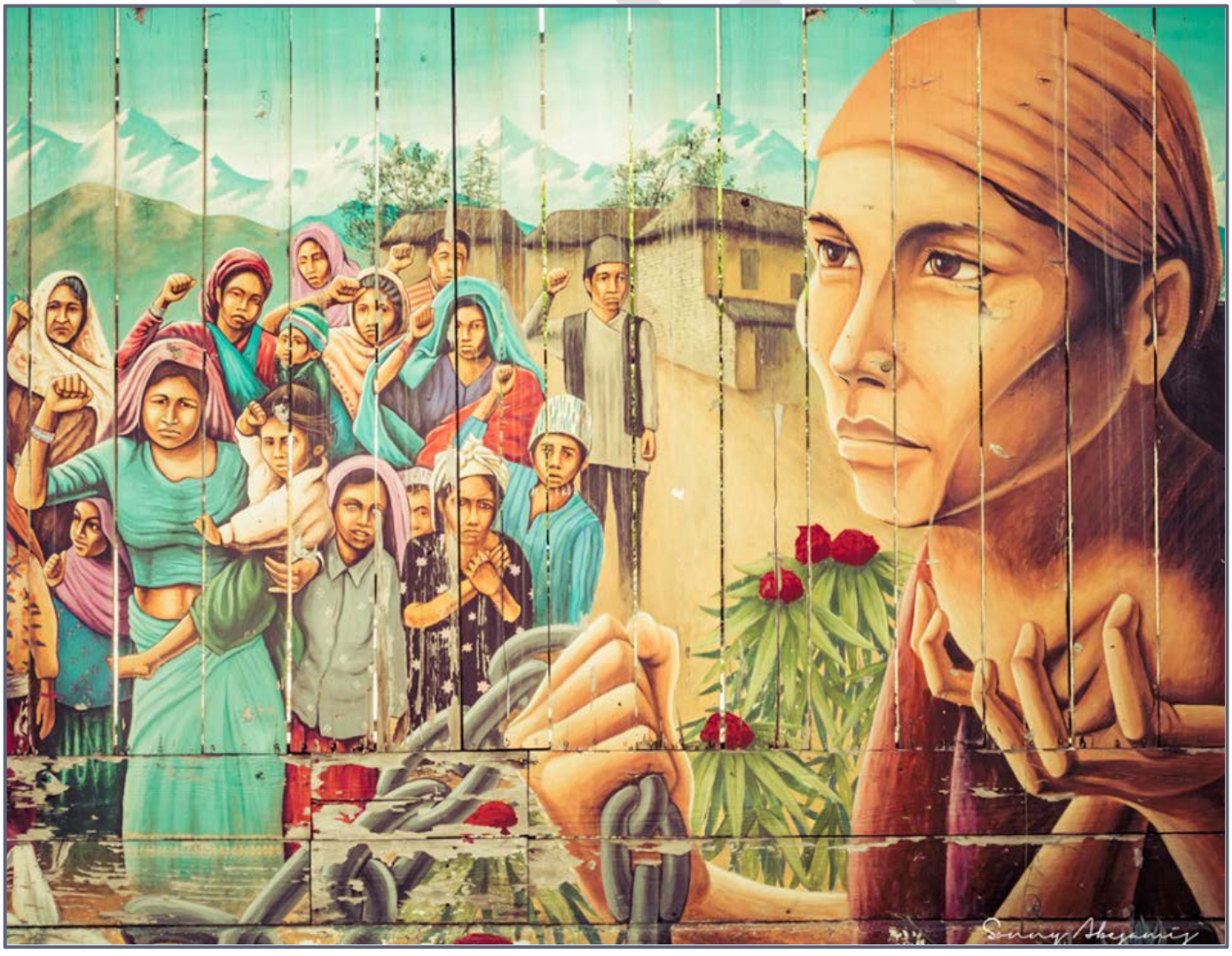
San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Mental Health Services Act (MHSA) 2018-19 Annual Report

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



Mural on Balmy Alley in the San Francisco Mission District

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MHSA County Compliance Certification

County: _____

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

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

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

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

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

County:_____

Date:_____

MHSA County Fiscal Accountability Certification[1]

☐ Three-Year Program and Expenditure Plan

County/City: _____ ☐ Annual Report

☐ Annual Revenue and Expenditure Report

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

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

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

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30, _____. I further certify that for the fiscal year ended June 30, _____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

_____ _____

County Auditor Controller/City Financial Officer (PRINT) Signature Date

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

Director's Message

The Mental Health Services Act (MHSA) program in San Francisco continues to foster healthy communities through programs that increase mental health awareness, decrease stigma associated with mental illness and increase access to care. The principles that guide the MHSA program includes community collaboration, recovery & wellness, health equity, client & family member involvement, and integrated services promoting whole-person care.

This year's Annual Update outlines outcomes achieved in Fiscal Year (FY) 16/17 and highlights program plans for FY18/19. In developing this report, the MHSA program held an array of stakeholder engagement meetings to ensure community involvement in program evaluation, planning and implementation. The MHSA program continues to provide services in various wellness categories including prevention, early intervention, vocational, housing, peer-to-peer, workforce development, information technology, and intensive case management services.

In collaboration with local stakeholders, the MHSA program continues to develop innovative ways to provide high quality culturally and linguistically appropriate services. In the upcoming year, MHSA will begin to implement a peer linkage program designed to ensure successful transition to appointment-based outpatient services for clients discharged and/or referred from an intensive case management program. It is our goal to support clients through their recovery journey to live independent, productive and meaningful lives.

In support of the San Francisco Department of Public Health's mission, the MHSA program is committed to protecting and promoting the health of all San Franciscans.

We look forward to the years ahead in partnership with our stakeholders and residents of San Francisco.

Kavoos Ghane Bassiri
Director, SF Behavioral Health Services

Imo Momoh
Director, SF Mental Health Services Act

Introduction

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

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

WELLNESS • RECOVERY • RESILIENCE

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

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

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

- SFDPH MHSA merged all Full Service Partnership (FSP) programs under the Adult and Older Adult System of Care to provide better oversight of and streamline services. The categories of "FSP" and "non-FSP" were created to better organize and differentiate these similar but unique services.
- SFDPH MHSA invests in the training, support, and deployment of peer providers throughout SF Department of Public Health. SFDPH MHSA partners with local service providers, including the Richmond Area Multi-Services to brainstorm ways to better support the peer provider community.

- SFDPH MHSA recently invested in the SF Community Health Equity and Promotion Department to better support the "whole health" (physical and mental health) of the City's Black/African American communities through the Black/African American Wellness and Peer Leadership Initiative.
- SFDPH MHSA funds and supports behavioral health clinicians within primary care settings in effort to bridge the gap between mental health and primary care and to better identify mental health needs in the community.
- SFDPH MHSA regularly conducts outreach to many different cultures and communities throughout San Francisco in effort to engage outreach workers, identify mental health-related needs in these communities, and provide information on population-specific services available in the City.

SF-MHSA strongly promotes a vision of outreach and engagement, a philosophy of recovery and wellness, a belief in the strength and resiliency of each person with mental illness, and recognition that they are to be embraced as equal members of our community. Recovery from mental illness is not only possible, it is to be expected.

MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

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

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

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

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

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

General Characteristics of San Francisco

San Francisco ('the City') is a seven-by-seven square mile coastal, metropolitan city and county, located on the northern end of a peninsula that separates the San Francisco Bay from the Pacific Ocean. It is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. Though it is geographically small, it is the second most densely populated city in the nation (at 18,581 people per square mile) and fourth most populous city in the state (at 870,887 people). Between 2010 and 2016, the San Francisco population grew by 8%, outpacing California's population growth of 5% during this same time period. By 2030, San Francisco's population is expected to grow to nearly 1,000,000.

A proud, prominent feature of San Francisco is its culturally diverse neighborhoods, where 112 different languages are spoken. Currently, over one-third of the City's population is foreign-born and 44% of residents speak a language other than English at home. However, over the past 50 years, there have been notable ethnic shifts, including a steep increase in Asian/Pacific Islander population and decrease in Black/African American population. Over the next decade, the number of multi-ethnic and Latino residents is expected to rise, while the number of Black/African American residents is expected to continue to decline.

Housing in San Francisco is in increasingly high demand due to the recent tech industry boom. At the same time, due to geographic and zoning constraints, supply for housing is severely limited. These and other factors led to San Francisco becoming the most expensive rental housing market in the nation in 2015. This housing crisis, as it is commonly referred to today, is compounded by extremely high costs of living (at nearly 80% higher than the national average). Approximately 7,500 homeless individuals reside in San Francisco. High costs of living have contributed to huge demographic shifts in the City's population over the past decade, including a dramatic reduction in Black/African American populations and in the number of families with young children.

Although San Francisco was once considered to have a relatively young population, it has recently experienced a decrease of children and families with young children. Today it has the lowest percentage of children among all large cities in the nation. The high cost of living, prohibitive housing costs, and the young, often childless, composition of tech industry workers are assumed to be the leading causes of this population flight. In addition, it is estimated that the population of individuals over the age of 65 will increase to 20% by 2030 (from 14% in 2010). The projected growth in San Francisco's aging population has implications on the need for more long-term care options moving forward.

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

Honoring Mayor Edwin M. Lee

Edwin M. Lee, the 43rd Mayor of San Francisco, passed away unexpectedly on December 12, 2017 at age 65. Lee, an attorney and advocate of civil rights, was the first Asian American mayor of San Francisco.

Lee was appointed mayor on January 11, 2011 by the Board of Supervisors after former Mayor Gavin Newsom was elected Lieutenant Governor of California. Lee was then elected mayor on November 8, 2011 and reelected in 2015.

Lee dedicated himself as a public servant in San Francisco for nearly three decades. Prior to his seven year tenure as mayor, Lee served as City Administrator, Director of Public Works, and Director of City Purchasing.

As mayor, Lee oversaw the greatest period of economic and demographic change in San Francisco since the 1849 Gold Rush. Lee took office following the Great Recession and fought to boost employment in the city. His efforts to attract employers to the city ushered in the tech boom that brought San Francisco to the center of global innovation. This brought a population influx and a tremendous shift in personal wealth, ultimately driving a sharp rise in housing costs. However, during his time as mayor, Lee remained committed to finding affordable housing solutions and fighting homelessness.

Edwin Lee, 43rd Mayor of San Francisco.
In office January 11, 2011 – December 12, 2017

Lee is also remembered for his work to advance the rights of immigrants, as well as his humble and joking personality.

London Breed, as the then San Francisco Board of Supervisors President and, now mayor, stated: “Ed was not a politician. ... What mattered most to him always was helping his fellow San Franciscans. ... Opponents may have disagreed with him on policy, but everyone agrees, our mayor was a good man with a good heart.”

Thousands of friends, family, San Francisco residents, and other admirers came to pay their respects to Mayor Lee at a memorial service at San Francisco City Hall on December 30, 2017. He leaves behind his wife, Anita, and two daughters, Brianna and Tania. We, at San Francisco Department of Public Health, honor his legacy.

Community Program Planning & Stakeholder Engagement

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

From the Beginning

The San Francisco MHSA planning process began in 2005 with then-Mayor Gavin Newsom's creation of a 40-member, citywide Behavioral Health Innovation (BHI) Task Force, which was headed by the San Francisco Deputy Director of Health.

The BHI Task Force was responsible for identifying and prioritizing the greatest mental health needs of the community and developing a Three Year Program and Expenditure Plan to address these needs. The BHI Task Force held over 70 meetings over a five-month period with consumers, their families, behavioral health service providers, representatives from the criminal justice system, educational professionals, social support services providers and administrators, and members of the community. Information was collected through provider surveys, peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, as well as 80 position papers received from various constituents. This process resulted in the development of a Three Year Program and Expenditure Plan for the Community Services and Supports component. The plan was submitted to the California Department of Mental Health in November 2005 and approved in March 2006.

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

- **Workforce Development, Education, and Training (WDET)** planning meetings were held for eight months from April to December 2007. The Plan was submitted in March 2008 and approved in September 2008.

- **Prevention and Early Intervention (PEI)** planning meetings were held for six months from January 2008 to July 2008. The Plan was submitted to both the Department of Mental Health and the Oversight and Accountability Commission for their review and approval in February 2009. The plan was approved in April 2009.

- **Capital Facilities and Information Technology** planning processes were held separately. The Plan for the Capital Facilities component was submitted in April 2009, after a series of three community planning meetings held in February 2009. The Information Technology component CPP involved two informational meetings and six community planning meetings from November 2008 to April 2009. The Plan was submitted in March 2010 and was approved in August 2010.

- **Innovation** community meetings were held from April through August 2009. The Plan was submitted in March 2010 and approved in May 2010.

Community Program Planning & Stakeholder Engagement Activities

Exhibit 1 provides an overview of San Francisco's ongoing community program planning (CPP) activities. San Francisco MHSA employs a range of strategies focused on upholding the MHSA principles and engaging stakeholders in various ways at all levels of planning and implementation. Our CPP process provides a number of opportunities for stakeholders to participate in the development of our three-year plans and annual updates, and stay informed of our progress in implementing MHSA-funded programs.

Exhibit 1. Key Components of SFDPH MHSA Community Program Planning

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

In addition to the CPP activities listed in Exhibit 1, SFDPH MHSA host a number of activities and events throughout the year to promote mental health awareness. In May 2017, in honor of May is Mental Health Awareness Month, SFDPH BHS' Stigma Busters team hosted community wellness events, including its 3rd Annual Open Mic Night, its 2nd Annual Friday Fun Film Night, and inaugurated the tradition of San Francisco's City Hall lighting up in the Each Mind Matters campaign's iconic lime green. These events were designed to spark conversations about mental health needs and increase awareness of wellness and recovery services in our community.

MHSA Communication Strategies

San Francisco Department of Public Health seeks to keep stakeholders and the broader community informed about MHSA through a variety of communication strategies, including the SF BHS SFDPH MHSA website, regular communication with community groups, contributing content to the monthly Community BHS Director's Report, and providing regular updates to stakeholders.

The San Francisco MHSA webpage on the SFDPH website, https://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp, is in the process of being updated to incorporate a more user-friendly design, up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The redesigned webpage hosted now through the San Francisco Department of Public Health website, will showcase frequent program highlights and successes.

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

MHSA booth at the 2017 SFDPH Transgender Health Fair.

MHSA Advisory Committee & Our Commitment to Consumer Engagement

SFDPH MHSA Advisory Committee

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

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

The SFDPH MHSA Advisory Committee's robust recruitment efforts focuses on engaging members from the mental health community, with an emphasis on the following underrepresented community members: those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of over 25 active members.

For FY 17-18, the SFDPH MHSA Advisory Committee meeting schedule is as follows: 8/16/17; 10/18/17; 12/6/17; 2/21/18; 4/18/18; and 6/20/18. The purpose of these meetings are to gather Committee member feedback on MHSA programming and the needs of priority populations. Topics for these meetings include, but are not limited to, the following:

- Community Program Planning for MHSA activities and the FY18/19 Annual Update
- Innovations planning for potential new learning projects
- 2018 Vocational Summit planning
- Transition Age Youth System of Care activities
- Intensive Case Management to Outpatient Flow Innovations Project
- Full Service Partnership planning
- Hummingbird Place Peer Respite Innovations learning project
- Request for Proposals (RFPs) planning
- Annual Consumer, Peer and Family Conference
- Annual MHSA Awards Ceremony
- PEI and INN regulations and reporting protocol
- New SF-MHSA Electronic Reporting System
- Highlights and Spotlight programs
- No Place Like Home initiative
- MHSA evaluation efforts

Increasing Consumer Engagement

SFDPH MHSA continues to partner with the Mental Health Association of San Francisco (MHASF), with the goal of increasing consumer representation and participation in MHSA Advisory Committee meetings.

MHASF assists with the following objectives:

- Supporting the consumer Co-Chair of the MHSA Advisory Committee to participate in developing meeting agendas and presentations for each meeting
- Identifying strategic objectives, including policy issues related to stigma/awareness and developing partnerships with community-based organizations/business leaders to reduce stigma and discrimination as it relates to mental health.

SFDPH MHSA has also been working to foster a stronger collaboration with the BHS Client Council. The Client Council is a 100 percent consumer/client driven and operated advisory body. The mission of the Client Council is to advance the cause of the San Francisco mental health consumer/client to protect their rights, advocate their issues, and ensure their participation in all phases of systematic changes in services, implementation of programs, and treatment development. The goal of the Client Council is to advise BHS regarding policies and practices that directly influence consumers/clients in mental health and substance abuse services. As a result of this new collaboration, the Client Council and MHSA Advisory committee share some members.

Strengthening Relationships

SFDPH MHSA engages with various oversight bodies, including the SF Mental Health Board and the Health Commission, to gather feedback and guidance. Support from these groups helps facilitate MHSA programming and ensures that these services fit into the MHSA System of Care. The relationship between SFDPH MHSA and these groups provide an ongoing channel of communication and support.

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

SFDPH MHSA has also recently increased collaborative efforts with the Health Commission by presenting new MHSA strategies and collecting feedback from this valuable oversight body. SFDPH MHSA has also started presenting before the Integration Steering Committee to collect additional input on MHSA activities before presenting to the full Health Commission.

SFDPH Mental Health Board members discuss mental health needs of the community in FY17-18.

Recent Community Program Planning Efforts

Community Program Planning (CPP) in Fiscal Year 2016-2017

As part of the 2017-2020 MHSA Program and Expenditure Plan, SF DPH conducted extensive community outreach and engagement activities across the City and County. These community outreach and engagement efforts were critical in guiding MHSA program improvements and planning for future programming.

In addition to including the community input and program feedback in the 2017-2020 MHSA Program and Expenditure Plan, MHSA published a separate FY 2016-17 Community Program Planning Report. This report was intended to provide a comprehensive summary of our community outreach and engagement efforts, as well as our plans to integrate the community feedback into MHSA programming, so that we can build our relationships with the community in continuing to plan for and improve MHSA programming. The report was circulated to the eleven San Francisco neighborhoods and settings in which we hosted engagement meetings, the greater San Francisco community, and other local collaborative partners and stakeholders.

SF DPH remains committed to continuous community outreach and engagement to ensure consumers have the appropriate wellness tools and resources to support them in their recovery journey.

Community and Stakeholder Involvement

The San Francisco Department of Public Health has strengthened its' MHSA program planning by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In Fiscal Year 2017-18, SFDPH MHSA hosted 18 community engagement meetings across the City to collect community member feedback on existing MHSA programming and better understand the needs of the community.

Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders. In Fiscal Year 2017-18, we identified that certain groups that were involved in previous Community Program Planning efforts should be more engaged in this series of community planning. We are happy to report that we recently increased our outreach efforts to include more involvement with certain stakeholder groups including Law Enforcement, San Francisco Veterans, Transition Age Youth, vocational participants, the Older Adult community and the LGBTQ (Lesbian, Gay, Bisexual, Transgender, Questioning) community.

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

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

2018 CPP Meeting at Excelsior Family Connections

The FY2017-18 Community Program Planning (CPP) meetings are listed in the following table.

Community Program Planning (CPP) Meetings	
Date	**CPP Location**
November 8, 2017	The Village Visitacion Valley Service Providers 1099 Sunnydale Avenue San Francisco, CA 94134
November 28, 2017	Sunset Mental Health Center Service Providers & Community Advisory Board Members 1990 41st Avenue, Suite 207 San Francisco, CA 94116
January 24, 2018	Excelsior Family Connections: Chinese families & Excelsior Family Connections staff 60 Ocean Avenue San Francisco, CA 94112
January 29, 2018	SF LGBT Center Population Focused Engagement 1800 Market Street San Francisco, CA 94102
February 5, 2018	Curry Senior Center MHSA Advisory Committee meeting 315 Turk Street – John Stanley Room San Francisco, CA 94102
February 7, 2018	TAY Full Service Partnership Meeting 755 South Van Ness San Francisco, CA 94110
February 15, 2018	Richmond District Neighborhood Center Service Providers Meeting 4301 Geary Boulevard San Francisco, CA 94118
February 26, 2018	Department of Rehabilitation (DOR-BHS) Co-op Administration Meeting (Vocational Programs) 455 Golden Gate Avenue, #7727 San Francisco, CA 94102
February 28, 2018	San Francisco Veterans Town Hall Meeting Veterans & Service Providers Meeting 401 Van Ness Avenue San Francisco, CA 94102
March 2, 2018	Excelsior Family Connections Spanish Speaking Families & Staff Meeting 60 Ocean Avenue San Francisco, CA 94112
March 2, 2018	SFDPH BHS Adult/Older Adult Service Providers Meeting 1 South Van Ness San Francisco, CA 94103
March 9, 2018	API Wellness Center Transgender Program Community Members & Service Providers 730 Polk Street San Francisco, CA 94109

Community Program Planning (CPP) Meetings	
Date	**CPP Location**
March 13, 2018	Rafiki Coalition Black/African American Community 601 Cesar Chavez Street San Francisco, CA 94124
March 14, 2018	Huckleberry Youth Programs TAY Service Providers Meeting 555 Cole Street San Francisco, CA 94117
March 14, 2018	Crisis Intervention Training Meeting Workgroup – Law Enforcement, Peers & Service Providers 870 Market Street #785 San Francisco, CA 94102
April 18, 2018	SF Behavioral Health Services MHSA Advisory Committee Meeting 1380 Howard Street San Francisco, CA 94103
June 13, 2018	San Francisco Public Library Combined MHSA Provider and Advisory Committee Meeting 100 Larkin Street San Francisco, CA 94102
June 13, 2018	City College of San Francisco - Health Education Dept. Workforce Development Networking Session 50 Phelan Avenue San Francisco, CA 94112

In each of the community meetings, MHSA staff presented an overview of the Mental Health Services Act, including its core components, guiding principles, and highlights of existing programs and services. MHSA staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health needs and strategies to address these needs. These discussions also addressed how SFDPH can improve existing MHSA programming. Feedback from community members at the meetings were captured live, on flip charts and via transcription, in effort to maintain a high-level of transparency. MHSA staff addressed how the feedback would be incorporated into the SFDPH MHSA 2018-2019 Annual Update and inform future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the SFDPH MHSA 2018-2019 Annual Update.

Community and Stakeholder Feedback

The feedback and input shared by our community stakeholders is under careful review and consideration by MHSA leaders and staff. This valuable feedback will be used to guide and refine MHSA-funded programming.

Perhaps not surprisingly, the feedback collected throughout the various community planning efforts was fairly consistent. At

Individuals who experience mental health challenges should be asked, "You are part of the village and how do we get you to wellness?"

-Community Member

each community meeting, whether it was a meeting of behavioral/mental health service consumers and their families, peers, service providers, community members, or other stakeholders, many echoed the same key behavioral and mental health-related needs of the community including, but not limited to, the following needs.

Addressing Social, Cultural, Community and Systemic Needs

- The need for drop-in employment opportunities.
- The need for more legal assistance to address xenophobia, immigration and institutional racism.
- The need to increase culturally specific approaches to wellness.
    - Recognize & honor indigenous/tribal practices.
    - Hold a Post Traumatic Slave Syndrome support circle.
    - Organizations need to teach cultural humility to their staff who are service providers and utilize more innovative way of collaborating across communities.
    - More clinicians of color to better represent the diverse populations of the City.
    - Increase services for the Black/African American, Mongolian, Farsi, Russian and Arab communities.
- The need to increase support for veterans.
    - Service providers should be educated on veteran's experiences and best practices when working with this population.
    - Better educate veterans about substance use and abuse issues.
- The need for increased support for parents and teachers regarding early identification of mental health concerns in children & youth.
- The need to increase training and support for law enforcement personnel that interact with individuals experiencing psychiatric and mental health emergences.
    - Increase the de-escalation training activities.
    - Provide training on how to access all mental health services via the phone or tablet so they know where to refer clients.
- The need to better address trauma-related issues in school-age youth.
    - Address bullying in schools as a behavioral health crisis, especially for children of color, and address this issue with the entire family.
    - Provide support to schools and address anxiety associated with recent mass violence in school settings.
    - Support children who have undocumented parents and fear related to deportation.
- The need to expand Wellness Centers at schools and after-school programs focused on mental health services.

Strengthening the Mental Health System

- The need for more successful transitions and a warm hand-off from program to program.
    - Better transitions from Children, Youth and Families Services, to Transition Age Youth services and then to Adult services.
    - Better transitions from Full-Service Partnership programs to Outpatient care.
    - Support patients who are discharged from the hospital who slip through the cracks before they can get connected to a facility providing targeted service.
    - Increase inter-agency and multidisciplinary collaboration.
- The need to increase access to services

> *"We should implement more interventions for families who experience intergenerational trauma."*
>
> -MHSA Stakeholder

    - Increase services, support and interventions to people directly on the street.
    - Increase access to those who are older adults, disabled or experiencing social isolation.
    - More walk-in mental health services rather than making an appointment.
- The need to increase other forms of therapy including drama, art, sound, and singing modalities.
- The need for more mind-body healing approaches.
    - Acupuncture, Mindfulness interventions, Nutrition/cooking education, body positivity workshops, and utilize Taoist healers & the like.
- The need for 24 hour crisis coverage specifically tailored to the TAY population.

2018 MHSA CPP Meeting at Excelsior Family Connections

<u>Staff Support & Resources</u>

- The need to increase networking and capacity building opportunities for intern and student staff.
- The need to leverage training resources by combining and/or sharing trainings.
- The need for clinics to have the workforce capacity to handle increased caseloads of clients.

<u>Innovative Approaches with Technology</u>

- The need for more technology-based interventions for behavioral health clients.
    - Technology-based options including text message, social media, crisis live chatting, web-based tele-health and appointment reminders can help increase access to services and resources.
    - Technology assisted treatment seems most suitable for young people, the TAY population, the transgender population, those who are disabled and those who are isolated.
    - Technology based mental health solutions should include multi-lingual interventions like peer and group chatting for specific populations.
    - This poses the need to have basic computer, smart phone and tablet training courses for those would like to utilize this modality but need some support.
- The need to increase partnerships between MHSA and local technology businesses.

<u>Feedback that was Consistent in Previous Years</u>

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

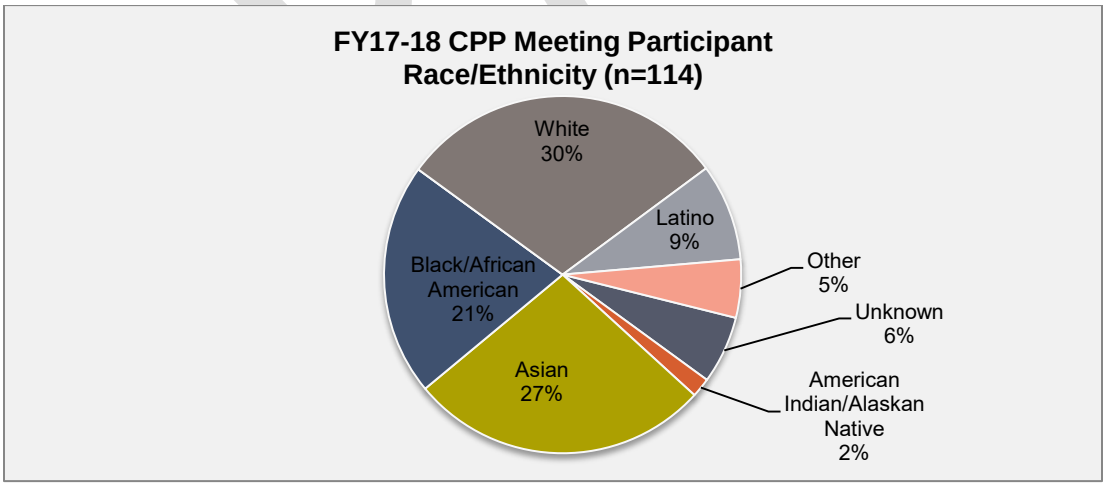
- The need for safe and stable (affordable) housing, particularly for those with serious mental illness, transitional age youth, and older adults.
- The need for community education and stigma reduction around behavioral/mental health needs, particularly cultural and linguistic needs.
- The need for a clear understanding of what behavioral/mental health (MHSA-funded) programs and services already exist.
    - The DPH website is difficult to navigate and should include a Directory of Service Providers that is routinely updated so that consumers and service providers can understand what services are currently offered/where they are available.

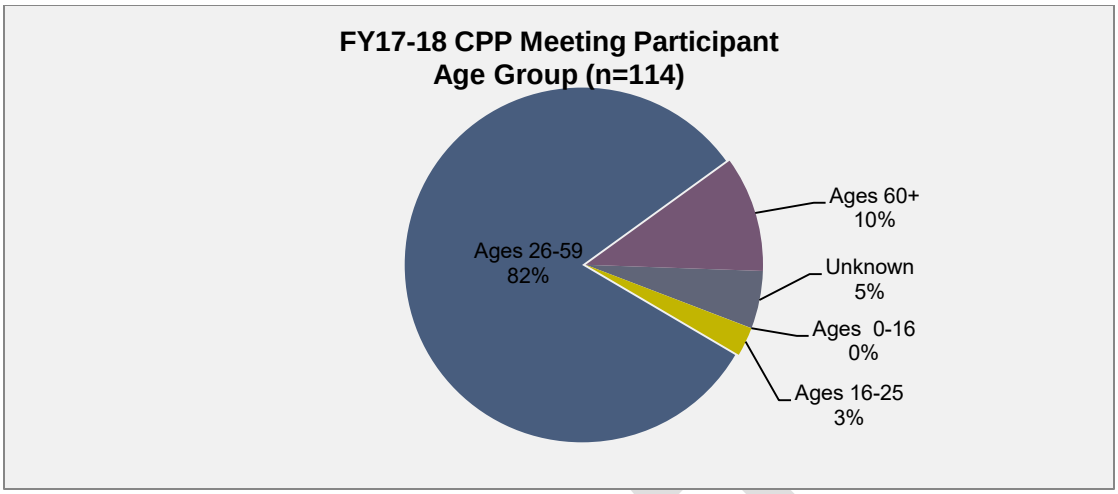
While most community members readily agreed that these were amongst the most pressing needs of the community, with regard to behavioral/mental health, many other ideas were also shared throughout the CPP process. This feedback includes, among other things, ideas to further engage unserved/underserved populations, the importance of qualitative as well as quantitative data evaluation for programming, ideas for better helping clients navigate complex behavioral health systems that sometimes work in silos and increasing the number of MHSA-funded programs that match Medi-Cal dollars.

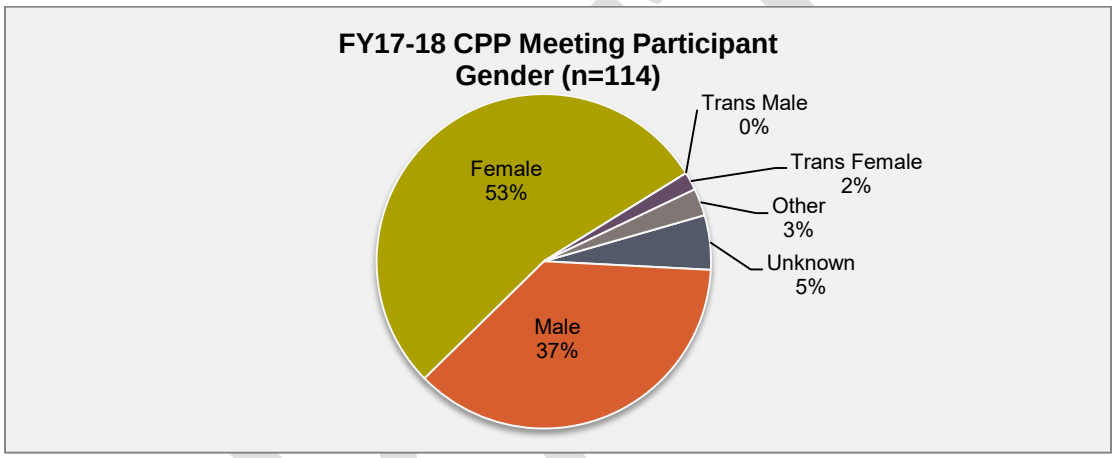
Community Program Planning Meeting Participation

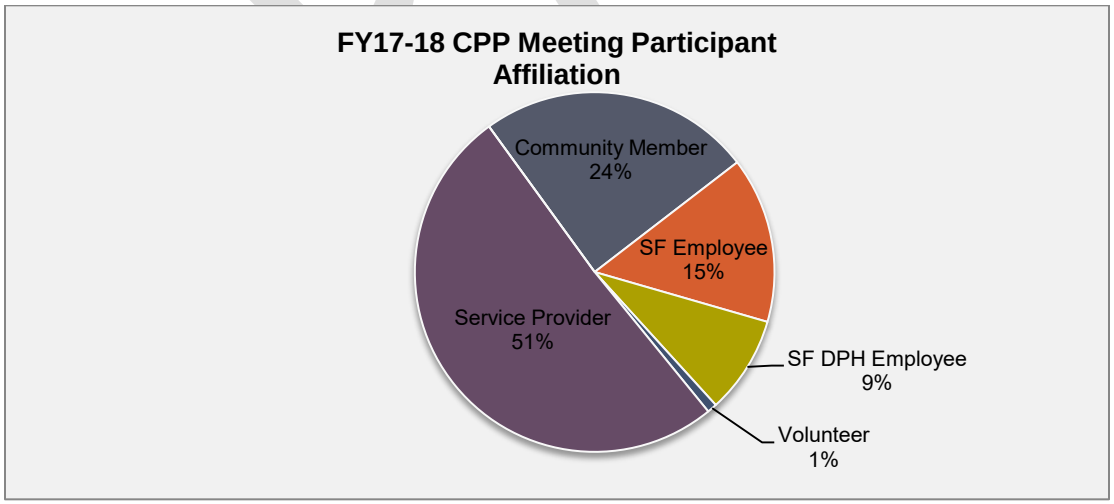
Over 250 people participated in the SFDPH MHSA community meetings held in Fiscal Year 2017-2018. Of those attendees, SFDPH MHSA staff collected demographic data on 114 individuals and those data are reflected in the charts below. It is worth noting that the number of Black/African American participants is likely underrepresented as participant demographics were not collected at one of our Black/African American community meetings (in Visitacion Valley on November 8, 2017).

Please see demographics below.









CPP with Service Provider Selection

SF MHSA includes elements of the CPP in developing and refining each of our programs. Frequently, this takes the form of an ad hoc committee or planning groups made of various stakeholders, including people with expertise or lived experience of specific populations. The MHSA principle of engaging consumers and family members is applied to all programs. The following

are examples of recent CPP efforts that took place in developing Request for Proposals (RFP) or Request for Qualifications (RFQ) and contracting with service providers.

