BOARD of SUPERVISORS

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M E M O R A N D U M

TO: Dr. Grant Colfax, Director, Department of Public Health

FROM: Stephanie Cabrera, Assistant Clerk, Public Safety and Neighborhood Services Committee, Board of Supervisors

DATE: September 21, 2022

SUBJECT: LEGISLATION INTRODUCED

The Board of Supervisors' Public Safety and Neighborhood Services Committee has received the following proposed legislation, introduced by Mayor Breed on September 13, 2022

File No. 220972

Resolution authorizing adoption of the San Francisco Mental Health Services Act Annual Update Fiscal Year (FY) 2022-2023.

If you have any additional comments or reports to be included with the file, please forward them to me at the Board of Supervisors, City Hall, Room 244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102 or by email at: Stephanie.Cabrera@sfgov.org.

Attachment

cc: Dr. Naveena Bobba, Department of Public Health
Sneha Patil, Department of Public Health
Ana Validzic, Department of Public Health

FILE NO. 220972 RESOLUTION NO.

[Mental Health Services Act Annual Update - FY2022-2023]

Resolution authorizing adoption of the San Francisco Mental Health Services Act Annual Update Fiscal Year (FY) 2022-2023.

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

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

WHEREAS, In order to access MHSA funding from the State, counties are required to 1) develop Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates, in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Behavioral Health Commission; and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for Three-Year Program and Expenditure Plan (Integrated Plan) for FY2020-2023 on file with the Clerk of the Board of Supervisors in File No. 200669; and

WHEREAS, The San Francisco Mental Health Services Act Annual Update FY2022-2023, a copy of which is on file with the Clerk of the Board of Supervisors in File No. _____, which is hereby declared to be a part of this resolution as if set forth fully herein, complies with the MHSA requirements above, and provides an overview of progress implementing the various component plans in San Francisco for FY2020-2021 and identifies new investments planned for FY2022-2023; and

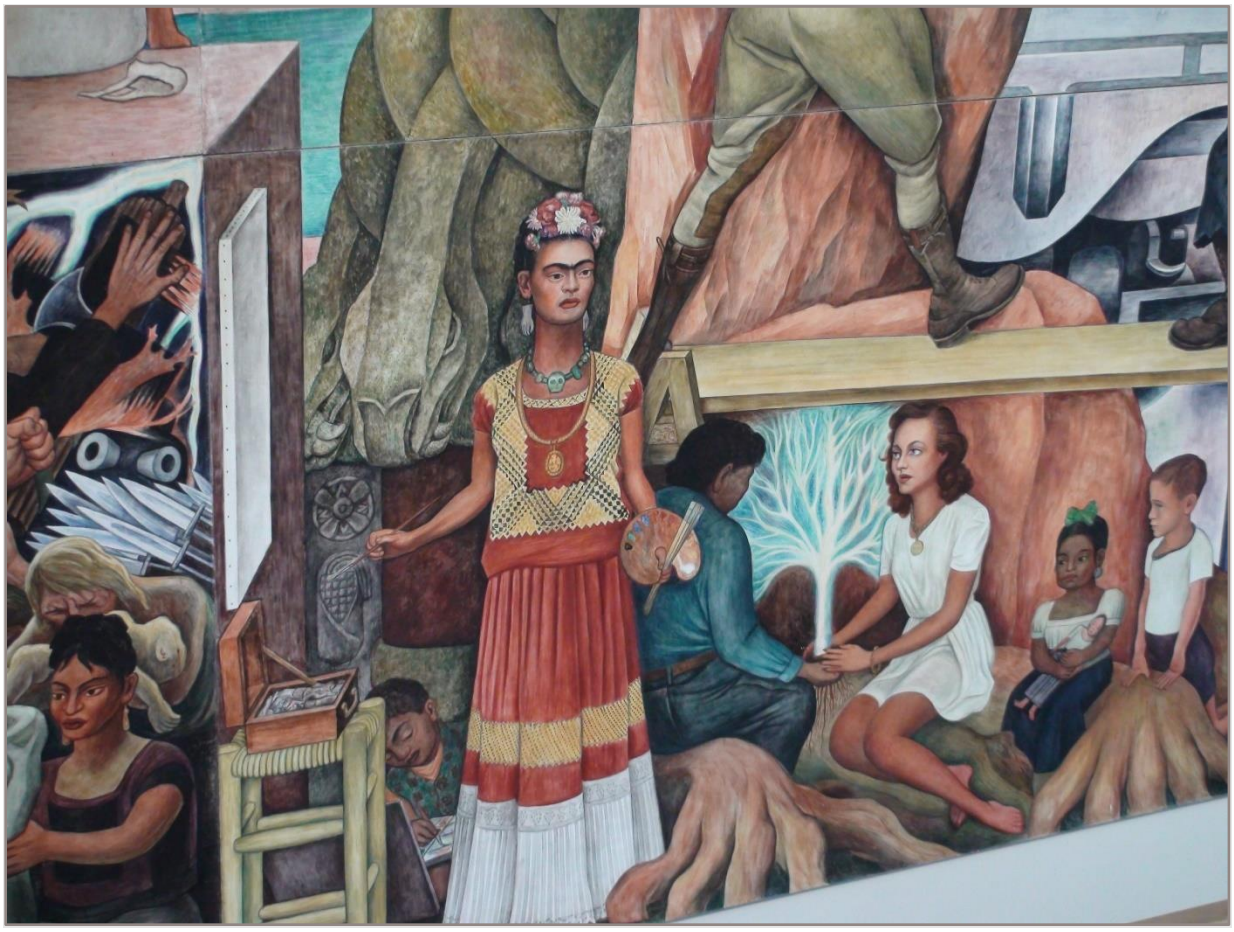
WHEREAS, Recently enacted legislation, California State Assembly Bill No. (AB) 1467, adds the requirement that MHSA Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of Supervisors prior to submission to the State; now, therefore, be it

RESOLVED, That the San Francisco Mental Health Services Act Annual Update FY2022-2023 is adopted by the Board of Supervisors.

San Francisco Health Network
Behavioral Health Services

San Francisco
Mental Health Services Act (MHSA)
2022-23 Annual Update

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



Frida Kahlo appears in Diego Rivera's Pan American Unity Mural, displayed at SFMOMA, on loan from City College SF in 2021

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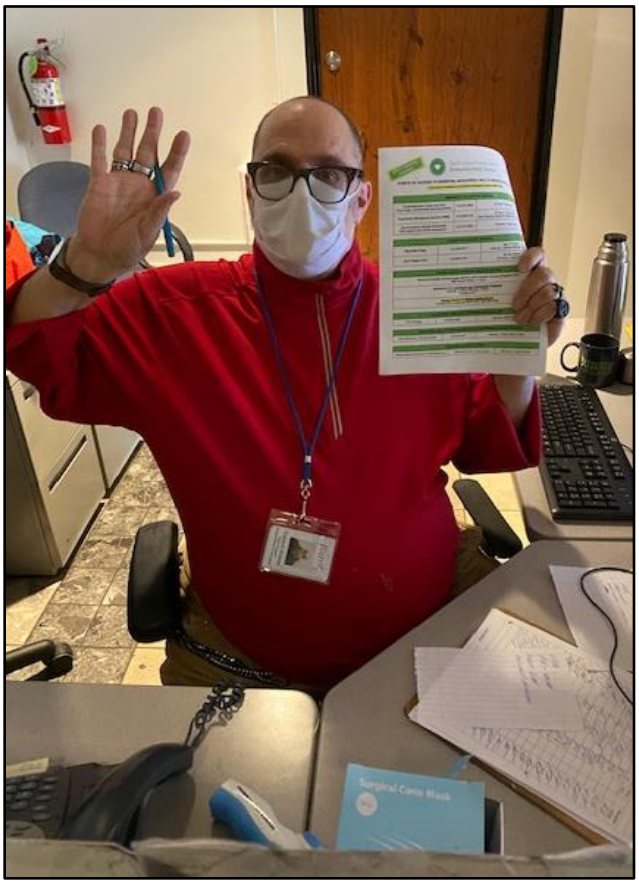
Organization of this Report

The San Francisco Annual Update of the Mental Health Services Act program provides information and updates our work conducted during Fiscal Year 2020-2021, some key updates from FY 2021-2022, and our proposed plans for FY 2022-2023. The report's introductory section provides an overview of the Mental Health Services Act (MHSA), the general landscape of San Francisco, our department's behavioral health response to the COVID-19 pandemic, our Community Program Planning (CPP) activities, MHSA program highlights from the past year, and the report's formal review process.

In our section on activities from FY2020-21, we present highlights for SF DPH MHSA's seven service categories, as well as our Mental Health Promotion and Early Intervention (MH PEI) Programs and Innovation (INN) Programs. Each section also includes a description of the overarching purpose of the service category, an overview of the programs within that category, and a description of the target population.

The sections are as follows: 1. Recovery-Oriented Treatment Services; 2. Peer-to-Peer Support Programs and Services; 3. Vocational Services; 4. Housing Services; 5. Mental Health Promotion & Early Intervention Programs; 6. Innovation Programs; 7. Behavioral Health Workforce Development; and 8. Capital Facilities & Information Technology.



Ed Welcomes Visitors to 1380 Howard in 2021!

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 Behavioral Health Commission. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on July 20, 2021.

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.

_____ _____

Signature Date

Dr. Hillary Kunins

Local Mental Health Director/Designee

County: San Francisco County

Date: July XX, 2022

MHSA County Fiscal Accountability Certification[1]

County/City: San Francisco

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

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: Hillary Kunins, MD, MPH	Name: Ben Rosenfield
Telephone Number: (415) 554-2500	Telephone Number: (415) 554-7500
E-mail: hillary.kunins@sfdph.org	E-mail: ben.rosenfield@sfgov.org
Local Mental Health Mailing Address: 1380 Howard Street 4th Floor San Francisco, CA	

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

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

Hillary Kunins, MD, MPH

Local Mental Health Director (PRINT)

DocuSigned by:
Hillary Kunins
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8/18/

Signature, Date

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

MHSA County Fiscal Accountability Certification

I hereby certify that for the fiscal year ended June 30, 2021 , 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 February 2, 2022 for the fiscal year ended June 30, 2021. I further certify that for the fiscal year ended June 30, 2021, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

DocuSigned by:
2E4612F76714413...

Ben Rosenfield

County Auditor Controller / City Financial Officer (PRINT)

Signature, Date

Director's Message

Since 2004, The California Mental Health Services Act (MHSA) provides funding to enhance other state- and federal funding for public mental health services. MHSA also sets guiding principles of community collaboration, recovery & wellness, health equity, client & family member involvement, and integrated client-driven services. By partnering with a variety of programs throughout San Francisco, MHSA has continued to use MHSA funding to enhance mental health care through an equity and social justice framework that serves and cares for the most vulnerable and marginalized communities.

San Francisco continues to use MHSA funding to address important gaps in traditional sources of behavioral health funding to help address the numerous challenges facing our community; including continuing our pandemic response efforts, serious mental illness, expanding programming to reduce accidental substance use overdose related-deaths, high rates of people experiencing homelessness with concomitant mental health and/or substance use challenges.

In fiscal year 2020/21, the San Francisco Department of Public Health (SFDPH) employees, including many in Behavioral Health, were deployed to fill many roles related to the COVID pandemic beyond their usual work scopes. Additionally, SFDPH, and in particular, Behavioral Health Services began implementation of significant new services under Mental Health SF. Funded by Proposition C, a tax-payer initiative for persons experiencing homelessness, these local initiatives intend to fill significant gaps in behavioral health services in San Francisco, particularly for people experiencing homelessness, and to transform the system of care into a well-coordinated, proactive, accessible, and equitable one. MHSA fits in to both the overall behavioral health systems of care, as well as the expanding work under MHSF and Proposition C, by continuing to center equity throughout our systems of care, promoting peer involvement, and recovery and wellness. This work has included training, education, affinity groups, examining policies and helping to shape the recruitment/hiring process for new employees. MHSA is committed to being a part of San Francisco's behavioral health system transformation that provides behavioral health care to all San Franciscans who lack insurance, are publicly insured, or who are experiencing homelessness.

MHSA-specific projects in FY20/21 included:

- Expansion of capital projects
- Expansion of Full-Service Partnerships: MHSA contributed an additional $2.5 million dollars to expand treatment slots in FSP programs.
- The MHSOAC approved our new Innovation project in FY20/21 with the launch of the "Culturally Congruent Practices for Black/African American Communities" project starting in FY21/22. MHSA hired the first peer employees to staff this initiative with full staffing coming in FY22/23.

In FY22/23, the San Francisco MHSA program will continue to provide services in various wellness categories including prevention, early intervention, vocational, housing, peer-to-peer, workforce development, information technology, and intensive case management services. We also look forward to working closely with MHSA to expand services for those with substance use disorders by leveraging PEI funds for our overdose prevention programs and harm reduction services. As a Division of Behavioral Health Services, MHSA will be working towards the full implementation of Mental Health SF to increase coordination of and timely access to behavioral health care to achieve improved health outcomes for San Franciscans with serious mental illness. In addition, coming in FY21/22 and FY 22/23, we look forward to:

- Hiring of 200+ BHS employees
- Implementation of CalAIM
- Support for Birthing People
- Capital Improvement Projects on 5 clinic sites

In support of the SFDPH mission, the MHSA program is committed to protecting and promoting the health of all San Franciscans and doing “whatever” it takes to support our clients’ journey of wellness and recovery within an equity and social justice lens.

Tracey Helton, MPA
Interim Director, San Francisco Mental Health Services Act

Introduction to MHSA

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.

WELLNESS • RECOVERY • RESILIENCE

The MHSA sets goals for local counties to raise awareness, promote the early identification of mental health problems, make access to treatment easier, improve the effectiveness of services, reduce the use of out-of-home and institutional care, and eliminate stigma toward those with severe mental illness or serious emotional disturbance. Counties were also required to collaborate with diverse community stakeholders to realize the MHSA’s vision of recovery and wellness. This vision was based on the belief in the strengths and resiliency of each person with mental illness and has been fundamental to the development of more comprehensive, innovative, culturally responsive services for individuals and families served by local mental health systems.

As dictated by the law, the majority of San Francisco MHSA funding must be allocated to the development and delivery of treatment services. In San Francisco, MHSA funding has 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."
San Francisco MHSA has worked diligently to expand its programming and better serve all San Franciscans. The following examples illustrate some of the many ways in which MHSA contributes to the wellness of the San Francisco community.

- MHSA works closely with the San Francisco Department of Public Health (SFDPH) Behavioral Health Services (BHS)'s Office of Equity and Workforce Development to share resources and collaborate with programming.
- MHSA invests in the training, support, and deployment of peer providers throughout SFDPH. MHSA partners with local service providers and community members to brainstorm ways to better support the peer provider community.
- MHSA regularly conducts outreach to many different cultures and communities throughout San Francisco in effort to engage outreach workers, identify mental health-related needs in these communities, and provide information on population-specific services available in the City.

SF MHSA strongly promotes a vision of outreach and engagement, a recovery and wellness approach, 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.

MHSA staff at the MHSA Consumer Peer and Family Conference December 2019.

California's 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.

San Francisco City Hall

Behavioral Health Trends in San Francisco

San Francisco ('the City') is a unique, diverse, and complex region. With a land area of only **46.9** square miles and a 2020 population of **873,965,** San Francisco has a population density of **17,179** persons per square mile, the highest density of any US county outside of New York. San Francisco is also extremely diverse, with persons of color making up **59.8%** of the total population.[2, 3]

San Francisco faces severe crises of mental illness, overdose, homelessness, and housing insecurity—each factor exacerbated by the high cost of living and the compounding effects of trauma and systematic racism. In 2020, there were 711 overdose deaths, 61% more than the 441 overdose deaths recorded in 2019 and 220% more than the 222 recorded in 2017. African American/Black San Franciscans are more likely to die of an overdose, at 418.2 per 100,000 people (compared to 91.4 per 100,000 white San Franciscans).[4]

Overdose deaths are being driven by fentanyl and related analogues, often in combination with cocaine or methamphetamine. This trend predates the pandemic. From 2018 to 2019, the rate of overdose death in San Francisco from opioids, cocaine, and methamphetamine increased by 70%. In 2020, males aged 50 to 59 years and Black/African Americans had the highest rates of overdose mortality related to opioids, methamphetamine, and cocaine/crack. During the year following the March 2020 onset of the pandemic, synthetic opioid (i.e., fentanyl) overdoses were responsible for more than doubling the number of deaths of persons experiencing homelessness in SF—totaling 331.5 Elsewhere in the nation, COVID-19 was the leading cause of death among those who were unhoused during that same period.

> **"**Driven by structural forces like systemic racism, years of unjust drug policy that punishes rather than offers care, and unaffordable housing, the overdose epidemic exposes the profound health inequities faced by communities of color. In San Francisco, Black/African Americans have four times the rate of overdose deaths than white San Franciscans. One-third of overdose deaths are among people who are unhoused.
>
> - *Dr. Hillary Kunins*
> *Director of Behavioral Health Services and Mental Health SF*

Other behavioral health indicators point to a mental health *Services and Mental Health SF* crisis in the City, and in the country as whole. In SF, the number of hospitalizations among adults due to major depression exceeds that of asthma or hypertension, and the City's per capita suicide rate is **twice as high** as its homicide rate, with suicide being the **12th** leading cause of death.[7] SFDPH BHS reported a **33% citywide increase in client suicide attempts** (requiring and not requiring emergency service interventions) and a **13% increase in deaths among adult and older adult clients**, most of which are expected to be related to increased suicide and mental health-related issues upon further investigation. Community-based social service providers report seeing increased numbers of clients with mental health and substance use issues.

COVID-related mental health stressors and access issues have likely disproportionately impacted **historically marginalized Black/African American and Latinx communities** in San Francisco. These communities are often affected by higher incidence and prevalence rates of COVID-19, inequities that in turn intensify adverse mental health due to the impact of social determinants of health such as poverty, violence, substance use, exposure to trauma, systematic racism, and unemployment.

SF saw a 76% increase in the number of people who are unsheltered and experiencing homelessness between 2010 and 2020, compared to a statewide increase of 31%. This staggering rise in California occurred as homelessness nationwide actually *decreased* by nine percent. Indeed, roughly 30% of the growth in homelessness occurring in the U.S. since 2017 can be attributed to just the Bay Area, with San Francisco "virtually tied with New York City and the District of Columbia for the highest concentration of homelessness in the nation."[8] The behavioral health needs of this population far outweigh resources.

Among those who are experiencing homelessness in SF, 41% self-report having a substance use disorder (SUD) and 39% self-report having a psychiatric condition.[9] The Department of Housing and Urban Development determined that a minimum of 45% of people who are homeless have a mental illness, including 25% with severe mental illness.[10] An in-depth data analysis by San Francisco's Mental Health Reform team found that, among all adults who experienced homelessness in 2018-19, 22% (or 4,000 individuals) also suffered co-occurring mental health and substance use disorders.[11]

On December 6, 2019, the San Francisco Board of Supervisors passed an ordinance amending the Administrative Code to establish Mental Health San Francisco (Mental Health SF). This program is designed to expand access to mental health services, substance use treatment, and psychiatric medications to adult San Francisco residents with serious mental illness and/or substance use disorder who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. The Ordinance establishes a Mental Health SF Implementation Working Group to advise policymakers – via formal recommendations – on the design and implementation of Mental Health SF efforts.

Mental Health SF Street Crisis Response Team

November 2021 marked the one-year anniversary of the launch of the Street Crisis Response Team, as part of Mental Health SF. In this first year, the initiative grew to include six teams who are providing San Francisco with 24/7 citywide coverage. The teams respond rapidly to people who are having a crisis on City streets with a behavioral health approach that deescalates situations and addresses a person's immediate needs for care, treatment, and shelter.
In the first year, SCRT has **engaged with nearly 3,000 people in crisis**. In early 2022, a seventh team with six additional staff will launch to provide additional coverage. Demonstrating the program's success as an alternative to law enforcement, SCRT diverted more than one-third of all 911 calls (38%) for "mentally disturbed persons" from law enforcement cumulatively during its first year of operation. With six teams launched, SCRT is now diverting over half (58%) of calls monthly for "mentally disturbed persons" from law enforcement. Once fully operational, SCRT seeks to divert 100% of calls. SCRT is an important component of the City's Mental Health SF initiative for transforming the behavioral systems of care. Most people who SCRT serves (76%) are currently experiencing homelessness, a condition that puts them at significantly higher risk for negative health outcomes and creates challenges in accessing services and long-term mental health and medical care. SCRT's street-based response offers a different approach from the traditional facility-based care by delivering support directly to communities.

[2] U.S. Census Bureau QuickFacts for San Francisco County, California. 2020. https://www.census.gov/quickfacts/sanfranciscocountycalifornia
[3] San Francisco Community Health Needs Assessment 2019 https://www.sfdph.org/dph/hc/HCAgen/2019/May%207/CHNA_2019_Report_041819_Stage%204.pdf
[4] Jung, Yoohyun. San Francisco Accidental Overdose-Related Deaths, San Francisco Chronicle Special Report April 26, 2022. https://www.sfchronicle.com/projects/2021/san-francisco-drug-overdoses-map/
[5] Cawley, Caroline, et al. "Mortality Among People Experiencing Homelessness in San Francisco During the COVID-19 Pandemic." *JAMA Network Open*, vol. 5, no. 3, 2022.
[6] Coffin, Phillip O. MD MIA, et al. "Substance Use Trends in San Francisco through 2020," DPH, City and County of SF, Dec. 20, 2021. https://www.csuhsf.org/substance-use-trends-san-francisco
[7] Local Homeless Coordinating Board. "Healthy Streets Operation Center, Public Safety & Neighborhood Services Presentation." *SF HSH*, Healthy Streets Operation Center, 20 November 2019.
[8] Bay Area Council Economic Institute. "Bay Area Homelessness, New Urgency, New Solutions." *Bay Area Council Economic Institute*, June 2021.
[9] Local Homeless Coordinating Board. "Healthy Streets Operation Center, Public Safety & Neighborhood Services Presentation." *SF HSH*, Healthy Streets Operation Center, 20 November 2019.
[10] Tarr, Peter. "Homelessness and Mental Illness: A Challenge to Our Society." *Brain & Behavior Research Foundation* |, 19 November 2018.
[11] Bland, Anton. "Mental Health Reform." *Department of Public Health*, San Francisco Department of Public Health, October 2020

SFDPH MHSA Response to COVID-19

During the COVID-19 pandemic, San Francisco and its residents have faced intersecting public health, mental health, and economic crises. Recognizing that the pandemic itself has strained San Franciscans' mental health, the SFDPH MHSA team has intensified its efforts to address residents' mental health needs.

Starting in the spring of 2020, at the onset of the pandemic, MHSA staff quickly adapted to make programs accessible virtually. MHSA staff were soon deployed as Disaster Service Workers in response to the Mayor's declared citywide emergency to provide hands-on support with the City's COVID-19 relief efforts, including peer support, vaccine delivery, contact tracing, and task force leadership and guidance.

SF Thank You to Healthcare Workers, 2021

As 2021 marked the second year of the global pandemic, MHSA staff worked to better understand the needs of community members and our service provider partners, particularly for historically marginalized groups who were affected disproportionately by the pandemic, including Latinx, Black/African American, and housing insecure populations. In effort to meet these needs, MHSA provided additional funding for our community-based programs to create and deliver culturally-resonant responses for their communities. Some of the program successes include:

- Behavioral Health in Primary Care patients were provided with assistance to travel to vaccine sites and manage their second dose appointments. Some homebound clients received in-home vaccination from Curry Senior Center, an MHSA-funded program.
- RAMS Asian & Pacific Islander Mental Health Collaborative Community Partners (the Filipino Mental Health Initiative, San Francisco Samoan Wellness Initiative, and South East Asian Mental Health Initiative) advocated for and received additional funds so their respective communities could purchase culturally-specific foods and ingredients to supplement donations from food security organizations.
- Hospitality House was funded to purchase more PPE (personal protective equipment) for their staff who conduct outreach in hard-hit communities (specifically in the Tenderloin & 6th Street corridor).
- Mental Health Promotion and Early Intervention Programs made wellness checks by phone with their community members - asking how they were doing, what kinds of support do they need and connecting them with resources.
- Workforce development programs FACES for the Future (a high school health care/mental health care career track program for juniors and seniors), the Community

Mental Health Academy (a 16-week workshop series for frontline staff of non-mental health programs – e.g. after school programs – who can benefit from a community mental health knowledge base and basic counseling skills) , and City College of San Francisco's Addiction & Recovery (substance abuse treatment) Counseling certificate program and Community Mental Health Certificate Program (prepares students for entry level mental health care roles) smoothly transitioned from in-person classes to remote learning. More details about these programs are provided in the program descriptions of the annual update section of this report.

- Through the Technology Assisted Mental Health Solutions Project, BHS offered 10,000 free Headspace Wellness app licenses to individuals who live and/or work in San Francisco to support wellness. For FY 21-22, MHA SF is planning on distributing up to 60 devices (tablets and keyboards) and accompanying WIFI to clients, focusing on Transitional Age Youth (TAY) and Transgender community members, in order for them to participate in digital literacy education and receive support to access on-line mental health resources.

MHSA Advisory Board

The MHSA Advisory Board transitioned to virtual meetings in March 2020, before shelter in place mandates, in order to protect participant safety. This shift away from in-person meetings is allowing participation of community members who otherwise would not have been able to attend meetings.

Community Program Planning (CPP) & Stakeholder Engagement

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

Community Program Planning (CPP) & Stakeholder Engagement Activities

Exhibit 1 provides an overview of San Francisco's ongoing CPP activities. San Francisco MHSA employs a range of strategies to engage stakeholders at all levels of planning and implementation. Our CPP process provides opportunities for stakeholders to participate in the development of our three-year plans and annual updates, and stay informed of our progress in implementing MHSA-funded programs.

Exhibit 1. Key Components of MHSA CPP

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

In addition to the ongoing CPP activities listed in Exhibit 1, MHSA hosts activities and events throughout the year to promote mental health awareness. Since the onset of COVID-19 pandemic, these activities have moved to virtual and socially-distanced settings but continue to engage community members.

In honor of "May is Mental Health Awareness Month," SF DPH worked with the City of San Francisco to light San Francisco City Hall green on May 6, 2021, as lime green is recognized as the official color of mental health awareness. On May 10th City Hall was also lit up in lime green in honor of National Children's Mental Health Awareness. SF DPH also offered webinars, trainings, and promotional materials to bring further awareness in May including webinars on Psychological Safety and Wellness during a Global Pandemic, Headspace App training, promotional giveaways, and peer success presentations. Suicide Prevention and Awareness outreach activities have transformed in recent years. In 2021, SFDPH adopted a new approach

to connecting with our community by partnering with local organizations for Suicide Awareness month in September. We built on our partnerships with service providers, such as Rafiki Coalition for Health and Wellness, and affordable housing providers, including La Fenix in the Mission, and other new partners to display suicide awareness campaign posters and brochures, in English and Spanish. SFDPH also tabled at a health and safety event hosted by Old Navy, with a new nonprofit partner, The Struggle, to deliver additional outreach materials, as well as LGBTQ+ mental health awareness brochures, suicide awareness tent cards, and half-sheet handouts on “Know the Signs.”

MHSA Communication Strategies

San Francisco Department of Public Health seeks to keep stakeholders and the broader community informed about MHSA through a variety of communication strategies, including the SF BHS MHSA website, regular communication with community groups, contributing content to the monthly Community BHS Director’s Report, and providing regular updates to stakeholders. The San Francisco MHSA webpage on the SFDPH website, https://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp provides up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The webpage is now hosted through the San Francisco Department of Public Health website. The monthly BHS Director’s Report provides another forum for sharing information about the implementation of MHSA with a broad group of stakeholders. Each month, MHSA provides updates about program implementation, upcoming meetings and other MHSA news.

Each Mind Matters outreach table at 1380 Howard in 2021

MHSA Advisory Committee & Our Commitment to Consumer Engagement

MHSA Advisory Committee

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

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

The MHSA Advisory Committee's robust recruitment efforts focuses on engaging members from the mental health community, with an emphasis on the following underrepresented community members: those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of over 25 active members. For 2021, the MHSA Advisory Committee meeting schedule was as follows: 5/5/21, 6/30/21, 9/29/21 and 12/8/21. The purpose of these meetings is to gather Committee member feedback on MHSA programming and the needs of priority populations. The 2021 meetings covered the following important topics, training and collaborative efforts:

- BHS Racial Equity Action Plan and Racial Equity Champions
- BHS and Trauma-Informed Systems
- Cultural Competency Reporting
- Training on:
    - Unlearning Racism
    - Administering Naloxone/Narcan with BHS Pharmacy Team
    - Program evaluation and logic modeling
- Peer programming and the 2021 Peer Forum
- MHSA 2022-23 program planning and reporting on FY2020-21
- Additional collaborations with the BHS Cultural Competence Task Force, the BHS Office of Equity and Workforce Development, and the BHS Office of Quality Management

Increasing Consumer Engagement with the SF BHS Client Council

MHSA and the San Francisco Behavioral Health Services Client Council. The Client Council is a 100 percent consumer/client driven and operated advisory body. The mission of the Client Council is to support San Francisco mental health consumers/clients 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 use services. As a result of this new collaboration, the Client Council and MHSA Advisory committee share some members.

The BHS Client Council remains flexible in providing support to our clients as we respond to changing needs in the community. Throughout 2021, the Council met virtually every third Tuesday of the month. The Council responded to numerous inquiries for support in implementing program changes through the system of care. For example, the Street Crisis Response Team requested input from the Client Council in designing the program evaluation. Other presenters who have sought input and feedback from the Client Council have shared how helpful feedback has been and are requesting to return to the council for additional support in the future.

Strengthening Relationships

MHSA engages with various oversight bodies, including the SF Behavioral Health Commission and the Health Commission, to gather feedback and guidance. Additionally, via the BHS Director and the Mental Health SF MHSF Leadership Committee, we ensure that programmatic areas funded or supported by MHSA compliment and/or extend MHSF work, but do not duplicate efforts. The relationship between MHSA and these groups provide an ongoing channel of communication and support.

Community Program Planning session in 2019.

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

MHSA has also recently increased collaborative efforts with the Health Commission by presenting new MHSA strategies and collecting feedback from this valuable oversight body. MHSA has also started sharing program and department updates with the SF Integration Steering Committee to collect additional input on MHSA activities before presenting to the full Health Commission. MHSA has presented to the MHSF Steering and Leadership Committee, to share the vital work of MHSA that centers equity and client participation and decision-making. Similarly, via regular BHS Executive Team meetings, where work across BHS is shared and reviewed, initiatives are coordinated and program leaders provide and receive feedback between the MHSA and other programs and systems of care.

Recent Community Program Planning Efforts

Community Program Planning and the MHSA 2022-23 Annual Update

SFDPH continued our extensive community outreach and engagement efforts to inform program planning for the MHSA 2022-23 Annual Update. Community members' voices are critical in guiding MHSA program improvements and developing new programming. Beginning in 2020, due to the COVID-19 pandemic, community outreach and engagement efforts moved to a virtual format. While the nature of virtual community meetings can pose new barriers to engagement, such as access to technology, it also allowed us to continue to build connections with our community during the COVID-19 pandemic. Virtual meetings also provided opportunities for us to reach new audiences who may otherwise have faced barriers to attending in-person meetings, such as transportation. This report provides a comprehensive overview of our community outreach and engagement efforts and key findings in 2020-21 programming, and our plans to integrate community feedback into MHSA programming. SFDPH remains committed to conducting community outreach and engagement to ensure consumers have the appropriate wellness tools and resources to support them in their recovery journey.

The SFDPH MHSA team consistently engages with the community and conducts ongoing and extensive CPP efforts. In 2021, the MHSA team captured community member feedback and integrated feedback into our program improvement efforts through a transparent process. Meeting announcements, participant registration, open communication, thorough and note-taking, and follow-up efforts have led to successful and meaningful community participation in our program planning efforts. When CPP efforts moved to virtual community meetings in March 2020, collection of demographic data of our CPP participants became more challenging. The team has since identified a solution to collect these data but data for the year are limited.

MHSA staff presents at 2019 CPP meeting on Housing Needs

Community and Stakeholder Involvement

SF DPH strengthens our MHSA program planning by collaborating with behavioral health service consumers, their families, peers, and providers to identify the most pressing behavioral health-related needs of the community and develop strategies to meet these needs. In 2021, **MHSA hosted 20 community engagement meetings across the city** to collect community member feedback on existing MHSA programming and better understand the needs of the community and to develop this annual update. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders. In recent years, the MHSA team identified certain groups that had not been involved in previous CPP. We are happy to report that we have since increased our outreach efforts to include more involvement with certain stakeholder groups, including local veterans, Transition Age Youth, vocational program participants, the

Older Adult community, the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) community, primary care and medical staff, employees of municipal agencies and law enforcement.

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

The 2021 CPP meetings are listed in the following table.

2021 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening** ***(most meetings held virtually due to COVID-19)***
2/1/21	MegaBlack SF Community Meeting –CPP Culturally Responsive Practices for Black/African American Communities
2/25/21	Vocational and ICM Program Planning Meeting: Stakeholder Planning CPP
3/12/21	City College of San Francisco: Addiction & Recovery Counseling Certificate Program Community Advisory Committee Meeting
3/15/21	Vocational and ICM Program Planning Meeting: Stakeholder Planning CPP
3/25/21	Family Support CPP Peer-to-Peer Services Discussion on Needs
4/7/21	Stakeholder Planning CPP Meeting: Culturally Responsive Practices for Asian/Pacific Islander Communities
4/21/21	Stakeholder Planning CPP Meeting: Culturally Responsive Practices for Asian/Pacific Islander Communities
4/21/21	Impact Meeting: Gathering Input on Evaluation Measures and Logic Models
5/4/21	Vocational and ICM Program Planning Meeting: Stakeholder Planning CPP
5/5/21	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
5/5/21	Indigena Health & Wellness Collaborative Stakeholder Planning Meeting
5/11/21	Filipino Mental Health Initiative - San Francisco and AGASAN: CPP to discuss/address ancestral trauma & self-care

2021 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening** ***(most meetings held virtually due to COVID-19)***
6/8/21	Filipino Mental Health Initiative - San Francisco and AGASAN: CPP to discuss/address ancestral trauma & self-care
6/9/21	Innovation Project Stakeholder Planning CPP Meeting: Culturally Responsive Practices for Black/African American Communities
6/17/21	Impact Meeting: Data Collection to inform MHSA Program Success/Evaluation
6/23/21	Peer-to-Peer Forum: Input Gathering from Peer Specialists and Consumers
6/30/21	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
8/11/21	Innovation Project Stakeholder Planning CPP Meeting: Culturally Responsive Practices for Black/African American Communities
9/29/21	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
12/8/21	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting

In each community meeting, MHSA staff presented an overview of the Mental Health Services Act, including its core components, guiding principles, and highlights of existing programs and services. Staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health needs and strategies to address these needs. These discussions also addressed how DPH can improve existing MHSA programming. Feedback from community members at the meetings was captured live, on flip charts and via transcription, to maintain a high-level of transparency. MHSA staff addressed how the feedback would be incorporated into the MHSA 2022-23 MHSA Annual Update and inform future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the MHSA 2022-23 MHSA Annual Update.

Community and Stakeholder Feedback

The feedback and input shared by our community stakeholders is under careful review and consideration by MHSA leaders and staff. This valuable feedback will be used to guide and refine MHSA-funded programming. Community and stakeholder feedback is typically scheduled around existing community meetings with service providers, the MHSA Advisory Committee, and other community partners, in order to reach a large number of community members. This also allows MHSA staff to collaborate with service providers, consumers, and stakeholders who work with historically marginalized and underserved populations. These service providers often hold a valuable connection to the community and provide unique perspective and suggestions on MHSA programming and the needs of our community.

> ***"I really appreciate uplifting Black Trans folk. I want to be sure we also uplift Black Migrants."***
> - *Community Member*

Community Program Planning shifted in 2021, with many community members recognizing the emerging challenges that arose from the pandemic in the "new normal." Those with behavioral health challenges suffered due to illness, illness and death of friends and family, social isolation, inability to continue with their normal routines, healthcare and other service interruptions, and financial and housing insecurity. Furthermore, homelessness and the increasingly deadly drug overdose epidemic was seen and felt by all community members, which has led to an overwhelming sense of crisis. However, there is also a deepened sense of community, heightened levels of awareness and empathy, and a revitalized focus on healing. The community meetings MHSA staff attended in effort to plan MHSA program improvements uncovered many basic needs of the community and identified specific ways to meet those needs. Many community members are feeling increased stress related to the pandemic, including lost wages, work/school and childcare interruptions, and illness. Meetings still focused greatly on the City's greatest challenges around homelessness and housing insecurity, income inequality, community effects of substance use and accidental overdose, serving historically marginalized and underserved populations - including Black/African American, Latinx, Asian/Pacific Islander, Transitional Age Youth, transgender populations, those who are housing insecure, socially-isolated seniors, and others.

<u>Asian Pacific Islander Community Feedback</u>

- Increase focus on reducing Asian racism and create inclusive campaigns in partnership with immigrants and other population subgroups
- Acknowledge and address the stigma within the API community around receiving services
- Reduce stigma within the API community by offering more culturally-responsive, community-oriented services and community events
- Incorporate best practices for serving the API community and identify where there are gaps in services by looking at data
- Continue to meet the demand of language capacity needs and reduce the amount of time clients are waitlisted
- Language diversity is increasing and there is a resulting need for translation services and cultural sensitivity trainings.
- Continuing barriers for these community groups relate to language barriers, lack of trust with government systems, and fear of losing immigration status.

> ***"Our best bet would be an improving mental health project addressing stigma and the impact of hate violence.***
>
> - *Community Member*

- Clients prefer appointments with a community member, advocate, or translator who speaks and understands their language and culture. Language barriers persist especially for the South Asian communities. Traumatic events experienced in this country and internationally have had a huge impact in residents receiving much needed care. Two big examples of this are violence against the elderly (specifically the North Beach neighborhood), and time previously spent in refugee camps.
- Due to the impact of traumatic events in the API community, CPP participants prioritized the need for trauma-informed care across government-based services.
- Overall, the behavioral health budget should be increased to meet the needs of the community.

Black/African American Community Feedback

- There is a need for cultural healing practices for Black/African American community, such as Healing Circles, art therapy, quilting, storytelling, group exercise classes, traditional ceremonies, herbs
- There is a need to encourage community to participate in all areas of positive health to address overall wellness
- Emotional wellness can be promoted through stress and trauma reduction, support groups, physical wellness through exercise classes, nutrition education and healthy food access, spiritual wellness through healing circles and mindfulness practices, environmental wellness through healthy spaces, social wellness through healthy community connections, financial and intellectual wellness with financial literacy, education, and skill building.

> ***"To reduce health disparities, build a strong sense of community and improve the health and well-being of African American individuals and families Citywide."***
>
> ***-****YMCA Service Provider*

Latinx Community Feedback

- Mental and behavioral health and wellness services are at maximum capacity with long waitlists - acting as a barrier to accessing services for many people
- Programming should be available virtually and in-person, whenever possible, to ensure ease of access
- Bringing food to community meetings has contributed to significant increase in engagement - this is, at least in part, due to client's inability to access healthy and affordable foods in the pandemic, most often due to lost wages
- MHSA should work with service providers who are connected to indigenous populations

Community Feedback from the MHSA Advisory Council

- There is a need for intranasal naloxone to be widely available, along with training on how to use it
- Service delivery staff should be trained in trauma-informed care.
- Staff should also be trained in unlearning racism.
- There are critical staffing shortages at many health clinics across the city

Peer Programming Feedback

- There is a need for more peer voice in BHS housing programs
- Other city programs need peer supervisors
- Peer programs need a better way to work together - to create a service network

- These programs are great but there is still not enough support offered to struggling families whose loved ones are severely mentally ill

Commitment to Continuous Program Improvements

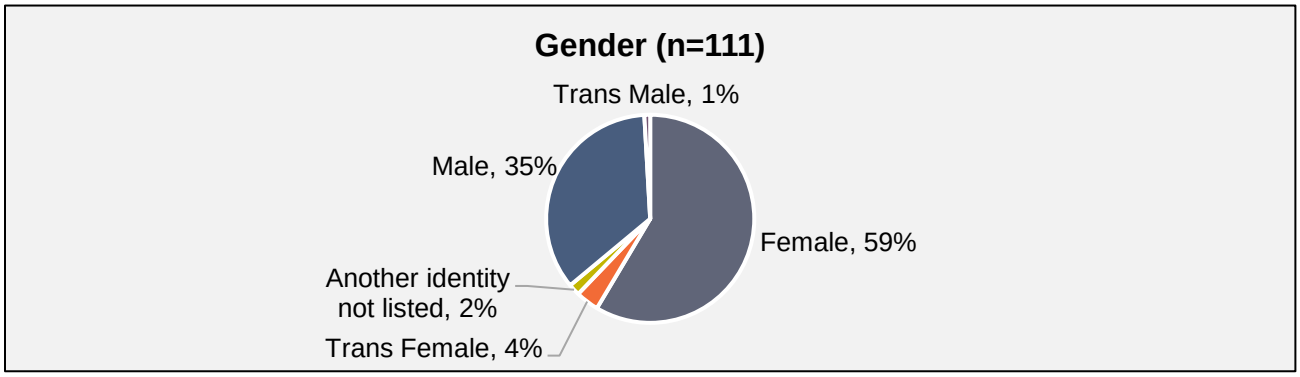
The needs of the community continue to be large and are differentiated across the many populations that are part of San Francisco. MHSA continues to engage with service providers and clients in effort to refine programming and evaluate overall program effectiveness to understand how we are meeting the needs of different communities. Additionally, MHSA is working to compliment the significant and needed new programs and system of care reforms taking place in San Francisco under Mental Health SF and Proposition C.

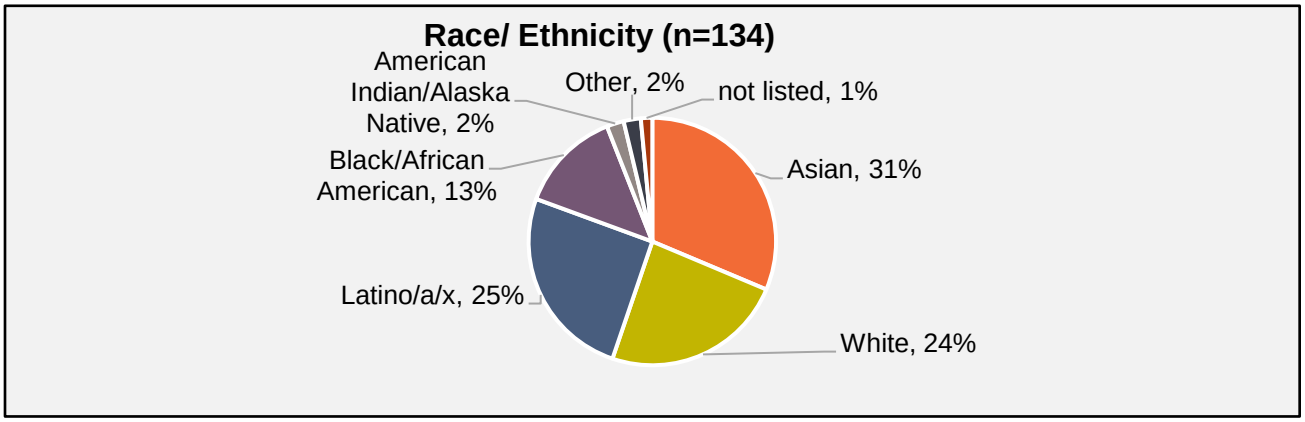
SF MHSA has begun the 5-Year Workforce Development Needs Assessment and Strategic Plan for 2022-2027 with expected completion by June 30th, 2022, for a launch of our plan on July 1, 2022. We are also identifying staff capacity for SF-MHSA to implement all MHSA activities listed in the FY22/23 Annual Update.

CPP includes a focus on the Needs of Trans Women of Color

CPP Meeting Participation

Many CPP meetings were unable to collect participant demographic data. For that reason, only MHSA Advisory Meeting data are included below.





Community Program Planning with Service Provider Selection

MHSA includes elements of the CPP in developing and refining each of our programs. Frequently, this takes the form of an ad hoc committee or planning groups made of various stakeholders, including people with expertise or lived experience of specific populations. The MHSA principle of engaging consumers and family members is applied to all programs. The following are examples of recent CPP efforts to support development of Request for Proposals (RFP) or Request for Qualifications (RFQ) and contracting with service providers.

- Peer-to-Peer Behavioral Health Services
- Vocational Rehabilitation Services
- Faces for the Future
- Peer-to-Peer Employment Services & Peer Specialist Mental Health Certificate program
- Mental Health Certificate Program

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

- Black African American Wellness and Peer Leadership Program (BAAWPL)
- Community Drop-In Services
- Peer Health and Advocacy programs

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

We want to thank all of our collaborative partners including San Francisco's community members, behavioral health consumers, peer specialists, service providers and individuals with lived experience and family members.

Assessment of San Francisco's Mental Health Needs and Capacity to Implement Proposed Services

The County must include a narrative analysis of its assessment of the County's mental health needs and its capacity to implement proposed programs/services. Below is a brief summary of our work to meet these regulations. In 2019, SFDPH BHS/MHSA set a goal of understanding the current composition of the BHS civil service workforce and then described progress made towards the aims of the 2017-2022 Workforce Needs Assessment and Strategic Plan. An initial data crosswalk was completed to identify data needs and gaps, while checking against MHSA regulations to ensure County compliance. Quantitative workforce and consumer data were then identified, collected, and analyzed. Qualitative data on progress towards the Plan's four goals was collected through interviews and review of secondary program documents.

In addition, data for the Needs Assessment Update was collected on 680 BHS civil service staff from the internal Human Resources (HR) database, and on 18,190 BHS consumers from the SFDPH electronic health record system, Avatar. Publicly available demographic data on the Medi-Cal eligible population in the City and County of San Francisco was also used. Finally, as recent data was unavailable, data from 2014 on BHS contractors was pulled from the *San Francisco Behavioral Health Services Workforce Disparities Analysis* report as part of the original planning process for the initial 2017-2022 Workforce Needs Assessment and Strategic Plan. Data were analyzed to create a demographic profile of BHS Civil Service staff and to identify distinctions between civil service provider type. When possible, characteristics of the BHS contractor population (as of 2014) are outlined. The analysis also examines comparisons between workforce and consumer demographics to ensure that we are meeting the demographic needs of our behavioral health consumers.

For a summary of the data described above and for additional background information on population demographics, health disparities, and inequalities, please see the 2019 San Francisco Community Health Needs Assessment located at

https://www.sfdph.org/dph/hc/HCAgen/2019/May%207/CHNA_2019_Report_041819_Stage%204.pdf.

Please also see our Community Program Planning (CPP) section for a detailed summary of the mental health needs identified by San Francisco community members and stakeholders. In the coming years, SF-MHSA is planning to conduct another more thorough assessment. This new assessment will better highlight the mental health needs of San Francisco and the BHS/MHSA workforce's ability and capacity to address these needs. This robust new assessment is intended to be a component of our next Three-Year Program and Expenditure Plan.

Program Implementation

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

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

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Proposition 63, an emphasis was placed on the importance of consumer participation in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. **SF-MHSA funded 323 peers in FY20/21** throughout our behavioral health system. Consumers can be found working in almost all levels and types of positions, including: peer counselors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management.

San Francisco's Integrated MHSA Service Categories

As discussed in the introduction to this report, San Francisco's initial MHSA planning and implementation efforts were organized around MHSA funding components - Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components. The Mental Health Services Act, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, MHSA realized that developing an Integrated Plan with a common vision and shared priorities is difficult when funding streams were used as the framework. In partnership with our stakeholders, MHSA simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 2 below). These MHSA Service Categories have allowed us to plan programs and services for specific populations and to expand our continuum of services with clear outcomes – including integration of peers into service delivery, promoting culturally competent care, increasing access to housing and employment, and developing high quality recovery-oriented treatment services. **It is important to note that several of our Service Categories include services funded by Innovations (INN).** INN funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes.

