	159,918	-	-	-	866,504
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	335,295	331,542	3,753	-	-	-
PEI Administration	83,994	83,994	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	10,268,051	6,512,503	4,170	-	-	3,751,378

	Fiscal Year 2021/22					
	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	185,107	185,106.69	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	577,652	540,343	-	-	-	37,309
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,150,540	2,045,036	-	-	-	105,504
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,079,266	479,754	-	-	-	2,599,512
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	38,373	37,943	430	-	-	-
7. PEI 7. CalMHSA Statewide Programs	68,635	68,635	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	577,652	540,343	-	-	-	37,309
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,150,540	2,045,036	-	-	-	105,504
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,026,422	159,918	-	-	-	866,504
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	345,354	341,488	3,866	-	-	-
PEI Administration	86,514	86,514	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	10,286,054	6,530,117	4,295	-	-	3,751,643

	Fiscal Year 2022/23					
	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	185,107	185,107	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	579,412	541,989	-	-	-	37,423
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,150,999	2,045,473	-	-	-	105,527
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,079,266	479,754	-	-	-	2,599,512
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	39,524	39,081	442	-	-	-
7. PEI 7. CalMHSA Statewide Programs	68,635	68,635	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	579,412	541,989	-	-	-	37,423
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,150,999	2,045,473	-	-	-	105,527
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,026,422	159,918	-	-	-	866,504
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	355,714	351,733	3,982	-	-	-
PEI Administration	89,109	89,109	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	10,304,598	6,548,259	4,424	-	-	3,751,915

Innovations (INN) Estimated Budget – FY20/21 through FY22/23

	Fiscal Year 2020/21					
	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 18. Intensive Case Management Flow	734,583	734,583	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	813,266	813,266	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	400,000	400,000	-	-	-	-
4. INN 22. FUERTE	300,000	300,000				
5. TBD - Population-focused mental health program	600,000	600,000				
INN Administration	396,679	396,679	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,244,528	3,244,528	-	-	-	-

	Fiscal Year 2021/22					
	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 18. Intensive Case Management Flow	737,120	737,120	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	813,266	813,266	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	400,000	400,000	-	-	-	-
4. INN 22. FUERTE	300,000	300,000	-	-	-	-
5. TBD - Population-focused mental health program	600,000	600,000				
INN Administration	397,127	397,127	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,247,513	3,247,513	-	-	-	-

	Fiscal Year 2022/23					
	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 18. Intensive Case Management Flow	739,734	739,734	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	813,266	813,266	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	400,000	400,000	-	-	-	-
4. INN 22. FUERTE	300,000	300,000	-	-	-	-
5. TBD - Population-focused mental health program	600,000	600,000				
INN Administration	397,588	397,588	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,250,588	3,250,588	-	-	-	-

Workforce, Education and Training (WET) Estimated Budget – FY20/21 through FY22/23

	Fiscal Year 2020/21					
	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	1,536,435	1,001,430	-	93,284	-	441,720
2. Career Pathways	694,139	694,139	-	-	-	-
3. Residency and Internships	444,503	444,503	-	-	-	-
WET Administration	83,994	83,994	-	-	-	-
WET Evaluation	83,892	83,892	-	-	-	-
Total WET Program Estimated Expenditures	2,842,962	2,307,957	-	93,284	-	441,720

	Fiscal Year 2021/22					
	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	1,564,296	1,019,590	-	94,976	-	449,730
2. Career Pathways	694,139	694,139	-	-	-	-
3. Residency and Internships	449,671	449,671	-	-	-	-
WET Administration	86,514	86,514	-	-	-	-
WET Evaluation	84,997	84,997	-	-	-	-
Total WET Program Estimated Expenditures	2,879,616	2,334,910	-	94,976	-	449,730

	Fiscal Year 2022/23					
	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	1,592,021	1,037,660	-	96,659	-	457,701
2. Career Pathways	694,139	694,139	-	-	-	-
3. Residency and Internships	454,993	454,993	-	-	-	-
WET Administration	89,109	89,109	-	-	-	-
WET Evaluation	86,135	86,135	-	-	-	-
Total WET Program Estimated Expenditures	2,916,397	2,362,037	-	96,659	-	457,701

Capital Facilities/Technological Needs (CFTN) Estimated Budget – FY21/22 through FY22/23

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 5. Southeast Health Center	2,000,000	2,000,000	-	-	-	-
3. Cap 8. Chinatown/Northbeach Exam Room	120,000	120,000	-	-	-	-
4. Cap 9. Comprehensive Crisis Services/CTT Team Build Out	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
1. IT 1. Consumer Portal	150,732	150,732	-	-	-	-
2. IT 2. Vocational IT	1,073,245	1,073,245	-	-	-	-
3. IT 3. System Enhancements	125,316	125,316	-	-	-	-
CFTN Administration	150,104	150,104	-	-	-	-
Total CFTN Program Estimated Expenditures	3,619,396	3,619,396				

	Fiscal Year 2021/22					
	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. TBD	100,000	100,000				
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	155,254	155,254	-	-	-	-
9. Vocational IT	1,073,245	1,073,245	-	-	-	-
10. System Enhancements	129,076	129,076	-	-	-	-
CFTN Administration	154,607	154,607	-	-	-	-
Total CFTN Program Estimated Expenditures	1,612,181	1,612,181				

	Fiscal Year 2022/23					
	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. TBD	100,000	100,000				
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	159,911	159,911	-	-	-	-
9. Vocational IT	1,073,245	1,073,245	-	-	-	-
10. System Enhancements	132,948	132,948	-	-	-	-
CFTN Administration	159,245	159,245	-	-	-	-
Total CFTN Program Estimated Expenditures	1,625,349	1,625,349				

Appendix 1: New Innovation Proposal

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Innovations Learning Project Proposal:

Culturally Congruent and Innovative Practices for Black/African American Communities

San Francisco Mental Health Services Act

2020

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Culturally Congruent and Innovative Practices for Black/African American Communities Innovations Proposal

Local Review

The recent San Francisco Community Planning Process (CPP) involved various opportunities for community members and stakeholders to share input in the development of our Innovations Project. Please see the CPP meetings section below for details.

