File No. 131186 Committee Item No. 2
Board Item No. 6

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Committee **Date** March 5, 2014

Board of Supervisors Meeting **Date** March 11, 2014

Cmte	Board	
☐	☐	Motion
☒	☒	Resolution
☐	☐	Ordinance
☐	☐	Legislative Digest
☐	☐	Budget and Legislative Analyst Report
☐	☐	Youth Commission Report
☐	☐	Introduction Form
☒	☒	Department/Agency Cover Letter and/or Report
☐	☐	MOU
☐	☐	Grant Information Form
☐	☐	Grant Budget
☐	☐	Subcontract Budget
☐	☐	Contract/Agreement
☐	☐	Form 126 – Ethics Commission
☐	☐	Award Letter
☐	☐	Application
☐	☐	Public Correspondence

OTHER **(Use back side if additional space is needed)**

☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Completed by: Linda Wong **Date** February 28, 2014
Completed by: L.W. **Date** March 6, 2014

FILE NO. 131186 RESOLUTION NO.

[Annual Update - Mental Health Services Act Program and Expenditure Plans - FY2013-2014]

Resolution authorizing adoption of the FY2013-2014 Annual Update to Mental Health Services Act Program and Expenditure Plans.

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

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

WHEREAS, In order to access MHSA funding, counties are required to 1) develop Three-Year Program and Expenditure Plans, and Annual Updates, in collaboration with stakeholders; 2) post the plans for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Mental Health Board; and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for three-year program and expenditure plans for each MHSA component; and

WHEREAS, The FY2013-14 MHSA Annual Update provides an overview on progress implementing the various component plans in San Francisco; and

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

WHEREAS, The San Francisco Department of Public Health's Community Behavioral Health Services section has developed an Annual Update in compliance with AB 1467, having worked with stakeholders to develop the plan, posted the plan for public comment, and held a public hearing with the San Francisco Mental Health Board; and

WHEREAS, San Francisco County is projected to receive MHSA revenue of $21,252,784 for FY2013-2014 (Community Services and Support - $16,152,115; Prevention and Early Intervention - $4,038,028; Innovation - $1,062,639); and these projections have been submitted to be included in the FY2013-2014 Annual Appropriations Ordinance; and

WHEREAS, The approval of the Mental Health Services Act Contract No. 07-77338-000 and the designation of the Community Behavioral Health Director as the signatory of this agreement is on file with the Clerk of the Board of Supervisors in File No. 080122, which is hereby declared to be a part of this resolution as if set forth fully herein; now, therefore, be it

RESOLVED, That the FY2013-2014 MHSA Annual Plan Update is adopted by the Board of Supervisors; and, be it

FURTHER RESOLVED, That the Board of Supervisors authorizes the modification of the MHSA Agreement to include the FY2013-2014 Annual Plan Update.

RECOMMENDED:

Barbara A. Garcia, MPA

Director of Health

San Francisco
Mental Health Services Act
2013-2014 Annual Update

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

Table of Contents

Appendix

MHSA COUNTY COMPLIANCE CERTIFICATION

County: San Francisco

Local Mental Health Director	Program Lead
Name: **Jo Robinson, MFT**	Name: **Marlo Simmons**
Telephone Number: **415-255-3440**	Telephone Number: **415-255-3915**
Email: **jo.robinson@sfdph.org**	Email: **marlo.simmons@sfdph.org**
County Mental Health Mailing Address: **1380 Howard Street, Room 210B** **San Francisco, CA 94103**	

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

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

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

All documents in the attached annual update are true and correct.

Jo Robinson, MFT

Local Mental Health Director/Designee (PRINT)

Signature

5-12-13
Date

County: San Francisco

Date: August 2013

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: Jo Robinson	Name: BEN ROSENFIELD
Telephone Number: (415) 255-3440	Telephone Number: (415) 554-7500
E-mail: jorobinson@sfdph.org	E-mail: CONTROLLER@SFGOV.ORG
Local Mental Health Mailing Address: 1380 Howard Street, 5th Floor, San Francisco, CA, 94103	

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

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

Jo Robinson
Local Mental Health Director (PRINT)

Jo Robinson 7-22-13
Signature Date

I hereby certify that for the fiscal year ended June 30, 2012, 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 1/8/2013 for the fiscal year ended June 30, 2012. I further certify that for the fiscal year ended June 30, 2012, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

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

Signature Date 7/24/13

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

Directors' Message

In San Francisco, as in all counties throughout California, the success of the Mental Health Services Act (MHSA) is measured by how effectively it transforms local mental health systems. This Annual Update reflects our commitment to the principles outlined in the MHSA and the progress we are making to actively engage clients, consumers, and families; to promote wellness, recovery, and resilience; and to implement integrated models of care.

In 2011-2012, we continued to make significant strides in meeting the priorities and goals identified in our previous community-wide MHSA planning efforts. The MHSA has enabled us to further build a service approach that is culturally and linguistically responsive to the needs of children, transition age youth, adults, and older adults. Our treatment services are being enhanced through a focus on recovery and a greater recognition of the central role that consumers, clients, and family members play in self-directing care. We strengthened our dedication to prevention and early intervention by promoting resilience, expanding interpersonal connections, and raising individuals' general level of health and well-being before serious mental health issues develop. We continued to learn from innovative strategies that encouraged creativity and aimed to improve outcomes. Moreover, we encouraged entry into and retention in our behavioral health workforce through trainings and professional development opportunities to help us meet the increasing demands on our system.

Our progress is deeply rooted in the valuable contributions of a broad, diverse network of stakeholders that includes consumers, family members, behavioral health service providers, MHSA-funded community contractors, MHSA staff, representatives from other systems of care (e.g., education, human services), and San Francisco MHSA Advisory Committee members. We appreciate and respect the hard work and commitment of our partners to best practices and for their participation at various levels of the MHSA process.

We will continue to reflect on all that we have learned thus far and continue promoting a culture of recovery, resiliency, and wellness. Alongside our community partners and stakeholders, MHSA will continue to play a critical role in strengthening and expanding the public mental health system in San Francisco.

We look forward to the year ahead.

Jo Robinson, MFT

Director, Community Behavioral Health Services

Marlo Simmons, MPH

Director, San Francisco MHSA

1. Introduction

Proposition 63 was approved by California voters in November 2004 to provide funding to create fundamental changes to the access and delivery of mental health services throughout the state. Once enacted into law in January 2005, it became known as the Mental Health Services Act (MHSA). The MHSA called upon local counties to transform their public mental health systems to achieve the goals of raising awareness, promoting the early identification of mental health problems, making access to treatment easier, improving the effectiveness of services, reducing the use of out-of-home and institutional care, and eliminating stigma toward those with severe mental illness or serious emotional disturbance.

WELLNESS · RECOVERY · RESILIENCE

Counties were also required to collaborate with diverse community stakeholders in order to realize the MHSA's vision of recovery and wellness. This vision was based on the belief in the strengths and resiliency of each person with mental illness and has been fundamental to the development of more comprehensive, innovative, culturally responsive services for individuals and families served by local mental health systems.

In addition to required Annual Revenue and Expenditure Reports, MHSA requires that Counties prepare and submit annual updates on MHSA program implementation. This report provides updates on the implementation of previously approved MHSA Program and Expenditure Plans. Organized around an integrated set of Service Categories, we provide general descriptions of services delivered, and highlights of outcomes of services provided in fiscal year 2011-12. We discuss how MHSA resources are being leveraged to develop services rooted in the principles of recovery, resiliency, and wellness. Generally, implementation activities proceeded as described in the individual approved MHSA plans. This report also discusses program changes and identifies new investments planned for fiscal year 2013-14.

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's Integrated MHSA Service Categories

San Francisco's initial MHSA planning and implementation efforts were organized around MHSA funding components (e.g., Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN)). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components.

The MHSA, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, we 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, we simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 1).

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

It is important to note that the majority of our MHSA Service Categories include services funded by INN. INN funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes.

Exhibit 1. SF MHSA Service Categories

SF MHSA Service Category	Description
Recovery-Oriented Treatment Services	▪ Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment) ▪ Uses strengths-based recovery approaches
Mental Health Promotion & Early Intervention (PEI) Services	▪ Aims to reduce risk factors ▪ Promotes a holistic view of wellness ▪ Delivers programs in community settings
Peer-to-Peer Support Services	▪ Offers recovery and other support services that are provided by consumers and family members
Vocational Services	▪ Helps consumers secure employment (e.g., training, job search assistance and retention services)

Exhibit 1. SF MHSA Service Categories (continued)

SF MHSA Service Category	Description
Housing	▪ Helps individuals with serious mental illness who are homeless or at risk of homelessness secure or retain permanent housing ▪ Facilitates access to short-term stabilization housing
Behavioral Health Workforce Development	▪ Recruits members from unrepresented and under-represented communities ▪ Develops skills to work effectively in the mental health field
Capital Facilities/ Information Technology	▪ Improves facilities ▪ Increase client access to personal health information

Stakeholder Process

SF MHSA Annual Update Development and Stakeholder Involvement

In preparing for San Francisco's 2013-14 MHSA Annual Update, MHSA staff and stakeholders compiled and reviewed the list of all previously approved programs and services funded in fiscal year 2011-12, challenges experienced during implementation, and the outcomes that were achieved. Community priorities identified in previous MHSA planning efforts had not yet received funding helped guide the development of priorities for future program development and expansion.

Our stakeholder process involved various opportunities to share input in the development of our current Annual Update and to learn about the progress of our MHSA-funded programs, including:

+ MHSA Advisory Committee

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

- Work collaboratively with CBHS 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

Structure and Membership

- Consists of up to 25 members who are consumers, family members, and providers
- Includes consumers and family members of at least 51% of total membership
- Reflects MHSA priority populations and areas of mental health expertise
- Has no term limits for membership
- Selects two co-chairs who will assist with the facilitation of Advisory Committee meetings
- Convenes an Executive Committee of members who are nominated by the larger group to review membership every year

- Holds meetings every two months
- Encourages community participation at meetings

Composition of 2012 SF MHSA Advisory Committee

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

- Thirteen service providers (59 percent), 12 consumers (55 percent), and 7 family members (32 percent)
- Six service providers worked with PEI-funded programs, four service providers each worked with WET- and CSS-funded programs, and three service providers worked with INN-funded programs
- Whites (37 percent), African Americans/Blacks (17 percent), Native Americans (13 percent), Latinos (13 percent), Asians (13 percent), and Native Hawaiians/Pacific Islanders (7 percent)
- Gay, lesbian, or queer (11 percent), questioning (5 percent), and bisexual (5 percent) individuals
- Twelve females (55 percent), seven males (32 percent), two individuals of another gender (9 percent), and one transgender female (5 percent)
- Members' ages ranged from 30 to 72 and the average age was 43 years old
- Two members (9 percent) speak Spanish and one member (5 percent) speaks Cantonese

+ **Other Meaningful Stakeholder Input.** Providers from MHSA-funded agencies met on a quarterly basis to discuss local MHSA program activities and to provide feedback on the Annual Update. We also solicited feedback from diverse stakeholder groups, including Full Service Partnership workgroups, staff across the CBHS Systems of Care, ad hoc groups (e.g., projects for older adults, 12N Steering Committee), San Francisco Mental Health Board, CBHS Client Council, San Francisco Health Commission, and CBHS Executive Leadership Team.

Deepening Community Engagement

While our funded programs involve collaborations with stakeholders from Law Enforcement and Veterans Services, future goals for our Advisory Committee include recruiting members representing these areas. We will also work to more actively include Transitional Age Youth in our community engagement and planning efforts. In addition, we are improving our website to disseminate information about our MHSA achievements and how to get involved in local MHSA efforts.

Local Review Process

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Annual Update Report is posted on the SF MHSA website at http://www.sfdph.org/dph and http://sfmhsa.org. Our 2013-14 Annual Update was posted for a period of 30 days from June 11, 2013 to July 11, 2013. Members of the public were requested to submit their comments either by email or by regular mail. It was circulated by email to approximately 600 individuals representing community based mental health organizations, substance abuse organizations, housing agencies, prevention agencies, community and primary care clinics, consumer groups, and advocacy groups. In addition, feedback was obtained from the following: Health Commission, Board of Supervisors, MHSA funded agencies, MHSA Advisory Committee, and the Mental Health Board.

Public Hearing

Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board on July 10, 2013.

Comments Received

There were no substantive comments received that required changes to the plan. This plan was then submitted to the Health Commission and Board of Supervisors for their review and adoption. The SF Board of Supervisors resolution adopting this plan is below.

FILE NO. **RESOLUTION NO.**

[Approval of Mental Health Services Act FY2013-2014 Annual Plan Update]

Resolution authorizing adoption of the Fiscal Year 2013-2014 Annual Update to Mental Health Services Act Program and Expenditure Plans.

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

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

WHEREAS, In order to access MHSA funding, counties are required to 1) develop Three-Year Program and Expenditure Plans, and Annual Updates, in collaboration with stakeholders; 2) post the plans for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Mental Health Board; and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for three-year program and expenditure plans for each MHSA component; and

WHEREAS, The Fiscal Year 2013-14 MHSA Annual Update provides an overview on progress implementing the various component plans in San Francisco; and

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

WHEREAS, The San Francisco Department of Public Health's Community Behavioral Health Services section has developed an Annual Update in compliance with AB 1467, having worked with stakeholders to develop the plan, posted the plan for public comment, and held a public hearing with the San Francisco Mental Health Board; and

WHEREAS, San Francisco County is projected to receive MHSA revenue of $21,252,784 for Fiscal Year 2013-2014 (Community Services and Support - $16,152,115; Prevention and Early Intervention - $4,038,028; Innovation - $1,062,639); and these projections have been submitted to be included in the FY 2013-2014 Annual Appropriations Ordinance; and

WHEREAS, The approval of the Mental Health Services Act Contract No. 07-77338-000 and the designation of the Community Behavioral Health Director as the signatory of this agreement is on file with the Clerk of the Board of Supervisors in File No. 080122, which is hereby declared to be a part of this resolution as if set forth fully herein; now, therefore, be it

RESOLVED, That the Fiscal Year 2013-2014 MHSA Annual Plan Update is adopted by the Board of Supervisors; and, be it

FURTHER RESOLVED, That the Board of Supervisors authorizes the modification of the MHSA Agreement to include the FY2013-2014 Annual Plan Update.

RECOMMENDED:

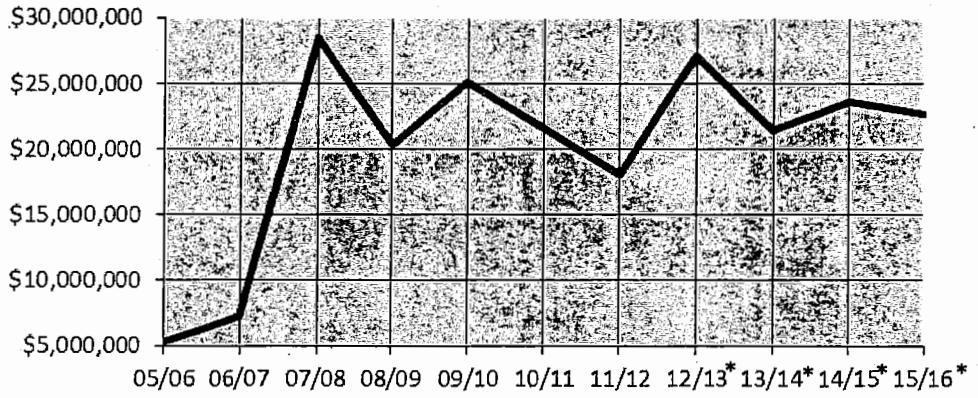
Barbara A. Garcia, MPA

Director of Health

MHSA Budget

Declines in San Francisco's MHSA revenue occurred in fiscal years 2010-11 and 2011-12 due to the budget downturn that affected California. However, projections for fiscal years 2012-13 through 2015-16 suggest that MHSA revenue will experience some growth and then level off (see Exhibit 2 below).

Exhibit 2. San Francisco MHSA Revenue by Fiscal Year

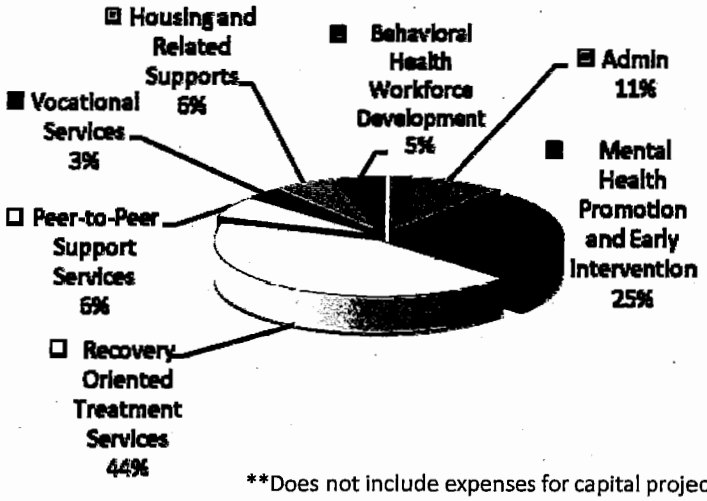


*Estimated revenues

MHSA expenditures for fiscal year 2011-12 were approximately $24.5 million. Expenditures included 92 FTE Personnel (civil service) and 71 contracted programs with 46 organizations.

As shown in Exhibit 3 on the right, the majority of MHSA funds (44%) supported Recovery-Oriented Treatment Services followed by Mental Health Promotion and Early Intervention services (25%). MHSA funding was distributed to other service categories including Housing and Related Supports (8%), Peer-to-Peer Support services (6%), Behavioral Health Workforce Development (5%), and Vocational services (3%). All service categories included funding for INN-related projects.

Exhibit 3. MHSA Expenditures by Service Category (FY 11/12)**



**Does not include expenses for capital projects

General Population Characteristics in San Francisco

San Francisco is a seven by seven square mile, coastal, metropolitan city and county. It is densely populated with culturally diverse neighborhoods where over twelve different languages are spoken. The most recent U.S. Census found that San Francisco has a population of 805,235 people and experienced mild growth since the last census (four percent). Although San Francisco was once considered to have a relatively young population, it has experienced a decrease among children and families with young children; there are more people moving out of San Francisco than moving in. In addition, over the next two decades, it is estimated that 55 percent of the population will be over the age of 45, and the population over age 75 will increase from 7 percent to 11 percent. The projected growth in San Francisco's aging population has implications on the need for more long-term care options moving forward. For additional background information on population demographics, health disparities, and inequalities, see the 2012 Community Health Status Report for the City and County of San Francisco http://www.cdph.ca.gov/data/informatics/Documents/San%20Francisco%20CHSA_10%2016%2012.pdf.

Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date. The following seven sections describe the overarching purpose of each of San Francisco's MHSA Service Categories, the services delivered, the outcomes of services provided, and areas identified for program expansion in future fiscal years. The last section summarizes how MHSA-funded programs are achieving the MHSA guiding principles, the challenges encountered in 2011-12, and recommendations to further strengthen San Francisco's mental health system.

2. Recovery-Oriented Treatment Services

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

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

Full Service Partnership Programs

Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with SMI or SED to lead independent, meaningful, and productive lives. Nine FSP programs served a diverse group of clients in terms of age, race/ethnicity, and stage of recovery (see Exhibit 4). In 2011-12, FSP programs served 914 clients. The majority of clients served were adults (57 percent), followed by children, youth, and families (26 percent), and TAY (9 percent) and older adults (9 percent).

Exhibit 4. Summary of Full Service Partnership Programs

Target Population	Lead Agency	Services
Children & Adolescents	Seneca SF Connections	Offers wraparound services to help children and their families achieve stability and increase access to community resources
	Family Mosaic Project	Provides intensive case management and wraparound services in the Bayview, Mission, and Chinatown neighborhoods
TAY	Family Service Agency	Provides physical health care, mental health treatment, medication management, employment assistance, housing support, and peer support
	Community Behavioral Health Services - TAY	Conducts intensive services (e.g., training on independent living skills, mental health and substance abuse counseling) with youth transitioning out of foster care and the child welfare system
Adults	Family Service Agency	Conducts wellness and creative arts workshops, holds community cultural events, offers support groups, and organizes healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods

Exhibit 4. Summary of Full Service Partnership Programs (continued)

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

Costs per Client

FSP expenditures for fiscal year 2011-12 were an estimated $6.3 million, the majority of which were allocated to services for adults. The expenditures for specific target populations are listed in Exhibit 5.

Exhibit 5. FSP Expenditures (FY 11/12)

Target Population	FSP Expenditure	Cost per Client
Children, Youth, &Families	$ 961,112	$ 4,021
TAY	$ 863,100	$ 10,789
Adults	$ 3, 646,185	$ 6,932
Older Adults	$ 786, 278	$ 9,828

FSP Outcomes

The Data Collection and Reporting (DCR) system tracks outcome indicators for all FSP clients. Outcomes for FSP clients can include time spent in different residential settings and the occurrence of emergency events requiring intervention. Specific outcomes are the number of days clients spent in a residential setting and the rate of emergency events (measured by the number of events per person-year).