Exhibit 2. MHSA Service Categories

MHSA Service Category	Description
Recovery-Oriented Treatment Services: *CSS Funding*	● Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment) ● Uses strengths-based recovery approaches
Peer-to-Peer Support Services: *CSS Funding*	● Trains and supports consumers and family members to offer recovery and other support services to their peers
Vocational Services: *CSS Funding*	● Helps consumers secure employment (e.g., training, job search assistance and retention services)
Housing: *CSS Funding*	● 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
Mental Health Promotion & Early Intervention Services: *PEI Funding*	● Raises awareness about mental health and reduces stigma ● Identifies early signs of mental illness and increase access to services
Behavioral Health Workforce Development: *WET Funding*	● 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: *CFTN Funding*	● Improves facilities and IT infrastructure ● Increases client access to personal health information

Developing this Annual Update

The SF DPH MHSA 2022-23 Annual Update developed in collaboration with MHSA consumers, peers, family members, service providers, local residents, and other stakeholders. The SF DPH MHSA community outreach and program planning efforts were coordinated by a core team of MHSA staff, which included the MHSA Director and Program Managers. Independent consulting firms, Hatchuel Tabernik & Associates and Harder+Company Community Research, provided assistance with program planning and implementation, project management, coordination, community outreach, technical writing, and program outcome data analysis and reporting.
In the planning work conducted for the 2022-23 Annual Update, the MHSA team incorporated the stated goals of the Mental Health Services Act, the mission of the San Francisco Department of Public Health, newly expanding work in behavioral health funded under Mental Health SF, local data about community need, and revisited our local MHSA priorities and needs identified in our 2017-2020 Program and Expenditure Plan and subsequent Annual Update Reports. Most importantly, the Community Program Planning (CPP) strategies outlined in the previous section of this report enabled the MHSA team to identify and integrate direct program feedback from the individuals we serve, and the greater community, in planning for future MHSA programming. In addition to incorporating community feedback into our planning process, the MHSA team relied on several other strategies to inform future program improvements, including:

- Reviewing the recent three-year MHSA Program and Expenditure Plan (2020-2023) and MHSA Annual Update Reports submitted for each MHSA component. This was done to understand how well priorities identified in those plans have been addressed and determine if all programs had been implemented as originally intended.
- Reviewing MHSA regulations, laws and guidelines released by the State (e.g., Department of Mental Health, Mental Health Services Oversight and Accountability Commission, California Housing Finance Agency, and new IMHSA Innovations and Prevention and Early Intervention regulations) to ensure all required reporting information is incorporated in this plan.
- Reviewing informational materials produced by California Mental Health Services Authority, California Mental Health Director's Association, and Office of Statewide Health Planning and Development.
- Reviewing MHSA Annual Year-End Program Reports and demographic data submitted by SF DPH contractors and civil service providers.
- Conducting program planning with service providers and consumers through robust contracting efforts throughout the Department

Local Review Process

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

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA FY2022-23 Annual Update was posted on the MHSA website at www.sfdph.org/dph. **The MHSA FY2022-23 Annual Update was posted for a period of 30 days from June 17, 2022 through July 20, 2022.** Members of the public were requested to submit their comments either by email or by regular mail. The following is a summary of the public comments during the 30-day posting and Behavioral Health Commission:

Summary of Public Comments and BH Commission on the FY22/23 MHSA Annual Update		
Community Member	**Summary of Comments**	**DPH Response**
Wynship Hiller	Stakeholder was concerned that the initial 30-day posting ended before the BH Commission meeting and concerned that the comments at the BH Commission would not be included in this Annual Update.	DPH responded directly to the BH Commission to clarify that all comments/revisions from the BH Commission will be included in the Annual Update. The posting close date was also extended.
Liza Murawski	Stakeholder commented that the Annual Update should further break down data tables to include more data, rather than displaying data in groups/categories. Comment also requested evaluation criteria to explain how certain wraparound services displayed client improvement.	DPH responded to stakeholder to explain that these comments will be included in the FY22/23 Annual Update. These comments will be discussed in an upcoming MHSA leadership meeting as well.
Terezie Bohrer	Stakeholder asked questions about the specific number of clients served in programs, questions about unspent Innovation funding and other clarifying questions about specific programs.	DPH responded to stakeholder to explain that these comments will be included in the FY22/23 Annual Update. These comments will be discussed in an upcoming MHSA leadership meeting as well.
Michael Schocket	Stakeholder emphasized the need for MHSA to continue funding the Department of Rehabilitation vocational program to serve residents of SF.	DPH responded to stakeholder to explain that these comments will be included in the FY22/23 Annual Update. SF-MHSA will continue funding this vital program.

Wynship Hiller	Stakeholder noted that there are no special members of any kind at the BH Commission, as noted on page 19. Stakeholder also noted that it may be against MHSA regulations to fund the BH Commission staff.	Page 19 was revised to reflect accuracy. These comments will be included in the FY22/23 Annual Update. These comments will also be discussed in an upcoming MHSA leadership meeting.
Stephen Banuelos	Stakeholder inquired which MHSA programs are funded fully by MHSA dollars and which programs are funded partially by MHSA. Stakeholder asked other clarifying questions and provided a revision on page 79.	Page 79 was revised to reflect accuracy. Answers to these questions were shared at the BH Commission meeting.
Lisa Wynn	Stakeholder inquired about the vetting process for psychologists, telehealth services, screening for peers, overdose rates for fentanyl, statistics for the homeless communities, ESL emotional support learning programming, the integrated service delivery system, evaluating wellness and recovery and other questions.	Answers to these questions were shared at the BH Commission meeting.
Comments from various BH Commission Members and Stakeholders at the 7/20/22 public hearing	1. Stakeholder asked MHSA to list the organizations that MHSA is funding versus MediCare, SUD, etc. 2. Stakeholder asked if MHSA funds were being routed through HSH (Dept of Homelessness and Supportive Housing). 3. Stakeholder asked about data that tracks engagement and milestones for clients along their wellness and recovery journey. 4. Stakeholder asked about staffing ratios of staff vs. caseloads. Stakeholder also asked about evaluation measures. 5. Stakeholder asked for a list of activities and programs that MHSA funds.	Answers to these questions were shared at the BH Commission meeting. 1. The list of programs that are funded by MHSA are listed in the Annual Update. Please see the budget at the end of the report. 2. MHSA has a collaborative agreement with HSH, as they coordinate the placements for coordinated entry. 3. The Quality Management team developed several data tables and charts for the FSP clients to demonstrate progress. Please see the FSP section. We will also consult with QM to obtain more information about this. 4. MHSA educated public about data collection methods in BHC meeting. 5. The best resource for this information is the FY22/23 Annual Update.

Following the 30-day public comment and review period, **a public hearing was conducted by the Behavioral Health Commission of San Francisco on July 20, 2022.** The FY22/23 Annual Update was also presented before the **Board of Supervisors Audit and Oversight Subcommittee on XXXX,** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted the FY22/23 Annual Update on XXXXXX.**

Public Hearing & Board of Supervisors Resolution

Insert Resolution Here

Resolution placeholder page

Highlights of MHSA

In FY20/21, MHSA served a total of 46,355 individuals *through our outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic services; and service linkage efforts.*

10th Annual MHSA Awards Ceremony

The 10th annual MHSA Awards Ceremony took place December 18th, 2020, and was hosted by the Mental Health Association of San Francisco. This year's event was held via Zoom with 150 attendees. A total of 171 people were recognized and awarded Achievements in Recovery. The theme of the MHSA Awards Ceremony was Unmasking the Stigma- Everyday Heroes. There was a total of 11 MHSA Awards committee members who helped put on this wonderful event. There were many performances such as a drag music video, laughter yoga, and poetry. Many attendees indicated that they preferred the remote event due to their social anxiety. Other attendees indicated that the music and the comradery of a large online event decreased their feelings of social isolation. Overall, MHASF received great feedback around the online event and plans to host the following event either online or in a hybrid model in order to meet our community's needs.

National Suicide Prevention Month, September 2021

National Suicide Awareness and Prevention Month & Week, World Suicide Prevention Day, and National Recovery Month all occurs in the month of September. In honor of World Suicide Prevention Day on September 10th, the SF MHSA Team partnered with San Francisco City Hall to have the civic landmark illuminated in purple and teal, the colors which symbolize suicide awareness and prevention. This lighting of city hall purple and teal took place during Suicide Prevention Week, the week of September 6, and was part of the City's efforts to bring awareness to the issue of suicide prevention. During Suicide Prevention Week, MHSA also shared with providers and partners daily communications with resources from Each Mind Matters (EMM) which included webinars, virtual events, and activity ideas that reflected this year's theme of "Hope, Resilience and Recovery." Also in September 2021, RAMS/BHS Liaison Heather Haney received suicide prevention tool kits from Your Social Marketer and distributed them to all SFDPH BHS clinics.

State Bill 803 (SB803)

SB80, passed by Governor Gavin Newsom in November 2020, outlines requirements for counties to use in developing certification programs for the certification of peer support specialists (defined as "individuals who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both"). The bill authorizes a county to develop a peer support specialist certification program and certification fee schedule, both of which would be subject to department approval. Starting January 2021, the California Department of Health Care Services began to develop statewide requirements in accordance with this legislation. Under this legislation, certifications and related programming may be paid for by Medi-Cal. The City of San Francisco has long-standing and highly-regarded peer programming embedded within MHSA programs, and is working to integrate these new requirements and leverage the additional funding. MHSA staff are also working to grandfather in peers who are already working in these efforts.

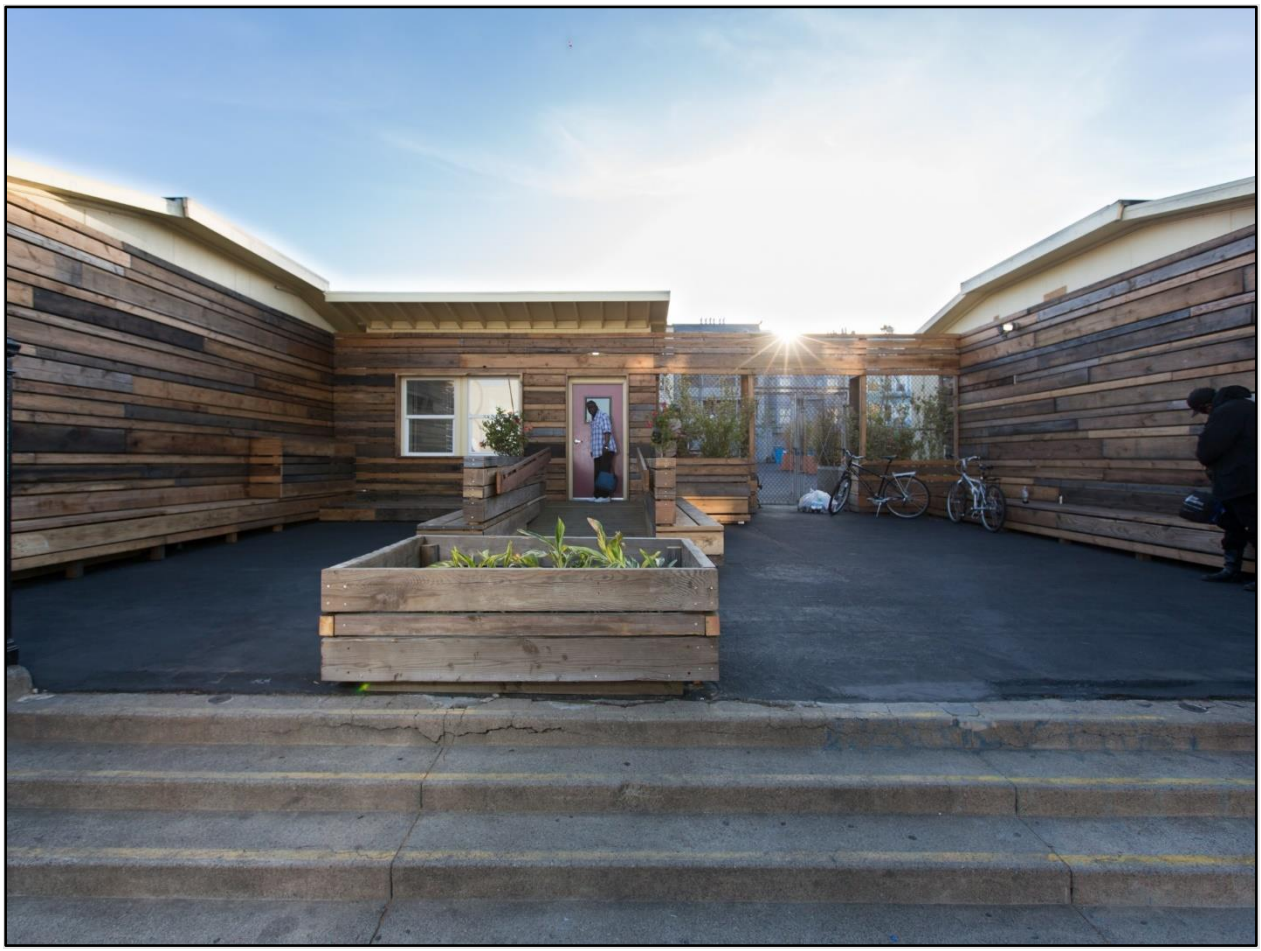
Staff Updates

In FY20-21, the following staffing changes occurred in the MHSA/JEDI (Justice, Equity, Diversity and Inclusion) division:

- Jessica Brown – OEWD Director (starting in Nov 2021)
- Josephine Ayankoya – Interim OESM (formerly 'OEWD') Director (Nov. 2019 – Nov. 2020); took on new position as SFMTA Race, Equity, and Inclusion Officer in Jan 2021
- Tracey Helton – Interim MHSA Director (starting in March2021)
- Teresa Yu – Interim MHSA Director (Feb. 2020 - Feb. 2021)
- Jeff Simbe – MHSA Housing Program Manager (June 2021)
- Ryan Fuimaono – BHS Internship Coordinator (Aug. 2021)
- Rosa Serpas – BHS Staff Wellness Coordinator (Jan. 2021)
- Sharon Lu – BHS Training Unit Staff, Training Support Specialist (Jan. 2021)
- Ali Jones-Bey – BHS Training Unit Staff, Training Support Specialist (Feb. 2021)

In FY20-21, the following staffing changes occurred in the MHSA QM division:

- Diane Prentiss – Interim Quality Management Director (starting in Jan. 2021)
- Trena Mukherjee – Epidemiologist (Sept. 2020)
- Allan Flores – Epidemiologist (Feb. 2021)
- Seth Pardo – Epidemiologist (deployed at SFDPH COVID Task Force throughout FY20-21); took on new role as Director of Center for Data Science in Population Health in Oct. 2021



San Francisco Supportive Housing

Spotlight on MHSA Vital Partnerships

Overdose Prevention Work
San Francisco saw a record-high of 711 reported drug-related overdose deaths in 2020. In response, the BHS Pharmacy Team worked to expand the availability of the drug Narcan/Naloxone to program staff and participants. In 2020, San Francisco lost more individuals to overdose than Covid-19. San Francisco is working to reverse this trend by expanding the distribution of Narcan/Naloxone to clients in our mental health treatment system. Additionally, the BHS Pharmacy Staff conducted trainings on administering Narcan/Naloxone at our MHSA advisory committee, and the executive leadership team meeting, and at program sites including many of our MHSA programs. In addition, staff members at programs such as Wellness In The Streets and Transgender Pilot Project carry Narcan/Naloxone and make it available for clients.

Dream Keeper Initiative
The Dream Keeper Initiative was created to reinvest and foster comprehensive support to San Francisco's Black/African American community. This initiative has become one of MHSA's key partners. The Dream Keeper Initiative is a citywide effort launched in 2021 to reinvest $60 million annually into San Francisco's diverse Black/African American communities. This initiative is part of Mayor London N. Breed's roadmap for reforming public safety and addressing structural inequities in San Francisco. SF-MHSA is excited to collaborate to help address and remedy racially disparate policies so that the dreams of young Black/African Americans and their families are no longer deferred, and they have the needed resources and support to thrive in San Francisco.

SF DPH MHSA FY2022-23 Annual Update

As a result of the feedback we received during our MHSA CPP efforts, and positive outcomes on evaluation outcomes, the following programs/projects will operate as approved in the previous Three-Year Plan and approved thorough our CPP process.

Note: The Full-Service Partnership (FSP) and new programs are denoted.

- **Recovery-Oriented Treatment Services**
  - Strong Parents and Resilient Kids (SPARK) **(FSP Program)**
  - SF Connections **(FSP Program)**
  - Family Mosaic Project **(FSP Program)**
  - TAY Full-Service Partnership at Felton **(FSP Program)**
  - SF Transition Age Youth Clinic **(FSP Program)**
  - TAY Full-Service Partnership at Seneca **(FSP Program)**
  - Adult Full-Service Partnership at Felton **(FSP Program)**
  - Adult Full-Service Partnership at Hyde Street **(FSP Program)**
  - Assisted Outreach Treatment (AOT) **(FSP Program)**
  - SF First **(FSP Program)**
  - Forensics at UCSF Citywide **(FSP Program)**
  - Older Adult FSP at Turk **(FSP Program)**
  - AIIM Higher
  - Community Assessment and Resource Center (CARC)
  - Behavioral Health Access Center (BHAC)
  - Behavioral Health Services in Primary Care for Older Adults
  - PREP - TAY Early Psychosis Intervention and Recovery (also known as ReMIND)
- **Peer-to-Peer Support Programs and Services**
  - LEGACY
  - Peer to Peer, Family to Family
  - Peer Specialist Certificate, Leadership Academy and Counseling
  - Gender Health SF
  - Peer to Peer Employment
  - Peer Wellness Center
  - Peer-to-Peer Linkage Services
  - Transgender Pilot Project
- **Vocational Services**
  - Department of Rehabilitation Vocational Co-op
  - i-Ability Vocational Information Technology (IT) Program
  - First Impressions (Building Maintenance, Construction and Remodeling) Program
  - SF First Vocational Project
  - Janitorial Services
  - Café and Catering Services
  - Clerical and Mailroom Services
  - Growing Recovery and Opportunities for Work Through Horticulture (GROWTH)
  - TAY Vocational Program
- **Housing - CSS**
  - Emergency Stabilization Housing
  - FSP Permanent Supportive Housing
  - Housing Placement and Support

- TAY Transitional Housing

- **Mental Health Promotion and Early Intervention – PEI**
  - Peer Outreach and Engagement Services
  - Behavioral Health Services at Balboa Teen Health Center
  - School Based Mental Health Services
  - School Based Youth Early Intervention
  - School Based Wellness Centers
  - Trauma and Recovery Services
  - Senior Drop-In Center
  - Addressing the Needs of Socially Isolated Adults Program
  - Ajani Program
  - Black/African American Wellness and Peer Leaders (BAAWPL)
  - API Mental Health Collaborative
  - Indigena Health and Wellness Collaborative (Latinx including indigenous Mayan communities)
  - Living in Balance
  - South of Market (6th Street) Self-Help Center
  - Tenderloin Self-Help Center
  - Community Building Program
  - Homeless Outreach & Treatment Program
  - Population Specific TAY Engagement and Treatment – Latino/Mayan
  - Population Specific TAY Engagement and Treatment - Asian/Pacific Islander
  - Population Specific TAY Engagement and Treatment - Juvenile Justice/others
  - Population Specific TAY Engagement and Treatment – LGBTQ+
  - Population Specific TAY Engagement and Treatment - Black/African American
  - TAY Homeless Treatment Team Pilot
  - ECMHCI Infant Parent Program/Day Care Consultants
  - ECMHCI Edgewood Center for Children and Families
  - ECMHCI Richmond Area Multi-Services
  - ECMHCI Homeless Children's Network
  - ECMHCI Instituto Familiar de la Raza
  - Mobile Crisis
  - Child Crisis
  - Crisis Response
- **Innovation - INN**
  - FUERTE School-Based Prevention Groups project
  - Wellness in the Streets
  - Technology-Assisted Mental Health Solutions
  - Intensive Case Management/Full-Service Partnership to Outpatient Transition Support
  - Culturally Responsive Practices for the Black/African American Communities
- **Behavioral Health Workforce Development – WET**
  - Community Mental Health Worker Certificate
  - Community Mental Health Academy
  - Faces for the Future Program
  - Online Learning Management System
  - Trauma Informed Systems Initiative
  - TAY System of Care Capacity Building – Clinician's Academy; now funded partially by MHSA in FY21/22 (Felton) – confirmed
  - Fellowship for Public Psychiatry in the Adult/Older Adult System of Care
  - Public Psychiatry Fellowship at SF General

- BHS Graduate Level Internship Program
- Child and Adolescent Community Psychiatry Training Program (CACPTP)

- **Capital Facilities and Information Technology - CF/TN**
  - Consumer Portal - IT
  - Consumer Employment – IT
  - System Enhancements – IT
  - Recent Renovations – Capital Facilities - DPH

1. Recovery-Oriented Treatment Services: CSS Funding

Service Category Overview

Recovery-Oriented Treatment Services include screening and assessment, clinical case management, individual and group therapy, and medication management.

In San Francisco, the majority of MHSA funding for Recovery-Oriented Treatment Services is allocated to Full-Service Partnership (FSP) Programs. The remaining funds are distributed to the following programs and initiatives.

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

FSP Programs

Program Collection Overview

FSP programs reflect an intensive and comprehensive model of an integrated treatment case management based on a client- and family-centered philosophy of doing “whatever it takes” to assist individuals diagnosed with serious mental illness (SMI) or, for children with serious emotional disturbance (SED), to lead independent, meaningful, and productive lives. In this model, clients have access to 24/7 support and are working with someone they know.
FSP services at all programs consist of the following:

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

Target Populations

Nine FSP programs have served a diverse group of clients, in terms of age, race/ethnicity, and stage of recovery, since 2006. In 2015-16, two new programs began to enroll clients: Instituto Familiar de la Raza (IFR) created the Strong Parents and Resilient Kids (SPARK) program to serve families with a child or children aged 0-5 with attachment disorders; and Citywide Case Management, which 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.

Spotlight on Expanding FSPs

The Intensive Case Management (ICM) Academy curriculum was created to address the training needs of Adult, Older Adult, and TAY ICM & FSP providers, peers, clinicians, and anyone who works within the ICM system of care. The mission is to provide training courses on a range of subjects related to clinical case management work, with a focus on aspects that impact/interface with TAY, Adult and Older Adult ICM & FSP programs. This includes assessment tools, San Francisco city and county programs, supports, and any other relevant aspects.

Goals

- Workforce Development to ensure that staff has the shared foundational knowledge, skills and tools needed to provide case management in behavioral health programs.
- Quality of care - ensuring individuals receiving services in a variety of settings have access to consistent case management support.
- Broaden individual and system case management capabilities.

There is a high level of interest in the ICM Academy and program staff are working to make it more accessible for all FSP and ICM Providers to participate. This is, in part, is why all of the sessions have been virtual. Trainings are also recorded and posted online so that anyone who cannot attend the live session may be able to view all or part of a training later. Program staff are continuing to research different ways to increase accessibility. Average attendance has been 16-20, which allows for effective attendee engagement and Q&A, particularly for sensitive subjects, however the attendee numbers have continued to increase with the case management expansion. Most sessions are 1.5-2 hours.

Training session topics include: Co-Occurring Disorders: ICM Academy Training Part 1 & 2; Eligibility; Trauma-Informed Approaches; Integrated Care: An Overview of Behavioral Health Services in SFHN Primary Care; Culturally Responsive Practices: Latin/o/a/e/x; Residential System of Care; Coordinated Entry; Self-Care & Vicarious Trauma; Recovery Models/Strength-Based Approaches with Rick Goscha and CIBHS Interfacing with Psychiatric Emergency Services; Where the Behavioral Health and Criminal Justice Systems Meet; Hierarchy of Need; Conservatorship; Culturally Responsive Practices: Black & African American; Culturally Responsive Practices: Asian American & Pacific Islander; Culturally Responsive Practices: Native & Indigenous American; Transitions & Placement; and Evidence-Based Practices.

FSP Programs			
Target Population	**Program Name *Provider***	**Name Listed on ARER, Budget**	**Additional Program Characteristics**
Children 0-5 & Families	Strong Parents and Resilient Kids (SPARK) *Instituto Familiar de la Raza*	CSS Full-Service Partnership 1. CYF (0-5)	Provides trauma focused dyadic therapy, intensive case management, and wraparound services to the population of 0-5-year-old and their caregivers.
Children & Adolescents	SF Connections *Seneca Center*	CSS Full-Service Partnership 2. CYF (6-18)	Through close partnerships with Human Services Agency, Juvenile Probation, and other organizations, Seneca and Family Mosaic Project provide trauma informed, unconditional, family-centered, strengths-based, and outcome-oriented alternatives to group care placements, for children and youth ages 5-18 with complex and enduring needs at risk of out of home placement.
	Family Mosaic Project (FMP) *SFDPH*		
Transitional Age Youth (TAY)	TAY FSP *Felton Institute*	CSS Full-Service Partnership 3. TAY (18-24)	Supporting youth, ages 16-25, with mental health needs, substance use, substance use disorders, homelessness, HIV/AIDS, and/or foster care experience, to help them stabilize, link to needed services, set and achieve treatment goals, improve functioning in daily life, and engage in meaningful socialization, vocational, volunteer, and school activities. The programs also work with family members, significant others, and support-persons in the clients' lives.
	SF TAY Clinic *SFDPH*		
	TAY FSP *Seneca Center*		
Adults	Adult FSP (Bayview, Oceanview, and Western Addition neighborhoods) *Felton Institute*	CSS Full-Service Partnership 4. Adults (18-59)	Offers an integrated recovery and treatment approach for individuals with serious mental illness, homelessness, substance use disorder, and/or HIV/AIDS by centering care with the individual and involving family members, significant others, and support persons in the clients' lives.
	Adult FSP (Tenderloin neighborhood) *Hyde Street Community Services*		Provides culturally relevant services to the diverse ethnic and racial populations residing in the Tenderloin, especially Arab-speaking, Southeast Asian, African American, and Latinx individuals living with mental illness and substance use disorders.

FSP Programs			
Target Population	**Program Name *Provider***	**Name Listed on ARER, Budget**	**Additional Program Characteristics**
Adults/Older Adults	Assisted Outpatient Treatment (AOT) *SFDPH & UCSF Citywide Case Management*	CSS Full-Service Partnership 6. AOT	Outreaches to and engages individuals with known mental illness, not engaged in care, who are experiencing worsening symptoms or declining functional status. AOT is a court process that uses peer counselors to facilitate individuals' access to essential mental health care.
	SF Fully Integrated Recovery Services (SF FIRST) *SFDPH*	CSS Full-Service Partnership 4. Adults (18-59)	Provides FSP services to highly vulnerable individuals with multiple medical, psychiatric, substance use, and psychosocial difficulties, including chronic homelessness.
	Forensics *UCSF Citywide Case Management*	CSS Full-Service Partnership 4. Adults (18-59)	Provides compassionate, respectful, culturally and clinically competent, comprehensive psychiatric services to individuals with serious mental illness (often co-existing with substance use disorders) involved in the criminal justice system.
	Older Adult FSP at Turk *Felton Institute*	CSS Full-Service Partnership 5. Older Adults (60+)	Serves older adults age 60 and older with severe functional impairments and complex needs, by providing specialized geriatric services related to mental health and aging.

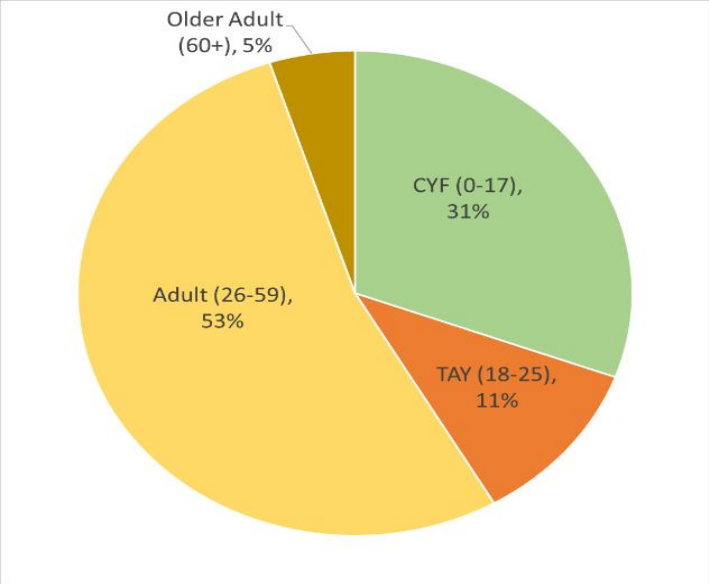
FSP Participant Demographics, Outcomes, & Cost per Client

San Francisco had twelve Full-Service Partnership (FSP) programs during fiscal year 2020-2021.The tables and graphs below describe the demographic characteristics of clients served in the FSPs from July 1, 2020 through June 30, 2021. Data are captured in the programs' electronic health record program, Avatar. Sex, gender identity, race/ethnicity, and primary language are reported by FSP Program and by client age group (as of July 1, 2020).

Nine clients were served by two different FSPs during the fiscal year, due to "aging up" or transferring programs for other reasons. For reporting, clients are represented only once.

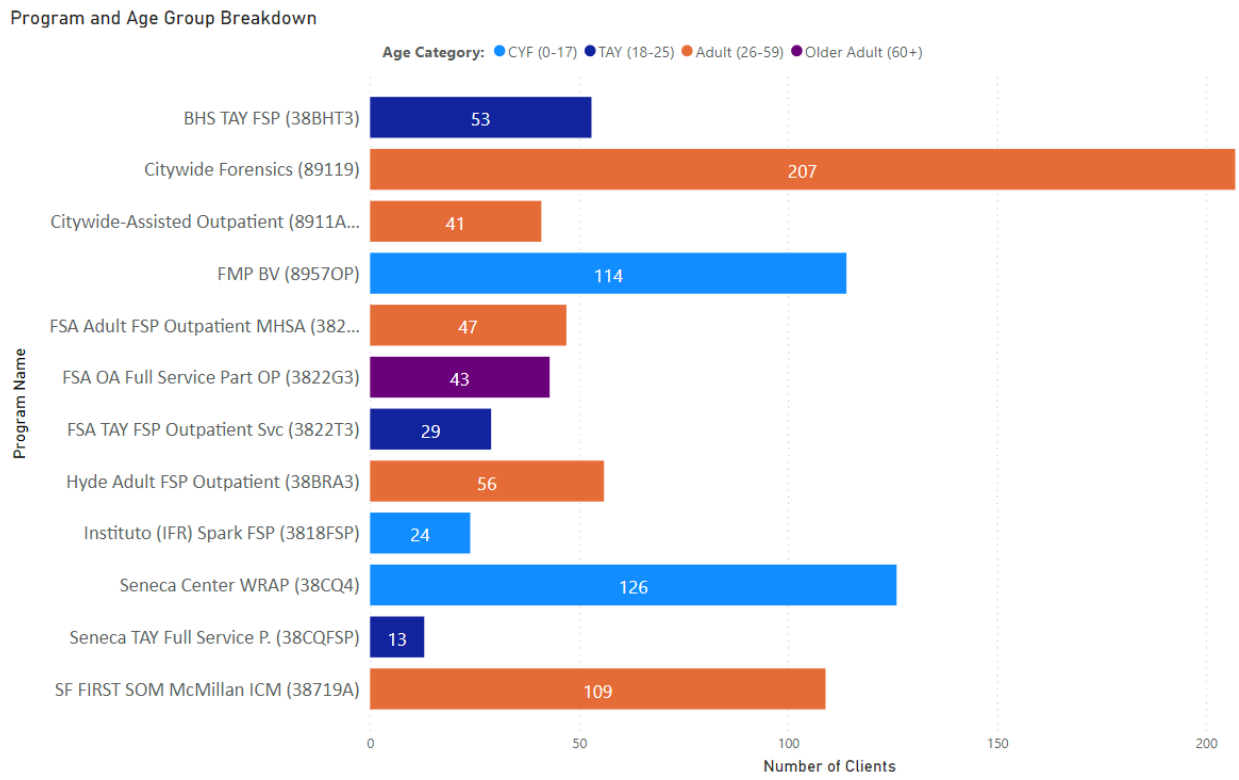
For demographic reporting, any cell size with fewer than 10 clients is represented as "<10" to protect the privacy of FSP clients and not compromise anyone's identity.

FSP Client Age Groups (n=862)



Clients by FSP Program and Age Group

Program	CYF (0-17)	TAY (18-25)	Adult (26-59)	Older Adult (60+)	Total
BHS Tay FSP		53			53
Citywide Forensics			207		207
Citywide Assisted OP			41		41
FMP BV	114				114
FSA Adult FSP			47		47
FSA OA				43	43
FSA TAY		29			29
Hyde Adult FSP			56		56
IFR Spark	24				24
Seneca WRAP	126				126
Seneca TAY		13			13
SF First			109		109
Total	264	95	469	43	**862**



Client Sex and Gender

Historically, client gender has been entered into the electronic health record (Avatar) with only binary options, female and male. This is changing under new SOGI (Sexual Orientation and Gender Identify) data recommendations. The FSP programs served 328 (38%) females and 534 (62%) males for the 2020-2021 fiscal year.

Client Age Groups by Gender

Age Category	Female	Male	Total
CYF (0-17)	135	129	264
TAY (18-25)	31	64	95
Adult (26-59)	138	322	460
Older Adult (60+)	24	19	43
Total	328	534	862

Where more granular data have been entered in compliance with SOGI guidelines, 2.6% of clients identified as trans female, trans male or genderqueer/non-binary.

Gender Identity Breakdown by Age Group

Age Category	Female	Male	Trans Female	Trans Male	Gender-Queer or Non-Binary	Declined to State	No data or no entry	TOTAL
CYF (0-17)	37	33		<10	<10	14	117	264
TAY (18-25)	25	54	<10	<10	<10	<10	<10	95
Adult (26-59)	97	239	11	<10	<10	10	97	460
Older Adult (60+)	13	15					15	43
TOTAL	172	341						862

NOTE: Any cell size with fewer than 10 clients is represented as "<10" to protect the privacy of FSP clients and not compromise anyone's identity.

Client Sexual Orientation by Client Age Group

Similarly, as the sexual orientation-gender identity (SOGI) data collection policies and practices continued to be adopted, data on client sexual orientation (SO) were still underreported. Approximately 13-100% of clients had missing sexual identity, depending on client age group. For sexual orientation, available data show 5-44% of clients as Straight/Heterosexual, 0-5% identifying as Gay or Lesbian, and 1-5% Bisexual, Questioning or Unsure, depending on age group.

Client Race/Ethnicity

Race and Ethnicity data are captured in Avatar and recoded into seven categories plus other: African America/Black, Asian, Latino/a/e, Multi-ethnic, Native American, Native Hawaiian and Other Pacific Islander (NHOPI), White and Other. The majority of FSP clients overall are African American/Black, White or Latina/o/e. Amongst the younger age groups, few clients are Asian or White. The majority of adult FSP clients identified as White.

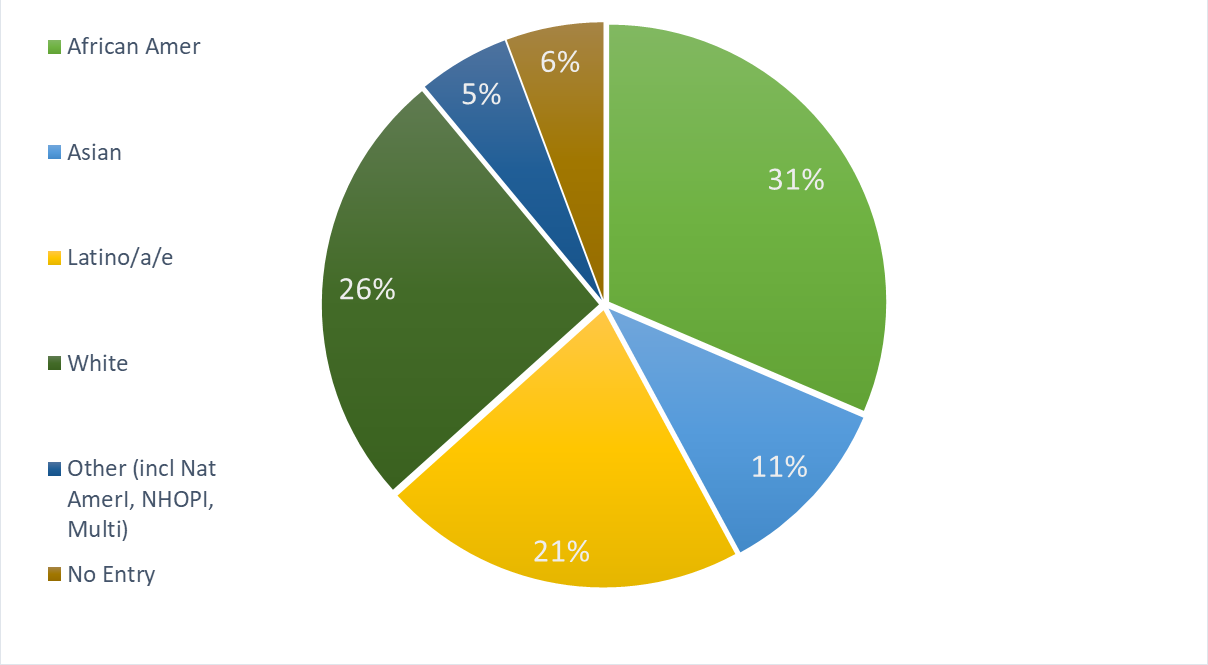
Client Race/Ethnicity by FSP Program

Program	African Amer / Black	Asian	Latino/a/e	Multi-Ethnic	Native Am.	NHOPI	White	Other	No Entry
BHS Tay FSP	15	<10	18	<10		<10	<10		
Citywide Forensics	75	19	27	<10	<10	<10	71	<10	<10
Citywide Assisted OP	<10	<10	<10	<10			14	<10	<10
FMP BV	27	21	42		<10	<10	<10	<10	17
FSA Adult FSP	18	<10	<10				12		
FSA OA	14	<10	<10		<10		19		<10

FSA TAY	<10	<10	<10	<10		<10	<10		
Hyde Adult FSP	21	<10	<10	<10		<10	23	<10	
IFR Spark	<10	<10	<10						<10
Seneca WRAP	50	10	37	<10	<10	<10	11	<10	12
Seneca TAY	<10	<10	<10				<10		
SF First	26	<10	<10	<10	<10	<10	51		<10

NOTE: Any cell size with fewer than 10 clients is represented as "<10" to protect the privacy of FSP clients and not compromise anyone's identity.

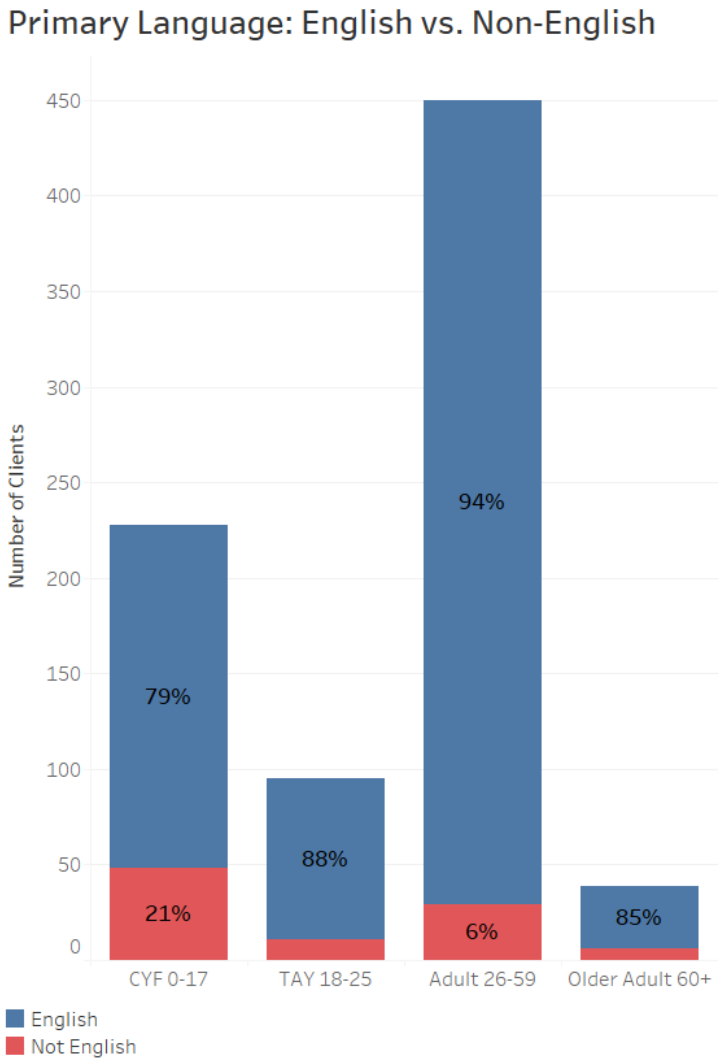
Client Race/Ethnicity



Client Primary Language

Client Primary Language is collected at FSP intake, and updated by case managers, as part of the Client Services Information (CSI) admission and treatment planning processes required by Medi-Cal. Most FSP clients indicate their primary language as English (82%).

Client Primary Language by Client Age Group



Overall, English is reported as the primary language for 83% of FSP Clients, Spanish (6%) Cantonese/Mandarin (3%) and other languages (2%). Other languages included: Vietnamese, Filipino, Tagalog, Russian, German, and Arabic. As defined by DHCS Medi-Cal eligibility, the "threshold" languages for San Francisco are: Spanish, Cantonese, Mandarin, Vietnamese and Russian.

FSP Data Collection and Reporting (DCR) Outcomes

The MHSA Data Collection and Reporting (DCR) system tracks outcome indicators for all Full-Service Partnership (FSP) clients across the state of California using a web-based portal managed by the Department of Health Care Services (DHCS). Providers enter client data into the portal throughout the duration of a client's partnership. On a regular basis, San Francisco downloads this data from the DHCS server into a San Francisco County SQL server data warehouse. From this, we generate datasets using SQL and Crystal Reports, sharing them regularly with FSP programs.

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

FSP Residential Outcomes

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

Reporting Methodology. Residential Settings data were extracted using the Enhanced Patient Level Data (EPLD) portal maintained by the Mental Health Data Alliance for DHCS and prepared for reporting using Access and Excel. The graphs include all **clients** active in the FSP during FY20-21 with a completed PAF, who have served **in the FSP partnership for at least one continuous year and up to four years**. These graphs exclude clients who have been active in the FSP for less than one year or more than four.

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

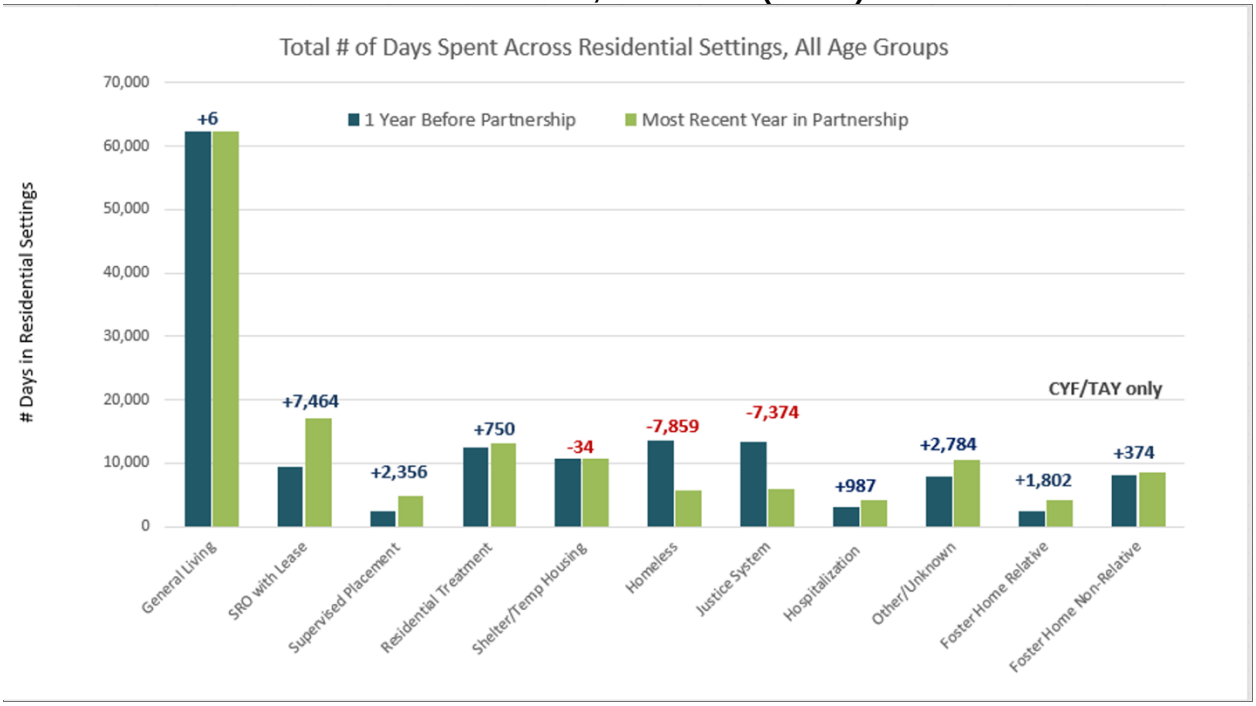
Residential settings are displayed from more desirable (i.e. generally more independent and less restrictive) to less desirable. However, this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for one client, for many the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

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

Clients in All FSPs

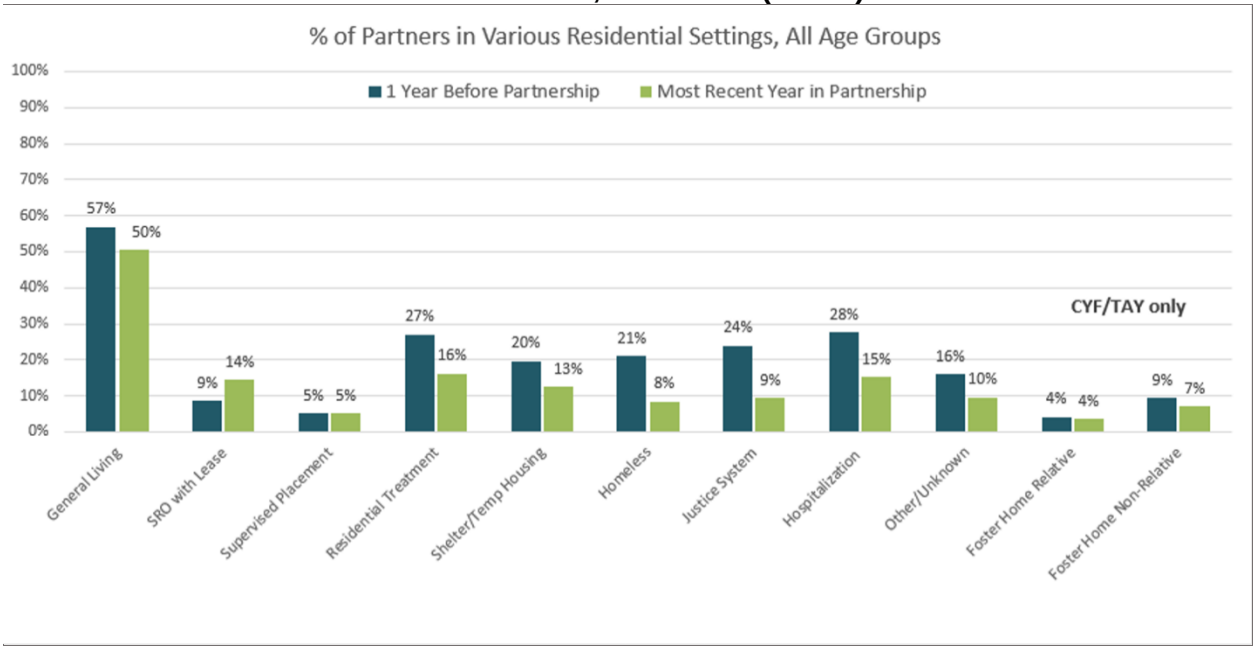
Across all age groups, the residential outcomes below (Exhibit RES-All-1) show reductions in the number of days that all clients enrolled between 1-4 years in an FSP program experienced homelessness and the justice system, but an increase in hospitalizations in their baseline year (pre-FSP) compared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

Exhibit RES-All-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=395)



While time spent in stable settings increased, and simultaneously decreased for less stable or more restrictive settings, the number of clients experiencing these residential settings dropped or remained steady for most unstable or restrictive settings (Exhibit RES-All-2). Looking at the above and below graphs together, it's helpful to notice the direction of days spent and the direction of percentage of clients experiencing that setting. For example, a smaller percentage of clients experienced Residential Treatment and Hospitalizations in the most recent year (16% down from 27%, and 15% down from 28%, respectively). However, those fewer clients spent more days in Residential Treatment and Hospitalization in the most current year, compared to the baseline year (up 750 and 987 days, respectively).

Exhibit RES-All-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=395)



Child, Youth and Family Clients (CYF)

CYF client data show movement from residential treatment into home-based settings during FSP treatment (Exhibit RES-CYF-2). For Foster Home with Relative and Non-relatives, however, fewer clients logged more time than for the baseline. (Exhibit RES-CYF-1). Justice involvement decreased from 9% to 2%. Although homelessness and hospitalizations decreased from 3% to 1% and 14% to 3%, respectively, fewer clients logged 76 and 742 greater number of days in each setting.

