File No. 240355 **Committee Item No.** 5
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee **Date** May 22, 2024
Board of Supervisors Meeting **Date** _____

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☒	☐	**Resolution**
☐	☐	**Ordinance**
☐	☐	**Legislative Digest**
☐	☐	**Budget and Legislative Analyst Report**
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OTHER **(Use back side if additional space is needed)**

☒	☐	MHSA Expenditure Integrated Plan FYs 2023-2026
☒	☐	Section 62 of Cal Assembly Bill 1467
☒	☐	MHSA 3-Year Plan Summary
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Completed by: Brent Jalipa **Date** May 16, 2024
Completed by: Brent Jalipa **Date** _____

[Mental Health Services Act - Three-Year Program and Expenditure Plan - FYs 2023-2026]

Resolution authorizing adoption of the San Francisco Mental Health Services Act Three-Year Program and Expenditure (Integrated Plan) for Fiscal Years (FYs) 2023-2026.

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

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

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

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for Three-Year Program and Expenditure Plan (Integrated Plan) for Fiscal Year (FY) 2020-2023 on file with the Clerk of the Board of Supervisors in File No. 200669; and

WHEREAS, The San Francisco Mental Health Services Act Three-Year Program and Expenditure Plan FY2023-2026, a copy of which is on file with the Clerk of the Board of Supervisors in File No. 240355, which is hereby declared to be a part of this Resolution as if set forth fully herein, complies with the MHSA requirements above, and provides an overview

of progress implementing the various component plans in San Francisco for FY2022-23 and identifies new investments planned for FY2023-2026; and

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

RESOLVED, That the San Francisco Mental Health Services Act Three-Year Program and Expenditure Plan FY2023-2026 is adopted by the Board of Supervisors.

San Francisco Health Network
Behavioral Health Services

San Francisco
Mental Health Services Act (MHSA) 2023-2026 Three Year Program and Expenditure Integrated Plan

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

Mural in Balmy Alley, San Francisco

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Organization of this Plan

The San Francisco Mental Health Services Act Three-Year Program and Expenditure Plan provides information and outcomes of our work conducted during Fiscal Year 2021-2022, key updates from FY22-23, and our proposed plans for FY23-26. The plan's introductory section provides an overview of the Mental Health Services Act (MHSA), the general landscape of San Francisco, Community Program Planning (CPP) activities, MHSA program highlights from the past year, and the plan's formal review process.

In our section on activities from FY21-22, we present highlights for San Francisco Department of Public Health (SFDPH) MHSA's eight service categories. Each section includes a description of the overarching purpose of the service category, an overview of the programs within that category, and a description of the target population.

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

UCSFs WARD 86 Clinical Staff Luncheon 2022

MHSA County Compliance Certification

County: _____

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

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

This plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local Behavioral Health Commission. All input has been considered with adjustments made, as appropriate. The plan was adopted by the County Board of Supervisors on XXX, 2023.

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 plan are true and correct.

_____ _____

Signature Date

Dr. Hillary Kunins

Local Mental Health Director/Designee

County: San Francisco County

Date: July XX, 2023

MHSA County Fiscal Accountability Certification

County/City: San Francisco

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

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

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

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

Hillary Kunins, MD, MPH
Local Mental Health Director (PRINT)

DocuSigned by:
Hillary Kunins
2DAAE14FF8AC4A7...
Signature

8/17/2023 | 6:10 PM PDT
Date

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

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

I hereby certify that for the fiscal year ended June 30, 2022 , 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 March 1, 2023 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Ben Rosenfield

County Auditor Controller / City Financial Officer (PRINT)

DocuSigned by:

8/31/2023

Signature Date

Director's Message

California's Proposition 63 brought a promise to improve the delivery of public mental health services to people with mental health conditions and their family members. San Francisco Mental Health Services Act (MHSA) programs and projects aim to help people navigate complex behavioral health systems, receive culture-centered mental health support, and support change in traditional mental health systems. San Francisco MHSA makes investments in mental health prevention and early intervention services, vocational programs and peer support services for individuals experiencing mental health disorders. This also includes workforce development efforts to bring more practitioners of color to the labor force, system infrastructure, technology, training, and other strategies to strengthen the city's public behavioral health system.

As we continue to recover from the impacts of COVID-19, we pivoted our efforts to be more inclusive and collaborative with our behavioral health equity and trauma-informed initiatives. Since the beginning of the COVID-19 pandemic, SFDPH MHSA programs have stayed grounded in providing care to their community members. Similar to other cities, San Francisco's mental health disparities were magnified with the onset of COVID-19 – casting a light on the lack of licenses, clinical therapists who speak languages other than English and come from similar backgrounds and cultural understandings as clients, growing demand for mental health services; job losses; home evictions; families who do not have computer equipment to participate in telehealth; homes that do not have Wi-Fi for their children and youth to participate in online school sessions; and community-based organizations that are severely understaffed. This called for us to improve our dedication to ensure that our programs had the support and respond to center equity and an anti-racist framework to ensure that we provide high-quality mental health and substance use interventions for our vulnerable communities. In 2020, we merged our MHSA and trauma informed sections with the Office of Justice, Equity, Diversity and Inclusion, as known as JEDI.

Our JEDI Team comprises the Mental Health Services Act, Trauma-Informed Systems, Equity, Staff Wellness, and Workforce Development & Training. This JEDI structure allows us to expand our responsibilities to ensure that equity is embedded throughout all systems of care. JEDI is responsible for providing the vision and leadership to over 900 employees within BHS while collaborating with senior leadership on innovative equity-focused internal and external practices that operationalize equity efforts that impact our workforce and provide high-quality and timely access in care to our diverse clinics.

JEDI/MHSA continues to partner with BHS in offering a wide range of behavioral health services provided by a culturally diverse network of community behavioral health programs and private psychiatrists, psychologists, and therapists. With the impacts of COVID-19, merging our equity, trauma-informed and MHSA initiatives has allowed us to expand and improve our mental health and substance use services, including outpatient treatment, inpatient treatment, medication management, linkage services, and an extensive array of more specialized treatment services. Since integrating our efforts, the SFDPH JEDI/MHSA achieved numerous accomplishments in FY 21-22, as outlined below:

- Sustaining funding for current programs and services with demonstrated impact;
- Providing additional funding to strengthen population-focused: Mental Health Promotion and Early Intervention Programs;
- Augmenting capital projects;
- Growing Full-Service Partnerships (FSP) by expanding treatment slots;
- Launching and Implementing the MHSOAC-approved innovation project for "Culturally Congruent Practices for Black/African American Communities;"
- Expanding the San Francisco Dream Keeper Initiative (www.dreamkeepersf.org), which provides comprehensive support for 300 Black/African American families struggling to meet basic needs due to systemic failure and educational activities for 500 Black/African American youth;
- Provide funding to continue the Dream Keeper Initiative's fatherhood and Black/African American children programming;
- Piloting a project to bring culturally affirming patient navigation support to the City's Chinatown North Beach Clinic;
- Piloting a Pre- and Post-Natal Program for Black/African American Birthing Parents;
- Launching a Maternal Mental Health Project for Birthing Parents; and
- Providing Talk Therapy to Black/African American Clients throughout San Francisco.

As we enter FY23-24, the SFDPH JEDI/MHSA program will continue supporting culturally responsive and equity-focused community-based programs that are well-versed in providing innovative mental health services. We will continue to expand workforce development programs that are dedicated to diversifying the City's public mental health workforce to better reflect the disenfranchised and marginalized communities being served. Furthermore, our efforts will focus on providing housing security to our most vulnerable clients while providing intensive case management to further support clients in our dedicated housing units.

Leading with race and prioritizing intersectionality, including sex, gender, sexual orientation, age, class, nationality, language, and ability. JEDI/MHSA strives to move forward on the continuum of becoming an anti-racist, multicultural institution by honoring the cultural and linguistic needs of our clients and workforce; reducing mental health and substance use disparities; and empowering our communities by incorporating their voices, conditions, and ideas into our JEDI/MHSA programs and initiatives. We are committed to building solidarity and becoming a healing organization in partnership with our workforce, clients, and communities.

In Community,

Jessica Brown

Jessica Brown, Director of SFDPH MHSA and JEDI

Juan Ibarra

Juan Ibarra, Acting Assistant Director for SFDPH MHSA and JEDI

Introduction to MHSA

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

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

As dictated by the law, the majority of San Francisco MHSA funding must be allocated to the development and delivery of treatment services. In San Francisco, MHSA funding expanded access to intensive treatment services, housing, employment services and peer support services for thousands of individuals with mental illness, 50 percent of whom are homeless or at-risk of becoming homeless. Promising outcomes from MHSA investments include declines in arrests, mental and physical health emergencies, school suspensions and expulsions, and the number of days in residential treatment, per data collected from the MHSA Year-End Reports. Proposition 63 also stipulates that 20 percent of the funds support programs "effective in preventing mental illnesses from becoming severe" and "reducing the duration of untreated severe mental illnesses."

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

- MHSA integrated with the SFDPH BHS Office of Justice, Equity, Diversity, and Inclusion (JEDI) in order to expand our system-wide equity efforts.
- JEDI/MHSA invests in the training, support, and deployment of peer providers throughout SFDPH. JEDI/MHSA partners with local service providers and community members to brainstorm ways to better support the peer provider community.
- JEDI/MHSA regularly conducts outreach to many different cultures and communities throughout San Francisco in effort to engage outreach workers, identify mental health-related needs in these communities, and provide information on population-specific services available in the City.

In FY21-22, MHSA served a total of 63,518 individuals through outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic services; and service linkage efforts.

SFDPHJEDI/MHSA strongly promotes a vision of outreach and engagement, a recovery and wellness approach, a belief in the strength and resilience of each person with mental illness, and recognition that they are to be embraced as equal members of our community.

SF Nightlife and Entertainment Summit in 2022

California's MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

1. **Cultural Competence**
   Services should reflect the values, customs, beliefs, and languages of the populations served, and eliminate disparities in service access.

2. **Community Collaboration**
   Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.

3. **Client, Consumer, and Family Involvement**
   Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.

4. **Integrated Service Delivery**
   Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers, and families.

5. **Wellness and Recovery**
   Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

SF City Hall lighting in recognition of Trans Awareness Month, September 2022

Community Program Planning (CPP) & Stakeholder Engagement

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

Community Program Planning (CPP) & Stakeholder Engagement Activities

Exhibit 1 provides an overview of San Francisco's ongoing CPP activities. San Francisco MHSA employs a range of strategies to engage stakeholders at all levels of planning and implementation. Our CPP process provides opportunities for stakeholders to participate in the development of our Three-Year Program and Expenditure Plans and Annual Updates, and stay informed of our progress in implementing MHSA-funded programs.

Exhibit 1. Key Components of MHSA CPP

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

In addition to the ongoing CPP activities listed in Exhibit 1, MHSA hosts activities and events throughout the year to promote mental health awareness. This includes activities for Mental Health Awareness Month in May, Suicide Awareness Month in September, Overdose Awareness Day on August 31st, Each Mind Matters webinars, as well as ongoing activities for the BHS Client Council, Stigma Busters, and JEDI.

JEDI/MHSA Communication Strategies

SFDPH keeps stakeholders and other community members updated about MHSA through a variety of communication strategies, including the SFDPH BHS MHSA website, regular communication with community groups, contributing content to the BHS Biweekly Newsletter, and providing regular updates to stakeholders.

The San Francisco MHSA webpage on the SFDPH website, https://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp provides up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The webpage is now hosted through the San Francisco Department of Public Health website. The biweekly BHS Director's Report provides another forum for sharing information about the implementation of MHSA with a broad group of stakeholders. Each month, MHSA provides updates about program implementation, upcoming meetings and other MHSA news.

Each Mind Matters outreach table at 1380 Howard in 2021

MHSA Advisory Committee & Our Commitment to Client Engagement

JEDI/MHSA Advisory Committee

The JEDI/MHSA Advisory Committee is an integral component of community engagement, which 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 JEDI/MHSA Advisory Committee includes the following:

- Working collaboratively with BHS to support broad community participation in the development and implementation of MHSA initiatives.
- Discussion on BHS equity goals and culturally responsive care for diverse communities
- Guiding MHSA resources to target priority populations as identified in existing MHSA plans
- Ensuring that San Francisco's mental health system adheres to the MHSA core principles
- Holding meetings every two months
- Encouraging community participation at meetings

The JEDI/MHSA Advisory Committee's robust recruitment efforts focus on engaging community members, including those with behavioral health disorders, their family and friends, service providers, and other stakeholders, with an emphasis on the following underrepresented community members: those with lived experience with substance use disorder and the justice system, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of more than 25 active members. The 2022 MHSA Advisory Committee meeting schedule was as follows: 3/30/22, 7/13/22, 9/28/22 and 12/14/22. The purpose of these meetings is to gather committee member feedback on MHSA programming and the needs of priority populations. The 2022 meetings covered the following important topics: training and collaborative efforts, including MHSA budget and programmatic updates as well as presentations from the JEDI team and Community Mental Health Academy.

Increasing Client Engagement with the SF BHS Client Council

The Client Council is a 100 percent client-driven and operated advisory body. The mission of the Client Council is to support San Francisco mental health clients to protect their rights, advocate their issues, and ensure their participation in all phases of systematic changes in services, implementation of programs, and treatment development. The goal of the Client Council is to advise BHS regarding policies and practices that directly influence clients in mental health and substance use services.

The BHS Client Council remains flexible in providing support to clients as they respond to the changing needs in the community. Throughout 2022, the Council met remotely at least once each quarter (3/30/22, 6/29/22, 7/13/22, 9/28/22, and 12/7/22). The Council responded to numerous inquiries for support in implementing program changes through the system.

Strengthening Relationships

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

Community Program Planning session in 2019.

JEDI/MHSA partners with the SF Behavioral Health Commission to gather valuable feedback regarding MHSA strategies. The SF Behavioral Health Commission has been closely involved since the initial development of MHSA in San Francisco. The Commission works as an oversight body to provide education to MHSA leadership teams and to ensure that the needs of the community are met. JEDI/MHSA provides updates to the SF Behavioral Health Commission at monthly board meetings to keep them abreast of new developments and activities. The Commission includes members with personal lived experience with the mental health system. Its members are strong advocates for FSP programs and their clients.

Recent Community Program Planning Efforts

Community Program Planning and the JEDI/MHSA 2023-26 Program and Expenditure Plan

The SFDPH JEDI/MHSA team regularly engages with the community and conducts ongoing and extensive CPP efforts. SFDPH continued conducting extensive community outreach and engagement efforts to inform program planning for the MHSA 2023-26 Program and Expenditure Plan. Community members' voices are critical in guiding MHSA program improvements and developing new programming. Beginning in 2020, due to the COVID-19 pandemic, community outreach, and engagement efforts moved to a virtual format. While the nature of virtual community meetings can pose new barriers to engagement, such as access to technology, it also allowed us to continue to build connections with our community during the COVID19 pandemic. Virtual meetings also provided opportunities for us to reach new audiences who may otherwise have faced barriers to attending in-person meetings, such as transportation. This report provides a comprehensive overview of our community outreach and engagement efforts and key findings in 2021-22 programming, and our plans to integrate community feedback into MHSA programming. SFDPH remains committed to conducting community outreach and engagement to ensure clients have the appropriate wellness tools and resources to support them in their recovery journey.

Community and Stakeholder Involvement

MHSA staff presents at 2019 CPP meeting on Housing Needs

SFDPH strengthens the MHSA program planning by collaborating with behavioral health service clients, their families, peers, and providers to identify the most pressing behavioral health-related needs of the community and develop strategies to meet these needs. In 2022, **JEDI/MHSA hosted 16 community engagement meetings across the city** to collect community member feedback on existing programming and to better understand the needs of the community and to develop this plan. **More than 165 people attended**, including mental health and other service providers, clients of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders.

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

The 2022 CPP meetings are listed in the following table.

2022 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening**
3/4/22	Impact Meeting Mid-Year Reporting/Technical Assistance (TA)
3/30/22	Advisory Committee Meeting MHSA Budget
4/19/22	RAMS: Asian and Pacific Islander Mental Health Collaborative
4/21/22	Peer Employees MHSA Budget
5/12/22	Mayan, Latino/a/e/x, Immigrant/Indigenous Latino/a/e/x Program Improvement and Planning

2022 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening**
5/17/22	Curry Senior Center Clients Drop-In Center Request for Qualifications (RFQ) & Older Adult BH Needs
5/17/22	Impact Meeting FY22-23 Program Objectives/TA
6/28/22	Peer Forum Presentations from Peer Programs (RAMS, NAMI, MHASF)
7/13/22	Advisory Committee Meeting MHSA Updates
8/30/22	Impact Meeting Year-End Reporting/Technical Assistance
9/8/22	Crisis Operations Meeting Tenderloin Center Operations
9/28/22	Advisory Committee Meeting MHSA Updates, Presentations from JEDI Team, and Community Mental Health Academy
10/07/22	Adult/Older Adult System of Care All Provider Meeting Peer Transition Teams – Most Beneficial Parts of the Program and Program Ideas
11/16/22	Behavioral Health Commission Increasing Budget Involvement
12/14/22	Meeting with Vocational Coop Partners Outreach-Referral Strategy Planning Session
12/14/22	Advisory Committee Meeting MSHA Updates

In each community meeting, SFDPH JEDI/MHSA staff presented an overview of the MHSA, including its core components, guiding principles, and highlights of existing programs and services. Staff also provided training on the equity framework and substance use/overdose prevention strategies. Staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health and strategies to address needs. These discussions also addressed how SFDPH can improve existing MHSA programming. SFDPH MHSA staff addressed how the feedback would be incorporated into the 2023-26 Plan and in future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the MHSA 2022-23 MHSA Program and Expenditure Plan.

Community and Stakeholder Feedback

The feedback and input shared by our community stakeholders, which is typically scheduled around the Advisory Committee meetings with service providers and other community partners present. Their feedback is used as an ongoing valuable resource to help inform the direction of the programming.

CPP meetings in 2022 built on existing community and MHSA programming meetings to understand the general behavioral health needs of the community, as well as specific program improvement planning and other feedback. The following notes highlight the key takeaways from these meetings. This feedback is incorporated into our continuous program improvement planning efforts.

> ***"Wellness and recovery services promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives."***
> **-** *Service provider*

- Culturally responsive services reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access – this is of upmost importance in overcoming stigma, connecting clients to services, and successfully engaging with them.
- It is critical that mental health clinicians and staff are representative of the clients our programs serve, particularly when serving communities that are culturally, medically, economically, or otherwise isolated. This includes certain populations (e.g., TAY, LGBTQ+, racial and ethnic groups) as well as entire neighborhoods (e.g. Bayview/Hunter's Point).
- Some SFDPH JEDI/MHSA-funded programs develop personal success plans with each client to assist them in defining their health and wellness, employment, education, community, and interpersonal goals and then helping them to reach those goals. This promotes individuals' success in the program and beyond.
- Promoting collaboration across service providers to strengthen partnerships and referral networks helps connect clients with better opportunities for employment, housing, and education.
- Some JEDI/MHSA-funded programs have long waitlists (such as programs serving socially isolated older adults), which makes it difficult for people to access the services they need.
- Moving services to virtual or hybrid format has helped connect to many clients who may otherwise not be able to participate in programming due to barriers to attending in-person. Many clients are interested in continuing virtual and hybrid program options, but this requires programmatic flexibility to be able to understand and be responsive to client needs and program requirements.
- Simple tips to relieve stress and anxiety are in high-demand and these types of supports have been well received by the community, especially given the rise of COVID19.
- The use of evidence-based practices, coupled with peer intervention, has seen great outcomes in addressing loneliness and isolation among older adults in the UCSF/Curry Senior Center programming. The use of evidence-based practices demonstrates a reduction in loneliness, depression, and barriers to socialization for clients.
- Children and youth have been struggling with behavioral needs, particularly in school settings, and service providers are finding success in supporting them by prioritizing individual and meaningful connections with caring adults, mentors, coaches, and other youth. This type of programming has helped youth create strong, lasting bonds that redirect negative behaviors. Teachers have shared positive feedback about the students

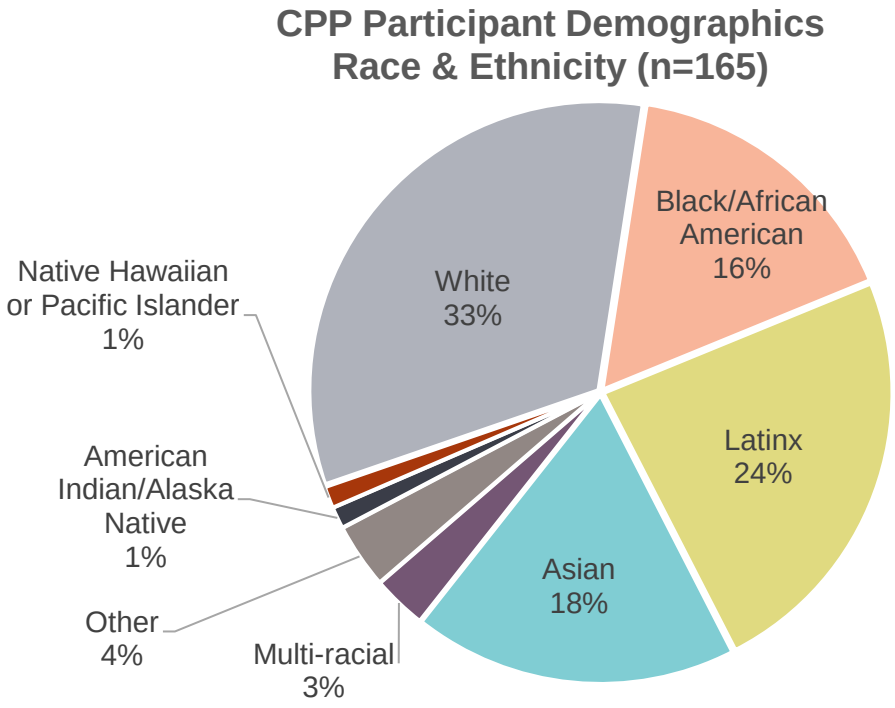
who engage in this programming, noting a reduction in anger and an improvement in communication.

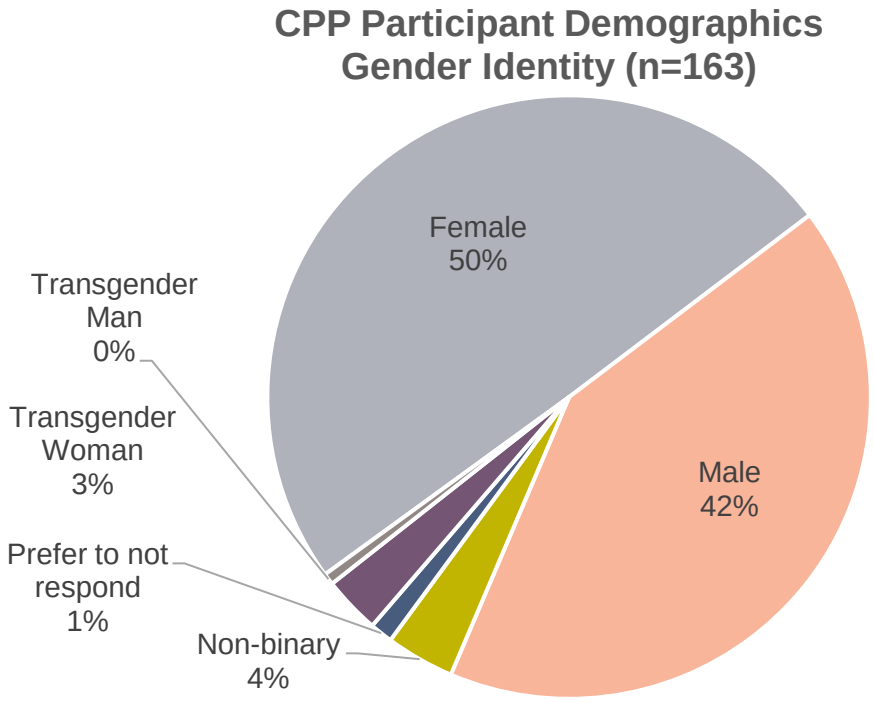
- During the peak of the COVID19 pandemic, children struggled with understanding the pandemic and were faced with stressors that dominated their lives; MHSA programs helped children to redirect, normalize mental health challenges, and reduce the stigma to seek help; children and their families, along with providers, were appreciative this resource remained in place and with such high success rates.
- Some JEDI/MHSA-funded programming were the only mental health programs open and operating during the first half of FY21-22. Programs are reporting an increase in requests for additional services, hours, and a larger breadth of services, with an emphasis in adult mental wellness due to the stressors that continue to be related to COVID19.
- The Community Building Program has seen a significant increase in the number of people needing rental assistance; many people within the community have not paid rent due to the financial hardship of the pandemic.

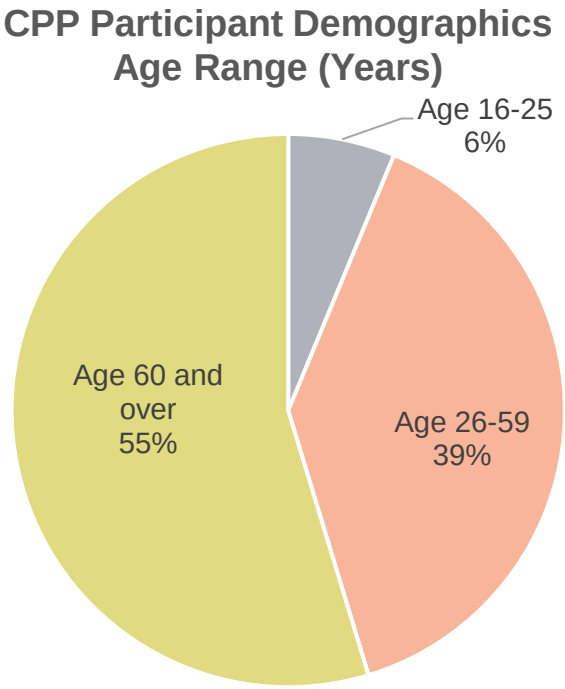
MHSA Staff Celebrating Their Successes in 2022

CPP Meeting Participation

More than 165 individuals attended a CPP meeting in 2022. CPP client demographics (race/ethnicity, gender identity, age) for 2022 are included below. CPP events were held virtually in 2022, which made the collection of meeting client demographic data more challenging to collect as clients often do not complete demographic survey requests.







Community Program Planning with Service Provider Selection

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

- Community Drop-In and Resource Support Services
- Peer Health and Advocacy Programs
- Population-focused Activities

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

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

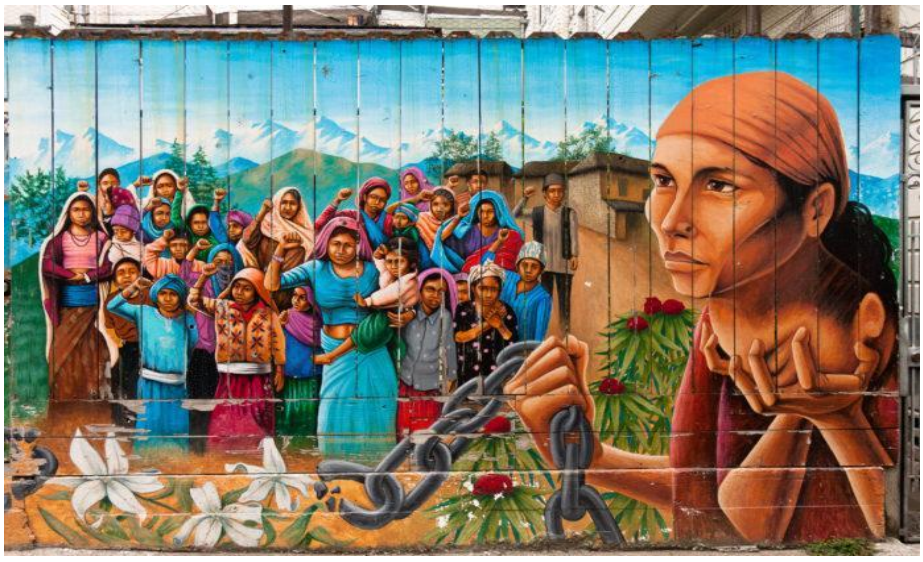
Assessment of San Francisco's Mental Health Needs and Capacity to Implement Proposed Services

Per the California Mental Health Services Act, the County must include a narrative analysis of its assessment of the County's mental health needs and its capacity to implement proposed programs and services. Below is a brief summary of our work to meet these regulations.

BHS and JEDI/MHSA units conducted a thorough analysis to determine the needs of the San Francisco community. This analysis identifies the shortage of qualified staff to provide valuable services and the staff needed to address the various mental health needs of our community. SFDPH JEDI/MHSA has a workforce program with dedicated funding to help remedy these gaps. As a result of this analysis, we developed a report that discusses these shortages, the progress we have made over the past few years and plans to further increase the supply of professional staff and other staff that we anticipate will be needed to continue providing exceptional MHSA programming to our communities. BHS Leadership worked with various stakeholders and community members to develop a logic model, action plan priorities, a list of challenges and needs, staff data tables, and recommendations.

For a summary of the data described above and for additional background information on population demographics, health disparities, and inequalities, please see Appendix A.

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



"NAYA BIHANA" (A New Dawn) mural by Martin Travers, San Francisco Mission

CPP in Program Implementation

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

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

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Proposition 63, an emphasis was placed on the importance of consumer participation in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. **SF MHSA funded 258 peers in FY21-22** throughout our behavioral health system. Consumers can be found working in almost all levels and types of positions, including: peer counselors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management.

San Francisco's Integrated JEDI/MHSA Service Categories

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

Exhibit 2. MHSA Service Categories

JEDI/MHSA Service Category	Description
Recovery-Oriented Treatment Services: *CSS Funding*	● Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment) ● Uses strengths-based recovery approaches
Peer-to-Peer Support Services: *CSS Funding*	● Trains and supports clients and family members to offer recovery and other support services to their peers
Vocational Services: *CSS Funding*	● Helps clients secure employment (e.g., training, job search assistance and retention services)
Housing: *CSS Funding*	● Helps individuals with serious mental illness who are experiencing homelessness or at-risk of homelessness to secure or retain permanent housing ● Facilitates access to short-term stabilization housing
Mental Health Promotion & Early Intervention Services: *PEI Funding*	● Raises awareness about mental health and reduces stigma ● Identifies early signs of mental illness and increase access to services
Behavioral Health Workforce Development: *WET Funding*	● Recruits members from unrepresented and under-represented communities ● Develops skills to work effectively providing recovery-oriented services in the mental health field
Capital Facilities/Information Technology: *CFTN Funding*	● Improves facilities and IT infrastructure ● Increases client access to personal health information

Developing this Program and Expenditure Plan

The SFDPH MHSA 2023-26 Program and Expenditure Plan was developed in collaboration with MHSA clients, peers, family members, service providers, local residents, and other stakeholders. The SFDPH JEDI/MHSA community outreach and program planning efforts were coordinated by a core team of JEDI/MHSA staff, which included the JEDI/MHSA Director and Program Managers. Independent consulting firms, Hatchuel Tabernik & Associates and Harder+Company Community Research, provided assistance with program planning and implementation, project management, coordination, community outreach, technical writing, and program outcome data analysis and reporting.

In the planning work conducted for the FY23-26 Three Year Plan, the MHSA team incorporated the stated goals of the JEDI/MHSA, the mission of the San Francisco Department of Public Health, newly expanding work in behavioral health funded under Mental Health SF, local data about community need, and revisited local MHSA priorities and needs identified in our previous Program and Expenditure Plan (2020-2023) and subsequent Annual Update Reports. Most importantly, the Community Program Planning (CPP) strategies outlined in the previous section of this report enabled the MHSA team to identify and integrate direct program feedback from the individuals we serve, and the greater community, in planning for future MHSA programming. In addition to incorporating community feedback into our planning process, the MHSA team relied on several other strategies to inform future program improvements, including:

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

Local Review Process

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

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of **San Francisco's MHSA FY2023-26 Program and Expenditure Plan was posted on the MHSA website at www.sfdph.org/dph for a period of 30 days from February 5, 2024 through March 6, 2024.** Members of the public were requested to submit their comments either by email or by regular mail. The following is a summary of the public comments during the 30-day posting and Behavioral Health Commission public hearing:

Summary of Public Comments and BH Commission on the FY23-26 Program and Expenditure Plan		
Community Member/ Stakeholder	Summary of Comments	SFDPH Response
Wynship Hillier	Stakeholder asked that SF-MHSA extend the 30-day comment period to ensure that the public comments from the public hearing would be included in this report.	Stakeholder was assured that comments from the public hearing will be included in this report. SF-MHSA posted for a full 30-day public comment period. SF-MHSA will adhere to all MHSA state regulations.
Margaret Fine	Stakeholder inquired if anyone has a complete list of all mental health programs in SF to avoid duplication.	A complete list of SFDPH Behavioral Health Services can be found on the BHS website at https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/
BH Commissioner Wynn	Stakeholder inquired about how TAY will receive housing and how providers will make referrals, now that Prop 1 has past. Suggestions were made to work closely with HSH and prioritize ICM/FSP clients regarding housing.	Over the next several months, the SF-MHSA Team will hold various stakeholder meetings to plan and implement programming in compliance with new Prop 1 regulations.
BH Commissioner Murawski	Stakeholder requested more outreach activities and requested a list of CBOs that receive MHSA funding. Stakeholder also requested that peers receive increased pay and increased cultural competency training. Stakeholder asked that acronyms are spelled out in the report and asked that the Three-Year	All MHSA programs and funding are listed in this FY23-26 Three-Year Plan. Stakeholder was thanked for the input, and the suggestions will be considered during implementation of the Three-Year Plan.

	Plan be translated into 9 languages, among other suggestions.	
Chair/BH Commissioner Banuelos	Stakeholder suggested art programs for seniors living with HIV/AIDS and therapy programs using AI. Stakeholder also inquired about the distribution of MHSA funds and requested that we look at how the city has redistributed funds for housing and see what improvements need to be made.	Stakeholder was thanked for the input, and these suggestions will be considered during implementation of the Three-Year Plan.
BH Commissioner Stevens	Stakeholder asked questions on how to ensure communication is clear, how to ensure that clients are being met where they are at and how the housing application process can be clearly explained to everyone.	Stakeholder was thanked for the input, and these suggestions will be considered during implementation of the Three-Year Plan.
BH Commissioner Murphy	Stakeholder asked various questions about how Prop 1 will adjust priorities and how stakeholder feedback will be incorporated into the final implementation plan.	Over the next several months, the SF-MHSA Team will hold various stakeholder meetings to plan and implement programming in compliance with new Prop 1 regulations.
BH Commissioner Jackson	Stakeholder talked about the desperate need for housing for homeless individuals and women with children, the need for BIPOC/LGBTQ+ community/school services and other suggestions.	Stakeholder was thanked for the input, and these suggestions will be considered during implementation of the Three-Year Plan.
Stakeholder	Stakeholder requested better coordination of all behavioral health services and systems to ensure that programs are not being duplicated.	Stakeholder was thanked for the input, and these suggestions will be considered during implementation of the Three-Year Plan.

Following the 30-day public comment and review period, **a public hearing was conducted by the Behavioral Health Commission of San Francisco on March 21, 2024.** The public comments from the Behavioral Health Commission meeting are included above. The FY2023-26 Program and Expenditure Plan was also presented before the **Board of Supervisors Audit and Oversight Subcommittee on MONTH DATE 2024** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted this FY2023-26 Program and Expenditure Plan on MONTH DATE 2024.**

Public Hearing & Board of Supervisors Resolution

Placeholder

Resolution placeholder page

SFDPH JEDI/MHSA 2023-26 Program and Expenditure Plan

As a result of the feedback we received during our JEDI/MHSA CPP efforts, and positive outcomes on evaluation outcomes, the following programs/projects will operate as approved in the most recent Annual Update and approved thorough our CPP process.

I. Recovery-Oriented Treatment Services

- Strong Parents and Resilient Kids (SPARK) (FSP Program)
- San Francisco (SF) Connections (FSP Program)
- Family Mosaic Project (FSP Program)
- Transitional Age Youth (TAY) Full-Service Partnership at Felton (FSP Program)
- SF Transition Age Youth Clinic (FSP Program)
- SF Transitional Age Youth Full-Service Partnership at Seneca (FSP Program)
- Adult Full-Service Partnership at Hyde Street (FSP Program)
- Assisted Outreach Treatment (AOT) (FSP Program)
- SF First (FSP Program)
- Forensics at UCSF Citywide (FPS Program)
- Older Adult FSP at Turk (FSP Program)
- AIIM Higher
- Community Assessment and Resource Center (CARC)
- Behavioral Health Access Center (BHAC)
- Behavioral Health Services in Primary Care for Older Adults
- PREP - TAY Early Psychosis Intervention and Recovery (also known as ReMIND)

II. Peer-to-Peer Support Programs and Services

- LEGACY
- Peer-to-Peer, Family to Family
- Peer Specialist Certificate, Leadership Academy and Counseling
- Gender Health SF
- Peer-to-Peer Employment
- Peer Wellness Center
- Peer-to-Peer Linkage services
- Transgender Pilot Project

III. Vocational Services

- Department of Rehabilitation Co-op
- i-Ability Vocational Information Technology (IT) Program
- First Impressions
- SF First Vocational Project
- Janitorial Services
- Café and Catering Services
- Clerical and Mailroom Services
- Growing Recovery and Opportunities for Work Through Horticulture (GROWTH)
- TAY Vocational Program

IV. Housing

- Emergency Stabilization Housing
- FSP Permanent Supportive Housing
- Housing Placement and Support
- Transitional Housing
- TAY Transitional Housing

V. Mental Health Promotion and Early Intervention

- Peer Outreach and Engagement Services
- Behavioral Health Services at Balboa Teen Health Center
- School Based Mental Health Services
- School Based Youth Early Intervention
- School Based Wellness Centers
- Trauma and Recovery Services
- Senior Drop-In Center
- Addressing the Needs of Socially Isolated Adults Program
- Ajani Program
- Black/African American Community Wellness and Health Initiative (BAACWHI)
- Improving Maternal Mental Health for Black/African American Birthing People
- Homeless Children's Network MA'AT Program
- Kummba Peer Fellowship Program
- API Mental Health Collaborative
- Indigena Health and Wellness Collaborative (Latinx including indigenous Mayan communities)
- Living in Balance
- South of Market (6th Street) Self-Help Center
- Tenderloin Self-Help Center
- Community Building Program
- Homeless Outreach & Treatment Program
- Population Specific TAY Engagement and Treatment – Latino/Mayan
- Population Specific TAY Engagement and Treatment – Asian Pacific Islander
- Population Specific TAY Engagement and Treatment – Juvenile Justice/others
- Population Specific TAY Engagement and Treatment –LGBTQ+
- Population Specific TAY Engagement and Treatment – Black/African American
- TAY Homeless Treatment Team Pilot
- ECMHCI Infant Parent Program/Day Care Consultants
- ECMHCI Edgewood Center for Children and Families
- ECMHCI Richmond Area Multi-Services
- ECMHCI Homeless Children's Network
- ECMHCI Instituto Familiar de la Raza
- Mobile Crisis
- Child Crisis
- Crisis Response

VI. Innovation

- FUERTE School-Based Prevention Groups project
- Wellness in the Streets
- Technology-Assisted Mental Health Solutions
- Intensive Case Management/Full-Service Partnership to Outpatient Transition Support
- Culturally Responsive Practices for the Black/African American Communities

VII. Behavioral Health Workforce Development

- Community Mental Health Worker Certificate
- Community Mental Health Academy
- Faces for the Future Program
- Online Learning Management System
- Trauma Informed Systems Initiative
- TAY System of Care Capacity Building – Clinician's Academy (Felton)
- Fellowship for Public Psychiatry in the Adult/Older Adult System of Care

- Public Psychiatry Fellowship at SF General
- BHS Graduate Level Internship Program
- Child and Adolescent Community Psychiatry Training Program (CACPTP)

VIII. Capital Facilities and Information Technology - CF/TN

- Expansion of Telehealth Kiosks – Capital Facilities
- Consumer Portal – IT
- Consumer Employment – IT
- System Enhancements – IT

Positive Resource Center outreach table 2021

1. Recovery-Oriented Treatment Services: CSS Funding

Service Category Overview

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

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

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

FSP Programs

Program Collection Overview

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

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

Target Populations

FSP programs have served a diverse group of clients, in terms of age, race/ethnicity, and stage of recovery. FSP programs serve clients with serious mental illness who are at-risk or may have fallen out of care. BHS and SF MHSA implement a “do whatever it takes” approach to engage with FSP clients, provide therapeutic support and help link them to appropriate levels of care.

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

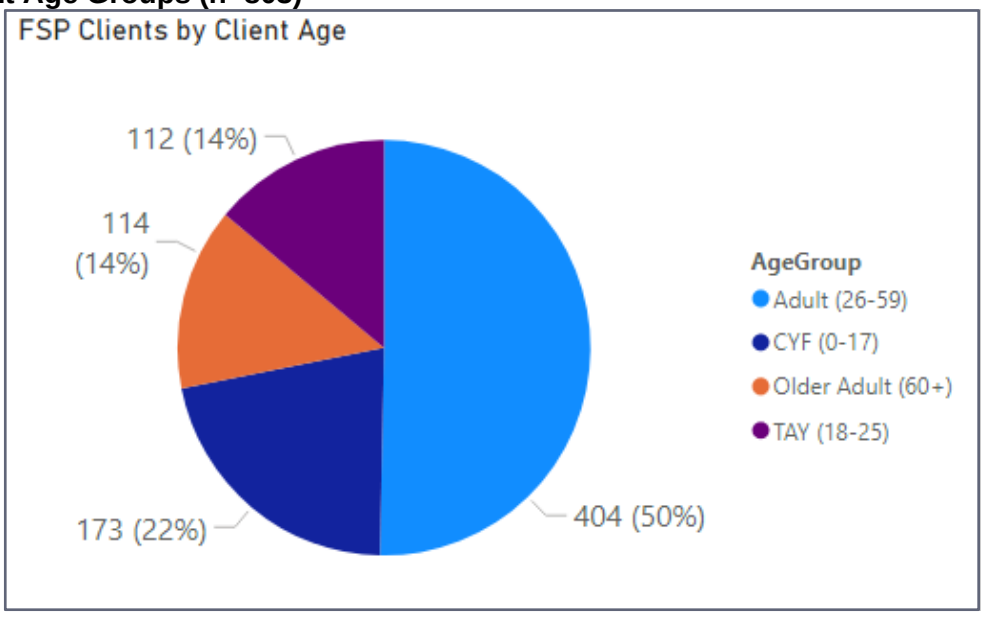
FSP Programs			
Target Population	Program Name *Provider*	Name Listed on ARER, Budget	Additional Program Characteristics
Adults/ Older Adults	Assisted Outpatient Treatment (AOT) *SFDPH & UCSF Citywide Case Management*	CSS Full-Service Partnership 6. AOT	Outreach and engagement for individuals with known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

FSP Client Demographics, Outcomes, & Cost per Client

San Francisco had twelve Full-Service Partnership (FSP) programs during fiscal year 2021-2022. The tables and graphs below describe the demographic characteristics of clients served in the FSPs from July 1, 2021 through June 30, 2022. Data are captured in the programs' electronic health record program, Avatar. Sex, gender identity, race/ethnicity, and primary language are reported by FSP Program and by client age group (as of July 1, 2021).

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

FSP Client Age Groups (n=803)

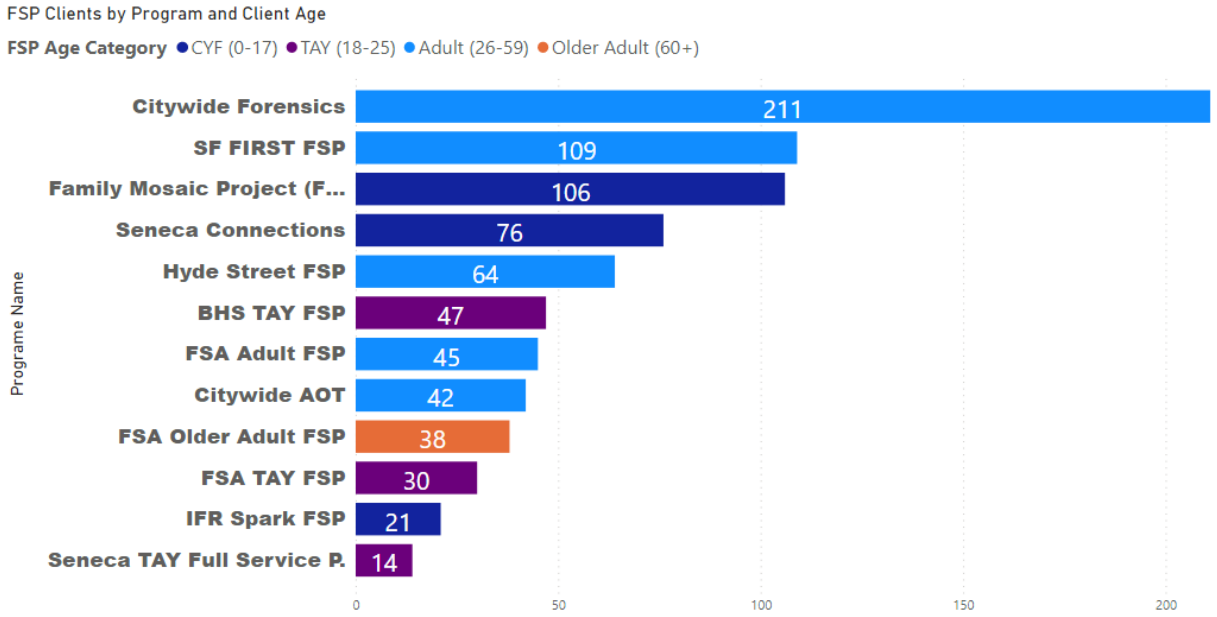


Clients by FSP Program and Age Group

Program	CYF (0-17)	TAY (18-25)	Adult (26-59)	Older Adult (60+)	Total
BHS Tay FSP		43	<10		
Citywide Forensics		<10	185	25	
Citywide Assisted OP		<10	33	7	
Family Mosaic Project	100	<10			
FSA Adult FSP		<10	39	<10	
FSA Older Adult			<10	37	
FSA TAY		19	11		30
Hyde Adult FSP			49	15	64
IFR Spark	21				21
Seneca WRAP	52	24			76
Seneca TAY		14			14
SF First			109		109
Total	173				803

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

FSP Programs Enrollment by FSP Age Category



Client Sex and Gender

Historically, client gender has been entered into the electronic health record (Avatar) with only binary options, female and male. The FSP programs served 306 (38%) females and 497 (62%) males for the 2021-2022 fiscal year.

Client Age Groups by Gender

Age Category	Female	Male	Total
CYF (0-17)	94	79	173
TAY (18-25)	44	68	112
Adult (26-59)	120	284	404
Older Adult (60+)	48	68	114
Total	306	497	803

Under new Sexual Orientation and Gender Identity (SOGI) data recommendations, more granular data have been entered in compliance with SOGI guidelines; 2.9% of clients identified as trans female, trans male, or genderqueer/non-binary.

Gender Identity Breakdown by Age Group

Age Category	Female	Male	Trans Female	Trans Male	Gender-Queer or Non-Binary	Declined to State	No data or no entry	TOTAL
CYF (0-17)	28	22		<10	<10	<10	111	173
TAY (18-25)	29	53	<10		<10	<10	23	112
Adult (26-59)	93	236	<10	<10	<10	<10	55	404
Older Adult (60+)	27	46	<10			<10	38	1144
TOTAL	177	357						803

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

Client Sexual Orientation by Client Age Group

Similarly, as the sexual orientation-gender identity (SOGI) data collection policies and practices continued to be adopted, data on client sexual orientation (SO) were still underreported. Approximately 44% of clients had no data entry on the sexual orientation field. However, for those clients with sexual orientation data, 49% identified as straight/heterosexual, 4% as gay or lesbian, 4% as bisexual, and 1% as questioning/unsure.

Client Race/Ethnicity

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

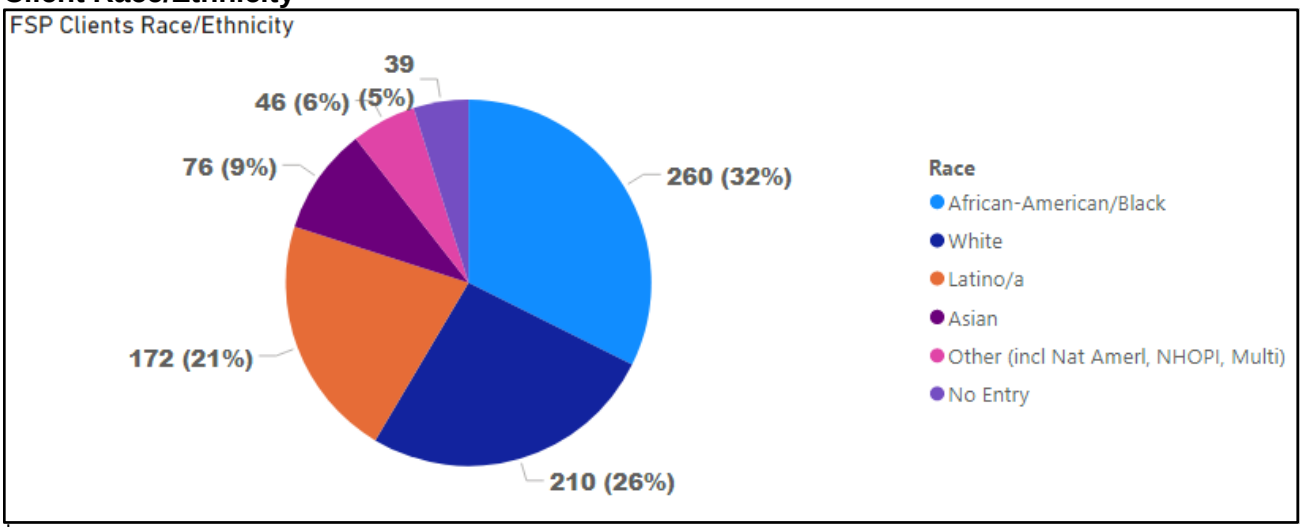
Client Race/Ethnicity by FSP Program

Program	African Amer / Black	Asian	Latino/a/e	Multi-Ethnic	Native Am.	NHOPI	White	Other	No Entry
BHS Tay FSP	15	<10	16	<10		<10	<10		
Citywide Forensics	82	<10	27	<10	<10	<10	73	<10	<10
Citywide Assisted OP	<11	<10	<10	<10			<10		<10
Family Mosaic Project (FMP) BV	25	16	45	<10	<10	<10	<10	<10	13
Family Services Agency	18	<10	10				10	<10	

Program	African Amer / Black	Asian	Latino/a/e	Multi-Ethnic	Native Am.	NHOPI	White	Other	No Entry
(FSA) Adult FSP									
FSA OA	15	<10	<10				15		<10
FSA TAY	<10	<10	<10	<10		<10	<10	<10	<10
Hyde Adult FSP	23	<10	<10	<10		<10	28	<10	
IFR Spark	<10	<10	<10						<10
Seneca WRAP	31	>10	17	<10	<10	<10	<10	<10	<10
Seneca TAY	<10	<10	<10	<10		<10	<10		
SF First	28	<10	18	<10	<10	<10	50		<10

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

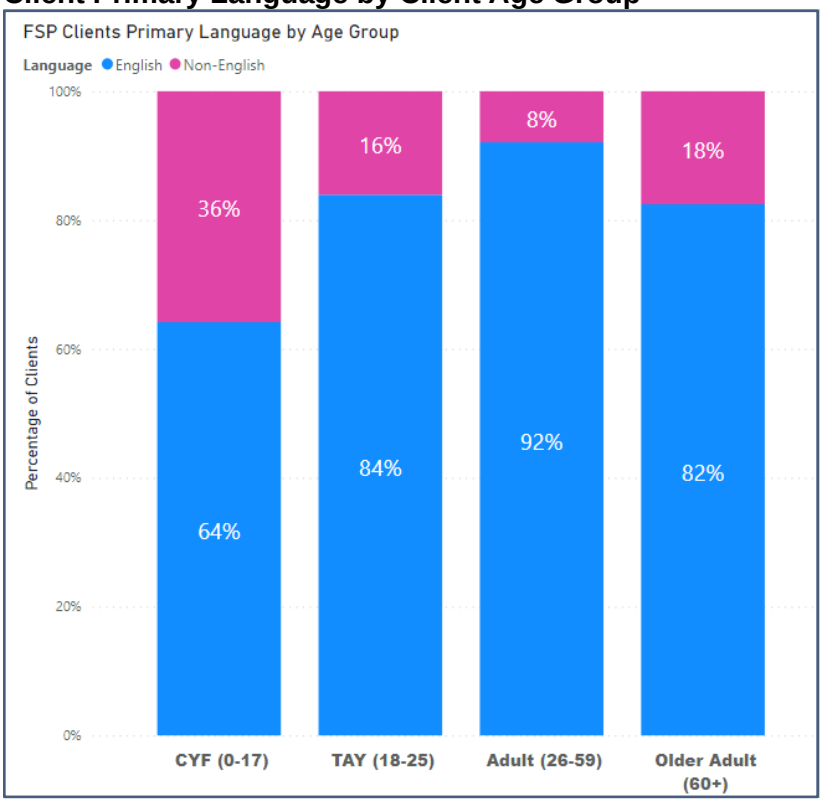
Client Race/Ethnicity



Client Primary Language

Client Primary Language is collected at FSP intake, and updated by case managers, as part of the Client Services Information (CSI) admission and treatment planning processes required by Medi-Cal. Most FSP clients indicate their primary language as English (89%).

Client Primary Language by Client Age Group



Overall, English is reported as the primary language for 89% of FSP Clients, Spanish (7%) Cantonese/Mandarin (2%) and other languages (2%). Other languages included: Vietnamese, Filipino, Tagalog, Russian, German, and Arabic. As defined by DHCS Medi-Cal eligibility, the "threshold" languages for San Francisco are: Spanish, Cantonese, Mandarin, Vietnamese and Russian.

FSP Data Collection and Reporting (DCR) Outcomes

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

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

FSP Residential Outcomes

Data Collection. Residential settings data were extracted using the Enhanced Patient Level Data (EPLD) portal maintained by the Mental Health Data Alliance for DHCS and prepared for reporting using Access and Excel. The graphs include all **clients** active in the FSP during FY21-22 with a completed PAF, who have served in the **FSP partnership for at least one continuous year and up to four years.** These graphs exclude clients who have been active in the FSP for less than one year or more than four.

Chart Interpretation

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

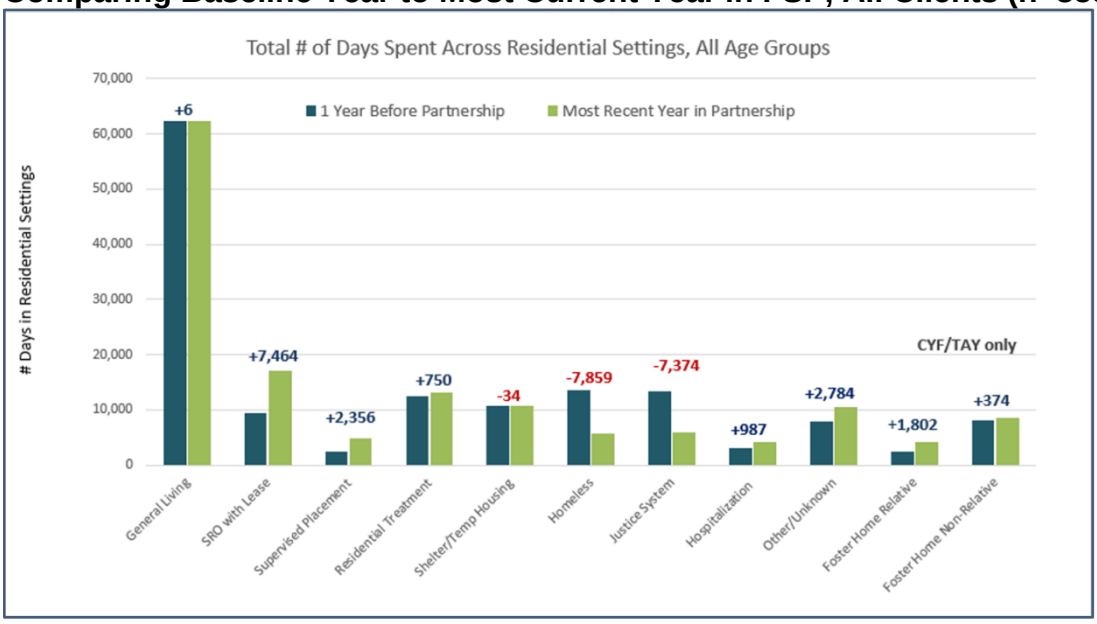
Residential settings are displayed from more desirable (i.e., generally more independent and less restrictive environments) to less desirable for clients. However, this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for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

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

Clients in All FSPs

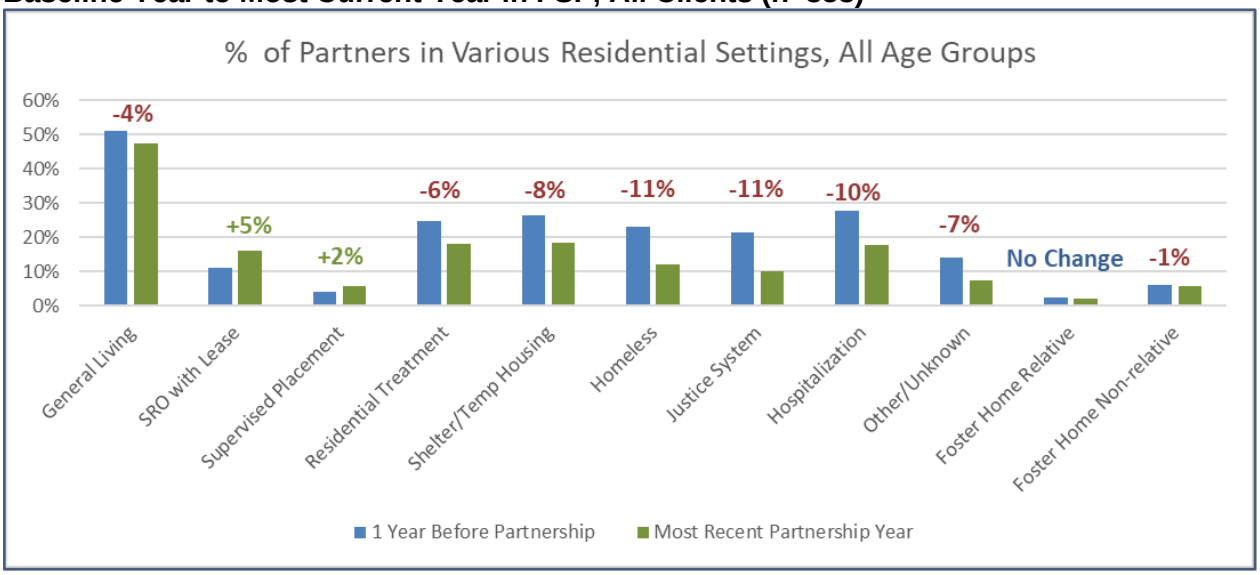
Across all age groups, the residential outcomes below (Exhibit RES-All-1) show reductions in the number of days that all clients enrolled between 1-4 years in an FSP program experienced homelessness and the justice system, but an increase in hospitalizations in their baseline year (pre-FSP) compared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

Exhibit RES-All-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=358)



Time spent in stable settings (General Living, SRO with lease, Supervised placement, Residential Treatment) increased considerably from baseline to the most current year of FSP treatment and simultaneously decreased for less stable or more restrictive settings (Homeless, Justice System). Additionally, the number of clients experiencing these residential settings dropped or remained steady for most unstable or restrictive settings (Exhibit RES-All-2). Looking at the above and below graphs together, it's helpful to notice the direction of days spent and the direction of percentage of clients experiencing that setting. For example, a smaller percentage of clients experienced Residential Treatment and Hospitalizations in the most recent year (18% down from 25%, and 18% down from 28%, respectively). However, those fewer clients spent more days in Residential Treatment and Hospitalization in the most current year, when compared to the baseline data year (up to 1,625 and 205 days, respectively).

Exhibit RES-All-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=358)



Emergency Events

Data Collection. Emergency events include arrests, mental health, or psychiatric emergencies (which include substance use events), and physical health emergencies, as well as school suspensions and expulsions for children and TAY. Physical health emergencies are those which require emergency medical care (usually a visit to a hospital emergency department), not those of a psychiatric nature. The KET is designed for case managers to enter these events as they occur, or the first opportunity thereafter. Key events were entered for 685 of the 803 clients who were active in FSP programs for FY21-22.

Report Methodology. The graphs below compare Emergency Events for **all FSP clients active any time in the fiscal year 2021-22** from the one-year baseline to an **average of emergency events over all years while in the FSP.**

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

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

Limitations. The CYF trends for emergency events highlight two contrasting possibilities: Either the data are complete and FSPs are drastically reducing emergency events for clients following engagement in FSP; or the Key Events data is not complete, and these decreases are artifacts

of a documentation issue in the DCR. Data Quality reports suggest that there are some missing DCR data for CYF clients; thus, trends should be interpreted with caution.