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of the Wellness in the Streets Innovations Project was posted on the San Francisco Mental Health Services Act (SF-MHSA) website at www.sfdph.org/dph and www.sfmhsa.org. This **project was included in the FY20-2023 MHSA Three-Year Program and Expenditure Plan that was posted for a period of 30 days from February 6, 2020 to March 9, 2020.** Members of the public were requested to submit their comments either by email or by regular mail.

Following the 30-day public comment and review period, **a public hearing was conducted by the San Francisco Behavioral Health Commission on May 20, 2020.** This Innovations project plan was also **adopted by the San Francisco Board of Supervisors Budget and Finance Committee on September 16, 2020.**

Project Background

The San Francisco Department of Public Health (SF-DPH) Behavioral Health Services (BHS) Division is proposing a five-year project serving Black/African American San Francisco residents with mental health needs. To begin, we looked at the challenges faced by this population in the county as a whole. The United States is a country built upon a foundation of slavery and overarching white supremacy. The traditional medical model of care was not designed with the needs of people of color and, specifically, not designed with the Black/African American population in mind. While progress has been made, health disparities exist at all levels of both public and private health systems.

Turning the lens specifically to mental health, according to the National Alliance on Mental Illness, approximately 1 in 5 adults in the United States experience mental illness in a given year. Yet only approximately 30% of Black/African American adults with mental illness receive treatment each year, compared to the U.S. average of 43%. In addition, according to the U.S. Department of Health and Human Services Office of Minority Health, adult Black/African Americans are 20 percent more likely to report serious psychological distress than adult White Americans.

Historically, Black/African Americans have been and continue to be negatively affected by prejudice and discrimination in the health care system. Misdiagnoses, inadequate treatment and a lack of cultural competence by health professionals cause distrust and prevent many Black/African Americans from seeking or staying in treatment. Black/African Americans in the United States are less likely to receive accurate diagnoses than their Caucasian counterparts. Schizophrenia, for instance, has been shown to be over-diagnosed in the Black/African American population.

We also looked at local statistics in the City of County of San Francisco to find that recent publications by the County note that Black/African Americans have the highest rate of

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hospitalization for depression in San Francisco. Also, our County Behavioral Health Services system shows a high penetration rate of Black/African Americans in our Child, Youth and Families System of Care. Black/African Americans have the highest penetration of any group for 5 or more visits. Overall, our mental/behavioral health system statistics continue to show that Black/African Americans in San Francisco are receiving services at a disproportionate rate compared to the Black/African American population in San Francisco.

Lack of Culturally Responsive Providers and Programs

Implicit and explicit biases of mental health providers and medical mistrust against mental health professionals in general often prevent many Black/African Americans from accessing care due to prior experiences with historical misdiagnoses, inadequate treatment and a lack of cultural understanding.

Few Black/African American clinicians and health workers within the system are available. According to a local Workforce Needs Assessment conducted in 2019, 19% of Behavioral Health Services (BHS) clients are Black/African American in San Francisco while only 13% of licensed mental/behavioral health clinicians are Black/African American. More concerning is the fact that only 4% of BHS medical staff are Black/African American. Therefore, we have a local need to hire behavioral health professionals that better represent this population we serve. We also have a need to provide culturally competent health care providers and culturally adaptive mental health interventions all throughout our system.

In addition, Black/African Americans often tend to rely on family, religious and social communities for emotional support rather than turning to health care professionals, even though this may at times be necessary. The health care providers they seek may not be aware of this important aspect of the person's life. The role these family structures and spiritual advisors may play is frequently dismissed in the traditional medical model.

Other Factors

Socio-economic factors significantly impact the mental health and wellness of the Black/African American population. In the U.S. in 2017, 11% of Black/African Americans had no form of health insurance. Black/African Americans living below the poverty level, as compared to those over twice the poverty level, are twice as likely to report psychological distress. These issues are a result of systemic barriers and a lack of access to mental health services among various Black/African American communities. In San Francisco, Black/African American individuals make up 5% of the population, however, 37% of the homeless population in San Francisco is Black/African American.

What is "Not Working"

There is currently only one specialty mental health civil service clinic specializing in serving Black/African American clients with severe mental illness that only serves an annual average of 18 (male-only) clients. This program has been around for over a decade and has not been able to expand to other subgroups including women and parents. After years of trying to expand, we realized the need to explore other options to engage this population.

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We identified the need to evaluate robust outreach efforts to determine how to best engage our unique Black/African American communities within San Francisco that face very unique challenges. We also identified the need to evaluate culturally-adaptive interventions that are receptive to these communities. We identified the need to innovate.

Community Planning Process

The San Francisco Department of Public Health (SF-DPH) Behavioral Health Services (BHS) has strengthened its Mental Health Service Act program planning by better 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 the Fall of 2019, San Francisco Mental Health Services Act (SF-MHSA) hosted nineteen (19) community engagement meetings inviting participants from all over the city to collect community member feedback to 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.

All meetings were advertised through email distribution, with flyers and via word-of-mouth to service providers and community members. Printed and electronic materials were translated and interpretation was provided at all public community meetings, as needed. A brief training was provided to the Community Program Planning participants regarding the specific purposes of gathering input and MHSA requirements for Innovations Projects. The community input gathered from these meetings helped to shape the Innovations Proposal for this project.