Exhibit RES-CYF-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, CYF only (n=158)

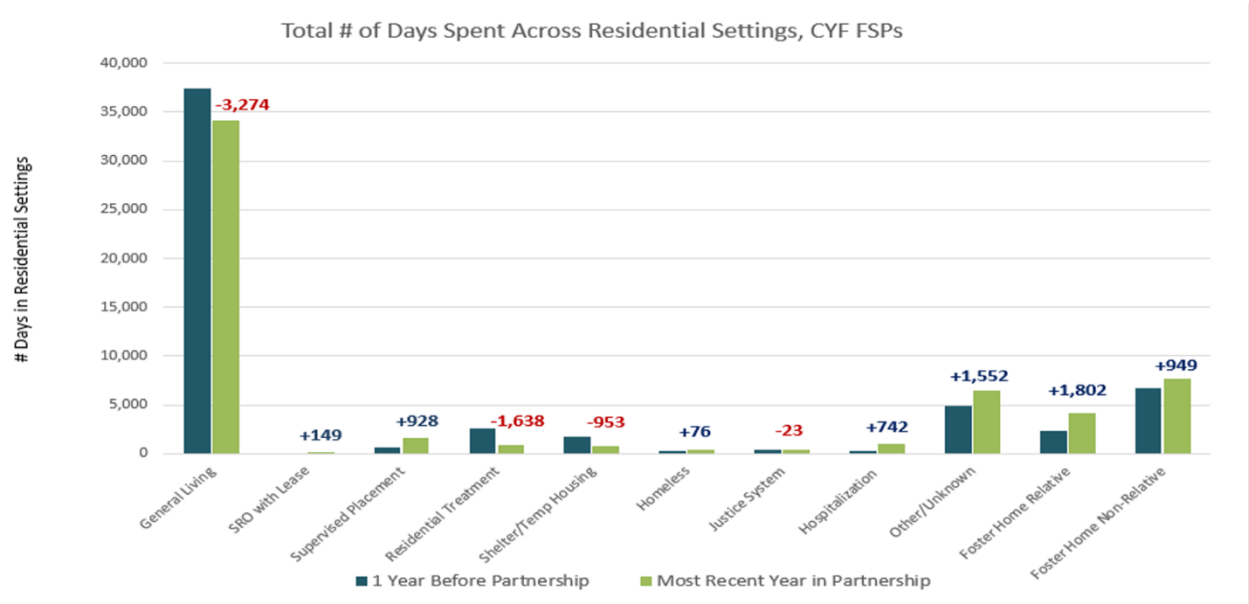
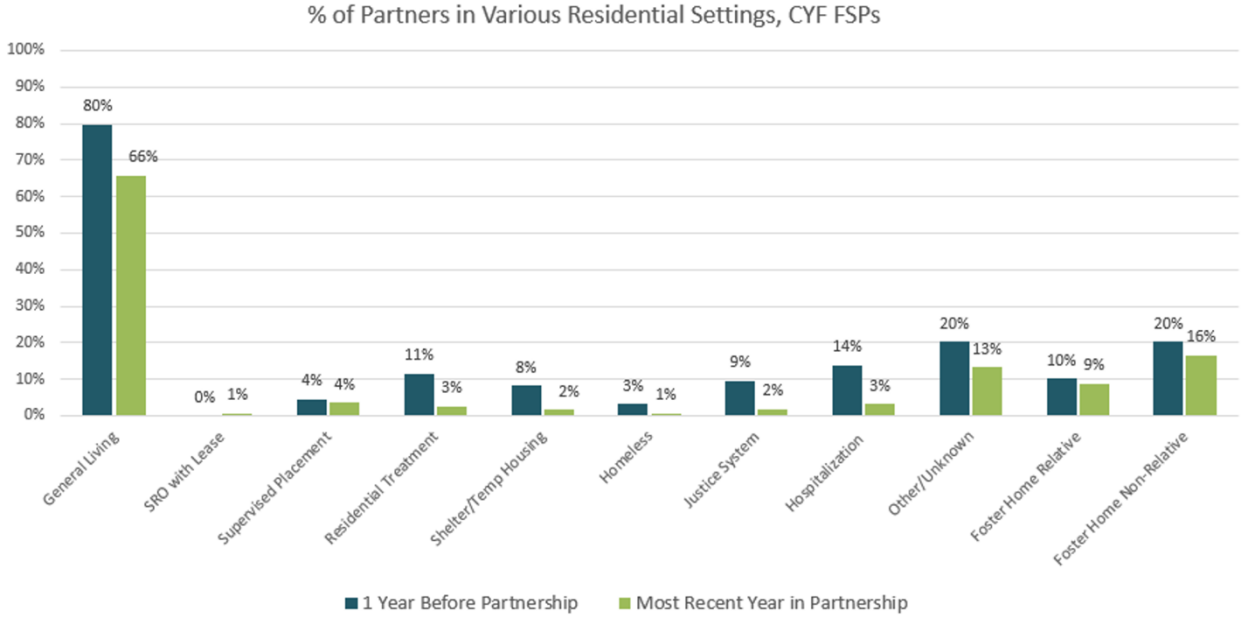


Exhibit RES-CYF-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, CYF only (n=158)



Transition Age Youth (TAY)

From the baseline year to the most current year in FSP, TAY clients spent more time in stabilizing settings like General Living, SRO with Lease and Supervised Placement; and less time in less stabilized settings, including experiencing homelessness, being hospitalized or in the justice system (Exhibit RES-TAY-2). For more unstable or restrictive settings (i.e. homeless, justice system, hospitalization), TAY logged fewer days (Exhibit RES-TAY-1) than in their baseline year. This suggests that TAY clients are gaining access to housing or maintaining more stable housing.

Exhibit RES-TAY-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, TAY only (n=55)

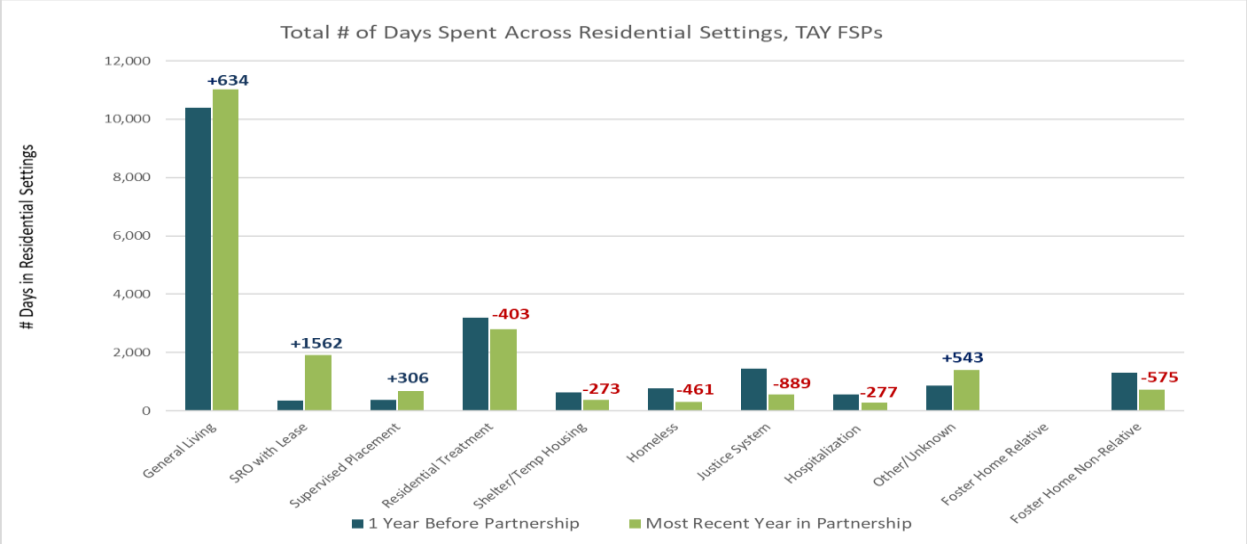
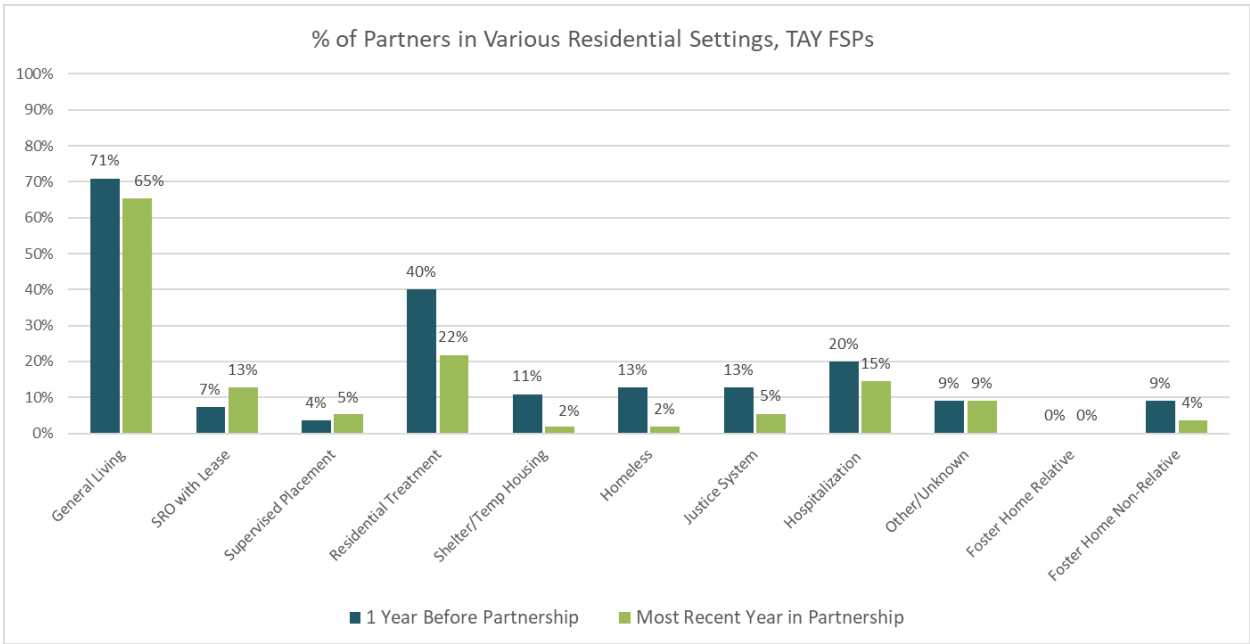


Exhibit RES-TAY-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, TAY only (n=55)



Adult Clients

Adult clients saw an increase in General Living, SRO with Lease, and Supervised Placement in both the amount of time spent in each setting (Exhibit RES-A-1), and the number of clients (Exhibit RES-A-2). A smaller proportion of clients spent a greater number of days in General Living, Residential Treatment and Shelter/Temp Housing. The proportion of Homeless clients and the days spent homeless decreased by 23% and 6,705 days. The proportion of clients in involved in the Justice System decreased over two-fold; resulting in 6462 few days spent in criminal justice settings. Similarly, Hospitalizations decreased by more than two-fold, but a smaller proportion of clients spent a greater number of days (+271) hospitalized. Fewer clients spent time in Residential Treatment (-10%), but those few clients spent more days (+1946) days in this setting, which may represent an advancement in recovery for FSP clients who have not previously accessed care.

Exhibit RES-A-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Adult Clients only (n=155)

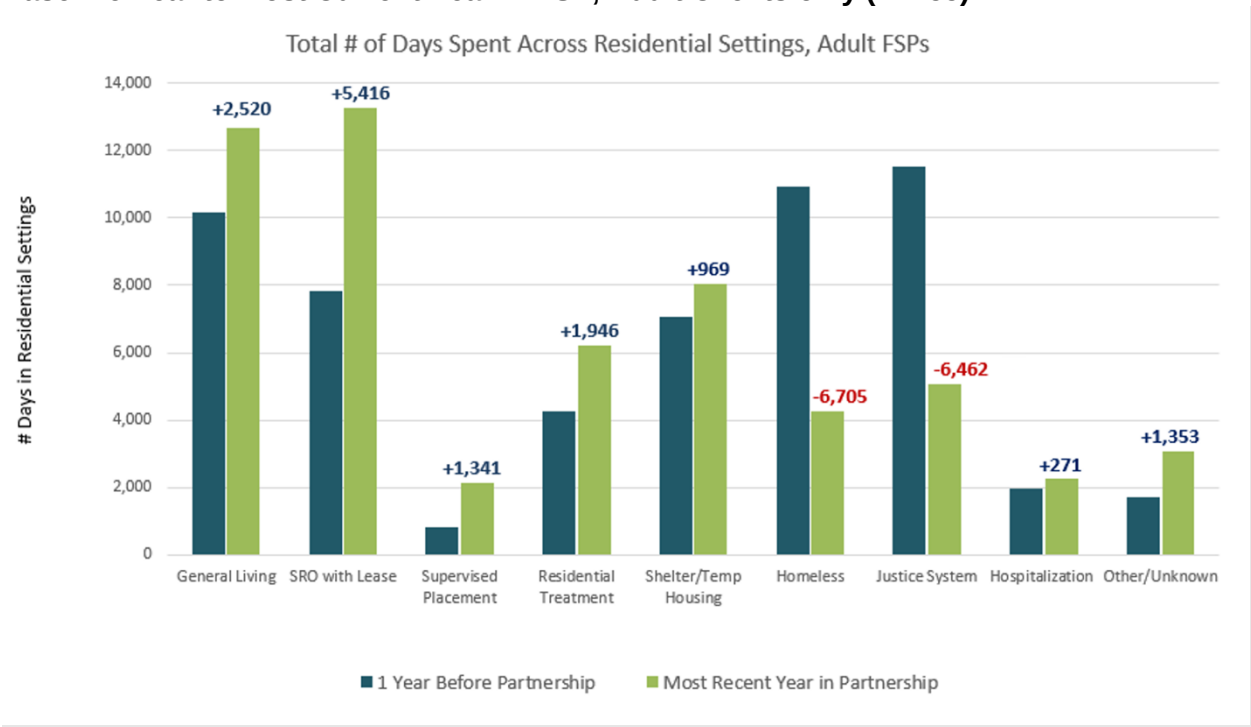
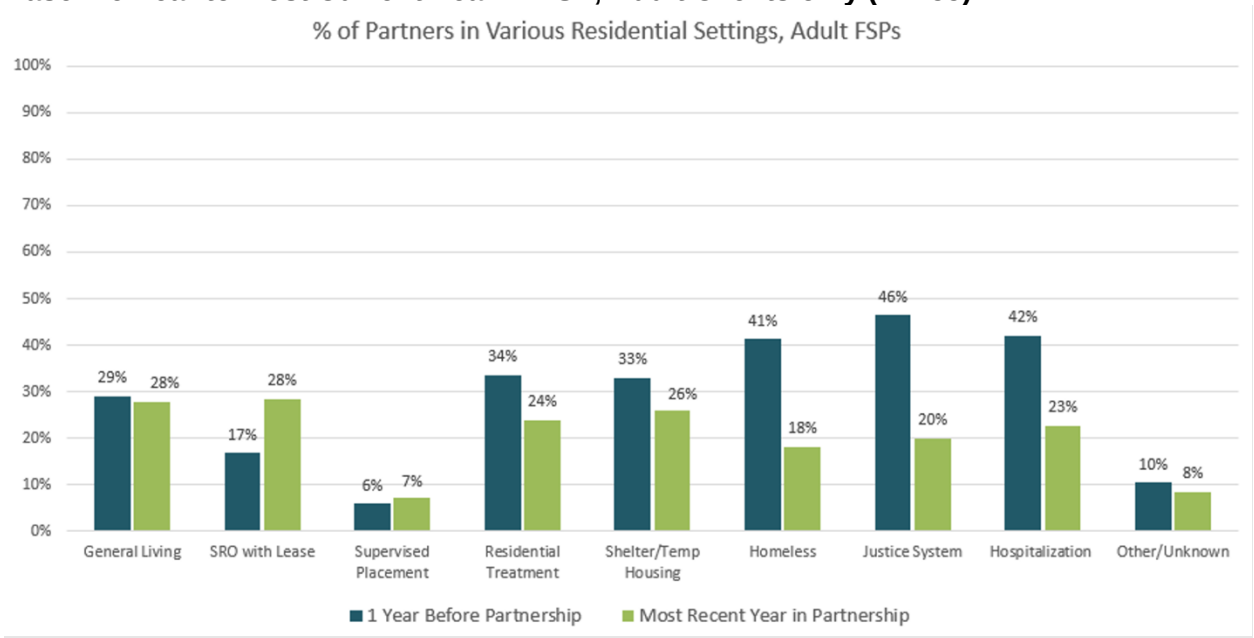


Exhibit RES-A-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Adult Clients only (n=155)



Older Adult Clients

Compared to the year prior to entering FSP programs, Older Adult FSP clients (+7%) spent less time in General Living arrangements (-206 days). In contrast, a greater proportion of clients spent a greater number of days in SROs with Lease (+337) and in Residential Treatment (+380) (Exhibit RES-OA-1/Exhibit RES-OA-2). The number of clients and the number of days spent homeless decreased by 15% and 828 days. Finally, hospitalization rate (+3%) and number of days (+331) hospitalized increased slightly.

Exhibit RES-OA-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Older Adults only (n=27)

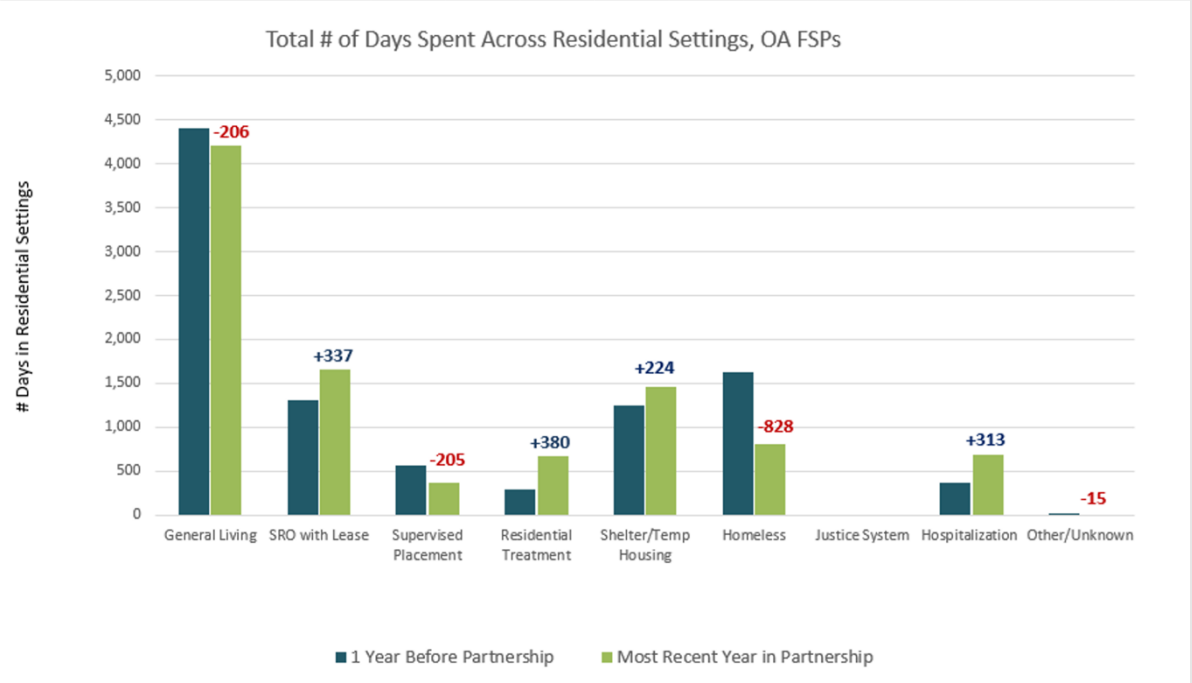
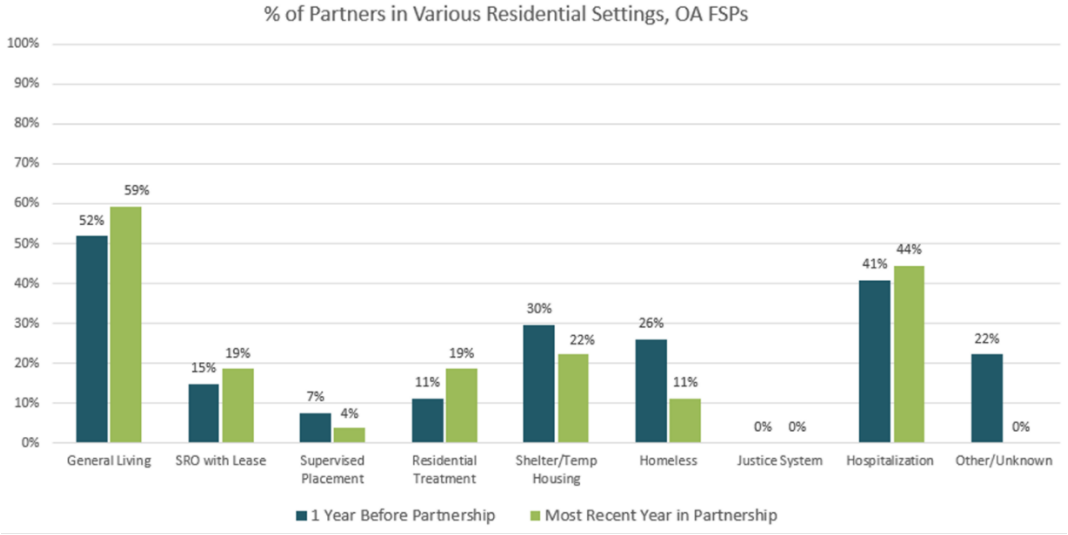


Exhibit RES-OA-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Older Adults only (n=27)



Emergency Events

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

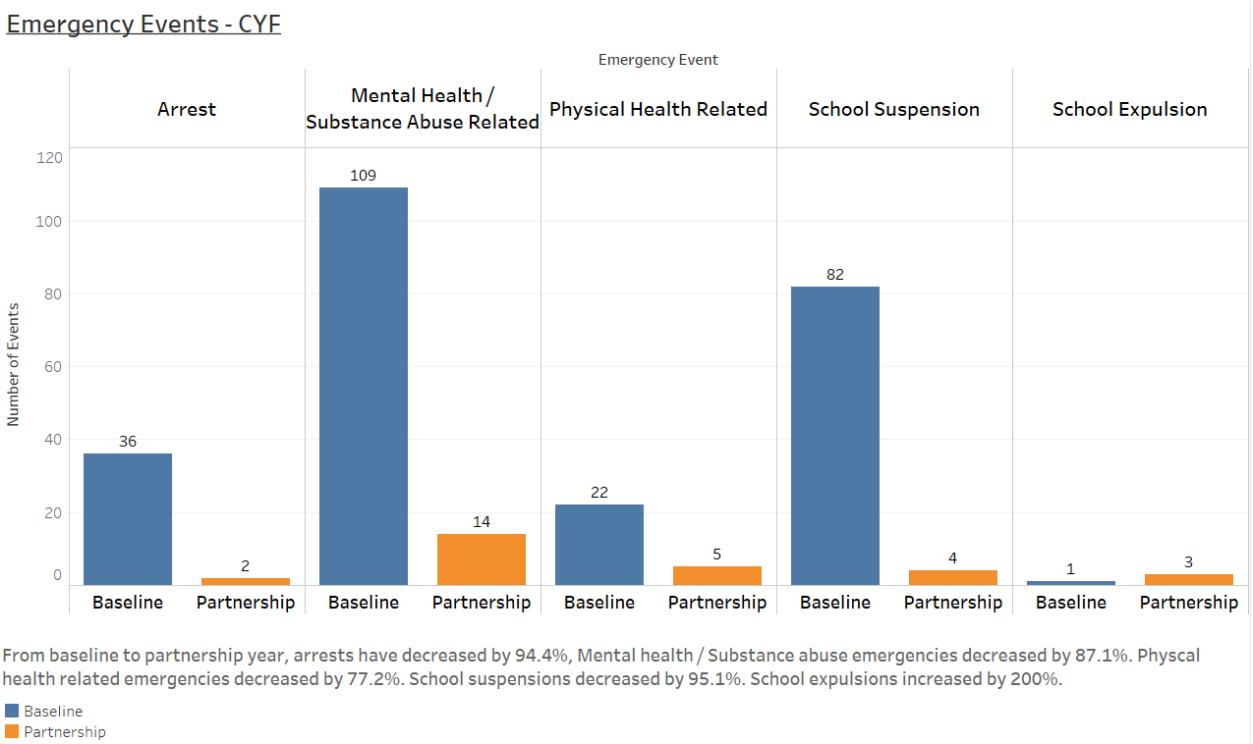
Report Methodology. The graphs below compare Emergency Events for **all FSP clients active any time in the fiscal year 2020-21** from the one-year baseline to an **average of emergency events over all years while in the FSP**.

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

Among child clients, fewer emergency events were reported after entering FSP (Exhibit EE-CYF)**.** Compared to baseline trends, there were marked declines across all types of emergency events reported for child clients. One contributing factor to reduced expulsions is that the San Francisco Unified School District (SFUSD) established a policy that disallows expulsions. Because some clients' baseline and follow up years were prior to this policy change, or they are students outside the SFUSD, small numbers of expulsions do still appear in the graph. Expulsion is the only emergency event that has increased from baseline to partnership year but has too few events to make conclusions about the impact of participation in Full Service Partnership.

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

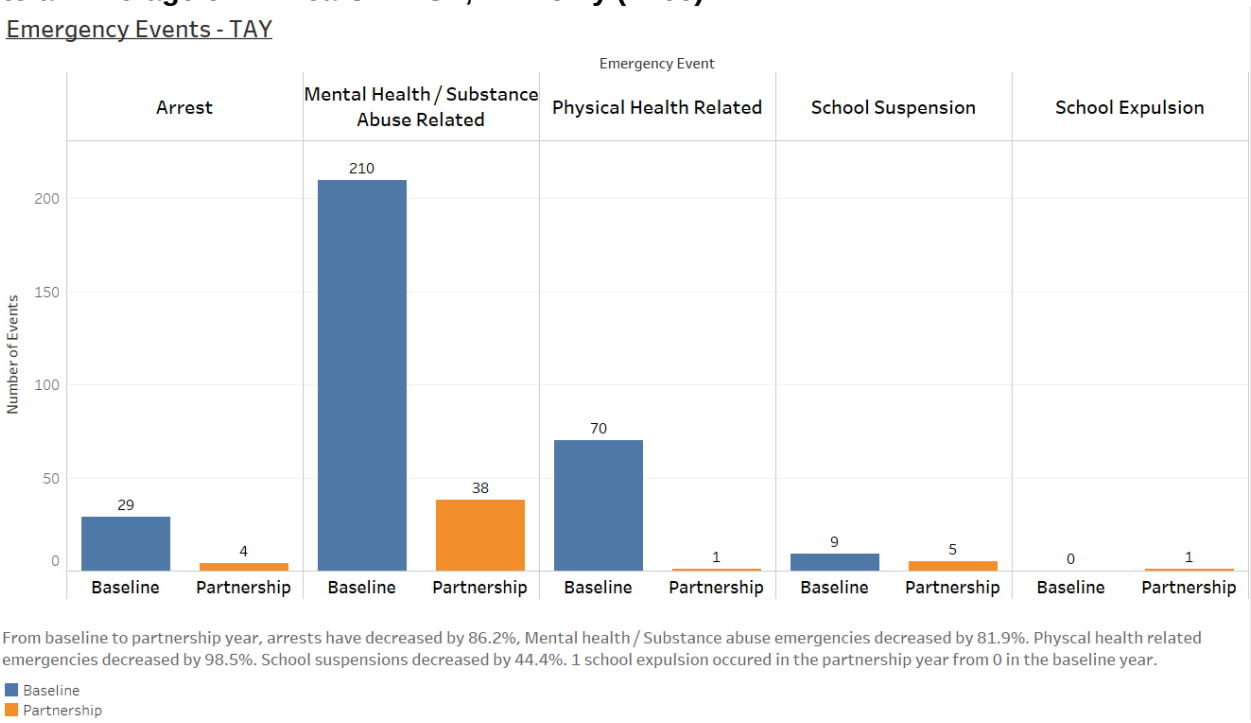
Exhibit EE-CYF. Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, CYF only (n=269)



Among TAY clients, fewer emergency events were reported (Exhibit EE-TAY)**.** Declines appear across all emergency events experienced by TAY clients with the exception of school expulsions (from 0 to 1 event) This increase is difficult to interpret because of the small size.

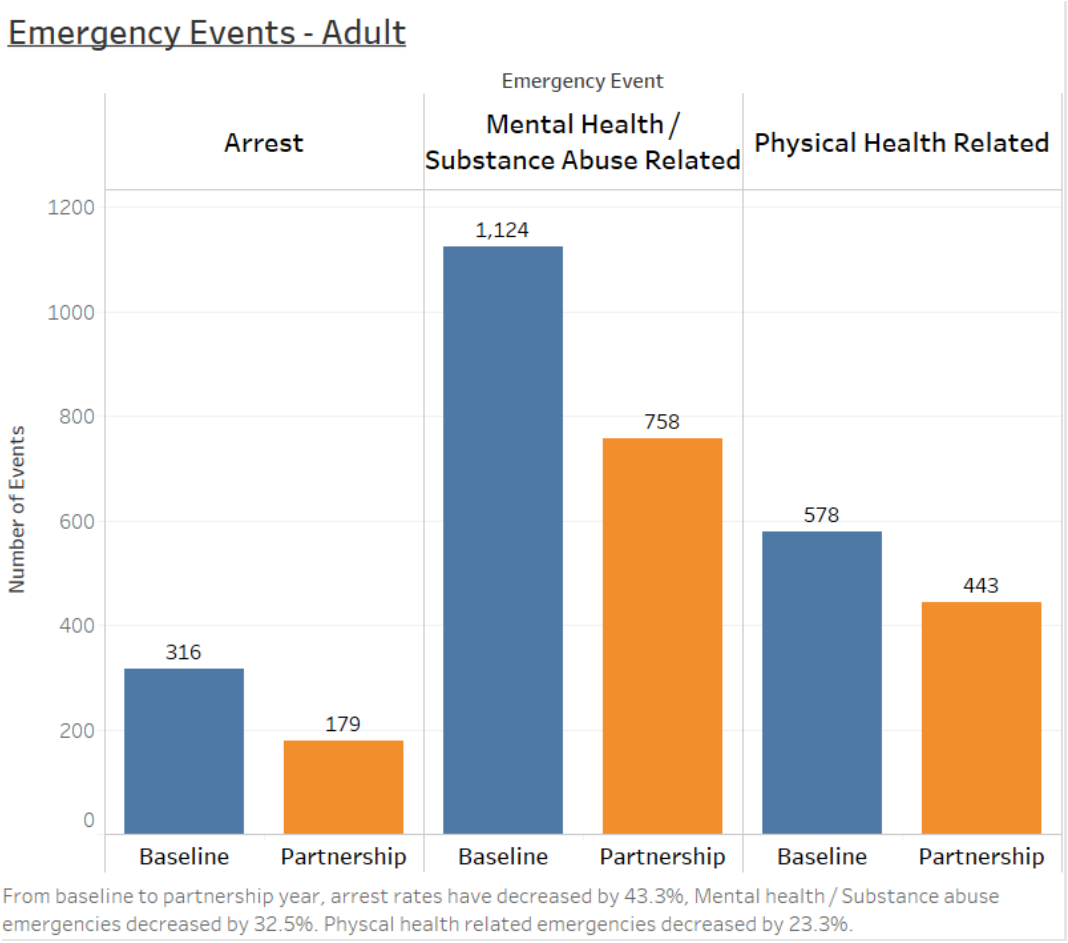
Discharge data also suggest that TAY engagement may be a major challenge (see Exhibit RFD, page 18). Data suggest that TAY clients may leave the FSP programs within the first year of service. Due to loss to follow up, the full sample of TAY clients served may be under-estimated in the emergency events graphs below.

Exhibit EE-TAY. Change in Incidence of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, TAY only (n=95)



Among Adult clients, fewer emergency events were reported compared to baseline FSP data (Exhibit EE-A)**. D**eclines occurred across all emergency events experienced by adult FSP clients. For example, arrests, mental health/substance use, and physical health emergencies all decreased by 43%, 32%, and 23% respectively.

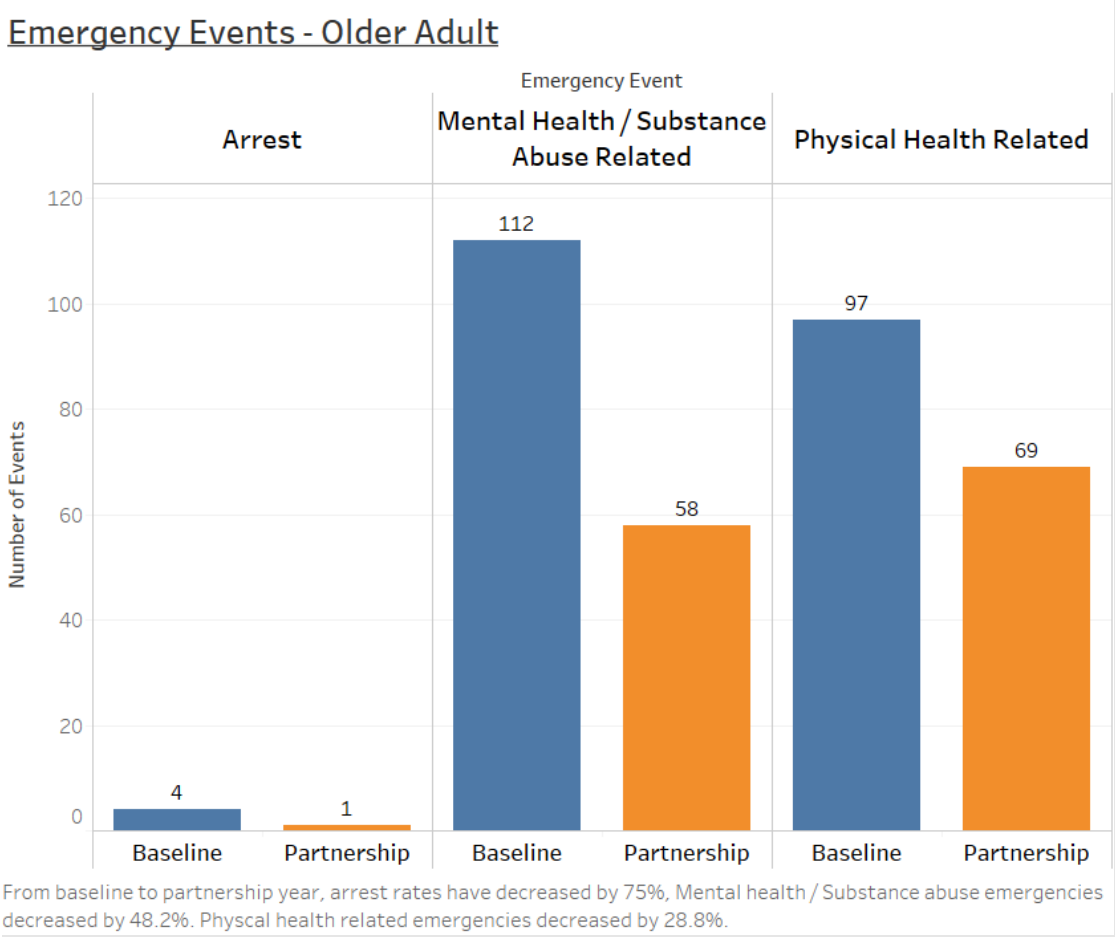
Exhibit EE-A. Change in Incidence of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Adult Clients only (n=466)



Despite high levels of physical health emergencies among older adult clients at baseline, (Exhibit EE-OA), marked declines appear across all emergency events experienced by this population of clients. For example, arrests, mental health/substance use, and physical health emergencies improved (declined) by over 65%.

While physical health emergencies may be common among older adults, particularly those served by FSP programs, the number of physical health emergencies decreased 28.8% after at least one year of FSP service. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

Exhibit EE-OA. Change in Incidence of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Older Adults only (n=43)

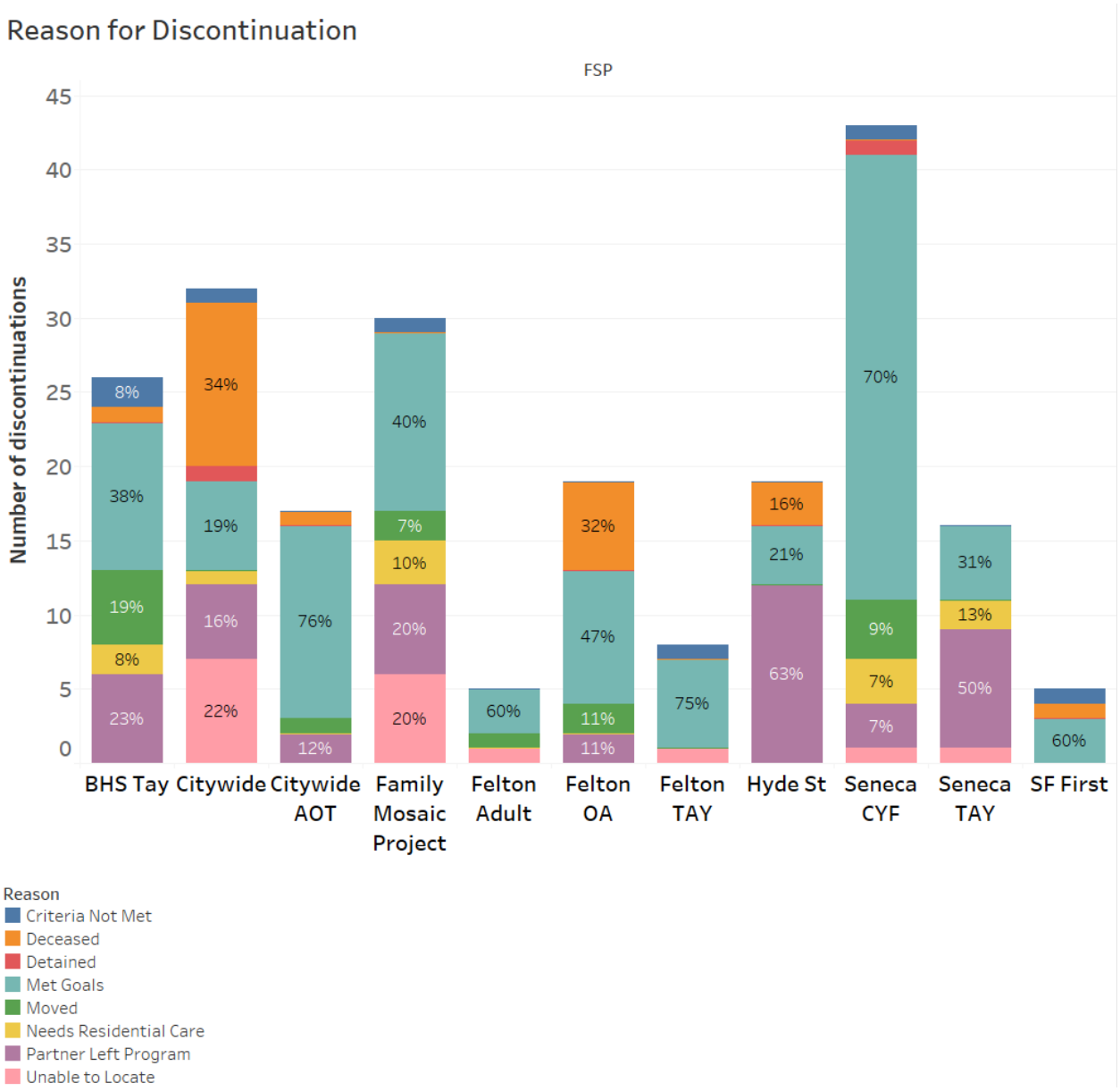


Reason for Discontinuation

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

Reasons for Discontinuation from FSP varied widely in FY 20-21 (Exhibit RFD), with the most often reported reason being “Met Goals” (45.9%). Of concern is that 10.9% (n=24) of discontinuations among adults were due to death. Although the cause of death is not clear, this population suffers from long-term substance use disorders, chronic medical conditions, homelessness, and poor access to medical care. Moreover, San Francisco experienced a rise in deaths related to COVID-19 and overdose in the past year, both of which this population is vulnerable to.

Exhibit RFD. Reason for Discontinuation for All Clients, by Program (n=220)



Note: Data on reason for discontinuation are not available for IFR Spark.

Improving DCR Data Quality

Since the inception of the DCR, ensuring high quality KET data to capture 100% of residential changes, emergency events and other life events has proven challenging. The KETs are prospective data that capture key events for clients, and case managers have difficulty both in being informed with the details of those events and in taking time to record them in the DCR.

San Francisco continues to manage DCR activity through the DCR Workgroup, comprised of MHSA evaluators from BHS Quality Management and an IT staff person. The Workgroup works with FSP programs to support accurate and timely client data entry into the DCR, in part by generating several data quality and data outcome reports shared frequently with the FSP programs. These reports and data discussions help monitor and increase the level of completion for KETs and Quarterly Assessments.

The Workgroup also provides a KET tracking template as a tool to help case managers record KETs as the events occur and remember to enter them in the DCR at a later time. Data quality and completion are affected by staffing capacity of the program to support DCR data entry.

The DCR Workgroup also provided one-on-one and group trainings on DCR online during COVID-19 and visited individual programs as needed, when safe to do so. In FY20-21, the DCR Workgroup provided virtual DCR user trainings for new FSP case managers and ongoing support in both data entry and reporting. Based on these trends, more communication and support are needed to increase the completion rate of DCR data.

Staffing Shortages with FSPs

A brief survey was administered to Directors of Full-Service Partnerships (FSPs) in November 2021 to understand more about staffing shortages, and how they may affect FSP availability and quality of care. Five (n=5) Directors responded, with a response rate of 45.5%.
Most Directors described staffing shortages across all categories of staff (i.e., case managers/clinical staff, administrative staff, or other staff), with the largest staffing shortages seen amongst case managers/clinical staff. On average, clinics needed an average of 2.4 more case managers/clinical staff to be at full capacity. Additional staffing needs ranged from one to nine additional clinical staff members. Although Directors described staffing shortages amongst Administrative or Other staff as well, this shortage was smaller at 0.1 and 0.2 staff, on average. Directors also described more case managers leaving their agencies than they have been able to hire and onboard. Staffing shortages contribute to high caseloads per case manager, with an average caseload of 13.8 clients per case manager, ranging from 7 to 22 clients per case manager. (Table 1). This contributes to high anxiety, stress and burnout, and subsequent resignations. When asked about burnout, all Directors reported that their case managers reported feeling burnout, with 80% strongly agreeing (Box 1).

Table 1. FSP Staffing	***Average***	***Range***	***Range of shortage***
Case Managers/Clinical Staff			(-1 – 9)
The number of case managers/clinical staff currently employed	6.9	(3-15)	
The number of case managers/clinical staff who should be employed (if were fully staffed)	9.3	(3-24)	
Administrative Staff			(0 – 0.4)
The number of administrative staff currently employed	1.7	(0-4)	
The number of administrative staff who should be employed (if were fully staffed)	1.8	(0-4)	
Other Staff			(0 – 1)
The number of other staff currently employed	2.1	(0-6)	
The number of other staff who should be employed (if were fully staffed)	2.3	(0-6)	
Case Managers & Case Load			
How many case managers have left your agency since January 1, 2021?	3.8	(0-11)	
How many new case managers have you hired and onboarded since January 1, 2021?	3.0	(0-6)	
What is the average case load per case manager at your FSP?	13.8	(7-22)	

FSP Staffing Shortages & Quality of Care

When asked about staffing shortages since January 1, 2021...

- 4 out of 5 Directors (80%) strongly agreed that wait times for FSP entry had increased
- All Directors (100%) agreed or strongly agreed that case managers were experiencing burnout
- 4 out of 5 Directors (80%) agreed or strongly agreed that it was becoming more difficult to provide culturally congruent care

Finally, most FSP Directors stated that the high cost of living in the Bay Area and low salaries were the primary reason they could not attract or retain case managers/clinical staff. With salary opportunities nearly double at Kaiser, compared to community-based organizations (CBOs) in San Francisco, it is difficult for CBO-operated FSPs to attract, hire and retain qualified case managers/clinicians. This further contributes to high caseloads, staff burnout and resignations, as exemplified in the following quote:

> *"Most of our case managers at exit interview state that they like the mission, the clinical work, and the support/camaraderie on the time. They state that they are leaving due to extreme burnout from complex documentation, UOS/productivity stress and coverage need, being unable to afford living in the Bay Area given their salaries, and long commutes. A significant portion of our staff leave on average after two years with us or once they have collected sufficient hours to sit for their licensing exam. All of this is having deleterious effect on the care we provide, as we have not been fully staffed since 2019 and thus in perpetual coverage mode. With COVID and frequent need for leave*

(e.g., with any respiratory symptoms), the coverage requirements are further increased. Our jobs are posted for months, and we are having few candidates that are fit for the job. This means we are hiring less qualified individuals who require more training/support and fuel concerns about the quality (and quantity) of service. Adding centralized utilization management requirements of clinicians having to request continuation of service every 6 months (as it is shaping up currently) will provide further need for documentation and lead to time away from providing direct clinical care (i.e., poorer care) and likely drive more people away given that documentation is a major reason for leaving. The situation is frankly dire." –FSP Director (anonymous)

In fiscal year 20-21, BHS hired 15 new clinicians and administrative staff within county-run FSPs. As part of MHSF, our goal is to expand access to intensive case management and full service partnerships and will hire additional new behavioral health clinicians under this expansion (MHSF). Furthermore, implementation of CalAIM includes documentation redesign, which has the potential to streamline documentation requirements for Medi-Cal and reduce staff burnout.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[2]
Full-Service Partnership (Children)	269 Clients	$1,226,579	$4,560
Full-Service Partnership (TAY)	95 Clients	$1,237,627	$13,028
Full-Service Partnership (Adult)	466 Clients	$4,833,210	$10,372
Full-Service Partnership (Older Adult)	43 Clients	$1,798,498	$41,826

Behavioral Health and Juvenile Justice System Integration

Program Collection Overview

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

Target Populations

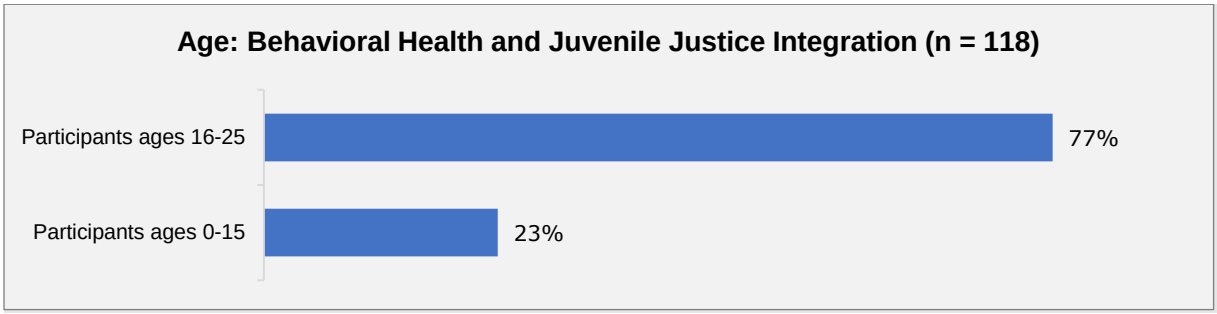
The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11- 21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. These programs and their affiliated programs operate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

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

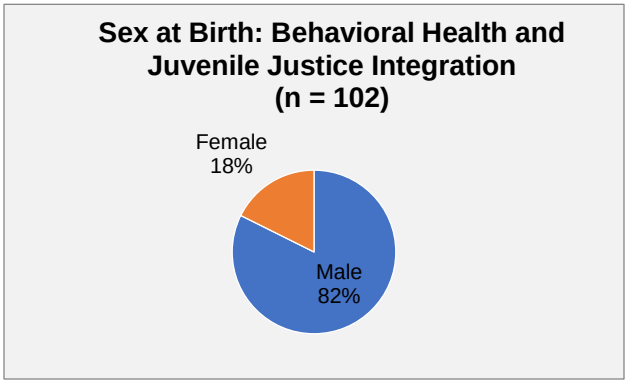
comfortable whether it is at home, school, or in the community. Services are also offered at the Juvenile Justice Center and in Juvenile Hall.

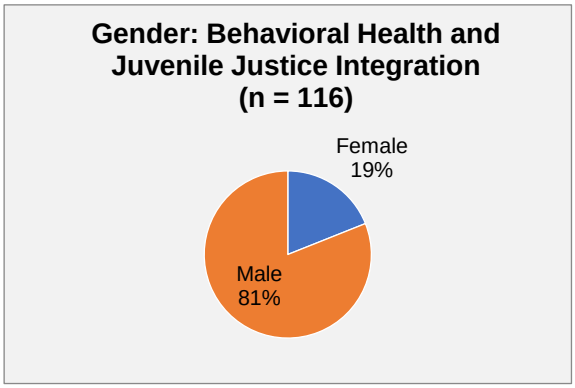
Behavioral Health and Juvenile Justice System Integration Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Assess, Identify Needs, Integrate Information & Match to Services (AIIM) Higher *Seneca Center and SFDPH*	CSS Other Non-FSP 5. Integration of Behavioral Health into the Juvenile Justice System	AIIM Higher is a partnership among the San Francisco Juvenile Probation Department, the Child, Youth and Family System of Care, and Seneca Center. The AIIM Higher team is comprised of mental health clinicians who conduct clinical assessments and facilitate community behavioral health linkages for probation-involved youth in San Francisco.
Community Assessment and Resource Center (CARC) *Huckleberry Youth Programs*		CARC is a partnership among Huckleberry Youth Programs (the managing provider), Juvenile Probation, San Francisco Sheriff's Department, San Francisco Police Department, Community Youth Center and Instituto Familiar de la Raza. A valuable service is the availability of MHSA supported on-site therapists who provide mental health consultation to case managers, family mediation, and individual and family therapy. Mental health consultation is provided through weekly client review meetings and during individual case conferences.