Exhibit EE-All. Emergency Events, Comparing the Baseline Year to an Average of All Years in for Al Age Groups (n=685)

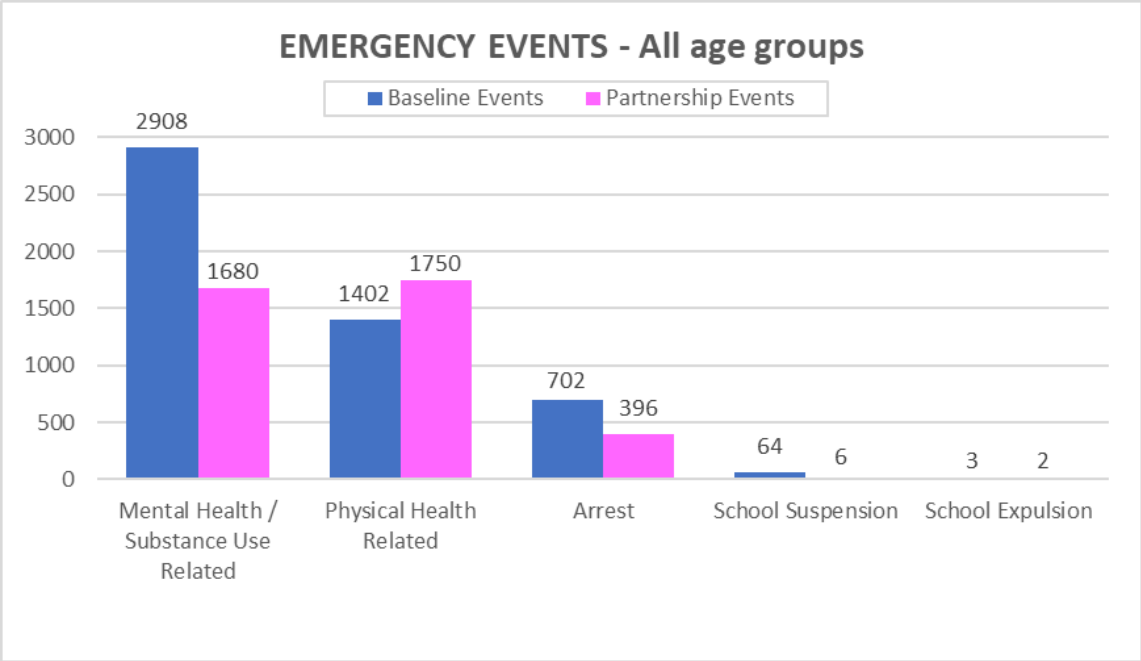
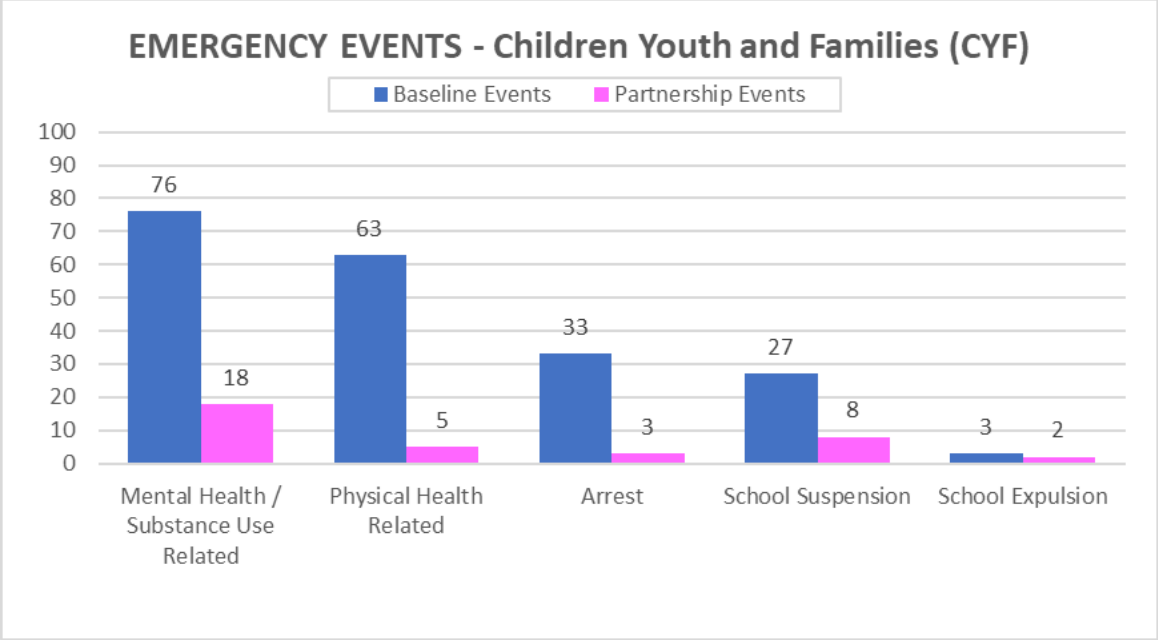


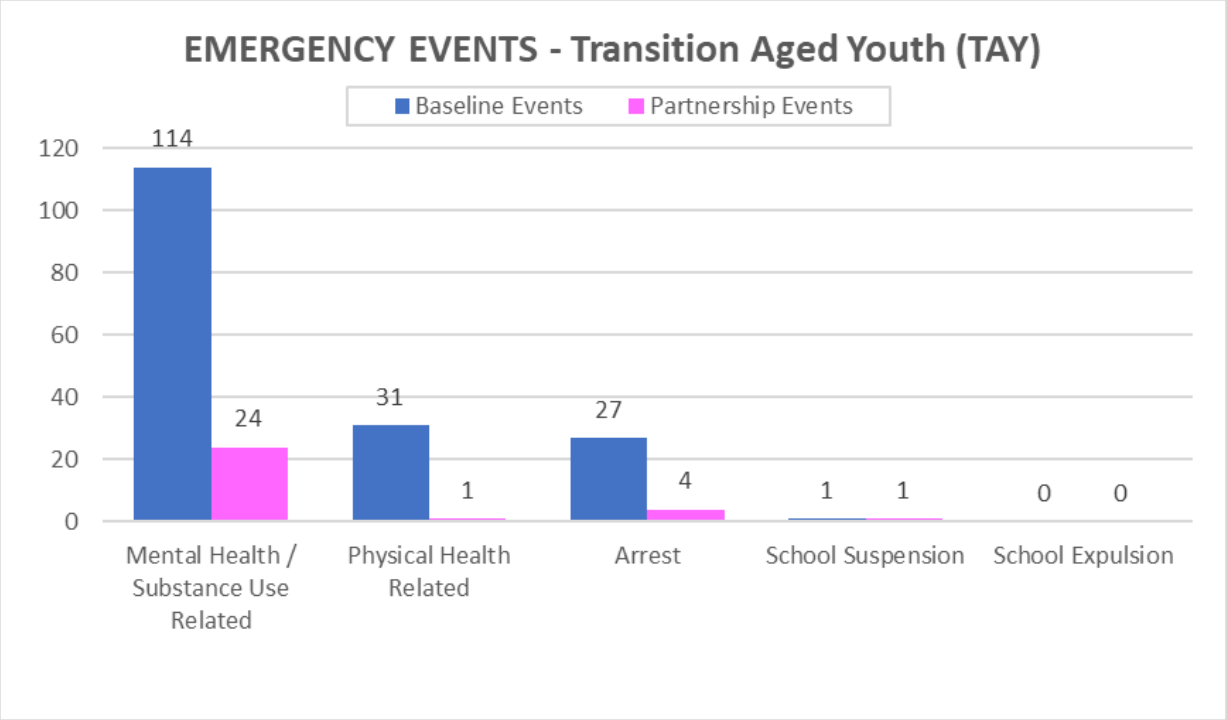
Exhibit EE-CYF, Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, CYF only (n=161)



Among TAY clients, fewer emergency events were reported (Exhibit EE-TAY). Declines appear across all emergency events experienced by TAY clients with the exception of school suspensions which remained the same. This increase is difficult to interpret because of the small size.

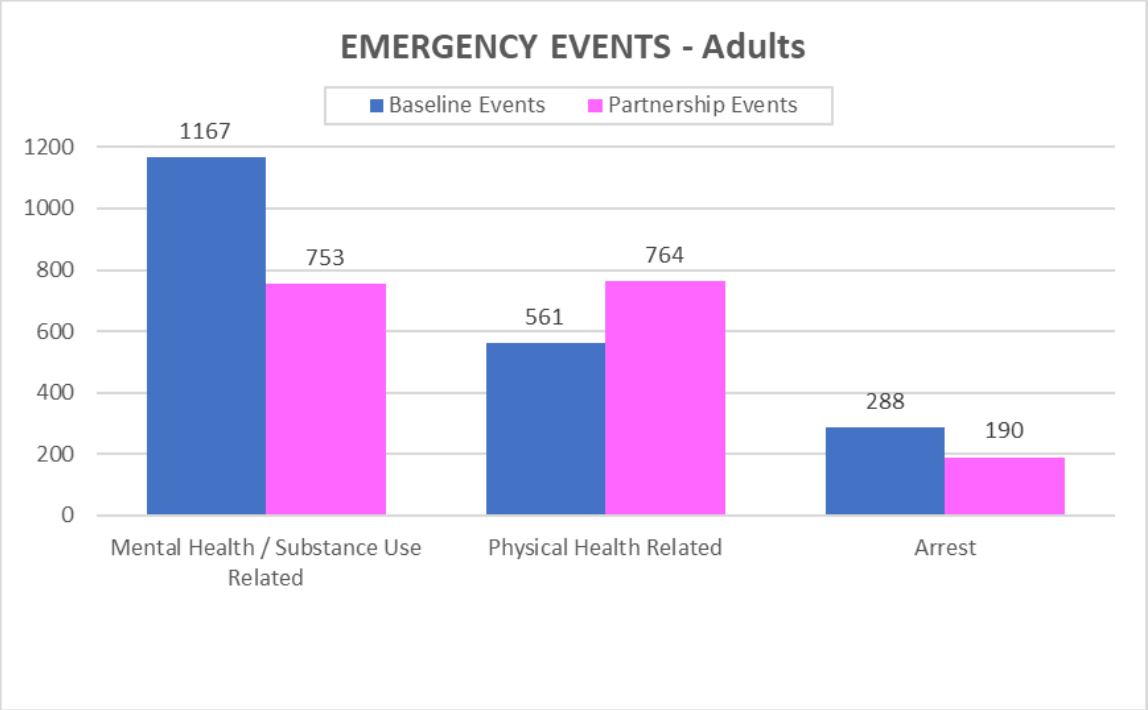
Discharge data also suggest that TAY engagement may be a major challenge (see Exhibit RFD, page 18). Data suggest that TAY clients may leave the FSP programs within the first year of service. Due to the loss of follow up, the full sample of TAY clients served may be under-estimated in the emergency events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

Exhibit EE-TAY. Change in Incidence of Emergency Events, Comparing the Baseline Year to an Average of all Years in FSP, TAY only (n=80)



Among Adult clients, fewer emergency events were reported compared to baseline FSP data (Exhibit EE-A). Declines occurred across all emergency events experienced by adult FSP clients. Although there were more physical health related events recorded in partnership compared to baseline for adults, there were fewer clients who experienced physical health related events during the partnership. The event rates per client for incidences related to mental/substance abuse health, physical health, and arrests declined by 87%, 74%, and 86%, respectively.

Exhibit EE-A. Change in Incidence of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Adult Clients only (n=404)



Older Adult clients. Despite high levels of physical health emergencies among older adult clients at baseline, (Exhibit EE-OA), marked declines appear across all emergency events experienced by this population of clients. For example, arrests, mental health/substance use, and physical health emergencies improved (declined) by over 64%.

While physical health emergencies may be common among older adults, particularly those served by FSP programs, the number of physical health emergencies decreased 86% after at least one year of FSP service. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

Exhibit EE-OA. Change in Incidence of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Older Adults only (n=35)

Reason for Discontinuation

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

A total of 181 discontinuations were logged for FY21-22. Reasons for Discontinuation from FSP varied widely in FY21-22 (Exhibit RFD), with the most often reported reason being “Met Goals” (41%). Of concern is that 18% (n=32) of discontinuations were due to death. Although the cause of death is not clear, this population suffers from long-term substance use disorders, chronic medical conditions, homelessness, and poor access to medical care. Moreover, San Francisco experienced a rise in deaths related to COVID19 and overdose in the past year, both of which this population is vulnerable to.

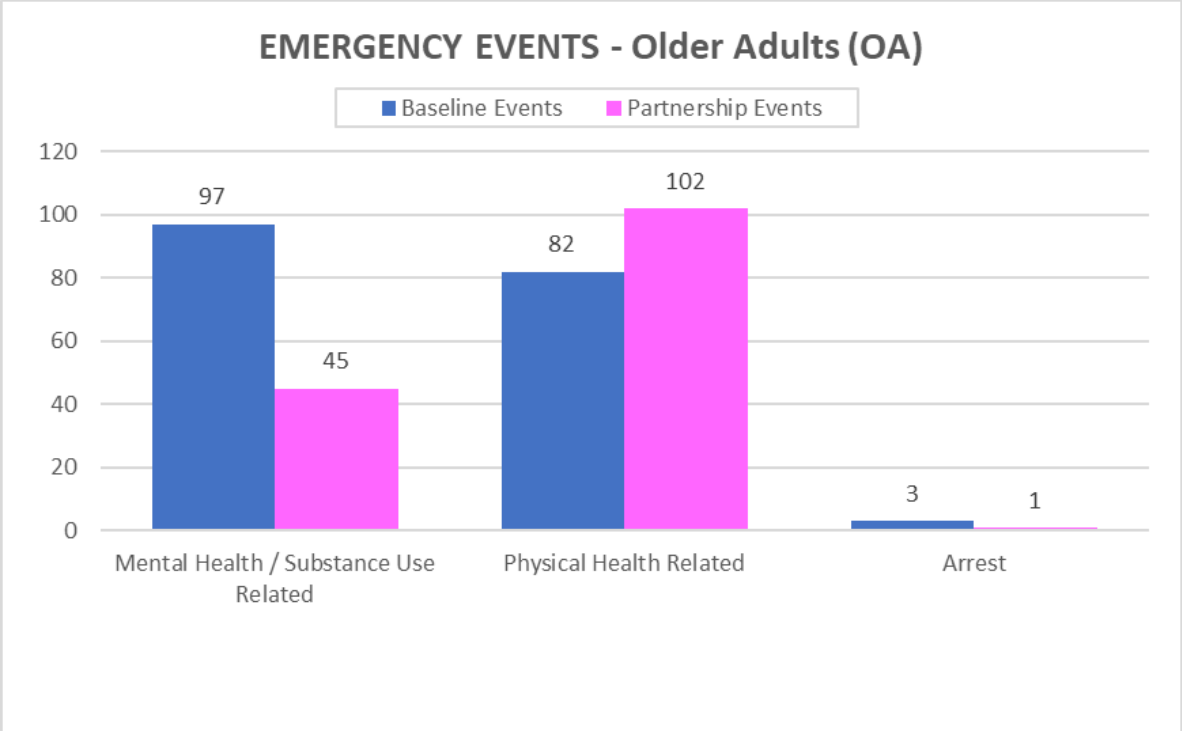
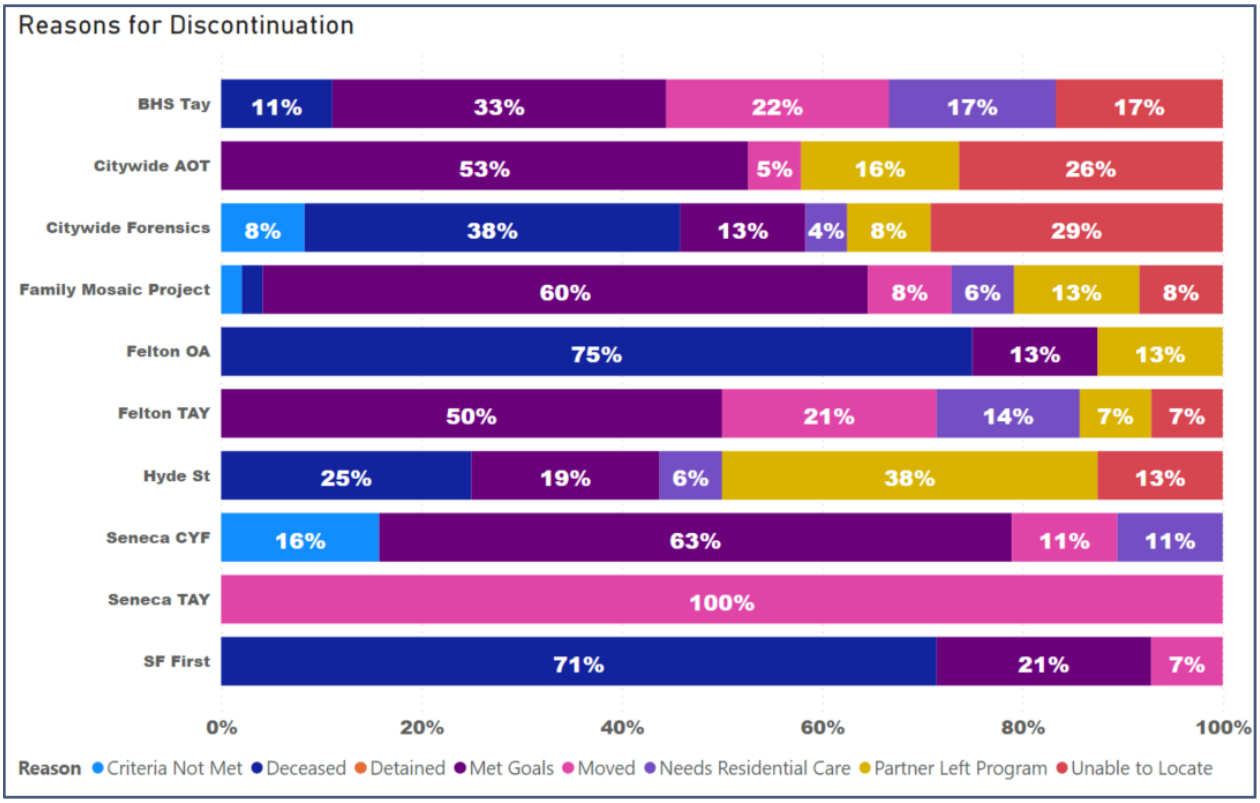


Exhibit RFD. Reason for Discontinuation for All Clients, by Program (n=181)



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

Improving DCR Data Quality

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

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

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

In FY21-22, the DCR Workgroup provided virtual DCR user trainings for new FSP case managers and ongoing support in both data entry and reporting. As has been the case since the

inception of the DCR, more communication and support are needed to increase the completion rate of DCR data.

FY21/22 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[1]
Full-Service Partnership (Children)	173 Clients	$1,294,707	$7,484
Full-Service Partnership (TAY)	112 Clients	$1,167,123	$10,421
Full-Service Partnership (Adult)	404 Clients	$5,740,973	$14,210
Full-Service Partnership (Older Adult)	114 Clients	$1,617,489	$14,189

FSP Three-Year Projection

The following table provides a projected number of clients to be served for the Three-Year Plan. These figures are estimates based on data from the number of clients served from FY17-18 through FY21-22.

FY23/24 – FY25/26 Three-Year Client Projection			
Program	FY23/24	FY24/25	FY25/26
Full-Service Partnership (Children)	203 Clients	203 Clients	203 Clients
Full-Service Partnership (TAY)	108 Clients	108 Clients	108 Clients
Full-Service Partnership (Adult)	439 Clients	439 Clients	439 Clients
Full-Service Partnership (Older Adult)	100 Clients	100 Clients	100 Clients

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

Behavioral Health and Juvenile Justice System Integration

Program Collection Overview

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

Target Populations

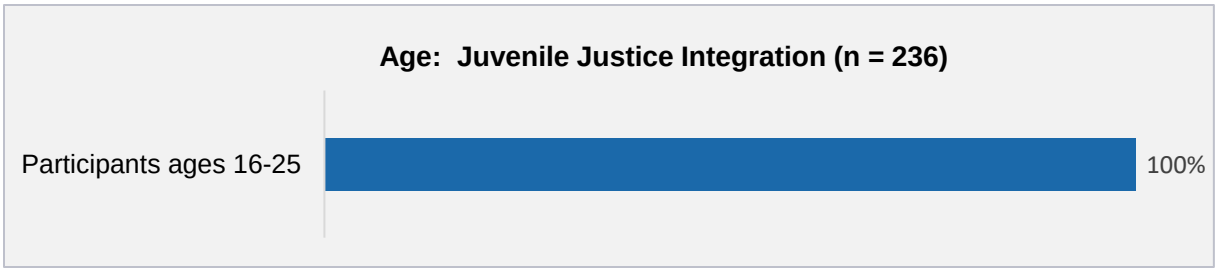
The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11- 21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. These programs and their affiliated programs operate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

Behavioral Health and Juvenile Justice System Integration Programs

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

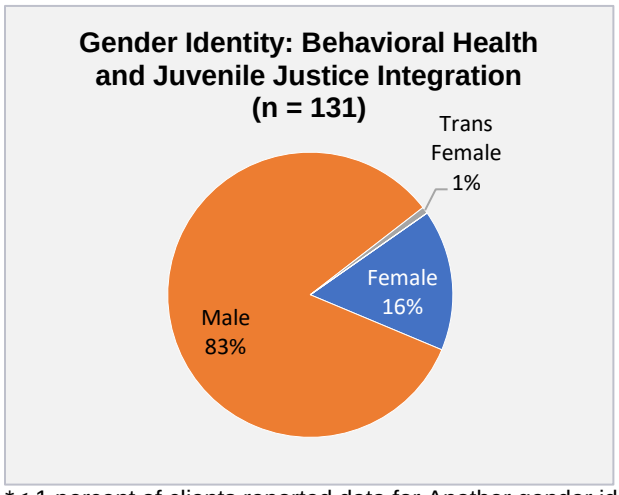
Client Demographics, Outcomes, and Cost per Client

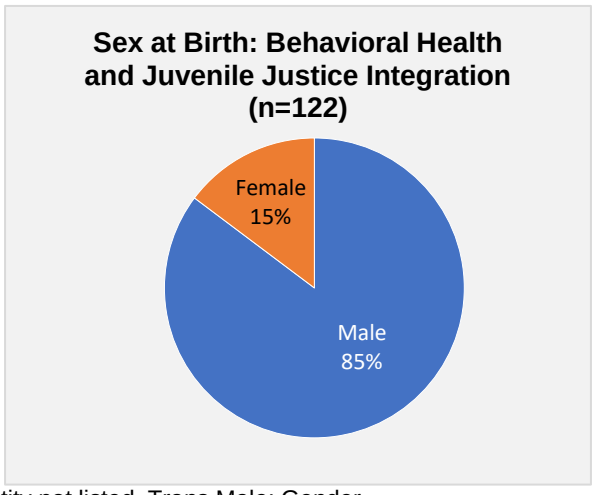
Demographics: Behavioral Health and Juvenile Justice Integration



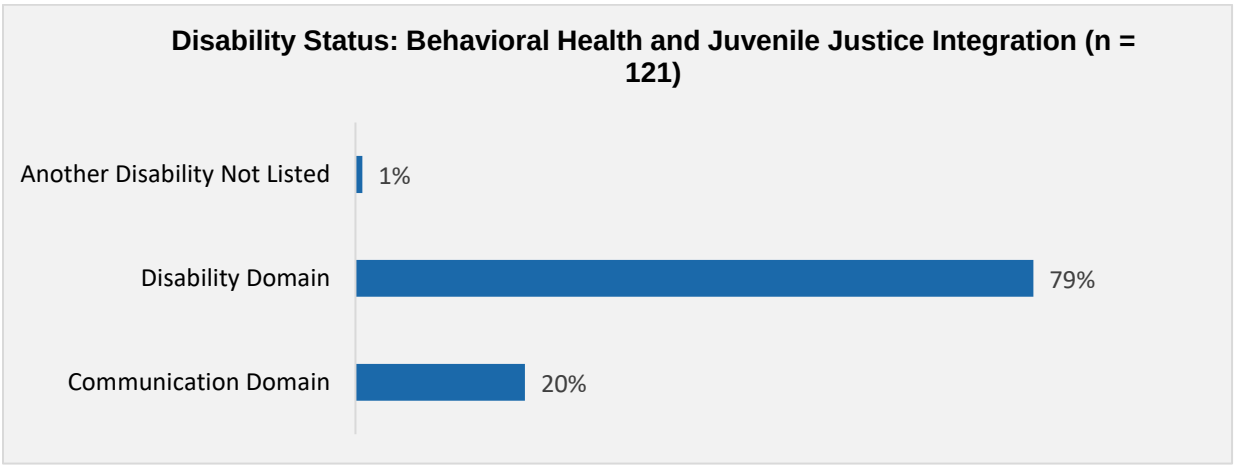
*No data available for clients in age ranges 0-15, 26-59, and 60+

Sexual orientation data was not available for Recovery Oriented Treatment Services – Behavioral Health and Juvenile Justice Integration





*< 1 percent of clients reported data for Another gender identity not listed, Trans Male; Gender



*< 1 percent of clients reported data for None; Disability Status

Race/Ethnicity	n	%
Black/African American	58	46%
American Indian or Alaska Native	<10	-
Asian	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	5%
Other Race	48	38%
Hispanic/Latino	39	87%
Non-Hispanic/Non-Latino	<10	-
More than one Ethnicity	6	13%
Total	170	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

Language data was not available for Recovery Oriented Treatment Services – Behavioral Health and Juvenile Justice Integration

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

Program	FY21-22 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher – Seneca Center and SFDPH	131 youth were screened for behavioral health needs and eligibility for services. Of those referred for services, 66% attended three sessions with community-based providers. All families who completed a survey agreed they were linked to the correct service.

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[2]**
Behavioral Health & Juvenile Justice Integration	236 Clients	$340,562	$1,443

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

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

Program Overview

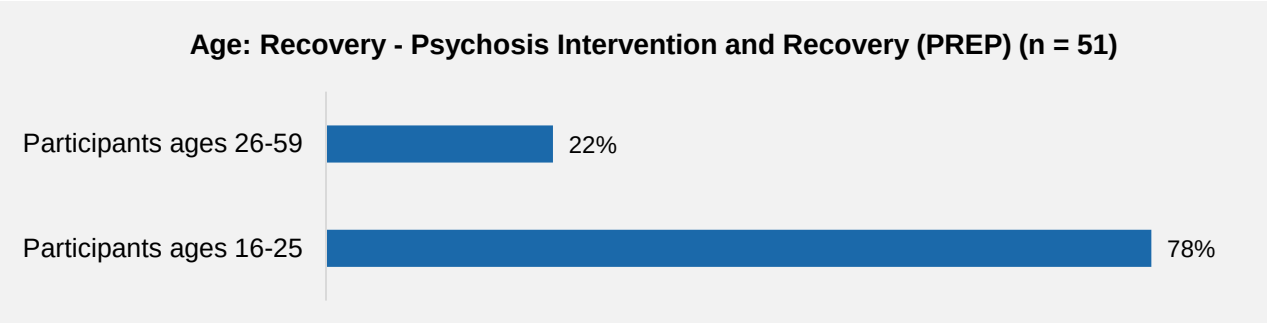
PREP also known as (re)MIND is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs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

Target Populations

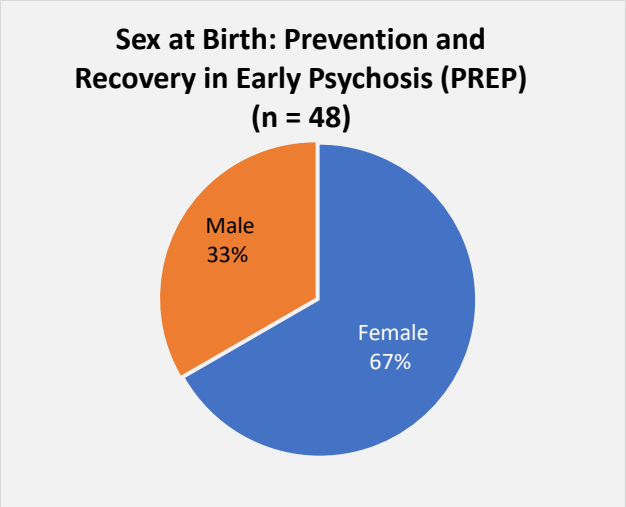
PREP serves youth and young adults between the ages of 14-35. Most clients are transition age youth (TAY), between age 16 and 25. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk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

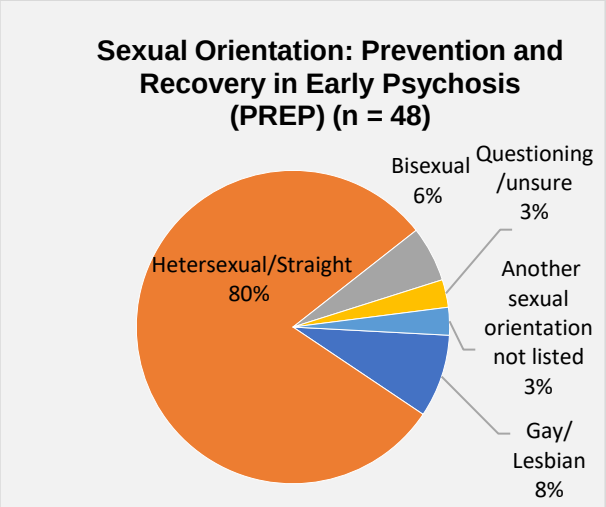
Client Demographics, Outcomes, and Cost per Client

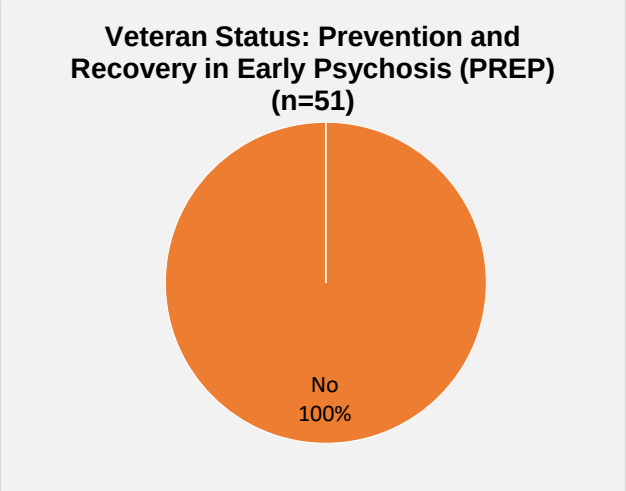
Demographics: Prevention and Recovery in Early Psychosis (re)MIND

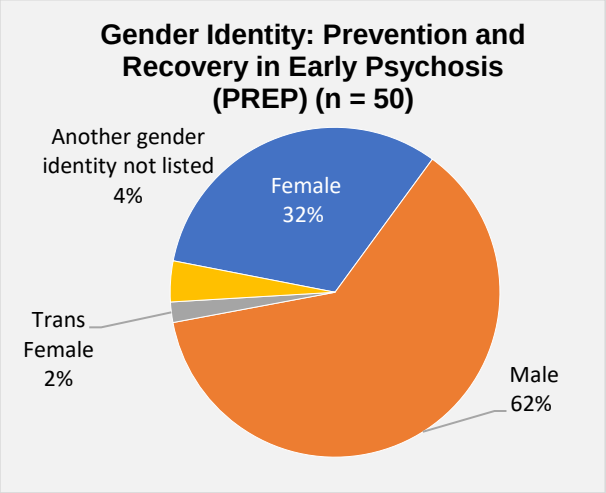


*< 1 percent of clients reported data for 0-15 and 60+; Age

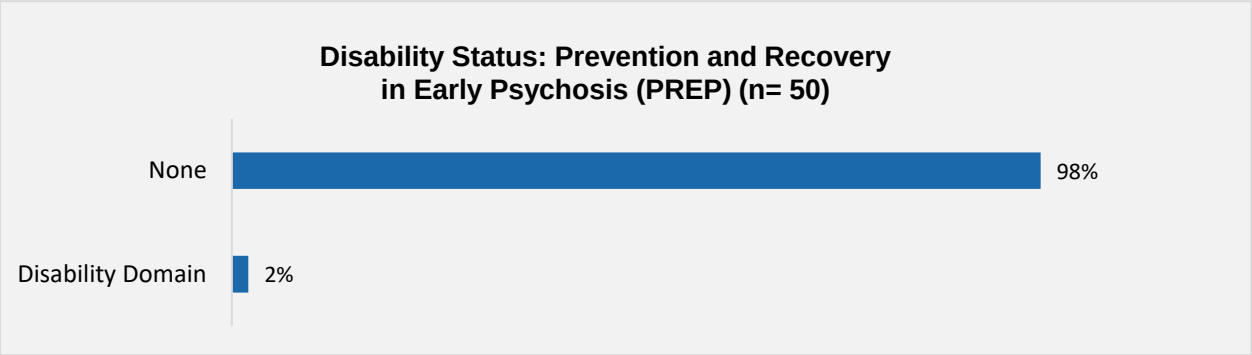








*No clients reported Yes; Veteran Status
*< 1 percent of clients reported data for Trans Male; Gender



*< 1 percent of clients reported data for Another Disability, Communication Domain; Disability Status

Race/Ethnicity	n	%
Black/African American	12	28%
American Indian or Alaska Native	<10	-
Asian	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	-
Other Race	12	28%
Hispanic/Latino	20	42%
Non-Hispanic/Non-Latino	28	58%
More than one Ethnicity	<10	-
Total	91	

Primary Language	n	%
Chinese	<10	-
English	44	86%
Russian	<10	-
Spanish	<10	-
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	51	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

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

Program	FY21/22 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP) also known as (re)MIND – Felton Institute	• 70% (n = 23) of clients increased their capacity to cope with challenges • 91% (n = 30) of clients were engaged in new employment or education • 60% (n = >10) of clients decreased the number of acute inpatient episodes

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[3]**
Prevention and Recovery in Early Psychosis (PREP)	48 Clients	$634,684	$13,222

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

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

Program Overview

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

1) Mental health access for authorizations into the Private Provider Network and to BHS mental health treatment
2) The Treatment Access Program (TAP) for assessment, authorization, and placement into residential substance use disorder treatment
3) The Offender Treatment Program (OTP) to place justice mandated clients into substance use and dual diagnosis treatment
4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opioid Treatment.
5) The BHS Pharmacy provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol withdrawal management medications for TAP clients, naloxone for opioid overdose prevention, specialty behavioral health medication packaging and serves as a pharmacy safety net for all BHS clients

As a program that serves clients on both a drop-in and appointment basis, BHAC seeks to provide the necessary care coordination for all San Franciscans in need of behavioral health care.

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

Lastly, it is important to note that the City and County of San Francisco added resources to BHAC as part of the Mental Health SF and Proposition C initiatives. Through Mental Health SF and Proposition C funding, BHAC hours were expanded to include evenings (5pm to 7pm) starting in June 2022, and weekends (9am-5pm) starting in July 2023.

In parallel, the BHS Pharmacy extended hours of operation to weekday evenings and weekends in order to better serve clients.

Target Populations

The BHAC target population includes various underserved and vulnerable populations such as those with serious mental illness, substance use disorder, and dual diagnosis clients. A substantial number of clients are impoverished, experiencing homelessness, non-English speaking, and/or in minority populations.

Outcomes, Highlights, and Cost per Client

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

Program	FY21/22 Key Outcomes and Highlights
Behavioral Health Access Center (BHAC) – SFDPH	891 Clients received services

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[4]**
Behavioral Health Access Center	16,560 clients	$922,627	$55.71

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

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

Program Collection Overview

SFDPH worked toward fully integrated care over the last two decades, including implementing the Primary Care Behavioral Health (PCBH) model in the majority of DPH primary care clinics. In this model, behavioral health clinicians work as members of the primary care team. Services include the delivery of brief, evidence-based therapeutic interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management. (e.g., class and group medical visits).

MHSA made investments to bridge Behavioral Health Services and Primary Care in other ways. MHSA supported behavioral health clinics that act as a "one-stop clinic" so clients can receive primary care services and fund specialized integrated services throughout the community.

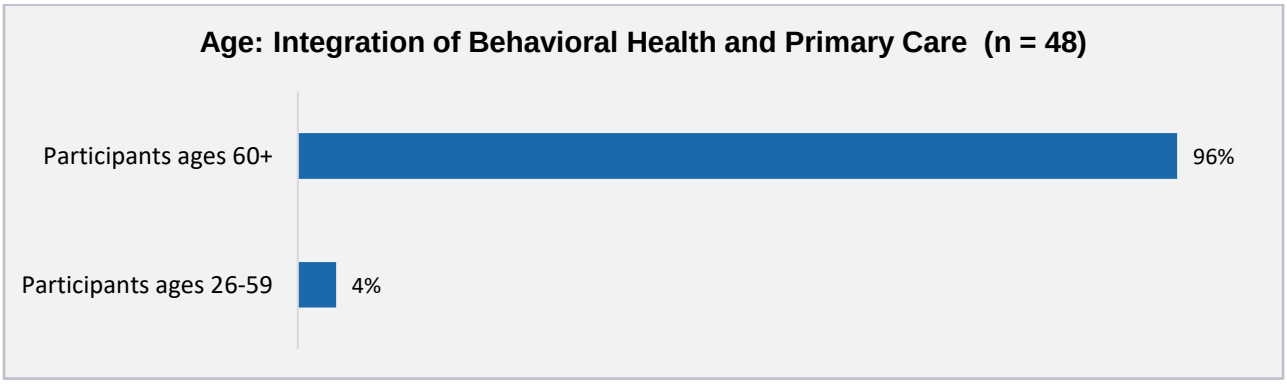
Lastly, the Curry Senior Center's Behavioral Health Services in Primary Care program provides wrap-around services including outreach, primary care, and comprehensive case management as stabilizing strategies to engage isolated older adults in mental health services. The program's Nurse Practitioners screen clients for mental health, substance use, and cognitive disorders.

Target Populations

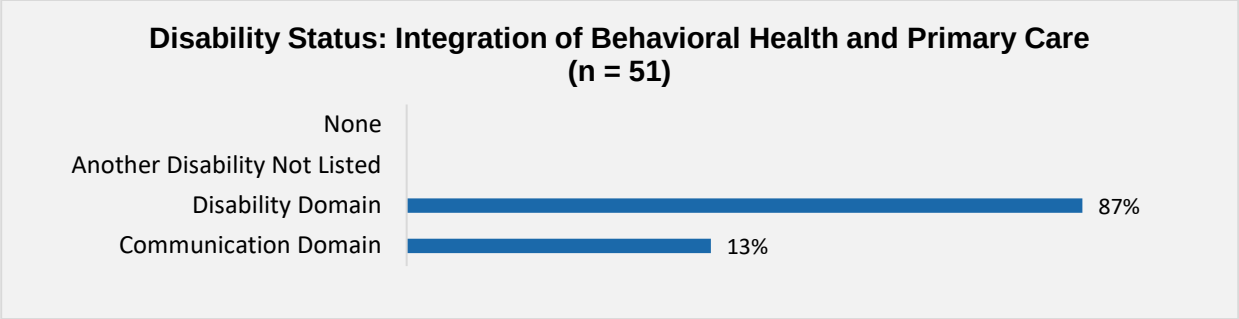
The target populations for these services are individuals and families served in primary care clinics with behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

Client Demographics, Outcomes, and Cost per Client

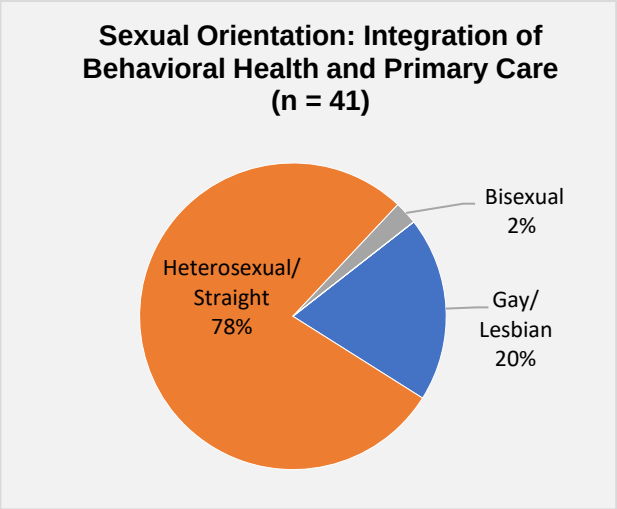
Demographics: Integration of Behavioral Health and Primary Care

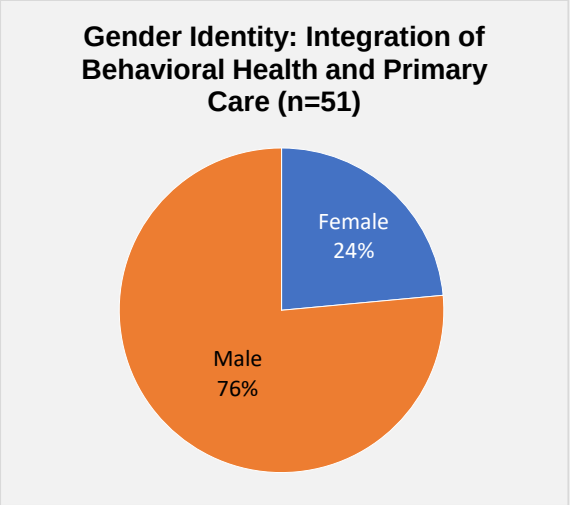


*< 1 percent of clients reported data for 0-15 and 16-25

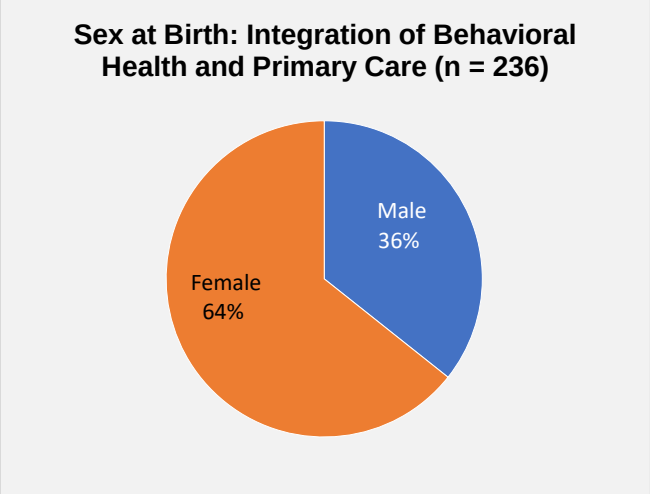


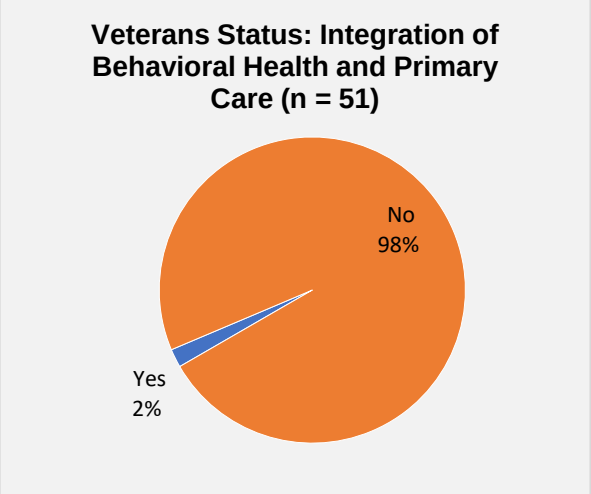
*< 1 percent of clients reported data for Another Disability, None; Disability Status





*< 1 percent of clients reported data for Another Sexual Orientation Not Listed, Questioning/unsure; Sexual Orientation
*< 1 percent of clients reported data for Another gender identity not listed, Trans Female, Trans Male; Gender



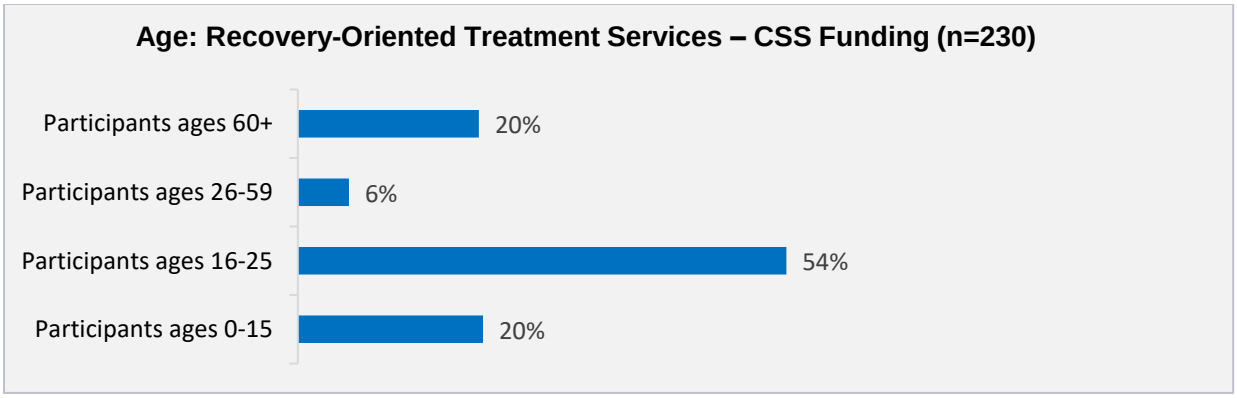


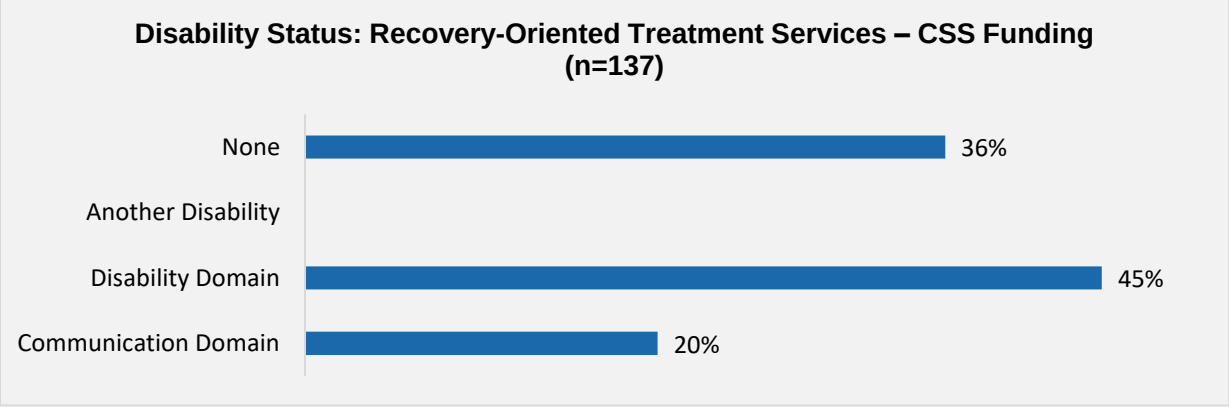
Race/Ethnicity	n	%
Black/African American	12	24%
American Indian or Alaska Native	<10	-
Asian	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	27	53%
Other Race	<10	-
Hispanic/Latino	<10	-
Non-Hispanic/Non-Latino	34	67%
More than one Ethnicity	<10	-
Total	102	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

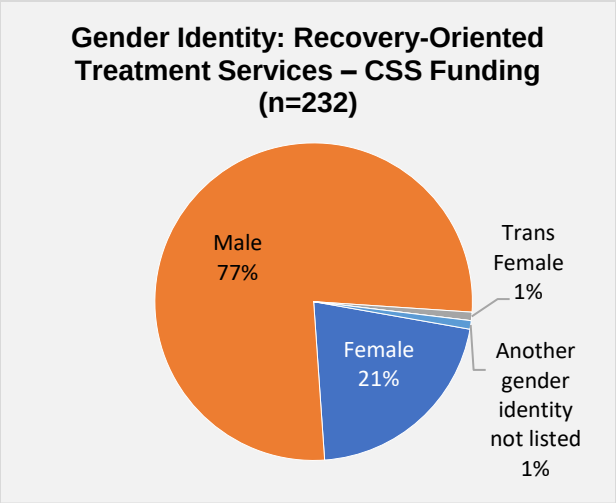
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

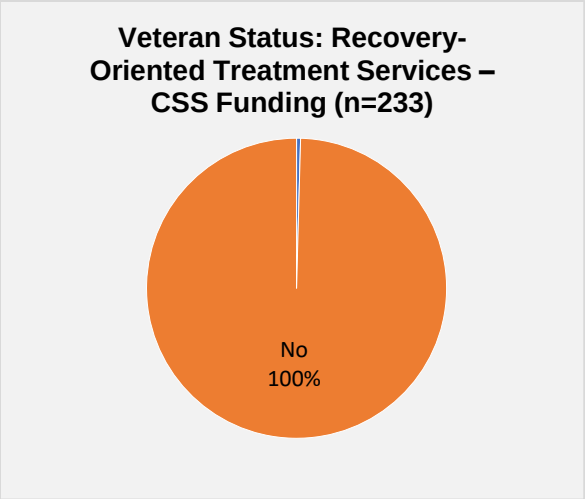
Language data was not available for Recovery Oriented Treatment – Recovery Oriented Treatment Services – Integration of Behavioral Health and Primary Care

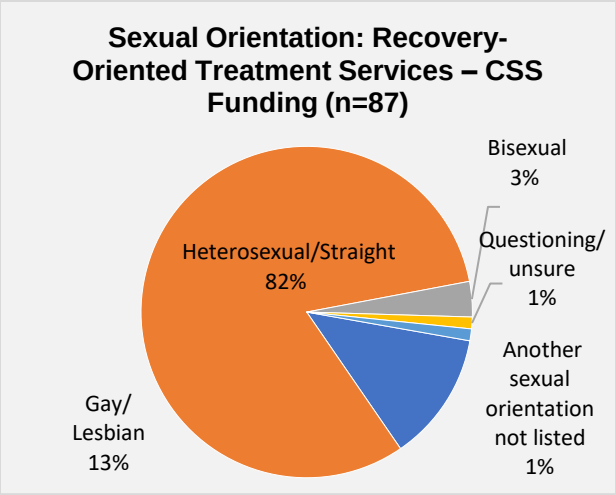


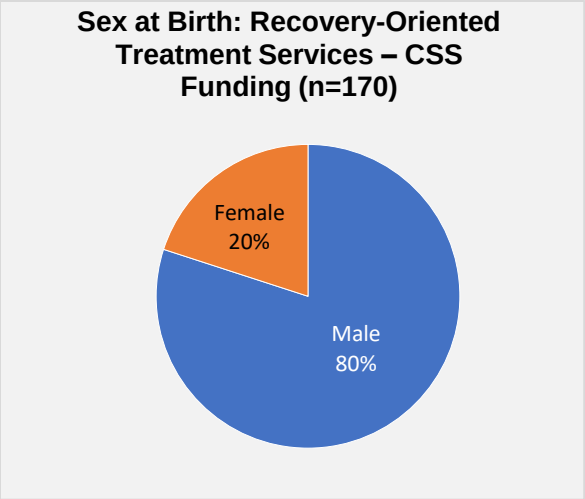


*< 1 percent of clients reported data for Another Disability; Disability Status









*< 1 percent of clients reported data for Trans Male; Gender

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

Program	FY21/22 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – Curry Senior Center	100% (n=32) of clients referred to Behavioral Health Services attended at least one appointment.

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[5]**
Integration of Behavioral Health and Primary Care	401 Clients	$1,774,562	$4,425

Moving Forward in Recovery-Oriented Treatment Services

New Reporting Requirements

Assembly Bill 2265 (Quirk-Silva, 2020) enacted Welfare and Institutions Code 5891.5, which requires counties to report to DHCS the number of people assessed for co-occurring mental health and substance use disorder and the number of people assessed for co-occurring substance use disorder who were later determined to have only a substance use disorder without another co-occurring mental health condition.

Behavioral Health Access Center (BHAC)

Recent changes and project updates for the Behavioral Health Access Center, including updated timelines and future plans for FY21-22 and FY22-23 are outlined below.

- FY21-22 saw the continued rollout and implementation of a new caller software platform that created efficiencies and streamlined the processes for a better client experience with the Behavioral Health Access Line (BHAL). This new system collects critical indicators and other metrics that will yield higher productivity and an improved provision of services across the system of care.
- BHAC continued to be impacted by the global pandemic, as face-to-face interactions decreased in mid-year.
- In July 2022, BHAC expanded its hours of operation to 7pm Monday through Friday, with an expectation for weekend hours as staff can be recruited. Additional funding for these staff was provided by a local tax-payer initiative, Proposition C, and under the local mental health reform plan, Mental Health SF.
- In November 2022, BHAC and BHAL both implemented the use of EPIC as a new electronic medical record platform; this was preceded by four months of advanced planning; and the use of EPIC has brought the use of medical records that track, record, and convey critical data to fruition.
- Over the course of 2022, BHAC developed specific workflows affecting substantially vulnerable populations. These defined processes involved the promotion of seamless access for hospital discharges, discharging for justice-involved people leaving jail, perinatal/postpartum, and the Street Overdose Response Team (SORT).
- BHAC continued responding to the high number of overdoses in San Francisco, equipping and training all staff on the use of naloxone, which has led to successfully reversing five overdoses in the clinic.
- As of December 2022, there were five vacant positions, which remain unfilled. Recruitment of eligible and suitable staff continues to be a challenge. However, during the first half of FY21-22, nine positions were filled through successful recruitment.

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

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

Service Category Overview

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

2020 Trans Peer Event Poster

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

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

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

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

Target Populations

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

Population Served by Peers: Peers will conduct culturally and linguistically congruent outreach, education and peer support to clients of residential, community, mental health care and primary care settings within SFDPH.

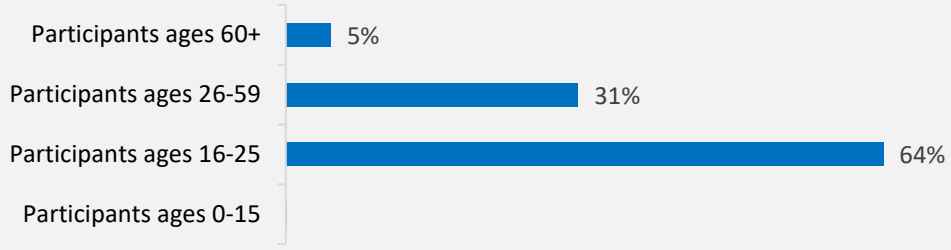
Peer-to-Peer Support Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) – SFDPH	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	Peer-based, family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

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

Client Demographics, Outcomes, and Cost per Client

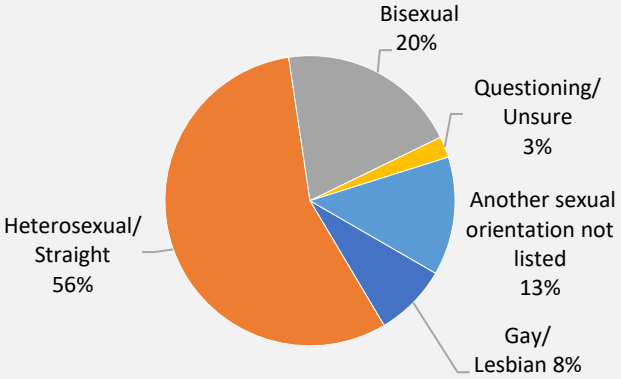
Demographics: Peer-to-Peer Support Programs

Age: Peer-to-Peer Support Programs and Services – CSS Funding (n = 6,230)

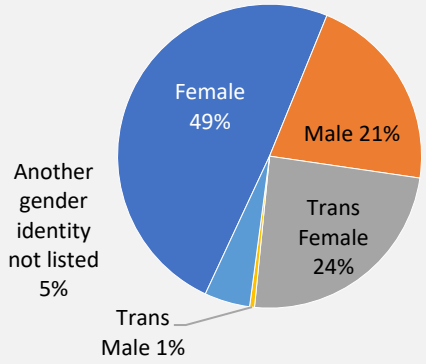


*<1 percent of clients reported data for 0-15; Age

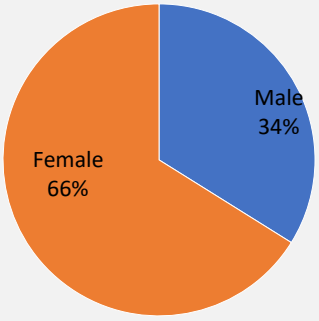
Sexual Orientation: Peer-to-Peer Support Programs and Services – CSS Funding (n=1,107)



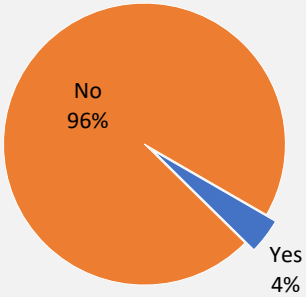
Gender Identity: Peer-to-Peer Support Programs and Services – CSS Funding (n = 1,343)

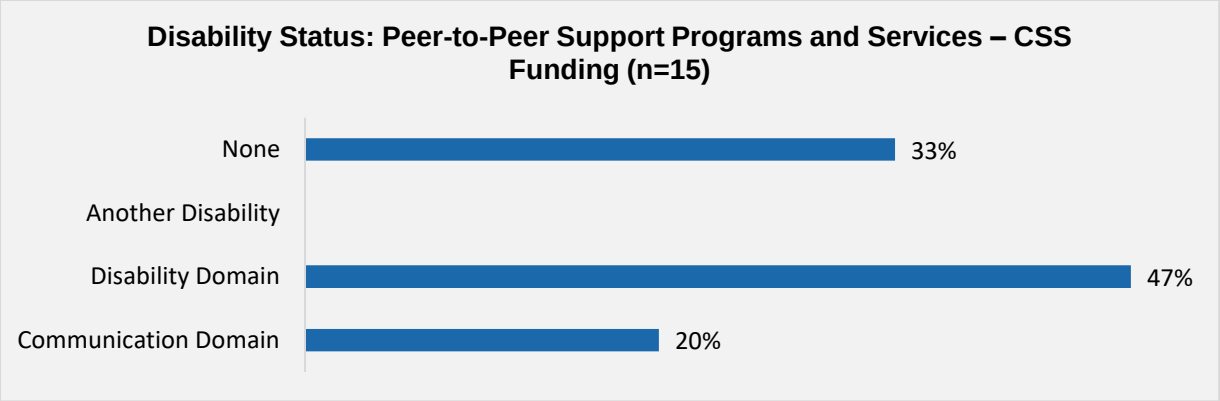


Sex at Birth: Peer-to-Peer Support Programs and Services – CSS Funding (n=1,204)



Veteran Status: Peer-to-Peer Support Programs and Services – CSS Funding (n=546)





*< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	262	23%
American Indian or Alaska Native	17	2%
Asian	207	18%
Native Hawaiian or Pacific Islander	19	2%
White	424	38%
Other Race	190	17%
Hispanic/Latino	432	39%
Non-Hispanic/Non-Latino	631	57%
More than one Ethnicity	39	4%
Total	2,221	

Primary Language	n	%
Chinese	53	6%
English	637	70%
Russian	<10	-
Spanish	209	23%
Tagalog	12	1%
Vietnamese	<10	-
Another Language	<10	-
Total	914	

*Clients may be counted in multiple categories and therefore percentages do not total 100%.
*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

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

Program	FY21/22 Key Outcomes and Highlights
Lifting and Empowering Generations of Adults, Children and Youth (LEGACY) - SFDPH	• 73% (n=55) of clients successfully completed two or more self-identified goals.
Peer-to-Peer, Family-to-Family - NAMI	• 91% (n=28) of clients reported an increased understanding of their mental illness and were better able to recognize signs and symptoms.
Peer Specialist Certificate, Leadership Academy and Counseling – Richmond Area Multi-Services (RAMS)	• 98% (n=41) of clients indicated plans to pursue or continue a career (job, volunteer, further education) in the health & human services field (behavioral health, health, community services).
Gender Health SF – SFDPH	• 90% (n=26) of clients reported the programming was worthwhile.

Program	FY21/22 Key Outcomes and Highlights
Peer-to-Peer Employment - Richmond Area Multi-Services (RAMS)	• 100% (n=52) of program employees working 16+ hours/week participated in four skill development or wellness trainings/sessions.
Peer Wellness Center - Richmond Area Multi-Services (RAMS)	• 95% (n=82) of clients reported they felt socially connected.
Transgender Pilot Project – SFDPH	• 90% of clients (n=22) reported increased social connection as a result of working with the peer advocate.

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[6]**
Peer-to-Peer Programs	9,112 Clients	$2,811,910	$309

Moving Forward in Peer-to-Peer Support Programs

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

SFDPH recently allocated additional funding to expand services to the National Alliance on Mental Illness (NAMI) Peer-to-Peer, Family-to-Family program in order to reach new target populations. This program is imperative and utilizes trained peers to provide outreach, engagement, and navigation in the community. Peer mentors meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the client by meeting weekly for one hour and assisting the client with their journey to wellness and recovery. Mentors also act as a community resource for helping a client direct their own path to wellness and recovery. With the unique understanding of people with lived experience, these programs and support groups provide outstanding free education, skills training, and support. Courses consist of NAMI Basics (e.g., for parents and guardians); NAMI Family-to-Family; and NAMI Homefront (e.g., families, caregivers and friends of military service members and veterans with mental health conditions); NAMI Peer-to-Peer (e.g., for adults with mental health conditions); and NAMI Provider (e.g., for mental health professionals. Outreach, advocacy, and wellness are the cornerstone of the NAMI program.

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

3. Vocational Services: CSS Funding

Service Category Overview

Through JEDI/MHSA funding, SFDPH incorporates vocational services within its mental health programming. These vocational services support individuals with serious mental illness and co-occurring disorders in their journey to secure meaningful, long-term employment. Research shows that supported employment programs help individuals with mental illness achieve and sustain recovery.

