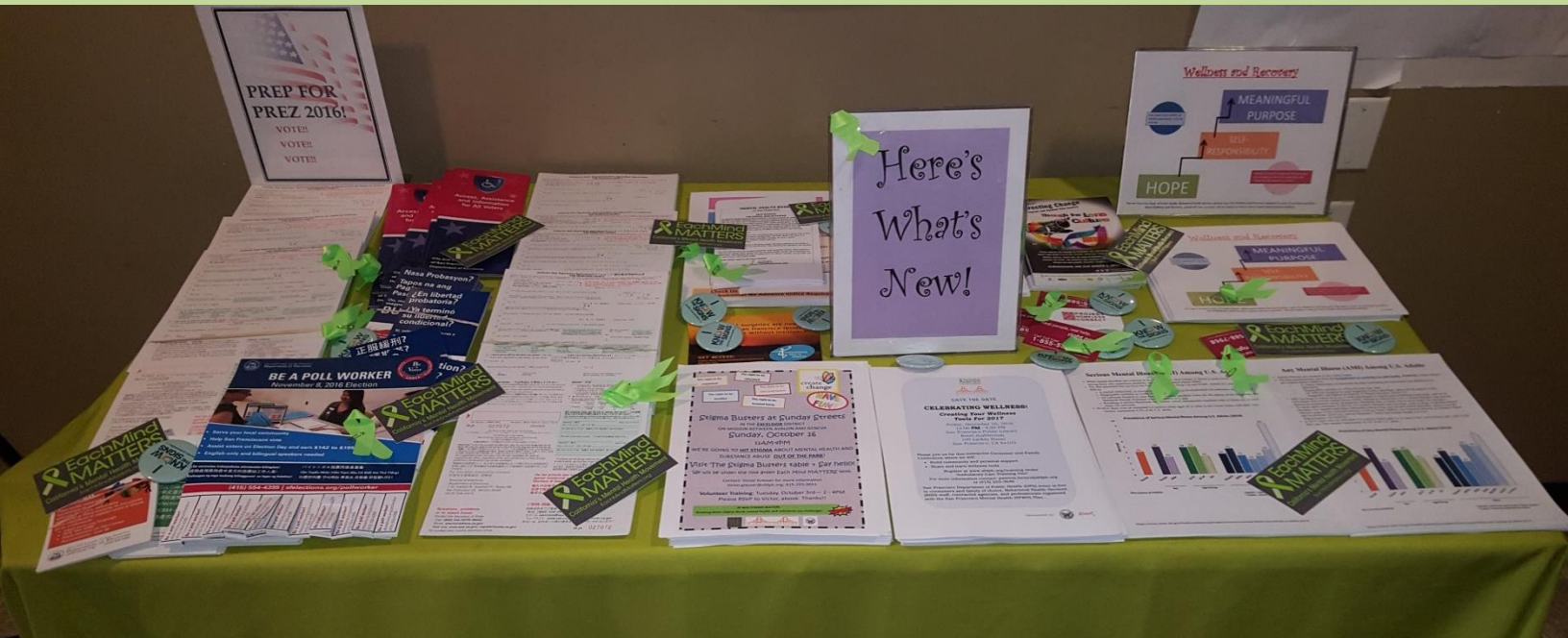
San Francisco
Mental Health Services Act (MHSA)
2016-2017 Annual Report

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



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MHSA COUNTY COMPLIANCE CERTIFICATION

County: _____

Local Mental Health Director	Program Lead
Name: Telephone Number: Email:	Name: Telephone Number: Email:
County Mental Health Mailing Address:	

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

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

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

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

County:_____

Date:_____

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: _____

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

Local Mental Health Director	Program Lead
Name:	Name:
Telephone Number:	Telephone Number:
Email:	Email:
County Mental Health Mailing Address:	

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

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

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

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

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

_____ _____

County Auditor Controller/City Financial Officer (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 (02/14/2013)

Directors' Message

The City and County of San Francisco continues to strive towards providing quality behavioral healthcare services that are community-informed, recovery-oriented, culturally responsive and wellness-driven. The principles outlined in the Mental Health Services Act (MHSA) continues to be one of our driving forces towards a system that promotes community collaboration, client and stakeholder involvement and the integration of services that addresses an individual's overall wellness. In our last annual report, we highlighted various MHSA funded programs that, as a collective, are designed to strengthen San Francisco's public mental health system and overall behavioral health system of care that serves adults, older adults, children, youth and their families.

In 2014-15, in collaboration with our countywide partners, we continued to make major strides in meeting our goals and working towards our priorities identified in our ongoing community-wide MHSA planning efforts. We have been successful in expanding our Vocational Services program to help consumers build trade skills and secure employment. With our Recovery-oriented Treatment Services, we continue to use strength-based recovery approaches and community-defined practices that continue to produce positive outcomes for our consumers. We also continue to put emphasis on prevention and early intervention by aiming to reduce the risk factors associated with a mental illness, promote protective factors and provide services in community settings in an effort to create access for unserved and underserved populations. Also, we continue to put an emphasis on program monitoring and evaluation to ensure desired outcomes are being met and also as a tool to improve the quality of services being delivered. Since a lot of this work depends on a diverse and skilled workforce, we continue to invest in our workforce by providing education and training opportunities to build and expand the skills and competencies of our workforce. We also strive to ensure that we have a diverse workforce that reflects the diversity and cultures of the people that we serve.

In support of the San Francisco Department of Public Health's mission, the MHSA program is committed to promoting and protecting the health of all San Franciscans. We will continue to work towards reducing health disparities, ensuring equal access for all and providing quality services that are culturally and linguistically appropriate.

We look forward to the years ahead.

Marcellina A. Ogbu, DrPH
Acting Director, SF Behavioral Health Services

Imo Momoh, MPA
Director, SF Mental Health Services Act

Introduction

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

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

WELLNESS • RECOVERY • RESILIENCE

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

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

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

MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

1. **Cultural Competence**. Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
2. **Community Collaboration**. Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
3. **Client, Consumer, and Family Involvement**. Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.
4. **Integrated Service Delivery**. Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.
5. **Wellness and Recovery**. Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

General Characteristics of San Francisco

San Francisco is a seven by seven square mile, coastal, metropolitan city and county. Though geographically small, it is the second most densely populated major city in the country and fourth most populous city in California (17,179 people per square mile). The city is known for its culturally diverse neighborhoods where over twelve different languages are spoken. The most recent U.S. Census found that San Francisco has a population of 805,235 people and experienced mild growth since the last census (four percent). Although San Francisco was once considered to have a relatively young population, it has experienced a decrease among children and families with young children; there are more people moving out of San Francisco than moving in. The high cost of living and increasing rents (both residential and commercial) are several causes of the flight. Approximately 6,500 homeless individuals and 670 homeless families with children reside in San Francisco. Twelve percent of residents live under the poverty level. In addition, over the next two decades, it is estimated that 55 percent of the population will be over the age of 45, and the population over age 75 will increase from seven percent to 11 percent. The projected growth in San Francisco's aging population has implications on the need for more long-term care options moving forward. For additional background information on population demographics, health disparities, and inequalities, see the 2012 Community Health Status Report for the City and County of San Francisco located at www.cdph.ca.gov/data/informatics/Documents/San percent20Francisco percent20CHSA_10 percent2016 percent2012.pdf.

Community Program Planning (CPP) and Stakeholder Engagement

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

From the Beginning

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

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

Community Program Planning (CPP) and Stakeholder Engagement Activities

Exhibit 1 provides a visual overview of San Francisco's ongoing community program planning activities. San Francisco MHSA (SF MHSA) employs a range of strategies focused on upholding the MHSA principles and engaging stakeholders in various ways at all levels of planning and implementation. Our CPP provides various opportunities for stakeholders to participate in the development of our three-year plans and annual updates and to stay informed on our progress implementing MHSA-funded programs. This section provides a description of our general CPP activities. In addition to the broad strategies described below, each section in this report includes highlights of program-specific CPP activities.

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

MHSA Communication Strategies

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

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

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

MHSA Advisory Committee and a Commitment to Consumer Engagement

SF MHSA has had many successes engaging consumers and family members at every level of the CPP process and in the implementation of the vast majority of programs. In 2015-2016, the SF MHSA Advisory Committee continued robust recruitment efforts focusing on members from the mental health community, with a focus on the following underrepresented community members: those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Current Advisory members were instrumental in outreaching to these communities to fill gaps. Our Advisory group now consists of 25 active members.

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

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

SF MHSA has also been working to foster a stronger collaboration with the BHS Client Council. The Client Council is a 100 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 FY 15-16, SF MHSA held 6 Advisory meetings which occurred on the following dates: 8/19/15, 10/21/15, 12/1/15, 2/17/16, 4/20/16, and 6/15/16. The purpose of these meetings were to gather feedback from the committee comprised of mostly consumers and peers. Topics for these meetings included, but were not limited to, the following:

- MHSA Advisory Committee structure, ideas for new member recruitment, and brainstorm on the agenda for the upcoming fiscal year
- Innovations Projects, including past and current program updates and highlights
- Upcoming RFQs and community planning efforts
- Population-focused outcomes and highlights
- Wellness and Recovery in Action activities
- Presentation on Assisted Outpatient Treatment
- Client Council, Mental Health Board of San Francisco, and Stigma Buster updates and collaborative efforts
- BHS Vocational Services presentation
- Transgender Health Services presentation
- BHS Workforce Development 5-Year Plan

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

- Work collaboratively with BHS to support broad community participation in the development and implementation of MHSA initiatives
- Guide MHSA resources to target priority populations as identified in existing MHSA plans
- Ensure that San Francisco's mental health system adheres to the MHSA core principles
- Hold meetings every two months (meetings alternate between meetings at MHSA and our partnering community-based organizations)
- Encourage community participation at meetings

FY 14-15 Advisory Committee Member Demographic Profile

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

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

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

- Majority (47 percent) of participants identify as female, while seven (41 percent) identify as male, and two (12 percent) identify as trans female
- Nine (53 percent) identify as straight and six (35 percent) identify as gay/queer
- Six (35 percent) identify as white/Caucasian, four (24 percent) identify as Asian, five (29 percent) identify as black/African American, two (12 percent) identify as Hispanic/Latino, and two (12 percent) identify as American Indian/Alaskan Native
- Several members also speak languages other than English; two (12 percent) speak Spanish, while other members speak Vietnamese (one), Mandarin (one), Chata (Choctow American Indian dialect) (one), and Punjabi and Hindi (one)

Program and Populations Planning and RFP Selection Committees

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

- For the Population Focused Request for Qualifications (RFQ), SF MHSA collected information from mental health consumers, family members of mental health consumers, the broader community and MHSA-funded community based organizations to better understand San Franciscans' mental health needs and desired support services. SF MHSA held three focus groups/dinners among various communities to gather feedback. The feedback revealed the need for honoring the heritage, histories, cultural and spiritual beliefs of oppressed and

marginalized communities regarding health and mental health, and the need to respect community-defined practices toward wellness. These focus groups also revealed that Population Focused services should be centered on acknowledging the healing practices, ceremonies and rituals of diverse communities with an emphasis on understanding the cultural context first and working in partnership with programs to design culturally relevant and appropriate services. Programs should honor participants' cultural backgrounds and practices of mental health while also making available a variety of non-clinical support services.

- In FY 15-16, the Peer-to-Peer Services department conducted several focus groups to elicit feedback to redesign existing peer programming. The Peer-to-Peer Services department conducted six peer, consumer, and family member focus groups to assess the needs of the community in order to redesign and better integrate the BHS peer-to-peer programs. In addition, consumers, family members and advocates consistently participated in manager meetings, staff meetings and decision-making meetings to provide valuable input in all areas of policy development, program development, implementation, budgeting, and evaluation. As a result, a new peer model was designed including streamlined services, additional training opportunities, better supervision, increased on-the-job support, and support/consultation groups for peers.

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 consumers in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. In FY 15-16, over half of all grantees/contracts indicated that their program employs consumers or participants through MHSA funding, totaling over 125 peers as employees. Consumers could be found working in almost all levels and types of positions, including: peer mentors, health promoters, community advocate, workgroup leaders, teaching assistants, and management. Several programs have positions created specifically for clients and consumers, including mentoring, advocacy, and peer facilitators.

Evaluation

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

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

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

1) the MHSA program evaluation team from Quality Management providing TA on a specific evaluation topic or on county or state requirements
2) a program presentation highlighting challenges to program implementation, lessons learned, evaluation plans, and consumer success stories-consumers are encouraged to also present on their experience with the program highlighting the program's successful impacts on their lives.

Attendance usually ranges from 20-30 people, including program providers and consumers. A list of meeting topics for FY 15-16 include:

- July: Presentations by Bayview YMCA Healthy People Program & the Reducing Stigma in the Southeast (RSSE) Project
- August: Presentation by Transgender Health & Wellness Program & TA on completing contract performance objectives
- September: Presentation by the Vocational Services CO-OP program
- November: Presentation by the RAMS Asian American Pacific Islander Mental Health Coalition
- December: TA session on performance objectives - data collection and reporting
- January: TA session on effective presentation skills
- February: TA session and discussion on how to increase survey response from consumers
- March: Presentation by Curry Senior Center's Reaching Isolated Older Adults Program
- April: TA session on how to conduct focus groups
- May: Presentation by Behavioral Health Services Vocational Services followed by an interactive discussion focusing on evaluation of this program
- June: TA session and discussion on new State PEI regulations

Statewide Evaluation Efforts

MHSA funded staff within the BHS Office of Quality Management also play an active role in supporting statewide evaluation efforts and activities for MHSA, providing another opportunity to actively engage a broader range of stakeholders. Notable activities in 2015-16 are listed below.

- Serving on the MHSOAC Evaluation Committee, representing San Francisco DPH, for a two-year term
- Serving on an advisory group for an evaluation contracted by the MHSOAC to University of California, San Diego of the Recovery Orientation of MHSA programs across California
- Participating, as one of three counties, in the MHSOAC-contracted evaluation of the Recovery Orientation of Community Services & Support (CSS) Programs
- Serving on an advisory group for an evaluation contracted by the MHSOAC to design and pilot and new system to replace the existing Data Collection and Reporting (DCR) and CSS data collection systems
- Serving on the CalMHSA Statewide Evaluation Expert (SEE) Team to provide research and evaluation guidance and consultation to CalMHSA programs and RAND.
- Participating in a Latino stakeholders' focus group as part of the California Reducing Disparities Project's Strategic Plan for Reducing Mental Health Disparities
- Contributing actively to the County Behavioral Health Directors Association (CBHDA) effort to identify MHSA activities and measureable outcomes for the Measurements, Outcomes and Quality Assessment (MOQA)
- Attending and contributing to MHSOAC-sponsored discussions in Sacramento and the Bay Area to address new requirements in the regulations regarding demographic and outcome data collection for Prevention and Early Intervention (PEI) programs

Moving Forward in FY 16-17 with CPP

Strengthening SF MHSA's Advisory Committee

For FY 15-16, SF MHSA has established a goal to strengthen the Advisory Committee by focusing on structure and guidelines for governance. Efforts will also include addressing gaps in member recruitment and collaborating together to build a calendar of meeting topics for the upcoming year. SF MHSA will work with advisory members to better develop strategies to elicit feedback, even from members who may not be able to attend certain meetings. Ideas already generated include the creation of a MHSA Advisory Website and a monthly SF MHSA newsletter.

Strengthening the CPP Efforts for the 3-Year Integrative Plan

SF MHSA plans to strengthen the efforts for the 3-Year Integrative Plan by assessing current gaps in the CPP process and working with consumers and others stakeholders to fill these gaps. SF MHSA has

started to develop a plan to better identify groups and committees to hold community forums, create CPP documents to be used at community forums, create better marketing flyers for community forums and strengthen the mechanism in which to elicit feedback.

San Francisco's Integrated MHSA Service Categories

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

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

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

Exhibit 2. SF MHSA Service Categories

SF MHSA Service Category	Description
Recovery-Oriented Treatment Services	■ Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment) ■ Uses strengths-based recovery approaches
Mental Health Promotion & Early Intervention (PEI) Services	■ Raises awareness about mental health and reduces stigma ■ Identifies early signs of mental illness and increase access to services
Peer-to-Peer Support Services	■ 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

It is important to note that the majority of our MHSA Service Categories include services funded by Innovations (INN) component of MHSA. 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.

Moving Forward in FY 16-17 with MHSA Leadership

We are proud to announce that the SF MHSA Director, Marlo Simmons, MPH, was recently promoted to Deputy Director of Behavioral Health Services. The MHSA department will still remain under the oversight of Ms. Simmons, as she brings several years of expertise working with MHSA activities. We are also proud to announce the hiring of a new SF MHSA Director, Imo Momoh, MPA. Mr. Momoh comes to us with work experience in Contra Costa County as a Health Services Planner/Evaluator and as the Ethnic Services Manager & Workforce Education and Training Manager. He also worked in San Bernardino County and served as the Cultural Competency Officer.

Local Review Process

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Annual Update Report was posted on the SF MHSA website at www.sfdph.org/dph and www.sfmhsa.org. Our 2016-17 Annual Report was posted for a period of 30 days from 12/16/16 to 1/16/17. Members of the public were requested to submit their comments either by email or by regular mail. There were no public comments during the posting. Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board of San Francisco on 1/18/17. The Annual Report was also presented before the Public Safety and Neighborhood Services Committee on XXXX. Add public comments:

Public Hearing & Board of Supervisors Resolution

Insert Resolution Here

Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date, as well as efforts moving forward. The following seven sections describe the overarching purpose of each of San Francisco's MHSA Service Categories. Each program section includes an overview and description, the target population, highlights and successes, as well as efforts moving forward in FY 16-17 for the following seven categories:

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

Recovery-Oriented Treatment Services

Service Category Overview

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

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

Full Service Partnership (FSP)

Program Overview

Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client-and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with severe mental illness (SMI) or severe emotional disturbance (SED) to lead independent, meaningful, and productive lives. FSP programs were designed under the leadership of the former California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system to implement more recovery-oriented treatment modalities for the clients in the public health system who require more intensive levels of support than regular outpatient clinics can provide.

Recovery-oriented services are grounded in the principle that recovery is a possible and expected outcome of treatment. These services must also be client-focused and client-driven, culturally-competent, and respectful of racial, cultural (including religion and language), gender identity, and sexual orientation. In fact, clients must be involved at every level of service, including in the program

planning, delivery, and evaluation of services. In existence since 2005, FSP programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families. See Exhibit 3 for a summary breakdown of FSP programming.

Exhibit 3. Summary of Full Service Partnership Programs

Target Population	Lead Agency	Services
Children 0-5 & Families	Instituto Familiar de la Raza (IFR)	Provides trauma focused dyadic therapy, intensive case management and wraparound services to the 0 – 5 population.
Children & Adolescents	Seneca SF Connections	Offers wraparound services to help children and their families achieve stability and increase access to community resources
	Family Mosaic Project	Provides intensive case management and wraparound services in the Bayview, Mission, and Chinatown neighborhoods
Transition Age Youth (TAY)	Family Service Agency	Provides physical health care, mental health treatment, medication management, employment assistance, housing support, and peer support
	Behavioral Health Services - TAY	Conducts intensive services (e.g., training on independent living skills, mental health and substance abuse counseling) with youth transitioning out of foster care and the child welfare system
Adults	Family Service Agency	Conducts wellness and creative arts workshops, holds community cultural events, offers support groups, and organizes healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods
Adults	SF-Behavioral Health Services & UCSF Citywide Case Management (AOT)	Improves the quality of life of participants, supports them on their path to recovery and wellness, and prevents cycling through acute services and incarceration with a particular focus on providing community-based services and multiple opportunities for an individual to engage in voluntary treatment
Adults	Hyde Street Community Services	Implements mental health promotion efforts to homeless individuals in the Tenderloin who have not successfully engaged with outpatient services and frequently experience multiple co-occurring disorders
	SF Fully Integrated Recovery Service Team	Provides services (e.g., individual or group therapy, medication management) to individuals with SMI who have been homeless for an extended time
	UCSF Citywide Case Management Forensics	Provides consultation, services, screening and assessment, and other mental health services to adults who are engaged with the Behavioral Health Court
Older Adults	Family Service Agency	Serves older adults age 60 and above who need specialized geriatric services related to mental health and aging

New Programs in FY 15-16

In the summer of 2014, a thorough community needs assessment was conducted to determine the gaps in service for San Francisco's most vulnerable populations—those with serious mental illness or disorders, those who are homeless, or have experienced excessive trauma. San Francisco's Full Service Partnership (FSP) programs currently serve that population, but there are certain populations whose needs still go unmet. The needs assessment found that there was a dearth in services and support for

young children, aged 0-5, and their families who are living with the effects of trauma, substance abuse, and mental illness. The needs are particularly great for young children who are in the foster care system as a result of multiple and/or chronic experiences of trauma. These young children are in need of intensive mental health services.

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

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

As a result, a new FSP program will be developed to support the stabilization and recovery of families in crisis who are also caring for children under the age of 5. An RFQ was issued in April 2015 for the provision of intensive-level case management and mental health services to families with children aged 0-5. Most of the program participants will be residents of one of the four HOPE SF public housing sites. Seven RFQ proposals were submitted. A review panel reviewed each of the proposals and chose three applicants to interview. On May 13, 2015, the review panel met again to interview the finalists and one agency was chosen to contract with. On July 1st, CYF leadership and staff will meet with the selected agency, Instituto Familiar de la Raza (IFR), to begin the process of developing a scope of work and contract deliverables.

FY 15-16 Highlights and Successes

The Strong Parents and Resilient Kids (SPARK) program is designed to operationalize the philosophy and vision of the MHSA. In FY 15-16, the SPARK team made significant efforts to hire clinicians who reflect the community it serves. The team is fully staffed and has three African-American, one Samoan and one Hispanic clinician. There is also diversity in gender with 3 females and 2 males working on the team. The

clinicians are participating in community events and partnering with other service providers who support the target community.

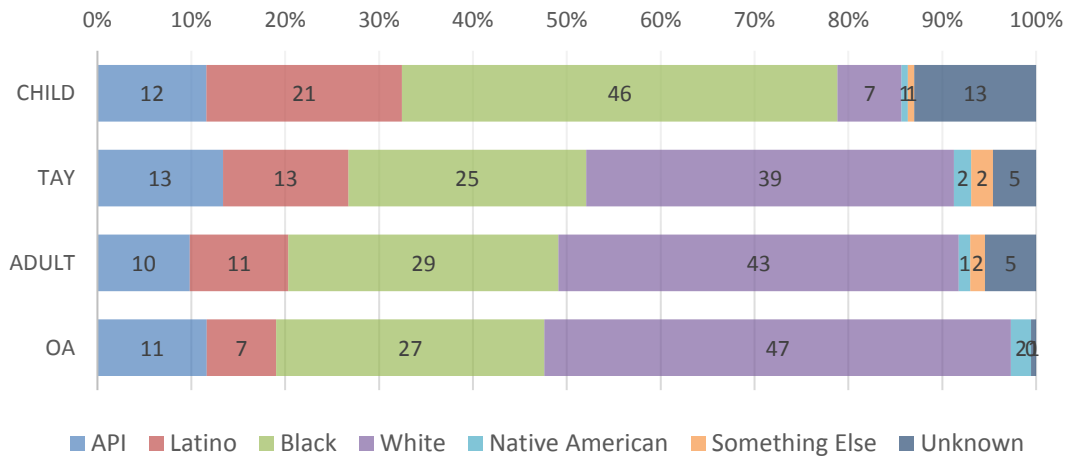
Moving Forward in FY 16-17

IFR is committed to learning about the history and current day practices of institutionalized oppression and neglect for members of the Sunnydale neighborhood in San Francisco. SPARK clinicians understand that in order to move forward with operationalizing the philosophy and vision of MHSA, it is vital that community members be at the forefront. A significant effort has been placed on developing community trust and building a service network with strong, collaborative relationships. Moving forward, the SPARK team will continue to enhance its community outreach efforts and build upon these connections. SPARK will strengthen outreach efforts to Early Learning Centers and Family Resource Centers in FY 16-17.

Target Population

Eleven 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 who have experienced a single or several traumatic events, which then adversely impact the parent-child attachment relationship as well as the child's ability to return to a normal developmental trajectory. 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. In 2015-16, the eleven FSP programs served 1051 clients (300 children, 91 TAY, 615 adults, and 45 older adults)

Exhibit 4. Ethnicity (percent) of Clients Active FY 15-16, by Age Group



Ethnicity varies by age group, but most striking is the larger proportion of African American children in the CYF programs.

FY 15-16 Highlights and Successes

FSP Data Collection and Reporting (DCR) Outcomes

The Data Collection and Reporting (DCR) system tracks outcome indicators for all FSP clients across the state of California. Outcomes for FSP clients can include time spent in different residential settings and the occurrence of emergency events requiring intervention. These data are entered into the DCR using Key Event Tracking (KET) Assessments, ideally *as they occur.*

Residential Settings

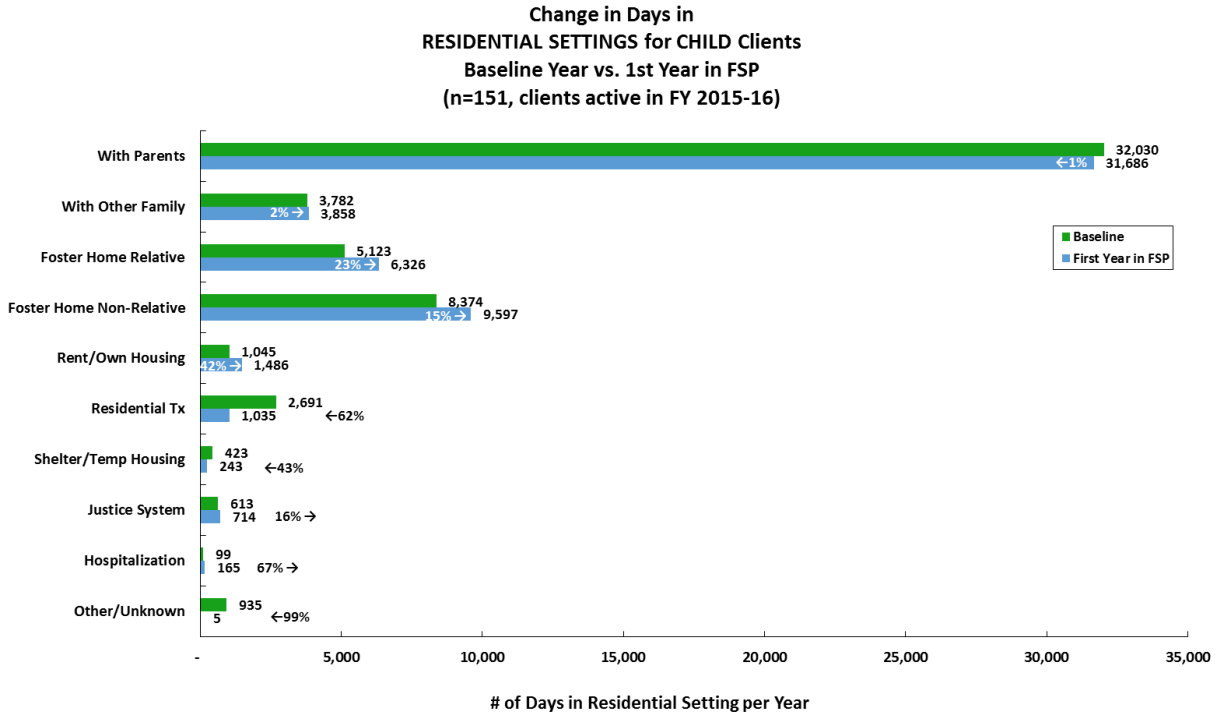
Days in residential settings are automatically calculated in the DCR based on the start of each KET that registers a changed living situation. Specific outcomes reported here include the number of days clients spent in a residential setting and the rate of emergency events (measured by the number of events per person-year).

The following charts focus on FSP clients' Residential Settings by comparing the total number of days all clients spent in each setting between the baseline year (the 12 months immediately preceding entry into the FSP) and the first year enrolled in the FSP. Some clients spent days in more than one setting over the course of each year. Residential outcomes reporting includes all clients active in the FSP during FY 15-16 and for at least one continuous year.

Residential settings are displayed from more desirable to less desirable, but this interpretation is variable by age group as well as for individuals. In other words, while a supervised placement may represent a setback for one client, for another the move could be a sign of getting into care for the first time.

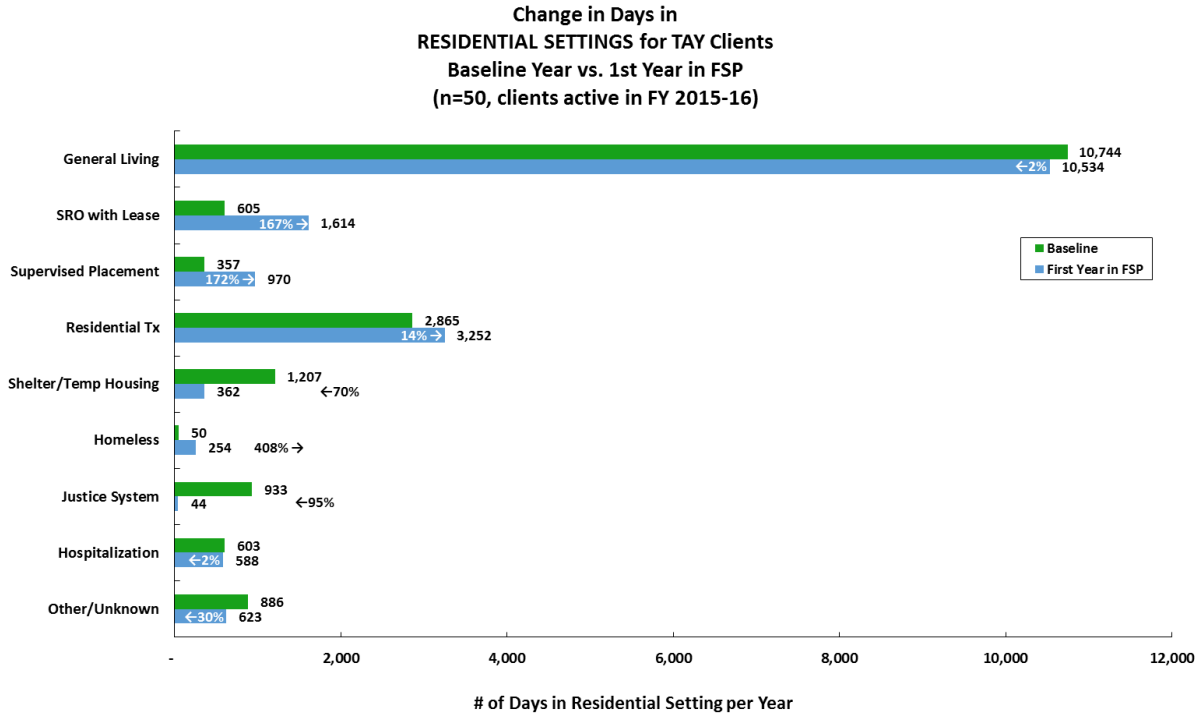
Because residential settings differ greatly between children and all other age groups, the following graphs (Exhibits 5-8) show all age groups separately.

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



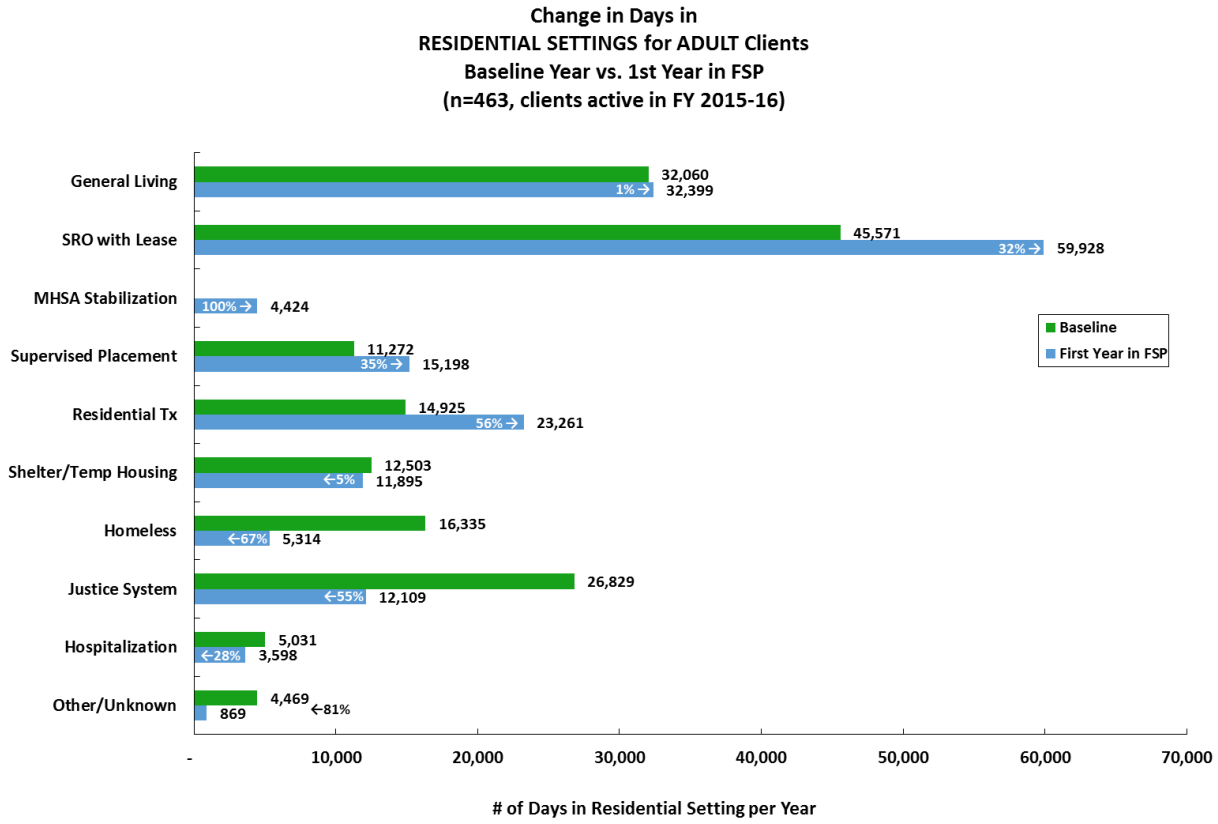
Child, youth, and family clients (i.e., child) data show movement from restrictive settings (e.g., residential treatment) into more family-based settings during FSP treatment. Most significantly, days in Residential Treatment dropped 62 percent while with other family (not parents) and foster care saw increases of 2 percent and 23 percent respectively. Shelter/Temp housing dropped 43 percent, however Justice Settings (16 percent) and Hospitalizations (67 percent), while small in number, increased in percentage from Baseline to first year in FSP.