Demographics: Behavioral Health and Juvenile Justice Integration

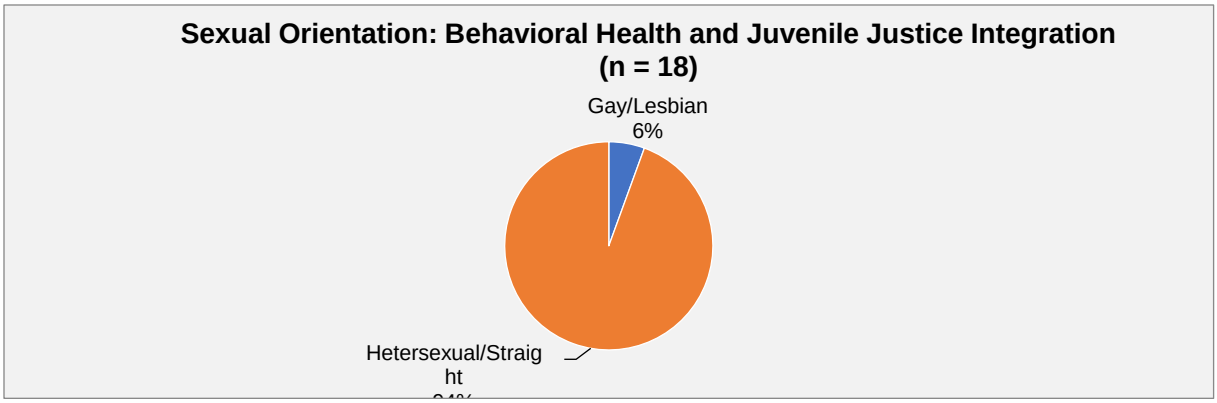


*< 1 percent of participants reported Adult (26-59), Older Adults (60+); Age





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



*No participants reported data for Yes; Veteran Status
*No participants reported valid data; Disability Status

Race/Ethnicity	n
Black/ African American	83
Asian	26
Native Hawaiian or Pacific Islander	12
White	45
Other Race	21
Hispanic/Latino	47
Non-Hispanic/ Non-Latino	98
More than one Ethnicity	17
Total	349

Primary Language	n	%
Chinese	<10	<4%
Russian	211	91%
Tagalog	13	6%
Vietnamese	<10	<4%
Another Language	3	1%
Total	231	100%

*No participants reported data for American Indian or Alaska Native; Race/Ethnicity
*No participants reported data for English, Spanish; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher – Seneca Center and DPH	• 118 youth (78%) received the full scope of AIIM Higher services (16 youth) or received consultation, information, referral or Linkage services (102 youth). • 100% of clinical staff were trained in the Crisis Assessment tool (CAT) and certified in the Child and Adolescent Needs and strengths (CANS). • 16 youth (100%) were referred for behavioral health services. • 14 clients (87%) were successfully connected to services. 12 families (75%) submitted warm hand off surveys.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[3]
Behavioral Health & Juvenile Justice Integration	118 Clients	$448,137	$3,798

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

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

Program Overview

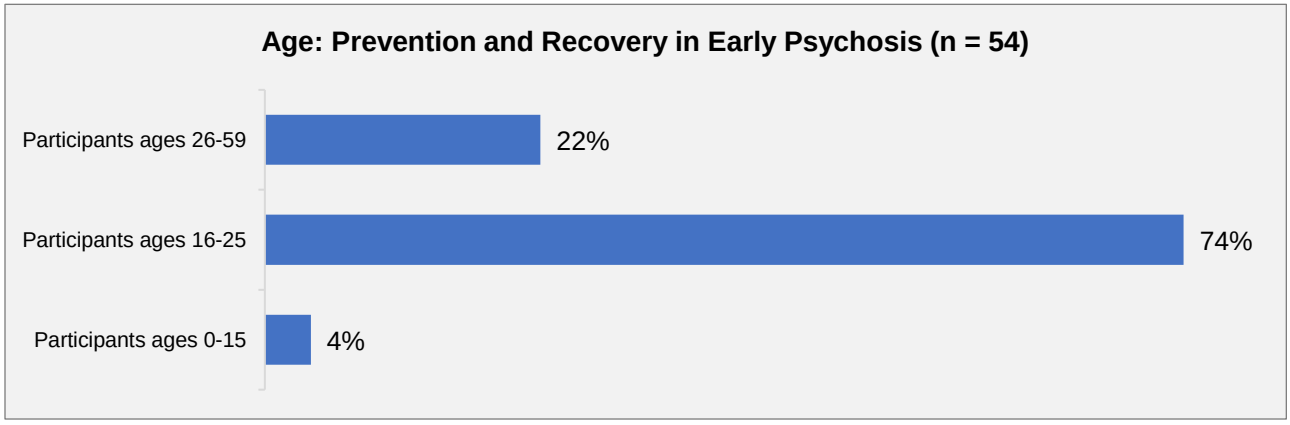
PREP also known as (re)MIND is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs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

Target Populations

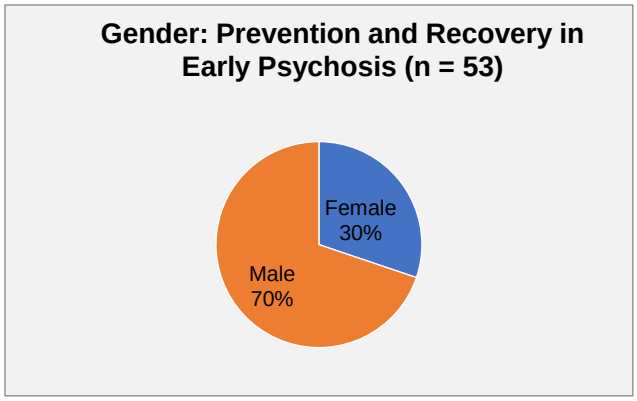
PREP serves youth and young adults between the ages of 14-35. Most clients are transitional age youth (TAY), between age 16 and 25. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years.

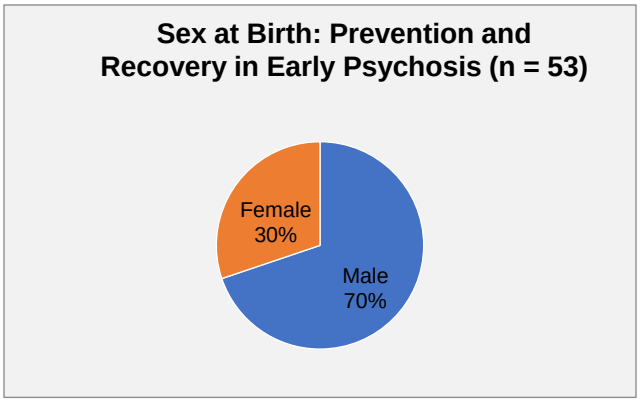
Participant Demographics, Outcomes, and Cost per Client

Demographics: Prevention and Recovery in Early Psychosis (re)MIND

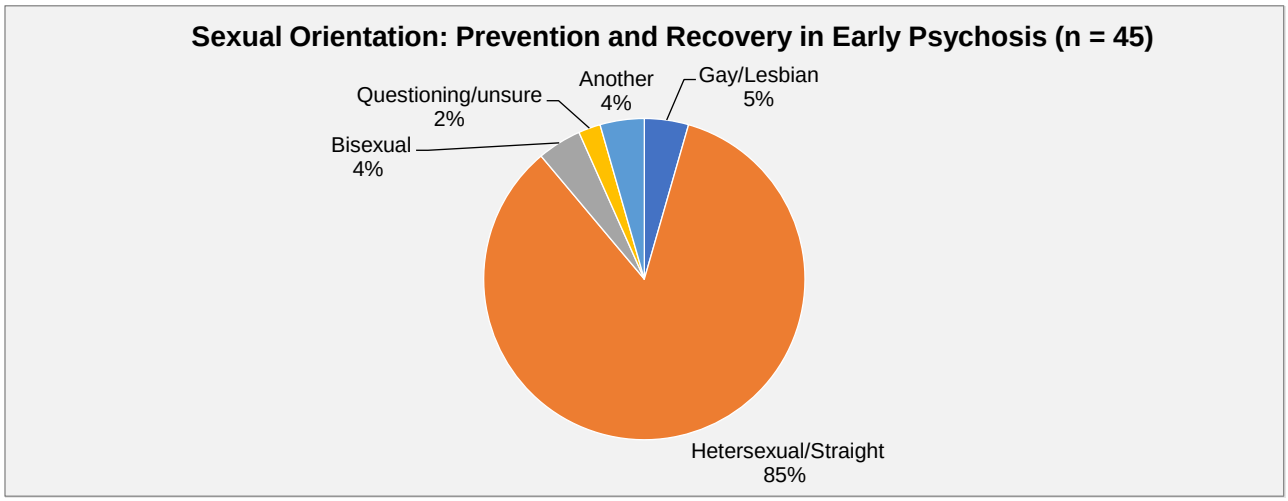


*< 1 percent of participants reported data for Older Adults (60+); Age





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



*No participants reported data for Yes; Veteran Status
*No participant reported valid data; Disability Status

Primary Language	n	%
English	47	87%
Spanish	<10	<18%
Tagalog	<10	<18%
Vietnamese	<10	<18%
Another Language	<10	<18%
Total	54	100%

Race/Ethnicity	n
Black/ African American	<10
Asian	13
Native Hawaiian or Pacific Islander	<10
White	<10
Other Race	21
Hispanic/Latino	12
Non-Hispanic/ Non-Latino	42
More than one Ethnicity	10
Total	118

*No participants reported data for American Indian or Alaska Native; Race/Ethnicity
*No participants reported data for Chinese; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY19/20 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP) – Felton Institute	• 9 programs (60%) received outreach presentations to establish and maintain referral relationships. • 30 organizations (150%) received outreach related to serving TAY population, MH clinics, Neighborhood Health Centers, Social Justice organizations and faith-based organizations. • 76 individuals (217%) received phone screenings and/or consultations regarding potential referrals to determine need for further comprehensive diagnostic assessment. • 50% of new enrollments during FY 20-21 were representative of San Francisco Southeast Sector residents. • 21 structured diagnostic assessments (SCID) (140%) were conducted to determine need for specialized Early Psychosis treatment services. • 11 program participants (34%) participants enrolled in the program for 12 months or more were engaged in new employment or education, as measured by enrollments documented in CIRCE and Avatar records. • 6 program participants (67%) enrolled in the program for at least 12 months had at least one acute inpatient episode within 12 months prior to enrollment. Of that number • 4 program participants (67%) participants had a decrease in acute inpatient episodes • 5 program participants (83%) had a decrease in days hospitalized. • 26 program participants (81%) enrolled in the program for at least 12 months had no acute inpatient setting episodes within the 12 months prior to their enrollment. • 22 program participants (85%) remained with zero acute inpatient

Program	FY19/20 Key Outcomes and Highlights
	episodes during the first 12 months of program enrollment. • 31 program participants (91%) enrolled in the program for 12 months or more built capacity to cope with challenges they encounter, as measured by the increase of at least 1 PCI (Standardized Performance Change Index) point on staff ratings on the CANS/ANSA.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[4]
Prevention and Recovery in Early Psychosis (PREP)	54 Clients	$637,811	$13,856

Behavioral Health Access Center (BHAC) – SFDPH (CSS Other Non-FSP 1. Behavioral Health Access Center)

Program Overview

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

1) Mental health access for authorizations into the Private Provider Network
2) The Treatment Access Program for assessment, authorization, and placement into residential treatment
3) The Offender Treatment Program to place justice mandated clients into addiction and dual diagnosis treatment
4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy
5) The BHS Pharmacy that provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol withdrawal management medications for Treatment Access Program clients, naloxone for opioid 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 also been instrumental in in the implementation of Proposition 47 in San Francisco County. Proposition 47 will allow certain eligible and suitable formerly incarcerated people to access community-based care funded through an allocated grant from DHCS. Proposition 47

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

funding has allowed San Francisco County to increase the amount of residential treatment capacity in the community and interrupt potential re-incarceration or continued criminal behaviors, therefore reducing recidivism. BHAC will provide treatment matching and placement authorization to participants in this program.

Target Populations

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

Outcomes, Highlights, and Cost per Client

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Behavioral Health Access Center (BHAC) – Department of Public Health	• In FY20/21, BHAC served a total of 980 unduplicated clients in the clinic. • BHAC staff served 16,560 residents of San Francisco seeking access to mental health services though the Access Line (phone referrals to services). • Conducted 799 face-to-face contacts with clients accessing care and in need of concurrent primary care services.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[5]
Behavioral Health Access Center	16,560 clients	$878,964	$53.08

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

Integration of Behavioral Health and Primary Care – Curry Senior Center (CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care)

Program Collection Overview

DPH has worked toward fully integrated care in various forms for the last two decades. In 2009, after an extensive community planning process, DPH implemented the Primary Care Behavioral Health (PCBH) model in the majority of DPH primary care clinics. In this model, behavioral health clinicians work as members of the primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based therapeutic interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management. (e.g., class and group medical visits).

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

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

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

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

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

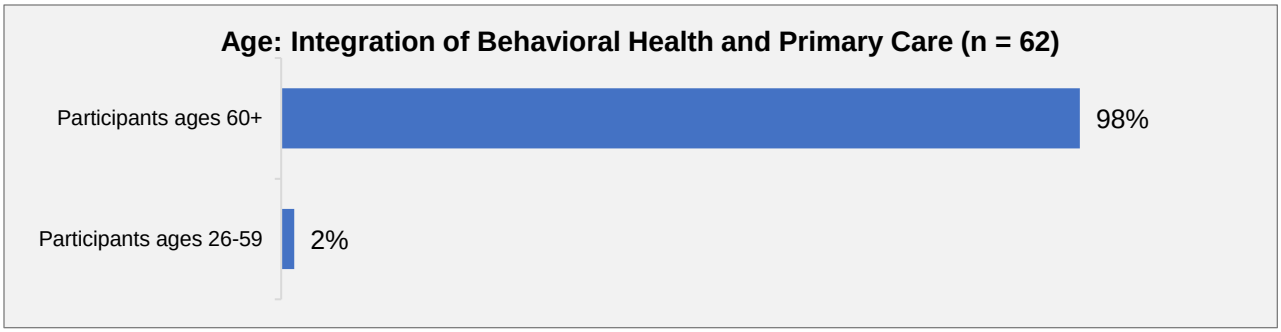
- The SPY Project
- Disability Clinic
- Hawkins Village Clinic
- Cole Street Youth Clinic
- Balboa High School Health Center

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

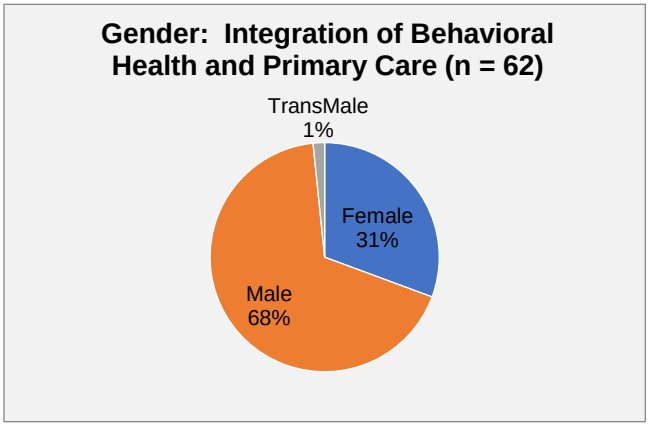
Target Populations

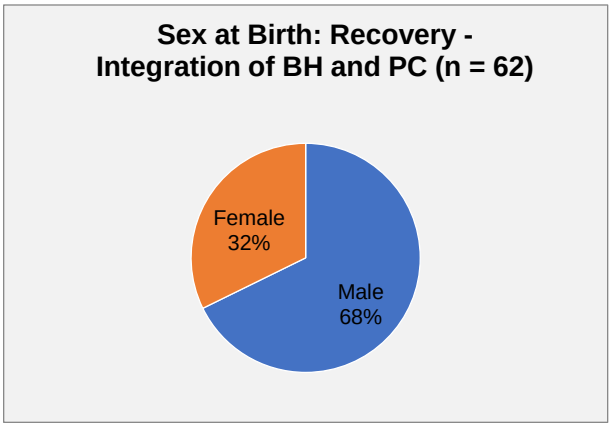
The target populations for these services are individuals and families served in primary care clinics with behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

Demographics: Integration of Behavioral Health and Primary Care

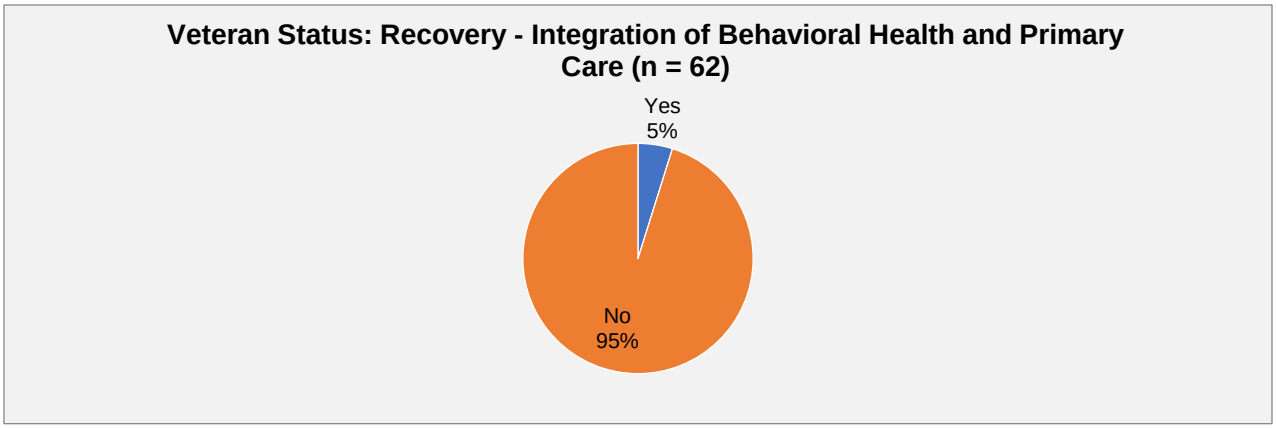


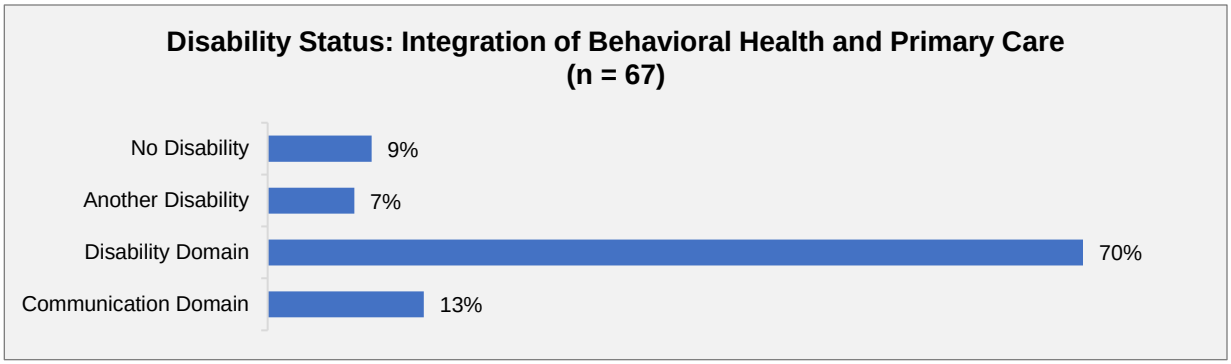
*< 1 percent of participants reported data for 0-15, 15-25; Age





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





Race/Ethnicity	n
Black/ African American	16
Asian	<10
White	34
Hispanic/Latino	<10
Non-Hispanic/ Non-Latino	56
More than one Ethnicity	<10
Total	119

Primary Language	n	%
English	57	92%
Spanish	<10	<16%
Vietnamese	<10	<16%
Another Language	<10	<16%
Total	62	100%

*No participants reported data for Chinese, Russian, Tagalog; Primary Language
*Participants may be counted in multiple categories
*No participants reported data for American Indian or Alaska Native, Native Hawaiian or Pacific Islander, Other Race; Race/Ethnicity

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – Curry Senior Center	• 976 individuals (100%) received Face-to-Face encounters as evidenced by Behavioral Health Navigator Face to Face Statistical Encounter Log administered by the Data Analyst Manage. • 110 Medical Clinic clients (100%) were screened using one of the following tools: PHQ-9, brief psychiatric scale. • 30 clients (60%) who were screened by the NP were referred to Behavioral Health Services as evidenced by the Case Manager Statistical Log administered by the Data Analyst Manager.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[6]
Integration of Behavioral Health and Primary Care	976 Clients	$1,466,641	$1,503

Moving Forward in Recovery-Oriented Treatment Services

Full-Service Partnership (FSP) Programs

In FY21-22, MHSA expanded the Full-Service Partnership programs, which was a contribution of an additional $2.5 million dollars to expand treatment slots in FSP programs.

Behavioral Health Access Center (BHAC)

- BHAC staff remain limited in their ability to meet face-to-face with clients. In 2021, staff were exposed to COVID-19 despite following CDC guidelines. COVID-19-related staff absences, disaster-response deployment contributed to staffing shortages during the year.
- Four (4) new full-time-equivalency (FTE) staff were brought on board in FY20-21, against a vacancy of 11. There were no changes to key staff during the period.
- Ongoing planning and coordination for the proposed expansion of BHAC hours continued through the year, though met with unexpected delays as the pandemic continued to impact staff capacity and programming in 2021. In FY21-22 BHAC will expand its hours of operation to 66 hours per week.

Behavioral Health Services in Primary Care

In FY2020-21, the program continued to pivot and adapt due to the pandemic in order to maintain high quality care in supporting our clients. After a shift to virtual services with the COVID-19 pandemic in 2020, we resumed face-to-face meetings and behavioral health screenings in 2021. In 2021, we responded to clients calls to support their basic needs by ensuring clients had food and medicine, were connected to providers, and were continuing to receive IHSS services. When vaccines were available, we provided our clients with transportation assistance to get to vaccine sites and schedule their second dose appointments. A number of clients who were homebound were able to receive vaccines from Curry Senior Center's Nurse Practitioner who did home-visits. To date, all clients have been reconnected to receive regular medical care in addition to care for delayed medical procedures and diagnostic workups, especially for cardiac related issues and cancer.

Mental Health and Substance Use Disorder Assessment Reporting Form

Assembly Bill 2265 (Quirk-Silva, 2020) enacted Welfare and Institutions Code 5891.5 which requires counties to report to the California Department of Health Care Services the number of people assessed for co-occurring mental health (MH) and substance use disorder (SUD) and the number of people assessed for cooccurring SUD who were later determined to have only an SUD without another co-occurring MH condition. In fiscal year 2020-21, San Francisco saw 23,863 people over age 5 assessed for co-occurring MH and SUD.

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

2. Peer-to-Peer Support Programs and Services: CSS Funding

Service Category Overview

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

2020 Trans Peer Event Poster

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

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

There is also a key role for peer-based strategies in the ongoing work of educating the public on stigma reduction. Peer-to-Peer Support Service programs reach out to a wide range of public venues, such as health fairs, senior centers, and youth service centers, in order to demonstrate that consumers can recover and make positive contributions to the community. Through presentations and dialogue with community residents, consumers can offer a vision for wellness, especially to communities that are facing stigma and hopelessness about the possibility of recovery. The stigma of mental illness is often culturally influenced, which makes it that much more essential that peers reflect the gender, language, age groups and culture of the City and County of San Francisco.

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

Target Populations

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

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

Peer-to-Peer Support Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) *SFDPH*	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	LEGACY is a peer-based, family engagement, and leadership program that is youth-focused and family-driven. This program provides education, navigation support, workshops, case management, and support groups to help empower transitional-aged youth (TAY) and families involved in the San Francisco child-serving system. LEGACY promotes family and youth voices within the integrated delivery systems and supports the development of strong relationships among individuals, families, and service providers as these relationships are critical to promoting cultural humility and person-centered care. LEGACY also provides peer internship opportunities and facilitates the TAY Community Advisory Board.
Peer to Peer, Family-to-Family *National Alliance on Mental Illness (NAMI)*		NAMI Peer-to-Peer, Family-to-Family program utilizes trained peers to provide outreach, engagement, navigation in the community. Peer mentors meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the participant by meeting weekly for 1 hour and assisting the participant with their wellness and recovery journey. Mentors also act as a community resource for helping a participant direct their own path to wellness and recovery.
Peer Specialist Mental Health Certificate and Leadership Academy *Richmond Area Multi-Services (RAMS)*		The Certificate Program (Entry and Advanced courses) prepares BHS consumers and/or family members with skills & knowledge for peer specialist/counseling roles in the systems-of-care. In addition, the program offers the Leadership Academy which is a monthly training series designed to support and educate peer providers in the behavioral health field. Trainings will also focus on building skills for participation in a variety of activities that request peer provider/consumer input (e.g., boards and advisory

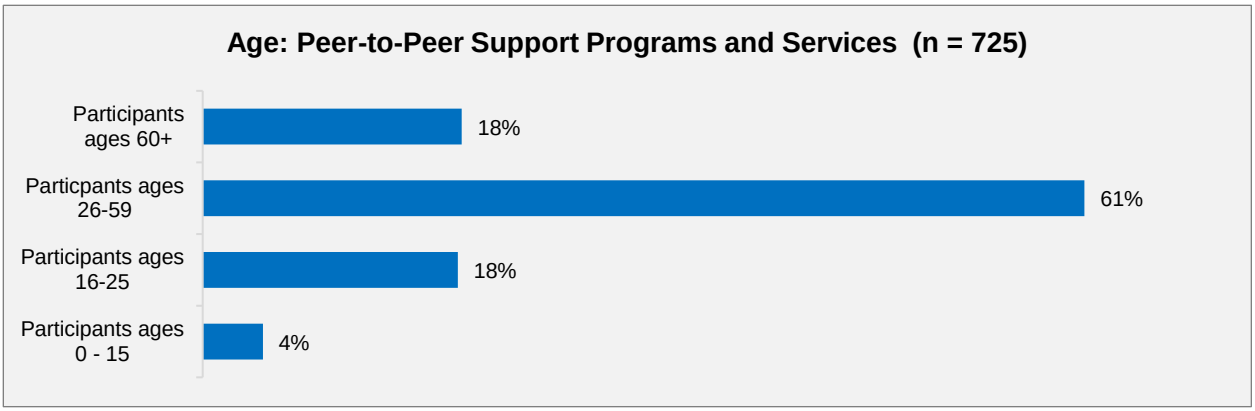
Peer-to-Peer Support Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
		committees, review panels, policy development, advocacy efforts, etc.).
Gender Health SF (formerly known as Transgender Health Services) *SFDPH*		Gender Health SF program provides access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. MHSA began funding the peer counselor positions only, to support this program as a supplemental enhancement. Peer counselors ensure proper coordination of behavioral health services and ensure all behavioral health needs are addressed.
Peer-to-Peer Employment Program *Richmond Area Multi- Services (RAMS)*		The Peer Counseling & Outreach facilitates wellness activities and enhances treatment services by providing peer counseling and supportive case management & resource linkage to clients of BHS clinics/programs. The services, offered by individuals with lived experience, aim to improve the level of engagement with clients, foster feelings of hope, and promote recovery & wellness. The Peer Internship offers entry-level placements in peer direct services and administrative support roles. In a collaborative learning and supported environment, peer interns work with other peer providers in a variety of DPH programs. The paid internships are nine months (20 hours/week) in duration.
Peer Wellness Center *Richmond Area Multi-Services (RAMS)*	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	The Peer Wellness Center is for adult/older adult consumers of BHS in need of additional support, with services provided by peer counselors and wellness staff who have lived experience. Consumers gain empowerment skills, engage in mindfulness practices, and participate in whole health wellness within a safe environment that utilizes empathy & peer support to help promote and inspire recovery. Also, the Center offers information for supportive services and linkages to a variety of behavioral health and primary health care resources in San Francisco.
Transgender Pilot Project (TPP) *SFDPH*		The Transgender Pilot Project (TPP) is designed to increase evaluation planning in order to better collect data on the strategies that best support Trans women of color with engaging in behavioral health services. TPP entered the pilot year of operations in FY15-16 as a MHSA INN Project. The two primary goals are to increase social connectedness and provide wellness and recovery-based groups. The ultimate goal of the groups is to support clients with linkage into the mental health system and services.

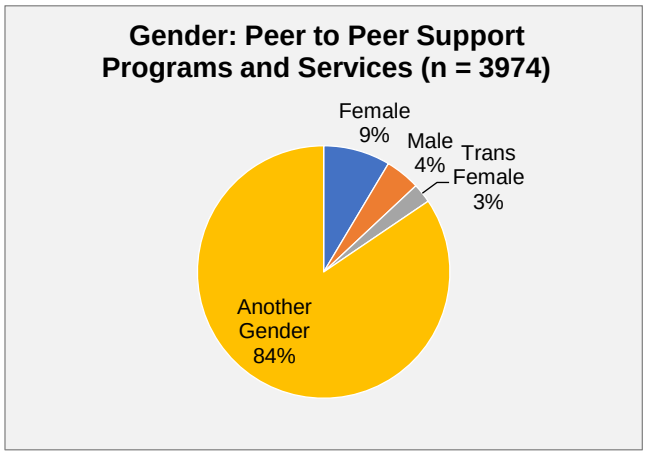
Spotlight on Peer Billing Pilot Program

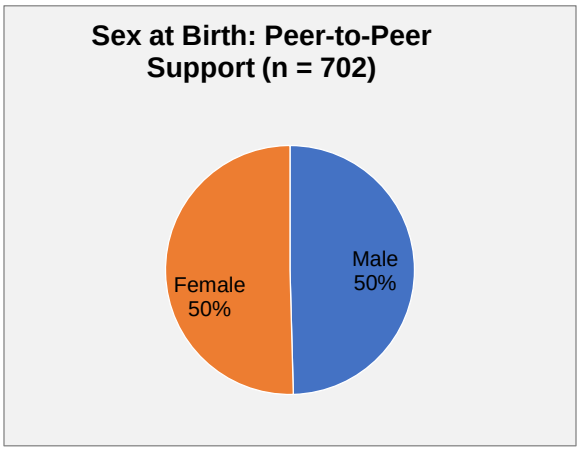
We are excited to announce that we have launched a new project with MHSA Peer Services. The program is peer billing pilot with six peer specialists who already perform Medi-Cal billable work. We are partnering with Richmond Area Multi-Services (RAMS) and the civil service clinics where these peers perform counseling services.

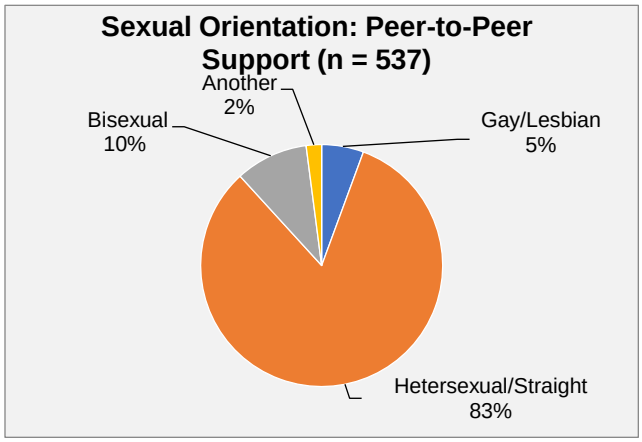
RAMS has provided support/training to the peers regarding Medi-Cal Billing. BHS/MHSA also developed training materials to support this unique training, especially training regarding progress notes that meet Medi-Cal standards for case management brokerage, individual rehabilitation, and group rehabilitation. The peers were all trained in our Electronic Medical Record system, Avatar. The peers' site supervisors have also provided extensive support and these supervisors will sign off on all progress notes and provide ongoing continued support. The peers report excitement over this new learning opportunity.

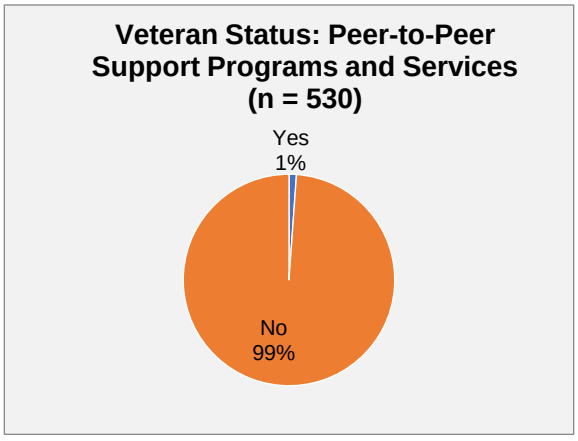
Demographics: Peer to Peer Support Programs

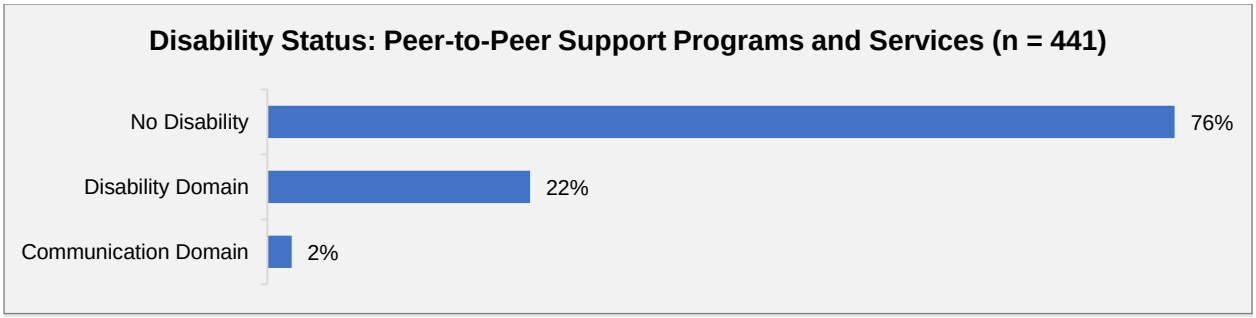












Race/Ethnicity	n
Black/ African American	51
American Indian or Alaska Native	<10
Asian	54
Native Hawaiian or Pacific Islander	<10
White	31
Other Race	13
Hispanic/Latino	22
Non-Hispanic/ Non-Latino	63
More than one Ethnicity	<10
Total	243

Primary Language	n	%
Chinese	11	7%
English	136	82%
Spanish	12	7%
Tagalog	<10	<6%
Vietnamese	<10	<6%
Another Language	<10	<6%
Total	165	100%

*No participants reported data for Russian; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Lifting and Empowering Generations of Adults, Children and Youth (LEGACY) – DPH	• 13 organizations (81%) received presentations informing community organizations about LEGACY services. • 114 referred individuals (100%) individuals were screened to receive culturally and linguistically appropriate services through one-on-one peer-to-peer support to address their and/or their children's mental health needs. • 51 consumers (69%) completed at least one type of self-identifying behavioral health goal. • 26 survey participants (93%) reported feeling more connected to their peers after partaking FSN. • 20 surveyed participants (71%) agreed strongly to feeling more connected to their peers.
Peer to Peer, Family to Family – NAMI	• 24 Peer to Peer participants (92%) reported an increased understanding of their mental illness as a diagnostic medical condition and felt better able to recognize signs and

Program	FY20/21 Key Outcomes and Highlights
	symptoms as evidenced by the completion of a relapse prevention plan. • 115 Family to Family (95%) and BASICS participants reported feeling more prepared to solve future problems with their loved one living with a mental health condition and better connected to the community and available resources. • 24 Peer to Peer participants (89%) reported an increased awareness and skills to better practice self-care.
Peer Specialist Certificate, Leadership Academy and Counseling – Richmond Area Multi-Services (RAMS)	• 35 program graduates (100%) indicated plans to pursue and/or continue a career in the health & human services field. • 35 students (88%) graduated from the program. • 35 program graduates (100%) reported an increase in skills and knowledge due to participation in the program. • 4 virtual social networking events (100%) were held in FY20-21: two Student Alumni Networking Panels and two Alumni Reunions.
Gender Health SF – DPH	• 7 participants (78%) in provider training focused on general information about vaginoplasty felt "more confident" and reported, "greater knowledge" and "better skills" when speaking with patients about vaginoplasty. • 27 participants (100%) in provider training on pre-surgical assessment agreed or strongly agreed that they learned how to properly complete a pre-surgical assessment for trans patients. • 27 participants (100%) learned how to help patients set more realistic expectations from their surgery outcomes. • 27 participants (100%) felt they now had the necessary resources to better advocate for their TGNB patients. • 23 participants (85%) reported feeling ready to put their learning into practice. Overall, a majority of the providers (23/27, 85%) rated the facilitator as "excellent." • 100% of staff agree to the following statements reflecting satisfactory workforce development: "My supervisor treats me with respect." "My supervisor and I have a good working relationship." "My supervisor supports my need for work-life balance." "My job and GHSF helps me grow as a person." "Overall, I am satisfied with my experience working at GHSF."
Peer to Peer Employment - Richmond Area Multi-Services (RAMS)	• 42 program employees (84%) working 16+ hours/week participated in four skills development trainings/sessions. • 42 program employees (84%) working 16+ hours/week participated in four wellness trainings/sessions. • 68 clients/participants (86%) surveyed reported that they feel socially connected as a result of the peer support services they participated in. • 10 enrolled interns (91%) successfully completed the program. • 7 intern graduates (100%) who completed the post-program evaluation reported improvements in their abilities to manage

Program	FY20/21 Key Outcomes and Highlights
	stress in the workplace.
Transgender Pilot Project – DPH	• 24 program participants (more than 75%) reported increased social connection on a client survey administered by SFDPH. • 20 program participants (more than 75%) reported. improvements to health, wellness and recovery as a direct result of program as evidenced by participants rating 4 or above on evaluations provided after the Trans Health and Wellness fair on a client survey administered by SFDPH**.**

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[7]
Peer-to-Peer Programs	5,764 Clients	$2,179,575	$378

Moving Forward in Peer-to-Peer Support Programs

Peer-to-Peer services remain an important and strong component of SF-MHSA programs. Our MHSA stakeholders and community members are committed to and enthusiastic about peer services and frequently express how these services are a vital resource for our San Francisco communities. These services remain in high demand.

Starting in FY21/22, SF-MHSA will start funding the Peer-to-Peer Linkage program which is integrated into the Richmond Area Multi-Services (RAMS) Division of Peer-Based Services. This program enhances treatment services by providing peer-based supportive case management and resource linkage to clients at contracted SF DPH behavioral health clinics. Peer Service Coordinators, will deliver services to improve the level of engagement with clients, foster feelings of hope, and to promote the possibility of wellness and recovery.

On December 18, 2021, Mental Health Association SF hosted the 10th annual MHSA Awards Ceremony over Zoom with 150 people in attendance and 171 people were recognized and awarded Achievements in Recovery. Over 90% of attendees answered an evaluation survey affirming they agreed/strongly agreed that “The event helped me feel proud of my community's accomplishments,” and “The event helped me feel more connected to my community.”

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

3. Vocational Services: CSS Funding

Service Category Overview

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

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

In FY2019-20, SFDPH MHSA's Vocational Services Programs have succeeded in reducing barriers to services. For example, the programs are now accepting referrals from BHS clients with or without a unique identifying behavioral health services number (BIS) if they are receiving services from a civil-service or contracted BHS site/program/clinic. We have also partnered with the Adult Probation Department a partner of UCSF Citywide Employment Team to pilot a program allowing the California Department of Rehabilitation Co-op program to accept referrals for clients from the Community Assessment and Services Center (CASC; provides services for formerly incarcerated individuals).

Target Population

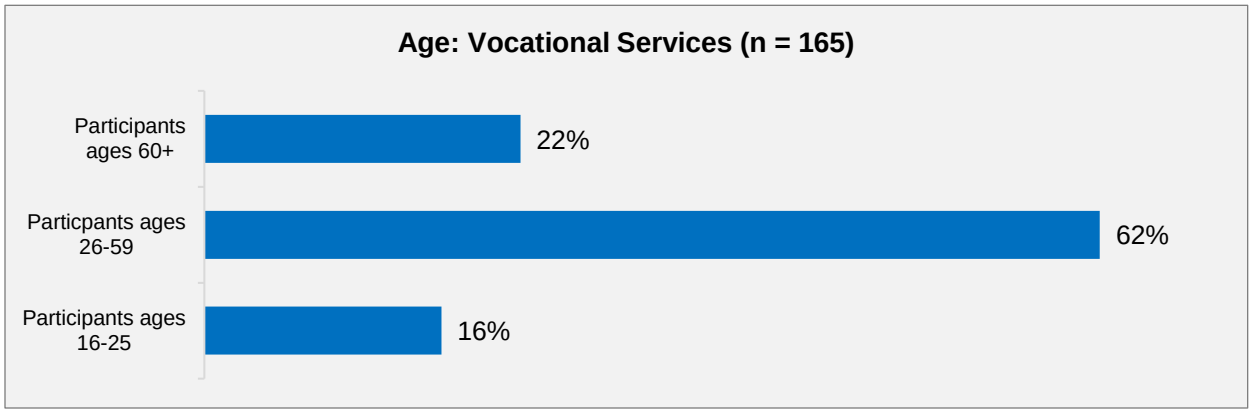
The target population consists of clients with behavioral health needs as well as other community residents in need of employment assistance. Particular outreach is made to underserved populations and those interested in job readiness programs, on-the-job training, internships, competitive employment and meaningful activities leading to work.

Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Department of Rehabilitation Vocational Co-op (The Co-op) *SFDPH and State of California*	CSS Other Non-FSP 8. Vocational Services (45% FSP)	The San Francisco Department of Rehabilitation (DOR) and BHS collaborate to provide vocational rehabilitation services to consumers of mental health services. Services offered by this program include vocational assessments, the development of an Individualized Plan for Employment, vocational planning and job coaching, vocational training, sheltered workshops, job placement, and job retention services.
First Impressions *UCSF Citywide Employment Program*		First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls, ceilings, and doors; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, vocational planning, job coaching, vocational training, workshops, job placement, and job retention services.
SF Fully Integrated Recovery Services Team (SF FIRST) *SFDPH*		The SF FIRST Vocational Training Program offers training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitator, as well as other positions. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal setting and hygiene maintenance for the workplace.
Janitorial Services *Richmond Area Multi-Services (RAMS)*		The Janitorial Services program provides janitorial and custodial vocational training to behavioral health consumers.

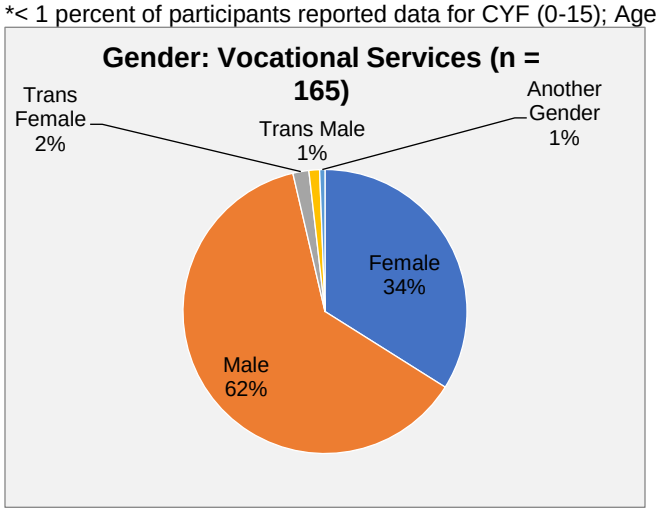
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Café and Catering Services *UCSF Citywide Employment Program*		The Café and Catering Services program provides café, barista, catering and customer service vocational training to behavioral health consumers. Consumers learn café and catering related skills while working towards competitive employment.
Clerical and Mailroom Services *Richmond Area Multi- Services (RAMS)*		The Clerical and Mailroom Vocational Programs provides both time-limited paid internships and long-term supported employment opportunities to participants of BHS. Participants learn important skills in the area of administrative support, mailroom distribution and basic clerical services. Participants also receive soft skills training, retention support services, coaching and linkage to services to obtain employment in the competitive workforce, if desired.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) *UCSF Citywide Employment Program*		The GROWTH Project provides training for individuals looking to establish careers in the horticulture and landscaping field. Consumers are taught skills in the field while focusing on draught-resistant landscaping.
TAY Vocational Program *Richmond Area Multi- Services (RAMS)*		The TAY Vocational Program offers training and paid work opportunities to TAY with various vocational interests. Consumers learn work-readiness skills while working towards competitive employment.
i-Ability Vocational IT Program *Richmond Area Multi-Services (RAMS)*	IT 2. Vocational IT	The i-Ability Vocational Information Technology training program prepares consumers to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at the BHS IT Department. The program includes three components: • Desktop: Learn new skills in the deployment and support of office equipment including; desktops, laptops, servers, printer, etc. Skills learned include the installation of software,

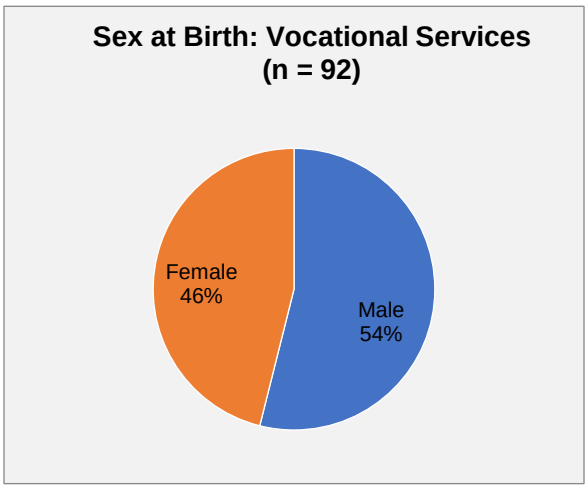
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
		application testing, break/fix, presentation skills, resume writing, etc. ● Advanced Desktop: Participants continue to expand their knowledge in the area of desktop support services. Additionally, participants serve as mentors for participants of the Desktop program. ● Help Desk: Participants learn customer and application support skills through the staffing Avatar Electronic Health Record (EHR) help desk, a call center. Skills learned include application support, customer service skills, working in a collaborative environment, resume writing, documentation development, etc. ● Advanced Help Desk: Participants continue to expand their knowledge in the area of application support gained through their successful graduation from the Help Desk program. Additionally, participants serve as mentors for participants of the Help Desk program. ● Employment: Graduates of the IT vocational training program are provided with the opportunity to apply for a full-time position with the IT department. Services offered by the program include vocational assessments, vocational counseling, job coaching, skill development and training.

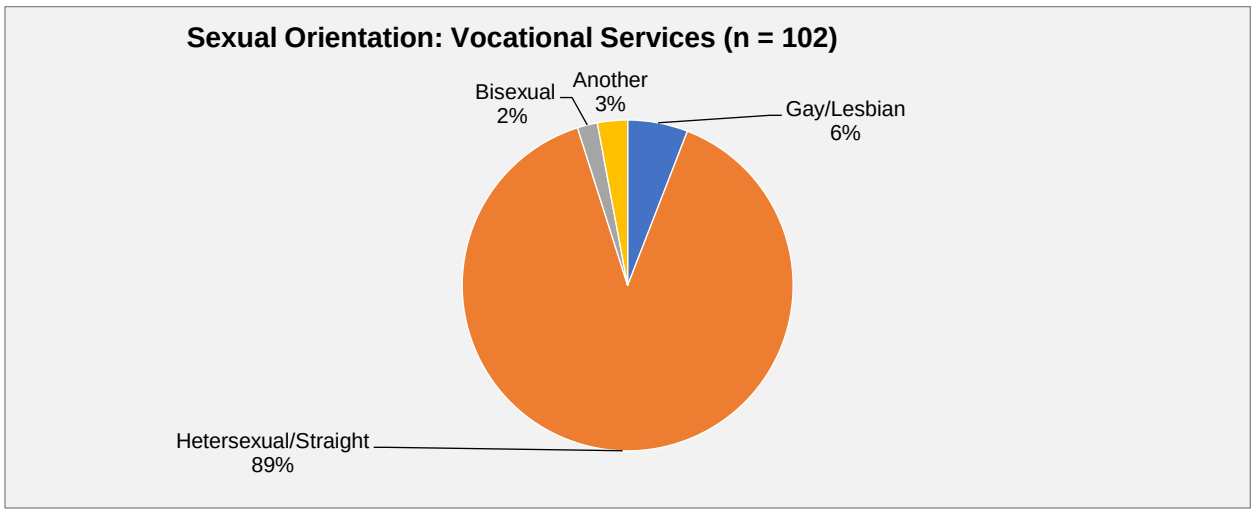
Demographics: Vocational Services



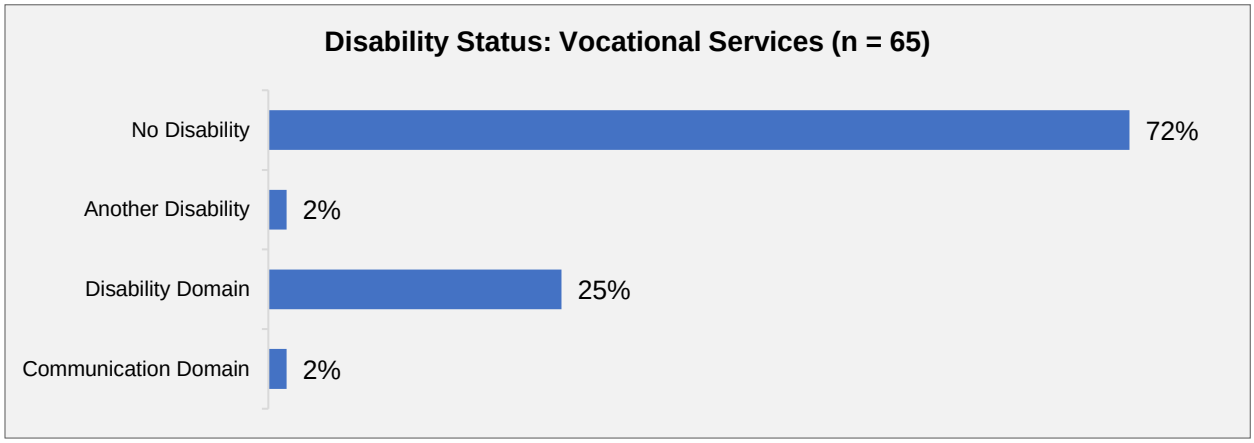
*< 1 percent of participants reported data for CYF (0-15); Age







*No participants reported Yes; Veteran Status



Race/Ethnicity	n
Black/ African American	129
American Indian or Alaska Native	<10
Asian	132
Native Hawaiian or Pacific Islander	<10
White	226
Other Race	20
Hispanic/Latino	217
Non-Hispanic/ Non-Latino	345
More than one Ethnicity	63
Total	1146

Primary Language	n	%
Chinese	116	7%
English	294	82%
Spanish	98	7%
Tagalog	<10	2%
Another Language	<10	<2%
Total	515	100%

*No participants reported Russian, Vietnamese; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Department of Rehabilitation Co-op – DPH and California State	• 447 consumers (60%) served through the SF Co-op DOR program. • 232 consumers (85%) placed in employment consistent with IPE. • 91 successful closures (47) achieved meaning participants remained in employment position for at least 3 months. • 47 outreach events held to promote services through vocational programs.
i-Ability Vocational IT Program – Richmond Area Multi-Services (RAMS)	• 19 enrolled trainees (83%) have successfully completed the program. • 21 surveyed trainee graduates (100%) indicated improvement to their coping abilities. • 21 surveyed trainee graduates (100%) indicated an increase in readiness for additional meaningful activities related to vocational services. • 21 trainees (91%) participated in exit interviews in which they completed the program feedback tools.
First Impressions – UCSF Citywide Employment Program	• 8 BHS consumers (100%) enrolled in the First Impressions Program as measured by the First Impressions staff and documented in client records. • 5 consumers (62%) graduated the First Impressions Program, as evidenced by the final performance evaluation conducted by the First Impressions staff. • 5 graduates (100%) reported an improvement in development in work readiness skills to use toward future opportunities (work/education/volunteering) as evidenced by the final performance evaluation conducted by the First Impressions staff. • 5 graduates (100%) reported an improvement in confidence to use the new skills learned.
SF Fully Integrated Recovery Services (SF First) Vocational Project – DPH	• 3 stipend positions re-instated and have resumed community integration activities. • Enrolled clients (73%) are fully vaccinated.
Janitorial Services - Richmond Area Multi-Services (RAMS)	• 3 participants (75%) who received services for at least three months successfully completed the program. • 2 surveyed intern graduates (100%) reported improvement in their coping abilities in the workplace. • 2 surveyed intern graduates (100%) reported report an increase in readiness for additional meaningful activities related to vocational services (e.g. educational program,

Program	FY20/21 Key Outcomes and Highlights
	advanced internship, advanced training program, employment, volunteer work, etc.). • 3 intern graduates (100%) expressed motivation in being engaged in vocational related activities as evidenced by completing the referral form for the RAMS Hire-Ability Employment Services program.
Café and Catering Services – UCSF Citywide Employment Program	• 16 BHS consumers (100%) were enrolled in the Slice of Life Café and Catering Program. • 6 BHS consumers (67%) graduated this fiscal year. • 6 graduates (100%) reported an improvement in development of work readiness skills. • 6 graduates (100%) reported an improvement in confidence to use the new skills learned.
Clerical and Mailroom Services – Richmond Area Multi-Services (RAMS)	• 4 participants (57%) who received services for at least three months successfully completed the program. • 4 graduates (100%) reported improvement in their coping abilities in the workplace. • 4 intern graduates (100%) reported report an increase in readiness for additional meaningful activities related to vocational services (e.g. educational program, advanced internship, advanced training program, employment, volunteer work, etc.). • 4 intern graduates (100%) expressed motivation in being engaged in vocational related activities as evidenced by completing the referral form for the RAMS Hire-Ability Employment Services program.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) – UCSF Citywide Employment Program	• 12 consumers (100%) enrolled in the GROWTH Project. • 5 consumers (42%) graduated the GROWTH Project. • 5 graduates (100%) reported an improvement in development of work readiness skills. • 5 graduates (100%) reported an improvement in confidence to use the new skills learned.
Transitional Age Youth Vocational Program – Richmond Area Multi-Services (RAMS)	• 14 participants (100%) enrolled after three months successfully graduated from Career Connections. • 14 surveyed intern graduates (100%) indicated improvement in their coping abilities in the workplace, as evidenced by items on the program feedback tools. • 13 surveyed intern graduates (93%) reported an increase in readiness for additional meaningful activities related to vocational services (e.g. educational program, advanced internship, advanced training program, employment,

Program	FY20/21 Key Outcomes and Highlights
	volunteer work, etc.), as evidenced by items on the program feedback tools. • 14 participants (100%) completing Phase II, who are interested in competitive community employment, were either placed in competitive community employment or were referred to an appropriate program to receive employment services as evidenced by the case closure notes.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[8]
Vocational Programs	598 Clients	$1,002,619	$1,677

Moving Forward in Vocational Services

In FY2020-21, Vocational program staff continued to pivot programming to better meet the emerging needs of the community as a result of the COVID-19 pandemic. All three BHS Vocational Services staff were deployed to serve as Disaster Service Workers in response to the Mayor's declared citywide emergency for the first quarter of 2021. Even once returned to their regular position, staff acted in support of the City's recovery from the pandemic as they worked with the community to take a new look at program planning to identify client needs, gaps in services, and assess and implement service delivery improvements. For example, Vocational staff met with BHS Adult and Older Adult System of Care Manager, SF FIRST program staff, RAMS Hire-ability and Peer Division program staff to identify vocational program needs, which resulted in the following program improvements being implemented: 1) client pay rates were increased to the SF Minimum Compensation Ordinance rate, and 2) RAMS hired a new staff person who works directly with clients to support their engagement in the program (paid for by MHSA funds). RAMS program also requested and received funding to lease a car to better able to work with clients in the community.