The nineteen (19) community engagement meetings are listed in the following table:

2019 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Location**
March 13, 2019	MHSA Advisory Committee Meeting SF Public Library,100 Larkin Street, San Francisco CA 94102
April 3, 2019	BHS Workforce Development Programs City College of San Francisco, 50 Frida Kahlo Way, San Francisco, CA 94112
April 8, 2019	Provider staff from Roadmap to Peace Instituto Familiar de la Raza and Bay Area Community Resources 2929 19th Street, San Francisco, CA 94110
April 22, 2019	Asian & Pacific Islander Mental Health Collaborative Samoan Community Development Center 2055 Sunnydale Ave, San Francisco CA 94134
June 12, 2019	MHSA Advisory Committee Meeting 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102

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2019 Community Program Planning (CPP) Meetings

Date	CPP Stakeholder Group/Location
September 11, 2019	MHSA Advisory Committee Meeting 1380 Howard Street, San Francisco, CA 94103
September 19, 2019	Mo'MAGIC Meeting African American Arts & Culture Complex 762 Fulton Street, San Francisco, CA 94102
October, 3, 2019	City & County Workforce Meeting 6th Floor Conference Room 25 Van Ness, San Francisco, CA, 94102
October 4, 2019	SF Behavioral Health Services Providers Meeting Atrium Conference Room 1 South Van Ness, San Francisco, CA 94103
October 11, 2019	Trans Women of Color San Francisco Community Health Center 730 Polk St, San Francisco, CA 94109
October 15, 2019	B'MAGIC Meeting Joseph Lee Recreation Center 1395 Mendell Street, San Francisco, CA, 94124
October 30, 2019	Individuals with history of criminal justice system-involvement Community Assessment and Services Center (CASC) 564 6th Street, San Francisco, CA 94103
November 5, 2019	MHSA consumers and family members (Spanish-speaking) Excelsior Family Connections 5016 Mission Street, San Francisco, CA 94112
November 7, 2019	African American/Black, Latino/x men who have sex with men 25 Van Ness, Rm 330A, San Francisco, CA 94102
November 14, 2019	SF State University and City College San Francisco students Towers Conference Center 798 Font Blvd, San Francisco, CA, 94132
November 19, 2019	SF BHS Client Council and MHSA consumers Peer Program Planning and RFQ Implementation 1380 Howard Street, San Francisco, CA 94103
November 23, 2019	MHSA consumers, family members, and community members from the Chinese community Kaiser Permanente, 4131 Geary Blvd., San Francisco, CA 94118
December 2, 2019	Individuals experiencing homelessness Including veterans and the trans community SF Main Library, 100 Larkin St, San Francisco, CA 94102

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2019 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Location**
December 11, 2019	MHSA Advisory Committee Meeting 1380 Howard Street, San Francisco, CA 94103

In addition to the community meetings described above, SF-MHSA implemented a new process to request ideas from the community including behavioral health consumers, family members and other stakeholders. A "*Mental Health Services Act Proposed Innovation Project Form*" was broadly disseminated and SF-MHSA received 27 forms for possible Innovation projects. Our SF-MHSA Selection Committee reviewed all ideas and consulted with BHS Leadership and other BHS managers. We were pleased to receive several strong concepts and BHS decided to combine the components of four ideas that were submitted by community members:

1) Expanding ICM Services to African American Adults at Mission MH Alternatives
2) African American MH Team at SOMA MH ACT
3) African American Churches and Mental Health Services
4) Addressing Mental Health Needs of African American Parents

These concepts were integrated into this final Innovation Proposal to focus on **Culturally Congruent and Innovative Interventions for Black/African American Communities**.

Following the community meetings and the Innovation Idea Process described above, SF-MHSA met with various community leaders, community members, mental health professionals and residents of the San Francisco Black/African American communities throughout the Spring and Summer of 2020 to incorporate input into this proposal. We collected input from consumers from the Behavioral Health Commission, from some of our advanced peer specialists who represent the Black/African American communities, and from consumers at our MHSA Advisory Committee meetings.

Community Feedback

The below feedback was collected from service providers, SF-DPH consumers, community members, and other stakeholders in 2019 and 2020. SF-MHSA went directly to service providers, consumers, and stakeholders who work with specific populations (i.e. the Black/African American communities) to ask for their perspective and suggestions on SF-MHSA programming and the needs of our community.

Much of the input we received involved the needs of the Black/African American communities. Here is a summary of that feedback.

The Needs of Black/African Americans in San Francisco

- The greatest need is for mental health providers and diversity in the mental health workforce.
- Community members suggested to incentivize people of color working in the mental health sector.

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> ***"I'd like to see programs that address racism. Programs are impacted by racism as well as providers."***
>
> **- Community Member**

- Providers need to deliver culturally responsive services, especially in neighborhoods with deep cultural vibrancy (i.e. Bayview-Hunters Point district).
- We need more awareness of services that exist and how to access services for this community.
- There is a need to hire people directly from the communities being served.
- Community healing practices should be offered to the Black/African American community.
- Training staff and community members about restorative justice might open the opportunity to discuss trauma-informed methods that particularly affect the Black/African American communities.
- We need better ways to incorporate a person's cultural values into the services being provided.
- The County should integrate art, socialization, life-skills and family-based groups when working with this population.
- We need better community violence interventions and crisis response efforts for the San Francisco African American community.

Priority Needs

The re-occurring themes to arise from the Community Planning Process were **more innovative and culturally congruent practices for the Black/African American communities of San Francisco and creating more diversity in the current mental health workforce to better engage consumers.**

The one constant in San Francisco is change. Unfortunately, our clinic based mental health system has been slow to adapt the dynamic needs of the community at large. MHSA Innovation funding would be the kick-start to creating culturally responsive services that meet the needs of a population that is being underserved in the San Francisco community.

Based on the information we received in our research and our Community Planning Process, the priorities for this San Francisco priority population include:

- ✓ Research and evaluate cutting edge practices to see if they are well received and efficacious with our San Francisco Black/African American communities.
- ✓ Determine best practices from our Mission Mental Health Alternatives program which is a small-scale Intensive Case Management program that specializes with Black/African Americans.
- ✓ Develop new innovative strategies to outreach to Black/African American clients.
- ✓ Hire staff for this project who reflect the population being served, prioritizing the Black/African American communities.
- ✓ Consider developing a Navigation Program for this priority population at South of Market Mental Health clinic to better assess needs, introduce innovative cultural practices and support consumers with system navigation.
- ✓ Train staff on the needs of Black/African American communities and the new culturally congruent innovative practices.

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- ✓ Provide outreach and linkage services with San Francisco churches and barbershops, a traditional source of support in the Black/African American community.