Exhibit 6. Change in Days in Residential Settings for TAY Clients



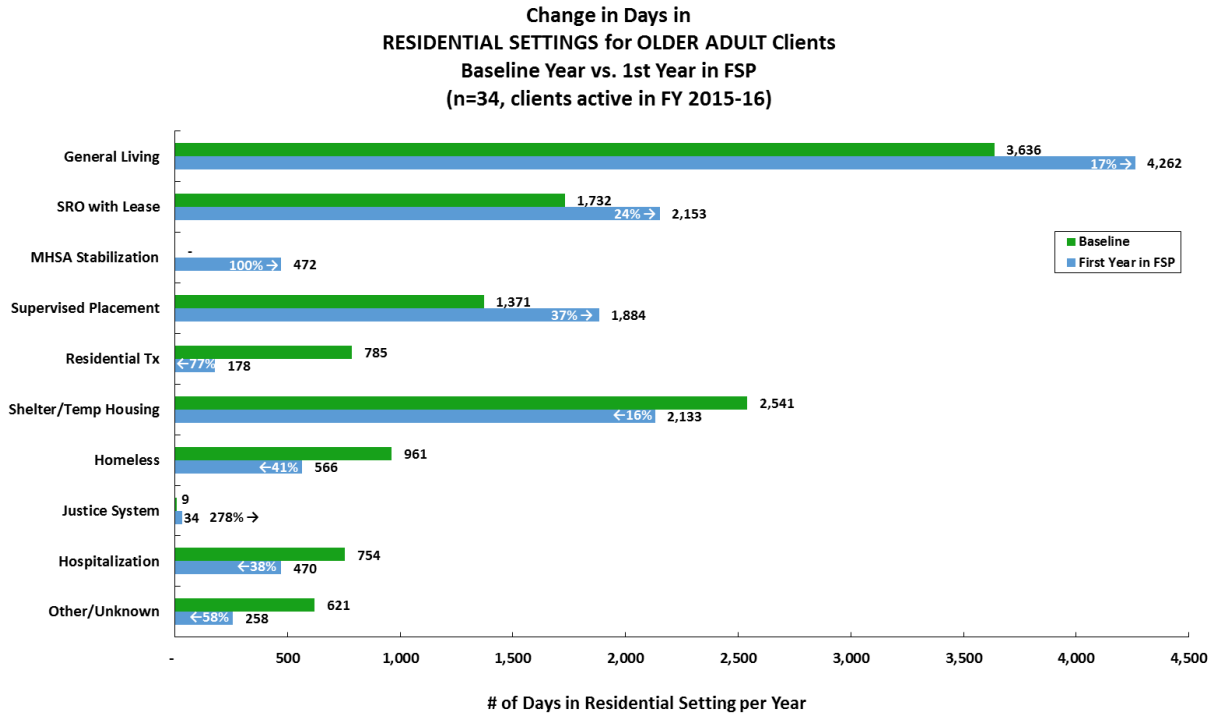
For TAY clients, several settings shift from baseline to SP treatment. Positive signs are evident from TAY having moved out of Shelter/Temp housing (-70 percent), Justice (-95 percent), and Hospital settings (-2 percent) in the first 12 months in the FSP. Increases in Supervised Placement of 172 percent, and SRO with Lease of 281 percent suggest that the some TAY clients are getting access to housing.

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



Among adult clients, improvements are reflected in the shift in days away from Shelter/Temporary Housing, Homeless, Criminal Justice, and Hospital settings to more stable settings. These stable settings include General Living, SRO with Lease, MHSA stabilization, Supervised Placement, and Residential Treatment. While Supervised and Residential Placements are relatively restrictive settings, they may represent advancement in recovery for FSP clients who have not previously accessed stabilizing care. From baseline to first year in the FSP, adults active in 15-16, reduce days in Homeless (-67 percent), Shelter/Temp Housing (-5 percent), Justice (-55 percent), and Hospitalization (-28 percent) and increase days in General Living (1 percent), SRO with Lease (32 percent), MHSA Stabilization (from 0 days to 4,424), Supervised Placement (35 percent), and Residential Treatment (56 percent).

Exhibit 8. Change in Days in Residential Settings for Older Adult Clients

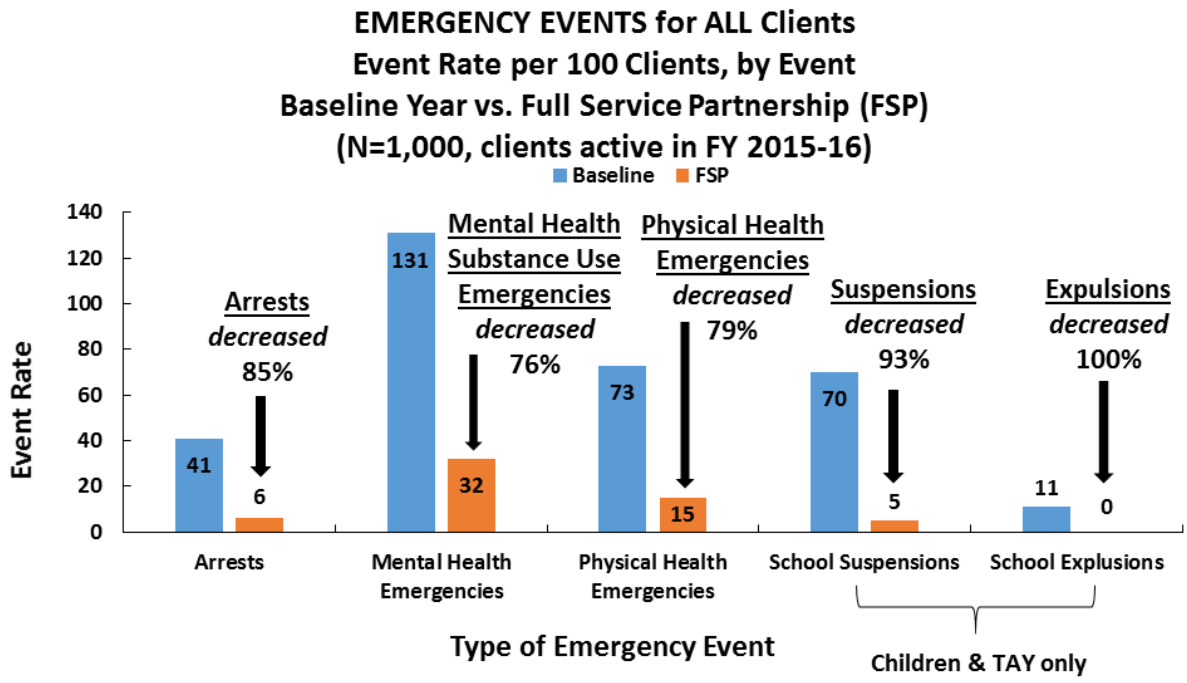


Older Adult FSP data indicate increases in SRO with Lease (24 percent), MHSA Stabilization (from 0 to 472 days), Residential Treatment (77 percent), and Supervised Placement (37 percent), suggesting positive outcomes, especially as days in shelter/temporary housing (-16 percent) and homelessness (-41 percent) decline during FSP treatment. Perplexing is the reduction in Hospitalization days (-38 percent) which typically increase for older FSP adults as they connect to case management. Justice increases from 9 days baseline to 34 days in FSP. While small in number, it indicates a percentage spike of 278 percent.

Emergency Events

Emergency events include arrests, mental health or psychiatric emergencies (which include substance use related events), and physical health emergencies, as well as school suspensions and expulsions for young children and TAY, for FSP clients active any time between July 2015 and June 2016. The baseline (pre-FSP) rate of emergency events is compared to the rate while in the FSP. Unlike the Residential Settings measure, which looks only at the ***first year in FSP*** for all clients, the emergency events FSP measure ***averages the annual event rate over all years in FSP***. Event rates are reported here, for simplicity, as number of emergency events per 100 clients.

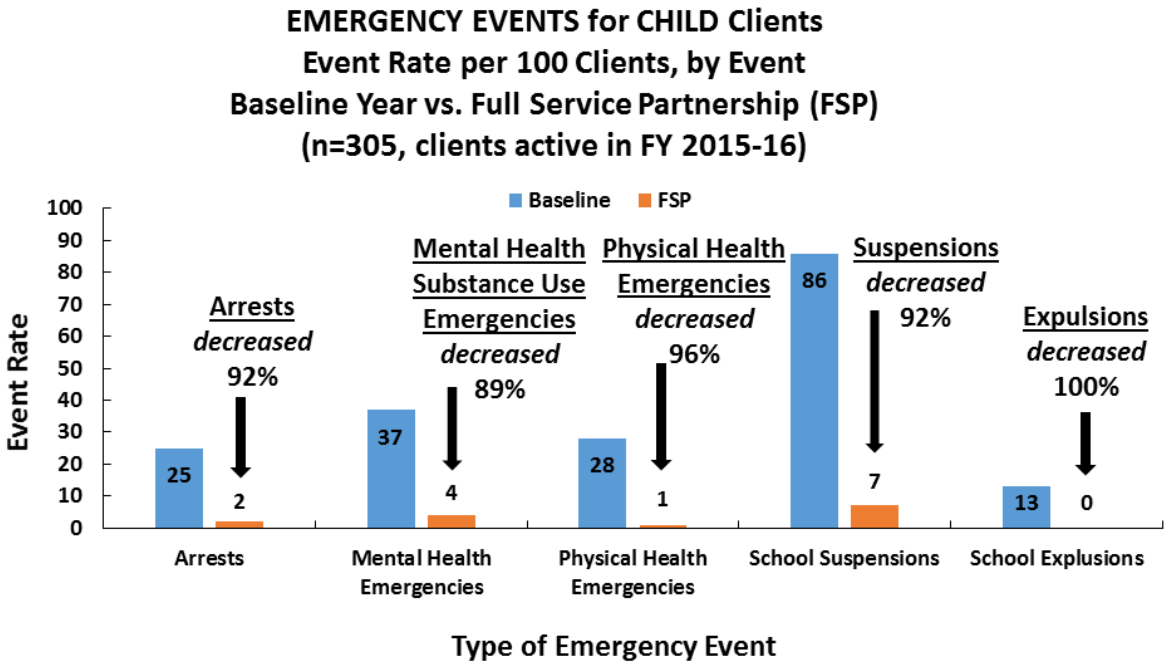
Exhibit 9. Emergency Events for All Clients



In 2015-16, over <u>all</u> age groups, arrests dropped 85 percent, from 41 per 100 clients in the baseline year, to 6 arrests during FSP years. Mental Health/Substance Use Emergencies, which are concentrated among TAY, decreased 76 percent across all age groups, from 131 events per 100 clients, to 32 emergencies during FSP years. Physical health emergency events, most common among older adults, registered 73 events per 100 clients at baseline and decreased to 15 events per 100 clients during FSP years, a 79 percent reduction. For younger children and TAY, school suspensions were reduced a combined 70 percent, from 70 suspensions per 100 youth at baseline to 5 during FSP years. School

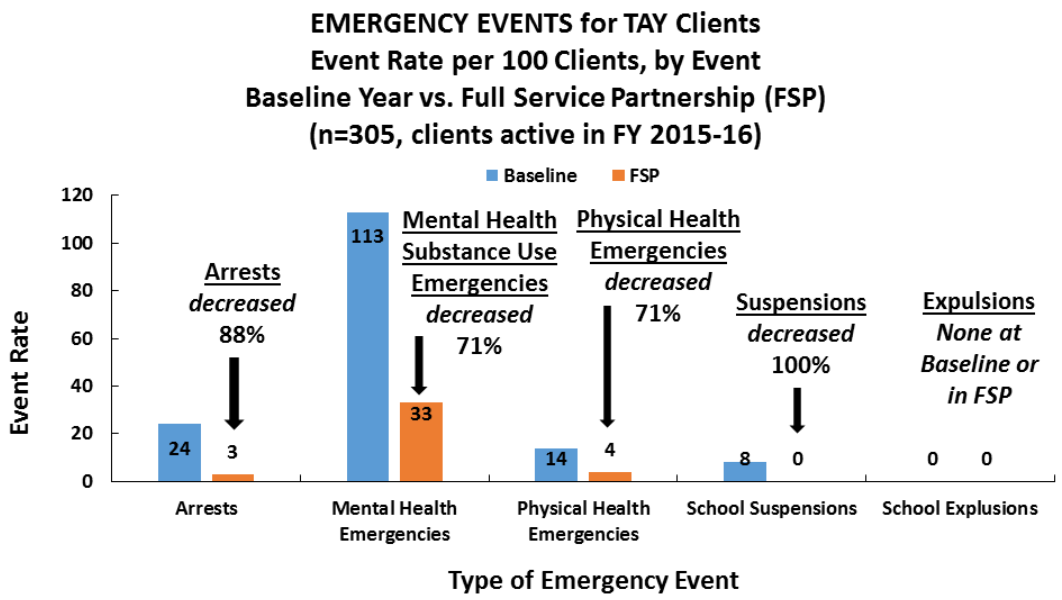
expulsions, which occur much less often (11 expulsions per 100 students at baseline) reduced to zero during FSP years.

Exhibit 10. Emergency Events for Child Clients



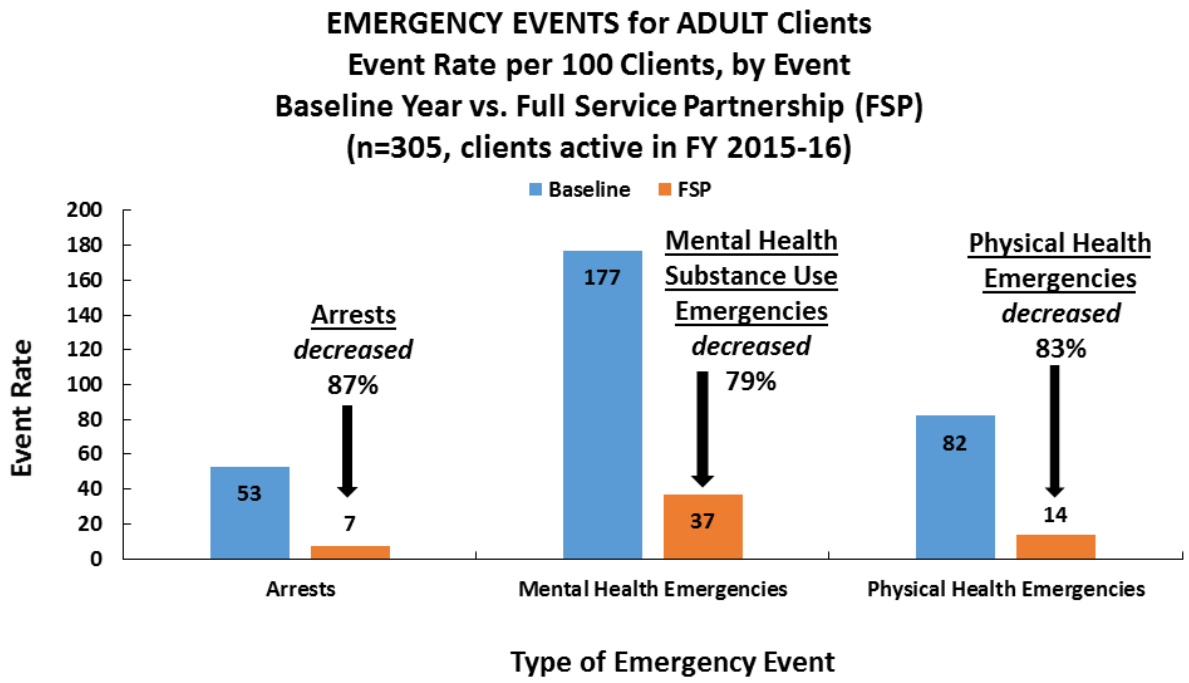
Emergency events occurred less often among child clients. There were marked declines across all types of emergency events reported for child clients. So few events displayed for the FSP treatment suggest that data entry for the Key Events is not complete. Data Quality reports indicate missing DCR data for CYF clients.

Exhibit 11. Emergency Events for TAY Clients



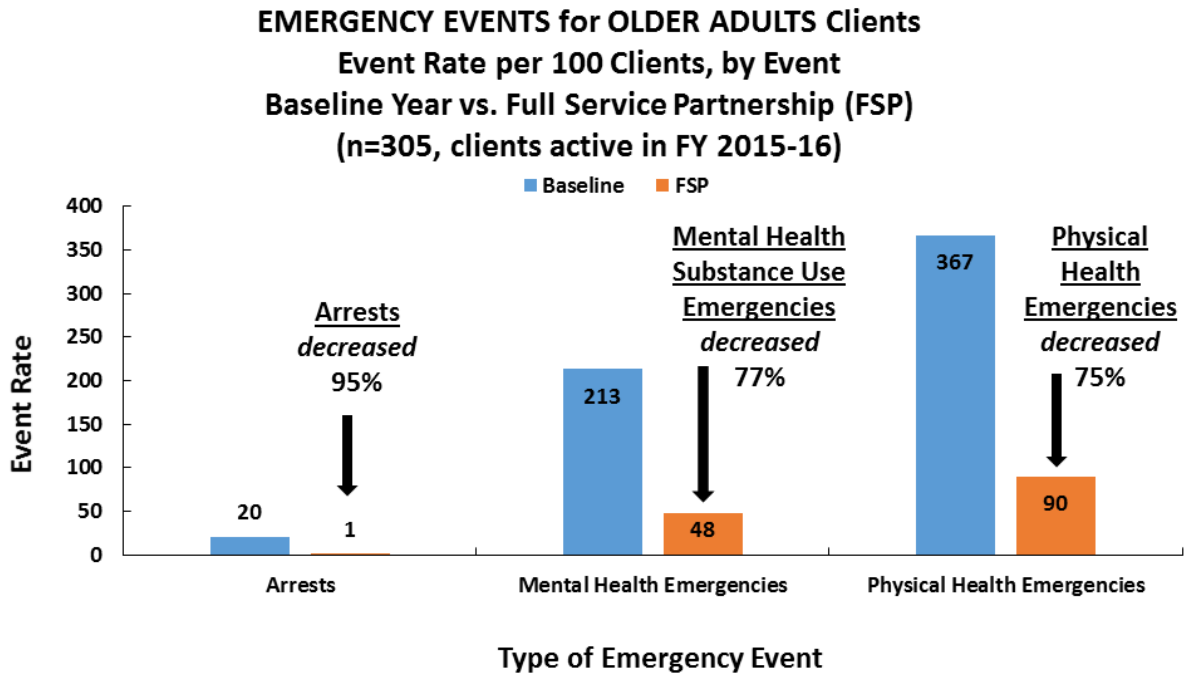
For TAY clients fewer emergency events are reported as well. As shown, marked declines appear across all emergency events experienced by TAY clients. Most noticeably, mental health emergencies dropped from 113 events per 100 clients in the baseline year, to 33 events per 100 clients in the FSP years. It is noteworthy that TAY clients are likely to leave the FSP within one year, suggesting that some TAY clients with highest distress are under-represented in the follow-up FSP rate. Arrests (88 percent reduction) and School Suspensions (from 8 to 0) also showed significant improvement. No school expulsions were reported in the baseline or FSP years for TAY active in 2015-16.

Exhibit 12. Emergency Events for Adult Clients



Adult clients also show fewer emergency events since enrollment in FSP programs. As depicted below, there were substantial declines reported across all emergency events. Arrests dropped 87 percent, from 53 per 100 clients in the baseline year, to 7 events per 100 clients in the FSP years. Reports of mental health emergencies declined 79 percent from 177 per 100 clients in the baseline year, to 37 events per 100 clients in FSP. Physical Health Emergencies were reduced from 82 per 100 clients in the baseline year, to 14 in 100 in the FSP years (83 percent decrease).

Exhibit 13. Emergency Events for Older Adult Clients



Older adult clients show a different pattern from the other age group, as with age they experience declining physical health. Report of Arrests, which are not high to begin with, reduced to zero (95 percent reduction). The rates of mental and physical health emergencies also dropped 77 percent and 75 percent respectively. Physical health emergencies are commonly reported for older adults, as many as 90 per 100 even while in FSP treatment. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

FSP: Improving DCR Data Quality

Since the inception of the DCR, ensuring high quality KET data to capture 100 percent of residential changes, emergency events and other life events has proven a formidable challenge. The San Francisco DCR Workgroup, comprised of two MHSA evaluators and one IT staff person, works with FSP programs to support accurate and timely client data entry into the DCR. The Workgroup developed several data quality and data outcome reports, which are shared monthly with the FSP programs in an effort to help monitor and increase the level of completion for KETs. The Workgroup has also shared a KET tracking template as a tool to help case managers record KETs as the events occur and remembering to enter

them in the DCR at a later time. Data quality and completion appear to be impacted or enhanced, depending on the capacity of the program to support DCR data entry as a priority.

In 2015-16, BHS adopted a new contract performance objective, based on DCR compliance, in an effort to increase the visibility of the DCR and underscore the importance of the functional outcomes for FSP clients. Expectations were that programs would have 100 percent of their Quarterly Assessments completed within 30 days of the due date. We measured all Quarterly Assessment *items completed* against all *items expected*. For FY 15-16, 3,285 Quarterly assessments were due, and within those, 74 percent of the assessment *items* were completed.

The DCR Workgroup also provides in person trainings in the DCR and visits individual programs as needed. In FY 15-16, the DCR Workgroup conducted four (4) DCR new user trainings – roughly one per quarter, five (5) site visits to different programs to discuss DCR related issues and outcomes, and ongoing daily support in both data entry and reporting over email and phone. Clearly, more communication and support are needed to increase the completion rate of DCR data.

FSP Program Example: Family Mosaic Project

Program Overview

Family Mosaic Project is a part of San Francisco Department of Public Health's Children Youth and Family Services that provides intensive case management and care coordination within the wraparound model to children, youth and their families. Since 1998, Family Mosaic Project has provided Wraparound services to children, youth and families in an effort to avoid out-of-home placement or a higher level of care. Its mission is to support children and families in their communities by providing extraordinary outreach and innovative approaches to mental health services. It brings the services to consumers and their family at home, school and/or the community. The following are the principles The Family Mosaic Project uses throughout delivery of services:

- **Family Voice and Choice.** The families make the decisions about services and goals.
- **Team Based.** The Wraparound team consists of individuals agreed upon by the family.
- **Natural Supports.** The Wraparound team seeks out and encourages participation from family members and community relationships.
- **Collaboration.** Team members work together and share responsibility in developing, implementing, monitoring and evaluating the Wraparound plan.
- **Community-based.** The Wraparound team implements services that are accessible and convenient to the family.
- **Individualized.** The team develops a plan to address the goals identified by the family and providers. The plan is tailored to fit the family.

- **Strength-based.** The Wraparound plan will build on the strengths, knowledge and skills of the family.
- **Persistence.** Despite challenges, the team will work together until the wraparound process is no longer required.
- **Outcome-Based.** The team is accountable to the family and to all team members by measuring the success of goals and strategies.

Target Population

San Francisco youth under the age of 18 are eligible to participate in the program. The program is particularly geared towards youth who are currently at risk of out-of-home placement or a higher level of care. Youth must also have a funding stream connected to the County of San Francisco (38) including full-scope Medi-Cal, share-of-cost Medi-Cal, or SF Healthy Children/Healthy Families.

It is anticipated that many youth will already be active in public systems including Community Behavioral Health Services, Department of Social Services, and Probation Department. Referral agencies include Foster Care Mental Health Program (FCMHP) for Katie A. designated youth, AIIM (Assess, Identify Needs, Integrate Information, and Match to Services) Higher, Probation Department, CCCS, and BHS Outpatient clinics.

FY 14-15 Highlights and Successes

The Family Mosaic Project is committed to working to provide comprehensive mental health services that meet families' needs. Its services are provided with dignity and respect and its goals are simple. The Family Mosaic Project wants to keep youth in schools, out of trouble, and safe at home with their families and caregivers. It is well known that youth thrive best in their natural homes and communities. The Family Mosaic Project partners with families and communities in San Francisco in order to promote permanency and stability for youth at risk of out-of-home placements. Its program seeks to achieve the following goals for youth and families:

- Stabilize home environments
- Improve functioning in homes, schools and communities
- Create and improve permanent relationships amongst family members and identified natural supports
- Foster collaborative and efficient relationships with families and community partners

FSP Program Example: TAY Clinic

Program Overview

The Transitional Age Youth Full Service Partnership program, through the TAY Clinic, provides intensive behavioral health services to youth who are between the ages of 17-25. The clinic provides intensive case management and linkage; individual, family, and group therapy; medication evaluation and medication monitoring; socialization and wellness activities; and a drop-in center for young people who are working with the program. It focuses on helping young people stabilize and reduce the impact of mental health symptoms, develop independent living skills, and create and increase connection to meaningful activities (such as vocational and educational activities). It works with youth, with their families, with other providers, and with larger systems to coordinate care and increase support.

Target Population

The TAY Clinic target population includes 17-25 year olds with SMI diagnosis, being unserved or underserved in traditional outpatient programs. Many have histories of psychiatric hospitalizations or crisis visits, involvement in foster care and/or juvenile justice systems, homelessness or living in marginal or unstable housing, living with family but in need of more support in order to be able to remain at home, and high case management and service linkage needs.

FY 15-16 Highlights and Successes

Notable achievements for FY 15-16 include the following:

- Increased use of team-based care model
- Further developing collaboration with Foster Care Mental Health and Human Service Agency to support youth in extended foster care and exiting foster care
- Developing collaboration with the BHS Children, Youth & Family System of Care
- Beginning collaboration with BHS School-Based Mental Health Services

Moving Forward in FY 16-17

TAY Clinic will continue focusing on developing and strengthening relationships and collaborations with key systems, agencies, and providers. The clinic is focusing in FY 16-17 on increasing its socialization and wellness activity programming as well as use of the clinic's drop-in center and have already had some successes in that area. Additionally, the drop-in center was chosen to be redesigned by First Impressions, an MHSA-funded vocational program, which will be happening later this year.

FSP Program Example: SF FIRST

Program Overview

SF FIRST is a behavioral health treatment team that provides intensive wraparound services to high users of multiple services (HUMS). The team is multidisciplinary and is composed of case managers, social workers, medical staff, peer workers, health workers, a representative payee, and vocational experts who provide clinic as well as street-based services. SF FIRST utilizes a client-centered approach. Its goal is to assist enrolled clients with stabilizing their symptoms and to form a partnership with them as they strive to achieve their full potential and live a self-defined meaningful life in a community of their choice.

The team provides a broad array of services to enrolled clients some of which include outreach and engagement, clinical assessment, intensive case management, psychiatric services, employment assistance, money management services, linkage to primary care, crisis services, peer counseling, therapy, access to temporary and permanent housing, and community integration. SF FIRST embraces the "whatever it takes" philosophy as indicated in the Full Service Partnership Toolkit in order to connect its clients with essential services in the community which helps them to sustain or improve their quality of life.

Target Population

SF FIRST uses the principles of wellness and recovery and a trauma-informed approach to treat hard-to-reach San Francisco residents who suffer from multiple diagnoses and are severely disabled. Many struggle with severe and persistent psychiatric, medical and substance use disorders and are chronically homeless.

FY 14-15 Highlights and Successes

FY 14-15 was very eventful for SF FIRST. It was preparing to temporarily relocate to 1380 Howard St. as a result of a pre-scheduled 7 month renovation plan of the South of Market Mental Health Clinic (SOMMHC). In addition, SF FIRST was adjusting to significant team transitions and celebrating the upcoming retirement of a couple of the program's employees. Preparation for the relocation was an extensive process that required numerous meetings so that the move can occur in an efficient and coordinated manner.

SF FIRST recognized the vulnerability of most of its clients and the various ways that relocating could potentially exacerbate their severe mental illness. To prevent incidents of decompensation, it had a series of innovative planning meetings that focused on service delivery and continuity of care. SF FIRST developed a few very effective team-based ideas that it has decided to implement as part of its program

due to the ideas' success amongst clients and the team cohesion that it fosters with the staff. Specific highlights from FY 14-15 include:

- SF FIRST Outreach Groups: To continue to provide optimum team-based care to SF FIRST enrolled clients during the 7 month relocation period, SF FIRST developed two multi-disciplinary outreach group mini teams. Each outreach group is on a two month rotation schedule which allows most SF FIRST staff to participate. The ultimate goal of the group is to provide every enrolled client with regular ongoing contact with a small segment of SF FIRST staff to provide crisis interventions, medication support services, welcoming recently enrolled clients into the program, wellness checks, linkage with vocational services, money management services, linkage with community integration activities or simply a friendly visit and team support. These services occur concurrently with regular meetings with their assigned case manager and medical provider.

- Greeters: SF FIRST developed stipend greeter positions at 1380 Howard staffed by SF FIRST clients. This allowed clients that were apprehensive about going to 1380 Howard for services to be greeted and welcomed by a peer. This was especially helpful to clients who were anxious about the relocation. The greeters provided a level of comfort, re-assurance and encouragement about the new location and that their services will continue.

Moving Forward

SF FIRST's goal for the future is to continue to provide high quality intensive case management and psychiatric services to enrolled clients. It will continue to be client centered and utilize principles of wellness and recovery in its services. To accomplish this, it recently started a Strength Based Assessment Workgroup that meets weekly to discuss ways to further implement this treatment approach into every aspect of its program. In addition, SF FIRST started the Full Service Partnership University (FSPU) which is a team discussion and overview of the FSP toolkit. FSPU occurs on the 2nd and 4th Wednesdays of each month. Every staff of SF FIRST selected a chapter of the FSP toolkit to present to the team. The presenter also facilitates a discussion amongst the team that is focused on SF FIRST clients and services. The FSPU presentations are extremely interesting and strengthen staff knowledge about its model, encouraging staff to explore ways to improve its services in order to promote good outcomes for clients.

FSP Program Example: Assisted Outpatient Treatment (AOT) Program

Program Overview

In July 2014, San Francisco's Board of Supervisors authorized Assisted Outpatient Treatment (AOT), most commonly referred to as Laura's Law, as a response to Mayor Ed Lee's 2014 Care Task Force.

Implemented November 2, 2015, the San Francisco AOT Model is utilized as an intervention and engagement tool designed to assist and support individuals with mental illness (www.sfdph.org/aot). The program has been constructed to employ principles of recovery and wellness, and has a particular focus on community-based services and multiple opportunities for an individual to engage in voluntary treatment. The ultimate goal of the program is to improve the quality of life of participants and support them on their path to recovery and wellness, as well as prevent decompensation and cycling through acute services (e.g., psychiatric hospitalization) and incarceration.

The AOT Care Team is a three-person team comprised of the *Director* (a psychologist with forensic experience), a *Peer Specialist,* and a *Family Liaison*. The AOT Care Team is housed within the San Francisco Department of Public Health's Behavioral Health Services. In addition to the AOT Care Team, a *Clinical Team* from Zuckerberg San Francisco General Hospital (ZSFG) Division of Citywide Case Management provides intensive case management services, which includes conducting psychiatric assessment and treatment coordination, for individuals court-ordered into treatment through AOT and supports individuals who have voluntarily agreed to services in linking to long term care.

San Francisco relies on a highly collaborative model of delivery and program improvement. Prior to the San Francisco AOT program being implemented, staff conducted over 60 trainings to stakeholders (e.g., community based organizations, hospitals, behavioral health clinics, patient's rights advocates) to ensure that the community was well informed of the unique implementation of the law in San Francisco. Further, San Francisco has been instrumental in partnering with other counties that have adopted AOT, and has worked to initiate a quarterly conference call to share information.

FY 15-16 Highlights and Successes

In San Francisco, the AOT program places an emphasis on promoting voluntary engagement by utilizing a strength-based and client-centered approach, as well as accessing an individual's natural support system (i.e., family and friends). If after 30+ days of engagement the staff is unable to successfully engage an individual in care, a petition to court order an individual into outpatient treatment may be pursued. This order uses the "black robe" effect (i.e., symbolic weight of the court) to leverage an individual into care. In FY 15-16 AOT received 80 referrals and the Care Team has made contact with 36 referrals (many referrals are not eligible for AOT). While a court petition had been filed in four cases, 19 individuals accepted voluntary services.