- Intensive Case Management Modality Services – Full Service Partnerships and Non-Full Service Partnerships Programs RFP
- Children, Youth and Families RFQs
- Transition Age Youth System of Care RFQ
- Behavioral Health Services In Primary Care For Older Adults RFQ
- Fiscal Intermediary For Peer Employment And Services RFQ

CPP with the Client Council

As mentioned above, SF-MHSA has also been working to foster a stronger collaboration with the BHS Client Council. The Client Council is a 100 percent consumer/client driven and operated advisory body. The goal of the Client Council is to advise BHS regarding policies and practices that directly influence consumers/clients in mental health and substance abuse services. As a result of this collaborative effort, SF-MHSA has gathered feedback from the Client Council on numerous MHSA funded initiatives throughout Fiscal Year 2017/18. The input gathering meeting dates include the following:

July 18, 2017	August 15, 2017	September 19, 2017
October 17, 2017	November 21, 2017	December 19, 2017
January 16, 2018	February 20, 2018	March 20, 2018
April 17, 2018	May 15, 2018	June 19, 2018

2017 CPP Meeting at Sunset Mental Health

Program Implementation

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

- Providers from MHSA-funded agencies meet on a regular basis to discuss local MHSA program activities and to provide feedback.
- Population-Focused Mental Health Promotion Contractors Learning Circles: In order to promote a culturally competent and inclusive process, SFDPH MHSA is holding a series of meetings called 'Learning Circles' with population-focused programs to collectively discuss and agree on service types, activities and outcomes. The shared performance objectives that have been developed are measured and reported on for the next fiscal year. The Learning Circles also provide an opportunity for programs to share their progress on implementation, goals and strategies for evaluation.
- Consumers and peers are involved in all areas of the program life-cycle. Consumers and peers participate in Request for Qualifications and Request for Proposals (RFQ/P) review panels, provide input as a vital stakeholder during the program planning and contract negotiation phase, and support with technical assistance during implementation to ensure the program is meeting the appropriate deliverables.

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Proposition 63, an emphasis was placed on the importance of consumer participation in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. In FY 16-17, over two thirds of all grantees/contracts indicated that their program employs consumers or participants through MHSA funding, totaling 310 peers as employees. Consumers could be found working in almost all levels and types of positions, including as: peer mentors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management. Several programs have positions created specifically for clients and consumers, including mentoring, advocacy, and peer facilitators.

Highlights of SFDPH MHSA

In Fiscal Year 2017-18, a number of position changes occurred in the SFDPH MHSA division, including:

- A new Transition Age Youth System of Care Manager (TAY SOC) was hired to oversee MHSA TAY contracts, activities, and the restructuring of the TAY SOC.
- A new Staff Wellness Coordinator was hired to ensure clinicians and support staff are taking care of themselves. Her duties include promoting self-care in the workplace, organizing staff wellness activities and groups, and offering debriefing sessions for staff. This is a SFDPH Behavioral Health Services position that is funded by MHSA.
- The vacant MHSA Innovations Program Manager position was filled to lead activities that assess community needs.
- Two vacant Health Program Coordinator III positions were recently filled to help expand contract monitoring and program evaluation.
- A new Health Worker III position was filled to assist with BHS training activities.
- A vacant Health Worker II position was filled to provide Administrative Support and conduct outreach and engagement activities in an effort to raise mental health awareness and reduce stigma.
- A vacant Health Educator position was recently filled to conduct community outreach, stigma reduction, training, and cultural competency activities.

API Wellness booth at the SFDPH 2017 Transgender Health Fair

San Francisco's Integrated MHSA Service Categories

As discussed in the introduction to this report, San Francisco's initial MHSA planning and implementation efforts were organized around MHSA funding components (e.g., Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN)). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components. The MHSA, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, SFDPH MHSA realized that developing an Integrated Plan with a common vision and shared priorities is difficult when funding streams were used as the framework. In partnership with our stakeholders, SFDPH MHSA simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 2 below).

Exhibit 2. SFDPH MHSA Service Categories

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

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

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

Developing this Annual Update

This Annual Update was developed in collaboration with various consumers, peers and other stakeholders. Our Annual Update Planning effort was coordinated by a planning group comprised of the SFDPH MHSA Director and Program Managers, with independent consulting firms (Hatchuel Tabernik & Associates and Harder + Company Community Research) providing data analysis, program planning and report writing services.

UCSF Citywide's GROWTH Landscaping Program

In these planning efforts, SFDPH MHSA incorporated the stated goals of MHSA and revisited the local priorities and needs identified in previous planning efforts. All of the Community Program Planning strategies outlined in the previous section were employed in developing this plan. Additional strategies in this process are listed below.

- Reviewed the previous three-year Program and Expenditure plan submitted for each MHSA component. This was done to understand how well priorities identified in those plan have been addressed, as well as to determine if all programs had been implemented as originally intended.
- Reviewed MHSA regulations, laws and guidelines released by the State (e.g., DMH, OAC, CalHFA, new INN and PEI regulations) to ensure all mandated information would be incorporated in this plan.
- Reviewed informational materials produced by CalMHSA, CMHDA, and OSHPD.
- Reviewed Annual Year-End Program Reports and demographic data submitted by contractors and civil service programs.
- Conducted program planning with service providers and consumers through robust RFQ, program negotiation and contracting efforts throughout the Department. Applications have been received for all MHSA RFQs published in recent months. Negotiations and program development efforts are currently underway.

Much of this Annual Update is made up of programs implemented through the previous Three-Year Program and Expenditure Plan (Integrated Plan). Most of our CPP activities over the last year have been focused on the development of this Annual Update.

Local Review Process

Our Community Planning Process involved various opportunities for community members and stakeholders to share input in the development of our Annual Update planning efforts and learn about the process of our MHSA-funded programs, including MHSA Advisory Committee meetings, BHS client council meetings, and community engagement meetings. Please see the components on MHSA Communication Strategies and MHSA Advisory Committee for a specific list of meeting dates and topics.

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Annual Update was posted on the SFDPH MHSA website at www.sfdph.org/dph and www.sfmhsa.org. Our 2018-19 Annual Update Plan was posted for a period of 30 days from July 2, 2018 to July 31, 2018. 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:

Community Member	Summary of Comment	DPH Response
Manjot (Manu) Multani, MSPH - Program Manager, Adult Housing Programs at Dept of Homelessness and Supportive Housing	Updates to the MHSA Housing section were provided and recommended, as the San Francisco Department of Homelessness and Supportive Housing has implemented recent changes.	SF-MHSA was appreciative of the updates and noted that all revisions would be included. SF-MHSA included all revisions in the final version that was sent to the SF Board of Supervisors and the state.
Josephine Ayankoya, MPH – MHSA Program Manager at San Francisco Dept of Public Health	Minor spelling edits were provided in addition to minor updates regarding the Housing section.	SF-MHSA was appreciative of the updates and noted that all revisions would be included. SF-MHSA included all revisions in the final version that was sent to the SF Board of Supervisors and the state.
Kimberly Ganade, MSW - MHSA Program Manager at San Francisco Dept of Public Health	Minor grammatical edits were provided in addition to updates to the Population-Focused and Workforce Development programs.	SF-MHSA was appreciative of the updates and noted that all revisions would be included. SF-MHSA included all revisions in the final version that was sent to the SF Board of Supervisors and the state.
Helynna Brooke - Executive Director of San Francisco Mental	Minor grammatical edits were provided.	SF-MHSA was appreciative of the updates and noted that all revisions would be included.

Community Member	Summary of Comment	DPH Response
Health Board		SF-MHSA included all revisions in the final version that was sent to the SF Board of Supervisors and the state.
Mary Kate Bacalao – representing Larkin Street Youth Services	Recommendations to increase services to the TAY population were provided; including the need to better collaborate and increase services for child welfare dependents, suicidal youth, criminal justice involved TAY, and TAY needing emergency stabilization housing. Recommendations also included; the need to increase psychiatrists for TAY, better marketing for the Consumer Portal, a homeless TAY peer to work with the Wellness in the Streets program and the need to better link clients existing FSP's.	SF-MHSA was appreciative of the feedback. Since most of the community feedback is to increase/modify services, this community feedback will be used to influence the development of the next Annual Update and implementation plan for FY19/20.

Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board of San Francisco on August 1, 2018. The Annual Report was also presented before the Public Safety and Neighborhood Services Committee on [INSERT DATE}.

Peer Specialists with the Transgender Pilot Project

Public Hearing & Board of Supervisors Resolution

Insert Resolution Here

MHSA Fiscal Year 2018-2019 Annual Update

As a result of the feedback we received during our Community Program Planning efforts and due to our successful evaluation outcomes, the following programs/projects will continue to operate as approved in the previous 3-Year Program and Expenditure Plan:

- **Recovery-Oriented Treatment Services**
  - Strong Parents and Resilient Kids (SPARK) **(FSP Program)**
  - SF Connections **(FSP Program)**
  - Family Mosaic Project **(FSP Program)**
  - TAY Full-Service Partnership at Felton **(FSP Program)**
  - SF Transition Age Youth Clinic **(FSP Program)**
  - TAY Full-Service Partnership at Edgewood **(FSP Program)**
  - Adult Full-Service Partnership at Felton **(FSP Program)**
  - Adult Full-Service Partnership at Hyde Street **(FSP Program)**
  - Assisted Outreach Treatment (AOT) **(FSP Program)**
  - SF First **(FSP Program)**
  - Forensics at UCSF Citywide **(FSP Program)**
  - Older Adult FSP at Turk **(FSP Program)**
  - AIIM Higher
  - Community Assessment and Resource Center (CARC)
  - Behavioral Health Access Center (BHAC)
  - Behavioral Health Services in Primary Care for Older Adults
- **Mental Health Promotion and Early Intervention**
  - Behavioral Health Services at Balboa Teen Health Center
  - School Based Mental Health Services
  - School Based Youth Early Intervention
  - School Based Wellness Centers
  - Trauma and Recovery Services
  - Senior Drop-In Center
  - Ajani Program
  - Black/African American Wellness and Peer Leaders (BAAWPL)
  - API Mental Health Collaborative
  - Indigena Health and Wellness Collaborative
  - Living in Balance
  - 6th Street Self-Help Center
  - Tenderloin Self-Help Center
  - Community Building Program
  - TAY Early Psychosis Intervention and Recovery
  - Population Specific TAY Engagement and Treatment - Latino
  - Population Specific TAY Engagement and Treatment - Asian/Pacific Islander
  - Population Specific TAY Engagement and Treatment - Juvenile Justice
  - 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
- **Peer-to-Peer Support Programs and Services**
    - Peer Engagement Services
    - Addressing the Needs of Socially Isolated Adults Program **(INNOVATIONS)**
    - LEGACY
    - Peer to Peer, Family to Family
    - Peer Specialist Certificate, Leadership Academy and Counseling
    - Gender Health SF
    - Peer to Peer Employment
    - Peer Wellness Center
    - Transgender Pilot Project **(INNOVATIONS)**
    - Reducing Stigma in the South East (RSSE)
- **Vocational Services**
    - Department of Rehabilitation Vocational Co-op
    - i-Ability Vocational IT Program
    - First Impressions **(INNOVATIONS)**
    - SF First Vocational Project
    - Janitorial Services
    - Café and Catering Services
    - Clerical and Mailroom Services
    - GROWTH
    - TAY Vocational Program
- **Housing**
    - Emergency Stabilization Housing
    - FSP Permanent Supportive Housing
    - Housing Placement and Support
    - TAY Transitional Housing
- **Behavioral Health Workforce Development**
    - Community Mental Health Worker Certificate
    - Faces for the Future Program
    - Trauma Informed Systems Initiative
    - TAY System of Care Capacity Building
    - Street Violence Intervention Prevention and Professional Development Academy
    - Community Mental Health Academy
    - Fellowship for Public Psychiatry in the Adult/Older Adult System of Care
    - Public Psychiatry Fellowship at SF General
    - BHS Graduate Level Internship Program
- **Capital Facilities and Information Technology (IT)**
    - Recent Renovations – Capital Facilities
    - Consumer Portal - IT
    - Consumer Employment – IT
    - System Enhancements - IT

In addition to continuing the program/project investments described above, SF MHSA will also introduce **three new and innovative initiatives in programming.** These three initiatives have been vetted through our stakeholder and Community Program Planning (CPP) process and these initiatives represent the only additional expenditures planned for the SF MHSA budget. Additional information on these programs can be found later in this report.

- Intensive Case Management/Full-Service Partnership to Outpatient Transition Support (approved by MHSOAC)
- Wellness in the Streets (pending MHSOAC approval)
- Technology-Assisted Mental Health Solutions (pending MHSOAC approval)

Organization of this Report

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

1. **Recovery-Oriented Treatment Services**
2. **Mental Health Prevention & Early Intervention Services**
3. **Peer-to-Peer Support Programs and Services**
4. **Vocational Services**
5. **Housing Services**
6. **Behavioral Health Workforce Development**
7. **Capital Facilities & Information Technology**

SFDPH MHSA Transitional Age Youth group activity in FY17-18.

1. Recovery-Oriented Treatment Services

Service Category Overview

Recovery-Oriented Treatment Services include services traditionally provided in the mental health system, such as screening and assessment, clinical case management, individual and group therapy, and medication management.

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

- The Prevention and Recovery in Early Psychosis Program
- Trauma Recovery Programs
- Behavioral Health and Juvenile Justice Integration
- Dual Diagnosis Residential Treatment
- The Behavioral Health Access Center
- Behavioral Health and Primary Care Integration

Full Service Partnership Programs

Program Collection Overview

Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with serious mental illness (SMI) or, for children, serious emotional disturbance (SED), to lead independent, meaningful, and productive lives.

- FSP services at all programs consist of the following:
- Intensive case management
- Wraparound services
- Medication management
- Housing support
- Employment assistance and vocational training
- Substance use harm reduction and treatment
- Individual and group therapy and support groups
- Peer support
- Flex Funds for non- MediCal needs

Target Populations

Nine FSP programs have served a diverse group of clients, in terms of age, race/ethnicity, and stage of recovery, since 2006. In 2015-16, two new programs began to enroll clients: Instituto Familiar de la Raza (IFR) created the Strong Parents and Resilient Kids (SPARK) program to serve families with a child or children aged 0-5 with attachment disorders; and Citywide Case Management now provides services through the Assisted Outpatient Treatment (AOT) program to clients with serious mental illness who have not previously engaged effectively with Behavioral Health Services but remain at great risk to themselves or others.

FSP Flex Funds

Flex funds are monies that are set aside specifically to address children, youth, adults, older adults, and their families' needs and to provide support services that are outside the scope of traditional specialty mental health services. Flex funds are designed to build collaborative service plans with children, youth, adults, and older adults and their families, focused on healing, wellness, and recovery. SF-MHSA uses these flex funds to support the philosophy of doing "whatever it takes" for those who experience symptoms related to Severe Mental Illness or Severe Emotional Disturbance and intended to help them lead healthy, connected, family-centered, independent, meaningful, and engaged lives.

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

Full Service Partnership Programs		
Target Population	**Program Name** ***Provider***	**Additional Program Characteristics**
	Assisted Outpatient Treatment (AOT) *SF BHS & UCSF Citywide Case Management*	Outreaches to and engages individuals with known mental illness, not engaged in care, who are on a downward spiral. AOT is a court process that uses peer counselors to facilitate individuals' access to essential mental health care.
	SF Fully Integrated Recovery Service Team (SF FIRST) *DPH*	Provides FSP services to highly vulnerable individuals with multiple medical, psychiatric, substance abuse, and psychosocial difficulties, including chronic homelessness.
	Forensics *UCSF Citywide Case Management*	Provides compassionate, respectful, culturally and clinically competent, comprehensive psychiatric services to individuals with severe and persistent mental illness (often co-existing with substance abuse) involved in the criminal justice system.
Older Adults	Older Adult FSP at Turk *Felton/Family Services Agency*	Serves older adults age 60 and older with severe functional impairments and complex needs, by providing specialized geriatric services related to mental health and aging.

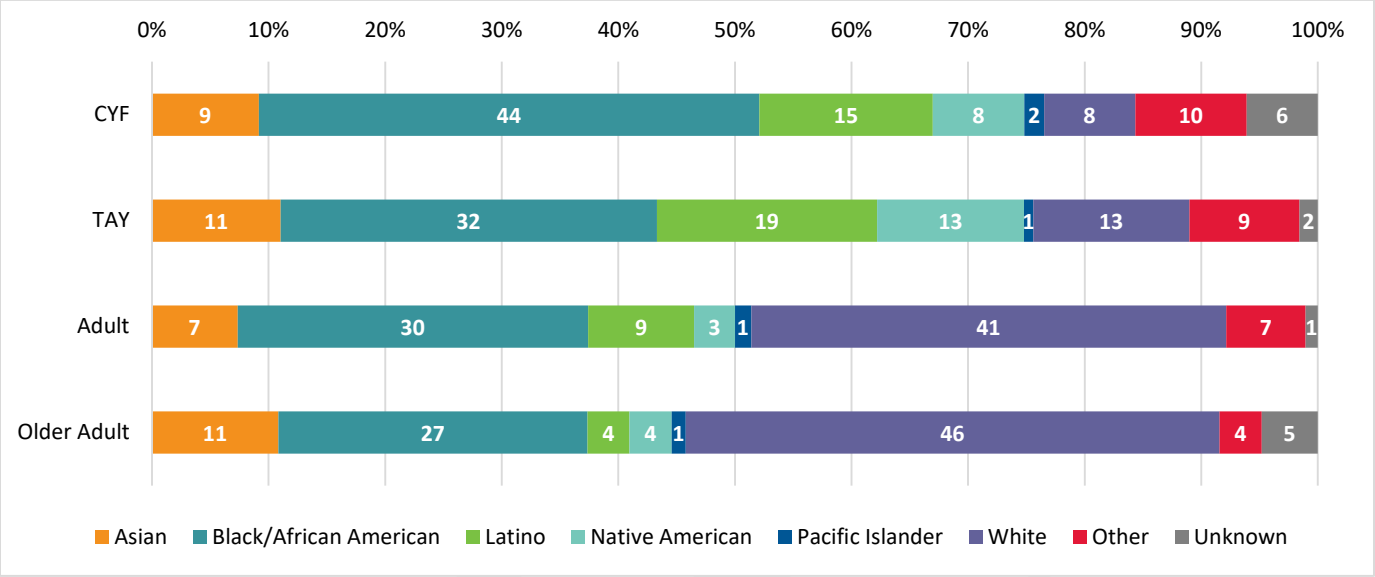
Participant Demographics, Outcomes, & Cost per Client

Demographics: Full Service Partnership

Total number of FSP Clients, Active in FY16-17, by Age Group

	N	%
Children Youth and Family (CYF)	513	40%
Transitional Age Youth (TAY)	127	10%
Adult	572	45%
Older Adult	83	7%
Total	**1,282**	**100%**

Ethnic Distribution for FSP Clients, Active in FY16-17, by Age Group



Ethnicity varies by age group. There is a higher proportion of Latino/a clients in the CYF and TAY programs compared to our Adult and Older Adult programs. There is a greater percentage of African American clients in the CYF programs compared to the other programs. There are proportionally more White clients in the Adult and Older Adult programs compared to the TAY and CYF programs.

FY16-17 Key Outcomes and Highlights

FSP Data Collection and Reporting (DCR) Outcomes

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

Residential Settings

Residential settings are first recorded on the Partnership Assessment Form (PAF). Any changes to this initial residential setting are logged in a KET, and a date is included. This date starts the clock in a calculation of the number of days a client spends in each living situation until the next change in setting. Specific outcomes reported here include the number of clients who spent days in each residential setting and the % of total days all clients spent in a residential setting. The following charts show the total number of clients who reported living in each setting, and compares the baseline year (the 12 months immediately preceding entry into the FSP) to the end of the first year enrolled in the FSP, as well as the percentage change in time spent in each setting for the baseline year as compared to the first year in FSP. Typically clients spend time in more than one setting over the course of each year.

Residential reporting includes all clients with a completed Partnership Assessment Form (PAF) active in the FSP during FY16-17 and for at least one continuous year in the DCR. Residential settings are displayed from more desirable (generally more independent, less restrictive) to less desirable, but this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for one client, for another the move could be an indication of getting into much needed care for the first time. Because residential settings differ greatly between children and all other age groups, the following graphs (Exhibits 3-6) show each age group separately.

Exhibit 3a. Change in Residential Settings for CYF Clients (1 of 2)

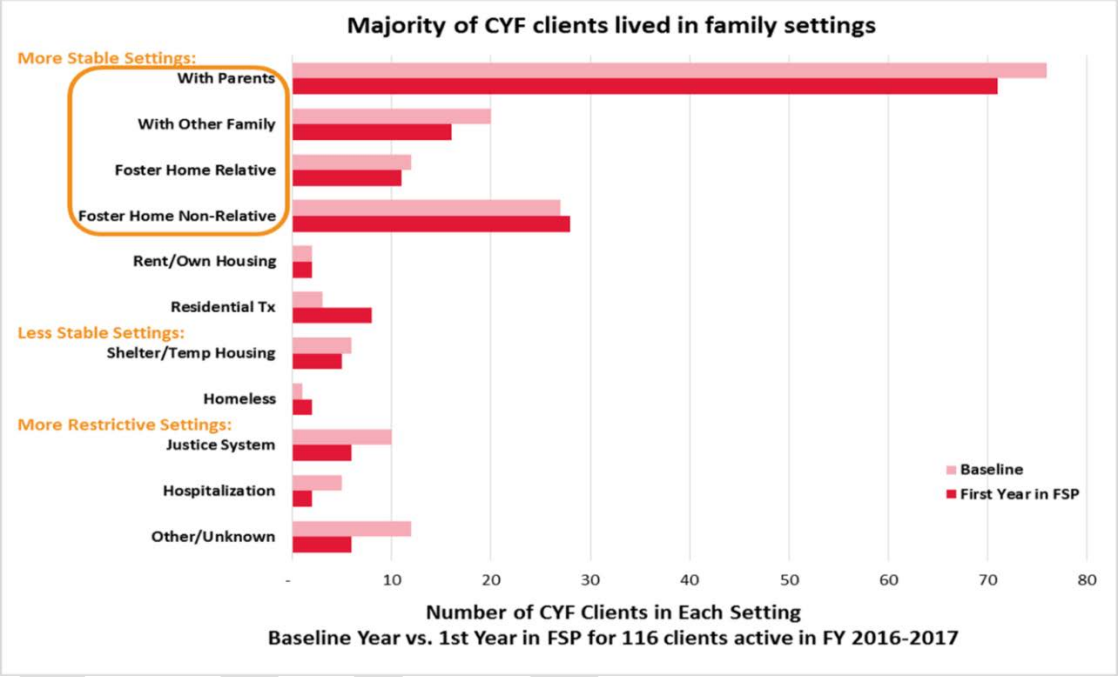
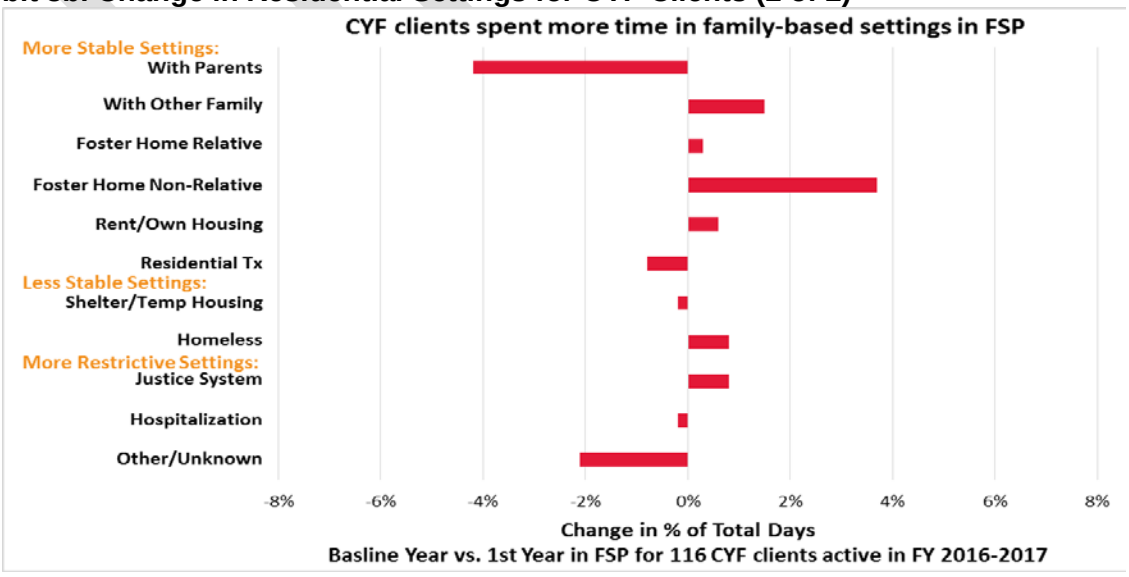


Exhibit 3b. Change in Residential Settings for CYF Clients (2 of 2)



Child, youth, and family (CYF) clients' data show movement from restrictive settings into more home-based settings during FSP treatment. Child clients are typically more stable in their residences than older clients, especially once in FSP, and show more modest changes in settings. Though the number of CYF clients living With Other Family and Foster Home Relative decreased in the first year in FSP (Exhibit 3a), the amount of time (days) clients spent in these settings increased (Exhibit 4b). This suggests that clients who move into home-based settings in FSP tend to stay in them longer. While the number of clients and the amount of time clients spent living With Parents decreased in FSP, over 61% of CYF clients still live With Parents.

Exhibit 4a. Change in Residential Settings for TAY Clients (1 of 2)

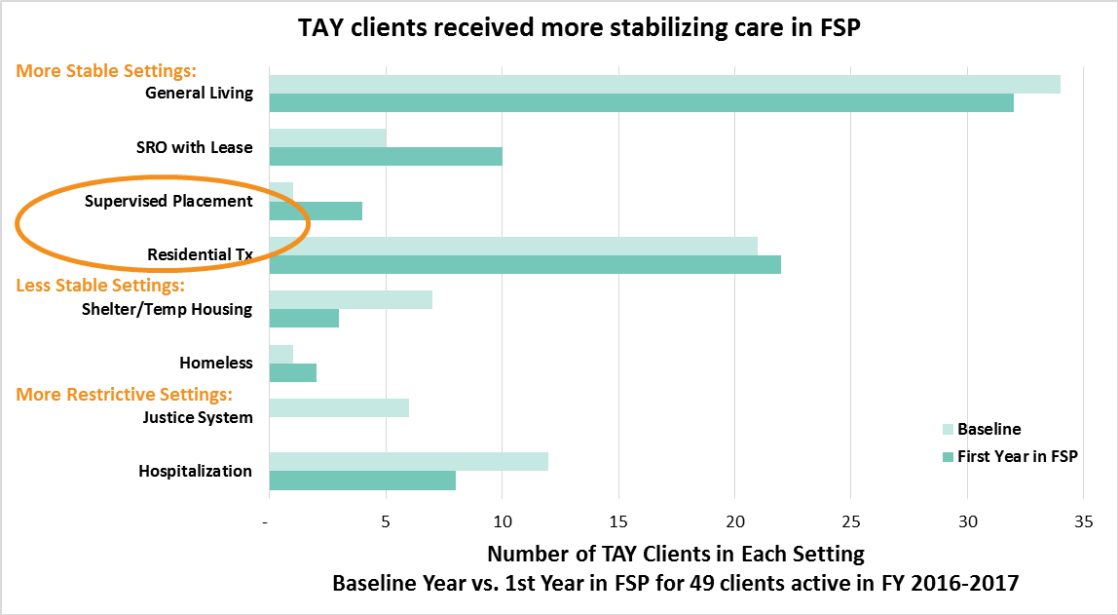
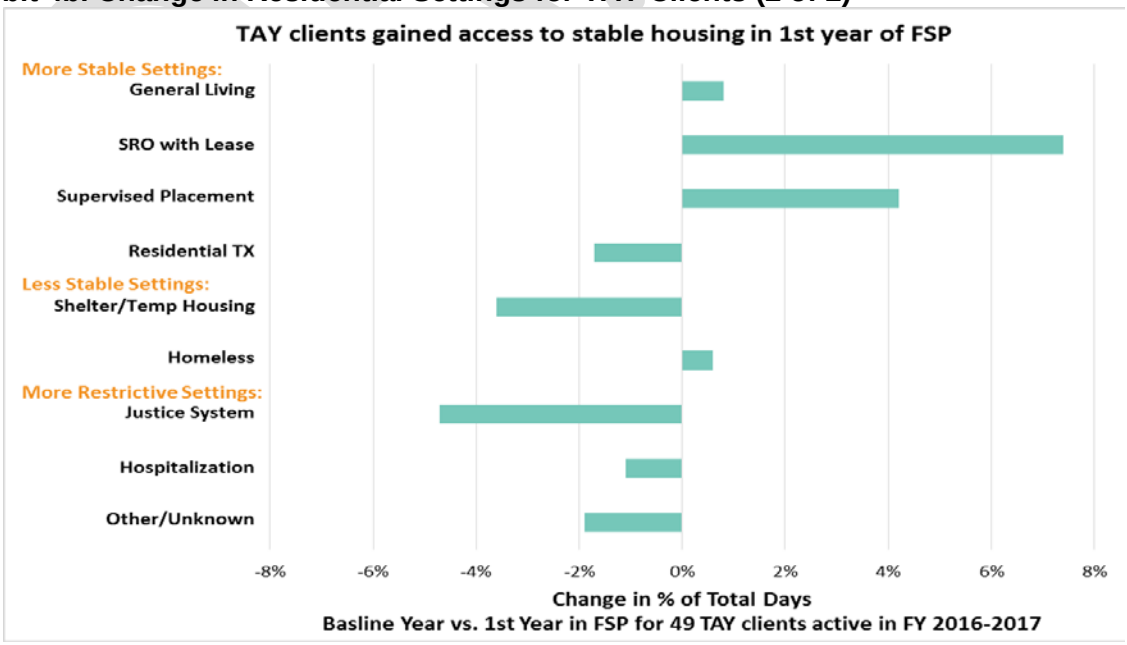


Exhibit 4b. Change in Residential Settings for TAY Clients (2 of 2)



TAY clients accessed more stabilizing settings in FSP treatment. More TAY moved into Single Room Occupancy hotels (SRO) with Lease, Supervised Placement, and Residential Treatment in their first year in FSP and spent more time (days) in each of these settings than they did prior to enrolling in FSP services (Exhibit 4a). TAY spent 7.4% more total time in SRO with Lease, 4.2% more in Supervised Placement, and almost 1% more time in General Living settings during their first year in FSP (Exhibit 4b), suggesting some TAY clients are gaining access to housing and/or stabilizing enough to maintain more stable housing. The positive changes in residential settings are further reflected by TAY having spent 4.7% fewer days in Justice System settings, 1.7% fewer days in Residential Treatment, and 1.1% fewer days Hospitalized (Exhibit 4b). While Homeless increased 0.6%, this increase reflects the addition of 1 homeless TAY in the FSP programs since Baseline.

Exhibit 5a. Change in Residential Settings for Adult Clients (1 of 2)

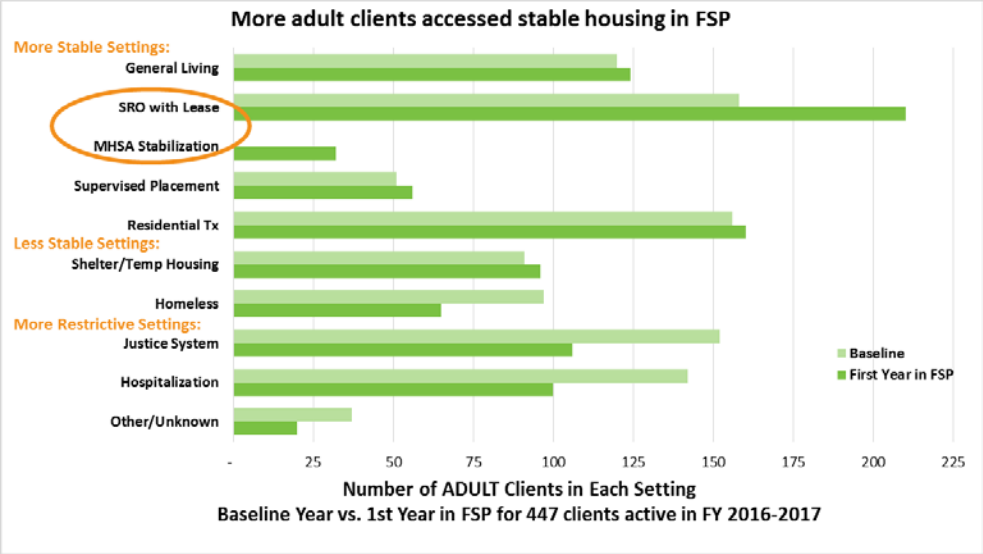
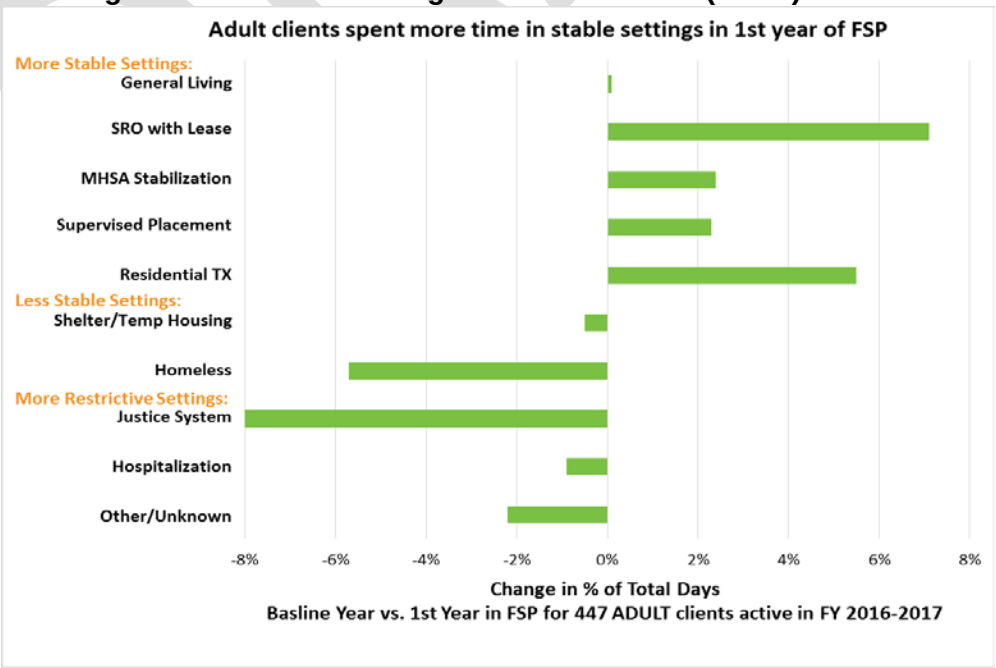


Exhibit 5b. Change in Residential Settings for Adult Clients (2 of 2)



More adult clients were observed in stable housing between baseline and the first year in an FSP, and increased time spent in stable, less restrictive settings. There was a reduction in both number of clients and amount of time spent in Homeless, Justice System, and Hospital settings after the first year in FSP services. From baseline to first year in FSP during FY16-17, there were fewer adults and less time spent Homeless (-32 people, -5.7% days), in the Justice System (-46 people, -8% days), and Hospitalized (-42 people, -0.9% days). There was an increase in the number of people (+52) and in the % of days spent in SRO with Lease (+7.1%), MHSA Stabilization (+32 people, +2.4% days), Supervised Placement (+5 people, +2.3% days), and Residential Treatment (+4 people, +5.5% days). While Supervised Placement and Residential Treatment are relatively restrictive settings, they may represent advancement in recovery for FSP clients who have not previously accessed care.