In describing outcomes related to residential settings, the following charts compare the total number of days for each setting, for all clients between the baseline year (the 12 months immediately preceding entry into the FSP) and the first year enrolled in the FSP. Clients may have spent days in more than one setting over the course of each year. Included in residential outcomes reporting are all clients who were active for at least one continuous year in the FSP at any time from the inception of the DCR through December 2012.

Each residential setting is then highlighted by the percent change from baseline to the first year in the FSP. In general, the residential settings are displayed from more desirable to less desirable, but this is highly variable by age group as well as for individuals. In other words, while a supervised placement may represent a setback for one client, for another client this may be a sign of progress, depending on the circumstances of their recovery.

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

Outcomes for Emergency Events

Emergency events include Arrests, Mental Health or Psychiatric Emergencies (which includes substance use related events) and Physical Health Emergencies, as well as School Suspensions and Expulsions for young children and TAY, for FSP clients active during FY 2011-12. The rate at which emergency events occur for clients in the baseline (pre-FSP) year is compared to the rate while in the FSP. Unlike the Residential Settings measure, which looks only at the first year in FSP for all clients, the emergency events FSP measure averages the annual event rate over all years in FSP.

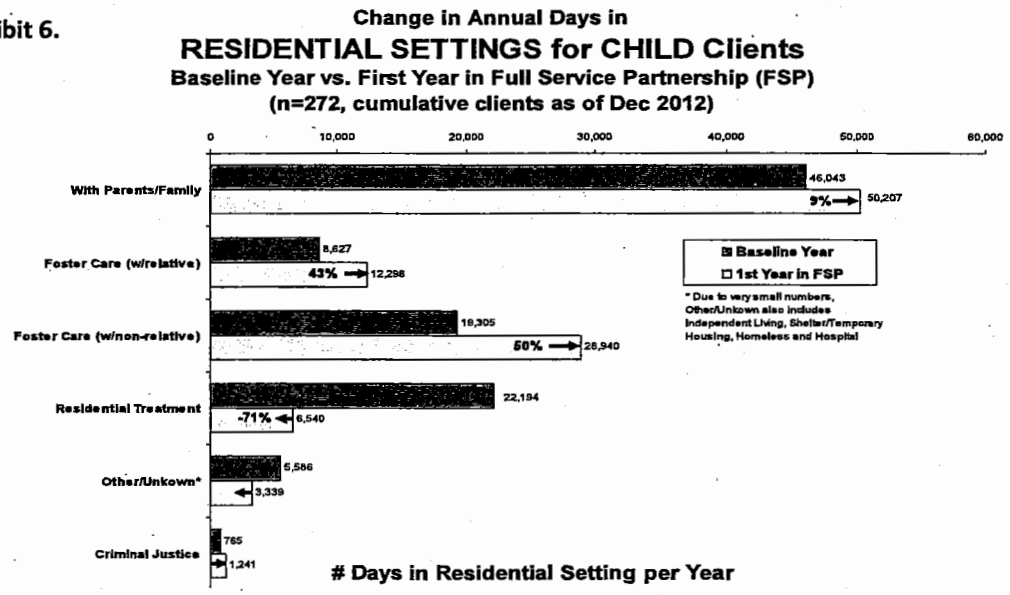
In 2011-12, over all age groups, Arrests dropped 80% from 41 per 100 clients in the baseline year to 8 arrests during FSP years. Mental Health/Substance Use Emergencies, which are concentrated among TAY, also decreased 80% across all age groups from 144 events per 100 clients to 29 emergencies during FSP years. Physical Health Emergency events, most common among Older Adults, registered 72 events per 100 clients at baseline and decreased to 10 events per 100 clients during FSP years, an 86% reduction. For younger children and TAY, School Suspensions were reduced a combined 61% from 76 suspensions per 100 youth at baseline to 30 during FSP years. School Expulsions, which occur much less often (8 expulsions per 100 students at baseline) reduced to zero during FSP years.

In 2011-12, all emergency events showed event rate declines for all event categories, across all age groups

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

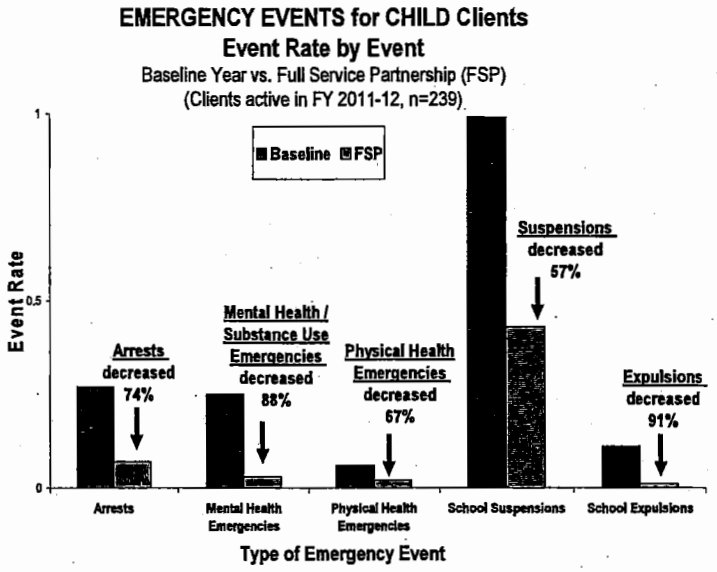
Child, youth, and family clients (i.e., child) data show movement into more family-based settings during FSP treatment from restrictive settings (e.g., residential treatment). Most significantly, days in Residential Treatment dropped 71%, and increases from 9% to 50% appear in settings with parents or in foster care (see Exhibit 6). While days in hospital and homeless settings are overall relatively low, and therefore grouped in the Other/Unknown category, the decline from 275 to 105 days (-62%), and 120 to zero (-100%), respectively, are encouraging outcomes for Child clients. Other /Unknown overall decreased 40%, and Criminal Justice days were increased 62%.

Exhibit 6.



Emergency events occurred less often among child clients. There were marked declines across all types of emergency events experienced by child clients as depicted in Exhibit 7, particularly in the rate of School Expulsions (91% reduction) and Mental Health / Substance Use emergencies (88% reduction).

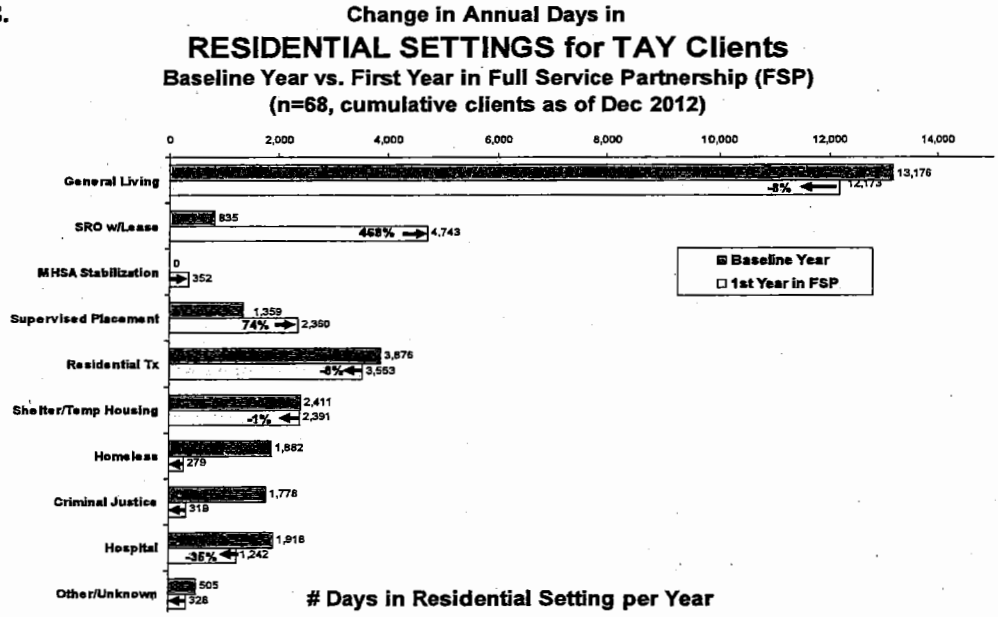
Exhibit 7.



Outcomes for TAY Clients

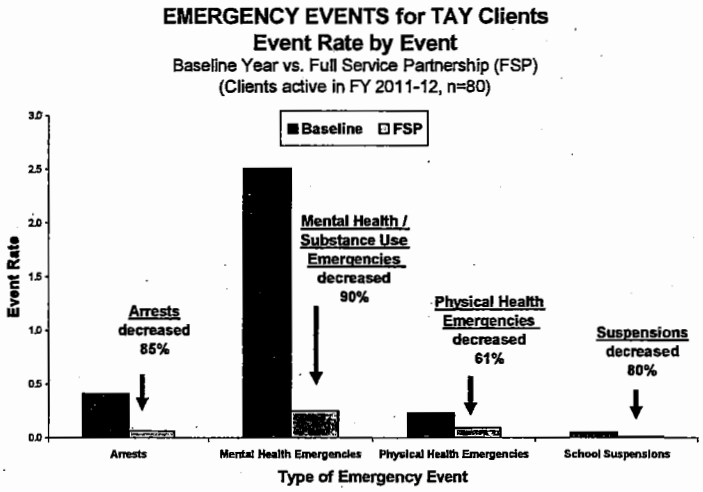
For TAY clients, several settings shift from baseline to FSP treatment. Positive signs are evident in Exhibit 8 from TAY having moved out of homelessness (85% reduction), justice (82% reduction) and hospital settings (35% reduction) and into MHSA Stabilization units for the first time, supervised placement (74% increase), or permanent housing (SRO with Lease, 468% increase).

Exhibit 8.



TAY clients experienced fewer emergency events. As shown in Exhibit 9, there were marked declines across all types of emergency events experienced by TAY clients. Most dramatically, Mental Health Emergencies dropped from more than 2.5 per person in the baseline year, to one out of every four clients (.25) in the FSP years. It is noteworthy that TAY clients are likely to leave the FSP within one year, suggesting that some TAY clients with highest distress are under-represented in the follow-up FSP rate. Arrests (85% reduction) and School Suspensions (80% reduction) also showed significant improvement. No school expulsions were reported in the baseline or FSP years for TAY active in 2011-12.

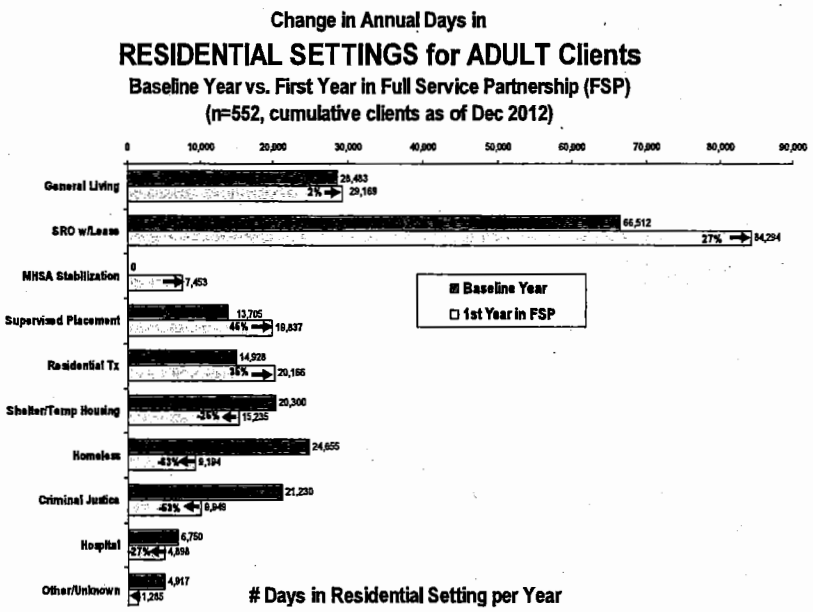
Exhibit 9.



Outcomes for Adult Clients

Among adult clients reported in Exhibit 10, improvements are reflected in the shift in days away from Shelter/Temporary Housing, Homeless, Criminal Justice, and Hospital settings to more stable settings. These stable settings include General Living, SRO with Lease, MHSA stabilization, Supervised Placement, and Residential Treatment. In previous years, General Living has decreased from baseline to FSP, so the uptick shown this year (2%) is a positive result. While Supervised and Residential Placements are relatively restrictive settings, they may represent advancement in recovery for FSP clients who have not previously accessed stabilizing care.

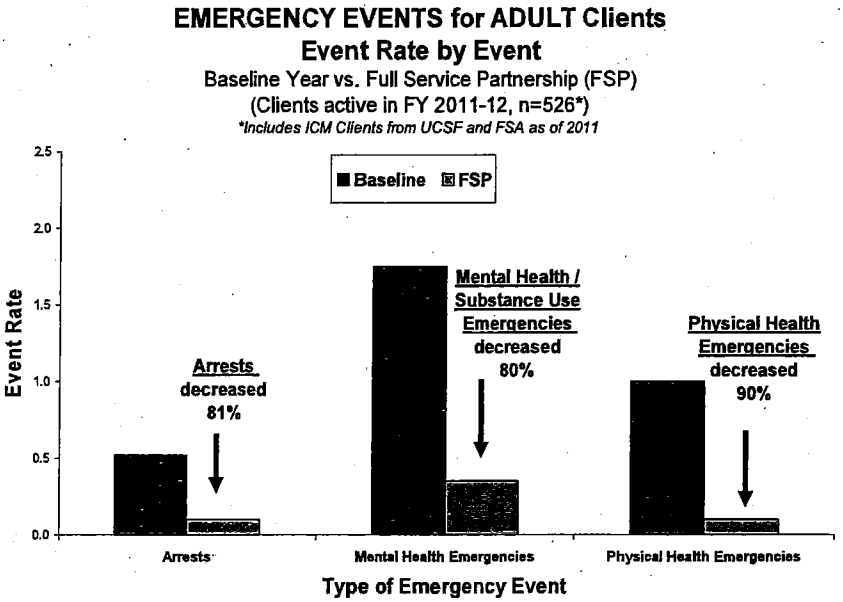
Exhibit 10.



Adult clients show fewer emergency events since enrollment in FSP programs. As depicted in Exhibit 11, there were substantial declines across all types of emergency events, particularly in the rate of

physical health emergencies (90% reduction). Like the TAY group, adults' Mental Health Emergencies dropped from nearly 2 per person in the baseline year, to one out of three (.35) clients in the FSP years. Arrests declined from one for every two clients (.52) in the baseline year to one in 10 (.10) in the FSP years (81% decrease). The subset of adults with arrests in the FSP years averaged nearly two per person.

Exhibit 11.



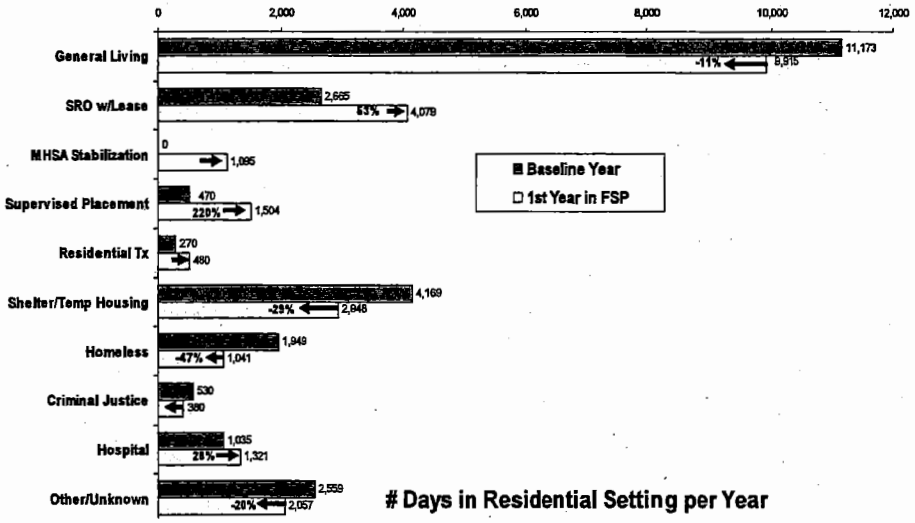
Outcomes for Older Adult Clients

Unlike other age groups, Older Adults experienced a greater decrease in General Living (11% reduction) and an increase in Hospital days (28%). For some older clients, the first year in FSP treatment may include access to long-overdue medical care due to previously untreated conditions, combined with advancing age. Similar to the other age groups, increases appear for SRO with Lease, MHSA Stabilization, Supervised Placement, and Residential Treatment, suggesting positive outcomes, especially as days in shelter/temporary housing, homelessness, and criminal justice (-28%) all decline in FSP treatment. Older adults are often relocating either into special care settings or permanent housing, which reflects improved stability and care for their needs.

Exhibit 12. Change in Annual Days in

RESIDENTIAL SETTINGS for OLDER ADULT Clients

Baseline Year vs. First Year in Full Service Partnership (FSP)
(n=68, cumulative clients as of Dec 2012)

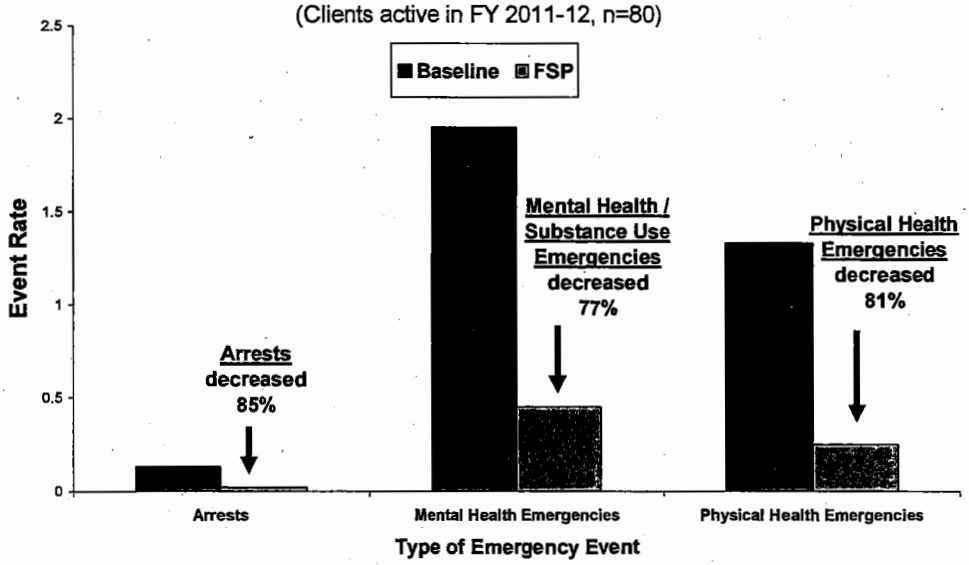


Older adult clients show fewer emergency events since enrollment in FSP programs. Similar to other age groups, older adult clients experienced major decreases across all emergency event types, particularly in the rate of Arrests (85% reduction; see Exhibit 13), although the rates of Mental and Physical Health Emergencies also dropped dramatically. The numbers of events reduced is encouraging, from 156 Mental Health emergencies at baseline to 66 during FSP, and from 106 Physical Health events to 37 in the FSP years.

Exhibit 13. **EMERGENCY EVENTS for OLDER ADULT Clients**

Event Rate by Event

Baseline Year vs. Full Service Partnership (FSP)
(Clients active in FY 2011-12, n=80)



Strengthening Recovery Practices in FSPs

DCR Meetings: These monthly meetings provided an opportunity for FSP program directors and clinical supervisors to share best practices and challenges in data collection and program goals. DCR data quality and outcomes were shared regularly and discussed, generating innovative suggestions on improving client recovery and program performance. Of particular interest in 2011-12 was participation in the development and pilot testing of the Recovery Checklist (see below).

FSP Graduation Efforts: At the start of 2011, a cross-disciplinary team of MHSA administrators, evaluators, peer counselors, and clinical supervisors began to focus on identifying clients nearing readiness for graduation from the FSP programs toward a more independent phase of recovery. Mid-fiscal year, under training from the California Institute for Mental Health (CiMH) as part of the Advancing Recovery Practices (ARP) Learning Collaborative, the team carried out a series of small tests of change, known as Plan-Do-Study-Act (PDSA) efforts, to refine a Recovery Checklist and incorporate other recovery-oriented tools. Several efforts were initiated and tested at the pilot site (Citywide Forensics FSP):

Creation of a Recovery Committee, featuring "Recovery Moments" or stories of success

Use of the U-Kansas Strengths Assessment and Strengths-base Group Supervision

Process for identifying clients ready to graduate (i.e., Recovery Checklist and clinical review)

Peer-led meetings to share hope and personal experiences in recovery and facilitate connections to natural supports in the community

The DCR meetings allowed sharing of progress in ARP with all other FSP programs, and many of them tested the Recovery Checklist and provided input to the graduation process. Future plans include testing the Recovery Checklist more widely and initiating tests of the Linkage Process. In addition, with support of CBHS Leadership, efforts will be made to spread selected ARP practices to the FSPs as well as to other intensive case management (ICM) programs.