Though the program is still new, to date there has been a great deal of positive feedback from families and referred individuals about the support offered to them by the AOT program. Initial feedback from participants was overwhelmingly positive with 100 percent of those who responded to a questionnaire indicating that they feel hopeful about their future. Further, a family member was noted to say, "I'm really grateful for everything that AOT is doing because I couldn't be there and do anything. It had gotten to the point where it was the [mental health] system of nothing… If it wasn't for [AOT], I don't know where he'd be." In one success story, the AOT Care Team's first referral Mr. X, a white male young

adult referred by a family member, had multiple previous psychiatric crises, psychiatric hospitalizations and incarcerations where he received mental health treatment in the last five years. Prior to the referral to AOT, Mr. X had been homeless, refusing mental health services, and had not been successfully engaged in treatment. Given the intensive outreach conducted by the AOT Team over the course of 3 months, as well as the support he received from loved ones and providers, Mr. X accepted voluntary services and is now independently housed and continues to be engaged in regular contact with a mental health provider.

Exhibit 14. Outcomes for Active AOT Participants

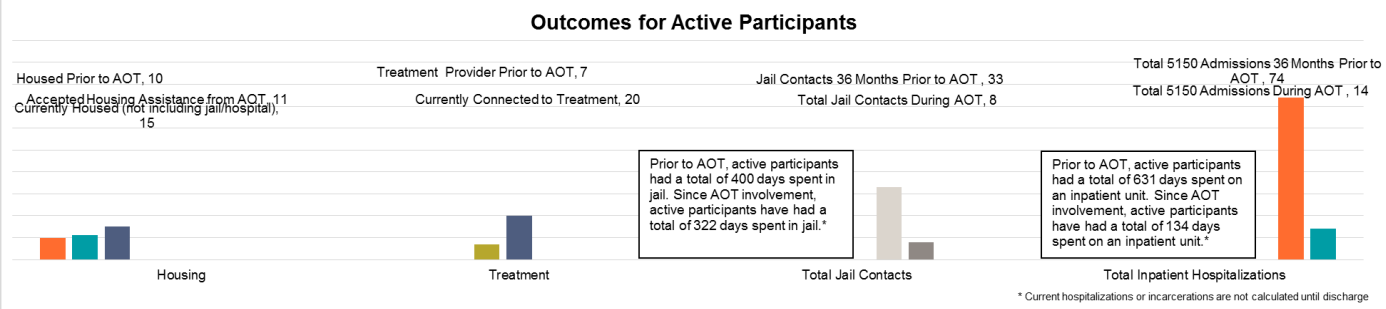
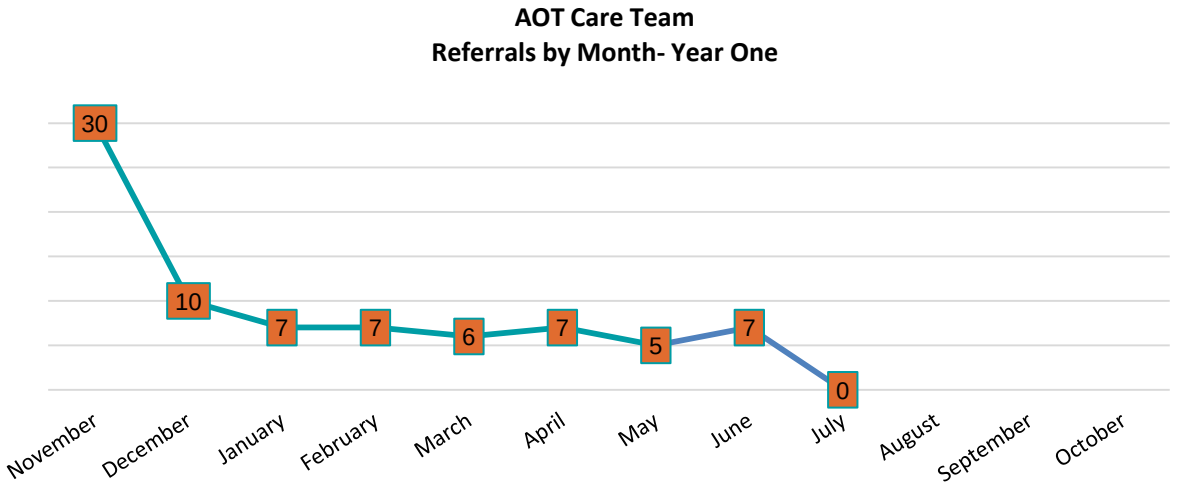


Exhibit 15. AOT Referrals by Month



Moving Forward in FY 16-17

In FY 16-17, the AOT Team will be rehiring a funded Health Worker II (2586) position and hiring a newly funded Senior Behavioral Health Clinician (2932) to better serve the individuals outreached by this program. In FY 16-17 the Clinical Team with Zuckerberg San Francisco General Hospital (ZSFG) Division of Citywide Case Management will rehire a part time peer specialist and hiring a part time safety staff and

nurse practitioner to support outreach and engagement in services. Finally, Harder+Company Community Research will continue to support AOT by completing the annual report to the State Department of Mental Health and supporting data collection for the three year comprehensive evaluation to the Board of Supervisors.

FSP Evaluation

Background

Full service partnership (FSP) programs were designed under the leadership of the former California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system to implement more recovery-oriented treatment modalities for the clients in the public health system who require more intensive levels of support than regular outpatient clinics can provide.

Recovery-oriented systems are grounded in the principles that recovery is a "possible and expected outcome of treatment, and that the full range of comprehensive services and supports that an individual needs to meet his or her recovery goals be accessible, flexible, individualized, and coordinated" (Felton et al, 2010, p. 441) These services must also be client-focused and client-driven, culturally-competent, and respectful of racial, cultural (including religion and language), gender identity, and sexual orientation. In fact, clients must be involved at every level of service, including in the program planning, delivery, and evaluation of services. In existence since 2005, FSP programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

Behavioral Health Services Quality Management is conducting an evaluation of the FSP system in San Francisco. The team from QM recruited stakeholders from FSP programs, MHSA program staff, FSP program directors and clinical line staff as well as behavioral health consumers or former consumers. Consumers receive a stipend for their participation.

First convening in early 2016, the FSP Evaluation stakeholders group established the goals of the evaluation and continues to advise on a monthly basis the priorities, methodology and implementation of the evaluation.

Learning Objectives

- Understand what FSPs are intended to do;
- Learn more about the populations FSPs are intended to serve;
- Understand what "success," "recovery," and "independence" mean to different stakeholders (e.g., FSP participants; providers; program directors);
- Learn more about what the current system challenges for stakeholders of FSPs are; and

- Learn more about the current unmet needs of FSP stakeholders.

Summary of Evaluation Activities

To date, **12 interviews** have been conducted in total.

- **Seven (7)** program directors;
- **Four (4)** program staff
  - Two (2) peer counselor
  - Two (2) clinical providers
  - *Two (2) additional staff interviews are scheduled for November 2016*
- **One (1)** FSP participant
  - *Two (2) additional participant interviews are currently being scheduled*

Summary of Key Findings

What are FSPs intended to do?

Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with serious mental illness (SMI) to lead independent, meaningful, and productive lives. In this report, *meaningful* and *productive* have been operationalized as fewer hospitalizations observed within a 12-month period, reduced recidivism (jails), reduced homelessness (also operationalized as increased housing stability), increased vocational capacities, and for children, reductions in out of home placements.

We discussed with FSP program directors and staff what they saw as the key differences between FSP programs and Intensive Case Management (ICM) programs.

How are Full Service Partnerships (FSPs) different from Intensive Case Management (ICM)?

In practice, there are few differences between ICM programs and FSP programs because one is a stand-alone subordinate component of the other. That is, FSPs engage in intensive case management with their clients. ICM programs, however, may or may not engage in the "*whatever it takes*" philosophy of the FSP model. This has created confusion amongst staff at both FSP and non-FSP programs. In addition, programs that engage in intensive case management, but that are <u>not</u> FSPs, do not have the same sort of *flexible spending mechanisms* as FSPs. In practice, FSP intensive case management looks identical to non-FSP programs' ICM.

Are FSPs serving the populations they are intended to serve?

Children and adolescents identified as having a serious mental illness (SMI) are eligible for FSPs if they meet the criteria outlined in the Welfare and Institutions Code section 5600.3, subdivision (a). Adults and older adults identified to have a SMI are eligible for FSPs if they meet the criteria set forth in

subdivision (b) of section 5600.3. In brief, the services are oriented towards individuals who live with serious mental illness who also have recent histories of intensive service utilization or homelessness.

Usually, the San Francisco Department of Public Health (SFDPH) FSP programs serve the clients who they are intended to serve. Typically these clients include those who have severe mental illness, which may or may not be complicated by substance abuse, and who are often the same clients who are high utilizers of the health care system. FSP clients served also include those who are chronically homeless, who are underserved or not engaged in the health system, and who require intensive case management, individual therapy, and linkage assistance.

Across the FSP directors, there were some common themes highlighting instances where FSPs were called upon to serve clients who did **not** meet or who **exceeded** the service eligibility criteria. Some of the common characteristics of clients who did not meet FSP eligibility criteria included those who displayed severe behavioral problems (aggression, violence), and those whose severe mental illness were secondary to chronic severe substance abuse, in particular alcohol and/or meth use. In some cases, FSPs were called upon to take on clients with dementia or traumatic brain injuries who could no longer stay in any residential programs.

What are the challenges or unmet needs of your program?

In brief, themes that emerged from the director stakeholder interviews regarding unmet needs strongly resonated around the 17:1 or higher client-to-provider caseloads. There was consensus that these caseloads are too high for the severity of the clients being served by the FSPs. Another prominent theme is the lack of affordable housing in San Francisco in general, but in particular for FSP clients who often have inconsistent or absent rental histories or recurring behavioral problems.

Other themes included a desire for more social space for clients to come and socialize on site at the clinic with other members of their communities, a desire for better relationships across FSP and outpatient program staff, transition-support teams for when clients are referred to outpatient services, vocational programs for FSP clients, help with reducing staff burnout, and reducing the length of time to rehire when a provider leaves his/her position

Behavioral Health Access Center

Program Overview

Designed and implemented in 2008 to promote more timely access to behavioral health services and to better coordinate the intake, placement authorization, and referral process for individuals seeking care, the Behavioral Health Access Center (BHAC) was one of the first projects funded by MHSA. The BHAC is a portal of entry into San Francisco's overall 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, and 5) the BHS Pharmacy that provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol detoxification medications for Treatment Access Program clients, naloxone for opiate overdose prevention, specialty behavioral health medication packaging and serves as a pharmacy safety net for all BHS clients.

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

- A Psychiatric Nurse Practitioner who provides expertise in treatment planning, identification of primary care concerns, stabilization of behavioral health issues, and is able to conduct health screenings, TB testing, and other lab work, thus reducing barriers to accessing care.

- Two Eligibility Workers who help increase client access to entitlements (e.g., Medi-Cal, Healthy SF) and to care through linkages with the Private Provider Network and BHGS clinics in the community.

- Two clinical pharmacists who provide expertise in client medication management services (e.g., drug specific monitoring) and lead client medication and smoking cessation groups. A full-time pharmacy technician who assists the BHS Pharmacists to provide Substance Use Disorder Treatment medications, clinical tracking and support to prescribers.

In FY 15-16 BHAC implemented enhanced overnight and out-of-hours interventions through the expansion of after-hours access line at Suicide Prevention of San Francisco, Inc. Suicide prevention provides night, weekend and holiday coverage, for BHAC in the event that a client is in crisis, and/or in need of services. Through the use of MHSA resources, BHAC trained Suicide Prevention staff in the handling of such calls engagement and triage, and follow-up for placement into services. Through the use of MHSA support, A truly 24/7, 365 day intervention has been created to ensure that San Franciscans in need are able to connect to care around the clock.

Target Population

The BHAC target population includes multiple underserved and vulnerable populations including the chronic and persistently seriously mentally ill, substance use disorder and dual diagnosis clients. A substantial number of clients are indigent, homeless, non-English speaking, and/or in minority populations. One of the pharmacists is bilingual and provides direct client treatment for medication management, medication review, and smoking reduction services to the Cantonese-speaking population at Chinatown North Beach Clinic and Sunset Mental Health Center. One of the Eligibility Workers is tri-lingual and able to serve clients speaking English, Spanish, and Tagalog.

FY 14-15 Highlights and Successes

- Provided 1,714 unduplicated care episodes with access to behavioral health and physical health care
- BHAC staff received 20,160 calls from residents of San Francisco seeking access to mental health services within the clinic system of care or in the Private Provider Network (PPN).
- BHAC conducted 712 face to face contacts with clients accessing care and in need of concurrent primary care services.
- RAMS peer staff/enrollers were brought onsite to assist in enrolling clients not already receiving benefits for Medi-Cal and Drug Medi-Cal. 78 applications were brought to completion.
- For buprenorphine, there were 2903 encounters at BHS Pharmacy, with an average of 107 active clients each month.
- For methadone, there were 242 encounters at BHS Pharmacy
- In FY 14-15, 253 clients were served in the clinic as part of the Substance Use Disorder Treatment programs

Prevention and Recovery in Early Psychosis (PREP)

Program Overview

Roughly half of all lifetime mental disorders have been shown to start by the mid-teens and three-fourths by the mid-20s. Severe disorders like schizophrenia are typically preceded by earlier behavioral, social and emotional signs and symptoms that seldom receive clinical attention. Research shows that intervening during the early stages of psychosis improves outcomes. However, treatment is often not accessed until a number of years later. Missing this critical window for early intervention can lead to greater suffering, trauma, and functional deterioration.

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

Since its launch in 2010, the PREP program has shown positive outcomes with participants demonstrating reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services.

Target Population

PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years. Due to the nature of psychosis – which strikes without regard to income or socioeconomic status – the distribution of cases is expected to approximate the demographic distribution of youth and young adults in San Francisco, but with a somewhat greater proportion of low-income youth and families. PREP partner organizations Larkin Street Youth Services and the Sojourner Truth Foster Care Agency work with special populations of at-risk youth (i.e. foster care and homeless youth).
PREP operates citywide and offers services at the PREP San Francisco office. However, when requested, therapists and staff meet with clients at offsite locations (e.g. client's home, school, etc.) throughout the city. PREP also conducts outreach throughout San Francisco and recently began conducting additional outreach to the Bayview Hunters Point neighborhood (zip code: 94124).

FY 14-15 Highlights and Successes

In FY 14-15, PREP provided outreach across San Francisco's diverse communities, with a focus on providing education about the program, and guidance on recognizing signs of early psychosis, creating awareness, promoting wellness, and reducing stigma. Outreach was conducted in a variety of settings, including neighborhood centers, community mental health organizations, schools, churches, after-school programs, organized sports activities, libraries, shopping centers, and juvenile justice centers. Special efforts were made to engage and reach out to traditionally underserved population groups. In total, PREP reached out to 130 programs and community stakeholders, and provided 32 presentations to various organizations.

Exhibit 16. FY 14-15 Key Outcomes

- Overall, 85 percent of clients had a job, were in school, or volunteering continuously or at some time in the course of their enrollment at PREP.
- Among consumers, there was a 26 percent reduction in total number of acute inpatient episodes and a 44 percent reduction in total number of acute inpatient setting days.
- 74 percent of consumers enrolled in the program for 6 months or more demonstrated improved well-being, as evidenced by a reduction in symptoms related to depression, measured by the Patient Health Questionnaire (PHQ-9) scale improvement definition.
- 68 percent of consumers enrolled in the program for 12 months or more showed improvement in at least one ANSA domain.

A total of 289 phone screens were completed in FY 14-15, with 49 individuals deemed eligible for assessment at PREP and 34 ultimately completing assessment and enrolling in the program. All of the resulting PREP interventions were designed to address the spectrum of impacts caused by psychosis. Clients were served based on their individual needs and willingness to participate, and services were provided at locations of the clients and families' choosing. In total, PREP staff provided 4,530 hours of direct and indirect treatment services.

Looking Forward

In the upcoming fiscal year, PREP San Francisco will take major steps forwards in supporting young adults with both their employment and their education goals. These steps are made possible in large part to the increased funding from the SAMHSA block grant. PREP's new Supported Employment and Education Services (SEES) Director has hired a full-time dedicated Employment and Education Specialist (EES) who will carry a caseload of up to twenty active clients and maintain resources and records for additional clients who are not in need of direct services. The SEES Director will continue to develop and improve upon PREP's use of the IPS (Individualized Placement and Support) model for supported employment and apply it to supported employment services as well.

IPS was developed at Dartmouth and is now overseen by an independent research team. IPS is utilized across the country and the world. Nineteen states and regions (Alameda County is one) in the US are part of the formalized learning community as well as three European countries. The eight principles of

IPS that PREP will strive to uphold are: competitive employment as the goal, supported employment integrated with mental health treatment, zero exclusion from supported employment services-eligibility is based on individual's choice, attention to client preferences, importance of benefits counseling, rapid job search, systematic job development, and time un-limited support.

The new EES and the SEES Director will be working towards offering every PREP client the opportunity for IPS services for their employment / education goals. These services will begin with goal development and the development of an employment/education profile. The EES will then proceed to build contacts and relationships in the community to support the person's goals- speaking with employers, education teams, resources, etc.

Trauma Recovery Program

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

The Trauma and Recovery project was selected during the original CSS planning process to address the need for community-based, client-driven prevention and early intervention for individuals, families and communities impacted by violence. The program aids youth and families through comprehensive services that aim to reduce psychiatric symptoms, increase functioning and increase coping skills and lessen the likelihood for further intervention in the future.

Horizons Unlimited: Emic Behavioral Health Services Program (EBHS)

Program Overview

The primary goal of Horizons EBHS program is to meet the unmet mental health needs of youth and families whose problems place them at significant risk, and impede adequate functioning within their family, school, community and mainstream society.

The EBHS treatment model combines culturally informed, evidence based substance abuse and mental health principles and practices that are linguistically sensitive, strength based, family focused and bio-psychosocially oriented.

The program is designed to carry out a process to improve Horizons Unlimited's capacity to provide a safe, inclusive environment, while addressing the needs of unstable community members suffering from undertreated co-occurring disorders and other behavioral health concerns.

Target Population

The EBHS program serves Latino and other youth of color—ages 12-25—and their family members who face multiple risk factors, show symptoms of mental health related challenges, and reside in the Mission District and throughout the city. 80 percent of Latino youth in the Mission District come from low income and immigrant families, over 50 percent of the youth are newcomers, and approximately 60 percent of the youth are undocumented. Horizons Unlimited has historically served both native and immigrant youth, and has been a major point of access for Latino youth and their families. The youth are faced with a number of risk factors, including: 1) community, the availability of drugs, weapons, low attachment to traditional institutions, extreme poverty, etc.; 2) family, multi-generational involvement in crime, substance abuse, school drop outs, poor parenting practices, family conflict, etc.; 3) school, failure and lack of attachment to school, truancy, suspension and expulsion, etc.; and 4) peers, association with peers who have similar risk behaviors and withdrawal from conventional school norms.

FY 14-15 Highlights and Successes

EBHS was outreached to 2,528 individuals in FY 14-15, through events like Carnaval SF, SF Pride, Bay to Breakers, Parent/Teacher Nights, Horizons Unlimited's open house, Grupo Guiles, Pink Saturday, Victory Outreach Church Carnival, and others. In addition, six community forums were held throughout the year, reaching approximately 100 individuals.

Throughout FY 14-15, 234 clients were screened and/or assessed for behavioral health concerns. Of those individuals, 72 percent were referred to behavioral health services. 223 clients participated in wellness promotion activities, such as drumming and educational presentations, and 36 clients were enrolled in one-on-one therapeutic services. Of those 36, 70 percent completed at least one of the behavioral health goals set at the onset of service.

FY 15-16 Highlights and Successes

EBHS attended over 10 community tabling events in FY 15-16, connecting with community members, youth, and families. Staff also spoke with SFUSD Wellness Coordinators at various high schools, reaching 1,439 unduplicated students in total.

90 clients were screened and/or assessed for behavioral health concerns, of which 62 percent were referred to behavioral health services. 105 individuals participated in wellness promotion activities throughout the year, with the addition of Zumba classes proving highly popular. Overall, 94 percent of

participants in wellness activities completed at least 10 sessions and reported an increase in their quality of life, as measured by the Quality of Life survey.

The EBHS mental health therapist provided therapeutic intervention to approximately 50 clients, with approximately 20 reaching their therapeutic goals. 58 clients in total received non-clinical case management services, and were referred to behavioral health and/or social services. 100 percent of the clients receiving non-clinical case management services completed at least one of their care goals.

Instituto Familiar de la Raza (IFR): La Cultura Cura

Program Overview

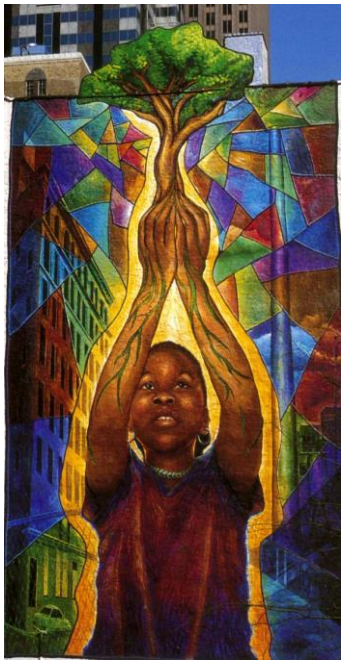
Instituto Familiar de la Raza provides trauma recovery and healing services through its Cultura Cura Program to individuals ages 12 to 25 and their families, with an emphasis upon Mission District youth and Latinos citywide. Services include prevention and intervention modalities to individuals, agencies and the community. The goal of IFR's Trauma Recovery and Healing Services is to 1) reduce the incidence and prevalence of trauma related conditions in children, youth and families, including the risk for retaliation among youth engaged in negative street activity that furthers community violence; 2) increase violence prevention providers' understanding of mental health issues in the context of violence; 3) mitigate risk factors associated with vicarious trauma among violence prevention providers; and 4) decrease stigma among youth and families in accessing public health services.

Target Population

IFR provides youth ages 12 to 25 and their families who reside in the Mission District, and Latinos citywide, with trauma recovery services. The target population consists of youth and their families affected by street and community violence. The program has a primary focus on zip codes 94110, 94112, 94102 and 94103.

In addition to individual and family centered interventions to address trauma related conditions, mental health consultation is provided to violence prevention staff of The Road Map to Peace initiative, and other San Francisco violence prevention providers that impact the target population including case managers and peer advocates who provide violence prevention services at Instituto Familiar de la Raza.

FY 14-15 Highlights and Successes



In FY 14-15 IFR's mental health specialist conducted a total of 55 risk assessments that qualified participants for access to Trauma Recovery and Healing Services treatment. The specialist also presented a workshop for the Latinas Unidas group on the impact of family separation and reunification on child development and attachment, prepared and implemented a presentation on Trauma Informed Care for 25 teachers at San Francisco's International High School, and conducted 10 quality assurance peer review meetings with Violence Prevention Care Managers.

In total, the program served 388 participants and providers. IFR received 276 referrals, of which 274 (99 percent) received follow-up contact. 35 youth in total received individual treatment, with 21 demonstrating improvement. In addition, staff held 37 capacity development consultation meetings to affect violence prevention providers' ability to better understand the impacts of trauma on youth, families, and providers.

FY 15-16 Highlights and Successes

In FY 15-16 IFR provided trauma screening to determine eligibility for services to 267 unduplicated clients, 100 percent of whom received resource information, access to treatment, or triage to other programs. In addition, the behavioral health specialist conducted 48 CANS treatment assessments to referred and enrolled youth.

Throughout the year, IFR's mental health specialist facilitated care conferencing, capacity building trainings, and self-care practices to various staff and providers. Topic examples include HIPAA, best practices on mandated reporting, healthy boundaries, restorative justice, and trauma informed practices. IFR also hosted 3 Drumming for Peace sessions for the public, to focus on promoting peace in the neighborhood and support individual, family, and community healing. Behavioral health specialists provided over 40 care manager development sessions for violence prevention case managers from La Cultura Cura and Roadmap to Peace initiatives, group facilitators, substance abuse treatment providers, and employment development specialists.

In FY 15-16, 27 youth were served through individual treatment services, with 70 percent of youth receiving 12 months of ongoing service. In addition, 7 youths and 13 parents/caregivers participated in trauma informed psychoeducational workshops, mostly facilitated in Spanish.

YMCA Urban Services: PASS Program

Program Overview

The overall goal of the PASS Program is to aid youth and families through effective and comprehensive services, which aim to reduce psychiatric symptoms, increase functioning, and increase coping skills such that the likelihood of further intervention in the future is lessened. Long-term goals with all youth include providing supports and opportunities such that they grow to be self-sufficient adults. Specifically, the program seeks to effectively reengage chronically truant youth in San Francisco back into some sort of educational experience. The four major tenets of the program include: mental health and needs assessments for youth and families, case management for linkage and specialized assistance, short-term safe transportation to address environmental safety issues that prohibit consistent school attendance, and peer outreach and empowerment for affecting positive community change.

Target Population

The PASS Program aims to reach consumers who have suffered traumatic events in this their lives or who are facing the emotional, physical or behavioral effects of trauma exposure in their environment. Clients under this program do not currently have Medi-Cal or other health coverage and are at grave risk for sustained impairment in functioning and even decompensating without treatment. The population of clients served under this program is nearly all school-aged public school students in San Francisco, mostly struggling communities rife with community violence. 80 percent of the school campuses are in the neighborhoods of Bayview Hunters Point, Potrero Hill, and the Western Addition. Client race and ethnicity in this program has historically been comprised of African American, Latino, Asian and Pacific Islander, and Caucasian individuals

FY 14-15 Highlights and Successes

In FY 14-15, 29 youth received brief assessments, crisis intervention, and linkage support in a first responding environment, within the school setting. In addition, 147 individuals received psychoeducation and advocacy consultation around topics such as de-stigmatizing mental health, interventions for students diagnosed with ADHD and PTSD, and responding to behavioral health issues. These individuals were mostly teachers, school staff, and parents.

The PASS program assessed and accepted 24 clients into recovery oriented treatment services in FY 14-15. Of the 24 clients served, 22 made improvements between assessments, and 17 clients received crisis intervention services.

FY 15-16 Highlights and Successes

In FY 15-16, the PASS program served 38 youth, of which 13 received case management services and 28 received mental health services. The majority of the 38 youth served reduced their school absenteeism by at least 50 percent, and 74 percent of clients were actively engaged in school. In addition, 40 youth and their families received family needs assessments. Overall, a majority of PASS clients experienced a decrease in their mental health symptoms and an increase in school attendance and achievement.

Integration of Behavioral Health into the Juvenile Justice System

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

With different roles to play, probation and behavioral health can be at odds about how to best address the needs of youth who have committed crimes and have had difficulty engaging in treatment. To develop plans that mitigate risk and support therapeutic progress, San Francisco Juvenile Probation and the CYF System of Care have partnered to establish a collaborative planning and shared decision-making approach with youth, families and caregivers. This approach is a critical foundation for making good decisions and doable plans with youth and families about the support and care to address needs, and bolster strengths for safe, productive and healthy lives.

AIIM (Assess, Identify Needs, Integrate Information, and Match to Services) Higher

Program Overview

In 2015-16, AIIM provided services to a total of 272 youth (71 percent male; 69 percent under age 17; and 68 percent SF residents). AIIM takes a collaborative path that eliminates subjectivity and puts standardized identification of youth needs and strengths with the Child Adolescent Needs and Strengths (CANS) assessment at the center of a structured decision-making, service planning and treatment engagement process. AIIM began in 2008 with a small grant from the Criminal Justice and Mental Health Collaboration program, US Department of Justice and these services were expanded and sustained in 2010 with MHSA and Medi-Cal funding. AIIM is a multidisciplinary and cross agency team (from Instituto Familiar de La Raza, Seneca Family of Agencies, and City and County of San Francisco) that includes a psychologist, social workers, and a psychiatrist that provide standardized assessment and planning that supports the engagement of youth and families in appropriate and effective services. Its continuum of core services include: behavioral health screening; consultation with probation, courts,

and other legal stakeholders and community providers; resource referral and information; standardized assessment; and linkage and engagement services for youth and families; and family-driven care planning.

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

Target Population

The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11-21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. AIIM Higher and its affiliated programs operate citywide and serve youth and their families wherever they feel most comfortable whether it is at home, school, or in the community. Services are also offered at the Juvenile Justice Center and in Juvenile Hall.

FY 15-16 Highlights and Successes

From 7/1/15 to 6/30/16, 51 youth received psychiatric medication support services through the MHSA program. A total number of 242 contacts were provided to these youth by the psychiatrists at the Juvenile Justice Center, with total number of 163.82 hours during this past fiscal year.

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

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

AIIM also monitors prevalence rates and serves as a barometer for treatment access and gaps in needed community services for probation-involved youth, families and caregivers. AIIMs has used this information to guide the expansion of our continuum of care with therapeutic court programs and targeted community-based interventions (Aggression Replacement Training (ART), Family Intervention,

Reentry and Supportive Transitions (FIRST), and SF Youth Back on TRACK (Treatment to Recovery through Accountability, Collaboration and Knowledge).

Court Programs. AIIM's three court programs include: the Juvenile Wellness Court for youth experiencing significant impairment such as, traumatic brain injury, psychosis and so on; and the Competency Attainment Program for youth who have been found incompetent due to developmental immaturity, disability, or behavioral health problems.

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

Initially funded with $1M in US DOJ grants, FIRST and TRACK are recently launched programs that provide portable services throughout the City and State (for youth in placement). Both programs are evidence-informed and have a built-in a training, supervision and coaching infrastructure for high quality implementation and sustainability. Like AIIM, these programs are multi-disciplinary, cross agency teams designed to leverage local expertise. Agencies involved include: Instituto Familiar de la Raza (IFR), OTTP, Seneca, UCSF Young Adult and Family Center, YMCA Urban Services, and Richmond Area Multi-Services, Inc. (RAMS). Blended teams also insure that we have the cultural and linguistic competence needed to meet the needs and support the strengths of our youth and families.

FIRST engages youth and families at the point of referral to placement and supports them with case management and Intensive Family Therapy (an adaption of Brief Strategic Family Therapy) while youth are away and as they reenter for a successful return to family and community. In 2015-16, 13 youth and families have received these services.

TRACK provides intensive outpatient treatment out in the community and at its milieu (606 Portola) across from the Juvenile Justice Center to youth and their families with co-occurring substance use and other behavioral health disorders. TRACK clinicians provide individual, group and family therapy within a collaborative treatment framework to insure that probation supervision and recovery practices work in sync to support youth progress. In 2015-16, 35 youth and their families were served in this program.

Integration of Behavioral Health and Primary Care: San Francisco Health Network (SFHN)

Program Overview

Integrated behavioral health and primary care continues to be a priority for healthcare and efforts have been strengthened by the redesign of primary care in response to the Affordable Care Act. The San Francisco Department of Public Health has worked toward fully integrated care in various forms for the last two decades. In 2009, after an extensive community planning process, SFDPH implemented the Primary Care Behavioral Health (PCBH) model in the majority of SFDPH primary care clinics. In this model, behavioral health clinicians work as members of the primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based therapeutic interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management services (e.g., class and group medical visits). In 2014, this program was expanded to include primary care clinics based at Zuckerberg San Francisco General Hospital (ZSFG), and as of the past year, Tom Waddell Urban Health has been included in the PCBH model. Services have also been expanded to include pediatric primary care services in the community and at ZSFG. MHSA has provided resources to support this initiative.

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

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

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

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

Target Population

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

FY 15-16 Highlights and Successes

As reported last year in FY 14-15, depression screening and interventions have been an area of focus for PCBH. Last year we examined seven of our 14 San Francisco Health Network (SFHN) primary care clinics and found that 17.6 percent of primary care patients at the seven studied health centers had a depression diagnosis, and of those, 53 percent had a note related to a telephone or face-to-face encounter with a Behavioral Health Clinician. The clinics reviewed last year were Castro-Mission, Chinatown Public Health, Maxine Hall, Ocean Park, Potrero Hill, Silver Avenue, and Southeast Health Center, representing 39 percent of our community-based primary care clinic population (20,356 of 52,000 patients.)

SFHN's goal in FY 15-16 has been to expand the scope of its depression work to include a greater percentage of SFHN clinic patients. The first intervention has been to expand its collaboration and data to include Curry Senior Center, Larkin Street Youth Services, Tom Waddell Urban Health, and the ZSFG primary care clinics: Family Health Center, Richard Fine Peoples' Clinic, and the Children's Health Center.

While SFHN stated the goal of standardizing depression screening across all of its primary care clinics last year, it has encountered a number of barriers, largely related to expanding to a number of new clinics and needing engagement from other disciplines who are already working at capacity to roll out a comprehensive universal depression screening.

With 2020 Medi-Cal Waiver (PRIME), which incentivizes identifying and treating depression, reducing recidivism, screening for substance use and offering brief interventions and referrals to treatment, and also increasing the number of patients who receive counseling related to tobacco smoking cessation, there is a new additional impetus and concomitant system-wide support to continue this work. While there is only limited data on these measures at this point, there has been considerable work done to lay the groundwork including defining standard work and establishing baselines for measurables. The PRIME project extends to 2020, and the staffing support that has gone into creating the infrastructure will contribute to the expected results.