For most of 2021, BHS vocational staff continued to work remotely and some sites remained closed to in person services. UCSF FIRST Impressions program shifted from building maintenance and construction, with many offices mostly closed, and instead began to learn about 3-D printing machine maintenance and making PPE to deliver to BHS programs and staff. RAMS Clerical and Mailroom Vocational Program clerical internships were put on hold as the internships rely on BHS sites being open and working with staff in-person. RAMS Café Catering also pivoted as they did not have the Café open and instead, prepared and packaged meals that were delivered to the community.

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

All program outreach was conducted virtually, with one-on-one vocational information sessions still promoted regularly and the Outreach Coordinator met, on average, with one client per month for the drop-in vocational hour. A few staff were able to attend the Restorative Justice Reentry Fair, which was held in-person in late 2021. We anticipate moving back to work in-person in the coming year and will offer in-person outreach. Other program highlights in 2020-21 include:

- Solicited a Request for Qualifications for several vocational programs
- CSF Citywide Employment Services was awarded for the GROWTH (horticulture and landscaping) & Café and Catering program
- RAMS Hire-ability was awarded for the Employee Development, TAY, Janitorial, Clerical & Mailroom, and IT program
- Vocational staff participated in trainings on racial equity, COVID safety, tools for the virtual workplace, and others
- Developed and launched the first Latinx Wellness Webinar
- Participated in the 50th Annual Carnival
- Vocational Services Specialist was hired into a permanent civil-service position
- Built partnerships with Civic Makers group and others in effort to strategize how to best reach and serve marginalized groups in SF

4. Housing Services: CSS Funding

Service Category Overview

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

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

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

SF-MHSA, the Department of Homelessness and Supportive Housing (HSH), Mayor's Office of Housing and Community Development (MOHCD), DPH, and other agencies are working in partnership to facilitate this program. Collaborating stakeholders meet monthly to discuss the integration of new NPLH units into San Francisco's pipeline of permanent support housing. MOHCD and HSH, will be taking the lead on this project. DPH will work in partnership with MOHCD and HSH, to develop and implement the supportive services portion of the NPLH program.

<u>Coordinated Entry</u>

The NPLH program mandates that to qualify to live in a NPLH unit, people must have been assessed with a standard assessment tool that ensures people with the greatest need for and most barriers to housing are prioritized. Starting in 2017, HSH launched three Coordinated Entry (CE) processes to centralize the housing referral and placement process throughout the county. There are now CE processes for Adult (18+), Family, and Youth (18-24) to evaluate and prioritize the needs of people experiencing homelessness.

CE aims to reduce barriers for clients and providers by streamlining and standardizing the intake process for housing. CE will support the most marginalized people experiencing homelessness for housing, while also supporting other unsheltered people with problem solving

and linkage to available resources. Each person (or family) who encounters CE will complete a primary assessment to determine if they will be prioritized for a vacancy within the housing system or referred to problem-solving resources. This assessment will ensure that people are evaluated for housing based on their barriers to housing, vulnerability (including mental illness, substance use disorder, and medical conditions), and amount of time homeless (scaled for equity across age groups).
The implementation of CE is an exciting change that will impact housing programs managed by MHSA, while simultaneously expanding housing access to clients who are otherwise not served in MHSA-funding housing programs. The MHSA program will continue to monitor the development of the NPLH program and its impact on the County's Annual MHSA Revenue Allocation due to the bond repayment.

Emergency Stabilization Units (ESU)

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The 25 MHSA-funded ESUs are located within several single room occupancy (SRO) hotels in San Francisco and are available to FSP clients. In the 2018-2019 Fiscal Year, referral and discharge procedures were created for MHSA-funded stabilization units, to refine the efficiency of the program operations. Procedures for the use of MHSA-funded ESUs were shared and discussed with all FSP Programs on November 9, 2018.

FSP Permanent Supportive Housing (PSH)

In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million by creating housing for MHSA clients. In addition, San Francisco added $2.16 million from Community Services and Supports (CSS) to housing in 2007-08. MHSA-capital-funded housing units were developed within larger mixed-population buildings with on-site supportive services and linked to the larger infrastructure of intensive case management services provided by FSPs.

Through referral from FSP providers and with confirmation of eligibility by BHS, all MHSA-funded PSH units are reserved for clients experiencing or at risk of imminent homelessness, who are also living with mental illness. TAY-specific housing is intended for TAY with varying levels of mental health challenges, while MHSA-funded housing for adults and older adults is intended for FSP participants living with serious mental illness. Currently, there are a total of 191 MHSA-funded permanent supportive housing (PSH) units dedicated to people with mental health challenges. Of these 191 PSH units, 152 units are earmarked for FSP participants from the TAY, and Adult and Older Adult Systems of Care, while the remaining 39 units are for non-FSP clients. MHSA-funded housing units include a mix of units developed with MHSA capital funding, located throughout San Francisco.

Through partnership with HSH, MHSA-funded PSH sites are managed by the HSH Supportive Housing Programs Team.

Housing Placement Services

MHSA-funded PSH units will continue to be reserved for FSP clients at adult housing sites, and TAY experiencing mental health challenges at TAY housing sites. Prioritization for MHSA-funded units are conducted through the Coordinated Entry process. Beyond the MHSA

inventory of 191 units, clients served by MHSA programs can access and be prioritized for housing in the general pools of housing for homeless youth, adults, and families.

Supportive Services

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

The MHSA team in San Francisco collaborates with HSH to coordinate the provision of supportive services at properties with MHSA-funded PSH units. HSH contracts with several supportive housing stakeholders to support people living with mental health illness in retaining their housing. Tenderloin Neighborhood Development Corporation (TNDC), Community Housing Partnership (CHP), Lutheran Social Services (LSS) and the HSH Support Services team provide supportive services for 137 MHSA-funded PSH units for FSP clients. Swords to Plowshares manages the on-site support service needs for 8 adult PSH units reserved for FSP participants who are Veterans. Finally, the 46 PSH units for TAY experiencing mental health challenges receive on-site supportive services from Larkin Street Youth Services and Mercy Housing California. Supportive service providers are an essential complement to primary case managers/personal service coordinators working with clients in the FSP programs. In collaboration with the MHSA Program Manager for Housing Programs, HSH Program manager for MHSA-funded housing, FSP program staff, property management, and payee providers, the support service providers help resolve issues that compromise housing retention through ongoing communication and cooperation. With TNDC and CHP specifically, the supportive service providers facilitate monthly property management and operations meetings with the aforementioned stakeholders.

MHSA-Funded Housing for TAY

While TAY served by MHSA who are age 18 and up can access adult housing, they can also be placed at youth-center housing sites. Youth with mental health and substance use issues have unique and complex needs for housing. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transitional- aged youth with Larkin Street Youth Services (LSYS). The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street). In fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, life skills training, wrap-around case management, mental health interventions, and peer-based counseling.

Program Names	Name Listed on ARER and Budget
Emergency Stabilization Housing	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)
Full-Service Partnership Permanent Supportive Housing	CSS FSP Permanent Housing (capital units and master lease)

Housing Placement and Support	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)
ROUTZ Transitional Housing for TAY	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)

SF Department of Homelessness and Supportive Housing Center's New Navigation Center

MHSA-Funded PSH Housing: FY20-21						
MHSA Housing Site	**Operator**	**MHSA Units**	**Target Population**	**Services**	**Type of Project**	**Referral Source**
Cambridge	**CHP**	9	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**
Hamlin	**CHP**	0	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**
Iroquois	**CHP**	10	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**
Rene Cazenave	**CHP**	10	Adults	**Citywide + FSP**	MHSA Capital	**CE**
Richardson	**CHP**	12	Adults	**Citywide + FSP**	MHSA Capital	**CE**
San Cristina	**CHP**	15	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**
Senator	**CHP**	3	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**
Camelot	**DISH**	11	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**
Empress	**DISH**	7	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**
LeNain	**DISH**	3	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**
Pacific Bay Inn	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**
Star	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**
Windsor Hotel	**DISH**	6	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**
Aarti/Routz	**Larkin St.**	40	TAY	**Larkin - All**	MHSA GF - TH	**BHS Placement**
1100 Ocean	**Mercy**	6	TAY	**FPFY + FSP**	MHSA Capital	**BHS Placement**
Veterans Commons	**Swords**	8	Veterans	**Swords/VA + FSP**	MHSA Capital	**BHS Placement**
Ambassador	**TNDC**	9	Adults	**TNDC + FSP**	HSH Supportive Housing	**CE**
Dalt	**TNDC**	10	Adults	**TNDC + FSP**	HSH Supportive Housing	**CE**
Kelly Cullen	**TNDC**	17	Adults	**TNDC + FSP**	MHSA Capital	**CE**
Polk Senior	**TNDC**	10	Seniors	**LSS + FSP**	MHSA Capital	**CE**
Ritz	**TNDC**	2	Adults	**TNDC + FSP**	HSH Supportive Housing	**CE**
Willie B. Kennedy	**TNDC**	3	Seniors	**NCHS + FSP**	MHSA Capital	**CE**
TOTAL UNITS		**191**				

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

Spotlight on Housing Programming

MHSA Success Story, Kelly Cullen Community

Jesús moved into Kelly Cullen Community in March of 2013 after experiencing over 15 years of homelessness in San Francisco. Before that, Jesús had experienced homelessness in other states prior to San Francisco for over 5 years. Prior to moving into Kelly Cullen Community, he was linked with Citywide Forensics for medical care and mental health care where he worked closely with a Full-Service Partnership (FSP) Case Manager. Jesús worked well with his FSP Case Manager and continued to receive services after moving out of homelessness.

Moving from the streets to a home can be a huge transition for folks. Jesús now had rules to follow, a home to manage and keep up to property management standards of safety. The transition was a bit bumpy at first with multiple violations around housekeeping and house rules. During this transition, Jesús was on the road toward eviction due to these violations. But with the robust support from FSP Case Management and onsite Social Work Services, Jesús was able to enroll in housekeeping services to help with his home and engage in continuous conversations and coaching around expectations around house rules. Jesús was also able to work with the onsite money management Case Manager to budget money for housekeeping supplies and, this coupled with housekeeping services through Homebridge who picked up the supplies, Jesús was able to get his home back to an acceptable and comfortable level.

Since then, Jesús has learned how to build his self-sufficiency. He has kept his living space in order, followed site rules, and overall shown excellent improvement with the help of staff and FSP case management. He is now in good standing with his building's property management for over six years and is stable in housing and his medical and mental health have stabilized as well. He continues to link with onsite services of money management, social work, nursing and housekeeping agency and links weekly with his FSP. Jesús has been successful in his home for nine years and reports "it feels good to come home every day." We are so happy to see the progress that Jesús has made in his housing and treatment and are excited to see him continue to grow here at Kelly Cullen Community.

Participant Demographics and Outcomes

Demographics: Housing Programs[9]

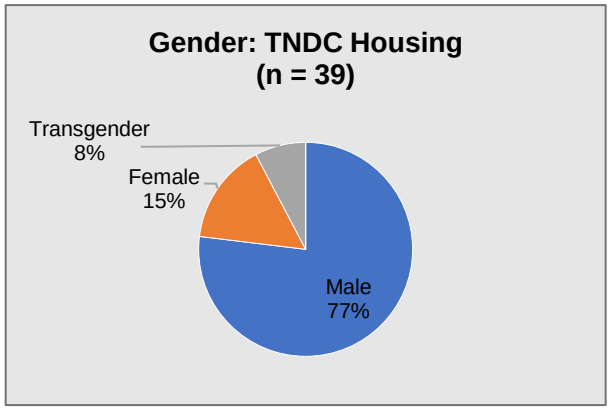
Program	Clients
Swords to Plowshares Housing	8
Tenderloin Neighborhood Development Corporation (TNDC) Housing	39
Delivering Innovative Supportive Housing (DISH)	40
HomeRise	31
1100 Ocean	6
Aarti	53
Grand Total	177

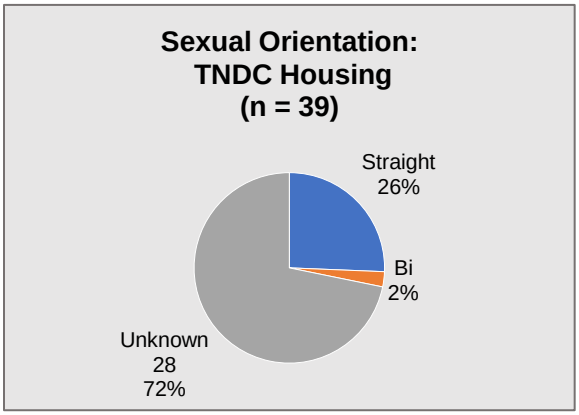
Swords to Plowshares Housing

Race	n
White	<10
African Am.	<10
Grand Total	8

Values are suppressed to protect personally identifiable data.
*No participants reported Latino or Asian; Race
*No participants reported data other than Male; Gender
*No valid data recorded for sexual orientation or ethnicity
*Participants may be counted in multiple categories

Tenderloin Neighborhood Development Corporation (TNDC) Housing





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

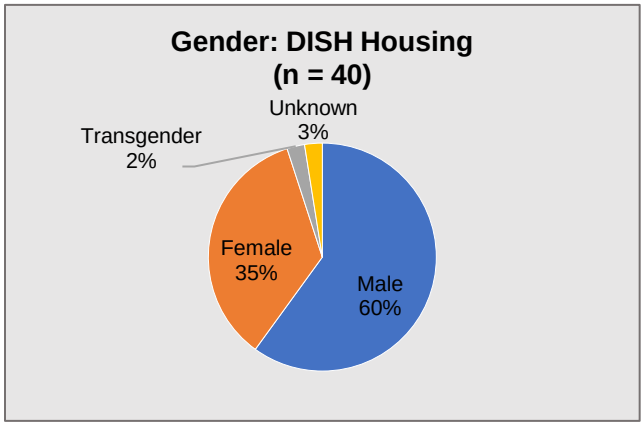
Race	n
White	11
African Am.	18
Latino/a	<10
Asian	<10
Native Am.	<10
Unknown	<10
Multi race	<10
Grand Total	39

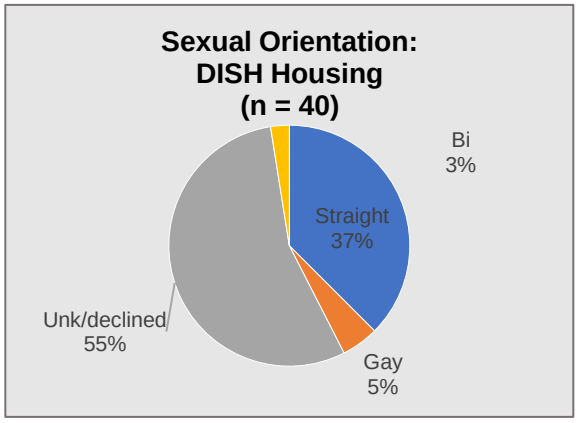
*Participants may be counted in multiple categories

Ethnicity	n
Hispanic	<10
Non-Hisp.	32
Unknown	<10
Grand Total	39

*Participants may be counted in multiple categories

Delivering Innovative Supportive Housing (DISH)





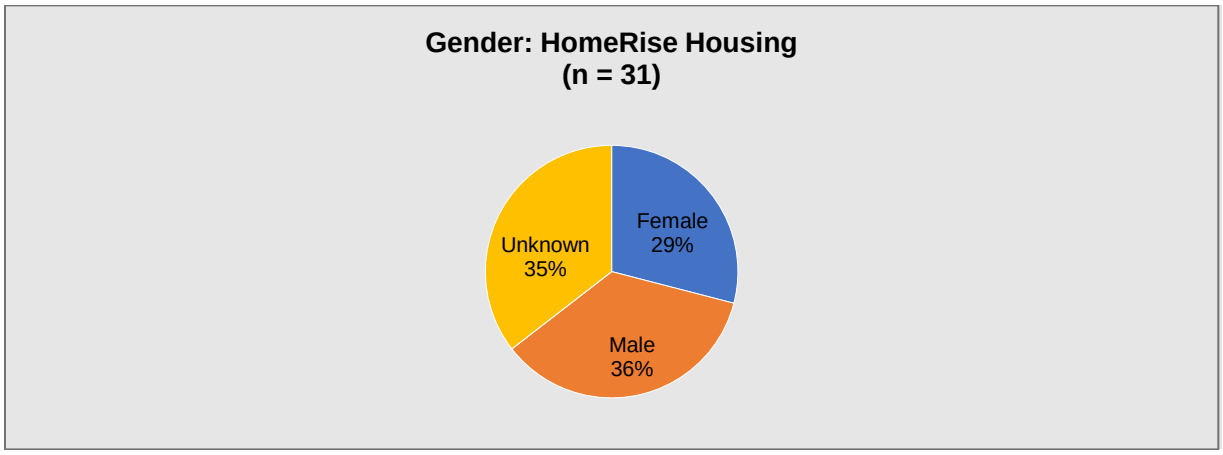
Race	n
African Am.	18
White	15
Asian	<10
Mixed	<10
Unknown	<10
Grand Total	40

*Participants may be counted in multiple categories

Ethnicity	n
Non-Hispanic	14
Unknown	26
Grand Total	40

*Participants may be counted in multiple categories

HomeRise



Race	n
White	13
African Am.	13
Asian	<10
Other	<10
Unknown	<10
Grand Total	31

Ethnicity	n
Hispanic	<10
Non-Hispanic	30
Grand Total	31

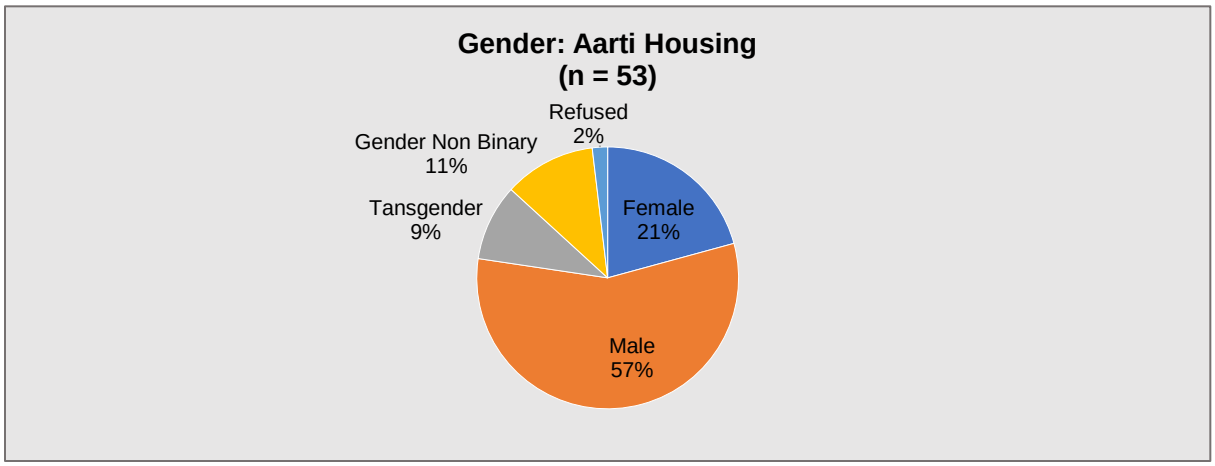
*No participants reported valid data; Sexual Orientation
*Participants may be counted in multiple categories

1100 Ocean

Race	n
African Am.	<10
Asian	<10
Middle Easter	<10
Latino/a	<10
White	<10
Grand Total	6

Values are suppressed to protect personally identifiable data.
*No participants reported data other than Male; Gender
*No valid data recorded for sexual orientation or ethnicity
*Participants may be counted in multiple categories

Aarti



Race	n
African Am.	17
Asian	<10
Latino/a	<10
White	13
Multi racial	<10
Unknown	<10
Grand Total	53

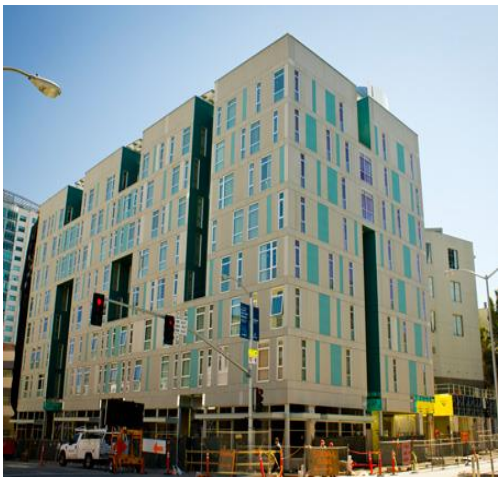
*No valid data recorded for sexual orientation or ethnicity
*Participants may be counted in multiple categories

Outcomes: Housing Programs[10]

Emergency Stabilization Units (ESUs)

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

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



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

Length of Stay by Program

Swords to Plowshares		
Length of Stay	n	%
1 year	1	13%
5 years or more	6	75%
Unknown	1	13%
Grand Total	**8**	100%

DISH		
Length of Stay	n	%
1 year	18	45%
2 years	12	30%
3 years	5	13%
4 years	3	8%
Unknown	2	5%
Grand Total	40	100%

TNDC		
Length of Stay	n	%
1 year	4	10%
2 years	4	10%
3 years	6	15%
4 years	5	13%
5 years or more	18	46%
Unknown	2	5%
Grand Total	39	100%

1100 Ocean		
Length of Stay	**n**	**%**
3 years	**1**	**17%**
4 years	**4**	**13%**
5 years or more	**1**	**17%**
Grand Total	**6**	**46%**

HomeRise		
Length of Stay	n	%
1 year	4	13%
2 years	6	19%
3 years	2	6%
4 years	6	19%
5 or more years	6	19%
Unknown	7	23%
Grand total	31	100%

Aarti		
Length of Stay	**n**	**%**
1 year	**21**	**40%**
2 years	**12**	**23%**
3 years	**1**	**2%**
4 years	**19**	**36%**
Grand Total	**53**	**100%**

Proportion of FSP Units by Housing Site

Swords to Plowshares	
Site	FSP %
Veteran Commons	100%

TNDC	
Site	FSP %
Ambassador	100%
Dalt	100%
KCC	100%
Polk	100%
Ritz	100%
Willie B. Kennedy	100%

HomeRise	
Site	FSP %
Cambridge	86%
Iroquois	100%
RCA	90%
Richardson	100%
San Cristina	70%
Senator	100%

DISH	
Site	FSP %
Camelot	100%
Empress	100%
Le Nain	100%
Pacific Bay Inn	100%
Star	100%
Windsor	100%

TAY	
Site	FSP %
Aarti	100%
1100 Ocean	100%

Moving Forward in Housing Services

SFDPH MHSA continues to make strides in the No Place Like Home Program by improving the coordination and implementation of administrative matters to meet client needs, as well as continued planning efforts to expand programming. SF DPH and HSH are working together to improve the use of administrative data from DPH and other partners for Coordinated Entry assessment and prioritization and strengthen the role that DPH clinical staff play in prioritization and matching as necessary for identifying NPLH-eligible clients in the homeless response system. DPH and HSH are partnering to implement a PSH Enhanced Services Model to bring consultative, coaching, and training support directly to PSH service providers through a phone/email triage system and through training and development activities; and to provide on-site mobile care solutions to both bridge services in the short term and to provide longer-term direct service support.

In addition, HSH is partnering with the Department of Disability and Aging Services (DAS) and the In-Home Support Services (IHSS) program to pilot improved assessment and referral processes for PSH tenants who need IHSS services through a Collaborative Care Giver Team. Early learnings of the pilot have shown a significant impact, including streamlined approval of IHSS service hours, resolution of hygiene and unit habitability issues that can often lead to housing instability, and positive client feedback. This pilot will be expanded in the first NPLH supportive housing site opening in San Francisco in spring 2022.

The Round 1 NPLH award was disbursed in its entirety to 1064 Mission, a new permanent supportive housing site that will provide 153 units of housing for adults experiencing homelessness, and 103 units for seniors experiencing homelessness. 49% of the senior units and 49% of the adult units in this building will be funded by NPLH (127 total NPLH units). The site has been in construction since March 2020. Despite suffering damage from an unusual fall rainstorm, the building is set to open in the spring of 2022. The projects that we'd planned to fund from our Round 2 award were delayed. 78 Haight, which will include 15 NPLH units for transition-age youth (TAY) experiencing homelessness, is scheduled to begin construction in spring 2022 and be completed in spring 2024.

Moving forward, future planning efforts include: 600 7th Street will include 70 NPLH units for adults and families experiencing homelessness. Construction start is now expected to begin in summer 2022. 730 Stanyan will include 20 NPLH units for families experiencing homelessness and will start construction in summer 2023. Additionally, MOHCD, HSH and DPH meet regularly to plan for future PSH projects that are a good fit for NPLH funding.

5. Mental Health Promotion and Early Intervention Programs: PEI Funding

Service Category Overview

San Francisco's MHSA groups its Mental Health Promotion and Early Intervention (PEI) programs into five major categories:

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

The focus of all PEI programs is to raise people's awareness about mental health conditions; reduce the stigma around mental illness; and increase individuals' access to quality mental health care. MHSA investments support mental health capacity of programs and grassroots organizations that typically don't provide mental health services (e.g. schools, cultural centers).

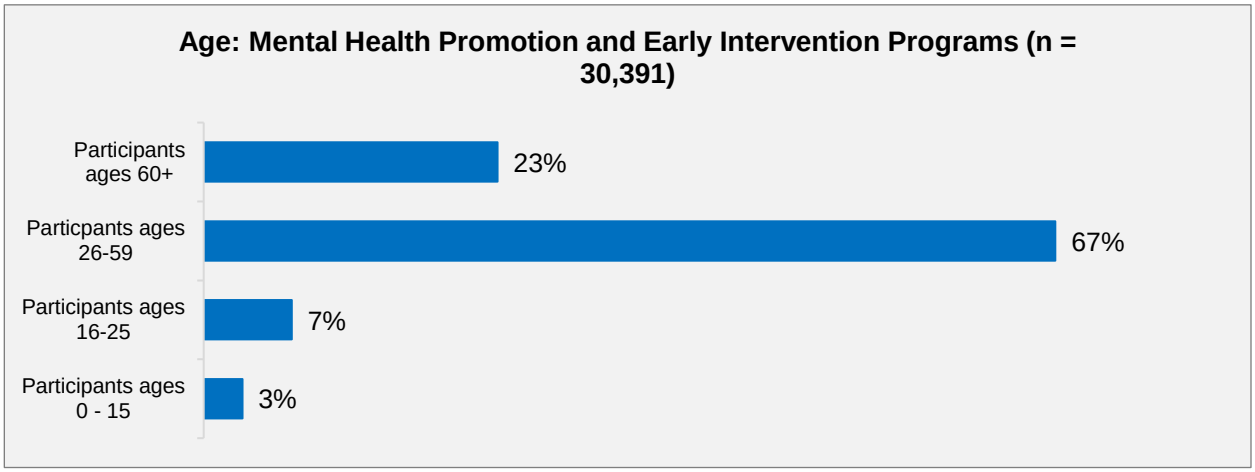
CALIFORNIA MHSA PEI Category	SF-MHSA PEI Programming
1. Prevention Programs	All Population-Focused Programs and School-Based Programs are Prevention Programs
2. Early Intervention Services	All Population-Focused Programs and ECMHCI are Early Intervention Programs.
3. Outreach for Increase Recognition of Early Signs of Mental Illness Programs	All Population-Focused Programs are Outreach Programs.
4. Stigma and Discrimination Reduction	The Peer Engagement Program is our designated Stigma Reduction Program. All Population-Focused Programs are Discrimination Reduction Programs.
5. Access and Linkage to Treatment Programs	All Population-Focused Programs and Comprehensive Crisis Programs are Access and Linkage Programs.
6. Suicide Prevention Program	SF-MHSA does not provide PEI funding for a Suicide Prevention Program, as San Francisco County already has an established County-wide Suicide Prevention Program called "San Francisco Suicide Prevention" using alternate funding.

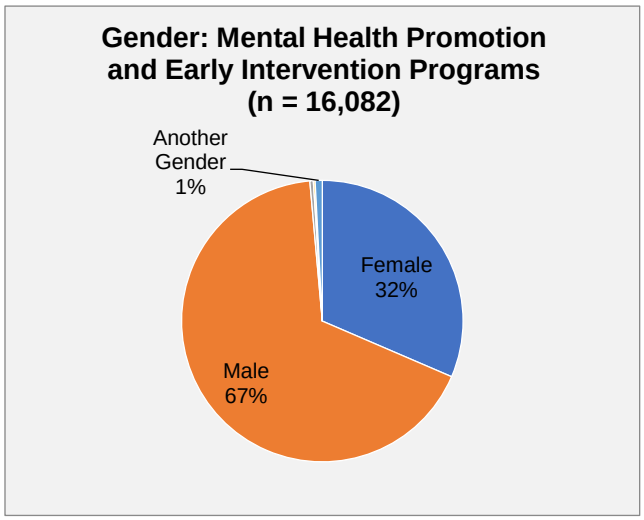
Regulations for Statewide PEI Programs

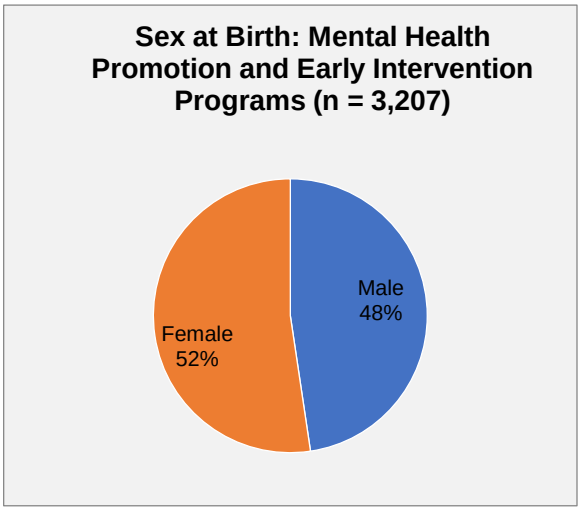
To standardize the monitoring of California PEI programs, the MHSOAC requires particular county data elements and reporting. These include number of people served by a program; the demographic characteristics of program participants [e.g. age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)]; and the interval of time between a referral and client participation in referred services. The MHSOAC calls this "referral-to-first participation in referred services period" a successful linkage; and successful linkages are one indicator among many that signifies clients' timely access to care. Given the need for the MHSOAC to know and better understand the communities being served by MHSA resources, it is extremely important for MHSA to develop processes and instruments that will afford programs the ability to capture required data in a manner that is respectful and does not offend, discourage or alienate individuals who are seeking help. All counties are required to include these demographic data in their Annual PEI Report to the MHSOAC, which is part of a county's Annual Update or 3-Year Program and Expenditure Plan.

Demographics: All PEI Programs

Total Clients Served: 134,986
Total Unduplicated: 1,949
Served for Early Intervention: 4,977
Served for Mental Illness Prevention: 1,629

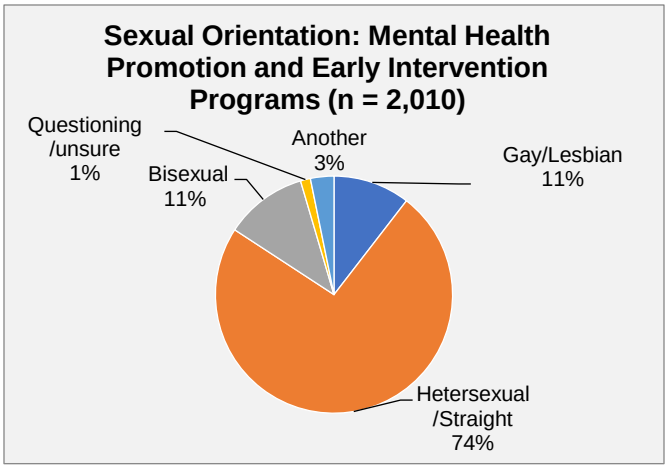


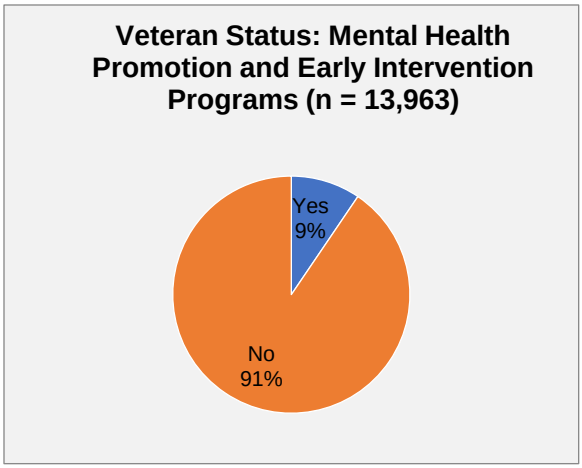


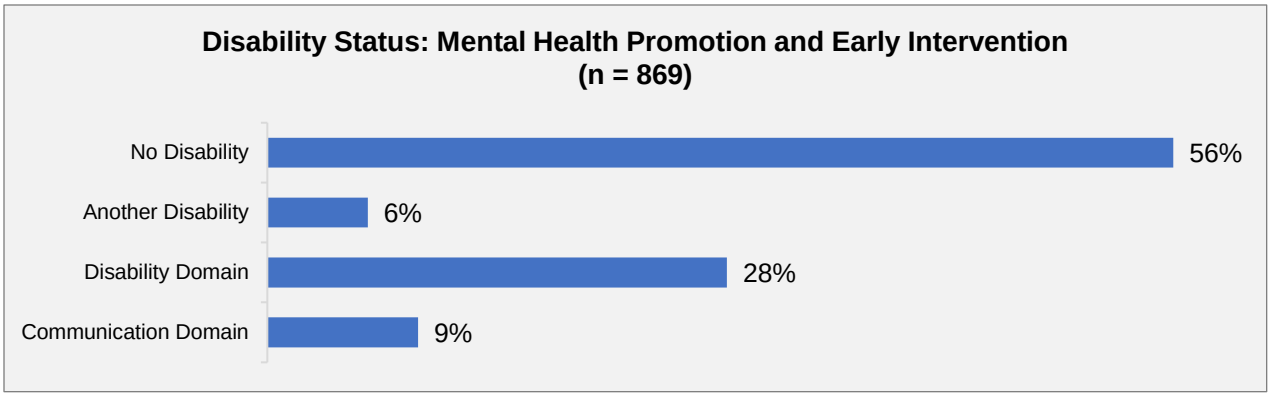


*< 1 percent report data on Trans Female, Trans Male; Gender Identity

PEI







Race/Ethnicity	n
Black/ African American	5352
American Indian or Alaska Native	439
Asian	2227
Native Hawaiian or Pacific Islander	236
White	4201
Other Race	3042
Hispanic/Latino	2602
Non-Hispanic/ Non-Latino	11828
More than one Ethnicity	350
Total	30277

Primary Language	n	%
Chinese	471	1%
English	2104	79%
Russian	14	0%
Spanish	824	19%
Tagalog	47	1%
Vietnamese	143	0%
Another Language	195	0%
Total	3798	100%

*Participants may be counted in multiple categories

Service Indicator Outcomes for all PEI Programs FY 20/21

Service Indicator	Program Results for FY 20/21
Total family members served	723 family members; average 55.6 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: hospital fellows, community mental health students, law enforcement personnel, wellness program students/instructors, peer providers, support group members, high school faculty, partner agency staff, teachers, administrators, case managers, nurses and providers, school social workers, parent liaisons, school administrators and other personnel, community members, juvenile justice department staff, occupational therapists, social workers, HSA personnel, drop-in center staff, health clinic staff, therapists, program coordinators, community center staff, religious leaders, resource center staff, harm-reduction specialists, physicians, behavioral health specialists, probation officers, program directors, site supervisors, early childcare experts, family support specialists, and home visitation staff.
Total individuals with severe mental illness referred to treatment	551 individuals; average 55.1 individuals across 10 reporting programs.
Types of treatment referred	Responses included: specialty mental-health sites, individual or family mental health services, inpatient psychiatric assessment and care, substance use disorder treatment, housing, primary care, health clinics, suicide prevention, emergency care, psychiatry, medication access, case management, hospital and outpatient services, and longer-term services.
Individuals who followed through on referral	317 individuals; average 35.22 individuals across 9 reporting programs.
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report this data. Example responses include: - 4 days - 2 weeks - 3 weeks - 3 months 6-12 months
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include: - 1 week - 17 days - 3 weeks - 3 months (reported by 2 programs)
Total number of referrals of underserved populations to services for prevention, early	730 individuals; average 60.83 individuals across 12 reporting programs.

Service Indicator	Program Results for FY 20/21
intervention, and treatment beyond early onset	
Types of underserved populations referred to prevention program services	Ethnic/Racial Groups, Black, Indigenous, People of Color (BIPOC), Latinx, Filipinos, Samoans, Cambodians, Lao, Vietnamese, Mongolians, Central American indigenous people (Mayan; Mexico, Guatemala, El Salvador, Nicaragua). Age Groups: transitional age youth, inner city teens, isolated older adults, southeast Asian youth, unaccompanied youth, unhoused elders, Social Minorities/Resource-limited: people experiencing homelessness, unstably or marginally housed people, families isolated by COVID, LGBTQ, gender affirming care clients, low-income, non-English speaking, functionally impaired, unemployed, refugee, 1st or 2nd generation immigrant, formerly incarcerated, Spanish speaking, under-insured, undocumented, systems-involved, those with a history of mental health needs or substance misuse, people housed in multifamily/crowded homes, those disconnected from services access for basic needs, survivors of community violence, educators impacted by COVID,
Individuals who followed through on referral	481 individuals; average 43.73 individuals across 11 reporting programs.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include: - 6 days - 1-2 weeks - 2 weeks (reported by 2 programs) - 17 days - 3 months
How programs encourage access to services and follow-through on referrals	Responses include: ● The audience receives an informational packet that provides a list of resources in San Francisco. We also discuss the Warmline and CALHOPE phone support as well as the many support groups we offer. ● An interdisciplinary team encourages access to mental health services, including coordinating tabling activities during student events, and partnering with student representatives to outreach their fellow peers. Upon assessing the student, the clinician, will make the appropriate referrals to community-based organizations for specialty mental health treatment. ● Our program centers building relationships with all support staff at school sites who then can make a warm handoff to the mental health consultants. Additionally, MHCs make themselves available with flexible hours and through various mediums (in person, zoom, phone etc.) and meet families where they are at. ● Clients who do not meet medical necessity, do not qualify for full-scope MediCal or do not have any insurance, were able to receive mental health assessment, treatment or referrals if they had chronic school attendance challenges.

Service Indicator	Program Results for FY 20/21
	• Staff outreach and continuity of contact; events and weekly peer groups; internal referrals based on needs assessment. • We have a mental health coordinator and announce our services weekly on Friday evenings in our call-em-all voice calls to all clients about services available and how to contact us. • Partner coordinators work closely with clients to navigate them to services. Site coordinators are encouraged to conduct follow-up call with clients to ensure they have followed through with their referrals/appointments. • After a client is provided with a service referral and possibly a warm hand off or navigation support, staff will call the client up to 3 times to ensure that the clients need was met and also to confirm the connection was made. • We track referrals and linkages in our program management system. Reminders are automatically generated for staff to conduct follow-up 3 days later. We have also been doing outreach through food box deliveries. • Peer-based staff approach social work with knowledge, understanding, empathy and non-judgement. Over time and utilizing the principles of harm reduction, we build up trusting relationships with community members and are then better able to pinpoint specific needs and direct individuals to the appropriate services and resources. • We have enhanced and streamlined our referral screening, assignment and follow-up process for the entire outpatient program. Staff are expected to respond to referral source within 48 hours/2 working days of assignment. • Warm hand-offs; at least 3 follow up contacts after referral is made. • Soft handoffs, engagement in WRAP Care, collateral sessions with other providers. • Our program provided information of community resources to staff and families in meetings and through newsletters; we also facilitated linkage to other internal programs. • Established ongoing relationships with many community organizations. When referral are made, consultants follow up with parents, teaching staff, family advocates, or other managers on the status of the referral. • Consultants provide individualized referrals to clients and families based on their needs and factoring for any barriers to access. Consultants will also follow up on referrals and, when possible, provide additional support to ensure access.

Service Indicator Outcomes for all PEI Programs FY 19/20

Service Indicator	Program Results for FY19/20
Total family members served	784 family members; average 60.34 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: Outreach specialists, case managers, partner agency staff, school personnel and parents, social workers, peer advocates
Total individuals with severe mental illness referred to treatment	263 individuals; average 32.88 individuals across 8 reporting programs.
Types of treatment referred	Medical, mental health, substance use, case management, education support
Individuals who followed through on referral	338 individuals; average 37.56 individuals across 9 reporting programs.
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report this data. Example responses include a range of 1-3 months.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include a range of: - 1 week (mentioned twice) - 11 days - 3 weeks - 29.4 days - 33 days
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	1,605 individuals; average 133.75 individuals across 12 reporting programs.
Types of underserved populations referred to prevention program services	Ethnic/racial groups: communities of color, Black/African Americans, American Indian and Alaskan Native, Latinx, Chicanx, Maya, Filipinx, Somoan, Laotian, Cambodian, Vietnamese Age Groups: TAY from communities of color, youth In-custody, gang affiliated, youth experiencing academic truancy, children in foster care, children and families, isolated older adults Social Minorities/Resource-limited: Homeless, families at risk of homelessness, families in public housing, low income, those living below the poverty line, LGTBQ, queer, immigrants (elders, newcomers, and unaccompanied youth), systems-involved (legal, foster, etc.), limited English speakers, families impacted by substance use and dependency.

Service Indicator	Program Results for FY19/20
Individuals who followed through on referral	1,119 individuals; average 93.25 individuals across 12 reporting programs.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include a range of: - 1 week (mentioned twice) - 1-3 weeks (mentioned twice) - 11 days - 16.6 days
How programs encourage access to services and follow-through on referrals	Responses include: ● We provide follow up and most of our relationships are ongoing - as we prioritize building relationships and building community to buffer the impacts of systemic racism and Covid-19 pandemic related stress. Many of the families who were provided referrals also participated in support groups run by the mental health consultant and families received regular wellness calls once SIP took place. ● The case manager is heavily involved in the engagement of youth and families in this program, and works collaboratively with clinicians to assist in physical access to services. Case manager works with clinician to assure clients are receiving basic needs so that educational needs can be addressed. ● Staff outreach and continuity of contact: events and weekly peer groups; Internal referrals based on needs assessment ● Participants are screened and wellness checks are conducted to better identify need. Referral forms are completed and database is reviewed and/or clinician is reached out to for participation usage. ● Encourage access to services through anti-stigma messages via outreach and engagement, and wellness promotion activities to normalize mental illness and mental health service use. Staff conducts regular check-ins to ensure referrals are followed through and goals are met. ● In response to COVID-19, the case management need increased tremendously, and we have pivoted services to provide telehealth calls, link to basic food needs, and emergency funding. ● Employing peer-based staff who are from the neighborhood and/or who share similar lived experiences as the community members served; applying a low-threshold, harm reduction approach to services offered; weekly staff training and development in topics such as cultural humility, mental health first aid, de-escalation, conflict resolution, etc.; street level outreach; building trust by offering basics such as coffee and water, snacks, use of phone and computer, use of bathroom; employing Spanish-speaking staff who can assist monolingual Spanish speakers ● Our Intake Coordinator contacts referrals sources and potential clients within 48 hours of receiving services, offering a timely access appointment within 10 days of receipt of referral. Potential Clients are outreached to while waiting to be assigned to a therapist and advised

Service Indicator	Program Results for FY19/20
	of the wait to obtain services, and are offered linkages to other services when appropriate. ● Our agency provides warm handoffs to agencies that have capacity. We will accompany clients to meeting if there is a desire and capacity. We will also encourage family or other acting support systems to encourage or accompany clients. We keep our caseloads open for clients whom have trouble engaging and adjust our services to meeting them where they are. ● Staff often times make calls alongside youth participants to support initial connection and check-in informally. If a young person returns to drop-in programming to ask if the young person has accessed the referred program/agency. ● Mental health consultants are placed at early learning centers and residential programs serving families with young children in SF and are regularly present at these sites, building relationships with families and staff; these relationships enable the consultant to be embedded in trusted settings where families are served. ● Services were provided on site facilitating the referral process and decreasing barriers to access ● We assist clients with connecting to referrals and we keep the case until they have made their first appointment.