Exhibit 6a. Change in Residential Settings for Older Adult Clients (1 of 2)

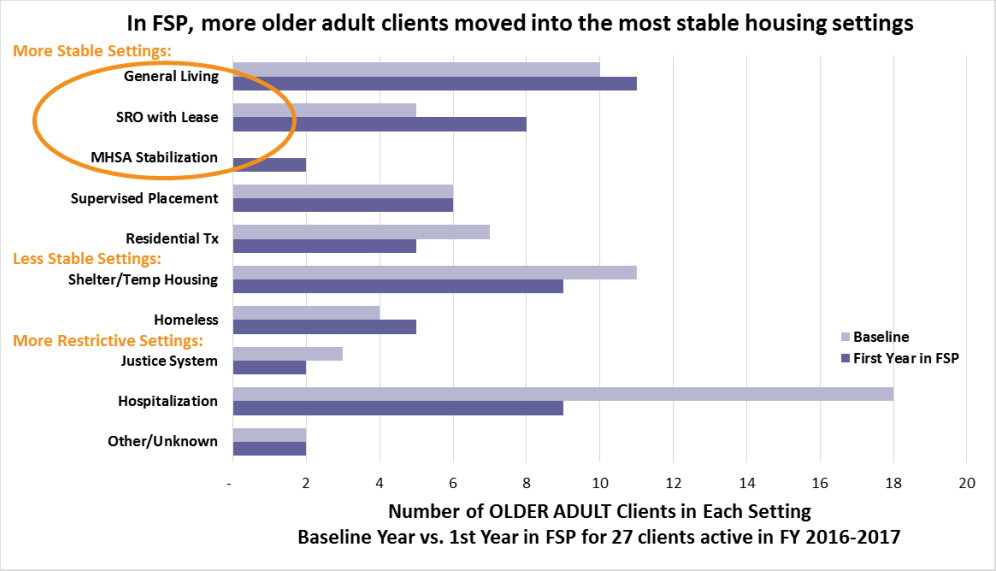
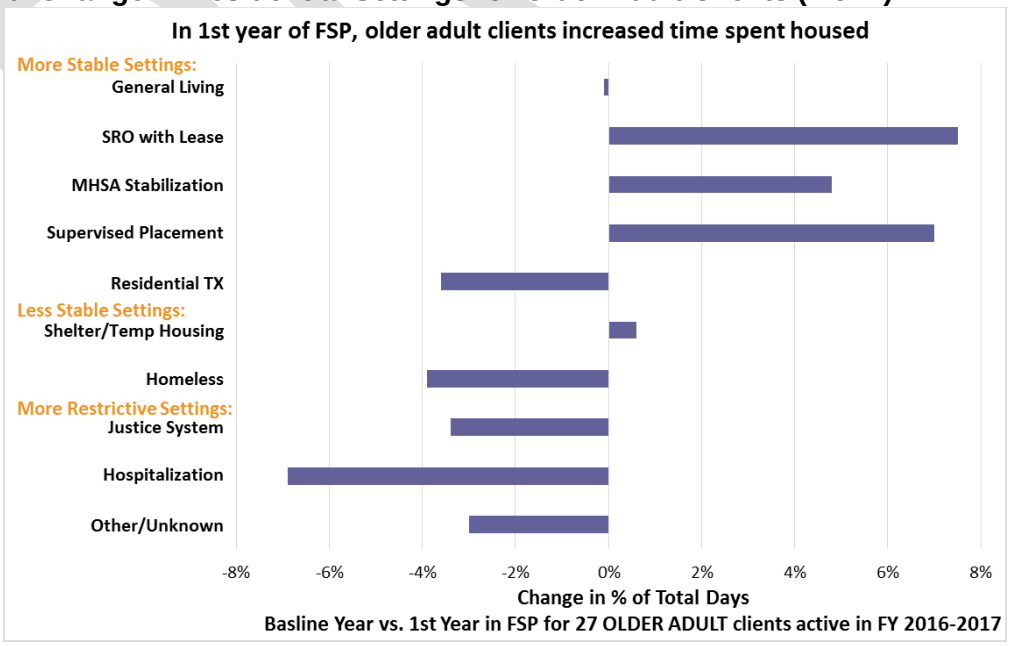


Exhibit 6b. Change in Residential Settings for Older Adult Clients (2 of 2)

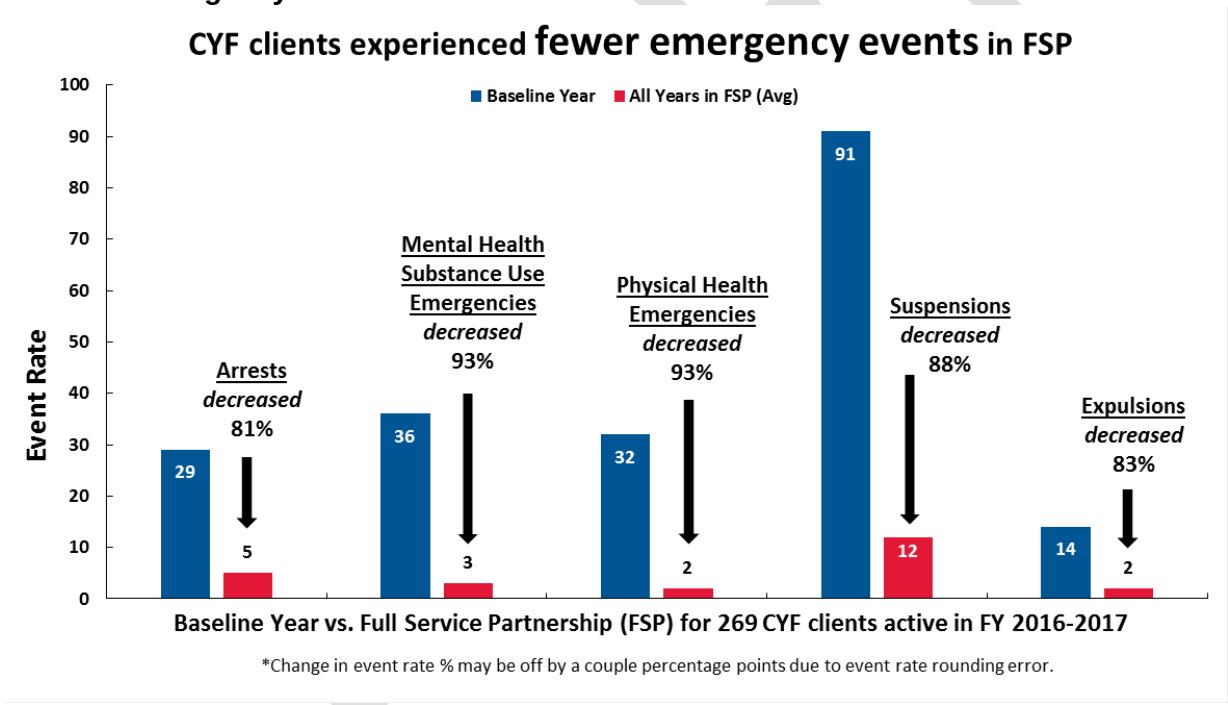


Older Adult FSP clients show significant decreases in time spent in unstable settings. Data indicate more older adult clients spent a higher percentage of total days during their first year in FSP in SRO with Lease (+3 people, +7.5% days) and MHSA Stabilization (+2 people, +4.8% days), suggesting positive outcomes, especially as the number of clients and time spent in Hospitalization (-9 people, -6.9% days) and Justice System (-1 person, -3.4% days) declined during FSP treatment. While the number of clients Homeless increased by 1 person, the amount of time spent Homeless decreased by -3.9%.

Emergency Events

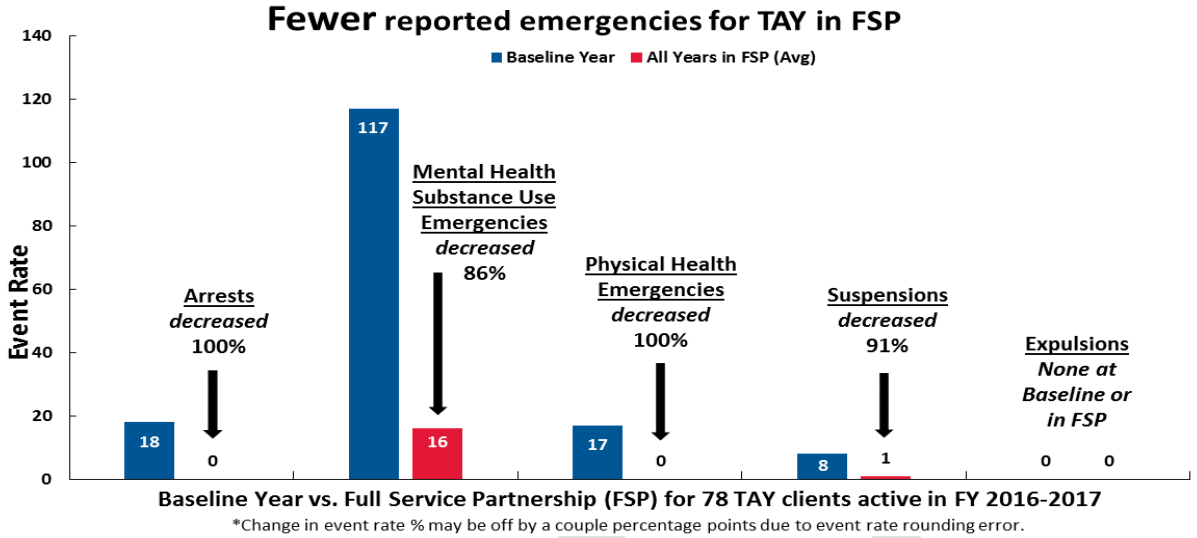
Emergency events include arrests, mental health or psychiatric emergencies (which include substance use related events), and physical health emergencies, as well as school suspensions and expulsions for young children and TAY, for FSP clients active any time between July 2016 and June 2017. For the rate of emergency events (measured by the number of events per person-year), the baseline rate of events (pre-FSP) is compared graphically below to the rate of events while in FSP. Unlike the Residential Settings measure, which looks only at the first year in FSP for all clients, the emergency events FSP measure averages the annual event rate over all years in FSP. Event rates are reported here, for simplicity, as number of emergency events per 100 clients.

Exhibit 7. Emergency Events for Child Clients



Emergency events were reported much less often among child clients. There were marked declines across all types of emergency events reported for child clients. The few events displayed for clients during their first years in FSP service suggest that data entry for Key Events is not complete. Data Quality reports indicate missing DCR data for CYF clients.

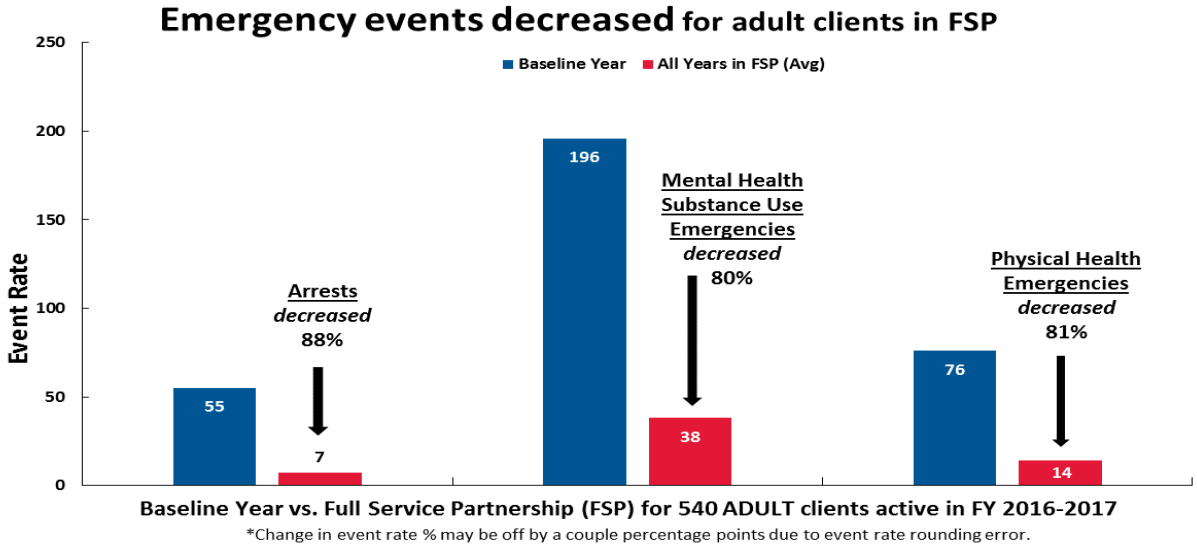
Exhibit 8. Emergency Events for TAY Clients



For TAY clients, fewer emergency events were reported. Marked declines appear across all emergency events experienced by TAY clients. Most noticeably, physical health emergencies and arrests decreased 100%, from 17 events per 100 clients to 0 and 18 events to 0, respectively. Mental Health Substance Use emergencies dropped from 117 events per 100 clients in the baseline year, to 16 events per 100 clients in the FSP years.

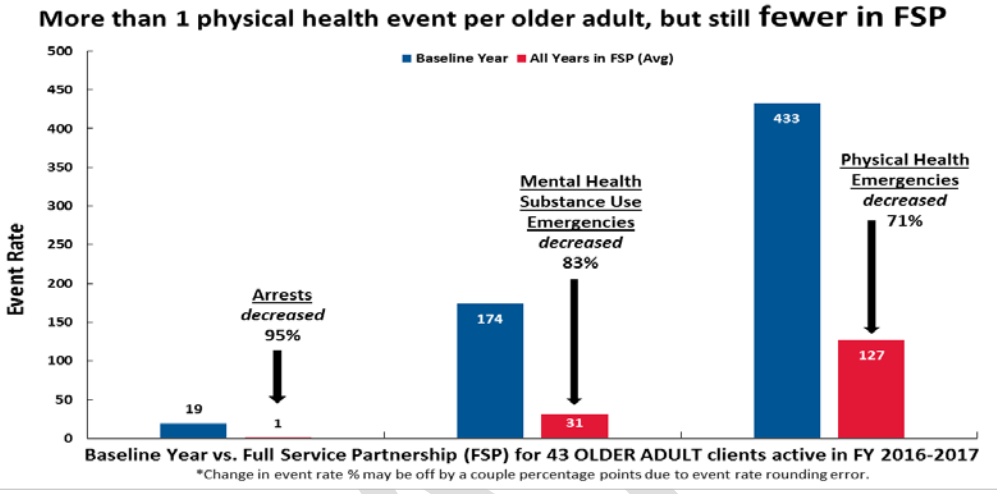
Based on discharge data that suggest engaging with TAY is a major challenge (see Exhibit 11 that shows 11% "Unable to Locate" and 21% "Partner Left Program"), many TAY clients are likely to leave the FSP within year one. This suggests that some TAY clients with high distress are under-represented in the follow-up FSP rate. School Suspensions (reduced from 8 to 1 per 100 clients) also show significant improvement. No School Expulsions were reported in the baseline or FSP years for TAY active in 2016-17. Either expulsions are under-reported, or this decrease reflects a recent policy change in the school district, which strongly discourages student expulsions.

Exhibit 9. Emergency Events for Adult Clients



Adult clients show fewer emergency events since enrollment in FSP programs. As depicted, there were substantial declines reported across all emergency events. Arrests dropped 88%, from 55 per 100 clients in the baseline year, to 7 events per 100 clients in the FSP years. Reports of Mental Health Substance Use Emergencies declined 80% from 196 per 100 clients in the baseline year, to 38 events per 100 clients in FSP. Physical Health Emergencies declined 81% from 76 per 100 clients in the baseline year, to 14 in 100 in the FSP years.

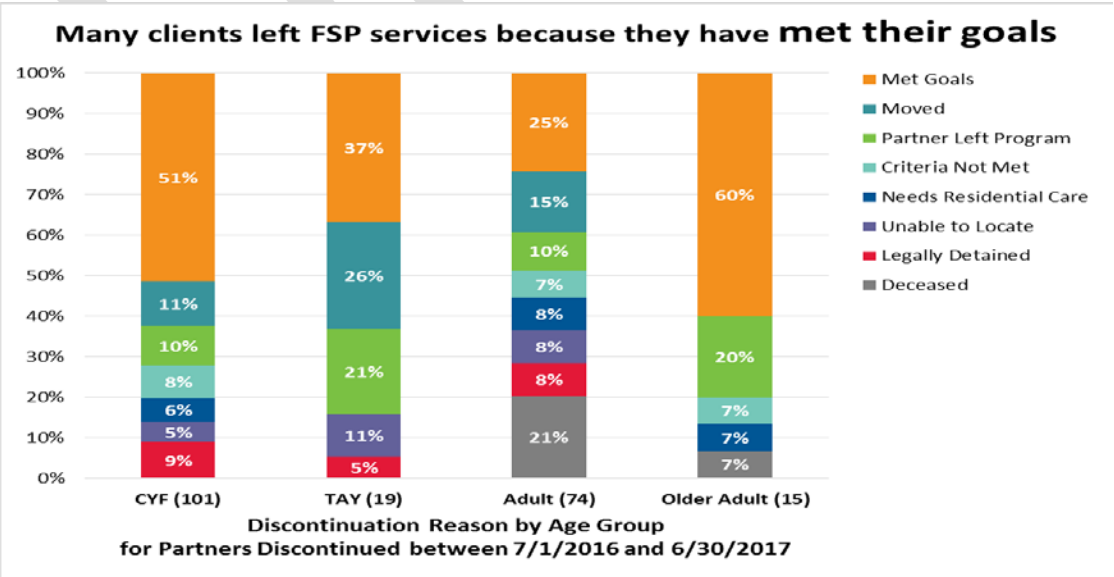
Exhibit 10. Emergency Events for Older Adult Clients



Despite high levels of physical health emergencies among older adult clients at baseline, data reveal improvements after the first year in FSPs. Arrest rates reduced 95% from 19 to 1. The rates of mental and physical health emergencies also dropped 83% and 71% respectively. Physical health emergencies are commonly reported for older adults, as many as 127 per 100 clients even while in FSP treatment. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

Reason for Discontinuation

Exhibit 11. Reason for Discontinuation for All Clients



Reasons for Discontinuation vary widely, however "Met Goals" is the most reported reason for discontinuation across the four age groups. Most concerning in this display is that, that among adults, 21% of discontinuations are due to death, most likely premature, caused by long term substance overuse, chronic medical conditions, homelessness, and poor access to medical care.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[2]**
Full Service Partnership (Children)	513 Clients	$1,368,334	$2,667
Full Service Partnership (TAY)	127 Clients	$1,060,067	$8,347
Full Service Partnership (Adult)	572 Clients	$3,883,642	$6,790
Full Service Partnership (Older Adult)	83 Clients	$968,654	$11,671

Trauma Recovery Programs

Program Collection Overview

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

Target Populations

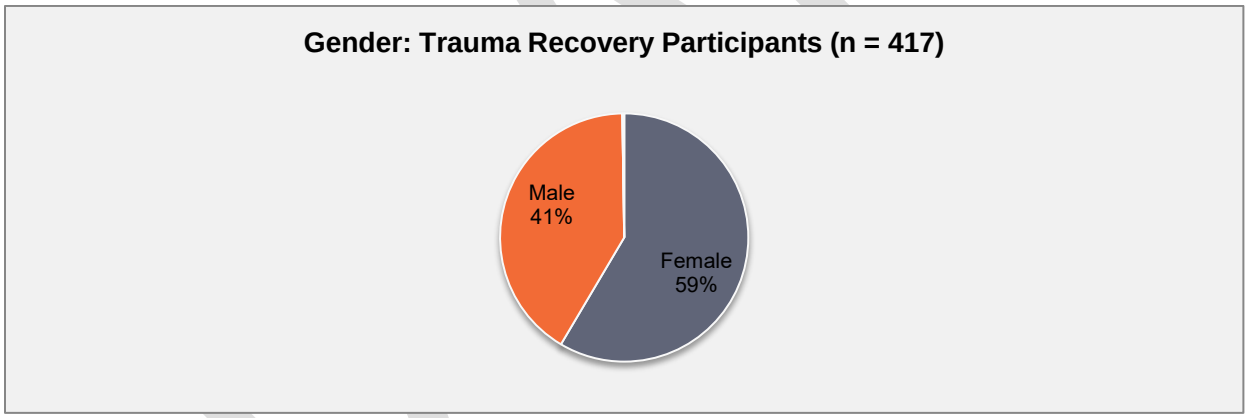
The Trauma Recovery programs serve youth ages 12 to 25, as well as their families, with a focus on youth of color, particularly Latinos who reside in the Mission District, and youth who come from low-income and/or immigrant families. Program participants are typically individuals who have been affected by violence. Most often, these youth are faced with a number of additional risk factors, including lack of educational success/withdrawal from school, familial mental health and substance use disorders, multi-generational family involvement in crime, community violence, and extreme poverty.

[2] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

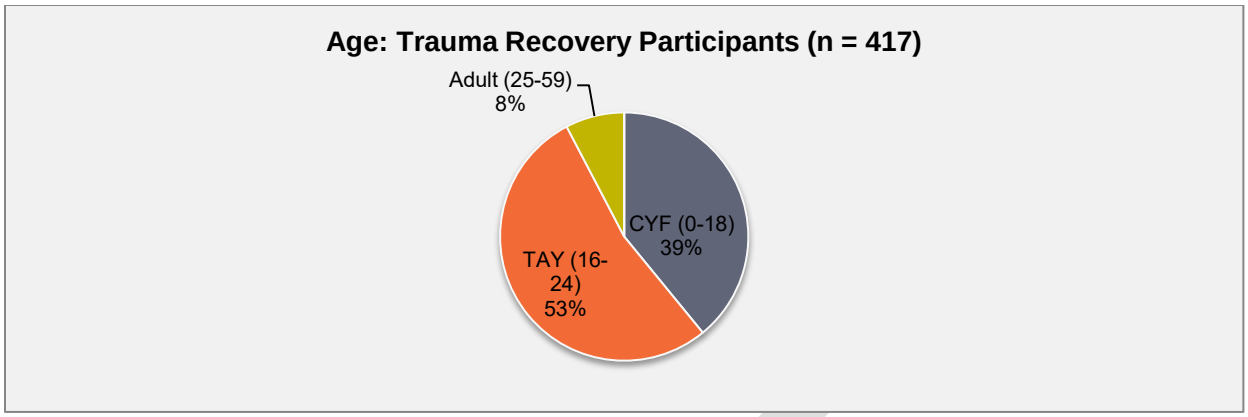
Trauma Recovery Programs	
Program Name (Provider)	**Services Description**
La Cultura Cura/Trauma Recovery and Healing Services - Instituto Familiar de la Raza	Instituto Familiar de la Raza provides trauma recovery and healing services through its Cultura Cura Program to individuals ages 12 to 25 and their families, with an emphasis upon Mission District youth and Latinos citywide. Services include prevention and intervention modalities to individuals, agencies and the community.
Emic Behavioral Health Services - Horizons Unlimited	Horizon Unlimited's Emic Behavioral Health Services (EBHS) program provides services to meet the unmet mental health needs of youth and families whose problems place them at significant risk, and impede adequate functioning within their family, school, community and mainstream society. The EBHS treatment model combines culturally informed, evidence based substance abuse and mental health principles and practices that are linguistically sensitive, strength based, family focused and bio-psychosocially-oriented.

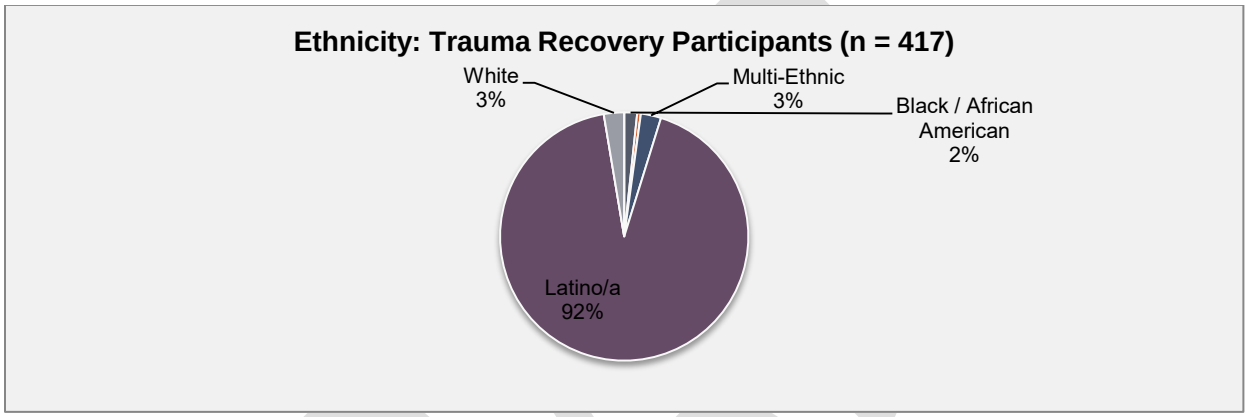
Participant Demographics, Outcomes, and Cost per Client

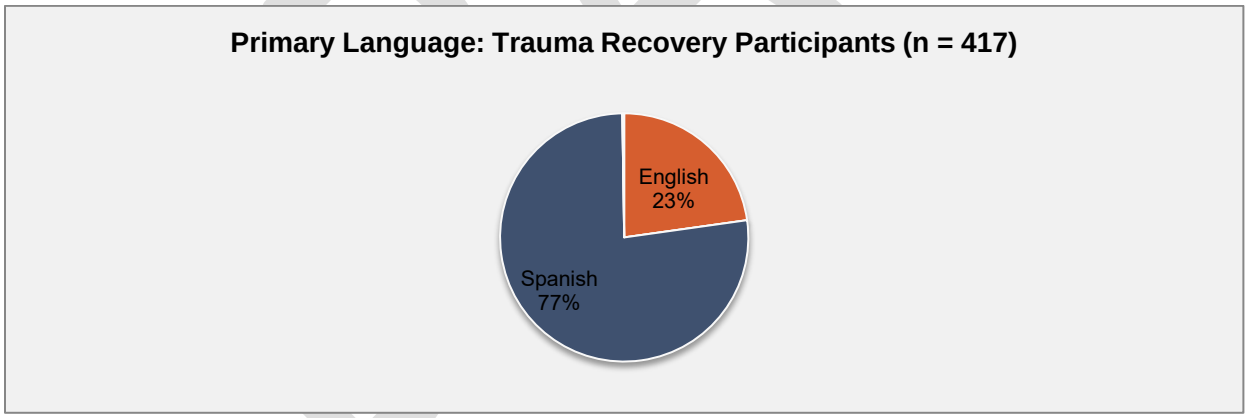
Demographics: Trauma Recovery[3]



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


Age: Trauma Recovery Participants (n = 417)
Adult (25-59) 8%
CYF (0-18) 39%
TAY (16-24) 53%


Ethnicity: Trauma Recovery Participants (n = 417)
White 3%
Multi-Ethnic 3%
Black / African American 2%
Latino/a 92%


Primary Language: Trauma Recovery Participants (n = 417)
English 23%
Spanish 77%

Program	FY16-17 Key Outcomes and Highlights
La Cultura Cura – Instituto Familiar de la Raza	• Mental Health Specialists conducted a total of 66 assessments of program participants' needs and strengths, utilizing the Child and Adolescent Needs and Strengths (CANS) assessment and/or UCLA Post Traumatic Stress Disorder Screening tool. • 72% of program participants receiving individual treatment services improved in their functioning. • 66 community members participated in two Drumming for Peace events. • 100% of all participants referred to services received follow-up services as documented in a referral binder.
Emic Behavioral Health Services – Horizons Unlimited	• 129 clients were screened and assessed for behavioral health concerns. • 85 of the 129 clients (236% of goal) were referred to an array of services. • 44 individuals (110% of goal) participated in wellness promotion activities either in the Newcomer Wellness Groups or in drumming sessions held during various times of the year. • 24 of the 40 clients (104% of goal) reported having learned coping skills to help them manage stressful situations.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[4]**
Trauma Recovery Programs	455 Clients	$454,047	$998

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.

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

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.

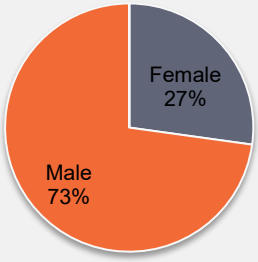
Behavioral Health and Juvenile Justice System Integration Programs	
Program Name (Provider)	**Services Description**
AIIM Higher – Seneca Center and SFDPH	AIIM Higher is a partnership among the San Francisco Juvenile Probation Department, the Child, Youth and Family System of Care, and Seneca Center.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

MHSA Consumer, Peer and Family Conference 2017

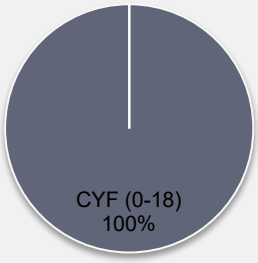
Participant Demographics, Outcomes, and Cost per Client

Demographics: Behavioral Health and Juvenile Justice Integration[5]

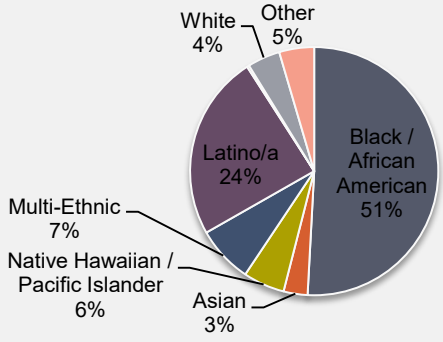
Gender: Behavioral Health & Juvenile Justice Participants (n = 353)



Age: Behavioral Health & Juvenile Justice Participants (n = 366)

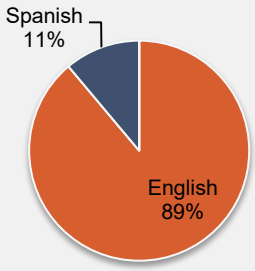


Ethnicity: Behavioral Health & Juvenile Justice Participants (n = 352)



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

Primary Language: Behavioral Health & Juvenile Justice Participants (n = 36)



Program	FY16-17 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to Services (AIIM Higher) – SFDPH and Seneca	• Of the 366 youth screened, 254 were eligible for services and depending on acuity were offered either AIIM Higher clinical consultation, linkage to services, or the full SF AIIM. • Of the 254 eligible youth, 39 youth and their families were provided with Child Adolescent Needs & Strengths (CANS) assessment, planning, linkage and engagement services. • AIIM Higher served 10 active youth in the Wellness Court program, receiving and serving 6 new youth during this time period and successfully dismissing 7.
Community Assessment and Resource Center (CARC) – Huckleberry Youth Programs	• 7,836 duplicated TAY were engaged in outreach and utilized drop-in centers. • 64% of the youth served were not rearrested during a one-year period after closing with the program. • 359 TAY screened for behavioral/mental health concerns. • 99% of TAY who were screened and/or assessed were re-ferred or received on-site behavioral health services. • 139 TAY and/or their families received a written plan of care. 87 TAY and/or their families (76% of those with written care plans) achieved at least one case/care plan goal.

FY16/17 Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[6]
Behavioral Health & Juvenile Justice Integration	696 Clients	$407,670	$586

[6] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

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

Program Overview

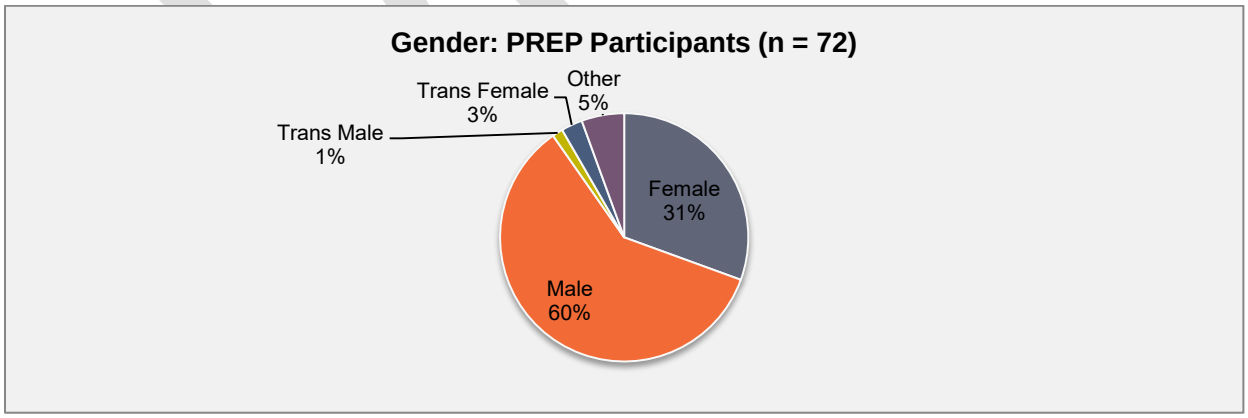
PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs internationally in Australia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

Target Populations

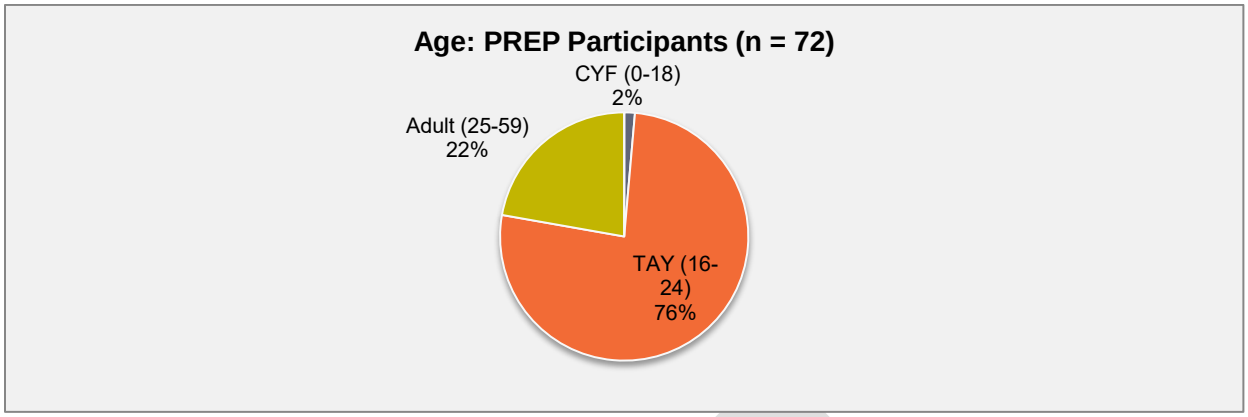
PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years.