What SFHN has established as its baseline data for FY 15-16 for clinical depression screening and follow-up is 38.7 percent. This is above the 25th percentile national benchmark of 10 percent, but falls short of the 90th percentile benchmark of 79 percent. PCBH will continue to work with the multidisciplinary team to increase rates of screening and follow-up over the next four years leading to the year 2020.

Moving Forward in FY 16-17

- Over the next twelve months (July 2016-June 2017) a plan will be developed to implement depression screening and treatment across 12-14 of our SFHN primary care clinics. Our approach will include developing a multidisciplinary team to develop workflows for the Patient Health Questionnaire-2 (PHQ-2), following up positive results with the PHQ-9.
- A "treat-to-target" protocol for depression is being developed for clinicians to have clear guidelines regarding both the tracking of progress as well as treating lack of progress.
- A measure of remission rates is also being developed to monitor improvements in patients with depression.
- The multidisciplinary team working on depression will apply to participate in the year-long Quality Leadership Academy to further develop skills to track and monitor progress and support quality improvements.
- Continued work of developing workflows for screening and addressing substance use and tobacco cessation is also continuing.

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

Recovery Orientation of MHSA Programs: SF Results from Statewide Evaluation

In March 2017, ten CSS programs from San Francisco voluntarily participated in a statewide evaluation of the Recovery Orientation of programs (ROE), commissioned by the MHSOAC and led by Dr. Todd Gilmer at the University of California - San Diego.

Four Full Service Partnerships (FSPs) and six non-FSP programs completed three measures to assess different perspectives and aspects of the recovery orientation of mental health services. The measures included (1) the Recovery Self-Assessment (RSA-R), a client-reported measure of perceived recovery orientation of services, (2) the Recovery Culture Progress Report (RCPR), a provider-reported measure of recovery oriented practices, and (3) the Housing First Fidelity Scale (HFFS), a provider-reported measure of fidelity to the Housing First model – a recovery oriented model commonly applied in FSP programs.

One hundred sixty-eight (168) clients from across eight programs filled out the RSA-R. As a whole, clients rated programs highly, with an average score of 4.17 out of 5 for all programs. Client agreed most strongly with items such as, *"staff welcome me and help me feel comfortable in this program," "staff listen to me and respect my decisions about my treatment and care,"* and *"staff believe I can recover."* On the lower end of the scale, clients agreed a little less with the statements, *"I am encouraged to attend agency advisory boards and/or management meetings if I want"* and *"I can easily change my clinician or case manage if I want to."*

Exhibit 17. RSA-R high and low scores for 168 clients (8 programs)

Highest Scoring Items	**Mean**
Staff welcome me and help me feel comfortable in this program.	4.46
Staff listen to me and respect my decisions about my treatment and care.	4.43
Staff believe I can recover.	4.41
Lowest Scoring Items	
I am encouraged to attend agency advisory boards and/or management meetings if I want.	3.56
I am encouraged to help staff with the development of new groups, programs, or services.	3.84
I can easily change my clinician or case manager if I want to.	3.86

All 10 programs participating in the ROE submitted the RCPR. They rated their programs lowest on items relating to consumer inclusion, specifically *client choice of service provider*, and highest on those relating to staff morale and recovery, such as receiving *emotional support from supervisors*. Non-FSP participating programs also ranked themselves highly on their welcoming and accessibility capabilities, particularly their role in *reducing barriers to services*. All programs indicated room for growth in their ability to offer an *after-hours system* for client care.

Our four adult FSP programs completed the HFFS. The survey confirmed what we already understand about challenges in our San Francisco housing market: there is not enough housing to meet the demand, so there is little leeway in housing choice and separation of housing and services, the two domains our FSPs ranked the lowest on the HFFS. Programs did, however, score themselves higher on those domains on which they have more control: service philosophy, team structure, and service array.

While the RSA-R was offered to all clients who received services at eight CSS programs in the month of March, all by one of the ten CSS programs completed the RCPR as a group activity and reported back that it was a team-building experience. Many programs used a meeting or several meetings to go through the RCPR items one-by-one and discuss them to reach a unified response. They shared that this was a meaningful way to reflect on program strengths and highlight what could still be done. Our Adult FSP programs also reported that the HFFS confirmed what they already felt to be true about difficulties in finding housing for our clients in San Francisco. Together with the data collected from other counties, our CSS programs contributed to the state's understanding of recovery orientation in our system, and

MH Promotion & Early Intervention Services

Service Category Overview

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

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

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

Stigma Reduction

Program Overview

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

Target Population

SOLVE peer speakers reach individuals including community members, public policy makers, health care providers, corporate and community leaders, students and school employees, law enforcement and emergency service providers, and behavioral health providers. The SOLVE team is comprised of consumers who are 18 years or older. The current SOLVE team is comprised of Transition Age Youth (26 percent), adults (56 percent) and older adults (18 percent) who reside in communities that are severely under-served and less likely to access or obtain support for prevention, wellness, and recovery. These areas include the Tenderloin, Mission, Bayview/Hunter's Point, Excelsior, Chinatown, and Visitacion Valley neighborhoods in San Francisco. SOLVE works with community centers, religious institutions, and schools in each of these areas to deliver culturally-specific neighborhood-based presentations and provide linguistically appropriate referral materials. SOLVE also leverages community and partnership resources in order to provide interpretation for presentations to monolingual Chinese, Russian, Spanish, and Tagalog-speaking audiences. In addition, SOLVE targets more of the diverse gender-variant community within San Francisco.

Demographically the SOLVE team demonstrates racial/ethnic and linguistic diversity. Figure 2 below indicates that, at 15 percent of the SOLVE team, African Americans are better represented than their 6 percent share of the overall San Francisco population. At 15 percent of the SOLVE team, Asians are less well represented than their 34 percent demographic overall. Latino/as comprise 15 percent of the overall demographic and the SOLVE team. Given that stigma is influenced by cultural factors, it is important to ensure that there are SOLVE team members from across the ethnic, racial and cultural landscape of the City. Figure 2 clearly demonstrates that virtually all ethnic groups are represented on the team. Similarly, while English is the preferred language of more than half of the SOLVE team, there is ample representation from other languages to ensure that the stigma reduction effort is tailored to a wide array of language and cultural groups. This rough demographic analysis doesn't take into consideration differences in the incidence or intensity of stigma in different language and cultural groups. Further literature review and/or local evaluation may be useful to fine tune the engagement and training of individuals of different subgroups in San Francisco.

FY 15-16 Highlights and Successes

Peer Educators from SOLVE co-facilitated all peer orientation trainings with Mental Health Association (MHA-SF) staff and the further development of training curricula. In addition, 15 aspiring SOLVE members entered into the 12-hour training program, and of those, 11 new Peer Educators completed the training and were accepted into the SOLVE program this past year. Two other Peer Educators returned to SOLVE to complete the training or to resume a Peer Educator role. As a part of their continuous learning commitment, all Peer Educators are required to attend at least three Advanced Trainings or equivalent individual trainings with the Program Manager or Community Advocate. These Advanced Trainings focus on subjects such as: Recovery is not Linear; Language Matters; Peer-to-Peer, SF General and Beyond; Recovery; and Becoming a More Dynamic Speaker.

SOLVE conducted 55 community presentations, each featuring anti-stigma messaging with an emphasis on prevention and early intervention, recovery, services within the community and challenging misconceptions of mental illness. SOLVE provided featured presentations to the San Francisco Police Department's specialized Crisis Intervention Team (CIT) Training on a quarterly basis. In addition to serving a variety of service providers and policy groups, SOLVE also conducted peer-to-peer presentations that were focused on reduction of self-stigma among consumers.

Target Population and Program

Evaluation

The SOLVE leadership conducts a 15 minute debrief session after each presentation. These strengths-based, supportive sessions allow for participants to decompress immediately after the presentation, provide constructive feedback to SOLVE leaders and to request immediate support. Of the 1,003 participants in SOLVE presentations, only 572 (57 percent) completed evaluations. These participants were highly diverse and reflective of the overall population of the City. Only TAY seem to be over-represented in the service population, but, given the issues of stigma in the TAY community, this may merely reflect the pressing need for stigma reduction resources among TAY consumers and service providers.

Exhibit 18. FY 15-16 Key Outcomes

- In FY 15-16 Solve Peer Educators conducted 55 community presentations to over 1,000 individuals. Each community presentation featured anti-stigma messaging with an emphasis on personal empowerment, recovery, services within the community and on replacing misconceptions about mental health challenges with accurate information.
- 97 percent of service providers and professionals who attended anti-stigma presentations delivered by Peer Educators demonstrated a better understanding of the effects of stigma on people with mental health challenges and conditions.

Exhibit 19. Age of Stigma Reduction Program Participants (n=556)

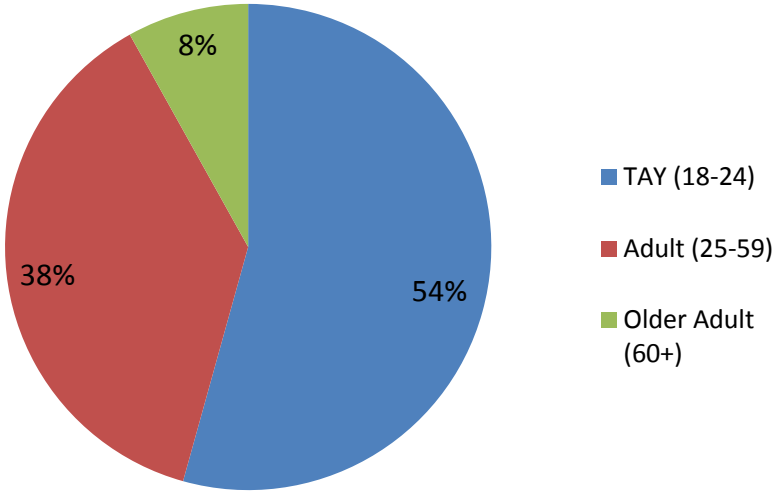
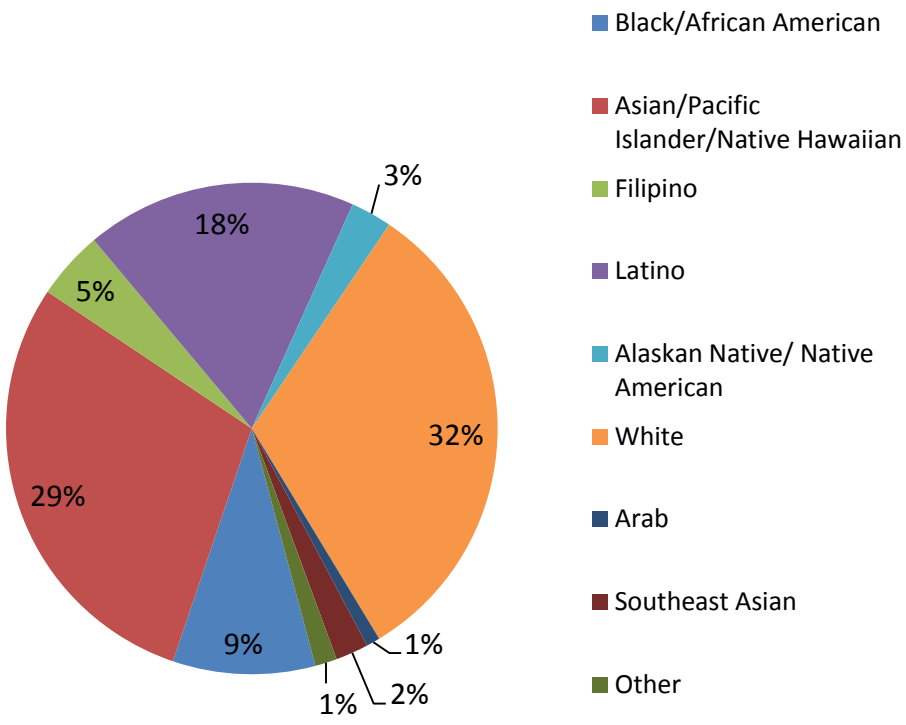


Exhibit 20. Race/Ethnicity of Stigma Reduction Program Participants (n=555)



SOLVE Team and community participants provided feedback to evaluate the presentations and, in the process, provided feedback on the evaluation process itself. Some key findings were:

1. More emphasis was requested on recovery-oriented language and how it can positively shape the way the Peer Educators tell their stories and think about themselves.
2. Development and enhancement of Advanced Trainings was called for – breaking some sessions into smaller increments to aid in memory and to provide reinforcement of learning over time.
3. Creating more flexible time for Peer Educators to receive individual support and guidance as their schedules allowed.
4. Organize and promote the MHSA Awards Ceremony to honor 225 consumers in their process of recovery and wellness; 500 individuals were present at the ceremony.
5. The evaluation process used during 2014-15 was not judged to be sufficiently user friendly; the survey format was not as conducive to participation, especially because the focus of the presentations has been actively shifting to mitigating self-stigma which is highly personal; participants felt more comfortable providing their thoughts in a verbal format vs. in writing; as a result SOLVE will be rolling out a newly designed "Peer-to-Peer Presentation Evaluation".
6. While SOLVE continues to carry the peer wellness message to its "traditional" agencies that provide mental health services across a wide demographic spectrum in San Francisco, based on consumer feedback, SOLVE has shifted the emphasis to issues of self-stigma whereby the consumer Peer Educators and other SOLVE program participants are learning to speak and think about themselves through a recovery and wellness framework.

FY 14-15 Highlights and Successes

SOLVE has exceeded its program objectives as follows:

- 96 percent of surveyed service providers/professionals who attended SOLVE presentations agreed that they have a better understanding of mental health challenges and local behavioral health resources, and that they have a clearer idea of how stigma affects everyone, and how it may affect their relationships with family, friends and community.
- 93 percent of surveyed community members who participated in Peer Educator presentations indicated that they demonstrated a better understanding of mental health challenges and conditions, and expressed less fear/more acceptance of people with mental health challenges, have a clearer idea of how stigma affects everybody, and are less inclined to engage in behaviors that discriminate or otherwise contribute to stigmatization and isolation of consumers and family members. The achievement of these goals resulted in higher levels of prevention and early intervention of serious mental illness.
- 100 percent of the surveyed Peer Educators reported that they experienced reduced self-stigma, reduced risk factors, improved mental health, improved resilience and protective factors, and increased access to care and empowerment.

School-Based Mental Health Promotion

Program Overview

School-Based Mental Health Promotion – 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 with services 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 prevention and early intervention 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.

The Mental Health Service Act (MHSA) Prevention and Early Intervention (PEI) component funds the school-based mental health promotion programs. PEI funds programs and services that help recognize and treat mental health issues in their early stages, raise awareness of available treatment services, develop short-term strategies to prevent issues from worsening, and develop resiliency with individuals and in underserved communities. These programs include meaningful involvement and engagement of the diverse communities they serve, following the MHSA guiding principles of cultural competency, community collaboration, client, consumer, and family involvement, integrated service delivery, and wellness and recovery. Since 2006, school-based mental health promotion programs have experienced systemic changes to become an integrated part of the schools in which they operate and currently serve nearly 10,000 individuals within SFUSD.

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. These programs are offered at the following SFUSD schools:

- Abraham Lincoln High School
- Academy of Arts & Sciences
- Balboa High School
- Dr. Charles R. Drew College Preparatory Academy
- Downtown High School
- Galileo High School
- George Washington High School
- Hillcrest Elementary School
- Ida B. Wells Continuation High School

- James Lick Middle School
- John O'Connell High School
- June Jordan High School
- Lowell High School
- Mission High School
- Philip & Sala Burton High School
- Raoul Wallenberg High School
- Ruth Asawa San Francisco School of the Arts High School
- San Francisco International High School
- School of the Arts
- Thurgood Marshall high School

An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and to 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.

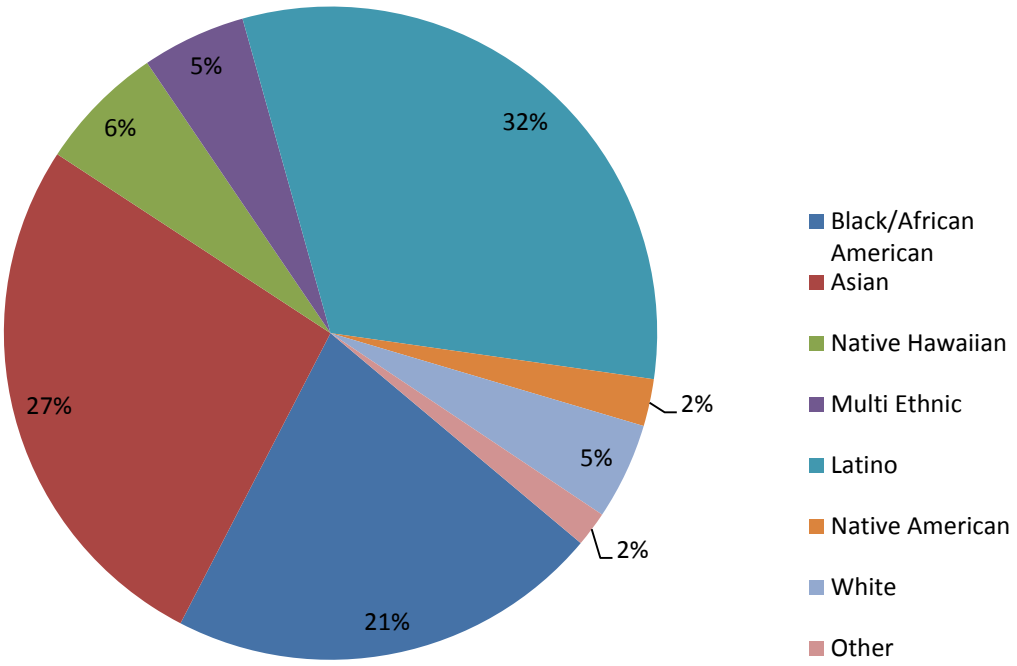
These programs also provide regular mental health consultation to teachers, support staff, and administrators, with particular focus on teachers and staff who are challenged by students' emerging mental health and behavioral needs. This includes professional development and training on topics such as child development, behavioral de-escalation, trauma triggers, staff dynamics and creating inclusive environments for children with disabilities. Program staff also facilitate regular mental health collaborative meetings with school personnel and community mental health providers to create and maintain a seamless system of care.

Target Population

School-based mental health promotion programs are designed to serve all students who request support services, with a special focus on low-performing students who are experiencing difficulties in school due to trauma, immigration and acculturation issues, poverty, and family dysfunction. This population includes children/youth who are frequently tardy, absent or truant from school and who are at-risk of school failure. The programs also provide services to students' families/caregivers and school personnel.

In FY 14-15, these programs served 3,066 individuals. Of those for whom demographic data was collected (N=1,671), the majority of individuals served were females (51 percent), children, youth and families (94 percent), and Latino (32 percent).

Exhibit 21. Ethnicities Served in FY 14-15 School-Based Programs (N=1,671)



FY 14-15 Highlights and Successes

In Fiscal Year 2014-15, school-based mental health promotion programs successfully raised community awareness of mental health issues and existing support services. Additionally, these programs succeeded in identifying the specific needs of the target populations, providing the appropriate services in meeting these needs, and facilitating referrals and linkages to additional support services.

Moreover, the programs decreased mental health crisis episodes, increased students' ability to skillfully deal with difficulties in their lives, cope with stress, and make healthy decisions, improved students' self-esteem and social connectedness, and developed their problem-solving and healthy communication skills. The programs also improved teachers' self-efficacy, increased capacity among school personnel and parents/caregivers in providing appropriate responses to children's behavior by offering professional development and education opportunities, and improved school connectedness.

The following data points help to illustrate the successes these programs accomplished with regard to improving students' outcomes.

- *Increasing students' ability to skillfully deal with difficulties in their lives:* Of the students who received academic and intensive Case Management services at Burton High School, 85

percent demonstrated an increased ability to skillfully deal with difficulties in their lives, as demonstrated by personal testimony from youth, staff members, and survey responses.

- *Increasing students' ability to cope with stress:* Of the students who received MHSA services at the high school Wellness Centers, 77 percent reported improvements in their ability to cope with stress.
- *Improved students' social connectedness:* Of the students who participated in the high schools' Youth and Government leadership program, 100 percent reported having built a healthy social community by the end of the program, as demonstrated by survey responses.
- *Developing students' problem-solving capacities:* Of the students who participated in Behavior Coaching at the Dr. Charles Drew Preparatory Academy (N=29), 69 percent showed an increase in their Teacher-Preferred, Peer-Preferred, and Classroom Adjustment Behaviors, with an average (mean) score increase of 20.3 percent, as measured by pre- and post-service Walker-McConnell Scale surveys.

Also in 2014, the San Francisco Department of Public Health (SFDPH) engaged an independent consulting firm to conduct a program evaluation of the MHSA-funded school-based mental health promotion programs. The purpose of the evaluation was to assess the degree to which school-based mental health services contribute to positive student outcomes and document lessons learned regarding the key factors that enable MHSA providers and schools to implement school-based mental health programs and services effectively.

For the purposes of the evaluation, the consulting firm conducted student interviews, wherein the students indicated that their work with MHSA-funded service providers has motivated them to stay in school, helped them see the connection between success in school and accomplishing future goals, and improved their feelings toward school overall. Furthermore, by addressing the mental and emotional needs of students, MHSA services helped students improve their academic performance by helping them to engage and focus in the classroom. In fact, 75 percent of high school students who received MHSA services (N=73) reported doing better in school after participating in MHSA services.

The following lessons learned in implementing effective school-based mental health programs and services were documented as part of the evaluation.

- Building effective relationships with school sites
    - aligning the priorities and needs of the programs with those of the schools
    - maintaining consistent staffing
    - establishing role clarity for MHSA service providers and school staff
    - providing school staff with adequate access to service providers
- Creating a safe space for students
    - ensuring confidentiality
    - providing consistent and flexible services
    - communicating directly with students
- Providing opportunities for teacher reflection and skill-building

Moving Forward in FY 16-17

The San Francisco Department of Public Health, Behavioral Health Services (SFDPH BHS) will release a Request for Qualifications (RFQ) for providers of school-based mental health promotion programs in the summer of 2016 and will begin contracting with the selected service providers in July 2017. This RFQ will outline the school-based mental health promotion programs and seek to identify qualified service providers to support, sustain and advance the school-based mental health promotion programs element of the Mental Health Service Act's Prevention and Early Intervention programming for School-Based Wellness Promotion Services at high schools and Early Intervention Program Consultation at elementary and middle schools. A vital component to these programs will be a strong partnership between the service provider and BHS, and collaboration among other BHS school-based, vocational, educational and community programs, in order to learn about other programs and provide an array of opportunities to the children/youth and their families.

The selected service providers will be required to work in close partnership with the SFDPH Office of Quality Management to develop a comprehensive evaluation plan and tools to measure outcomes and evaluate service delivery. The selected service providers will be responsible for compiling evaluation reports in summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on consumer feedback. Service providers will also be required to comply with the statewide MHSA Prevention and Early Intervention Program (PEI) regulations that were adopted on October 6, 2015. These PEI regulations require that MHSA-funded programs collect program data, measure the efficacy of program services and report the impact of services on its intended communities. BHS will work closely with service providers to educate and provide technical assistance in adhering to the PEI regulations.

In the summer of 2016, the oversight and monitoring of the MHSA school-based programs will slowly transition from the SF MHSA Department to the Child, Youth and Family (CYF) System of Care under the CYF Director of School-Based Services. The services will continue to operate under Behavioral Health Services under the San Francisco Department of Public Health. A decision was made to organize all school-based programs under one umbrella in order to promote cross-program collaboration, share best practices and leverage resources. SF MHSA will continue to support these projects and ensure that MHSA principles are integrated into all aspects of programming.

Population-Focused Mental Health Prevention and Early Intervention

Program Overview

As a component of the Prevention and Early Intervention planning processes in San Francisco, a number of specific underserved populations were identified, including but not limited to socially isolated older adults, transition age youth, LGBTQ individuals, the homeless, and several racial/ethnic groups. 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 SF 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 first and to provide non-clinical services that incorporate these practices. The population focused programs also concentrate on raising awareness about mental health, reducing stigma, intervening early and increasing access to services. As a result, all of the programs emphasize outreach and engagement to a very specific population group. Collectively these programs reached out to more than 37,000 individuals during the 2014-15 fiscal year.

The specific service populations are:

- Socially Isolated Older Adults
- Asians and Pacific Islanders
- African Americans
- Mayan/Indigenous Latino
- Native American
- Homeless Adults
- Homeless or System Involved TAY

Funded population focused programs provide some or all of 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

The following programs are serving specific target populations that might otherwise go unserved or inappropriately served. Exhibit 22 below provides a summary. More intensive services will be summarized via brief individual program reports below.

Exhibit 22. Summary of Programs and Services by Population

Category	Agency/ Program	Target Population and Services Provided	Outreach Number
Socially Isolated Older Adults	Felton/Family Service Agency: Senior Peer Recovery Center	The target population is seniors with behavioral health needs. Program reaches hard-to-engage participants with informal outreach and relationship building; assists participants with housing, addiction treatment groups, socialization and cultural activities, and making linkages to more formal behavioral health services when feasible.	120
	Institute on Aging: Older Adult Behavioral Health Screening Program	The target population is language-diverse clients age 55+ in IOA's citywide care management programs. Program provides home-based, routine, multi-lingual and broad spectrum behavioral health screening. Screening participants also receive culturally competent clinical feedback, prevention-focused psycho-education, and linkage support to appropriate behavioral health intervention services.	537
African American	African American Healing Alliance	The target population is African American residents of San Francisco who have been exposed to violence and trauma. Program leaders have been convening a monthly AAHA membership meeting and collaboratively planning with other relevant groups such as the school district, the Department of Housing and Urban Affairs and the SF Department of Public Health.	In planning phase in 2014-15
	Westside Community Services: Ajani Program	The target population is low-income African American families who suffer from mental illness and racism. 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.	N/A
	YMCA Bayview	The target population is African American individuals and families in Bayview, Ocean View and Western Addition communities. Program promotes healthy social connections and opportunities to contribute to others.	88

Exhibit 22. Summary of Programs and Services by Population			
Category	**Agency/ Program**	**Target Population and Services Provided**	**Outreach Number**
API	Community Youth Center: API Youth Family Community Support Services	The target population is API and LGTBQQ youth ages 11-18 and their families. Program provides screening and assessment, case management and referral to other mental health services.	119
	Richmond Area Multi-Services: API Mental Health Collaborative	The target population is Filipinos, Samoans and South East Asians of all ages. The API Collaborative has convened three work groups of 6-8 culturally and linguistically congruent agencies to focus on each component of the target population across the lifespan and in appropriate community settings. The Collaborative has engaged in substantial outreach and community education.	10,567
Mayan/ Indigena	Instituto Familiar de la Raza: Indigena Health and Wellness Collaborative	The target population is Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, to support spiritual and cultural activities and community building, and social networks of support. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.	492
Native American	Native American Health Center: Living in Balance	The target population is 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.	1,283
Homeless Adults	Central City Hospitality House: 6th Street Self-Help Center	The target population is adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. Program provides a low-threshold engagement that includes peer programs, case management, primary care access, support groups and socialization. Many	4442

Exhibit 22. Summary of Programs and Services by Population			
Category	**Agency/ Program**	**Target Population and Services Provided**	**Outreach Number**
		are referred to mental health services prior to assessment due to the acuity of their needs.	
	Central City Hospitality House: Community Building Program	The target population is traumatized, homeless and multiply diagnosed adult residents of the Tenderloin neighborhood. The program conducts outreach, screening, assessment and referral to mental health services. It also conducts wellness promotion and a successful 18-week peer internship training program.	203
	Central City Hospitality House: Tenderloin Self-Help Center	Target population is adults with behavioral health challenges and homelessness who live in the Tenderloin neighborhood. Program provides a low-threshold engagement that includes peer programs, case management, primary care access, support groups and socialization. Many are referred to mental health services prior to assessment due to the acuity of their needs.	9,139
Homeless or System Involved TAY	Huckleberry Youth Programs: TAY Multi-Service Center	The target population is low-income African American, Latino or Asian Pacific Islander TAY (16-24) exposed to trauma and involved or at-risk of entering the justice system – with physical and behavioral health needs. Many participants may be already involved with the Community Assessment and Resource Center which focuses on the 16-17 year olds. The program will include street outreach, mental health assessment and support, case management and positive youth development services.	3,587 duplicated
	Larkin Street Youth Services: ROUTZ Program	The target population is TAY youth with serious mental illness from all of San Francisco. This high intensity, longer term program includes housing and supportive services, including wraparound case management, mental health intervention and counseling, peer-based counseling, and life skills development.	37

Target Population

Population-focused programs explicitly serve multiple underserved groups, specifically African American, Asian and Pacific Islander, Native American, Latino/Mayan, older adults, homeless adults, and

Homeless/System Involved Transitional Age Youth Target neighborhoods include the South of Market, Tenderloin, Bayview Hunters Point, Oceanview, Mission, Potrero Hill, Visitacion Valley, and Western Addition. Since some population groups, such as Asian and Pacific Islanders, African Americans, Mayan and Latinos, and Native Americans, are clustered in specific neighborhoods, there is a deliberate focus on building culturally specific access and services in neighborhoods that are home to different groups of underserved cultural and ethnic communities. In contrast, citywide efforts are focused on LGBTQ, homeless adults, TAY, and older adult communities that are less geographically concentrated.

During 2014-15, the population focused programs served 27,066 at all levels of intensity. Of these participants, 5 percent were children, 16 percent were transition age youth, 26 percent were older adults and 53 percent were adults.

Exhibit 23. Age of Population-Focused Mental Health Program Participants (n=27,066)

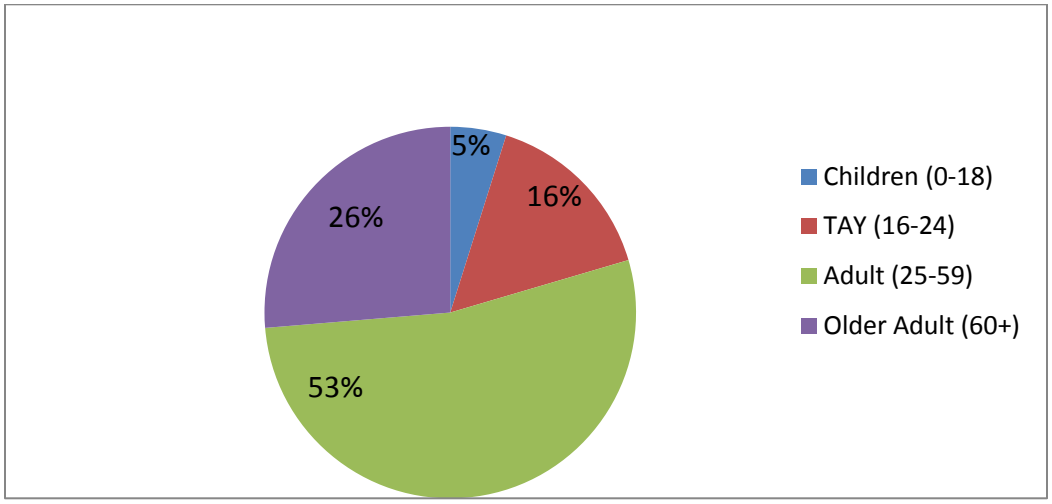


Exhibit 24. Race/Ethnicity of Population-Focused Mental Health Program Participants (n=26,531)

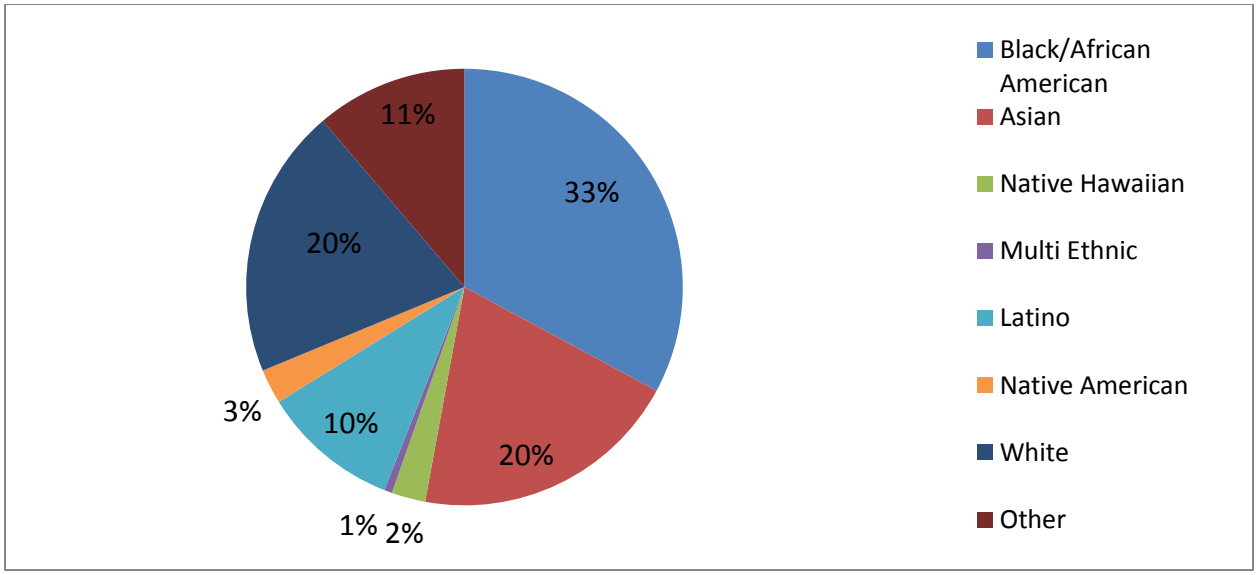
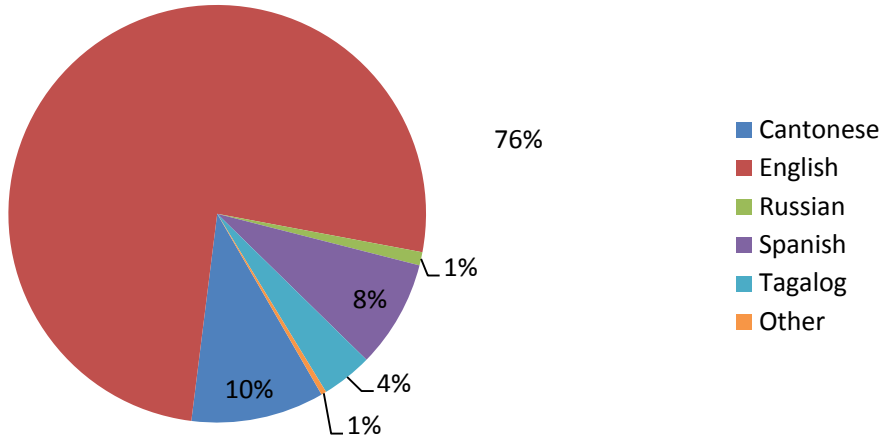


Exhibit 25. Preferred Language of Population-Focused Mental Health Program Participants (n=24,478)



FY 14-15 Highlights and Successes

The fiscal year 2014-15 Population Focused programming has continued to use innovative strategies to reach out to and engage individuals who are coping with homelessness, physical and behavioral health conditions, poverty, exposure to violence, and trauma. Examples include, tying outreach efforts to existing social programming such as bingo nights for seniors, cultural events, peer support groups, a variety of friendship/warm/hot lines with multiple language capacity, and a wide array of wellness activities. As a result of this diligent work, the Population Focused agencies and their partners have reached 27,066 individuals.