Service Indicator Outcomes for all PEI Programs FY 18/19

PEI Data Requirement	Program Summary for FY18/19
Total family members served	1,408 family members; average 108.31 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: (Listed in order of prevalence) educators and other school staff, social workers and case managers, therapists and psychiatric service workers, childcare workers and pediatricians, parole and probation officers, and community referral/linkage service workers.
Total individuals identified as needing a higher level of care for mental illness who were referred to treatment	57 individuals; average 9.5 across 6 reporting programs.
Types of treatment referred	Responses include: • Assessment for either Case Management Services, Substance use counseling or mental health therapy • Parent child therapy • Substance abuse treatment/support services, medical services/health care, and Mental Health Support • Child Crisis - assessment and stabilization • Psychiatric, Mobile Crisis, employment, housing • Orientation to therapy, Monk blessing, Internal referral (agency workshops)

PEI Data Requirement	Program Summary for FY18/19
	• Parent-child playgroup at Infant-Parent Program
Individuals identified as needing a higher level of care who followed through on referral	63/71 or approximately 89% across six reporting programs.
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report this data. Example responses include a range of: - 1 week - 2-3 weeks - 3 months - 1 year
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include - 1 week - 2 days contact, 12 days intake - 7-10 days, - 24 days
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	646 individuals; average 49.7 individuals across 13 reporting programs.
Types of underserved populations referred to prevention program services	Responses include: Homeless, families at risk of homelessness, families in public housing, low income, those living below the poverty line, older adult, LGTBQ, queer, and communities of color, African Americans, American Indian and Alaskan Native, Latinx, Chicanx, TAY from communities of Color (Black, Asian, Hispanic) living in Bayview Hunters Point, Filipinx, Somoan, Laotian, Cambodian, Vietnamese, Vietnamese youth, immigrants (elders, newcomers, and unaccompanied youth), In-custody, gang affiliated, young children and their families, systems-involved (legal, foster, etc.), children in foster care, inner city teens, youth experiencing academic truancy, limited English speakers, families impacted by substance use and dependency, isolated older adults. Ethnic/racial groups: communities of color, Black/African Americans, American Indian and Alaskan Native, Latinx, Chicanx, Maya, Filipinx, Somoan, Laotian, Cambodian, Vietnamese Age Groups: TAY from communities of color, youth In-custody, gang affiliated, youth experiencing academic truancy, children in foster care, children and families, isolated older adults Social Minorities/Resource-limited: Homeless, families at risk of homelessness, families in public housing, low income, those living below the poverty line, LGTBQ, queer, immigrants (elders, newcomers, and unaccompanied youth), systems-involved (legal, foster, etc), limited English

PEI Data Requirement	Program Summary for FY18/19
	speakers, families impacted by substance use and dependency.
Individuals from underserved populations who followed through on referral to any prevention service	284/383 or approximately 74% across 13 reporting programs.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses: - 1 week (mentioned three times) - 1-3 weeks - 4-6 weeks

How programs encourage access to services and follow-through on referrals	Responses include: • The Peer Outreach Specialists are available to program participants every day. The Mental Health Association of SF presents monthly to participants which includes Mental Health resources in the community. • Engaging and encouraging to follow through on referrals, sometimes escorting to referrals. • Consultants prefer doing a warm handoff for mental health referrals. When possible, they accompany the family to the initial appointment. Otherwise, having a clear contact person and calling the referral agency ask the best way to link families is also done. Maintaining relationships with community partners is also key • Case Manager and Therapist facilitate a warm hand off to the service provider of the program referred. • Provides navigations services to the clients to make the referral process less stressful. We also follow up all referrals with 2 calls to the client to ensure service connections. • Services provided on-site, decreasing barriers to access • TAY referred agency, need to follow-up with referral agency and TAY within two days of the referral to identify if a point of contact had been made. • The community health worker tracks linkages and referrals in case management notes. For non-case management members that receive a referral, the Administrative Assistant conducts follow-up 72 hours afar the referral.

	• Community members are encouraged by community leaders to access services so that they turn help their families and other community members access the same services and resources. • Consultants follow up either with the family liaison at the sites, or with the specific clinic or programs to ensure engagement. • Our Service Navigator follows up on referrals with individuals. Our Mental Health Specialist also tracks the number of clients seen who have been referred internally. • Mental Health Consultants are placed at early learning centers and residential programs serving families with young children in SF and are regularly present at these sites, building relationships with families and staff; these relationships enable the consultant to be embedded in trusted settings where families are served. • We encourage access to services by conducting outreach to underserved populations, conduct workshops on common mental health disorders, including signs and symptoms. We follow through on internal referrals by following up with the client within two days. • When identified, the client is referred and verified by sign -in sheet participation, phone contact with referral agency, or follow up directly with client for participation. • Case manager accompanies clients to appointments within the community (by driving them in agency van specifically for this purpose to remove any barriers to transportation), works around the client's schedule to assure they can access needed services.

Stigma Reduction: Peer Outreach and Engagement Services – Mental Health Association of San Francisco

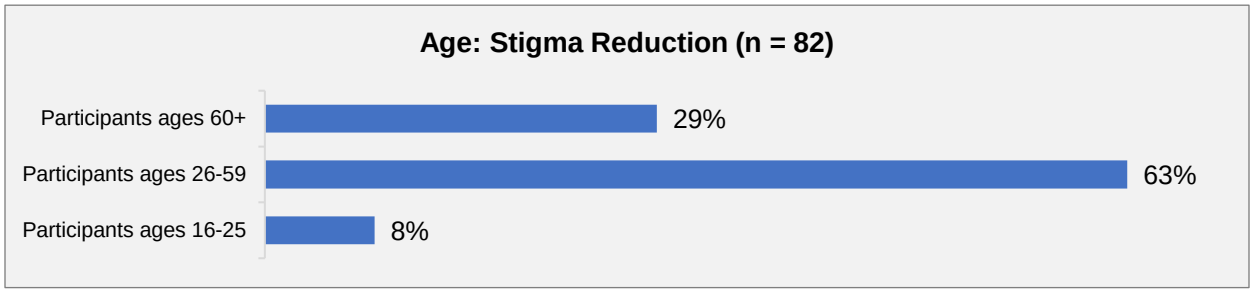
Program Overview

Peer Outreach and Engagement Services – Mental Health Association of San Francisco is funded by both CSS and PEI funding. The Program is divided into three components:

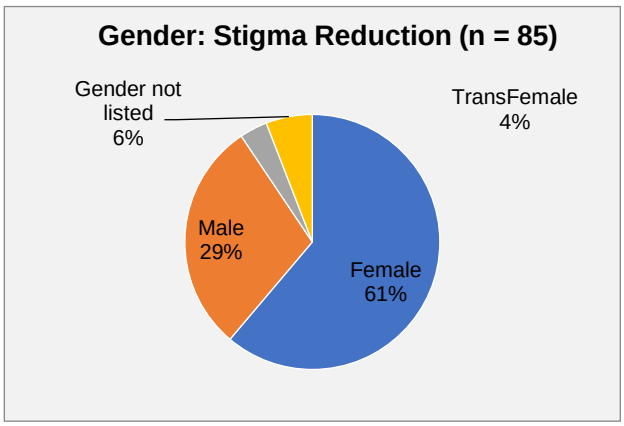
- SOLVE aims to reduce stigma (including self-stigma, structural stigma, and societal stigma) discrimination and bias, related to mental illness/mental health conditions as well as to empower those affected by stigma to advocate for their communities' needs.
- SUPPORT (previously known as Peer Response Team) aims to improve outcomes for mental health consumers by providing individual and group interventions that focus on increasing peer wellness, recovery, and resiliency.
- NURTURE aims to empower mental health consumers by teaching basic nutrition, fitness, and mindfulness-based skills, and by encouraging participants to apply and practice these new skills.

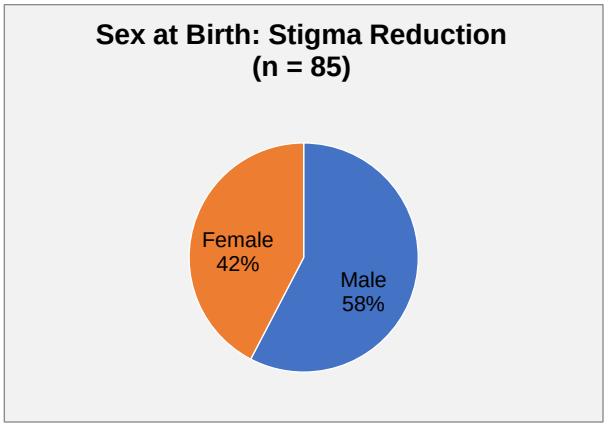
Participant Demographics, Outcomes, and Cost per Client

Demographics: Stigma Reduction



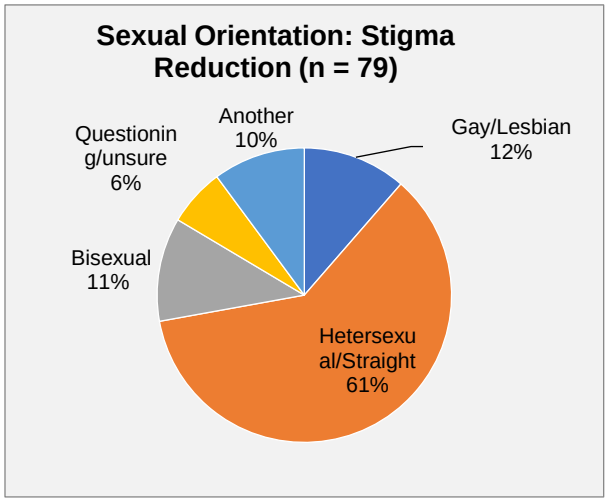
*< 1 percent reported data on CYF (0-15); Age

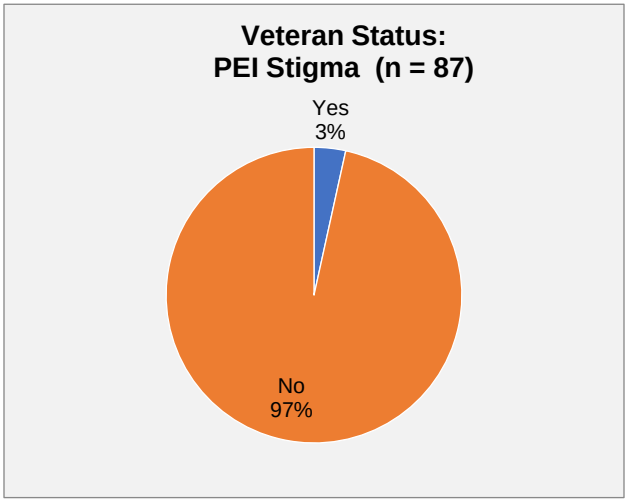


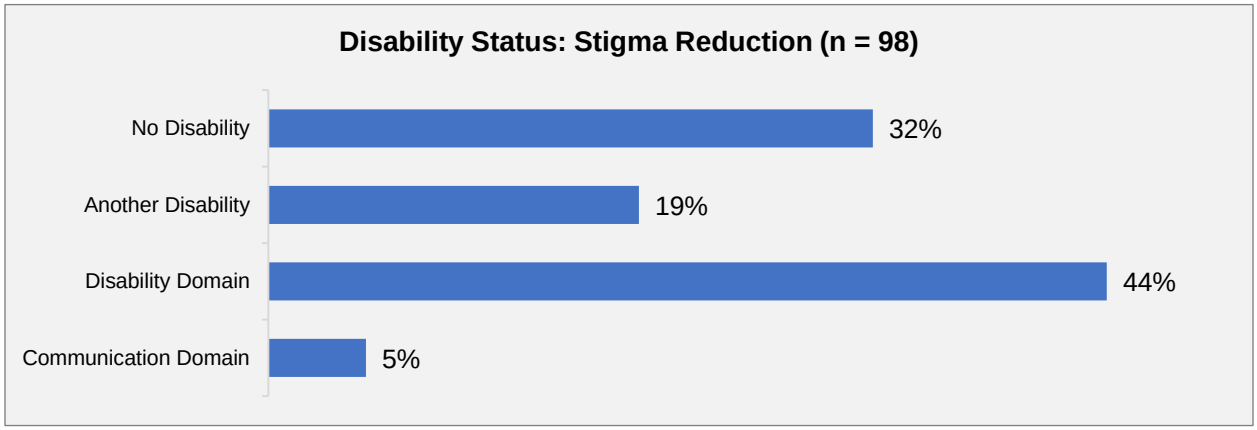


*< 1 percent reported Trans Male; Gender

PEI







Race/Ethnicity	n
Black/ African American	<10
American Indian or Alaska Native	<10
Asian	14
White	49
Other Race	<10
Hispanic/Latino	14
Non-Hispanic/ Non-Latino	58
More than one Ethnicity	<10
Total	153

Primary Language	n	%
English	87	97%
Spanish	<10	<11%
Total	90	100%

*No participants reported Native Hawaiian or Pacific Islander; Race/Ethnicity
*No participants reported Russian, Chinese, Tagalog, Vietnamese, Another Language ; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Stigma Reduction: Peer Outreach and Engagement Services – Mental Health Association of San Francisco	• 30 community presentations (100%) were completed, reaching a total of 504 community members (100.8%). • 72 individuals (95%) who responded strongly agreed/agreed to the following statement: "As a result of this presentation, my understanding that mental health recovery is possible for anyone, has improved". • 46 individuals (92%) received 1:1 peer counseling via Telehealth or in-person as is evidenced by documentation in each participant's case notes and program attendance logs. • 102 evaluations (100%) from the People of Color support group reported: "As a result of my participation in this program I (often) or (some of the time) feel less isolated from others," "As a result of my participation in this program I (often) or (some of the time) feel more included," and "As a result of my participation in this program I (often) or (some of the time) feel that I have more companionship with others." • 94 evaluations (93%) for the Depression Support Group reported "As a result of my participation in this program I (often) or (some of the time) feel less isolated from others."

PEI

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[11]
Stigma Reduction	101 Clients	$167,501	$1,658

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

School-Based Mental Health Promotion (K-12)

Program Overview

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

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

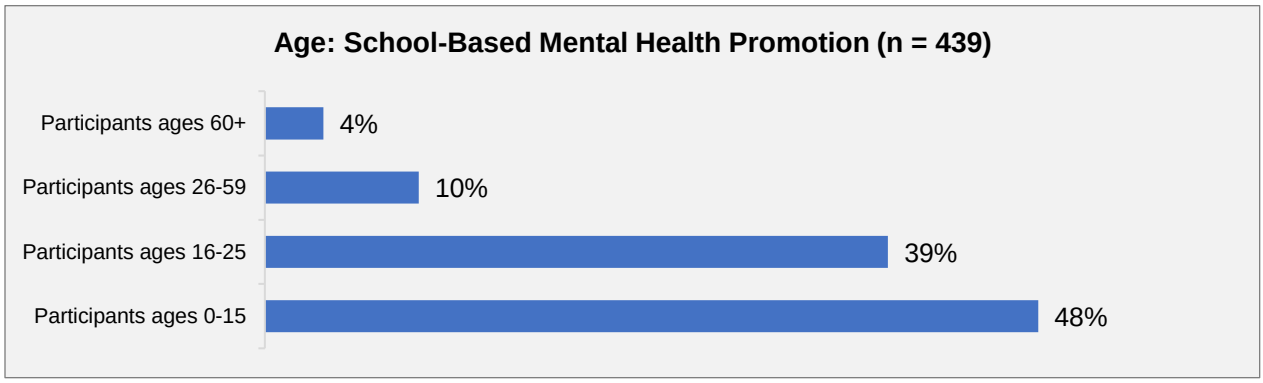
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To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

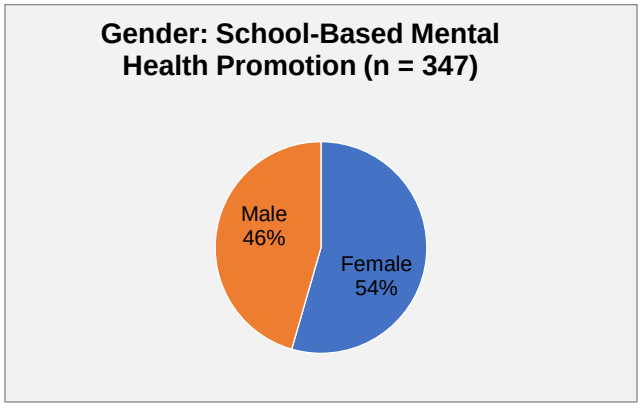
Target Populations

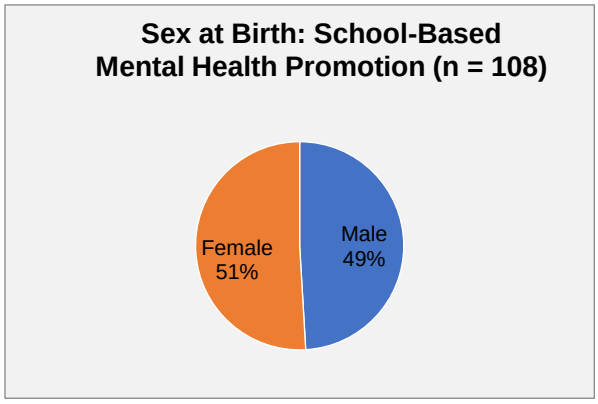
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

Participant Demographics, Outcomes, and Cost per Client

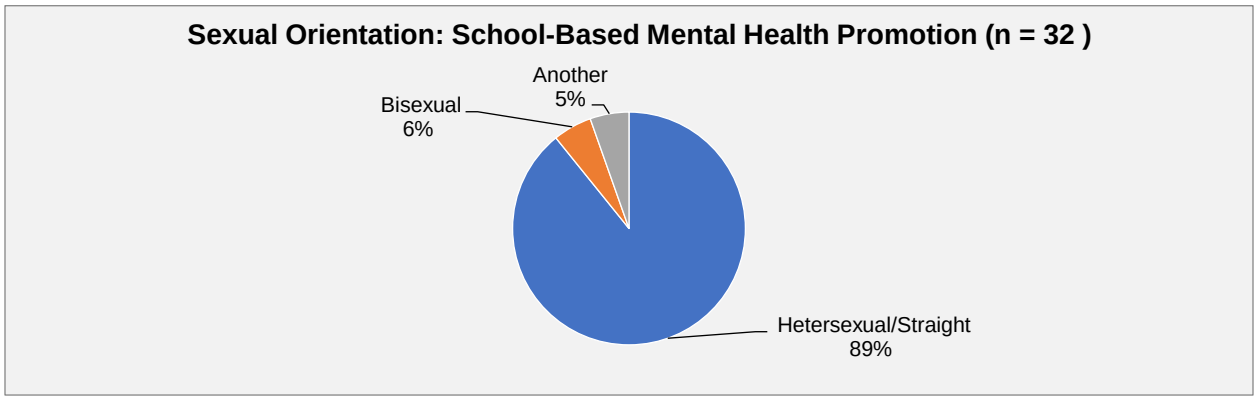
Demographics: School Based Prevention (K-12)





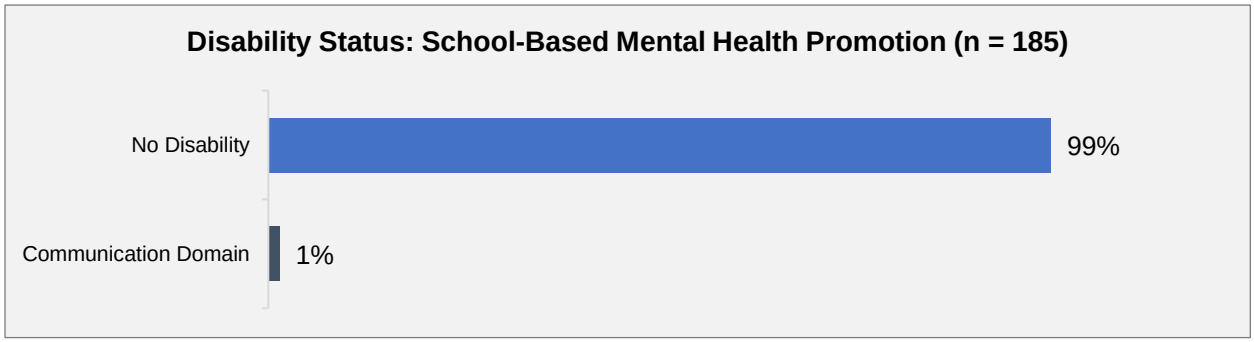


*< 1 percent reported on Trans Female, Trans Male, Another Identity; Gender



PEI

*< 1 percent of participants reported data on Gay or Lesbian, Questioning/Unsure; Sexual Orientation



*No participants recorded Yes; Veteran Status

Race/Ethnicity	n
Black/ African American	76
Asian	28
Native Hawaiian or Pacific Islander	<10
White	17
Other Race	19
Hispanic/Latino	222
Non-Hispanic/ Non-Latino	<10
More than one Ethnicity	<10
Total	371

Primary Language	n	%
Chinese	<10	<3%
English	180	52%
Spanish	165	47%
Total	348	100%

*No participants reported American Indian or Alaska Native; Race/Ethnicity
*No participants reported Russian, Tagalog, Vietnamese, Another Language; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center – Bayview Hunter's Point Foundation	• Salary expense (100%) obligated by the work done on this contract have been paid out. • Operating expenses (100%) budgeted to this contract have been paid out. • 1 position (50%) was staffed during this contract period.
Mental Health Services – Edgewood Center for Children and Families	• 6 participant respondents (67%) agreed or strongly agreed with the statement "I was able to adequately handle the challenges of teaching this past school year." • 9 participant respondents (100%) agreed or strongly agreed with the statement "I want to continue working here as a teacher next year." • 5 participant respondents (55.6%) agreed or strongly agreed with the statement "I feel more successful now than earlier in the school year in dealing effectively with challenging student

Program	FY20/21 Key Outcomes and Highlights
	behaviors on my own." • 10 participant respondents (100%) agreed or strongly agreed with the statement "I received support that was helpful when I was feeling stressed," "I feel more able to support my children with their needs now than earlier in the school year," and ""I and/or my family have benefited from the resources and supports that Edgewood and/or the school have provided." • 19 students served (57.9%) for whom we received complete data, showed an increase from pre-post services. • 8 participant respondents (100%) agreed or strongly agreed with the statement "I found this group helpful."
Youth Early Intervention – Instituto Familiar de la Raza	• 25 teachers/staff and community partners (87%) at Hillcrest Elementary School felt that working with the mental health consultant moderately or substantially increased their understanding of childhood mental health or behavior issues and social/emotional needs of students. • 26 teachers/staff and community partners (90%) at Hillcrest Elementary School felt that working with MHC increased their capacity of working better with their students and improving their relationship with students and their families. • 25 respondents (85%) were satisfied or very satisfied with MHC services offered at Hillcrest. • 6 respondents (86%) at James Lick Middle School shared that they felt that the group had helped strengthen the relationship they have with their child. • 6 respondents (86%) at James Lick Middle School shared that the group helped them feel safe and helped them have a space where they could process their emotions and name their needs. • 6 respondents (86%) at James Lick Middle School shared that after attending the group they felt more comfortable expressing their emotions and needs with others. • 6 respondents (86%) at James Lick Middle School shared they have a better understanding of the different tools needed to manage their stress after having attended the group. • 7 respondents (100%) shared that they would recommend this group to someone else.
Wellness Centers – Richmond Areas Multi-Services (RAMS)	• 499 hours (471%) of Outreach & Promotion services were provided. • 205 hours (148%) of Screening & Assessment services were provided. • 400 hours (166%) of Mental Health Consultation. services were provided. • 245 hours (155%) of Group Therapeutic Services were provided.

Program	FY20/21 Key Outcomes and Highlights
	• 990 individuals (172%) were served through the program. • 119 youth (105%) received screening and Assessment. • 266 individuals (134%) received Mental Health Consultation. • 72 individuals (135%) received Group services.
Trauma and Recovery Services – YMCA Urban Services	• 18 participants (82%) have increased their engagement in school as a result of our case manager and clinician's work with them. • 16 clients (73%) engaged in the pass program have re-engaged in their academic experience. • 20 unduplicated clients (91%) completed a family needs assessment. • 10 clients (45%) had actionable "CANS" pairs, which allows the ratings to be compared to see if improvement occurred. • 6 clients (60%) showed improvement.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[12]
School-Based Mental Health Promotion (K-12)	703 Clients	$986,044	$1,403

James Lick Middle School - SFUSD

PEI

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

Spotlight on PEI Programs

In FY20-21, Promotion and Early Intervention (PEI) programs continued to provide services in the community, in partnership with our key community partners. Program staff remained dedicated to identifying new ways to reach clients and engage them and connecting community members to other support services such as assistance for housing and mental health. The Hospitality House programs saw an increase in outreach and engagement and exceeded their goals, but experienced challenges with Wellness Promotion activities and support groups that used to be held in person. To mitigate this, some of the groups were held virtually which allowed community members to reconnect and not feel isolated.

The Sixth Street Help Center increased outreach and collaboration efforts with key community partners such as SF HOT, Street Medicine Outreach Team and Drug Overdose Prevention and Education Project (DOPE) as well as increasing sidewalk/neighborhood engagements. While the Community Building Program collaborated with Season of Sharing and Catholic Charities to provide support and services to those facing fears of eviction. CBP Case Managers worked with community members with applications for back rent and connected them to other rental assistance resources such as City SF Rent and the State of California rental assistance. Additionally, the Case Managers connected community members experiencing behavioral health concern to the Harm Reduction Therapist Center (HRTC). Community members expressed that HRTC helped them manage stress by providing them with practical tools and ongoing therapy.

Additionally, PEI programs have been able to deal with the reduction of staff capacity due to the COVID safety protocols. The Tenderloin Self Help Center was able to increase individual staff development, along with having more time for staff training and skill building for each team member. In addition to this their Peer Advocate job class it has been able to spend an increased amount of time and effort providing more intensive services to each community member they engage with, connecting community members to Shelter-in-place hotels, Behavioral Health services, and reconnecting community members with supportive people in their lives. While Indigena Health Wellness successfully increased the access to behavioral health services to clients in our community who have been impacted by Covid-19. These services include assessment to evaluate client's current mental/emotional health, individual therapy and family therapy

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SF MHSA Service Provider, Hospitality House Self-Help Center

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

- Outreach and engagement: Activities intended to establish/maintain relationships with individuals and introduce them to available services; and raise awareness about mental health
- Wellness promotion: Activities for individuals or groups intended to enhance protective factors, reduce risk-factors and/or support individuals in their recovery; promote healthy behaviors (e.g., mindfulness, physical activity)
- Screening and assessment: Activities intended to identify individual strengths and needs; result in a better understanding of the health and social concerns impacting individuals, families and communities, with a focus on behavioral health issues.
- Service linkage: case management, service coordination with family members; facilitate referrals and successful linkages to health and social services, including specialty mental health services
- Individual and group therapeutic services: Short-term (less than 18 months) therapeutic activities with the goal of addressing an identified behavioral health concern or barrier to wellness

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

PEI

Target Populations

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

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

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 use. As a result, the MHSA planning process called for proposals from a wide variety

of qualified organizations in order to break down barriers and improve the accessibility of services through culturally tailored outreach and services. These population-focused services acknowledge and incorporate participants' cultural backgrounds, including healing practices, rituals and ceremonies, in order to honor the cultural context and provide non-clinical services that incorporate these practices. These population-focused programs focus on raising awareness about mental health needs and available services, reducing stigma, the importance of early intervention, and increasing access to services. As a result, all of the programs emphasize outreach and engagement to a very specific population group.

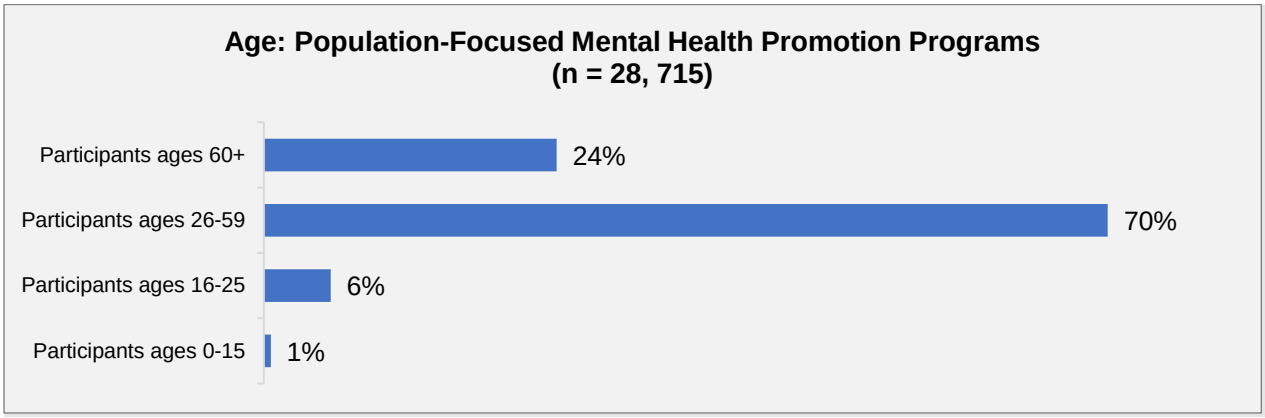
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Socially Isolated Older Adults	Senior Drop-In Center *Curry Senior Center*	The Curry Senior Drop-in Center is a multi-service center located in the Tenderloin neighborhood. It provides drop-in peer-led wellness-based services, including primary and behavioral health care, case management services, and socialization opportunities.
	Addressing the Needs of Socially Isolated Older Adults *Curry Senior Center*	The program provides peer-based outreach and engagement services to socially isolated older adults with mental health concerns living in the central neighborhoods of San Francisco.
Blacks/African Americans	Ajani Program Westside *Community Services*	The Ajani program helps to build strong families by providing an understanding how healthy families function and by encouraging them to develop leadership, collective responsibility and mentoring skills.

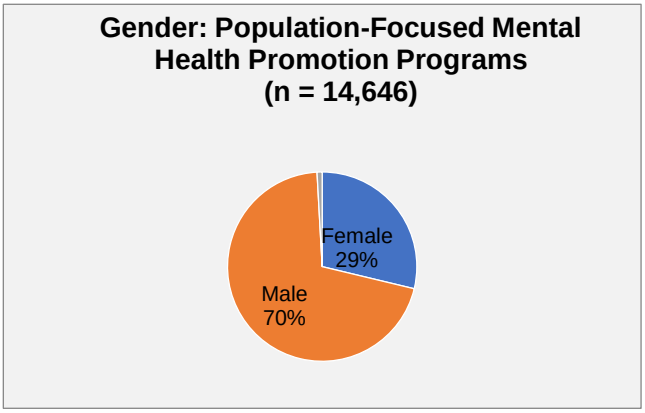
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
	Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional Initiative*	The Black/African American Wellness & Peer Leadership (BAAWPL) initiative takes a collective impact approach where the City, community, and two lead community-based organizations – the YMCA Bayview and the Rafiki Coalition – that are intent on decreasing the physical and mental health disparities of San Francisco's Black/African American populations.
Asians/Pacific Islanders (API)	API Mental Health Collaborative *Richmond Area Multi-Services (RAMS)*	The program serves Filipino, Samoan and Southeast Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Latinx including Indigenous Mayan communities	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	The program serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance *Native American Health Center*	The program serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Adults who are Homeless or At-Risk of Homelessness	South of Market Self-Help (6th Street) Center *Central City Hospitality House*	The program serves adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs This program now offers outreach and treatment support during extended hours to better engage with adult residents facing homelessness.
	Tenderloin Self-Help Center *Central City Hospitality House*	The program serves adult residents facing behavioral health challenges and homelessness in the Tenderloin neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs.
	Community Building Program *Central City Hospitality House*	The program serves traumatized, homeless and dual-diagnosed adults in the Tenderloin neighborhood. The program conducts outreach, screening, assessment, and referral to mental health services. It also conducts wellness promotion and includes an 18-week peer internship training program.
Latinx/Mayan TAY	Population Specific TAY Engagement and Treatment – Latinx/Mayan *Instituto Familiar de la Raza*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Latino/Mayan community.
Asian/Pacific Islander TAY	Population Specific TAY Engagement and Treatment – Asian/Pacific Islander *Community Youth Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Asian/Pacific Islander community.

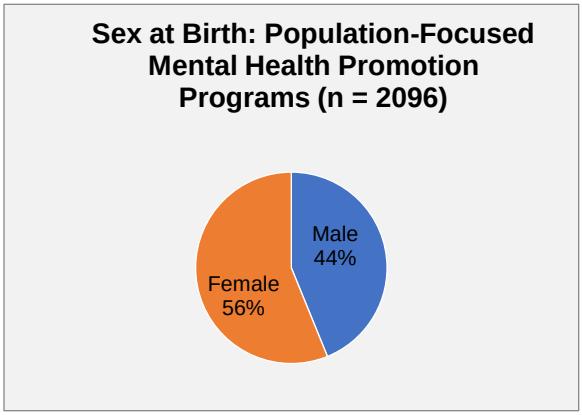
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name *Provider***	**Services**
Black/African American TAY	Population Specific TAY Engagement and Treatment – Black/African American *Third Street Youth Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Black/African American community.
TAY who are LGBTQ+	Population Specific TAY Engagement and Treatment – LGBTQ+ *SF LGBT Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and more) community.
TAY who are Homeless or At-Risk of Homelessness or Justice Involved	Population Specific TAY Engagement and Treatment *Huckleberry Youth Programs*	The program serves low-income African American, Latino, Asian Pacific Islander, or LGBTQ TAY (ages 16-24) who have been exposed to trauma, are involved or at-risk of entering the justice system and may have physical and behavioral health needs. Program participants may be involved with the City's Community Assessment and Resource Center (CARC) which focuses on 16 and17 year old youth. The program conducts street outreach, mental health assessments and support, case management and positive youth development services.

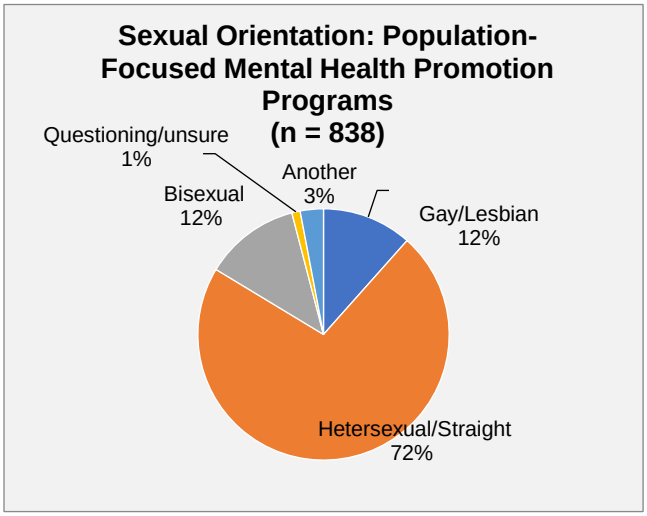
Demographics: Population Focused Mental Health

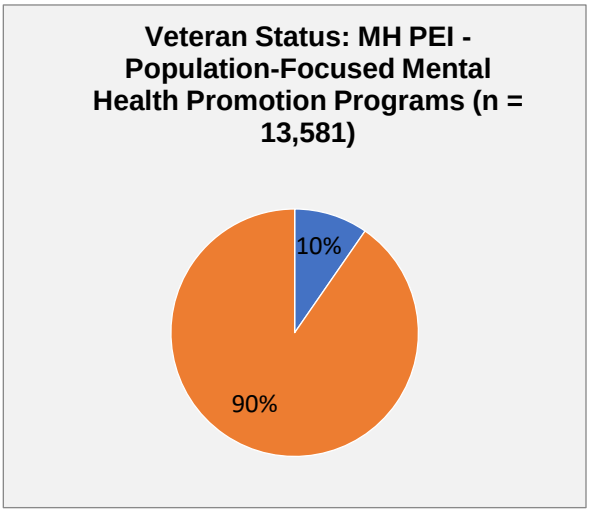




*< 1 percent of participants reported data for Trans Female, Trans Male, and Another Identity; Gender







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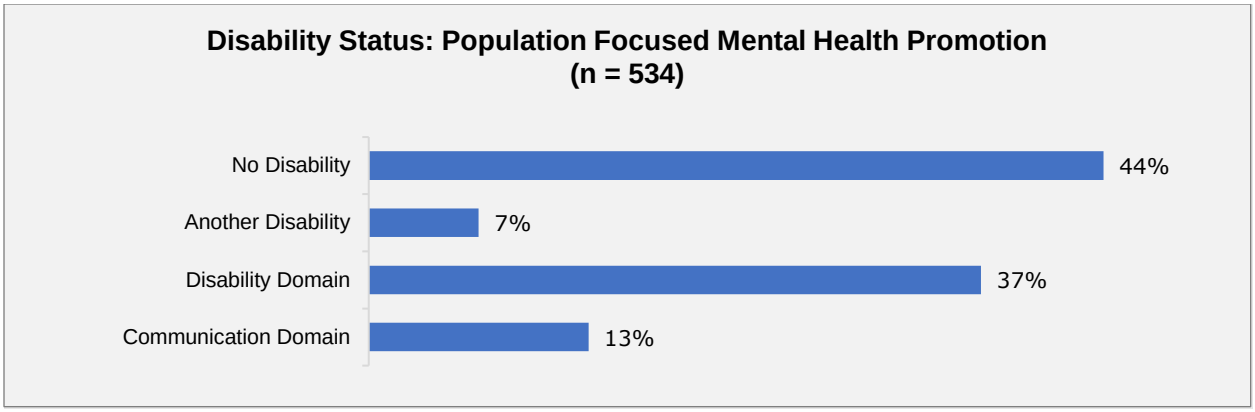


Race/Ethnicity	n
Black/ African American	5112
American Indian or Alaska Native	427
Asian	1899
Native Hawaiian or Pacific Islander	222
White	3955
Other Race	2865
Hispanic/Latino	2050
Non-Hispanic/ Non-Latino	11559
More than one Ethnicity	332
Total	28421

*Participants may be counted in multiple categories

Primary Language	n	%
Chinese	263	12%
English	1235	54%
Russian	<10	<1%
Spanish	404	18%
Tagalog	45	2%
Vietnamese	143	6%
Another Language	174	8%
Total	2272	100%

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Senior drop-in Center	• 25 seniors (100%) were assessed for non-behavioral health services as evidenced by referral/linkage participating log. • 25 seniors (100%) were referred to services • 8 limited English-speaking seniors (100%) were referred • 100 seniors (100%) attended wellness-based activities • 27 seniors (93%) reported an increase in socialization.
Addressing the Needs of Socially Isolated Older	• 83 older adults (111%) were screened for behavioral health needs using a preclinical Behavioral Health screening tool. • 83 older adults (138%) were screened for the need for clinical

Program	FY20/21 Key Outcomes and Highlights
Adults – Curry Senior Center	individual and/or group therapy • 83 older adults (138%) were screened for non-behavioral health needs.
Black/African American Wellness and Peer Leadership Program – DPH Inter-Divisional Initiative (collaborative of AA Holistic Wellness and SF Live D10 Wellness)	• 521 unduplicated individuals (1158%) who participated in program offerings and support (Mindful Monday, Men's Harambee, Healing/Resiliency Circles, COVID 19 CT work, Wellness Calls) were screened for behavioral health needs. • 280 unduplicated individuals (622%) who participated in program offerings and/or referred by outside community agencies were screened for health and wellness needs. • 280 participants (100%) screened for health and wellness needs were referred to internal and/or external services/programs (nature walks/hikes, physical activity sessions, tai chi, food bank, hot meal delivery). • 319 individuals participated in at least 3 sessions of continuously offered Wellness and Promotion educational activities (Virtual and In-Person physical activity sessions) as measured by participation data and maintained in the Program Database. 638 % of goal met and exceeded. • 16 unduplicated clients (160%) attended least five (5) 1:1 therapeutic counseling sessions.
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	• 45,804 individuals (916%) were outreached and engaged. • 54 individuals (135%) were screened and assessed for behavioral health and/or basic-holistic needs using an AA-PI specific assessment tool. • 43 individuals (80%) were screened and assessed identify a behavioral health concern or barrier to wellness. • 499 individuals (250%) participated in APIMHC culturally-relevant mental health promotion activities. • 34 participants (87%) in culturally relevant wellness promotion activities demonstrated increased knowledge about mental health issues • 43 individuals (100%) needing behavioral health services met one goal in their care/case plan.
Indigena Health and Wellness Collaborative – Instituto Familiar de la Raza	• 2471 individuals (346%) have participated in program activities and/or been contacted by Health Promoters (IE; phone calls, community walk-through, open community events, or other telehealth platforms such as zoom and texts. • 157 unduplicated participants (157%) were screened and/or assessed for practical, emotional and mental health concerns using the "Information & Referral Form". • 157 participants (157%) who were referred to internal & external services received 3 attempts for follow up and

Program	FY20/21 Key Outcomes and Highlights
	completed at least one successful internal or external referral. • 333 individuals (111%) participated in cultural/ceremonial/social events; via virtual platforms or in person when appropriate (e.g. Dia de los Muertos, Water Walk). • 65% of surveyed individuals participating in the Psychosocial Peer Support groups/talleres will demonstrate increase or maintain social connectedness. • 100% of surveyed individuals participating in the Psychosocial Peer Support groups/talleres will demonstrated increase or maintained social connectedness.
Living in Balance – Native American Health Center	• 27 individuals (270%) were screened and assessed. • 25 members (96%) were referred to behavioral health treatment after screening and assessment. • 11 surveyed members (73%) of members who had attended wellness promotion groups for social connectedness reported a maintained or increased feeling of social connectedness. • 12 surveyed members (80%) reported they have people who will listen and support them when needed. • 11 surveyed members (73%) reported feeling more connected to their culture and community. • 12 members (80%) reported that they have people who they can do enjoyable things with.
South of Market Self-Help Center (6th Street) – Central City Hospitality House	• 7,797 community member (797%) participated in a range of socialization and wellness services. • 117 community members (292%) were referred to behavioral health services.
Tenderloin Self-Help Center – Central City Hospitality House	• 4,077 community members (163%) have participated in a range of socialization and wellness services. • 113 community members (141%) were screened and assessed for behavioral health concerns. • 60 community members (120%) achieved one case plan goal.
Community Building Program - Central City Hospitality House	• 227 unduplicated community members (151%) participated in community events. • 56 unduplicated community members (93%) have been screened and assessed for behavioral health concerns. • 10 community members (250%) have increased their social connectedness as assessed by staff through observation of community members participating in community organizing. • 48 community members (96%) have participated in individual therapy with a stated case plan, as measured by HRTC.

Program	FY20/21 Key Outcomes and Highlights
	• 40 community members (160%) achieved one case goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - Instituto Familiar de la Raza	• 95 community participants (316%) attended at least 1 community ceremony. • 14 unduplicated TAY clients (78%) receiving MH services, decreased MH symptoms and impairments as indicated by a 1-point reduction in 1 CANS/ANSA item rated a 2 or 3. • 5 TAY participants (100%) completed at least 5 out of 8 TAY psycho-educational group sessions. • 5 TAY participants (100%) reported that because of the group they now recognize what Depression and Trauma means, • 4 TAY participants (80%) reported that they are able to recognize anxiety and reported that they know more about mental health now than when they first started the groups. • 11 respondents (100%) agree or strongly agree that as a result of services they are better at handling daily life; that when in crisis, they would seek the support they need from family and friends; and that as a result of services they are better able to cope and handle when things go wrong.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander - Community Youth Center	• 89 TAY participants (178%) were screened. • 63 A&PI youth (126%) enrolled in case management service have successfully attained at least one of their treatment goals. • 67 AA & PI Youth (85%) who completed our survey, reported agree or strongly agree in an increase of participation in meaningful activities. • 69 AA & PI Youth (88%) who completed our survey, reported agree or strongly agree in experiencing fewer conflicts with others.
Population Specific TAY Engagement and Treatment – LGBTQ+ - SF LGBT Center	• 102 unduplicated participants (85%) recorded Navigation Services. • 58 TAY clients (100%) who requested mental health services were either seen by our Mental Health Specialist or actively referred to other mental health services. • 22 youth (110%) were provided individual therapy services.
Population Specific TAY Engagement and Treatment – Black/African American – Larkin Street Youth Services and Third Street Youth Center	• 52 youth (130%) completed and intake and were screened mental health and trauma. • 52 clients referred for BH services (54%) were assessed to be appropriate and willing to engage in weekly therapy sessions. All 52 youth recommended to begin ongoing mental health treatment worked regularly with an 3rd Street clinician. • 12 health-promoting messages (100%) were published on social media. • 80% youth who attended at least three individual or group

Program	FY20/21 Key Outcomes and Highlights
	therapy sessions reported improvement in their ability to manage stress and uncertainty • 90% of providers who attended training reported increased knowledge of topic. • 100% of TAY reported that they would refer and friend or relative to 3rd Street's BH services.
Population Specific TAY Engagement and Treatment – Juvenile Justice/Others - Huckleberry Youth Programs	• 105 TAY were screened and/or assessed, for behavioral/mental health outcomes as documented by the date and stored in the agency tracking database Salesforce. • 80 out of 105 TAY (76%) who were screened and/or assessed were referred for or received on-site behavioral health services as evidenced by supporting documentation in the agency tracking database Salesforce. • 12 TAY Frontline Workers meetings (100%) facilitated to provide program updates, discuss trends, policy issues, facilitate referrals and provide trainings. • 100% of respondents who attended a Frontline Workers meeting and were asked to fill out an anonymous survey at mid-year to solicit ideas for improved facilitation and topics for the year, responded to the question "how effective are Frontline Worker meetings in the following categories? [Network development]" with a score of 5 (very effective) or 4 (effective).
TAY Homeless Treatment Team – Larkin Street Youth Services	• 28 youth (64%) housed who were engaged in individual therapy demonstrated an ability to manage their mental health as evidenced by an average rating of 4 or higher (out of a 5-point scale) on a series of questions related to mental health management in the youth's Case Management Assessment. • 268 youth (100%) who initiated an individual therapy session continued services with an internal Larkin Street Clinician or an external provider. • 12 trainings and professional development sessions (100%) held by TAY Clinicians with non-clinical Larkin Street staff. • 91 staff (95%) surveyed post-training responded that the training increased their knowledge and skills in the training topic. • 91 staff (95%) surveyed post-training responded that they would put skills learned into practice in their work.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[13]
Population-Focused Mental Health Promotion	19,140 Clients	$2,902,606	$152

Early Childhood Mental Health Consultation Initiative

Program Overview

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

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the evidence-based work[14] of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and delivered in the following settings: center-based and family childcare, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. Four county agencies provide funding and partnership to deliver ECMHCI: DPH/BHS; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco.

Services may include case consultation, program consultation, training and support for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic play groups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families.

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

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

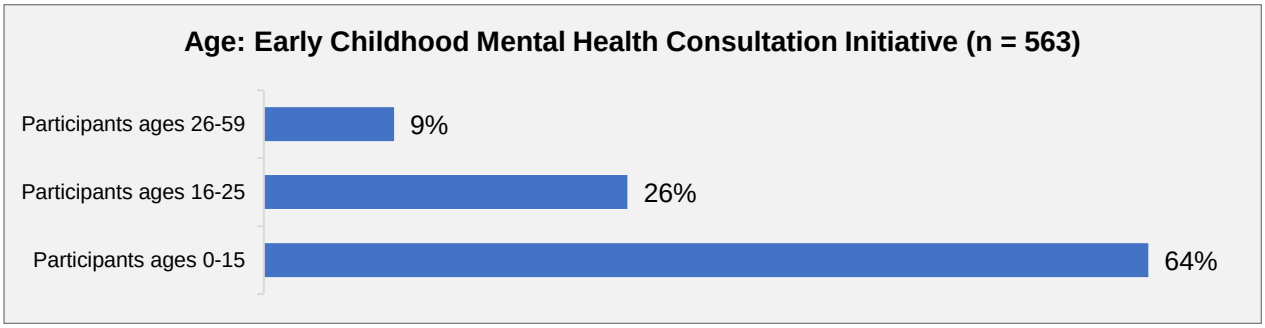
- Infant Parent Program - Day Care Consultants
- Edgewood Center for Children and Families
- Richmond Area Multi-Services
- Homeless Children's Network
- Instituto Familiar de la Raza

Target Populations

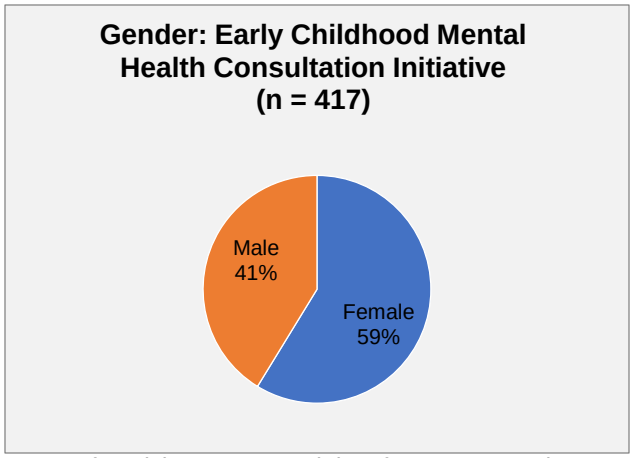
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients and families who experienced trauma, substance use disorders, homelessness, and other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

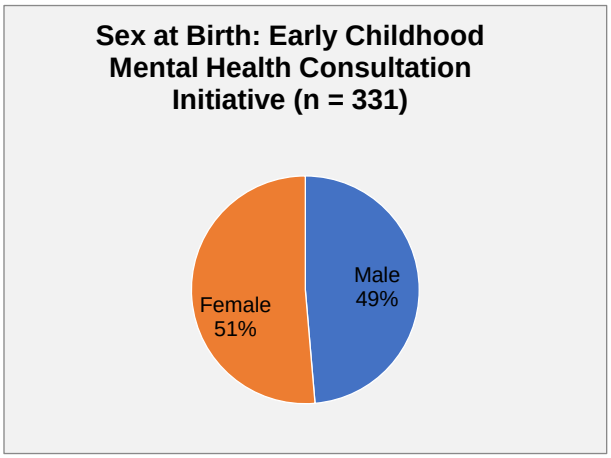
Participant Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative

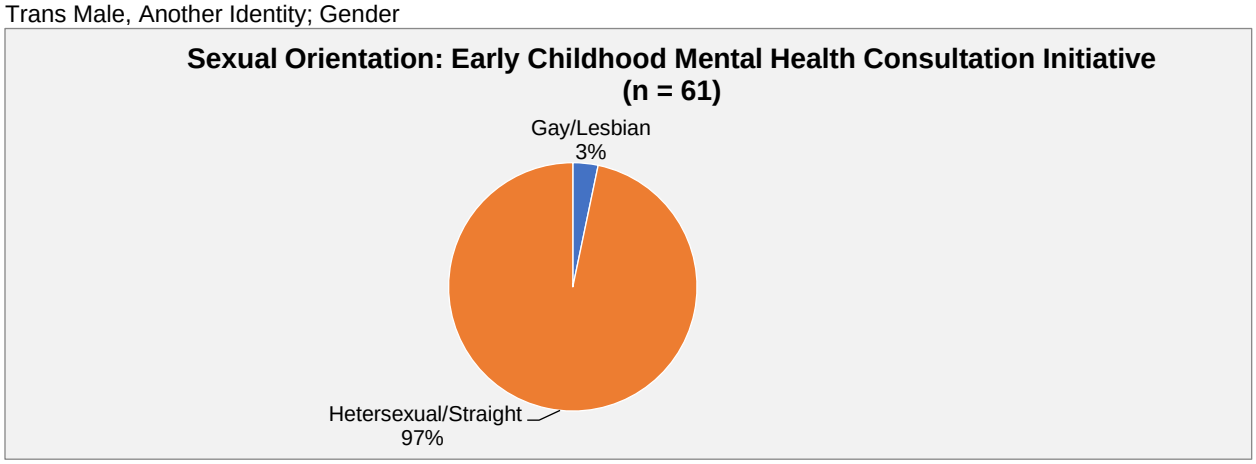


*< 1 % of participants reported data for Older Adult (60+) for Age

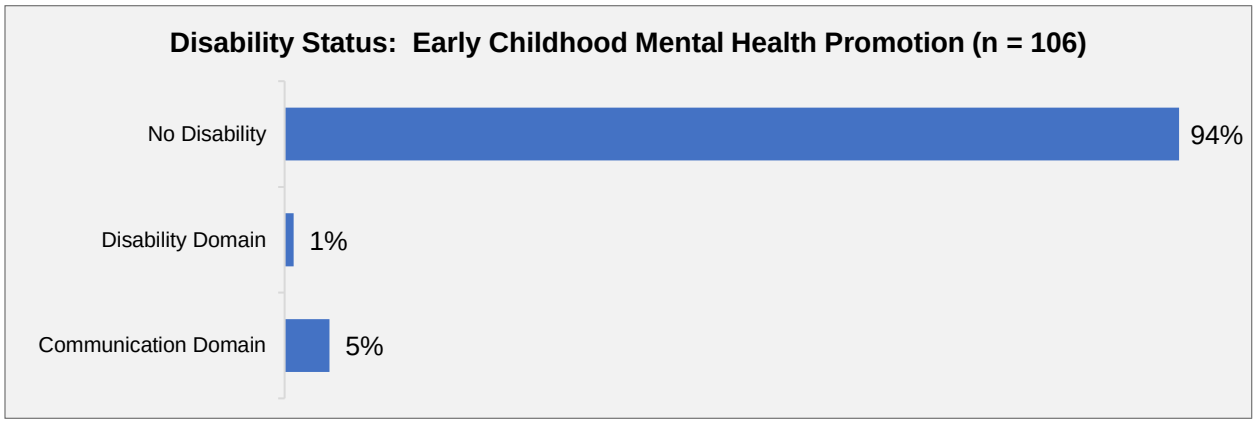




*< 1% of participants reported data for Trans Female, Trans Male, Another Identity; Gender



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



*<1% of participants reported Yes; Veteran Status

Race/Ethnicity	n
Black/ African American	70
American Indian or Alaska Native	<10
Asian	224
Native Hawaiian or Pacific Islander	<10
White	74
Other Race	71
Hispanic/Latino	206
Non-Hispanic/ Non-Latino	183
More than one Ethnicity	12
Total	850

Primary Language	n	%
Chinese	185	27%
English	287	42%
Spanish	184	27%
Another Language	20	3%
Total	676	100%

*No participants reported data for Russian, Tagalog, Vietnamese; Primary Language
*Participants may be counted in multiple categories

FY20/21 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[15]
Mental Health Consultation and Capacity Building	858 Clients	$682,209	$795

Comprehensive Crisis Services

Background and Community Need

Comprehensive crisis response and stabilization services are considered a crucial element of public behavioral health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. Crisis response to incidents of violence can reduce the long-term impact of complex trauma exposure.