FSP Focus Groups: In an effort to better understand existing strengths and challenges in the process to transition clients from FSPs to outpatient care, several focus groups were conducted with FSP staff. The resulting report highlighted the need for better communication between staff at different programs on behalf of, and including the client, and a clearly articulated process for transferring clients from the FSPs to less intensive services.

Recovery Knowledge Inventory (RKI) surveys: In May 2011, evaluators surveyed nearly 1,000 CBHS staff and contractors to assess self-report on several recovery measures. Recovery oriented trainings were put in place and a follow-up survey is planned.

Prevention and Recovery in Early Psychosis (PREP)

PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with co-workers, peers, and family members. PREP is a partnership involving five agencies. The lead agency is Family Service Agency, UCSF and the Mental Health Association of San Francisco are primary partners, and Larkin Street Youth Services and the Sojourner Truth Foster Care Agency work with special populations of at-risk youth (i.e., foster care and homeless youth). PREP treatment services include the following: algorithm-based medication management, cognitive rehabilitation, cognitive behavioral therapy for early psychosis, multi-family groups (MFG), strengths-based care management, and neuropsychiatric and other advanced diagnostic services.

Highlights

PREP delivered 1,787 hours of direct treatment services and helped raise community awareness about the importance of early intervention and early psychosis. PREP conducted 60 community presentations (e.g., at mental health clinics, nonprofit organizations, shelters, school wellness centers) and completed a public campaign using the PREP website, social media, and traditional media outlets.

After enrollment in PREP, consumers showed reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services from baseline to 12 months, as measured from consumer and clinician perspectives. Based on findings from the Patient Health Questionnaire Depression Scale (PHQ9), for example, consumers reported change consistent with a move from the moderate to mild range of depression. Another notable finding is that the total number of hospitalizations among consumers decreased from 17 hospitalizations during the year prior to admission to seven during the course of PREP enrollment.

Providers reported improvements in consumers' performance in school, work, and domestic responsibilities as well as enhanced peer relationships and greater involvement with families. Participation in MFG contributed to improvements in family members' knowledge about schizophrenia, consumers' and family members' use of positive problem solving approaches, and family relationships.

Trauma Recovery

Trauma Recovery programs address the need for community-based, client-driven therapeutic interventions for individuals, families and communities who are impacted by violence. MHSA-funded lead agencies partner with community response networks and frontline violence response programs (see Exhibit 14).

Exhibit 14. Summary of Trauma Recovery Programs

Lead Agency	Program	Services
Instituto Familiar de la Raza (IFR)	La Cultura Cura – Trauma Recovery and Healing Services	Provides trauma recovery and healing services (e.g., assessment, grief counseling, crisis response, collateral intervention) to youth between ages 14 to 25 and their families, particularly to residents in the Mission District and Latinos citywide
Urban Services YMCA	Trauma and Recovery Services	Offers comprehensive mental health, clinical case management, and outreach services to youth, families, and communities affected by violent events

Highlights

Clients reported baseline levels of satisfaction with their health care coverage and stable living situations after being discharged from the *Trauma and Recovery Services* program. After participating in the *La Cultura Cura* program, 60 percent of youth reported fewer trauma-related emotional and psychological symptoms (e.g., irritability, feelings of hopelessness, avoidant behaviors) and physical symptoms (e.g., hyperarousal). In response to a lack of capacity to serve monolingual Spanish speaking youth, MHSA provided funds for IFR to hire an additional bilingual therapist.

Behavioral Health and Juvenile Justice Integration Programs

Since 2010-11, all youth detained for more than 72 hours at San Francisco's Juvenile Justice Center are assessed for behavioral health needs (see Exhibit 15). Any identified needs are presented to the Juvenile Probation Department to be addressed in case planning with local courts. MHSA funds additional psychiatric services in the Youth Guidance Center Clinic – a clinic providing free primary health care, case management and psycho-social services to incarcerated youth ages 8-18. Youth exiting the Juvenile Justice Center may be referred to MHSA funded case-management and mentoring.

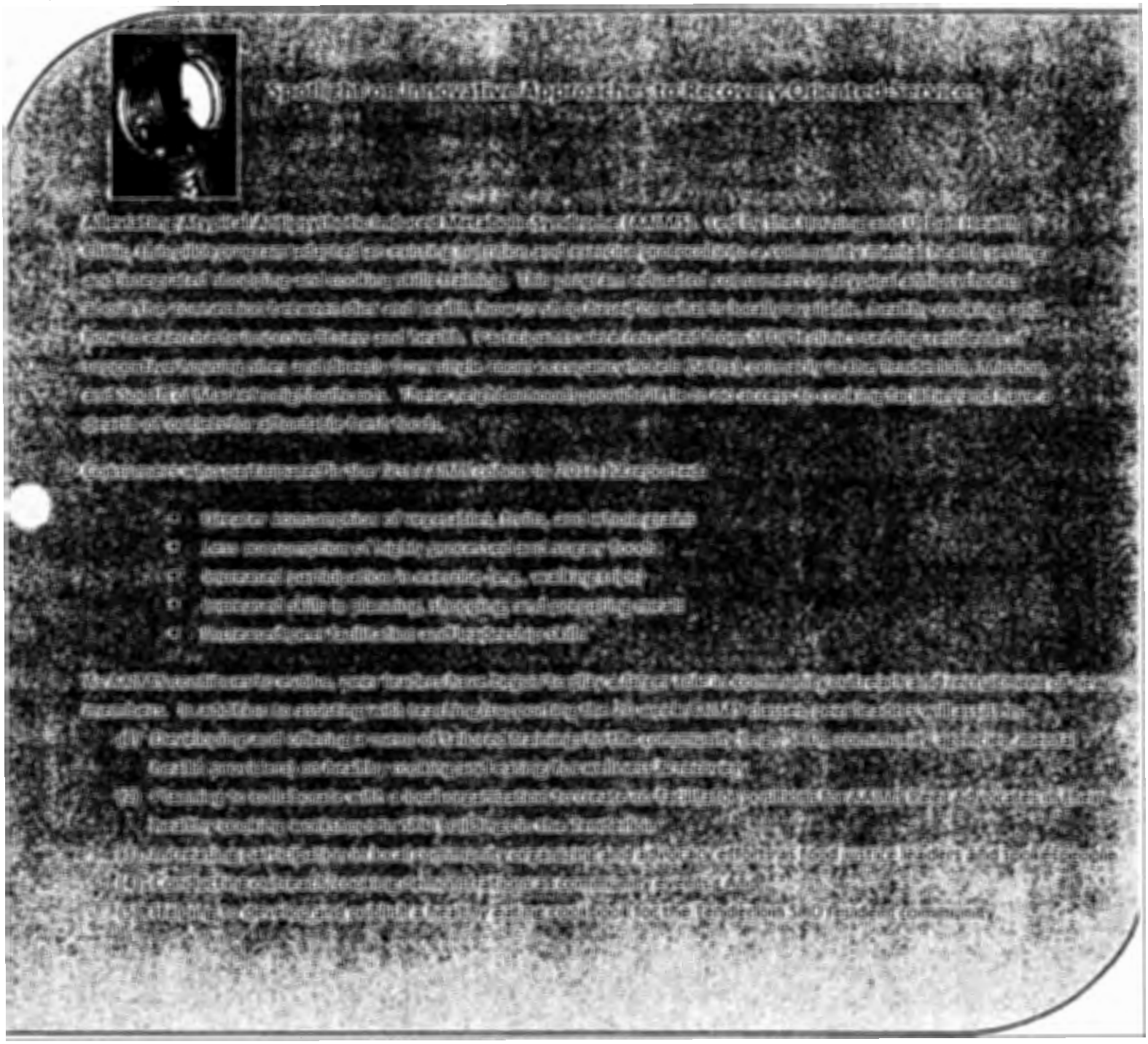
Exhibit 15. Summary of Behavioral Health and Juvenile Justice Integration Programs

Lead Agency	Program	Services
Seneca Center	AIIM (Assess, Identify Needs, Integrate Information, & Match Services) Higher	Provides data-driven assessment, planning, and linkage services to connect probation-involved youth with mental health needs to community-based services
Youth Justice Institute	Mentoring & Mental Health for Youth	Provides comprehensive mental health, mentoring, and after care services for youth involved in the juvenile justice system
San Francisco Department of Public Health	Youth Guidance Center Clinic	Conducts assessments and provides medication management for youth involved in the juvenile justice system

Highlights

AIIM Higher clinicians provided face-to-face assessment and brief early intervention services for 103 youth (and their families) with moderate to severe mental health needs. Eighty-six youth who returned

to the community were successfully linked to behavioral health services. Participants of the *Mentoring and Mental Health for Youth* program for at least a year were often those who had not transitioned out of custody. However, no youth re-offended by the end of 2011-12 fiscal year.



Spotlight on Innovative Approaches to Recovery Oriented-Services (continued)

Digital Storytelling (DST) for Adults: DST is an innovative, promising behavioral health practice that weaves images, music, narrative and voice together in helping consumers and their families heal from trauma they have experienced in their lives. DST promotes hope, recovery and wellness by helping youth and caregivers share and tell their stories in a safe, consumer-friendly behavioral health/clinical setting. Through the DST process, this two-year pilot project aims to help consumers and family members heal from their individual trauma and link them to behavioral health services to help reduce the impact of behavioral health challenges, such as Post Traumatic Stress Disorder.

Participants for 2011-12 DST workshops were recruited from various behavioral health care and social service agencies (e.g., Support for Families of Children with Special Needs, Human Services Agency). Recruitment encouraged agency collaboration with CBHS and educated staff about the use of DST as a therapeutic intervention. All participants reported that there was therapeutic value in the process of creating their digital stories. For example, participants reflected on the process of accepting their experiences of trauma and self-discovery.

Consumers produced three digital stories: (1) Voices from Behavioral Health, Family-Driven Care, (2) Partnering with families who are survivors of violence and trauma, and (3) Youth Violence Prevention Curriculum. MHSA funding for this project was not extended beyond fiscal year 2011-12 due to the high costs of producing DST videos. However, the three digital stories that were created continue to be used as a learning tool to raise awareness about mental health and societal issues in different venues (e.g., Oakes Day Treatment School, community partner meetings with CBHS).

Dual Diagnosis Residential Treatment

Dual diagnosis residential treatment and support is provided by two social service nonprofit organizations, Haight Ashbury Free Clinics and Walden House. Services are provided to individuals who do not have Medi-Cal coverage and who would otherwise not be eligible for services. Haight Ashbury Free Clinics and Walden House merged in 2011 and created a seamless, integrated model of care that allows clients to receive the full spectrum of services, including: substance abuse treatment, mental health services, primary medical care, case management, parolee services, workforce development, and gender-specific residential treatment homes for adults with co-occurring disorders. In 2012, to mark the one year anniversary of the merger, Haight Ashbury Free Clinics – Walden House adopted a new name, HealthRIGHT 360.

Highlights

An expanded team of MHSA-funded staff provided support for HealthRIGHT 360's Walden Recovery and Psychiatric Stabilization program (WRAPS), which served 24 clients in 2011-12. The total length of residential care among these clients was 673 days and the average stay was 29 days.

Behavioral Health Access Center

The Behavioral Health Access Center (BHAC) is a portal of entry into San Francisco's overall system of care. BHAC co-locates the following five behavioral health programs: 1) Mental Health Access for authorizations into the Private Provider Network, 2) the Treatment Access Program for assessment and placement into addiction and dual diagnosis treatment, 3) the Offender Treatment Program (formerly SACPA Prop 36) to place mandated clients into addiction and dual diagnosis treatment, 4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy, and 5) the CBHS Pharmacy. 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.

Highlights

BHAC has relied on MHSA resources to increase the depth of clinical care and other services. Through the provision of additional staff, clients receive a higher quality of care and are linked to services within a meaningful period of time. This helps increase positive client outcomes and improves access to care. BHAC programs were supported by an expanded team of MHSA-funded staff in 2011-12, including:

- A Psychiatric Nurse Practitioner who provided expertise in treatment planning, identification of primary care concerns, and stabilization of behavioral health issues
- Two Eligibility Workers who helped increase client access to entitlements (e.g., Medi-Cal, Healthy SF, and SFPATH) and to care through linkages with the Private Provider Network

- Full-time and part-time clinical pharmacists who provided expertise in client medication management services (e.g., drug specific monitoring) and led client medication groups
- A full-time pharmacy technician who assisted the CBHS Pharmacy in its efforts to provide e-prescribing registration, training, and support to over 100 CBHS prescribers

Behavioral Health and Primary Care Integration

Too many people go without their mental health needs being adequately identified and addressed. Of equal concern is the substantial physical suffering and premature death for individuals with serious mental illness. To address these concerns, the Department of Public Health has been making great strides to integrate physical and behavioral healthcare. In 2009, after an extensive community planning process, DPH decided to implement the Primary Care Behavioral Health Model in DPH primary care clinics. In this model, behavioral health clinicians work as a member of a primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based and practical interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management services (e.g., class and group medical visits). MHSA has provided resources to support this initiative.

Highlights

Through the DPH behaviorist initiative, which is partially funded through MHSA, supports behavioral health staff stationed at the following Primary Care Clinics:

- Third Street Youth Center and Clinic
- Larkin Street Youth Clinic
- Cole Street Clinic
- Balboa High School Health Center
- Hawkins Clinic
- Primary Care Clinic at Curry Senior Center
- Tom Waddell Health Center
- Southeast Health Center
- Potrero Health Center
- Chinatown Child Development Center

The DPH Behaviorist Initiative served an average of 643 clients per month. Referrals from primary care providers address mental health issues such as depression (reported by 25% of clients), anxiety (reported by 11% of clients), and stress (reported by 7% of clients) as well as substance abuse issues related to tobacco use (reported by 7% of clients) and alcohol dependence (reported by 5% of clients).

MHSA also supports additional staff such as nurses at South of Market Mental Health, Behavioral Health Access Center and the Chinatown Child Development Center and a peer staff member for Chinatown Mental Health Clinic's pilot smoking cessation program.

Balboa Teen Health Center (BTHC). The addition of an MHSA-funded position enabled BTHC to increase individual behavioral health services from 2,280 to 2,605 individual encounters, and overall groups by approximately 10%. Moreover, as this position was filled by a Cantonese-speaking therapist, service utilization by this population of youth, many of whom tend to present with anxiety and depressive disorders, increased by 17%. Key to this work has been the deeper connection between the classroom and the school-based clinic, including classroom presentations to support the de-stigmatizing of utilization of mental health services by youth from cultures that may not support mental health services. This was best accomplished by going into English Language Learner (ELL) classrooms on multiple occasions to build trust with both the therapist and school-based clinic. Adding to the anti-stigma work in the classroom was significant classroom information and education by a group of highly trained youth on stipends (several of whom are Chinese and Latino) to talk about their own use of clinic services, particularly behavioral health. As a positive side effect to this work, it appears that there was also an increase in accessing physical health services.

3rd Street Youth Center and Clinic. MHSA funds have allowed us to build significant school-linked services in the southeast sector of the city and attempting to better address the significant overall health needs of the youth in this community. The MHSA-funded psychologist has allowed us to connect with many more youth, build rapport and eventually support stronger connections to other services that are clinic-based in their home community. The psychologist was also able to implement an internship program with the Wright Institute in which two PsyD students are placed in high schools where Bayview youth are likely to attend. As with the Balboa program, this project is also attempting to provide significant outreach and education to youth who may be in need of our services. This has included participation in Spring Health Fairs at Thurgood Marshall and Burton High Schools. These events are also staffed by well-trained youth who are part of 3rd Street's Youth Outreach Squad or Youth Advisory Board. The psychologist has also been instrumental in working with other local agencies (e.g., Bayview YMCA, BMagic) to further support this work.

Hawkins Clinic. The MHSA-funded position of the social worker has created major inroads in working more effectively with youth, particularly males, from the Visitacion Valley neighborhood. These youth are highly likely to have experienced significant trauma in their lives which affects both their positive development and attachment to school. At school, the social worker has been able to build rapport with many youth and carries a caseload of more than 20 youth at any given time. This has been best accomplished by seeing youth individually several times a week, often for brief check-ins, and bringing youth together in support groups to build on positive peer relationships, address some of the causes of trauma in their lives, and offer positive afterschool alternatives. Some of these youth are then also engaged in the community through sports and other positive recreational events where the social worker collaborates with other neighborhood agencies.

While we have attempted to move to a brief intervention model in behavioral health services generally, this project offers strong evidence that effectively dealing with the level of trauma in these youths' lives means a long term commitment, building strong positive relationships, and building bridges between school, neighborhood agencies and the youth and their families.

Celebrating Successes in Recovery and Wellness

- **MHSA Awards Ceremony:** The second annual awards ceremony that took place on October 19, 2012 publicly recognized 120 individuals and teams for their personal achievements in wellness and recovery. This event was a collaborative effort between consumers, MHSA staff, and the Mental Health Association of San Francisco who were involved in selecting award criteria, coordinating logistics, and presenting awards.

- **Wellness and Recovery Program at Sunset Mental Health:** Planning efforts continued in 2011-12. This program aims to leverage client strengths to help them achieve their personal goals for wellness, recovery, and independence. Two Peer Counselors were hired and trained to co-facilitate stress management groups and to implement Wellness and Recovery Action Plans (WRAP) with clients.

Moving Forward with Recovery-Oriented Treatment Services

The activities outlined below describe ways that we will continue to enhance MHSA-funded programs in this service category in fiscal year 2013-14.

+ Conduct Plan Do Study Act (PDSAs) to attempt small tests of change towards improving outcomes for clients of Full Service Partnership (FSP) programs. Assessments will involve local stakeholders and results will inform funding priorities to further improve FSP programs.

+ Focus on improving transitions from the Children's System of Care to the Adult System of Care

+ Improve outcomes for TAY

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

Background

Mental Health Promotion and Early Intervention (PEI) Services are expected to include meaningful involvement and engagement of diverse communities, individual participants, their families, and community partners. Programs are developed to build capacity for providing mental health prevention and intervention services at sites where people would not normally go for mental health services (e.g., community-based organizations, schools, ethnic specific cultural centers, health providers).

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

Populations Served

PEI Services served a total of 56,876 individuals. As seen in Exhibit 16 on the right, the majority of program participants were males (62%), adults (48%), and African Americans/Blacks (34%). Eighteen percent (18%) of clients spoke Cantonese and 10 percent spoke Spanish.

Exhibit 16. Populations Served by PEI Services, 2011-12[a]

Gender	n = 39,534
Male	24,490 (62%)
Female	14,307 (36%)
Transgender	392 (1%)
Other gender	345 (1%)
Age	**n = 46,789**
Adults	22,676 (48%)
Children, Youth, & Families	10,206 (22%)
TAY	7,890 (17%)
Older Adults	6,017 (13%)
Race/Ethnicity	**n = 41,887**
African American/Black	14,109 (34%)
Asian	9,878 (24%)
White	8,127 (19%)
Latino/a	5,631 (13%)
Other race/ethnicity	2,013 (5%)
Native Hawaiian/Pacific Islander	887 (2%)
Native American	843 (2%)
Multi-Ethnic	399 (1%)
Primary Language	**n = 41,645**
English	26,875 (65%)
Cantonese	7,585 (18%)
Spanish	4,246 (10%)
Other language	2,076 (5%)
Tagalog	643 (2%)
Russian	220 (1%)

[a] Total served does not match totals listed for each demographic category because of unreported data

School-Based Mental Health Promotion

School-Based Mental Health Promotion – a collaboration of community-based organizations and San Francisco K-12 campuses – applies school-based best practices that address non-academic barriers to learning. With public schools serving as hubs, this initiative offers a range of supports and opportunities to children, youth, and their families. Moreover, these services are provided during and after the school day to accommodate working

families' schedules. The precision of this coordinated approach is designed to support student success by combining the full spectrum of prevention, early intervention, and linkages to behavioral health services with existing supports already housed in school settings. The gamut of available services described in Exhibit 17 reflects the breadth of expertise that each initiative partner brings (e.g., philosophies rooted in a prevention and resiliency, youth development approaches, peer education paradigm, cultural or ritual-based healing, family support). Of note, the San Francisco State University's Student Success Program was originally included in San Francisco's WDET plan, but was moved to this section because its goals align with those of school-based PEI programs.