Understandably, a much smaller number of individuals engage in wellness and recovery focused services with the various agencies. These programs' level of intensity varies widely from community engagement and education programs to therapeutic housing and wraparound services for severely mentally ill participants.

Some of the programs use a deliberate collaborative approach to reach out to different language and cultural groups. For example the RAMS API Mental Health Collaborative utilized three teams to reach out and serve individuals from the Filipino, Samoan and Southeast Asian communities. This approach is ideal to meet the goal of the Collaborative, "to promote mental wellness, increase awareness of mental health and reduce stigma of mental illness…" On the other end of the spectrum, the TAY Multi-Service project is focused on serving very high need, high risk youth who are already engaged in the public welfare and/or correctional systems. This Center is a collaboration between Huckleberry Youth Center, Larkin Street Youth Services, 3rd Street Youth Center and Clinic, and San Francisco Department of Public Health's Community Health Programs for Youth.

Population Focused programs are making best efforts to become data driven in their daily practice – to provide formative feedback to program staff and to better report progress to funders, including SFDPH. However, there are significant challenges that have been cited by several programs. These challenges include the following.

- Many participants do not feel that satisfaction and other program surveys are useful ways to gather meaningful information from participants; they refuse to complete these evaluation forms and feel that it is more relevant to have a dialogue about their program critiques; it would be useful to engage the MHSA evaluators to address this issue.
- Given that many services are now delivered in the field, access to appropriate technology is limited for staff to record their notes and complete their tracking forms in a timely and accurate manner.
- Several case management programs are reporting the percentage of participants who have complete at least one goal on their individual wellness/recovery plans; while this is a useful metric, there isn't any consistency between programs or acknowledgement that all goals are not equally important. This might also be an issue for the MHSA evaluators to address.

Program data indicates individuals who have been outreach to and engaged in mental health assessment show a high level of successful referrals to other intervention and treatment programs. This is very promising since a key goal of the Population Focused initiative is to build trust among individuals who may be highly resistant to accessing mainstream mental health services. The fact that programs are achieving such a high rate of successful referrals bodes well for meeting program goals. An example is the Central City Hospitality House, 6th Street Self-Help Center. Of 147 unduplicated referrals to behavioral health services, 121 (82 percent) individuals attended harm reduction support groups.

A number of programs also reported difficulty completing an intake and mental health assessment prior to referring the individual to a treatment program and/or housing resource. Because the very nature of the Population Focused programs is to lower the barriers to participation – e.g., paperwork, language barriers, appointments, etc. – individuals simply access the programs regardless of their acuity or the urgency of their need. For example, an individual may be imminently losing his/her housing or may require immediate hospitalization. In these and other cases, a referral is often made very quickly and the niceties of paperwork are not being completed.

Moving Forward in FY 16-17

The Black/African American Wellness & Peer Leadership initiative (BAAWPL) is a joint effort of SF MHSA, Population Health Division (PHD) and HOPE SF that will implement the first year of collective programming in FY 17/18. BAAWPL focuses on Black/African American communities who reside in the four HOPE SF sites and citywide. This new initiative works to achieve health equity and outcomes through a spectrum of prevention activities that address community, individual, and policy and systems changes. The BAAWPL creates environments that make the healthy choice the easy, accessible choice. It

also works to improve holistic health with a focus on heart health and behavioral health outcomes by increasing opportunities for physical activity, healthy eating, stress reduction and social connectedness. The SF MHSA funded projects for the BAAHI collaborative include the following programs; the African American Holistic Wellness Program, the African-American Healing Alliance and the SF Live D10 Wellness project.

Mental Health Consultation and Capacity Building

Program Overview

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the evidence-based work[2] of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and are delivered in the following settings: center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. The Initiative is made possible through a partnership between four county agencies: San Francisco's Department of Public Health/Behavioral Health Services; 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.

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 primary service providers for the ECMHCI program are the Infant Parent Program/Day Care Consultants, Edgewood Center for Children and Families, Richmond Area Multi-Services, Homeless Children's Network, and Instituto Familiar de la Raza. These agencies bring specific competencies to support children, families and caregivers.

Target Population

In aggregate, the five programs served 1,255 children during the 2014-15 fiscal year. The largest ethnic groups included Asians (33.1 percent), African American (22.0 percent), Latino/a (19.1 percent), White (10.2 percent), multiethnic (7.3 percent), Hawaiian/Pacific Islanders. If we compare staff and service

[2] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91

providers by ethnicity, we find that Asians comprise 35.2 percent of provider population, followed by Latino/as (19.9 percent), African Americans (19.5 percent), White (16.5 percent), 3.8 percent for multiethnic and Native American providers, and less than 1 percent for Hawaiian/Pacific Islanders. From a strictly ethnic perspective it seems that the service providers are well matched to the service population.

Exhibit 26. Ethnicity of Children Served FY 14-15 ECMHCI (n=1,255)

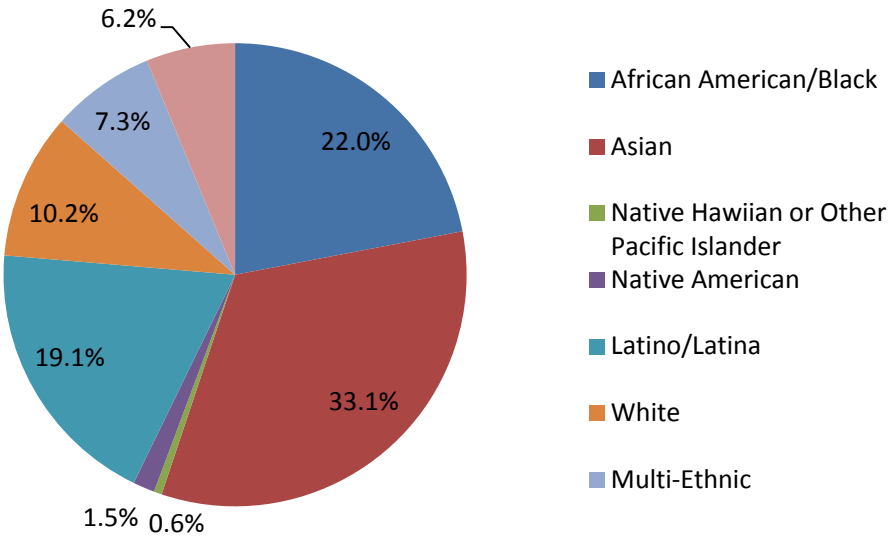


Exhibit 27. Ethnicity for Providers and Staff FY 14-15 ECMHCI (n=236)

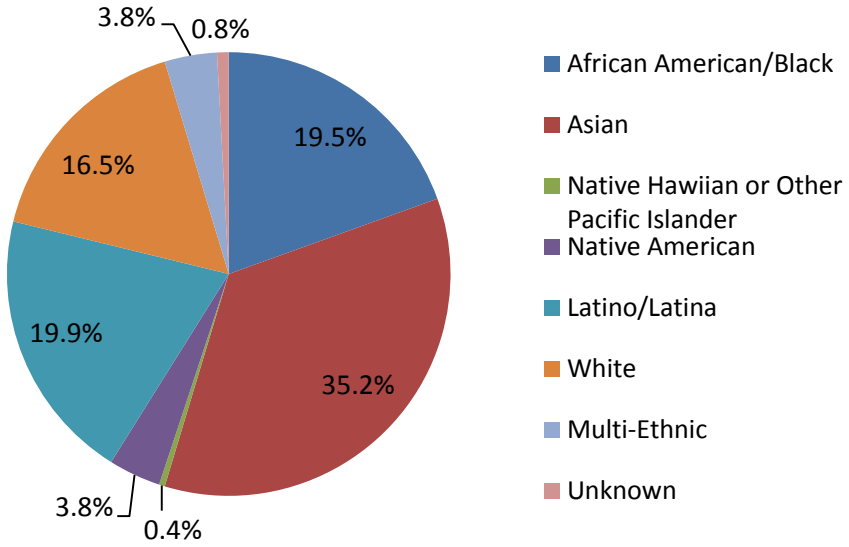
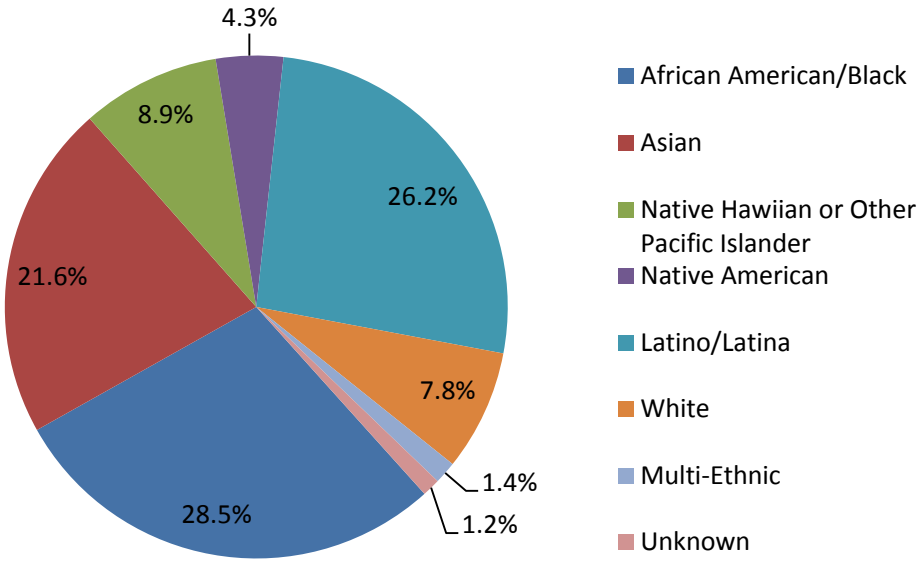


Exhibit 28. Ethnicity for Parents and Caregivers FY 14-15 ECMHCI (n=347)



When considered from the linguistic perspective, the majority (51.9 percent) of the children spoke English as their primary language, followed by Cantonese (24.0 percent), Spanish (17.0 percent), and small numbers who speak Mandarin, Vietnamese, Korean and other non-English languages. Parents and caregivers were most likely to speak English (62.8 percent) followed by Spanish (18.2 percent), Cantonese (16.4 percent) and Mandarin, Vietnamese, Korean and other non-English languages in very small numbers. Staff and providers there were reasonably well aligned in linguistic capacity with English speakers at 60.2 percent, followed by Spanish (16.1 percent), Cantonese (19.9 percent), Vietnamese, Mandarin and other non-English primary languages in very small numbers.

Exhibit 29. Language of Children Served FY 14-15 ECMHCI (n=1,255)

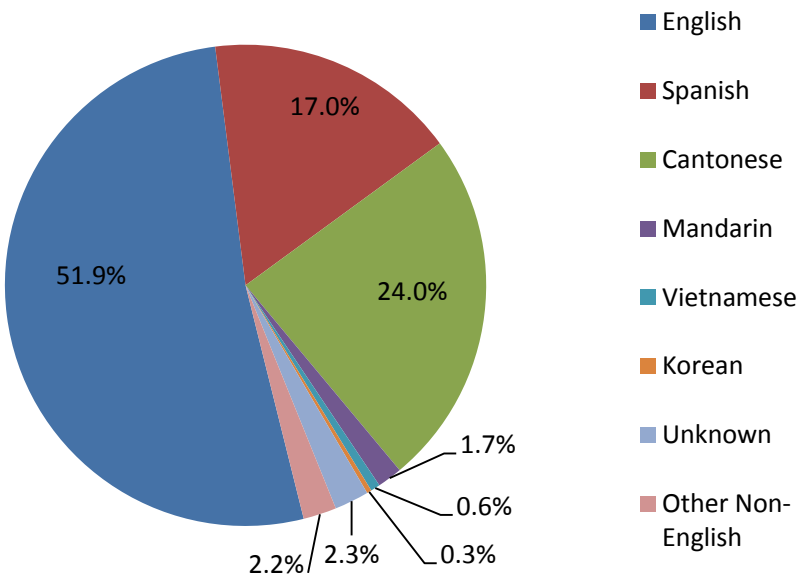


Exhibit 30. Language of Providers and Staff FY 14-15 ECMHCI (n=236)

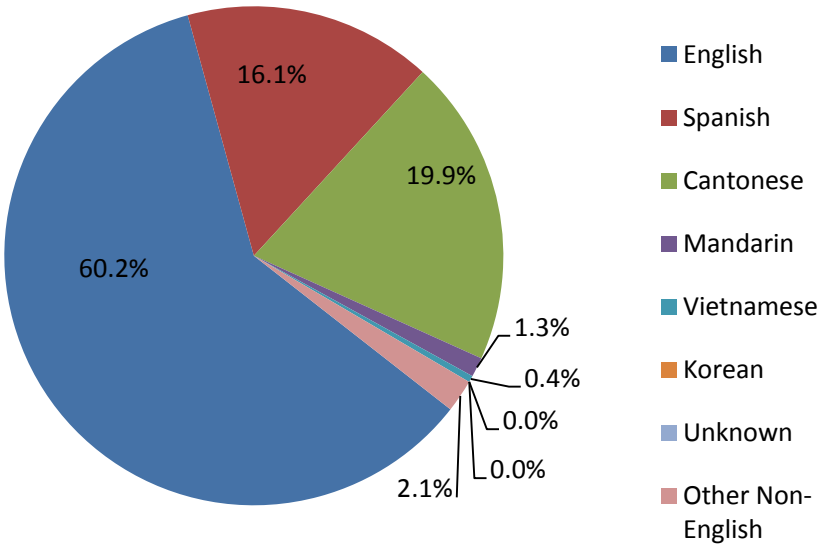
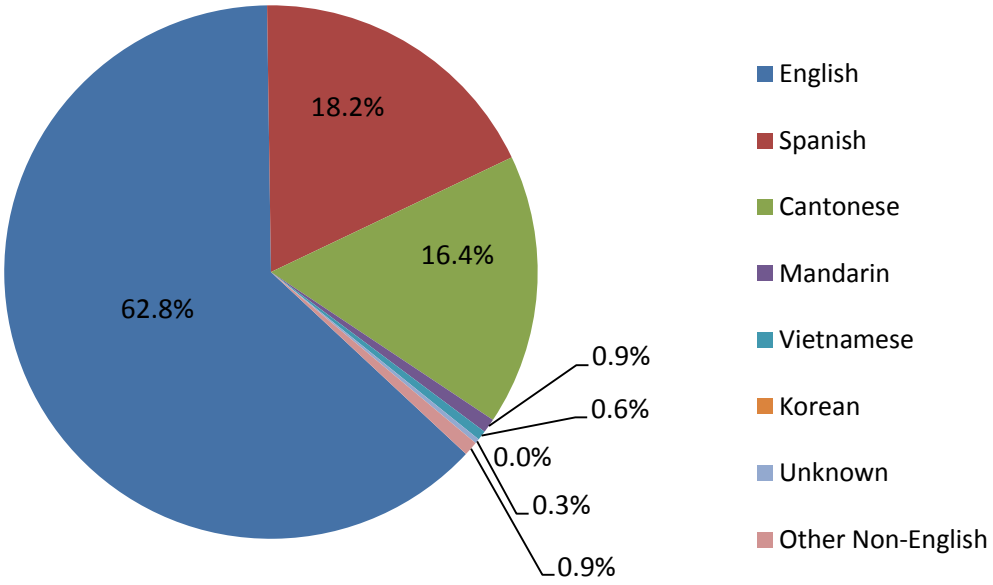


Exhibit 31. Language of Parents and Caregivers FY 14-15 ECMHCI (n=347)



FY 14-15 Highlights and Successes

Mental health consultation and capacity building service providers were asked to have both program staff and parents complete a survey that identified their satisfaction with ECMHCI services and whether those services helped to build staff skills in working with children and families and whether the services helped families to support their child(ren) to be more successful in childcare. The results of these surveys are listed below.

- 100 percent of care providers surveyed at MHSA funded sites reported that the mental health consultation increased their understanding and response to children's emotional and developmental needs.
- 98 percent of care providers surveyed at MHSA funded sites reported that mental health consultation helped them improve their relationship with parents when communicating about their children's strengths and needs.
- 75 percent of programs at MHSA funded sites reported that their mental health consultant is actively working with them to increase program flexibility to better accommodate each child's individual needs.
- 100 percent of programs of MHSA funded sites think that mental health consultation was helpful in retaining children in their program who are at risk of expulsion.
- 73 percent of parents surveyed at MHSA funded sites reported that the mental health consultation increased their awareness of the connection between the child's environment and behavior.
- 92 percent of parents surveyed at MHSA funded sites reported that mental health consultation helped them as a parent.

Comprehensive Crisis Services

Program Overview

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

SF MHSA funds a portion of Comprehensive Crisis Services (CCS), which is a mobile, multidisciplinary, multi-linguistic agency that provides acute mental health and crisis response services. CCS is comprised

of four different teams (see Exhibit 20). These teams provide caring and culturally competent assistance throughout the San Francisco community. Services include: follow up contact within a 24-48 hour period of the initial crisis/incident; short term case management; and therapy to individuals and families that have been exposed to trauma. MHSA funds four members of the crisis response team.

Summary of San Francisco Comprehensive Crisis Services

Team	Services and Target Populations
Mobile Crisis	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older.
Child Crisis	Offers 5150 assessments & crisis intervention for suicidal, homicidal, gravely disabled and out of control children and adolescents regardless of health insurance status. Clients with publically funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response	Provides mobile response to homicides, critical shootings, stabbings, and suicides; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

FY 14-15 Highlights and Successes

Individual

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

Program

- CRT staff provided more community base services to assist individuals that are trauma exposed.
- After being notified of a trauma exposed individual by San Francisco Police and/or San Francisco General Hospital, CRT conducted outreach to those individuals within a 24-hour period of being notified.
- CRT staff provided community activities to assist with promoting healing and wellness.
- CRT staff provided debriefing services to communities and providers to assist with reducing the effects of vicarious trauma and to promote self -care.

System

- Individuals in need of mental health services related to trauma exposure were identified and referred by the San Francisco Police Department and San Francisco General Hospital. This early

identification and referral leads to timely intervention and a reduction in the burden of suffering caused by delay in or lack of access to services.

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

Moving Forward in FY 16-17 in MH Promotion and Early Intervention Services

In FY 16-17, SF MHSA is coordinating efforts with BHS and other departments to convert several fiscal intermediary staffing positions into civil service staffing positions. These efforts include identifying appropriate positions to be converted, coordinating hiring panels, and providing hands-on technical assistance with the on-line application submission for peers and behavioral health consumers.

SF MHSA has hired a new Transitional Age Youth Program Manager to oversee all of the PEI-funded TAY contracts. Under the oversight of the TAY Program Manager, SF MHSA will publish a new TAY Request for Qualifications (RFQ) to ensure that each TAY program has coordinated efforts and streamlined best practices. The TAY RFQ will include the following programs; Asian Pacific Islander (API) Youth & Family Community Support Services, Emic Behavioral Health Services, Trauma Recovery and Healing Services, Prevention and Recovery in Early Psychosis (PREP) Services, Transitional Age Youth (TAY)- Full Service Partnership, Huckleberry TAY Multi-Service Center, Routz TAY Housing & Supportive Services, and Routz TAY Wellness Services.

In FY 16-17, SF MHSA will also publish a Community Drop-In & Resource Support Services RFQ in order to coordinate the efforts of the drop-in services that provide outreach, assessment, wellness promotion, service linkage, and individual and group services. This Drop-In RFQ will include the following programs; Senior Drop-In Center at Curry Senior Center, Community Building Program, Sixth Street Self-Help Center, and the Tenderloin Self-Help Center.

Peer-to-Peer Support Services

Service Category Overview

The San Francisco Department of Public Health has been committed to the engagement of mental health consumers and family members as an integral part of the service delivery system of care for Children, Youth, Transition Age Youth, Adults and Older Adults. This effort was considerably expanded with the advent of the MHSA of 2005, which further prioritized this approach across the state and provided funding to expand peer-to-peer support resources in San Francisco. 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 services are largely supported through the Community Services and Supports and Innovations funding streams.

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

1. Peer training and certificate programs that provide various levels and intensity of training for different age, gender, and demographic groups of consumers in order to meet the diverse needs of the City and County of San Francisco
2. Peer outreach to underrepresented and underserved populations who are typically facing challenges to accessing services due to stigma, lack of linguistic or cultural competency, economic pressures, substance abuse, and age- or gender-related barriers
3. Peer support for a variety of demographic groups, such as children and youth, non-English speakers, hoarders, transgender, and underrepresented ethnic groups
4. Supporting consumers who are facing legal, housing, employment, child support and other challenges
5. Acting as a beacon of hope to inspire consumers that wellness and recovery are attainable

The peer-to-peer programs funded for fiscal year 2014-15 (FY 2014-15) include:

Exhibit 32. Funded Peer-to-Peer Program Outputs

Agency	Program	Type of Service	Demographic Groups	Program Outputs
Curry Senior Center (Innovations funded)	Addressing the Needs of Socially Isolated Older Adults	Peer Outreach and Engagement; Screening and Assessment	Older Adults	1,982 served through outreach; 254 served through screening & assessment
San Francisco Department of Public Health (SF DPH)	LEGACY (Lifting and Empowering Generations of Adults Children and Youth)	Family and Youth Navigation; Stigma Reduction	Families and Youth	113 peers trained
Mental Health Association of SF (MHASF)	Peer Response Team	Peer Outreach, Engagement and Treatment	Adults and Older Adults	1,190 total served
National Alliance on Mental Illness (NAMI)	Peer-to-Peer; Family-to-Family	Peers trained to provide outreach, engagement, navigation, etc.	N/A	61 peers trained
Richmond Area Multi-Services (RAMS)	Peer Specialist Certificate & Counseling	Peers trained to provide outreach, engagement, navigation, etc.	TAY, Adults and Older Adults	164 peers trained

All Peer-to-Peer Support Service programs provide some form of training for peers and/or family members to ensure that they have the requisite knowledge, skills and resiliency to work with other individuals who are involved in the mental health system and/or are facing some form of mental illness. In some instances, this training includes a course of study and results in a certificate. In addition, programs sometimes provide follow-up support and training and social networks to support recovery, mentoring skills and professionalism.

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 of San Francisco.

Peer-to-Peer Support Service programs have begun to positively influence the capacity of the Mental Health System of Care to engage hard-to-reach populations who have traditionally been underrepresented and underserved by the mental health system. Trained peers are part of outreach teams, conduct marketing campaigns, help with navigation of the system, provide input to staff training programs, and provide a number of other inwardly and outwardly facing services within the DPH and our partner agencies.

Target Population

This report reflects the year-end data for the Peer-to-Peer Support Service programs for Fiscal Year 2014-15. Since these demographic data are not always complete across all programs, there are differences in the aggregate numbers served and in program participant descriptive data, such as gender, age, and ethnicity. The gender breakdown for the 732 individuals reported was 54% female, 44% male, 1% transgender male, and 1% transgender female.

Exhibit 33 demonstrates that English speakers represent 75 percent of the Peer-to-Peer service recipients. This raises the need to ensure that other languages are adequately reflected in the participation of Peer-to-Peer Support Services programs.

Exhibit 33. Primary Languages of FY 14-15 Peer-to-Peer Program Participants (N=732)

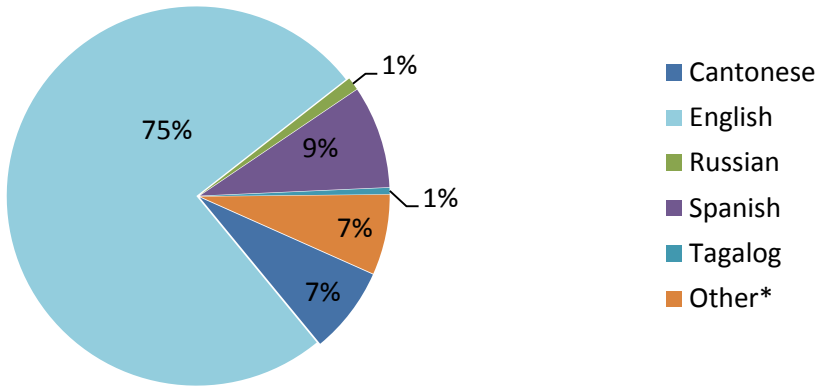


Exhibit 34. Race/Ethnicity of FY 14-15 Peer-to-Peer Program Participants (N=729)

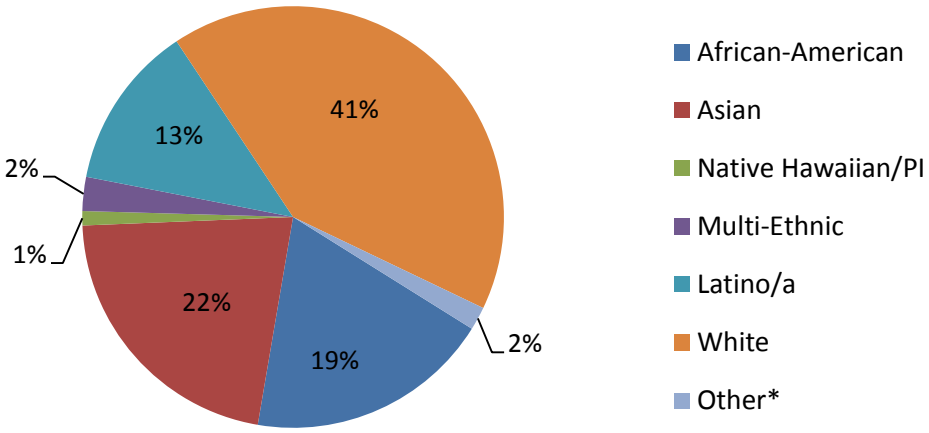
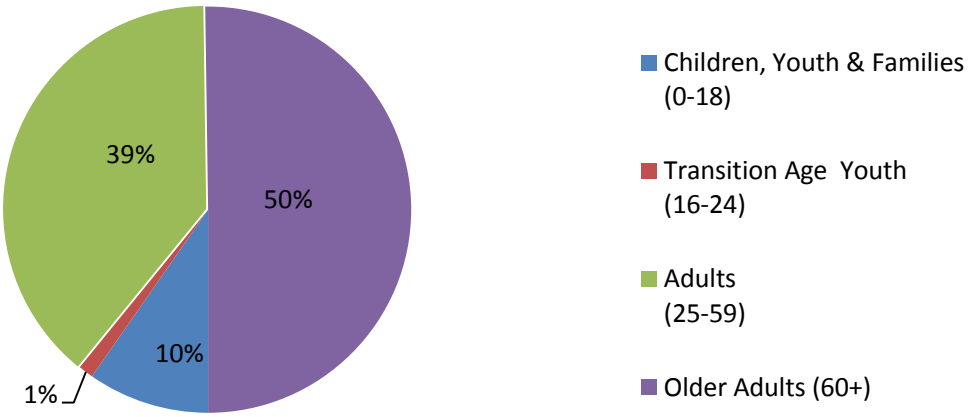


Exhibit 35. Age Groups of FY 14-15 Peer-to-Peer Program Participants (N=671)



FY 2014-15 Highlights and Successes

Overall, during FY 2014-15, the Peer-to-Peer Services system provided services to over 1,780 individuals by providing a wide range of services, including, but not limited to:

1. Navigation of the Children's System of Care, including social services, education, juvenile probation, behavioral health, housing, nutrition and food security
2. Community education and stigma reduction
3. Outreach and engagement for hard-to-access populations due to discrimination and stigma (e.g., transgender, hoarding, early onset, homeless, etc.)
4. Successful participation of 732 individuals receiving peer to peer services, many of whom reported an increase in coping skills

While we do not have comprehensive data on all of the individuals touched by peer outreach, engagement, education, navigation and stigma reduction, anecdotally we are confident there were thousands of unduplicated recipients of peer services. Providers will be encouraged to collect more participation and satisfaction data in the coming years.

Each program also had specific objectives that relate to the number of individuals with lived experience who receive peer training, including Peer Specialist Certification and other advance level training. Other programs' objectives measure the number of individuals served by Peer Specialists and other trained peer employees and/or volunteers.

Exhibit 36. Specific Program Objectives and Outcomes

Agency/ Program	Objective	Outcome
Curry Senior Center	Outreach materials and information provided to 450 individuals, 90 percent of whom receive information about available services	Connected with 1,982 individuals of whom 100 percent received information about available services
San Francisco Department of Public Health - LEGACY	1. 48 caregivers and 20 youth supported 2. 20 caregivers graduate from skills training 3. 10 female youth graduation from Girls' Circle 4. 20 youth graduation from Trauma Informed Healing 5. 10 caregiver/youth support groups	1. 43 caregivers; 10 youth 2. 14 caregivers graduate 3. 7 female youth graduate 4. 8 youth graduate 5. 10 groups provided
Mental Health Association of SF (MHASF)	1. 30 individuals receive one-to-one peer support 2. 80 percent participants reduce hoarding/cluttering 3. 80 percent of participants report improved problem solving capacity	1. 52 supported by peers 2. 88 percent reduce hoarding/clutter 3. 83 percent report improved problem solving capacity 4. 92 percent at lower risk

Exhibit 36. Specific Program Objectives and Outcomes		
Agency/ Program	**Objective**	**Outcome**
	4. 80 percent report housing at lower risk post service	
National Alliance on Mental Illness (NAMI)	80 percent of Peer-to-Peer participants and family members report increased knowledge, communication techniques and advocacy skills.	Outcomes range between ~60-80 percent on a variety of measures
Richmond Area Multi-Services (RAMS) – Peer Specialist Certificate	1. 75 percent graduates of Peer Specialist Certificate intend to pursue a human service career 2. 23 will attain Peer Specialist certification 3. 75 percent graduates indicate employment or volunteer involvement in human services	1. 96 percent graduates intend to pursue a career 2. 27 attain Certificate 3. 89 percent report involvement in human services

One of the overarching goals of the Peer-to-Peer initiative is to prepare consumers to successfully enter, retain and advance in pre-employment volunteer positions and in paid positions in the human services field, and in other competitive employment opportunities.

There have been some remarkable advances in the Peer-to-Peer initiative during FY 2014-15. A few examples include:

- Mental Health Association of San Francisco (MHASF) continued to implement the Peer Response Team focused on Hoarding and Cluttering. PRT has had good success because the voice of consumers was deeply included in the program design, and trained consumers are an integral part of the intervention strategy which includes respect for the individuals, their possessions and their timetable for change. Over time the program has moved away from a "professional" leadership model to a truly peer led initiative which has proven to be more successful. "Nothing about us without us" is the watch word for the program. This program has also been highlighted as an exemplary model nationally and the PRT is presented at scores of conferences and trainings across the USA and Canada, including the National Mental Health Association annual conference.

- By the end of FY 2014-15, Hummingbird Place, a new peer-led day program, was launched to provide a healing refuge and new direction on the path to wellness for up to 20 individuals who are at risk for requiring hospitalization or psychiatric emergency services. Seven staff with lived experience provide the staffing for this program, and guests express high approval ratings for the place itself and the impact of the program on their ability to meet their goals and improvement in various life domains. Participants show reduced crisis utilization of hospital and

psych emergency services.

- The Richmond Area Multi-Services, Inc. trained 30 individuals who earned a Peer Specialist Mental Health Certificate after completing a 12-week training to become a Peer Counselor with expertise in Wellness Recovery Action Planning (WRAP), professional conduct and ethics, cultural competence, peer intervention and harm reduction interventions. Alumni are provided a number of supportive activities such as social networking events and class reunions. Peer Specialists also participated in a number of outreach events to raise awareness about mental health and to introduce consumers and family members to available resources. Peer counselors served 134 consumers at the RAMS outpatient program and conducted 180 support groups. Eighty nine percent (89 percent) of the Peer Specialists reported that they were engaged in the health and human services field through employment, volunteer positions, career advancement, and/or further education within six months of graduation.