Program Overview

Comprehensive Crisis Services (CCS) is a mobile, multidisciplinary, multi-linguistic unit 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

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

and families that have been exposed to trauma. MHSA funds four members of the crisis response team.

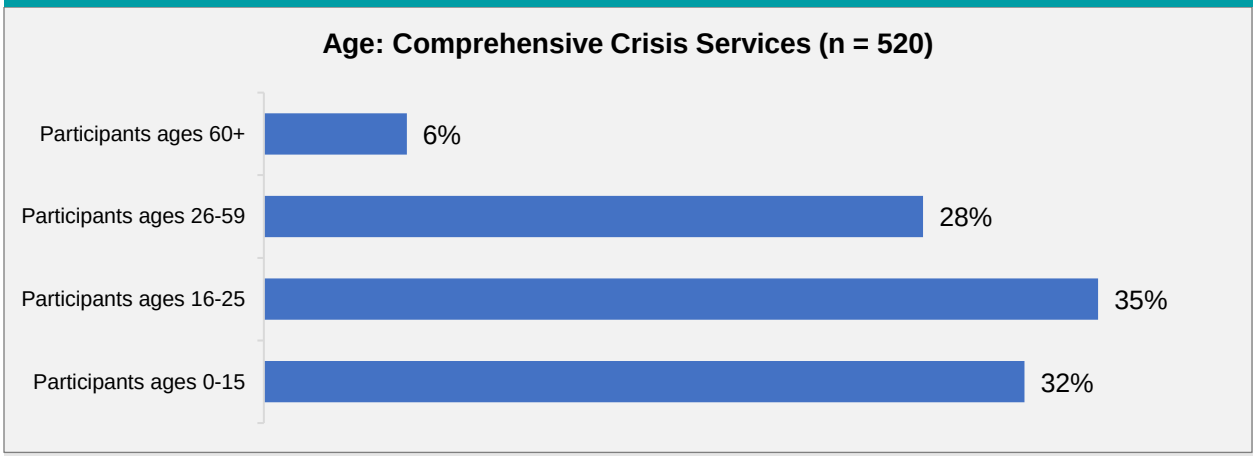
Target Populations

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

Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older.
Child Crisis Team	Offers 24/7 mobile 5150 assessments & crisis intervention for suicidal, homicidal and gravely disabled children and adolescents regardless of health insurance status. Clients with publicly health insurance or without health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response Team	Provides 24/7 mobile response to homicides, critical shootings, stabbings, suicides and pedestrian fatalities; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

Program Outcomes, Highlights and Cost per Client

Demographics: Comprehensive Crisis Services



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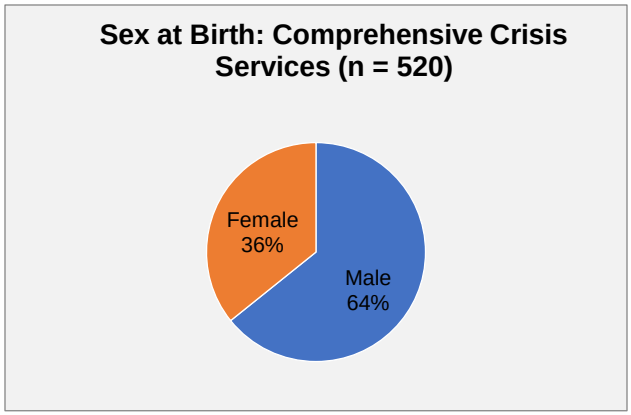
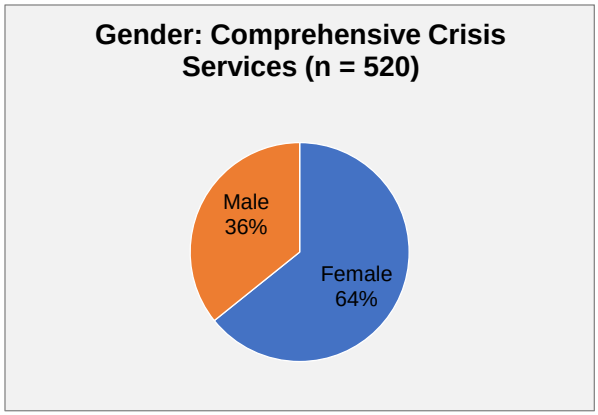




*< 1% of participants reported data for Trans Female, Trans Male, Another Identity; Gender
*<1% of participants reported Yes; Veteran Status
*< 1% of participants reported data; Sexual Orientation
*<1% of participants reported data; Disability

Race/Ethnicity	n
Black/ African American	80
American Indian or Alaska Native	<10
Asian	62
Native Hawaiian or Pacific Islander	<10
White	100
Other Race	32
Hispanic/Latino	68
Total	348

Primary Language	n	%
Chinese	20	6%
English	285	83%
Russian	<10	<3%
Spanish	32	9%
Tagalog	<10	<3%
Total	345	100%

*No participants reported data for Non-Hispanic/Non-Latino, More than one Ethnicity; Race/Ethnicity
*No participants reported data for Vietnamese, Another Language; Race/Ethnicity
*Participants may be counted in multiple categories

FY20/21 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[16]
Comprehensive Crisis Services	225 Clients	$461,794	$2,052

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

6. Innovations Projects: INN Funding

Service Category Overview

MHSA Innovations (INN) funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes. INN funding provides up to five years of funding to pilot projects.

SFDPH MHSA currently oversees four INN Learning Projects integrated throughout the seven MHSA Service Categories. These include:

1. Intensive Case Management/Full-Service Partnership to Outpatient Transition Support – Richmond Area Multi-Services (RAMS)
2. FUERTE – University of California San Francisco (UCSF)
3. Wellness in the Streets – Richmond Area Multi-Services (RAMS)
4. Technology Assisted Mental Health Solutions – Mental Health Association of San Francisco

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

Program Overview

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

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

The major goals of this project are to increase client engagement in behavioral health outpatient services among those stepping down from ICM/FSP services, improve the overall client experience for those in transition, and support and further develop a peer-driven model of care. The team consists of five culturally and linguistically diverse peers, including at least one TAY peer, at least one Spanish-speaking or Chinese-speaking peer, and one clinician. Peers serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers. The team conducts outreach to transitional clients in order to support them to have successful linkages to mental health outpatient services. They are available to guide the client through all the various steps from preparation to successful placement and/or discharge.

After release of the RFQ 2018 for the project, SF-MHSA entitled the program to be Peer Transition Team (PTT). After review of the proposals, the RFQ was awarded to Richmond Area Multi Services agency (RAMS), which launched the program in July 2019.

Family Unification and Emotional Resiliency Training (FUERTE) - UCSF

Program Overview

The Family Unification and Emotional Resiliency Training (FUERTE) program is a prevention program with a goal of reducing behavioral health disparities among Latinx newcomer youth. FUERTE is a school-based prevention program that serves as the frontline for reducing disparities in behavioral health access and increasing mental health literacy and service access, as it has been largely enacted through a unique collaboration between the San Francisco Unified School District (SFUSD), the San Francisco Department of Public Health, and the Departments of Psychiatry and Pediatrics at the University of California, San Francisco.

Target Populations

FUERTE school-based prevention services are targeted to recently-immigrated Latinx youth.

Wellness in the Streets - RAMS

Program Overview

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

Target Populations

Wellness in the Streets is a peer-led, peer-run project that operates a support team of formerly homeless individuals to provide peer counseling and service referrals to homeless San Franciscans.

Technology-Assisted Mental Health Solutions – Mental Health Association of San Francisco

Program Overview

The primary purpose of this INN Tech Suite Project is to increase access to mental health care and support and to promote early detection of mental health symptoms. Through the utilization of multiform-factor devices, such as smart phones, tablets and laptops, as a mode of connection and treatment to reach people who are likely to go either unserved or underserved by traditional mental health care, project services will focus on prevention, early intervention, family and social support to decrease the need for psychiatric hospital and emergency care service. The

Innovations Technology-Assisted Mental Health Solutions project (Tech Suite) has been preparing for multi-county marketing efforts. With input from all counties, a brand, logo, and outreach materials are being created. A formal name for the Tech Suite has been adopted, which is Help@Hand. Help@Hand is being envisioned as a multi-city and county collaborative whose vision is to improve the well-being of Californians by integrating promising technologies and lived experiences. Please see Appendix B titled, “Technology-Assisted Mental Health Solutions Innovation Project Update” at the end of this report for more information.

Target Populations

This project will be open to all San Francisco residents who experience behavioral health challenges with a focus on transition age youth and socially isolated transgender individuals.

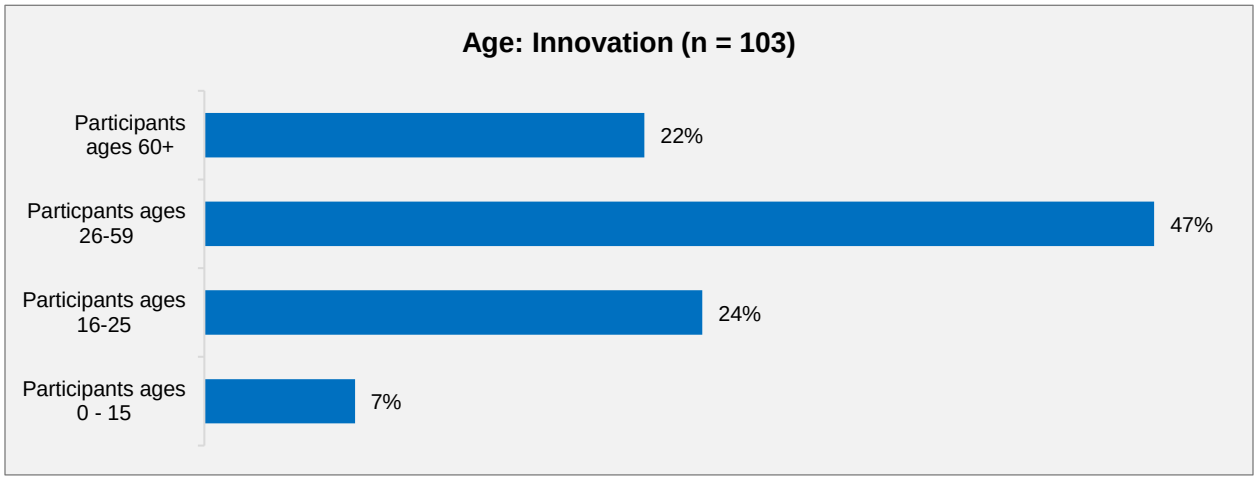
Virtual Transgender Health Fair 2021

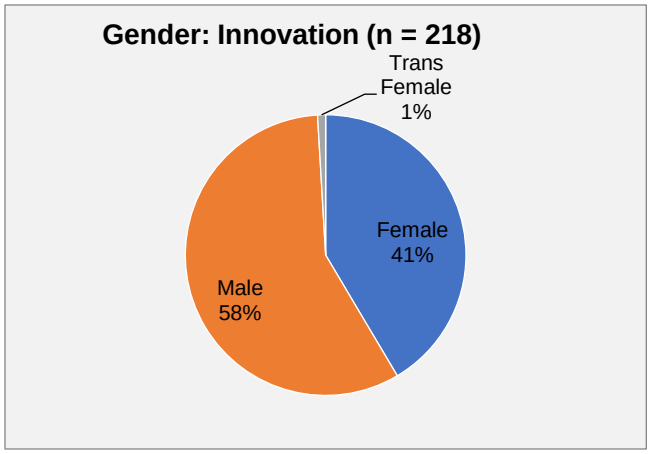
INN

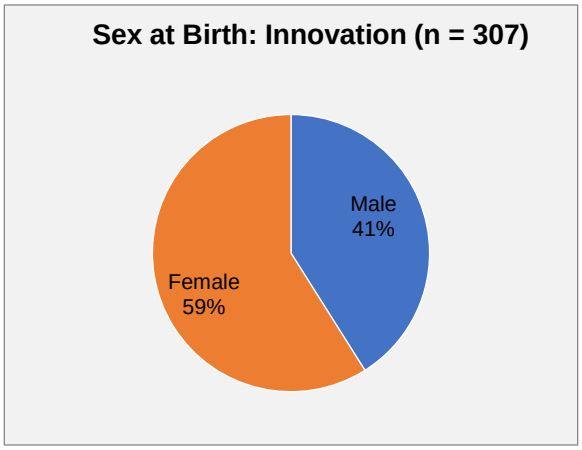
Participant Demographics, Outcomes, and Cost per Client for all Innovation Programs

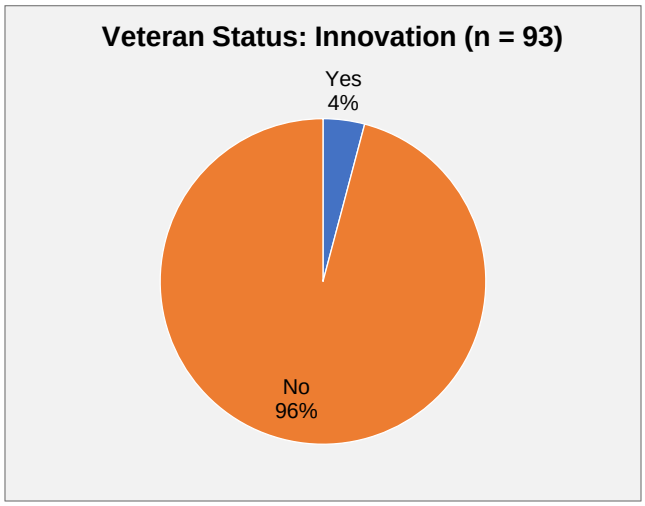
Service Indicator Type	Program Results
Total family members served	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Potential responders for outreach activities	Responses include: 3 counseling interns at SFUSD schools, 2 case managers at CBOs, 1 high school counselor, 1 family liaison at a high school, 1 Community Health Outreach Worker at a school, 2 doctoral students in clinical psychology at universities, 2 clinical social workers at CBOs; 4 nurses in Shelter in Place hotels, 9 behavioral health clinicians at Dept. of Public Health and community-based organizations.
Total individuals with severe mental illness referred to treatment	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Types of treatment referred	Responses include: Responses include: Behavioral health outpatient clinics; intensive case management services; primary care clinics
Individuals who followed through on referral	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Average duration of untreated mental illness after referral	34 individuals from 1 reporting program.
Average interval between referral and treatment	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	48 individuals; average 24 individuals across 2 reporting programs.
Types of underserved populations referred to prevention program services	Responses include: ● Latinx immigrant youth between the ages of 12-24 years old ● Individuals who are experiencing homelessness
Individuals who followed through on referral	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.

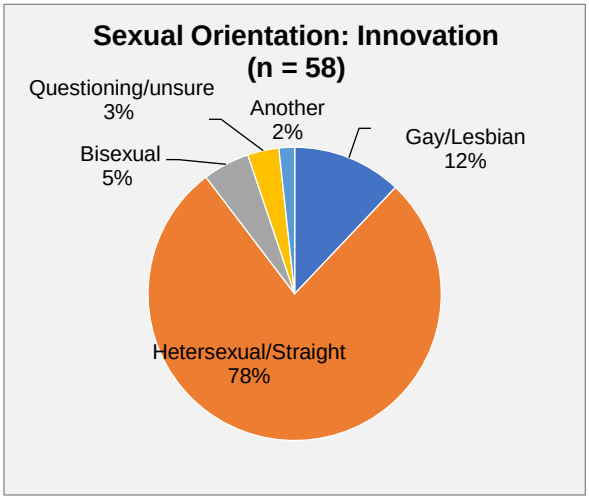
Service Indicator Type	Program Results
Average interval between referral and treatment	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
How programs encourage access to services and follow-through on referrals	Responses include: ● Groups are co-facilitated by two professionals in the mental health field, at least one who must be a terminal level provider of mental health services (i.e. MSW, MFT) who can identify and refer students who need additional services or may be in crisis. Additionally, the groups allow youth to build a supportive relationship with mental health services providers, who will be leading psychoeducation on mental health and help decrease stigma against seeking mental health support. Program staff reach out to screen participants for socioemotional functioning and utilization of services prior to the start of the program, at the end of the program, and 3 months following program completion. ● Working collaboratively with the city's Behavioral Health Services Shelter in Place Hotel team and with the city's Shelter Health nurses.

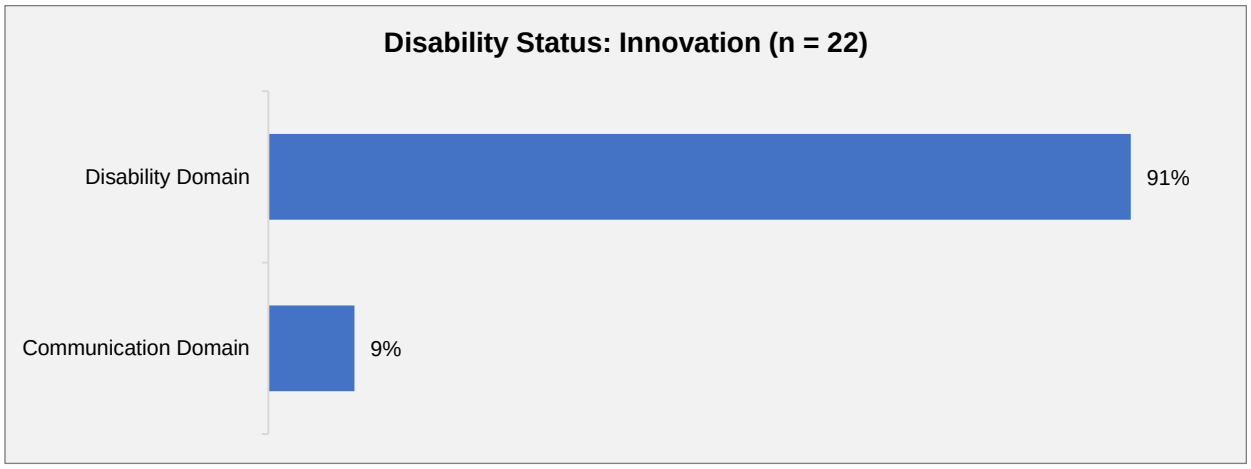












*<1 percent of participants reported data for Trans Male, Another Gender; Gender
*<1 percent of participants reported Another Disability; Disability Status

Race/Ethnicity	n
Black/ African American	34
American Indian or Alaska Native	11
Asian	<10
Native Hawaiian or Pacific Islander	<10
White	43
Other Race	20
Hispanic/Latino	63
Non-Hispanic/ Non-Latino	32
More than one Ethnicity	<10
Total	217

Primary Language	n	%
Chinese	<10	<5%
English	215	79%
Spanish	51	19%
Tagalog	<10	<5%
Vietnamese	<10	<5%
Total	271	100%

*<1 percent of participants reported data for Russian; Primary Language
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support – Richmond Area Multi-Services (RAMS)	• 42 clients (84%) successfully met with their Peer Counselor, within 30 days of program enrollment. • 26 clients (100%) reported they "Strongly Agree" or "Agree" with feeling heard and understood by their Peer Counselor. • 22 surveyed clients (96%) reported they "Strongly Agree" or "Agree" with feeling more comfortable with their new provider. • 14 surveyed ICM providers from referral clinics (93%) reported that the Peer Transition Team was helpful in transitioning clients to less intensive services.
FUERTE – University of California San Francisco (UCSF)	• 3 high schools (150%) and one middle school in the San Francisco Unified School District held Fuerte groups. • 12 new group facilitators (120%) were trained on the Fuerte program curriculum, as evidenced by training logs. • 41 students (102%) participated in the Fuerte program as evidenced by a group participant logs. • 29 participants (94%) who attended at least 2 sessions completed the PSC-35 screening. • 12 students (29%) who participated in Fuerte sessions

	attended the focus groups. • 12 students who attended at least 70% of Fuerte group sessions attended the focus groups and indicated an increase in their social connectedness as indicated by focus group data.
Wellness in the Streets – Richmond Area Multi-Services (RAMS)	• 180 unduplicated clients (120%) engaged in outreach activities by the WITS team. • 170 clients (94%) reported their need was addressed by a WITS team member. • 40 clients (97%) surveyed reported that they felt supported by the WITS team member.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[17]
Innovations	277 Clients	$1,662,483	$6,002

Moving Forward in Innovations

Intensive Case Management and Full-Service Partnership to Outpatient Programs (RAMS Peer Transitions Team) is a five-year MHSA Innovations Project designed to assist clients as they transition from Intensive Case Management (ICM) to Outpatient (OP) care. This program began in 2019. As of August 2021, the PTT program has received 73 referrals, with Citywide Linkages referring the largest number of clients. The program has enrolled 27 clients, and 32 clients have exited the PTT program since its inception in 2019. On average, clients spend 8.5 months enrolled in the program. Twenty-two clients (69%) successfully completed transition to OP level of care; 8 clients (25%) partially completed transition to OP level of care; and 2 clients (6%) didn't complete transition to OP level of care. In annual and exiting program satisfaction surveys, clients indicated that participating in the program has improved upon their personal relationships and their living situation. A few clients indicated that the PTT program had alleviated their involvement in legal issues or had provided more structure in their lives. Clients also indicated that they felt supported and more comfortable with their new provider, that they were attending their appointments with their new provider, and were better at using transportation to get where they needed to go, as a result of working with the PTT. Some clients still needed assistance managing their medication refills and being able to recognize their strengths.

Culturally Congruent and Innovative Practices for San Francisco's Black/African American Communities

In March of 2021, SF-MHSA was approved by the California Mental Health Services Oversight Committee to fund and implement a new Innovation project to provide culturally congruent and innovative practices for San Francisco's Black/African American communities. As with all INN-approved funds, this will reserve funds to be allocated to fund the program for at least five years. The project officially launched January 2022.

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

The project has four (4) primary learning goals:

1. Implement and evaluate new outreach and engagement practices for Black/African American clients including those who are currently underserved by the County mental health plan.
2. Implement and evaluate culturally adaptive interventions and practices that increase consumer satisfaction, efficacy and retention.
3. Implement and evaluate the efficacy of using peers with lived experience who represent the Black/African American communities and have specialized expertise working with this population.
4. Develop a wellness-oriented manualized curriculum that emphasizes elements of the Sankofa framework.

The project will also implement and evaluate the following culturally congruent interventions/practices:

- Better link consumers with someone who is representative of intersecting identities such as race, gender, sexual identity and age.
- Implement African Centered story-telling, expressive arts, community rituals and/or spirituality practices based on the interest of the participants.
- Hold trauma-informed community healing circles at community programs, churches, faith-based programs, barbershops or other community settings.

SF-MHSA held regularly scheduled stakeholder meetings to plan the implementation of this project in 2021. Throughout these meetings, SF-MHSA managers and stakeholders discussed and planned how to roll out the following:

- The training manual focusing on the Sankofa framework.
- How to navigate the city's human resources system to ensure quality civil service staff that meet this project's unique needs are hired.
- How to implementation a comprehensive evaluation plan to meet the learning objectives by partnering with the DPH Quality Management team and other evaluation staff/resources.
- How to implement the peer services component successfully.
- And other activities like budgeting, procedure planning and equity promotion.

<u>FUERTE</u>

In 2020-21 the FUERTE program continued activities remotely due to the ongoing challenges of the COVID-19 pandemic and school closures. These activities included the facilitator training, participant recruitment, PSC-35 screening, demographics data collection, and group meetings. Although the recruitment and engagement of participants and their caregivers was challenging compared to in person and some students had internet or privacy barriers. There was a total of 41 participants from 3 different high schools and 1 middle school that took part in the program. The program found creative ways to increase the interaction of participants by allowing the youth participants to facilitate social connectedness to others. Since students were spending less time outside the home due to stay-at-home orders, and less interaction with their peers. In addition, the remote format allowed students who had jobs or sibling childcare responsibilities to participate more easily. Around a third of the participants of 2 or more sessions were identified as high risk and they were all referred to specialty mental health services.

FUERTE Program changes in 20-21:

1. Recruitment related changes: Additional funding was received for a website with interactive components for FUERTE program participants and design of a youth-friendly participant manual

2. Staffing: The addition of a bilingual (English/Spanish) clinical coordinator starting from 20-21 moving forward to help improve recruitment, retention, and outreach efforts:
    - To increase the recruitment and retention of participants by having a staff member who is dedicated to outreach, recruitment, and retention of participants in the program.
    - To increase the number of participants connected with specialty mental health services as this clinical coordinator will be responsible for outreach and referrals for FUERTE youth participants who are found to be at risk for specialty mental health concerns.

Wellness In The Streets

As COVID-19 created the need for alternative models of care to support unhoused individuals, the Wellness In the Streets (WITS) program staff were deployed as Disaster Service Workers focusing their efforts towards providing peer support and resource linkage to guests in the City's SIP hotels. MHSA approved this shift in the WITS team's role, as it was still consistent with providing services to and collecting relevant program-development information from the unhoused community in San Francisco.

During fiscal year 2020-21, the WITS team received referrals from the BHS SIP team with requests to outreach to specific clients in the SIP hotels who were part of the identified Mental Health SF population, which meant that clients served had a history of care in the BHS system due to co-occurring mental health and substance use disorders, in addition to experiencing homelessness. The WITS team outreached in-person and by phone to nearly 180 clients across more than 20 SIP sites, while also working with occasional clients not in the SIP hotels who they encountered in the community or who were referred by community partners. The team provided essential services, including accompanying clients to medical appointments; helping them access their prescribed medications; working with them to access Coordinated Entry housing assessments and housing documents, Medi-Cal, CalFresh, and primary care providers, among other resources. WITS staff also accompanied BHS staff during outreach to SIP hotels, working collaboratively to support clinical assessments and promote rapport-building with clients from a strengths-based approach. As a result of their deployment as Disaster Service Workers during the first half of FY20-21, the WITS team was an integral part of the MHSA 2020 Team of the Year, awarded to the RAMS peer staff deployed to provide peer support for clients in the SIP hotels.

During the second half of FY20-21, the WITS team deepened into their roles as Disaster Service Workers with clients in the SIP hotels, frequently collaborating on care coordination with multiple community partners across multiple systems of care to help clients prepare for housing transitions and connect with ongoing behavioral health services and medical services. While working in this capacity, the WITS team also piloted partnerships with other community-based organizations to collaborate on occasional joint outreach in the Tenderloin and South of Market neighborhoods. As we anticipate the SIP hotels phasing out in the upcoming FY21-22, the WITS team will be prepared to return to its original model of outreach to unhoused individuals.

Technology Assisted Mental Health Solutions (SOLVE)

In 2020-21 SF-MHSA with the Technology Assisted Mental Health Solutions (SOLVE) assessed and implemented new methods for communication and to support the mental health needs of the community through online applications. SF-MHSA performed a review of various mental health technology applications and selected Take-My-Hand peer-based chat application to meet the needs for peer chat support expressed by the community as part of MHSA's community

planning process meetings. The application, created by Riverside County, is being adapted to meet the needs of San Francisco's population and staff are creating evaluation measures for a pilot with the support of the University of California, Irvine. In addition, SF MHSA gathered input from the community to implement this project with an equity lens by hosting and facilitating 12-part Digital Literacy Education trainings and one-on-one digital support services, with a focus on TAY and Transgender community members. To strengthen the digital access along with digital reediness, SF-MHSA has been developing a process for FY21-22 to distribute tablets and keyboards as well as providing Wi-Fi access to those who need it. Another part of the program is to provide training on how to utilize devices and access virtual mental health resources.

California Counties that were involved in the statewide project got an expedited Headspace application option due to COVID, which provided a discounted license rate for this mindfulness and medication app. San Francisco provided free Headspace licenses to community members to support the mental health needs that have emerged during COVID. SF-MHSA conducted outreach regarding this opportunity through 16 presentations to 12 community organizations, reaching 266 community members. Outreach was also done through social media and radio ads. SF MHSA achieved 299,846 (target 50,000) media impressions utilizing social media channels (Instagram and Facebook), landing page engagement, and audio impressions.

During this period the Technology Assisted Mental Health Solutions Innovation Project TAMHS established partnerships with local community-based organizations such as RAMS, San Francisco University High School, CAYEN Local Level Advocacy Group Transitional Aged Youth Action Team, HOPE SF Wellness Center, and PROPEL.

FUERTE Program Staff 2019

7. Behavioral Health - Workforce Development: WET Funding

Service Category Overview

The Behavioral Health Workforce Development service category addresses the shortage of qualified individuals who provide services in San Francisco's public mental health system. This includes developing and maintaining a culturally humble and competent workforce that includes individuals who have experiences as service recipients, family members of service recipients and practitioners who have experience providing client- and family-driven services that promote wellness and resiliency. This service category includes 1) the Mental Health Career Pathways Program, 2) Training and Technical Assistance, and 3) Residency and Internship Programs.

In 2009, MHSA received an initial $4.6 million allocation of MHSA funding to support Workforce, Development, Education and Training (WDET) activities. San Francisco has developed a strong collection of activities and programs designed to achieve WDET goals. Through Career Pathway Program (CPP) activities, we sustained MHSA WDET activities, described below, with CSS funds. MHSA's goal is to develop a behavioral health workforce development pipeline to increase the number of individuals that are informed about, choose to prepare for, and are successful in entering and/or completing behavioral health training programs. To accomplish this goal, MHSA staff member collaborate with SFDPH BHS as a whole, along with San Francisco Unified School District (SFUSD), City College of San Francisco, San Francisco State University, and California Institute of Integral Studies.

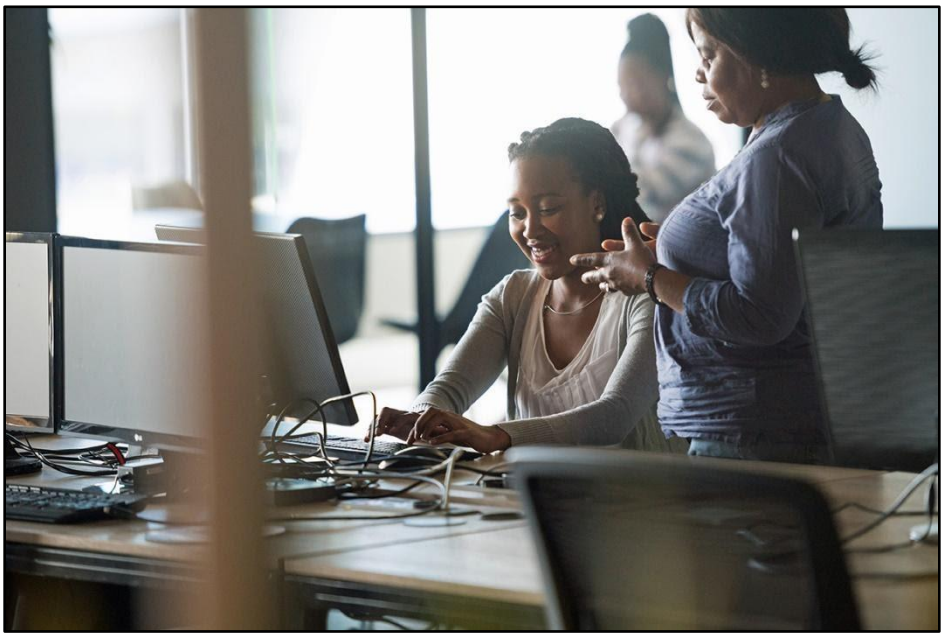
Target Populations

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

Mental Health Career Pathway Programs	
Program Name ***Provider***	**Services Description**
Community Mental Health Certificate Program *City College of San Francisco*	The Community Mental Health Worker Certificate (CMHC) program at City College of San Francisco (CCSF) is a 16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through consumer-directed goal setting and collaboration between mental health service consumers and mental health providers. The program educates and trains culturally and linguistically diverse consumers of mental health, family members of consumers and mental health community allies to enter the workforce as front-line behavioral health workers who are able to deliver culturally congruent mental health care to underrepresented populations (e.g., African American; Asian;

Workforce Dev

Mental Health Career Pathway Programs	
Program Name ***Provider***	**Services Description**
	Pacific Islander; Latino; Native American; Lesbian, Gay, Bisexual, Transgender, Questioning; and immigrant communities).
Community Mental Health Academy *Crossing Edge Consulting*	SFDPH BHS partnered with the City College of San Francisco's Community Mental Health Worker Certificate Program to create a 16-week mental health seminar series called the Community Mental Health Academy (Academy) that is designed to equip community based organizations' frontline staff with foundational knowledge about community mental health; culturally affirming techniques on how to approach and address someone who is in need of mental health support; and efficient ways to link someone with mental health care.
FACES for the Future Program *Public Health Institute*	Faces for the Future program (FACES) is nationally recognized for healthcare career preparation work with high school students. The FACES program introduces John O'Connell High School students to career pathways in healthcare, public health and mental and behavioral health while supporting them with academic interventions, coordination of wellness services, referrals to outside agencies when needed and youth leadership development opportunities.



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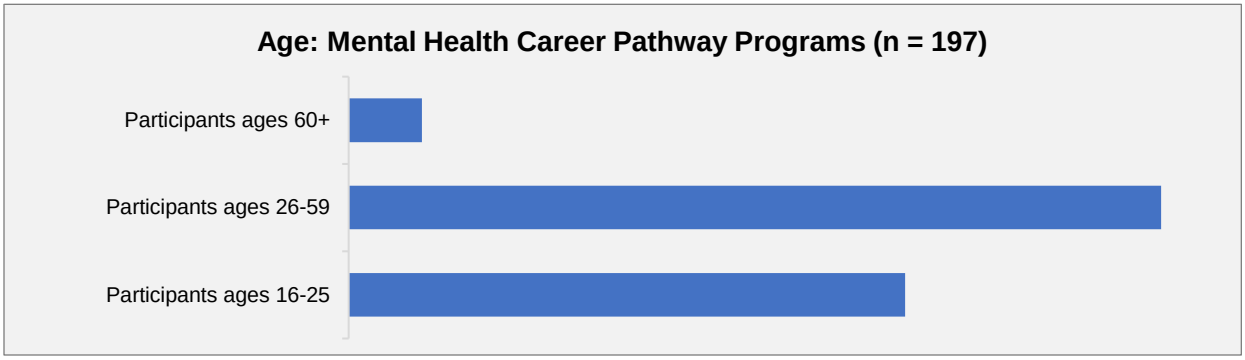
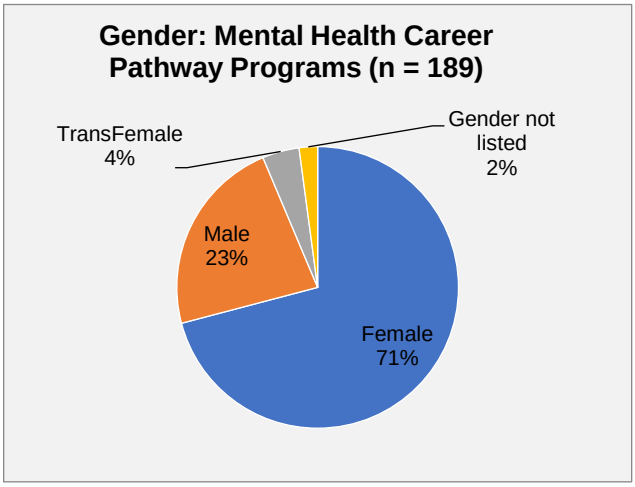
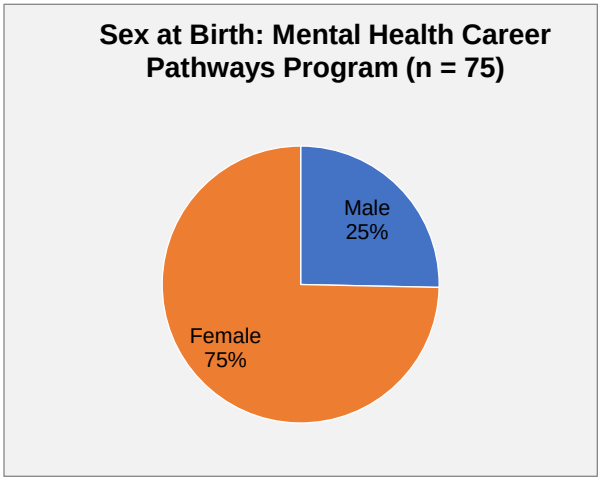
Demographics: Mental Health and Career Pathways

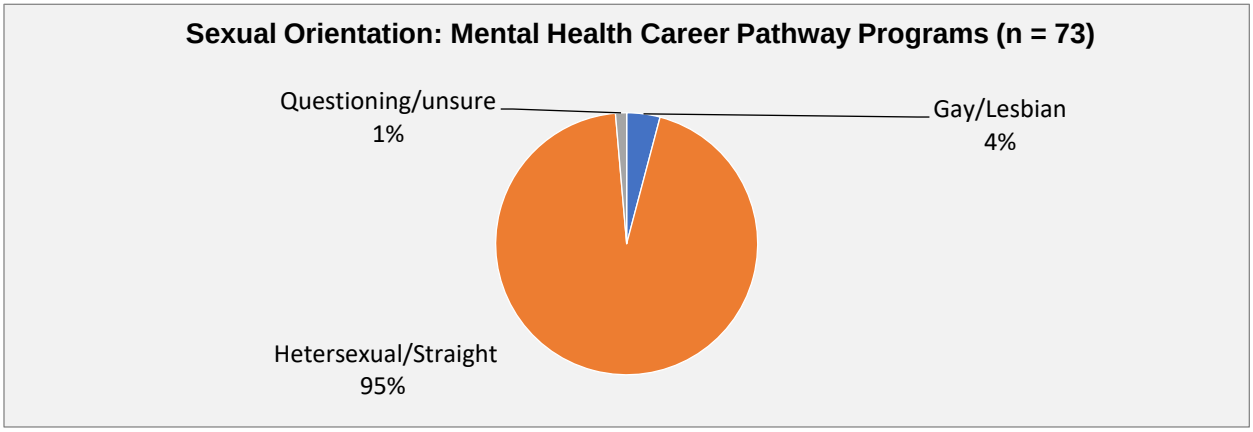


*< 1% of participants reported data for CYF (0-15); Age





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



*< 1% of participants reported data for No Disability; Disability Status
*<1 percent of participants reported Yes; Veteran Status

Workforce Dev

Race/Ethnicity	n
Black/ African American	14
American Indian or Alaska Native	16
Asian	16
Native Hawaiian or Pacific Islander	14
White	41
Other Race	<10
Hispanic/Latino	70
More than one Ethnicity	13
Total	188

Primary Language	n	%
Chinese	<10	<5%
English	120	69%
Russian	<10	<5%
Spanish	33	19%
Tagalog	<10	<5%
Vietnamese	<10	<5%
Another Language	<10	<5%
Total	174	100%

*No participants reported Non-Hispanic/Non-Latino; Race Ethnicity
*Participants may be counted in multiple categories

In the following table, numeric values represent the number of units (e.g. participants, events, etc.) reported in providers' year-end reports and percentages represent the *portion of the stated goal for the fiscal year* that those service units comprise.

Program	FY20/21 Key Outcomes and Highlights
Community Mental Health Worker Certificate – City College of San Francisco	• 6 CMHC cohort students (94%) successfully completed their internship. • 17 graduating students (100%) expressed readiness to pursue subsequent work/educational opportunities. • 17 graduating students (100%) expressed interest in pursuing health related careers. • 17 graduating students (100%) expressed knowledge of pathways into health-related careers.
Community Mental Health Academy – Crossing Edge Consulting	• 10 meetings (100%) occurred between Dr. Sal Nunez met and the Native American Health Center (NAHC) leadership to introduce the Mental Health Academy. • 20 staff members (100%) completed the CMH Academy and were awarded a certificate of completion. • 14 participants (100%) who completed the survey, reported that they would be able to recognize someone who may be experiencing mental health distress.
Faces for the Future Program – Public Health Institute	• 50 students (100%) enrolled in the FACES Program. • 50 students (125%) participated in one-to one phone or video conference check ins.

Program	FY20/21 Key Outcomes and Highlights
	• 50 students (125%) completed 7, 40-minute internship training workshops. • 50 students (125%) participated in one-to one phone or videoconference check ins. • 48 students (120%) completed 10, 40-minute internship training workshops. • 37 student respondents (86%) reported sustained or increased interest in pursuing a health profession. • 41 students (95%) respondents expressed they can identify three supportive adults who can help them if they experience challenges.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[18]
Mental Health Career Pathways	198 Clients	$689,781	$3,484

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

Program Outcomes, Highlights and Cost per Client

Program	FY20/21 Key Outcomes and Highlights
Trauma Informed Systems Initiative - DPH	• 183 educational sessions reached a total of 2,366 individuals. • 15 new trainees were certified in the trauma-informed systems approach.

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

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[19]
Training and Technical Assistance	1,800 Served	$899,853	$500

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

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

	placements and several students attend the training seminars that are provided within our system of care.

Program Outcomes, Highlights and Cost per Client

Program	FY20/21 Key Outcomes and Highlights
Fellowship for Public Psychiatry in the Adult/Older Adult System of Care and SF General Hospital - UCSF	• 2 MHSA-funded Public Psychiatry Fellows during FY20/21. One fellow was a child and adolescent psychiatrist who was a Senior Psychiatric Physician Specialist at his SFHN-BHS Foster Care Mental Health and Comprehensive Crisis Services. The second fellow was the first resident from the Stanford University to participate in the UCSF Public Psychiatry Fellowship Fast-track program. That fellow is now the Associate Medical Director at Casa Del Sol in Oakland, CA. • 4 early career psychiatrists participating in the new two-year DPH Public Psychiatry Administrative Fellowship, a two-year program with a mission to build community among emerging public psychiatry leaders within the SFHN-BHS • Fellows from FY20/21 attended multiple external trainings: 1) a Mental Health Advocacy training at the Steinberg Institute and California Psychiatric Association and 2) various forensic field trips (Virtual Behavioral Health Court, Citywide Forensic, SFPD Ride Along, San Quentin Correctional Facility). • 2 fellows disseminated their capstone project findings virtually at the 2021 Annual Meeting of the American Psychiatric Association. Both MHSA-funded fellows are preparing manuscripts for publication to Psychiatric Services.
Child and Adolescent Community Psychiatry Training Program (CACPTP) - UCSF	• 2nd year Child and Adolescent Fellows, one fellow at each of the following clinics one afternoon a week: Chinatown Child Development Center**,** Family Mosaic Project, Mission Family Center, OMI Family Center and Sunset Mental Health. • Additionally, one of the fellows was recruited to work for SFDPH and has started as a Staff Psychiatrist at Foster Care Mental Health. Additionally, she is participating in the UCSF Public Psychiatry Fellowship as an SFDPH employee.
BHS Clinical Graduate Training Program - DPH	• 18 BSW, MSW, MFT, and psychology graduate students received Multicultural Student Stipend awards. Of those, 6 interns/trainees attended 29 weekly didactic trainings and case conferences.

FY20/21 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[20]
Psychiatry Residency and Fellowships	180 Served	$491,375	$2,730

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

Workforce Dev

Spotlight for Office of Equity and Workforce Development

BHS Unlearning Racism Train the Trainer and Learning Community Update
Over the course of 2021, the Office of Equity and Workforce Development has been working with Jason Seals & Associates to provide select BHS staff with a "Train the Trainer" (TTT) series. The goal of this series was to immerse the BHS Racial Equity Champions in Professor Seals' Unlearning Racism (UR) curriculum in such a way that would equip them with the foundational knowledge needed to carry out UR trainings of their own throughout BHS. Starting in June 2021, the TTT series was delivered over the course of four 2-hour sessions, one session for each learning module, plus a makeup session.

Following the Train-the-Trainer series, in July, a survey was distributed to the TTT participants to gauge their interest and capacity to co-facilitate their own Unlearning Racism trainings and/or Racial Affinity groups throughout BHS programs/sites. The responses for this survey were collected in August.

In the fall of 2021, OEWD again collaborated with Jason Seals and his Learning Specialist Selena Wilson to launch a 3-session Unlearning Racism Learning Community of Practice, serving as a platform to acquire additional skills in leading discussions on race while also serving as a safe space to share their knowledge, experiences and resources amongst each other. The final session with Jason Seals took place in mid-December.

Also in the fall of 2021, the first BHS Racial Affinity/Accountability Group Planning session was held. This included a presentation from Kathy Broussard, who shared her experiences being among the first leaders of a Black/African American Affinity Group within her department, the SF Municipal Transportation Authority. A second BHS Affinity Group Planning session was held in December.

Several pilot Racial/Affinity Groups will be launched across the BHS Systems of Care in 2022, including: Black/African American Affinity Group, Asian Pacific Islander Affinity Group, White Accountability Group, and the Latin-a-o-e-x Affinity Group

Also in 2022, Nia Hamilton-Ibu will be leading monthly 90-minute Affinity Group/Unlearning Racism Learning Community sessions to provide coaching, strategic support and wellness for the co-facilitators of these pilot groups and those who will be leading the UR trainings in the future.

OEWD intends to launch and proliferate its own Unlearning Racism trainings, based off and expanding on the existing curriculum in Summer 2022. In addition to Nia and Jason Seals, co-facilitators will also be supported by members of the BHS Racial Equity Action Council, to whom they will be reporting monthly. By doing so, a system of accountability and resource sharing will be fostered. OEWD will be facilitating this level of engagement. This is in addition to its ongoing outreach efforts to ensure maximized utilization of these valuable platforms for fostering education, solidarity and ultimately equity at the system and community levels.

Moving Forward in Behavioral Health Workforce Development

MHSA BH Workforce Development Staffing Updates
In fiscal year 2020-21, MHSA hired a new BHS Training Consultant to assist with workforce development needs.