Exhibit 17. Summary of School-Based Mental Health Promotion

Lead Agency	Program	Services
YMCA Bayview	Burton High School Prevention & Early Intervention Program	Supports student success by combining the full spectrum of prevention, early intervention, and linkages to behavioral health services (e.g., wellness promotion workshops, family engagement and support, career planning, mentoring, crisis intervention, case management) with existing resources already housed in school settings.
Bayview Hunter's Point Foundation	Balboa Teen Health Center Behavioral Health Services	
Edgewood Center for Children and Families	Charles Drew College Preparatory School & Edgewood Partnership	
Instituto Familiar de la Raza	School-Based Early Intervention Program at James Lick Middle School & Hillcrest Elementary School	
Richmond Area Multi-Services, Inc. (RAMS)	Wellness Centers Program	
San Francisco State University	Student Success Program (SSP)	
Instituto Familiar de la Raza	**Mindfulness Training Intervention for Youth and Providers	Conducts a 10-week, group-based mindfulness intervention for chronically stressed and disadvantaged youth to help them deal with and manage stress effectively

**INN-Funded Program

Populations Served

School-Based Health Promotion programs served a total of 9,212 participants (see Exhibit 18). The majority of participants were females (55%), children, youth, and families (59%), and Asians (37%). Sixteen percent of participants spoke Spanish and 13 percent spoke Cantonese.

Exhibit 18. Populations Served by School-Based Health Promotion Programs, 2011-12[a]

Gender	n = 2,994
Female	1,652 (55%)
Male	1,339 (45%)
Transgender	3 (<1%)
Age	**n = 2,981**
Children, Youth, & Families	1,744 (59%)
TAY	796 (27%)
Adults	423 (14%)
Older Adults	18 (1%)
Race/Ethnicity	**n = 2,731**
Asian	1,018 (37%)
Latino/a	753 (28%)
African American/Black	501 (18%)
Multi-ethnic	154 (6%)
Other race/ethnicity	110 (4%)
Native Hawaiian/Pacific Islander	104 (4%)
White	87 (3%)
Native American	4 (<1%)
Primary Language	**n = 2,731**
English	1,792 (66%)
Spanish	442 (16%)
Cantonese	358 (13%)
Tagalog	69 (3%)
Other language	68 (2%)
Russian	2 (<1%)

[a] Total served by does not match totals listed for each demographic category because of unreported data

Highlights

School-Based Mental Health Promotion programs achieved outcomes focused primarily on raising awareness about mental health and local resources and increasing access to behavioral health and early intervention services. Notable accomplishments during 2011-12 include:

Outreach & Engagement

- SSP increased client participation in and utilization of drop-in services, social events and activities, and peer mentorship by 23 percent.
- Sixty-one (61) percent of 9th graders at Balboa High School reported that they were moderately comfortable in accessing services at the Balboa Teen Health Center.

Referrals

- Forty-seven (47) percent of students receiving services through SSP received one or more referrals to resources on- and off-campus (e.g., San Francisco State University psychiatrist, Counseling and Psychological Services, Student Health Services).

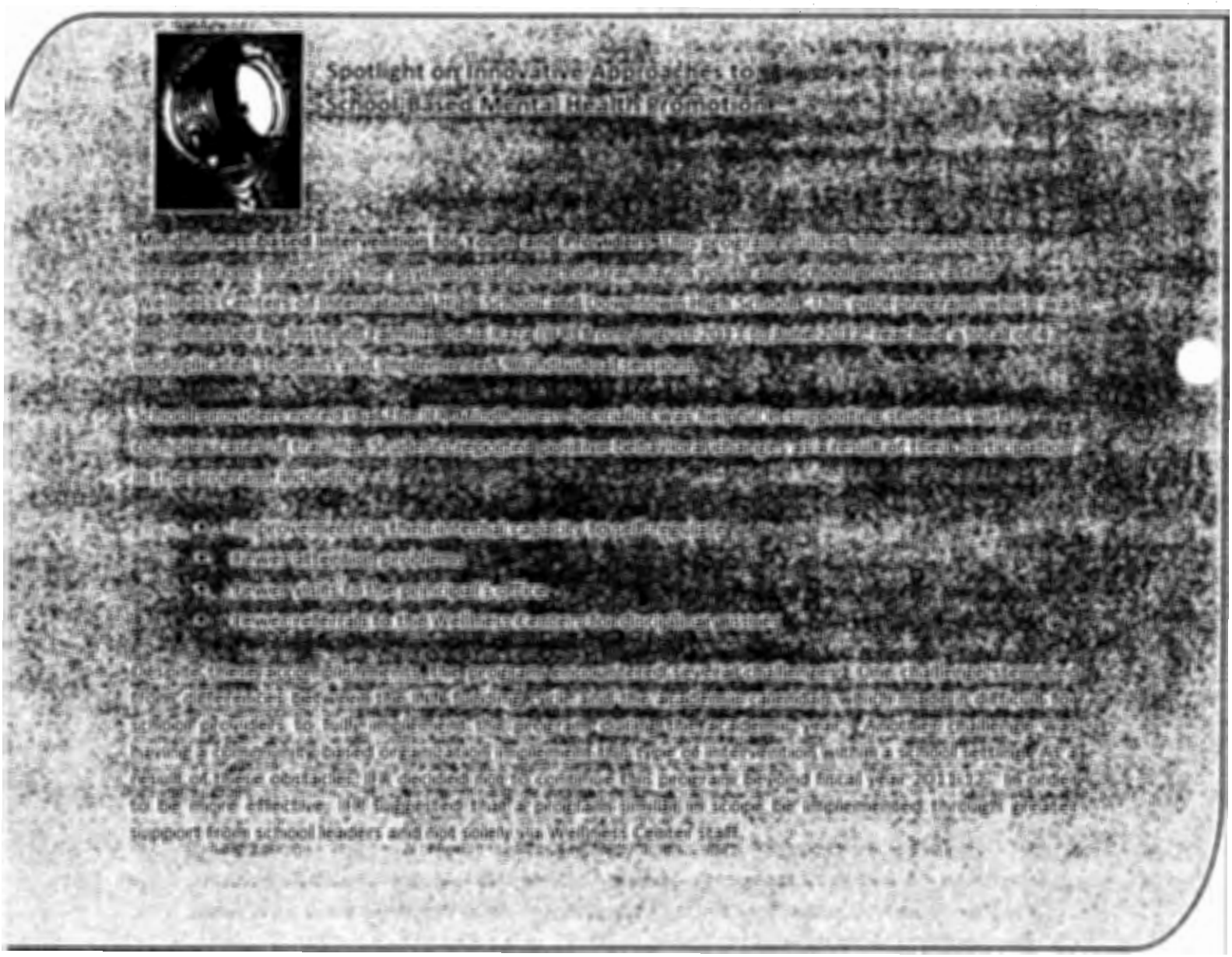
Consultations

- Sixty-five (65) percent of staff at James Lick Middle School met at least once with a consultant through the IFR CARE early intervention program. Sixty-eight (68) percent of staff who received consultation services reported "agreed" or "strongly agreed" that the consultant improved their knowledge about students' emotional needs.

- At Hillcrest Elementary School, 100 percent of staff reported that consultation services increased their knowledge about students' emotional needs.

Individual/Group Therapy

- Seventy-four (74) percent of students receiving counseling or participating in groups through SSP reported measurable progress towards their individual educational and wellness goals.
- Ninety-one (91) percent of youth who participated in the Wellness Center Program reported improvements in their ability to cope with stress.



Population-Focused Mental Health Promotion

Population-focused mental health promotion services are typically delivered in community-based settings. This service category generally includes outreach and engagement, mental health promotion activities and psycho-social education, behavioral health screening and assessment, referrals and linkage, and short-term therapeutic services.

Services originated from a Holistic Wellness Initiative focused on increasing: 1) participants' problem-solving capacity and accountability for personal wellness; 2) knowledge about the early symptoms of potentially severe and disabling mental illness; 3) inter-dependence and social connections within families and communities; and 4) satisfaction with program activities and/or services. This initiative stemmed from our PEI plan and used a model of best practices that was developed for San Francisco's Native American population (i.e., the Holistic System of Care for Native Americans in an Urban Environment). This model was later adapted to meet the cultural and linguistic needs of other underserved populations. San Francisco's holistic wellness work has not only been influential in reaching underserved communities, but has also helped reduce barriers to access.

Our community planning efforts have also prompted us to utilize available MHSA resources more effectively to further reduce disparities to service access. By broadening the Holistic Wellness Initiative to the Population-Focused Mental Health Promotion service category, we are more intentional about San Francisco's focus on underserved and priority populations, including: 1) racial/ethnic populations; 2) gay, lesbian, transgender and questioning individuals; 3) socially isolated older adults; and 4) homeless individuals. This service category has allowed us to assess MHSA services more comprehensively, avoid duplication, and promote cultural competence.

Exhibit 19. Summary of Population-Focused Mental Health Promotion Programs

Target Population	Lead Agency	Program	Services
Older Adults	Institute on Aging	Older Adult Behavioral Health Screening and Response Project	Originally designed to provide evidence-based behavioral health screening and treatment in primary care medical settings. Due to system-wide implementation of behavioral health and primary care integration, this program was redesigned in FY 11/12 to focus on home-based behavioral health screening.
	Family Service Agency	Curry Drop-in Center	Offers health care, wellness, and housing support services to older adults in the Tenderloin neighborhood
	Central City Hospitality House	Older Adult Prevention & Early Intervention	Engages participants who access drop-in services, conducts outreach to local senior programs and hotels, completes mental health screenings, and provides case management

Exhibit 19. Summary of Population-Focused Mental Health Promotion Programs (continued)

Target Population	Lead Agency	Program	Services
Asian & Pacific Islander	Community Youth Center of San Francisco	Asian & Pacific Islander Youth & Family Community Support Services	Uses a Multi-Systemic Therapy approach to address mental health stigma, improve access to linguistically and culturally appropriate services, and target co-factors (e.g., violence, HIV/AIDS, substance use)
	Richmond Area Multi-Services, Inc. (RAMS)	Asian & Pacific Islander Anti-Stigma Campaign (Planning Pilot)	Convened the Asian Pacific Islander Health Parity Coalition steering committee and general members to develop strategies that would lead to the de-stigmatization of mental illness and help-seeking behavior
African American	Bayview Hunter's Point YMCA	*African American Holistic Wellness Program	Conducts wellness and creative arts workshops, holds community cultural events, offers support groups, and organizes healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods
	Westside Ajani	African American Outreach and Engagement	Offers individual, family, and group therapy to African American families who live in low-income communities, are affected by mental illness, and/or are impacted by racism
	SF-Live District 10 (D10)	Wellness Collaborative	Implements mental health promotion efforts to residents in San Francisco's Southeast sector
Mayan/Indigenous Latino	Instituto Familiar de la Raza	*Indigena Health & Wellness Collaborative	Conducts workshops that focus on different health topics and cultural activities, community forums on trauma and spiritual and cultural Mayan/Indigenous ceremonies, self-risk and needs assessments, individual therapeutic services, training, and outreach.
Native American	Horizons Unlimited of San Francisco	Emic Behavioral Health Services	Focused on planning for this pilot program that includes a treatment model that will combine culturally informed, evidence-based substance abuse and mental health practices.
	Native American Health Center	*Native Wellness Center: Living in Balance	Provides outreach and engagement, wellness promotion, individual and group therapeutic services, pro-social community building events, direct services, and service linkage.
Homeless Adults	Central City Hospitality House	*Holistic Violence Prevention & Wellness Promotion Project	Conducts prevention activities that address safety in the community through the Healing, Organizing, & Leadership Development Program, completes mental health screenings, and holds community violence prevention events
	Central City Hospitality House	Tenderloin Self-Help Center	Offers low-threshold services for those who do not otherwise utilize traditional service delivery models (e.g., peer counseling, case management, peer-led support groups, employment resource center). This includes the integration of various services funded through General Systems Development.

Exhibit 19. Summary of Population-Focused Mental Health Promotion Programs (continued)

Target Population	Lead Agency	Program	Services
Homeless Adults	Central City Hospitality House	Sixth Street Self-Help Center	Provides counseling and case management support, holistic behavioral health services and primary care triage, support groups, and socialization activities for residents of the Sixth Street/South of Market neighborhood
	Project Homeless Connect	**Seeding Resilience Project	Trains homeless, formerly homeless, and individuals with severe mental health issues on how to utilize community gardens and urban farm spaces
Homeless or Disconnected TAY	Larkin Street Youth Services	ROUTZ TAY Wellness Services	Conducts drop-in programming (e.g., group and individual counseling, psychiatric consultation, medication management, crisis planning, and psychoeducation)
	Huckleberry Youth Programs	TAY Multi-Service Center	Provides community outreach and education, delivers coordinated clinical case management services, and screens TAY for development leadership services
	Children's System of Care	**Adapt the WRAP	Trains groups of TAY between the ages of 18 to 22 to develop a Wellness Recovery Action Plan (WRAP)
LGBTQ	Steering Committee includes SF Youth Commission, SF Human Rights Commission, SF MHSA, SF Community Programs for Youth	**12N	Develops a youth-inspired training video on LGBTQ sensitivity issues and evaluates the training. All City and County employees who provide training services to youth or who work affects youth will be required to participate in this training on an annual basis.
Arab	Arab Cultural and Community Center	Iraqi Refugees Support Group (Planning Pilot)	Focused on planning that will provide culturally responsive mental health support.

* Holistic Wellness Program; **INN-Funded Program

Populations Served

Population-Focused Mental Health Programs served a total of 35,792 clients (see Exhibit 20). The majority of clients were males (67%), adults (69%), and African Americans/Blacks (40%). Thirteen percent of clients spoke Cantonese and 10 percent spoke Spanish.

Highlights

Population-Focused Mental Health Program objectives were focused around outreach and engagement, mental health promotion activities and psychosocial education, behavioral health screening and assessment, referrals and linkage, and short-term therapeutic services. Notable achievements in 2011-12 are listed below.

- Forty older adults developed harm reduction plans during their involvement in the Older Adult Prevention and Early Intervention program. Forty-five older adults received mental health screenings.
- Treatment goals were reached by all participants who received case management services in the Asian and Pacific Islander Youth and Family Community Support Services program.
- The Tenderloin Self-Help Center engaged 19,521 participants through its drop-in services. A total of 147 participants increased their knowledge about community resources as indicated by engagement in case management services.

Exhibit 20. Populations Served by Population-Focused Mental Health Programs, 2011-12[a]

Gender	n = 30,626
Male	20,450 (67%)
Female	9,585 (31%)
Other gender	345 (1%)
Transgender	246 (1%)
Age	**n = 31,958**
Adults	22,043 (69%)
Older Adults	5,989 (19%)
TAY	2,649 (8%)
Children, Youth, & Families	1,277 (4%)
Race/Ethnicity	**n = 30,506**
African American/Black	12,327 (40%)
White	6,964 (23%)
Asian	4,457 (15%)
Latino/a	3,425 (11%)
Other race/ethnicity	1,738 (6%)
Native American	762 (2%)
Native Hawaiian/Pacific Islander	700 (2%)
Multi-Ethnic	133 (<1%)
Primary Language	**n = 30,097**
English	20,966 (70%)
Cantonese	3,875 (13%)
Spanish	3,105 (10%)
Other language	1,494 (5%)
Tagalog	486 (2%)
Russian	171 (1%)

[a] Total served does not match totals listed for each demographic category because of unreported data

- Sixth Street Self-Help Center engaged a total of 73 participants in case management services and helped them developed harm reduction plans that resulted in decreased substance abuse and other harmful behaviors.

- The Holistic Violence and Wellness Promotion Project provided mental health screenings for 119 participants. One hundred participants (84 percent) returned to Central City Hospitality House for therapy or medical services. Four community violence prevention events were also held with 256 community members in attendance.

- Ninety-eight (98) percent of youth housed at Larkin Street Youth Center's Routz housing program engaged in individual or group mental services.

- Eighty-four (84) percent of TAY enrolled in Larkin Street Youth Center's Peer-Based Services for TAY programs engaged in educational and/or employment and prevocational services.

- One hundred (100) percent of African American Holistic Wellness Program participants who completed an exit survey reported increased knowledge about positive ways to deal with their challenges and enhanced their problem-solving skills to Sixty-four (64) percent of participants in the African American Holistic Wellness Program reported that they felt they got along better with others since completing the program. One participant shared, "now I can think more logically and less emotionally. Before I was like hey, you got a problem with me? Do you want to see me outside? Now, you know, I have to think about things. I have to think about my son. It is just not a game anymore.

- Mayan/Indigenous individuals receiving individual/family therapeutic services through the Indigena Health and Wellness Collaborative were successfully linked to health, mental health, and social service agencies.

- A total of 115 individuals attended a Gathering of Native Americans' Water Walk event that focused on interconnectedness and personal responsibility for wellness and living in balance. Among participants who completed a Community Needs and Interest survey and PEI Large Event Questionnaire, 92 percent reported an increased awareness about the services offered by the Native American Health Center. Participants also mentioned that this event was "a way of healing as a community" and helpful in "solidifying the Native American community."

Spotlight on Innovative Approaches to Population-Focused Mental Health Promotion

Seeding Resilience Project (SRP). SRP was managed by Project Homeless Connect (PHC) and funded by the Mental Health Services Act in collaboration with the San Francisco Department of Public Health (SFDPH). PHC is a national best practice that provides a single location where nonprofit, medical and social service providers collaborate to serve the homeless of San Francisco with free, comprehensive, holistic services. This INN-funded project was funded between May 2010 to July 2012. During that time, SRP hosted six citywide events at eight community garden/farm sites that provided free whole body care to 2,612 individuals. SRP also provided 631 skill shares to 197 individuals at the Growing Home Community Garden (GHCG). SRP provided valuable insights on how to effectively utilize garden spaces to promote mental health care through the use of: 1) skill shares, 2) employment training, and 3) citywide events that provide free whole body care. Elements of the SRP model are currently being replicated at various civil service mental health clinics.

Adapt the WRAP (ATW). Between June 2011 and May 2012, the San Francisco Children's System of Care (CSOC) implemented this project. WRAP is an evidence-based system developed by the Copeland Center for Wellness and Recovery. WRAP teaches individuals with mental health challenges to identify early warning signs of stress, develop action plans to address crises, and conduct post-crisis planning. The ATW project tailored the WRAP to meet the cultural and developmental needs of TAY.

At the end of fiscal year 2011-12, 42 TAY [illegible] completed the ATW training and reported improvements in their interpersonal relationships and increased skills in coping with stress (e.g., identifying personal triggers to stress). As a result of these achievements, MHSA has continued to fund this project. CSOC currently conducts ATW trainings at San Francisco's Juvenile Justice Center with incarcerated youth and at various local middle and high schools.

12N. Chapter 12N of the San Francisco Administrative Code requires all City departments to provide LGBTQ sensitivity and anti-stigma training to all staff who have direct contact with youth, or whose work directly affects youth. Agencies who receive $50,000 from the city must also comply with this ordinance. The 12N Steering Committee includes members from the SF Youth Commission, SF Human Rights Commission, SF MHSA, and SF Community Programs for Youth.

As INN's first Community Grants pilot project, 12N developed a youth-inspired training video on LGBTQ sensitivity issues, supporting documents, and pre/post evaluation. The Bayview Hunters Point Center for Arts and Technology (BAYCAT) developed the video with LGBTQ youth. To date, the 12N training video and pre/post-tests have been posted online. Staff at seven agencies have completed the 12N training to date and trainings will take place in the coming months with seven other agencies. To address providers' requests for additional agency-wide trainings, SF MHSA will partner with LGBTQ-identified youth to help facilitate and conduct 12N discussions with providers.

Lessons Learned from Holistic Wellness Programs

One component of the evaluation of San Francisco's PEI efforts focused on the impact of Holistic Wellness programs. Consumers were asked to share their thoughts and experiences about their involvement in Holistic Wellness programs in focus groups and written surveys. Evaluation results were shared with San Francisco's MHSA Advisory Committee in November 2012 and included the following:

- As a result of their participation in a Holistic Wellness program, consumers reported improvements in their physical, mental, and emotional health; social connectedness, community building, and coping skills
- Peer leaders gained leadership, mentorship, employment development, and community building skills
- Program staff were responsive to community needs and helped create safe spaces for participants
- Consumers' suggestions related to program improvement included making the activities more fun, improving outreach to isolated members (e.g., young men, homeless, older adults) providing child care, and expanding program hours.

These results also generated ideas to enhance collaboration between the MHSA-funded agencies, including cosponsoring events, sharing information about successful strategies to reach diverse ethnic populations, and describing innovative approaches to meet specific cultural and linguistic needs. A separate report provides in-depth data from these focus groups, but the following quotes capture the essence of the benefits of participation in holistic wellness programs:

"I stopped coming [to this center] because I was able to get a job. This is only because the program has helped me overcome my personal and family crises."

"We feel a community responsibility for one another. We are sincerely concerned about each other's well-being."

"[This program] allows us to keep the focus away from depression, allows us to learn to move along to bring spirit to a positive level."

"I have gone back to school at San Francisco State to get a peer mental health certificate...I am so happy. None of this would have happened if it wasn't for this program."