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

Target Population

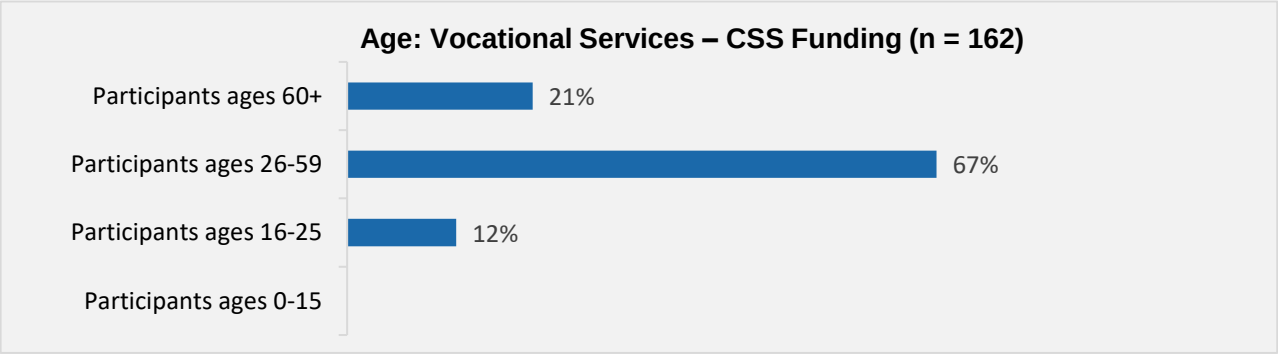
The target population consists of clients with behavioral health needs as well as other community residents in need of employment assistance. In particular, outreach is made to underserved populations and those interested in job readiness programs, on-the-job training, internships, competitive employment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

Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Department of Rehabilitation Vocational Coop (The Coop) *SFDPH and State of California*	CSS Other Non-FSP 8. Vocational Services (45% FSP)	The San Francisco Department of Rehabilitation (DOR) and BHS collaborate to provide vocational rehabilitation services to Clients of mental health services. Services offered by this program include vocational assessments, the development of an Individualized Plan for Employment, vocational planning and job

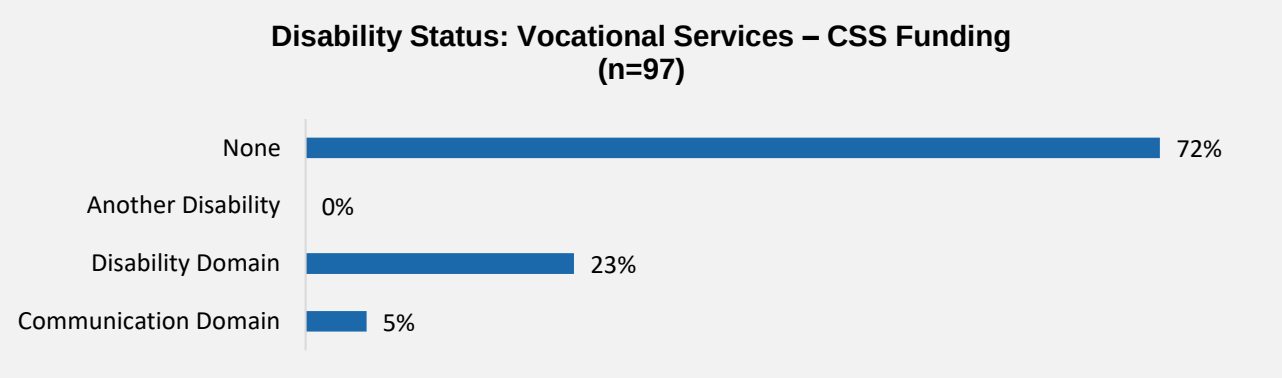
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
		coaching, vocational training, sheltered workshops, job placement, and job retention services.
SF Fully Integrated Recovery Services Team (SF FIRST) *SFDPH*		Offers training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitator, as well as other positions. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal setting and hygiene maintenance for the workplace.
Janitorial Services *Richmond Area Multi-Services (RAMS)*		Provides janitorial and custodial vocational training to behavioral health Clients.
Café and Catering Services *UCSF Citywide Employment Program*		Provides café, barista, catering and customer service vocational training to behavioral health Clients. Clients learn café and catering related skills while working towards competitive employment.
Clerical and Mailroom Services *Richmond Area Multi-Services (RAMS)*		Provides both time-limited paid internships and long-term supported employment opportunities to clients of BHS. Clients learn important skills in the area of administrative support, mailroom distribution and basic clerical services. Clients also receive soft skills training, retention support services, coaching and linkage to services to obtain employment in the competitive workforce, if desired.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) *UCSF Citywide Employment Program*		Provides training for individuals looking to establish careers in the horticulture and landscaping field. Clients are taught skills in the field while focusing on draught-resistant landscaping.
TAY Vocational Program *Richmond Area Multi-Services (RAMS)*		Offers training and paid work opportunities to TAY with various vocational interests. Clients learn work-readiness skills while working toward competitive employment.

Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
i-Ability Vocational IT Program *Richmond Area Multi-Services (RAMS)*		Prepares Clients to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at the BHS IT Department. The program includes three components: ● Desktop: Learn new skills in the deployment and support of office equipment including; desktops, laptops, servers, printer, etc. Skills learned include the installation of software, application testing, break/fix, presentation skills, resume writing, etc. ● Advanced Desktop: Clients continue to expand their knowledge in the area of desktop support services. Additionally, clients serve as mentors for clients of the Desktop program. ● Help Desk: Clients learn customer and application support skills through the staffing Avatar Electronic Health Record (EHR) help desk, a call center. Skills learned include application support, customer service skills, working in a collaborative environment, resume writing, documentation development, etc. ● Advanced Help Desk: Clients continue to expand their knowledge in the area of application support gained through their successful graduation from the Help Desk program. Additionally, clients serve as mentors for clients of the Help Desk program. ● Employment: Graduates of the IT vocational training program are provided with the opportunity to apply for a full-time position with the IT department. Services offered by the program include vocational assessments, vocational counseling, job coaching, skill development and training.
First Impressions *UCSF Citywide*		Provides Clients of behavior health the opportunity to learn building and machine maintenance through 3D printing. The aim of the program is to provide an opportunity for clients to develop transferable work skills, as well as the soft skills they need to maintain employment post-program.

Demographics: Vocational Services



*< 1 percent of clients reported data for 0-15; Age



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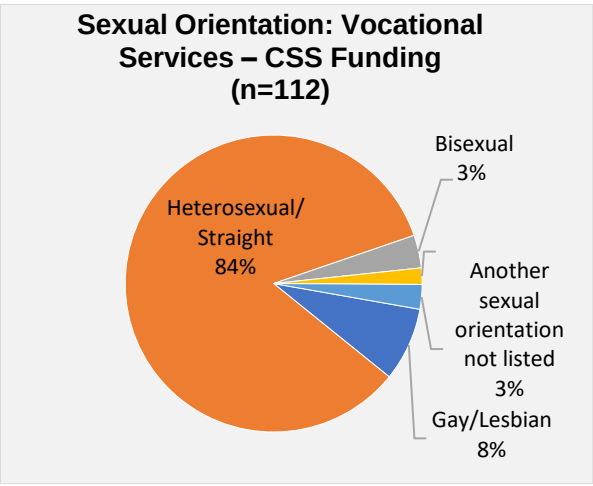
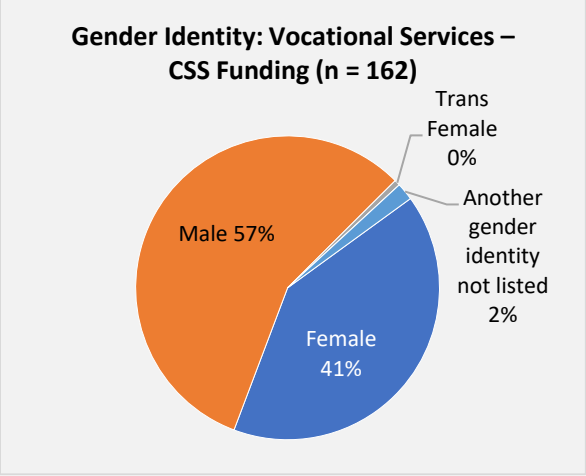
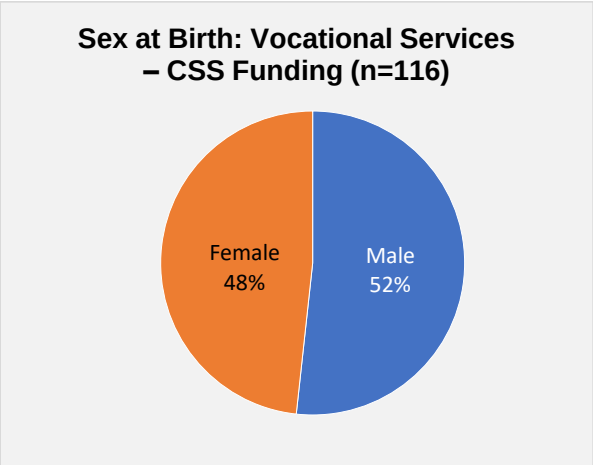
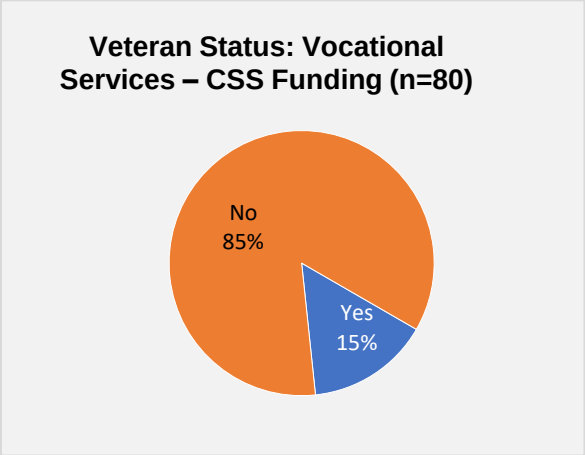




*< 1 percent of clients reported data for Trans Male; Gender





Race/Ethnicity	n	%
Black/African American	44	28%
American Indian or Alaska Native	<10	-
Asian	37	24%
Native Hawaiian or Pacific Islander	<10	-
White	48	31%
Other Race	20	13%
Hispanic/Latino	27	24%
Non-Hispanic/Non-Latino	75	67%
More than one Ethnicity	10	9%
Total	267	

Primary Language	n	%
Chinese	<10	-
English	131	81%
Russian	<10	-
Spanish	14	9%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	162	

*Cell sizes with fewer than 10 clients are represented as “<10” to protect the privacy of clients and not compromise anyone’s identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.
*Cell sizes with fewer than 10 clients are represented as “<10” to protect the privacy of clients and not compromise anyone’s identity.
*Due to rounding, total does not equal 100%

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

Program	FY20/21 Key Outcomes and Highlights
Department of Rehabilitation Co-op – SFDPH and California State	• 459 referrals were received, the vast majority were from individuals who identify as people of color.
i-Ability Vocational IT Program - Richmond Area Multi-Services (RAMS)	• 82% (n=18) of enrolled trainees successfully completed the program; 100% reported improved coping abilities and increased readiness for additional activities related to vocational services.
First Impressions– UCSF Citywide Employment Program	• 50% (n= <10) of BHS Clients graduated from the program; 100% reported improved work readiness skills and confidence to use their new skills.
SF Fully Integrated Recovery Services (SF First) Vocational Project - SFDPH	• 77% (n=10) of clients completed the nine-month program; nearly all (90%, n<10) indicated improvements in coping abilities.
Janitorial Services - Richmond Area Multi-Services (RAMS)	• 100% (n= <10) of clients who received services for at least three months successfully completed the program; 100% (n= <10) reported improved workplace coping skills, increased readiness for additional activities related to vocational services, and were interested in engaging in future vocational related activities.
Café and Catering Services - UCSF Citywide Employment Program	• 74% (n=14) of BHS clients graduated from the program; 100% (n=14) reported an improvement in development of work readiness skills and improved confidence.
Clerical and Mailroom Services - Richmond Area Multi-Services (RAMS)	• 83% (n= <10) of clients successfully completed the program; 100% (n= <10) reported improvement in their workplace coping skills, readiness for additional activities related to vocational services, and were interested in engaging in future vocational related activities.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) - UCSF Citywide Employment Program	• 63% (n= <10) of Behavioral Health Services clients graduated from the program; 100% (n= <10) reported an improvement in work readiness skills and were confident about being able to use the new skills they learned.
Transitional Age Youth Vocational Program – Richmond Area Multi-Services (RAMS)	• 100% (n= <10) of clients enrolled after three months graduated from the program; 100% (n= <10) reported their coping abilities improved and 75% (n= <10) reported they feel more prepared for their next opportunity.

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[7]**
Vocational Programs	539 Clients	$2,040,788	$3,786

Moving Forward in Vocational Services

Plans for Vocational Services in FY22-25 include the following:

- Develop a new case service contract that will enable MHSA to hire a 2587 Health Worker III position funded by the California Department of Rehabilitation;
- Hire another 2587 Health Worker III position to be funded by MHSA;
- Provide certificates of appreciation to top referring clinicians;
- Expand Co-op Vocational services to non-BHS clients who meet DOR eligibility;
- Expand RAMS hire-ability and UCSF Citywide paid work internships (both are BHS contracted services) to non-BHS clients who meet DOR eligibility;
- Expand referrer credentials to include Nurse Practitioners and Registered Nurses;
- Develop robust vocational outreach plan; and
- Build collaborations between Coop partners and community providers, with a focus on those who serve justice-involved and underserved residents.

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

4. Housing Services: CSS Funding

Service Category Overview

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

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

On July 1, 2016, California Governor Jerry Brown signed legislation enacting the No Place Like Home (NPLH) Program to dedicate $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are living with serious mental illness (SMI) and are in need of mental health and/or substance use services and are experiencing chronic homelessness, or are at-risk of chronic homelessness, or homelessness. The bonds are repaid by funding from the MHSA fund.

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

<u>Coordinated Entry</u>

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

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

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

Emergency Stabilization Units (ESU)

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

FSP Permanent Supportive Housing (PSH)

In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million by creating housing for MHSA clients. In addition, San Francisco added $2.16 million from Community Services and Supports (CSS) to housing in FY07-08. MHSA capital-funded housing units were developed within larger mixed-population buildings with on-site supportive services and linked to the larger infrastructure of intensive case management services provided by FSPs.

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

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

Housing Placement Services

MHSA-funded PSH units will continue to be reserved for FSP clients at adult housing sites, and TAY experiencing mental health challenges at TAY housing sites. Prioritization for MHSA-funded units is conducted through the CE process. Beyond the MHSA inventory of 191 units, clients served by MHSA programs can access and be prioritized for housing in the general pools of housing for homeless youth, adults, and families.

Supportive Services

Supportive services are designed to be flexible in order to meet the unique needs of individuals participating in the housing programs. Services may include, but are not limited to; case

management support, transportation assistance and needs-related payments that are necessary to enable an individual to remain stable in their housing.

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

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

Transitional Housing

The Marilyn Inn is a new MHSA-funded housing program. The Marilyn Inn located in the Nob Hill District of San Francisco is a 30-bed facility that offers up to 24 months of “sober living” transitional housing. This housing program has a goal of moving clients into permanent supportive housing or other types of housing that fits the client’s needs. Conard House is the non-profit organization that provides the support and management at the Marilyn Inn working and collaborating with clients to improve their independent living skills so they can thrive in permanent and supportive housing.

The soft opening was in April 2022. Since July 1, 2022, there have been 29 total admissions from residential 90-day programs. Clinical staff and case managers are on duty Monday through Friday 9am-5pm providing support and leading groups during the weekdays. There are also 24-hour desk clerks and staff onsite. The Marilyn Inn is a sober living environment with a harm reduction and trauma informed approach so clients can get full support on their way to wellness, recovery and empowerment.

MHSA-Funded Housing for TAY

While TAY served by MHSA who are age 18 and up can access adult housing, they can also be placed at youth-center housing sites that are tailored to their needs. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transition-age youth with Larkin Street Youth Services (LSYS). The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street). In fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness such as

intake and assessment, life skills training, wrap-around case management, mental health interventions, and peer-based counseling.

Program Names	Name Listed on ARER and Budget
Emergency Stabilization Housing	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)
Full-Service Partnership Permanent Supportive Housing	CSS FSP Permanent Housing (capital units and master lease)
Housing Placement and Support	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)
ROUTZ Transitional Housing for TAY	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)

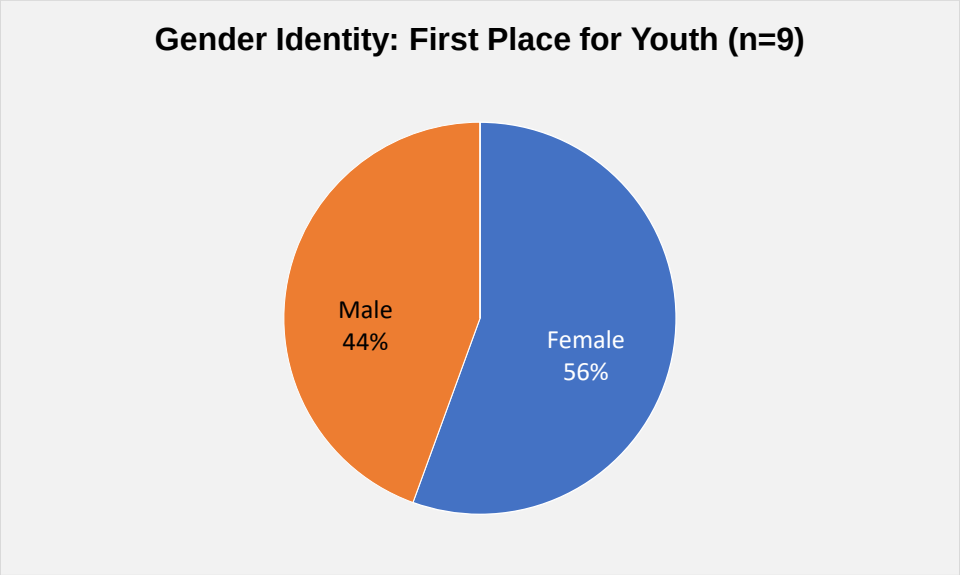
MHSA-Funded PSH Housing: FY21-22						
MHSA Housing Site	**Operator**	**MHSA Units**	**Target Population**	**Services**	**Type of Project**	**Referral Source**
Cambridge	CHP	9	Adults	CHP + FSP	HSH Supportive Housing	CE
Hamlin	CHP	0	Adults	CHP + FSP	HSH Supportive Housing	CE
Iroquois	CHP	10	Adults	CHP + FSP	HSH Supportive Housing	CE
Rene Cazenave	CHP	10	Adults	Citywide + FSP	MHSA Capital	CE
Richardson	CHP	12	Adults	Citywide + FSP	MHSA Capital	CE
San Cristina	CHP	15	Adults	CHP + FSP	HSH Supportive Housing	CE
Senator	CHP	3	Adults	CHP + FSP	HSH Supportive Housing	CE
Camelot	DISH	11	Adults	HSH + FSP	HSH Supportive Housing	CE
Empress	DISH	7	Adults	HSH + FSP	HSH Supportive Housing	CE
LeNain	DISH	3	Adults	HSH + FSP	HSH Supportive Housing	CE
Pacific Bay Inn	DISH	4	Adults	HSH + FSP	HSH Supportive Housing	CE
Star	DISH	4	Adults	HSH + FSP	HSH Supportive Housing	CE
Windsor Hotel	DISH	6	Adults	HSH + FSP	HSH Supportive Housing	CE
Aarti/ Routz	Larkin St.	40	TAY	Larkin - All	MHSA GF – TH	BHS Placement
1100 Ocean	Mercy	6	TAY	FPFY + FSP	MHSA Capital	BHS Placement
Veterans Commons	Swords	8	Veterans	Swords/VA + FSP	MHSA Capital	BHS Placement

Ambassador	TNDC	9	Adults	TNDC + FSP	HSH Supportive Housing	CE
Dalt	TNDC	10	Adults	TNDC + FSP	HSH Supportive Housing	CE
Kelly Cullen	TNDC	17	Adults	TNDC + FSP	MHSA Capital	CE
Polk Senior	TNDC	10	Seniors	LSS + FSP	MHSA Capital	CE
Ritz	TNDC	2	Adults	TNDC + FSP	HSH Supportive Housing	CE
Willie B. Kennedy	TNDC	3	Seniors	NCHS + FSP	MHSA Capital	CE
TOTAL UNITS		**191**				

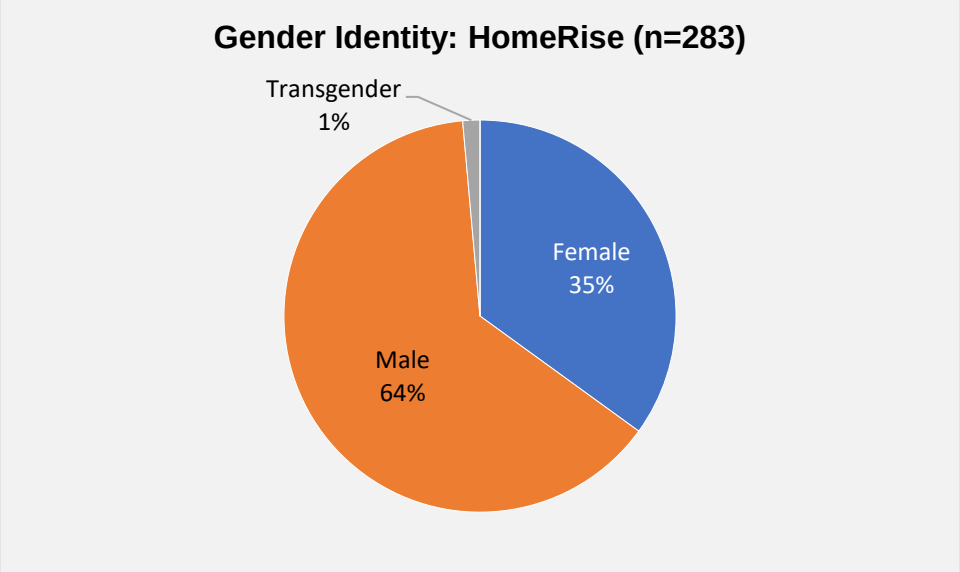
UNITS BY SUPPORTIVE SERVICE PROVIDER	
Total Units Supported by Community Housing Partnership (CHP)	51
Total Units Supported by Delivering Innovative Supportive Housing (DISH)	35
Total Units Supported by Mercy Housing	6
Total Units Supported by Larkin Street Youth Services (LSYS)	40
Total Units Supported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

Client Demographics and Outcomes

Demographics: Housing Programs[8]



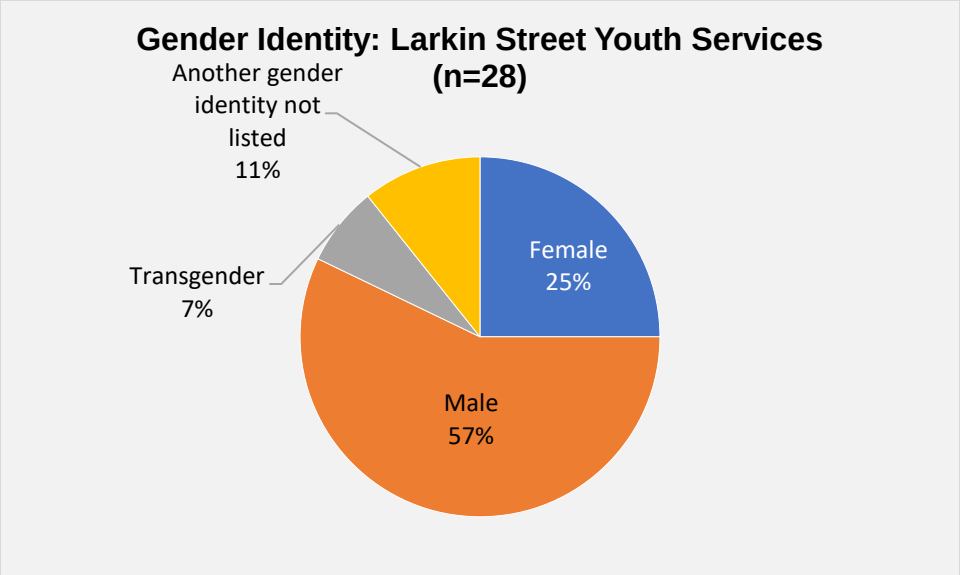
*< 1 percent of clients reported data for Another gender identity not listed, Transgender; Gender

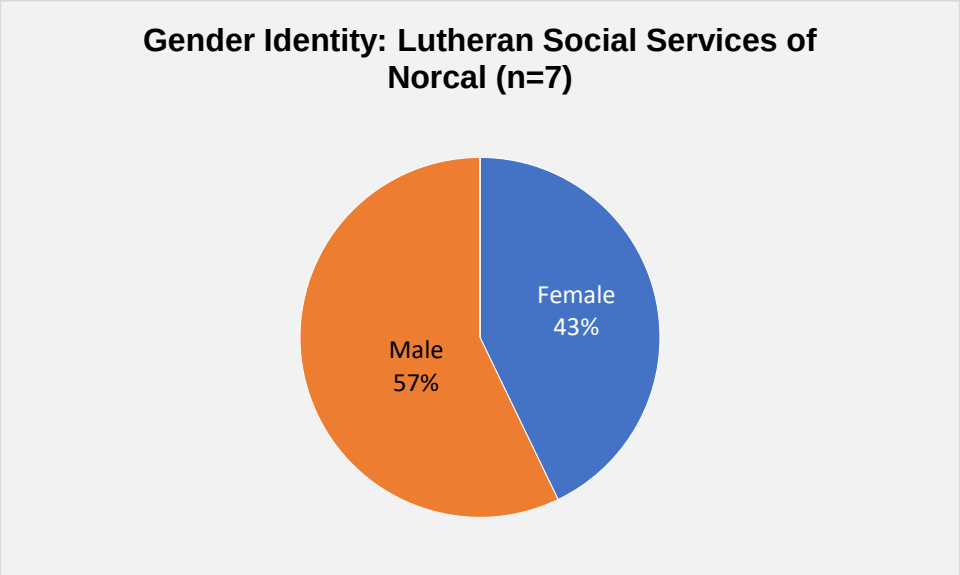


*< 1 percent of clients reported data for Another gender identity not listed; Gender

Housing

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





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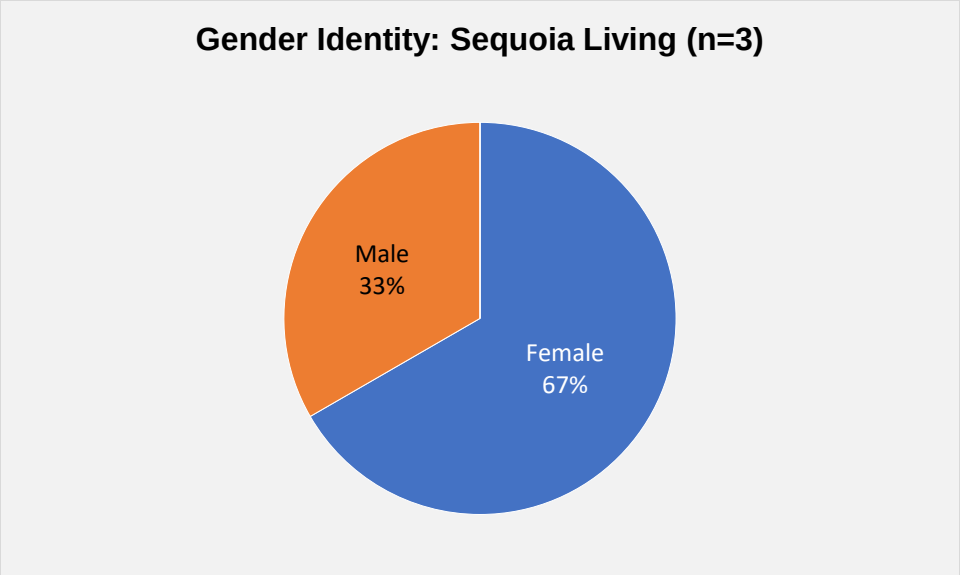

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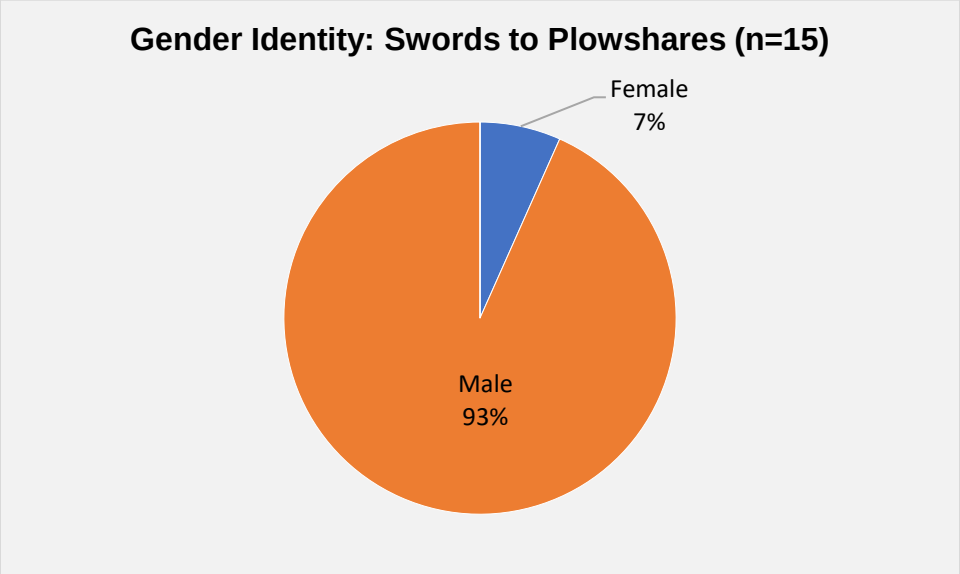

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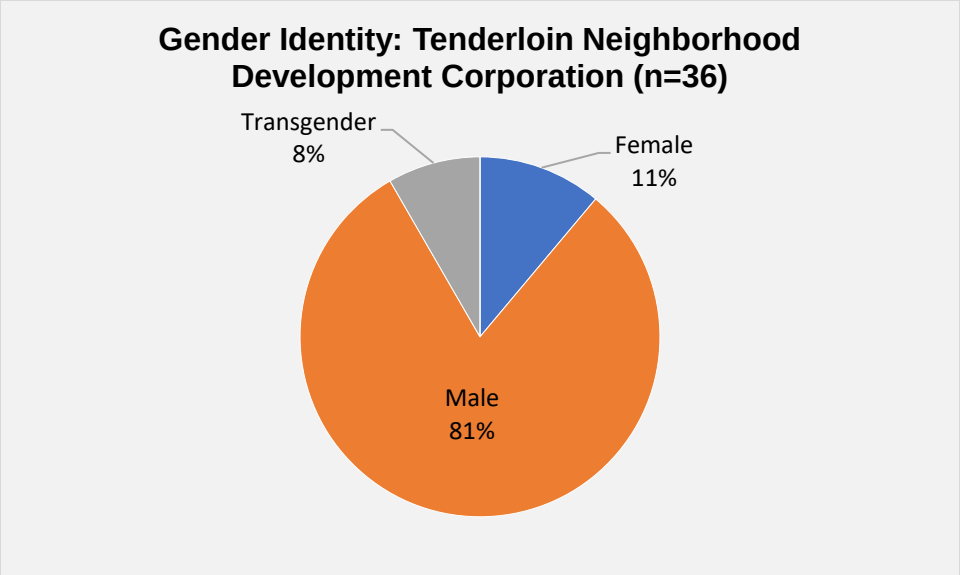

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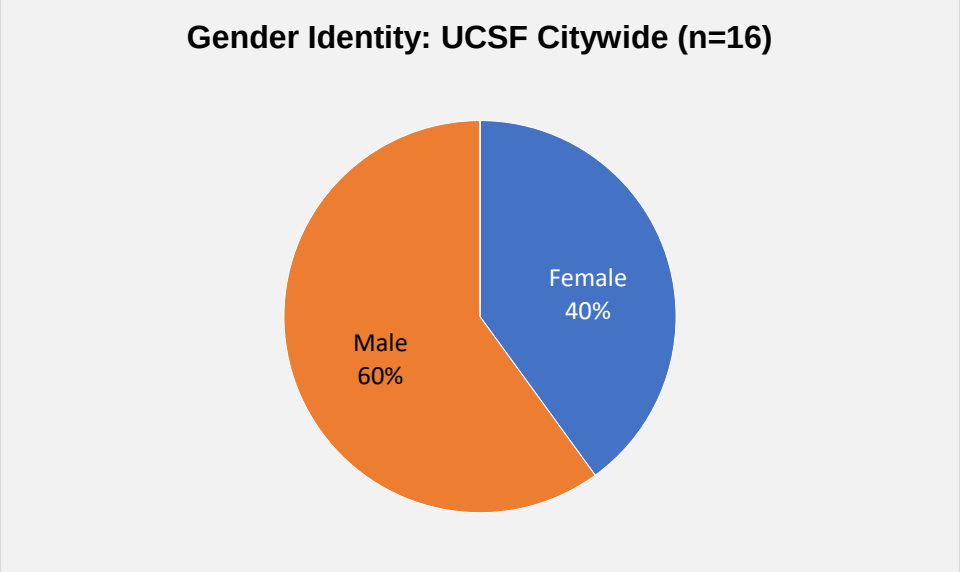

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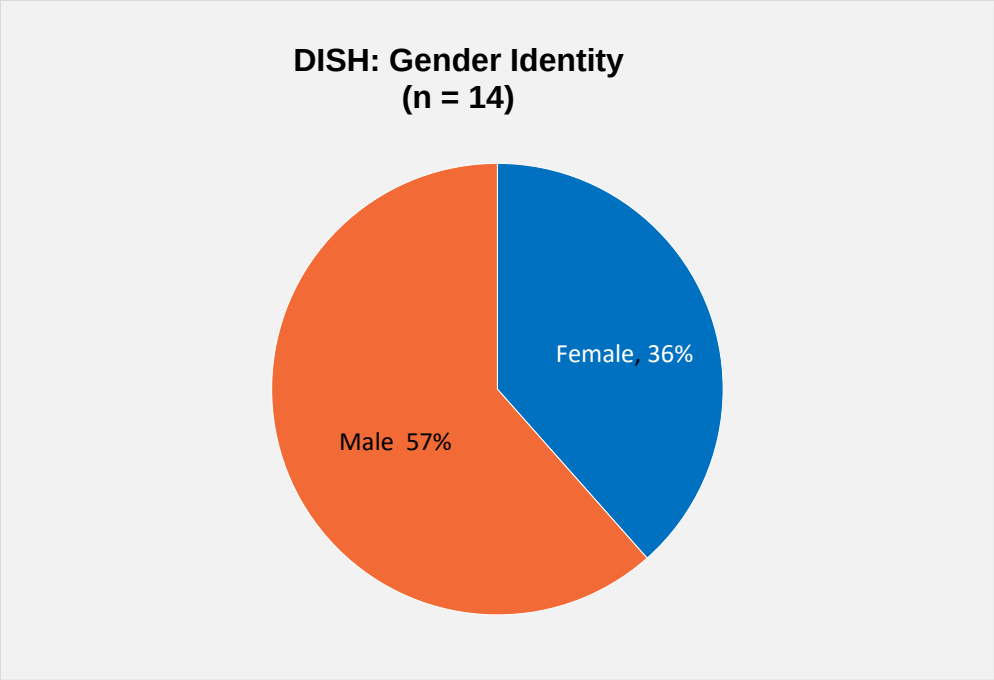
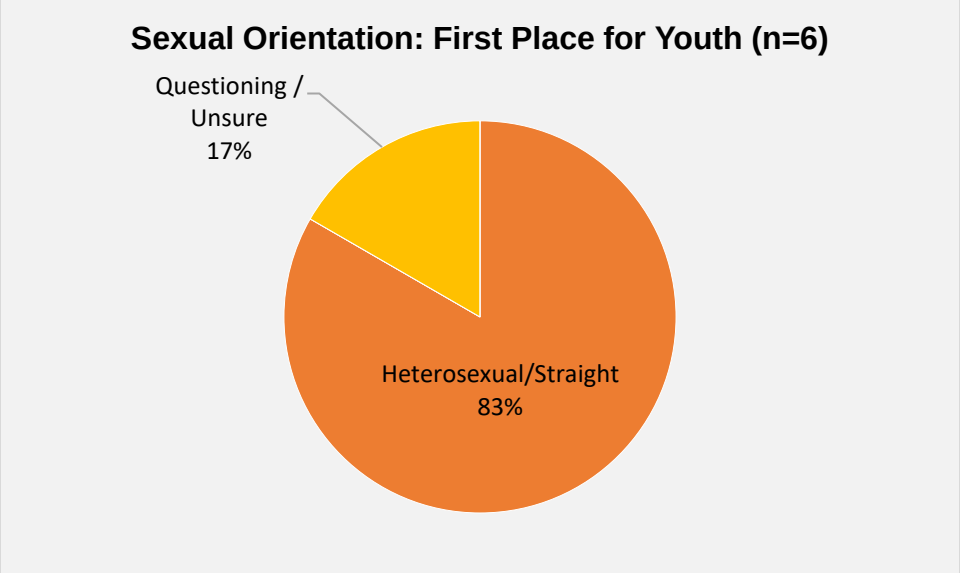
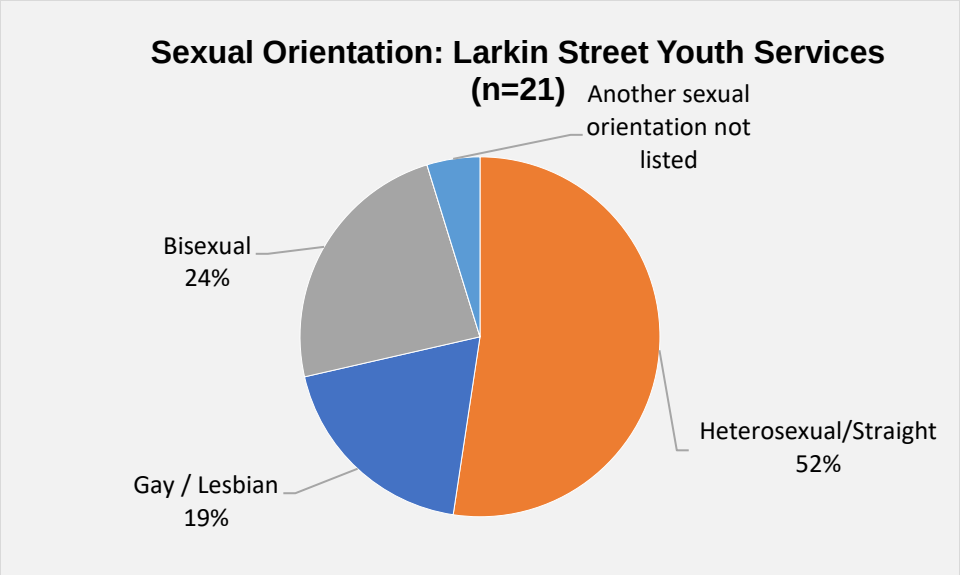


*< 1 percent of clients reported data for Another gender identity not listed, Transgender; Gender

Sexual Orientation



*< 1 percent of clients reported Gay / Lesbian, Bisexual, Another sexual orientation not listed; Sexual Orientation



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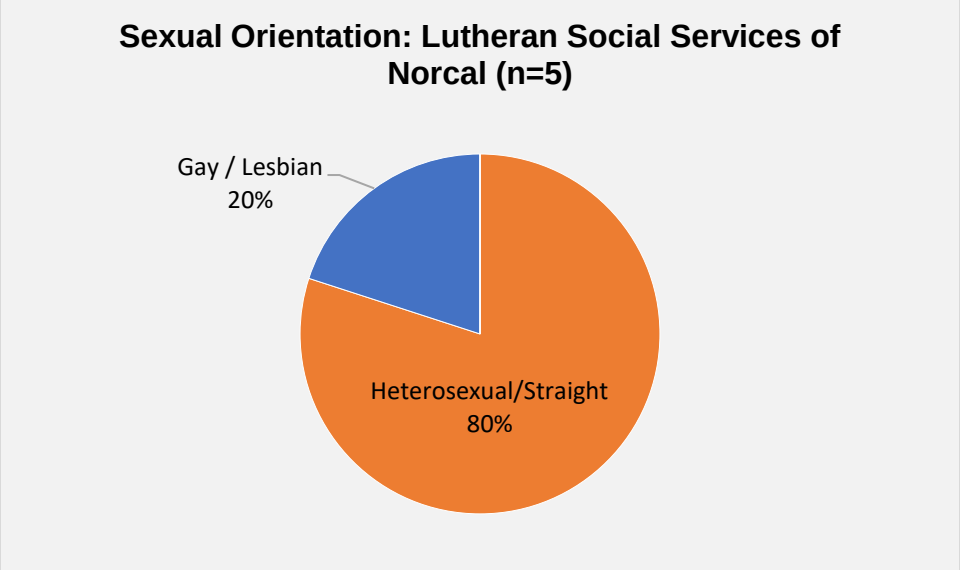

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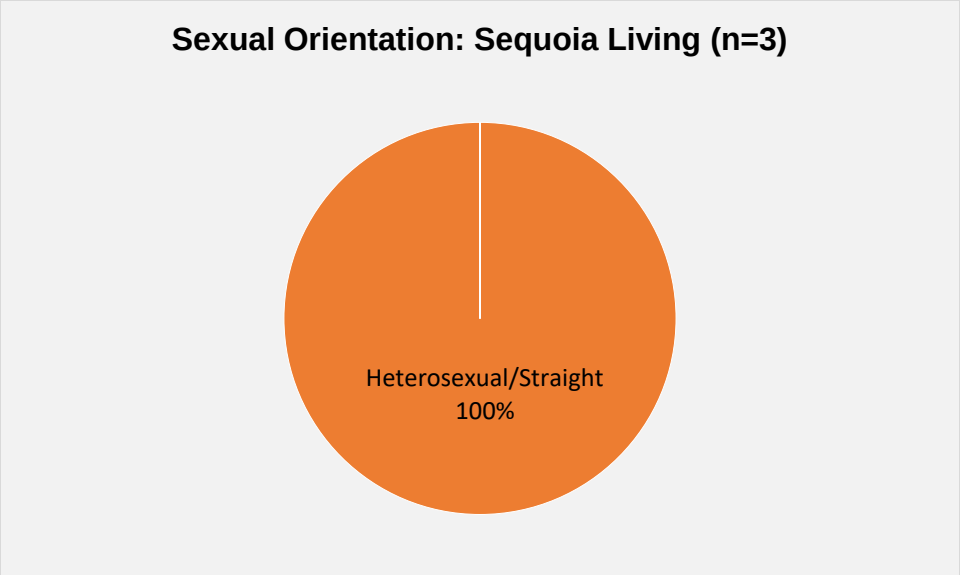
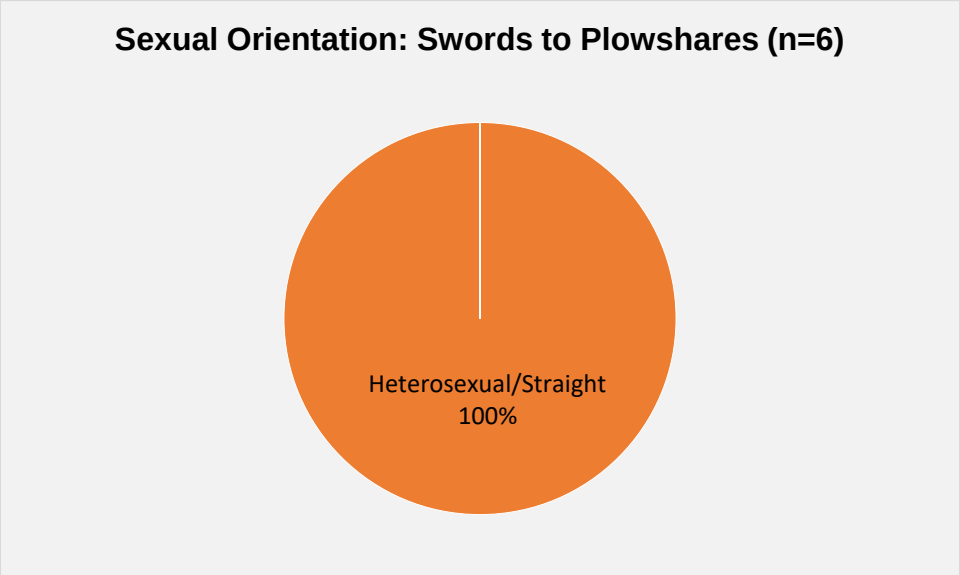


*< 1 percent of clients reported Gay / Lesbian, Bisexual, Questioning/Unsure Another sexual orientation not listed; Sexual Orientation



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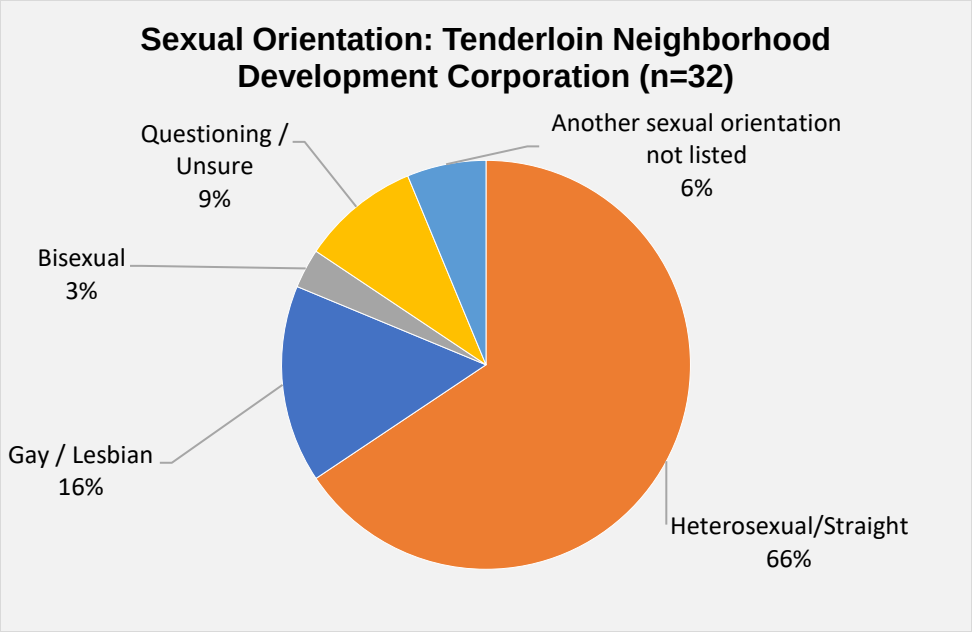
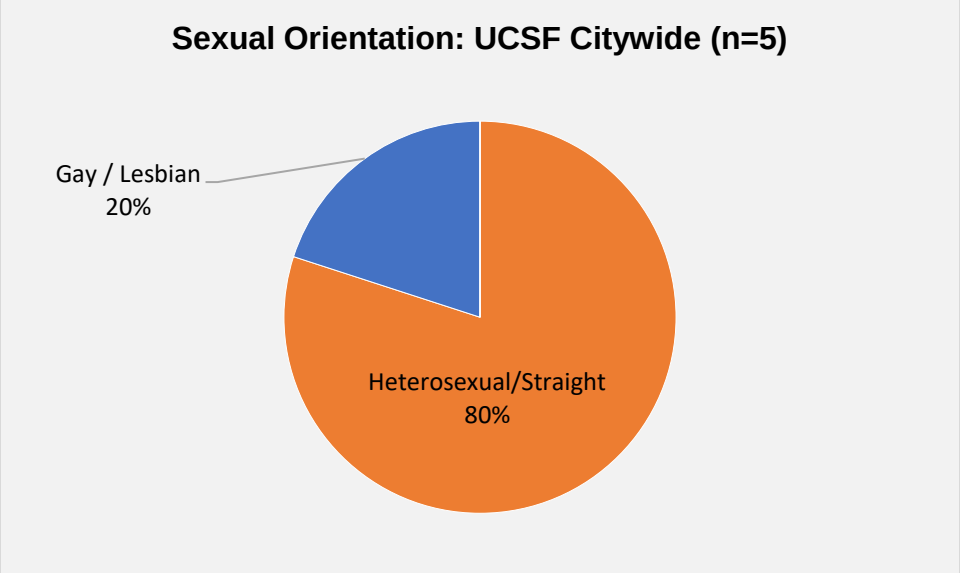
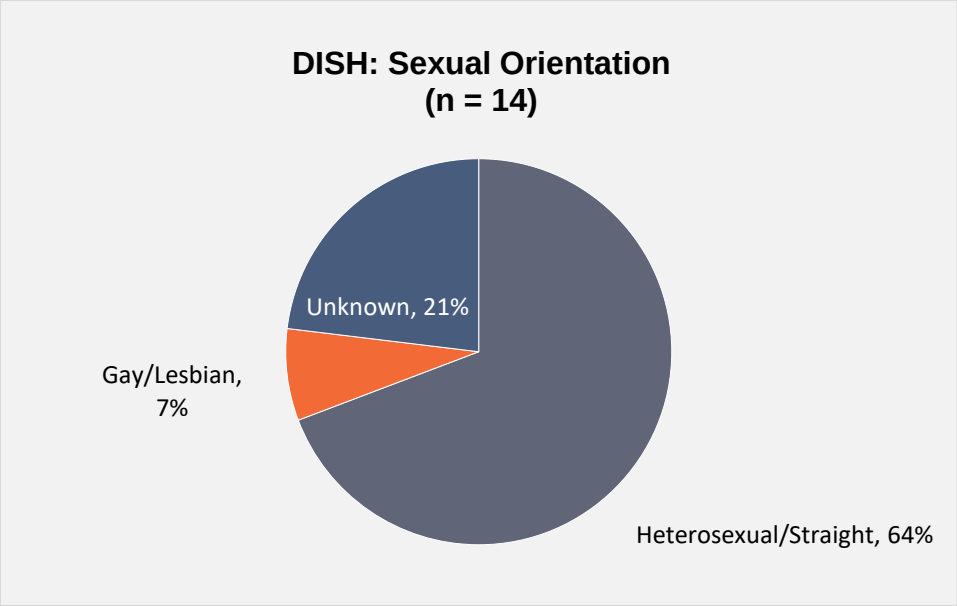




*< 1 percent of clients reported Bisexual, Questioning/Unsure, Another sexual orientation not listed; Sexual Orientation



*< 1 percent of clients reported Bisexual, Questioning/Unsure, Another sexual orientation not listed; Sexual Orientation

Race/Ethnicity

First Place for Youth

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	<10	-
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	-
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	<10	-
Total	15	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

HomeRise

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	11	4%
Black, African American, or African	135	48%
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	10	4%
White	116	41%

Hispanic/Latin(a)(o)(x)	44	16%
Non-Hispanic/Non-Latin(a)(o)(x)	239	84%
Total	566	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

Larkin Street Youth Services

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	13	57%
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	-
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	23	82%
Total	51	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

Lutheran Social Services of Norcal

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	<10	-
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	-
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	<10	-
Total	14	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

Sequoia Living

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	<10	-
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-

White	<10	-
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	<10	-
Total	6	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

Swords to Plowshares

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	<10	-
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	10	67%
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	15	100%
Total	30	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

Tenderloin Neighborhood Development Corporation

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	16	44%
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	13	36%
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	30	83%
Total	72	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

UCSF Citywide

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	<10	-
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	-
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	10	77%
Total	23	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

DISH

	Number	Percent
American Indian, Alaska Native, or Indigenous	<10	-
Asian or Asian American	<10	-
Black, African American, or African	<10	-
Multi-Racial	<10	-
Native Hawaiian or Pacific Islander	<10	-
White	<10	-
Hispanic/Latin(a)(o)(x)	<10	-
Non-Hispanic/Non-Latin(a)(o)(x)	<10	-
Unknown	<10	-
Total	<10	

Outcomes: Housing Programs[9]

Emergency Stabilization Units (ESUs)

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

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

Length of Stay by Program

First Place for Youth

	Number	Percent
1 Year	<10	-
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	<10	-
Total	<10	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

HomeRise

	Number	Percent
1 Year	29	10%
2 Years	11	4%
3 Years	37	13%
4 Years	31	11%
5+ Years	175	62%
Total	283	

*Clients may be counted in multiple categories and therefore percentages do not total 100%.

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

Larkin Street Youth Services

	Number	Percent
1 Year	12	71%
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	<10	-
Total	<10	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

Lutheran Social Services of Norcal

	Number	Percent
1 Year	<10	-
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	<10	-
Total	10	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

Sequoia Living

	Number	Percent
1 Year	<10	-
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	<10	-
Total	<10	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

Swords to Plowshares

	Number	Percent
1 Year	<10	-
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	11	73%
Total	15	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

Tenderloin Neighborhood Development Corporation

	Number	Percent
1 Year	<10	-
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	22	61%
Total	36	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

UCSF Citywide

	Number	Percent
1 Year	<10	-
2 Years	<10	-
3 Years	<10	-
4 Years	<10	-
5+ Years	<10	-
Total	16	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

Emergency Stabilization Data (ESU)

Overall

	Number
Average age of individual (years)	46
Average length of stay (days)	103
Average time between referral and admittance date (days)	8

16th Street

	Number
Average age of individual (years)	46
Average length of stay (days)	101
Average time between referral and admittance date (days)	9

Crystal

	Number
Average age of individual (years)	46
Average length of stay (days)	97
Average time between referral and admittance date (days)	5

Eddy

	Number
Average age of individual (years)	46
Average length of stay (days)	112
Average time between referral and admittance date (days)	4

Oak Tree

	Number
Average age of individual (years)	46
Average length of stay (days)	103
Average time between referral and admittance date (days)	5

*No data on length of stay available for Empress, Pacific Bay Inn, Camelot, Le Nain, Star, and Windsor.

Moving Forward in Housing Services

SFDPH JEDI/MHSA continues to make strides in the NPLH program by improving the coordination and implementation of administrative matters to meet client needs, as well as continued planning efforts to expand programming. In 2022, San Francisco completed an evaluation of the Coordinated Entry (CE) System, and the Department of Homelessness and Supportive Housing (HSH) led a redesign working group with representation from SFDPH and other community stakeholders, including people with lived experience of homelessness. SFDPH and HSH are working together to improve the use of administrative data from SFDPH and other partners for Coordinated Entry assessment and prioritization. This new process will strengthen the role that SFDPH clinical staff play in prioritization and matching when identifying MHSA and NPLH-eligible clients in the homeless response system.

SFDPH and HSH are partnering to implement SF's Proposition C-funded Permanent Housing Advanced Clinical Services (PHACS) program to bring clinical consultation, coaching, and training support directly to PSH service providers through a phone/email triage system and development training activities. This will program will provide on-site mobile care solutions to bridge physical and behavioral health services for short-term needs and connect residents to longer-term direct service support.

In addition, HSH is partnering with the Department of Disability and Aging Services (DAS) and the In-Home Support Services (IHSS) program to expand the Collaborative Caregiver Support Team (CCST) to strengthen assessment and referral processes for PSH tenants who need IHSS services. In its first year, the CCST has shown a significant impact including a higher approval rate for IHSS services to PSH residents who need assistance with activities of daily living, streamlined approval of IHSS service hours, resolution of hygiene and unit habitability issues that can often lead to housing instability, and positive client feedback. The CCST expanded into the first NPLH supportive housing site that opened in winter 2022 and is currently serving over 40% of PSH programs.

In Fall 2022, 1064-1066 Mission completed construction by adding two adjacent new permanent supportive housing sites with 153 units of housing for adults experiencing homelessness and 103 units for seniors experiencing homelessness. The Round 1 NPLH award was disbursed in its entirety to this project, including 76 units for adults and 51 units for seniors (127 total NPLH

units). The building completed lease-up in January 2023. It provides 256 studio apartments with a continuum of on-site services including intensive case management, nursing, the IHSS CCST program and community engagement activities.

Moving forward, there are new NPLH projects under development. Construction began in summer 2022 on 600 7th Street. The building is expected to open in summer 2024 and will include 70 NPLH units for adults and families experiencing homelessness. 730 Stanyan Street will include 19 NPLH units for transition age youth (TAY) and families experiencing homelessness and will start construction in summer 2023. 78 Haight Street will include 15 NPLH units for TAY experiencing homelessness. This project is expected to begin construction in 2023 and should be completed in late 2025. 71 Boardman Place, a new PSH site that will include up to 45 NPLH units, is expected to start construction in spring 2025. Lastly, the Mayor's Office of Housing and Community Development (MOHCD), HSH and SFDPH meet regularly to plan for future PSH projects that are a good fit for NPLH funding.

We also partner with Concord to expand our housing profile and added Transitional Housing.

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

Service Category Overview

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

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

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

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

Regulations for Statewide PEI Programs

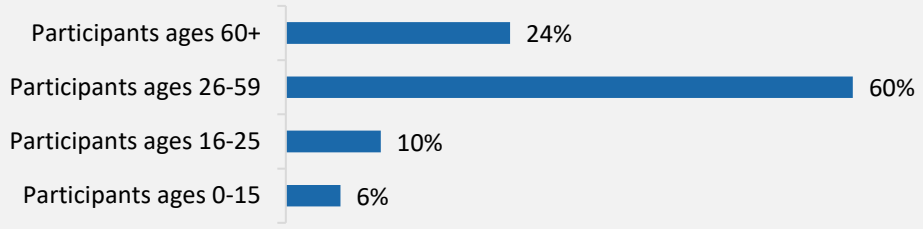
To standardize the monitoring of California PEI programs, the MHSOAC requires specific data elements and reporting. These include number of people served by a program; the demographic characteristics of program clients [e.g., age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)];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

their Annual PEI Report to the MHSOAC, which is part of a county's Annual Update or Three-Year Program and Expenditure Plan.

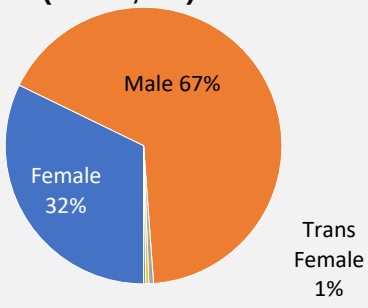
Demographics: All PEI Programs

Total Clients Served: 69,631
Total Unduplicated: 31,815
Served for Early Intervention: 4,921
Served for Mental Illness Prevention: 1,277

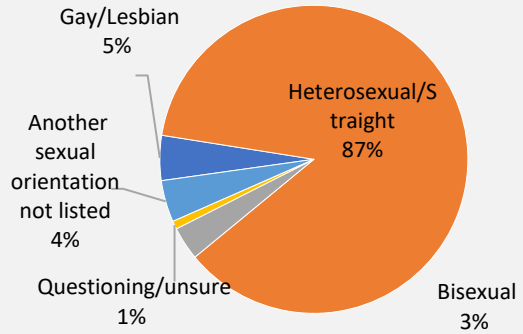
Age: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 29,266)



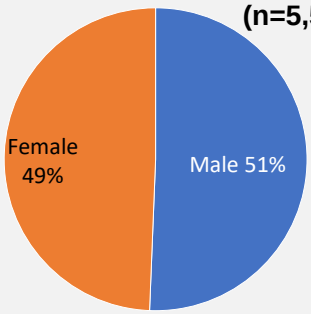
Gender Identity: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 27,644)



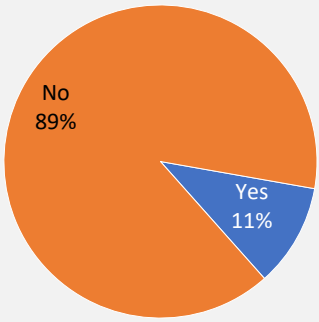
Sexual Orientation: Mental Health Promotion and Early Intervention Programs – PEI Funding (n=3,366)



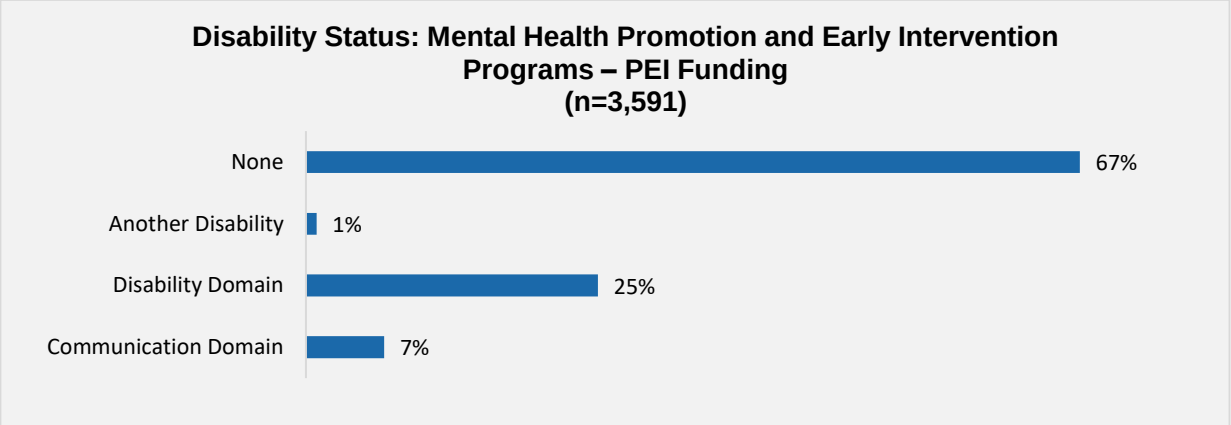
Sex at Birth: Mental Health Promotion and Early Intervention Programs – PEI Funding (n=5,536)



Veteran Status: Mental Health Promotion and Early Intervention Programs – PEI Funding (n=25,153)



*< 1 percent of clients reported data for Another gender identity not listed, Trans Male; Gender



Race/Ethnicity	n	%
Black/African American	5,951	35%
American Indian or Alaska Native	201	1%
Asian	3,366	20%
Native Hawaiian or Pacific Islander	365	2%
White	5,349	31%
Other Race	1,878	11%
Hispanic/Latino	4,088	65%
Non-Hispanic/Non-Latino	1,965	31%
More than one Ethnicity	235	4%
Total	23,408	

Primary Language	n	%
Chinese	449	11%
English	2,247	53%
Russian	<10	-
Spanish	696	17%
Tagalog	37	1%
Vietnamese	283	7%
Another Language	501	12%
Total	4,214	

*Clients may be counted in multiple categories and therefore percentages do not total 100%.