Innovative Component

The “Culturally Congruent and Innovative Practices for Black/African American Communities” Innovations project will implement changes to existing mental health practices that have not yet been demonstrated to be effective, including, but not limited to, adaptation for a population. This project is unique to San Francisco since **we will test and utilize innovative and culturally congruent interventions that have not previously been offered to San Francisco’s Black/African American communities.**

We will hire a very skilled and specialized team of behavioral health staff who have a background in culturally responsive interventions that are specific to the Black/African American communities <u>and</u> hire staff who demographically represent the Black/African American priority communities being served. These staff may include:

- Program Director
- Program Managers and Clinical Supervisor
- Behavioral Health Clinicians
- Peer Specialists
- Peer Supervisor
- Nurse Practitioner or Psychiatrist
- Administrative Staff
- Evaluation Staff
- Practice Improvement and Analytics Coordinator

> ***“At least in the South [racism] is overt, but here, especially in San Francisco, where everyone is so liberal and so civilized and so literate, they throw it under the rug.”***
>
> ***- James Baldwin 1963.***

We intend to hire staff who have the time and expertise to conduct research and create an innovative program that produces culturally appropriate, evidenced-based practices that demonstrate better outcomes for our San Francisco Black/African American communities. This project will include six primary learning goals.
<u>Six (6) main learning goals:</u>

1. Conduct **a comprehensive Community Needs Assessment** in order to:
   i. Identify innovative and creative strategies to better engage and retain the Black/African American community members into mental/behavioral health services.
   ii. Identify a list of innovative and culturally congruent practices that have not been offered to San Francisco’s Black/African American communities.
2. Implement and evaluate **new outreach and engagement practices for Black/African American clients** in the county mental health system including those who are currently underserved by the County mental health plan.
3. Implement and evaluate **culturally adaptive practices** that increase consumer satisfaction, efficacy and retention.
4. Implement and evaluate the efficacy of using **peers with lived experience** who represent the Black/African American communities and have specialized expertise working with Black/African American cultural practices.

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5. Develop a **wellness-oriented manualized curriculum that provides best practices** when working with this priority population.
6. Develop a **network of trained staff to lead training sessions for other providers** interested in undertaking these models/practices.

Proposed Project / Response to Community Needs

Primary Project Components

The "Culturally Congruent and Innovative Interventions for Black/African American Communities" Innovations project will be a five-year project that will test new ways of service delivery and engaging with Black/African American San Francisco residents. As stated above, this Innovation project will test and support six primary learning targets.

1. **Conduct a comprehensive Community Needs Assessment in order to:**
   i. **Identify innovative and creative strategies to better engage the Black/African American community members into mental/behavioral health services.**
   ii. **Identify a list of innovative and culturally congruent practices that have not been offered to San Francisco's Black/African American communities.**

The first component of this Innovation project will involve a comprehensive Community Needs Assessment in order to identify the full scope of the innovative and create strategies that will be tested. We gathered feedback from the community and included several innovative activities in this proposal below, however, we would like to provide the time and resources to develop a robust list of activities we can use to better engage and serve clients from the Black/African American communities.

We will hire a program manager, peer specialists and evaluation staff to help conduct our Community Needs Assessment that will be specific to the San Francisco Black/African American communities in San Francisco. We will conduct extensive community outreach and engagement activities across the City and County of San Francisco. These community outreach and engagement efforts will be critical in guiding the design of the activities that will be used in this project. As a result of direct community and stakeholder feedback, we will ensure consumers have the appropriate wellness tools and resources to support them in their recovery journey.

All engagement meetings will be advertised through email distribution, with flyers and via word-of-mouth to service providers and community members. Printed and electronic materials will be provided at all public community meetings. A brief training will be provided to the Community Program Planning participants regarding the specific purposes of gathering input for this project.

2. **Implement and evaluate new outreach and engagement practices for Black/African American clients in the county mental health system including those who are currently underserved by the County mental health plan.**

We will use the community feedback and data we receive from the Community Needs Assessment to create a list of innovative and "never-been-used" engagement strategies to connect with the Black/African American community in San Francisco, in hopes to engage those in need of

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mental/behavioral health services. The primary objective would be to enroll individuals in appropriate mental health services by using these identified innovative engagement strategies.

In addition, **we intend to hire peer specialists from the Black/African American community** who can go out and conduct outreach on the streets, in community spaces and local places including churches, barbershops and other places where members of the Black/African American communities may congregate. This Innovation project will seek to build rapport and engage with individuals over time through a process of mapping out locations and resources that have value to potential program participants. These areas will then be prioritized and targeted.

Engagement will be made based on building a relationship between the peer and the participant, verses a traditional quick triage of what a caseworker perceives the needs of the person in front of them to be. A diverse team of peer counselors will go out in the community in pairs to engage this priority population in meaningful connections, based on the needs of the residents. This stage of this project will be primarily focused on engaging and building a relationship with community members, and simply asking community members what they may want and need for their respective community. Small items may be used as engagement tools such as coffee, snacks and health-related gift bags. Once a trusting relationship is developed with community members, education about mental/behavioral health services will be offered and linkage to services will be provided.

3. **Implement and evaluate culturally adaptive practices to increase consumer satisfaction, efficacy and retention.**

Getting clients through the door is one issue. Keeping them there is another. BHS has made significant strides in updating the offerings at clinic sites, however, there is still significant room for improvement. Through the Black/African American Health Initiative (BAAHI), department staff have had an opportunity to learn about the impact racism has on health outcomes. Through the department wide Trauma Informed Care Initiative, clinical care staff have developed an understanding on how trauma impacts the daily lives of those we serve. Through MHSA, there is a much broader understanding of Wellness and Recovery. Yet, the system still struggles to fully meet the needs of Black/African American clients seeking services. We would like to evaluate what types of culturally relevant practices are judged by clients as making an impact on their mental health and personal wellness. We also want to evaluate what types of practices and interventions work best to retain clients in care.

We will use the community feedback and data we receive from the Community Needs Assessment to create a list of innovative and “never-been-used” culturally congruent interventions to increase the number of Black/African American who are satisfied with services, those who report improvement with their overall mental/behavioral health and wellness and those who report the willingness to continue care.