Mental Health Consultation & Capacity Building

The Mental Health Consultation and Capacity Building PEI subcategory is comprised of the following two programs: (1) Early Childhood Mental Health Consultation Initiative (ECMHCI) and (2) Youth Agency Mental Health Consultation (YAMHC). The ECMHCI is grounded in the work of mental health professionals who provide support to children, parents, and caregivers of San Francisco's youngest residents between the ages of 0-5. ECMHCI services are delivered in a variety of settings, including center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers and substance abuse treatment centers. YAMHC provides consultation services to agencies who serve youth who are involved in the juvenile justice system or at-risk of being involved in the juvenile justice system. See Exhibit 21 for a summary of services.

Exhibit 21. Summary of Mental Health Consultation & Capacity Building

Lead Agency	Program	Services
Infant Parent Program/Day Care Consultants, Children's Council, Edgewood Center for Children & Families, Family Service Agency, RAMS/Fu You Project, Hamilton Family Center, Homeless Children's Network, Instituto Familiar de la Raza, Jewish Family & Children's Services	Early Childhood Mental Health Consultation Initiative	Provides case consultation, program consultation, staff and parent trainings, referrals, therapeutic play groups, direct psychotherapeutic interventions, crisis intervention, parent education and support groups, and advocacy for families
Edgewood Center for Children & Families	Youth Agency Mental Health Consultation	Provides program consultation, staff trainings and coaching, organization development, and individual therapeutic services (e.g., assessments, crisis intervention, short-term therapy)

Populations Served

Mental Health Consultation and Capacity Building Services served a total of 11,872 clients (see Exhibit 22). The majority of clients were females (52%), children, youth, and families (48%), and Asian (51%). Thirty-eight percent of clients spoke Cantonese and eight percent spoke Spanish.

Exhibit 22. Populations Served by Mental Health Consultation & Capacity Building Services, 2011-12[a]

Gender	**n = 5,914**
Female	3,070 (52%)
Male	2,701 (46%)
Transgender	143 (2%)
Age	**n = 11,850**
Children, Youth, & Families	7,185 (61%)
TAY	4,445 (38%)
Adults	210 (2%)
Older Adults	10 (<1%)
Race/Ethnicity	**n = 8,650**
Asian	4,403 (51%)
Latino/a	1,453 (17%)
African American/Black	1,281 (15%)
White	1,059 (12%)
Other race/ethnicity	165 (2%)
Multi-Ethnic	112 (1%)
Native Hawaiian/Pacific Islander	100 (1%)
Native American	77 (1%)
Primary Language	**n = 8,817**
English	4,117 (47%)
Cantonese	3,352 (38%)
Spanish	699 (8%)
Other language	513 (6%)
Tagalog	89 (1%)
Russian	47 (1%)

[a] Total served does not match totals listed for each demographic category because of unreported data

Highlights

Mental Health Consultation and Capacity Building program objectives were related to training and coaching, outreach, and treatment. Program objectives aimed to: 1) improve capacity among parents and caregivers to provide appropriate responses to children's behavior; 2) increase access to and utilization of behavioral services; and 3) increase ability to manage symptoms and/or achieve desired quality-of-life goals. Notable achievements in 2011-12 are listed below.

- A mental health consultant provided individual therapeutic counseling for 50 youth and 35 youth participated in at least three sessions. Twenty-four (69 percent) of youth who attended at least three sessions showed improved functioning as measured by a mini-mental health status and Global Assessment of Functioning assessments. Nineteen youth (79 percent) reported improvements in their health after their participation in these sessions.
- Among agency staff who received mid-level consultation from YAMHC, 78 percent reported satisfaction with the consultation services they received.
- Among agency staff who received mental health consultation from ECMHCI, 91 percent reported satisfaction with the consultation services they received. Ninety-one (91) percent of staff also reported increased knowledge of children's needs and development as a result of the consultation.

Eighty-eight (88) percent of staff reported improved communication skills with parents of children who have challenging behaviors as a result of the consultation services they received.

Comprehensive Crisis Services

Comprehensive Crisis Services (CCS) is a multidisciplinary, multi-linguistic agency that provides acute mental health and crisis response services. CCS is comprised of five different teams (see Exhibit 23).

Exhibit 23. Summary of SF Comprehensive Crisis Services

Team	Services
Mobile Crisis Treatment	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older.
Child Crisis	Offers 5150 assessments & crisis intervention for suicidal, homicidal, gravely disabled and out of control children and adolescents regardless of health insurance status. Clients with publically funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response	Provides mobile response to homicides, critical shootings, stabbings, and suicides; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.
Crisis Wrap	Delivers up to 18-month intensive mental health wraparound services including education support, respite, mentoring, placement stabilization, and family support to youth who are under the age of 18 and are either wards of the court through the Department of Human Services or Juvenile Justice System.
Multi-Systemic Therapy	Delivers an intensive family-based treatment that focuses on multiple systems (home, school, community, peers) that affect juvenile offenders between the ages of 12 and 17.5. Provides parents/caregivers with the skills and resources to address chronic, violent, or delinquent behaviors and serious mental health problems.

Highlights

MHSA supports a limited number of staff on the CCS teams listed above and helps improve access to mental health services among those who have experienced trauma and violence. Notable achievements in 2011-12 include the following:

- Crisis Response Team clinicians provide assessments for trauma; conduct debrief/drop-in services to victims who have experienced or witnessed community violence; and enhance the frequency of responses 24 hours a day, seven days a week to homicide victims' family. MHSA funds have allowed the team to be creative in providing these services and provide temporary shelter to protect client safety.

- Increased capacity for the Child Crisis Team to provide crisis services for children and adolescents 24 hours a day, seven days a week. Crisis clinicians provided interventions that focused on alleviating symptoms of trauma and help prevent placement in a psychiatric inpatient unit. Clinicians also provided psychological first aid and linkage to mental health services to individuals who experience a critical incident.

- The Director of the Comprehensive Crisis program integrated three different types of crisis services and provided staff trainings that helped increase capacity to meet community needs. Innovative strategies were also developed to build rapport with underserved populations, decrease the high utilization of emergency and inpatient services, and to effectively act as the liaison between different systems and stakeholders that utilize crisis services.

Moving Forward with PEI Services

The activities outlined below describe ways that we will continue to enhance MHSA-funded programs in this service category in fiscal year 2013-14. These activities are grounded in different community cultures.

+ Implement the *Iraqi Refugees Support Group* for Iraqi refugee women who are experiencing post-war trauma, severe depression, and isolation

+ Support the *Indigena Health and Wellness Collaborative*, which works to improve the health and well-being of Indigena immigrant families. This partnership between Instituto Familiar de la Raza and Asociacion Mayab promotes community building, strengthens social support networks, and addresses mental health issues.

+ Develop trauma services for African Americans through INN-funded Community Grants. A subcommittee will identify priority issues that will influence funding decisions.

+ Support the *Asian Pacific Islander Health Parity Coalition* (APIHPC), which was contracted to lead a planning effort to develop an innovative approach to addressing stigma in the Asian and Pacific Islander community. APIHPC will conduct outreach to and convene the identified sub-groups which have the most disparities in needs and services: the Filipino, Southeast Asian, and Samoan communities of San Francisco. APIHPC will also convene workgroups with each of the sub-groups to plan culturally relevant holistic mental health promotion activities and identify workforce and agency capacity development needs to support the future implementation of those services. The workgroups will partner with CBHS to develop a three-year plan for mental health promotion activities and holistic mental health service delivery for the three identified communities.

5. Peer-to-Peer Support Services

Background

Peer support is an integral element of a recovery-oriented behavioral health system; and provision of behavioral health support by persons who have had experience with these issues innately brings empathy and empowerment that can inspire recovery in others. MHSA funding for Peer-to-Peer Support Services gives peer providers, who have significantly recovered from their illnesses, the opportunity to assist others by teaching how to build the skills necessary that lead to meaningful lives. The programs that provide Peer-to-Peer Support Services are listed in Exhibit 24. INN funding also supports several programs in this MHSA service category.

Exhibit 24. Summary of Peer-to-Peer Support Services

Lead Agency	Program	Services
San Francisco Study Center	Office of Self-Help	Provides socialization, recreational activities, employment development, and a warm line.
San Francisco Department of Public Health	Pathways to Discovery	Facilitates therapeutic activities, conducts peer counseling, escorts clients to other services, assisted with daily living activities.
Mental Health Association of San Francisco	**Peer-led Hoarding & Cluttering Program	Provides interventions and access to services that address hoarding and cluttering.
San Francisco Department of Public Health	Peer Support Staff Integrated in the CBHS Systems of Care	Facilitates support groups, performs administrative duties in clinic settings, and assists clients in navigating services.
San Francisco Department of Public Health	**Reducing Stigma in the Southeast (RSSE)	Engages faith-based organizations and families in Bayview/Hunter's Point and Visitaction Valley in order to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers.
San Francisco Department of Public Health	**Transgender Peer-to-Peer Support Services	Facilitates the Wellness and Recovery group for transgender consumers and provides resources for those in county jail.

**INN-funded Program

Populations Served

Peer-to-Peer Support Services served a total of 245 clients (see Exhibit 25). The majority of clients were males (56%), adults (63%), and Whites (42%). Four percent of clients spoke Spanish.

Exhibit 25. Populations Served by Peer-to-Peer Support Services, 2011-12 (N = 245)[a]

Gender	
Male	138 (56%)
Female	105 (43%)
Transgender	2 (1%)
Age	
Adults	154 (63%)
Older Adults	82 (33%)
TAY	9 (4%)
Race/Ethnicity	
White	102 (42%)
African American/Black	79 (32%)
Asian	18 (7%)
Multi-Ethnic	15 (6%)
Latino/a	13 (5%)
Other race/ethnicity	9 (4%)
Native American	6 (2%)
Native Hawaiian/Pacific Islander	3 (1%)
Primary Language	
English	224 (91%)
Spanish	10 (4%)
Tagalog	4 (2%)
Cantonese	3 (1%)
Other language	3 (1%)
Russian	1 (<1%)

[a] Data are from the following programs: RSSE, Office of Self-Help, SOLVE, and Hoarding and Cluttering

Highlights

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

Notable achievements in 2011-12 are listed below.

- Eighty (80) percent of service providers and professionals who attended SOLVE presentations demonstrated a better understanding of mental illness. Eighty-four (84) percent of community members, as a result of SOLVE's Peer Educator presentations, reported having a better awareness of mental health services and local behavioral health resources.

- Pathways to Discovery team members facilitated support groups twice a week at one of San Francisco General Hospital's locked facilities and at The Coronado, a single room occupancy hotel. The Pathways team also provided social activities for clients who lived in residential care facilities. This work was supported by four interns from the City College of San Francisco's Mental Health Certification Program and two volunteers. One volunteer helped develop a resource binder of self-help materials and another volunteer assisted with improvements to an art program.

Spotlight on Innovative Approaches to Peer-to-Peer Support Services

Peer-Led Hoarding and Cluttering Support Team. A Peer Response Team was created to provide peer support and assistance navigating the community and systems of care for individuals dealing with hoarding and cluttering challenges. In 2011-12, the Peer Responders [illegible]

- Raised awareness about hoarding and cluttering in local media and at national and regional gatherings (e.g., International Conference on Hoarding and Cluttering, CASRA Conference, National Association of Professional Organizers meetings).
- Added a Project Coordinator to help actively engage the community, providers, and advocates.
- Made numerous referrals (e.g., to the Eviction Defense Collaboration, Adult Protection Services) to prevent eviction among consumers.

Findings from an evaluation survey showed that as a result of linkages with Peer Responders:

- 90 percent of consumers reported a reduced risk of homelessness, isolation, and physical harm.
- 100 percent of consumers reported increased engagement with treatment and greater peer support services.
- 100 percent reported a decrease in self-stigma.

Collaboration with the Faith Community. Reducing Stigma in the Southeast (RSSE) is a peer-based program that engages faith-based organizations and families in the Bayview Hunters Point and Visitacion Valley communities. The program aims are to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers. In 2011-12, RSSE accomplished the following:

- Conducted outreach to over 50 percent of health-related organizations and more than 10 faith-based congregations located in the Southeast sector of San Francisco.
- Conducted three community-based mental health workshops.
- Conducted three Healing Circle support groups that address community concerns related to health, nutrition, recovery, education, violence prevention, and wellness.

Transgender Peer-to-Peer Support Services. A Wellness and Recovery group exclusively for transgender consumers, particularly transwomen of color, was created in September 2011. Transgender Wellness and Recovery Support Groups take place in the community, at the local jail, and at CBHS office. These groups are facilitated by peer staff from the Consumer Employment Program and Pathways to Discovery Program who were trained in various psycho-education topics (e.g., wellness, nutrition, self-esteem, stress reduction, trauma, and the Wellness and Recovery Action Plan). A total of 34 participants attended this group. Participants also received linkages to program resources and wellness calls/checks from peer staff. In addition, outreach efforts focused on individuals who were socially isolated and/or lived in shelters or single-room occupancy (SRO) hotels.

Moving Forward with Peer-to-Peer Support Services

The activities outlined below describe ways that we will continue to enhance MHSA-funded programs in this service category in fiscal year 2013-14.

- Hire a Peer-to-Peer Support Service Coordinator to coordinate existing peer-to-peer services. This new position will allow CBHS to develop clear outcome program measures, identify hiring strategies for peers, and promote the professional development of peer staff.

- Convene a subcommittee to help expand the INN-funded Community Grants Program focused on the transgender population

- Hire and train two Peer Counselors to co-facilitate WRAP and other stress management groups at Sunset Mental Health's Wellness and Recovery Program. Peer Counselors will also be trained to work individually with clients.

- Implement an INN-funded Community Grants Program that focuses on developing effective peer support strategies and practices for socially isolated older adults. Through a stakeholder process that involved older adult service providers and peer supports, social isolation was identified as one of the key concerns for older adults living in San Francisco. The goals for this new INN-funded program will be to: (1) produce programming (e.g., culturally-informed training curriculum, supervision/support plan, engagement tools) that will improve our system of support for socially isolated adults, (2) build effective partnerships between individuals and organizations who provide peer support services and programs for socially isolated adults, and (3) develop a more coordinate system of care for socially isolated adults.

- Provide three core NAMI programs in primary care clinics. *NAMI Family-to-Family Education* is a 12-week curriculum that offers a wide range of information about mental illness and assists caregivers in understanding how the experience of mental illness affects their family member. *NAMI Peer-to-Peer Recovery Education* is a nine-week program that combines lectures, interactive exercises, and structured group process to promote awareness about the impact of mental illness. This program will be translated to Spanish. *In Our Own Voice: Living with Mental Illness* is an interactive, multi-media consumer presentation designed to educate the general public and to change attitudes. Trained consumers, some of whom speak Spanish, share personal experiences of living with mental illness and convey messages of treatment, access and recovery.

6. Vocational Services

Background

MHSA funding for vocational services assists consumers and family members in securing and maintaining meaningful employment. Vocational services include job coaching, situational assessment, trainings, and job placement services (see Exhibit 26).

Exhibit 26. Summary of Vocational Services

Lead Agency	Program	Services
Richmond Area Multi-Services, Inc. (RAMS)	i-Ability Vocational IT Program	Prepares consumers to provide information technology (IT) support services (i.e., desktop, help desk) at the CBHS IT Department through its Vocational Information Technology Training Program.
Department of Rehabilitation Collaborative *Subcontractors:* Citywide Forensics, Community Vocation Enterprises, Inc., RAMS Hire-Ability	Vocational Co-Op	Provides vocational intake assessments, vocational training, sheltered workshops and other employment opportunities (e.g., job development and placement, job coaching).
UCSF Citywide Employment Program	Supported Employment and Cognitive Training (SECT)	Helps individuals with serious mental illness obtain jobs by combining evidence-based supported employment practices with computerized cognitive training

Populations Served

Vocational Services served a total of 470 clients (see Exhibit 27). The majority of clients were males (81%), adults (97%), and Whites (52%). Seven percent of clients spoke Russian.

Highlights

Notable achievements in Vocational Services in 2011-12 are listed below.

- Seven program trainees of the i-Ability program completed the helpdesk training component. Two graduates received competitive employment at CBHS.
- The DOR collaborative served 412 clients.
- The Vocational Rehabilitation Counselor met with trainees to conduct, develop, and maintain vocational assessments, progress notes, and vocational plans. The Counselor also helped address barriers to employment.

Exhibit 27. Populations Served by Vocational Services, 2011-12[a] (N = 58)

Gender	
Male	47 (81%)
Female	11 (19%)
Age	
Adults	56 (97%)
TAY	1 (2%)
Older Adults	1 (2%)
Race/Ethnicity	
White	30 (52%)
Multi-Ethnic	12 (21%)
African American/Black	10 (17%)
Latino/a	3 (5%)
Asian	2 (3%)
Native American	1 (2%)
Primary Language	
English	52 (90%)
Russian	4 (7%)
Cantonese	1 (2%)
Other language	1 (2%)

[a] Total served does not match totals listed for each demographic category because of unreported data

Spotlight on Innovative Approaches to Vocational Services

Supported Employment and Cognitive Training (SECT). SECT harnessed two evidence based interventions in order to empower individuals with serious mental illness to obtain competitive jobs in the community. SECT combined state-of-the-art supported employment practices with computerized cognitive training that sharpens clients' thinking, memory, and problem-solving skills. Clients participated in daily computerized cognitive training exercises to improve their brain information processing abilities and received individualized job placement and support. Preliminary results in 2011-12 suggest that a combined treatment of supported employment and an intensive schedule of computerized training can be implemented in a community mental health setting with a relatively low attrition rate of 17%.

Moving Forward with Vocational Services

The activities outlined below describe ways that we will continue to enhance MHSA-funded programs in this service category in fiscal year 2013-14.

+ Issued an RFQ in December 2012 for the MHSA-funded Basic Construction and Remodeling Vocational Program. The goal of this program is to help consumers in the mental health system to learn marketable skills, receiving on-the-job-training and mentoring and secure meaningful employment opportunities. Program participants will be involved with redecorating projects at clinics and programs (e.g., renovation of waiting rooms). Hiring for a Program Coordinator and Contractor are currently underway and this program is expected to begin in July 2013.

+ Expanded the Vocational IT budget to give IT department a budget to hire peers

7. Housing

Background

The Housing service category helps address the need for a continuum of accessible and safe supportive housing to help formerly homeless clients with serious mental illness or severe emotional disorders maintain their housing. This work is made possible through collaborative partnerships between the City of San Francisco, Department of Public Health, the Mayor's Office of Housing, the San Francisco Redevelopment Agency, housing developers, and local landlords. MHSA-funded housing units are developed within larger mixed-population buildings with on-site supportive services coordinated with and linked to the larger infrastructure of supports provided by Full Service Partnership programs. This service category includes housing units, other MHSA housing supports, and Emergency Stabilization Units.

Housing Units

There are a total of 63 MHSA-funded housing units online. These units help those who are homeless or at risk of homelessness and are located in various neighborhoods in San Francisco including the Tenderloin, Rincon Hill, and Ingleside (see Exhibit 28).

Exhibit 28. Summary of MHSA Permanent Supported Housing Units[a]

Target Population	Development	Developers	MHSA-Funded Units (N=63)
Older Adults	*Polk Senior Housing* 990 Polk St.	Tenderloin Neighborhood Development Corporation & Citizens Housing Corporation	10
Adults	*Drs. Julian & Raye Richardson Apartments* 365 Fulton St.	Community Housing Partnership & Mercy Housing California	12
	Kelly Cullen Community 220 Golden Gate Ave.	Tenderloin Neighborhood Development Corporation	17[b]
	Rene Cazenave Apartments 530 Folsom St.	Community Housing Partnership & BRIDGE Housing	10[b]
Veterans	*Veterans Commons* 150 Otis St.	Swords to Plowshares & Chinatown Community Development Center	8[b]
TAY	*Phelan Loop Affordable Housing Project* 110 Ocean Ave.	Bernal Heights Neighborhood Center & Mercy Housing California	6[c]

[a] Developed with one-time capital housing funds
[b] Renovation or new construction occurred in 2011-2012 and is expected to be completed in 2012-2013.
[c] Planning for new construction occurred in 2011-2012. Construction is expected to begin in 2012-2013.

Highlights

Polk Senior Housing

- Ten MHSA-funded units located at *Polk Senior Housing* continued to provide housing and supports to low-income older adults. An integrated services team provided this housing community with a full range of on-site and off-site resources (e.g., education opportunities, referrals, crisis intervention). In addition, Full Service Partnership programs provided recovery and treatment services to address the needs of severely mentally ill older adult residents.
- The *Doctors Julian and Ray Richardson Apartments* opened in October 2011 and included twelve MHSA-funded units. Residents who lived in these units were provided integrated recovery and treatment services to help them live in the community and to maintain the greatest possible independence, stability, and level of functioning. Services were offered by the UCSF Citywide Case Management team, the Housing and Urban Health Clinic, and three FSP programs.