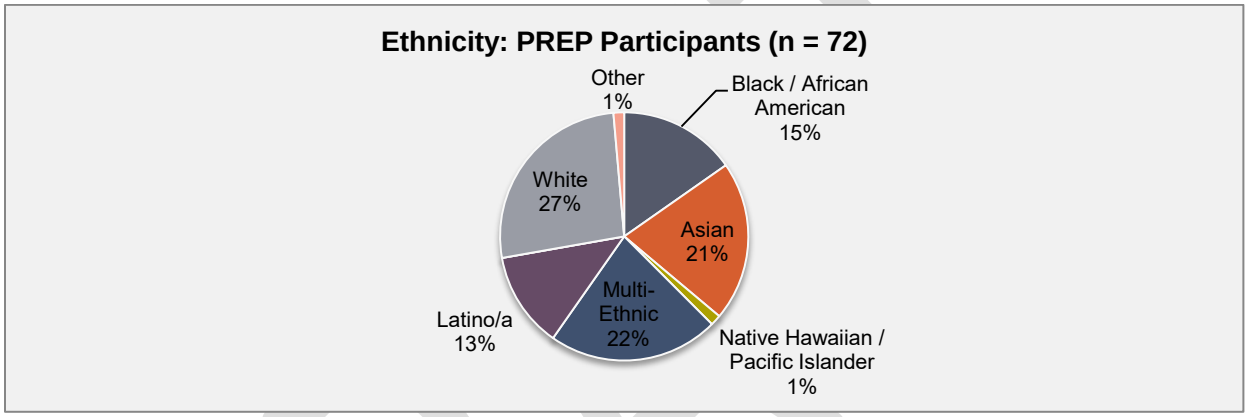
Participant Demographics, Outcomes, and Cost per Client

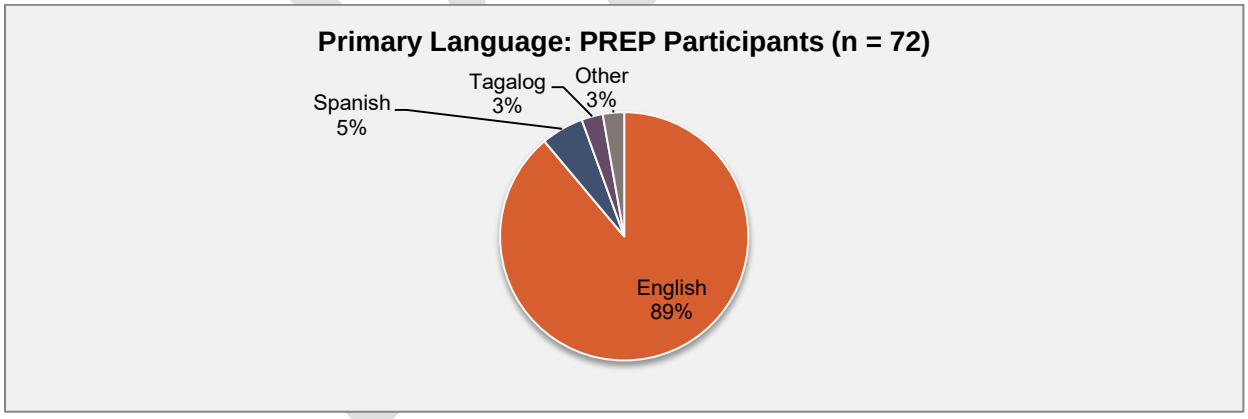
Demographics: PREP[7]



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







Program	FY16-17 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP) – Felton Institute	• 16 out of 34 clients (120% of goal) with no acute inpatient setting episodes within 12 months prior to their enrollment, had no acute inpatient setting episodes during the first 12 months of enrollment in PREP. • PREP contacted 30 programs and/or community stake-holder groups during FY16-17 to provide information regard-

Program	FY16-17 Key Outcomes and Highlights
	ing early psychosis services. • A total of 23 clients completed assessments to determine need for early psychosis services. • PREP staff provided 3,015 hours of individual direct treatment services.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[8]**
Prevention and Recovery in Early Psychosis (PREP)	72 Clients	$976,673	$13,565

Behavioral Health Access Center (BHAC) - SFDPH

Program Overview

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

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

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

BHAC continues to prepare for the implementation of the Drug Medi-Cal – Organized Delivery System (DMC-ODS) in San Francisco. San Francisco County's Implementation Plan was one of the first approved by the California Department of Health Care Services and part of the plan ap-

[8] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

points and empowers BHAC to act as the portal of entry into the organized delivery system for those seeking care for substance use disorders. Through the provision of high quality provision of services and best practices, BHAC will engage with vulnerable populations while provision Medi-Cal beneficiaries with appropriately matched interventions using proven placement criteria.

The establishment of the ODS in San Francisco marks a huge change to the way that services are provided and how reimbursement is provided for an array of treatment interventions not previously covered. As part of preparations for DMC-ODS implementation, BHAC has created a beneficiary enrollment process through a cooperative agreement with Richmond Area Multi Services, Inc. The goal of this effort is to ensure that any person seeking care is enrolled in Medi-Cal. Onsite enrollment occurs five days per week, and an addition to enrollment, the program provides information, inter–county transfer assistance and access to other entitlements.

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

BHAC Remodel with help from the First Impressions Project

Target Populations

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

Program Outcomes, Highlights and Cost per Client

Program	FY16-17 Key Outcomes and Highlights
Behavioral Health Access Center - SFDPH	• 1,233 face-to-face contacts with individuals seeking access to care. • 19,223 telephone interventions through the Access Call Center. • 219 new Medi-Cal beneficiary enrollments.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[9]**
Behavioral Health Access Center	1,233 Clients	$770,964	$625

WRAPS Dual Diagnosis Residential Treatment – HealthRIGHT 360

Program Overview

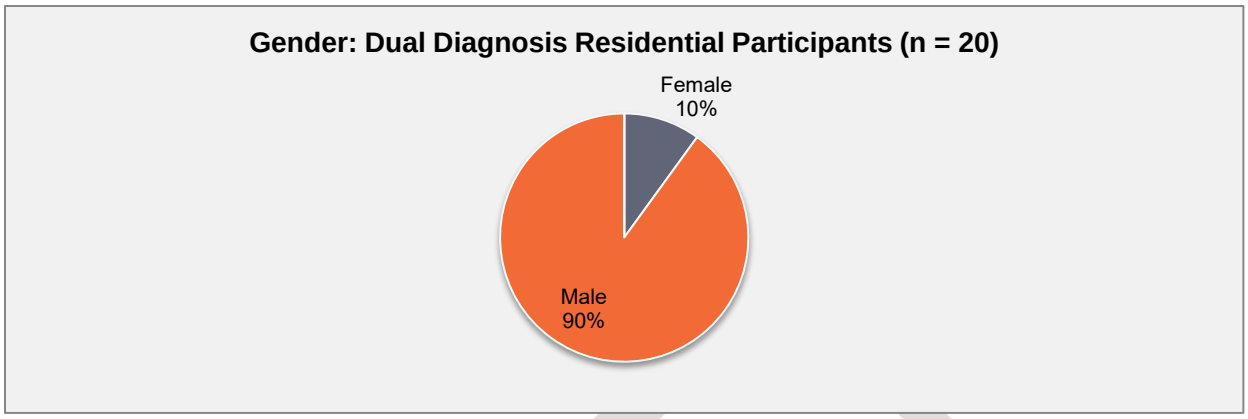
HealthRight 360 (HR 360) WRAPS provides brief residential psychiatric stabilization, designed for clients who might otherwise be diverted to Psychiatric Emergency Services or an Acute Diversion Unit setting. WRAPS is a well-established resource for clients who require residential stabilization. Clients participate in the larger structure of groups, individual services and care management that all clients in the facility receive. Groups include Wellness Recovery Action Plan, Dialectical Behavioral Therapy, Grief and Loss, Skills Training, etc. Individual services include Drug and Alcohol Counseling, Individual Therapy if needed, access to psychiatric services through the four medical clinics, case management, linkage and referral to community services.

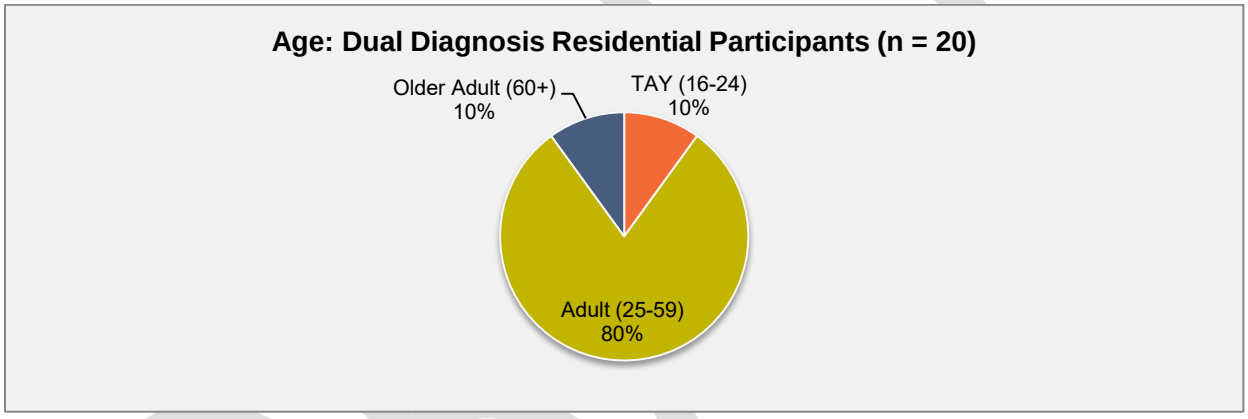
Target Populations

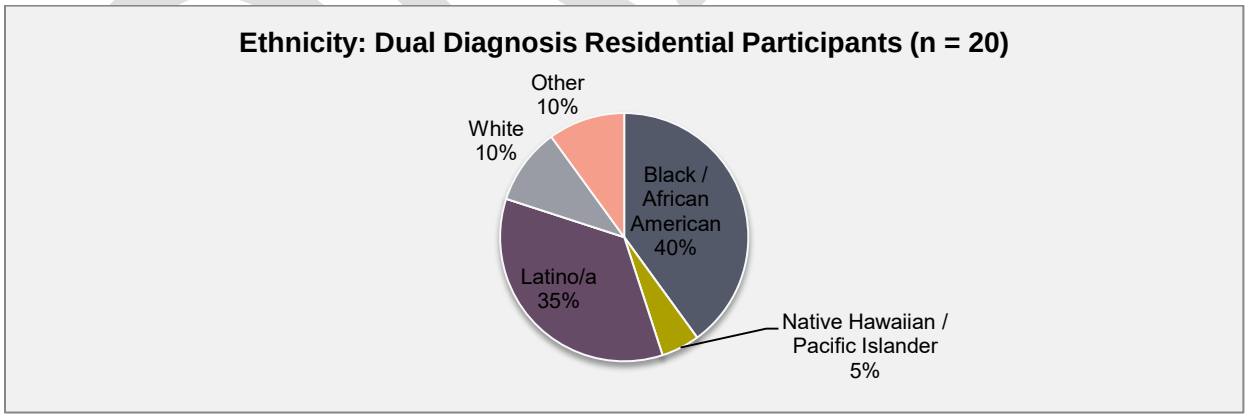
Dual diagnosis residential treatment services are provided to individuals who do not have Medi-Cal coverage and who would otherwise not be eligible for services. As a result of the Affordable Care Act (ACA), more individuals are now eligible to enroll in Medi-Cal than ever before. SFDPH MHSA intends to partner with the service provider and other stakeholders to evaluate how ACA may impact the target population for this program.

[9] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

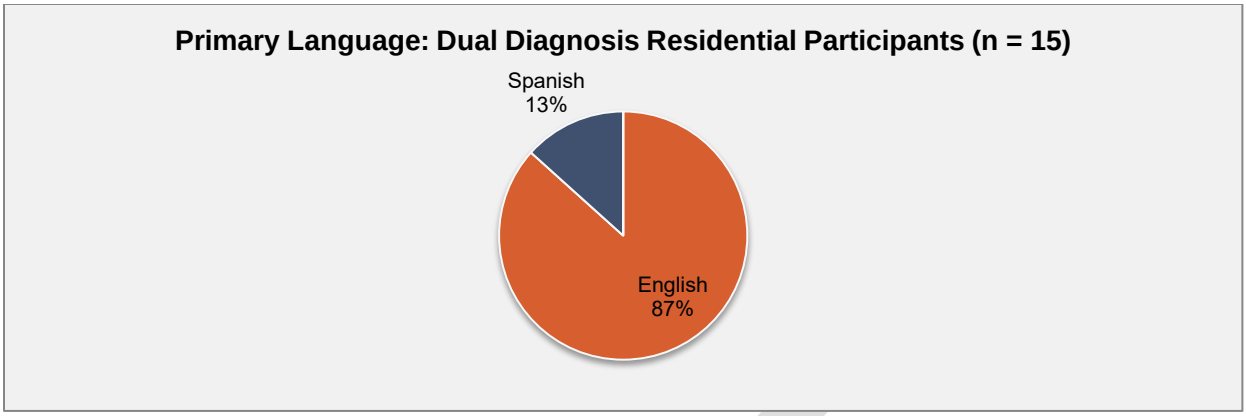
Demographics: Dual Diagnosis Residential[10]







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



Program	FY16-17 Key Outcomes and Highlights
WRAPS Dual Diagnosis Residential Treatment - HealthRIGHT360	• 65% of clients who completed their time at WRAPS were linked to an appropriate level of continuing care and support, as measured by internal outcome measurement system and documented in client files. • 100% of clients avoided PES/hospitalization for mental health reasons for the duration of their stay, as measured by internal outcome measurement system and documented in client files.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[11]**
WRAPS - Dual Diagnosis Residential Treatment	20 Clients	$83,117	$4,156

Integration of Behavioral Health and Primary Care - San Francisco Health Network and Curry Senior Center

Program Collection Overview

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

[11] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

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

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

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

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

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

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

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

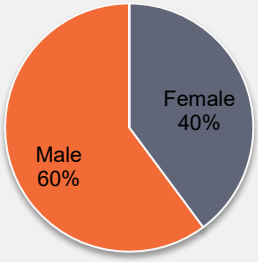
Target Populations

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

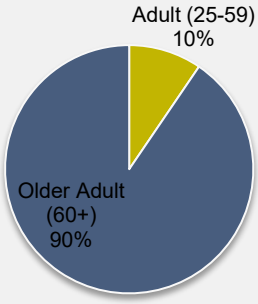
Participant Demographics, Outcomes, and Cost per Client

Demographics: Primary Care Integration

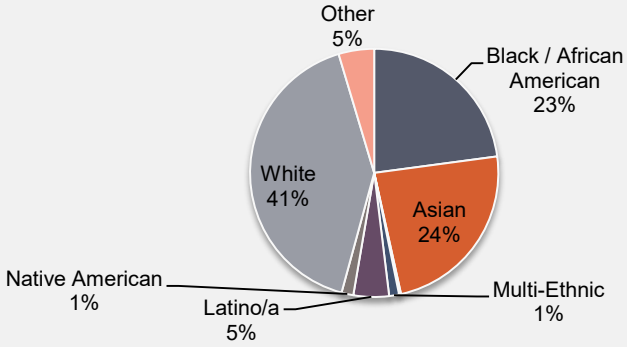
Gender: Primary Care Integration Participants (n = 389)

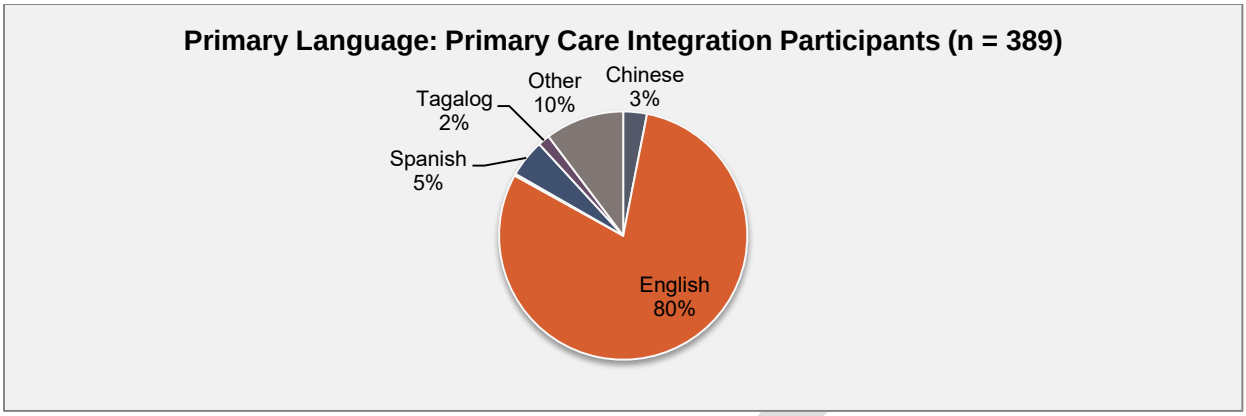


Age: Primary Care Integration Participants (n = 389)



Ethnicity: Primary Care Integration Participants (n = 389)





Program	FY16-17 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – Curry Senior Center	• Curry Peers connected with and engaged over 1,174 older adults – providing them with information and referrals to Curry's and other services. • 280 seniors were screened and assessed by Curry Senior Center's Nurse Practitioners for mental health and cognitive disorders. • 82% of the case management program participants have demonstrated an increased ability to manage symptoms (102% of goal). • The Nurse Practitioners provided primary care services to older adults with mental health issues with a total number of 1,307 encounters.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[12]
Integration of Behavioral Health and Primary Care	4,251 Clients	$1,314,216	$309

Moving Forward in Recovery-Oriented Treatment Services

Full Service Partnership (FSP) Programs

SFDPH MHSA is supporting a new project called The Collaborative Courts program. The program is a partnership across the Department of Aging and Adult Services, Office of the Public Conservator, the Department of Public Health, and the San Francisco Collaborative Courts. This program aims to provide intensive community support and outreach to promote stability, enhance their successful integration in the community, and improve quality of life. The program plans to launch in the spring of 2018.

[12] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

With stakeholder and community feedback, SFDPH MHSA evaluated the Acute Psychiatric Stabilization program and determined that these services would benefit from being integrated with other residential treatment programs and Full-Service Partnership programs within the BHS Adult/Older Adult System of Care. SFDPH MHSA will continue to assess the needs of this specific population in subsequent years to ensure that adequate programming continues into the future.

SFDPH MHSA recently collaborated with the Adult/Older Adult System of Care to streamline and organize the Intensive Case Management Modality Services, comprised of Full Service Partnerships (FSP) and Non-Full Service Partnerships (Non-FSP) Programs. Various stakeholders work to develop a new model and design. SFDPH issued a Request for Proposals in the summer of 2017 describing the new integrated model with an anticipated start date of January 1, 2018. Services provided under this new design are funded through a combination of Medi-Cal, County general fund, State realignment, MHSA, Medicare, grants and other revenues dedicated to mental health. The Adult/Older Adult System of Care will manage and integrate these services in effort to share resources, best practices, and policies.

SFDPH recently published a Transition Age Youth (TAY) Request for Qualifications (RFQ) to identify a service provider to further plan, implement and evaluate a new TAY FSP program that will add to the newly developed TAY System of Care. This project will launch in July of 2018.

SF-MHSA has worked in collaboration with the Adult/Older Adult (A/OA) System of Care (SOC) and Quality Management to implement **new efforts to help improve the outcomes of the FSP programs.** These efforts include:

- Streamlining the authorization process for A/OA FSPs, and clarifying that a sole authorizer from the A/OA SOC will sign off on new clients
- Updating all authorization forms for TAY and A/OA to reflect the actual practices when authorizing new TAY FSP clients
- Streamlining the housing referral process for TAY and A/OA clients
- Coordinating activities; establishing a sole FSP staff person to:
    - Be a liaison (between the SOC and FSP Program) for Authorization requests. This is typically and will remain the FSP Programs Director
    - Be a housing referral liaison (between the FSP Program and the Department of Homelessness and Supportive Housing)
- Informing FSP staff of the new forms (if applicable) as related to authorizing new clients and referring clients to housing
- The Quality Management (QM) team has provided a great deal of technical assistance for FSP programs that had difficulties logging into the Data Collection and Reporting System (DCR). QM and Information Technology (IT) teams are supporting program managers to report accurate and up-to-date DCR data.
- There have been a series of meetings with the Children, Youth and Families (CYF) FSPs in which we clarified the various steps for authorizing new clients. Each CYF FSP maintains an authorization process specific to their needs. In these meetings, we have learned that the majority of CYF FSP clients and their families have housing through other support systems.

<u>Assisted Outpatient Treatment Program</u>

In July 2014, San Francisco's Board of Supervisors authorized Assisted Outpatient Treatment as a response to Mayor Ed Lee's 2014 Care Task Force. Implemented November 2, 2015, the San Francisco Assisted Outpatient Treatment Model is utilized as an intervention and engagement tool designed to assist and support individuals with serious mental illness. The

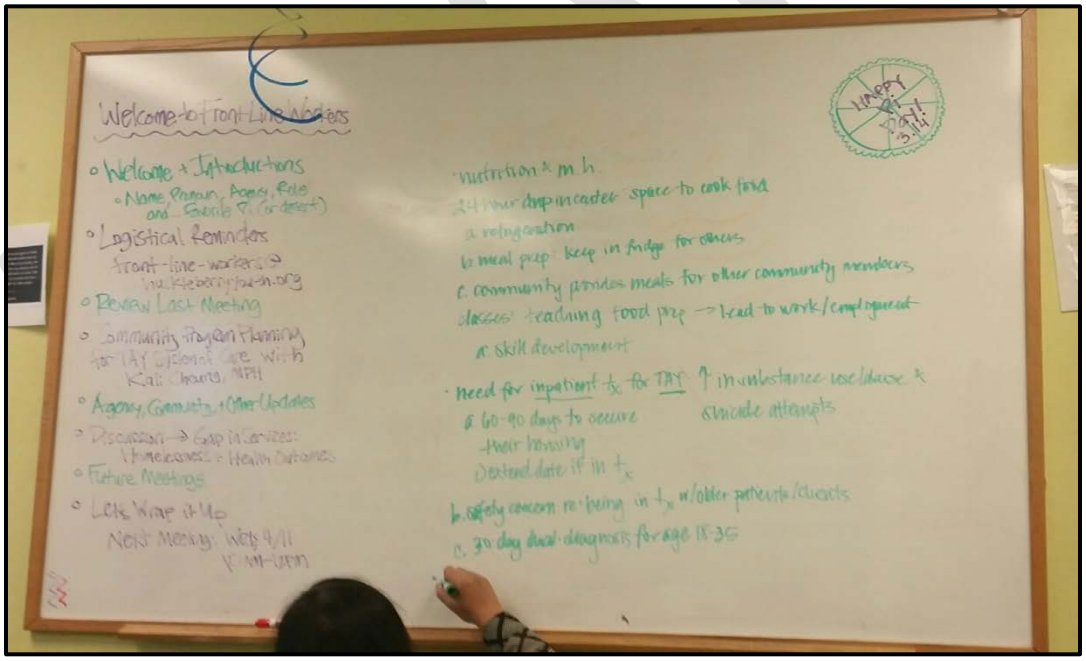
program has been constructed to employ principles of recovery and wellness, and has a particular focus on community-based services and multiple opportunities for an individual to engage in voluntary treatment. The ultimate goal of the program is to improve the quality of life of participants and support them on their path to recovery and wellness, as well as prevent decompensation and cycling through acute services (e.g., psychiatric hospitalization) and incarceration.

As the Assisted Outpatient Treatment (AOT) program continues to grow, program evaluation will build on current findings and will be expanded to include the following: (1) input and perspective from additional stakeholder groups, and (2) analysis of the program's cost and financial impact. Moving forward, AOT staff will utilize the findings of future evaluations to inform program implementation and the provision of effective services to clients.

Behavioral Health Access Center

The Behavioral Health Access Center (BHAC) engages with vulnerable populations who seek access to care in San Francisco. BHAC has served thousands of people since 2009 and continues to be a high profile portal of entry into the system of care.

In FY18-19, BHAC will recruit a complement of licensed and certified staff, bringing increased clinical depth to the program, and readying the program for the anticipated volume increase of clients seeking care under Drug Medi-Cal. These six new staff will be oriented to our system of care, and assist in reducing barriers to accessing care. These recruitment efforts will be part of the Drug Medi-Cal – Organized Delivery System.



2018 MHSA CPP Meeting with Transition Age Youth

Spotlight on INNOVATIONS

Intensive Case Management Flow Project

The ICM Flow initiative is centered on the need to support behavioral health clients who no longer require the intensive level of care and service provided by the ICM and Full Service Partnership (FSP) programs. Clients who show progress toward recovery and engagement may be more appropriately and well supported at an outpatient clinic. Unfortunately, several factors can impede a successful transition—defined as linkage and engagement—to outpatient care. With ICM Flow, more clients will transition safely to outpatient care, living more self-directed lives that support their wellness and connection to a community that has meaning for them.

An ICM Flow project planning team was formed in early 2017, consisting of leadership from the Adult and Older Adult System of Care, Quality Management, and Mental Health Services Act staff. Supported by facilitators from Learning for Action, this planning team strategized and organized a series of six meetings between (1) ICM/FSP program directors; (2) Outpatient program directors; (3) Consumer/peer advocacy programs; and (4) Individual consumers and peers with experience transitioning to a lower level of care from ICMs/FSPs.

The meetings focused upon refining understanding of the problem informed by data from QM, and brainstorming and discussing possible solutions and innovative project models. A consumer panel shared their experiences of transitions from ICM/FSP to Outpatient programs and additional consumers participated in small group discussions focused on improvement ideas for specific aspects of the transition. Peer representation was also provided through peer advocacy CBO organizations' participation in meetings, and the MHSA Peer-to-Peer Programs Manager's participation in the planning team and subsequent ICM/FSP convenings.

The proposed service model which emerged from feedback during these six meetings informed the writing of an Innovation funding proposal to MHSOAC. This proposal is final and was submitted to MHSOAC in December 2017. The MHSOAC approved this proposal.

The model that was proposed is one of an autonomous peer linkage team that can provide both wrap around services and a warm hand off. The team will include highly skilled and culturally and linguistically diverse peers and a supervising clinician. Peers will serve as step-down specialists and help connect clients with resources and information, set expectations, provide follow up, and communicate with providers. The team will outreach to clients prior to transition, and would guide each client through each stage of their transition, from preparation to successful placement and/or discharge.

The primary service goals of this project include clients having successful, long-term engagement in an outpatient setting and an overall improved experience for those in transition. As Innovation projects are pilot projects that focus upon learning questions, the project will also focus upon how effective a highly skilled peer team is, as well as learning about what elements:

- Create successful peer linkage teams
- Lead to effective relationships between peers and their clients
- Contribute to successful provider communication and collaboration
- Contribute to the wellbeing and professional development of peer staff

Please see Appendix A for more details.

2. Mental Health Promotion and Early Intervention

Service Category Overview

The Mental Health Promotion and Early Intervention (PEI) service category is comprised of the following five program areas:

1) Stigma Reduction,
2) School-Based Mental Health Services and Wellness Centers,
3) Population-Focused Mental Health Promotion,
4) Mental Health Consultation and Capacity Building, and
5) Comprehensive Crisis Services.

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

With a focus on underserved communities, the primary goals of PEI services are to raise awareness about mental health, address mental health stigma, and increase access to services. PEI builds capacity for the provision of early intervention services in community-based settings where mental health services are not traditionally provided (e.g., community-based organizations, schools, ethnic specific cultural centers and health providers). Innovation funding also supports several programs in this MHSA service category.

PEI Evaluation

Since 2013, MHSA administration has collaborated with the SFDPH Office of Quality Management in an attempt to strengthen PEI program performance objectives. This collaboration was in effort to build the capacity of MHSA PEI programs. MHSA and the Office of Quality Management convened a series of technical assistance sessions ("Learning Circles") and held individual program meetings with eighteen Population-Focused Mental Health Promotion PE programs. This process included identifying programs' target populations, goals, specific activities, global processes, and outcomes objectives, and ultimately developing program-specific processes and outcome objectives that reflected the SMART model. SMART objectives meet the following standards:

S: Specific – concrete, detailed, and well defined
M: Measurable – numbers and quantities provided
A: Achievable – feasible and easy to put into action
R: Realistic – considers constraints, such as resources, personnel, cost, and time
T: Time-Bound – clearly defined time frame that is within reach

These capacity building efforts have shown a sustained improvement for each program, starting in the second year. In the past four years, all PEI programs have increased the percentage of SMART performance objectives to 100 percent.

Stigma Reduction: Sharing Our Lives, Voices and Experiences (SOLVE)

Program Overview

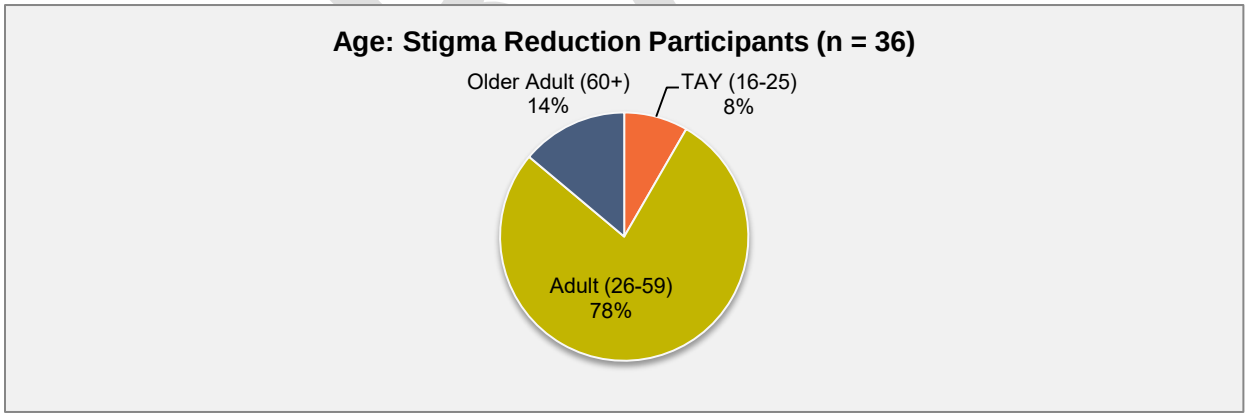
Sharing Our Lives, Voices and Experiences (SOLVE) is a stigma elimination program managed by Mental Health Association of San Francisco. SOLVE trains people in the community ("peer educators") who have been living with mental health challenges to share their personal experiences to help to reduce the social barriers that prevent people from obtaining treatment.

Target Populations

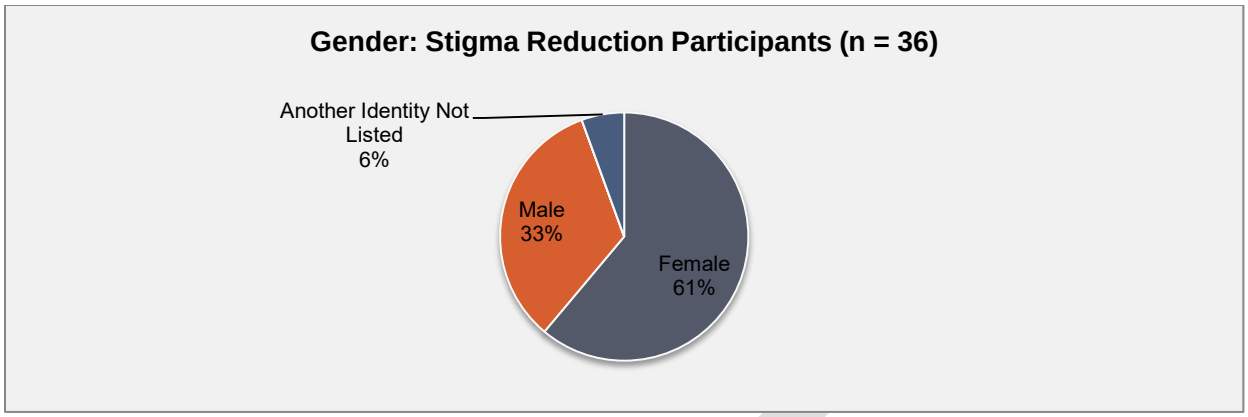
SOLVE peer educators serve a wide range of community members, including BHS consumers, public policy makers, corporate and community leaders, students, school leaders, law enforcement, emergency response service providers, health care providers, and behavioral health and social service providers. The current SOLVE team is comprised of Transition Age Youth, adults and older adults who reside in communities that are severely underserved and less likely to access or obtain support for prevention, wellness, and recovery. These areas include the Tenderloin, Mission, Bayview/Hunter's Point, Excelsior, Chinatown, and Visitacion Valley neighborhoods in San Francisco. SOLVE also targets diverse gender-variant communities within San Francisco.

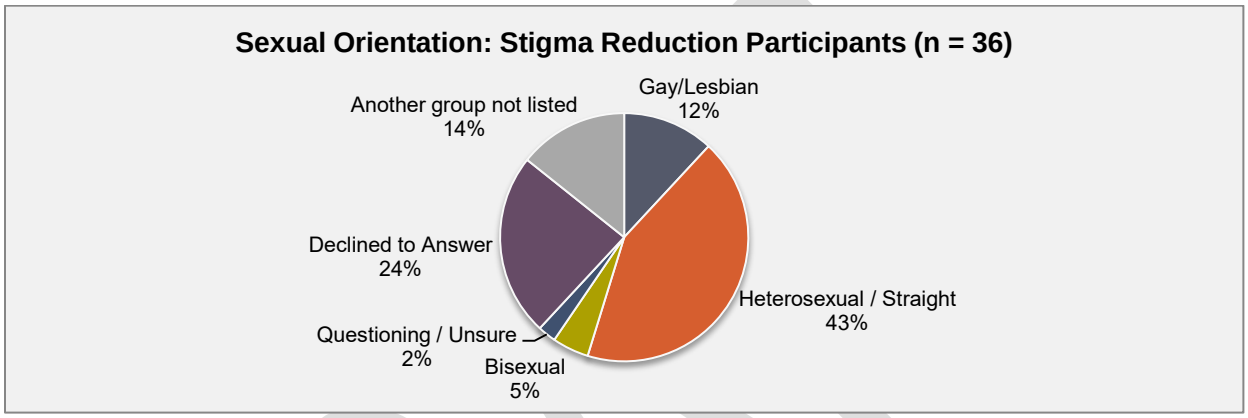
Participant Demographics, Outcomes, and Cost per Client

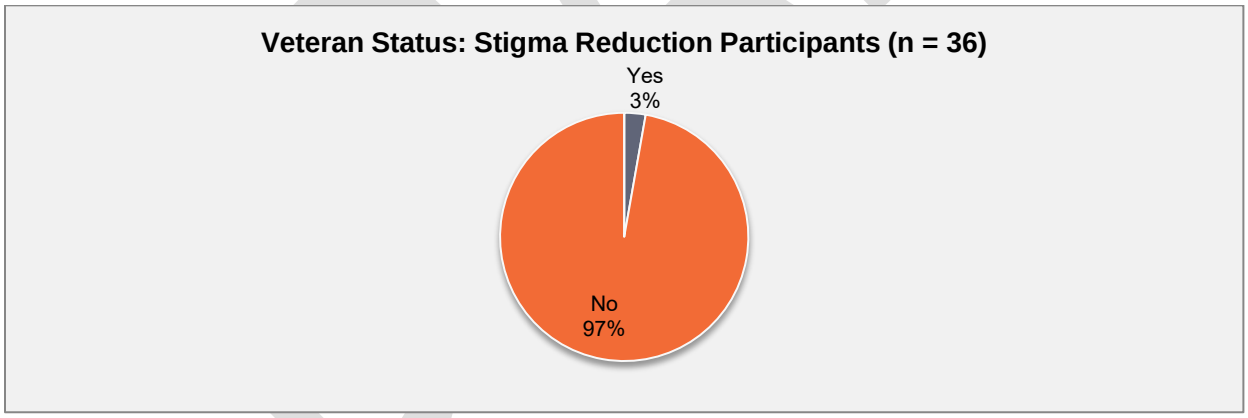
Demographics: Stigma Reduction[13]

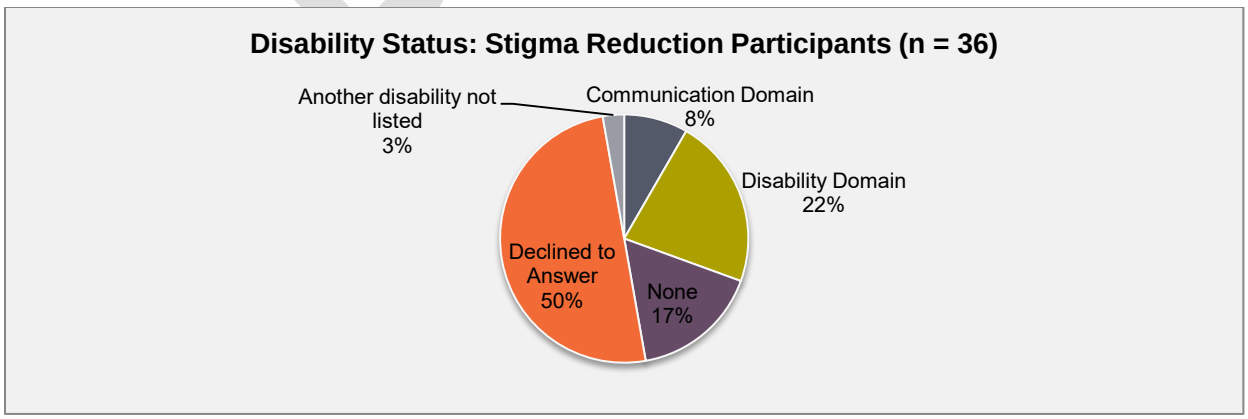


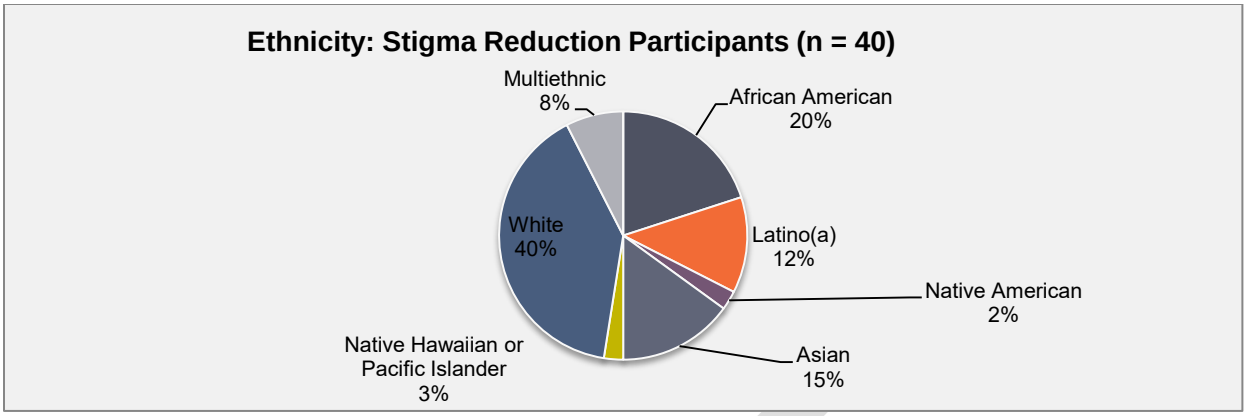
[13] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).