*Cell sizes with fewer than 10 clients are represented as “<10” to protect the privacy of clients and not compromise anyone’s identity.

*Due to rounding, total does not equal 100%

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

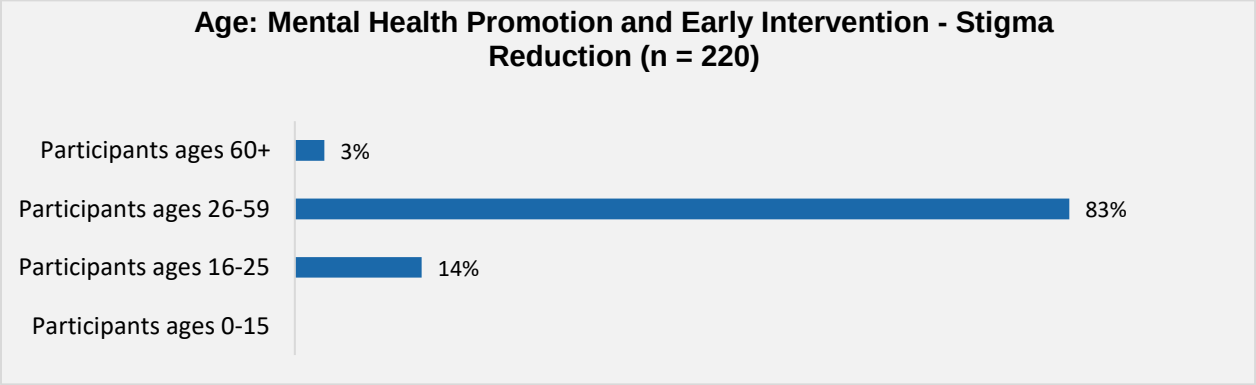
Program Overview

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

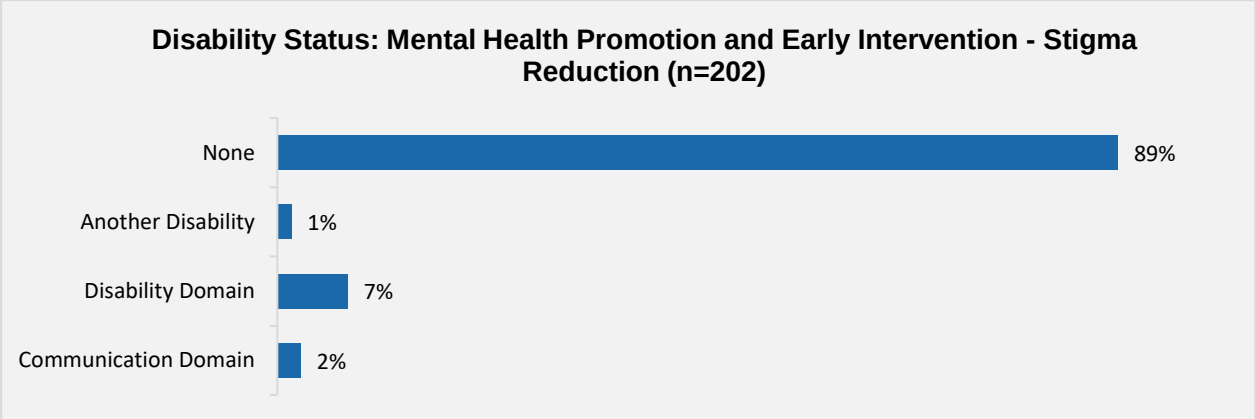
- SOLVE aims to reduce stigma (including self-stigma, structural stigma, and societal stigma) discrimination and bias, related to mental health conditions as well as to empower those affected by stigma to advocate for their communities' needs.
- SUPPORT (previously known as Peer Response Team) aims to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

Client Demographics, Outcomes, and Cost per Client

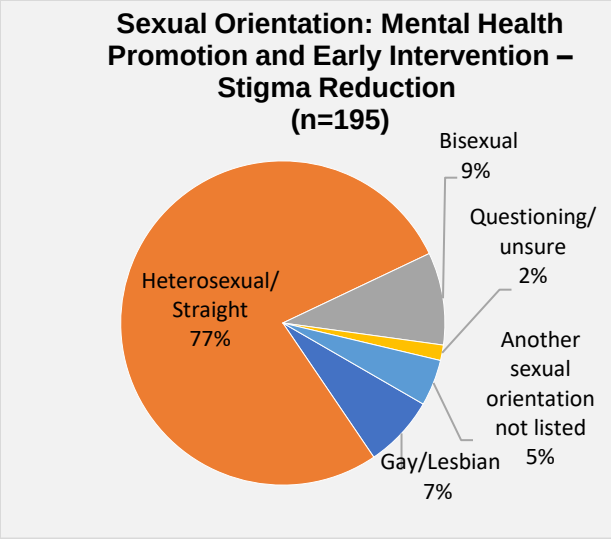
Demographics: Stigma Reduction

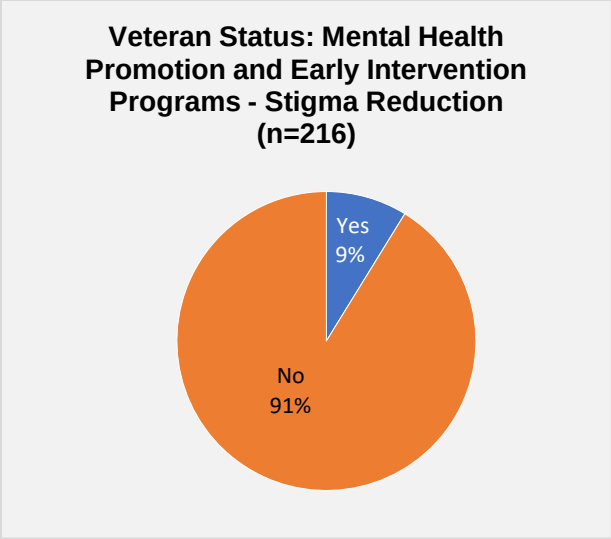


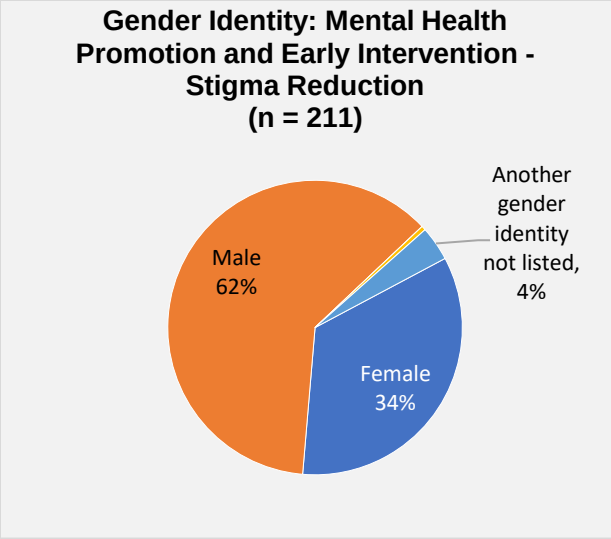
*< 1 percent of clients reported data for 0-15; Age
*< 1 percent of clients reported data for Trans Female, Trans Male; Gender



PEI





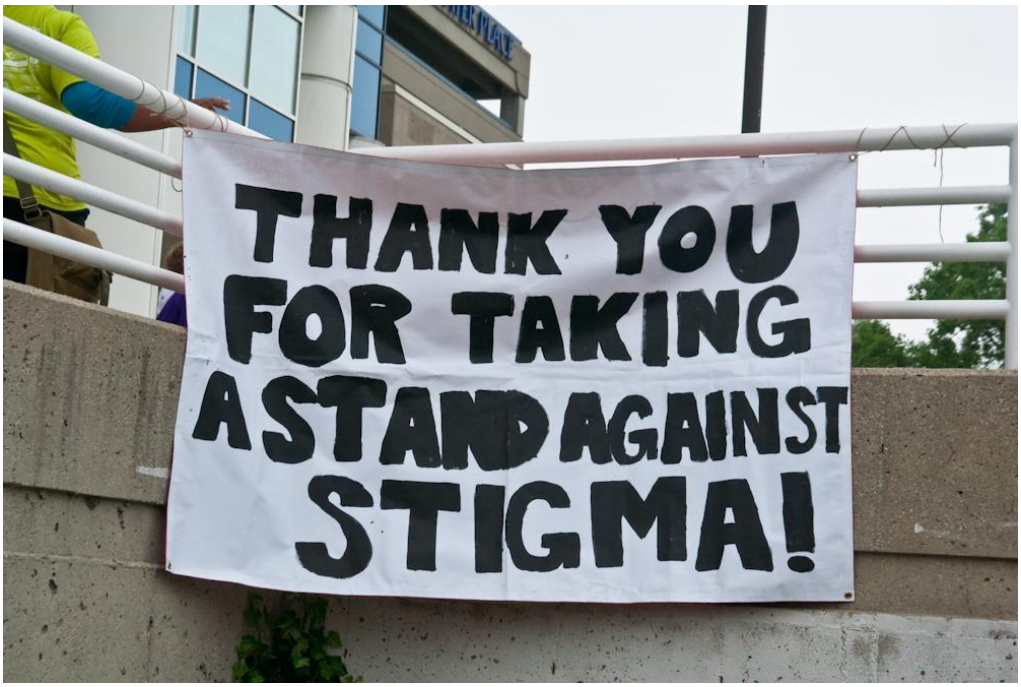


Race/Ethnicity	n	%
Black/African American	<10	-
American Indian or Alaska Native	<10	-
Asian	43	26%
Native Hawaiian or Pacific Islander	<10	-
White	97	59%
Other Race	<10	-
Hispanic/Latino	38	7%
Non-Hispanic/Non-Latino	494	92%
More than one Ethnicity	<10	-
Total	701	

*Sex at birth data is not available for Mental Health Promotion and Early Intervention – Stigma Reduction
*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.
*Language data was not available for Mental Health Promotion and Early Intervention – Stigma Reduction
In the following table, numeric values represent the number of units (e.g. clients, events, etc.) reported in providers' year-end reports and percentages represent the portion of the stated goal for the fiscal year that those service units comprise.

Program	FY21-22 Key Outcomes and Highlights
Peer Outreach and Engagement Services – Mental Health Association of San Francisco	100% (n=146) of clients who received group support reported feeling less isolated and had more companionship with other people.

FY21/22 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[10]
Stigma Reduction	573 Clients	$196,835	$344



PEI

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

School-Based Mental Health Promotion (K-12)

Program Overview

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

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

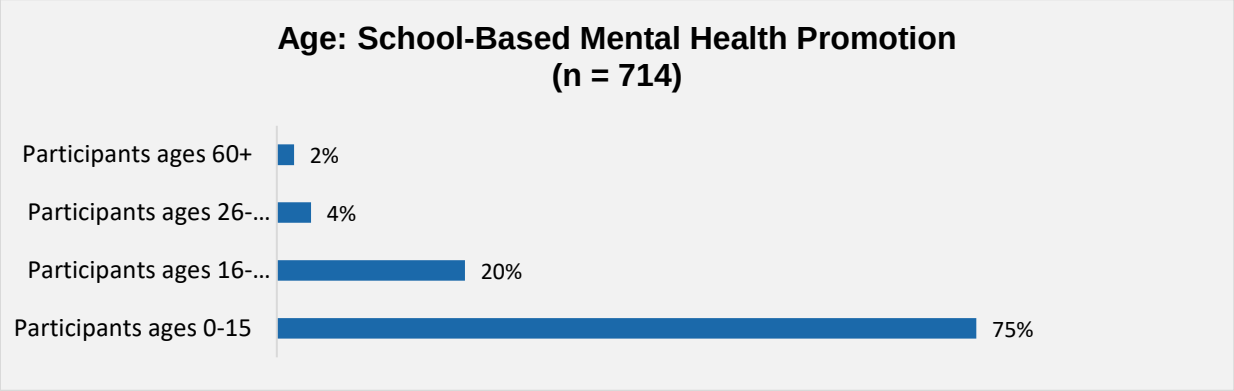
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To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

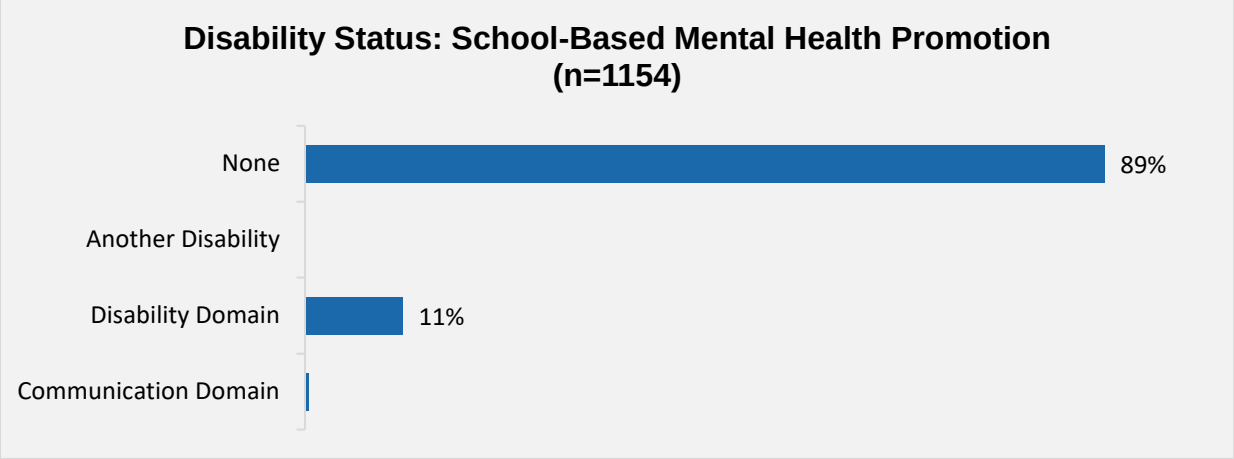
Target Populations

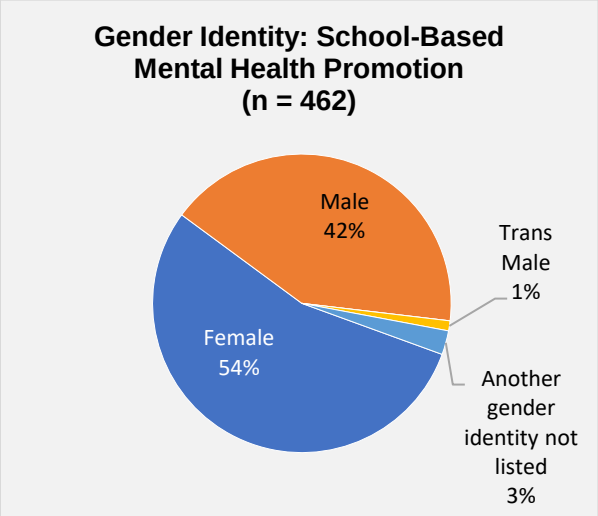
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

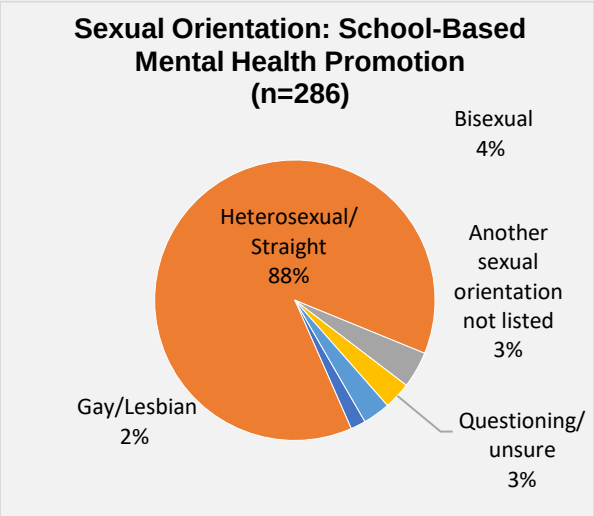
Client Demographics, Outcomes, and Cost per Client

Demographics: School Based Prevention (K-12)





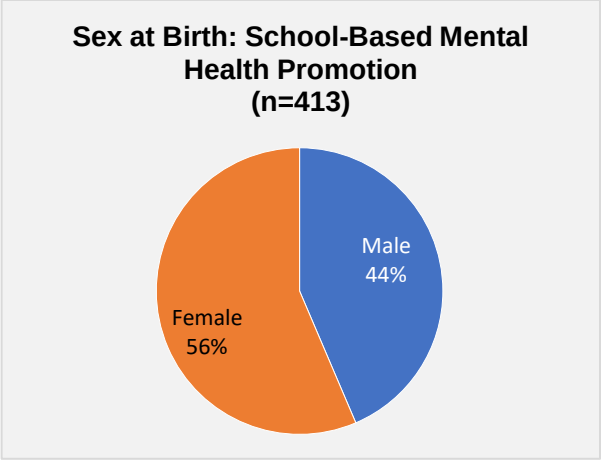


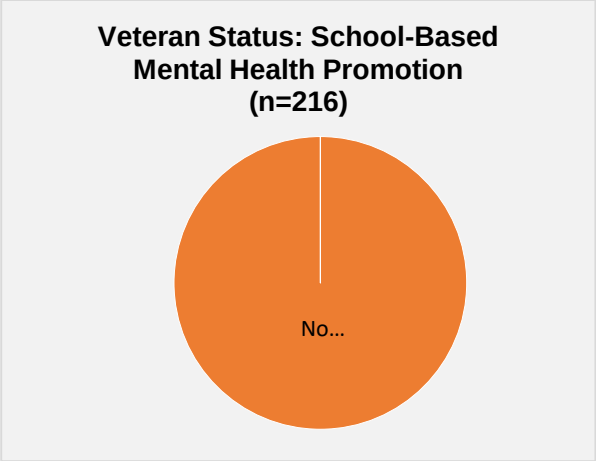


*< 1 percent of clients reported data for Trans Female; Gender

*No clients reported Yes; Veteran Status

PEI





*< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	80	24%
American Indian or Alaska Native	<10	-
Asian	99	30%
Native Hawaiian or Pacific Islander	<10	-
White	27	8%
Other Race	121	37%
Hispanic/Latino	241	42%
Non-Hispanic/Non-Latino	318	55%
More than one Ethnicity	21	4%
Total	909	

Primary Language	n	%
Chinese	<10	-
English	354	75%
Russian	<10	-
Spanish	106	22%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	472	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

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

Program	FY21-22 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - Bayview Hunter's Point Foundation	• 100% (n=12) clients were linked to long-term community-based mental health support and services.

Program	FY21-22 Key Outcomes and Highlights
Mental Health Services – Edgewood Center for Children and Families	• 70% (n=20) of students showed an increase from pre to post services (with a mean increase of 29%).
Youth Early Intervention – Instituto Familiar de la Raza	• 70% (n=99) of staff expressed the consultant helped with increased understanding of mental health and socio-economic needs of the student and family.
Wellness Centers – Richmond Areas Multi-Services (RAMS)	• 92% (n=139) reported their need was addressed by a team member, and 88% (n=84) reported feeling supported by the team member.
Trauma and Recovery Services – YMCA Urban Services	• 40% (n= <10) of clients re-engaged in their academic experience.

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[11]**
School-Based Mental Health Promotion (K-12)	1,646 Clients	$1,051,363	$639

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

Spotlight on the Homeless Children's Network MA'AT Program

The Homeless Children's Network's Ma'at Program launched in 2021 and is designed around seven core values: balance, order, righteousness, harmony, justice, truth, and reciprocity. The overarching program goal is to improve behavioral health outcomes for Black/African American children, youth, and families in San Francisco and address the historical legacy of intergenerational racism, inequity, and trauma. Ma'at uses a whole-person approach to offer Afro-centric, culturally responsive, heartfelt, behavioral health care. Not only does it aim to improve behavioral health outcomes for Black/African American individuals and families in San Francisco, but it addresses the historical legacy of intergenerational racism, inequity and trauma within the community. The goal is to support individuals and families of African descent to passionately and unconditionally affirm Blackness, in addition to helping them improve mental health and functioning, increase coping skills, and improve relationships with families, educational programs, peers and community. There is no program like it in San Francisco.

At the heart of the Ma'at model of mental health services is a cadre of diverse Black/African American therapists and case managers who reflect the various communities represented by the clients and their families. This team is held by an infrastructure of Black/African American managers and directors that, likewise, reflect the lived experiences of the Ma'at clientele. Below are the additional components of the Ma'at model of mental health services for Black/African American individuals and families.

- Affirm Blackness
- Focus on self-acceptance
- Focus on resilience
- Identify unique areas of strength
- Normalize clients' experiences
- Reframe stigma of mental health amongst the Black community
- Acknowledge range of religious/spiritual practices within the Black community
- Encourage clients to believe in their capability and choice to engage in their own healing
- Integrate family and community members into the services
- Offer space to process collective grief and fear without judgment
- Address barriers to accessing resources and basic needs
- Facilitate "difficult" conversations
- Trauma informed
- Love informed
- Services are both rooted in the community and mobile.

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SF MHSA Service Provider, Hospitality House Self-Help Center

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

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

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

PEI

Target Populations

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

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

Many of these populations experience extremely challenging barriers to service, including but not limited to language, culture, poverty, stigma, exposure to trauma, homelessness and substance use. As a result, the MHSA planning process called for proposals from a wide variety of qualified organizations in order to break down barriers and improve the accessibility of

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

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

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name *Provider***	**Services**
	Black/African American Community Wellness and Health Initiative (BAACWHI)	Takes a collective impact approach where the City, community, and two lead community-based organizations – the YMCA Bayview, Booker T. Washington Community Service Center,and the Rafiki Coalition – that are intent on decreasing the physical and mental health disparities of San Francisco's Black/African American populations.
Asians/Pacific Islanders (API)	API Mental Health Collaborative *Richmond Area Multi-Services (RAMS)*	Serves Filipino, Samoan and Southeast Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Latinx including Indigenous Mayan communities	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	Serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance *Native American Health Center*	Serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.

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

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

Spotlight on Improving Maternal Mental Health for Black/African American Birthing People

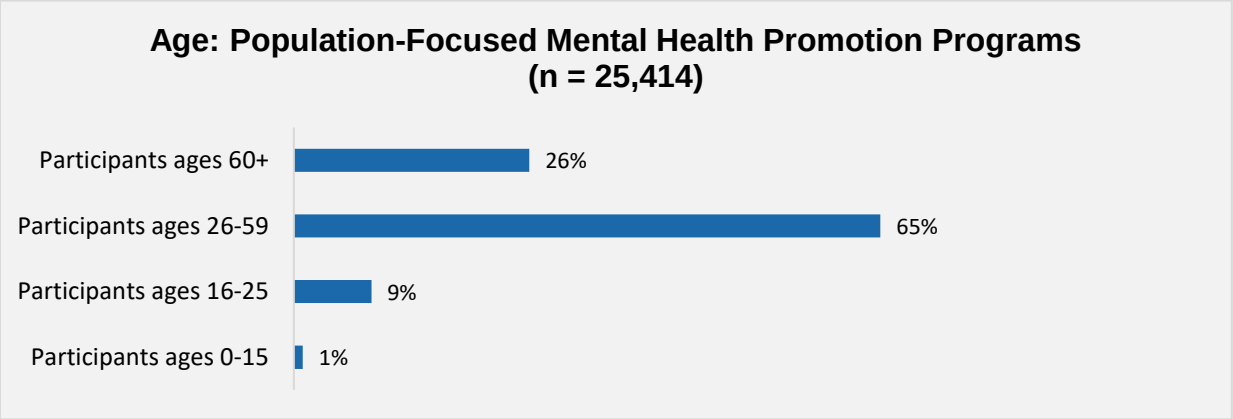
The Improving Maternal Mental Health for Black/African American Birthing People program is a new PEI-funded program that is aimed at addressing the significant mental health needs of pregnant people. It is estimated that 20% of pregnant people have a mental health (MH) condition that would benefit from MH support services, such as counseling and therapy. Among Black/African American women, this number is higher because of the increased stress levels resulting from structural and interpersonal racism.

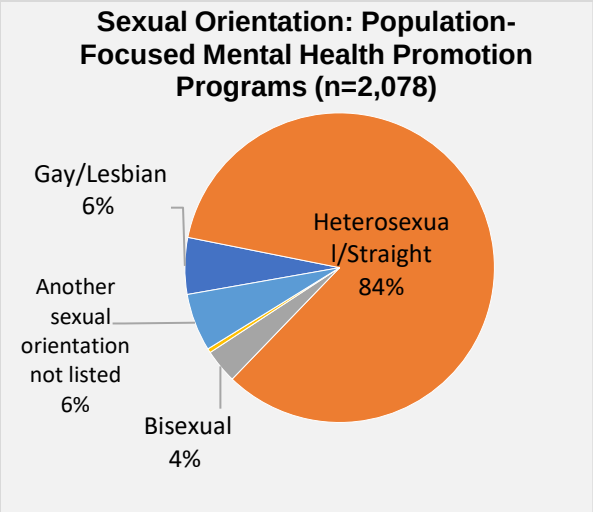
To address this critical need, San Francisco must invest in (1) building and sustaining a workforce of Black/African American therapists who specialize in treating pregnant/postpartum people and (2) creating the infrastructure to ensure these therapists are easily accessible to pregnant people and well-coordinated with the rest of their pregnancy care team.

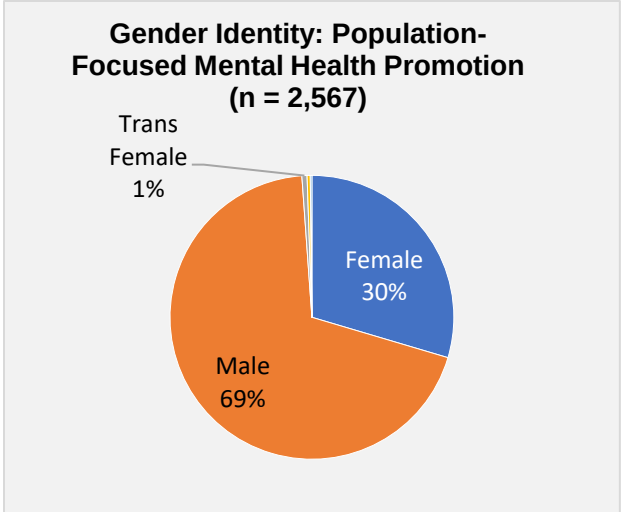
Starting in FY23/24, the program will employ and train four Black/African American therapists to provide MH support services to Black/African American pregnant/postpartum clients via formal and informal sessions, telemedicine, and/or in a group support setting. We also will be providing funding and training for Behavioral Health Clinicians on perinatal/postnatal MH support; provide materials and resources for community-centered, non-traditional therapeutic activities such as expressive arts and other somatic therapies; and have therapists available at community events to connect and establish relationships with new clients; provide informal one-on-one sessions; and provide group therapeutic activities.

The program will also provide financial support to the operations of the Pregnancy Pop-Up Village, which includes monthly events designed to offer pregnant people a one-stop-shop to access multiple pregnancy-related services MH providers will work alongside SFDPH perinatally-focused program providers (Black Infant Health and the Public Health Nursing Home Visiting Program) and other core healthcare providers and CBOs providing services to pregnant/postpartum City residents.

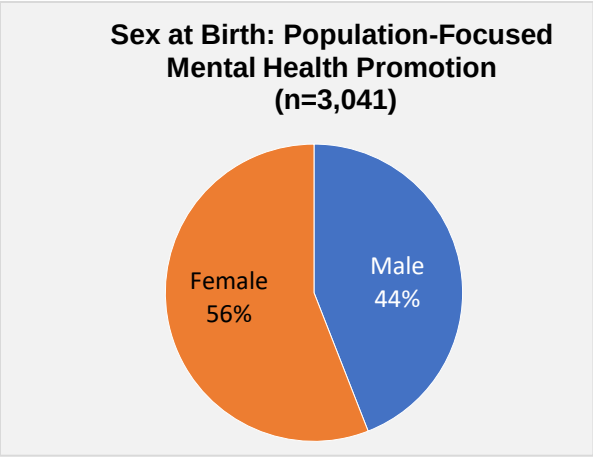
Demographics: Population Focused Mental Health

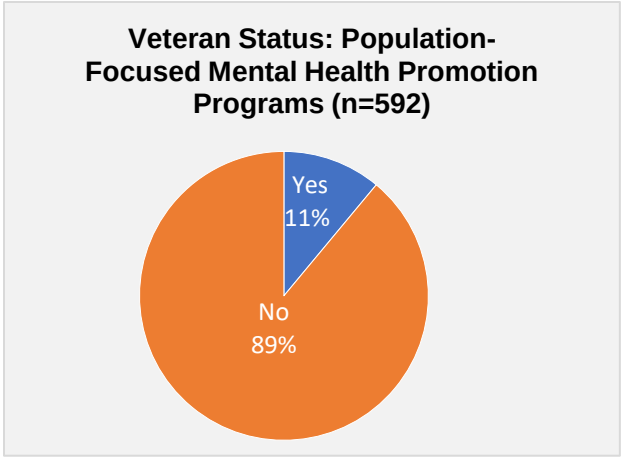




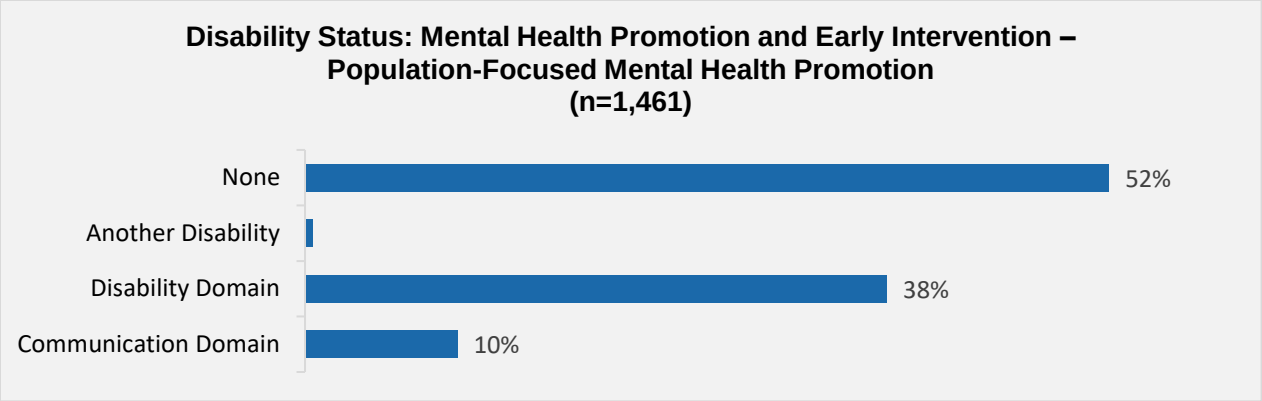


*< 1 percent of clients reported Questioning/unsure; Sexual Orientation
*< 1 percent of clients reported data for Another gender identity not listed, Trans Male; Gender





PEI



*< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	5,026	35%
American Indian or Alaska Native	169	0%
Asian	2,860	19%
Native Hawaiian or Pacific Islander	280	2%
White	5,036	34%
Other Race	1,554	10%
Hispanic/Latino	2,391	75%
Non-Hispanic/Non-Latino	652	20%
More than one Ethnicity	138	4%
Total	18,106	

Primary Language	n	%
Chinese	218	8%
English	1,243	47%
Russian	<10	-
Spanish	377	14%
Tagalog	36	1%
Vietnamese	282	11%
Another Language	479	18%
Total	2,636	

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

*Due to rounding, total does not equal 100%

Program	FY21-22 Key Outcomes and Highlights
Senior Drop-in Center	• 80% (n=66) of clients attending three activities or more reported increased socialization.
Addressing the Needs of Socially Isolated Older Adults – Curry Senior Center	• 100% (n=119) of isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services (including case management, substance use, mental health, and social support groups).

Program	FY21-22 Key Outcomes and Highlights
Black/African American Wellness and Peer Leadership Program – SFDPH Inter-Divisional Initiative (collaborative of AA Holistic Wellness and SF Live D10 Wellness)	• 100% (n=65) of individuals were linked to wellness services such as food insecurity support, COVID 19 services, family resource centers, and/or physical wellness coaching.
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	• 94% (n=48) of clients reported increased knowledge about how people can be affected by mental health. • 97% (n=38) of clients agreed they felt better as a result of participating in therapeutic activities.
Indigena Health and Wellness Collaborative – Instituto Familiar de la Raza	• 100% (n=67) of individuals receiving non-clinical case management achieved at least one goal in their case/care plan.
Living in Balance – Native American Health Center	• 39% (n=15) of individuals receiving case management achieved at least one early intervention advocacy goal.
South of Market Self-Help Center (6th Street) – Central City Hospitality House	• 100% (n=58) of community members with a written case plan achieved at least one case plan goal.
Tenderloin Self-Help Center - Central City Hospitality House	• 100% (n=63) of community members with a written case plan achieved at least one case plan goal.
Community Building Program - Central City Hospitality House	• 100% (n=37) of clients achieved at least one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - Instituto Familiar de la Raza	• 100% (n=28) of transition age youth who were connected by program staff to internal behavioral health services attended an initial appointment or meeting.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander - Community Youth Center	• 95% (n=60) of Asian/Pacific Islander transition age youth receiving our case management services successfully attained at least one of their treatment goals.
Population Specific TAY Engagement and Treatment – LGBTQ+ - SF LGBT Center	• 100% of youth referred to mental health services received follow-up calls and were moved from waiting lists to assessment and intake.

Program	FY21-22 Key Outcomes and Highlights
Population Specific TAY Engagement and Treatment – Black/African American – Larkin Street Youth Services and Third Street Youth Center	• 89% of transition age youth who were connected by program staff to internal or external behavioral health services attended an initial appointment or meeting.
Population Specific TAY Engagement and Treatment – Juvenile Justice/Others - Huckleberry Youth Programs	• 100% (n= 99) of youth referred to behavioral health services participated in at least one initial appointment.
TAY Homeless Treatment Team – Larkin Street Youth Services	• 75% of clients who received program treatment and healing services maintained their outcomes (i.e., they neither regressed nor progressed; rather, they maintained stability)

FY21/22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[12]**
Population-Focused Mental Health Promotion	27,226 Clients	$4,578,785	$168

Early Childhood Mental Health Consultation Initiative

Program Overview

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

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

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is evidence-based [13] and delivered in the following settings: center-based and family childcare, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. Four county entities provide funding and partnership to deliver ECMHCI: SFDPH/BHS; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco.

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

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

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

Target Populations

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

Early Childhood Mental Health Consultation Initiative	
Program Name	**Services Description**
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Infant Parent Program/Day Care Consultants ***UCSF***	Focuses on relationships between young children and their adult caregivers. The IPP embeds perinatal mental health specialists in the Obstetric 5M Clinic at Zuckerberg San Francisco General Hospital. In-clinic mental health treatment is provided to high risk, mostly immigrant, and indigent pregnant people. The aim of the program's intervention is to reduce psychiatry symptoms in those about to be parents, thereby improving their parental functioning and, in turn, the outcomes for their children. Families seen in this program are overseen through labor and delivery, and, if needed, the Neonatal Intensive Care Unit and Pediatric Clinics to ensure continuity of care.
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Edgewood Center	Works to tailor services to meet the unique and common needs of all clients, including conversations with struggling students, which yields a more focused understanding of the obstacles they are encountering and taking a collaborative approach to remedy the problem and put them on a positive path. Parental support is also

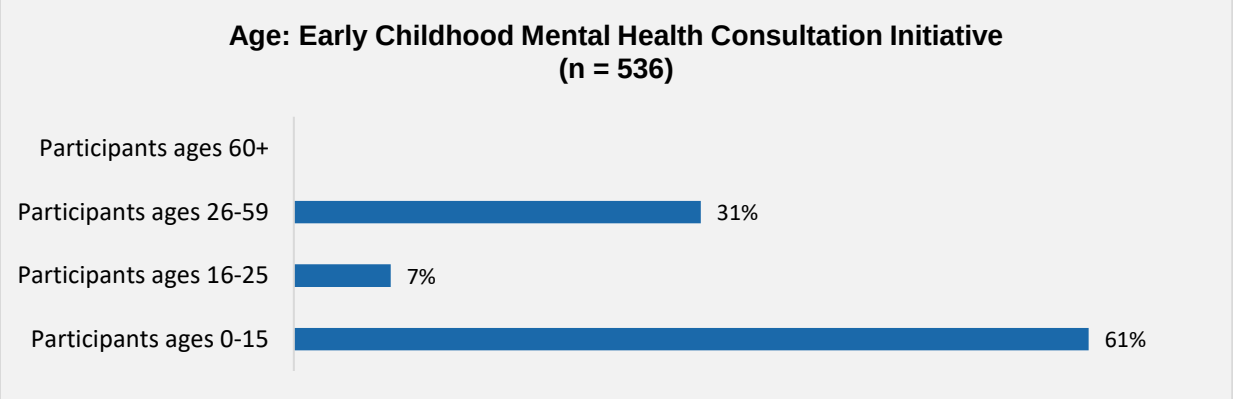
PEI

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

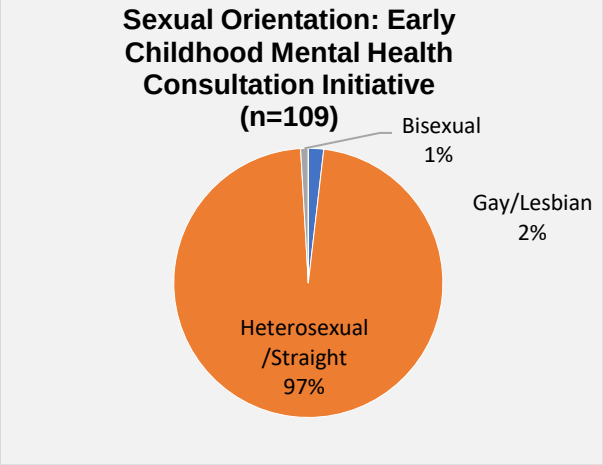
Early Childhood Mental Health Consultation Initiative	
Program Name	**Services Description**
for Children and Families	provided by asking questions to better understand their challenges, concerns, and needs, helping them to better understand what works and what does not work as it relates to getting support. For this program, it is important to meet parents "where they are" without judgement and drawing from shared/common experiences to best support them. These services promote resiliency for students, staff, and the families we serve.
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Fu Yau Project *Richmond Area Muli-Services*	One of five grantees of ECMHCI, which has combined five funding sources. In 2021, we connected with the Family Child Care Association of San Francisco's leadership to help foster their role in the program services as co-facilitators. During FY2022, we made changes to the program; instead of having two different topics per month, our two facilitators work together on one topic. These groups were facilitated in Cantonese and Mandarin, two core languages spoken by our clients. During COVID-19, virtual services were available, allowing the Mental Health Consultant the ability to continue monthly support groups focused on parent/caregiver support with an average of 12 clients per meeting.
Early Childhood Mental Health Consultation Initiative (ECMHCI) – Homeless Children's Network	Due to COVID-19, all discussions and work surrounding the redesign of this program were placed on hold, given the high demand for mental health support in FY20-21. Joining funders, including Clarity Consulting Group, are working in partnership to gather data and client feedback as the beginning stages of the redesign take shape. Many consultation sites have slowly reopened following the pandemic, and guidance on how best to provide support has been coordinated at each site. Additionally, the program received three new consultation sites, increasing the overall program budget. Our diverse team of consultants hold a strong, relationship-focused, equitable, and trauma-informed approach to services, maintaining high standards of care.

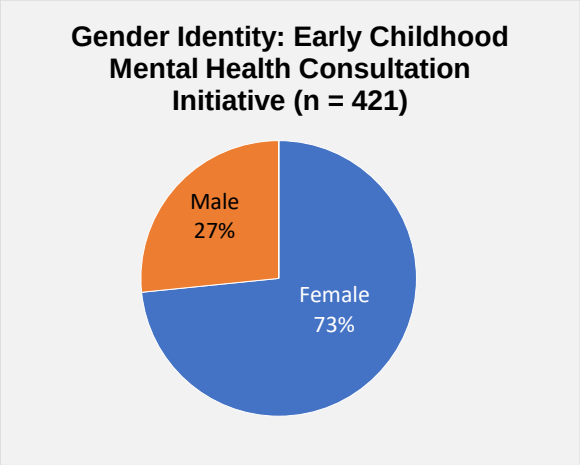
Client Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative

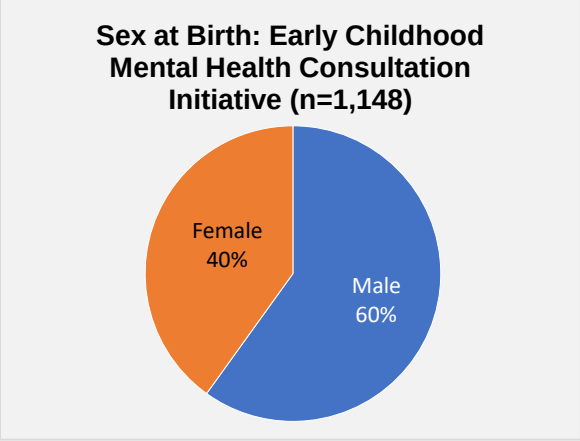


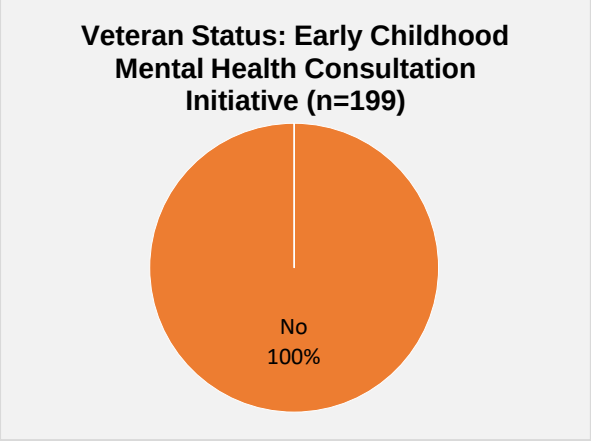
*< 1 % of clients reported data for Older Adult (60+) for Age





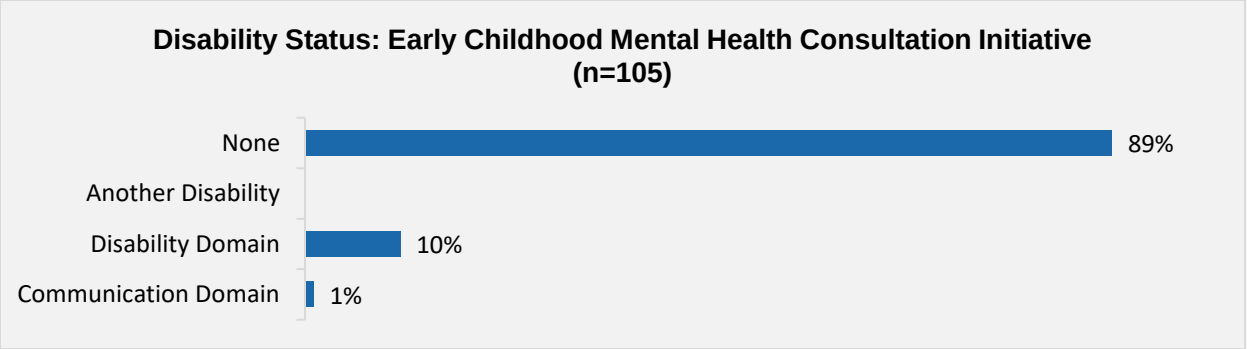
*< 1 percent of clients reported Another Sexual Orientation Not Listed, Questioning/unsure; Sexual Orientation
*< 1 percent of clients reported data for Another gender identity not listed, Trans Female, Trans Male; Gender





*No clients reported Yes; Veteran Status

PEI



*< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	189	28%
American Indian or Alaska Native	<10	-
Asian	254	38%
Native Hawaiian or Pacific Islander	26	4%
White	96	14%
Other Race	98	15%
Hispanic/Latino	811	98%
Non-Hispanic/Non-Latino	12	1%
More than one Ethnicity	<10	-
Total	1,500	

Primary Language	n	%
Chinese	214	31%
English	330	48%
Russian	<10	-
Spanish	135	20%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	688	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

PEI

Program	FY21-22 Key Outcomes and Highlights
Infant Parent Program Day Care Consultants	• 74% (n = 16) of parents who received four or more mental health treatment sessions focused on parenting ended services; 100% (n = 6) reported services to be excellent and would recommend the program to other pregnant people
Edgewood Center for Children and Families	• 70% (n = 20) of classroom teachers reported feeling more successful in dealing with challenging student behaviors on their own

FY21-22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[14]**
Mental Health Consultation and Capacity Building	1,381 Clients	$792,800	$574

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

Comprehensive Crisis Services

Background and Community Need

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

Program Overview

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

Target Populations

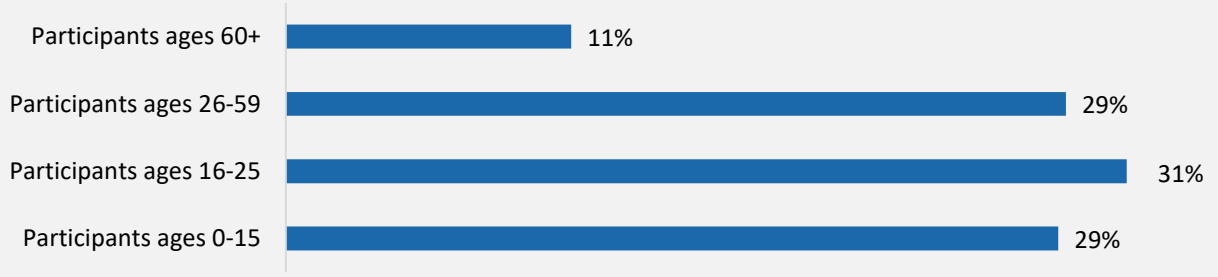
The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and in need of support.

Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older.
Child Crisis Team	Offers 24/7 mobile 5585/5150 assessments & crisis intervention for suicidal, homicidal and gravely disabled children and adolescents regardless of health insurance status. Clients with public health insurance or without health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response Team	Provides 24/7 mobile response to homicides, critical shootings, stabbings, suicides, and pedestrian fatalities; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

Program Outcomes, Highlights and Cost per Client

Demographics: Comprehensive Crisis Services

Age: Comprehensive Crisis Services (n=704)



Program	FY21-22 Key Outcomes and Highlights
Comprehensive Crisis Services – SFDPH	• Four new staff members were hired to better respond to crises. A new roving team was implemented to provide more services in the field

FY21-22 Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[15]
Comprehensive Crisis Services	897 Clients	$574,412	$640

Moving Forward in PEI

Serving Older Adults

Older adults are a growing population in San Francisco. Within our Community Planning Process, we identified a significant need to increase services for older adults with cognitive impairments such as dementia. Specifically, we identified the following needs:

- We have services that can assess and diagnosis cognitive impairments, yet we have few services that can provide ongoing treatment and support.
- We have a need for a memory care clinic and programming for cognitive impairments.
- SFDPH's Long-term Care Council has extensive data documenting this long-standing need within the community.
- There is a need to develop new PEI-funded programming that would provide screening and referral services for this population and strengthen support at the drop-in center level.
- We are considering increasing support for those who are in more advanced stages of a cognitive impairment and those who are underserved within BHS.

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

The Kuumba Healing Project (KHP): A new program that serves disenfranchised families of Black/African American descent living in San Francisco, KHP provides culturally relevant community and school-based services around the psychosocial and academic needs of our targeted population. KPH is embedded in the San Francisco Unified School District (SFUSD) and collaborates closely with community-based programs. KPH provides behavioral health services, including school-based individual and group therapy, and restorative circles and Social Emotional Learning (SEL) focused curriculum in SFUSD. KPH also provides clinical consultation to SFUSD instructors and administrators, as well as classroom observation and clinical assessment services.

The Kuumba Healing Project collaborates with NAMI (National Alliance on Mental Illness) by creating relevant psycho-educational content and co-facilitating classes that target the mental wellness of youth and families of Black/African American descent in San Francisco. The position of the Kuumba Fellow, a peer specialist, will provide paraprofessional support to KHP's clinical team in schools and the community. Additionally, the Kuumba Fellow will support and co-facilitate the provision of SEL curriculum, restorative circles, psychoeducation and outreach in SFUSD and local community organizations. In FY21-22, we began outreach and recruitment for two peer specialists to be filled in FY22-23.

In FY22-23, KHP's goal is to increase accessibility to culturally relevant mental health services for youth and families of Black/African American descent in San Francisco. KHP will recruit to fill the two vacant Kuumba Fellow positions. KHP will engage Kuumba Fellows to assist with the co-facilitation of the SEL curriculum and Restorative Circles in the classroom setting by the end of FY23-24 school year. KHP will create content and co-facilitate one additional class for youth and families of Black/African American descent with NAMI-SF on Post-traumatic stress disorder by the end of FY23-24.

6. Innovations Projects: INN Funding

Service Category Overview

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

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

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

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

Program Overview

SFDPH MHSA received funding from the California Mental Health Services Oversight and Accountability Commission in FY17-18 for a five-year project to support client transitions from Intensive Case Management/Full-Service Partnership programs to Outpatient Treatment Services.

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

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

Family Unification and Emotional Resiliency Training (FUERTE) - UCSF

Program Overview

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

Target Populations

This program serves recently immigrated Latinx youth.

Wellness in the Streets - RAMS

Program Overview

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

Target Populations

This program serves people experiencing homelessness.

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

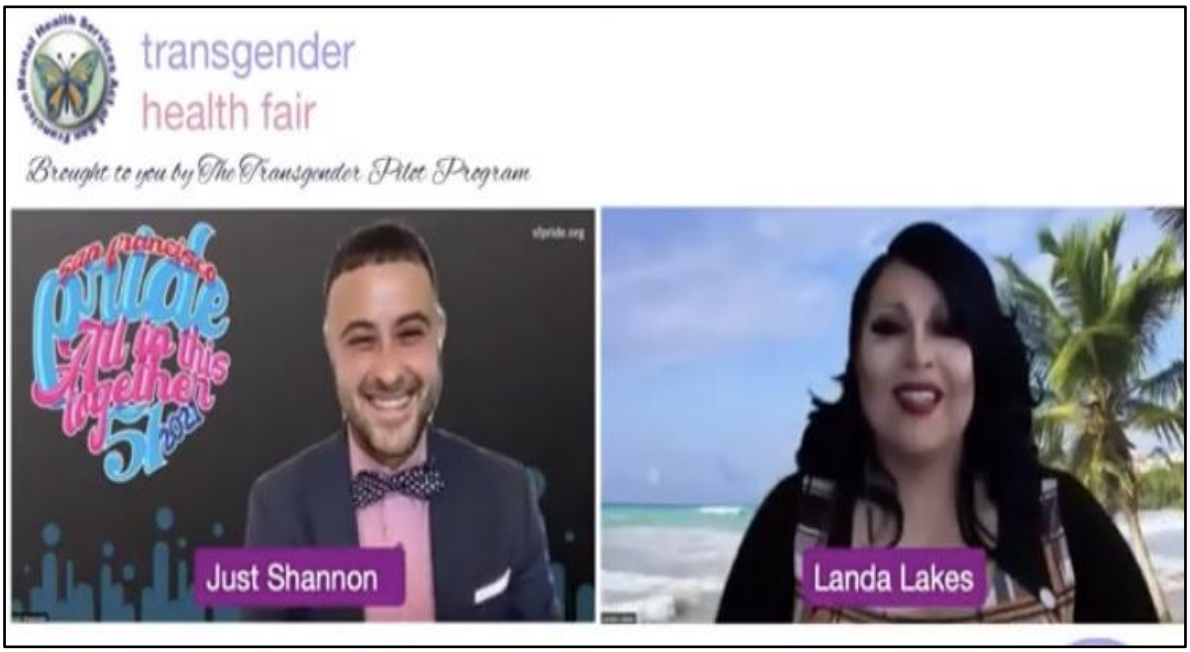
Program Overview

The primary purpose of this INN Tech Suite Project is to increase access to mental health care and support and to promote early detection of mental health symptoms. Through the utilization of digital devices, such as smart phones, tablets and laptops, as a mode of connection and treatment to reach people who are likely to go either unserved or underserved by traditional mental health care, project services will focus on prevention, early intervention, family and social support to decrease the need for psychiatric hospital and emergency care service. The Innovations Technology-Assisted Mental Health Solutions project (Tech Suite) is preparing for multi-county marketing efforts. With input from all counties, a brand, logo, and outreach materials are being created. A formal name for the Tech Suite has been adopted, which is

Help@Hand. Help@Hand is being envisioned as a multi-city and county collaborative whose vision is to improve the well-being of Californians by integrating promising technologies and lived experiences. Please see Appendix B titled, “Technology-Assisted Mental Health Solutions Innovation Project Update” at the end of this report for more information.

Target Populations

All San Franciscans who experience behavioral health challenges with a focus on transition age youth and socially isolated transgender individuals.



Virtual Transgender Health Fair 2021

INN

Spotlight for Culturally Congruent Practices for the Black/African American Communities

The Culturally Congruent and Innovative Practices for Black/African American Communities program is in the process of rolling out the programs, with collaborative work with human resources on fully staffing this important project. The goal of the program is to identify and hire culturally congruent providers with lived experience with Black/African American communities. Health Educators have already been hired and have been providing groups to the community including expressive arts groups, such as a hip hop therapy group for Transition-Age Youth (TAY). Some clinicians have been hired, while the remaining positions are currently being filled. Training on the Sankofa model for providers will be conducted in the coming year.

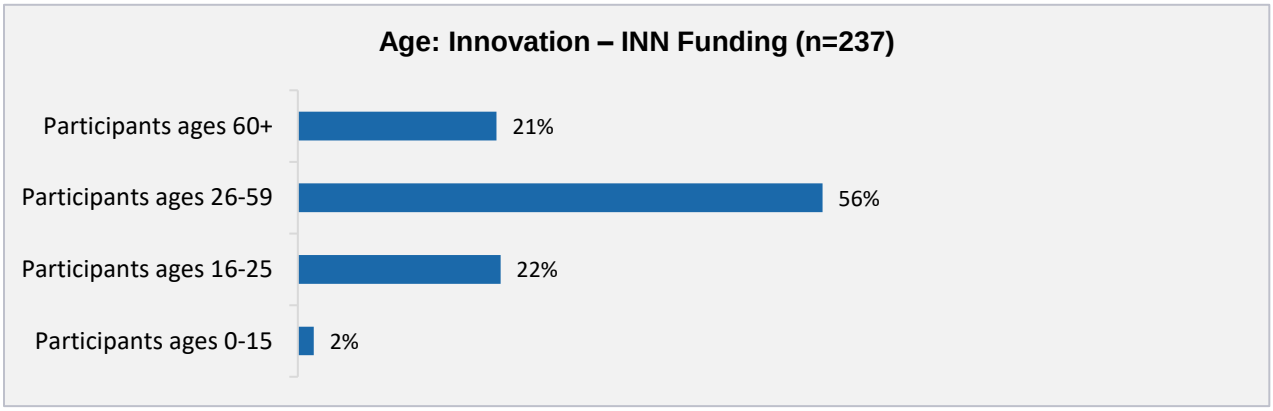
This project will be implemented in the following four civil service clinics:

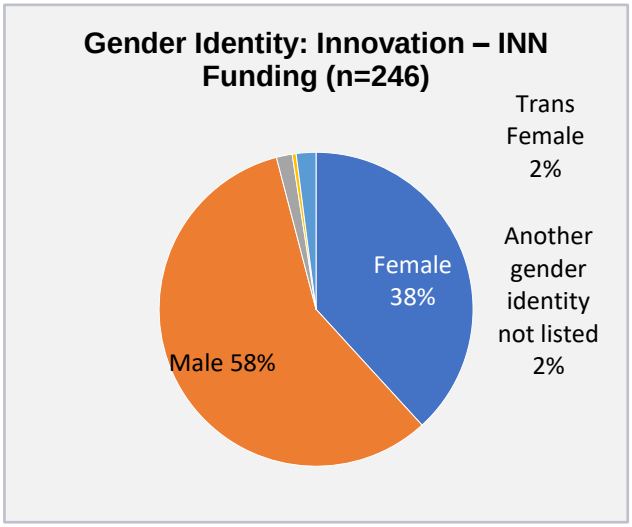
- Mission Mental Health Clinic Alternatives Case Management
- South of Market Mental Health
- DPH TAY Clinic
- OMI Family Center

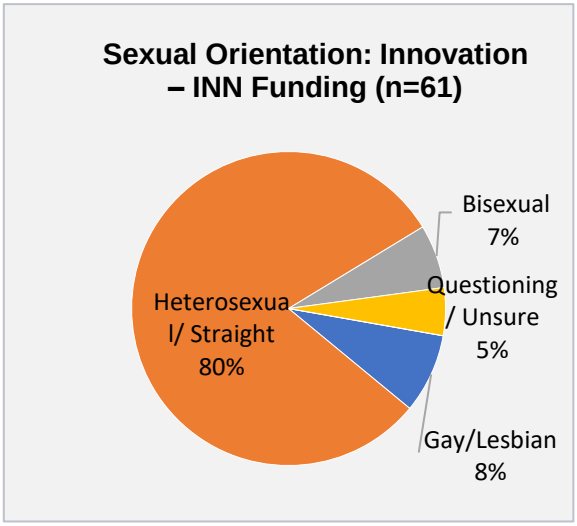
We are currently working with a provider and listening to community feedback on how to better market this program. Recently, an evaluator was selected for this project, providing additional oversight and programmatic development. A cultural liaison will be working on ensuring community input and feedback are integrated into the development of this project every step of the way.

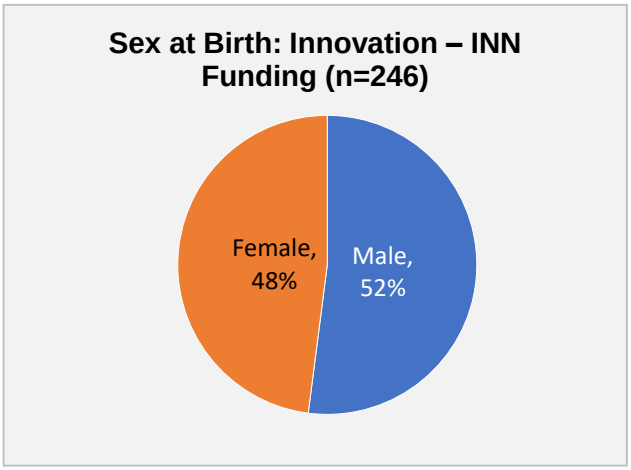
Client Demographics, Outcomes, and Cost per Client for all Innovation Programs

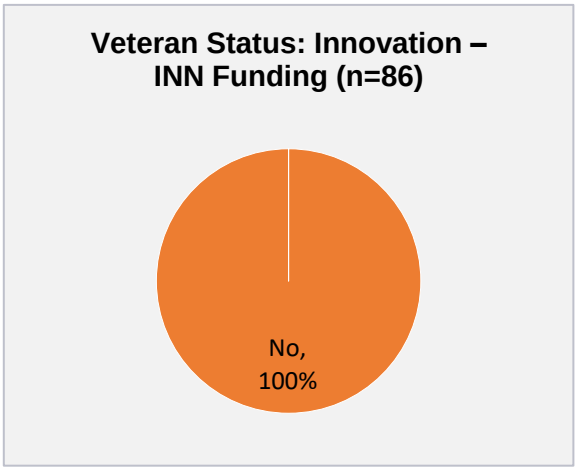
Service Indicator Type	Program Results for FY21-22
Total family members served	No INN programs were able to report these data.
Potential responders for outreach activities	Response included: social work interns
Total individuals with severe mental illness referred to treatment	No INN programs were able to report these data.
Types of treatment referred	No INN programs were able to report these data.
Individuals who followed through on referral	No INN programs were able to report these data.
Average duration of untreated mental illness after referral	No INN programs were able to report these data.
Average interval between referral and treatment	No INN programs were able to report these data.
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	13
Types of underserved populations referred to prevention program services	Response included: Latinx immigrant youth between the ages of 12-21 years old and individuals who are experiencing homelessness
Individuals who followed through on referral	No INN programs were able to report these data.
Average interval between referral and treatment	No INN programs were able to report these data.
How programs encourage access to services and follow-through on referrals	Responses included: ● Use of qualified staff who can identify and appropriately refer to services. ● Offering services that build supportive relationships with mental health services providers. ● Screen clients for socioemotional functioning and utilization of services prior to the start of the program.