Kelly Cullen Community

- Renovation of *Kelly Cullen Community* continued in 2011-2012. Kelly Cullen Community will include 17 MHSA-funded units for chronically homeless individuals. This site will also include a Housing and Urban Health Clinic. Renovation is expected to be completed in early 2013.
- Groundbreaking for the construction of the *Rene Cazenave Apartments* took place in April 2012. The new construction will be one of the first residential projects in the Transbay Redevelopment Area. All residents will be extremely low income, formerly homeless individuals referred by the San Francisco Department of Public Health's Direct Access to Housing program. Ten units will be reserved for MHSA clients.

Veterans Commons

- Renovation of the *Veterans Commons* continued in 2011-2012. Units will provide permanent supportive housing for chronically homeless veterans with disabilities, eight of which will be supported by the MHSA Housing Program. Veterans Commons will also include space for counseling, group meetings, case management, an exam room for community health practitioners, and social activities. Renovation was completed in November 2012.
- Planning for the construction of the *Phelan Loop Affordable Housing Project* took place in 2011-2012. This development will include six MHSA-funded units. The CBHS Transition-Aged Youth

Program will work with property management and two FSPs to provide residents with intensive, wraparound, recovery-oriented treatment for homeless youth who appear to be inadequately served by the existing system. Construction is expected to begin in mid-2013.

Other MHSA Housing and Related Supports

San Francisco is the only county in California to use its MHSA dollars beyond the housing allotment for permanent units. San Francisco allocated additional General System Development funds to develop housing for transition aged youth (TAY) with Larkin Street Youth Services (LSYS). The Larkin MHSA TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites. In fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, like skills training, wraparound case management, mental health interventions, and peer based counseling.

Through a partnership with Direct Access to Housing, additional housing units were funded through the MHSA. This includes units in scatter site locations managed by the Tenderloin Neighborhood Development Corporation. Sixteen units housed adults and five units housed older adults.

Emergency Stabilization Units

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. ESUs are located within four hotels in San Francisco. As depicted in Exhibit 29, 111 clients were placed in ESUs in 2011-12. The average length of stay in an ESU was about a month among the 46 Full Service Partnership clients served (28 nights), followed by Intensive Case Management's 52 adult and older adult clients (25 nights). On average, Central City Hospitality House's 13 adult clients stayed in an ESU for three weeks (22 nights).

Exhibit 29. Clients Placed in Emergency Stabilization Units (N=111), 2011-12

Program	TAY		Adult		Older Adult	
	Clients	Total Length of Stay (Nights)	Clients	Total Length of Stay (Nights)	Clients	Total Length of Stay (Nights)
Full Service Partnership	6	110	36	727	4	448
Intensive Case Management	--	--	50	1,009	2	297
Central City Hospitality House	--	--	13	291	--	--

Moving Forward with Housing

Three MHSA-funded units at the Richardson Apartments will be added in fiscal year 2013-14.

8. Behavioral Health Workforce Development

Background

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 competent workforce that includes individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency. This service category includes the Mental Health Career Pathways Program, Training and Technical Assistance, Residency and Internship Programs, Financial Incentive Programs, and Workforce Staffing Support.

Mental Health Career Pathways Program

The Mental Health Career Pathways Program focuses on developing a workforce pipeline that will usher in the next generation of mental health and behavioral health practitioners and include members of underserved and underrepresented communities. The agencies and programs involved in this program are listed in Exhibit 30.

Exhibit 30. Summary of Mental Health Career Pathways Program

Lead Agency	Program	Services
Richmond Area Multi-Services, Inc. (RAMS)	Summer Bridge	Teaches high school students about behavioral health fields and encourages them to explore their interests in behavioral health careers
Richmond Area Multi-Services, Inc. (RAMS)	Peer Specialist Mental Health Certificate	Provides a 12-week program, in collaboration with San Francisco State University's Department of Counseling, for consumers and family members. Focuses on preparation for entry-level employment in behavioral and mental health fields.
City College of San Francisco	Community Mental Health Worker Certificate (CMHC)	Trains a diverse group of frontline health workers to provide culturally responsive mental health and recovery services to clients. This 16-unit program is based on the mental health wellness and recovery model that is focused on the process of recovery through consumer-directed goal setting and collaboration between consumers and providers.
California Institute for Integral Studies (CIIS)	CIIS MHSA Project	Expands student support services within CIIS's School of Professional Psychology (SPP) program to increase recruitment and retention of students from underrepresented groups through a variety of activities (e.g., trainings, individualized educational plans, workshops on time management, referrals)

Populations Served

Mental Health Career Pathways Programs served a total of 1,685 clients (see Exhibit 31). The majority of clients were females (68%), adults (81%), and Whites (29%). Four percent of clients spoke Cantonese and four percent spoke Spanish.

Exhibit 31. Populations Served by Mental Health Career Pathways Programs, 2011-12[a]

Gender	n = 325
Female	220 (68%)
Male	96 (30%)
Transgender	9 (3%)
Age	**n = 316**
Adults	257 (81%)
TAY	57 (18%)
Older Adults	2 (1%)
Race/Ethnicity	**n = 315**
White	92 (29%)
African American/Black	70 (22%)
Asian	61 (19%)
Latino/a	50 (16%)
Multi-Ethnic	15 (5%)
Native Hawaiian/Pacific Islander	12 (4%)
Native American	12 (4%)
Other race/ethnicity	3 (1%)
Primary Language	**n = 283**
English	240 (85%)
Other language	18 (6%)
Spanish	12 (4%)
Cantonese	10 (4%)
Tagalog	3 (1%)

[a] Total served does not match totals listed for each demographic category because of unreported data

Highlights

Mental Health Career Pathways Programs developed outcome objectives that address the following MHSA goals specifically related to developing a workforce pipeline for mental health and behavioral health practitioners. These programs aim to increase:

- Knowledge about the relationship between mental, emotional, and spiritual well-being and how it is related to overall health;
- Readiness for entry-level employment in the behavioral health system for targeted population;
- Enrollment in post-secondary behavioral health training programs for targeted populations; and
- Interest in behavioral health careers for targeted populations

In 2011-12, programs achieved outcomes focused primarily on increasing recruitment and enrollment of students in behavioral health educational and certificate programs (including consumers of mental health services and family members); increasing retention of students; and expanding support services for students (e.g., peer support) to complete trainings. Some outcomes were also related to increasing the number of workshops and seminars offered; building the capacity of faculty and staff who support students in MHSA-funded programs; expanding outreach to disenfranchised communities and culturally and linguistically diverse populations; and improving youth leadership development. Notable achievements are listed next.

- Eighty (80) percent of RAMS Summer Bridge Program participants reported greater knowledge of mental wellness and psychological well-being in post-surveys.

- The CIIS Student Support Services program enrolled 15 students in five Master's in Counseling Psychology programs.

- The CMHC program retained 75 percent of its students. Thirty percent of program graduates expressed interests in enrolling in postsecondary education programs (e.g., graduate school) and certification in other health-related fields. Online survey results showed that 33 percent of supervising staff (i.e., preceptor) at host agencies where CMHC interns are placed felt that their interns practiced strong skills in cultural humility. As an indicator of preceptor's value for these skills, several interns were invited to lead client groups and engage with clients one-on-one. Results also indicated that 38 percent of interns were strong in most skills that are important for community mental health workers to demonstrate (e.g., professional conduct, basic counseling skills, interviewing, wellness and recovery action planning) and 50 percent were proficient to strong in most skills.

Training and Technical Assistance

The MHSA supports staff trainings on topics such as wellness and recovery, family support, intensive case management, and the integration of primary care and mental health services. Mental health service consultation is also provided. Consultation focuses on recovery-based methods and emphasizes the inclusion of individuals in implementing organizational and service provision change. See Exhibit 32 for a summary of trainings and technical assistance.

Exhibit 32. Summary of Trainings and Technical Assistance

Lead Agency	Trainings	Focus
San Francisco Department of Public Health	Seeking Safety	To increase service providers' knowledge of a psychotherapy treatment model for PTSD and substance abuse that emphasizes safety, integrated treatment, case management, and attention to therapists' processes
	Illness Management and Recovery Program	To help those who have experienced psychiatric symptoms develop personalized strategies for managing their illness
Adolescent Health Working Group	Adolescent health issues	To conduct community research, public policy, advocacy, and trainings in order to advance the health and well-being of youth and young adults in San Francisco
City College of San Francisco	Medicinal Drumming Apprenticeship Pilot Project	To provide a forum for communities to explore their traditional healing ways and support them in reintegrating these into their praxis

Highlights

- Service providers in public mental health clinics throughout San Francisco were trained on the content and implementation of the *Seeking Safety* model.

- Preparation for the *Medicinal Drumming Apprenticeship Pilot Project* was initiated and included plans to train staff on a community congruent wellness and recovery model.

- The first *Indigenously-Based Wellness and Recovery convening* was held June 28 – 29, 2012 in partnership with the City College of San Francisco, San Francisco State University, and the California Institute of Integral Studies. This convening focused on the integral components of a mental health workforce that is grounded in cultural congruent competencies. It featured the work of Dr. Peter Mataira (Director of Indigenous Affairs, University of Hawai'i's School of Social Work) and Dr. Kenneth Ryan (Tribal Leader of the Assiniboine Tribe in Wolf Point Montana).

- The *Adolescent Health Working Group* (AHWG) hosted the first Annual TAY Provider event with over 160 community-based providers who serve TAY in attendance. This event featured recent field work around adolescent brain development and trauma. AHWG also held its Ninth Annual Teen/Young Adult Provider Gathering, which highlighted the work of local programs designed to prevent and eliminate human trafficking and commercial sexual exploitation.

Residency and Internship Programs

In order to address San Francisco's behavioral health workforce shortages and supplement its existing workforce, the MHSA funds psychiatric residency and internship programs leading to licensure (see Exhibit 33).

Exhibit 33. Summary of Residency and Internship Programs

Lead Agency	Program	Focus
San Francisco Department of Public Health	Fellowship Program for Public Psychiatry in the Adult System of Care	To further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asians, health care utilization by LGBTQ individuals) and services for adults diagnosed with severe mental illness
UCSF Langley Porter Psychiatric Institute	Child & Adolescent Psychiatry Fellowship Program	To further develop fellows' knowledge and skills in psychiatric evaluations and services for children ages 4 to 18, the Community Behavioral Health system, and working with diverse populations

Highlights

- Two fellows completed the *Fellowship Program for Public Psychiatry in the Adult System of Care*. Both psychiatrists then continued to work in the public mental health system, one of whom became a Medical Director.

- Three second-year fellows from the *Child and Adolescent Psychiatry Fellowship Program* provided services at Sunset Mental Health, Mission Family Center, and the Chinatown Child Development Center on a weekly basis

Workforce Staffing Support

Significant coordination is necessary to create and strengthen alliances with San Francisco's educational systems and graduate schools to ensure that San Francisco has an increasingly representative behavioral health workforce and that consumers are better served by way of a culturally and linguistically

competent staff. In 2011-2012, plans for a CBHS Clinical Internship Coordinator position were developed. This position is expected to be filled in 2012-2013 in order to assist in the development, implementation, and evaluation of a centralized and coordinated public mental health internship/practicum program.

Financial Incentive Programs

MHSA funding supports stipends, scholarships, and loan forgiveness programs that serve as financial incentives to recruit and retain both prospective and current mental health employees. The Mental Health Loan Assumption Program (MHLAP) is one resource that encourages mental health providers to practice in underserved locations in California by authorizing a plan for repayment of some or all of their educational loans in exchange for their service in a designated hard-to-fill/retain position in the public mental health system. In 2011-2012, San Francisco fully expended the total amount ($102,000) awarded through MHLAP funds. The MHLAP selection process was highly competitive with only 11 individuals from a pool of 131 applicants who were awarded acceptance into the program.

Moving Forward with Behavioral Health Workforce Development

The activities outlined below describe ways that we will continue to enhance MHSA-funded programs in this service category in fiscal year 2013-14.

+ Continue to fund this service category using CSS funds because WDET funds will be exhausted by the start of fiscal year 2013-14.
+ Update the workforce assessment focusing on reducing disparities
+ Hire a Clinical Intern Coordinator

9. Capital Facilities/Information Technology

Background

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.

Capital Facilities

The original MHSA Capital Facility Program and Expenditure Plan included projects to renovate three buildings – Silver Avenue Health Center, Redwood Center and Sunset Mental Health. Subsequent proposals were approved to support renovation projects at Southeast Health Center and 220 Golden Gate. Silver Avenue Family Health Center (SAFHC) was the first capital project to be completed, facilitating the co-location of mental health professionals in primary healthcare settings by adding six new private counseling rooms, a large group room, waiting and reception area, and administrative space.

Highlights

- Renovation began in February 2012 to improve **Sunset Mental Health Services** and included:
  - Expansion of office space (e.g., new kitchen, meeting room) to accommodate growth in staff size
  - Updates to the waiting room (e.g., addition of digital media broadcasting mental health messages, improvements to the interior design)
  - Increases in security to protect clients and staff
  - Increases in accessibility (e.g., meet current guidelines for the American with Disabilities Act)
  - Abatement of asbestos and lead
  - Installation of a new ventilation and heating system

- In addition to MHSA-funded housing units, **Kelly Cullen Community** will include a new 12,000-square-foot Integrated Housing and Urban Health Clinic (IHHC). Two federally qualified health centers, the Housing and Urban Health Clinic and Tom Waddell Clinic, are relocating to this site which will serve 25,000 people annually. The new IHHC will include offices for IHHC staff, 17 exam rooms, 1 group behaviorist office, 2 nursing/vitals offices, 7 counseling spaces, 3 intake/benefits stations, a pharmacy, a phlebotomy lab, a large group meeting room and a waiting area with reception desk that can accommodate approximately 30 patients. The new clinic will provide integrated physical, mental, and substance abuse services onsite with an emphasis on holistic services, wellness, and permanence.

- The enhancement of the Southeast Health Center (SEHC), which is partially funded by MHSA, will allow for the integration of behavioral health services, substance abuse services, crisis intervention

and specialty services, and citywide behavioral health services. This **Southeast Health Campus** will bring together the expertise of existing children's behavioral health services and primary care. This growth is expected to increase SEHC's capacity to serve an estimated 1,250 additional children and families. SEHC will also be able to operate on evenings and weekends and better meet the schedules of working parents.

- In the MHSA Program and Expenditure Plan for Capital Facilities, the **Redwood Center** was identified as a potentially appropriate site as a dual diagnosis-ready residential treatment facility. The Redwood Center is located on property owned by the Public Utilities Commission (PUC) in San Mateo County, which had been used by the Department to deliver residential substance abuse services through a community based organization. The site was closed in fiscal year 2009-10 for renovations.

  SFDPH was forced to terminate the renovation process in early fiscal year 2012-13 because of financial and operational challenges and limitations posed by the site's designation as "historical." As a result, SFDPH will develop a more cost-effective alternative in San Francisco.

Information Technology

The goals of the Community Behavioral Health Services (CBHS) Information Systems (BHIS) are to (1) Have sufficient computing resources available to every clinician in order to make possible real-time use of an "EHR" (Electronic Health Record) for coordination of client care and documentation of all health records, including ePrescribing; (2) Provide for full compliance with all billing, privacy, security and health information management regulations; (3) Provide consumer and family member access to health information; (4) Facilitate consumer access to services; (5) Enhance consumer-provider communications.

Further progress in modernizing San Francisco's clinical and administration information systems and utilizing technology to further consumer empowerment was made in 2011-2012. The approved MHSA IT Program and Expenditure Plan includes projects to 1) add Consumer Connect, a consumer portal to Avatar and the CBHS Electronic Health Record (EHR), and 2) Vocational IT Projects to fully support the implementation and maintenance of consumer access to the EHR.

Highlights

- The implementation of **Consumer Connect** required unanticipated expenditures related to the roll out of Avatar (e.g., additional licenses to increase clinician access to the system). The project will be enhanced by adding electronic signatures, document imaging, and e-prescribing licenses.

- The **Vocational Information Technology Training Program** was launched in March 2011. This program, which is a joint effort between CBHS and Richmond Area Multi-Services, Inc. (RAMS), prepares consumers for the role of providing IT support services.

- A full-time Behavioral Health Information System (BHIS) and MHSA Consumer Advocate was hired to lead the consumer focus planning forum for CBHC MHSA IT and to provide technical consumer input to the CBHS MHSA workgroups.
- Consumers were hired and trained by the IT Department to assist with the Consumer Help Desk. These consumers will assist with the data collection and entry for Consumer Connect.
- The Helpdesk program, which works with RAMS Hire-Ability, continued to train consumers to respond to clinician's IT-related questions about the AVATAR electronic health information system. The nine-month curriculum allowed CBHS to serve two overlapping cohorts per year, ensuring continuity of service and peer support.
- The Desktop Support Program was developed to assist staff with the installation of software packages and coordinate conference room IT configurations. After extensive discussions, the IT Steering Committee decided not to implement the Document Imaging Project.

Moving Forward with Capital Facilities/Information Technology

In fiscal year 2013-14, we will reassign an estimated $1.4 million that was originally slated for the Redwood Center. These unspent capital dollars will be used to augment renovations of the Southeast Health Center.

10. Transforming San Francisco's Mental Health System

The MHSA's core principles serve as a critical benchmark as we implement our MHSA-funded programs and services. Fidelity to these principles reflects the successes of MHSA funding and the impact of MHSA on the lives of the clients, consumers, and family members we serve. As described by our program achievements in 2011-12, we continue to move the needle in achieving MHSA's goals. This section summarizes information from annual program reports and site visits from MHSA-funded contractors. This summary describes how funded programs achieved the goals of the MHSA in 2011-12, the challenges that were experienced, and program recommendations to further strengthen our mental health system in future fiscal years.

2011-12 Summary of MHSA-Funded Program Achievements

Wellness & Recovery

In 2011-12, several programs described the positive impact that their programs have had on their clients. For example, one program reported that 90 percent of clients have been housed and continue to follow through with their service plan; similarly, another commented on the number of clients who have attained permanent housing with assistance from their program. Other positive client outcomes included consumers graduating from programs and integrating back into the workforce and school; socially isolated participants broadening their sphere of comfort and engaging in social activities; and young clients showing marked improvements in behavior regulation both at home and school. Some programs also shared individual client stories and successes in treatment and reported satisfaction with the services received.

Client, Consumer, and Family Involvement

The commitment to hiring consumers and peers continues to grow among San Francisco's MHSA-funded programs. One program stated that "lived mental health and family member experience" is preferred for all paid and internship positions. Another program emphasized that one of its guiding principles is having "community-based, peer-led programs."

Consumers were either hired as staff or were volunteers in MHSA-funded programs in 2011-12. Twenty-eight programs employed consumers and two programs offered volunteer opportunities for consumers. Consumers were hired to fill a range of positions including: Peer Advocate, Program Support, Case Manager/Aide, Peer Counselor, Peer Provider/Assistant, Vocational Specialist, Peer Educators, Peer Trainer/Facilitator, Promotora, and Garden Educator. A few organizations also hired consumers in management roles including a .5 FTE Program Director and .75 FTE Program Manager. In some

instances, consumers were hired on staff after graduating or participating in a program. One program, for example, shared that it hired a recent consumer graduate as a teaching assistant.. Another program specifically created a new position—Peer Counselor Trainee—to be filled by former program participants. This new position afforded consumers with a leadership role and gave them the opportunity to facilitate small group discussions.

Consumers also volunteered their time in a range of activities including supporting office work and wellness promotion events. Several programs provided volunteer stipends to those who participated in their Advisory Boards.

Overall, programs emphasized participant engagement. Programs utilized a number of formal and informal approaches to involve participants in planning, implementation, and evaluation of programs, including client satisfaction surveys, focus groups and interviews, consumer advisory boards, and community meetings. Programs highlighted the importance of ensuring participant feedback and conducted various engagement activities, including:

- **Gathering client feedback. MHSA programs are required** to implement evaluation activities to solicit feedback from clients about program successes and suggestions for improvement. Programs distributed satisfaction surveys and conducted focus groups and individual interviews. One program used community-based research methods to ensure participant engagement.

  One program requested input from youth on various program issues including how to make the program space more comfortable and another solicited participant input to inform the development of workshops and groups. Another youth program implemented client feedback on the design of a youth study space that would provide access to computers, school supplies, text books, and tutoring.

- **MHSA Evaluation Workgroup.** Launched in January 2010, this workgroup has brought together client advocates, staff from civil services and MHSA-funded programs, and SFDPH administrative and evaluation staff. In this monthly forum, MHSA-funded programs received technical assistance and feedback on their evaluation plans. This group also strengthened linkages between county and agency staff, bolstered capacity for evaluation, and integrated consumer voices in program design and outcomes. The success of meetings was further reflected in consistent attendance, active participant dialogue, and ongoing input and engagement in the content of trainings and presentations.