Gender: Stigma Reduction Participants (n = 36)
Another Identity Not Listed 6%
Male 33%
Female 61%


Sexual Orientation: Stigma Reduction Participants (n = 36)
Another group not listed 14%
Gay/Lesbian 12%
Declined to Answer 24%
Heterosexual / Straight 43%
Questioning / Unsure 2%
Bisexual 5%


Veteran Status: Stigma Reduction Participants (n = 36)
Yes 3%
No 97%


Disability Status: Stigma Reduction Participants (n = 36)
Another disability not listed 3%
Communication Domain 8%
Disability Domain 22%
Declined to Answer 50%
None 17%



Program	FY16-17 Key Outcomes and Highlights
Stigma Reduction: Sharing Our Lives, Voices and Experiences (SOLVE) – Mental Health Association of San Francisco	• 36 Peer Educators participated in the SOLVE Program in FY16-17, 12 individuals entered the new Peer Educator training series, and 3 previously inactive Peer Educators returned to the program. • SOLVE gave 52 presentations to 1054 unduplicated individuals in FY16-17. • 97% of community members, as a result of Peer Educator presentations, demonstrated a better understanding of mental health challenges and conditions, expressed less fear of people with mental health challenges, had a clearer idea of how stigma affects everybody, and were less inclined to engage in behaviors that discriminate or otherwise contribute to stigmatization and isolation of consumer and family members. • 100% of Peer Educators who responded experienced reduced self-stigma, reduced risk factors, improved mental health, improved resilience and protective factors, and increased access to care and empowerment.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[14]**
Stigma Reduction	36 Clients	$225,246	$6,257

[14] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

School-Based Mental Health Services and Wellness Centers (K-12)

Program Collection Overview

School-Based Mental Health Services and Wellness Centers (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 prevention and early intervention behavioral health services, as well as linkages to additional support services. These programs build on the strengths of community partners and existing school support services to incorporate a wide variety of philosophies, which are rooted in a prevention or resiliency model, such as youth development, peer education, cultural or ritual-based healing, and wraparound family supports.

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.

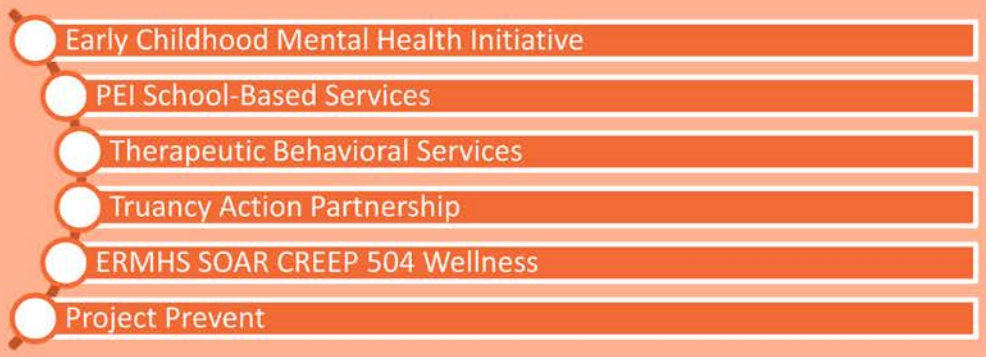
Target Populations

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.

Spotlight on
School-Based Mental Health Promotion (K-12)

MHSA provides Prevention and Early Intervention dollars to fund school-based services in two primary areas: Early Intervention Program Consultation at Elementary and Middle Schools and School-Based Wellness Promotion Programs at High Schools. Exhibit 12. demonstrates the School-Based Mental Health Services offered.

Exhibit 12. School-Based Mental Health Services



Current SFDPH MHSA-funded School-Based Mental Health Promotion service providers include: Bayview Hunters Point Foundation, Edgewood Center for Children and Families, Instituto Familiar de la Raza, and Richmond Area Multi Services Center.

Early Intervention Program Consultation at Elementary and Middle Schools are offered at the following sites: Charles Drew College Preparatory Academy, Hillcrest Elementary School, and James Lick Middle School.

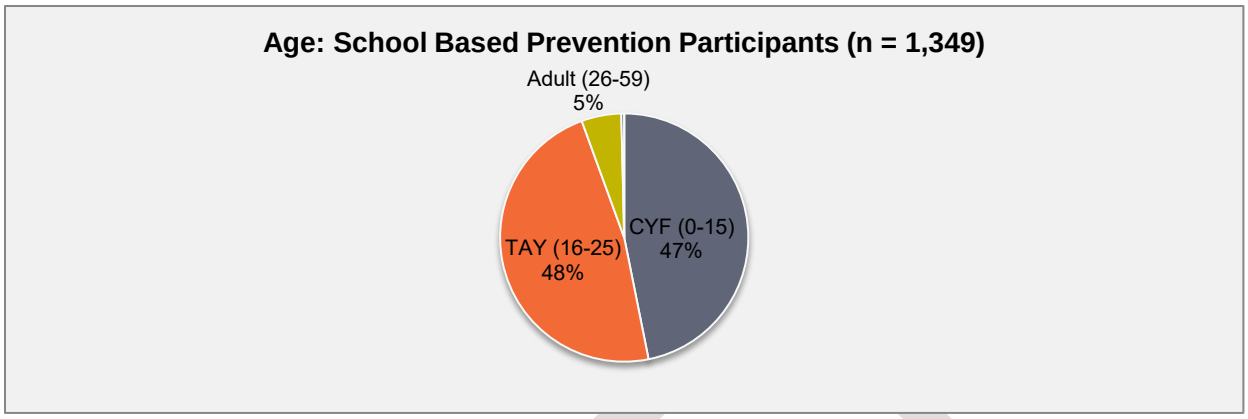
School-Based Wellness Promotion Programs include:

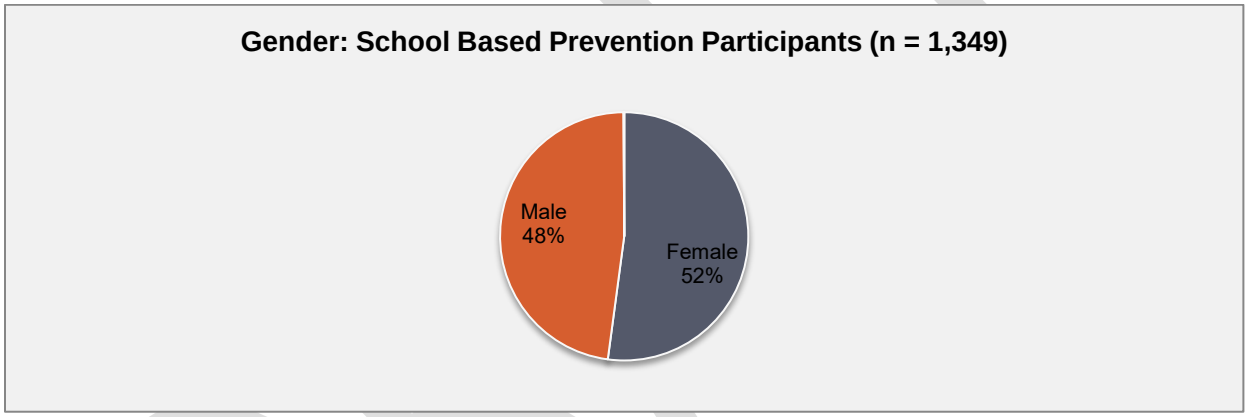
- Wellness Centers at Burton High, Balboa High, June Jordan High, the San Francisco School of the Arts High School; and Independence High School
- Trauma-focused services serving identified students within the San Francisco Unified School District high schools provided by YMCA Urban Services
- Truancy Supportive services serving identified students within the San Francisco Unified School District high schools

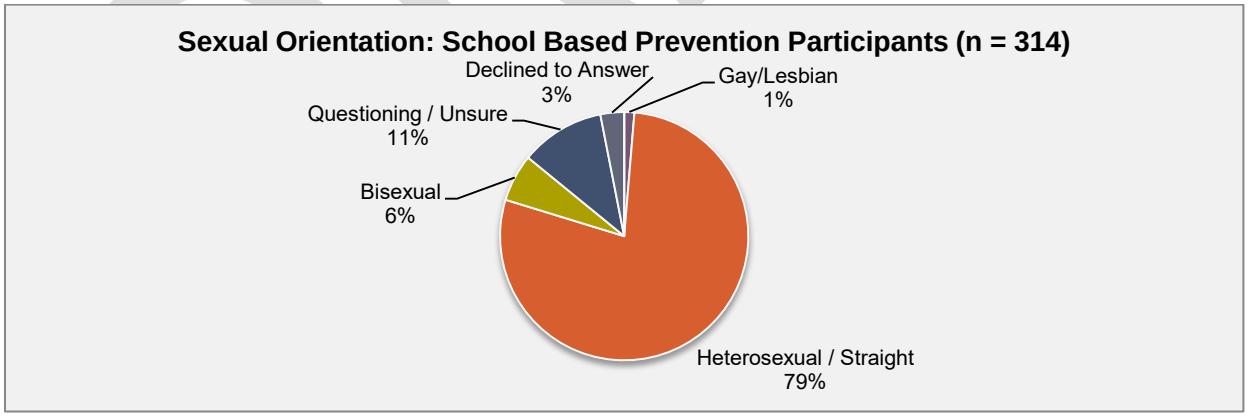
Lowell High School, mural in hallway.

Participant Demographics, Outcomes, and Cost per Client

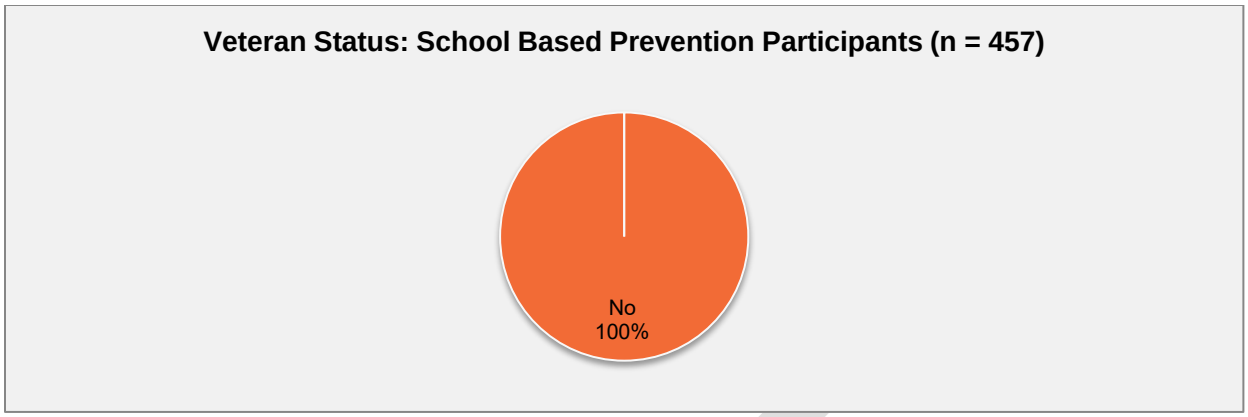
Demographics: School Based Prevention (K-12)[15]

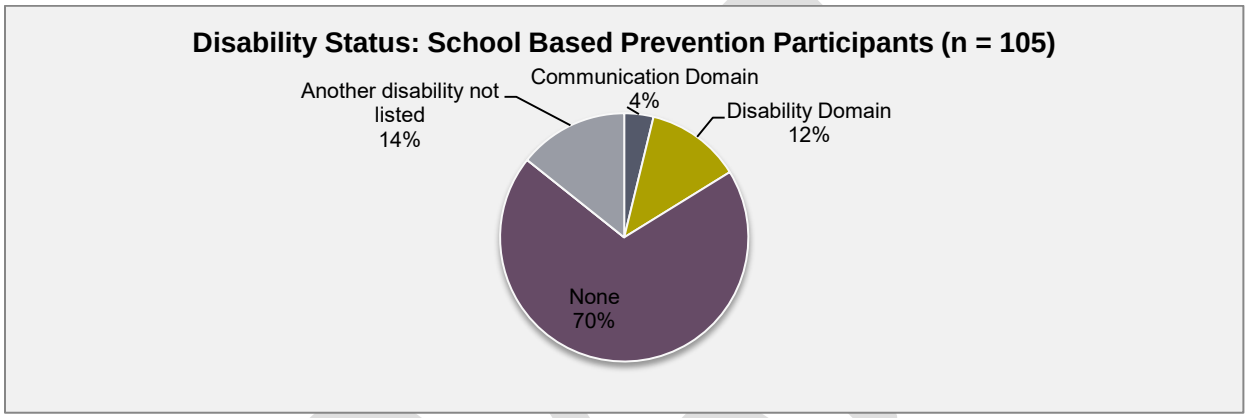


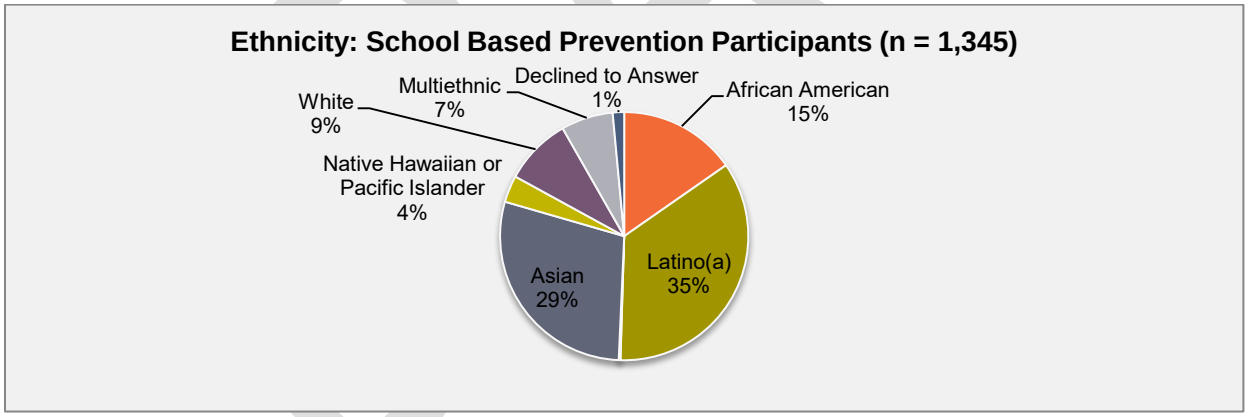


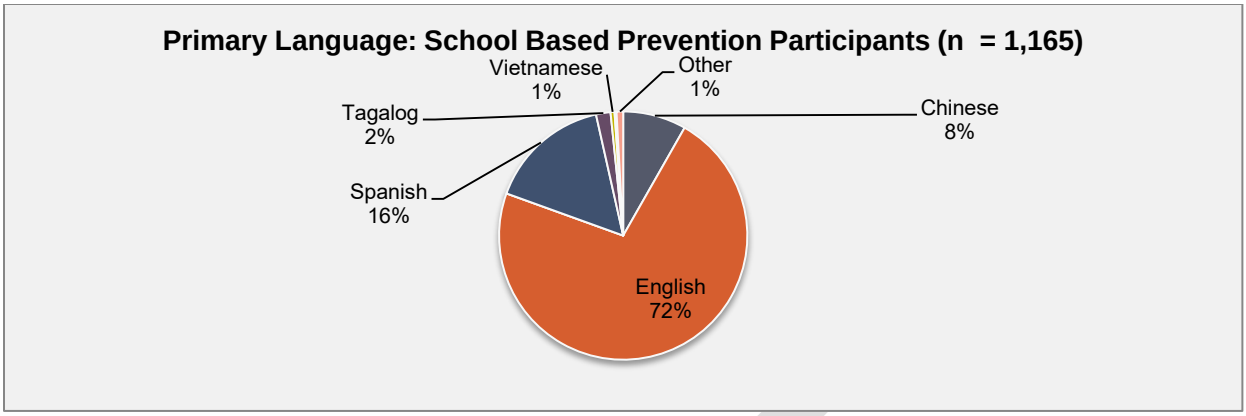


[15] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).


Veteran Status: School Based Prevention Participants (n = 457)
No
100%


Disability Status: School Based Prevention Participants (n = 105)
Another disability not listed
14%
Communication Domain
4%
Disability Domain
12%
None
70%


Ethnicity: School Based Prevention Participants (n = 1,345)
White
9%
Multiethnic
7%
Declined to Answer
1%
African American
15%
Native Hawaiian or Pacific Islander
4%
Asian
29%
Latino(a)
35%



Program	FY16-17 Key Outcomes and Highlights
School Based Early Intervention at Burton High School - YMCA Bayview	• The Prevention Services Team case managed a total of 113 unduplicated clients for a total of 258 case management hours and 260 drop-in hours. • The Prevention Services Coordinator (PSC) case managed 8 teens, providing 78.3 case management service hours, and 151.5 drop-in hours to the larger Burton Community. • Student Advocates (SA) provided 17 teens with on-going case management, for a total of 180 hours, and provided 108 drop-in hours to the larger Burton Community. • 98% of students enrolled in individual and group case management services reported an increase in their ability to skillfully deal with difficulties in their lives.
Behavioral Health Services at Balboa Teen Health Center - Bayview Hunter's Point Foundation	• 76% of students seen for three or more individual therapy visits were able to identify one or more skills they can utilize to reduce stress or other symptoms, and were able to identify one positive goal they were working towards. • The Youth Advisory Board made a total of 31 presentations during health education classes, school health fairs, and at school wide theater events. • Balboa Teen Health Center staff conducted a total of five parent workshops. • Over 130 hours of crisis intervention services were provided in FY16-17, for a total of 261% of the projected hours for the year.

Program	FY16-17 Key Outcomes and Highlights
School Based Mental Health Services- Edgewood Center for Children and Families	• Behavior Coaching served 26 different students on an individual and/or small group basis, provided social skills support for five classes, and ran a total of five social skills groups by grade level (for grades 1, 3, and 4), ranging in size from 4-7 students. • The Family Advocate served 25 unduplicated parents over the course of the school year. • 96% of students receiving behavior coaching showed an increase in score from pre to post-services.
School Based Youth Early Intervention – Instituto Familiar de la Raza	• At Hillcrest, 92% of the staff reported that meeting with the consultant increased their understanding and response to a child's emotional and developmental needs. • At James Lick Middle School, 80% of the staff reported that meeting with the consultant increased their understanding and response to a child's emotional and developmental needs.
Wellness Centers - Richmond Area Multi-Services, Inc. (RAMS)	• 1,044 hours of individual therapeutic services were provided to 247 students in FY16-17. • 93% of clients reported they had met or somewhat met their treatment goals. • 80% of students reported improvements in relationships with family/friends as a result of therapy. • 95% of students reported being able to cope with stress better as a result of therapy.
Trauma and Recovery Services - YMCA Urban Services	• Of 19 unduplicated severely truant clients, 14 reduced their absenteeism by at least 50%. • 79% of clients re-engaged in school during FY16-17. • 100% of clients received a Family Needs Assessment and were connected with appropriate supports and services.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[16]**
School-Based Mental Health Promotion (K-12)	3,181 Clients	$1,123,575	$353

[16] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

School-Based Mental Health Promotion – Higher Education

Program Overview

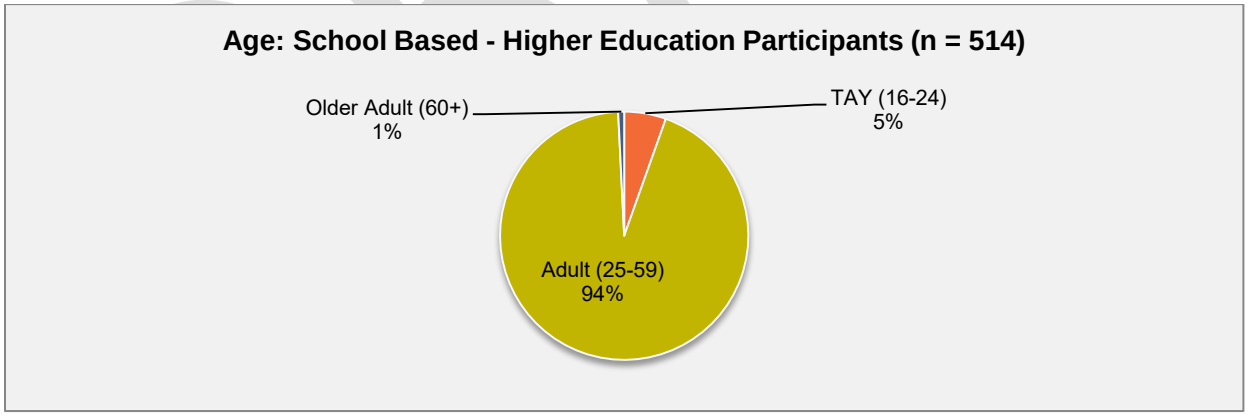
The California Institute of Integral Studies (CIIS) Masters in Counseling Psychology (MCP) program seeks to advance the development of a diverse and culturally competent mental health pool of higher education students by engaging and supporting communities who are underrepresented in licensed mental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

Target Populations

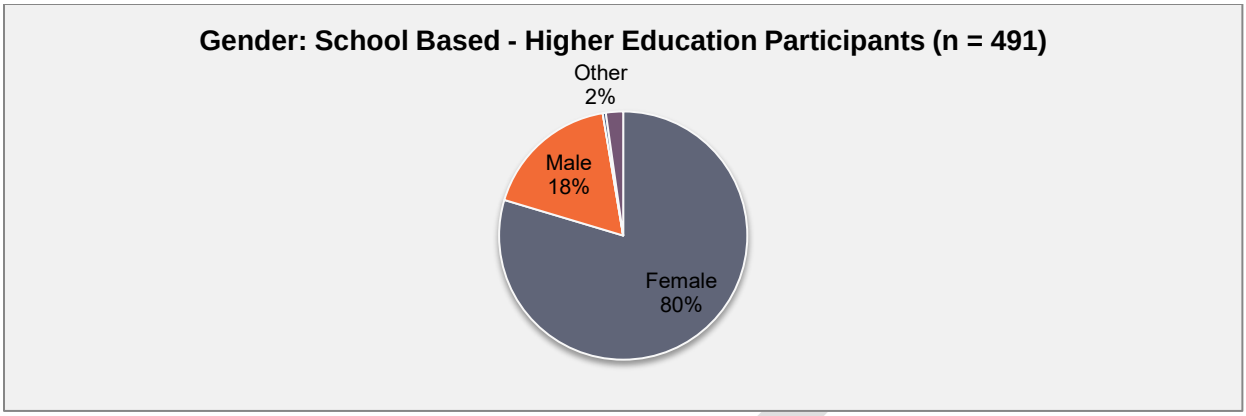
This program works with college students with populations who are currently underrepresented in licensed mental health professions; and mental health consumers, family members and individuals who come from ethnic groups that are not well represented in the mental health/behavioral professions (e.g., African American; Latino; Native American; Asian; Pacific Islander; Lesbian, Gay, Bisexual, Transgender, and Questioning communities).

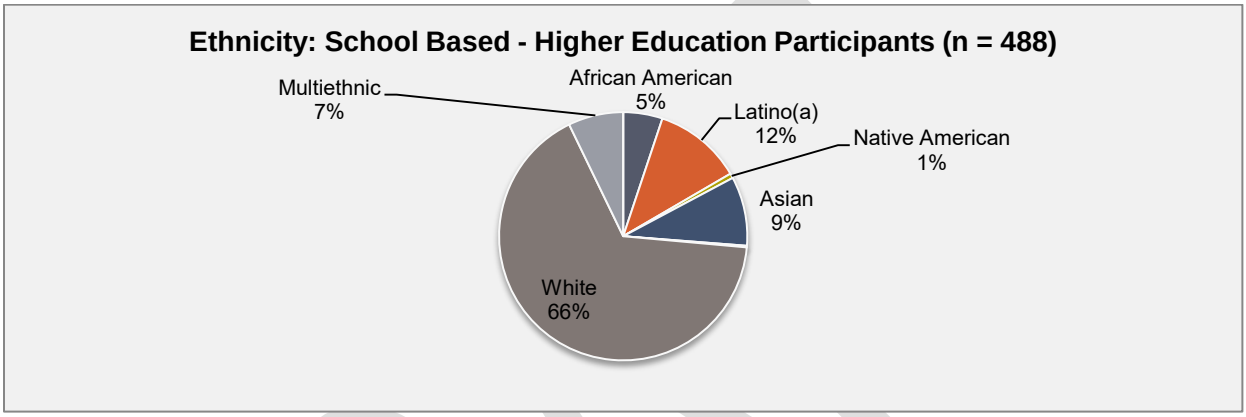
Participant Demographics and Outcomes

Demographics: School-Based Mental Health Promotion – Higher Education[17]



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





Program	FY16-17 Key Outcomes and Highlights
Masters in Counseling Psychology Project - California Institute of Integral Studies (CIIS)	• Staff provided individual and group academic career development services to 184 students (approximately 36% of all MCP students) in FY16-17, exceeding their goal by 142%. • 119 students (23% of total MCP students) received formal counseling on educational, professional, and personal goals.

FY16/17 Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[18]
School-Based Mental Health Promotion – Higher Education	1,503 Clients	$180,893	$120

[18] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SFDPH 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

San Francisco's Mental Health Services Act (MHSA) continues to strengthen its specialized cohort of 16 Population-focused: Mental Health Promotion and Early Intervention programs that serve distinct groups based on ethnic and cultural heritage, age and housing status.

Target Populations

As a component of the SFDPH MHSA Prevention and Early Intervention (PEI) program planning processes, a number of underserved populations were identified, including, but not limited to, the following:

- Socially isolated older adults
- Transitional Age Youth (TAY)
- Lesbian, Gay, Bisexual, Transgender, and Questioning
- Individuals who are homeless or at-risk of homelessness
- Native Americans
- Asians and Pacific Islanders
- African Americans
- Mayan/Indigenous

Many of these populations experience extremely challenging barriers to service, including but not limited to: language, culture, poverty, stigma, exposure to trauma, homelessness and sub-

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

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name - Provider**	**Services**
Socially Isolated Older Adults	Senior Peer Recovery Center Program – Felton Institute	The Senior Peer Recovery Center program reaches hard-to-engage participants with informal outreach and relationship building; assists participants with housing, addiction treatment groups, socialization and cultural activities, and making linkages to more formal behavioral health services when feasible.
	Older Adult Behavioral Health Screening Program – Institute on Aging	The Older Adult Behavioral Health Screening program provides home-based, routine, multilingual and broad spectrum behavioral health screening. Screening participants also receive culturally competent clinical feedback, prevention-focused psycho-education, and linkage support to appropriate behavioral health intervention services.
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.
	African American Healing Alliance (AAHA) – Bayview Hunters Point Foundation	This program serves Black/African-American residents of San Francisco who have been exposed to violence and trauma. Program leaders convene a monthly AAHA membership meeting and collaboratively plan with other stakeholders such as the school district, the Department of Housing and Urban Affairs and the SF Department of Public Health.
	Black/African American Wellness and Peer Leadership Program – SFDPH Interdivisional Initiative	*See "Spotlight" below for program description.*
Asians/Pacific Islanders (API)	API Youth Family Community Support	The program primarily serves Asian/Pacific Islander and Lesbian, Gay, Bi-sexual, Transgender,

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name - Provider**	**Services**
	Services – Community Youth Center	and Questioning youth ages 11-18 and their families. The program provides screening and assessment, case management and referral to mental health services.
	API Mental Health Collaborative – Richmond Area Multi-Services	The program serves Filipino, Samoan and South East Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Mayans/Indigena	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, to support spiritual and cultural activities and community building, and social networks of support. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance – Native American Health Center	The program serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.
Adults who are Homeless or At-Risk of Homelessness	South of Market Self-Help Center – Central City Hospital House	The program serves adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. Program provides a low-threshold engagement that includes peer programs, case management, primary care access, support groups and socialization. Many are referred to mental health services prior to assessment due to the acuity of their needs.
	Tenderloin Self-Help Center –	The program serves adults with behavioral health challenges and homelessness who live in the

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name - Provider**	**Services**
	Central City Hospital House	Tenderloin neighborhood. Program provides a low-threshold engagement that includes peer programs, case management, primary care access, support groups and socialization. Many are referred to mental health services prior to assessment due to the acuity of their needs.
	Community Building Program – Central City Hospital House	The program serves traumatized, homeless and dual-diagnosed adult residents of the Tenderloin neighborhood. The program conducts outreach, screening, assessment and referral to mental health services. It also conducts wellness promotion and a successful 18-week peer internship training program.
Transition Age Youth (TAY) who are Homeless or At-Risk of Homelessness	TAY Multi-Service Center – Huckleberry Youth Programs	The program serves low-income African American, Latino or Asian Pacific Islander TAY (ages 16-24) who have been exposed to trauma, are involved or at-risk of entering the justice system and may have physical and behavioral health needs. Program participants may be involved with the City's Community Assessment and Resource Center (CARC) which focuses on 16 and17 year old youth. The program conducts street outreach, mental health assessments and support, case management and positive youth development services.
	ROUTZ TAY Wellness – Larkin Street Youth Services	The program serves TAY youth with serious mental illness from all of San Francisco. This high intensity, longer term program includes supportive services, including wraparound case management, mental health intervention and counseling, peer-based counseling, and life skills development.

Spotlight on
TAY Behavioral Health System of Care

Transition Age Youth (TAY; youth ages 16-24) have traditionally accessed behavioral health services from many programs across the Children Youth and Families and Adult and Older Adult behavioral health systems, however, there is significant overlap across these systems which highlight the need for a multi-level system coordination of services to maximize a positive TAY-centered experience to accessing care.

The TAY System of Care (TAY SOC) is an initiative within the Behavioral Health Services (BHS) Division at the San Francisco Department of Public Health to build out an integrated coordination of care. BHS is engaging new partners and collaborating with other city departments and community-based organizations to address the social and behavioral risk factors and improve services, accessibility and outcomes for underserved youth ages 16-24. BHS aims to integrate coordination of care across systems serving TAY, including foster care, juvenile and criminal justice, homeless services, education and workforce development and to leverage resources around shared behavioral health priorities.

Through a comprehensive needs assessment conducted in 2016, BHS identified the following priority needs for the TAY SOC:

- A need for a robust system that addresses treatment services at all levels of care and smooth transitions between systems for TAY.
- A need for staff and systems to be better equipped to address emerging behavioral health issues and to link TAY to services.
- A need to reduce barriers for TAY accessing behavioral health services and stigma attached to access or about services.
- A need to strengthen partnerships and coordination among TAY-serving systems so youth do not fall through the cracks.
- A need to develop and increase access to developmentally, culturally relevant and responsive behavioral health services for specific underserved populations.

BHS issued a TAY SOC Request for Qualifications (RFQ) that included the existing BHS services and new services to meet the developmental needs of TAY who experience behavioral health issues. These services (not all funded by MHSA) include:

- TAY Linkage Program (new)
- Prop 47 TAY Substance Use Disorder Linkage Program (new)
- TAY Full Service Partnership Programs (two programs – ongoing)
- Early Psychosis Intervention and Recovery (ongoing)
- Outpatient Population Specific Engagement & Treatment Programs (expanded)
- Homeless TAY Mobile Treatment Team (new pilot program)
- TAY-Specific Vocational Services (two programs – ongoing)
- Supportive Housing Program

Spotlight on Black/African American Wellness & Peer Leadership Initiative

For its first time ever, San Francisco's Department of Public Health's Behavioral Health Services (BHS) and Community Health Equity & Promotion (CHEP) divisions partnered to spring board an initiative that focuses on the duality of whole health (physical health and mental health) for the city's Black/African American communities. Three organizations – Rafiki Coalition, YMCA Bayview and YMCA Urban Services -- were selected to bring this vision to fruition. This broad scope initiative builds upon the years of community work done by the YMCA Bayview's African American Holistic Wellness program and the SF Live District 10 Wellness Collaborative performed by the Rafiki Coalition and the YMCA Bayview.

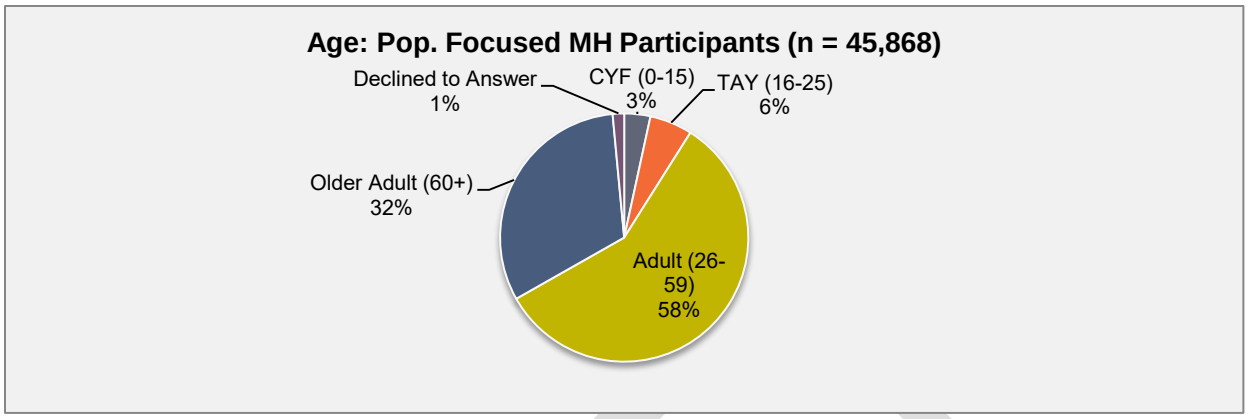
The Black/African American Wellness & Peer Leadership (BAAWPL) initiative is comprised of two lead community-based organizations – the YMCA Bayview and the Rafiki Coalition – that are intent on decreasing the physical and mental health disparities of Black/African Americans who reside in San Francisco's HOPE SF communities and citywide. This community wellness initiative takes a collective impact approach where community members, community based organizations and San Francisco's Department of Public Health BHS and CHEP form a common agenda with a dogged determination to bring health equity to its beneficiaries.