In addition, the Innovations project will evaluate other practices that have not been used in San Francisco with this priority population. These interventions/practices may include:

- ➢ Develop and offer a wide array of culturally specific art interventions.
- ➢ Better link consumers with someone who is representative of intersecting identities such as race, gender, sexual identity and age.
- ➢ Create and use an assessment tool to better inquire about one's culture and plan how to integrate the specific culturally responsive practices into the services provided.
- ➢ Better integrate spirituality and the consumer's faith into the mental/behavioral health services provided.
- ➢ Better integrate family, community and natural support systems into the services provided.
- ➢ Develop and implement culturally congruent interventions that are family-focused, culturally humble, and wellness and recovery oriented.
- ➢ Conduct culturally congruent wellness, skill-building, socialization and life-skills and other evidence-based groups.
- ➢ Explore the use of integrating drumming, acupuncture, singing, and/or spirituality practices.
- ➢ Hold trauma-informed healing circles at churches or faith-based programs.
- ➢ Provide mental health stigma reduction outreach and education at local barbershops
- ➢ Provide tele-care support to increase access to services.
- ➢ Engage individuals in services and activities based on their own acculturation level.
- ➢ Create a navigation center to provide a centralized system for consultation, navigation and linkage to services.
- ➢ Collect ongoing feedback from the community so they can create their own indicators of success.

4. **Implement and evaluate the efficacy of using peers with lived experience who represent the Black/African American communities and have specialized expertise working with Black/African American cultural practices.**

A peer is defined as an individual with personal lived experience who is a current or former client of mental/behavioral health services, or a family member of a current or former client. Peer-to-Peer services encourage peers to utilize their lived experience, when appropriate and at the discretion of the peer, to benefit the wellness and recovery of the clients being served. Each peer working with this project will:

- ✓ Demographically represent the Black/African American communities
- ✓ Be trained as a peer specialist with experience in a mental health workplace
- ✓ Have personal experience with culturally-responsive practices
- ✓ Hold a vast understanding of the mental health system.

We plan to hire peer specialists representative of the Black/African American communities. We will hire these positions at the launch of this project to assist with program development, evaluation planning and implementation. The peer specialists will also play an important role in conducting the Community Needs Assessment. Later the peer specialists will play a role working as peer counselors integrated into the culturally responsive intervention and care team.

The peers will be a vital component to designing the program details, developing the policies, implementing the scope of work, monitoring the progress and evaluating the desired outcomes. The peer specialists will be a driving force through all phases of this project from beginning to end and will act as leaders for the communities being served. Our peer staff will also help provide

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outreach and education about this program to San Francisco residents among various community settings.

Peer specialists will be trained using the current 12-week BHS Peer Specialist Mental Health Certificate Program, the Advanced Peer Certificate Program and the Leadership Academy monthly training seminars for peers. Additional training will be offered including, but not limited to; culturally congruent best practices, Wellness Recovery Action Plan (WRAP), harm reduction, motivational interviewing, and psycho-education on mental health and coping skills. Peer specialists will also be trained in implementing some of the cultural practices that were identified to be most well-received by our Black/African American communities.

Lastly, this component of the project will work with the SF-DPH Department of Human Resources to better equip and link these peer specialists to long-term civil service employment.

5. **Develop a wellness-oriented manualized curriculum that provides best practices when working with this priority population.**

Based on findings from our community needs assessment and from promising outcomes from our evaluation efforts, we will develop a wellness-oriented manualized curriculum that outlines the best practices and most well-received interventions. This curriculum will include, but not limited to, best practices in the following areas:

a. Hiring and retaining staff who represent the Black/African American communities
b. Outreach and engaging with this population
c. Retaining this population in care
d. Culturally adaptive practices for San Francisco
e. How to address disparities in San Francisco
f. Identify what was learned as a community

This curriculum will be used as a resource to train other behavioral health staff and community-based organizations within Behavioral Health Services. We may also use this curriculum as a resource for other Bay Area Counties that may benefit from our findings and research.

6. **Develop a network of trained staff to lead training sessions for other providers interested in undertaking these models/practices.**

Once our wellness-oriented manualized curriculum is developed, we will identify some clinical staff and peer specialists from the program to also act as “trainers”. These trainers will provide education and training at behavioral health sites that may include other behavioral health clinics within BHS, community-based organizations, system-of-care team meetings, our private provider network and other community locations. These trainers may also provide education to our behavioral health staff located at our SF-DPH primary care clinics throughout San Francisco. Lastly, our trainers will likely provide education and presentations to our BHS Executive

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Leadership Team, our San Francisco Behavioral Health Commission and nearby Bay Area Counties that demonstrate an interest in our research.

Please Note: Due to COVID-19, certain activities in this proposal may need to be adjusted to adhere to local and State laws, and the health and the safety of program participants and staff members. The key components of this project may be adapted during program implementation as needed in order to respond appropriately to the Public Health Emergency. Examples of modified activities may include, but not limited to: providing telecare services through video conferencing platforms, increasing phone call activities while reducing face-to-face activities, implementing social distancing measures, wearing personal protective equipment and/or masks, screening participants to assess risk levels, developing ongoing internal policies and procedures, reporting on safety protocol and outcomes, etc.

Target Populations and Clients Served

To provide this level of services, the project will be based out of three civil service clinics within BHS. The three identified clinics will be South of Market Mental Health (SOMMH), Mission Mental Health Clinic, and Outer Mission/Ingleside (OMI) Family Center. In addition, we envision partnering with several community-based organizations that serve Black/African Americans in San Francisco.

The services will focus on **serving individuals from the Black/African American communities** and may focus on specific subgroups from this priority community that may, or may not include:

- ✓ Adults
- ✓ Older Adults
- ✓ Transition Age Youth (TAY ages 16-24)
- ✓ Children
- ✓ Parents
- ✓ Women
- ✓ Expecting mothers
- ✓ Justice involved individuals
- ✓ Veterans
- ✓ Homeless individuals and families
- ✓ Members of faith-based communities
- ✓ LGBTQQ+ communities

We anticipate implementing this project in phases; first trying to engage with Adults and Older Adults, and then moving forward with engaging TAY and younger participants.

Extensive outreach will focus on reaching these subgroups. We envision developing partnerships with several San Francisco organizations to engage these individuals and more information on these collaborative relationships can be found below.