FY 2015-16 Highlights and Successes

The Creation of Transgender Health Services (THS) and Community Planning

Transgender Health Services is the result of years of community activism and advocacy with the Board of Supervisors and the Department of Public Health. Staff from the San Francisco Department of Public Health (SFDPH) teamed up with Transgender community members to form a Transgender Coordination and Collaboration (TCC) workgroup. TCC Members of this work group included SFDPH administrative officials, SFDPH clinical staff in both primary care and behavioral health, members of SFDPH's Transgender Advisory Group (facilitated through the Community Health Equity & Promotion Branch), and program evaluators from the SFDPH Community Assessment, System/Program Evaluation and Research (CASPER) working group. The TCC existed to improve the care of transgender, transsexual and gender non-conforming people throughout the public health system.

In November 2012, the San Francisco Health Commission approved the development of a new program (not funded by MHSA) to provide access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. Nothing like this had existed in the United States prior to this. Models and protocols needed to be developed in order to move forward.

A small group of medical and mental health providers met to create a new program to support medically underserved and disenfranchised members of the community to have access to surgical care. The integrated group worked collaboratively over the course of the year with community representatives and advocates to identify the needs of the community. A subgroup of the TCC group ensured that all surgical procedures would be paired with education and preparation services. The program planning was guided by four key principles: (1) Health improvement, (2) Financial responsibility, (3) Evidence-based practice, and (4) Quality. The integrated group worked collaboratively with community advocates over the course of the year to ensure services through the local hospital would made available and that

services that were not available could be contracted out. Over the following years, increased numbers of procedures were made available in order to meet the needs of patients. This process continues. The Department of Public Health formally established Transgender Health Services to provide access to gender confirmation surgeries and related education and preparation services, becoming the first program in the United States to do so.

SF-MHSA Supports THS

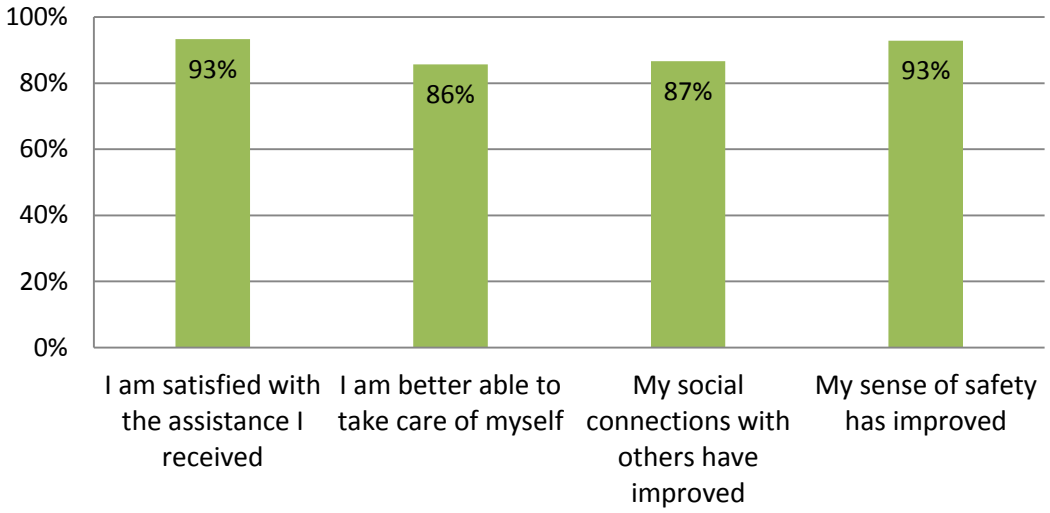
As a result of the community planning efforts, SF MHSA began funding peer counselors to support this project. SF-MHSA supports this project as a supplemental enhancement to the existing services described above. SF-MHSA provides peer counselors to ensure proper coordination of behavioral health services and ensure that all behavioral health needs are addressed.

FY15-16 marks the launch of the CSS-Funded portion of the Transgender Health Services (THS) project. THS has 2.5 FTE peer counselors working on this project helping to provide education, linkage and peer support. FY15-16 also launched the first full year of robust evaluation planning for THS, as MHSA recently secured an evaluator to dedicate time and resources to support this project.

The Hummingbird Peer Respite (INN) Outcomes

As part of an evaluation of the Hummingbird Peer Respite services, a brief survey was administered to all guests who visited the peer respite during June through July 2016. A total of 15 surveys were collected by peer staff. Survey results are depicted in the chart below.

Exhibit 37. Evaluation of Participants

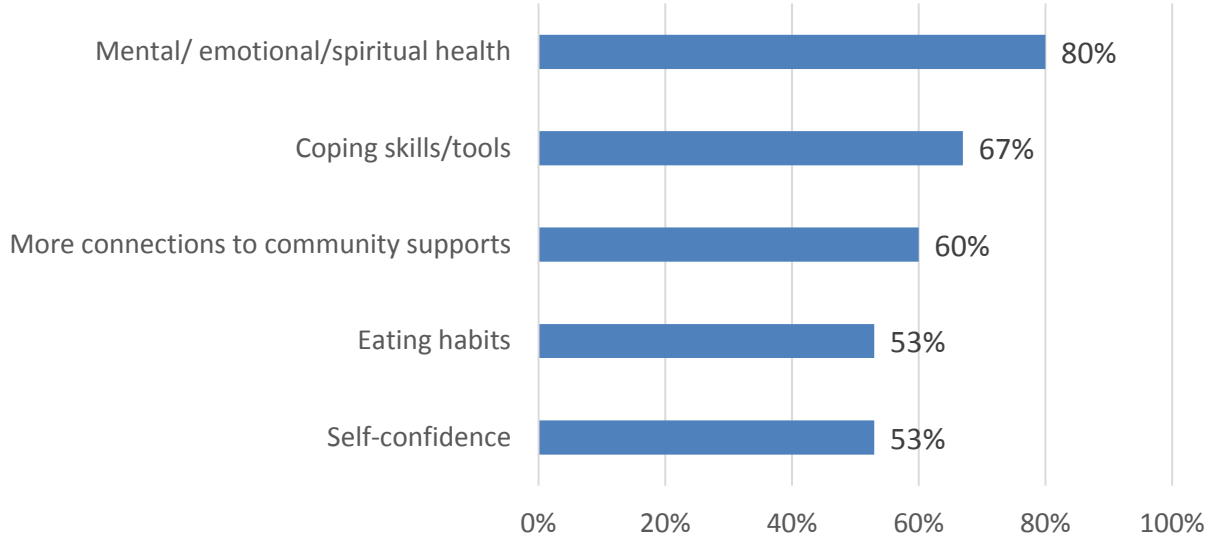


Overall, a large majority of the survey respondents had positive outcomes as a result of coming to the Hummingbird Place. In particular, they expressed being satisfied with the assistance they received, and

reported that they are better able to take care of themselves, improved social connections and their sense of safety.

In addition, the following graph displays the life domains that were chosen by at least 50 percent of the guests, N=15.

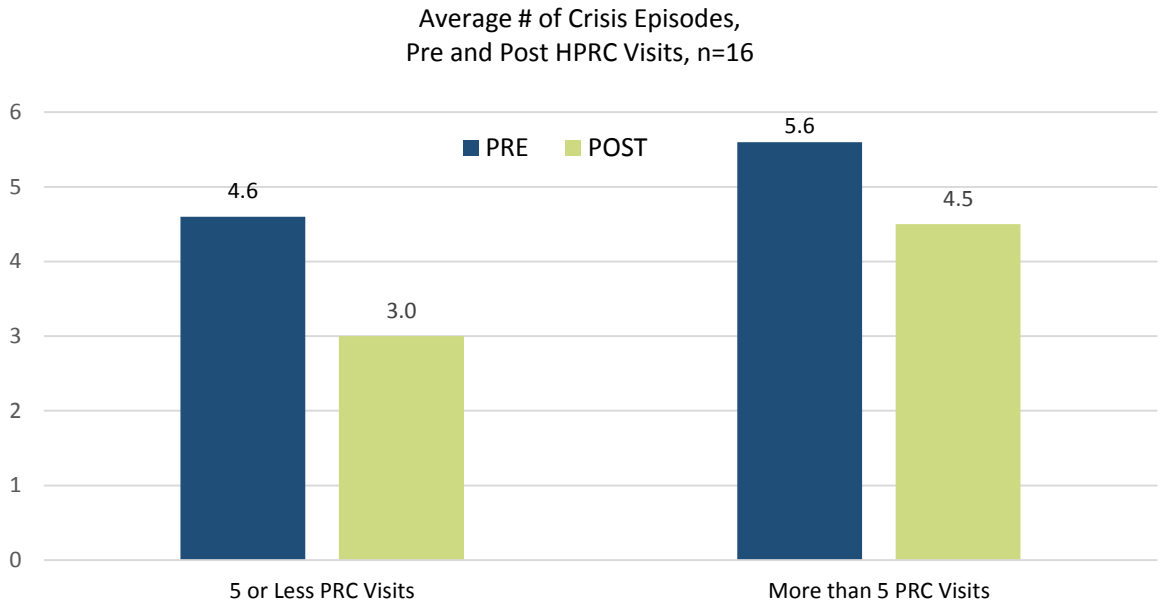
Exhibit 38. Life Domains



Guests most often indicated that their health (mental, emotional, & spiritual) improved as result of coming to the HP. Other life domains selected by at least 50 percent of HP guests and that improved for them included coping skills (67 percent), connections to community supports (60 percent), eating habits (53 percent), and self-confidence (53 percent).

Lastly, participants show reduced crisis utilization of hospital and psych emergency services as we evaluated crisis episodes both pre and post visits to the Hummingbird Peer Respite Center (HPRC).

Exhibit 39. Crisis Utilization



Moving Forward in FY 16-17

The Peer-to-Peer Services section of SF MHSA plans to further build upon the very successful foundation that has been developed over the years in collaboration with peers, consumers, family members and community members. The following includes the new activities for FY 16-17:

- In FY 16-17, SF MHSA plans **to increase the planning efforts to recruit more diverse peers** – especially parent partners, Cantonese speakers, Transgender, and LGBTQ individuals.
- FY 16-17 will be the first year of full programming for this **Peer to Peer Employment program** after the pilot launched last fiscal year. The programming this year will focus on shared objectives for peer projects and increase evaluation efforts. RAMS, in collaboration with SFDPH BHS and consumers, is responsible for the design and implementation of a cohesive and collaborative system of peer services to recruit, employ, train, place, support and supervise peer-to-peer staff within DPH, BHS and community settings. RAMS operates and evaluates the current service delivery system and peer-to-peer services that are received by behavioral health consumers. RAMS also oversees the day-to-day operations and the direct supervision of all peer staff, peer coordinators, peer managers, volunteers, interns and support staff that provide peer-to-peer support to behavioral health consumers in the community.
- FY 16-17 marks the first full-year of programming for this **Peer Wellness Center** project since the pilot launched in April of 2016. As part of the Peer to Peer Employment program, RAMS recently added a peer drop-in Wellness Center which is: 1) an engagement center for adults with

behavioral health needs seeking peer-based counseling services and peer-led activity groups; 2) a community resource for clients to receive linkages to a variety of behavioral health and primary health resources and services; 3) a safe place for clients to learn self-help skills within an environment that uses empathy and empowerment to help support and inspire recovery; and 4) a milieu where individuals can foster social connections through attending a variety of events regularly conducted by the program which include cultural, educational and recreational activities. Evaluation efforts will increase in FY 16-17. One key outcome objective is as follows: At least 75 percent of clients participating in group services and/or Wellness Center services will report that they have maintained or increased feelings of social connectedness; this will be evidenced by client/participant surveys.

- FY 16-17 also marks the first full-year of programming of the **Leadership Academy** after the pilot launched the previous fiscal year. The Leadership Academy provides short-term training for peers/consumers, generally a 2-3 hour course, in specific topics and offer courses frequently throughout the year at various days/times to reach a broad audience. This project teaches peers and consumers basic education in peer counseling best practices, self-care and burnout prevention, boundaries & ethics, de-escalation techniques, wellness and recovery, trauma-informed training, budgeting, policy development, program development, program implementation, quality assurance, evaluation, RFP/RFQ review process, among others. These training courses help peers and consumers develop skills to feel better equipped for participating in activities that request consumer input. In addition, FY 16-17 launched the first full-year of programming for the Advanced-Level Peer Certificate program. This program provides classroom and hands-on peer counseling skills for peer counselors interested in advancement within their career. This program teaches participants management, leadership, committee, and board member skills that may be useful for advancement opportunities.

- In FY 16-17, several changes took place within The **Hummingbird Peer Respite**. During recent program evaluation efforts, it became evident from discussions with the clients/guests that they were not interested in attending groups. One guest noted, “We are forced to attend groups everywhere.” Participants wanted a safe place where they could engage with peer counselors on their own timetable. In fact, the respite staff found a mix of responses as some participants were seeking a quiet space to be alone, while others wanted to talk with a counselor for up to four hours at time. Due to an issue with the initial plan of leveraging funding with another department, the Peer Respite was not able to launch a 24-hour operation. This setback has reduced the scope of

what was originally planned. The program operates daily from 10:00 a.m. to 6:00 p.m., Monday through Saturday. In 16/17, we are looking to secure funding for a night portion to work toward operating 24-hours per day, seven days per week. The daytime operation continues to show an increase in attendance and active participation of guests. Evaluation efforts continue to increase in FY 16-17.

- In FY 16-17, The **Transgender Pilot Program** (TPP) will 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 Innovations Project. The two primary goals involve increasing social connectedness and providing wellness and recovery based groups. The ultimate goal of the groups is to support clients with linkage into the mental health system and services. The TPP focuses on the mental health needs of Trans Women of Color. These women historically have the highest rates of trauma and hate violence, lowest incomes, lowest literacy rates, and highest rates of HIV. By using peers (individuals with lived mental health experience) from the community, the TPP works to engage un-linked transgender women into the Behavioral Health Services system of care.

- In FY 16-17, SF MHSA is launching a **Peer Billing Pilot**. Within this project, RAMS will recruit, train, supervise and monitor peer specialists to perform billable activities and document according to Medi-CAL standards. SF MHSA has identified ten peer specialists that can appropriately bill for Medi-CAL services. SF MHSA and RAMS have devised a plan and started implementing the peer billing pilot and, in FY 16-17, SF MHSA will be preparing ways to launch the pilot towards the implementation phase.

- In FY 16-17, overall **peer programming evaluation planning efforts will continue to increase** over last year. Our MHSA evaluators have been working closely with the program staff and managers to design tools and feedback mechanisms that adequately capture necessary information. The evaluators have provided some useful insight from program participants to implement changes that make services more responsive to the needs of the people being served.

- In FY 16-17, SF MHSA will expand funding for stipends for those involved in the **NAMI peer program**. Peer mentors will meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors will be supportive of the participant by meeting weekly for 1 hour and assisting the participant with their wellness and recovery journey. Mentors will also act as a community resource for helping participants direct his or her own path to wellness and recovery.

- In FY 16-17, **The San Francisco Mental Health Peer-Run Warm Line** will continue to strengthen its successful programming. This project connects a person in emotional distress to a Peer Counselor through a phone call or chat session. Each counselor completes over 40 hours of training and attends continuing education workshops provided by the Mental Health

Association of San Francisco. The Warm Line is the first line of defense in preventing mental health crises by providing a compassionate, confidential and respectful space to be heard. The Warm Line existence continues to alleviate over-burdened crisis lines, law-enforcement, and mental health professionals.

- The INN funding for the **Peer Response Team** (PRT) ended in June 2015, however, many key functions of this project were maintained under Community Services and Support (CSS) funding for FY 16-17 due to overwhelming support from the community, peers and behavioral health consumers. In FY 16-17, Peer Responders with lived experience with hoarding or cluttering behaviors continue to support individuals with similar needs. The peers use their experience to provide non-judgmental, harm reduction-based, one-on-one peer support often including multiple home visits. In addition, the team gives community presentations that message anti-stigma and discrimination, empowerment, and the possibility of recovery.

- In February 2016, SF MHSA hired a new **Peer Programs Manager**. This is a new position that oversees MHSA peer projects including the RAMS contract, the NAMI peer to peer services, The San Francisco Study Center, the Peer Respite Center, and the Transgender Pilot Program.

- The **MHSOAC recently voted to extend both the Transgender Pilot Program and the Program for Socially Isolated Adults** for an additional two years beyond FY 16-17. These INN projects are now approved until June 30, 2019. These projects will now be a total duration of 5 years.

- In FY 16-17, SF MHSA is working to develop a 5-Year Workforce Development Plan. This plan will include a goal to **increase and better integrate peers across the BHS workforce**. Some of the proposed objectives for reaching this goal may include the following: 1) Improve peer supervision skills and double the number of advancement opportunities for peer workforce; 2) Double the number of qualified peers with lived experience in the BHS workforce, with an emphasis on programs that serve families and youth; 3) Increase the capacity to provide youth-to-youth, parent-to-parent and family-to-family services; and 4) Increase training efforts to ensure that all peers receive a minimum of 55 hours of specialized training per year.

Innovations Highlights for Peer to Peer Services

- FY 16-17 marked the first year of the implementation of the "**Guidelines for Sun-setting Innovations Projects".** These guidelines were developed by a steering committee comprised of consumers, peers, community members and INN program staff in order to develop local protocol when deciding how to best transition Innovations funded projects that are ending. These new guidelines now involve a committee made up of consumers and other stakeholders that will review proposals and provide recommendations on the efficacy and the sustainability of each project.

- SF MHSA hosted its first ever **Innovations Showcase** event on July 15, 2015 at the Community Justice Court. Staff from the Office of Quality Management and MHSA worked closely together with the Innovations program staff to help them prepare for the Showcase event. The Showcase highlighted Innovations projects through live presentations and table demonstrations. The Showcase featured five presentations, which included the Peer Response Team from the Mental Health Association of SF, Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS), Reducing Stigma in the Southeast Sector (RSSE), LEGACY from BHS, and First Impressions from UCSF Citywide. More than 75 individuals attended, including BHS staff, peers, families of consumers, providers, staff from MHSA and Quality Management, members of the BHS executive team, and an Innovations representative from the state Mental Health Services Oversight and Accountability Commission. Overall, results from the evaluation survey were positive. Out of 36 total surveys, more than 90 percent thought the presentations and the table presentations were inspiring and 94 percent thought the event was well-organized and expressed being satisfied with the overall event.

Vocational Services

Service Category Overview

The San Francisco Department of Public Health incorporates vocational services within its mental health programming through MHSA funding. These services ensure that individuals with serious mental illness and co-occurring mental health and substance abuse issues are able to secure meaningful, long-term employment. Research shows that supported employment programs help individuals with mental illness achieve and sustain recovery.[3]

In collaboration with The California Department of Rehabilitation, the San Francisco Department of Public Health has identified a need for various training and employment support programs to meet the current 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.

Program Overview

Department of Rehabilitation Vocational CO-OP Program

The San Francisco Department of Rehabilitation (DOR) and the City and County of San Francisco's Community Behavioral Health Services (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. These services are provided by University of California, San Francisco's Citywide Employment Full Service Partnership (UCSF Citywide FSP) program. Most program participants receive services through the UCSF Citywide FSP Intensive Case Management program and all participants meet the criteria for having a severe mental illness with current/history of criminal justice system

[3] Substance Abuse and Mental Health Services Administration. Supported Employment: The Evidence. DHHS Pub. No. SMA-08-4364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. http://store.samhsa.gov/shin/content//SMA08-4365/TheEvidence-SE.pdf

involvement. This program is overseen by BHS and supported by a Vocational Coordinator, who will assist in planning and coordinating services between DOR and BHS and provide overall administrative support to the contract. The Vocational Coordinator also conducts outreach to BHS staff and consumers in effort to increase referrals to the CO-OP.

i-Ability Vocational IT Program

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: a single point of contact for end-users of BHS computers and hardware to receive support and maintenance within BHS computing environment.
- Help Desk: a single point of contact for end-users of the BHS electronic health record system ("Avatar") to receive technical support.
- Advanced Help Desk: a single point of contact for end-users of the BHS electronic health record system ("Avatar") to receive advanced technical support.

Services offered by the program include vocational assessments, vocational counseling and job coaching, vocational skill development and training.

First Impressions

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 and job coaching, vocational training and workshops, job placement, and job retention services.

Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS)

The Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) program provides nutrition, exercise, and health education and training. The program educates program participants on the

connection between diet and health, provides healthy cooking and exercise classes, information on shopping for healthy food based on local availability with the goal of decreasing participants metabolic syndrome issues and increasing their social connectedness. AAIMS peer leaders also advocate for neighborhood food access.

SF Fully Integrated Recovery Services Team (FIRST) Vocational Training Program

The SF Fully Integrated Recovery Services Team (FIRST) Vocational Training Program offers consumers a weekly stipend position to learn skills necessary for securing successful employment. Some of the trainee positions are located at South of Market Mental Health Services and others are located in the community. Traditionally, these program participants are consumers in the SF FIRST Full Service Partnership (FSP) program who face additional difficulties engaging and remaining engaged in behavioral health services.

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 donations 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.

The SF FIRST Vocational Training program recently launched a new vocational rehabilitation activity which originated from the ideas of a civil service peer staff person. The activity involves doll making in which participants learn how to design and sew together “rag dolls” using a variety of materials. Completed dolls are slated to be donated to children served at the Homeless Pre-Natal Program. Skills learned by participants in this project include sewing, design, organizing, sequencing, and effective communication.

Assisted Independent Living (Baker Places)

The Baker Places vocational consumer employment project supports consumer employees in building skills related to clerical/administrative support and mail distribution. This supported employment project is located on-site at Baker Places and provides training, supervision and advanced support to a team of consumers with an emphasis on professional development. The Assisted Independent Living

project aims to help consumers to identify professional development goals and breakdown barriers in reaching their goals. The project also links consumers to the Department of Rehabilitation's job placement services and other vocational programs within the BHS system.

Target Population

The target population served through the vocational services programming are San Francisco residents who suffer from serious mental illness and co-occurring mental health and substance abuse issues. Over 55 percent of the consumers receiving vocational services through these MHSA-funded programs will be full-service partnership (FSP) participants in an intensive case management program who are identified as needing additional support to help consumers achieve their wellness goals.

FY 2014-15 Highlights and Successes

Notable accomplishments in Vocational Services in fiscal year 2014-15 include the following:

- One hundred percent (100 percent) of i-Ability trainee graduates met their vocational goals.
- Eighty-five percent (85 percent) of i-Ability trainee graduates reported improvements to their abilities to cope with stress.
- Over seventy-five percent (75 percent) of i-Ability trainees successfully completed the training program or exited the program early due to obtaining meaningful employment.
- One hundred percent (100 percent) of i-Ability trainee graduates were participating in a paid vocational opportunity (e.g., employment, internship, and training programs) within three months after graduation.
- One hundred percent (100 percent) of First Impressions trainee graduates reported improvements to their abilities to cope with stress.
- Consumers at clinics remodeled by First Impressions remarked, "It is inspiring to see a change in an urban setting," and "The new wait room just makes you feel good."
- Eighty percent (80 percent) of First Impressions trainee graduates met their vocational goals by program completion.

Moving Forward in FY 2016-17

The Vocational Services section of SF MHSA plans to further build upon the very successful foundation that has been developed over the years in collaboration with peers, vocational consumers, family members and community members. The following includes the new activities for FY 16-17:

- FY 16-17 marks the first full fiscal year of programming for the **expansion of the DOR CO-OP**. The DOR CO-OP expanded in January 2016 to include two new vocational programs, Toolworks

and Occupational Therapy Training Program (OTTP), to serve residents of San Francisco with mental illness. Both Toolworks and OTTP provide services that include employment preparation, job development and placement, and support for employment retention. Toolworks specializes in working with clients who are deaf or hard of hearing, while OTTP specializes in working with transition age youth (TAY), ages 15-24 years. OTTP also started a pilot program in August 2016 utilizing the evidence-based Individual Placement and Support (IPS) model which provides vocational assessment, case management, group training, experiential fieldtrips, education, and time-limited paid internships to TAY with mental illness. The goal of this program is to provide healthy activities, entry-level work exploration and experience, and support to TAY who are receiving services in the BHS system of care.

- Through a recent Vocational Programs RFQ, SF MHSA expanded the internship and supported employment components for the **1) Clerical and mailroom, 2) Janitorial services, and 3) Café and catering Services** to provide more opportunities for BHS consumers to learn workforce skills that are innovative and commensurate with the competitive job market.

- SF MHSA hired a **Vocational Outreach Coordinator** to plan, develop, triage, and track all vocational referrals and other related projects. The Coordinator will work closely with a diverse group of stakeholders, behavioral health consumers, and family members to promote vocational services. The Coordinator will provide educational outreach to consumers and staff from the various civil service programs, the BHS contracted agencies and the San Francisco Health Network.

- FY 16-17 marks the first full year of programming for the **GROWTH (Growing Recovery and Opportunities for Work through Horticulture) project** which launched the pilot last fiscal year. This is a new landscaping and horticultural vocational program that will assist mental health consumers in learning marketable skills through on-the-job training and mentoring to secure competitive employment in the community. The program is based on the MHSA's Recovery Model, which is founded on the belief that all individuals - including those living with the challenges caused by mental illness – are capable of living satisfying, hopeful, and contributing lives. The GROWTH Project program involves three months of classroom education and training, followed by six months of paid work experience, coaching, and job placement support and retention services. The ultimate goal of the program is for consumers to learn marketable skills while connecting more deeply with their environment.

- FY 16-17 marks the first full year of programming for the **TAY Vocational Services** project. The overall goal of TAY Vocational Services is to provide vocational/occupational and interest assessment, case management, group training, fieldtrips, education and time-limited paid internships to transitional age youth ages 15 to 25. This project provides healthy activities and entry-level work exploration to help youth accomplish their personal recovery goals.

- The Mental Health Services Oversight and Accountability Commission **(MHSOAC) voted to extend the First Impressions program** for an additional two years, providing an extension to begin in FY

16-17. This MHSA Innovations project is approved through June 30, 2018. This INN project will be five years in duration.

- In FY 16-17, the **AAIMS project** transitioned from MHSA Innovations (INN) funding to Community Services and Supports (CSS) funding. The INN funding ended in June 2016, however, many key functions of this project were maintained under CSS funding for FY 16-17. A community planning process was implemented to develop this modified project which included, and continues to include, feedback from peers, other stakeholders and community members. The new AAIMS model continues to provide nutrition, exercise, and health education and training. The program educates program participants on the connection between diet and health, and provides healthy cooking and exercise classes.

- San Francisco hosted it's first-ever **MHSA Vocational Summit** event on August 31, 2016 at the San Francisco Public Library. More than 130 individuals, including consumers, families, providers, BHS staff, MHSA, Quality Management staff, and the California Department of Rehabilitation, attended the 2016 Vocational Summit. The Summit highlighted the Vocational Services programs through live presentations and table demonstrations. Program leaders described their referral process, menu of services, target population, outcomes, and had a consumer describe how vocational services has helped them. Table displays were hosted by several programs, including:

    - SF FIRST (San Francisco Fully Integrated Recovery Services Team) doll sale
    - South of Market Mental Health Clinic
    - San Francisco Human Resource Department's Access for City Employment (ACE) Program
    - CA Department of Rehabilitation's Limited Examination and Appointment Program (LEAP)
    - Hospitality House
    - PROPEL (The Bay Area's Peer Professional Network)
    - Mental Health Association of SF
    - Sunset Wellness Center' plant sale
    - Richmond Area Multi Services (RAMS) Hire-Ability
    - BHS Stigma Busters & Client Council

Housing

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.

Population-Specific Housing Training

In 2016, BHS facilitated several population-specific resource training sessions. These sessions covered resources for preventing and ending homelessness. Provider groups participating this year included the Population Focused PEI providers, Full Service Partnerships, and the Transgender Advisory Group.

Emergency Stabilization Housing

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The twenty ESUs are located within several single room occupancy (SRO) hotels in San Francisco. The units are available to Full Service Partnership clients, Intensive Case Management clients and Central City Hospitality House's housing support staff. In 2015-2016, many of the units that were previously used for ESUs have been pulled from the program. The buildings that contracted with DPH for these units have been able to lease out individual units or the entire building for higher amounts in the current rental market in San Francisco. As such, interim housing options for MHSA clients are severely limited.

FSP Permanent Housing

Program Overview

In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million. In addition, San Francisco added $2.16 million from CSS to housing in 2007-08. There are a total of 63 MHSA-funded housing units developed with capital funding. These units help those who are homeless or at risk of homelessness and are located in various neighborhoods in San Francisco including the Tenderloin, Rincon Hill, and Ingleside (see Exhibit 24). Six units for Transition-aged youth opened in 2015. An additional three units opened in 2016 at Rosa Parks II, a development for seniors. Summaries of these developments are provided below. SF

MHSA also has a contract with Tenderloin Neighborhood Development Corporation for 21 units of permanent housing at three of their affordable housing sites, as well as a contract with Community Housing Partnership for eight units of permanent housing at the Cambridge Hotel, another non-DAH supportive housing site.

Target Population

All units within the MHSA supportive housing portfolio are reserved for homeless clients with serious mental illness. MHSA-capital-funded housing units are developed within larger mixed-population buildings with on-site supportive services coordinated with and linked to the larger infrastructure of supports provided by Full Service Partnership programs.

Housing Placement and Supportive Services

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

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

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

Exhibit 40. MHSA Units 2015-16

MHSA Permanent/Transitional Housing List 2016

MHSA Housing Site	Owner/Operator	MHSA Units	Target Population	Services	Type of Project	Referral Source
1100 Ocean	Mercy	6	TAY	FSP + FPFY	MHSA Capital	BHS Placement
Aarti/Routz	Larkin St.	40	TAY	Larkin - All	MHSA GF - TH	BHS Placement
LeNain	*DISH*	*0-5*	Adults	DPH	DAH	DAH
Pacific Bay Inn	*DISH*	*0-5*	Adults	DPH	DAH	DAH
Windsor Hotel	*DISH*	*0-5*	Adults	DPH	DAH	DAH
Empress	*DISH*	*0-5*	Adults	DPH	DAH	DAH
Camelot	*DISH*	*0-5*	Adults	DPH	DAH	DAH
Star	*DISH*	*0-5*	Adults	DPH	DAH	DAH
San Cristina	*CHP*	*0-14*	Adults	FSP + CHP	DAH	DAH
Cambridge	*CHP*	*0-15*	Adults	FSP + CHP	DAH	DAH
Hamlin	*CHP*	*0-14*	Adults	FSP + CHP	DAH	DAH
Richardson	CHP	12	Adults	FSP + Citywide	MHSA Capital	DAH
Rene Cazaneve	CHP	10	Adults	FSP + Citywide	MHSA Capital	DAH
Rosa Parks II	TNDC	3	Seniors	FSP + TNDC	MHSA Capital	DAH
Polk Senior	TNDC	10	Seniors	FSP + TNDC	MHSA Capital	DAH
Kelly Cullen	TNDC	17	Adults	FSP + TNDC	MHSA Capital	DAH
Ritz	TNDC	2	Adults	FSP + TNDC	DAH	DAH
Ambassador	TNDC	8	Adults	FSP + TNDC	DAH	DAH
Dalt	TNDC	13	Adults	FSP + TNDC	DAH	DAH
Veterans Commons	Swords	8	Veterans	FSP + Swords/VA	MHSA Capital	BHS Placement
Total		**150-200**				

Moving Forward in FY 2016-2017

No Place Like Home

California lawmakers have approved a new package of supportive housing units to be developed for MHSA clients. In San Francisco, this will lead to several hundred new units available for MHSA clients, when the funds become available. This project is for homeless people with behavioral health issues but not specific to MHSA only.

San Francisco's Department on Homelessness and Supportive Housing

San Francisco has established a new city department to focus exclusively on ending homelessness. The Department on Homelessness and Supportive Housing (DHSH) was established in 2016. DHSH, with

support from SF MHSA, now oversees the Housing Placement and Supportive Services for MHSA units, and BHS has work-ordered its housing-specific funds to the new department to expedite placement of homeless FSP clients. This move promotes the MHSA principle of community collaboration and working with other sectors. In addition, DHSH is actively planning a coordinated entry process for permanent supportive housing that will begin with families in 2017 and implement for single adults in 2018.

Completed Project Profiles

Tenderloin Neighborhood Development Corporation: Polk and Geary Senior Housing

The **Polk and Geary** senior building, built in partnership with Citizens Housing Corporation, represents an innovative approach to address homelessness by combining services-rich supportive housing units within a larger low-income population. Ten of the units are fully accessible, and the remaining units are adaptable for individuals with disabilities. Fifty units are set aside for formerly homeless seniors; the rents and services for residents of these units are subsidized by the City of San Francisco. Of the 10 MHSA clients housed at this senior residence in 2016, one hundred percent (100 percent) were able to maintain housing for at least three years.