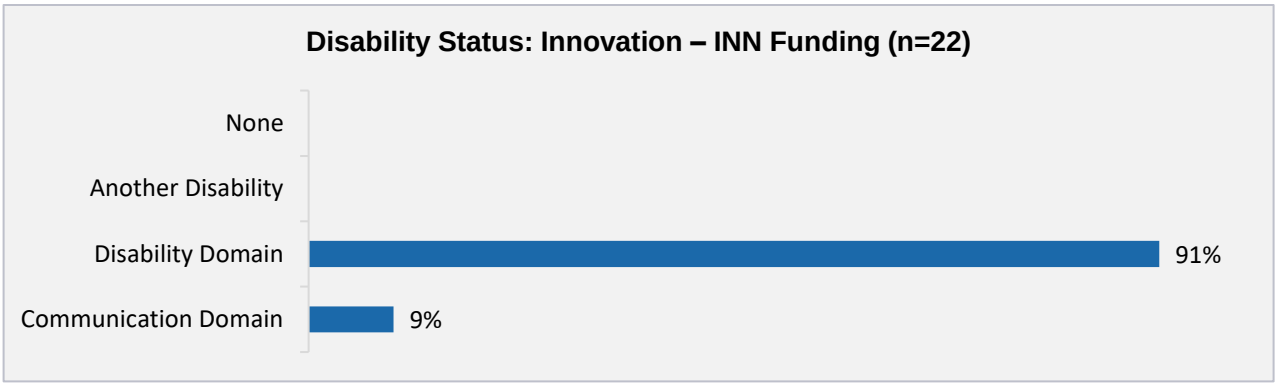

Age: Innovation – INN Funding (n=237)
Participants ages 60+
21%
Participants ages 26-59
56%
Participants ages 16-25
22%
Participants ages 0-15
2%


Gender Identity: Innovation – INN Funding (n=246)
Trans Female 2%
Another gender identity not listed 2%
Female 38%
Male 58%


Sexual Orientation: Innovation – INN Funding (n=61)
Bisexual 7%
Questioning / Unsure 5%
Heterosexual/ Straight 80%
Gay/Lesbian 8%


Sex at Birth: Innovation – INN Funding (n=246)
Female, 48%
Male, 52%


Veteran Status: Innovation – INN Funding (n=86)
No, 100%



< 1 percent of clients reported data for Another Sexual Orientation Not Listed; Sexual Orientation
*<1 percent of clients reported Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	62	32%
American Indian or Alaska Native	<10	-
Asian	14	7%
Native Hawaiian or Pacific Islander	<10	-
White	60	31%
Other Race	49	25%
Hispanic/Latino	59	94%
Non-Hispanic/Non-Latino	<10	-
More than one Ethnicity	<10	-
Total	257	

Primary Language	n	%
Chinese	<10	-
English	199	79%
Russian	<10	-
Spanish	46	18%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	253	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.
*Due to rounding, total does not equal 100%

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

Program	FY21-22 Key Outcomes and Highlights
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support – Richmond Area Multi-Services (RAMS)	• 83% (n = < 10) of clients reported they felt heard and understood by their Peer Counselor, and 80% reported feeling more comfortable with their new provider
FUERTE – University of California San Francisco (UCSF)	• 61% (n = 11) of clients reported an increase in social connectedness when sharing their favorite aspects of the program

Program	FY21-22 Key Outcomes and Highlights
Wellness in the Streets – Richmond Area Multi-Services (RAMS)	• 92% (n = 129) of clients reported their need was addressed by a team member, and 88% (n = 84) reported feeling supported by the team member
Technology Assisted Mental Health Solutions – Mental Health Association of San Francisco	• 69% (n = 16) of program's clients identified as transition age youth or transgender

FY21-22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[16]**
Innovations	252 Clients	$2,314,510	$9,185

Moving Forward in Innovations

Several of our Innovations programs will be ending during this upcoming three-year period. As Innovations programs near the end of their terms, we will continue to conduct community program planning sessions and collect feedback from stakeholders to assess areas for possible continuation as core programs. We will also review outcomes and evaluation reports to determine program strengths and successes.

There may also be some programs whose work overlaps with recent initiatives in other City departments. In these cases, their continuation will need to align with overall city priorities and strategies. The development of continued services to these populations will be planned in collaboration with other relevant parties and departments, while being informed by learning from their respective Innovation projects.

Intensive Case Management and Full-Service Partnership to Outpatient Programs
The RAMS Peer Transitions Team is a five-year MHSA Innovations Project designed to assist clients as they transition from Intensive Case Management (ICM) to Outpatient (OP) care. This program began in 2019. Community Program Planning meetings are being conducted to determine which aspects of the ICM to OP Transition Support Project have been the most beneficial to clients in determining the continuation of funding for certain program elements. Feedback is also being collected to determine the need for future programmatic improvements in the last year of the project and in the future. Some initial feedback has included suggestions to have more peers stationed onsite at outpatient clinics, more financial and programmatic supports for clients who are transitioning to outpatient programs, and support for vocational opportunities for clients involved in this project.

Culturally Congruent and Innovative Practices for San Francisco's Black/African American Communities
This project is in a "ramping up" period and we are working to fully staff this project with culturally congruent providers who have lived experience with Black/African American Communities. Behavioral Health Clinicians, Health Workers, and Peers have been hired and

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

have provided support groups to the community, including an expressive arts group such as hip-hop therapy for Transition-Age Youth. Some clinicians have been hired and remaining positions are being filled. Training on the a culturally responsive model for providers will be conducted in the coming year.

This project will be implemented in the following four civil service clinics:

- Mission Mental Health Clinic Alternatives Case Management Program
- South of Market Mental Health
- SFDPH TAY Clinic
- OMI Family Center

A marketing strategy is being developed with provider and community feedback. An evaluator was recently selected for this project. A cultural liaison will be working on ensuring community input and feedback in each step of the project.

FUERTE

COVID19 and coordinating remote services had a significant impact that created many challenges. However, FUERTE met its performance objective goals. Instead of going into classrooms to initiate students at the start of the group, visiting them at home, or having the school's assistance in enrolling students, the students were required to take the initiative and log into the online video platform. One obvious challenge was the lack of technology, including computers and the internet, among some students. Consequently, those students could not be contacted, despite being enrolled.

Key relationships with school and community partners have been integral to this program. Unfortunately, challenges arose when key contacts were on leave or unreachable following the COVID19 pandemic. For example, program expansion proved challenging when school contacts could not be reached due to COVID19.

Wellness in the Streets

As COVID19 created the need for alternative models of care to support people experiencing homelessness, the Wellness in the Streets (WITS) program staff were deployed as Disaster Service Workers focusing their efforts on providing peer support and resource linkage to guests in the City's Shelter-in-Place (SIP) hotels. This deployment began in FY20-21 and continued throughFY21-22.

During FY21-22, the WITS team continued to receive referrals from the BHS Shelter in Place (SIP) team with requests to outreach to specific clients in the SIP hotels who were a part of the identified Mental Health San Francisco population. This group of clients had a history of care in the BHS system due to co-occurring mental health and substance use disorders, in addition to experiencing homelessness.

As the year progressed, the WITS team worked with an increasing number of clients who either had not accessed behavioral health services in the past or who were not open to currently engaging in more conventional behavioral health services at this time (i.e. psychotherapy, psychiatry), but who were open to peer support services. The team also expanded services to include clients staying in congregate sites functioning as SIP sites, and also ramped up peer support for clients as they transitioned into permanent supportive housing.

Following the WITS team's adjustment to working with clients at SIP sites, the team found themselves prepared to adapt to new challenges. In FY21-22, we were able to safely reduce

COVID19 safety protocols and provide in-person services, while supporting clients with the navigation of SIP hotel closures and the transition to permanent housing.

This involved peer counselors on the team learning to bridge the gap in communication between various systems of care related to housing, behavioral health, primary care and benefits. The WITS team became more engaged and focused on harm reduction approaches, in collaboration with medical and integrated behavioral health providers.

While WITS was originally conceived as a program to provide peer support for people experiencing homelessness and help them build trust with the behavioral health system of care, it became essential for the team this year to work in tandem with providers and staff from across multiple agencies and systems of care.

Many WITS clients experienced extreme stress and anxiety related to the re-housing process and the closure of many SIP sites where they had been staying with some measure of stability since 2020. The WITS team focused on working collaboratively with SIP site staff, SFDPH nursing and behavioral health staff, and Department of Homelessness and Supportive Housing staff to help support clients during times of transition and uncertainty.

By building and maintaining these networks of communication, WITS has been able to provide peer support services and meet the needs of our clients more successfully. Overall, the program's peer support has proven to be essential in helping numerous clients during their journey of preparing for and moving into permanent housing and connecting to longer-term behavioral health and primary care services.

Technology-Assisted Mental Health Solutions (TAMHS) Project

SFDPH partnered with the Mental Health Association of San Francisco (MHASF) for the Technology-Assisted Mental Health Solutions (TAMHS) project. The project includes the Tech Borrowing and Distribution Program, which offers free devices, internet service, digital literacy education and peer support for community members. This program also includes a pilot of TakemyHand™, which continued to be planned during this period.

Furthermore, the project included client subscriptions to Headspace, an app that provides guided meditation and other mindfulness activities. The subscription was discontinued after the pandemic. A Tech Lead was hired and onboarded in February 2022 to support the TakemyHand™ pilot. The Tech Lead supported the digital literacy training and device distribution efforts after the Peer Program Manager left the project in June 2022.

The Tech Borrowing and Distribution Program aims to help residents understand how to use technology to access digital services to support their mental health. TAMHS has offered tablets, digital literacy training and peer support. The City and County of San Francisco finalized and approved various protocols and logistics, particularly those related to IT security.

Software was provided to collect data on the number of residents served and the use of virtual resources, since data collection is a high priority for this project. Digital literacy training was available through a learning platform, created by the TAMHS team, which included a 12-part series on relevant technology, mental health and how to connect to the internet. Topics included cyberbullying, technology use to promote wellness, computer skills and online safety.

To increase usage rates, MHASF connected with other Help@Hand counties and cities to increase engagement. Community partners played an integral role in distributing the devices to residents.

This project had many delays due to the complexity of the City's technology contracting policies and the uniqueness of the project. Consequently, it pivoted to mainly focus on promoting access to technology and supporting wellness for underserved communities. Approvals for technology-based peer chat support are still being developed and are anticipated to be piloted in FY22-23.

TakemyHand™ Pilot

In 2021, San Francisco was selected to pilot TakemyHand™. This program was adopted because their behavioral health clients expressed an interest in an anonymous chat to support and overcome feelings of social isolation.

The pilot is an extension of the California Peer-Run Warmline model in San Francisco, which is operated by the MHASF. Resources and emotional support are available through this pilot program. San Francisco County planned a six-month pilot with a focus on transition-age youth (TAY; aged 16-26) and trans-identified community members.

San Francisco County and MHASF worked with Riverside County, the developer of TakemyHand™, to finalize the contract and logistics. The logistics of this program include the following:

- Procedure Development: San Francisco County and MHASF are working with Riverside County to receive access to the live chat feature.
- Training and staffing for peer operators to answer chats on the platform: San Francisco County is working with the California Peer-Run Warmline to answer chats on the platform. There are now two Peer Chat Operators who are already trained in providing peer support. The project manager for San Francisco County's TakemyHand™ pilot is the California Peer-Run Warmline assistant manager, along with all of the San Francisco TakemyHand™ staff who have completed the California Peer-Run Warmline training, which includes classroom training. Progress continues on the website by MHASF and designs have been finalized.

7. Behavioral Health - Workforce Development: WET Funding

Service Category Overview

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

MHSA's goal is to develop a behavioral health workforce development pipeline to increase the number of individuals that are informed about, choose to prepare for, and are successful in entering and/or completing behavioral health training programs. To accomplish this goal, MHSA staff members collaborate with SFDPH BHS as a whole, along with San Francisco Unified School District (SFUSD), City College of San Francisco, San Francisco State University, and California Institute of Integral Studies.

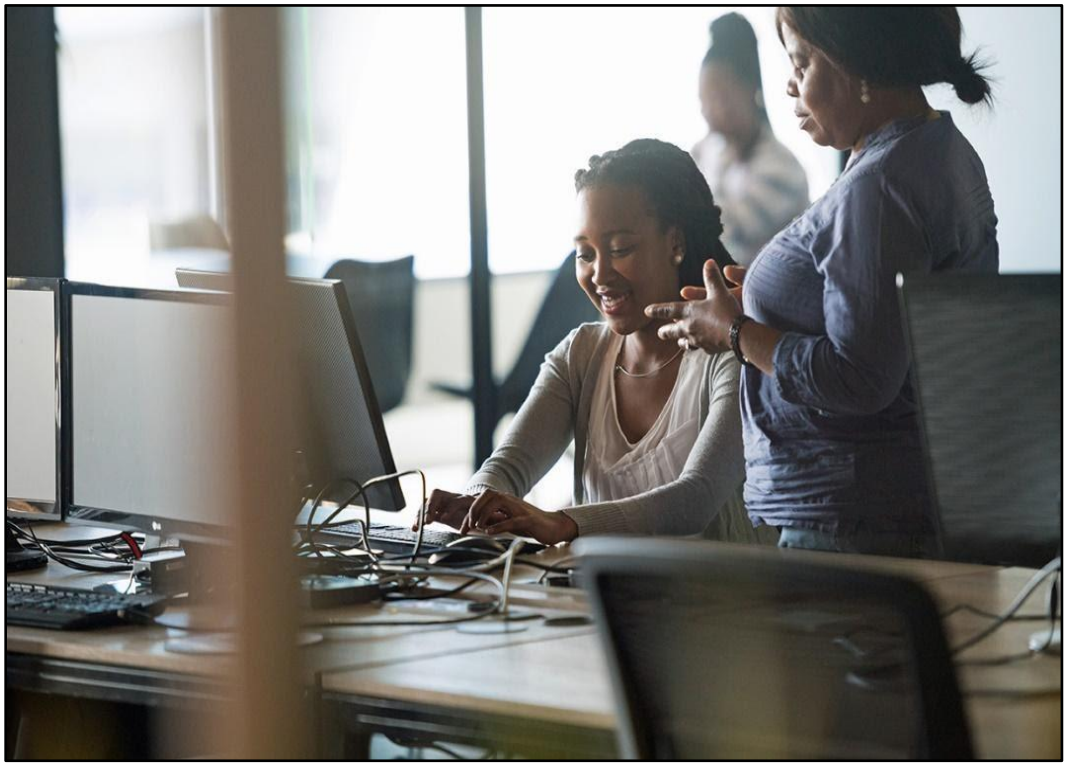
Target Populations

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

Mental Health Career Pathway Programs	
Program Name *Provider*	Services Description
Community Mental Health Certificate Program *City College of San Francisco*	16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through client-directed goal setting and collaboration between mental health service clients and mental health providers. The program educates and trains culturally and linguistically diverse clients of mental health, family members of clients and mental health community allies to enter the workforce as front-line behavioral health workers who can deliver culturally congruent mental health care to underrepresented populations (e.g., African American; Asian; Pacific Islander; Latino; Native American; Lesbian, Gay, Bisexual, Transgender, Questioning; and immigrant communities).
Community Mental Health Academy *Crossing Edge Consulting*	SFDPH BHS partnered with the City College of San Francisco's Community Mental Health Worker Certificate Program to create a 16-week mental health seminar series called the Community Mental Health Academy (Academy) that is designed to equip community based organizations' frontline staff with foundational knowledge about community mental health; culturally affirming techniques on how to approach and address someone who is in

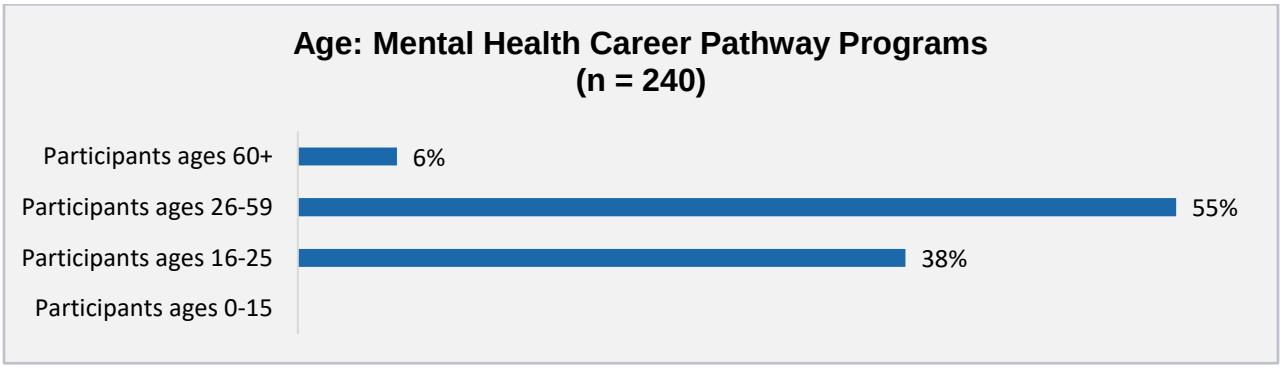
Workforce Dev

Mental Health Career Pathway Programs	
Program Name *Provider*	Services Description
	need of mental health support; and efficient ways to link someone with mental health care.
FACES for the Future Program *Public Health Institute*	This program is nationally recognized for healthcare career preparation work with high school students. The FACES program introduces John O'Connell High School students to career pathways in healthcare, public health and mental and behavioral health while supporting them with academic interventions, coordination of wellness services, referrals to outside agencies when needed and youth leadership development opportunities.

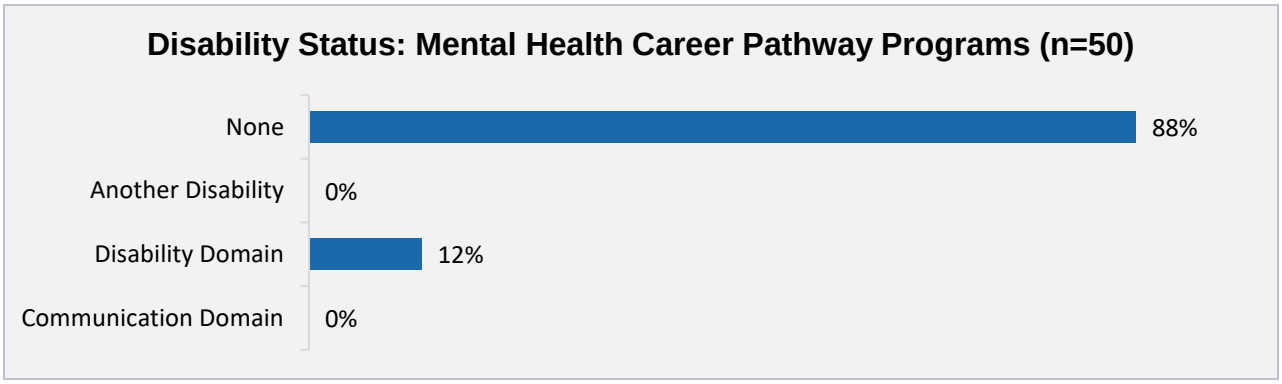


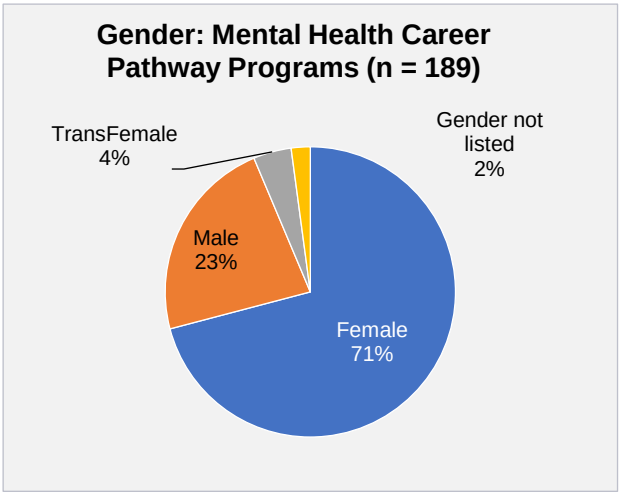
Client Demographics, Outcomes, and Cost per Client

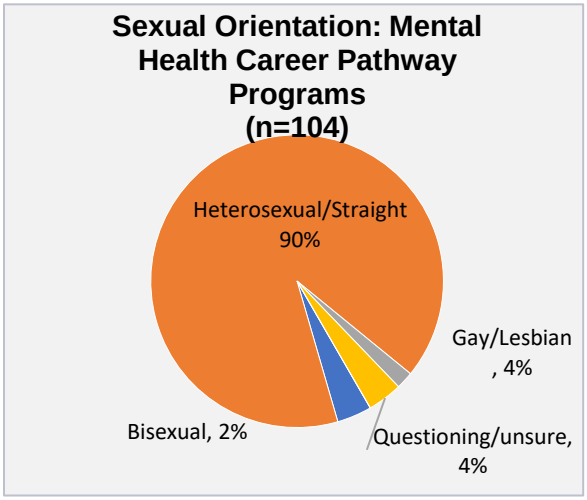
Demographics: Mental Health and Career Pathways



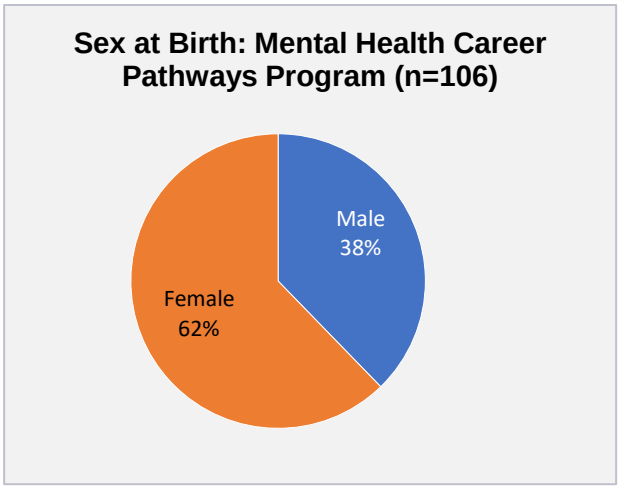
*< 1% of clients reported data for CYF (0-15); Age

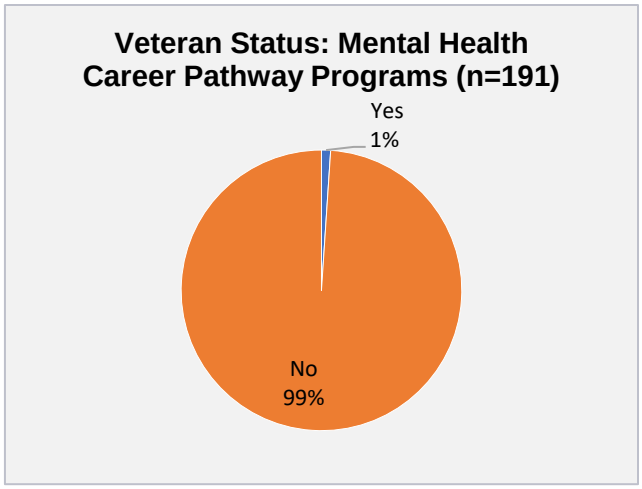






Workforce Dev



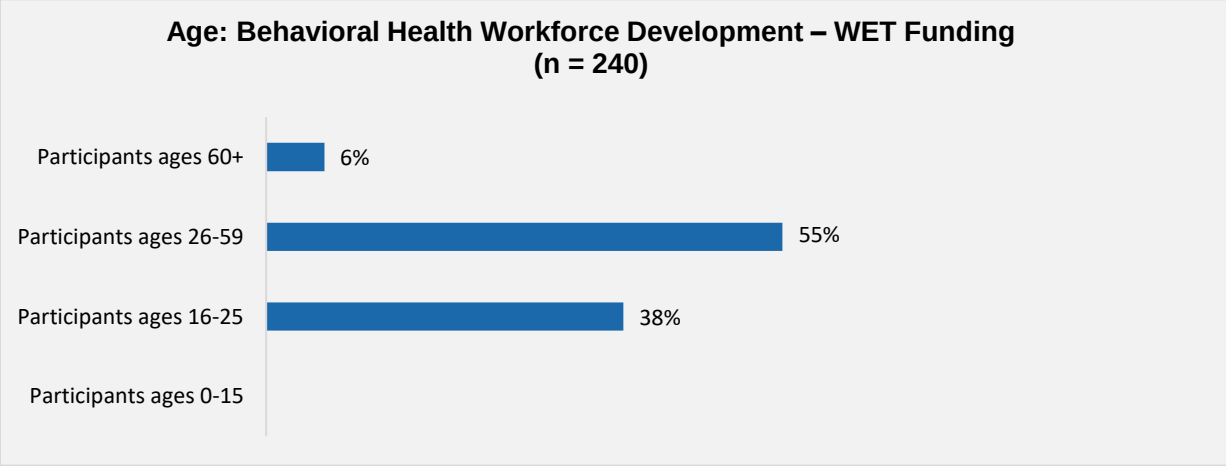


*< 1 percent of clients reported data for Another Disability, Communication; Disability Status

Race/Ethnicity	n	%
Black/African American	31	25%
American Indian or Alaska Native	21	17%
Asian	20	16%
Native Hawaiian or Pacific Islander	11	9%
White	42	33%
Other Race	<10	-
Hispanic/Latino	67	56%
Non-Hispanic/Non-Latino	23	19%
More than one Ethnicity	29	24%
Total	245	

Primary Language	n	%
Chinese	10	4%
English	169	70%
Russian	<10	-
Spanish	37	15%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	18	7%
Total	243	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.



*1 percent of clients reported data for 0-15; Age

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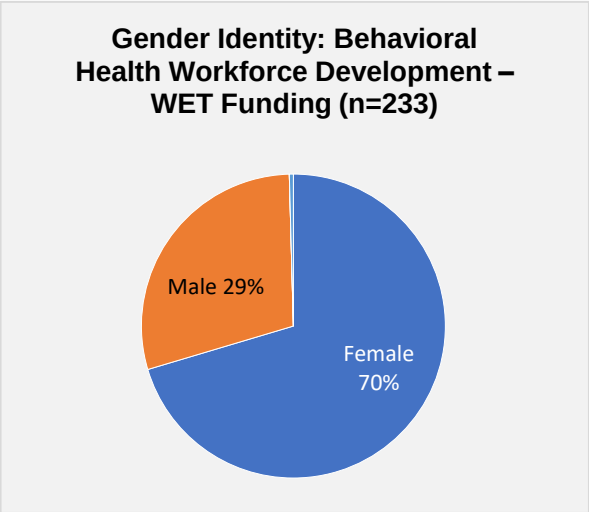

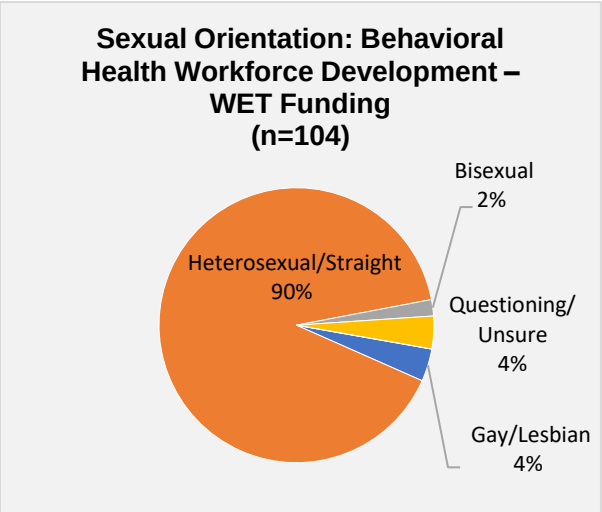

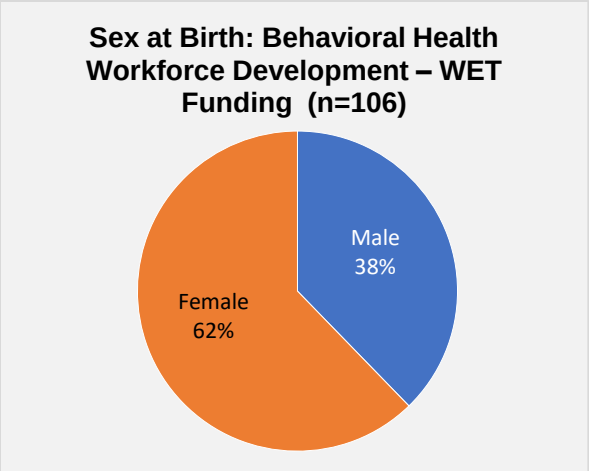

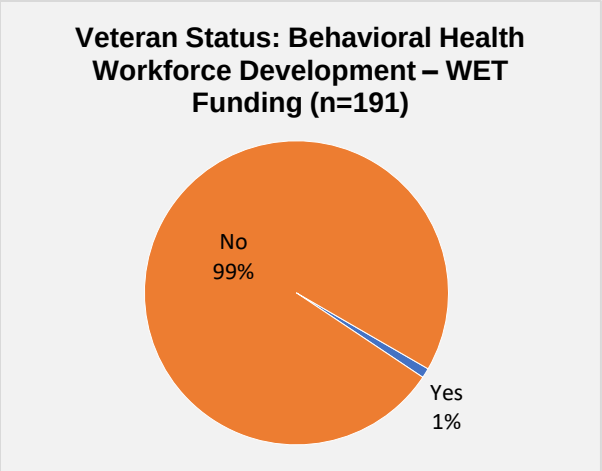

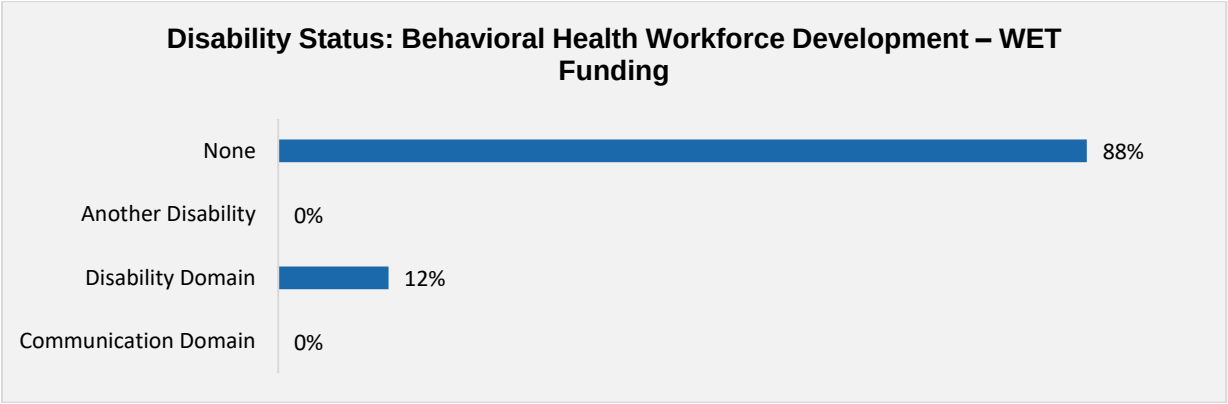

*< 1 percent of clients reported data for Another gender identity not listed, Trans Female, Trans Male; Gender
*< 1 percent of clients reported data for Another Sexual Orientation Not Listed; Sexual Orientation
*< 1 percent of clients reported data for Another Disability, Communication Domain; Disability Status

Race/Ethnicity	n	%
Black/African American	31	25%
American Indian or Alaska Native	21	17%
Asian	20	16%
Native Hawaiian or Pacific Islander	11	9%
White	42	33%
Other Race	<10	-
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More than one Ethnicity	29	24%
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Primary Language	n	%
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English	169	70%
Russian	<10	-
Spanish	37	15%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	18	7%
Total	243	

*Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
*Clients may be counted in multiple categories and therefore percentages do not total 100%.

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

Program	FY21-22 Key Outcomes and Highlights
City College of San Francisco: Community Mental Health Worker Certificate Program	• 100% (n = 14) of graduating students reported readiness to pursue their next work/educational opportunity, an interest in pursuing a health-related career, and demonstrated knowledge of pathways into health careers
Crossing Edge Consulting, Inc.: Community Mental Health Academy	• 100% (n = < 10) administrators and staff helped to design a specialized Community Mental Health Academy focusing on training designated staff in the delivery of wellness and recovery groups for the Native American Health Center
Faces for the Future Program – Public Health Institute	• 69% (n = 34) of students reported a sustained or increased interest in pursuing a health profession, and 76% (n = 37) were able to identify three supportive adults who can help them if they experience challenges to their retention in the health career path

FY21-22 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[17]
Mental Health Career Pathways	246 Clients	$919,416	$3,737

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

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

Program Outcomes, Highlights and Cost per Client

Program	FY21-22 Key Outcomes and Highlights
Trauma Informed Systems Initiative - SFDPH	• More than 1,000 individuals participated in Mindful Moment, 101 Online Training, Wellness Workshops, Implementation Summits, and Leadership Learning Committees. Additionally, 26 trainers were certified in SIYLI.
TAY System of Care Capacity Building (Clinician's Academy) – Felton Institute	• After participating in the program, transition age youth adapted better to using technology, including Zoom and texting

FY21-22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[18]**
Training and Technical Assistance	1,800 Clients	$1,085,968	$603

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

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

Program Outcomes, Highlights and Cost per Client

Program	FY21-22 Key Outcomes and Highlights
Fellowship for Public Psychiatry in the Adult/Older Adult System of Care and SF General Hospital - UCSF	• Two fellows continued to work at SFDPH BHS Civil Service clinics, and three fellows disseminated their capstone project findings at the 2022 Annual Meeting of the American Psychiatric Association

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Program	FY21-22 Key Outcomes and Highlights
Child and Adolescent Community Psychiatry Training Program (CACPTP) - UCSF	• The Community Psychiatry Rotation was rated a 9.4/10 by the fellows and noted it to be a great learning experience, offering mentorship, teaching, and excellent collaboration with the clinic teams.
BHS Clinical Graduate Training Program - SFDPH	• A partnership was established with the City College's Community Mental Health Certificate program to create a new undergraduate internship placement site at Chinatown North Beach Mental Health Clinic

FY21-22 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[19]**
Psychiatry Residency and Fellowships	150 clients served by the Fellows	$571,602	$3,811

Moving Forward in Behavioral Health Workforce Development

BHS Training Program
The MHSA training department at SFDPH BHS plans to hold another Anti-Racist and Culturally Humble Clinical Practices training series. We are planning to provide training on anti-racist evidence-based practices, as well as another six-month academy focused on Harm Reduction Therapy and a TAY Clinician Academy in FY23-24.

UCSF Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital and BHS Adult/Older Adult System of Care
This program is continuing the SFDPH Public Psychiatry Administrative Fellowship, a two-year program with a mission to build community among emerging public psychiatry leaders within BHS. SFDPH MHSA funds the training of two fellows in the San Francisco Health Network. Fellows completed all program activities as conducted in previous years, with additional field trips planned to sites in San Francisco that provide resources for those with housing insecurity and substance use disorders. For FY22-23, we received five applications for the fellowship, in addition to our previously matched fellow.

Child and Adolescent Community Psychiatry Treatment Program (CACPTP)
In FY23-24, the program will have six fellows rotating at clinical sites and one fellow participating in the Public Psychiatry Fellowship, spending two afternoons per week at one of BHS' clinics.

Trauma-Informed System (TIS) Initiative
An organizational change model centered on workforce development, racial justice and healing. It aims to support organizational capacity and workforce skills to recognize and respond to the impact of trauma and its effects on ourselves, our colleagues and the larger system.

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

Staff members have responded to the dual pandemic of COVID19 and racial inequities, and most recently helped staff re-enter work after being deployed for an extended period of time. TIS has approached the work by recognizing that racial justice is at the core of being trauma informed. In FY21-22, the TIS intention was to amplify healing and resilience in the workforce by expanding our training capacity, with the goal of certifying 18 additional staff to teach mindfulness and emotional intelligence.

Relias Online Learning Management System
SFDPH MHSA began contracting with Relias in FY21-22 to provide online training to staff. The Relias system offers over 500 training courses on behavioral health topics, with most courses offering credit required for staff licensure or certification. Many courses also meet the needs of our administrative staff, while including the ability for supervisors to build individual learning plans for staff, allowing them to meet their needs and the needs of BHS.

Soon, the training system will roll out to 800 civil service staff. Plans for FY22-26 include successfully rolling out the system, training supervisors to maximize the site usage, implementing efforts to maximize site usage, evaluating the impact on the BHS workforce and expanding to contracted staff.

Public Mental Health Systems Professionals Loan Forgiveness
In partnership with ten Greater Bay Area Counties and the City of Berkeley, SFDPH is implementing a Loan Repayment Program for eligible individuals who include public mental health systems' professionals that the local jurisdiction identifies as high priority in the region.

This is in effort to address the shortage of mental health practitioners in the public mental health systems and is done through a framework that engages regional partnerships and supports individuals through five categories including: Pipeline Development, Loan Repayment Program, Undergraduate College and University Scholarships, Clinical Master and Doctoral Graduate Education Stipends, and Retention Activities.

Public Health Institute
FACES for the Future Program at San Francisco Unified School District's John O'Connell High School continued to provide junior and senior-level students with career exploration and job shadowing, academic enrichment, wellness support and youth development opportunities with health and behavioral health careers.

The program also provides on-campus case management services for students, including referrals to behavioral health partners. The program partners with the Department of Family and Community Medicine at Zuckerberg San Francisco General Hospital to coordinate a Wellness Strategy for students enrolled in FACES program.

City College of San Francisco: Community Mental Health Worker Certificate Program
Provides a three-semester program that is designed to mimic a therapeutic milieu to increase resiliency, foster hope, and promote self-determination. The program prepares individuals to work as behavioral health providers, increases access for mental health services to underserved populations and trains frontline behavioral health workers in the wellness and recovery model.

Students also receive help with career development, internship placement and practice, student evaluation and wrap-around support services. The program supports recovery through peer mentorship, counseling, tutoring and socialization through an academic setting.

Community Mental Health Academy

This program provides culturally and linguistically congruent education and training to diverse community-based organizations that have frontline staff who are case managers, peer educators, community educators, outreach workers and other paraprofessionals.

In upcoming months, staff plan to develop a Spanish glossary for mental health terminology so that future therapy sessions hold closer meaning for Spanish-speaking clients. We will continue Community Mental Health Academies for non-mental health community-based organizations.

City College of San Francisco: Addiction & Recovery Counseling Certificate Program

Provides substance use disorder counselor certification training and formal educational pathways to train counselors in working as substance use disorder counselors.

The program prioritizes economically disadvantaged communities of color, marginalized groups, and large numbers of individuals from isolated and/or economically/socially marginalized communities (e.g., LGBTQ+, formerly incarcerated, in recovery, people who are experiencing homelessness or marginally housed).

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

Service Category Overview

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

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

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

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

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

Moving Forward in Capital Facilities

The Southeast Health Center
Funding dedicated to the relocation of the Southeast Health Center allowed the facility to move from a leased site to a city-owned location, with construction planning and design having commenced.

The development of the site will include the repurposing of existing structures to better meet the needs of the center. The interior tenant improvements will enable the center to relocate in the next two-to-three years. This project will renovate and upgrade space to expand the clinic's capabilities to support the historically underserved neighborhoods in southeast San Francisco.

The Hope San Francisco Sunnydale Project
This project is in the design and building phase in collaboration with the developer of the Sunnydale housing authorities. In spring 2023, $1.5 million will be utilized for site construction of the wellness clinic. The wellness clinic provides basic medical care and wellness programs onsite. Furthermore, it provides direct access for SFDPH staff to the largest four public housing site communities in San Francisco.

Consolidation of Older Adult Services
The $1 million dedicated construction funding for tenant improvements to support the consolidation of two older adult clinics is paused, as a real estate development opportunity did not materialize. The funding is still in place to support the tenant improvements once a suitable site is located and a lease is established.

Chinatown North Beach Clinic – 729 Filbert Street
Construction at the clinic's new location commences in 2023. The Chinatown Child Development Center will join the Chinatown Health Center as a city-owned property. The new location will be integrated with the upgraded primary care clinic supporting similar client communities.

Moving Forward in Information Technology

Avatar Update (JBOSSv7)
Over the last fiscal year, MHSA staff have been involved in updating an important Avatar (our electronic medical record system) mechanism. This update will maintain Avatar connectivity beyond 2022. Working with various SFDPH teams in cooperation with Avatar users, we are near the completion of this portion of the project, which was initiated in September 2022. This new system will enhance the security of the Avatar data and reporting functions.

Avatar VDI (Support and Maintenance)
Our contract provider agencies, including MHSA agencies, are now able to access Avatar via VDI (virtual desktops). Currently, we maintain access to two images: Avatar CBO (community-based organizations) and Avatar VMware View App. We continue to improve the features and functions of Avatar via VDI, including upgrading the images and security of the application.

Quarterly Avatar Technical Workgroup Meeting

To assist our contract providers' information technology, we have developed a partnership with these agencies to educate, train and prepare Avatar users at these sites for any Avatar modifications or alerts (application issues) that may arise. We have regular meetings that serve as an opportunity to receive feedback, discuss successes and trouble-shoot challenges at various sites.

DCR

Over the last fiscal year, MHSA staff have maintained, created, supported and managed all user accounts for Partnership Service Coordinators (PSCs) of various MHSA programs. Staff have also managed user groups for FSPs and PSCs within the DCR system, which includes:

- DCR account creation/deactivation
- Partner assignments/transfers between PSCs
- DCR support

Outreach Table at 1380 Howard in 2021

MHSA Expenditures

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

MHSA Integrated Service Categories

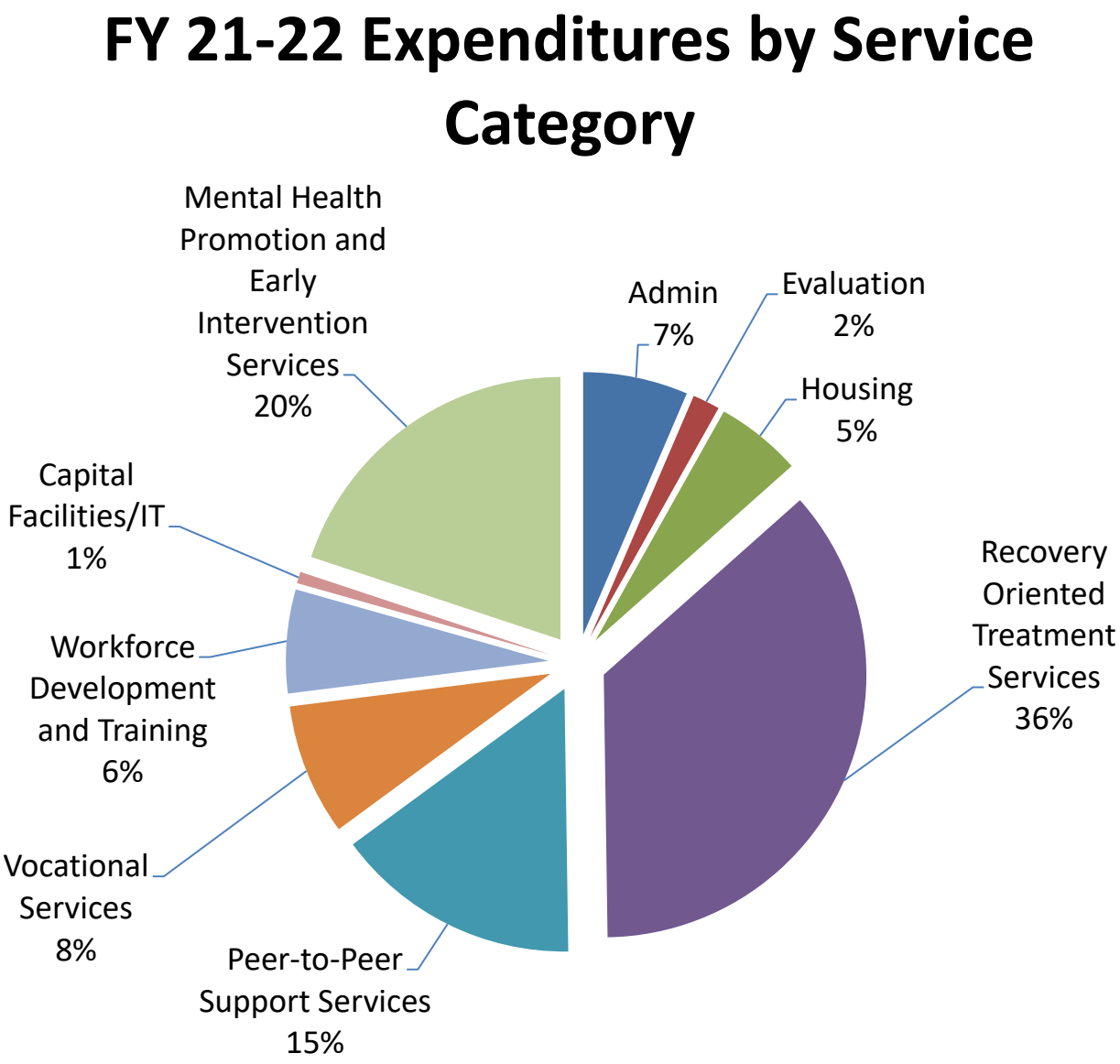
MHSA Integrated Service Categories	Abbreviation	FY 21-22 Expenditure Amount	Percentage
Admin	Admin	2,610,143.70	6%
Evaluation	Evaluation	677,833.01	2%
Housing	H	2,139,499.73	5%
Recovery Oriented Treatment Services	RTS	14,685,955.45	36%
Peer-to-Peer Support Services	P2P	6,122,559.75	15%
Vocational Services	VS	3,270,995.38	8%
Workforce Development and Training	WD	2,576,985.66	6%
Capital Facilities/IT	CF/IT	287,199.57	1%
Mental Health Promotion and Early Intervention Services	PEI	8,043,385.27	20%
TOTAL		**40,414,557.52**	**100%**

MHSA FY21/22 Actual Expenditures

SF MHSA Integrated Services Categori	Programs by Funding Component	FY 21-22 Expenditure
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 21-22, 53% was allocated to serve FSP clients	
Admin	CSS Admin	1,872,222.88
Evaluation	CSS Evaluation	541,816.92
H	CSS FSP Permanent Housing (capital units and master lease)	850,187.93
RTS	CSS Full Service Partnership 1. CYF (0-5)	410,260.24
RTS	CSS Full Service Partnership 2. CYF (6-18)	884,447.17
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,167,123.77
RTS	CSS Full Service Partnership 4. Adults (18-59)	4,740,973.42
RTS	CSS Full Service Partnership 5. Older Adults (60+)	943,786.11
RTS	CSS Full Service Partnership 6. AOT	1,673,703.10
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	922,627.10
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	634,684.63
RTS	CSS Other Non-FSP 3. Trauma Recovery	144,822.00
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,774,562.55
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	340,562.19
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,615,853.11
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,040,787.50
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	315,000.00
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	368,513.37
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	569,403.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	277,279.77
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	771,123.40
	SUBTOTAL Community Services and Support (CSS)	**25,859,740.16**

	Workforce, Development Education and Training (WDET) **$2.8M transferred from CSS to fund WDET activities in FY 21-22**	
WD	WDET 1. Training and TA	1,085,968.41
WD	WDET 2. Career Pathways	919,415.61
WD	WDET 3. Residency and Internships	571,601.64
Admin	WDET Admin	88,033.07
Evaluation	WDET Evaluation	136,016.09
	SUBTOTAL Workforce, Development Education and Training (WDET)	**2,801,034.82**
	Capital Facilities/IT **$6.3M transferred from CSS to fund Capital Facilities/IT activities in FY 21-22**	
CF/IT	IT 1. Consumer Portal	177,457.18
VS	IT 2. Vocational IT	1,230,207.88
CF/IT	IT 3. System Enhancements	109,742.39
Admin	IT Admin	271,981.02
	SUBTOTAL Capital Facilities/IT	**1,789,388.47**
	Other	
H	MHSA Housing Program	36,395.43
	SUBTOTAL Other	**36,395.43**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**30,486,558.88**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	196,834.74
PEI	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	1,051,362.72
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	4,578,785.28
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	792,800.21
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	574,412.09
PEI	PEI 7. CalMHSA Statewide Programs	41,387.61
Admin	PEI Admin	88,032.97
	SUBTOTAL Prevention and Early Intervention (PEI)	**7,323,615.62**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 18. Intensive Case Management Flow	508,993.60
P2P	INN 20. Technology-assisted Mental Health Solutions	647,094.13
P2P	INN 21. Wellness in the Streets (WITS)	350,618.91
PEI	INN 22. FUERTE	372,041.79
PEI	INN 23. Culturally Responsive Practices for the Black/African American Communities	435,760.83
Admin	INN Admin	289,873.76
	SUBTOTAL Innovation (INN)	**2,604,383.02**
	TOTAL FY 21-22 MHSA Expenditures	**40,414,557.52**

FY21/22 Expenditures by Service Category



MHSA Funding Summary

FY23-24 Through FY25-26 Three-Year Integrated Plan

Funding Summary

County: San Francisco Date: 6/30/23

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. Estimated FY23-24 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	26,801,234	15,837,383	6,166,241	351,873	8,253,339		57,410,069
2. Estimated New FY23-24 Funding (incl. interest)	71,845,827	18,012,785	4,778,603	2,364	19,527		94,659,106
3. Transfer in FY23-24	(11,394,888)			6,213,210	5,181,678	-	-
4. Access Local Prudent Reserve in FY23-24						-	-
5. Estimated Available Funding for FY23-24	87,252,173	33,850,168	10,944,844	6,567,447	13,454,544		152,069,175
B. FY23-24 MHSA Expenditures	40,504,180	16,535,740	3,225,140	6,213,210	5,609,221		72,087,491
C. Estimated FY24-25 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	46,747,993	17,314,427	7,719,704	354,237	7,845,323		79,981,685
2. Estimated New FY24-25 Funding (incl. interest)	47,622,064	11,905,516	3,133,031				62,660,611
3. Transfer in FY24-25	(12,447,798)			6,123,425	6,324,373	-	-
4. Access Local Prudent Reserve in FY24-25						-	-
5. Estimated Available Funding for FY24-25	81,922,260	29,219,943	10,852,735	6,477,662	14,169,696		142,642,296
D. Estimated FY24-25 Expenditures	42,042,923	15,671,236	2,191,918	6,123,425	4,994,874		71,024,376
E. Estimated FY25-26 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	39,879,336	13,548,707	8,660,816	354,237	9,174,822		71,617,919
2. Estimated New FY25-26 Funding (incl. interest)	48,640,000	12,160,000	3,200,000				64,000,000
3. Transfer in FY25-26	(12,781,849)			6,229,346	6,552,502	-	-
4. Access Local Prudent Reserve in FY25-26						-	-
5. Estimated Available Funding for FY25-26	75,737,488	25,708,707	11,860,816	6,583,583	15,727,324		135,617,919
F. Estimated FY25-26 Expenditures	43,356,060	15,920,899	1,847,587	6,229,346	4,061,095		71,414,988
G. Estimated FY25-26 Unspent Fund Balance	32,381,428	9,787,808	10,013,229	354,237	11,666,229		64,202,932

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	7,259,570
2. Contributions to the Local Prudent Reserve in FY23-24	0
3. Distributions from the Local Prudent Reserve in FY23-24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	7,259,570
5. Contributions to the Local Prudent Reserve in FY24-25	0
6. Distributions from the Local Prudent Reserve in FY24-25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	7,259,570
8. Contributions to the Local Prudent Reserve in FY25-26	0
9. Distributions from the Local Prudent Reserve in FY25-26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	7,259,570

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

CSS Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	720,396	439,471	-	-	76,758	204,168
2. CSS Full Service Partnership 2. CYF (6-18)	2,446,368	1,693,679	565,333	-	85,560	101,795
3. CSS Full Service Partnership 3. TAY (18-24)	4,562,125	2,858,693	1,670,576	-	-	32,856
4. CSS Full Service Partnership 4. Adults (18-59)	17,785,466	9,918,002	5,122,157	-	-	2,745,306
5. CSS Full Service Partnership 5. Older Adults (60+)	1,792,568	1,191,102	328,016	214,309	-	59,141
6. CSS Full Service Partnership 6. AOT	2,029,782	1,752,209	267,160	-	-	10,413
7. CSS FSP Permanent Housing (capital units and master lease)	2,444,872	2,444,872	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,513,569	3,503,344	-	168,396	-	841,829
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,947,184	1,172,304	-	275,867	-	499,012
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	189,000	189,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	121,685	121,685	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	341,642	341,642	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,622,347	1,137,484	209,380	-	-	275,484
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,132,115	679,874	142,544	-	-	309,696
3. CSS Other Non-FSP 3. Trauma Recovery	227,679	155,134	39,482	-	-	33,064
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,618,777	2,264,218	354,559	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,771,006	364,810	-	-	-	1,406,196
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,513,569	3,503,344	-	168,396	-	841,829
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,379,891	1,432,816	-	337,171	-	609,904
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	126,000	126,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	283,932	283,932	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	227,761	227,761	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	707,164	298,179	408,985	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	763,477	763,477	-	-	-	-
14. CSS Other Non-FSP 14. Overdose Prevention	1,087,830	1,087,830	-	-	-	-
CSS Administration	2,018,909	2,018,909	-	-	-	-
CSS Evaluation	534,407	534,407	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-				
Total CSS Program Expenditures	58,909,521	40,504,180	9,108,193	1,164,139	162,318	7,970,691
FSP Programs as Percent of Total	63%					

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	742,008	452,655	-	-	79,061	210,293
2. CSS Full Service Partnership 2. CYF (6-18)	2,540,866	1,759,103	587,171	-	88,865	105,727
3. CSS Full Service Partnership 3. TAY (18-24)	4,740,428	2,970,420	1,735,868	-	-	34,140
4. CSS Full Service Partnership 4. Adults (18-59)	18,265,091	10,185,464	5,260,288	-	-	2,819,340
5. CSS Full Service Partnership 5. Older Adults (60+)	1,874,526	1,245,561	343,013	224,108	-	61,845
6. CSS Full Service Partnership 6. AOT	2,127,171	1,836,281	279,978	-	-	10,912
7. CSS FSP Permanent Housing (capital units and master lease)	2,491,621	2,491,621	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,666,129	3,621,758	-	174,088	-	870,283
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,018,329	1,215,137	-	285,947	-	517,245
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	189,000	189,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	125,850	125,850	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	341,642	341,642	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,726,233	1,210,322	222,787	-	-	293,124
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,166,078	700,271	146,821	-	-	318,987
3. CSS Other Non-FSP 3. Trauma Recovery	234,510	159,788	40,666	-	-	34,056
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,787,784	2,410,343	377,441	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,824,136	375,754	-	-	-	1,448,382
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,666,129	3,621,758	-	174,088	-	870,283
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,466,847	1,485,168	-	349,490	-	632,188
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	126,000	126,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	293,649	293,649	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	227,761	227,761	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	757,532	319,416	438,115	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	798,961	798,961	-	-	-	-
14. CSS Other Non-FSP 14. Overdose Prevention	1,165,305	1,165,305	-	-	-	-
CSS Administration	2,141,466	2,141,466	-	-	-	-
CSS Evaluation	572,469	572,469	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	61,077,522	42,042,923	9,432,148	1,207,720	167,926	8,226,804
FSP Programs as Percent of Total	63%					

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	764,268	466,235	-	-	81,432	216,601
2. CSS Full Service Partnership 2. CYF (6-18)	2,619,775	1,813,733	605,406.03	-	91,625	109,011
3. CSS Full Service Partnership 3. TAY (18-24)	4,890,962	3,064,747	1,790,991.37	-	-	35,224
4. CSS Full Service Partnership 4. Adults (18-59)	18,842,371	10,507,381	5,426,543	-	-	2,908,447
5. CSS Full Service Partnership 5. Older Adults (60+)	1,937,663	1,287,513	354,566	231,656	-	63,928
6. CSS Full Service Partnership 6. AOT	2,200,447	1,899,536	289,623	-	-	11,288
7. CSS FSP Permanent Housing (capital units and master lease)	2,539,773	2,539,773	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,810,570	3,733,871	-	179,477	-	897,223
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,082,186	1,253,582	-	294,994	-	533,610
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	189,000	189,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	128,356	128,356	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	341,642	341,642	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,792,366	1,256,690	231,322	-	-	304,354
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,201,060	721,279	151,225	-	-	328,556
3. CSS Other Non-FSP 3. Trauma Recovery	241,545	164,581	41,886	-	-	35,077
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,894,921	2,502,975	391,946	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,878,860	387,027	-	-	-	1,491,833
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,810,570	3,733,871	-	179,477	-	897,223
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,544,894	1,532,156	-	360,548	-	652,190
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	126,000	126,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	299,496	299,496	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	227,761	227,761	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	787,833	332,193	455,640	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	826,632	826,632	-	-	-	-
14. CSS Other Non-FSP 14. Overdose Prevention	1,211,918	1,211,918	-	-	-	-
CSS Administration	2,212,744	2,212,744	-	-	-	-
CSS Evaluation	595,368	595,368	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	62,998,981	43,356,060	9,739,149	1,246,151	173,058	8,484,564
FSP Programs as Percent of Total	63%					

PEI Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	1,639,120	1,639,120.43	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	646,258	584,476	-	-	-	61,781
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,021,286	5,003,343	18,741	-	-	(798)
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	5,102,203	951,170	-	-	-	4,151,033
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	70,217	61,134	9,084	-	-	-
7. PEI 7. CalMHSA Statewide Programs	41,388	41,388	-	-	-	-
8. PEI 9. Overdose Prevention	1,706,338	1,706,338	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	646,258	584,476	-	-	-	61,781
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,021,286	5,003,343	18,741	-	-	(798)
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,700,734	317,057	-	-	-	1,383,678
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	631,957	550,202	81,755	-	-	-
PEI Administration	93,694	93,694	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Expenditures	22,320,739	16,535,740	128,320	-	-	5,656,679

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	217,175	217,175.26	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	669,933	605,888	-	-	-	64,045
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,171,924	5,153,443	19,303	-	-	(822)
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	5,273,845	983,168	-	-	-	4,290,677
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	75,219	65,488	9,731	-	-	-
7. PEI 7. CalMHSA Statewide Programs	41,388	41,388	-	-	-	-
8. PEI 9. Overdose Prevention	1,827,875	1,827,875	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	669,933	605,888	-	-	-	64,045
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,171,924	5,153,443	19,303	-	-	(822)
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,757,948	327,723	-	-	-	1,430,226
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	676,967	589,390	87,578	-	-	-
PEI Administration	100,368	100,368	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	21,654,499	15,671,236	135,914	-	-	5,847,349

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	223,691	223,691	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	691,145	625,072	-	-	-	66,073
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,202,497	5,183,907	19,417	-	-	(826)
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	5,436,887	1,013,563	-	-	-	4,423,324
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	78,227	68,107	10,120	-	-	-
7. PEI 7. CalMHSA Statewide Programs	41,388	41,388	-	-	-	-
8. PEI 9. Overdose Prevention	1,900,990	1,900,990	-	-	-	-
PEI Programs - Early Intervention						
9. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	625,072	625,072	-	-	-	-
11. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	7,142,476	5,183,907	-	-	-	1,958,569
12. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	468,798	337,854	130,943	-	-	-
13. PEI 6. Comprehensive Crisis Services (10% Prevention)	612,965	612,965	-	-	-	-
PEI Administration	104,383	104,383	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	22,528,518	15,920,899	160,480	-	-	6,447,139

Program Name	Childhood Trauma Prevention and Early Intervention	Early Psychosis and Mood Disorder Detection and	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	Culturally Competent and Linguistically Appropriate Prevention	Strategies Targeting the Mental Health Needs of Older Adults	Early Identification Programming of Mental Health Symptoms	Fiscal Year 2023/24 MHSA Funds	Fiscal Year 2024/25 Estimated MHSA Funds	Fiscal Year 2025/26 Estimated MHSA Funds
PEI 1. Stigma Reduction	X	X	X	X	X	X	X	$ 1,639,120	$ 217,175	$ 223,691
PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	X	X	X	X			X	$ 1,168,953	$ 1,211,776	$ 1,250,145
PEI 4. Population Focused Mental Health (50% Prevention)	X	X	X	X	X	X	X	$ 10,006,686	$ 10,306,886	$ 10,367,814
PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	X	X	X	X	X		X	$ 1,268,226	$ 1,310,890	$ 1,351,417
PEI 6. Comprehensive Crisis Services (10% Prevention)	X	X	X	X			X	$ 611,336	$ 654,877	$ 681,072
PEI 7. CalMHSA Statewide Programs	X	X	X	X	X	X	X	$ 41,388	$ 41,388	$ 1,900,990

INN Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	677,604	677,604	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	452,898	452,898	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	393,101	393,101	-	-	-	-
4. INN 22. FUERTE	1	1				
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,414,025	1,414,025				
INN Administration	287,511	287,511	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Expenditures	3,225,140	3,225,140	-	-	-	-

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 21. Wellness in the Streets (WITS)	404,894	404,894	-	-	-	-
2. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,485,448	1,485,448	-	-	-	-
INN Administration	301,577	301,577	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	2,191,918	2,191,918	-	-	-	-

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,537,548	1,537,548	-	-	-	-
INN Administration	310,040	310,040	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	1,847,587	1,847,587	-	-	-	-

WET Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs						
1. Training and TA	4,995,223	3,276,693	-	-	-	1,718,531
2. Career Pathways	1,672,442	1,672,442	-	-	-	-
3. Residency and Internships	953,059	953,059	-	-	-	-
WET Administration	147,766	147,766	-	-	-	-
WET Evaluation	163,250	163,250	-	-	-	-
Total WET Program Expenditures	7,931,740	6,213,210	-	-	-	1,718,531

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	5,090,961	3,339,494	-	-	-	1,751,468
2. Career Pathways	1,714,202	1,714,202	-	-	-	-
3. Residency and Internships	740,124	740,124	-	-	-	-
WET Administration	158,291	158,291	-	-	-	-
WET Evaluation	171,314	171,314	-	-	-	-
Total WET Program Estimated Expenditures	7,874,893	6,123,425	-	-	-	1,751,468

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	5,156,914	3,382,756	-	-	-	1,774,158
2. Career Pathways	1,757,214	1,757,214	-	-	-	-
3. Residency and Internships	748,587	748,587	-	-	-	-
WET Administration	164,623	164,623	-	-	-	-
WET Evaluation	176,167	176,167	-	-	-	-
Total WET Program Estimated Expenditures	8,003,504	6,229,346	-	-	-	1,774,158

CFTN Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CFTN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 11. Southeast Family Therapy Services	2,000,000	2,000,000	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	1	1	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	1	1	-	-	-	-
4. Cap 14. Chinatown Child Development Center	1,500,000	1,500,000	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	200,000	200,000	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	250,000	250,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
1. IT 1. Consumer Portal	188,879	188,879	-	-	-	-
2. IT 2. Vocational IT	1,317,798	1,317,798	-	-	-	-
3. IT 3. System Enhancements	116,782	116,782	-	-	-	-
CFTN Administration	35,760	35,760	-	-	-	-
Total CFTN Program Expenditures	5,609,221	5,609,221	-	-	-	-

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 11. Southeast Family Therapy Services	2,000,000	2,000,000	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	1	1	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	1,000,000	1,000,000	-	-	-	-
4. Cap 14. Chinatown Child Development Center	1	1	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	1	1	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	1	1	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	202,332	202,332	-	-	-	-
9. IT 2. Vocational IT	1,357,332	1,357,332	-	-	-	-
10. IT 3. System Enhancements	125,099	125,099	-	-	-	-
CFTN Administration	310,106	310,106	-	-	-	-
Total CFTN Program Estimated Expenditures	4,994,874	4,994,874	-	-	-	-

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 11. Southeast Family Therapy Services	-	-	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	2,000,000	2,000,000	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	1	1	-	-	-	-
4. Cap 14. Chinatown Child Development Center	1	1	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	1	1	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	1	1	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	210,425	210,425	-	-	-	-
9. IT 2. Vocational IT	1,398,052	1,398,052	-	-	-	-
10. IT 3. System Enhancements	130,103	130,103	-	-	-	-
CFTN Administration	322,511	322,511	-	-	-	-
Total CFTN Program Estimated Expenditures	4,061,095	4,061,095	-	-	-	-

San Francisco Health Network
Behavioral Health Services

2021 and 2022 Workforce Needs Assessment

These data were compiled to meet the requirements of MHSA Regulations 5820.a.b.