In addition, this program will be targeting outreach to Black/African American individuals who are currently underrepresented in the clinic system. This program will focus on serving individuals from neighborhoods including Bayview, Hunter's Point, Fillmore, Sunnydale, Visitacion Valley, Potrero Hill, South of Market Area, Downtown and other areas where many Black/African American residents live in San Francisco.

Staffing and Training

SF-MHSA/BHS would begin the process of hiring and/or identifying key staff people to work with this project. As noted above, **We will hire a very skilled and specialized team of behavioral health staff who have a background in culturally responsive interventions specific to the**

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Black/African American communities and hire staff who demographically represent the Black/African American priority communities being served. These staff may include, but not limited to:

- Program Director
- Program Managers and Clinical Supervisor
- Behavioral Health Clinicians
- Peer Specialists
- Peer Supervisor
- Nurse Practitioner or Psychiatrist
- Administrative Staff
- Evaluation Staff
- Practice Improvement and Analytics Coordinator

We intend to hire staff who have the time and expertise to conduct research and create an innovative program that produces culturally appropriate, evidenced-based practices that demonstrate better outcomes for our San Francisco Black/African American communities.

Training will be a vital component to this project. We will train the entire care team on culturally responsive interventions for the Black/African American communities. We will leverage resources with our BHS Training Unit and link our staff to training that will increase skills to deliver culturally congruent services identified as family-focused, culturally humble, and wellness and recovery oriented. We will ensure that staff have the knowledge and skills appropriate to thrive and grow within their roles as clinicians, behavioral health workers and peer specialists.

San Francisco Partnerships

SF-MHSA will partner with several local programs, organizations and communities to best implement this project. We envision collaborating with the following organizations/programs:

- The BHS Office of Equity, Social Justice and Multicultural Education
- The SF-DPH Office of Health Equity
- The San Francisco Behavioral Health Commission
- The San Francisco Human Rights Commission
- MegaBlack SF
- The San Francisco Office of Racial Equity
- Mental Health SF Leadership
- The SF-DPH Department of Human Resources
- Hope SF
- Maternal, Child and Adolescent Health
- Mission Mental Health
- South of Market Mental Health
- OMI Family Center
- Integrated Behavioral Health (formerly known as Bayview Mental Health)
- Third Street Youth Clinic
- Family Mosaic Project

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- SF-DPH TAY Clinic
- Westside Community Services
- YMCA Bayview
- BMAGIC
- Mo' MAGIC
- Rafiki Coalition
- The Peer Wellness Center
- The Peer Employment Program
- The Department of Homelessness and Supported Housing
- San Francisco faith-based programs and churches
- San Francisco barbershops
- Other community organizations for the Black/African American populations
- Other mental/behavioral health and community programs

Collaboration with the BHS Office of Equity, Social Justice and Multicultural Education (OESM) will be vital to this Innovation project to ensure that an equity lens is embedded throughout all project components. OESM also provides culturally-responsive and multicultural training for staff and peers through their BHS Training Unit. We envision leveraging existing training resources for this project.

In addition, this project will collaborate with the SF-DPH Department of Human Resources in order to better recruit, select and retain staff who represent the demographics of the Black/African American communities.

Language Capacity and Cultural Considerations

The City and County of San Francisco has three threshold languages: Spanish, Vietnamese and Cantonese. SF-MHSA will work in collaboration with the San Francisco Department of Public Health's Office of Equity, Social Justice and Multicultural Education (OESM) department to implement these services in the threshold languages and engage these specific populations. In addition, we will aim to hire peers who identify as Black/African American to assist with reaching these communities.

Confidentiality

All elements of this project will adhere to HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, and we will only implement HIPAA compliant protocol with a high concern to safe-guarding participant confidentiality.

The process of informed consent will be required before working with the care team. This will serve as the informed consent outlining the nature of the relationship, parameters of this project, confidentiality, data collection, etc.

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Contribution to Learning

This learning project will center on the development of a highly skilled team that will provide an expanded research and testing of culturally congruent interventions specifically designed for the Black/African American populations in San Francisco. We may test subgroups including Adults, Older Adults, TAY, Parents, Women, Expecting Mothers and the LGBTQ+ communities. Evaluation will be vital to this project and we plan to measure all of the project components and interventions along the way in order to truly determine the efficacious aspects of this program.

Key Learning Questions

1. What components of the culturally relevant program improves overall wellness for Black/African American clients?
2. What engagement strategies work best to engage Black/African American individuals into mental/behavioral health services?
3. What retention strategies work best to retain Black/African American individuals in mental/behavioral health services?
4. What strategies or activities are most successful to recruit staff into this program who are representative of Black/African American communities in San Francisco?
5. What culturally adaptive interventions are reported to result in improvement in the mental health and wellness of Black/African American consumers?
6. What activities lead to a positive experience for Black/African American clients throughout the continuum of care?

Evaluation / Learning Plan

SF-MHSA will work in close partnership with SF-DPH Quality Management (QM) to implement a comprehensive evaluation plan with tools to measure immediate outcomes and longer-term impact of the project. The final evaluation plan will include a logic model to guide the design and implementation of the Innovations Learning Project. An ethnically diverse group of consumers and community members will be involved in the design of the evaluation tools, particularly people who are representative of the Black/African American communities. The use of surveys and key informant interviews will be used, as well as other tools identified as effective in evaluating practices or interventions in Black/African American communities (i.e. community defined tools). SF-MHSA and QM will compile evaluation reports summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on stakeholder feedback. The specific outcomes to measure may include:

Projected Outcomes:

- ✓ Increasing feelings of personal value or self-worth
- ✓ Increasing quality (i.e. on patient-reported outcome measures)
- ✓ Reducing utilization (i.e. ED visits, hospitalization, frequency of in-person visits)