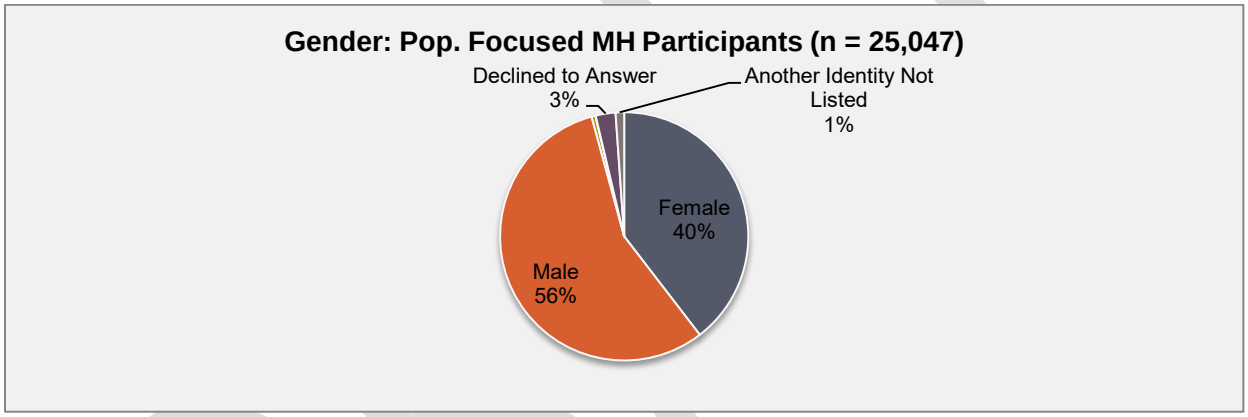
The programming (e.g., outreach, wellness promotion efforts, service linkages) delivered by the YMCA Bayview and Rafiki Coalition serve as systemic pressure points to begin the undoing of generational health inequities and will be measured for outcome accountability. The broad breadth of offered services are hemmed in with fun and engaging activities; educational settings to learn about wellness, social connectedness, stress reduction and healthy habits; and the commitment to service providers' professional development in the field of health.

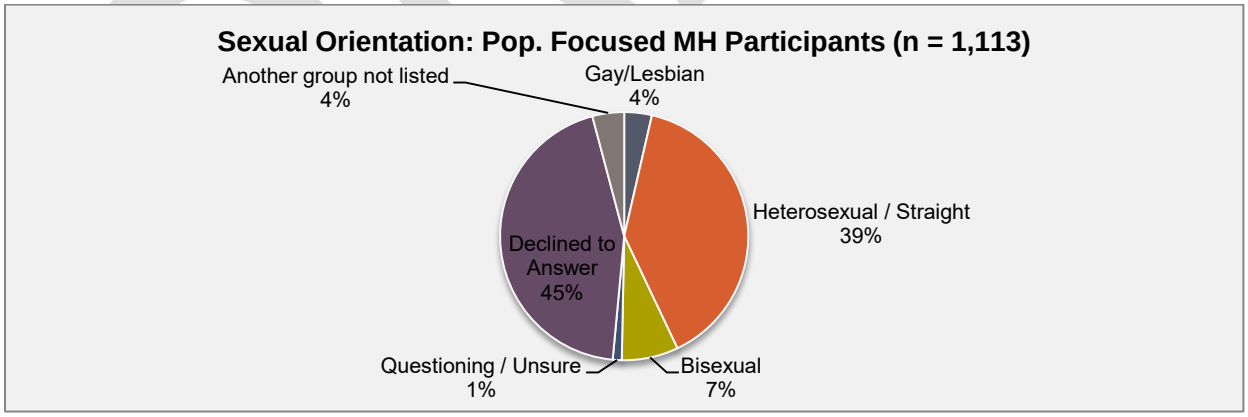
In FY2016-17, BAAWPL faced significant leadership changes and was still able to significantly increase community participation in program activities. Furthermore, the program added new programming based on community feedback, including yoga, Zumba, Harambee, a men's support group, senior lunches, and an organic garden project.

Participant Demographics, Outcomes, and Cost per Client

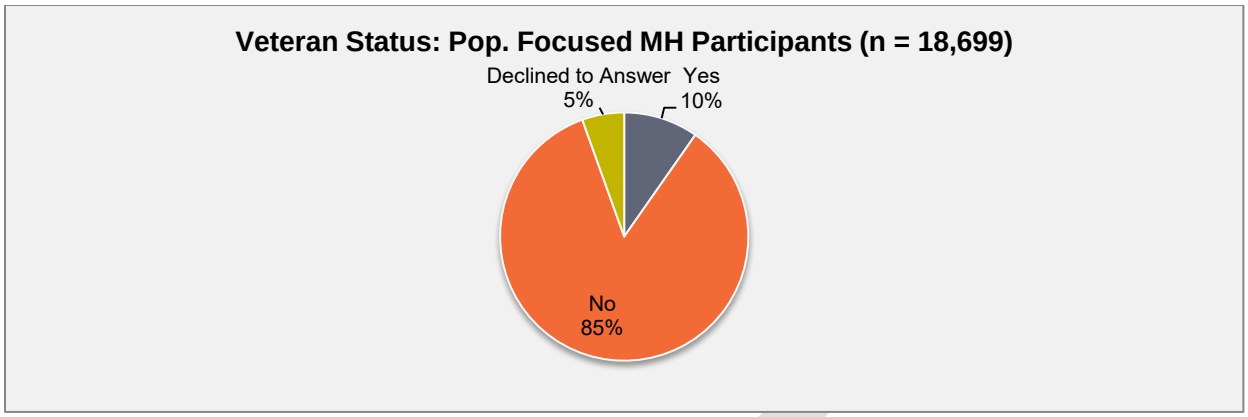
Demographics: Population Focused Mental Health[19]

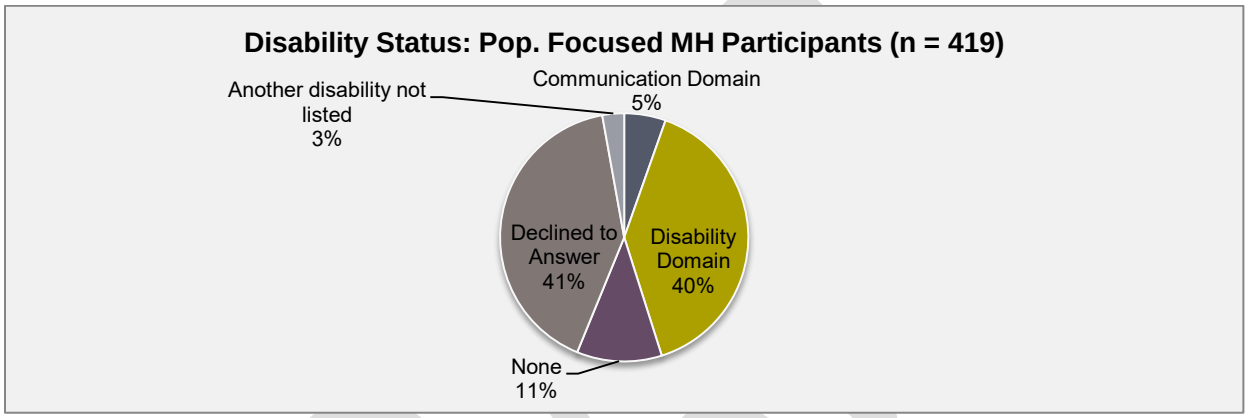


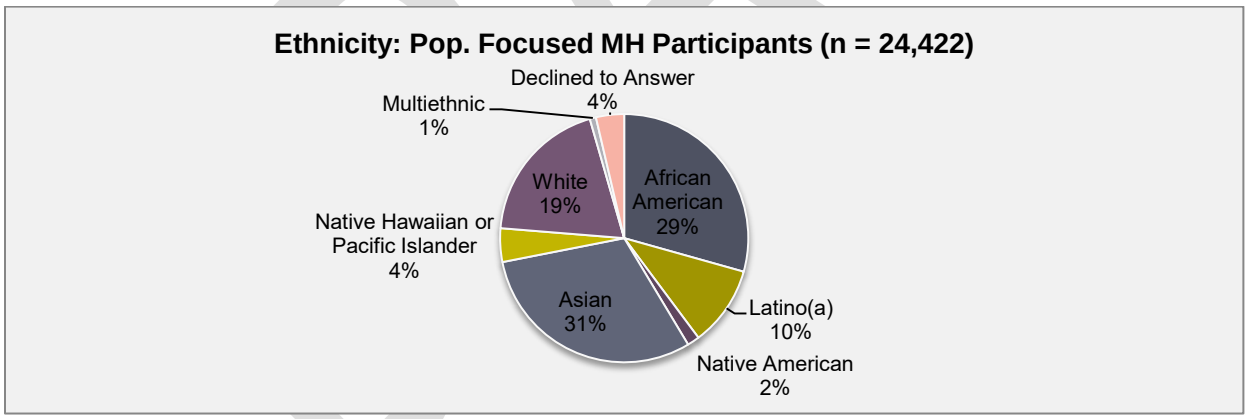


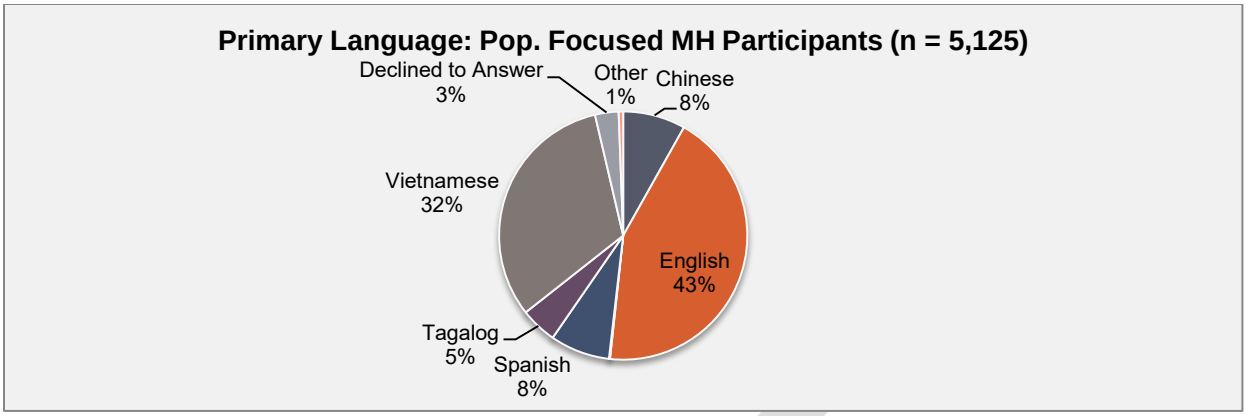


[19] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).


Veteran Status: Pop. Focused MH Participants (n = 18,699)
Declined to Answer 5%
Yes 10%
No 85%


Disability Status: Pop. Focused MH Participants (n = 419)
Another disability not listed 3%
Communication Domain 5%
Declined to Answer 41%
Disability Domain 40%
None 11%


Ethnicity: Pop. Focused MH Participants (n = 24,422)
Declined to Answer 4%
Multiethnic 1%
White 19%
African American 29%
Native Hawaiian or Pacific Islander 4%
Asian 31%
Latino(a) 10%
Native American 2%



San Francisco mural in response to residents being asked about local health issues.

Socially Isolated Older Adults	FY16-17 Key Outcomes and Highlights
Senior Peer Recovery Center Program - Felton Institute	• In FY16-17, this program conducted outreach activities to Project Homeless Connect twice and visited 7 programs at least once a month to provide resources to seniors and engage them in services. • 62% of the consumers reported an increase in social connectedness. • 33 guests were connected to behavioral health services, including substance use treatment programs; 105 guests completed care plans.
Older Adult BH Screening Program - Institute on Aging	• Staff provided 450 adults age 55+ first-level "Gating" screening, identifying symptom domains of depression, anxiety, social isolation, chronic pain, substance abuse, sleep quality, and cognition. • Staff provided 84 adults age 55+ with intensive behavioral health batteries. • 84 case managers and 76 clients were provided formal feedback on behavioral health screening results. Clients who completed behavioral health screening were offered formal feedback regarding severity of identified problems, treatment recommendations, and referrals.
Black/ African-American	**FY16-17 Key Outcomes and Highlights**
Ajani Program - Westside Community Services	• At least 83% of clients received mental health promotional information and linkages to culturally appropriate services. • Westside attended 12 community based events focused on underserved communities in FY16-17.
Black/African American Wellness and Peer Leadership Program – SFDPH Interdivisional Initiative with YMCA Bayview and the Rafiki Coalition	• As part of the initiative's African American Holistic Wellness Program, 98% of wellness promotion group participants reported maintaining or increasing their social connections in the community as a result of participating in programming, and 82 unduplicated individuals were connected to the program via outreach and engagement work. • Rafiki Coalition provided 161 stress reduction sessions, promoting and providing a minimum of movement options that reduce stress (e.g. physical activity, exercise, dance classes). • Rafiki Coalition provided 83 health screenings (Blood Pressure, Glucose, and Cholesterol) in FY16-17.

African American Healing Alliance - Bayview Hunters Point Foundation (Fiscal Intermediary)	• The African American Healing Alliance Website was published in FY16-17, along with a coordinated health and human services provider list. • The Alliance expanded membership to include six organizations in the Western Addition, through the Western Addition Wellness Coalition. • Staff facilitated and convened six membership/planning meetings throughout the year, and facilitated and co-sponsored three Community Summit meetings in the Western Addition.
Asian/ Pacific Islander	**FY16-17 Key Outcomes and Highlights**
Asian/Pacific Islander Youth and Family Community Support Services - Community Youth Center	• Staff provided screening and assessment services to 177 Asian/Pacific Islander youth in FY16-17, leading to the possible identification of mental health illness; 90% of those screened were referred to mental health and other services. • 169 Asian/Pacific Islander youth and families enrolled in case management services have successfully attained at least one of their treatment goals, exceeding the goal of 50 youth.
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services Center (RAMS)	• 86 individuals were able to achieve at least one of their stated goals in their case/care plan, exceeding the goal for the year of 70 individuals. • 94% of participants in culturally-relevant psycho-education curriculum sessions demonstrated increased knowledge about mental health issues, exceeding the yearly goal of 80%. • 100% of individuals screened and assessed were referred to services/resources, plus an additional 148 individual intakes and referrals were made. • Staff served 2,632 individuals in wellness promotion activities, educating and raising awareness on mental health through workshops, youth leadership development, anti-stigma presentations with digital stories, cultural/topic specific groups, and community gardening.
Mayan/Indígena	**FY16-17 Key Outcomes and Highlights**
Indígena Health and Wellness Collaborative – Instituto Familiar de la Raza (IFR)	• Staff provided outreach and engagement to 1,113 community members in FY16-17. • Staff screened and assessed 225 unduplicated individuals, helping the program to better understand what types of services the community needed. • 86% respondents in the Psychosocial Peer Support Groups reported an increase in their social connectedness, exceeding the annual goal of 65%

Native American	FY16-17 Key Outcomes and Highlights
Living in Balance - Native American Health Center (NAHC)	• Staff outreached to 664 unduplicated individuals and served 236 unduplicated individuals crossing Native American, African American, Asian and White communities – with the Native American community representing the majority of participants. • 92% of participants report that they get out more and participate with their community as a result of the circle. • 97% of participants report that they have more people they can trust because of these prevention groups. • 97% of the group's participants report an increase in learning new ways to maintain wellness.
Adults who are Homeless or At-Risk for Homelessness	**FY16-17 Key Outcomes and Highlights**
South of Market/6th Street Self-Help Center - Central City Hospitality House	• Staff conducted outreach and engagement activities, reaching 4,873 individuals in FY16-17. • 57 participants were assessed for case management services, 53 of whom received referrals to behavioral health. • The Harm Reduction Support Group served 200 individuals, 149 of whom reported a decrease in risk behavior.
Community Building Program - Central City Hospitality House	• Staff conducted outreach and engagement activities, reaching 459 individuals in FY16-17. • 12 individuals reported an increase in social connectedness, which is 300% of the FY16-17 goal.
Tenderloin Self-Help Center - Central City Hospitality House	• Staff conducted outreach and engagement activities, reaching 9,365 individuals in FY16-17. • 106 participants were assessed for case management services, all of whom received referrals to behavioral health. • The Harm Reduction Support Group served 304 people, 223 of whom reported a decrease in risk behavior.
Homeless or System Involved Transition Age Youth (TAY)	**FY16-17 Key Outcomes and Highlights**
TAY Multi-Service Center - Huckleberry Youth Programs	• Staff outreached to and engaged 1,875 TAY through drop-in sites, tabling at 22 separate events and continuation high schools. • 359 TAY were screened in-person for behavioral/mental health concerns and assessed for needs (e.g., housing instability, suicidal ideation, exploitation, depression, substance use), of which 355 were referred or received on-site behavioral health services. • 139 TAY and/or their families had a written plan of care, and

	87 TAY and/or their families achieved at least one care plan goal.
ROUTZ Transitional Age Youth Wellness - Larkin Street Youth Services	• Staff served 92 unduplicated individuals ages 16 to 24, comprised of 57 males, 23 females, one trans male, eight trans females and three who identified as other. • 80% of regular Fruity Wednesday participants reported an increase in their social connection, exceeding the annual goal of 60%. • 50% of individuals with a case plan achieved at least one case plan goal.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[20]**
Population-Focused Mental Health Promotion	27,727 Clients	$2,579,483	$93

Early Childhood Mental Health Consultation Initiative

Program Collection Overview

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

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the evidence-based work[21] of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and are delivered in the following settings: center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. The Initiative is made possible through a partnership between four county agencies: San Francisco's Department of Public Health/Behavioral Health Services; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco. Funding for the Initiative is contributed by all four county departments, as well as funds provided by the MHSA.

Services may include case consultation, program consultation, training and support for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, oc-

[20] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.
[21] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91

cupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic play groups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families. These services are meant to underscore the importance of early intervention and enhance the child's success.

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

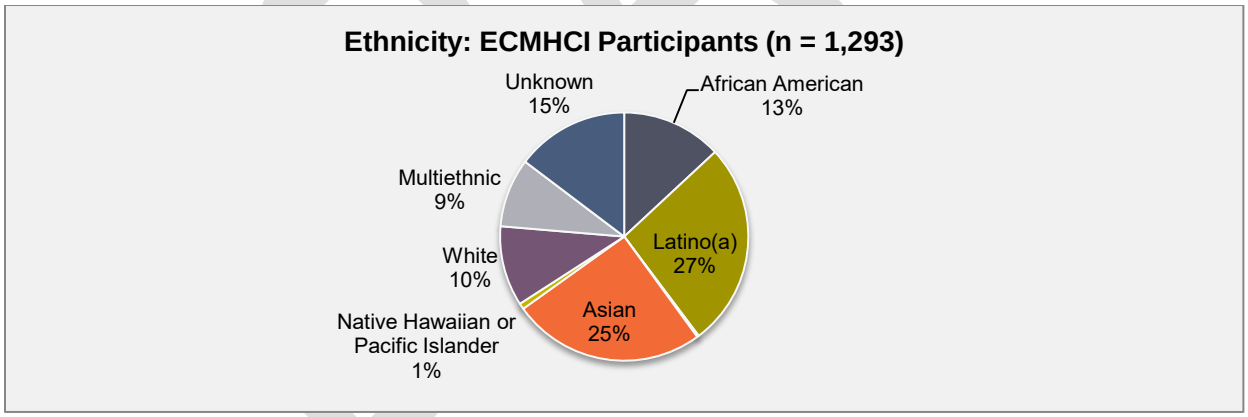
- Infant Parent Program - Day Care Consultants
- Edgewood Center for Children and Families
- Richmond Area Multi-Services
- Homeless Children's Network
- Instituto Familiar de la Raza

Target Populations

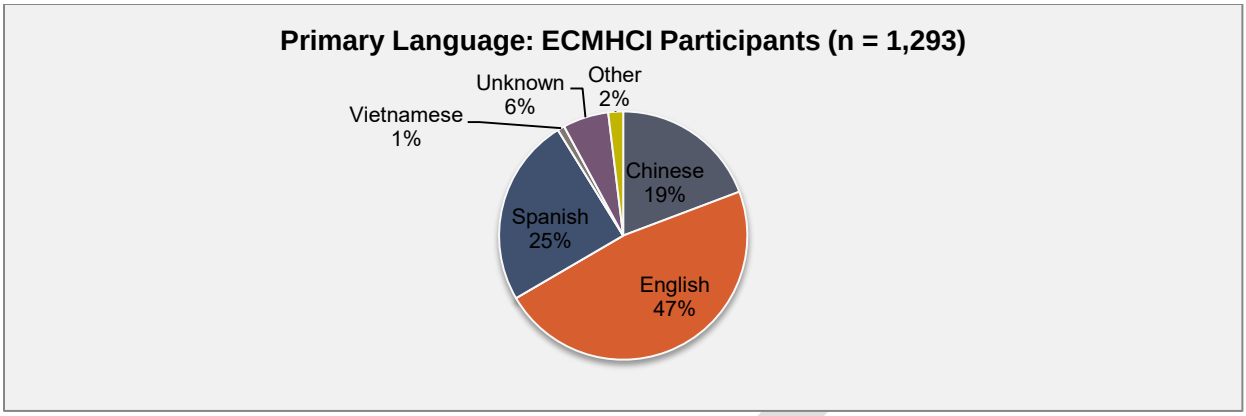
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients who experienced trauma, substance abuse, homelessness, and other challenges. The program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

Participant Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative[22]



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



Program	FY16-17 Key Outcomes and Highlights
Early Childhood Mental Health Consultation Initiative	• 100% of care providers surveyed at MHSA-funded sites reported that mental health consultation increased their understanding and response to children's emotional and developmental needs. • 100% of programs of MHSA-funded sites think that mental health consultation was helpful in retaining children in their program who are at risk of expulsion. • 89% of parents surveyed at MHSA-funded sites reported that mental health consultation helped them as a parent.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[23]**
Mental Health Consultation and Capacity Building	1,293 Clients	$779,902	$603

Comprehensive Crisis Services

Program Collection Overview

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

[23] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

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

Target Populations

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

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

Spotlight on Comprehensive Crisis Services

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

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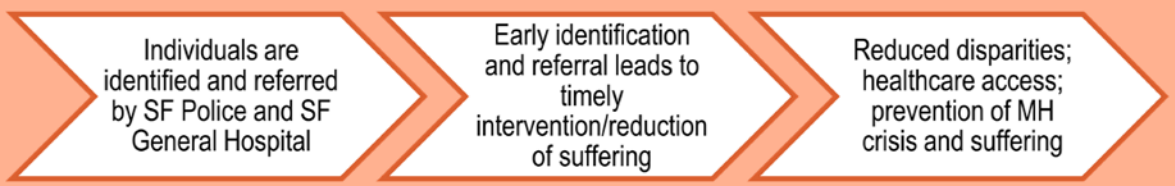
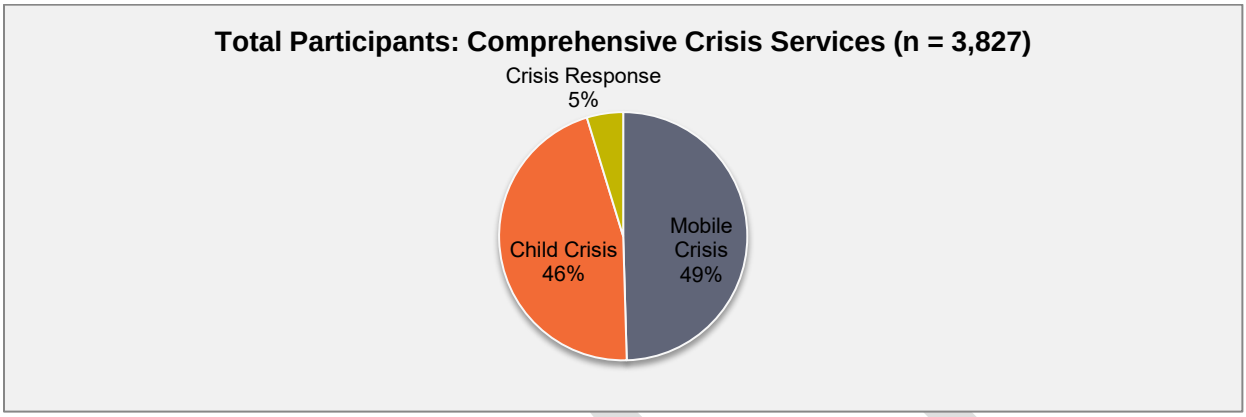
As a result of this intervention, communities in San Francisco that are most affected by violence and trauma-exposure will have better access to effective and timely crisis and case management services, which will reduce disparities in access to care and prevent the development of more chronic and severe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

Comprehensive Crisis Services recently implemented a new pilot program initiated from the Mayors/SFPD Office's Crisis Intervention Specialist Team and the pedestrian fatalities which is a part of the Vision Zero initiative. In addition, this program has added regularly scheduled debriefings and consultation for the crisis staff.



Program Outcomes, Highlights and Cost per Client

Demographics: Comprehensive Crisis Services



Program	FY16-17 Key Outcomes and Highlights
Comprehensive Crisis Services	• The Mobile Crisis Team served 1,896 individuals in FY16-17, providing behavioral health crisis triage, in-the-field crisis assessments/interventions, and short-term crisis case management. • The Child Crisis Team served 1,750 individuals, offering 24/7 mobile 5150 assessments & crisis intervention for suicidal, homicidal, gravely disabled and out of control children and adolescents. • The Crisis Response Team served 181 individuals, providing 24/7 mobile response to homicides, critical shootings, stabbings, suicides and pedestrian fatalities. • Comprehensive Crisis Services recently implemented a new pilot program initiated from the Mayors/SFPD Office's Crisis Intervention Specialist Team and the pedestrian fatalities which is a part of the Vision Zero initiative. • SF-MHSA continues to provide an investment for the cluttering clean-up activities through a collaborative relationship with the city's Human Services Agency.

FY16/17 Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[24]
Comprehensive Crisis Services	3,832 Clients	$445,812	$116

[24] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

Moving Forward in Mental Health Promotion and Early Intervention

School-Based Mental Health Promotion

The overall plan moving forward in the School-Based Mental Health Promotion K-12 programs is to sustain the programming and services as in previous years with a slightly reduced amount of funding. The Bayview YMCA School-Based Mental Health Promotion program will now be funded through the provider's internal funding sources to ensure that there is no disruption in services.

Based on stakeholder and community feedback, the School-Based Mental Health Promotion – Higher Education programs including the California Institute of Integral Studies' Masters in Counseling Psychology project and the San Francisco State University's Student Success Program will come to a conclusion. The lessons learned and activities will be absorbed into SF-MHSA's continuing school-based programming. The Student Success Program did not operate in FY16/17. Despite the programs' attempts to hire a new Program Director, the program was never able to resume programming from FY15/16.

The Institute on Aging's Behavioral Health Screening Program under Curry Senior Center

Per a recent Request for Qualifications (RFQ), the Institute on Aging's Older Adult Behavioral Health Screening program was awarded to Curry Senior Center for FY 2017-2018. This program will be folded under Curry Senior Center's peer program, Addressing the Needs of Socially Isolated Older Adults, which has been providing peer outreach and engagement services along with screening and assessment services to reduce isolation among individuals 55 years and older since 2015.

The Older Adult Behavioral Health Screening program provides home-based, routine, multilingual behavioral health screening. Under Curry Senior Center, screening participants will also receive culturally competent engagement services, access to group activities, peer support, and linkage support to appropriate behavioral health intervention/clinical services and social services, as needed.

SF-MHSA Staff FY 2017-18

3. Peer-to-Peer Support Programs and Services: Clinic and Community Based

Service Category Overview

First Impressions Team Huddle

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

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

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

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

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

Target Populations

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

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

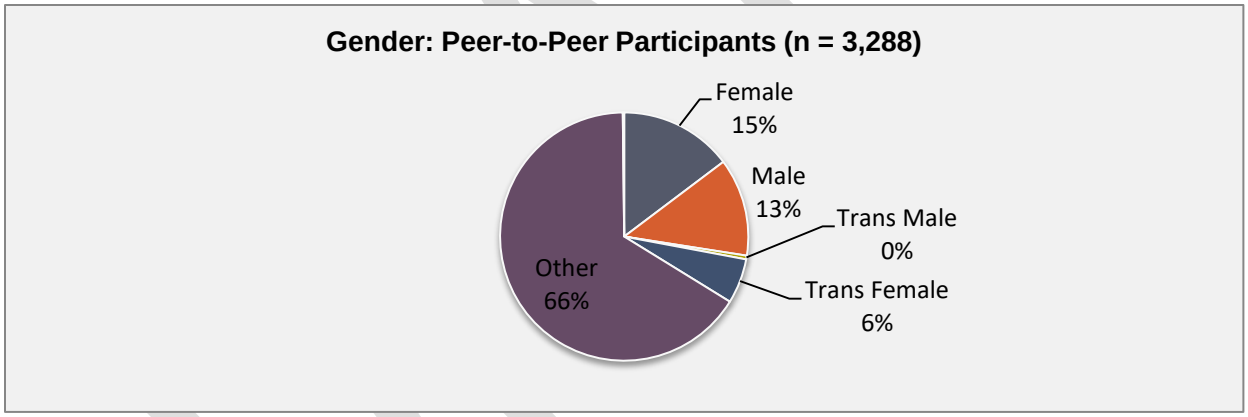
Peer-to-Peer Support Programs	
Program Name - Provider	**Services Description**
Addressing the Needs of Socially Isolated Older Adults (Innovations) – Curry Senior Center	The Curry Senior Center's Addressing the Needs of Socially Isolated Older Adults program provides peer outreach and engagement services along with screening and assessment services to reduce isolation among the older adult population.
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) - SFDPH	The San Francisco Department of Public Health's Lifting & Empowering Generations of Adults, Children, and Youth (LEGACY) program offers family and youth navigation services and education with a focus on stigma reduction.
Peer Response Team – Mental Health Association of San Francisco	The Mental Health Association of San Francisco (MHASF) Peer Response Team provides interventions and access to services that address collecting challenges. Peer Responders with lived experience with cluttering behaviors work to support individuals with similar needs. The peers use their experience to provide non-judgmental, harm reduction-based, one-on-one peer support, often including multiple home visits. In addition, the team gives community presentations that message anti-stigma and discrimination, empowerment, and the possibility of recovery.
Peer-to-Peer, Family-to-Family - NAMI	The National Alliance on Mental Illness (NAMI) Peer-to-Peer, Family-to-Family program utilizes trained peers to provide outreach, engagement, navigation in the community. Peer mentors meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the participant by meeting weekly for 1 hour and assisting the participant with their wellness and recovery journey. Mentors also act as a community resource for helping a participant direct their own path to wellness and recovery.
Peer Specialist Mental Health Certificate and Leadership Academy – Richmond Area	The Certificate Program (Entry and Advanced courses) prepares BHS consumers and/or family members with skills & knowledge for peer specialist/counseling roles in the systems-of-care. In addition, the program offers the Leadership Academy which is a monthly training series designed to support and educate peer providers in the behavioral health field. Trainings will also focus on building skills

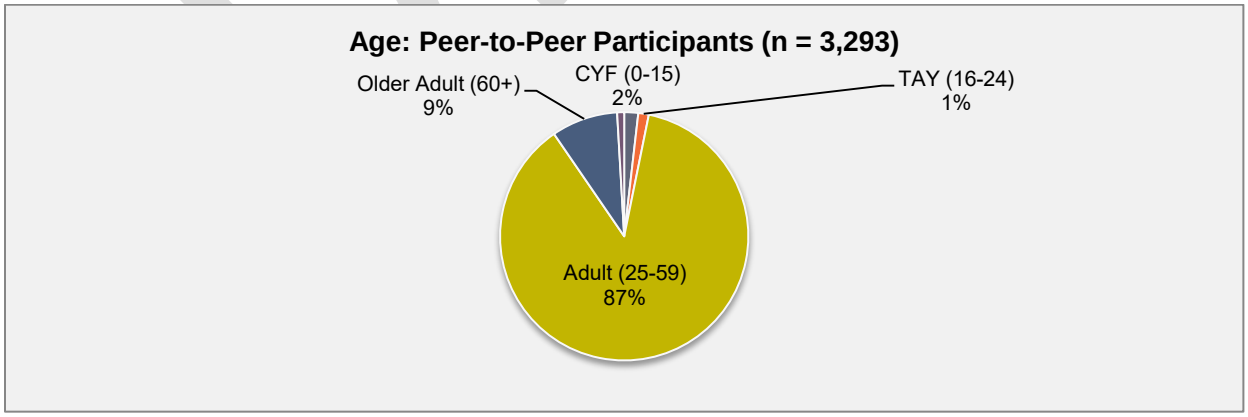
Peer-to-Peer Support Programs	
Program Name - Provider	**Services Description**
Multi-Services	for participation in a variety of activities that request peer provider/consumer input (e.g., boards and advisory committees, review panels, policy development, advocacy efforts, etc.).
Gender Health SF - SFDPH (formerly known as Transgender Health Services)	The San Francisco Department of Public Health Gender Health SF program provides access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. MHSA began funding the peer counselor positions only, to support this program as a supplemental enhancement. Peer counselors ensure proper coordination of behavioral health services and ensure all behavioral health needs are addressed.
Hummingbird Peer Respite (Innovations) - SFDPH	The San Francisco Department of Public Health Hummingbird Peer Respite program is a peer-run and peer-led program provides a respite and an alternative to crisis/PES services for those individuals who may inappropriately use emergent and emergency services. This program provides one-on-one peer counseling, groups, art and other peer modalities to engage individuals in need of support.
Peer-to-Peer Employment Program – Richmond Area Multi-Services	The Peer Counseling & Outreach facilitates wellness activities and enhances treatment services by providing peer counseling and supportive case management & resource linkage to clients of BHS clinics/programs. The services, offered by individuals with lived experience, aim to improve the level of engagement with clients, foster feelings of hope, and promote recovery & wellness. The Peer Internship offers entry-level placements in peer direct services and administrative support roles. In a collaborative learning and supported environment, peer interns work with other peer providers in a variety of SFDPH programs. The paid internships are nine months (20 hours/week) in duration.
Peer Wellness Center – Richmond Area Multi-Services	The Peer Wellness Center is for adult/older adult consumers of BHS in need of additional support, with services provided by peer counselors and wellness staff who have lived experience. Consumers gain empowerment skills, engage in mindfulness practices, and participate in whole health wellness within a safe environment that utilizes empathy & peer support to help promote and inspire recovery. Also, the Center offers information for supportive services and linkages to a variety of behavioral health and primary health care resources in San Francisco.
Transgender Pilot Project (Innovations) - SFDPH	The Transgender Pilot Project is designed to increase evaluation planning in order to better collect data on the strategies that best support Trans women of color with engaging in behavioral health services. TPP entered the pilot year of operations in FY15-16 as a MHSA Innovations Project. The two primary goals involve increasing social connectedness and providing well-ness and recovery based groups. The ultimate goal of the groups is to support clients with link-age into the mental health system and services.
Reducing Stigma in the Southeast (RSSE) - SFDPH	The San Francisco Department of Public Health Reducing Stigma in the Southeast program engages faith-based organizations and families in the housing community referred to as “The Village” in order to

Peer-to-Peer Support Programs	
Program Name - Provider	**Services Description**
	increase mental health awareness, decrease stigma, and provide community support by linking community members with vital resources (e.g. helping community members to connect with housing and food assistance programs).
Peer-Run Warm Line – Mental Health Association of San Francisco	MHASF Mental Health Peer-Run Warm Line connects a person in emotional distress to a Peer Counselor through a phone call or chat session. The Warm Line is the first line of defense in preventing mental health crises by providing a compassionate, confidential and respectful space to be heard. The Warm Line existence continues to alleviate over-burdened crisis lines, law-enforcement, and mental health professionals. Over the years, MHSA has provided support to this project, leveraging funds from other sources.