SF-MHSA Needs Assessment

Behavioral Health Services (BHS); Justice, Equity, Diversity and Inclusion (JEDI) and San Francisco Mental Health Services Act (SF-MHSA) units have conducted a thorough analysis to determine the needs of the San Francisco community. This analysis identifies the shortage of qualified staff to provide valuable services and the staff needed to address the various mental health needs of our community. SF-MHSA has a dedicated Workforce Program with dedicated funding to help remedy these gaps.

The following report discusses these shortages, the progress we have made over the past few years and plans to further increase the supply of professional staff and other staff that we anticipate will be needed to continue providing exceptional MHSA programming to our communities.

Leadership worked with various stakeholders and community members to develop an A3 analysis, a logic model, action plan priorities, a list of challenges and needs, staff data tables, and recommendations.

2019 Analysis

In 2019, SF-MHSA conducted an analysis on the Race/Ethnicity of Civil Service Staff, BHS Consumers, and Medi-Cal Eligible Individuals in San Francisco. We wanted to compare data to see how well we are meeting the needs of our communities. We know that it is very important to our communities that we have staff that represent the demographics of the clients being served.

Note: In this table, Asian includes Native Hawaiian/Pacific Islander.
Sources: SFDPH Human Resources, 2019; Avatar, 2019; California Department of Health Care Services, Certified Eligible Counts – Summary Tables: ACA Expansion Adult Age 19 to 64 as of April 2019, https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx, accessed 9/24/19

In the following pages, we conducted a new analysis in 2021 and 2022 to determine if we made any improvements from 2019.

San Francisco Health Network
Behavioral Health Services

Title: BHS Racial Equity A3 2022 | Owner: BHS OEWD Director

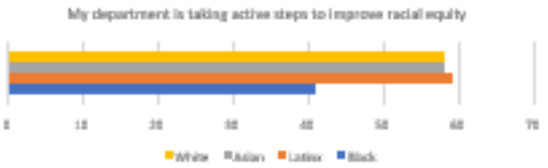
V: 5 | Date: 2/28/22

I. Background: What problem are you talking about and why focus on it now?

Since 2017, equity is a True North goal of both DPH and BHS. Health equity is defined as an outcome where everyone has a fair and just opportunity to be as healthy as possible. Those with the greatest needs and least resources require more, not equal, effort and resources to equalize opportunities

II. Current Conditions: What is happening today and what is not working?

The BHS workforce does not adequately represent clients served as exemplified by the low percentage of Black/AA licensed clinical staff (13%) compared to 20% penetration rates of Black clients. Only 41% of B/AA staff who responded to the employee engagement survey believed their department is taking active steps to improve racial equity and Black/AA staff across all classifications are paid $23k less than their white counterparts. Black/AAs are 14% of DPH employees yet 26% of all Disciplinary Actions and Latinx are 17% of DPH employees yet 26% of all Disciplinary Actions.



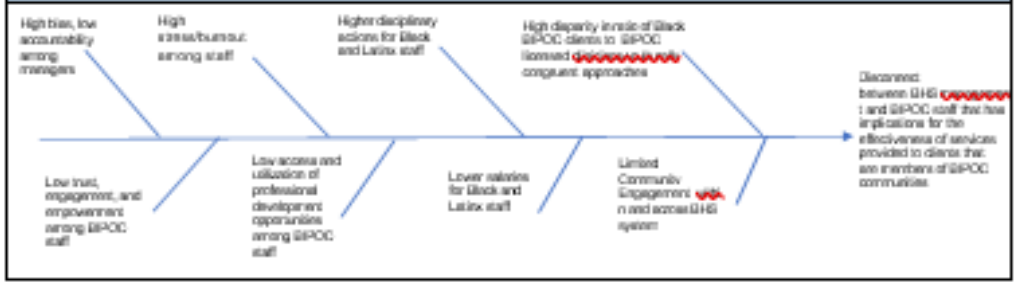
Problem Statement: What specific, measurable problem will serve as your baseline performance?

The BHS workforce does not adequately represent clients served e.g. low percentage of Black/AA licensed clinical staff (13%) compared to 20% penetration rates of Black clients, and culturally congruent services are not provided widespread.

III. Targets and Goals: What specific measurable outcomes are desired and by when?

Selected Metrics	Baseline	Benchmark	Target by [When]
% of surveyed Black/AA employees that respond affirmatively that their department is actively improving racial equity	41%	51%	Q4 2022
% of executives and managers receiving 360 anti-racism assessment and coaching	0%	25%	Q4 2022
% of completed PPARs with equity goals implemented	0%	0%	Q4 2022
% of Equity Champions actively implementing BHS equity framework	0%	0%	Q4 2022

IV. Analysis: Why does the problem exist, in terms of causes, constraints, barriers?



V. Possible Countermeasures: What countermeasures do you propose and why?

Cause/ Barrier	Countermeasure	Description ("If-Then")	Impact	Effort
A.	1. 360 Degree Anti-Racist Leadership Reviews	If executives' and managers participate, they will be able to build their capacity to identify explicit/implicit biases when conducting PPARS, PIPs, and providing feedback for staff.	H	L
B.	2. Racial Equity Champions, Fellows, Affinity Groups and Action Council	Relaunching equity groups will allow more staff to participate in racial equity efforts and build their capacity to facilitate discussions, develop and implement policies to affect change.	H	H
C.	3. Staff Wellness Retreats	Creating an environment for staff wellness and support to reduce staff stress and increase feelings of belonging and community.	H	H
D.	4. Training, Equity Learning Requirement, and Internship Program	Developing standardized process for equity trainings in order to align BHS with DPH OHE and HR.	H	H
E.	5. Recruitment, Hiring Offers, Salary Gaps, and Exit Interviews	If we implement of recruitment and hiring equity interventions during the Mayor emergency hiring initiative, than we will be able to ensure increase representation of the top five classifications with low B/AA and Latinx staff.	H	H
F.	6. Culturally Congruent Behavioral Health Approaches	If we develop culturally congruent behavioral health approaches, we increase linkage and retention into care for our most minoritized populations.	H	H
G.	7. Community Engagement	Integrating community engagement throughout BHS to ensure transparency and accountability.	H	H

VI. Plan: What, where, how will you implement, and by whom and when?

Counter-measure	Activities	Measures	Owner	Date
1.	Determine HR/Consultant, participating managers, and 360 Review questions	# participating managers; 360 Review Questions	Jessica Brown	7/1/2023
2.	Assessment of Affinity Groups and Equity Champions	# Racial Equity Champions; # Affinity Group Participants	Alicia St. Andrews and Michael Rojas	12/1/2022
3.	Development of Staff Wellness Retreats Assessment Tool	# Staff Wellness Retreats Evaluations	Rasa [redacted]	7/1/2023
4.	Develop Training Policy and Implementation of BHS Equity Trainings and Learning Management Platform	Training Policy; # Equity Trainings; # of users on learning management platform	[redacted] Williams	12/1/2022
5.	Implementation of equity interventions for hiring project	# Recruitment; # BIPOC clinicians; B/AA /Trans Special Conditions Hiring Waiver	Jessica Brown and Alicia St. Andrews	1/1/2023
6.	Develop Tri/racial equity approaches service standard; hire more BIPOC peers; deliver culturally congruent services to BIPOC clients by BIPOC staff	Program Proposal to State; evaluation curriculum; # culturally congruent approaches	Jessica Brown	7/31/2022
7.	Convene OEWD, MHSA, and BHS Exec to determine plan for community engagement spread	BHS wide community engagement plan	Jessica Brown	Done

VII. Follow-Up: How will you assure ongoing PDSA?

- BHS Executive Leadership Monthly Equity Focused Meetings
- BHS Racial Equity Action Council (Civil Service, Contractors/CBOs, and Racial Equity Champions)
- BHS Racial Equity Champions, Fellows, and Affinity Groups (Black/African American, Latinx, Asian, and white identified)

Continuum on Becoming an Anti-Racist Multicultural Organization

MONOCULTURAL ==> MULTICULTURAL ==> ANTI-RACIST ==> ANTI-RACIST MULTICULTURAL

Racial and Cultural Differences Seen as Deficits ==> Tolerant of Racial and Cultural Differences ==> Racial and Cultural Differences Seen as Assets

Exclusive An Exclusionary Institution	2. Passive A "Club" Institution	3. Symbolic Change A Compliance Organization	4. Identity Change An Affirming Institution	5. Structural Change A Transforming Institution	6. Fully Inclusive Anti-Racist Multicultural Organization in a Transformed Society
• Intentionally and publicly excludes or segregates African Americans, Native Americans, Latinos, and Asian Americans • Intentionally and publicly enforces the racist status quo throughout institution • Institutionalization of racism includes formal policies and practices, teachings, and decision making on all levels • Usually has similar intentional policies and practices toward other socially oppressed groups such as women, gays and lesbians, Third World citizens, etc. • Openly maintains the dominant group's power and privilege	• Tolerant of a limited number of "token" People of Color and members from other social identify groups allowed in with "proper" perspective and credentials. • May still secretly limit or exclude People of Color in contradiction to public policies • Continues to intentionally maintain white power and privilege through its formal policies and practices, teachings, and decision making on all levels of institutional life • Often declares, "We don't have a problem." • Monocultural norms, policies and procedures of dominant culture viewed as the "righ" way" business as usual" • Engages issues of diversity and social justice only on club member's terms and within their comfort zone.	• Makes official policy pronouncements regarding multicultural diversity • Sees itself as "non-racist" institution with open doors to People of Color • Carries out intentional inclusiveness efforts, recruiting "someone of color" on committees or office staff • Expanding view of diversity includes other socially oppressed groups *But...* • "Not those who make waves" • Little or no contextual change in culture, policies, and decision making • Is still relatively unaware of continuing patterns of privilege, paternalism and control • Token placements in staff positions: must assimilate into organizational culture	• Growing understanding of racism as barrier to effective diversity • Develops analysis of systemic racism • Sponsors programs of anti-racism training • New consciousness of institutionalized white power and privilege • Develops intentional identity as an "anti-racist" institution • Begins to develop accountability to racially oppressed communities • Increasing commitment to dismantle racism and eliminate inherent white advantage • Actively recruits and promotes members of groups have been historically denied access and opportunity *But...* • Institutional structures and culture that maintain white power and privilege still intact and relatively untouched	• Commits to process of intentional institutional restructuring, based upon anti-racist analysis and identity • Audits and restructures all aspects of institutional life to ensure full participation of People of Color, including their world-view, culture and lifestyles • Implements structures, policies and practices with inclusive decision making and other forms of power sharing on all levels of the institutions life and work • Commits to struggle to dismantle racism in the wider community, and builds clear lines of accountability to racially oppressed communities • Anti-racist multicultural diversity becomes an institutionalized asset • Redefines and rebuilds all relationships and activities in society, based on anti-racist commitments	• Future vision of an institution and wider community that has overcome systemic racism and all other forms of oppression. • Institution's life reflects full participation and shared power with diverse racial, cultural and economic groups in determining its mission, structure, constituency, policies and practices • Members across all identity groups are full participants in decisions that shape the institution, and inclusion of diverse cultures, lifestyles, and interest • A sense of restored community and mutual caring • Allies with others in combating all forms of social oppression • Actively works in larger communities (regional, national, global) to eliminate all forms of oppression and to create multicultural organizations.

San Francisco Health Network
Behavioral Health Services

BHS Office of Justice, Equity, Diversity, and Inclusion (JEDI)

2021-2022
BHS Racial Equity Action Plan Priorities

Achieving racial equity is everyone's job. Racially and culturally congruent workforces and services improve health outcomes.

- Racial Equity Action Council
- Staff Wellness
- Training and Workforce Development
- **Recruitment, Hiring, Retention, and Advancement**
- Culturally Congruent Behavioral Health Services
- Community Engagement

2022 Challenges & Needs

SF Emergency Hiring Order & BHS Hiring Extravaganza

Embedded equity team in recruitment, hiring, and onboarding process

Piloted equity interventions

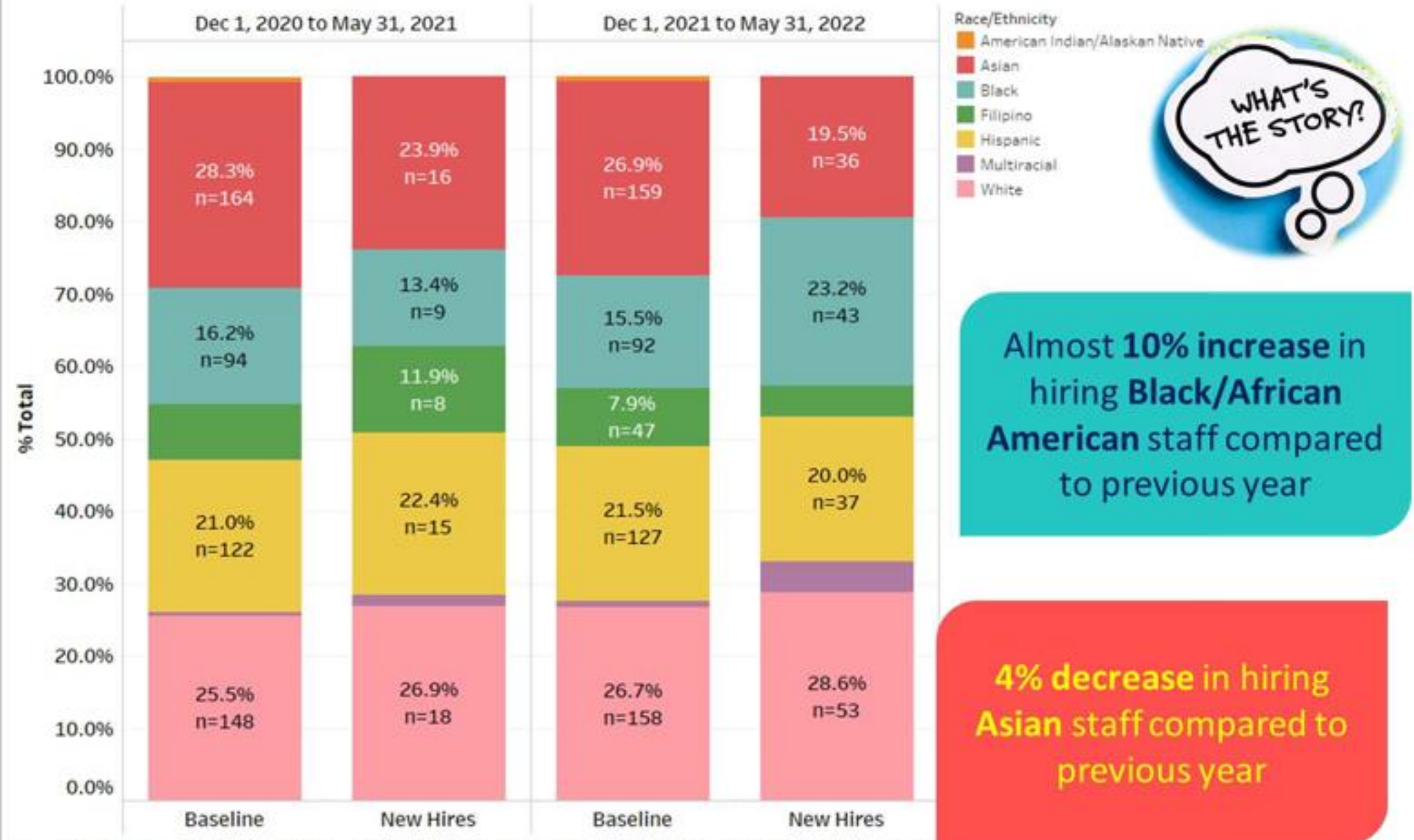
Hired 200 staff

Management and clinicians remain predominantly white and Asian despite equity interventions

Need more transparent, robust, and accountable equity interventions and infrastructure at CCSF, DPH, BHS, and team levels

Achieving racial equity is everyone's job. Racially and culturally congruent workforce and services improve health outcomes.

BHS New Hires by Race/Ethnicity

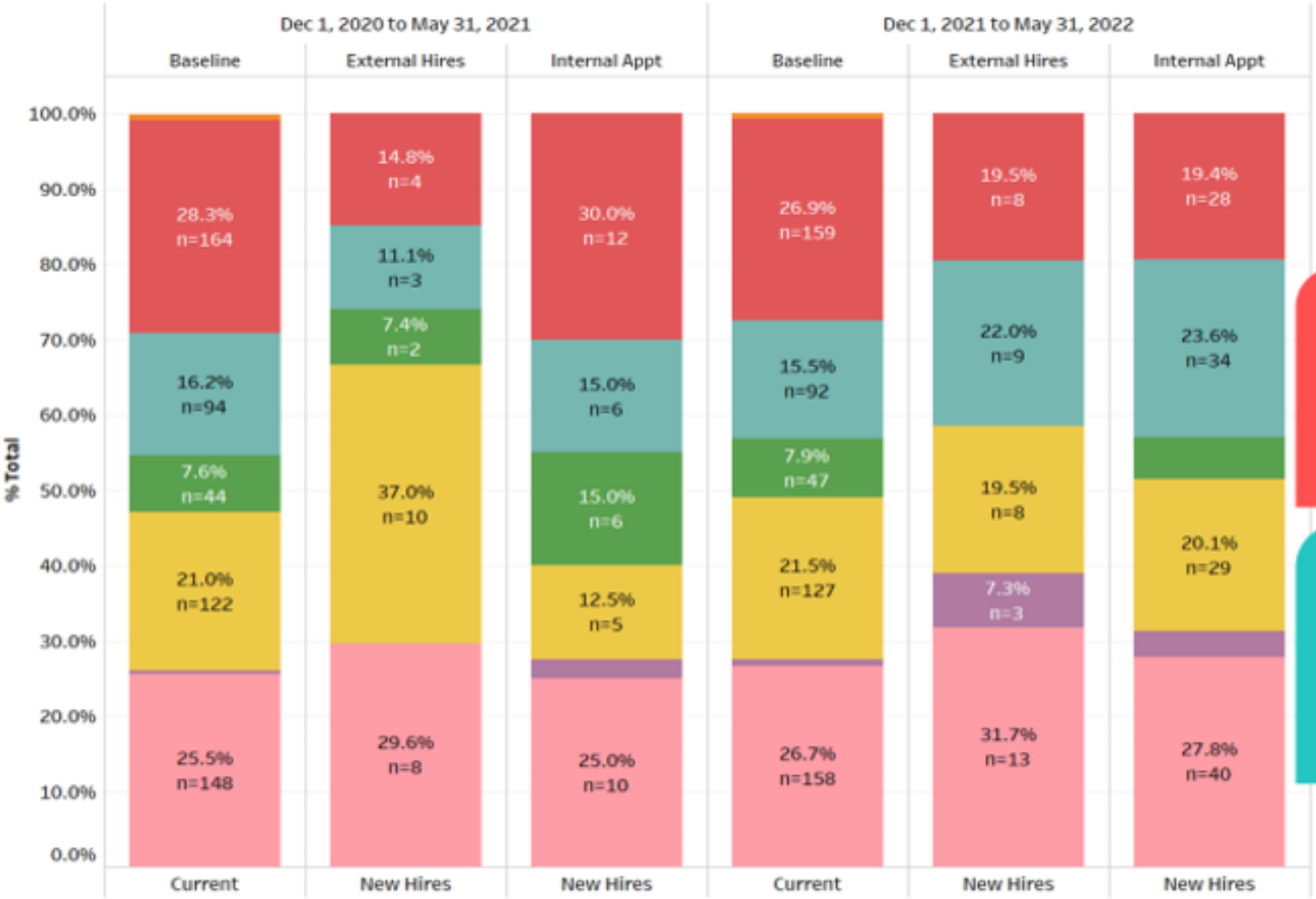


Almost **10% increase** in hiring **Black/African American** staff compared to previous year

4% decrease in hiring **Asian** staff compared to previous year

Behavioral Health Services (BHS) current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRIMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. BHS Emergency Hiring Order.

BHS New Hires: External Recruitments and Internal Appointments



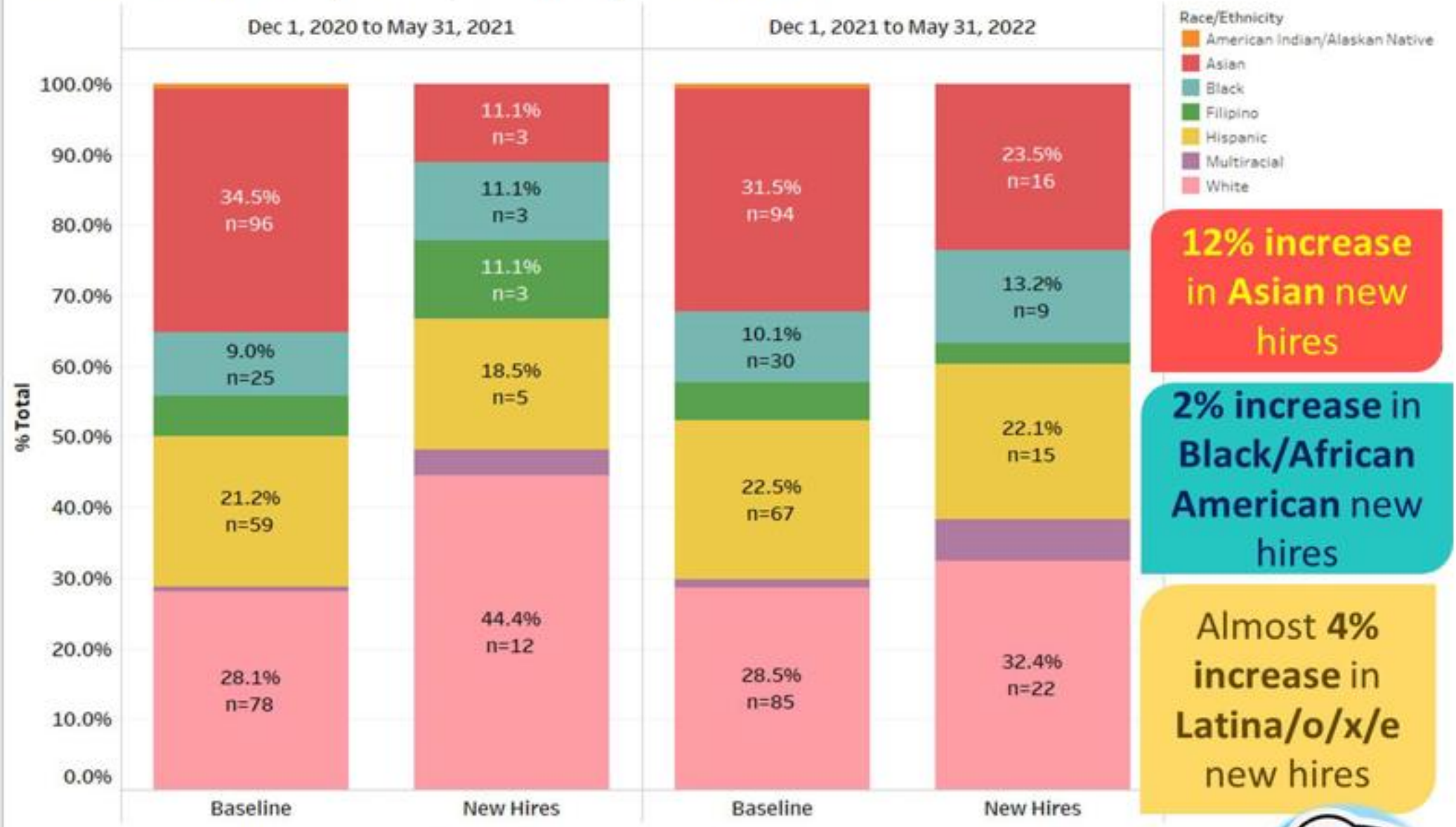
Almost **5% increase** in **Asian** external hires, and **11% decrease** in internal appts

Almost **11% increase** in **Black/African American** external hires, and **9% increase** in internal appts

Almost **18% decrease** in **Latina/o/x/e** external hires, and **8% increase** in internal appts

Behavioral Health Services (BHS) new hires versus external hires and internal appointments between 12/1/2020 and 5/31/2021 as well as 12/1/2021 by race/ethnicity based on data accessed in HRIMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. New internal appointments include any history of City and County of San Francisco Employment.

BHS New Hires by Race/Ethnicity: Clinicians



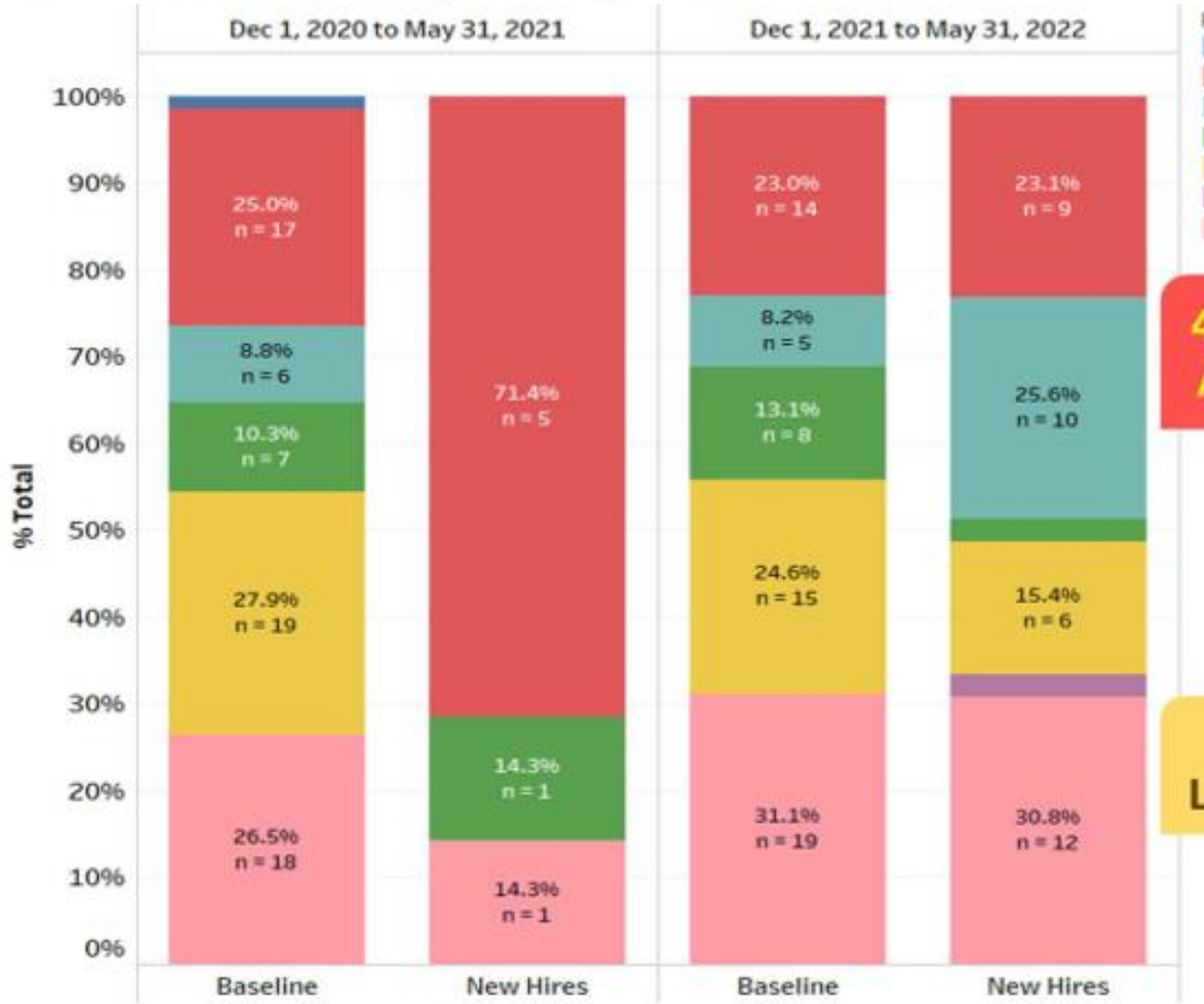
12% increase in **Asian** new hires

2% increase in **Black/African American** new hires

Almost **4% increase** in **Latina/o/x/e** new hires

Behavioral Health Services (BHS) clinicians current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Behavioral Health Clnicians (2930, 2932), Medical Doctors (2230, 2232, 2233, 2242, 2243), Pharmacists (2450, 2453, 2454), Psychiatric and Pharmacist Technicians (2305, 2409), and Nursing (2305, 2320, 2322, 2323, 2328, 2830).

BHS New Hires by Race/Ethnicity: Administrators



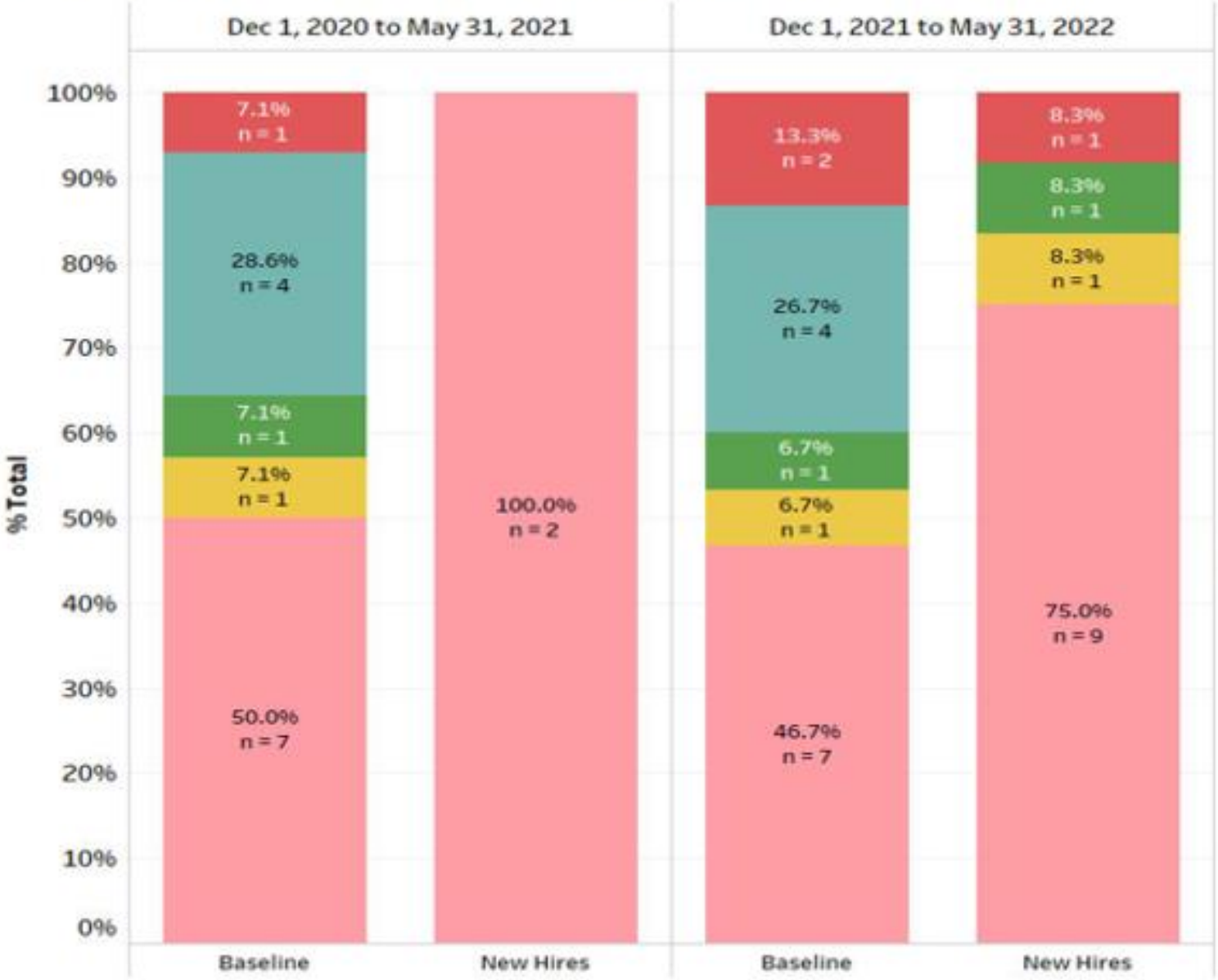
48% decrease in **Asian** new hires

100% increase in **Black/African American** new hires

100% increase in **Latina/o/x/e** new hires

Behavioral Health Services (BHS) administrators current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRIMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Administrators include Health Program Coordinators (2589, 2591, 2593), Analysts and Epidemiologists (2119, 2802, 2803, 1820, 1822, 1823, 1824).

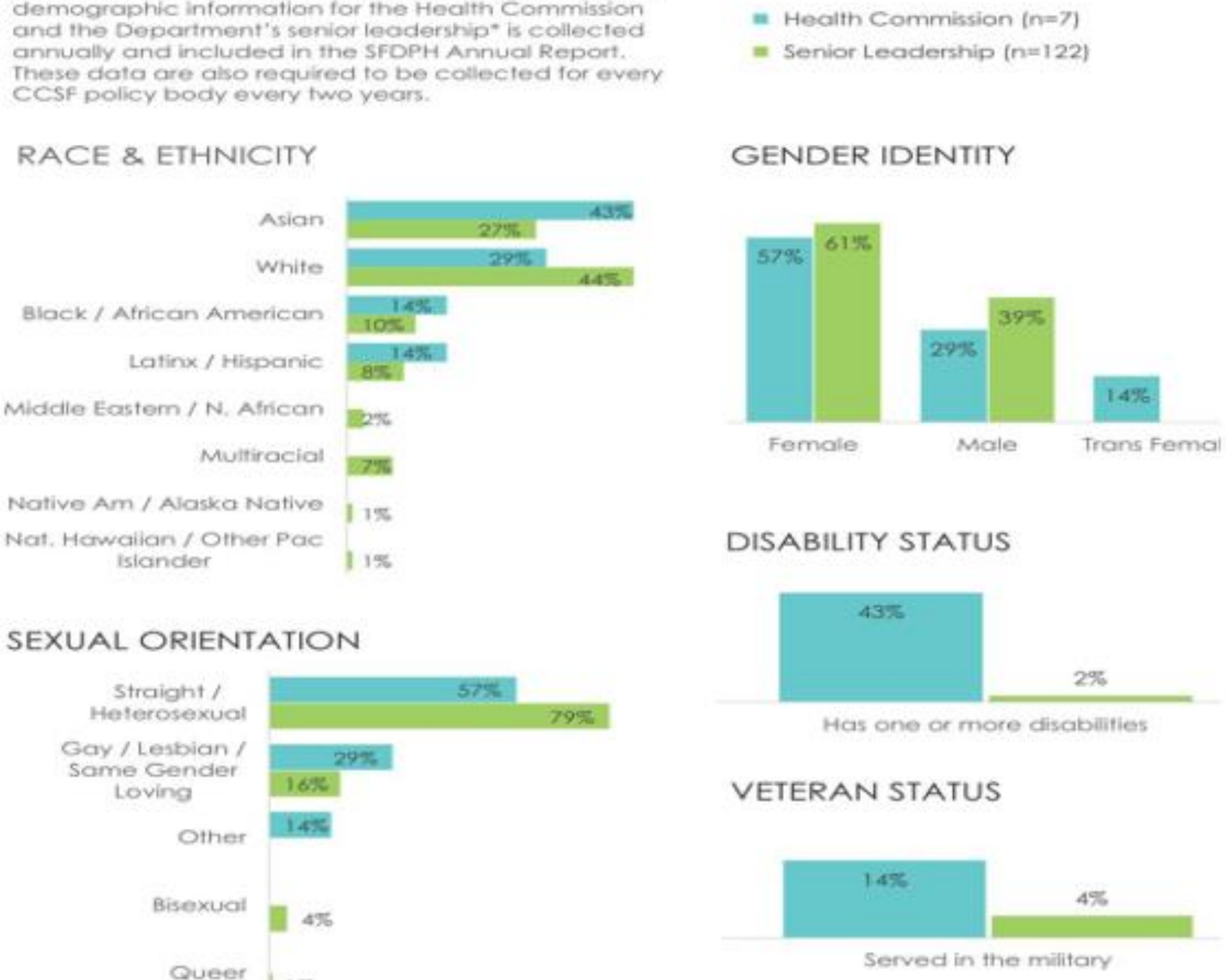
BHS New Hires by Race/Ethnicity: Directors/Managers



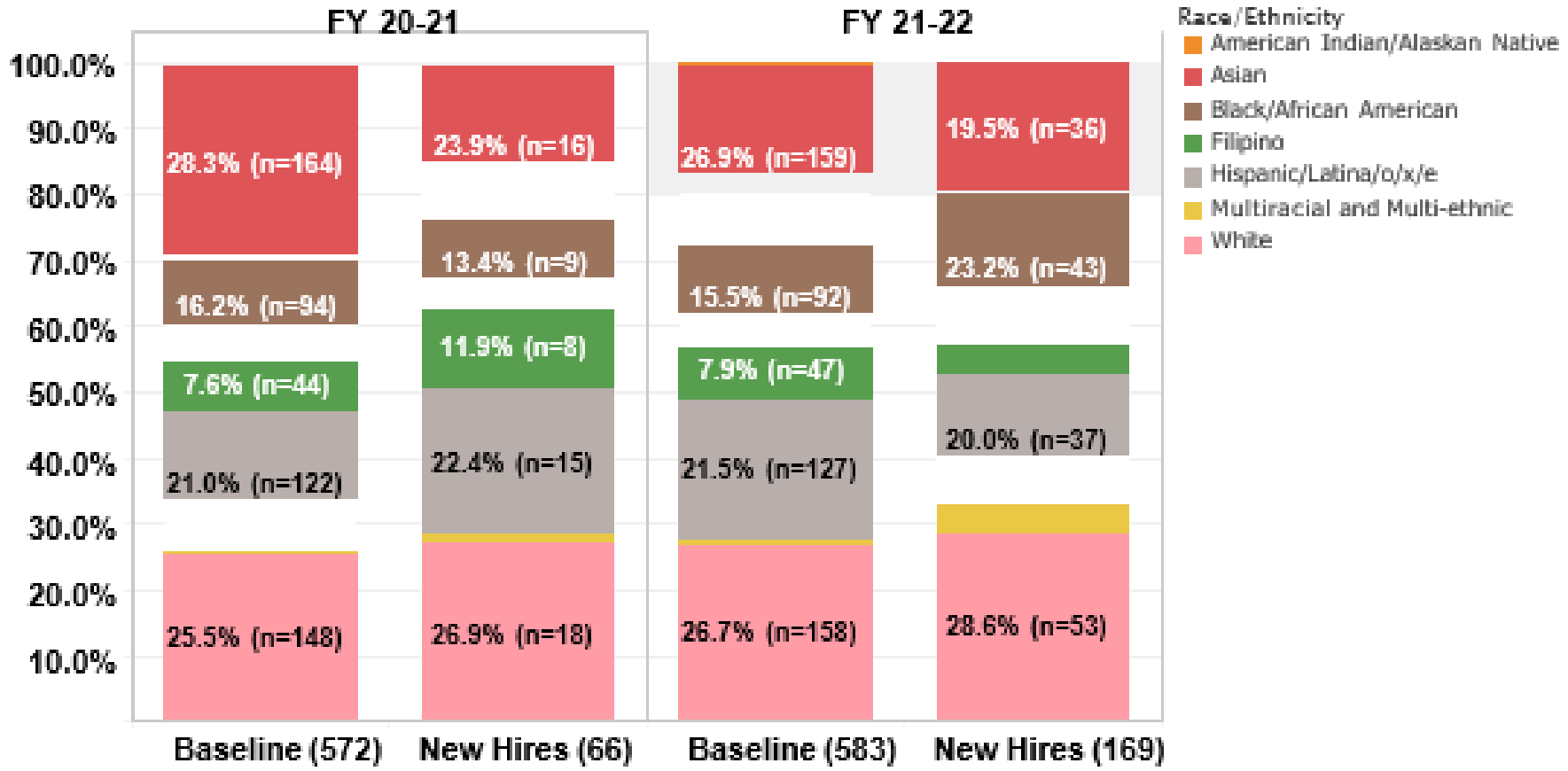
Behavioral Health Services (BHS) directors current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Directors/Managers have the following classifications: 922, 923, 932, 933, 941, 942, 943.

HEALTH COMMISSION & SENIOR LEADERSHIP DEMOGRAPHICS

As part of the Department's Racial Equity Action Plan, demographic information for the Health Commission and the Department's senior leadership* is collected annually and included in the SFDPH Annual Report. These data are also required to be collected for every CCSF policy body every two years.

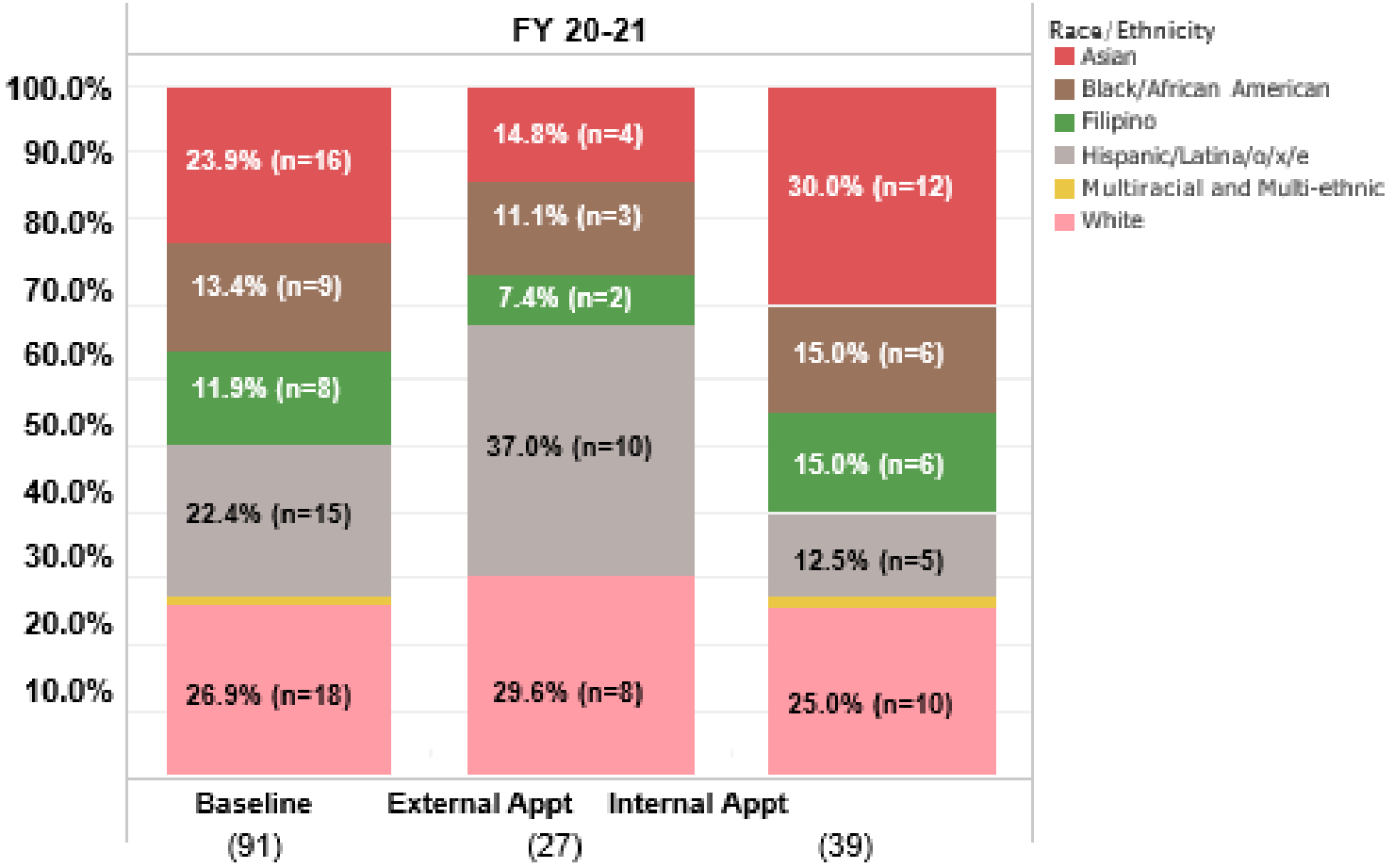


BHS New Hires by Race/Ethnicity



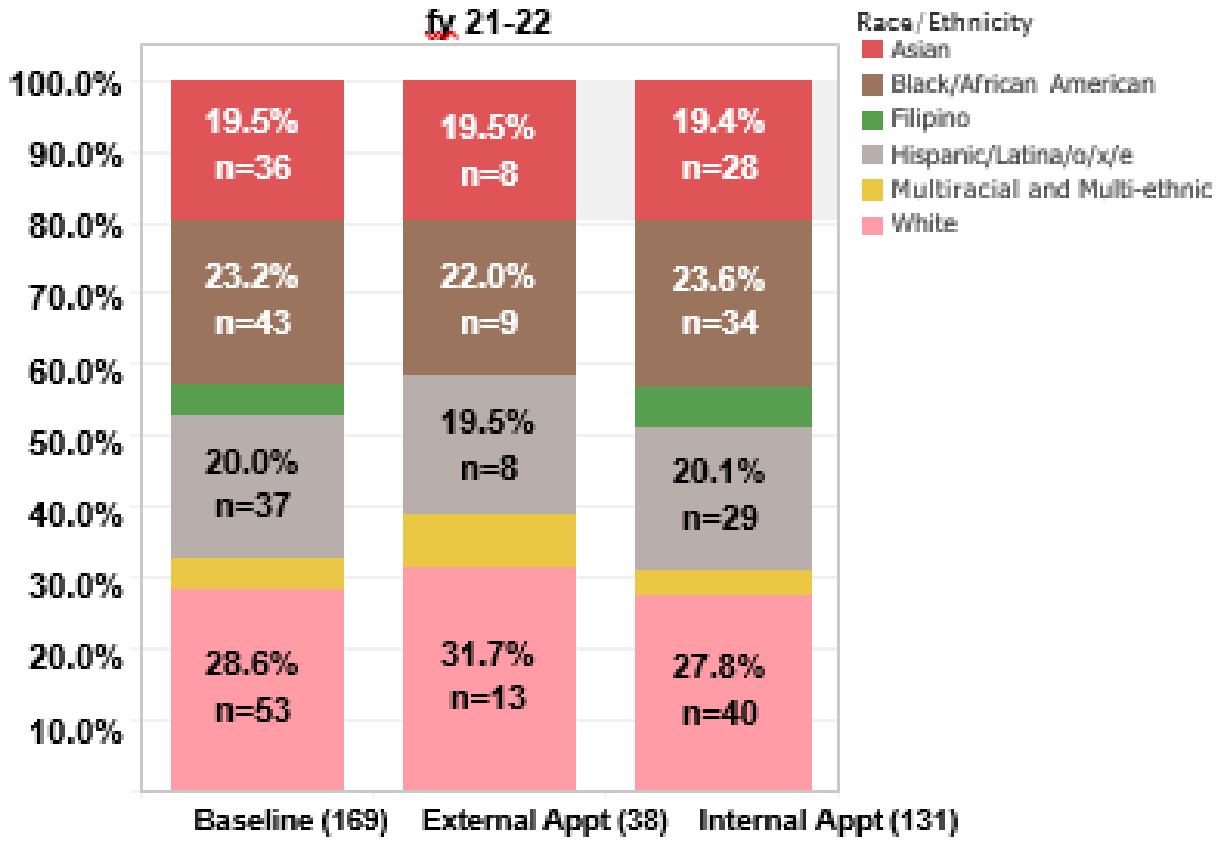
Behavioral Health Services (BHS) current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. BHS Emergency Hiring Order.

2020 BHS External Hires and Internal Appointments by Race/Ethnicity



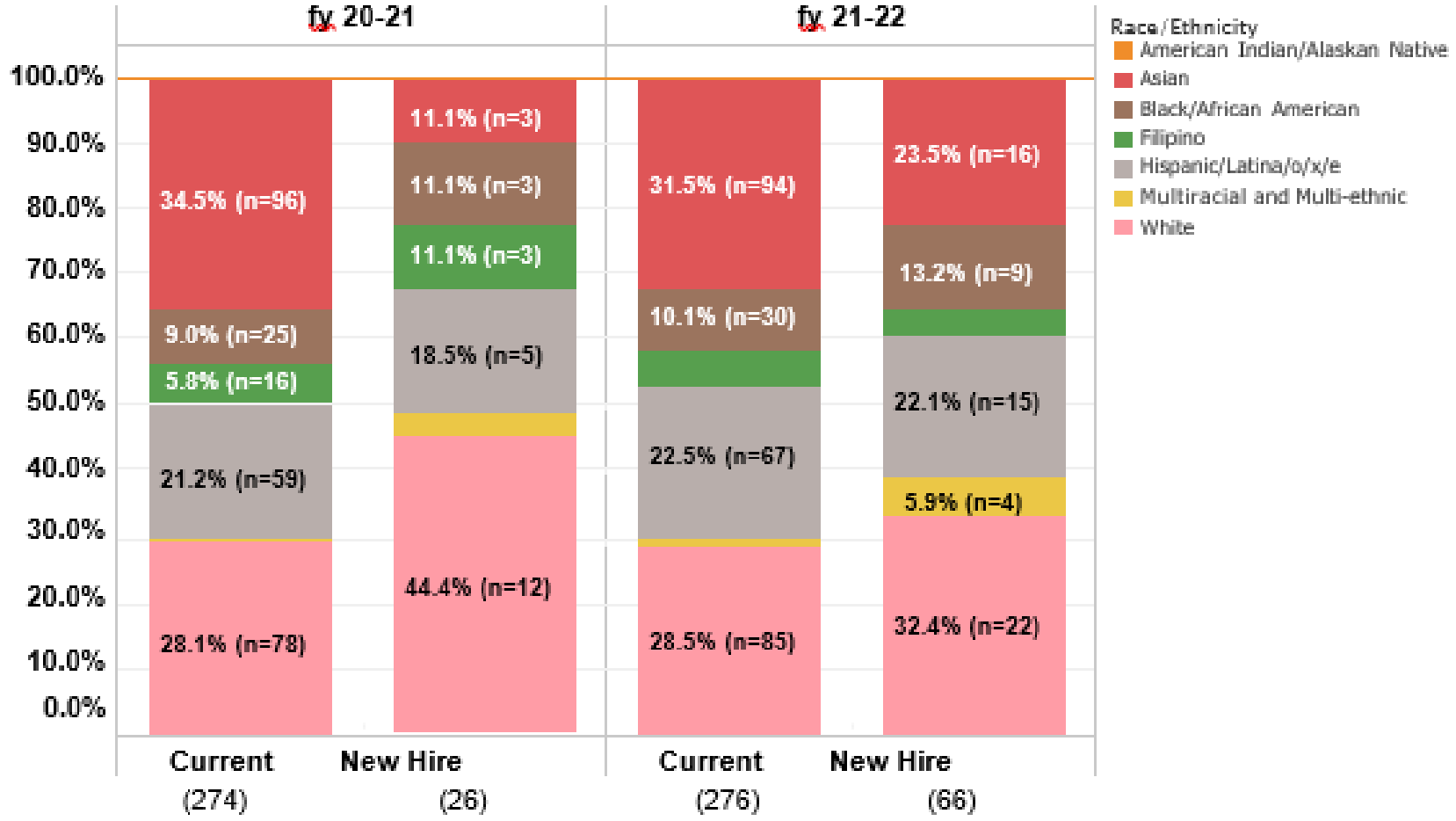
Behavioral Health Services (BHS) new hires versus external hires and internal appointments between 12/1/2020 and 5/31/2021 by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. New internal appointments include any history of SFCC Employment.

2021 BHS External Hires and Internal Appointments by Race/Ethnicity



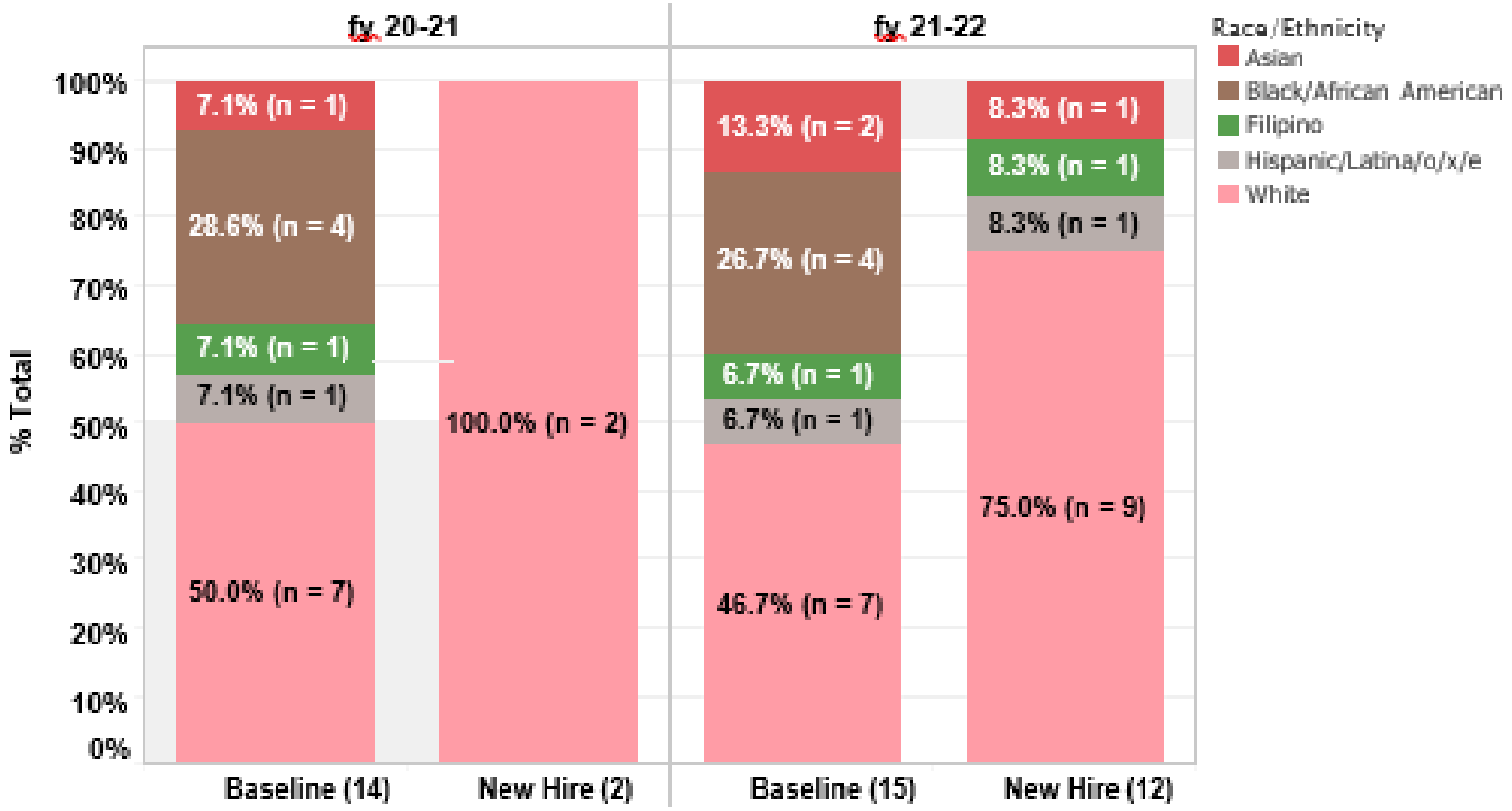
Behavioral Health Services (BHS) new hires versus external hires and internal appointments between 12/1/2021 and 5/31/2022 by race/ethnicity based on data accessed in HRiMS on 11/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. New internal appointments include any history of City and County of San Francisco Employment.

BHS New Hires by Race/Ethnicity: Clinicians



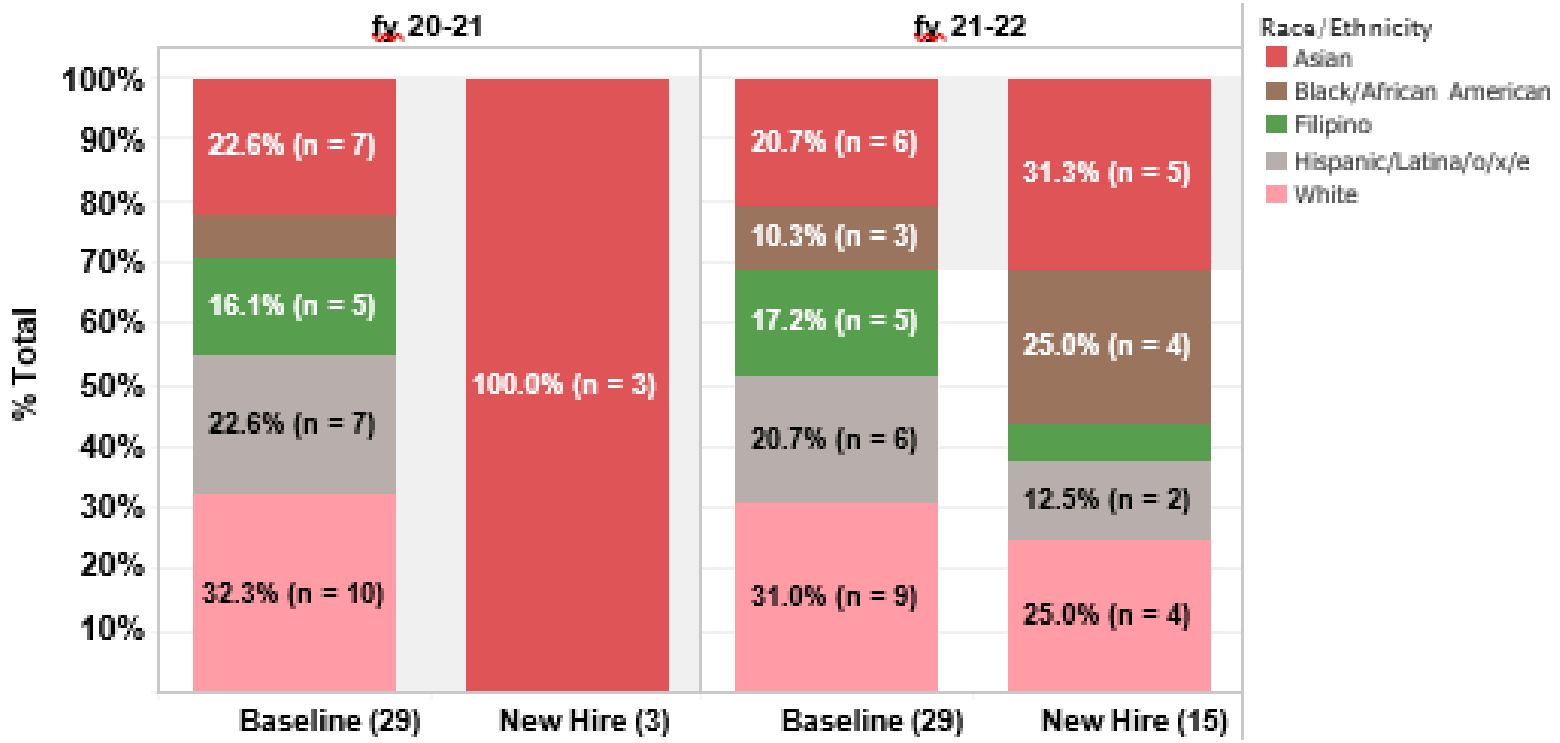
Behavioral Health Services (BHS) clinicians current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Behavioral Health Clinicians (2930, 2932), Medical Doctors (2230, 2232, 2233, 2242, 2243), Pharmacists (2450, 2453, 2454), Psychiatric and Pharmacist Technicians (2305, 2409), and Nursing (2305, 2320, 2322, 2323, 2328, 2830).