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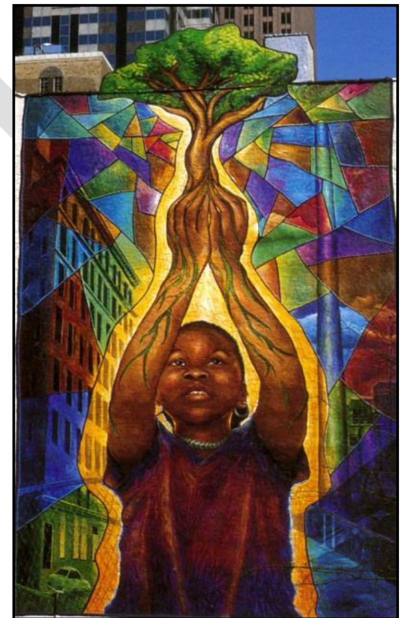
- ✓ Increasing community engagement
- ✓ Increasing social connectedness
- ✓ Increasing personal wellness
- ✓ Increasing knowledge of behavioral health services
- ✓ Satisfaction with intervention strategies
- ✓ Satisfaction with outreach/engagement strategies
- ✓ Reduction in mental health stigma

Social connectedness is defined as the measure of how people come together and interact with others such as friends, family and acquaintances, whether one on one or in groups. It can be structured or scheduled activities or unstructured visiting and conversation. It measures a person's comfort and trust with others such that they can ask for help when they need it.

Wellness is defined as the presence of purpose in life, active involvement in satisfying work and/or play, joyful relationships, a healthy body and living environment, and happiness. Wellness is often evident when individuals have "a reason to get out of bed in the morning," something to do, somewhere they want to be, along with the emotional and physical capacity to do it. It is often linked to purpose and optimism.



The final evaluation plan will: 1) set clear program S.M.A.R.T. [**S**pecific **M**easurable, **A**chievable, **R**elevant and **T**ime-Bound] objectives; 2) have solid methods of achieving those objectives; and 3) provide qualitative and quantitative evaluation efforts that include defined benchmarks, indicators and deliverables. Evaluation outcomes will demonstrate that this Innovation program has yielded the desired outcomes of BHS and the community.

<u>Data Collection</u>

We intend to collaborate with the DPH Quality Management (QM) department to finalize evaluation tools. An ethnically diverse group of consumers and community members will be involved in the design of all evaluation tools. Data collection tools may include, but not limited to:

- Consumer application, acceptance and enrollment log
- Enrolled consumer attendance log
- Self-confidence measures
- Measure of social and community connectedness
- Consumer feedback tools (satisfaction and recommendations for improvements)
- Consumer mental health recovery scale (measure well-being)

<u>Other Evaluation Measures</u>

As part of this project, we may explore and test different strategies for outreach, engagement, and intervention with the Black/African American communities as a PDSA (Plan-Do-Study-Act) in the early stages of implementation and review its value. The PDSA cycles should focus on

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community-informed recommendations for improving engagement and intervention strategies. Qualitative information gathered will inform the outcome objectives of forming best-practices. The PDSA cycle is expected to contribute to ongoing improvements, as based on the lessons learned from the activities used most successfully. Best practice protocols should be developed for both engagement and intervention activities.

Lastly, we will compile evaluation reports summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on stakeholder and participant feedback. We will disseminate these findings to a broad audience as described below.

Project Evaluation, Cultural Competence and Meaningful Stakeholder Involvement

The evaluation of this Innovation project will be conducted with sensitivity and awareness of our users' diverse experiences related to age, disabilities, as well as cultural, language, ethnic, sexual and gender identities. We seek to generate relevant and useful evaluation results by consulting with key stakeholders who help us ensure that any data collection reflect the values and diverse experiences of our mental/behavioral health community.

We have already established a group of stakeholders that includes community members, behavioral health leaders and peer advocates. The stakeholder group will be consulted on Innovations project learning goals, data collection tools, methods and language for data collection, and how best to summarize and communicate findings to suit diverse audiences. San Francisco also has an active Mental Health Board that meets monthly and a Behavioral Health Services Client Council, where issues important to client representatives, including Innovations project findings, are presented and discussed.

MHSA General Standards

Our Innovations Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320.

a) **Community Collaboration**
The project will be a collaboration between peer specialists, Behavioral Health Services, community-based organizations, the Office of Equity, Social Justice and Multicultural Education (OESM), and San Francisco community members.

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b) Cultural Competency
The project team will receive cultural humility training and they will reflect the diversity of the community being served.

c) Client-Driven/ Family-Driven
The project team will be a highly skilled team who will use their expertise to meet each client where they are at. The care team will work hard to integrate family members into all services, as deemed appropriate.

d) Wellness, Recovery, and Resilience-Focused
This project design will be consistent with the philosophy, principles, and practices of Wellness and Recovery for mental health consumers. It will promote concepts key to the recovery for mental illness such as: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

e) Integrated Service Experience for Clients and Families
This project focuses on offering new culturally congruent interventions to underserved Black/African American communities throughout San Francisco by integrating these services into the larger Behavioral Health Services system so these new services can be complementary to other evidenced based services in the community.

Plan after the Innovations Learning Project Ends

San Francisco Behavioral Health Services will utilize several strategies to secure continuation funding for the proposed Innovations Learning Project, if the entire project or components of the project are found to be effective in meeting our proposed outcomes.

The team will utilize data reports to identify successful interventions, population needs and opportunities. The Program Manager and Quality Management will analyze project data to determine the efficacious components of this project. These findings will be used to construct a rationale for the ongoing continuation of funding based both on the positive impact of the community being served.

Another approach involves an ongoing process of improving and enhancing citywide collaborations as a way to both expand services reimbursements and identify potential points of interaction or resource sharing that could create opportunities for alternate forms of continuation support. For example, the San Francisco Board of Supervisors recently passed the Mental Health SF legislation which will provide resources and increase funding for specific priority populations, including the Black/African American communities. We intend to support all Mental Health SF legislative goals and, although nothing is guaranteed, we anticipate that there may be additional funding for this community to sustain the successful components of this project once the Innovation funding ends.

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Continuity of Care for Individuals with Serious Mental Illness

Within the broader system of care, there is a network of trained mental/behavioral health staff and peer providers that provide services for clients with severe mental illness. In addition, a segment of services exists within a wide variety of MHSA providers. These contractors are funded by MHSA to provide specialized population-focused services, recovery-oriented services, peer-to-peer services, and other wellness and recovery programs. The existing menu of services includes; support groups, individual and group counseling, wellness activities and classes, linkage services, Intensive Case Management services, culturally specific activities and support for those interested in vocational activities.