Community Housing Partnership: Richardson Apartments

Drs. Julian and Raye Richardson Apartments, opened in 2011, is a five-story development including 120 studio units of housing for extremely low income, formerly chronically homeless individuals. Located at the corner of Fulton & Gough streets, the building also includes ground floor retail commercial space, common space and social service program space. Twelve units are designated for the MHSA Housing Program. The University of California-San Francisco Citywide Case Management team works with SFDPH's Housing and Urban Health Clinic (HUHC) and three adult Full Service Partnerships (FSPs) to provide the 11 MHSA residents with integrated recovery and treatment services appropriate for severely mentally ill adults to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. Community Housing Partnership manages the property. In July of 2016, 11 or 11 MHSA tenants had maintained housing for at least 24 months at this site.

Swords to Plowshares: Veterans Commons

Veterans Commons, opened in 2012, is an adaptive re-use of a nine-story steel-frame and concrete structure at 150 Otis Street in San Francisco. The building was originally constructed in 1916 as the City's first Juvenile Court and Detention Home, but now consists of permanent, affordable rental housing with on-site supportive services for homeless veterans. The project houses 76 U.S. veterans, eight of whom qualify for the MHSA Housing Program. Swords to Plowshares manages the property. The development includes space for intensive supportive services, including space for counseling, group meetings, case management, and social activities. Once the property had been operational for more than two years, the stability among MHSA placements increased to 100 percent of clients maintaining their housing for at least 12 months in 2015-2016.

Tenderloin Neighborhood Development Corporation: Kelly Cullen Community

Kelly Cullen Community is a $95 million renovation of the former Central YMCA at 220 Golden Gate and provides 172 efficiency studio units for chronically homeless individuals, including 17 MHSA units. Completed in 2012, the project includes a ground floor SFDPH-managed health and wellness clinic and a corner commercial retail space. 100 percent of MHSA residents at Kelly Cullen in 2015-2016 have maintained housing for at least 24 months.

Community Housing Partnership: René Cazenave Apartments

The **Rene Cazenave** Apartments were developed by Community Housing Partnership and BRIDGE Housing, and designed by Leddy Maytum Stacy Architects. The project was selected by the San Francisco Redevelopment Agency (SFRA), to develop affordable housing in the new Transbay Redevelopment Area. Rene Cazenave Apartments is the first of several development sites that will serve as a gateway to the SFRA's vision of a new "main street" along Folsom Street. Following completion of the project, Community Housing Partnership remains the owner and property manager of the site.

Rene Cazenave Apartments is a mid-rise, eight-story building that includes a total of 120 apartments. Twelve of these apartments are 1-bedroom units, while 108 are studios. Overall, 10 percent of the units are handicap accessible and all other units are adaptable for handicap use. All tenants are formerly homeless individuals and are being referred through the San Francisco Department of Public Health. Since the property has been opened last year, one-hundred percent (100 percent) of MHSA placements maintained housing.

Mercy Housing: 1100 Ocean Avenue

The **Ocean Avenue** development, completed in 2015, is a new construction project that includes 70 units of housing for families and transitional aged youth (TAY) and one property manager unit. The building has a mix of studios, one, two and three-bedroom units available to residents making no more than 50 percent of the area median income. Twenty-five units are restricted at 20 percent of the area median income. Six of the project's 25 TAY units are reserved for the MHSA Housing Program. An integrated services team provides the youth community with a full range of on-site and off-site resources, including community-building events, educational opportunities, information and referrals to local social services, case management and crisis prevention and intervention. In addition, Community Behavioral Health Services, works with property management and two TAY Full Service Partnerships to provide the 25 TAY residents with integrated recovery and treatment services appropriate for severely mentally ill youths to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. Mercy Housing Management Group, an affiliate of Mercy Housing California, manages the property. Of the six MHSA youth who entered housing in 2015, 100 percent remained housed at the time of this report.

Rosa Parks II Senior Housing

Rosa Parks II Senior Housing (RPII) is a planned 98-unit, five-story affordable senior housing development, with three units set aside for older adults under MHSA. The project is located at the corner of Turk and Webster streets in the Western Addition neighborhood of San Francisco, California. RPII is constructed on the parking lot of an existing public housing

facility, Rosa Parks, an eleven-story, 198-unit building owned and operated by the Housing Authority of the City and County of San Francisco since 1959. The project was developed by the Tenderloin Neighborhood Development Corporation and completed in summer 2016.

Community Housing Partnership Expansion

In the 2015-2016 fiscal year, BHS began referring people to reserved MHSA units within the Community Housing Partnership portfolio. These 43 units in non-profit housing include services coordination staff through a contract expansion with the Community Housing Partnership. This program targets single adults with serious mental illnesses who are currently homeless. Staffing includes two FTE Services staff to assist with on-site services, activities and groups, and to work directly with FSP providers on individual service plans. The sites used for housing placement are owned and operated by CHP and CCDC. They have been remodeled and are regularly inspected to monitor housing quality standards. Buildings include the Cambridge, Hamlin, San Cristina, and other CHP sites as vacancies become available. DAH administers a sole source contract for 43 units, including services.

ROUTZ Transitional Housing for Transition-Aged Youth (TAY) - Larkin Street Youth Services: Aarti Hotel

Youth with mental health and substance abuse issues have unique and complex needs for housing. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transition aged youth with Larkin Street Youth Services. The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites. In fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, like skills training, wraparound case management, mental health interventions, and peer based counseling. Eighty-eight percent (88 percent) of placements in this program maintained housing or had a stable exit after one year, exceeding the performance goal.

Behavioral Health Workforce Development

Service Category Overview

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

In 2009, MHSA received an initial $4.6 million allocation of MHSA funding to support Workforce, Development, Education and Training (WDET) activities. San Francisco has developed a strong collection of activities and programs designed to achieve WDET goals. Through Career Pathway Program (CPP) activities, the decision was made to sustain MHSA WDET activities, described below, with CSS funds. SF MHSA's goal is to develop a behavioral health pipeline to increase the number of individuals that are informed about, choose to prepare for, and are successful in entering and/or completing behavioral health training programs. This work involves collaboration between MHSA, BHS, SFUSD, City College of San Francisco, San Francisco State University, and CIIS.

Training and Technical Assistance

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

Behavioral Health Services (BHS) Trainings

Program Overview

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

integration of primary care and mental health services. The BHS Training Unit provided 112 trainings during FY 15-16 covering a wide range of topics, including those referenced above.

Developing Expertise in Group Treatment

As a pathway of treatment for clients presenting with complex mental health and substance abuse issues, BHS leadership identified the need for providers to offer group treatment models of care. The result is the implementation of Wellness Management and Recovery (WMR), an evidenced-based practice under SAMHSA.

Wellness Management and Recovery (WMR)

The Illness Management and Recovery Model (IMR) is an evidence-based program, developed and supported by SAMHSA. The model is comprised of a series of weekly sessions in which facilitators help people who have experienced psychiatric symptoms to develop personalized strategies for managing their mental illness and moving forward in their lives. In 2014, BHS adopted and renamed IMR as "Wellness Management and Recovery" (WMR). Wellness and Recovery is a non-linear journey which begins in utero and spans the entire length of individuals' lives. It is a constantly evolving, multi-dimensional path which grows from seeds of hope, cultivating self-awareness, courage, empowerment, strengths, resilience and family/community connection, all through a lens of cultural humility and holistic healing.

The Wellness and Recovery work in FY 15-16 focused on collaborating with multiple stakeholders to create a system-wide Wellness and Recovery definition which is meaningful to all clients within the BHS system of care, regardless of age. The definition is built on seven dimensions: Hope; Meaning and Purpose; Person/Family Centered and Strengths Based Care; Housing and Environment; Lifelong Integrative Health; Connection to Family/Community; and Race, Culture and All Other Realms of Difference.

In an effort to spread wellness and recovery practices to community clinics, the Wellness and Recovery Coordinator worked closely with Quality Management and Executive Leadership staff in facilitating monthly meetings focusing on how to increase the use of strengths based tools in clinical work, and to improve staff morale and wellness at BHS clinics. The Model for Improvement using the Plan-Do-Study-Act approach was championed with a goal of clinics conducting small, rapid, cycles of change to test out innovative ideas. The collaborative effort lasted for over a year and then the focus was shifted toward having the Wellness and Recovery Coordinator work with clinics on an individual basis.

The clinics also had an opportunity to apply for "mini-grant" funding which would allow them to try an innovative approach that would increase client wellness, decrease stigma and increase community integration. A learning question was central to each project and an evaluation was done at the conclusion of each project. The projects have been varied, ranging from integrative health practices

such as acupuncture and mindfulness, to collaborative mural painting focusing on themes of wellness within the community of the clinic. The system of care has learned a great deal from these creative projects and—moving forward—the objective is to spread the knowledge gained from them across the system of care.

Medicinal Drumming Apprenticeship Project

Program Overview

The availability of culturally congruent services is insufficient to meet the needs of San Francisco's diverse communities. Historically, western-based therapeutic services focus on the individual, while culturally diverse communities are generally group oriented. The American Psychological Association contends that new and alternative methods are needed to address the needs of the masses. Through research and applied practice, Dr. Sal Núñez and the community- defined evidence project have demonstrated that the Medicinal Drumming Praxis engages large groups of diverse populations through an interconnected journey of wellness and recovery. The Medicinal Drumming Apprenticeship is a pilot project designed to train community based behavioral health service providers in a culturally affirming wellness and recovery therapeutic methodology. This approach allows program participants to be supported in a culturally congruent manner, as they build and apply new skills that promote personal and community empowerment.

FY 14-15 Highlights & Successes

In FY 14-15 the pilot project identified five agencies – Westside Community Services (Westside), SFDPH's LEGACY program, the Veterans Administration (VA) at Fort Miley, Instituto Familiar de la Raza (IFR) and the Bayanihan Community Center (Bayanihan) -- to participate in this Medicinal Drumming Praxis training. Four of the five agencies instituted the drumming circles and are in the process of collecting data that will be analyzed for the effects of drumming on health and wellness. The fifth agency was not able to sustain its drumming group due to the service provider's medical leave.

A total of eight service providers from five different agencies were trained in the Medicinal Drumming Praxis. Site visits were conducted and preliminary plans for developing and offering therapeutic drumming groups were made. Examples of therapeutic plans include the following: stress reduction groups for veterans at the VA, Westside offering groups for youth and their families, groups for Filipino youth and adults at the Bayanihan Center, groups for women and their children at the LEGACY program, and sessions for youth, parents, and the community at IFR.

Moving Forward in FY 16-17

This pilot project was temporarily suspended in FY 15-16, as the principal investigator Dr. Sal Nunez was on sabbatical; but has now resumed in FY 16-17.

Adolescent /TAY Provider Capacity Building

Program Overview

The purpose of adolescent/TAY provider capacity building is to improve communication and coordination of health related activities and services among youth/young adult providers across service sectors – including CBOs, DPH, UCSF, SFUSD, Juvenile Justice, workforce development and housing – while also building provider capacity and support systems.

Target Population

The target population includes providers throughout the city with attention to those serving under-served populations and subgroups of youth and young adults such as TAY, LGBTQ, ethnic/racial minorities, and homeless youth. Many of the providers served are located in the Southeast Sector, Mission District, and Ingleside-Excelsior-Crocker Amazon.

FY 14-15 Highlights and Successes

The AHWG Coordinator and its Steering Committee (including Subcommittees) provided over 300 hours of service of capacity building among youth and young adult provider networks, including coordinating meetings, an annual provider gathering, and ongoing individual meetings with providers. The Youth and Young Adult Behavioral Health Working Group (YYABHWG) also provided over 190 service hours focused on improving referrals and wraparound services for TAY with significant behavioral and mental health needs. The AHWG Coordinator, in partnership with steering, subcommittee, and other stakeholder groups provided 400 service hours of planning and coordination that specifically addressed training and coaching needs for providers in order to improve young adult and adolescent health services.

This past FY also saw the start of AHWG's initiatives to improve LGBTQQIA youth health and wellness outcomes through strengthening and capacity building among provider in San Francisco who serve youth. AHWG began its next toolkit—titled, LGBTQQIA Youth Health & Wellness: A Toolkit for Providers, Youth & Families—and started a citywide policy and advocacy workgroup convening. AHWG launched a new web resource for youth and all clinic referral information and services are available electronically and mobile-friendly. The website—www.sfyouthhealthconnect.org—has mental health resources as well and includes tools and resources for youth to engage them in learning about mental wellness and provide self-care.

Exhibit 41. FY 14-15 Key Outcomes

- The AHWG Coordinator and its Steering Committee (including Subcommittees) provided over 300 hours of service of capacity building among youth and young adult provider networks.
- The Youth and Young Adult Behavioral Health Working Group (YYABHWG) provided over 190 service hours with the focus on improving referrals and wraparound services for TAY with significant behavioral and mental health needs.
- For the FY 14-15 AHWG provided 200 service hours to research and promote best practices and policies for youth and young adults.

Trauma Informed Systems Initiative: Expanding Training and Technical Assistance

Program Overview

The Trauma Informed Systems (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.

FY 15-16 Highlights and Successes

- **TIS foundational training coordination.** Coordinated over 93 live trainings for the DPH workforce and key community based organizations, training just over 2,600 employees and contractors in the basics of trauma.
- **TIS foundational training technical assistance.** Provided additional support and technical assistance to TIS initiative early adopter, Zuckerberg San Francisco General Hospital and Trauma Center UCSF Infant, Child and Adolescent Psychiatry (ICAP) program including: coordination and facilitation of TIS initiative overviews for ICAP staff groups in addition to scheduling special training dates for ICAP staff.

- **TIS foundational training evaluation.** Collected, coded, and analyzed data from the first year of the foundational training (n≈1,600) to examine participant reactions to the training content, attitudes toward becoming a trauma informed system, and practice change (Commitment to Change projects) completed by participants.

- **Foundational SF DPH Trauma Informed Systems (TIS) Article.** Began preparing a foundational article on the SFDPH Trauma Informed System model that illustrates the intersections between implementation science, trauma informed systems, healthcare, and organizational change to serve as a source of information and support to other systems who are moving to ameliorate the impact of trauma on clients, communities, and the workforce.

- **San Francisco Dept. of Public Health Trauma Informed Systems Initiative First Year Data Report April 2014 – March 2015.** Compiled and analyzed knowledge, practice, and systems level change data collected from TIS foundational training participants (n≈1,600).

- **Juvenile Justice involved youth.** Planned analysis of de-identified data, collected as part of the standard intake process for youth (ages 11 to 17) involved in San Francisco's Juvenile Justice and Probation Services, in order to: 1) provide a descriptive overview of the mental health needs and health care utilization of juveniles involved in SF juvenile justice and probation services; 2) to determine the association between mental health needs and treatment engagement and utilization among justice-involved youth in SF. Analyses is intended to serve as the foundation of examining TIS within juvenile justice.

- **TAY Behavioral Health System of Care.** Conducted mapping, surveying, and stakeholder engagement in the planning and development of a San Francisco TAY behavioral health system of care.

- **Child Parent Psychotherapy (CPP).** Provided consultation and support for implementation of Instituto Familiar de la Raza, S.P.A.R.K. program, a Full Service Partnership designed to support the stabilization and recovery of families in crisis with children under the age of 5 years old, through utilization of Child Parent Psychotherapy (CPP), an evidence-based trauma informed practice.

- **Regional applications.** Collected data from 7 Bay Area county TAY serving agencies using the TIAA (Trauma Informed Agency Assessment) tool developed by the Maine Thrive Initiative, a workforce survey, with planned administration of the corresponding youth caregiver surveys in 2017. Connected TIS evaluation outcomes with client level outcomes collected from TAY serving agencies in 2 of 7 Bay Area counties using National Outcome Management survey (SAMHSA tool) and the Child Family Outcomes Questionnaire (National Evaluation tool).

- **Youth leadership summit.** SF TAY partners co-hosted a regional Bay Area Youth Leadership Summit to apply best practices for youth TIS trainers from San Francisco implementation and build capacity for a regional TAY cohort of TIS leaders and trainers.

Moving Forward in FY 16-17

- **TIS foundational training.** The foundational training will also continue to be offered to the SFDPH workforce until all 9,000 employees are trained, in addition to SFZG, and key community based organizations.
- **TIS Initiative evaluation.** Future work will include system change data, which is currently being incorporated, as well as a pre/post examination of TIS attitudes from participants who attend the TIS foundational training and complete Commitment to Change projects. Comprehensive findings from the overall TIS Evaluation Program are published annually as part of the TIS Initiative's Year in Review publication.
- **TIS Champions Learning Collaborative.** Results of a pilot Champions Learning Collaborative will be used to inform future programming to support organizational culture change toward building Trauma Informed Systems within the San Francisco Bay Area (local and regional work).

Street Violence Intervention and Prevention (SVIP) Program

The nine-month SVIP Professional Development Academy builds upon the existing skills and talents of San Francisco's brave and courageous street outreach workers/crisis responders and educates them in the areas of community mental health, trauma, vicarious trauma and trauma recovery within the frameworks of cultural sensitivity, responsiveness and humility. Participants complete a nine-month long training program, and this Academy's unique learning and application setting allows the SVIP staff to build upon their already existing talents for working with and alongside of communities. The SVIP Professional Development Academy is built upon the core curriculum of the MHSA-funded Community Mental Health Certificate Program and has additional emphases on trauma, vicarious trauma and trauma recovery.

FY 14-15 Highlights and Successes

Academy participants learned about self-care and mental health; mental health first aid; wellness and recovery action planning; basic counseling skills; documentation; group facilitation; psychopharmacology; human development and effects of drugs; law, ethics and professional development; motivational interviewing, harm reduction; conflict resolution and mediation management; loss and grief; strengths-based communication; crisis intervention; fundamentals of victims response; and critical incident response. And on June 2, 2015 the Academy celebrated the graduation of its first cohort of 17 street outreach workers, coordinators and directors.

FY 15-16 Highlights and Successes

This year, 14 outreach workers, coordinators and directors were trained – seven who graduated and another seven on track to graduate in January 2017. Moreover, an additional cohort of seven workers will join the Academy in October 2016 with a planned graduation of May 2017.

FY 15-16 saw a new "train-the-trainer" series, where nominated SVIP staff were prepared to co-teach Academy lessons. As future instructors they learned about curriculum development; literary research strategies; lesson planning and module development; classroom facilitation; and other essential skills to become effective Academy teachers.

As a result of participation in the SVIP Professional Development Academy, 1 staff member enrolled and graduated from City College of San Francisco's Community Mental Health Certificate program, 1 applied to graduate school, and 1 re-enrolled in a bachelor's program. After training, workers reported being more effective with clientele and applying their newly learned skills of motivational interviewing, harm reduction, trauma recovery and mental health supportive counseling. Coordinators, managers and directors reported an elevation in work standards, and workers reported that they were better prepared to engage in conversations with licensed mental health providers and others in the system of care.

Mental Health Career Pathways Program

The Mental Health Career Pathways Program focuses on developing a workforce pipeline that will usher in the next generation of mental health and behavioral health practitioners and include members of underserved and underrepresented communities. The agencies and programs involved in this program are described below.

Richmond Area Multi-Services (RAMS): Summer Bridge Program

Program Overview

Summer Bridge is an eight-week summer mentoring program for youth ages 16-20 who are enrolled in or recently graduated from San Francisco Unified School District (SFUSD) high schools. The program aims to 1) educate youth about people's psychological well-being; 2) reduce the stigma associated with mental health; and 3) foster youth's interests in the fields of psychology and community mental health. The program participants meet 12 hours a week at a partner location, Horizons Unlimited in the Mission. Attendees hear presentations by guest speakers on topics ranging from identity, self-expression, mental health and stigma, LGBTQQ issues among adolescents and their families, body image and self-esteem, and personal stories from professionals in the field of mental health. The participants have also gone on various field trips: a RAMS staff training on racism and mental health, a visit to SFDPH/BHS, a tour of San Francisco State University and meetings with undergraduate and graduate faculty members, and an introduction to the RAMS Child, Youth and Families Outpatient Clinic to learn about psychotherapy and the youth-oriented services provided by the agency. Summer Bridge also invites previous graduates to return as stipended Peer Mentors to serve in leadership positions. In their roles they co-facilitate Summer Bridge small groups, participate in weekly staff meetings and serve on the agency's Youth Council (an advisory board for children, youth and family outpatient services at RAMS).

Target Population

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

FY 14-15 Highlights and Successes

A total of 58 youth were served with a total of 120 hours of workforce development programming and skill building – including basic counseling skills, empathy and reflective listening.

Exhibit 42. FY 14-15 Key Outcomes

- After participating in the program, 86 percent of participants reported knowing how to refer friends or family for mental health services.
- 80 percent of participants found role models in the health and human services field.
- 100 percent of Summer Bridge participants successfully completed the program.

FY 15-16 Highlights and Successes

During FY 15-16 the program served 58 students and provided 120-hours of career exploration, field learning and basic counseling skills development. This year saw the addition of a fun and interactive helping professions "scavenger hunt", where youth visited various community agencies to learn about different job opportunities, employee roles and populations served. Participating agencies included CalWORKS, the Bayanihan Center , West Bay Pilipino Multi-Service Center, Homeless Prenatal Program, Horizons Unlimited, Mission Family Center, Larkin Street Youth Services, Community Youth Center, Chinatown Family Development Center, Access Institute, Hamilton Family Center and Huckleberry Youth Programs.

Richmond Area Multi-Services (RAMS): Peer Specialist Mental Health Certificate Program

Program Overview

In 2009, Richmond Area Multi-Services, Inc. and San Francisco State University jointly developed the Peer Specialist Mental Health Certificate Program. Funded by the SFPDH-BHS-MHSA, the primary goal of the Peer Specialist Mental Health Certificate program is to prepare consumers of community behavioral health services or family members with the skills and knowledge for entry-level peer specialist/counseling roles in this system, as well as to provide individuals with experience and opportunities to further their career in the behavioral health field. The Peer Specialist Mental Health Certificate Program initially offered one 12-week classroom education and hands-on training course (now known as the Peer Specialist Mental Health Certificate Entry Course), twice annually. By the end of FY 14-15, the Peer Specialist Mental Health Certificate Program successfully completed 10 cohorts, with

well over 100 graduates. Furthermore, in Spring of 2015, the Peer Specialist Mental Health Certificate Program was awarded additional funding to expand to include additional training opportunities for peer providers and others interested in learning about peer-based services within the community behavioral health system of San Francisco.

Target Population

The RAMS Peer Specialist Mental Health Certificate Program's target population includes underserved and underrepresented San Francisco mental health consumers and their family members who: have experience in the community behavioral health systems, are interested in a mental health career path, may benefit from additional educational training, and may not yet be ready to enter the City College of San Francisco Community Mental Health Certificate Program and/or degree program.

The target population includes those of diverse backgrounds, with a balance between men and women, and at least 50 percent of participants are of underserved & underrepresented communities. The underserved and underrepresented San Francisco mental health consumers and their family members, include African Americans, Asian & Pacific Islanders, Latinos/as, Native Americans, and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQQ) individuals, among others. While this program is open to any residents of San Francisco, services are delivered in zip code 94103.

FY 14-15 Highlights and Successes

In FY 14-15, 27 participants successfully graduated from the Peer Specialist Mental Health Certificate Program across two cohorts (fall and spring). Of the 27 graduates, 24 completed post-program course evaluations. The results from the written evaluations showed that 100 percent of students had learned the basic skills and knowledge of peer counseling, were prepared for entry-level employment in the behavioral health field, were satisfied with the course, and would recommend it to others. 96 percent of student graduates indicated plans to pursue a career in the health and human services field. At 6-month follow up, 89 percent of graduates reported that they had been engaged with the health and human services field through employment, volunteer positions, career advancements, or further pursuit of education.

FY 15-16 Highlights and Successes

The RAMS Peer Specialist Mental Health Certificate Program expanded in FY 15-16 to offer two new training and education components: the Peer Specialist Mental Health Certificate *Advanced Course* and the Leadership Academy series. The 8-week Advanced Course provides specialized training and education to people who are currently providing peer services and advocacy in the community, and would like to obtain more knowledge and further develop skills in the field. The Leadership Academy—a free, three-hour monthly training series open to the community—is designed to support and educate

peer providers working or interested in working in the behavioral health field. These two new program components were run alongside the *Entry Course*, which continued to be offered twice annually.

Community Mental Health Worker Certificate (CMHC)

Program Overview

The Community Mental Health Worker Certificate (CMHC) program at City College of San Francisco (CCSF) is a 16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through consumer-directed goal setting and collaboration between mental health service consumers and mental health providers. The program 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 populations (e.g., African American, Asian, Pacific Islander, Latino, Native American, LGTBQ, and immigrant communities).

The curriculum promotes the workforce skills needed to be gainfully employed as a mental health worker, and to enhance the knowledge base of existing mental health employees. In addition, students have access to critical supports designed to facilitate student retention and success in the program, including the following:

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

Target Population

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

FY 14-15 Highlights and Successes

In FY 14-15 the CMHC Program graduated a cohort of 22 students, with 71 students completing the program's introductory course: Introduction to Recovery and Wellness in Mental Health, 22 students completing their internships, and 24 new students prepared to enter the FY 15-16 class cohort. During the school year, Peer Career Mentors (PCMs) provided stress reduction groups for students, as well as wellness and recovery groups. The program conducted outreach and engagement at three on-campus events, where 337 students learned about suicide prevention, early intervention, and behavioral health, and presented at the California Association of Social Rehabilitation Agencies (CASRA) and American Group Psychotherapy Association conferences. In addition, Program Director Dr. Sal Nunez provided six trainings to the PCMs in trauma recovery, basic counseling skills, wellness strategies, working with formerly incarcerated and severely emotionally distressed and diverse populations.

FY 15-16 Highlights and Successes

FY 15-16 witnessed 15 graduates from the program, 23 students primed for internships, 66 students who completed the program's introductory course and a total of 27 new students in the CMHC Program's FY 16-17 class cohort.

As a result of the rigorous training of the CMHC Program, a number of graduates have obtained new employment in the behavioral health field. Three are employed at the Peer Wellness Center in San Francisco, one at the University of California San Francisco's Citywide program, three at NAMI (National Alliance on Mental Illness) San Francisco's Mentors on Discharge program, three at NAMI San Francisco's Peer to Peer and Family to Family programs, and one as the HIV/STI Education Office Management Assistant with the Health Education Department at City College of San Francisco.

Moving Forward in FY 16-17

In FY 16-17 the CMHC Program will pilot a series of workshops at John O'Connell High School to identify youth who may have an interest in the CMHC program and support these candidates through the City College of San Francisco application process.

Public Health Institute: FACES for the Future Program

Program Overview

Given the need to recruit a more diverse behavioral health workforce – especially individuals from African American and Latino communities, San Francisco has begun this work in the high schools. 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.

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

FY 14-15 Highlights and Successes

Year 1 focused on program planning, curriculum development with O'Connell High School teachers and participation at on-campus activities (health fairs, recruitment and community outreach events) to showcase the work of FACES in the classroom. FACES taught weekly three-hour workshops for 26 weeks, with an average daily student attendance of 90 percent. In addition, FACES staff arranged clinical skills training for students with health professionals from Samuel Merritt University and University of California San Francisco. Staff recruited 60 students – 37 seniors and 23 juniors -- for the Fall 2015 program, and 20 students participated in a summer learning experience.

FY 15-16 Highlights and Successes

In FY 15-16 the program served 45 students (12 juniors and 33 seniors). 100 percent of the graduating seniors have enrolled in post-secondary programs beginning in Fall 2016: 67 percent will attend community colleges, 24 percent will attend state colleges, and 6 percent will attend University of California schools. During the school year, 100 percent of FACES students received psychosocial progress monitoring and support, which was carried out through weekly check-ins, and 100 percent of students participated in a two hour workshop on emotional triggers, self-care and crisis management. All senior students engaged in 24 hours of work-based learning internships, which were spread out over 13 sites and supervised by 16 preceptors, with each preceptor investing an average of 40 hours.

FACES student participants achieved a number of notable accomplishments in FY 15-16. A Latina student who believes that "everyone has the right to improve their lives regardless of immigration status" was selected to participate in the Global Health Youth Summit in Washington D.C., to explore and learn about global health professions through interactive learning and mentorship. In addition, two students participated in a two-week FACES Behavioral Health Undergraduate Summit in July 2016. They were awarded stipends for their participation in this program that is designed to strengthen their skills and professional development in pursuing careers in mental and behavioral health. One FACES graduate will be attending Skyline College in her pursuit to become a social worker, two graduates interested in the

field of nursing will begin their educational pathways at City College of San Francisco and San Francisco State University, a student who interned with San Francisco's Department of Public Health's Emergency Preparedness and Response team is enrolled at City College of San Francisco to launch his training with the EMT/Paramedic certification program, and another graduate will be attending the University of California Berkeley to start her social work education, so she can go on to advocate for people in her community.

California Institute of Integral Studies (CIIS)

Program Overview

CIIS seeks to advance the development of a diverse and culturally competent mental health workforce by engaging and supporting communities who are underrepresented in licensed mental health professions. CIIS recruits and enrolls students from underrepresented communities in the university's Masters in Counseling Psychology (MCP) program, provides them support services, and organizes trainings, workshops and lectures to attract individuals of color, consumers of mental health services and family members of consumers so that they will graduate with a psychology education and gain licensure. In addition, each MCP student completes an extensive year-long practicum in a public or community mental health agency.

FY 14-15 Highlights and Successes

In the 2014-15 school year, CIIS's MHSA project recruited and enrolled 17 underrepresented minority students, and provided support services to a total of 515 students. Throughout the year, staff organized a seminar on African/African American-centered psychology and research, a presentation by Mental Health Association – San Francisco peer educators, and a two day diversity training workshop that reached 280 students. Multiple seminars and workshops were held to increase the cultural competence of CIIS faculty and staff, including a curriculum and workshop by Dr. Joy DeGruy—author of Post-Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing—and three lectures and trainings on white privilege and classroom micro-aggressions facilitated by Dr. Ken Hardy. CIIS also hosted six indigenous wellness trainings for students, to introduce indigenous wellness practices and skills necessary to be an effective multidisciplinary team member.

FY 15-16 Highlights and Successes

In the 2015-16 school year, CIIS recruited and enrolled 14 students from underrepresented groups into the MCP program. Staff organized eight on-campus events to attract community members of color and individuals with "mental health system" lived experiences, which drew in approximately 400 participants. CIIS provided individual/group academic and career development services to 139 students, linked 523 students to on and off-campus resources, counseled 148 students on educational, professional, and personal goals, provided peer-counselor mentoring networking and academic support

to 98 students, and held 15 on-campus events that challenged faculty and staff to broaden their understanding of the university's diverse student body. In addition, program staff hosted eight indigenous wellness trainings for CIIS students and accompanied five Black/African American students to the Association of Black Psychologists International Convention.

San Francisco State University (SFSU): Student Success Program

Program Overview

The Student Success Program is offered through SFSU's Student Affairs and Enrollment Management, and is designed to increase student access and enrollment, enhance student retention and maximize graduation rates among mental health consumers, family members of consumers and members of underserved and underrepresented communities (e.g. Black/African American, Latino, Native American, Asian, Pacific Islander and LGBTQQI), who are preparing for careers in the public behavioral health system. The program's Wellness Promotion activities seek to enhance students' protective factors, reduce their risk factors, support individuals in recovery, promote healthy behaviors, provide cultural and social enrichment opportunities, foster hope, sense of belonging, and interdependence, increase problem solving capabilities, develop and strengthen community networks, raise awareness about mental health, reduce the stigma associated with mental illness, introduce students to resources and helpful services, and facilitate referrals and linkage to health and social services. Workforce Development activities within the program focus on providing information about the mental health field and its professions, outreaching to underrepresented communities, and offering career exploration opportunities.

FY 14-15 Highlights and Successes

The Student Success Program (SSP) conducted seven 2-hour socialization activities reaching 340 students and seven 2-hour psychoeducational and support groups reaching 120 students. For outreach and engagement the SSP participated in three campus-wide mental health related events and performed tabling at three events touching 3,800 students and 3,000 students respectively. Moreover, the SSP staff reached 232 students via five presentations at SFSU departmental orientations related to behavioral health, and connected with 1,362 participants through 30 presentations in human service related classes.

Exhibit 43. FY 14-15 Key Outcomes

- 96 students reported enhanced health and well-being, and reduced impact of health related challenges
- 83 students reported augmented social connections and a reduced sense of loneliness and isolation
- 83 students reported increased confidence and reduced feelings of anxiety, shame, hopelessness, and sense of being overwhelmed by demands related to academic performance
- 62 students identified a desirable career path in the field of behavioral health

Throughout the academic year, the SSP's drop-in center saw at least 600 unduplicated SFSU students, for a total of 6,942 contact hours. SSP staff

provided in-depth counseling—including intake, assessment, education, wellness planning and follow up—to 151 unduplicated students, for a total of 2,217 sessions.

Residency and Internship Programs

Psychiatry Fellowships

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

The mission of the UCSF Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital 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 UCSF Public Psychiatry Fellowship has developed a strong curriculum, which promotes leadership opportunities, a sense of community, and mentoring.

Since the program began in 2011, it have recruited from excellent and diverse residency training programs, including UCSF, Columbia, Yale and Stanford; it has had successful recruitment of Chief Residents (50 percent); and fellows have had publications in peer-reviewed journals and/or presented their fellowship projects at national academic meetings (100 percent).

This fellowship is notable for the tremendous networking opportunities for fellows interested in pursuing leadership roles in the public mental health care sector. This has been reflected in its success in retaining over 80 percent of fellowship graduates in the public mental health workforce in the San Francisco Bay Area.