BHS/MHSA 5-Year WDET Strategic Plan
SF-MHSA will start planning the 5-Year Workforce Development Needs Assessment and Strategic Plan for 2023-2028. We are at the initial stages of planning; however, we plan to be completed by June 30th, 2023 for a launch of our plan starting in the new fiscal year on July 1, 2023. Stakeholders have been strategizing ways to best identify the staff capacity for SF-MHSA to implement all MHSA activities listed in the FY22/23 Annual Update. We will continue planning and review the previous documents and reports including:

- 2019 BHS Workforce Needs Assessment and Plan
- 2017-2022 5-Year Workforce Plan
- 2017-2022 5-Year Workforce Plan PowerPoint
- MHSA Regulations

The planning is still taking place, however, SF-MHSA is considering making the following three goals the priority for this new plan:

1. GOAL 1: Diversity and Equity
2. GOAL 2: Building SFDPH BHS Workforce Development Pipeline of programs and services
3. GOAL 3: Careers at SFDPH BHS or with SFDPH BHS-funded Community Based Organizations that provide public mental health services

HS Unlearning Racism Train the Trainer and Learning Community
Starting in fiscal year 2020-21, the Office of Equity and Workforce Development began working with Jason Seals & Associates to provide select BHS staff with a "Train the Trainer" (TTT) series. The goal of this series was to immerse the BHS Racial Equity Champions in Professor Seals' Unlearning Racism (UR) curriculum in such a way that would equip them with the foundational knowledge needed to carry out UR trainings of their own throughout BHS. Starting in June 2021, the TTT series was delivered over the course of four 2-hour sessions, one session for each learning module, plus a makeup session. Following the Train-the-Trainer series, in July, a survey was distributed to the TTT participants to gauge their interest and capacity to co-facilitate their own Unlearning Racism trainings and/or Racial Affinity groups throughout BHS programs/sites. The responses for this survey were collected in August. In September/October, OEWD again collaborated with Jason Seals and his Learning Specialist Selena Wilson to launch a 3-session Unlearning Racism Learning Community of Practice, serving as a platform to acquire additional skills in leading discussions on race while also serving as a safe space to share their knowledge, experiences and resources amongst each other. The final session with Jason Seals took place in mid-December 2021.

Also in mid-September 2021, the first BHS Racial Affinity/Accountability Group Planning session was held. This included a presentation from Kathy Broussard, who shared her experiences being among the first leaders of a Black/African American Affinity Group within her department, the SF Municipal Transportation Authority. A second BHS Affinity Group Planning session was held in December.

Moving into the first quarter of 2022, several pilot Racial/Affinity Groups will be launched across the BHS Systems of Care. They are as follows: Black/African American Affinity Group; Asian Pacific Islander Affinity Group; White Accountability Group; Latin-a-o-e-x Affinity Group
In early 2022, Nia Hamilton-Ibu led monthly 90-minute Affinity Group/Unlearning Racism Learning Community sessions to provide coaching, strategic support and wellness for the co-facilitators of these pilot groups and those who will be leading the UR trainings in the future.

In Summer 2022, OEWD intends to launch and organize its own Unlearning Racism trainings, building upon the existing curriculum.

In addition to Nia and Jason Seals, co-facilitators will also be supported by members of the BHS Racial Equity Action Council, to whom they will be reporting on a monthly basis. By doing so, a system of accountability and resource sharing will be fostered. OEWD will facilitating this engagement, in addition to conducting ongoing outreach efforts to be sure that staff members use these valuable venues to fosters education, solidarity and ultimately equity at the system and community levels.

BHS' Clinical Graduate Training Program
In fiscal year 2020-21, 18 BSW, MSW, MFT, and psychology graduate students received Multicultural Student Stipend awards. Of those, 6 interns/trainees attended 29 weekly didactic trainings and case conferences. All trainings continued to be held virtually due to COVID-19 throughout FY2020-21.

New interns/trainees onboarding process was streamlined, with five new BHS clinic placements added for next year. Eleven new schools completed Student Agreement Memoranda of Understanding contracts so their students could be placed with our clinics. Also, in FY20-21, the program staff worked with Rick Goscha from the California Institute for Behavioral Health Solutions (CIBHS) to provide training on his Strengths Model - specifically the Strengths Assessment and Strengths-Based Group Supervision model which BHS is using for their monthly Case Conferences (part of the weekly didactic series).

We plan to hire FT Internship Coordinator to expand the current program to include high school and bachelor-level placements to start in the next fiscal year.

Intensive Case Management (ICM) Academy
There is a high level of interest in the ICM Academy and program staff are working to make it more accessible for all FSP and ICM providers to participate. Virtual trainings have helped increase accessibility. Trainings are also recorded and posted online for participants unable to attend the live sessions. Average attendance has been 16-20, which allows for effective attendee engagement, particularly for sensitive subjects, however the attendee numbers have continued to increase.. Most sessions are 1.5-2 hours.

Training session topics include:
- Co-Occurring Disorders: ICM Academy Training Part 1 & 2
- Eligibility
- Trauma-Informed Approaches
- Integrated Care: An Overview of Behavioral Health Services in SFHN Primary Care
- Culturally Responsive Practices: Latin/o/a/e/x
- Residential System of Care
- Coordinated Entry
- Self-Care & Vicarious Trauma

- Recovery Models/Strength-Based Approaches with Rick Goscha and CIBHS
- Interfacing with Psychiatric Emergency Services
- Where the Behavioral Health and Criminal Justice Systems Meet
- Hierarchy of Need
- Conservatorship
- Culturally Responsive Practices: Black & African American
- Culturally Responsive Practices: Asian American & Pacific Islander
- Culturally Responsive Practices: Native & Indigenous American
- Transitions & Placement
- Evidence-Based Practices

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

The UCSF Public Psychiatry Fellowship will continue remote learning per UCSF guidelines. In fiscal year 2020-21, we launched the UCSF Child and Adolescent Psychiatry (CAP) Fast-Track pilot with the first CAP-2 fellow (Dr. Emily Asher) participating in the program.

We also continued the DPH Public Psychiatry Administrative Fellowship, a two-year program with the goal to provide support among emerging public psychiatry leaders in the SFHN-BHS.

The Fellowship celebrates its 10-year anniversary this year.

Staffing changes that occurred in 2020-21:

- Dr. Kyle Jamison (2021 PPF graduate) joined the Fellowship as Assistant Director.
- Dr. Lisa Fortuna (Chief of Psychiatry at ZSFG, and Vice Chair of Psychiatry at UCSF) as Capstone Project Supervisor for CAP-2 fellow.
- Brian Pande stepped down as Education and Training Coordinator after nearly five years in the Fellowship, and a search is underway for his replacement.
- Please note that while MHSA funds support the training of two fellows in the San Francisco Health Network each year, we have expanded the program by three additional Fellows who are supported by other funding mechanisms. In addition to the CAP-2 fellow supported by UnitedHealth Group (CAP-2 fellow), we have two fellows in other counties, one each from TRUST and San Mateo North County Clinic. As such, this program has broad benefits beyond San Francisco County.

In the coming academic year, we will fund two MHSA-funded fellows. Dr. Stacie Collins is a Black child and adolescent psychiatrist working in SFHN-BHS Foster Care Mental Health. Dr. Rita Morales is a bilingual Latina psychiatrist working in both SFHN-BHS Mission Mental Health and Southeast Mission Geriatric Services. As described above, a third CAP-2 Public Psychiatry Fellow is placed at SFHN-BHS Family Mosaic Project. Fellows will complete all program activities, with some “field trips” converted to virtual activities due to COVID-19 restrictions. To supplement the Fellowship’s curriculum, fellows will also attend virtual workshops on Mental Health Advocacy organized by the Steinberg Institute among others and have an experiential exercise in advocacy. To expand the reach of the fellows’ capstone projects, we are emphasizing collaboration with and dissemination to mental health services consumers from each clinical site. Specifically, fellows will identify a consumer partner from their sites’ Community Advisory Board and work with them throughout the year, as well as disseminate their results to a broad group of stakeholders (e.g. consumers, clinic staff, leadership). These projects will be submitted to the annual meeting of the American Psychiatric Association meeting held in New Orleans in the spring of 2022.

Workforce Dev

We received a total of 8 applications for fiscal year 2020-21. We have accepted two fellows and have interviews scheduled with additional potential fellows.

Child and Adolescent Community Psychiatry Treatment Program (CACPTP)
The Psychiatry course took place in June 2021 and the rotation at the Juvenile Justice Center (JJC) is ongoing. Each fellow spends one morning a week for 2 months at the JJC for the Special Programs for Youth. They participate in providing psychiatric care under the supervision of the Medical Director. The program is creating a Community Psychiatry Track, which allows for one fellow to spend two afternoons a week in an SFPDH Clinic during FY 21/22.

In the coming year, the CACPTP program plans for six (6) fellows rotating at clinical sites and one fellow participating in the Public Psychiatry Fellowship, spending two afternoons at one of our sites. The Public Psychiatry Fellow will also be undertaking a quality improvement project.

SFDPH is supporting UCSF in interviewing for one Child and Adolescent Psychiatry Fellow to be in a Public Psychiatry Track. This track is devoted to working in Community Psychiatry Sites with a focus on drawing applicants with an interest in Public Health.

Trauma-Informed System Initiative
The Trauma-Informed System Initiative (TIS) at the San Francisco Department of Public Health (DPH) is an organizational change model centered on workforce development, racial justice and healing. Its aim is to support organizational capacity and workforce skills to recognize and respond to the impact of trauma and its effects on ourselves, our colleagues, and the larger system.

Through TIS, we cultivate healing environments by increasing organizational resilience, improving workforce experience, and ultimately supporting organizations in responding to and reducing the impact of trauma. TIS was established at the San Francisco Department of Public Health in 2012. In the nine years since it began, TIS has trained the entire Department of Public Health workforce, developed an onboarding process that includes our foundational TIS Training, published an article outlining the model and has been spotlighted by SAMHSA as a promising practice. Focused on organizational culture change to increase staff and organizational wellness, TIS has developed and implemented state of the art practices that have been embodied and embedded into the DPH infrastructure. TIS has now been replicated across San Francisco and the United States.

TIS has never been more necessary than during the Covid-19 pandemic, our country's reckoning with racism and increases in hate and violence on communities of color. TIS has approached the work by recognizing that racial justice is at the core of being trauma informed. Since the shelter-in-place orders took effect in March, 2020, TIS staff members have been responding to the dual pandemic of Covid-19 and racial inequities, and most recently helping staff re-enter work, after being deployed for an extended period of time. The impact of this trauma on our workforce has been profound.

In fiscal year 2020-21, program staff expanded our training capacities to include a Train the Trainer of the Search Inside Yourself Leadership Institute (SIYLI), with the aim of certifying 15 staff to teach mindfulness and emotional intelligence based on the latest neuroscience, with an emphasis on wellbeing, leadership, and the on-the-ground challenges of daily work. Most importantly, this work is centered on our deep commitment to contribute to the SFDPH trauma-informed mission of becoming a healing organization.

Online Learning Management System

The Online Management Learning System (also known as the RELIAS online learning platform) is under contract. The BHS Office of Equity and Workforce Development (OEWD) training unit team will begin implementation soon. We will undergo three (3) trainings on RELIAS implementation. Under the current contract we are providing access to approximately 572 BHS civil service employees; however, we plan to increase access to all BHS civil service and contracting employees. Those with access to Relias will be able to access trainings that will provide credits for Continuing Education, provide trainings to support professional development, as well as access to equity trainings. BHS employees are required to complete at least 4 hours/units of equity learning during each fiscal year. The RELIAS online requirement is one tool that will allow them to fulfill those requirements

Public Mental Health Systems Professionals Loan Forgiveness

In partnership with ten Greater Bay Area Counties and the City of Berkeley, we are implementing a Loan Repayment Program for eligible individuals who include public mental health systems' professionals that the local jurisdiction identifies as high priority in the region. This is in effort to address the shortage of mental health practitioners in the public mental health systems and is done through a framework that engages Regional Partnerships and supports individuals through five categories including: Pipeline Development, Loan Repayment Program, Undergraduate College and University Scholarships, Clinical Master and Doctoral Graduate Education Stipends, and Retention Activities.

8. Capital Facilities and Information Technology: CF/TN Funding

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.

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

Capital Facilities	
Renovations	**Services Description**
Recent Renovations (Cap 5. Southeast Health Center and Cap 8. Chinatown/North Beach Exam Room)	The Southeast Health Center is a DPH primary care clinic located at 2401 Keith Street serving San Francisco's historically underserved Bayview-Hunters Point neighborhood. The Southeast Health Center Expansion and Behavioral Health Integration Project was included in the FY16-17 Annual Update and the FY17-20 Integrated Three Year Plan. With the goal of better and more holistically meeting the needs of Bayview-Hunters Point patients and their families, this priority DPH project renovates and expands upon the existing facility, bringing a fuller and more integrated complement of DPH's healthcare resources and programs to one convenient campus.

Information Technology	
Program Name	**Services Description**
Consumer Portal	The Consumer Portal went live in May of 2017 and continues to provide support for consumers who have registered for the portal. In addition to providing first line support for consumers, portal staff work on marketing, hold walk-in hours to help consumers register for the portal and provide portal navigation training. Staff also conduct site visits to assist to encourage MH Clinics to issue registration PINS to consumers. The Consumer Portal project expected outcomes include: ● Increase consumer participation in care ● Help keep consumer information up to date ● Promote continuity of care with other providers

Information Technology	
Program Name	**Services Description**
	• Providing coverage and training support for the Help Desk • Perform outreach efforts to promote the Consumer Portal
Consumer Employment (Vocational IT)	The collaboration between BHS Ambulatory Applications and RAMS has resulted in significant opportunities for consumers to attain gainful employment this past fiscal year. Five IT training program graduates were hired for peer positions within the BHS Ambulatory Applications team. The RAMS i-Ability IT training staff's trainers/supervisors now includes graduates of the training program. Furthermore, two graduates of the Avatar Help Desk were hired for full-time positions with the city. Other graduates attained full-time employment outside of SFDPH this past fiscal year. The Avatar Accounts team is comprised of several consumers in the role of Onboarding/Offboarding the various administrative and clinical staff at the various mental health clinics that utilize Avatar as their Electronic Health Record system. The consumers working on this team will be critical to the transition from Avatar to Epic as the new Electronic Health Record system. Important contributions of these employed consumers include: ○ Processed 828 new Avatar account requests ○ Collaborate with Server and Compliance Departments ○ Monitor and Maintain Avatar access and security
System Enhancements	The System Enhancements project provides vital program planning support for IT system enhancements. Responsibilities include the following: • Ensuring that timelines and benchmarks are met by the entire EHR team • Manage dependencies by helping to ensure that equipment, personnel and other resources are deployed efficiently and according to timeline • Managing EHR-related professional development for all BHS staff in an effective and timely manner to ensure smooth implementation across the Division. • Conduct data analysis related to the projects • Three civil service Business Analyst positions funded by MHRS. These positions are dedicated to supporting the Avatar application and related projects that include the MHSA database. • Preparation for the transition to the Epic system (Electronic Health Record) in 2021.

Moving Forward in Capital Facilities

Future Capital Facilities Plans

Most mental health clinics in San Francisco require some level of capital improvements. The original MHSA Capital Facility Program and Expenditure Plan identified a set of projects specifically to improve four buildings requiring an amount of **$12,830,000** in one-time funding from MHSA. This plan will provide the necessary funding to complete these projects:

- $4M – Southeast Health Center: conversion of an existing building to include a specialty mental health clinic *(Cap 10. Southeast Family Therapy Services)*
- $2M - Hope SF Sunnydale Wellness Center *(Cap 11. Hope SF Sunnydale Wellness Center)*
- $1M 3500 Cesar Chavez - relocation of Southeast Mission Geriatrics from 3905 Mission *(Cap 12. 3500 Cesar Chavez)*
- $5M Chinatown Child Development Center *(Cap 13. Chinatown Child Development)*
- $250,000 TAY Clinic *(Cap 14. TAY Clinic at 755 South Van Ness)*
- $80,000 SE Child Family Therapy Services *(Cap 10. Southeast Family Therapy Services)*
- $500,000 BHS 1380 Howard *(Cap 15. Behavioral Health Services at 1380 Howard)*

The Southeast Health Center

The Southeast Health Center is a DPH primary care clinic located at 2401 Keith Street serving San Francisco's historically underserved Bayview-Hunters Point neighborhood. The Southeast Health Center Expansion and Behavioral Health Integration Project was included in the FY16-17 Annual Update and the FY17-20 Integrated Three Year Plan. With the goal of better and more holistically meeting the needs of Bayview-Hunters Point patients and their families, this priority DPH project renovates and expands upon the existing facility, bringing a fuller and more integrated complement of DPH's healthcare resources and programs to one convenient campus.

Chinatown North Beach Clinic- 729 Filbert Street

The project entails:

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

In fiscal year 2020-21, the Pharmacy remodel at 729 Filbert Street was completed.

Child Crisis and Comprehensive Mobile Crisis – 3801 Third Street -

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

FY 20-21 update – Installed new furniture and fixtures in existing office space and call center.

Future Plans for FY 21-22 and 22-23

MHSA-SF and the DPH Facilities department are discussing future plans of adding telehealth kiosks to Hope SF and remolding some of their clinics with future MHSA funding.

Moving Forward in Information Technology

DCR

In fiscal year 2020-21, MHSA staff maintained, created, supported, and managed all user accounts for PSCs (Partnership Service Coordinators) of various MHSA programs and has managed user groups for FSPs and PCSs withing the DCR (Data Collection and Reporting) system. This includes:

- DCR Account creation/deactivation
- Partner assignments/transfers between PSC's
- DCR support (email & phone)

In addition to managing and maintaining the DCR system, MHSA staff has written multiple reports to assist MHSA leadership, including:

- A new report to determine non-active users
- Populating the data warehouse with exports from DCR regarding:
    - Partnership Assessments
    - Key Event Tracking
    - Quarterly Assessments

Replacement of WebConnect with VDI (Remote Access to Avatar)

Our contract provider agencies, including MHSA agencies that use WebConnect have a long history of the challenges supporting this way of access Avatar from outside the SFDPH network. Most critical is solving the issue of inconsistent connectivity. In collaboration with DPH Security Operations and DPH VDI (Virtual Desktop Interface) Teams, we were able to resolve the challenging support issues and inconsistent connectivity by replacing WebConnect with a VDI solution. An added benefit to our contact provider agencies was that this new solution was compatible with other browsers and agencies could move away from the requirement to use Internet Explorer v11. A lot of planning, testing and develop in tandem with IT Support at the various contract provider agencies. This replacement has project started in 2020 was completed on October 15, 2021

Telehealth expanded

During 2020, the telehealth pilot grew into a much larger implementation to Civil Service clinics due to Covid-19 and the need to perform client services remotely. MHSA staff participated in the planning of this effort. The spreadsheet contains all clinics that received telehealth equipment during the implementation.

MHSA Program Evaluation

The MHSA Evaluation Team includes 4.0 full time equivalent (FTE) epidemiologists in SF BHS Quality Management (QM) team, one of whom leads the group. This fiscal year brought significant staffing challenges to the team. The lead MHSA epidemiologist held a dual role as Interim Director of QM, due to vacancies and other staffing needs within the department. Two additional epidemiologists were hired and onboarded this past fiscal year and are available to focus on MHSA evaluation work.

In the past fiscal year, the MHSA evaluation team led four Impact Meetings to provide general technical assistance, promote community collaboration, and share best practices. Topics for Impact Meetings included mid-year and year-end reporting, developing and utilizing logic models and theories of change for program evaluation, and strategies for data collection and increasing survey response rates.

Members of the evaluation team also meet with each of the Innovations implementing partners quarterly to review evaluation progress, ensure that evaluations incorporate the approved learning objectives, and offer technical assistance to optimize the quality of data collection. To assist with evaluation, the team facilitated a focus group discussion with Wellness in the Streets (WITS) peer counselors to better understand the peer-counselor experience, client engagement strategies, COVID-19 pandemic-related program adaptations and peer wellness and recovery. This discussion helped inform learning objectives, and also allowed us to better understand program successes and challenges, including adaptations to COVID-19. MHSA evaluators also worked with the Peer Transition Team (PTT) at RAMS, Inc. to prepare a presentation to highlight key steps in program development, evaluation and evaluation findings to convey best practices to the wider MHSA community.

Like the evaluation team, MHSA-funded programs are also facing staffing challenges. With assistance from the MHSA Program Director, the evaluation team developed and implemented a survey of Full-Service Partnership (FSP) directors to inquire about their staffing needs, and how staffing shortages may affect care. Findings are included in this Annual Update.

“Looking Ahead for SFDPH MHSA”

Our goal for MHSA is to continue to support the transformation San Francisco’s public mental health system. Along with local funding from San Francisco’s Prop C, Mental Health SF, MHSA will continue to strengthen and expand mental health services.
In the coming year, MHSA will work to implement and enhance the programming described in detail in this report. We will also strive to integrate the valuable feedback received in CPP meetings and other stakeholder engagements. We are committed to weaving this feedback into the core of MHSA programming. Over the next year, we will also focus efforts on a number of key areas. These areas of focus are detailed below:

- **We will place a strong emphasis on program evaluation across the MHSA components.** In the year ahead, we will work to enhance our monitoring and evaluation activities, in order to effectively meet the performance objectives of our MHSA-funded programs. We will continue to gather stakeholder feedback and make improvements to reporting tools that allow programs to submit mid-year and year-end reports that include demographics data, measurable outcomes, client success stories and more.
- **We will continue to implement our new projects/programs.** As stated in this Annual Update, we have several new projects/programs that were approved through our CPP process that we will continue to launch and implement for our community:
    - ICM/FSP to Outpatient Transition Support
    - Wellness in the Streets
    - Technology-Assisted Mental Health Solutions
    - Family Unification and Emotional Resiliency Training (FUERTE)
    - Online Learning Management System
    - New Innovation Project: Culturally Responsive Practices for the Black/African American Communities
- **We will continue to adapt during COVID-19 pandemic.** As stated earlier, SF-MHSA has modified programming to ensure that safety and access to care are top priorities for our San Francisco communities. We will continue to assess these ever-changing needs and we will continue to adapt our programming, as needed, to meet the various and diverse needs of our community members, consumers and stakeholders.
- **We will continue to play a significant role in implementing Mental Health SF.** December 12, 2019, the City and County of San Francisco passed new legislation to establish Mental Health SF, a mental health program designed to provide access to mental health services to all adult residents of San Francisco with mental illness and/or substance use disorders who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. SF-MHSA will continue to play a role with Mental Health SF as our priorities deeply align.
- **We will provide funding to the following initiatives.** These FY22/23 initiatives will enhance MHSA programming and the diverse communities we serve.

Initiatives	FY22-23 Projected Budget	Detail
3% Funding Increase to providers	$750,000	This funding will go to Contracted Service Providers to better serve their communities. This funding can go toward staff pay increases, etc., to

		ensure equity across the staffing structure.
Conversion of Temporary Positions to Permanent	$2,148,500	This funding will go toward the Culturally Congruent and Innovative Practices for Black/African Americans project. This funding will allow the temporary civil service positions to become permanent.
Overdose Prevention/ Harm Reduction Expansion	$2,095,130	This funding will go toward Overdose Prevention/Harm Reduction Expansion.
Hope SF	$480,000	This funding will go to the Hope SF program to enhance programming and improve outcomes.
BHS/MCAH Telehealth for Birthing People	$700,000	This funding will go to the care and system change efforts to improve birth and maternal outcomes for Black/African American pregnant women.
Capital Improvements	$12,830,000	This funding will toward capital improvement projects for the Civil Service Clinics.
Existing Programs	$7,037,332	This funding will go toward enhancing existing MHSA programs.
Prudent Reserve	$5,226,983	This will increase the prudent reserve fund for future years that may have a decrease in State funding, so MHSA programs can maintain operations at normal capacity.
Total	$31,267,945	Total

MHSA Expenditures

Please Note: The MHSA Budget is subject to change based on funding availability.

MHSA Integrated Service Categories

MHSA Integrated Service Categories	Abbreviation	FY 20-21 Expenditure Amount	Percentage
Admin	Admin	2,307,354.46	6%
Evaluation	Evaluation	497,349.84	1%
Housing	H	1,889,250.93	5%
Recovery Oriented Treatment Services	RTS	12,786,627.05	34%
Peer-to-Peer Support Services	P2P	5,787,223.67	16%
Vocational Services	VS	2,908,846.40	8%
Workforce Development and Training	WD	2,081,008.60	6%
Capital Facilities/IT	CF/IT	3,380,046.18	9%
Mental Health Promotion and Early Intervention Services	PEI	5,499,074.14	15%
TOTAL		**37,136,781.27**	**100%**

MHSA FY20/21 Actual Expenditures

SF MHSA Integrated Services Categori	Programs by Funding Component	FY 20-21 Expenditure
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 20-21, 53% was allocated to serve FSP clients	
Admin	CSS Admin	1,850,684.62
Evaluation	CSS Evaluation	467,879.84
H	CSS FSP Permanent Housing (capital units and master lease)	787,706.95
RTS	CSS Full Service Partnership 1. CYF (0-5)	399,991.28
RTS	CSS Full Service Partnership 2. CYF (6-18)	826,587.72
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,237,626.96
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,837,730.35
RTS	CSS Full Service Partnership 5. Older Adults (60+)	803,017.98
RTS	CSS Full Service Partnership 6. AOT	1,203,252.02
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	878,963.56
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	606,066.78
RTS	CSS Other Non-FSP 3. Trauma Recovery	87,457.72
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,466,641.34
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	448,136.54
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,406,380.09
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,775,713.29
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	285,000.00
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	216,154.98
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	600,389.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	322,232.00
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	668,922.79
	SUBTOTAL Community Services and Support (CSS)	**23,176,535.82**

	Workforce, Development Education and Training (WDET) **$2.2M transferred from CSS to fund WDET activities in FY 20-21**	
WD	WDET 1. Training and TA	899,852.54
WD	WDET 2. Career Pathways	689,780.70
WD	WDET 3. Residency and Internships	491,375.36
Admin	WDET Admin	85,349.79
Evaluation	WDET Evaluation	29,470.00
	SUBTOTAL Workforce, Development Education and Training (WDET)	**2,195,828.39**
	Capital Facilities/IT **$5.8M transferred from CSS to fund Capital Facilities/IT activities in FY 20-21**	
CF/IT	Cap 5. Southeast Health Center	3,000,000.00
CF/IT	Cap 8. Chinatown/Northbeach Exam Room	58,656.97
CF/IT	Cap 9. Comprehensive Crisis Services/CTT Team Build Out	39,883.09
CF/IT	IT 1. Consumer Portal	166,473.33
VS	IT 2. Vocational IT	1,133,133.11
CF/IT	IT 3. System Enhancements	115,032.79
Admin	IT Admin	35,760.00
	SUBTOTAL Capital Facilities/IT	**4,548,939.29**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**29,921,303.50**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	167,500.78
PEI	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	986,044.34
PEI	PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,902,606.94
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	682,208.69
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	461,794.41
PEI	PEI 7. CalMHSA Statewide Programs	17,279.90
Admin	PEI Admin	85,349.77
	SUBTOTAL Prevention and Early Intervention (PEI)	**5,302,784.83**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	-
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	-
P2P	INN 18. Intensive Case Management Flow	544,730.40
P2P	INN 20. Technology-assisted Mental Health Solutions	495,849.76
P2P	INN 21. Wellness in the Streets (WITS)	340,263.42
PEI	INN 22. FUERTE	281,639.08
Admin	INN Admin	250,210.28
Evaluation	INN Evaluation	-
	SUBTOTAL Innovation (INN)	**1,912,692.94**
	TOTAL FY 20-21 MHSA Expenditures	**37,136,781.27**

MHSA Expenditures

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. FY 2020/21 Funding							
1. Unspent Funds from Prior Fiscal Years	14,366,714	8,904,464	6,103,670	359,646	2,307,677		32,042,170
2. New FY2020/21 Funding (incl. interest)	44,342,065	11,136,844	2,969,145	2,364	19,527		58,469,945
3. Transfer in FY2020/21	(8,016,889)			2,195,828	5,821,060	-	-
4. Access Local Prudent Reserve in FY2020/21						-	-
5. Available Funding for FY2020/21	50,691,890	20,041,308	9,072,814	2,557,839	8,148,264		90,512,115
B. FY2020/21 MHSA Expenditures	23,176,520	5,302,785	1,912,693	2,195,828	4,548,939		37,136,766
C. Estimated FY2021/22 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	27,515,370	14,738,523	7,160,122	362,011	3,599,325		53,375,350
2. Estimated New FY2021/22 Funding (incl. interest)	46,382,620	11,595,655	3,051,488				61,029,763
3. Transfer in FY2021/22	(8,882,464)			3,112,294	5,770,170	-	-
4. Access Local Prudent Reserve in FY2021/22						-	-
5. Estimated Available Funding for FY2021/22	65,015,526	26,334,178	10,211,610	3,474,305	9,369,495		114,405,113
D. Estimated FY2021/22 Expenditures	28,683,782	8,807,258	4,165,471	3,112,294	1,499,874		46,268,680
E. Estimated FY2022/23 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	36,331,744	17,526,919	6,046,139	362,011	7,869,621		68,136,434
2. Estimated New FY2022/23 Funding (incl. interest)	46,382,620	11,595,655	3,051,488				61,029,763
3. Transfer in FY2022/23	(9,636,210)			3,432,062	6,204,148	-	-
4. Access Local Prudent Reserve in FY2022/23						-	-
5. Estimated Available Funding for FY2022/23	73,078,154	29,122,574	9,097,627	3,794,073	14,073,769		129,166,197
F. Estimated FY2022/23 Expenditures	32,009,078	12,705,676	4,249,910	3,582,062	13,917,833		66,464,559
G. Estimated FY2022/23 Unspent Fund Balance	41,069,076	16,416,899	4,847,716	212,011	155,936		62,701,638

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

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

CSS Estimated Expenditures through FY22/23

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	554,991	399,991	-	-	-	155,000
2. CSS Full Service Partnership 2. CYF (6-18)	835,580	826,588	-	-	-	8,992
3. CSS Full Service Partnership 3. TAY (18-24)	1,524,547	1,237,627	280,982	3,735	2,203	-
4. CSS Full Service Partnership 4. Adults (18-59)	7,918,862	3,837,730	1,091,913	529,264	50	2,459,904
5. CSS Full Service Partnership 5. Older Adults (60+)	1,182,884	803,018	267,619	1,300	-	110,947
6. CSS Full Service Partnership 6. AOT	1,535,735	1,203,252	91,195	94,481	-	146,807
7. CSS FSP Permanent Housing (capital units and master lease)	787,691	787,691	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (5	2,755,073	2,179,575	-	110,936	-	464,563
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,700,121	820,325	-	216,108	-	663,689
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	171,000	171,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Ac	64,846	64,846	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,118,974	878,964	-	-	-	240,010
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,053,039	606,067	145,953	-	-	301,020
3. CSS Other Non-FSP 3. Trauma Recovery	177,047	87,458	62,536	-	-	27,053
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,466,641	1,466,641	-	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,301,980	448,137	-	-	-	853,843
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,755,073	2,179,575	-	110,936	-	464,563
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,077,926	1,002,619	-	264,131	-	811,175
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	114,000	114,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	151,308	151,308	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	240,156	240,156	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	322,232	322,232	-	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	668,923	668,923	-	-	-	-
CSS Administration	1,850,685	1,850,685	-	-	-	-
CSS Evaluation	467,880	467,880	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-				
Total CSS Program Expenditures	33,157,428	23,176,520	1,940,199	1,330,890	2,253	6,707,566
FSP Programs as Percent of Total	55%					

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	571,641	411,991	-	-	-	159,650
2. CSS Full Service Partnership 2. CYF (6-18)	1,056,179	1,044,813	-	-	-	11,366
3. CSS Full Service Partnership 3. TAY (18-24)	1,756,088	1,425,591	323,656	4,302	2,538	-
4. CSS Full Service Partnership 4. Adults (18-59)	11,758,804	5,698,688	1,621,394	785,910	74	3,652,738
5. CSS Full Service Partnership 5. Older Adults (60+)	1,219,464	827,851	275,895	1,340	-	114,378
6. CSS Full Service Partnership 6. AOT	2,310,000	1,809,890	137,173	142,115	-	220,822
7. CSS FSP Permanent Housing (capital units and master lease)	787,691	787,691	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: (50% FSP)	3,589,667	2,839,833	-	144,541	-	605,293
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,075,923	1,001,653	-	263,877	-	810,394
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	193,128	193,128	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive (30% FSP)	64,317	64,317	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,157,224	909,009	-	-	-	248,214
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,084,631	624,249	150,331	-	-	310,051
3. CSS Other Non-FSP 3. Trauma Recovery	182,359	90,081	64,412	-	-	27,865
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,494,165	1,494,165	-	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,614,337	555,649	-	-	-	1,058,688
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,589,667	2,839,833	-	144,541	-	605,293
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,537,240	1,224,242	-	322,516	-	990,481
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	128,752	128,752	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	150,073	150,073	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	240,156	240,156	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	333,565	333,565	-	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,129,155	1,129,155	-	-	-	-
CSS Administration	2,058,895	2,058,895	-	-	-	-
CSS Evaluation	440,279	440,279	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	41,883,631	28,683,782	2,572,861	1,809,143	2,612	8,815,232
FSP Programs as Percent of Total	57%					

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	588,790	424,351	-	-	-	164,440
2. CSS Full Service Partnership 2. CYF (6-18)	1,112,404	1,100,433	-	-	-	11,971
3. CSS Full Service Partnership 3. TAY (18-24)	2,268,177	1,841,305	418,037.22	5,557	3,278	-
4. CSS Full Service Partnership 4. Adults (18-59)	12,858,569	6,231,668	1,773,038	859,414	81	3,994,368
5. CSS Full Service Partnership 5. Older Adults (60+)	1,550,467	1,052,557	350,782	1,704	-	145,424
6. CSS Full Service Partnership 6. AOT	2,389,470	1,872,155	141,892	147,004	-	228,419
7. CSS FSP Permanent Housing (capital units and master lease)	787,691	787,691	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: (50% FSP)	3,940,728	3,117,562	-	158,677	-	664,489
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,271,528	1,096,034	-	288,741	-	886,753
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	193,128	193,128	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive (30% FSP)	64,317	64,317	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,200,411	942,933	-	-	-	257,478
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,117,170	642,976	154,841	-	-	319,352
3. CSS Other Non-FSP 3. Trauma Recovery	187,830	92,784	66,345	-	-	28,701
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,641,438	1,641,438	-	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,662,765	572,318	-	-	-	1,090,447
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,940,728	3,117,562	-	158,677	-	664,489
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,776,311	1,339,597	-	352,905	-	1,083,809
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	128,752	128,752	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	150,073	150,073	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	240,156	240,156	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	356,105	356,105	-	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	874,761	874,761	-	-	-	-
13. CSS Other Non-FSP 14. Overdose Prevention	643,420	643,420	-	-	-	-
CSS Administration	2,667,306	2,667,306	-	-	-	-
CSS Evaluation	457,463	457,463	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	46,430,190	32,009,078	2,904,935	1,972,679	3,359	9,540,139
FSP Programs as Percent of Total	57%					

PEI Estimated Expenditures through FY22/23

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	167,501	167,501	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	515,491	493,022	-	-	-	22,469
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	1,463,203	1,451,303	11,662	-	238	-
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	2,919,622	511,657	-	-	-	2,407,965
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	46,179	46,179	-	-	-	-
7. PEI 7. CalMHSA Statewide Programs	17,280	17,280	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	515,491	493,022	-	-	-	22,469
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	1,463,203	1,451,303	11,662	-	238	-
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	973,207	170,552	-	-	-	802,655
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	415,615	415,615	-	-	-	-
PEI Administration	85,350	85,350	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Expenditures	8,582,141	5,302,785	23,323	-	476	3,255,557

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	180,813	180,813.37	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	544,644	520,905	-	-	-	23,739
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,073,223	3,048,229	24,493	-	500	-
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	2,915,225	510,886	-	-	-	2,404,339
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	70,136	70,136	-	-	-	-
7. PEI 7. CalMHSA Statewide Programs	17,280	17,280	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	544,644	520,905	-	-	-	23,739
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,073,223	3,048,229	24,493	-	500	-
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	971,742	170,295	-	-	-	801,446
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	631,227	631,227	-	-	-	-
PEI Administration	88,351	88,351	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	12,110,509	8,807,258	48,987	-	1,000	3,253,264

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	177,951	177,951	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	583,835	558,388	-	-	-	25,447
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	4,214,848	4,180,570	33,592	-	686	-
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	6,458,364	1,131,813	-	-	-	5,326,552
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	72,867	72,867	-	-	-	-
7. PEI 7. CalMHSA Statewide Programs	17,280	17,280	-	-	-	-
8. PEI 9. Overdose Prevention	702,976	702,976	-	-	-	-
PEI Programs - Early Intervention						
9. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	558,388	558,388	-	-	-	-
11. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	6,492,668	4,180,570	-	-	-	2,312,098
12. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	377,271	377,271	-	-	-	-
13. PEI 6. Comprehensive Crisis Services (10% Prevention)	655,806	655,806	-	-	-	-
PEI Administration	91,796	91,796	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	20,404,050	12,705,676	33,592	-	686	7,664,097

Program Name	Childhood Trauma Prevention and Early Intervention	Early Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	Competent and Linguistically Appropriate Prevention and Early Intervention	Strategies Targeting the Mental Health Needs of Older Adults	Early Identification Programming of Mental Health Symptoms	Fiscal Year 2020/21 MHSA Funds	Fiscal Year 2021/22 Estimated MHSA Funds	Fiscal Year 2022/23 Estimated MHSA Funds
PEI 1. Stigma Reduction	✓	✓	✓	✓	✓	✓	✓	$ 167,501	$ 180,813	$ 177,951
PEI 2. School-Based Mental Health Pomotion	✓	✓	✓	✓			✓	$ 986,044	$ 1,041,810	$ 1,116,776
PEI 4. Pop Focused MH Promotion & Early Interven	✓	✓	✓	✓	✓	✓	✓	$ 2,902,607	$ 6,096,459	$ 8,361,141
PEI 5. MH Consultation and Capacity Building	✓	✓	✓	✓	✓		✓	$ 682,209	$ 681,181	$ 1,509,083
PEI 6. Comprehensive Crisis Services	✓	✓	✓	✓			✓	$ 461,794	$ 701,364	$ 728,673
PEI 7. CalMHSA Statewide Programs	✓	✓	✓	✓	✓	✓	✓	$ 17,280	$ 17,280	$ 702,976

INN Estimated Expenditures through FY22/23

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	544,730	544,730	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	495,850	495,850	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	340,263	340,263	-	-	-	-
4. INN 22. FUERTE	281,639	281,639				
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	-	-				
INN Administration	250,210	250,210	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Expenditures	1,912,693	1,912,693	-	-	-	-

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	720,123	720,123	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	721,750	721,750	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	366,973	366,973	-	-	-	-
4. INN 22. FUERTE	431,640	431,640	-	-	-	-
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,300,165	1,300,165				
INN Administration	624,821	624,821	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	4,165,471	4,165,471	-	-	-	-

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	742,525	742,525	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	423,302	423,302	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	377,982	377,982	-	-	-	-
4. INN 22. FUERTE	444,589	444,589	-	-	-	-
5. INN 23. Culturally Responsive Practices for the Black/African American Communities	1,624,027	1,624,027				
INN Administration	637,487	637,487	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	4,249,910	4,249,910	-	-	-	-

WET Estimated Expenditures through FY22/23

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs						
1. Training and TA	1,474,190	899,853	-	-	-	574,337
2. Career Pathways	689,781	689,781	-	-	-	-
3. Residency and Internships	491,375	491,375	-	-	-	-
WET Administration	85,350	85,350	-	-	-	-
WET Evaluation	29,470	29,470	-	-	-	-
Total WET Program Expenditures	2,770,165	2,195,828	-	-	-	574,337

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	2,561,678	1,563,661	-	-	-	998,017
2. Career Pathways	933,351	933,351	-	-	-	-
3. Residency and Internships	497,461	497,461	-	-	-	-
WET Administration	88,351	88,351	-	-	-	-
WET Evaluation	29,470	29,470	-	-	-	-
Total WET Program Estimated Expenditures	4,110,311	3,112,294	-	-	-	998,017

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	3,335,572	2,036,050	-	-	-	1,299,523
2. Career Pathways	906,287	906,287	-	-	-	-
3. Residency and Internships	518,458	518,458	-	-	-	-
WET Administration	91,797	91,797	-	-	-	-
WET Evaluation	29,470	29,470	-	-	-	-
Total WET Program Estimated Expenditures	4,881,584	3,582,062	-	-	-	1,299,523

CTFN Estimated Expenditures through FY22/23

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CFTN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 5. Southeast Health Center	3,000,000	3,000,000	-	-	-	-
3. Cap 8. Chinatown/Northbeach Exam Room	58,657	58,657	-	-	-	-
4. Cap 9. Comprehensive Crisis Services/CTT Team Build Out	39,883	39,883	-	-	-	-
CFTN Programs - Technological Needs Projects						
1. IT 1. Consumer Portal	166,473	166,473	-	-	-	-
2. IT 2. Vocational IT	1,133,133	1,133,133	-	-	-	-
3. IT 3. System Enhancements	115,033	115,033	-	-	-	-
CFTN Administration	35,760	35,760	-	-	-	-
Total CFTN Program Expenditures	4,548,939	4,548,939	-	-	-	-

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 10. Expansion of Telehealth Kiosks	1	1	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	172,328	172,328	-	-	-	-
9. IT 2. Vocational IT	1,171,449	1,171,449	-	-	-	-
10. IT 3. System Enhancements	119,078	119,078	-	-	-	-
CFTN Administration	37,018	37,018	-	-	-	-
Total CFTN Program Estimated Expenditures	1,499,874	1,499,874	-	-	-	-

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 10. Expansion of Telehealth Kiosks		40,000				
10. Cap 11. Southeast Family Therapy Services	4,080,000	4,080,000	-	-	-	-
11. Cap 12. Hope SF Sunnydale Wellness Center	1,500,000	1,500,000	-	-	-	-
12. Cap 13. 3500 Cesar Chavez	1,000,000	1,000,000	-	-	-	-
13. Cap 14. Chinatown Child Development Center	5,000,000	5,000,000	-	-	-	-
14. Cap 15. TAY Clinic at 755 So Van Ness	250,000	250,000	-	-	-	-
15. Cap 16. Behavioral Health Services at 1380 Howard	500,000	500,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	179,058	179,058	-	-	-	-
9. IT 2. Vocational IT	1,206,592	1,206,592	-	-	-	-
10. IT 3. System Enhancements	123,720	123,720	-	-	-	-
CFTN Administration	38,463	38,463	-	-	-	-
Total CFTN Program Estimated Expenditures	13,877,833	13,917,833	-	-	-	-

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

SEC. 62.

Section 5847 of the Welfare and Institutions Code is amended to read:

5847.

Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the California Mental Health Directors Association and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

San Francisco Department of Public Health
Grant Colfax, MD
Director of Health

City and County of San Francisco
London N. Breed
Mayor

September 6, 2022

Angela Calvillo, Clerk of the Board
Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102

Dear Ms. Calvillo:

Attached please find an original single-sided and two single-sided, black and white copies of the proposed resolution for the Board of Supervisors approval which would adopt the San Francisco Mental Health Services Act (MHSA) FY2022-2023 Annual Update.

The Mental Health Services Act was passed in 2004 through a ballot initiative (Proposition 63) and provided funding to support new and expanded county mental health programs. San Francisco's MHSA FY2022-2023 Annual Update provides FY2020-2021 outcomes and implementation updates for FY2022-2023. This report is an update to the San Francisco Board of Supervisor's approved FY2020-2023 Three Year Program and Expenditure Plan. The MHSA FY2022-2023 Annual Update was developed with community and stakeholder input, posted for 30-day public comment, and heard at a Public Hearing at the San Francisco Behavioral Health Commission, as required by the State to access MHSA funding. State legislation AB-1467 (2011-2012) also requires adoption of the MHSA Annual Update by the County Board of Supervisors prior to submission to the State Mental Health Services and Oversight Accountability Commission.

The following is a list of accompanying documents:

- AB-1467 (2011-2012)
- The San Francisco MHSA FY2022-2023 Annual Update

Should you have any questions, please contact Tracey Helton, Acting Director of Mental Health Services Act. Ms. Helton can be reached at Tracey.Helton@sfdph.org.

Thank you for your time and consideration.

Sincerely,

Grant Colfax, MD
Director of Health

OFFICE OF THE MAYOR
SAN FRANCISCO

LONDON N. BREED
MAYOR

TO: Angela Calvillo, Clerk of the Board of Supervisors
FROM: Tom Paulino
RE: Mental Health Services Act Annual Update - FY2022-2023
DATE: September 12, 2022

Resolution authorizing adoption of the San Francisco Mental Health Services Act Annual Update FY2022-2023.

Should you have any questions, please contact Tom Paulino at 415-554-6153.

1 DR. CARLTON B. GOODLETT PLACE, ROOM 200
SAN FRANCISCO, CALIFORNIA 94102-4681
TELEPHONE: (415) 554-6141

From:	Lindsay, Claire (DPH)
To:	BOS Legislation, (BOS)
Cc:	Helton, Tracey (DPH); Mayer-Twomey, Charles (DPH); Abarquez, Hannah (DPH); Patil, Sneha (DPH); Validzic, Ana (DPH)
Subject:	Legislation Introduction - Department of Public Health - Resolution - MHSA Annual Update FY2022-23
Date:	Monday, September 12, 2022 2:22:45 PM
Attachments:	MHSA FY2022-23 Annual Update_SEND TO BOS.cleaned.pdf Section of AB 1467 (2011-2012).cleaned.pdf BOS Resolution_MHSA FY2022-2023 Annual Update_(09.12.22).docx BOS Cover Letter.pdf

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Hello,

Attached is a proposed resolution authorizing adoption of the San Francisco Mental Health Services Act (MHSA) FY 2022-2023 Annual Update.

The electronic attachments are listed below:

- ***BOS Resolution_MHSA FY2022-2023 Annual Update_(09.12.22)*** (word document version of proposed resolution)
- ***BOS Cover letter*** (cover letter, signed by DPH Director Colfax)
- ***MHSA FY2022-23 Annual Update_SEND TO BOS*** (MHSA FY2022-2023 Annual Update)
- ***Section of AB 1467 (2011-2012)*** (documentation showing requirement of BOS adoption)

For any questions or if you need additional documentation/information please contact Tracey Helton, Acting Director of Mental Health Services Act. Tracey can be reached at Tracey.Helton@sfdph.org.

Thank you for your time,
Claire

Claire Lindsay, MPH
Senior Health Program Planner | Office of Policy and Planning
San Francisco Department of Public Health
claire.lindsay@sfdph.org | desk: 415-554-2667 | mobile: 831-239-1094

From:	Paulino, Tom (MYR)
To:	BOS Legislation, (BOS)
Subject:	RE: Legislation Introduction - Department of Public Health - Resolution - MHSA Annual Update FY2022-23
Date:	Monday, September 12, 2022 4:09:37 PM
Attachments:	Mental Health Services Act Annual Update - FY2022-2023 Cover Letter.doc image001.png

Hi Jocelyn,

Thanks! And yes, that's the correct one. Does the attached suffice as a cover memo?

-Tom

From: BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Sent: Monday, September 12, 2022 3:53 PM
To: Paulino, Tom (MYR) <tom.paulino@sfgov.org>; BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Subject: RE: Legislation Introduction - Department of Public Health - Resolution - MHSA Annual Update FY2022-23

Hi Tom,

Thanks for letting us know. Would it be possible to get a cover memo so that we will be able to add it to the file when we process? And just to confirm it's for the attached?

Best regards,
Jocelyn Wong
San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102
T: 415.554.7702 | F: 415.554.5163
jocelyn.wong@sfgov.org | www.sfbos.org

(VIRTUAL APPOINTMENTS) To schedule a "virtual" meeting with me (on Microsoft Teams), please ask and I can answer your questions in real time.

Due to the current COVID-19 health emergency and the Shelter in Place Order, the Office of the Clerk of the Board is working remotely while providing complete access to the legislative process and our services

Click here to complete a Board of Supervisors Customer Service Satisfaction form

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation, and archived matters since August 1998.

Disclosures: *Personal information that is provided in communications to the Board of Supervisors is subject to disclosure under the California Public Records Act and the San Francisco Sunshine Ordinance. Personal information provided will not be redacted. Members of the public are not required to provide personal identifying information when they communicate with the Board of Supervisors and its committees. All written or oral communications that members of the public submit to the Clerk's Office regarding pending legislation or hearings will be made available to all members of the public for inspection and copying. The Clerk's Office does not redact any information*

from these submissions. This means that personal information—including names, phone numbers, addresses and similar information that a member of the public elects to submit to the Board and its committees—may appear on the Board of Supervisors' website or in other public documents that members of the public may inspect or copy.

From: Paulino, Tom (MYR) <tom.paulino@sfgov.org>
Sent: Monday, September 12, 2022 3:47 PM
To: BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Subject: Legislation Introduction - Department of Public Health - Resolution - MHSA Annual Update FY2022-23

Hi Clerks,

I hope you had a great weekend! Reaching out to follow-up on this item that was introduced by DPH and note that Mayor Breed would like to be listed as the Sponsor.

If there are any other steps that you need us to do, or if this request is sufficient. Many thanks!

Cheers,

Tom Paulino
He/Him
Liaison to the Board of Supervisors
Office of the Mayor
City and County of San Francisco

[Mental Health Services Act Annual Update - FY2022-2023]

Resolution authorizing adoption of the San Francisco Mental Health Services Act Annual Update Fiscal Year (FY) 2022-2023.

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

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

WHEREAS, In order to access MHSA funding from the State, counties are required to 1) develop Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates, in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Behavioral Health Commission; and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for Three-Year Program and Expenditure Plan (Integrated Plan) for FY2020-2023 on file with the Clerk of the Board of Supervisors in File No. 200669; and

WHEREAS, The San Francisco Mental Health Services Act Annual Update FY2022-2023, a copy of which is on file with the Clerk of the Board of Supervisors in File No. _____, which is hereby declared to be a part of this resolution as if set forth fully herein, complies with the MHSA requirements above, and provides an overview of progress implementing the various component plans in San Francisco for FY2020-2021 and identifies new investments planned for FY2022-2023; and

WHEREAS, Recently enacted legislation, California State Assembly Bill No. (AB) 1467, adds the requirement that MHSA Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of Supervisors prior to submission to the State; now, therefore, be it

RESOLVED, That the San Francisco Mental Health Services Act Annual Update FY2022-2023 is adopted by the Board of Supervisors.