- **Asking for input from Consumer Advisory Groups.** Curry Senior Center, for example, developed a Community Advisory Panel to provide feedback about its programs. Members of Larkin Street's Youth Advisory Council received leadership training and served as mentors to their peers. One program invited participants to attend quarterly Advisory Committee meetings to discuss issues related to the program.

- **Deepening peer and mentor involvement.** For many programs, clients, consumers, and family served as advocates, counselors, educators, and leaders.

- **Attending community meetings.** Community meetings provided a forum for clients to offer feedback and share how their needs can be better addressed. The Seedling Resilience Project, for example, held weekly garden meetings that were attended by at least 70 percent mental health consumers. At these meetings, resources and skills were shared and participants were encouraged to share ways to enhance garden activities.

- **Becoming involved in treatment planning.** Some programs discussed how they engage clients and families in treatment planning. One program noted that consumer and family-driven treatment planning also provided an opportunity for clients to offer feedback on the quality of care.

- **Conducting needs assessments.** One program engaged consumers in a series of needs assessments to inform the development of culturally responsive services. Another program trained and involved youth in carrying out its community needs assessment.

Cultural Competence

Our MHSA efforts continued to meet the mental health needs of underserved and other priority populations. Our Population-Focused Mental Health Promotion programs, for instance, aimed to improve access to mental health services and were responsive to different communities, including Iraqi refugees, Indigena immigrant families, Asians, and Pacific Islanders (e.g., Southeast Asian, Filipino, Samoan). We have also expanded our knowledge of culturally-specific healing practices and recruited members of target communities in program development and service delivery. Moreover, we have tailored services and programs to meet linguistic needs in Spanish, Arabic, and Cantonese.

Programs also participated in local, regional, and national conferences and meetings that helped educate the public about mental health. One program, for example, participated in a conference that educated families and community providers about early psychosis and treatment options. A national conference on hoarding and cluttering also provided the opportunity for peers to conduct a presentation that highlighted the benefits of peer support and empowerment.

Collaboration

Programs emphasized the new relationships they successfully forged with academic institutions, community groups, health care providers, and community-based organizations. One program articulated how improved relationships and collaborations have led to better referral processes and enhanced its ability to serve more clients. Other innovative partnerships included collaborations with Salesforce to collect and store outcome data.

Barriers and Challenges Reported by Contracted Programs

MHSA-funded programs encountered several challenges in 2011-12, including:

- **Management and staff turnover.** Staff turnover affected programs' capacity to provide services and participant enrollment. For one program, difficulties filling certain positions (e.g., case aides) limited its ability to fully engage consumers in community events. Staff turnover also delayed the start of some program activities.

- **Limited capacity for data collection and evaluation.** Programs cited difficulties with data collection, particularly to measure longitudinal outcomes. One program noted challenges in measuring student progress over time because of multiple student transitions and the lack of follow-up. Some programs received low response rates from client satisfaction surveys. One program suggested the need for a unified system for collecting and storing client data to make tracking clients easier.

- **Difficulties deepening consumer engagement.** Recruiting participants for certain program activities was challenging for some programs. For example, one program shared that it unexpectedly encountered difficulties recruiting participants for its Community Advisory Panel. A few programs discussed challenges engaging specific ethnic populations such as African Americans, Asians and Pacific Islanders, and Native Americans, and other underserved individuals such as those from the transgender community.

- **Limited space to conduct programs.** Several programs discussed lack of program space as a major challenge. One program outgrew its current space when its wellness promotion activities expanded and the number of parents who needed childcare increased. During one agency's transition to a new space, there were difficulties in providing a continuity of client care before the move was complete.

- **Limited funding.** A few programs encountered funding challenges that impacted their program in different ways. For one program, the loss of matching funds limited the program's scope of work; for another, insufficient funding meant that it could not provide stipends for its peer educators. One program added a staff member that was originally not included in the budget, causing financial stress on the program.

- **Limited capacity to support growth.** A few programs expressed concern about the capacity to support program growth. One program was concerned about the limited infrastructure support for its future expansion in the number of activities that it would provide and clients it would serve. Similarly, another program observed that staff workload was steadily increasing along with the number of clients served. Given its current organizational capacity, this program faced challenges in meeting outcome objectives.

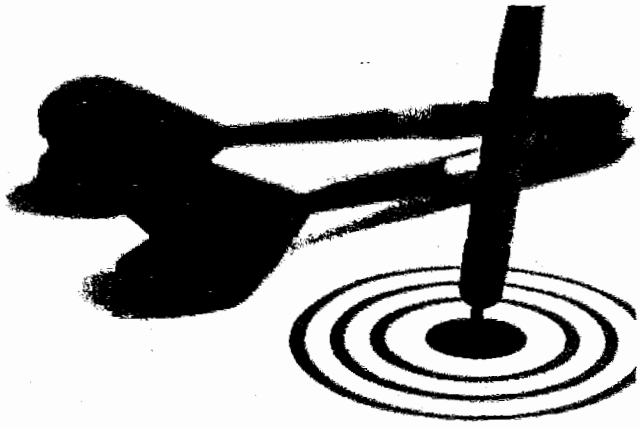
- **Need to develop and sustain effective partnerships.** While programs acknowledged the value of engaging with other agencies and community partners, they described difficulties they encountered when expectations were not met.

Recommendations from MSHA-funded Programs to Strengthen San Francisco's Mental Health System

Programs highlighted various ways that San Francisco's mental health system can be further improved in future fiscal years. The recommendations listed below highlight opportunities to deepen collaboration between agencies and increase awareness about mental health.

- **Increase networking activities.** Several programs mentioned the need for forums such as "meet and greets" to share information about agency-sponsored events and services that they provide. Other types of convenings such as rotating program open houses, bi-annual program meetings, or resource fairs were also mentioned as ways to facilitate program awareness and collaboration.
- **Provide staff trainings.** Programs mentioned that MHSA-sponsored trainings an important part of promoting an agency culture that is supportive and inclusive of clients, consumers, and families. Increased awareness of the specific needs and issues faced by diverse groups among staff at all levels of an agency supports culturally responsive mental health care.
- **Enhance opportunities for programs to learn from one another.** Some programs suggested that opportunities to facilitate learning and cooperation among MHSA-funded program should be integrated in existing provider quarterly and SF MSHA Advisory Committee meetings. For example, activities can include small group discussions among programs that serve similar target populations or are funded by the same service category. These activities can encourage programs to learn about best or promising practices and lessons learned from innovative strategies to service delivery.
- **Provide ongoing communication between agencies.** Several programs suggested developing a common listserv or online feedback platform. These strategies would provide a platform for sharing resources, announcing new initiatives, and informing one other about upcoming trainings and workshops.
- **Develop an MHSA resource guide.** Programs noted that a printed resource guide would be useful for clients and providers to help facilitate greater awareness about the availability of mental health resources.
- **Enhance the SF MHSA Website.** Programs offered a number of topics and types of information that they would like to see posted on the MHSA website. Several programs suggested that the MHSA website include a list of funded programs along with a brief summary of its services, contact information, and link to its website address. One program suggested that the MHSA website be linked to the SFDPH website. Other website recommendations included featuring a specific program, providing contact information of non-MHSA funded mental health resources, listing program events and trainings, describing a snapshot of program outcomes, listing a schedule of community and provider meetings, and providing access to program PowerPoint presentations.

The Future of the MHSA in San Francisco



In the years ahead, we will continue to transform San Francisco's public mental health system. Within the constraints of the resources available, the MHSA will play an important role in strengthening and expanding the transformation of public mental health services locally and throughout California. Our future efforts will include the dissemination of our 2013-16 Integrated Plan that brings together all of the MSHA components. We will also improve our monitoring and evaluation activities in order to effectively meet the outcome and performance objectives of our MSHA-funded programs.

Date: 5/16/13

County: San Francisco County

Work Plan #: INN # XX

Work Plan Name: Improve IT

Purpose of Proposed Innovation Project (check all that apply)

□Increase access to underserved groups

X□ Increase the quality of services, including better outcomes

X□ Promote interagency collaboration

□Increase access to services

Briefly explain the reason for selecting the above purpose

Important Note: IT in project refers to Information Technology, which is the implementation, support, or management of computer-based information systems. IT deals with the use of electronic computers and computer software to convert, store, protect, process, transmit and secure retrieve information.

Improve IT aims at changing the way new Information Technology (such as computers, hardware, and software) are brought into a mental health clinic by engaging recipients (staff) in the process and customizing support and training. Improve IT's goal is to *change* the way technology is brought into a mental health clinic, thus improving staff morale, which in turn will *increase the quality of services, including better outcomes* for clients.

Improve IT will *promote interagency collaboration* by partnering with a the CBHS IT team- which includes a team of consumer IT staff, staff and providers at the selected mental health clinic, CBHS leadership, and the San Francisco City Leadership (potentially including the SFDPH Budget Office).

Project Description

Jo Robinson, Director of SF CBHS, conducted a clinic by clinic assessment with a goal of enhancing client experience and staff satisfaction. Many themes emerges, including improving the physical facilities, however one of most common statements heard was "morale is low due to...slow computers and old equipment." Jo Robinson approached the MHSA team with this information, and wondered if something innovative could be done about this very issue. We brought this issue to the MHSA team meeting and the MHSA Advisory Committee meetings for brainstorming, and below is what emerged.

Traditionally, management will buy new computers, hardware, and software in bulk, install them, and assume, most often erroneously, that the recipients of these new products will automatically know what to do with them. Improve IT will select a mental health clinic and overhaul its IT system in a different way. CBHS IT team (which includes consumer staff) will assess the current IT system of the mental health clinic station by station. Additionally, they will conduct staff focus groups and interviews to determine what the strengths and challenges of that IT system are. Based on those findings, the IT team will install up-to-date hardware and software. Thorough agency-wide trainings will take place, but additionally, each staff member will be individually assessed by IT consumer staff to determine their hardware/software training needs, if any, and train them. One can only expect that this type of individualized and personalized approach to will increase moral and improve client satisfaction..

Goals of Improve IT are:

-Change the way on which IT is brought into a clinic from a top-down centralized way to an inclusive collaborative way

-Increase staff and provider engagement and improve clinic moral

-Increase client satisfaction with services, and

-Raise the awareness about the importance of investing in infrastructure in a systematic and engaged way

Expected Outcomes/Positive Change: If this project is successful, the primary outcomes would be:

- Improved collaboration on IT issues
- An increase in staff/provider engagement and moral
- An increase in client satisfaction with services and outcomes
- An increase in confidence in using new IT equipment by staff
- Increased efficiency for staff and clients

Title 9 General Standards: *Improve IT will apply the following general standards.*

- **Community Collaboration:** Improve IT will work in collaboration with: mental health clinic staff, CBHS leadership, CBHS IT team, which include consumer IT staff, and the SFDPH Budget Office.
- **Cultural Competence:** The overhaul of a mental health IT infrastructure will include the experience of all staff, thus incorporating the essence of the clinic's culture.
- **Integrated Service Experience:** Improve IT incorporated IT expertise with clinical expertise to help develop a technology delivery system that engages staff, consumers, and political stakeholders in a process will improve moral and client satisfaction.
- **Wellness, Recovery and Resilience focus:** Improve IT is fundamentally aligned with the Wellness, Recovery, and Resiliency focus by the collaboration of different groups and teams to change the IT structure and system within a clinic,

Contribution to Learning

Improve IT is ***NEW*** mental health program, in that that a collaborative rollout of an IT system has not been done with the inclusion of various groups of people, including peers with a lived experience with mental illness. We can anticipate that new IT equipment will improve staff moral and client satisfaction. However, what this innovative programs want to learn in how the process of bringing technology into a clinic in a *different way,* by engaging the staff and providers, makes a difference. Additionally, we would like to capture how this systematic way of investing in IT infrastructure, *with* staff and provider input in incredibly important. It *improves* moral, *improves* client satisfaction, and ultimately is cost effective.

Timeline

Phase I- Start Up and planning (1/2014-6/2014)

The 1st six months of planning will be dedicated to recruiting and forming the Improve IT collaborative team. This team will include members of the stakeholders such as members of the CBHS IT team, consumer IT staff, selected staff and providers at the selected mental health clinic, CBHS leadership, and a member of DPH leadership. This group will help develop the evaluation process and methods for Improve IT. In this phase, two clinics with the highest IT needs will be selected as pilot sites.

Phase II- Implementation (7/2014-12/2014)

This period will allow for the Improve IT collaborative team to implement the IT changes at two pilot clinic sites. During this phase, IT consumer staff will assess changes and provide one-on-one training and technical assistance to staff and providers of selected pilot sites. Exit interviews will be conducted on various levels of those affected by pilot. These include, but are not limited to: IT team, IT consumer staff, staff and providers of pilot sites, recipients of services at pilot sites. Evaluation will be implemented and data will be collected and preliminary analysis will be completed.

Phase III – Reflection, evaluation, and dissemination (1/2015-6/2015)

Phase III will include the complete analysis of evaluation efforts of Improve IT. The learning report will be written and shared. Additionally, a public report back will also take place. If the approach proves successful CBHS/MHSA will implement Improve IT at other clinical sites with CSS funds.

Project Measurement

There are a number of objectives that we will anticipate to measure, with the help of CBHS evaluation team and consumer input, we would like to measure/determine:

Staff and providers outcomes:

- Increase in collaboration regarding IT issues that are engaging and inclusive (qualitative)
- Level of staff/provider engagement in process and implementation of this program *and* how this engagement affected them (qualitative)
- Increase staff and provider engagement and improve clinic morale and work satisfaction (pre and post)

Overall program outcomes:

- Increase in client satisfaction (pre and post test)
- If Improve IT is successful, it's innovative model will be adopted by other local and state mental health clinics *and* will raise awareness about the importance of investing in IT infrastructure and training in a systematic way

Leveraging Resources (if applicable)

N/A

Budget

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	**$115,000**			
2. Operating Expenditures	**$49,000**			
3. Non-recurring expenditures	**$311,000**			
4. Training Consultant contracts	**$25,000**			
5. Work plan management				
6. Total proposed work plan expenditures	**$500,000**			
B. Revenues				
1. Existing revenues				
2. Additional revenues a. b.				
3. Total New Revenue				
4. Total Revenues				
C. Total funding requirements				**$500,000**

Date: 5/29/13

County: San Francisco County

Work Plan #: INN # XX

Work Plan Name: First Impressions

Purpose of Proposed Innovation Project (check all that apply)

□ Increase access to underserved groups

X□ Increase the quality of services, including better outcomes

X□ Promote interagency collaboration

□ Increase access to services

Briefly explain the reason for selecting the above purpose

The First Impression Project aims at changing the first impressions that mental health consumers have upon entering a mental health clinic, in two unique ways: 1) by engaging them and clinic staff in the decision making process of what they want their clinic to look like, and 2) by providing them with the vocational training in basic construction and remodeling to make significant changes to the look and feel of their clinic.

The First Impressions Project (FIP) will *increase the quality of services, including better outcomes* by improving the morale of clinical staff, thereby, improving productivity, creating a sense of ownership and pride of one's worksite, and most importantly increasing engagement with clients and improving services. FIP will *promote interagency collaboration* by partnering with a community-based mental health provider with experience in vocational services *and* a local building contractor with the openness and willingness to train consumers in basic construction and remodeling.

Although we anticipate that the following goals will also be achieved, we will not measure them. FIP will *increase access to underserved groups and increase access to services* by creating a welcoming clinic environment which reflects the community in which the clinic is located and the culture(s) of the recipients of services, thus increasing the likely that underserved groups will utilize the services of this clinic.

Project Description

It is has long been known that the look of a medical clinic can impact the impression that one may have of services they may be receiving. Additionally, the look of a clinic's reception area, may also make a client feel and ask themselves "wow, is this what they think of me?" Recipients of mental health services are very sensitive to these impressions. FIP aims at changing the impression consumers have of

their mental health clinic by engaging them in the process of clinic transformation *and* training them in basic construction and remodeling in order to make the necessary transformations of their clinic.

Goals of FIP are to increase consumer engagement by involving them in the decision making process, thereby increasing their mental health wellness and recovery and to help consumer learn marketable job skills, receive on-the-job training and mentoring and secure meaningful employment opportunities.

Training in basic construction and remodeling skills may include but not limited to: patching and painting walls, ceilings and doors; changing/applying window dressings; hanging décor; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; graffiti abatement; minor landscaping, etc. This program will not entail heavy construction. Ideally, the new program will provide participants with:
-at least three months of classroom and hands on training
-at least six months of supervised fieldwork experience, including redecorating projects at DPH clinics and programs, specifically work to renovate the waiting rooms at CBHS mental health clinics.
-at least minimum wage for participant's time, effort and participation in the fieldwork
-job placement support to assist consumers with job preparation; resume building, job placement in the competitive workforce and retention services

FIP vocational services will include, but are not limited to intake sessions, assessments, trainings, supervision, workshops, coaching, job placement and retention services. In addition, these services are intended to adhere to the Recovery Model helping consumers to improve their health and wellness. These services are intended to provide meaningful activities that foster a consumer's independence and increase her/his ability to participate in society in a meaningful way.

Expected Outcomes/Positive Change: If this project is successful, the primary outcome would be:

- An increase in consumer engagement in clinic and clinical services
- An increase in client satisfaction with services
- An increase in staff and provider moral
- An increase in consumers who have learned marketable job skills in basic construction and remodeling.

Title 9 General Standards: *FIP will apply the following general standards.*

- **Community Collaboration:** FIP will work in partnership with mental health clinic staff, the CBHS executive and operation teams, SF mental health clinic staff, building contractors, and clients/consumers from SF mental health clinics.
- **Cultural Competence:** The selected clinic for FIP will have a look and feel that reflects the clinic that it is located in and the clients that it serves.
- **Client Driven:** FIP is an empowerment driven approach in which the clients receiving services are the ones who will be deciding what their clinic will look like. Additionally, they will receive vocational training in basic construction and remodeling to make the changes in the look and feel of their clinic.

- **Wellness, Recovery and Resilience focus:** By empowering consumers in the decision making process of how their clinic will look *and* training them in making these changes will hopefully build internal skills to apply this wellness and recovery in other areas of their life.
- **Integrated Service Experience:** FIP is a service integration model in its very nature. FIP clients will be provided vocational services and support that will impact their ability to obtain and retain competitive employment in basic construction and remodeling.

Contribution to Learning

FIP is *adapted* mental health practice, in that there have been vocational training programs that teach basic construction to consumers. However, never have consumers been *engaged* in the process of how that want their clinic to look and feel, and then taught *and* allowed to make those changes.

We can anticipate that if the look and feel of a clinic is changed in a positive way, that it will impact client moral and perhaps services. However, FIP is novel and unique in that it engages consumers in the decision making process of how they want their clinic to look and feel, and then *trains* them to make these changes. We want to learn what the difference between the traditional way that clinic remodeling is done (consumers/clients are not included) verses including consumers every step of the way.

We predict that client involvement in this process will not only improve their recovery process, but that those who participate in the vocational services component will increase their capacity to attain and retain employment in the field of basic construction and remodeling.

In addition to the above consumer changes, we can anticipate an increased level of engagement and moral of staff and providers who work at this mental health clinic and a new found sense of respect for the consumers who made this decisions and changes.

Timeline

Phase I- Start Up and planning (7/2013-12/2013)

Program staff and consumers will spend the first X months of this project selecting a community-based organization that will provide the vocational services and the general building contractor to work with on this project. The next step will be to select two civil service clinics will be *transformed.* Program staff and consumers with work with MHSA evaluators to develop evaluation design. Consumer and staff focus groups will occur during this phase to determine what they want their clinic should look like. Begin recruitment of consumers who are interested training in basic construction and remodeling.

Phase II- Implementation (1/2014-12/2014)

This phase will be when the classroom and hand-on training on basic construction and remodeling will occur. Field work in basic construction and remodeling may entail painting, changing/applying window dressings, hanging décor, moving furniture, carpet repair and installation, and graffiti abatement, etc. FIP will not entail heavy construction. This phase will also include vocational services such as: intake

sessions, assessments, trainings, supervision, workshops, coaching, job placement and retention services. During this phase, evaluation will take place to track qualitatively how this process is affecting those who are involved in the vocational services, the staff and providers of the clinic, as well as other clients of the clinic who are not involved in this program, but are witnessing the transformation.

Phase III – Reflection, evaluation, and dissemination (1/2015-6/2015

This phase, the qualitative evaluation gathered in implementation will be analyzed to determine the overall affect that the clinic transformation had on participants of FIP, staff and providers, and other clinic staff. Writing of the learning report and dissemination of finding will also occur in this phase.

Project Measurement

There are a number of objectives that we will anticipate to measure, with the help of CBHS evaluation team and consumer input, we would like to measure/determine:

Consumer outcomes:

- Individuals will report a greater sense of empowerment due to the of involvement and engagement with FIP and clinic
- Individuals will demonstrate skills in basic building and construction
- Individuals will demonstrate in improvement in overall wellness and recovery

Staff and providers

- Staff will report a greater sense of work moral due to clinic transformation

Overall program outcomes:

- If FIP, MHSA SF will use this model to fund other capital projects with CSS funding.
- If FIP is successful, it's innovative model will be adopted by other clinics in SF, as well as other local and state mental health clinics.