One of the ongoing goals for the staff involved with this project will be to educate and link users into relevant services in the community. When the project ends, the clients/users involved in the project will have received an introduction to these services and be able to access them as part of their care plans.

Communication and Dissemination Plan

Feedback from participants will be shared regarding the successes and lessons learned from this project. The project team will be invited to present on progress, findings, and their experience of the project to stakeholders.

Project learnings and newly demonstrated successful practices will be shared within our county and to stakeholders. Successful elements of this project can be applied to other areas of the behavioral health system of care. Shared practices could change service delivery, possibly expanding the focus areas of future programming.

Successful practices and lessons learned will be shared with the San Francisco Mental Health Board and San Francisco Board of Supervisors, as well as with the BHS Executive Team. SF-MHSA team members will present findings at the MHSA Advisory Committee Meetings, which include peer-based organizations and community-based agencies, as well as community-based organizations that serve Black/African American communities such as BMagic and Rafiki. Project successes and challenges will be presented at the Client Council, a committee of consumers who perform an advisory role on BHS affairs. The findings will be disseminated to stakeholders via the SF-MHSA website, the email distribution system, and through the monthly BHS Director's Newsletter. These results may also be distributed regionally to the surrounding twelve (12) San Francisco Bay Area cities. Lastly, the results will be disseminated on a state-level to the MHSOAC and these findings may provide insight to other counties working on similar projects.

Estimated Timeline

The City and County of San Francisco is proposing a five-year timeline that will begin upon MHSOAC approval.

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Phase I- Start Up and Planning (10/1/2020-12/31/2020)

We will spend the first three months of this project hiring staff representative of the priority populations being served. We will begin planning for the Community Needs Assessment. The program will also fine-tune the scope of work, finalize the evaluation plan, and establish the necessary infrastructure to operate the program.

Phase II- Implementation (1/1/2021-6/30/2021)

In this phase, the project will conduct a very thorough Community Needs Assessment to determine innovative strategies to better engage the Black/African American community, identify new methods to increase recruitment and retention of Black/African American staff, and identify a list of innovative and culturally congruent practices that have not been offered to San Francisco's Black/African American communities.

Phase III- Implementation (7/1/2021-6/30/2025)

In this phase, the project will be fully operational and engaging with Black/African American San Francisco residents who are seeking culturally congruent sources of support. The evaluation activities will be refined and implemented throughout this phase.

Phase IV – Reflection, Evaluation, and Dissemination (7/1/2025-9/30/2025)

In this phase, the project will be wrapping up and the implementation phase will be tapering down. The evaluation data gathered in the implementation phase will be analyzed and we will work with stakeholders to determine best practices, lessons learned and the overall impact of the project. We will also assess the success of the community partnerships and the added value of their collaborative efforts. In partnership with consumers and stakeholders, we will determine whether and how to continue the successful components of this project. We will disseminate the results.

Budget Narrative

The total requested budget is $600,000 annually for years one, two and three; $1,200,000 annually for years four and five for a total Innovation budget of $4,200,000 over five (5) years. If approved by the MHSOAC, SF-MHSA will utilize FY20/21 Innovations Funding for the first year and will not utilize reversion funds.

A majority of funding for this project will be spent on behavioral health personnel and peer specialists that include the following:

- Program Director

- Program Managers and Clinical Supervisor
- Behavioral Health Clinicians
- Peer Specialists
- Peer Supervisor
- Nurse Practitioner or Psychiatrist
- Administrative Staff
- Evaluation Staff
- Practice Improvement and Analytics Coordinator

We are requesting $15,000 annually for years one, two and three; and $25,000 annually for years four and five for a total operating budget of $95,000 over five years to engage participants and operate the program including food, snacks, travel, stipends, art supplies, office supplies, curriculum publication materials and other items.

Lastly, we will place a strong emphasis on evaluation. Therefore, we are requesting $50,000 for years one, two and three; and $70,000 for years four and five for a total of $290,000 over five years to implement the evaluation activities. These efforts may be carried out by SF-DPH personnel and/or county contracted professional consultants.

Leveraged Funding

The training for the peer counselors and the peer supervisor will be leveraged through existing funds allocated to the BHS Peer Specialist Mental Health Certificate program, the Advanced Peer Certificate Program and the Leadership Academy's monthly training seminars for peers. BHS is estimating that $52,313 of these peer training funds can be leveraged for this Innovation Project annually.

We will also leverage training funding from the BHS Training Unit by using existing culturally-responsive and multicultural training seminars offered frequently to all BHS staff and peers. BHS is estimating that $10,000 of the BHS Training Unit funds can be leveraged for this Innovation Project annually.

In total, **BHS is estimating that $62,313 of funding can be leveraged annually (for a total of $311,565 over the 5-year program)** from other BHS programs to support this Innovation Project.

We anticipate a total operational program budget of $4,511,565 over five years.

Please refer to the Innovations Project Budget below for more details.

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Project Budget

INNOVATIONS BUDGET	Year One	Year Two	Year Three	Year Four	Year Five	Total
Personnel Budget	$ 535,000	$ 535,000	$ 535,000	$ 1,105,000	$ 1,105,000	$ 3,815,000
Evaluation Budget	$ 50,000	$ 50,000	$ 50,000	$ 70,000	$ 70,000	$ 290,000
Operating Budget	$ 15,000	$ 15,000	$ 15,000	$ 25,000	$ 25,000	$ 95,000
TOTAL INNOVATION BUDGET	**$ 600,000**	**$ 600,000**	**$ 600,000**	**$ 1,200,000**	**$ 1,200,000**	**$ 4,200,000**
Leveraged Funding	$ 62,313	$ 62,313	$ 62,313	$ 62,313	$ 62,313	$ 311,565
TOTAL OPERATIONAL BUDGET	**$ 662,313**	**$ 662,313**	**$ 662,313**	**$ 1,262,313**	**$ 1,262,313**	**$ 4,511,565**

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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