BHS New Hires by Race/Ethnicity: Directors/Managers



Behavioral Health Services (BHS) directors current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Directors/Managers have the following classifications: 922, 923, 932, 933, 941, 942, 943.

BHS New Hires by Race/Ethnicity: HPC I and II, Analysts, and Epidemiologists

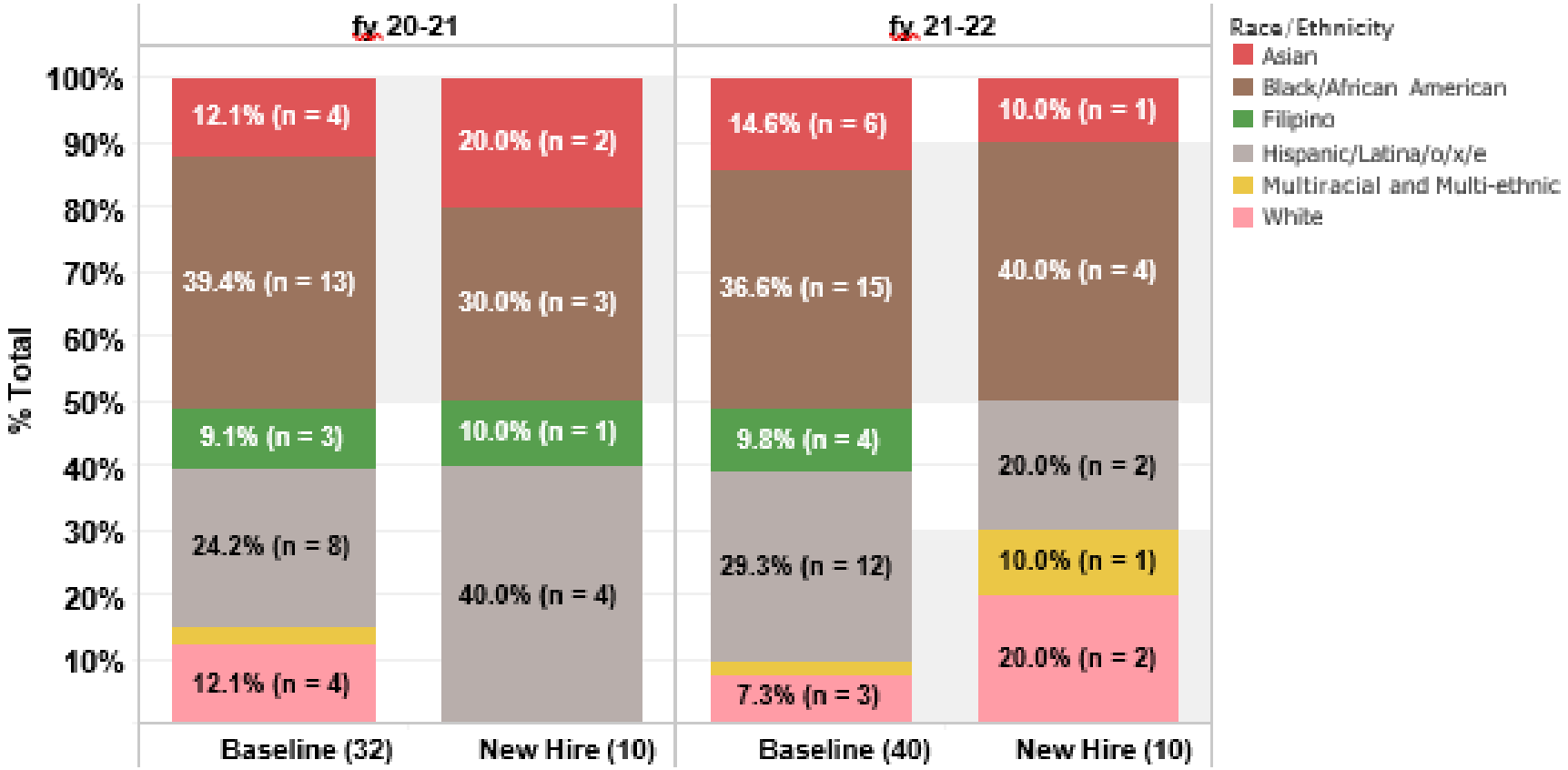


Behavioral Health Services (BHS) Health Program Coordinators I and II, Analysts, and Epidemiologists current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRIMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. These administrators include Health Program Coordinators (2589, 2591), Analysts and Epidemiologists (2119, 2802, 2803, 1820, 1822, 1823, 1824).

BHS New Hires by Race/Ethnicity: Health Program Coordinator IIIs

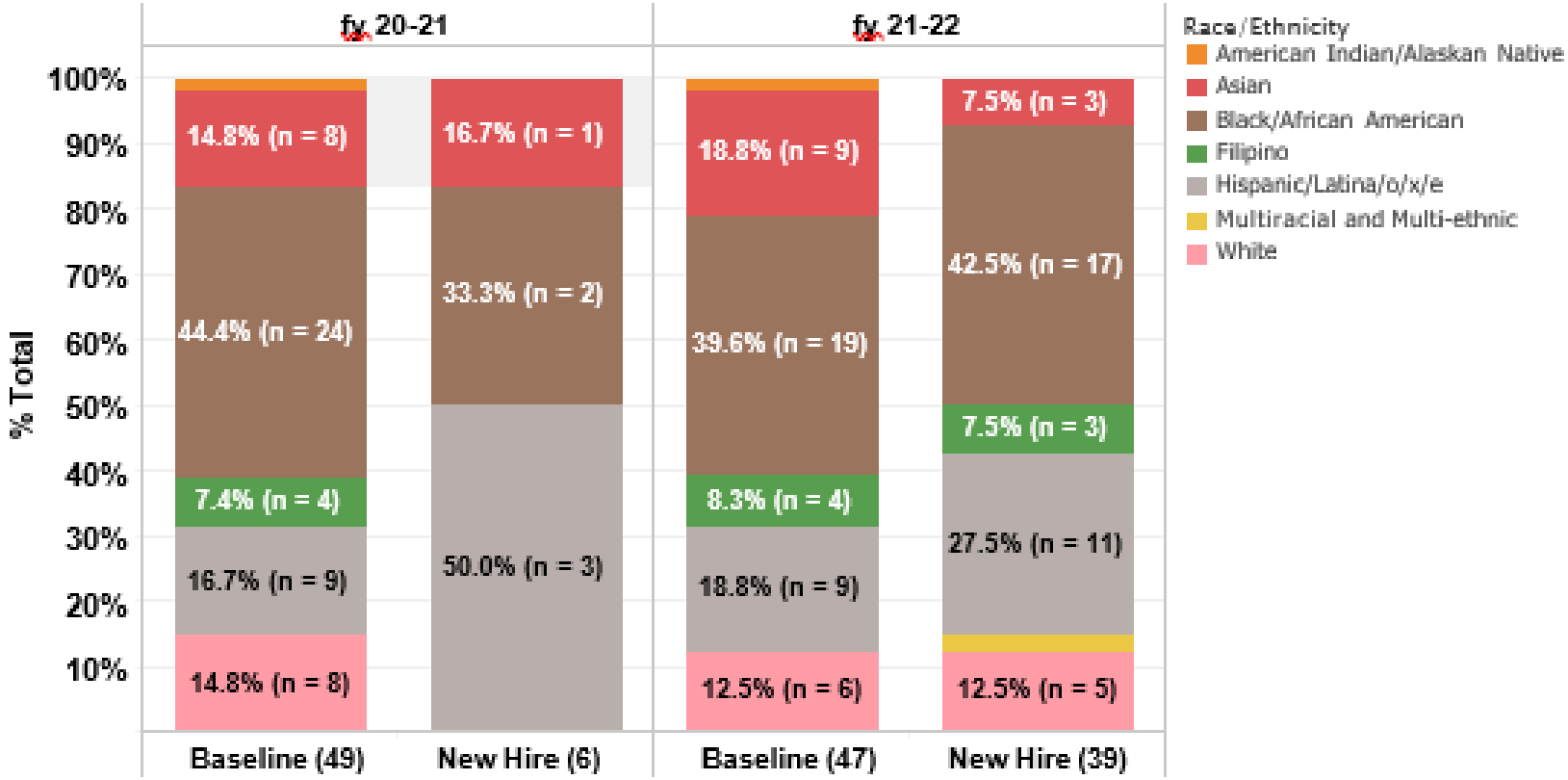
Behavioral Health Services (BHS) Health Program Coordinator IIIs current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022.

BHS New Hires by Race/Ethnicity: Health Workers I and II



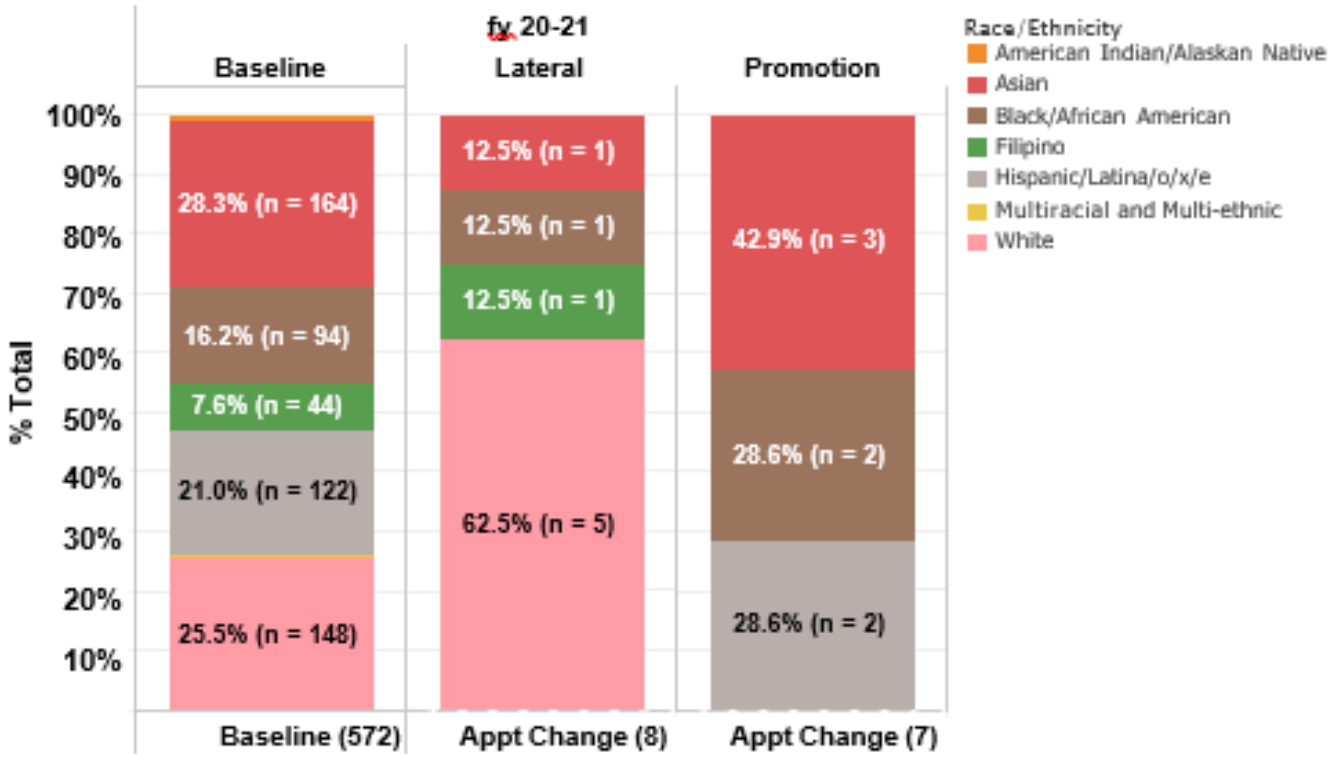
Behavioral Health Services (BHS) Health Workers I and II current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Health Workers I and II classifications (2585, 2586).

BHS New Hires by Race/Ethnicity: Health Worker III and IV



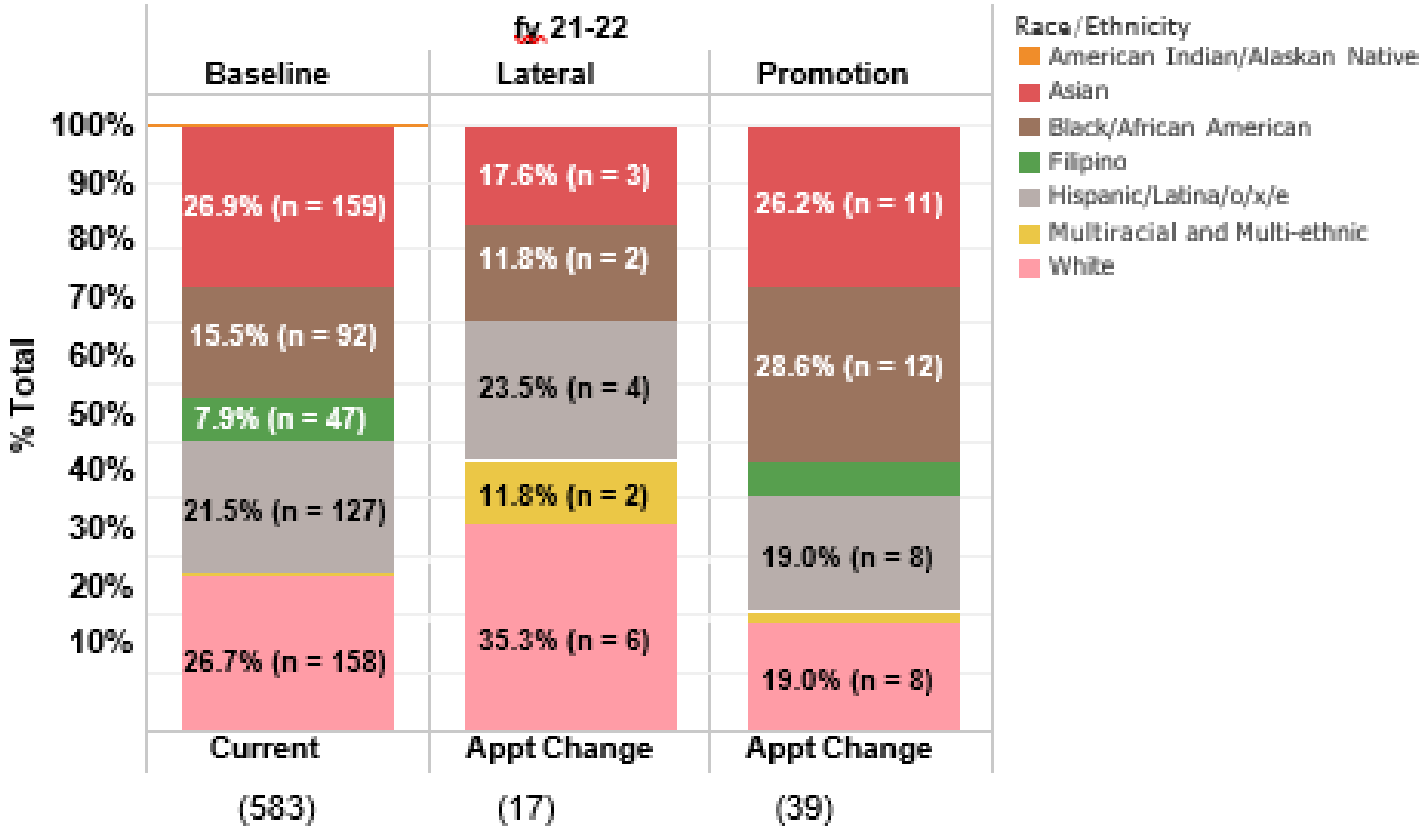
Behavioral Health Services (BHS) Health Workers III and IV current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022. Health Workers III and IV classifications (2587, 2588).

BHS Appointment Changes FY 20-21: Lateral Move and Promotions vs Current Workforce and New Hires



Behavioral Health Services (BHS) lateral moves and promotions vs current workforce (12/1/2020) and new hires (12/1/2020 through 5/31/2021) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 6/1/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, and 6/2/2021.

BHS Appointment Changes FY 21-22: Lateral Move and Promotions vs Current Workforce



Behavioral Health Services (BHS) lateral moves and promotions vs current workforce (12/1/2021) by race/ethnicity based on data accessed in HRIMS on 12/6/2021 and 6/13/2022 and PeopleSoft on 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022, 5/20/2022, and 5/31/2022.

Proposed Next Steps

Prevention, Early Intervention, and Response

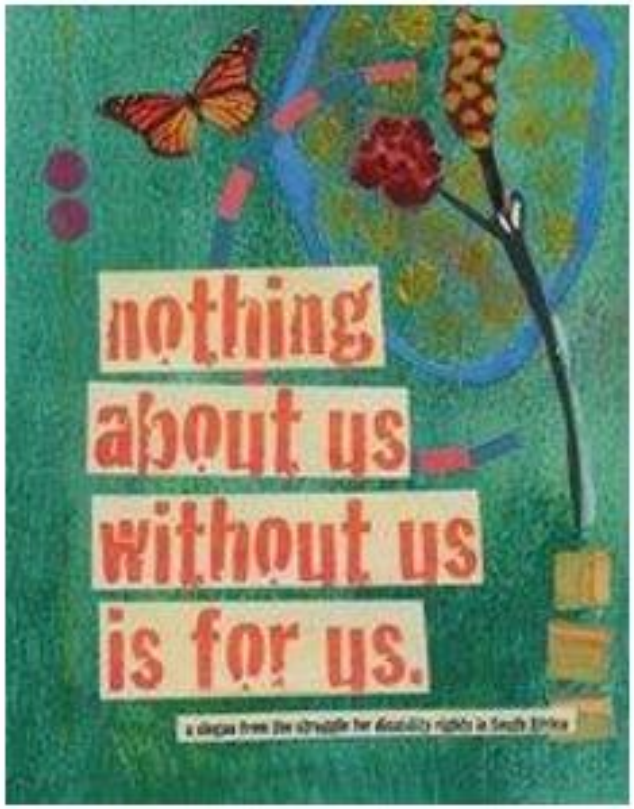
- Do no harm.
- When harm is done, acknowledge, apologize, and initiate racial reckoning at individual, interpersonal, and organizational levels.
- Support transparent and accountable measures for racial harm prevention, early intervention, and rapid response.

Proposed Next Steps

Recruitment and Hiring for all BHS Positions

BHS HR Pre-Approved Recruitment and Hiring Process and Procedures

- Equity introduction for all job announcements
- Desired qualifications bank
- Interview questions bank with response guidelines, opening, and closing statements
- Onboarding warm welcome and support



Proposed Next Steps

Recruitment and Hiring for Director/Manager, Higher Admin, and Clinical Positions

- Include Equity Director and/or designated equity lead in **every stage of hiring process.**
- Include equity introduction and **lived experience desired qualification** in all job announcements.
- Create **recruitment plans** that prioritize diversity, particularly those underrepresented.
- Assess applicants to **ensure a diverse candidate pool.**
- Include **weighted rating of lived experience** in application review form and notice of inquiry referral questionnaire rating.
  - Lived experience is defined as professional and verifiable experience working with a specific client population or community that the position aims toserve, or having lived experience as being a part of a specific client population or community.
- Include **lived experience interview question** and response guidelines in all interviews.
- Include **weighted assessment** of application, application review, notice of inquiry referral questionnaire, and interview.
- Base **merit** on organizational, positional, and lived experience, especially when considering internal candidates. Prepare internal staff to become eligible for promotive positions in partnership with HR that offers career coaching and advancement webinars.

Proposed Next Steps

Recruitment and Hiring for Director/Manager, Higher Admin, and Clinical Positions (continued)

- Provide **a warm welcome** onboarding process with additional **culturally relevant supports**, including SF-DPH Working Affinity groups.
- Ensure that **salaries are equitable and consistent**, including acting assignment pay, conversion of TEX positions to PCS, and appointment above entrance salary step requests.
- **Reduce racialized disciplinary outcomes**, including probation.
- **Ensure transparent accountability measures** for all directors/managers, higher administration, and clinical staff, so that actions are done fairly and equitably across all races, ethnicity, and gender.

San Francisco Health Network
Behavioral Health Services

Appendix B Three-Year Prevention and Early Intervention (PEI) Evaluation Report FY19-20 – FY21-22

Figure – Mural in San Francisco

Mental Health Services Act (MHSA) City and County of San Francisco

*This report is in compliance with the requirements for the Three-Year Prevention and Early Intervention Evaluation Report set forth in California Code of Regulations, Section 3560.020.

Mental Health Promotion and Early Intervention Programs: PEI Programming and Evaluation

Community Program Planning for Implementation of Prevention and Early Intervention Programming

SFDPH strengthens the MHSA program planning by collaborating with behavioral health service clients, their families, peers, and providers to identify the most pressing PEI-related behavioral health-related needs of the community and develop strategies to meet these needs.

In 2022, MHSA hosted several community engagement meetings across the city to collect community member feedback on existing PEI programming and better understand the needs of the community. Several people attended including mental health and other service providers, clients of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders.

All meetings were advertised on the SFDPH website, via word-of-mouth, and email notifications to providers. Printed and electronic materials were translated into Spanish, Mandarin, and other threshold languages, and interpretation was provided at all public community meetings, as needed.

The community feedback is incorporated into our continuous program improvement planning efforts including program planning and implementation, monitoring, quality improvement, evaluation and budget allocations. A summary of the PEI-related community feedback includes:

- Culturally competent services reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access – this is of upmost importance in overcoming stigma, connecting clients to services, and successfully engaging with them.
- It is critical that mental health clinicians and staff are representative of the clients our programs serve, particularly when serving communities that are culturally, medically, economically, or otherwise isolated. This includes certain populations (e.g., TAY, LGBTQ+, racial and ethnic groups) as well as entire neighborhoods (e.g. Bayview/Hunter's Point).
- Some PEI-funded programs develop personal success plans with each client to assist them in defining their health and wellness, employment, education, community, and interpersonal goals and then helping them to reach those goals. This promotes individuals' success in the program and beyond.
- Some PEI-funded programs have long waitlists (such as programs serving socially isolated older adults), which makes it difficult for people to access the services they need.
- Moving services to virtual or hybrid format has helped connect to many clients who may otherwise not be able to participate in programming due to barriers to attending in-person. Many clients are interested in continuing virtual and hybrid program options - but this requires programmatic flexibility to be able to understand and be responsive to client needs and program requirements.

- Children and youth have been struggling with behavioral needs, particularly in school-based settings, and service providers are finding success in supporting them by prioritizing individual and meaningful connections to caring adults, mentors, coaches, and other youth.
- The Community Building Program has seen a significant increase in the number of people needing rental assistance; many people within the community have not paid rent due to the financial hardship of the pandemic.

PEI Service Category Overview

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

6. Stigma Reduction
7. School-Based Mental Health Promotion;
8. Population-focused: Mental Health Promotion;
9. Mental Health Consultation and Capacity Building; and
10. Comprehensive Crisis Services

The focus of all PEI programs is to raise people's awareness about mental health conditions; reduce the stigma around mental illness; and increase individuals' access to quality mental health care. MHSA investments support mental health capacity of programs and grassroots organizations that typically don't provide mental health services (e.g. schools, cultural centers). Each San Francisco-based PEI program will be consistent with all applicable Mental Health Services Act General Standards, as set forth in Title 9 California Code of Regulations, Section 3320. Below is a table and crosswalk to correlate the San Francisco PEI Program with the California MHSA Categories and General Standards.

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

<u>Regulations for Statewide PEI Programs</u>

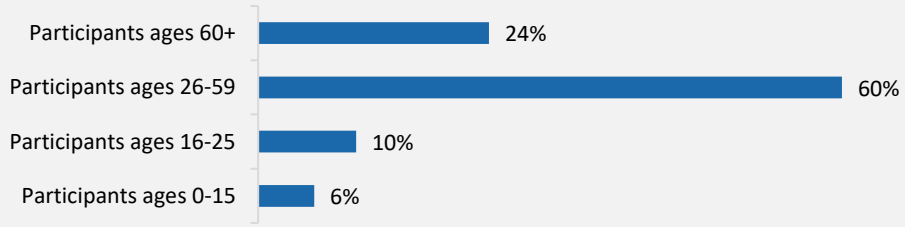
To standardize the monitoring of California PEI programs, the MHSOAC requires particular county data elements and reporting. These include number of people served by a program; the demographic characteristics of program clients [e.g., age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)]; and the interval of time between a referral and client

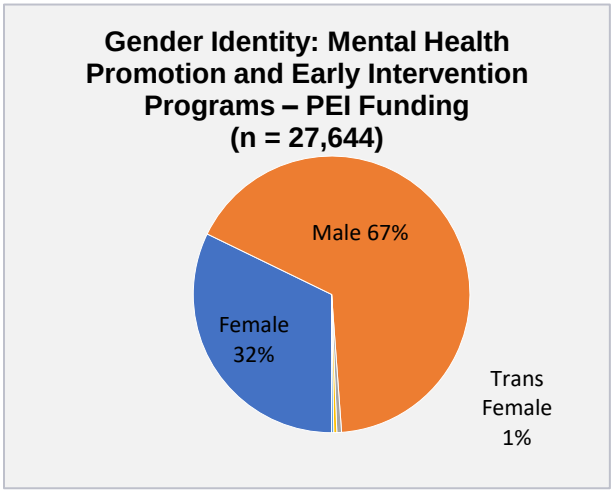
participation in referred services. The MHSOAC calls this “referral-to-first participation in referred services period” a successful linkage; and successful linkages are one indicator among many that signifies clients’ timely access to care. Given the need for the MHSOAC to know and better understand the communities being served by MHSA resources, it is extremely important for MHSA to develop processes and instruments that will afford programs the ability to capture required data in a manner that is respectful and does not offend, discourage or alienate individuals who are seeking help. All counties are required to include these demographic data in their Annual PEI Report to the MHSOAC, which is part of a county’s Annual Update or 3-Year Program and Expenditure Plan.

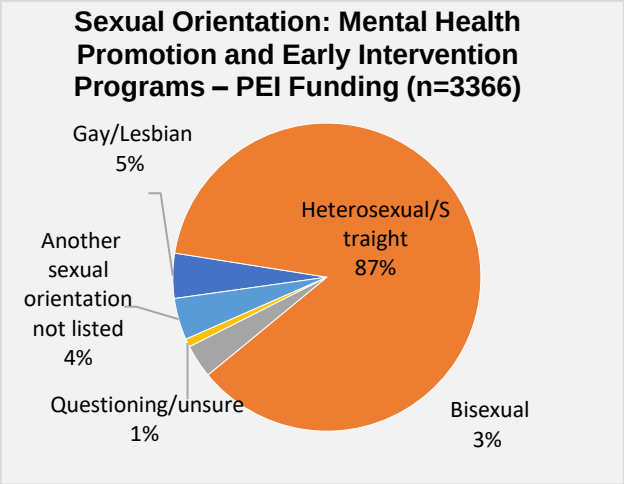
FY21-22 Demographics: All PEI Programs

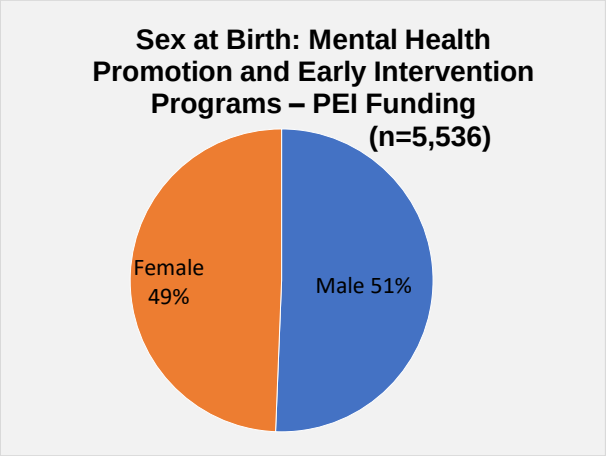
Total Clients Served: 69,631
Total Unduplicated: 31,815
Served for Early Intervention: 4,921
Served for Mental Illness Prevention: 1,277

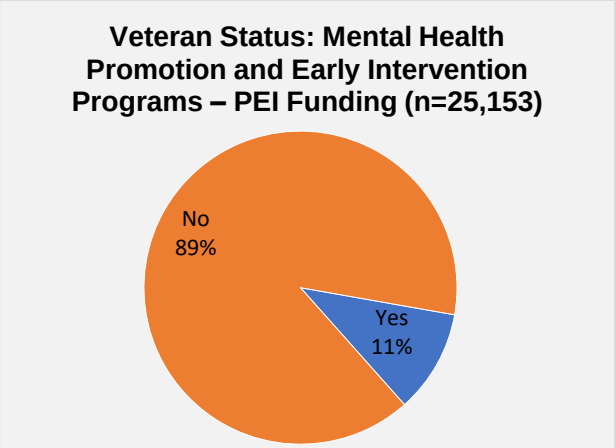
Age: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 29,266)



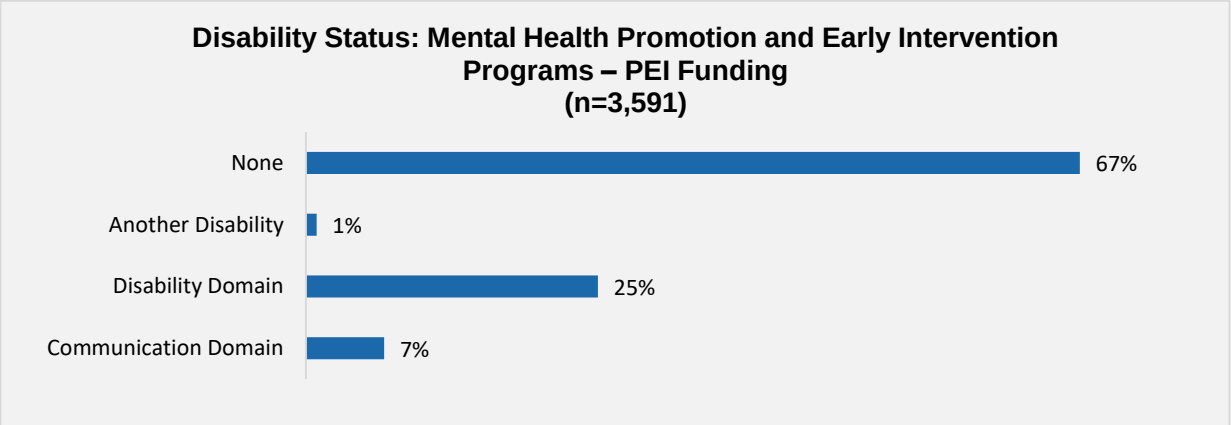








*< 1 percent of clients reported data for Another gender identity not listed, Trans Male; Gender



Race/Ethnicity	n	%
Black/African American	5,951	35%
American Indian or Alaska Native	201	1%
Asian	3,366	20%

Native Hawaiian or Pacific Islander	365	2%
White	5,349	31%
Other Race	1,878	11%
Hispanic/Latino	4,088	65%
Non-Hispanic/Non-Latino	1,965	31%
More than one Ethnicity	235	4%
Total	23,408	

Primary Language	n	%
Chinese	449	11%
English	2,247	53%
Russian	<10	0%
Spanish	696	17%
Tagalog	37	1%
Vietnamese	283	7%
Another Language	501	12%
Total	4,214	

**Clients may be counted in multiple categories and therefore percentages do not total 100%.*
**Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity*
**Due to rounding, total does not equal 100%*

Indicator Outcomes for all PEI Programs FY 21-22

Service Indicator	Program Results for FY 21/22
Total family members served	197 family members; average of 16.4 family members across the 12 reporting programs.
Potential responders for outreach activities	Responses included: behavioral health specialists, case managers, community members and liaisons, family success and educational coaches, health and mental health providers, probation officers, school/after school staff, social services, and social workers.
Total individuals with severe mental illness referred to treatment	96 individuals; average 8.7 individuals across 11 reporting programs.
Types of treatment referred	Responses included: case management, housing, medical care, mental health/therapy, substance abuse, and women's health.
Individuals who followed through on referral	319 individuals; average 26.6 individuals across 12 reporting programs.
Average duration of untreated mental illness after referral	Many programs either did not offer these services or were not able to track and report this data. Of those who did, responses included: - 7 days - 132 days - 4.5 months - 12 months - During pregnancy, and flexibly up to 2-19 months postpartum depending on need.
Average interval between referral and treatment	Many programs either did not offer these services or were not able to track and report this data. Of those who did, responses included: - 1-2 weeks - 1 month - 1.5 months - 51.4 days

Service Indicator	Program Results for FY 21/22
	- 2 months - 3-6 months
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	1,530 individuals; average 117.7 individuals across 13 reporting programs.
Types of underserved populations referred to prevention program services	Ethnic/racial groups: communities of color including American Indian and Alaskan Native, Black/African American, Cambodian, Filipino, Lao, Latinx, Mongolian, Native American, Samoan, and Vietnamese. Social Minorities/Resource-limited: adverse childhood experiences, functionally impaired, immigrant communities, indigenous, individuals suffering from complex trauma, individuals concerned about mental illness, LGBTQ+, low-income, non-English speaking, monolingual families, single parents, substance use, unhoused, and working parents with limited resources. Age Groups: immigrant youth, isolated older adults, Southeast Asian youth, transition age youth, and unhoused or marginal housed youth.
Individuals who followed through on referral	1,155 individuals; average 96.3 individuals across 12 reporting programs.
Average interval between referral and treatment	Some programs either did not offer these services or were not able to track and report this data. Of those who did, responses included: - 4 days - 1-2 weeks - 27 days - 26.29 days - 51.4 Days - 3-6 months - Case by case, and typically seen multiple times a week, weekly or biweekly depending on level of acuity and availability of the patient/client. If in-patient, a combination of in-person and telehealth visits may occur with more frequency.
How programs encourage access to services and follow-through on referrals	Responses are summarized below: ● Accept self-referrals ● Conduct warm handoffs ● Continuous communication, including reminders about future visits/meetings and wellness follow up calls ● Destigmatize mental health/create safe and confidential spaces

Service Indicator	Program Results for FY 21/22
	• Develop trusting relationships with families • Escort individuals to referral services • Hire peer advocates who have similar backgrounds or have experienced similar challenges • Identify multiple portals to connect families to help • Internal referrals • Partner/collaborate with other programs, services, and agencies • Provide care coordination • Stay in communication with youth waiting for available services. • Transportation, home visits, wrap around care, culturally and linguistically relevant services. • Use data to track participation • Use marketing/communication strategies

Service Indicator Outcomes for all PEI Programs FY 20/21

Service Indicator	Program Results for FY 20/21
Total family members served	723 family members; average 55.6 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: hospital fellows, community mental health students, law enforcement personnel, wellness program students/instructors, peer providers, support group members, high school faculty, partner agency staff, teachers, administrators, case managers, nurses and providers, school social workers, parent liaisons, school administrators and other personnel, community members, juvenile justice department staff, occupational therapists, social workers, HSA personnel, drop-in center staff, health clinic staff, therapists, program coordinators, community center staff, religious leaders, resource center staff, harm-reduction specialists, physicians, behavioral health specialists, probation officers, program directors, site supervisors, early childcare experts, family support specialists, and home visitation staff.
Total individuals with severe mental illness referred to treatment	551 individuals; average 55.1 individuals across 10 reporting programs.
Types of treatment referred	Responses included: specialty mental-health sites, individual or family mental health services, inpatient psychiatric assessment and care, substance use disorder treatment, housing, primary care, health clinics, suicide prevention, emergency care, psychiatry, medication access, case management, hospital and outpatient services, and longer-term services.
Individuals who followed through on referral	317 individuals; average 35.22 individuals across 9 reporting programs.

Service Indicator	Program Results for FY 20/21
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report this data. Example responses include: - 4 days - 2 weeks - 3 weeks - 3 months - 6-12 months
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include: - 1 week - 17 days - 3 weeks - 3 months (reported by 2 programs)
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	730 individuals; average 60.83 individuals across 12 reporting programs.
Types of underserved populations referred to prevention program services	Ethnic/Racial Groups, Black, Indigenous, People of Color (BIPOC), Latinx, Filipinos, Samoans, Cambodians, Lao, Vietnamese, Mongolians, Central American indigenous people (Mayan; Mexico, Guatemala, El Salvador, Nicaragua). Age Groups: transition-age youth, inner city teens, isolated older adults, southeast Asian youth, unaccompanied youth, unhoused elders, Social Minorities/Resource-limited: people experiencing homelessness, unstably or marginally housed people, families isolated by COVID, LGBTQ, gender affirming care clients, low-income, non-English speaking, functionally impaired, unemployed, refugee, 1st or 2nd generation immigrant, formerly incarcerated, Spanish speaking, under-insured, undocumented, systems-involved, those with a history of mental health needs or substance misuse, people housed in multifamily/crowded homes, those disconnected from services access for basic needs, survivors of community violence, educators impacted by COVID,
Individuals who followed through on referral	481 individuals; average 43.73 individuals across 11 reporting programs.

Service Indicator	Program Results for FY 20/21
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include: - 6 days - 1-2 weeks - 2 weeks (reported by 2 programs) - 17 days - 3 months
How programs encourage access to services and follow-through on referrals	Responses include: ● The audience receives an informational packet that provides a list of resources in San Francisco. We also discuss the Warmline and CALHOPE phone support as well as the many support groups we offer. ● An interdisciplinary team encourages access to mental health services, including coordinating tabling activities during student events, and partnering with student representatives to outreach their fellow peers. Upon assessing the student, the clinician will make the appropriate referrals to community-based organizations for specialty mental health treatment. ● Our program centers building relationships with all support staff at school sites who then can make a warm handoff to the mental health consultants. Additionally, MHCs make themselves available with flexible hours and through various mediums (in person, zoom, phone etc.) and meet families where they are at. ● Clients who do not meet medical necessity, do not qualify for full-scope MediCal or do not have any insurance, were able to receive mental health assessment, treatment or referrals if they had chronic school attendance challenges. ● Staff outreach and continuity of contact; events and weekly peer groups; internal referrals based on needs assessment. ● We have a mental health coordinator and announce our services weekly on Friday evenings in our call-em-all voice calls to all clients about services available and how to contact us. ● Partner coordinators work closely with clients to navigate them to services. Site coordinators are encouraged to conduct follow-up calls with clients to ensure they have followed through with their referrals/appointments. ● After a client is provided with a service referral and possibly a warm hand off or navigation support, staff will call the client up to 3 times to ensure that the client's need was met and also to confirm the connection was made. ● We track referrals and linkages in our program management system. Reminders are automatically generated for staff to conduct follow-up 3 days later. We have also been doing outreach through food box deliveries.

Service Indicator	Program Results for FY 20/21
	• Peer-based staff approach social work with knowledge, understanding, empathy and non-judgement. Over time and utilizing the principles of harm reduction, we build up trusting relationships with community members and are then better able to pinpoint specific needs and direct individuals to the appropriate services and resources. • We have enhanced and streamlined our referral screening, assignment and follow-up process for the entire outpatient program. Staff are expected to respond to referral source within 48 hours/2 working days of assignment. • Warm hand-offs; at least 3 follow up contacts after referral is made. • Soft handoffs, engagement in WRAP Care, collateral sessions with other providers. • Our program provided information of community resources to staff and families in meetings and through newsletters; we also facilitated linkage to other internal programs. • Established ongoing relationships with many community organizations. When referrals are made, consultants follow up with parents, teaching staff, family advocates, or other managers on the status of the referral. • Consultants provide individualized referrals to clients and families based on their needs and factoring for any barriers to access. Consultants will also follow up on referrals and, when possible, provide additional support to ensure access.

Service Indicator Outcomes for all PEI Programs FY 19/20

Service Indicator	Program Results for FY19/20
Total family members served	784 family members; average 60.34 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: Outreach specialists, case managers, partner agency staff, school personnel and parents, social workers, peer advocates
Total individuals with severe mental illness referred to treatment	263 individuals; average 32.88 individuals across 8 reporting programs.
Types of treatment referred	Medical, mental health, substance use, case management, education support
Individuals who followed through on referral	338 individuals; average 37.56 individuals across 9 reporting programs.

Service Indicator	Program Results for FY19/20
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report these data. Example responses include a range of 1-3 months.
Average interval between referral and treatment	Majority of programs were not able to track and report these data. Example responses include a range of: - 1 week (mentioned twice) - 11 days - 3 weeks - 29.4 days - 33 days
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	1,605 individuals; average 133.75 individuals across 12 reporting programs.
Types of underserved populations referred to prevention program services	Ethnic/racial groups: communities of color, Black/African Americans, American Indian and Alaskan Native, Latinx, Chicanx, Maya, Filipinx, Samoan, Laotian, Cambodian, Vietnamese Age Groups: TAY from communities of color, youth In-custody, gang affiliated, youth experiencing academic truancy, children in foster care, children and families, isolated older adults Social Minorities/Resource-limited: Homeless, families at risk of homelessness, families in public housing, low income, those living below the poverty line, LGTBQ, queer, immigrants (elders, newcomers, and unaccompanied youth), systems-involved (legal, foster, etc.), limited English speakers, families impacted by substance use and dependency.
Individuals who followed through on referral	1,119 individuals; average 93.25 individuals across 12 reporting programs.
Average interval between referral and treatment	Majority of programs were not able to track and report these data. Example responses include a range of: - 1 week (mentioned twice) - 1-3 weeks (mentioned twice) - 11 days - 16.6 days
How programs encourage access to services and follow-through on referrals	Responses include: ● We provide follow up and most of our relationships are ongoing - as we prioritize building relationships and building community to buffer the impacts of systemic racism and Covid-19 pandemic related stress. Many of the families who were provided referrals also participated in support groups run

Service Indicator	Program Results for FY19/20
	by the mental health consultant and families received regular wellness calls once SIP took place. ● The case manager is heavily involved in the engagement of youth and families in this program and works collaboratively with clinicians to assist in physical access to services. Case manager works with clinician to assure clients are receiving basic needs so that educational needs can be addressed. ● Staff outreach and continuity of contact: events and weekly peer groups; Internal referrals based on needs assessment ● Clients are screened and wellness checks are conducted to better identify need. Referral forms are completed and database is reviewed and/or clinician is reached out to for participation usage. ● Encourage access to services through anti-stigma messages via outreach and engagement, and wellness promotion activities to normalize mental illness and mental health service use. Staff conduct regular check-ins to ensure referrals are followed through and goals are met. ● In response to COVID-19, the case management need increased tremendously, and we have pivoted services to provide telehealth calls, link to basic food needs, and emergency funding. ● Employing peer-based staff who are from the neighborhood and/or who share similar lived experiences as the community members served; applying a low-threshold, harm reduction approach to services offered; weekly staff training and development in topics such as cultural humility, mental health first aid, de-escalation, conflict resolution, etc.; street level outreach; building trust by offering basics such as coffee and water, snacks, use of phone and computer, use of bathroom; employing Spanish-speaking staff who can assist monolingual Spanish speakers ● Our Intake Coordinator contacts referrals sources and potential clients within 48 hours of receiving services, offering a timely access appointment within 10 days of receipt of referral. Potential clients are outreached while waiting to be assigned to a therapist and advised of the wait to obtain services and are offered linkages to other services when appropriate. ● Our agency provides warm handoffs to agencies that have capacity. We will accompany clients to meetings if there is a desire and capacity. We will also encourage family or other

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

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

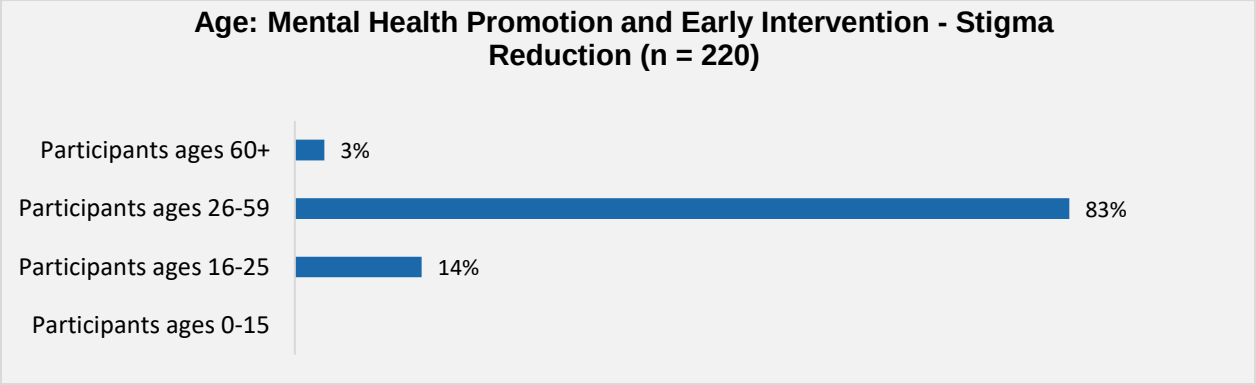
Program Overview

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

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

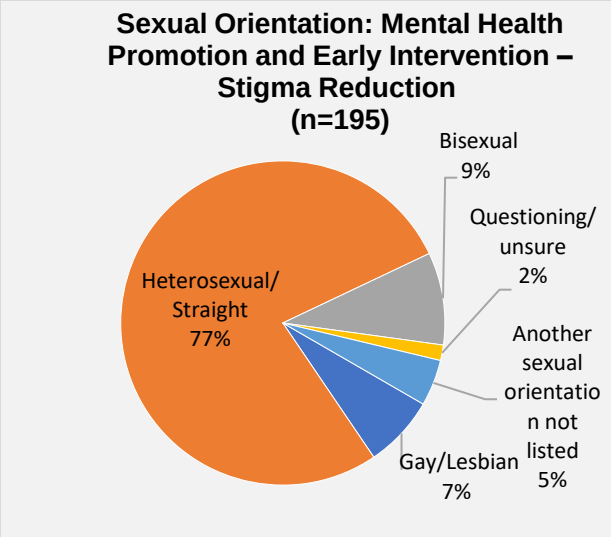
FY21/22 Client Demographics and Outcomes

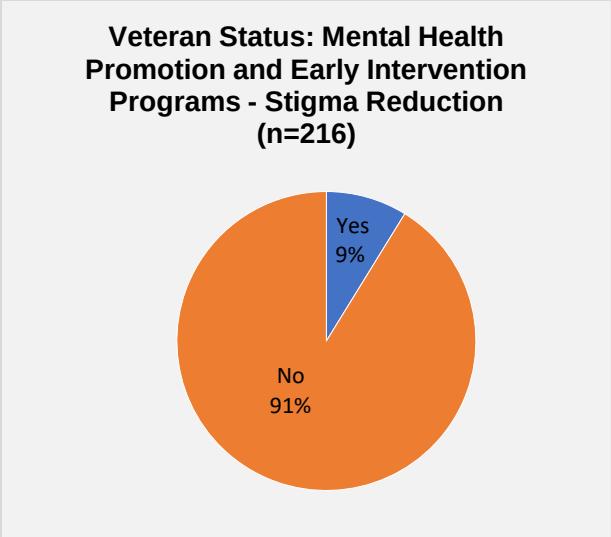
Demographics: Stigma Reduction

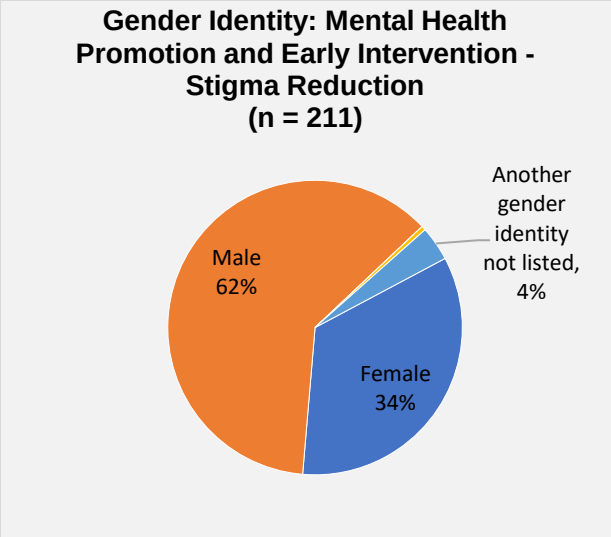


*< 1 percent of clients reported data for 0-15; Age

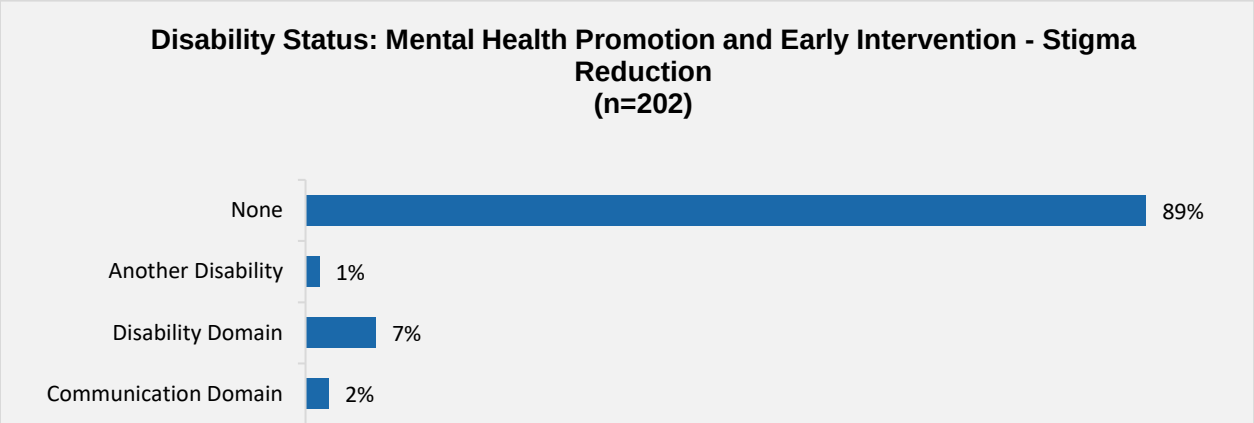
*< 1 percent of clients reported data for Trans Female, Trans Male; Gender







Race/Ethnicity	n	%
Black/African American	<10	5%
American Indian or Alaska Native	<10	2%
Asian	43	26%
Native Hawaiian or Pacific Islander	<10	4%
White	97	59%
Other Race	<10	4%
Hispanic/Latino	38	7%
Non-Hispanic/Non-Latino	494	92%
More than one Ethnicity	<10	1%
Total	701	200%



Sex at birth data is not available for Mental Health Promotion and Early Intervention – Stigma Reduction
**Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.*
**Clients may be counted in multiple categories and therefore percentages do not total 100%.*
Language data was not available for Mental Health Promotion and Early Intervention – Stigma Reduction
In the following table, numeric values represent the number of units (e.g. clients, events, etc.) reported in providers' year-end reports and percentages represent the portion of the stated goal for the fiscal year that those service units comprise.

Program	FY21-22 Key Outcomes and Highlights
Peer Outreach and Engagement Services – Mental Health Association of San Francisco	100% (n=146) of clients who received group support reported feeling less isolated and had more companionship with other people.

School-Based Mental Health Promotion (K-12)

Program Overview

School-Based Mental Health Promotion (K-12) programming – a collaboration of community-based organizations and San Francisco Unified School District (SFUSD) K-12 school campuses – applies best practices that address non-academic barriers to learning. These programs offer students and their families a range of support services, which are offered on-campus during and after the school day so that they are accessible to students and their families. This coordinated, collaborative approach supports students'

academic and personal successes by providing a full spectrum of PEI behavioral health services, as well as linkages to additional support services. These programs build on the strengths of community partners and existing school support services to incorporate a wide variety of philosophies, which are rooted in a prevention or resiliency model, such as youth development, peer education, cultural or ritual-based healing, and wraparound family supports. Services offered at the schools include leadership development, outreach and engagement, screening and assessment, crisis intervention, training and coaching, mental health consultation, and individual and group therapeutic services. Current school-based mental health programs include School-Based Wellness Promotion services at high schools, and Early Intervention Program Consultation at elementary and middle schools.

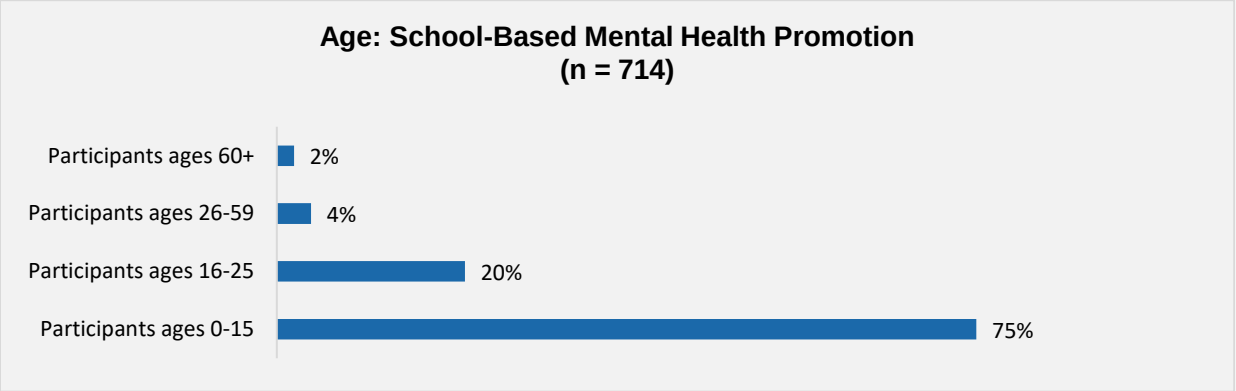
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To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

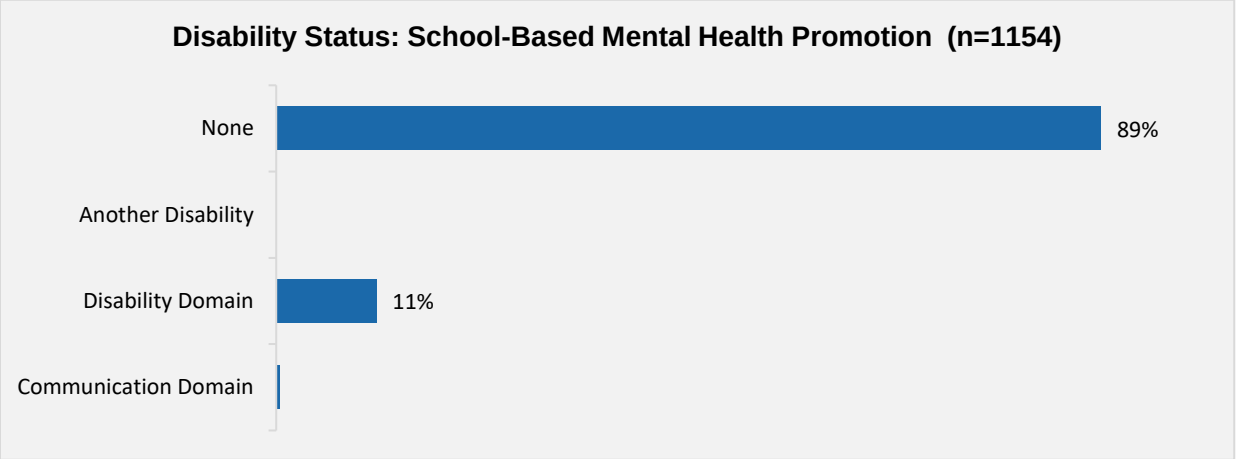
Target Populations

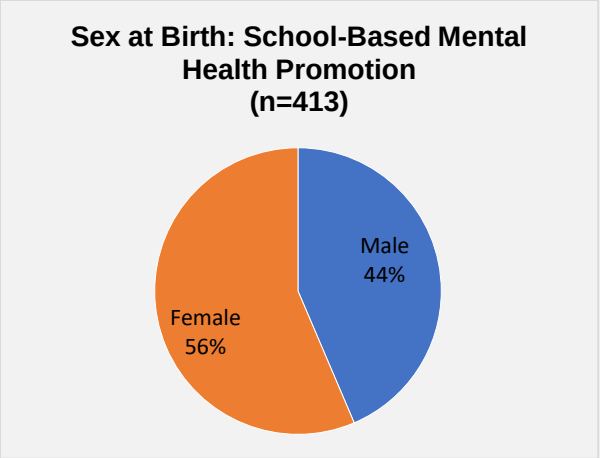
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

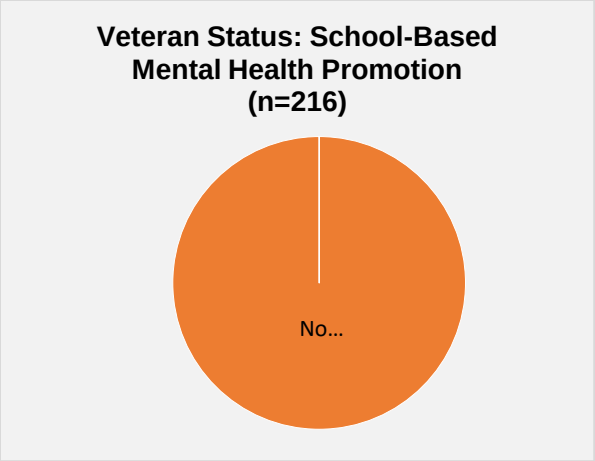
FY21/22 Client Demographics and Outcomes

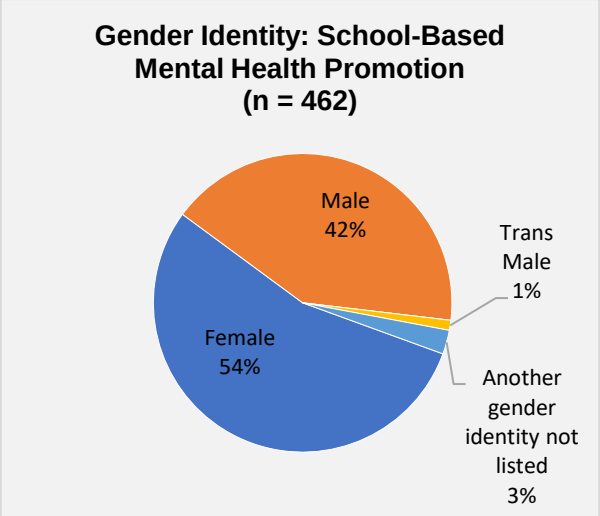
Demographics: School Based Prevention (K-12)

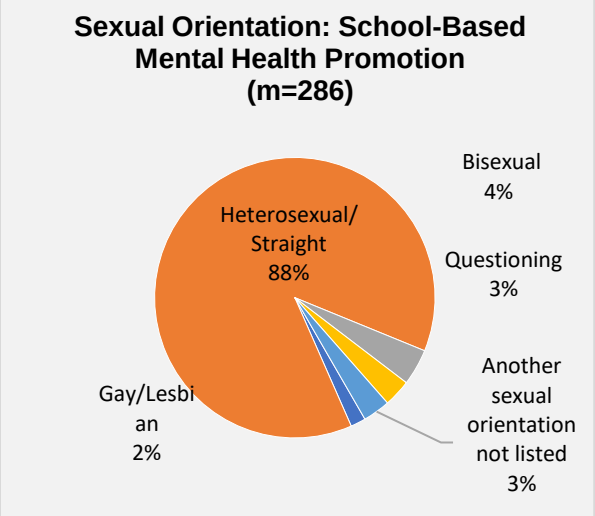












*< 1 percent of clients reported data for Trans Female; Gender
*No clients reported Yes; Veteran Status
*< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	80	24%
American Indian or Alaska Native	<10	-
Asian	99	30%
Native Hawaiian or Pacific Islander	<10	-
White	27	8%
Other Race	121	37%
Hispanic/Latino	241	42%
Non-Hispanic/Non-Latino	318	55%
More than one Ethnicity	21	4%
Total	909	

Primary Language	n	%
Chinese	<10	-
English	354	75%
Russian	<10	-
Spanish	106	22%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	472	

Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.

**Clients may be counted in multiple categories and therefore percentages do not total 100%.*

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

Program	FY21-22 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - Bayview Hunter's Point Foundation	• 100% (n=12) clients were linked to long-term community-based mental health support and services.
Mental Health Services – Edgewood Center for Children and Families	• 70% (n=20) of students showed an increase from pre to post services (with a mean increase of 29%).
Youth Early Intervention – Instituto Familiar de la Raza	• 70% of staff expressed the consultant helped with increased understanding of mental health and socio-economic needs of the student and family.
Wellness Centers – Richmond Areas Multi-Services (RAMS)	• 92% (n=139) reported their need was addressed by a team member, and 88% (n=84) reported feeling supported by the team member.
Trauma and Recovery Services – YMCA Urban Services	• 40% (n= <10) of clients re-engaged in their academic experience.