Leveraging Resources (if applicable)

CBHS Operations team will be included in this process to see if they can leverage any construction related resources, such as carpeting, drapery, and office furniture.

Budget

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
D. Expenditures				
7. Personnel Expenditures	**$248,000**			
8. Operating Expenditures	**$52,000**			
9. Non-recurring expenditures	**$152,000**			
10. Training Consultant contracts	**$48,000**			
11. Work plan management				
12. Total proposed work plan expenditures	**$500,000**			
E. Revenues				
3. Existing revenues				
4. Additional revenues a. b.				
3. Total New Revenue				
4. Total Revenues				
F. Total funding requirements				**$500,000**

FY 2013/14
MHSA FUNDING SUMMARY

County: San Francisco **Date:** 11/26/2013

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$10,467,419	$63,017	$4,828,875	$4,121,499	$4,106,517	
2. Estimated New FY 2013/14 Funding	$16,304,462			$4,076,116	$1,072,662	
3. Transfer in FY 2013/14[a/]	($1,300,000)	$1,300,000				
4. Access Local Prudent Reserve in FY 2013/14						
5. Estimated Available Funding for FY 2013/14	$25,471,881	$1,363,017	$4,828,875	$8,197,615	$5,179,179	
B. Estimated FY 2013/14 Expenditures	$16,992,725	$1,300,000	$2,000,000	$6,327,217	$1,285,802	
C. Estimated FY 2013/14 Contingency Funding	$8,479,156	$63,017	$2,828,875	$1,870,398	$3,893,377	

[a/]Per 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.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	$1,000,000
2. Contributions to the Local Prudent Reserve in FY 2013/14	$0
3. Distributions from Local Prudent Reserve in FY 2013/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$1,000,000

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

http://sfmhsa.org/about_us.html

Wong, Linda (BOS)

From: Marlo Simmons [Marlo.Simmons@sfdph.org]
Sent: Wednesday, January 08, 2014 12:47 PM
To: Wong, Linda (BOS)
Cc: Young, Victor; Minioza, Kathleen
Subject: Re: Request for documents - BOS File No. 131186 - Mental Health Service Act Program & Expenditure Plan
Attachments: SF MHSA 13-14 Annual Update_FINAL.pdf

Here you go. Please let us know if you have any questions.

Marlo Simmons, MPH
Director, Mental Health Services Act (MHSA)
SFDPH Community Behavioral Health Services
1380 Howard, 2nd Floor #210b
San Francisco, CA 94103
Phone (415) 255-3915
Fax (415) 252-3091
marlo.simmons@sfdph.org

Request for documents - BOS File No. 131186 - Mental Health Service Act Program & Expenditure Plan

Wong, Linda (BOS) to: Simmons, Marlo 01/02/2014 03:23 PM

Cc: "Young, Victor"

Hi Marlo,

Please provide the following document for the above mentioned file.

1. Three-Year Program and Expenditure Plans

Please feel free to contact me if you have any questions.
Sincerely,

Linda Wong
Board of Supervisors/ SF LAFCo
1 Dr. Carlton B. Goodlett Place, City Hall, Room 244
San Francisco, CA 94102-4689
Phone: 415.554.7719 | Fax: (415) 554-5163
Linda.Wong@sfgov.org | www.sfbos.org

Please complete a Board of Supervisors Customer Service Satisfaction form by clicking here.

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

Edwin M. Lee
Mayor

Barbara A. Garcia, MPA
Director of Health

TO: Angela Calvillo, Clerk of the Board of Supervisors

FROM: Jo Robinson, MFT
Director of Community Behavioral Health Services

THROUGH: Barbara A. Garcia, MPA
Director of Health

DATE: October 22, 2013

SUBJECT: Report on the Mental Health Services Act, including Adoption of Program and Expenditure Plans by County Boards of Supervisors - No Action Necessary

---

Purpose of Memorandum
This memorandum provides an explanation of the Mental Health Services Act ("MHSA or Act"), discusses San Francisco's compliance with MHSA requirements, and provides a description of your Board's role in the adoption of the San Francisco's MHSA program and expenditure plans.

Overview of the Mental Health Services Act
MHSA is a law enacted by the California electorate through a ballot initiative, Proposition 63, at the November 2, 2004, General Election. The Proposition itself and its implementing regulations are quite clear and specific regarding the intent of the Act, as set forth, below. The Act provides dedicated funds to expand county mental health programs by: (1) imposing a one percent personal income tax surcharge on taxpayers with annual incomes of more than $1 million; and (2) preventing future State funding allocations for county mental health programs from falling below the levels in place immediately preceding the law's enactment. The Act mandates that the dedicated funds be set aside in a special fund for distribution to counties, thereby protecting MHSA funds from being diverted by the Legislature and/or Governor during the annual State budget process. The Act also prohibits supplanting with MHSA funds any existing State or county funds utilized to provide mental health services.

Under the MHSA, funding is provided for county mental health programs to address a broad continuum of prevention, early intervention, and service needs, and for infrastructure, technology, and training needs. In San Francisco, MHSA funding is administered by the Community Behavioral Health Services (CBHS) section of the Department of Public Health.

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

components are: Community Services and Supports ("CSS"), Capital Facilities and Technological Needs ("CFT'N"), Workforce Education and Training ("WET"), Prevention and Early Intervention ("PEI"), and innovation ("INN"). For these various components, county mental health departments must develop and submit program and expenditure plans ("County Plans"), which are typically three-year plans, and annual updates.

Development of Plans

The MHSA provides funding to support new and expanded county mental health programs. It requires that MHSA program and expenditure plans "shall be developed with local stakeholders." Recent legislation reaffirms and reinforces this requirement. This same legislation now requires that these stakeholder-developed plans also be adopted by county boards of supervisors prior to submission to the State.

The MHSA specifies the stakeholders to be included: "adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, veterans organizations, providers of alcohol and drug services, health care organizations, and as well as other important interests".

MHSA implementing regulations, set forth in California Code of Regulations ("CCR's"), elaborate extensively on the stakeholder participation requirement, including specifying the following: "The County" shall develop the Three-Year Program and Expenditure Plans and update in collaboration with stakeholders, through the Community Program Planning Process. County programs and/or services shall only be funded if the Community Program Planning Process set forth in these regulations was followed. "Community Program Planning" is defined by the regulations to mean "the process to be used by the County to develop Three-Year Program and Expenditure Plans and updates in partnership with stakeholders to: (1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act. (2) Analyze the mental health needs in the community. (3) Identify and evaluate priorities and strategies to meet those mental health needs."

In preparing for San Francisco's 2013-14 MHSA Annual Update, MHSA staff and stakeholders reviewed previously approved programs and services funded in fiscal year 2011-12, challenges experienced during implementation, and the outcomes that were achieved.

This Annual Update reflects our commitment to the principles outlined in the MHSA and the progress we are making to actively engage clients, consumers, and families; to promote wellness, recovery, and resilience; and to implement integrated models of care. The MHSA has enabled us to further build a service approach that is culturally and linguistically responsive to the needs of children, transition age youth, adults, and older adults. Our treatment services are being enhanced through a focus on recovery and a greater recognition of the central role that consumers, clients, and family members play in self-directing care. We

strengthened our dedication to prevention and early intervention by promoting resilience, expanding interpersonal connections, and raising individuals' general level of health and well-being before serious mental health issues develop. We continued to learn from innovative strategies that encouraged creativity and aimed to improve outcomes. Moreover, we encouraged entry into and retention in our behavioral health workforce through trainings and professional development opportunities to help us meet the increasing demands on our system.

Community priorities identified in previous MHSA planning efforts that had not yet received funding helped guide the development of priorities for future program development and expansion. The following highlights various opportunities for stakeholders to share input in the development of our current Annual Update and to learn about the progress of our MHSA-funded programs.

MHSA Advisory Committee

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

- Work collaboratively with CBHS 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

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

- Thirteen service providers (59 percent), 12 consumers (55 percent), and 7 family members (32 percent)
- Whites (37 percent), African Americans/Blacks (17 percent), Native Americans (13 percent), Latinos (13 percent), Asians (13 percent), and Native Hawaiians/Pacific Islanders (7 percent)
- Gay, lesbian, or queer (11 percent), questioning (5 percent), and bisexual (5 percent) individuals
- Members' ages ranged from 30 to 72 and the average age was 43 years old

Other Meaningful Stakeholder Input

Providers from MHSA-funded agencies met on a quarterly basis to discuss local MHSA program activities and to provide feedback on the Annual Update. We also solicited feedback from diverse stakeholder groups, including Full Service Partnership workgroups, staff across the CBHS Systems of Care, ad hoc groups (e.g., projects for older adults, 12N Steering Committee), San Francisco Mental Health Board, CBHS Client Council, San Francisco Health Commission, and CBHS Executive Leadership Team.

Local Review Process and 30-Day Public Comment Period
In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Annual Update Report is posted on the SF MHSA website at http://www.sfdph.org/dph and http://sfmhsa.org. Our 2013-14 Annual Update was posted for a period of 30 days from June 11, 2013 to July 10, 2013. Members of the public were requested to submit their comments either by email or by regular mail. It was circulated by email to approximately 600 individuals representing community based mental health organizations, substance abuse organizations, housing agencies, prevention agencies, community and primary care clinics, consumer groups, and advocacy groups.

Public Hearing
Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board on July 10th, 2013.

Submission of County Plans
County Plans must be submitted to the State Mental Health Services Oversight and Accountability Commission ("Accountability Commission"). Until March 24, 2011, the Accountability Commission was responsible for annually reviewing and approving County Plans for expenditures for mental health services, and the State Department of Mental Health ("State DMH") was responsible for subsequently approving such plans. While State DMH's approval was a prerequisite to a county's receipt of MHSA funds, its review was limited to "ensuring the consistency of such mental health programs with other portions of the plan." In an effort to streamline the State approval process, the Legislature enacted AB 100 eliminating-the requirement that State DMH and the Accountability Commission annually review and approve County Plans and updates, and directing, effective July 1, 2012, that MHSA funds be distributed on a monthly basis to counties. In passing AB 100, the Legislature made clear that streamlining the approval process was not to be at the expense of accountability. AB 100 states: "It is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act. In eliminating state approval of county mental health programs, the Legislature expects the state in consultation with the Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services."

New Requirements
The following year, the Legislature enacted AB 1467. This legislation imposes a number of additional requirements on counties prior to the submission of County Plans to the Accountability Commission. First, County Plans and updates must include a certification by the county mental health director that "the county has complied will all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and non-supplantation requirements." Second, County Plans must include certification by the county mental health-director and 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." Third, County Plans and updates are required

to be "adopted" by the county board of supervisors. While Board of Supervisors' endorsement was not previously a requirement for plan submission, CBHS has sought and received resolutions from the Board supporting all previous MHSA revenue and expenditure plans and annual updates.

Next Steps

AB 1467, added the requirement that stakeholder-developed plans be adopted by County Boards of Supervisors prior to submission to the State. The 2013-2014 MHSA Annual Update must be submitted to the MHSA Oversight and Accountability Commission within 30-days of adoption by the Board of Supervisors.

MENTAL HEALTH SERVICES ACT
As Revised July 2013

SECTION 1. Title

This Act shall be known and may be cited as the "Mental Health Services Act."

SECTION 2. Findings and Declarations

The people of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

SECTION 3. Purpose and Intent.

The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

SECTION 4. Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:
  (1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
  (2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.
  (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
  (4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:
  (1) Suicide.
  (2) Incarcerations.
  (3) School failure or dropout.
  (4) Unemployment.
  (5) Prolonged suffering.
  (6) Homelessness.
  (7) Removal of children from their homes.

(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.

(f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

5840.2 (a) The department shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

SECTION 5. Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read:

Article 11. Services for Children with Severe Mental Illness.

5878.1 (a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3.

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890), county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The State Department of Health Care Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SECTION 6. Section 18257 is added to the Welfare and Institutions Code, to read:

18257. (a) The State Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

(b) Funds from the Mental Health Services Fund shall be made available to the State Department of Social Services for technical assistance to counties in establishing and administering projects. Funding shall include reasonable and necessary administrative costs in establishing and administering a project pursuant to this chapter and shall be sufficient to create an incentive for all counties to seek to establish programs pursuant to this chapter.

SECTION 7. Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary

mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
  (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
  (2) To promote consumer-operated services as a way to support recovery.
  (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
  (4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

SECTION 8. Part 3.1 (commencing with Section 5820) is hereby added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.1 HUMAN RESOURCES, EDUCATION, AND TRAINING PROGRAM

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.
(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.
(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.
(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Office of Statewide Health Planning and Development shall include in the five-year plan:
(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.
(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, masters degrees, or doctoral degrees.
(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.
(d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.
(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.
(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.
(g) Promotion of the employment of mental health consumers and family members in the mental health system.
(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).
(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.

(j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SECTION 9. Part 3.2 (commencing with Section 5830) is added to Division 5 of the Welfare and Institutions Code, to read:

Part 3.2 INNOVATIVE PROGRAMS

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:
  (1) To increase access to underserved groups.
  (2) To increase the quality of services, including better outcomes.
  (3) To promote interagency collaboration.
  (4) To increase access to services.

(b) All projects included in the innovative program portion of the county plan shall meet the following requirements:
  (1) Address one of the following purposes as its primary purpose:
    (A) Increase access to underserved groups.
    (B) Increase the quality of services, including measurable outcomes.
    (C) Promote interagency and community collaboration.
    (D) Increase access to services.
  (2) Support innovative approaches by doing one of the following:
    (A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
    (B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
    (C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.

(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:
  (1) Administrative, governance, and organizational practices, processes, or procedures.
  (2) Advocacy.
  (3) Education and training for service providers, including nontraditional mental health practitioners.
  (4) Outreach, capacity building, and community development.
  (5) System development.
  (6) Public education efforts.
  (7) Research.
  (8) Services and interventions, including prevention, early intervention, and treatment.

(d) If an innovative project has proven to be successful and a county chooses to continue it, the project work plan shall transition to another category of funding as appropriate.

(e) County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

SECTION 10. Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.7. OVERSIGHT AND ACCOUNTABILITY

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; 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. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(3) Establish technical advisory committees such as a committee of consumers and family members.
(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.
(5) Enter into contracts.
(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.
(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.
(8) Develop strategies to overcome stigma and discrimination and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.
(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.
(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.
(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the California Mental Health Directors Association.
(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

5846. (a) The commission shall adopt regulations for programs and expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention.
(b) Any regulations adopted by the department pursuant to Section 5898 shall be consistent with the commission's regulations.
(c) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.
(d) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

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 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 (6) 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 (d) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30–day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840, and Part 4 (commencing with Section 5850) of this division funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

SECTION 11. Section 5771.1 is added to the Welfare and Institutions Code, to read:

5771.1 The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the council specified in Section 5771.

SECTION 12. Section 17043 is added to the Revenue and Taxation Code, to read:

17043. (a) For each taxable year beginning on or after January 1, 2005, in addition to any other taxes imposed by this part, an additional tax shall be imposed at the rate of 1% on that portion of a taxpayer's taxable income in excess of one million dollars ($1,000,000).

(b) For purposes of applying Part 10.2 (commencing with Section 18401) of Division 2, the tax imposed under this section shall be treated as if imposed under Section 17041.

(c) The following shall not apply to the tax imposed by this section:

(1) The provisions of Section 17039, relating to the allowance of credits.

(2) The provisions of Section 17041, relating to filing status and recomputation of the income tax brackets.

(3) The provisions of Section 17045, relating to joint returns.

SECTION 13. Section 19602 of the Revenue and Taxation Code is amended to read:

19602. Except for amounts collected or accrued under Sections 17935, 17941, 17948, 19532, and 19561, and revenues deposited pursuant to Section 19602.5, all moneys and remittances received by the Franchise Tax Board as amounts imposed under Part 10 (commencing with Section 17001), and related penalties, additions to tax, and interest imposed under this part, shall be deposited, after clearance of remittances, in the State Treasury and credited to the Personal Income Tax Fund.

SECTION 14. Section 19602.5 is added to the Revenue and Taxation Code to read:

19602.5 (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Beginning with fiscal year 2004-2005 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal

to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004-2005, the applicable percentage shall be 0.70 percent. (3) Beginning with fiscal year 2006-2007, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the Act establishing this section.

(c) No later than March 1, 2006, and each March 1 thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1% imposed under Section 17043, as reflected on the original returns filed by October 15 of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1 of the year that is two years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

Tax Year	Estimated Tax Liability Increase from the Additional Tax
2005	$ 634 million
2006	$ 672 million
2007	$ 713 million
2008	$ 758 million

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of 7 percent to the

"estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

Applicable Fiscal Year	Estimated Revenue from Additional Tax
2004-05	$ 254 million
2005-06	$ 683 million
2006-07	$ 690 million
2007-08	$ 733 million

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007-08 and each applicable fiscal year thereafter shall be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than 10 business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

SECTION 15. Part 4.5 (commencing with Section 5890) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.5. MENTAL HEALTH SERVICES FUND

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.
(4) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that

would interfere with the carrying out of the object for which these funds were created.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

5892. (a) In order to promote efficient implementation of this act the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005-06, 2006-07, and in 2007-08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004-05 funds shall be allocated as follows:
  (1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.
  (2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).
  (3) Five percent for local planning in the manner specified in subdivision (c).
  (4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to

this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

(j) For the 2011-12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011-12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the California Mental Health Directors Association to meet the fiscal year 2011-12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the California Mental Health Directors Association.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011-12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for fiscal year 2011-12. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the California Mental Health Directors Association. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011-12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in fiscal year 2011-12 that exceed this obligation shall be distributed to counties for remaining fiscal

year 2011-12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The fund shall be increased by its share of the amount earned on investments.

5894. In the event that Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) of this division, are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however, that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 (commencing with Section 5800), or Part 4 (commencing with Section 5850) of this division, are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific time-line to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with 5800), Part 3.1 (commencing with 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

5898. The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.

(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of the Mental Health Services Act (MHSA) funds that were distributed to each county.
(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.
(3) Identify unexpended funds, and interest earned on MHSA funds.
(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of the following:

(1) Children's systems of care.
(2) Prevention and early intervention strategies.
(3) Innovative projects.
(4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

SECTION 16

The provisions of this act shall become effective January 1 of the year following passage of the act, and its provisions shall be applied prospectively.

The provisions of this act are written with the expectation that it will be enacted in November of 2004. In the event that it is approved by the voters at an election other than one which occurs during the 2004-05 fiscal year, the provisions of this act which refer to fiscal year 2005-06 shall be deemed to refer to the first fiscal year which begins after the effective date of this act and the provisions of this act which refer to other fiscal years shall refer to the year that is the same number of years after the first fiscal year as that year is in relationship to 2005-06.

SECTION 17

Notwithstanding any other provision of law to the contrary, the department shall begin implementing the provisions of this act immediately upon its effective date and shall have the authority to immediately make any necessary expenditures and to hire staff for that purpose.

SECTION 18

This act shall be broadly construed to accomplish its purposes. All of the provisions of this Act may be amended by a 2/3 vote of the Legislature so long as such amendments are consistent with and further the intent of this act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures for the collection of the tax surcharge imposed by Section 12 of this act.

SECTION 19

If any provision of this act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.

SECTION 1 (of AB 100)

(a) The Legislature hereby finds and declares that the statutory changes in this act are consistent with, and further the intent of, the Mental Health Services Act. These specified changes are necessary to adequately fund essential mental health services that would otherwise be significantly and substantially reduced or eliminated absent this temporary funding support.

(b) Further, it is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act. In eliminating state approval of county mental health programs, the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act.

City and County of San F ncisco D artment of Public Health

Gavin Newsom
Mayor

Mitchell H. Katz, MD
Director of Health

TO: Angela Calvillo, Clerk of the Board of Supervisors

FROM: Barbara Garcia, MPA
Director of Health

DATE: December 6, 2013

SUBJECT: New Proposed Resolution from Department of Health

GRANT TITLE: Approval of Mental Health Services Act FY2013-2014 Annual Plan Update

---

Attached please find the original and 2 copies of each of the following:

☒ Proposed grant resolution

☒ Report on the Mental Health Services Act, including Adoption of Program and Expenditure Plans by County Boards of Supervisors

☒ MHSA FY2013-2014 Annual Plan Update

☒ Text of the Mental Health Services Act

☐ Other (Explain)

Special Timeline Requirements:

Departmental representative to receive a copy of the adopted resolution:

Name: Marlo Simmons Phone: 255-3915

Interoffice Mail Address: CBHS, 1380 Howard Street, 2nd Floor # 210 b

Certified copy required Yes ☐ No ☒

(Note: certified copies have the seal of the City/County affixed and are occasionally required by funding agencies. In most cases ordinary copies without the seal are sufficient).

130479