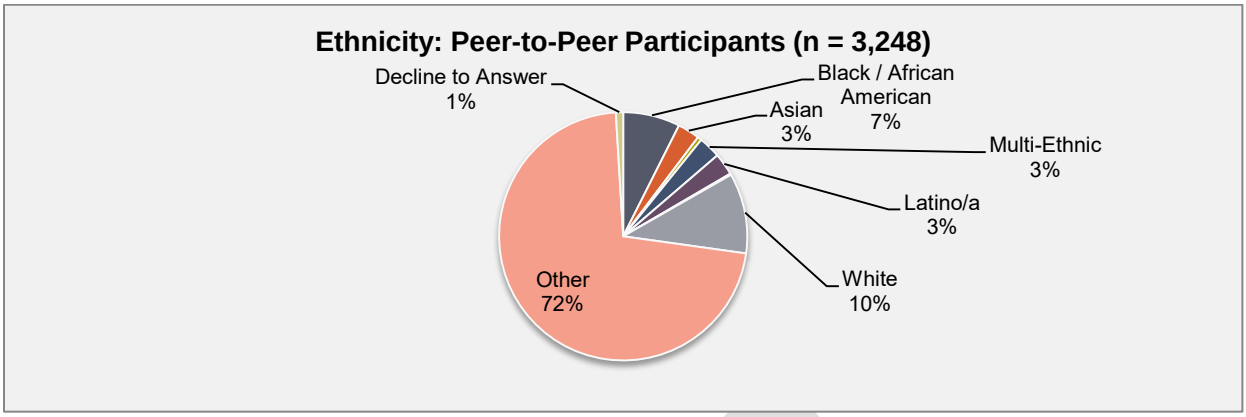
Participant Demographics, Outcomes, and Cost per Client

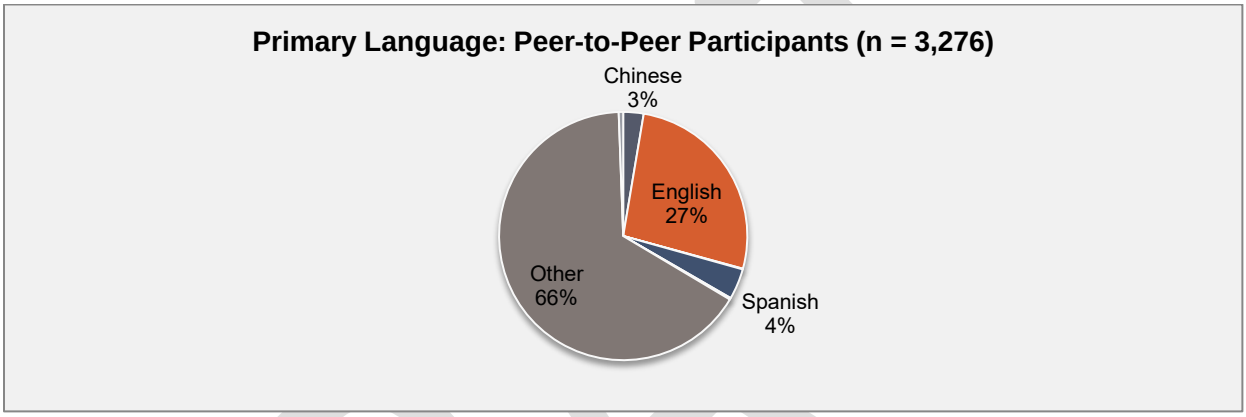
Demographics: Peer to Peer[25]





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





Program	FY16-17 Key Outcomes and Highlights
Addressing the Needs of Socially Isolated Older Adults (Innovations) - Curry Senior Center	• 61 unduplicated seniors were outreached in FY16-17, and 53 individuals received a total of 1,179 units of service. • Among clients participating in the program for at least six months, socialization was found to have increased 37% in FY16-17, and social isolation has decreased by 38%, as measured by the Curry Isolation Scale. • In FY16-17, 37 direct referrals were made to medical, substance use, mental health, or case management services, and 95 referrals were made to organized community social activities.
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) - SFDPH	• L.E.G.A.C.Y peer staff attended 22 case management meetings at four different CYF outpatients' clinics. • Staff hosted four Community Advisory Board (CAB) meetings, four TAY CAB meetings, and 12 CAB provider planning meetings at L.E.G.A.C.Y during FY16-17.

Program	FY16-17 Key Outcomes and Highlights
Peer Response Team – Mental Health Association of San Francisco	• 49 individuals (150% of the goal of 20) received 1:1 support from Peer Responders including phone support, office and home visits. • 66 unduplicated individuals participated in two ongoing peer-led support groups. • 30 of 36 respondents (83%) who had engaged in 1:1 support from Peer Responders reported they are more willing to engage in services and supports.
Peer-to-Peer, Family-to-Family – NAMI	• 43 individuals participated in Peer-to-Peer classes for adults living with mental health challenges taught by trained peers. • 69 individuals participated in 30-hour Family-to-Family classes for family members, caregivers and friends of individuals with mental health challenges taught by trained family members. • 100% of Peer-to-Peer participants agreed or strongly agreed they have learned to recognize the signs and symptoms of their mental illness, as evidenced by self-reported completion of a relapse prevention plan. • More than 96% of Family-to-Family participants agreed or strongly agreed that they have increased their understanding of mental illness as a diagnostic medical condition and recognize signs and symptoms of mental illness as evidenced by final class self-report evaluations.
Peer Specialist Mental Health Certificate and Leadership Academy – Richmond Area Multi-Services (RAMS)	• 54 participants were enrolled in the Peer Specialist Mental Health Certificate Program (Entry & Advanced Course) in FY16-17. • The Peer Specialist Mental Health Certificate program held 12 Leadership Academy trainings for a total of 38 seminar hours. • 481 individuals received workforce development skills by attending and participating in 12 Leadership Academy trainings. • 96% (24 out of 25) of those who completed the post-program evaluation indicated that they “Strongly Agree” or “Agree” with the statement, “After graduation, I am planning on pursuing a career in the field of health and human services by obtaining or maintaining a job, a volunteer position, further education in the field, and/or engaging in advocacy activities.”
Gender Health SF - SFDPH	• 87.75% of participants reported an increase in social connectedness in FY16-17. • 87% of participants reported improvements to health, wellness and recovery. • The program was staffed entirely by peers who were also certified WRAP facilitators.

Program	FY16-17 Key Outcomes and Highlights
Hummingbird Peer Respite (Innovations) - SFDPH	• FY16-17 marked the second full year of operations for the Hummingbird Peer Respite, with staff focused on building a core group of attendees at the space. • In FY16-17, 79% of participants reported an increase in social connection, and 83% reported an increase in the ability to care for themselves. • The Hummingbird Peer Respite was 100% peer-run in FY16-17, including all staff and the SFDPH Program Manager.
Peer to Peer Employment - Richmond Area Multi-Services (RAMS)	• 96% (148 of 154) of survey respondents of community-and-clinic-based Peer Counseling and Outreach Services reported overall satisfaction with services. • 98% (45 of 46) of program employees participate in at least four or more skills development and/or wellness trainings/sessions. • 87% (134 of 154) of survey respondents of community-and-clinic based Peer Counseling and Outreach Services reported improvement in their overall quality of life. • 80% (150 of 186) of survey respondents of community-and-clinic-based Peer Counseling and Outreach Services reported that they have maintained or increased feelings of connections to their community.
Transgender Pilot Project (Innovations) - SFDPH	• In FY16-17, the Transgender Pilot Project was staffed entirely by peers (three total), who are also certified WRAP facilitators. • In FY16-17, 88% of participants reported an increase in social connectedness as a result of their participation in the program. • 87% of participants in FY16-17 reported improvements to health, wellness, and recovery.
Reducing Stigma in the Southeast (RSSE) – SFDPH	• Staff facilitated bi-monthly groups to bring community participants together and address the concerns of the community, increasing knowledge and awareness of resources, and discussing topics such as health, nutrition, advocacy, recovery, education, violence prevention, and wellness. • Staff provided peer and family support, as well as resources and referrals. • Staff offered workshops on trauma and healing, dementia, and self-esteem.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[26]**
Peer-to-Peer Programs	4,202 Clients	$4,879,814	$1,161

Moving Forward in Peer-to-Peer Programs and Services

Peer-to-Peer Services has planned the following activities to support, improve, and enhance its programming over the next fiscal year

- The Peer-Run Warm Line provides assistance via phone and web chat to people who need to reach out when having a difficult time. The program offers emotional support and information about mental health resources. As a result of an assessment of needs, the MHSA portion of warm line funding has sunset in December 2017. MHASF has identified continuing funding to support the warm line from another source.
- An Annual Awards Ceremony was organized and hosted by MHA-SF and SF-MHSA on October 29, 2017 to recognize the achievements of roughly 200+ consumers who are in the process of their mental health recovery and are participants, clients, or former participants/clients in MHSA funded programs in San Francisco. Due to the overwhelming success of this event, SF-MHSA intends to hold another Award Ceremony in the Fall of 2018.
- As of September 30th 2017, the Innovation Project known as the Hummingbird Peer Respite has sunset. The model was considered so successful that the city decided to expand on the programming by creating a larger program in the existing space. The new Hummingbird is a 15 bed Navigation Center for homeless adults in crisis who are suffering from mental illness and drug addiction, and who need a place to recover and get on their way to stable housing. Peer counseling and support will be an integral part of the new expanded version of the Hummingbird Place. The lessons learned and best practices from the past few years will continue as the project will build upon such an innovative and successful learning project.
- After a thorough assessment of the needs of the community, SF-MHSA has decided to merge the peer educational and advocacy program with the AAIMS nutritional vocational project since there is substantial overlap with the two programs. After gathering input from the community and other stakeholders, it appeared most sensible to streamline these activities and combine funding, resources and best practices. The promotion of all practices from these 2 projects will continue with this positive system transformation.

Hummingbird Peer Respite Event 2017

[26] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

4. Vocational Services

Service Category Overview

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

SFDPH MHSA Vocational Project – Cafe760!

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

Target Population

The target population consists of San Francisco. Particular outreach is made to underserved populations and those interested in job readiness programs, on-the-job training, internships, competitive employment and meaningful activities leading to work.

Vocational Services	
Program Name - Provider	**Services Description**
Department of Rehabilitation Vocational Co-op (The Co-op) – SFDPH and State of California	The San Francisco Department of Rehabilitation (DOR) and the City and County of San Francisco's Behavioral Health Services (BHS) collaborate to provide vocational rehabilitation services to consumers of mental health services. Services offered by this program include vocational assessments, the development of an Individualized Plan for Employment, vocational planning and job coaching, vocational training, sheltered workshops, job placement, and job retention services.

Vocational Services	
Program Name - Provider	**Services Description**
i-Ability Vocational IT Program – Richmond Area Multi-Services	The i-Ability Vocational Information Technology training program prepares consumers to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at the BHS IT Department. The program includes three components: • Desktop: Learn new skills in the deployment and support of office equipment including; desktops, laptops, servers, printer, etc. Skills learned include the installation of software, application testing, break/fix, presentation skills, resume writing, etc. • Advanced Desktop: Participants continue to expand their knowledge in the area of desktop support services. Additionally, participants serve as mentors for participants of the Desktop program. • Help Desk: Participants learn customer and application support skills through the staffing Avatar Electronic Health Record (EHR) help desk, a call center. Skills learned include application support, customer service skills, working in a collaborative environment, resume writing, documentation development, etc. • Advanced Help Desk: Participants continue to expand their knowledge in the area of application support gained through their successful graduation from the Help Desk program. Additionally, participants serve as mentors for participants of the Help Desk program. • Employment: Graduates of the IT vocational training program are provided with the opportunity to apply for a full time position with the IT department. Services offered by the program include vocational assessments, vocational counseling and job coaching, vocational skill development and training.
First Impressions (Innovations) – UCSF Citywide Employment Program	First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls, ceilings, and doors; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, vocational planning and job coaching, vocational training and workshops, job placement, and job retention services.
Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) – API Wellness Center	The Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) program provides nutrition, exercise, and health education and training. The program educates program participants on the connection between diet and health, provides healthy cooking and exercise classes, information on shopping for healthy food based on local availability with the goal of decreasing participants metabolic syndrome issues and increasing their social connectedness. AAIMS

Vocational Services	
Program Name - Provider	**Services Description**
	peer leaders also advocate for neighborhood food access.
SF Fully Integrated Recovery Services Team (SF First) – SFDPH	The SF Fully Integrated Recovery Services Team (FIRST) Vocational Training Program offers training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitator, as well as other positions. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal setting and hygiene maintenance for the workplace.
Assisted Independent Living Vocational Program – Baker Places	The Assisted Independent Living Vocational Program supports consumer employees in building skills related to clerical/administrative support and mail distribution. This supported employment project is located on-site at Baker Places and provides training, supervision and advanced support to a team of consumers with an emphasis on professional development. The Assisted Independent Living project aims to help consumers to identify professional development goals and breakdown barriers in reaching their goals. The project also links consumers to the Department of Rehabilitation's job placement services and other vocational programs within the BHS system.
Janitorial Services – Richmond Area Multi-Services	The Janitorial Services program provides janitorial and custodial vocational training to behavioral health consumers.
Café and Catering Services – UCSF Citywide Employment Program	The Café and Catering Services program provides café, barista, catering and customer service vocational training to behavioral health consumers.
Clerical and Mailroom Services – Richmond Area Multi-Services	The Clerical and Mailroom Services program provides clerical, administrative support, mail sorting and mail distribution vocational training to behavioral health consumers.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) – UCSF Citywide Employment Program	The Growing Recovery and Opportunities for Work through Horticulture (GROWTH) is a landscaping and horticultural vocational program that assists mental health consumers in learning marketable skills through on-the-job training and mentoring to secure competitive employment in the community.
TAY Vocational Program - Richmond Area Multi-Services	The Transitional Age Youth (TAY) Vocational Program offers training and paid work opportunities to TAY with various vocational interests.

Spotlight on First Impressions

First Impressions, a Citywide Employment Services basic construction and remodeling vocational program that assists mental health consumers in learning light construction skills, is wrapping up its 5th year under innovations funding this year.

First Impressions offers 10-weeks of classroom training followed by 6-months of paid work experience for consumers of BHS services. The ultimate goal of the program is for consumers to learn marketable skills for the workforce while being a part of the transformation of the BHS Mental Health Care System. Finally, First Impressions aims to create a more welcoming environment in the wait rooms of BHS/DPH clinics that cultural reflect the community it serves.

First Impressions provides participants with:

- 10-weeks of classroom and hands on training
- Six-months of supervised work experience paid at minimum wage
- On-going job placement support, job preparation, resume building, competitive job placement and employment retention services

First Impressions' hands on training in basic construction and remodeling may include but not limited to: customer service, green building, beginning drywall – installation and repair, painting, installation of window treatments, furniture assembly, flooring – cleaning, repairing and new installation, graffiti abatement, and deconstruction.

First Impressions' services are intended to adhere to the Wellness and Recovery Model helping consumers to holistically improve their mental health and wellness. These services are intended to provide meaningful activities that foster a consumer's independence and increase her/his ability to participate in society in a meaningful way.

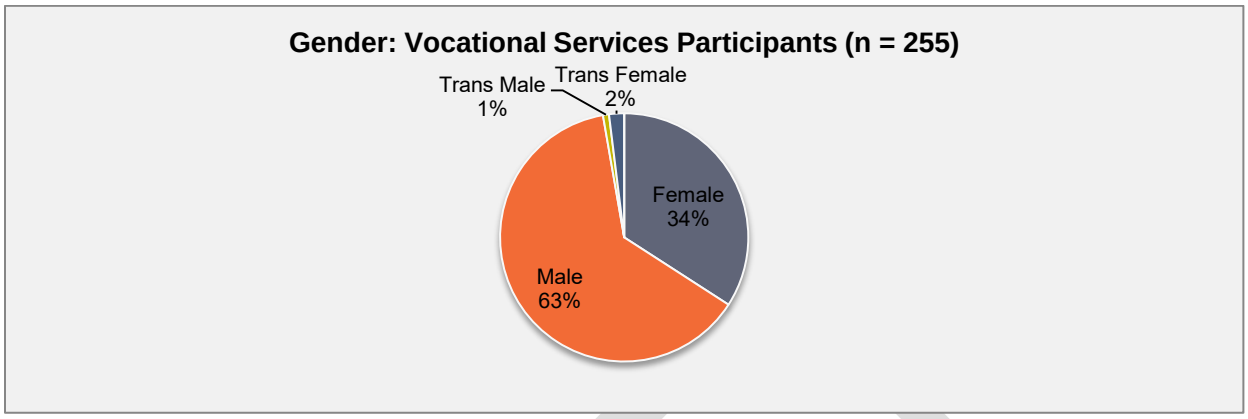
MHSA will be evaluating the efficacy of this project and the needs of the community to determine if all or parts of the project will continue under a different funding source. First Impressions renovated 13 clinic sites as of June 2017 and has successfully transformed the experience of the wait area for clients, visitors, and families.

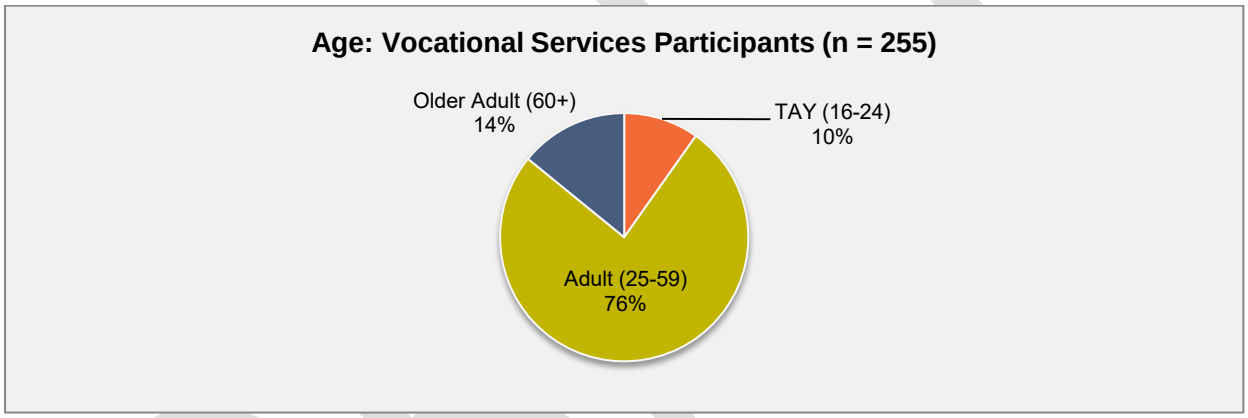
Expected outcomes of the First Impressions program include: (1) An increase in consumer engagement in clinic and clinical services; (2) An increase in client satisfaction with services; (3) An increase in consumers who have learned marketable job skills in basic construction and remodeling; (4) An improvement in general mental health through employment and esteem building; (5) Increase in staff and provider morale.

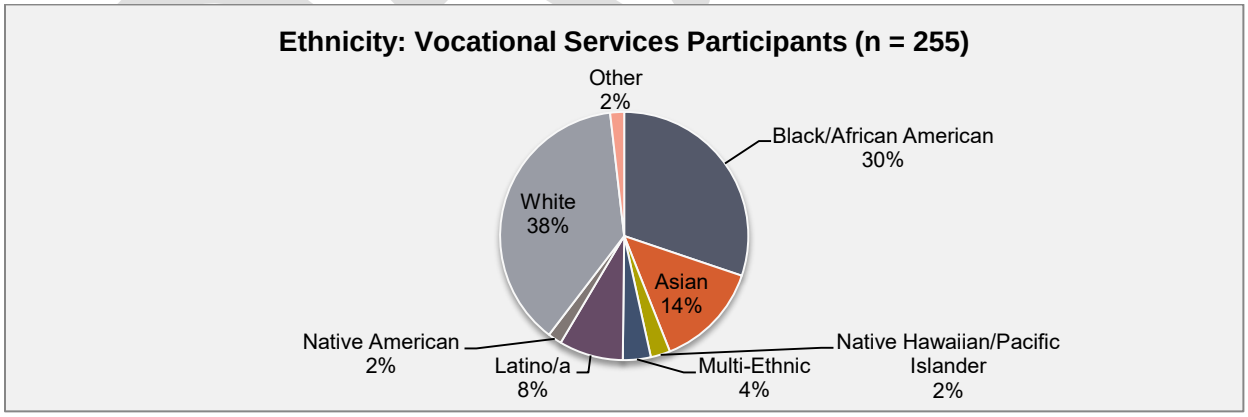
In FY16-17, 16 individuals enrolled in the First Impressions program and 8 graduated before the year's end. Three of those graduates secured competitive employment in the community at the time of graduation. A full 100% of graduates surveyed reported an improvement in their employable skill development.

Participant Demographics, Outcomes, and Cost per Client

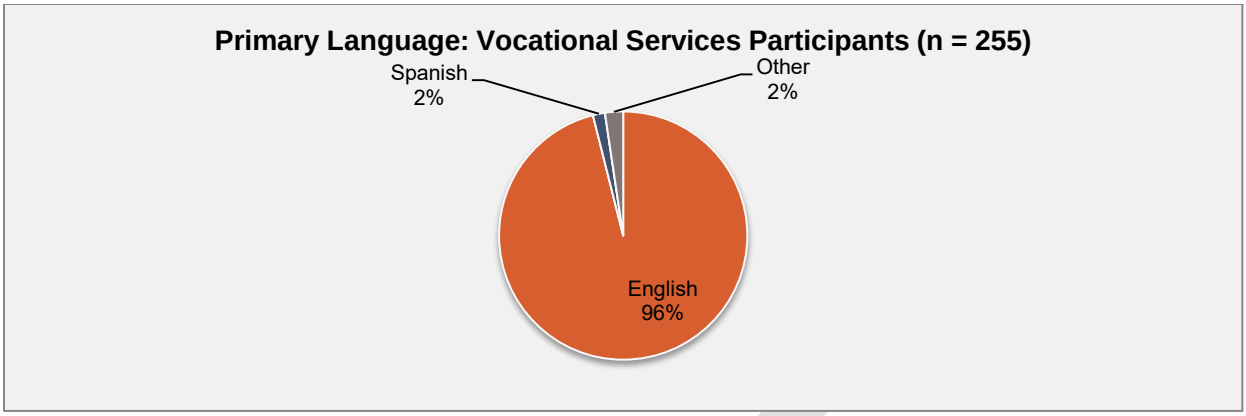
Demographics: Vocational Services[27]







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



Program – Provider	FY16-17 Key Outcomes and Highlights
Department of Rehabilitation Vocational Co-op (The Co-op) – SFDPH and State of California	• This program served 291 individuals in FY16-17 which is 105% of the annual goal. • In FY16-17, 162 individuals secured employment in the competitive workforce, as measured at the 90th day of employment. • In FY16-17, outreach activities more than doubled and referrals increased by 18%. • The 2nd annual Vocational Summit was a huge success with over 147 attendees.
i-Ability Vocational IT Program – Richmond Area Multi-Services (RAMS)	• 100% of trainee graduates have met their vocational goals. • 92% trainee graduates agreed/indicated improvements to their coping abilities, as reflected by post-program evaluations and satisfaction surveys. • 96% of i-Ability trainees successfully completed the training or exited the program early due to obtaining gainful employment or finding volunteering that is related to their vocational interests.
First Impressions (Innovations) – UCSF Citywide Employment Program	• In its fourth year, First Impressions provided BHS consumers ten weeks of classroom basic construction training, followed by six months paid work experience renovating SFDPH clinic wait rooms. • The First Impressions program enrolled a total of 16 consumers in FY16-17, with eight consumers graduating. • 100% of trainee graduates reported an improvement in the development of skills to use toward future opportunities as well as an improvement in confidence to use these new skills. • On Tuesday, October 3, 2017, UCSF's Citywide Employment Program teamed up with MHSA to present the second BHS art show in the Latino Room of the Main Library in San Francisco. We received over eighty pieces of art from mental health consumers from all over San Francisco spanning genres from paintings, dioramas, airbrush art, wood carvings to

Program – Provider	FY16-17 Key Outcomes and Highlights
	beaded bottles and more. From these submissions, the panel of judges narrowed it down to twenty pieces that were shown at the opening. With over 100 people at the opening, Imo Momoh, Director of MHSA, and Kavoos Bassiri, Director of BHS, gave moving speeches which further inspired the artists and attendees. Artists also spoke about their lives, struggles and accomplishments and explained the motivations and theories behind their art. Attendees enjoyed food provided by Citywide's own Slice of Life Catering program.
Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) – API Wellness Center	• In FY16-17, the AAIMS Project launched healthy cooking classes on a monthly basis at Larkin Street Youth Services and led educational group outings for program participants at various locations throughout San Francisco. • In FY16-17, 30% of program participants reported the ability to make changes to their lifestyle and maintain a healthier diet. • In FY16-17, the AAIMS Project provided nutrition education, outreach and services to 1,552 individuals; this was 115% of their annual goal.
SF Fully Integrated Recovery Services Team (SF First) Vocational Project – SFDPH	• 22 consumers (20%) out of a total SF FIRST caseload of 110 were served by the Stipended Training Program in FY16-17. • 13 consumers completed the entire nine-month program. • 90% of trainees (19 out of 22) indicated improvements in coping abilities as evidenced by post-program evaluations.
Assisted Independent Living Vocational Program – Baker Places	• AILP provided services to 81 clients in FY16-17. • Of the 79 clients enrolled in the supportive housing program at AILP for at least 60-days, three experienced psychiatric inpatient hospitalizations, resulting in a 3.8% client hospitalization rate. • Of the 15 clients registered in AILP since the beginning of FY16-17, 14 clients had a finalized Treatment Plan of Care within 60-days of the episode opening, but no later than the first planned service.
Café and Catering Services – UCSF Citywide Employment Program	• Ten consumers were enrolled in the Slice of Life Café Program and eight consumers were enrolled in the Slice of Life Catering Program in FY16-17. • 100% of trainee graduates reported an improvement in development of skills toward future opportunities and an improvement in confidence to use the new skills learned.

Program – Provider	FY16-17 Key Outcomes and Highlights
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) – UCSF Citywide Employment Program	• Eight consumers (goal of six) of cohort one of the GROWTH Project completed the six-month paid work experience. • 100% of trainee graduates who completed a final performance evaluation reported an improvement in development of skills to use toward future opportunities. • 100% of trainee graduates who completed a final performance evaluation reported an improvement in confidence. • The GROWTH Project enrolled 12 consumers (goal achieved) in cohort 2 of the classroom portion of GROWTH.
Transitional Age Youth Vocational Program – Richmond Area Multi-Services (RAMS)	• During FY 16-17, Career Connections staff conducted outreach to juvenile probation, fourteen CBO partners and the school-based Wellness initiative which covers all SFUSD high schools. • Of the eight participants selected for the first cohort, five participated in internships at the Cartoon Art Museum, SFDPH Food Safety, the Food Bank, the RAMS Peer Wellness Center and the KPOO Radio Station. • Of the program participants that continue to remain engaged in the program, 100% (ten out of ten) have maintained a 75% participation rate. • 80% of participants surveyed indicated feeling more prepared for their next opportunity and 100% reported feeling confident using the skills they have learned in the program.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[28]**
Vocational Programs	2,158 Clients	$1,960,299	$908

[28] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

UCSF Citywide's Cafe and Catering Vocational Program

Moving Forward in Vocational Services

SF First Vocational Training Program

SFDPH MHSA Staffing Changes

The previous vocational programs manager transferred to a new role to become the system of care program manager for the adult and older adult outpatient programs. This new role with the SOC will continue to support MHSA and further link vocational services from the clinics to the programs while also focusing on ways to improve client's and staff's experience in accessing vocational services.The vacant vocational programs manager role was recently filled in early 2018 by an individual with extensive knowledge in evaluation since he previously worked in the DPH Quality Management department.

RAMS Janitorial Services Program

SF-MHSA continues to make a small contribution to support the Janitorial Services program at Richmond Area Multi-Services (RAMS). We plan to better evaluate the outcomes and services and report on more highlights in future reports.

Occupational Therapy Training Program

Occupational Therapy Training Program (OTTP-SF) serves at-risk youth in a multitude of mental health, educational, and vocational programs and strives to engage them in meaningful activities that result in positive goal fulfillment. In April 2016 OTTP-SF responded to Department of Rehabilitation's invitation to do a pilot study on implementing the Individual Placement and Support (IPS) model in its work with youth ages 15-24 with a primary mental health diagnosis. Some of the core principles of IPS include rapid job search, attention to client preferences, and time unlimited support. In addition, IPS supported employment is integrated with the treatment team with competitive employment as the goal. SFDPH MHSA will continue to work with OTTP-SF and the community to determine the outcomes of this pilot and to reassess after FY17-18 to determine if this pilot should continue into the future.

Increased Collaborative and Engagement Efforts

In FY17-18, the Vocational Services department increased their engagement and collaborative efforts by reaching a broader audience through 29 community meetings/events. The feedback from these meetings also helped influence our CPP stakeholder feedback summary and guided our MHSA program planning for FY18-19. The FY17-18 vocational meetings include the following:

Date	Vocational Meeting Event	Location
July 27, 2017	Department of Rehabilitation Quarterly Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
August 28, 2017	Department of Rehabilitation Administrative Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
September 25, 2017	Department of Rehabilitation Administrative Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
October 3, 2017	UCSF Citywide Consumer Art Show	SF Public Library 100 Larkin Street San Francisco, CA 94102
October 5, 2017	Caminar Quarterly Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
October 19, 2017	RAMS Quarterly Meeting	RAMS Hire-Ability 1234 Indiana Street San Francisco, CA 94107
October 23, 2017	OTTP Quarterly Meeting	OTTP 425 Divisadero Street San Francisco, CA 94117
October 24, 2017	Citywide Quarterly Meeting	UCSF Citywide 982 Mission Street San Francisco, CA 94103
December 18, 2017	Department of Rehabilitation Quarterly Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
December 20, 2017	Citywide's GROWTH Graduation	SF Public Library 100 Larkin Street San Francisco, CA 94102
January 25, 2018	Department of Rehabilitation Quarterly Meeting	SF Department of Public Health 25 Van Ness Avenue San Francisco, CA 94102
January 26, 2018	Department of Rehabilitation Administrative Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
March 23, 2018	Intake Coordinators' Meeting	Behavioral Health Services 1380 Howard Street San Francisco, CA 94103
March 26, 2018	Department of Rehabilitation Administrative Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
April 10, 2018	Citywide Quarterly Meeting	UCSF Citywide 982 Mission Street San Francisco, CA 94103
April 12, 2018	Caminar Quarterly Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
April 19, 2018	OTTP Quarterly Meeting	OTTP 425 Divisadero Street San Francisco, CA 94117

Date	Vocational Meeting Event	Location
April 19, 2018	Citywide's GROWTH Graduation	SF Health Network 887 Potrero Ave San Francisco, CA 94110
April 20, 2018	Intake Coordinators' Meeting	Behavioral Health Services 1380 Howard Street San Francisco, CA 94103
April 24, 2018	RAMS Quarterly Meeting	RAMS Hire-Ability 1234 Indiana Street San Francisco, CA 94107
April 27, 2018	RAMS IT Help Desk Graduation Ceremony	Behavioral Health Services 1380 Howard Street San Francisco, CA 94103
May 15, 2018	Vocational Summit	SF Public Library 100 Larkin Street San Francisco, CA 94102
May 18, 2018	RAMS Peer Counseling Graduation Ceremony	Peer Wellness Center 1282 Market Street San Francisco, CA 94102
May 21, 2018	RAMS Peer Education Forum Training	SF Public Library 100 Larkin Street San Francisco, CA 94102
May 25, 2018	RAMS Peer Art Show	SF Public Library 100 Larkin Street San Francisco, CA 94102
May 21, 2018	Department of Rehabilitation Administrative Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102
June 12, 2018	Department of Rehabilitation Job Fair	SF Public Library 100 Larkin Street San Francisco, CA 94102
June 15, 2018	Intake Coordinators' Meeting	Behavioral Health Services 1380 Howard Street San Francisco, CA 94103
June 25, 2018	Department of Rehabilitation Administrative Meeting	California Dept of Rehabilitation 445 Golden Gate Avenue San Francisco, CA 94102

5. Housing Services

Service Category Overview

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

In 2016, BHS facilitated several population-specific resource training sessions. These sessions covered resources for preventing and ending homelessness. Provider groups participating this year included the Population Focused Prevention and Early Intervention (PEI) providers, FSPs, and the Transgender Advisory Group.

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

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

The NPLH program is still being developed by the State Department of Housing and Community Development. As of January 2017, the application process is still yet to be finalized. The NPLH Proposed Program Framework provides a tentative schedule of winter 2018 for the release of Notice of Funding Availability.

In San Francisco, the Mayor's Office of Housing and Community Development (MOHCD) and the Department of Homelessness and Supportive Housing (HSH), will be taking the lead on this project. The San Francisco Department of Public Health will work in partnership with MOHCD and HSH, to develop and implement the supportive services portion of the NPLH program.

The San Francisco Mental Health Services Act 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.

Target Population

MHSA-funded housing helps clients with serious mental illness or severe emotional disorders obtain and maintain housing. These programs serve individuals who are chronically homeless, at-risk for homelessness, enrolled in Full-Service Partnership programs, TAY, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Questioning) individuals, veterans, individuals with disabilities, older adults, extremely low income, and individuals with other needs. Some housing programs emphasize working with individuals with co-occurring mental health issues, alcohol and substance abuse problems, and/or complex medical conditions.