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

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

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

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

Target Populations

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

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

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

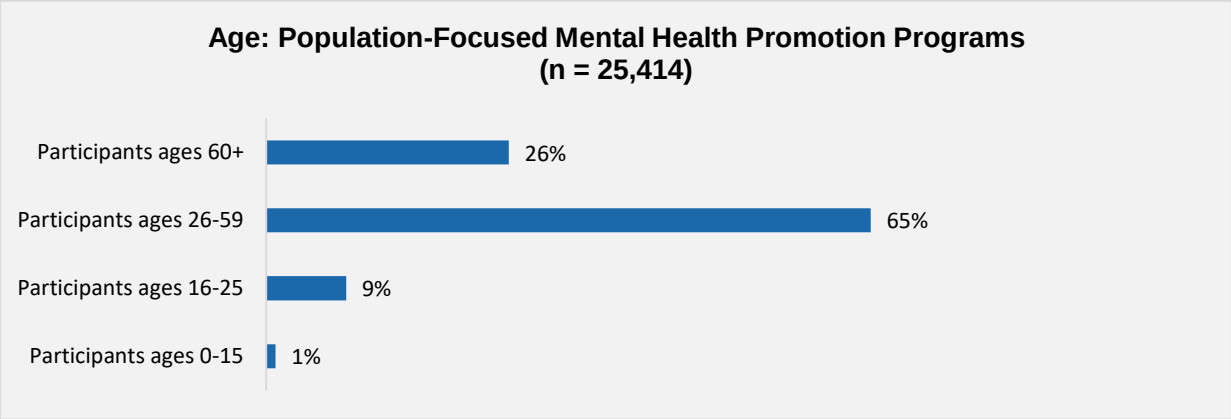
Population-Focused Mental Health Promotion Programs		
Target Population	Program Name *Provider*	Services
Socially Isolated Older Adults	Senior Drop-In Center *Curry Senior Center*	The Curry Senior Drop-in Center is a multi-service center located in the Tenderloin neighborhood. It provides drop-in peer-led wellness-based services, including primary and behavioral health care, case management services, and socialization opportunities.
	Addressing the Needs of Socially Isolated Older Adults *Curry Senior Center*	The program provides peer-based outreach and engagement services to socially isolated older adults with mental health concerns living in the central neighborhoods of San Francisco.
Blacks/African Americans	Ajani Program Westside *Community Services*	The Ajani program helps to build strong families by providing an understanding how healthy families function and by encouraging them to develop leadership, collective responsibility and mentoring skills.
	Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional Initiative*	The Black/African American Wellness & Peer Leadership (BAAWPL) initiative takes a collective impact approach where the City, community, and two lead community-based organizations – the YMCA Bayview and the Rafiki Coalition – that are intent on decreasing the physical and mental health disparities of San Francisco's Black/African American populations.
Asians/Pacific Islanders (API)	API Mental Health Collaborative *Richmond Area Multi-Services (RAMS)*	The program serves Filipino, Samoan and Southeast Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Latinx including Indigenous Mayan communities	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	The program serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance *Native American Health Center*	The program serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure,

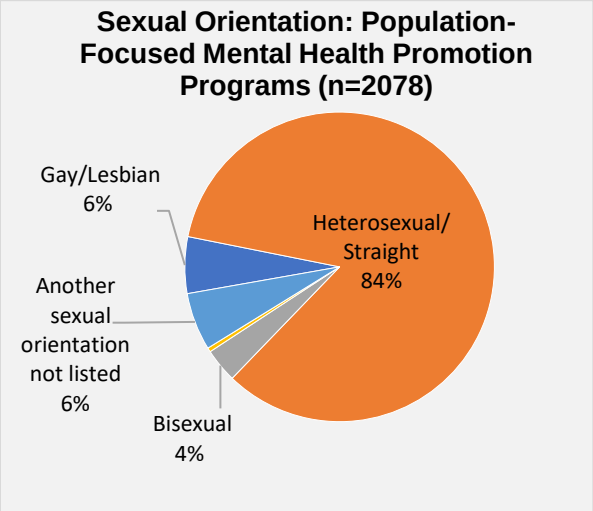
Population-Focused Mental Health Promotion Programs		
Target Population	Program Name *Provider*	Services
		and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles,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

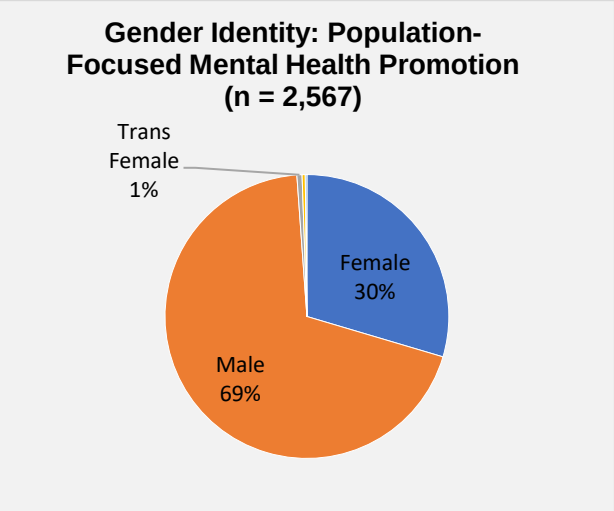
Population-Focused Mental Health Promotion Programs		
Target Population	Program Name *Provider*	Services
Asian/Pacific Islander TAY	Population Specific TAY Engagement and Treatment – Asian/Pacific Islander *Community Youth Center*	TAY population specific programs provide flexible, relationship-focused,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

FY21/22 Client Demographics and Outcomes

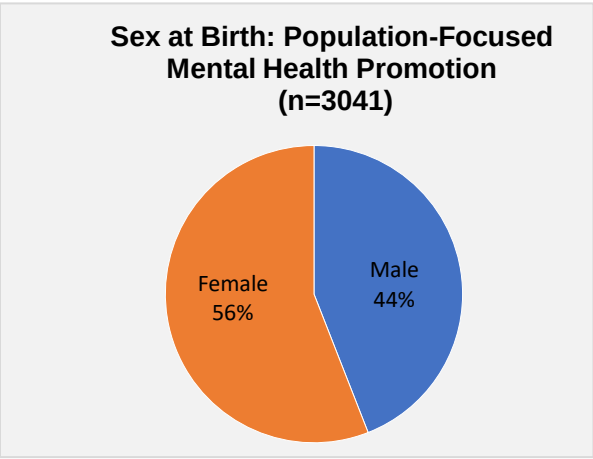
Demographics: Population Focused Mental Health

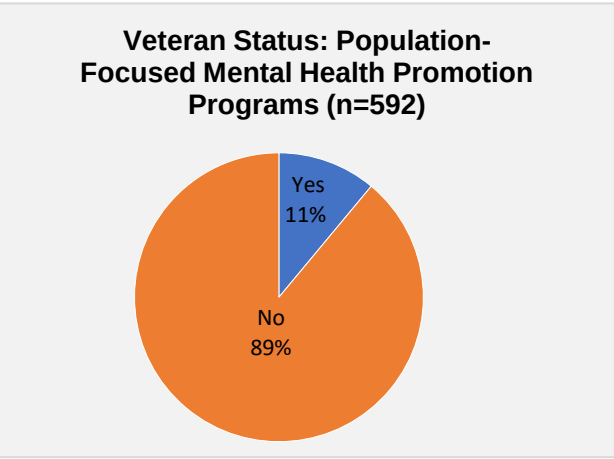


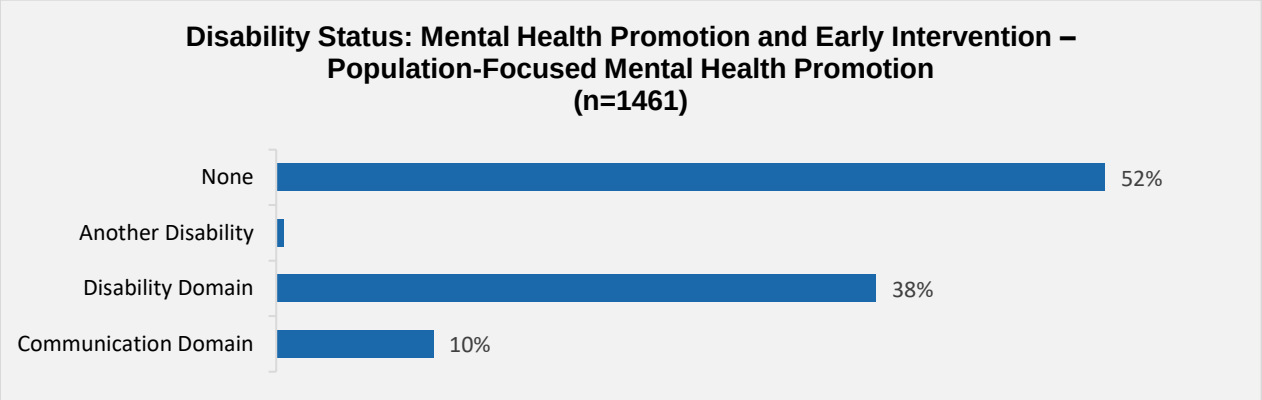




**< 1 percent of clients reported Questioning/unsure; Sexual Orientation*
**< 1 percent of clients reported data for Another gender identity not listed, Trans Male*







< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	5,026	35%
American Indian or Alaska Native	169	0%
Asian	2,860	19%
Native Hawaiian or Pacific Islander	280	2%
White	5,036	34%
Other Race	1,554	10%
Hispanic/Latino	2,391	75%
Non-Hispanic/Non-Latino	652	20%
More than one Ethnicity	138	4%
Total	18,106	
Primary Language	**n**	**%**
Chinese	218	8%
English	1,243	47%
Russian	<10	-
Spanish	377	14%
Tagalog	36	1%
Vietnamese	282	11%
Another Language	479	18%
Total	2,636	

**Clients may be counted in multiple categories*
In the following table, numeric values represent the number of units (e.g., clients, events, etc.) reported in providers' year-end reports and percentages represent the portion of the stated goal for the fiscal year that those service units comprise.
**Due to rounding, total does not equal 100%*

Program	FY21/22 Key Outcomes and Highlights
Senior drop-in Center	• 80% (n=66) of clients attending three activities or more reported increased socialization.
Addressing the Needs of Socially Isolated Older Adults – Curry Senior Center	• 100% (n=119) of isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services (including case management, substance use, mental health, and social support groups).

Program	FY21/22 Key Outcomes and Highlights
Black/African American Wellness and Peer Leadership Program – SFDPH Inter-Divisional Initiative (collaborative of AA Holistic Wellness and SF Live D10 Wellness)	● 100% (n=65) of individuals were linked to wellness services such as food insecurity support, COVID 19 services, family resource centers, and/or physical wellness coaching.
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	● 94% (n=48) of clients reported increased knowledge about how people can be affected by mental health. ● 97% (n=38) of clients agreed they felt better as a result of participating in therapeutic activities.
Indigena Health and Wellness Collaborative – Instituto Familiar de la Raza	● 100% (n=67) of individuals receiving non-clinical case management achieved at least one goal in their case/care plan.
Living in Balance – Native American Health Center	● 39% (n=15) of individuals receiving case management achieved at least one early intervention advocacy goal.
South of Market Self-Help Center (6th Street) – Central City Hospitality House	● 100% (n=58) of community members with a written case plan achieved at least one case plan goal.
Tenderloin Self-Help Center - Central City Hospitality House	● 100% (n=63) of community members with a written case plan achieved at least one case plan goal.
Community Building Program - Central City Hospitality House	● 100% (n=37) of clients achieved at least one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - Instituto Familiar de la Raza	● 100% (n=28) of transition age youth who were connected by program staff to internal behavioral health services attended an initial appointment or meeting.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander - Community Youth Center	● 95% (n=60) of Asian/Pacific Islander transition age youth receiving our case management services successfully attained at least one of their treatment goals.
Population Specific TAY Engagement and Treatment – LGBTQ+ - SF LGBT Center	● 100% of youth referred to mental health services received follow-up calls and were moved from waiting lists to assessment and intake.
Population Specific TAY Engagement and Treatment – Black/African American – Larkin Street Youth	● 89% of transition age youth who were connected by program staff to internal or external behavioral health services attended an initial appointment or meeting.

Program	FY21/22 Key Outcomes and Highlights
Services and Third Street Youth Center	
Population Specific TAY Engagement and Treatment – Juvenile Justice/Others - Huckleberry Youth Programs	● 100% (n= 99) of youth referred to behavioral health services participated in at least one initial appointment.
TAY Homeless Treatment Team – Larkin Street Youth Services	● 75% of clients who received program treatment and healing services maintained their outcomes (i.e., they neither regressed nor progressed; rather, they maintained stability)

Early Childhood Mental Health Consultation Initiative

Program Overview

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

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the evidence-based work[20] of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and delivered in the following settings: center-based and family childcare, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. Four county agencies provide funding and partnership to deliver ECMHCI: SFDPH/BHS; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco.

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

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

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

Target Populations

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

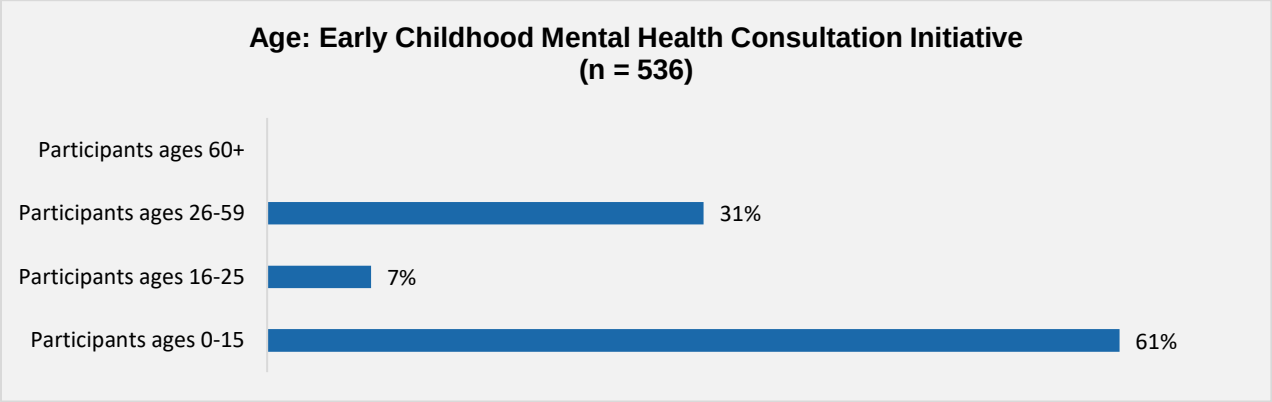
[20] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91

homelessness, and other challenges. The program works with children and families facing early developmental challenges.

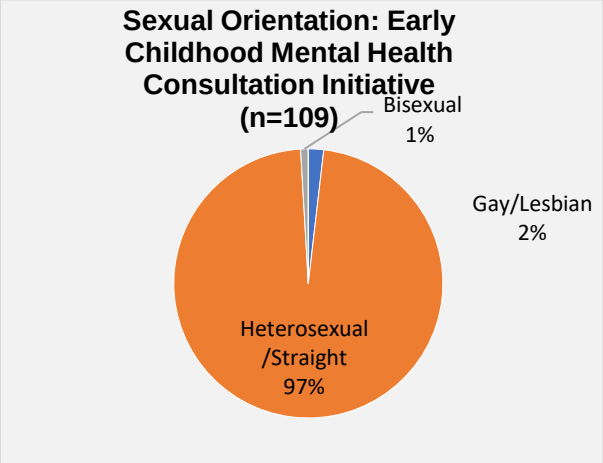
Early Childhood Mental Health Consultation Initiative	
Program Name	**Services Description**
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Infant Parent Program/Day Care Consultants ***UCSF***	An infant and early childhood mental health program, the Infant-Parent Program (IPP) focuses on relationships between young children and their adult caregivers. The IPP embeds perinatal mental health specialists in the Obstetric 5M Clinic at Zuckerberg San Francisco General Hospital. In-clinic mental health treatment is provided to high risk, mostly immigrant, and indigent pregnant people. The aim of the program's intervention is to reduce psychiatry symptoms in those about to be parents, thereby improving their parental functioning and, in turn, the outcomes for their children. Families seen in this program are overseen through labor and delivery, and, if needed, the Neonatal Intensive Care Unit and Pediatric Clinics to ensure continuity of care.
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Edgewood Center for Children and Families	The Edgewood program works to tailor services to meet the unique and common needs of all clients, including conversations with struggling students, which yields a more focused understanding of the obstacles they are encountering and taking a collaborative approach to remedy the problem and put them on a positive path. Parental support is also provided by asking questions to better understand their challenges, concerns, and needs, helping them to better understand what works and what does not work as it relates to getting support. For this program, it is important to meet parents "where they are" without judgement and drawing from shared/common experiences to best support them. These services promote resiliency for students, staff, and the families we serve.
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Fu Yau Project ***Richmond Area Muli-Services***	Fu Yau Project is one of five grantees of ECMHCI, which has combined five funding sources. In 2021, we connected with the Family Child Care Association of San Francisco's leadership to help foster their role in the program services as co-facilitators. During FY2022, we made changes to the program; instead of having two different topics per month, our two facilitators work together on one topic. These groups were facilitated in Cantonese and Mandarin, two core languages spoken by our clients. During COVID-19, virtual services were available, allowing the Mental Health Consultant the ability to continue monthly support groups focused on parent/caregiver support with an average of 12 clients per meeting.
Early Childhood Mental Health Consultation Initiative (ECMHCI) – Homeless Children's Network	Due to COVID-19, all discussions and work surrounding the redesign of this program were placed on hold, given the high demand for mental health support in 2020-2021. Currently, joining funders are working in partnership, including Clarity Consulting Group, to gather data and client feedback as the beginning stages of the redesign take shape. Many consultation sites have slowly reopened following the pandemic, and guidance on how best to provide support has been coordinated at each site. Additionally, the program received three new consultation sites, increasing the overall program budget. Our diverse team of consultants hold a strong, relationship-focused, equitable, and trauma-informed approach to services, maintaining high standards of care.

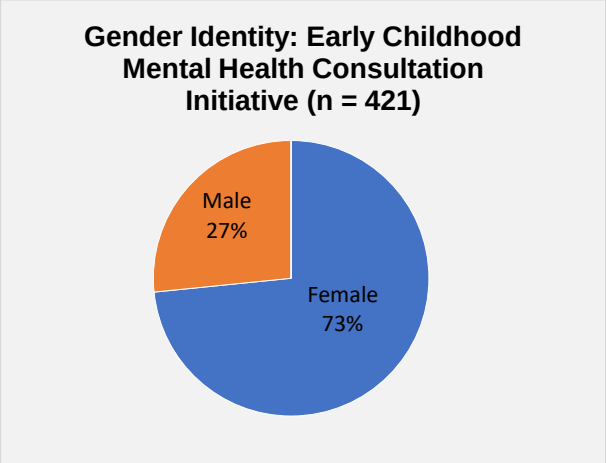
FY21/22 Client Demographics and Outcomes

Demographics: Early Childhood Mental Health Consultation Initiative



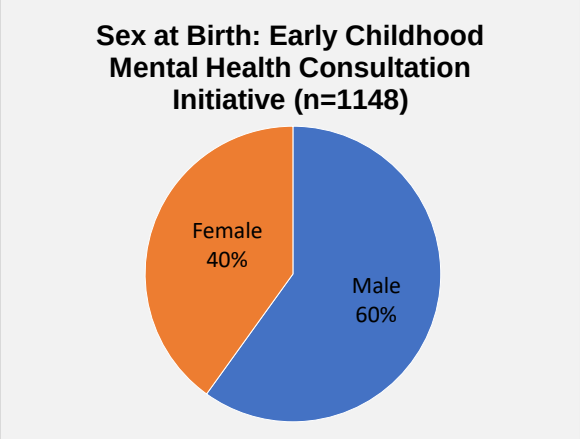
*< 1 % of clients reported data for Older Adult (60+) for Age

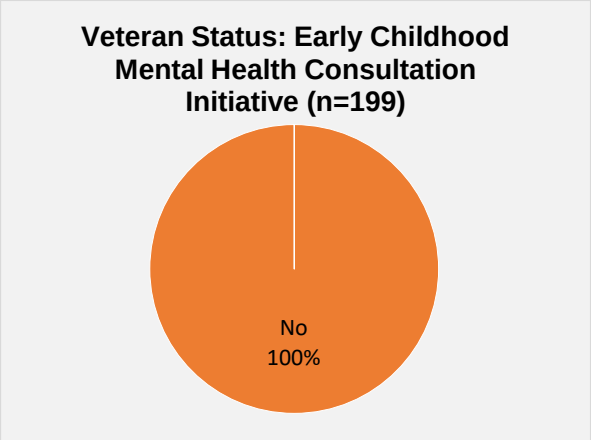




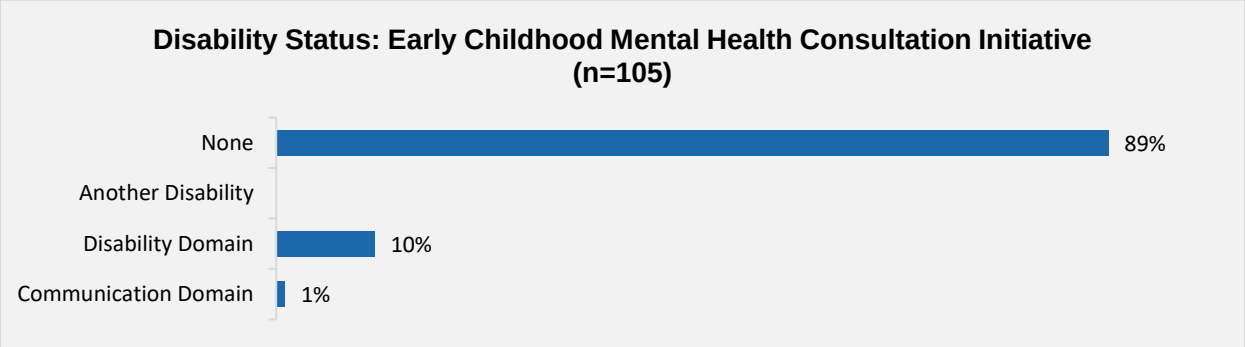
*< 1 percent of clients reported Another Sexual Orientation Not Listed, Questioning/unsure; Sexual Orientation

*< 1 percent of clients reported data for Another gender identity not listed, Trans Female, Trans Male; Gender





*No clients reported Yes; Veteran Status



*< 1 percent of clients reported data for Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	189	28%
American Indian or Alaska Native	<10	-
Asian	254	38%
Native Hawaiian or Pacific Islander	26	4%
White	96	14%
Other Race	98	15%
Hispanic/Latino	811	98%
Non-Hispanic/Non-Latino	12	1%
More than one Ethnicity	<10	-
Total	1,500	

Primary Language	n	%
Chinese	214	31%
English	330	48%
Russian	<10	-
Spanish	135	20%
Tagalog	<10	-
Vietnamese	<10	-
Another Language	<10	-
Total	688	

Cell sizes with fewer than 10 clients are represented as "<10" to protect the privacy of clients and not compromise anyone's identity.
Clients may be counted in multiple categories and therefore percentages do not total 100%.

Program	FY21-22 Key Outcomes and Highlights
Infant Parent Program Day Care Consultants	• 74% (n = 16) of parents who received four or more mental health treatment sessions focused on parenting ended services; 100% (n = 6) reported services to be excellent and would recommend the program to other pregnant people
Edgewood Center for Children and Families	• 70% (n = 20) of classroom teachers reported feeling more successful in dealing with challenging student behaviors on their own

Comprehensive Crisis Services

Background and Community Need

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

Program Overview

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

Target Populations

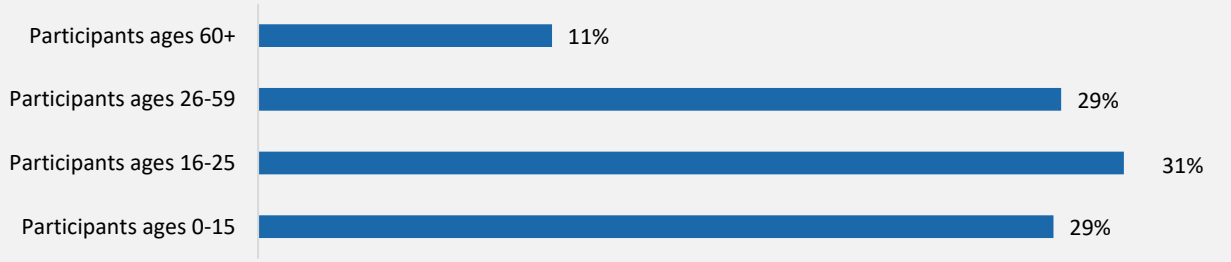
The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and in need of support.

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

FY21/22 Program Outcomes and Highlights

Demographics: Comprehensive Crisis Services

Age: Comprehensive Crisis Services (n=704)



Program	FY21-22 Key Outcomes and Highlights
Comprehensive Crisis Services – SFDPH	• Four new staff members were hired to better respond to crises. A new roving team was implemented to provide more services in the field

PEI Funding Table

Program Name	Childhood Trauma Prevention and Early Intervention	Early Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	Culturally Competent and Linguistically Appropriate Prevention and Early Intervention	Strategies Targeting the Mental Health Needs of Older Adults	Early Identification Programming of Mental Health Symptoms	Fiscal Year 2023/24 MHSA Funds	Fiscal Year 2024/25 Estimated MHSA Funds	Fiscal Year 2025/26 Estimated MHSA Funds
PEI 1. Stigma Reduction	✓	✓	✓	✓	✓	✓	✓	$ 1,639,120	$217,175	$223,691
PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	✓	✓	✓	✓			✓	$1,168,953	$1,211,776	$1,250,145
PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	✓	✓	✓	✓	✓	✓	✓	$10,006,686	$10,306,886	$10,367,814
PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	✓	✓	✓	✓	✓		✓	$1,268,226	$1,310,890	$1,351,417

PEI 6. Comprehensive Crisis Services (10% Prevention)	✓	✓	✓	✓			✓	$611,336	$654,877	$ 681,072
PEI 7. CalMHSA Statewide Programs	✓	✓	✓	✓	✓	✓	✓	$41,388	$41,388	$1,900,990

Evaluation Tools

Please see below for our current evaluation tools that are used to gather data from program providers and community members. Evaluation data are gathered two times per year through our MHSA Year-End and MHSA Mid-Year Report tools. These evaluation tools gather information from each PEI program for the “Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies”, per PEI Regulations.

Mental Health Services Act (MHSA)

FY21-22 YEAR-END PROGRAM NARATIVE REPORT

July 1, 2021 through June 30, 2022

Program Name:	
Organization:	
Staff Preparing Report:	
Phone:	
Email:	

INSTRUCTIONS:

- This program report should include all MHSA-funded activities conducted from July 1, 2021 through June 30, 2022.
- A separate report must be submitted for each program.
- **Full Service Partnership (FSP) programs are exempt from the Demographic Data Report. FSP Programs are required to submit the FSP Narrative Report only.**
- This report needs to be completed and submitted via e-mail to Hannah Abarquez, hannah.abarquez@sfdph.org by **Friday, September 16, 2022**.

Report Type	Report Components	Program Type	Reporting Period	Due Date
Year-End Report	1) Demographic Data	All Programs except FSPs	07/01/2021 - 06/30/2022	09/16/2022
	2) Program Narrative	All Programs including FSPs	07/01/2021 - 6/30/2022	09/16/2022

Please note that the program report consists of the following two parts:

- **PART 1** includes Head Count and Demographic Data.
  - **Demographic Data Report is NOT required for FSP programs**
- **PART 2** includes the Program Narrative and begins on page 2 of this document.
  - **FSP Programs should use the template titled "FSP - Program Narrative Report Template_MHSA FY21-22 YEAR-END Report"**

PART 2: PROGRAM NARRATIVE

1. For each of your finalized program objectives for FY21-22, briefly describe your progress using a summary of the data collected.

For example: *Objective: By June 30, 2022, 100 new participants will be screened for behavioral health issues, as measured by the assessment conducted by case managers and recorded in the monthly intake assessment forms. Results: 109 participants were screened, exceeding our goal (109%)*

Be sure to include both a number and percent.

Please ensure the Program Objectives that you are reporting on match with the MHSA FY21-22 Performance Objectives as they are listed on the CDTA website for your program: https://www.sfdph.org/dph/comupg/aboutdph/insideDept/CDTA/documents-PO.asp

Note: If your program falls under a different System of Care (SOC), other than MHSA, please refer to the appropriate SOC Performance Objectives document.

2. Briefly describe any key changes to your program, such as staff, community, location, and/or budget. Please specifically highlight any program changes due to COVID-19.

3. Briefly describe any key challenges, lessons learned, and/or successes your program experienced. Please specifically highlight any key challenges, lessons learned and/or successes as a result of COVID-19.

4. If the program **employs consumers/participants (i.e. peers),** please provide the total amount of MHSA funding allocated to hire peers, the number of FTEs dedicated for peer employment, and the number of individuals employed in those positions.

TOTAL amount of <u>MHSA funding</u> allocated to hire peers in FY 21-22:	
TOTAL number of <u>FTEs</u> dedicated for peer employment in FY 21-22:	
TOTAL <u>number of peers</u> employed in those positions in FY 21-22:	

Feel free to provide any additional comments regarding Question #4. If your program does not employ peers, please explain why it does not.

5. In addition to consumer employment, MHSA is built upon the following **guiding principles:**

- Cultural Competence. Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
- Community Collaboration. Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
- 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.
- Integrated Service Delivery. Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.
- 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.

A. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

6. Each MHSA program must collect information on client/participant experience, feedback, or satisfaction with the programming provided. There is no minimum number or % of participants required to provide feedback, but a reasonable effort must be demonstrated. The standard BHS Client Satisfaction Survey or any tool devised may be used.

- **A.** Please describe, in 1-2 sentences, your effort to collect feedback from program participants (i.e. method used).
- **B.** Summarize the results.
- **C.** What was learned from the participant feedback (1-2 key points)?
- **D.** Describe how the findings were reviewed by staff.
- **E.** What programmatic change(s) were adopted as a result of the findings?

If possible, please attach a copy of the survey/feedback tool or form (blank template) that your program utilized (if using something other than the standard BHS Client Satisfaction Survey) when you submit the Year-End Report.

7. Please share one of your participant success stories.

8. Please briefly describe how your program is screening or assessing for substance use disorders (SUD). If your program is not currently screening or assessing for SUD, please enter Not Applicable (N/A).

If you answered the question above, please complete the following:	
a) Number of people assessed for co-occurring Mental Health (MH) and SUD:	
b) Number of people assessed for co-occurring MH and SUD who were ultimately determined to have only an SUD without another co-occurring MH condition:	

San Francisco Health Network
Behavioral Health Services

Mental Health Service Act (MHSA)
FY20-21 YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT
July 1, 2021 through June 30, 2022

Instructions: This program report should include program participants served by MHSA-funded activities conducted between July 1, 2021 through June 30, 2022. A separate report must be submitted for each program. All MHSA-funded programs, **except** Full Service Partnership (FSP) programs, are required to complete the Year-End Demographic Data Program Report. Fill in each blue box with the appropriate information. However, programs will be able to provide a brief explanation if your program is unable to collect data for any part of this report.

Please remember that this program report is separate from other fiscal, performance, and compliance monitoring conducted by San Francisco Department of Public Health, Behavioral Health Services.

Please note that this Demographic Data Report is PART 1 of the Year-End Program Report, which consists of two parts. PART 2 includes the Program Narrative Report.

This report needs to be completed and submitted via e-mail to Hannah Abarquez at Hannah.Abarquez@sfdph.org by Friday, September 16, 2022.
We thank you for all your great work and continued service to the community!

MHSA Program Name:	
Organization:	
Staff Preparing Report:	
Phone:	
Email:	

Box A: Please provide the total number of individuals served July 1, 2021 through June 30, 2022 through MHSA funding. For any blue box left empty, please provide a brief reason explaining why the data was not collected.

A.1. Total number of individuals (including duplicates) served:	
A.2. Total number of unduplicated individuals served:	
A.3. Total number of unduplicated individuals at risk **(see endnote #1)** for mental illness (prevention) served:	
A.4. Total number of unduplicated individuals with early onset of a mental illness (early intervention) served:	

A.5. Please indicate a **percentage estimate** of clients this program served in FY21-22 who were experiencing homelessness **(see endnote #2)** at the time of service (if data is available):	

FY21-22 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

CURRENT GENDER IDENTITY	
Female	
Male	
Trans female*	
Trans male**	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**0**
If another identity is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**0**
If another disability is counted, please specify:	

SEX AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	**0**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

Box B: Please provide the numbers in the blue boxes for the demographic data as listed below:

FY21-22 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

AGE CATEGORIES	
0-15 yrs	
16-25 yrs	
26-59 yrs	
60+	
Declined to answer	
Unknown	
TOTAL	**0**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/straight	
Bisexual	
Questioning/unsure	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**0**
If another group is counted, please specify:	

***** Trans female – transgender women, transfeminine, or transwomen, sometimes referred to as male-to-female or MTFs

****** Trans male - transgender men, transmasculine, or transmen, sometimes referred to as female-to-male or FTMs

*** See endnote #3 for the definition of disability

FY21-22 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

Please report on the following major race/ethnic categories of participants (OK to choose more than one category).

RACE/ETHNICITY	
Black or African American	
American Indian or Alaska Native	
Asian	
Native Hawaiian or Other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	
TOTAL	0
If another race/ethnicity is counted, please specify:	

Hispanic or Latino	
Non-Hispanic or Non-Latino	
More than one ethnicity	
Declined to answer	

FY21-22 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

If appropriate to your program, please report on additional ethnicity categories for your participants.

Additional Ethnicity	
African	
Caribbean African	
Central American	
Chicano/Mexican American	
Mexican	
Puerto Rican	
South American	
Alaska Native	
First Nation (Canada)	
Indigena (Mexico, Central, & South America)	
Asian Indian	
Cambodian	
Chinese	
Filipino	
Hmong	
Japanese	
Korean	
Laotian	
Thai	
Vietnamese	
Native Hawaiian	
Pacific Islander	
Guamanian	
Samoan	
Tongan	
Eastern European	
European	
Middle Eastern	
Another ethnicity not listed	
If another ethnicity is counted, please specify:	

PRIMARY LANGUAGE	
Chinese	
English	
Russian	
Spanish	
Tagalog	
Vietnamese	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	0
If any other languages, please specify:	

For Chinese language total count above, please provide Dialect count (if data is available)	
Cantonese	
Mandarin	

FY21-22 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

For any demographic data marked as unknown or not collected in Box B, please provide a brief reason why in the blue boxes below:	
Type of demographic data unknown or not collected	**Reason not collected**

Box C: If your program serves families, please provide the total number of family members served. For any blue box left empty, please provide a brief reason explaining why the data was not collected.	
Total number of unduplicated family members served:	

Box D: For programs that perform outreach activities, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness [see endnote #4], provide support, and or refer individuals who need treatment) reached. For any blue box left empty, please provide a brief reason explaining why the data was not collected.	
Types of responders (i.e., employers, nurses, school personnel, promoters, etc.) reached & types of settings (i.e., schools, senior centers, churches, etc.) where potential responders were engaged:	*Example: 2 nurses at schools, 15 parents at schools, 15 parents at community centers, 15 teachers at schools, 5 police officers at community centers, & 1 police officer at a school.*

Box E: For programs that refer (see endnote #5) individuals with severe mental illness, please provide information for the categories below (for any blue box left empty, please provide a brief reason explaining why the data was not collected):	
E.1. Unduplicated number of individuals with severe mental illness referred to treatment:	
E.2. Types of treatment individuals were referred to:	

E.3. For internal referrals only (see endnote #6). Unduplicated number of individuals who followed through on referral and participated at least one time in referred program:	

E.4. For internal referrals only. Average duration of untreated mental illness for persons who are referred to treatment and who have not previously received treatment:	
E.5. For internal referrals only. Average interval between referral and participation at least one time in referred treatment program:	

Box F: For programs that refer underserved populations to services, please provide information for the categories below (for any blue box left empty, please provide a brief reason explaining why the data was not collected):	
F.1. Please specify the types of underserved populations (i.e., homeless, immigrant, communities of color, isolated older adults, etc.) that were referred to prevention program services:	
F.2. Total number of referrals of underserved populations to prevention services (see endnote #7), early intervention services (see endnote #8), or to treatment beyond early onset:	
F.3. For internal referrals only. Number of unduplicated individuals who followed through on referral and participated at least one time in referred program:	
F.4. For internal referrals only. Average interval between referral and participation at least one time in referred treatment program:	
F.5. Please describe ways your program encourages access to services and follow-through on referrals:	

THANK YOU FOR COMPLETING THIS REPORT

San Francisco Health Network
Behavioral Health Services

Endnotes - Definitions as provided by the PEI Regulations

(1) Risk factors for mental illness: include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, traumatic loss (e.g. complicated, multiple, prolonged, severe), having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

(2) Literally Homeless (definition from U.S. Dept. of Housing & Urban Development): Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
(i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
(ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
(iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution**.**

(3) Disability: physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

(4) Severe mental illness: a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

(5) Referral: Process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral.

(6) Internal referral: A referral made to a program which is provided, funded, administered, or overseen by the City and County of San Francisco mental health system. This includes referrals to programs within your agency or others within San Francisco.

(7) Prevention services: a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

(8) Early intervention services: treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

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

SF Mental Health Services Act Three-Year Integrative Plan FY23/24 – FY25/26

Jessica Brown, Director, Office Justice, Equity, Diversity, and Inclusion/Behavioral Health Services Act

SFBOS Budget and Finance Committee

May 22, 2024

San Francisco Health Network
Behavioral Health Services

Agenda

1. Overview of Mental Health Services Act (MHSA)
2. FY 21/22 Selected Outcomes
3. MHSA Three Year Integrative Plan - FY23/24 to FY25/26
4. Prop 1 and Behavioral Health Services Act (BHSA)

Mental Health Services Act Overview

MHSA Enacted into law in 2005

1% tax on personal income over $1 million

Designed to support the transformation of the mental health system to address unmet needs

Based on a set of core principles

MHSA's 5 Funding Components:
San Francisco's 7 Service Categories, funding 85 programs

Community Services & Supports (CSS)

Innovation (INN)

Prevention and Early Intervention (PEI)

Workforce Education and Training (WET)

Capital Facilities and Technology Needs (CF/TN)

1. Recovery-Oriented Treatment
2. Mental Health Promotion
3. Peer-to-Peer Support Services
4. Vocational Services
5. Housing for FSP Clients
6. Workforce Development
7. Capital Facilities and Information Technology

FY21/22 Selected Outcomes

These outcomes are a small sample of the outcomes we achieved. Please see our full Three-Year Plan for all outcomes reported.

- Sustaining funding for current programs and services with demonstrated impact;
- Providing additional funding to strengthen population-focused: Mental Health Promotion and Early Intervention Programs;
- Expanding the San Francisco Dream Keeper Initiative (www.dreamkeepersf.org), which provides comprehensive support for 300 Black/African American families struggling to meet basic needs due to systemic failure and educational activities for 500 Black/African American youth;
- Piloting a project to bring culturally affirming patient navigation support to the City's Chinatown North Beach Clinic;
- Developing a Request for Proposal for Community-Based Organizations to provide mental health services to Black/African American Birthing People
- Providing Talk Therapy to Black/African American clients throughout San Francisco;
- Providing support to various clients within our population-focused programming:
    - 97% of clients (n=38) within the Asian/Pacific Islander Mental Health Collaborative reported an increase in their quality of life and "feeling better", as a result of participating in therapeutic activities.

Peer Specialists are Critical to MHSA

MHSA emphasizes the importance of consumer participation in the mental health workforce. Peer Certification programs were created collaborating with Richmond Area Multi-Services, San Francisco State and City College of San Francisco. In addition, all MHSA programs are encouraged to hire peers as members of program staff. **SF-MHSA funded 258 peers in FY21/22** throughout our behavioral health system. Consumers can be found working in almost all levels and types of positions, including: peer counselors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management.

Emphasis on Evaluation

We place a strong emphasis on program evaluation across the MHSA components. Over the past years, we worked hard to enhance our monitoring and evaluation activities in order to effectively meet the objectives of our MHSA-funded programs.

- ✓ Increased the integration of MHSA principles into the larger BHS System
- ✓ Improved tracking efforts of ICM to Outpatient referrals and outcomes
- ✓ Increased evaluation efforts of Innovation Projects
- ✓ Improved SMART objectives for MHSA contracts
- ✓ Improved evaluation frameworks for new Request for Qualifications (RFQs)
- ✓ Increased evaluation efforts with Gender Health SF
- ✓ Improved the monitoring of PEI evaluation activities

FY21-22 Program Outcomes

Full-Service Partnership (FSP) Programs

- ✓ **86% decrease in arrests** for adults.
- ✓ **87% decrease** in mental health & substance use disorder **emergencies** for adults.
- ✓ A **decreased** percentage of clients experienced **Residential Treatment and Hospitalizations** in the most recent year (**18% down from 25%, and 18% down from 28%,** respectively).

Population-Focused Programs

- ✓ **97%** of clients within the Asian/Pacific Islander Mental Health Collaborative reported an **increase in their quality of life** and "feeling better", as a result of participating in therapeutic activities.
- ✓ **80%** of older adult clients attending the Senior Drop-In Center activities reported **increased socialization**.

Vocational Services

- ✓ **100%** of graduates from the i-Ability Vocational IT Program reported **improved coping abilities and increased readiness** for employment or additional activities related to vocational services.

Peer-to-Peer Support Services

- ✓ **91%** of Peer-to-Peer, Family-to-Family clients **reported an increased understanding** of their mental health needs and were better able to understand behavioral health signs.

FY23-26 Three-Year Integrative Plan

Each year BHS/MHSA is required to collect community and stakeholder input and integrate this feedback into all areas of MHSA programming. A Three-Year Integrative Plan or Annual Update is required each year.

The FY23-26 Three-Year Integrative Plan is a report that includes community program planning input, program outcomes/highlights from FY21/22 and plans for FY23/24, FY24/25 and FY25/26.

Community Program Planning Process

- ✓ In 2022, SF-MHSA hosted **16 community engagement meetings** across the City.
- ✓ Over **165 individuals participated** in these Community Program Planning meetings.
- ✓ Community member feedback helped shape existing and future MHSA programming, and the FY23-26 Three-Year Integrative Plan.

We increased our outreach efforts to include more involvement with certain stakeholder groups:

- Local veterans
- Transition Age Youth
- Vocational program participants
- Older Adult community
- LGBTQ+ community
- Primary care and medical staff
- Employees of municipal agencies
- Law enforcement
- Maternal health providers
- SFDPH Department of Equity
- Black/African American and Latinx Communities

Spotlight on SF's Changing Needs

San Francisco faces various crises of mental illness, overdose, homelessness, and housing insecurity—each factor exacerbated by the high cost of living and the compounding effects of trauma and systematic racism.

MHSA is committed to being a part of San Francisco's mental health system transformation that provides mental health care to all San Franciscans who lack insurance or who are experiencing homelessness.

- **MHSA provides 51% of its funding to address serious mental health and co-occurring substance use challenges through our Full-Service Partnership programs.**
- **MHSA provides comprehensive housing programs to better meet the needs of unhoused individuals.**
- **MHSA has population-focused programs that address racism and equity issues.**
- **The Wellness in the Streets program primarily works with individuals directly on the street and provides peer services, support and interventions in the community.**

FY23-24 through FY25-26 Three-Year Plan

The proposed MHSA Three-Year Plan includes the following:

- Sustaining funding for the current 85 MHSA programs and services that have demonstrated to have a significant positive impact on San Francisco communities;
- Continuing to implement, support and evaluate the newly funded MHSA programs:
  - Improving Maternal Mental Health for Black/African American Birthing People
  - Homeless Children's Network MA'AT Program
  - Kummba Peer Fellowship Program
  - FUERTE
  - Wellness in the Streets
  - Technology Assisted Mental Health Solutions
  - Culturally Responsive Practices for the Black/African American communities;
- Continuing to grow Full-Service Partnerships (FSPs) by expanding treatment slots;
- Continuing to monitor and engage in stakeholder collaborative meetings regarding
- Senate Bill 326 that proposes the modernization of the Mental Health Services Act.

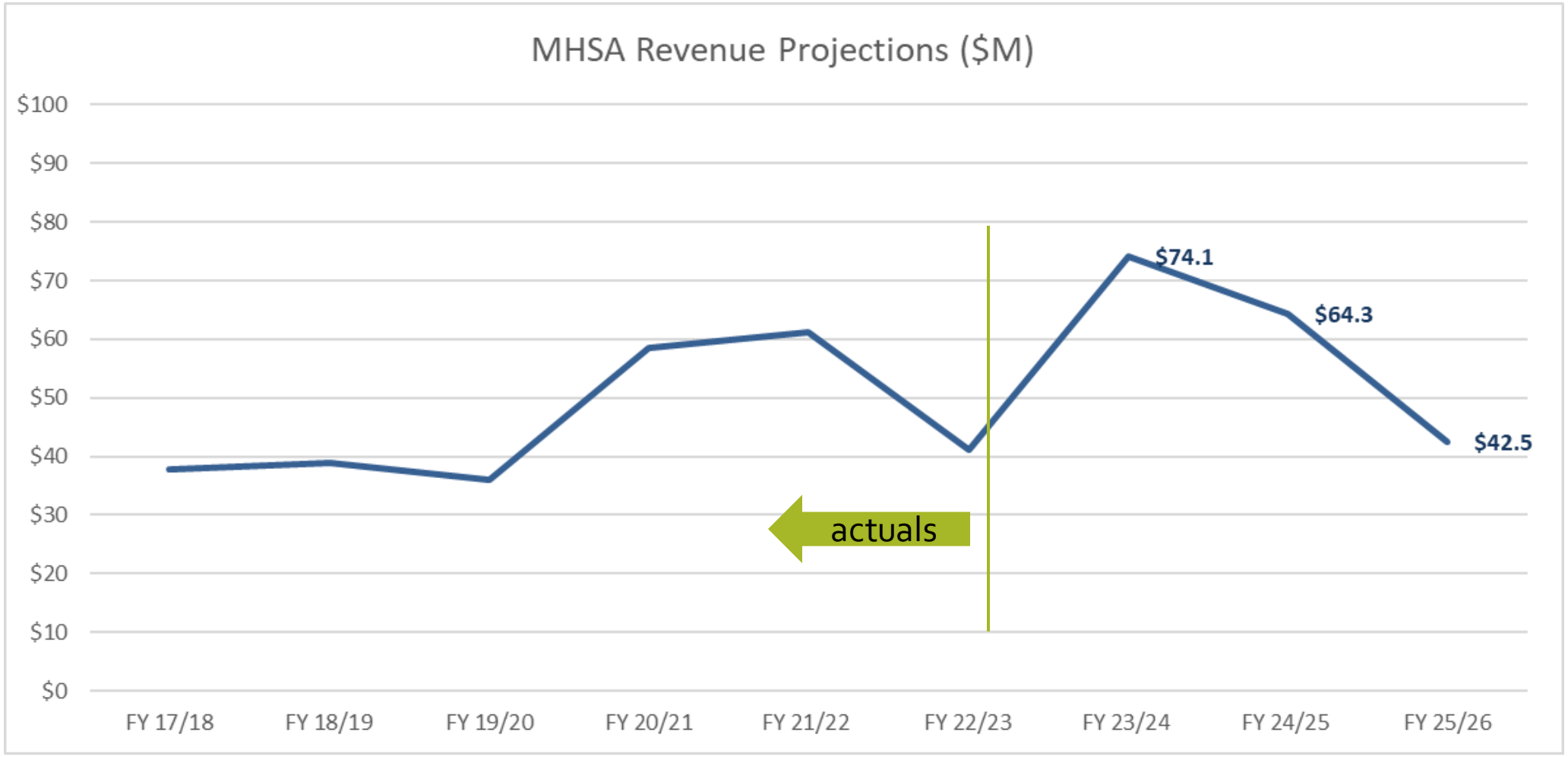
MHSA Three-Year Plan - Proposed Budget

MHSA budget is 13% of overall DPH-BHS budget

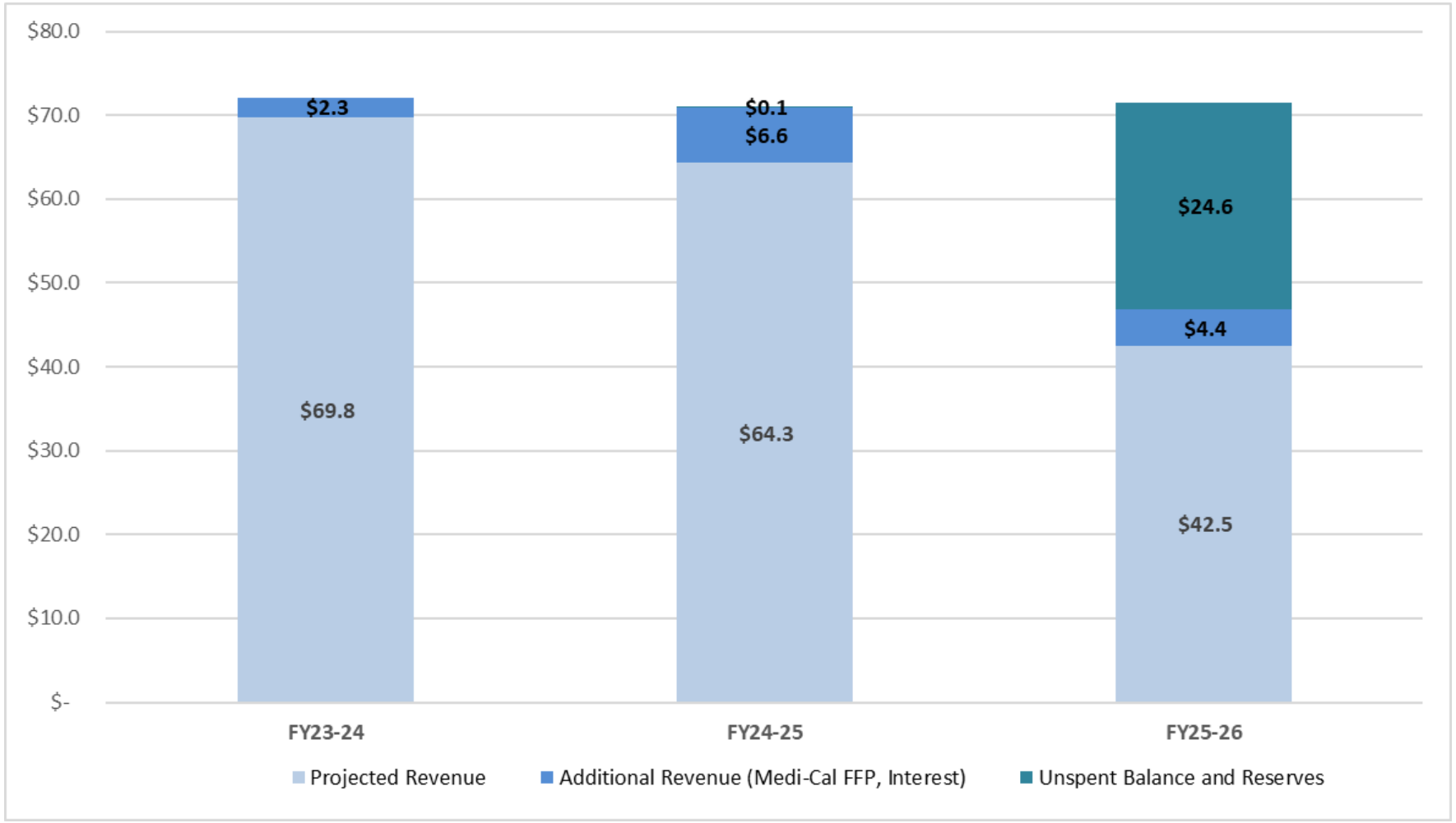
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Total
FY 23/24 Expenditures	$40.5M	$16.5M	$3.2M	$6.2M	$5.6M	**$72.1M**
Estimated FY 24/25 Expenditures	$42.0M	$15.7M	$2.2M	$6.1M	$5.0M	**$71.0M**
Estimated FY 25/26 Expenditures	$43.4M	$15.9M	$1.8M	$6.2M	$4.1M	**$71.4M**

Note: Spending plan developed prior to passing of Prop. 1

MHSA is a Volatile Revenue Source



Prior Year Unspent Balances and Reserves Are Needed to Support 3 Year Spending Plan Expenditures



At the end of FY 25-26, MHSA is projected to have $7.3M prudent reserve and $14.6M of additional balance.

Prop 1 (March 2024)

- Next Three-Year Plan (FY 26/27-FY 28/29) will reflect adjusted programming in alignment with the redesigned program categories under Prop 1, and will appear under the new program name, the **Behavioral Health Services Act (BHSA)**
- According to State guidelines, the implementation timeline is **until July 1, 2026**, to meet Prop 1 requirements.
- **Current MHSA spending is not fully in alignment with the BHSA.** DPH will be planning to bring our programming into alignment as the State releases additional guidance.
- State guidance on the next three-year plan will be released throughout 2025.

DHCS Initial BH Transformation Milestones

Below outlines high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Starting Spring 2024

Stakeholder Engagement

Stakeholder Engagement including public **listening sessions** will be utilized through all milestones to inform policy creation.

Beginning Summer 2024

Bond Funding Availability Begins

Requests for application for bond funding will leverage the BHCIP and HomeKey models.

Beginning Early 2025

Integrated Plan Guidance and Policy

Policy and guidance will be **released in phases** beginning with policy and guidance for Integrated Plans.

Summer 2026

Integrated Plan

New Integrated Plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle)

Source:

DHCS California Department of Health Care Services · CalHHS California Health & Human Services Agency · CalVET · California Housing and Community Development

Thank you for your time

Jessica N. Brown, MPH
Director, Office of Justice, Equity, Diversity and Inclusion/Behavioral Health Services Act
Behavioral Health Services
1380 Howard Street
San Francisco, CA 94103
Jessica.N.Brown@sfdph.org

SEC. 62.

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

5847.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco MHSA FY23-24 through FY25-26 Three-Year Plan

Mental Health Services Act (MHSA) Three-Year Program and Expenditure Integrated Plan

- The Three-Year Plan provides outcomes of our work conducted during FY21-22, key updates from FY22-23, and our proposed plans for FY23-24 through FY25-26.
- Each year BHS/MHSA is required by the State to present the plan to local legislative bodies.
- While planning is done at the local level, funding for MHSA is administered by the State.

History

- MHSA was enacted into state law in 2005 and places a 1% tax on personal income over $1 million; distribution and administration is conducted by the state of California.
- MHSA is designed to support the transformation of the mental health system to address unmet needs; MHSA is based on a set of core principles.
- San Francsico MHSA has 5 funding components spread among 7 different service categories, currently funding 85 programs.
- If Proposition 1 passes, the MHSA team will develop a new 3-Year Plan for FY26-27 through FY28-29.

Selected FY21-22 Outcomes

As a result of implementing the previous BOS approved Three-Year Plan, the Office of Justice, Equity, Diversity and Inclusion (JEDI) and the MHSA team were able to provide the following outcomes. These outcomes are a small sample of the outcomes we achieved. Please see our full Three-Year Plan for all outcomes reported.

- Sustaining funding for current programs and services with demonstrated impact;
- Providing additional funding to strengthen population-focused: Mental Health Promotion and Early Intervention Programs;
- Expanding the San Francisco Dream Keeper Initiative (www.dreamkeepersf.org), which provides comprehensive support for 300 Black/African American families struggling to meet basic needs due to systemic failure and educational activities for 500 Black/African American youth;
- Piloting a project to bring culturally affirming patient navigation support to the City's Chinatown North Beach Clinic;
- Providing Talk Therapy to Black/African American clients throughout San Francisco;
- Hosting 16 community engagement meetings to collect community member feedback to better understand the needs of the community and to develop this plan, with more than 165 people attending;
- Funding 258 peer specialists throughout our behavioral health system;
- Providing support to various clients within our population-focused programming:
    - 97% of clients (n=38) within the Asian/Pacific Islander Mental Health Collaborative reported an increase in their quality of life and "feeling better", as a result of participating in therapeutic activities.

FY23-24 through FY25-26 Three-Year Plan

The proposed MHSA Three-Year Plan includes the following:

- Sustaining funding for the current 85 MHSA programs and services that have demonstrated to have a significant positive impact on San Francisco communities;
- Continuing to implement, support and evaluate the newly funded MHSA programs:
    - Improving Maternal Mental Health for Black/African American Birthing People
    - Homeless Children's Network MA'AT Program
    - Kummba Peer Fellowship Program
    - FUERTE
    - Wellness in the Streets
    - Technology Assisted Mental Health Solutions
    - Culturally Responsive Practices for the Black/African American communities;
- Continuing to grow Full-Service Partnerships (FSPs) by expanding treatment slots;
- Continuing to monitor and engage in stakeholder collaborative meetings regarding Senate Bill 326 that proposes the modernization of the Mental Health Services Act.

FY21-22 Expenditures

MHSA Integrated Service Categories	Abbreviation	FY 21-22 Expenditure Amount	Percentage
Admin	Admin	2,610,143.70	6%
Evaluation	Evaluation	677,833.01	2%
Housing	H	2,139,499.73	5%
Recovery Oriented Treatment Services	RTS	14,685,955.45	36%
Peer-to-Peer Support Services	P2P	6,122,559.75	15%
Vocational Services	VS	3,270,995.38	8%
Workforce Development and Training	WD	2,576,985.66	6%
Capital Facilities/IT	CF/IT	287,199.57	1%
Mental Health Promotion and Early Intervention Services	PEI	8,043,385.27	20%
TOTAL		**40,414,557.52**	**100%**

3-Year Plan Projected Budget (FY23-24, FY24-25 and FY25-26)

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. Estimated FY23-24 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	26,801,234	15,837,383	6,166,241	351,873	8,253,339		57,410,069
2. Estimated New FY23-24 Funding (incl. interest)	71,845,827	18,012,785	4,778,603	2,364	19,527		94,659,106
3. Transfer in FY23-24	(11,394,888)			6,213,210	5,181,678	-	-
4. Access Local Prudent Reserve in FY23-24						-	-
5. Estimated Available Funding for FY23-24	87,252,173	33,850,168	10,944,844	6,567,447	13,454,544		152,069,175
B. FY23-24 MHSA Expenditures	40,504,180	16,535,740	3,225,140	6,213,210	5,609,221		72,087,491
C. Estimated FY24-25 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	46,747,993	17,314,427	7,719,704	354,237	7,845,323		79,981,685
2. Estimated New FY24-25 Funding (incl. interest)	47,622,064	11,905,516	3,133,031				62,660,611
3. Transfer in FY24-25	(12,447,798)			6,123,425	6,324,373	-	-
4. Access Local Prudent Reserve in FY24-25						-	-
5. Estimated Available Funding for FY24-25	81,922,260	29,219,943	10,852,735	6,477,662	14,169,696		142,642,296
D. Estimated FY24-25 Expenditures	42,042,923	15,671,236	2,191,918	6,123,425	4,994,874		71,024,376
E. Estimated FY25-26 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	39,879,336	13,548,707	8,660,816	354,237	9,174,822		71,617,919
2. Estimated New FY25-26 Funding (incl. interest)	48,640,000	12,160,000	3,200,000				64,000,000
3. Transfer in FY25-26	(12,781,849)			6,229,346	6,552,502	-	-
4. Access Local Prudent Reserve in FY25-26						-	-
5. Estimated Available Funding for FY25-26	75,737,488	25,708,707	11,860,816	6,583,583	15,727,324		135,617,919
F. Estimated FY25-26 Expenditures	43,356,060	15,920,899	1,847,587	6,229,346	4,061,095		71,414,988
G. Estimated FY25-26 Unspent Fund Balance	32,381,428	9,787,808	10,013,229	354,237	11,666,229		64,202,932

Note: Spending plan developed prior to passing of Proposition 1

City and County of San Francisco
London N. Breed
Mayor

San Francisco Health Network
Behavioral Health Services

March 18, 2024

Angela Calvillo, Clerk of the Board
Board of Supervisors
1 Dr. Carlton B Goodlett Place, Room 244
San Francisco, CA 94102-4689

Dear Ms. Calvillo:

Attached, please find an original and two single-sided, black and white copies of a proposed resolution for Board of Supervisors approval that would adopt the San Francisco Mental Health Services Act (MHSA) FY2023-2026 Three Year Program and Expenditure Plan.

The Mental Health Services Act was passed in 2004 through a ballot initiative (Proposition 63) and provided funding to support new and expanded county mental health programs. San Francisco's MHSA FY2023-2026 Three Year Program and Expenditure Plan was developed with stakeholder input, posted for 30-day public comment, and heard at a Public Hearing at the San Francisco Behavioral Health Commission, as required by the State to access MHSA funding. Recently enacted State legislation, AB 1467, also requires adoption of the MHSA Three-Year Program and Expenditure Plans by the County Board of Supervisors prior to submission to the State Mental Health Services and Oversight Accountability Commission.

The following is a list of accompanying documents:

- AB 1467
- The San Francisco MHSA FY2023-2026 Three Year Program and Expenditure Plan

Should you have any questions, please contact Jessica Brown, MPH, Director of the Office of Justice, Equity, Diversity and Inclusion/Mental Health Services Act. Ms. Brown can be reached at Jessica.N.Brown@sfdph.org or 415-255-3963.

Sincerely,

Grant Colfax, MD
Director of Health