Moving Forward in FY 16-17 in Workforce Development

In FY16-17, SF MHSA has been working in collaboration with the Department of Public Health's Workforce Development sector in order to develop a 5-Year Behavioral Health Services Workforce Development Plan. This final plan will include goals, objectives and a timeline of strategies in order to achieve specific workforce goals. An extensive CPP process has started which includes several steering committee meetings comprised of consumers, community members, workforce stakeholders and leaders among various DPH sectors. Some of the highlighted goals will include; recruiting a more diverse

workforce that better represents the unique demographics of the San Francisco Behavioral Health community, and doubling the number of peers working in advancement and leadership positions throughout the Behavioral Health System.

In addition, SF MHSA hired a new Training Coordinator in FY 16-17 to oversee the planning, coordination and evaluation of the various behavioral health training projects that will impact community behavioral health programs. This position will coordinate the training initiatives and internships for high school and graduate level interns, and will support the BHS Workforce Planning efforts.

Capital Facilities/Information Technology

Service Category Overview

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

The 2014 – 17 Integrated Plan included projects to renovate three buildings – Silver Avenue Health Center, Redwood Center and Sunset Mental Health. Subsequent proposals were approved to support renovation projects at Southeast Health Center and a new integrated clinic at 220 Golden Gate. The plan also called for an annual investment of $300,000 in capital improvements, beginning in FY 14-15 with the South of Market Mental Health Center. The majority of the work for this project began in FY 15-16.

Capital Facilities

South of Market Mental Health Center (SOMMHS)

On February 1st 2016, South of Market Mental Health Services (SOMMHS) resumed full operation in their newly remodeled space located at 760 Harrison Street. The SOMMHS remodel transformed an older leased clinic by applying MHSA funding and negotiated tenant improvements. The remodeled space ultimately benefits the client and staff experience at the South of Market Clinic. This renovation allows for integrated health services and supports the Public Health Department's goal of offering seamless access to Behavioral Health and Primary Care services.

The facility closed in June 2015 and clients were provided services at several locations. Offices at 1380 Howard Street, Mission Mental Health, OMI Family Center, and Tom Waddell Urgent Care Clinic at 50 Ivy were shared collaboratively. Thanks to the support of the directors and staff at sister clinics, we completed our project in a timely manner. Seven months of construction yielded the complete interior and exterior painting of the building and offices, the addition of a Wellness Center, additional offices and medical exam space, new flooring, a remodeled Pharmacy, and ADA upgrades. Additionally, upgrades to the phone systems were included.

Highlight of Benefits

- A Wellness Center to provide peer-led groups in support of wellness and improving healthcare outcomes.

- The addition of a new medical exam and ADA-compliant waiting area to improve patient flow and capacity for primary care services.
- Efficient space utilization facilitates additional staff offices with the implementation of a SAMHSA grant. The flexible conference room space will enable use of variably-sized groups.
- Alteration of the space for the money management program to enhance safety for staff and clients.
- Increase of space in the waiting room area to improve flow and security.
- Enhanced perimeter lighting which will contribute to safety at the clinic and in the surrounding neighborhood.

SOMMHS at a Glance

SOMMHS Outpatient Integrated Service Center (ISC) is a multi-service clinic for the Department of Public Health. The Filipino-American Counseling and Treatment (FACT) Team is a full-service team within the ISC that serves Filipino-Americans and their families. The San Francisco Fully Integrated Recovery Services Team (SF FIRST) is an ICM/FSP program at SOMMHS that mostly serves High-Users of Multiple Services (HUMS). The clinic includes a robust integrated primary care clinic in partnership with and Tom Waddell Urban Health. And the clinic has an integrated vocational services program as well. The 65 staff serve approximately 1400 clients.

The SOMMHS Outpatient ISC provides a full array of clinic-based mental health services and, as needed, off-site services for San Francisco adult residents aged 18 and over. The majority of clients reside in the South of Market, Tenderloin and Western Addition neighborhoods. Because the clinic is located nearby several shelters, many clients are homeless at the time of enrollment.

Approximately half of the clients served have a psychotic disorder, and the majority is dually-diagnosed with a major mental illness and one or more substance use disorders. Essential services offered include intake assessment and evaluation, case management and linkage, crisis evaluation and management, medication services, individual psychotherapy, and various groups including Filipino Cultural Awareness, Seeking Safety, Anger Management, and Wellness Management and Recovery.

SF FIRST intensive case management provides a continuum of care to homeless individuals especially those at risk for other emergency services. This treatment team provides wraparound intensive case management, counseling, medication services, transition into recovery, alternative activities, engagement with mentors in the community, and community integration for its clients. The team provides services to the chronic inebriate population who are high users of the emergency system. The team has expertise in providing services to the severely mentally-ill, homeless population, and may have a history of repeated hospitalizations or incarcerations within the last 12 months. The team uses the principles of strengths-based Wellness and Recovery as an approach to treatment.

The Integrated Primary Care Clinic in partnership with Tom Waddell Urban Health provides primary care services and preventive services to all SOMMHS clients. Primary care services which include health screenings, medical attention, and wellness activities are provided on-site in coordination with the clinic's multiple behavioral health service teams.

In Gratitude

Our special thanks to BHS leadership, Facilities and Operations, IT, BHS Pharmacy, Mission Mental Health, OMI, COPE/OBIC, BHAC, RAMS Inc., Tom Waddell Urban Health and Urgent Care, Deputy Sheriff's Department, and all staff at 1380 Howard St for providing the clinic with resources and support during the renovation period.

First Impressions

First Impressions is a basic construction remodeling vocational program that provides classroom and paid on-the job training and mentoring to clients at the BHS system by working with them to create a more welcoming environment in the wait rooms of DPH/BHS clinics. First Impressions works with facility operations and program administrators to identify clinics and prioritize the work to best address the needs of the clients we serve. Surveys are conducted to collect feedback from consumers and staff regarding their vision of a welcoming environment. The architect works closely with facility operations and First Impressions team to incorporate this feedback in the overall design while being mindful to minimize disruption of client services during the 2 month renovation. First Impressions trainees also receive individualized job preparation and employment support services from an employment specialist. The sites being renovated for FY 16-17 are the TAY Clinic, Southeast Geriatric Services and OMI Clinic.

Information Technology

As the 2014 – 2017 Integrated Plan discussed, the initial SF MHSA Information Technology (IT) Plan, approved in 2010, was developed through an extensive community planning process led by an MHSA-IT Planning Committee. The plan included three program areas: 1) Consumer Portal, 2) Consumer Employment and 3) System Enhancements. BHS has accomplished much of what was outlined in the initial plan. However, the BHS IT landscape has changed considerably the last five years since the planning process, thus resulting in the need to adapt the plan. Additional expenditures in the System Enhancements program area have been and will be needed to make basic IT infrastructure improvements required to respond to the changing landscape. In addition, as Avatar has been implemented and input has been collected from staff and consumers about IT infrastructure, a need has emerged for more basic improvements than originally planned.

Changing Landscape

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

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

Implementation Update

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

Consumer Portal

DPH decided to move forward with the NetSmart Consumer Portal, which plans to launch in FY 16-17. Current efforts include a scheduler that will be the primary source of collecting relevant data for clients. Roll-out efforts are pending and may include the implementation of kiosks.

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

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

In FY 15-16 the Consumer Portal Analyst led efforts on the implementation of the Appointment Scheduler in Avatar, supported general Consumer Portal project initiation, developed training videos, developed forms for the collection of client information, and developed reports.

Consumer Employment

The Consumer IT Support: Desktop and Help Desk project was modified to focus on desktop support, in order to provide participants with a more specialized and targeted vocational experience. Participants learn skills related to the steps required to deploy new workstations, including imaging, logistics of deployment, removal of old hardware, break-fix and equipment tracking.

System Enhancements

Hatchuel Tabernik and Associates provides vital program planning support for IT system enhancements. Responsibilities include the following:

- Project management of the Meaningful Use EHR implementation across BHS Division by facilitating meetings and other communications between information technology (IT) staff, administrative staff and clinical staff who are responsible for EHR deployment
- 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
- Creating, maintaining and updating the Meaningful Use implementation plan
- Managing EHR-related professional development for all CBHS staff in an effective and timely manner to ensure smooth implementation across the Division

Two Peer Interns provided system enhancement support at the San Francisco Study Center in FY 15-16. Responsibilities included the following:

- Preparing desktops for deployment
- Removal of old hardware
- Supporting Homeless Connect events
- Other duties related to hardware support

In FY 16-17, two Psychiatric Social Workers (Clinical Implementation Specialists) will be brought on to support system enhancements. Responsibilities will include the following:

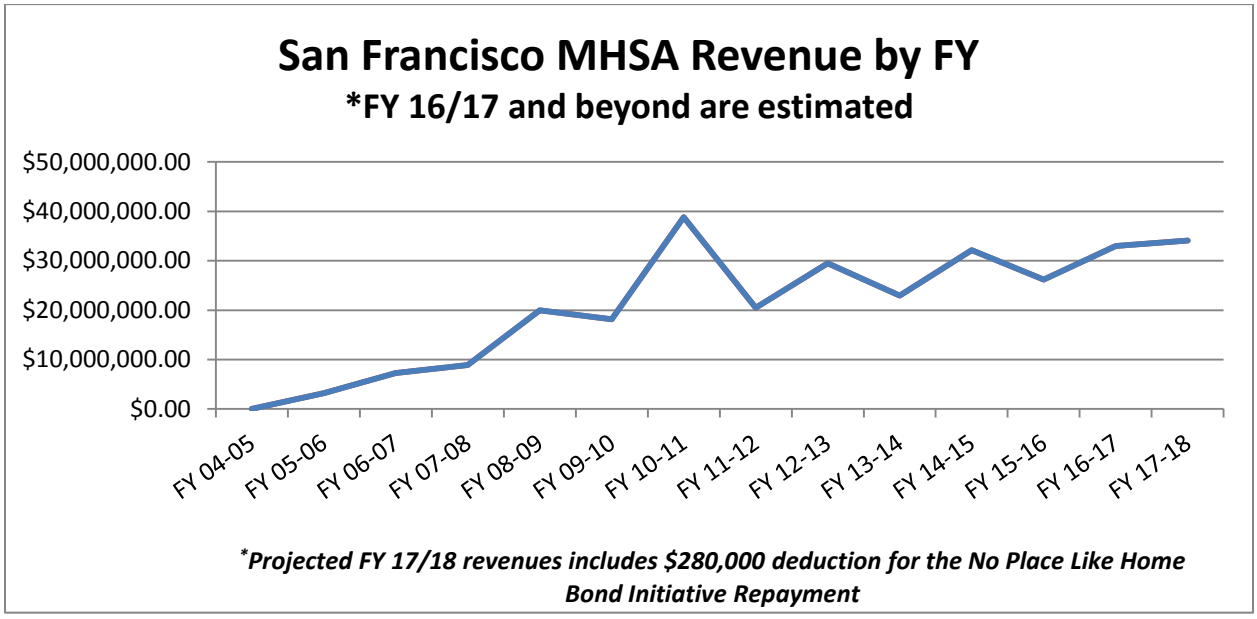
- Represent SOC programs and administrators at the various EHR committees
- Make decisions on behalf of SOC
- Play a key role in the implementation of EHR products: Appointment Scheduling, Client Portal and Meaningful Use, among others
- Clinic workflow analysis, development and implementation
- Provide clinical documentation support related to project
- Collaborate with clinical and administrative staff
- Provide end-user training related to the projects
- Provide leadership and guidance to the implementation team (HIT Coaches)
- Conduct data analysis related to the projects

MHSA Budget

Declines in San Francisco's MHSA revenue occurred in fiscal years 2010-11 and 2011-12 due to the budget downturn that affected California. Revenues for FY 12-13 showed growth. Projections through FY 2017-18 suggest that MHSA revenue will level off (see Exhibit 44 below).

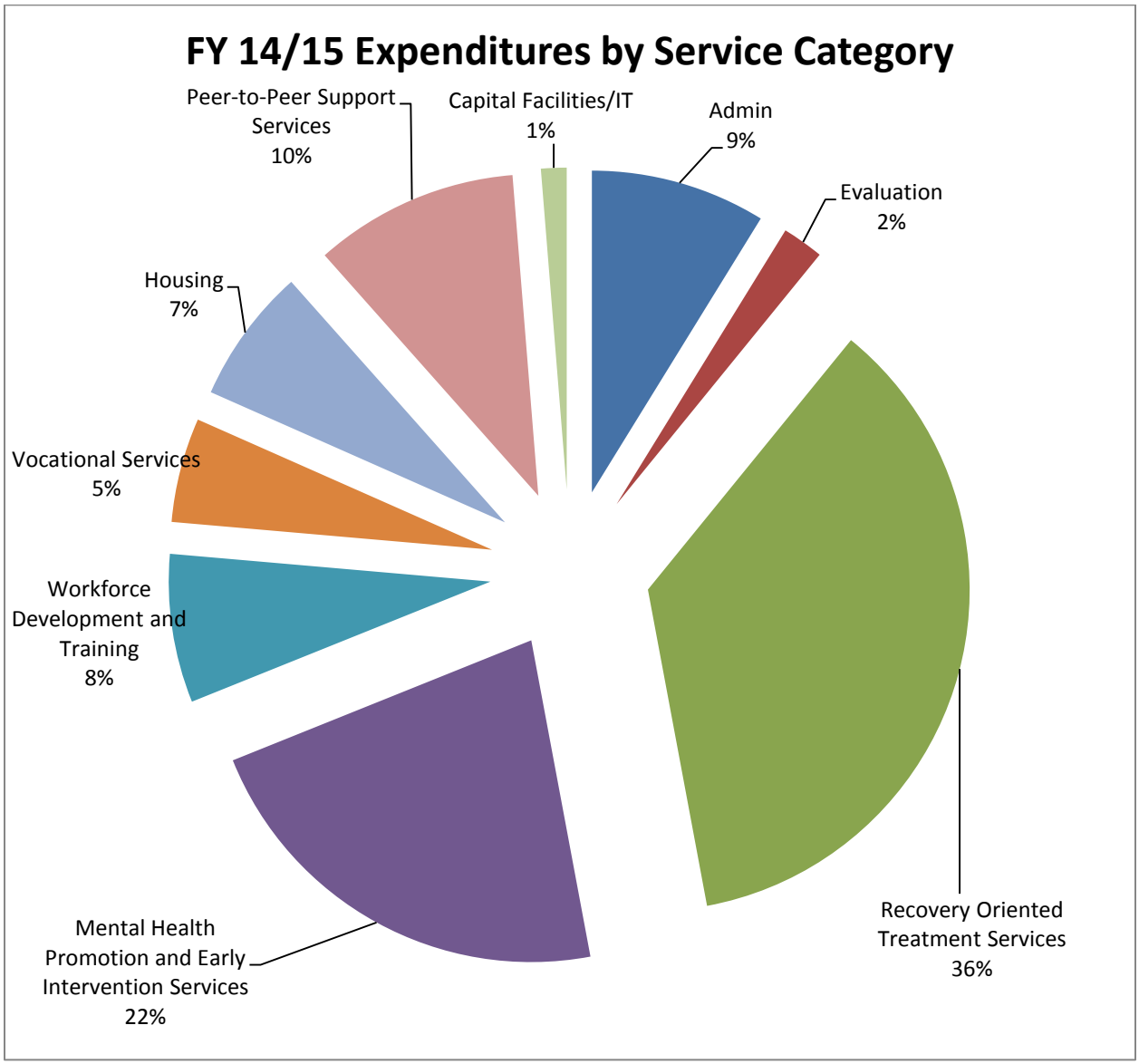
Exhibit 44. San Francisco MHSA Revenue by Fiscal Year

FY 16-17 and beyond are estimates based on State projection.



As shown in Exhibit 45, the majority of MHSA funds (36%) supported Recovery-Oriented Treatment Services followed by Mental Health Promotion and Early Intervention services (22%). MHSA funding was distributed to other service categories including Housing (7%), Peer-to-Peer Support services (10%), Behavioral Health Workforce Development and Training (8%), Vocational Services (5%), Admin (9%), and Evaluation (2%). All service categories included funding for INN-related projects.

Exhibit 45. FY 14-15 MHSA Expenditures by Service Category



Appendix A: MHSA Programs Expenditures by Funding Component

The table below details the MHSA FY 14-15 expenditures breakdown of programs by funding component.

SF MHSA Integrated Service Categories	Programs by Funding Component	FY 14/15 Expenditures
	Community, Services and Supports (CSS) 80% of total MHSA revenue (after INN calculated) In FY 14-15, 59% was allocated to serve FSP clients	
RTS	CSS Full Service Partnership 2. CYF (6-18)	932,813.49
RTS	CSS Full Service Partnership 3. TAY (18-24)	888,812.35
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,377,820.21
RTS	CSS Full Service Partnership 5. Older Adults (60+)	772,656.12
H	CSS FSP Permanent Housing (capital units and master lease)	591,832.14
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	717,535.00
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,145,676.14
RTS	CSS Other Non-FSP 3. Trauma Recovery	427,258.91
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	990,276.11
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	540,731.82
RTS	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	62,049.68
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,380,191.31
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	332,539.06
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	304,144.98
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	132,852.52
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	922,842.28
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	271,785.38
	CSS Admin	1,835,109.91
	CSS Evaluation	422,228.06

	SUBTOTAL Community Services and Support (CCS)	**17,049,155.46**
	Workforce, Development Education and Training (WDET) $2.3 million of CSS transferred to WDET	
WD	WDET 1. Training and Technical Assistance	988,576.18
WD	WDET 2. Career Pathways	693,630.11
WD	WDET 3. Residency and Internship	458,034.60
	WDET Admin	145,202.80
	WDET Evaluation	29,829.10
	TOTAL	**2,315,272.79**
	Capital Facilities/IT	
CF/IT	Cap 1. Silver Avenue FHC/South East Child & Family Therapy Center	10,768.88
CF/IT	Cap 2. Redwood Center Renovation	156.63
CF/IT	Cap 3. Sunset Mental Health	54,532.09
CF/IT	Cap 4. IHHC at Central YMCA (Tom Waddell)	12,666.85
CF/IT	IT 1. Consumer Portal	110,164.94
VS	IT 2. Vocational IT	577,581.22
CF/IT	IT 3. System Enhancements	179,400.54
	Technological Needs Administration	189,273.02
	TOTAL	**1,134,544.17**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**20,498,972.42**
	Prevention and Early Intervention (PEI) 20% of MHSA revenue (after INN calculated)	
PEI	PEI 1. Stigma Reduction	190,338.22
PEI	PEI 2. School-Based Mental Health Pomotion (K-12)	1,224,276.59
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention	3,442,537.55
PEI	PEI 5. Mental Health Consultation and Capacity Building	702,204.53
PEI	PEI 6. Comprehensive Crisis Services	607,642.85
PEI	PEI 7. CalMHSA Statewide Programs	100,000.00
	PEI Evaluation	-
	PEI Administration	149,823.11

	TOTAL	**6,416,822.85**
	Innovation (INN) 5% of total MHSA revenue	
VS	INN 11. WAIST Nutrition Project	277,337.77
RTS	INN 12. Building Bridges Clinic/School of Linking Project	244,395.61
VS	INN 14. First Impressions	317,500.00
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	143,253.97
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	423,949.38
	INN Evaluation	144,208.69
	INN Administration	202,663.24
	TOTAL	**1,753,308.66**
	TOTAL FY 14-15 MHSA Gross Expenditures.	**28,669,103.94**
	MHSA Integrated Service Categories	
	Recovery Oriented Treatment Services	**RTS**
	Mental Health Promotion and Early Intervention Services	**PEI**
	Peer-to-Peer Support Services	**P2P**
	Vocational Services	**VS**
	Workforce Development	**WD**
	Capital Facilities/IT	**CF/IT**
	Housing	**H**

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

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	14,861,050	2,304,253	4,132,535	-	2,437,332	
2. Estimated New FY2014/15 Funding	24,409,077	6,102,269	1,605,860			
3. Transfer in FY2014/15[a/]	(2,315,273)			2,315,273		
4. Access Local Prudent Reserve in FY2014/15						-
5. Estimated Available Funding for FY2014/15	36,954,854	8,406,522	5,738,395	2,315,273	2,437,332	
B. Estimated FY2014/15 MHSA Expenditures	17,049,155	6,416,823	1,753,309	2,315,273	1,134,544	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	19,905,699	1,989,699	3,985,086	-	1,302,788	
2. Estimated New FY2015/16 Funding	19,881,974	4,970,493	1,308,025			
3. Transfer in FY2015/16[a/]	(1,875,265)			1,552,668	322,597	
4. Access Local Prudent Reserve in FY2015/16						-
5. Estimated Available Funding for FY2015/16	37,912,408	6,960,193	5,293,111	1,552,668	1,625,385	
D. Estimated FY2015/16 Expenditures	19,882,188	5,511,635	1,915,447	2,809,544	2,243,822	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	18,030,219	1,448,558	3,377,664	(1,256,876)	(618,437)	
2. Estimated New FY2016/17 Funding	25,041,924	6,260,481	1,647,495			
3. Transfer in FY2016/17[a/]	(7,049,751)			4,066,558	2,983,193	
4. Access Local Prudent Reserve in FY2016/17						-
5. Estimated Available Funding for FY2016/17	36,022,392	7,709,039	5,025,159	2,809,682	2,364,756	
F. Estimated FY2016/17 Expenditures	24,660,964	5,670,346	1,485,755	2,809,682	2,364,756	
G. Estimated FY2016/17 Unspent Fund Balance	11,361,429	2,038,693	3,539,404	-	-	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	1,005,681
2. Contributions to the Local Prudent Reserve in FY 2014/15	5,491
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	1,011,172
5. Contributions to the Local Prudent Reserve in FY 2015/16	5,899
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	1,017,071
8. Contributions to the Local Prudent Reserve in FY 2016/17	5,899
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	1,022,970

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

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	CSS Full Service Partnership 1. CYF (0-5)	-	$ -				
2.	CSS Full Service Partnership 2. CYF (6-18)	1,190,952	932,813	75,393			182,746
3.	CSS Full Service Partnership 3. TAY (18-24)	1,076,592	888,812	180,025	1,656	2,775.00	3,324
4.	CSS Full Service Partnership 4. Adults (18-59)	11,031,777	3,377,820	1,780,365	2,706,551	167.00	3,166,874
5.	CSS Full Service Partnership 5. Older Adults (60+)	1,302,597	772,656	489,623	8,044		32,274
6.	CSS FSP Permanent Housing (capital units and master lease)	597,011	591,832				5,179
7.	Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,190,096	1,190,096				
8.	Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	149,643	149,643				
9.	Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	182,487	182,487				
10.	Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	39,856	39,856				
11.	Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	553,705	553,705				
Non-FSP Programs							
1.	CSS Other Non-FSP 1. Behavioral Health Access Center	888,632	717,535	171,097			
2.	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,322,405	1,145,676	136,210	1,311	1,014	38,194
3.	CSS Other Non-FSP 3. Trauma Recovery	440,235	427,259	10,058			2,918
4.	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	993,237	990,276	2,961			
5.	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,890,438	540,732	3,694			1,346,012
6.	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	63,686	62,050				1,636
7.	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,525,113	1,190,096				335,018
8.	CSS Other Non-FSP 8. Vocational Services (45% FSP)	182,896	182,896				
9.	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	121,658	121,658				
10.	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	92,997	92,997				
11.	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	369,137	369,137				
12.	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	380,893	271,785	109,108			
CSS Administration		1,835,110	1,835,110				
CSS Evaluation		422,228	422,228				
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		27,843,381	17,049,155	2,958,533	2,717,562	3,956	5,114,175
FSP Programs as Percent of Total		58.7%	estimated CSS funding over total CSS expenditures				

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

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	307,240	$ 307,240				
2. CSS Full Service Partnership 2. CYF (6-18)	1,266,681	1,008,542	75,393			182,746
3. CSS Full Service Partnership 3. TAY (18-24)	1,109,181	921,401	180,025	1,656	2,775	3,324
4. CSS Full Service Partnership 4. Adults (18-59)	11,446,387	3,792,430	1,780,365	2,706,551	167	3,166,874
5. CSS Full Service Partnership 5. Older Adults (60+)	1,139,307	609,367	489,623	8,044		32,274
6. CSS Full Service Partnership 6. AOT	343,667	338,488				5,179
7. CSS FSP Permanent Housing (capital units and master lease)	757,712	757,712				
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,401,051	1,401,051				
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	384,065	384,065				
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	155,281	155,281				
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	52,863	52,863				
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	435,302	435,302				
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,105,825	934,728	171,097			
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,092,453	915,724	136,210	1,311	1,014	38,194
3. CSS Other Non-FSP 3. Trauma Recovery	376,528	363,552	10,058			2,918
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,477,491	1,474,531	2,961			
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,815,776	466,070	3,694			1,346,012
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	69,808	68,172				1,636
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,736,068	1,401,051				335,018
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	469,412	469,412				
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	155,281	155,281				
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	211,452	211,452				
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	435,302	435,302				
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	469,191	360,083	109,108			
CSS Administration	1,771,369	1,690,392				80,977
CSS Evaluation	772,699	772,699				
CSS MHSA Housing Program Assigned Funds	307,316					
Total CSS Program Estimated Expenditures	31,064,707	19,882,188	2,958,533	2,717,562	3,956	5,195,152
FSP Programs as Percent of Total	58.3%	estimated CSS funding over total CSS expenditures				

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

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	332,583	$ 332,583				
2. CSS Full Service Partnership 2. CYF (6-18)	1,500,306	1,242,167	75,393			182,746
3. CSS Full Service Partnership 3. TAY (18-24)	1,453,406	1,265,626	180,025	1,656	2,775	3,324
4. CSS Full Service Partnership 4. Adults (18-59)	11,703,541	4,049,584	1,780,365	2,706,551	167	3,166,874
5. CSS Full Service Partnership 5. Older Adults (60+)	1,197,886	667,946	489,623	8,044		32,274
6. CSS Full Service Partnership 6. AOT	1,226,726	1,221,547				5,179
7. CSS FSP Permanent Housing (capital units and master lease)	866,150	866,150				
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,572,477	1,572,477.00				
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	680,565	680,565				
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	203,991	203,991				
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	321,330	321,330				
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	565,450	565,450				
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,218,894	1,047,797	171,097			
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,167,988	991,259	136,210	1,311	1,014	38,194
3. CSS Other Non-FSP 3. Trauma Recovery	406,517	393,541	10,058			2,918
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,512,403	1,509,442	2,961			
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,935,264	585,558	3,694			1,346,012
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	75,431	73,795				1,636
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,907,495	1,572,477				335,018
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	831,801	831,801				
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	135,994	135,994				
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	749,771	749,771				
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	376,967	376,967				
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	595,469	486,361	109,108			
CSS Administration	2,216,250	2,135,273				80,977
CSS Evaluation	781,512	781,512				
CSS MHSA Housing Program Assigned Funds	307,316					
Total CSS Program Estimated Expenditures	35,843,482	24,660,964	2,958,533	2,717,562	3,956	5,195,152
FSP Programs as Percent of Total	59.7%	estimated CSS funding over total CSS expenditures				

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

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	PEI 1. Stigma Reduction	190,338	190,338				
2.	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	615,111	612,138				2,973
3.	PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	0					
4.	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,450,465	1,721,269				729,196
5.	PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	2,966,883	526,653				2,440,230
6.	PEI 6. Comprehensive Crisis Services (10% Prevention)	63,253	63,253				
7.	PEI 7. CalMHSA Statewide Programs	100,000	100,000				
PEI Programs - Early Intervention							
8.	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	615,111	612,138				2,973
9.	PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	0					
10.	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,450,465	1,721,269				729,196
11.	PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	988,961	175,551				813,410
12.	PEI 6. Comprehensive Crisis Services (10% Prevention)	569,277	544,390	24,887			
PEI Administration		149,823	149,823				
PEI Evaluation		0					
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		11,159,686	6,416,823	24,887	0	0	4,717,976

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

		Fiscal Year 2015/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	PEI 1. Stigma Reduction	173,149	173,149				
2.	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	510,056	507,083				2,973
3.	PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	0	0				
4.	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,303,844	1,574,648				729,196
5.	PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	2,879,069	438,839				2,440,230
6.	PEI 6. Comprehensive Crisis Services (10% Prevention)	40,522	40,522				
7.	PEI 7. CalMHSA Statewide Programs	76,810	76,810				
PEI Programs - Early Intervention							
8.	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	510,056	507,083				2,973
9.	PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	0	0				
10.	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,303,844	1,574,648				729,196
11.	PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	959,690	146,280				813,410
12.	PEI 6. Comprehensive Crisis Services (10% Prevention)	389,586	364,699	24,887			
PEI Administration		107,872	107,872				
PEI Evaluation		0					
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		10,254,498	5,511,635	24,887	0	0	4,717,976

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

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	187,432	187,432				
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	531,815	528,842				2,973
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	0	0				
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,288,106	1,558,910				729,196
5. PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	2,924,741	484,511				2,440,230
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	45,664	45,664				
7. PEI 7. CalMHSA Statewide Programs	83,146	83,146				
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	531,815	528,842				2,973
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	0	0				
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,288,106	1,558,910				729,196
11. PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	974,914	161,504				813,410
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	435,866	410,979	24,887			
PEI Administration	121,606	121,606				
PEI Evaluation	0					
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	10,413,210	5,670,346	24,887	0	0	4,717,976

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

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditure	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11. WAIST Nutrition Project	277,338	277,338				
2. INN 12. Building Bridges Clinic/School of Linking Project	265,515	244,396	21,119			
3. INN 14. First Impressions	319,356	317,500				1,856
4. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	143,254	143,254				
5. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	423,949	423,949				
INN Administration	202,663	202,663				
INN Evaluation	144,209	144,209				
Total INN Program Estimated Expenditures	1,776,284	1,753,309	21,119	0	0	1,856

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

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditure	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11. WAIST Nutrition Project	272,634	272,634				
2. INN 14. First Impressions	289,376	268,256	21,119			
3. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	198,681	196,826				1,856
4. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	448,642	448,642				
5. INN 17. Hummingbird Place - Peer Respite	348,049	348,049				
	0					
INN Administration	271,529	271,529				
INN Evaluation	109,512	109,512				
Total INN Program Estimated Expenditures	1,938,422	1,915,447	21,119	0	0	1,856

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

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditure	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11. WAIST Nutrition Project	0	0				
2. INN 14. First Impressions	291,707	270,588	21,119			
3. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	214,917	213,061				1,856
4. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	0	0				
5. INN 17. Hummingbird Place - Peer Respite	684,291	684,291				
	0					
INN Administration	194,358	194,358				
INN Evaluation	123,457	123,457				
Total INN Program Estimated Expenditures	1,508,730	1,485,755	21,119	0	0	1,856

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

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,612,042	988,576				623,466
2. Career Pathways	714,020	693,630				20,390
3. Residency and Internships	458,035	458,035				
WET Administration	145,203	145,203				
WET Evaluation	29,829	29,829				
Total WET Program Estimated Expenditures	2,959,128.93	2,315,272.79	-	-	-	643,856.14

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

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,855,759.35	1,232,293.20				623,466.14
2. Career Pathways	993,314.25	972,924.25				20,390.00
3. Residency and Internships	391,001.55	391,001.55				
WET Administration	108,372.26	108,372.26				
WET Evaluation	104,952.53	104,952.53				
Total WET Program Estimated Expenditures	3,453,399.93	2,809,543.79	-	-	-	643,856.14

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

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,679,566.08	1,056,099.93				623,466.14
2. Career Pathways	1,102,344.52	1,081,954.52				20,390.00
3. Residency and Internships	432,813.64	432,813.64				
WET Administration	122,273.39	122,273.39				
WET Evaluation	116,540.99	116,540.99				
Total WET Program Estimated Expenditures	3,453,538.61	2,809,682.46	-	-	-	643,856.14

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

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center	10,769	10,769				
2. Redwood Center Renovation	157	157				
3. Sunset Mental Health	54,532	54,532				
4. IHHC at Central YMCA (Tom Waddell)	12,667	12,667				
5. Southeast Health Center	0					
6. South of Market Mental Health	0					
	0					
CFTN Programs - Technological Needs Projects						
11. Consumer Portal	110,165	110,165				
12. Vocational IT	577,581	577,581				
13. System Enhancements	179,401	179,401				
CFTN Administration	189,273	189,273				
Total CFTN Program Estimated Expenditures	1,134,544	1,134,544	0	0	0	0

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

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center	0					
2. Redwood Center Renovation	0					
3. Sunset Mental Health	153,620	153,620				
4. IHHC at Central YMCA (Tom Waddell)	0					
5. Southeast Health Center	0					
6. South of Market Mental Health	282,661	282,661				
	0					
CFTN Programs - Technological Needs Projects						
11. Consumer Portal	102,980	102,980				
12. Vocational IT	781,131	781,131				
13. System Enhancements	782,036	782,036				
CFTN Administration	141,393	141,393				
Total CFTN Program Estimated Expenditures	2,243,822	2,243,822	0	0	0	0

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

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center	0					
2. Redwood Center Renovation	0					
3. Sunset Mental Health	0	0				
4. IHHC at Central YMCA (Tom Waddell)	0					
5. Southeast Health Center	0					
6. South of Market Mental Health	0	0				
7. TBD through CPP	166,292	166,292				
CFTN Programs - Technological Needs Projects						
11. Consumer Portal	116,111	116,111				
12. Vocational IT	1,112,281	1,112,281				
13. System Enhancements	810,643	810,643				
CFTN Administration	159,429	159,429				
Total CFTN Program Estimated Expenditures	2,364,756	2,364,756	0	0	0	0

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.
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