Housing Services	
Program Name	**Services Description**
Emergency Stabilization Housing	Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The twenty ESUs are located within several single room occupancy (SRO) hotels in San Francisco. The units are available to Full Service Partnership clients, Intensive Case Management clients and Central City Hospitality House's housing support staff. In 2015-2016, many of the units that were previously used for ESUs have been pulled from the program. The buildings that contracted with SFDPH (now under HSH) for these units have been able to lease out individual units or the entire building for higher amounts in the current rental market in San Francisco. As such, interim housing options for MHSA clients are severely limited.
Full Service Partnership (FSP) Permanent Supportive Housing	In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million by creating many units of housing for MHSA clients that are still being operated within the provision of the MHSA. In addition, San Francisco added $2.16 million from Community Services and Supports (CSS) to housing in 2007-08. All units within the MHSA supportive housing portfolio are reserved for homeless clients with serious mental illness. MHSA-capital-funded housing units are developed within larger mixed-population buildings with on-site supportive services and linked to the larger infrastructure of intensive case management (ICM) services provided by FSPs. Currently there are a total of 66 MHSA housing units dedicated to those who are homeless or at risk of homelessness developed with capital funding located in various neighborhoods of San Francisco including the Tenderloin, Rincon Hill, and Ingleside. Human Services Agency (HSA) units are available to the transitional-aged youth and seniors in addition to single adults. Additionally, MHSA utilizes units that are scattered through a number of older affordable housing sites. This includes units at three sites of the Tenderloin Neighborhood Development Corporation (TNDC); and, units at the Community Housing Partnership's Cambridge Hotel. The scattered site units at CHP and TNDC are part of the Direct Access to Housing (DAH)

Housing Services	
Program Name	**Services Description**
	Program, now part of the Department of Homelessness and Supportive Housing (HSH) – Adult Housing Programs division. We are now contracted for 43 units with CHP at several different sites, which includes the units at the Cambridge Hotel. The new 35 units are filled as they become available via turn-over.
Housing Placement and Supportive Services	Established by the San Francisco Department of Public Health in 1998, the Direct Access to Housing (DAH) program is a permanent supportive housing program targeting low-income San Francisco residents who are homeless and have serious behavioral health and/or complex physical health needs. As a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelters, hospitals and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance abuse problems, and/or complex medical conditions. DAH expanded capacity to serve MHSA clients alongside FSPs and other ICM service providers.
ROUTZ Transitional Housing for TAY	Youth with mental health and substance abuse issues have unique and complex needs for housing. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transitional- aged youth with Larkin Street Youth Services (LSYS). The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites in SF. In Fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, life skills training, wrap-around case management, mental health interventions, and peer-based counseling.

<u>Supportive Services</u>

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

Other MHSA Housing Services MHSA Permanent/Transitional Housing List 2017						
MHSA Housing Site	**Owner/ Operator**	**MHSA Units**	**Target Population**	**Services**	**Type of Project**	**Referral Source**
1100 Ocean	Mercy	6	TAY	FSP + FPFY	MHSA Capital	BHS Placement
Aarti/Routz	Larkin St.	40	TAY	Larkin - All	MHSA GF - TH	BHS Placement
LeNain	DISH	0-5	Adults	HSH	DAH	DAH
Pacific Bay Inn	DISH	0-5	Adults	HSH	DAH	DAH
Windsor Hotel	DISH	0-5	Adults	HSH	DAH	DAH
Empress	DISH	0-5	Adults	HSH	DAH	DAH
Camelot	DISH	0-5	Adults	HSH	DAH	DAH
Star	DISH	0-5	Adults	HSH + FSP	DAH	DAH
San Cristina	CHP	15	Adults	FSP + CHP	DAH	DAH
Cambridge	CHP	9	Adults	FSP + CHP	DAH	DAH
Hamlin	CHP	0-5	Adults	FSP + CHP	DAH	DAH
Richardson	CHP	12	Adults	FSP + Citywide	MHSA Capital	DAH
Rene Cazaneve	CHP	10	Adults	FSP + Citywide	MHSA Capital	DAH
William B. Kennedy	TNDC	3	Seniors	FSP + TNDC	MHSA Capital	DAH
Polk Senior	TNDC	10	Seniors	FSP + LSS	MHSA Capital	DAH
Kelly Cullen	TNDC	17	Adults	FSP + TNDC	MHSA Capital	DAH
Ritz	TNDC	2	Adults	FSP + TNDC	DAH	DAH
Ambassador	TNDC	9	Adults	FSP + TNDC	DAH	DAH
Dalt	TNDC	10	Adults	FSP + TNDC	DAH	DAH
Veterans Commons	Swords	8	Veterans	FSP + Swords/VA	MHSA Capital	BHS Placement
Senator	CHP	3	Adults	FSP + CHP	DAH	DAH
Iroquois	CHP	2	Adults	FSP + CHP	DAH	DAH
TOTAL		**156-191**				

Community Partnerships

In FY15-16, BHS began referring people to reserved MHSA units within the CHP portfolio. These 43 units within existing affordable housing sites owned and operated by CHP include access to on-site support services staff through a contract expansion with CHP. This program targets single adults with serious mental illnesses who are currently homeless and are placed by the DAH program. Staffing for this contract includes two full-time equivalent support services staff to assist with on-site services, activities and groups, and to work directly with FSP provid-

ers on individual service plans. The various housing sites have been remodeled and are regularly monitored to meet housing quality standards. The 43 MHSA units are across the following buildings: the Cambridge, Hamlin, San Cristina, and the Iroquois. The contract for the 43 units is between HSH and CHP.

Developed by the Tenderloin Neighborhood Development Corporation (TNDC) and completed in FY16-17, Willie B. Kennedy Senior Housing (WBK) is a 98-unit, five-story affordable senior housing development, with three units set aside for older adults under the MHSA. The project is located at the corner of Turk and Webster streets in the Western Addition neighborhood of San Francisco, California. WBK is constructed on the parking lot of an existing public housing facility, Rosa Parks, an eleven-story, 198-unit building owned and operated by the SF Housing Authority since 1959.

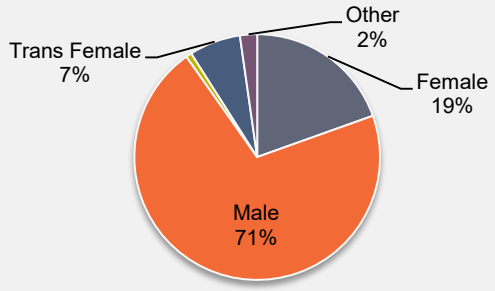
The Ocean Avenue development, completed in FY15-16, is a project that includes 6 units of housing for families and transitional aged youth (TAY) and one property manager unit. The building has a mix of studios, one, two and three-bedroom units available to residents making no more than 50 percent of the area median income.

Program Outcomes and Highlights

Demographics: Housing[29]

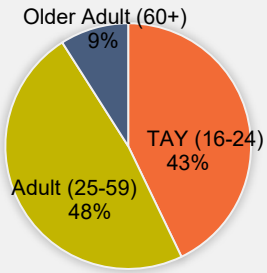
The Housing Demographics are highlighting the TAY and FSP Housing Programs:

Gender: Housing Participants (n = 133)

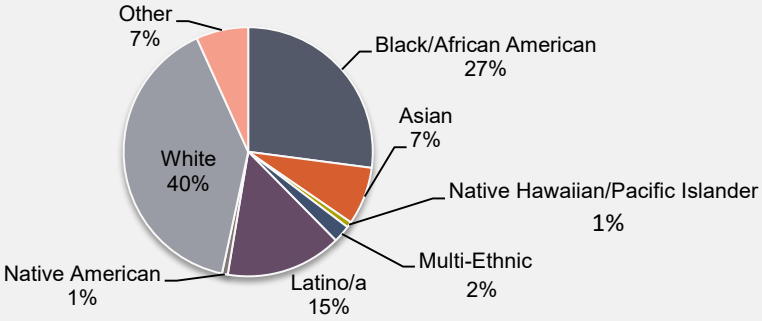


[29] In the following demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).

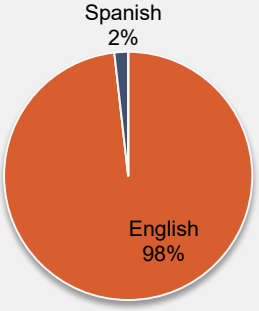
Age: Housing Participants (n = 133)



Ethnicity: Housing Participants (n = 133)



Primary Language: Housing Participants (n = 56)



	FY16-17 Key Outcomes and Highlights
FSP Permanent Supportive Housing	• These 66 units in non-profit housing include access to service coordination staff through a contract expansion with the Community Housing Partnership. This program targets those who are homeless or at risk of homelessness in various neighborhoods of San Francisco. • 11 households received 51 outreach visits when displaying housing instability issues

	FY16-17 Key Outcomes and Highlights
	• 22 households received 153 individual meetings on-site
Housing Placement and Support	• The program's individual referral prioritization system and its varied portfolio of housing sites allows for tailored placement based on the physical and clinical needs of the population such as: ➢ Level of medical acuity ➢ Substance use severity ➢ Homeless situation ➢ Match between clients' needs and available on-site services ➢ Availability and match of a housing unit
ROUTZ Transitional Housing for TAY	• 79% of youth were linked with a mental health provider to receive individual or group mental health services. • 71% of youth housed for at least one year showed an improvement in their ability to manage mental health issues. • 79% of youth remained in housing or exited to stable housing as of the end of the report period. • 85% of youth entering the program had a case plan completed within 30 days of entry and 95% of all youth had a case plan completed or updated at least once during the fiscal year.

Moving Forward in Housing Services

In November 2015, the Mayor announced the need for a central department in SF to focus exclusively on homelessness issues. As a result, the Department on Homelessness and Supportive Housing (HSH) was created and officially started in July 2016. HSH, with support from SFDPH MHSA, now oversees the Housing Placement and Supportive Services for MHSA units. BHS work-orders its housing-specific funds to the new department to expedite placement of homeless FSP clients. This move promotes the MHSA principle of community collaboration and working with our City partners to provide the best housing services. HSH is also actively implementing a Coordinated Entry System to continue providing integrated services for all permanent supportive housing programs in SF that began working with families in 2017 and will implement for single adults in 2018. In addition, the Direct Access to Housing (DAH) program that centralizes housing linkage and resources for the Department of Public Health, including MHSA funding housing units, also moved to the new HSH department. Please refer to the website of the new HSH Department for additional information: www.dhsh.sfgov.org

SF-MHSA will provide funding and support for hoarding and cluttering services for clients with severe mental illness. These funds will be used to develop a contract through an RFQ process for services with a vendor that will provide heavy clean-up and hauling services for vulnerable clients. The contract will be administered by the Adult Protective Services unit within the Human Service Agency for the benefit of adults with mental health disabilities and older adults that are experiencing self-neglect, abuse, or that are at risk of eviction.

Lastly, the California Housing Finance Agency (CalHFA) is providing the San Francisco Department of Public Health (SF-DPH) full authority and oversight of the MHSA housing unit named William B. Kennedy located at 1239 Turk Street. The Department of Housing and Urban Development (HUD) has also approved this plan. The San Francisco Board of Supervisor's Budget and Finance Committee met on January 11, 2018 and approved a resolution accepting the MHSA Assignment and Assumption Agreement Loan and related loan documents between CalHFA and SF-DPH in accordance with the San Francisco Mental Health Services Act Integrated Plan in the loan amount of $300,000 for FY2017-2018. See Appendix D for details.

SF-MHSA Director and Team Members at 2018 MHSA Boot Camp

6. Behavioral Health: Workforce Development

Service Category Overview

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

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

Target Populations

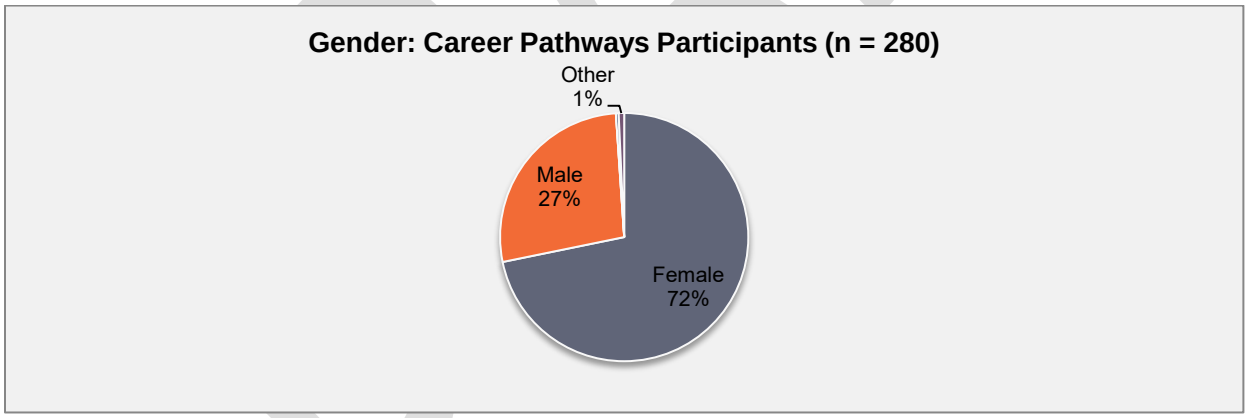
These programs work with college students with populations who are currently underrepresented in licensed mental health professions,: high school students who express career interests in the health care/behavioral health care industries; and mental health consumers, family members and individuals who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

Mental Health Career Pathway Programs	
Program Name - Provider	**Services Description**
Summer Bridge - Richmond Area Multi-Services	The Summer Bridge Program is an eight-week summer mentoring program for youth ages 16-20 who are enrolled in or recently graduated from San Francisco Unified School District high schools. The program aims to 1) educate youth about people's psychological well-being; 2) reduce the stigma associated with mental health; and 3) foster youth's interests in the fields of psychology and community mental health.
Community Mental Health Worker Certificate – City College of San Francisco	The Community Mental Health Worker Certificate (CMHC) program at City College of San Francisco (CCSF) is a 16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through consumer-directed goal setting and collaboration between mental health service consumers and mental health providers. The program educates and trains culturally

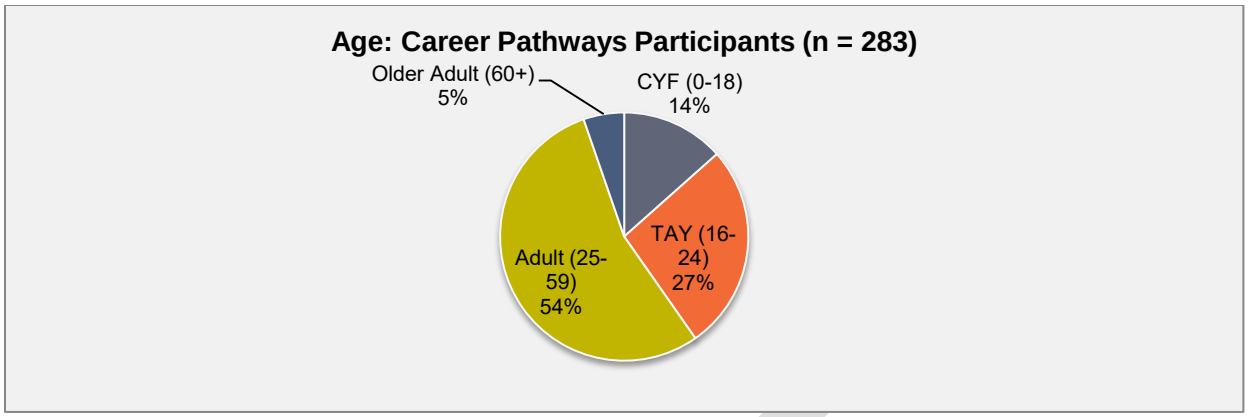
Mental Health Career Pathway Programs	
Program Name - Provider	**Services Description**
	and linguistically diverse consumers of mental health, family members of consumers and mental health community allies to enter the workforce as front-line behavioral health workers who are able to deliver culturally congruent mental health care to underrepresented populations (e.g., African American; Asian; Pacific Islander; Latino; Native American; Lesbian, Gay, Bisexual, Transgender, Questioning; and immigrant communities).
FACES for the Future Program – Public Health Institute	Faces for the Future program (FACES) is nationally recognized for healthcare career preparation work with high school students. The FACES program introduces John O'Connell High School students to career pathways in healthcare, public health and mental and behavioral health while supporting them with academic interventions, coordination of wellness services, referrals to outside agencies when needed and youth leadership development opportunities.

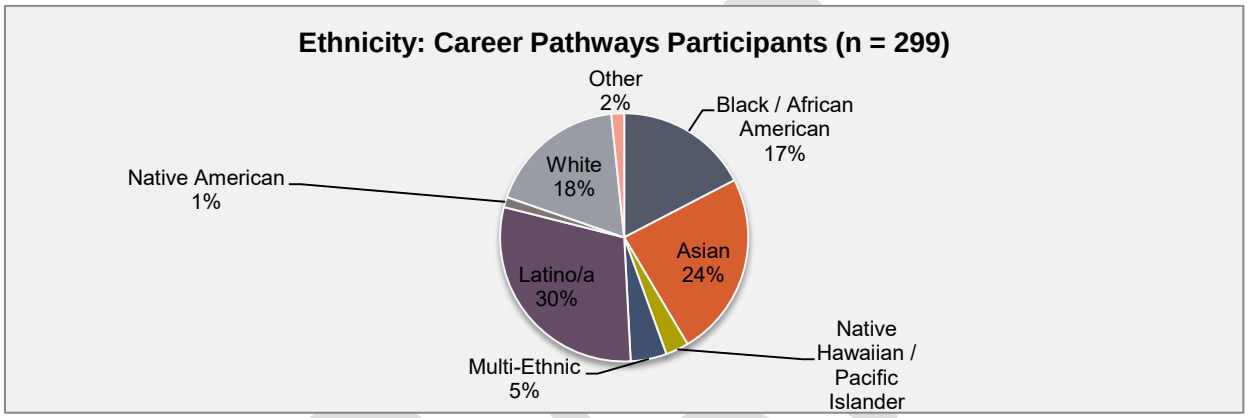
Participant Demographics, Outcomes, and Cost per Client

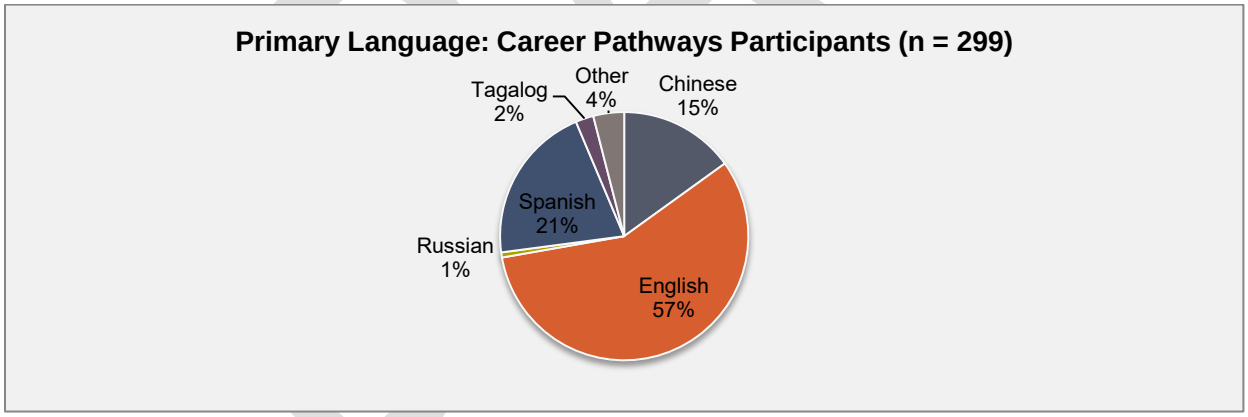
Demographics: Career Pathways[30]



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


Age: Career Pathways Participants (n = 283)
Older Adult (60+) 5%
CYF (0-18) 14%
TAY (16-24) 27%
Adult (25-59) 54%


Ethnicity: Career Pathways Participants (n = 299)
Other 2%
Black / African American 17%
White 18%
Native American 1%
Asian 24%
Latino/a 30%
Native Hawaiian / Pacific Islander
Multi-Ethnic 5%


Primary Language: Career Pathways Participants (n = 299)
Tagalog 2%
Other 4%
Chinese 15%
Spanish 21%
Russian 1%
English 57%

Program	FY16-17 Key Outcomes and Highlights
Summer Bridge – Richmond Area Multi-Services (RAMS)	• In FY16-17, Summer Bridge provided 120 hours of program activities directly to youth intended to develop a diverse and competent workforce. • 73% of participants surveyed agreed or strongly agreed with the statement, "I know how to refer family and/or friends for mental health support and/or services." • 82% of participants surveyed agreed or strongly agreed with the statement, "I have found role models in the health & human services field." • 100% of participants completed the program and graduated.
Community Mental Health Worker Certificate – City College of San Francisco	• 14 out of 15 students graduated from the program in FY16-17, representing a 93% successful completion rate for internship placement and performance. • 69 students were recruited for the program's Introduction to Recovery and Wellness in Mental Health course. • Staff provided two workshops, one focused on self-care and the other on the wellness domains.
Faces for the Future Program - Public Health Institute	• Staff identified and engaged 35 internship sites throughout the SFDPH system. • Each FACES student participated in at least 60 hours of internship. • 100% of FACES seniors enrolled in FY16-17 graduated from high school on time. • 100% of FACES seniors enrolled in post-secondary programs beginning in Fall 2017.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[31]
Mental Health Career Pathways	449 Clients	$776,838	$1,730

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

[31] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

Training and Technical Assistance Programs	
Program Name - Provider	**Services Description**
	of how trauma is experienced in both shared and unique ways.
Adolescent Health Issues - Adolescent Health Working Group	The purpose of adolescent/TAY provider capacity building is to improve communication and coordination of health related activities and services among youth/young adult providers across service sectors – including CBOs, SFDPH , UCSF, SFUSD, Juvenile Justice, workforce development and housing – while also building provider capacity and support systems.
Medicinal Drumming Apprenticeship Pilot – City College of San Francisco	The Medicinal Drumming Apprenticeship is a pilot project designed to train community based behavioral health service providers in a culturally affirming wellness and recovery therapeutic methodology. This approach allows program participants to be supported in a culturally congruent manner, as they build and apply new skills that promote personal and community empowerment.
Street Violence Intervention and Prevention (SVIP) – HealthRIGHT 360 (Fiscal Intermediary)	The nine-month SVIP Professional Development Academy builds upon the existing skills and talents of San Francisco's brave and courageous street outreach workers/crisis responders and educates them in the areas of community mental health, trauma, vicarious trauma and trauma recovery within the frameworks of cultural sensitivity, responsiveness and humility. Participants complete a nine-month long training program, and this Academy's unique learning and application setting allows the SVIP staff to build upon their already existing talents for working with and alongside of communities. The SVIP Professional Development Academy is built upon the core curriculum of the MHSA-funded Community Mental Health Certificate Program and has additional emphases on trauma, vicarious trauma and trauma recovery.

Program Outcomes, Highlights and Cost per Client

Program	FY16-17 Key Outcomes and Highlights
Trauma Informed Systems Initiative – SFDPH	• This project is ongoing and ramping up considerably. Active training seminars are taking place throughout Zuckerberg San Francisco General Hospital. • In FY16-17, we trained approximately 815 people at Zuckerberg San Francisco General Hospital. • A goal of our work is to "develop organizational mindful practices".

Program	FY16-17 Key Outcomes and Highlights
Adolescent Health Working Group – Adolescent Health Issues	• The AHWG Coordinator and interns disseminated 300 PrEP education/awareness resources to community partners, and updated AHWG.net outreach materials for parents, youth, and providers. • The AHWG Coordinator and Steering Committee (including Subcommittees) provided over 300 hours of capacity-building service to youth and young adult provider networks. • AHWG is actively building a social media presence to widen reach, having amassed a social media following of nearly 500 and growing.
Medicinal Drumming Apprenticeship Pilot – City College of San Francisco	• In FY16-17, a total of 14 Medicinal Drumming Praxis participants were recruited for the project. • 100% of these new apprentices completed their training and participated in the concurrent research process. • Although the official Medicinal Drumming Praxis project has come to a close, the apprentices continue to meet monthly for drumming sessions and interagency collaborations.
Street Violence Intervention and Prevention (SVIP) - HealthRIGHT 360 (Fiscal Intermediary)	• In FY16-17, the program provided train the trainer (training) to six SVIP staff members. • Fifteen (15) staff members completed the mental health academy training. • Staff members reported that in addition to their professional development, the information and skills attained from the academy has helped them be more supportive and emotionally present with their families.

FY16/17 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[32]**
Training and Technical Assistance	4,000 Served	$758,038	$190

Residency and Internship Programs	
Program Name	**Services Description**
Fellowship Program for Public Psychiatry in the Adult System of Care - UCSF	The goal of the Fellowship Program for Public Psychiatry in the Adult System of Care is to further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asian Pacific Islanders; health care utilization by Lesbian, Gay, Bi-sexual, Transgender, and Questioning individuals) and services for adults diagnosed with severe mental illness. In order to address San

[32] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

Residency and Internship Programs	
Program Name	**Services Description**
	Francisco's behavioral health workforce shortages and supplement its existing workforce, the MHSA funds psychiatric residency and internship programs.
Public Psychiatry Fellowship at Zuckerberg SF General Hospital - UCSF	The mission of the UCSF Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital is to train the next generation of public mental health care leaders who will provide patient-centered care to vulnerable populations with severe mental illness through: 1) understanding and implementing relevant, evidence-based psychosocial rehabilitation and psychopharmacological treatments, 2) promoting recovery, and 3) developing rewarding public-academic partnerships to examine their work. The UCSF Public Psychiatry Fellowship has developed a strong curriculum, which promotes leadership opportunities, a sense of community, and mentoring.
Behavioral Health Services Graduate Level Internship Program - SFDPH	*See "Spotlight" below for program description.*

FY16/17 Cost per Client			
Program	**Total Served**	**Annual Cost**	**Cost per Client**[33]
Psychiatry Residency and Fellowships	260 Served	$371,437	$1,429

MHSA Consumer, Peer and Family Conference 2017

[33] Cost per client is calculated by dividing the annual budget by the total number of unduplicated clients. Client counts may be lower than previous years due to increased efforts to report unduplicated clients.

Spotlight on Behavioral Health Services Graduate Level Internship Program

Behavioral Health Services (BHS) provides a culturally diverse network of programs, with services provided by psychiatrists, psychologists, therapists, nurses, health workers, peer professionals, and student trainees. This interdisciplinary workforce supports the needs of all SF residents who access our system by providing comprehensive behavioral health services to mentally ill adults and emotionally disturbed children, youth, and their families. As a system, we achieve this mission through a Wellness/Recovery and Trauma-Informed philosophy of care. Our emphasis on Wellness/Recovery supports a strengths-based process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. We emphasize responding through a lens, guided by six principles: Trauma Understanding, Safety and Stability, Cultural Humility and Responsiveness, Compassion and Dependability, Resilience and Recovery, and Empowerment and Collaboration. These learned strategies cause our workforce to develop individual & organizational resilience in order to create and maintain a healthier, strength focused, trauma-informed response toward our clients and colleagues.

Internships are with our Adult/Older Adult and Children's Civil Service Clinics and throughout our systems of care. These placements support more than 75 trainees who are able to provide a range of behavioral health services; Individual/family therapy, case management, Crisis and wraparound services. Our internship program provides training opportunities for psychology interns, masters-level trainees, peer interns, nursing and nurse practitioner students each year. SF County BHS Civil Service Clinics only accept trainees (a student who is actively enrolled in a graduate program (MSW, MFT, LPCC, Ph.D./Psy.D., etc. as defined by their academic institution) into its training program. Students are provided with weekly didactic training seminars at their local placements and several students attend the training seminars that are provided within our system of care. We also offer an Intern Lecture Series which is a monthly clinical presentation on topics that benefit students in our integrated health care and behavioral health systems. Regular in-service trainings and specialized staff trainings are also available for students through our departmental training unit, in a wide variety of topics such as Dialectical Behavior Therapy, Racial/Cultural Humility, Solution-Focused Therapy, Motivational Interviewing, and Cognitive Behavior Therapy.

The multi-cultural student stipend program (MSSP) is available to students training in behavioral health and substance use disorder treatment programs. The program is designed to assist students in their development of skills to work with culturally diverse populations, to encourage ethnic and cultural diversity among our interns, and to increase the pool of applicants with special skills and knowledge including language, culture, disabilities and principles on wellness and recovery for future employment with BHS. The MSSP is also aimed at providing support to students interested in public sector work, working with populations with health disparities and addressing shortages of culturally and linguistically competent staff. In academic year 16/17 we were able to support 26 students with stipends that totaled $75,000.

Moving Forward in Behavioral Health Workforce Development

From July 1, 2016 through June 30, 2017, SFDPH BHS developed a Five Year Workforce Development Plan (FY17/18 – FY21/22) in order to focus on the following objectives:

- Integrate Behavioral Health Career Pipeline programs and existing training initiatives.
- Establish priorities for new initiatives.
- Be driven by System of Care and staff needs.
- Identify staffing and resources needed to implement strategies.
- Define measurable objectives and mechanisms for monitoring success.

As a result of community and stakeholder feedback, the plan now reflects strategy shifts in workforce development investments, planning and infrastructure. These shifts include the conclusion of the Richmond Area Multi-Services (RAMS) Summer Bridge and the bolstering of civil service professional development, "Grow from Within" (growing talent from within existing workforce) efforts and career pipeline building.

In addition, the City College of San Francisco Medicinal Drumming program concluded on 6/30/17 due to the lessons learned and the workforce department's system transformation. The community decided that it was a natural end date based on a recent assessment of the project. SFMHSA introduced the practice to the point that the investment was made. Many providers were able to embed the practices into their internal systems so these services will continue throughout Behavioral Health Services. For example, the Rafiki program is currently promoting these activities due to the exposure of the Medicinal Drumming program. We are pleased to report that this project was a success and provided education on practices that will continue throughout DPH.

City College of San Francisco

<u>Child & Adolescent Services Workforce Program</u>

The Child & Adolescent Services Workforce Program is ongoing and currently providing active training in Trauma-Informed Systems at Zuckerberg San Francisco General Hospital. The training and implementation continues to receive high satisfaction from participants including the content areas, the trainer and the importance of the initiative to DPH. In addition the City Of San Francisco is considering adopting the model for other departments. Trauma Informed Systems has worked with Cultural Humility committee of the Black and African American Health Initiative to develop shared practices and align practices.

Child & Adolescent Community Psychiatry Training Program (CACPTP)

In the past Fiscal Year 16/17, the CACPTP had four second year fellows spend an afternoon a week in our Community Psychiatry Clinics. Additionally, one more fellow decided to do a three month elective in our System of Care. The fellows overwhelmingly evaluated the experience well; one of the fellows said "it was one of the best clinical experiences of my fellowship." Two of the 5 graduating Child Psychiatrists decided to join our system of care and provide psychiatric services to our clients. As a result of this highly successful project, these activities will continue throughout the coming fiscal year.

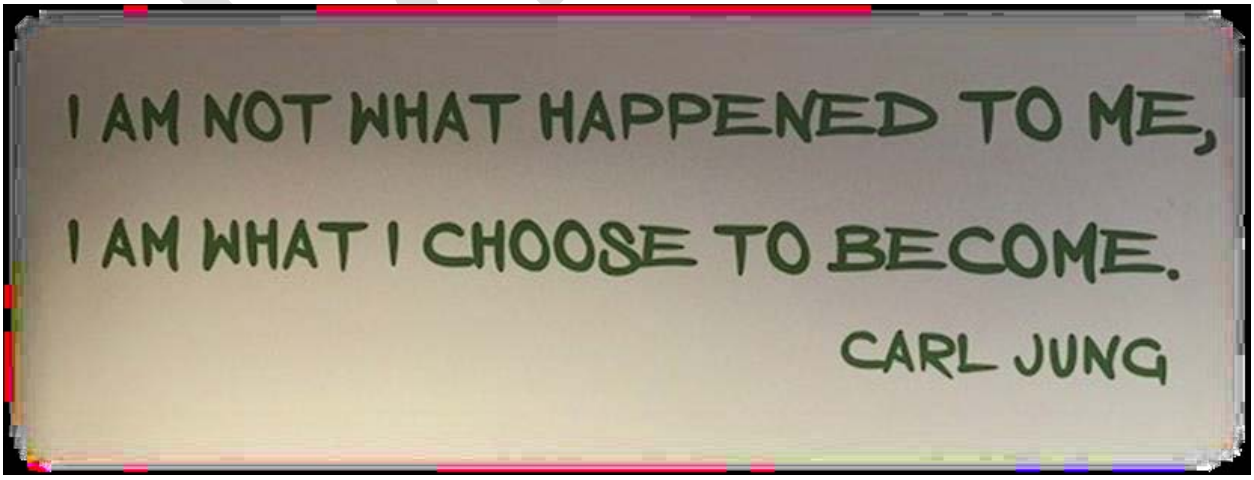
Behavioral Health Services Training Committee

BHS recently identified a Training Committee to inform and support the BHS training program in order to enhance professional development, improve workforce practices, and increase workplace experience. The Training Committee is comprised of BHS system of care staff including civil service & contracting agencies including administrative support staff, program supervisors, managers, peers and interns/trainees. The Committee will be led by the BHS Training Coordinator and be empaneled by a diverse group of stakeholders who embody the full range of racial, cultural, and educational backgrounds that represent our diverse workforce. The committee will evaluate the training needs of the workforce, make recommendations to inform the training plan, and identify resources that will support the training program. The committee will convene regularly; the frequency of which will be determined by the committee at a later date. The training committee will work to achieve the following objectives:

- Identify the needs & desires of the workforce that can be addressed through training.
- Improve the experience of staff in their work place by providing tools that help build respectful relationships among colleagues and with clients.
- Foster a culture of learning that supports ongoing practice improvement.
- Integrate uniform best practices and standards of care.
- Evaluate the impact of training resources on staff experience, client care, and practice improvement.

Director of Equity, Social Justice and Multicultural Education Role

BHS will be recruiting and selecting a new Director of Equity, Social Justice and Multicultural Education that will address and foster the growth of the BHS's cultural competency work and client relations with the public and communities being served. This position will identify local and regional behavioral health needs of ethnically and culturally diverse populations as they impact county systems of care, and develop appropriate plans and recommendations.



7. Capital Facilities and Information Technology

Service Category Overview

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

The 2017-20 Integrated Plan included projects to renovate various buildings depending upon available funding – with the Southeast Health Center Expansion and Behavioral Health Integration Project taking priority.

Capital Facilities	
Program Name	**Services Description**
Recent Renovations	The Southeast Health Center is a DPH primary care clinic located at 2401 Keith Street serving San Francisco's historically underserved Bayview-Hunters Point neighborhood. The Southeast Health Center Expansion and Behavioral Health Integration Project was included in the FY16/17 Annual Update and the FY17/18-19/20 Integrated Three Year Plan. With the goal of better and more holistically meeting the needs of Bayview-Hunters Point patients and their families, this priority DPH project renovates and expands upon the existing facility, bringing a fuller and more integrated complement of DPH's healthcare resources and programs to one convenient campus.

Information Technology	
Program Name	**Services Description**
Consumer Portal	The Consumer Portal went live in May of 2017. The portal provides consumers with access to selected clinical information. Staff have been working on the marketing, training and encouragement of staff and consumers to sign-up and use the portal. Additionally, the portal supports the notification of upcoming appointments for clients that are receiving services. The Consumer Portal project expected outcomes include: • Increase consumer participation in care • Improve communication between consumers and/or family members and their care team • Reduce medication errors • Improve appointment attendance • Help keep consumer information up-to-date • Promote continuity of care with other providers

Information Technology	
Program Name	**Services Description**
Consumer Employment	The Consumer Information Technology (IT) Support: Desktop and Help Desk project was modified to focus on desktop support, in order to provide participants with a more specialized and targeted vocational experience. Participants learn skills related to the steps required to deploy new workstations, including imaging, logistics of deployment, removal of old hardware, break-fix and equipment tracking.
System Enhancements	The System Enhancements project provides vital program planning support for IT system enhancements. Responsibilities include the following: • Project management of the Meaningful Use Electronic Health Record (EHR) implementation across BHS Division by facilitating meetings and other communications between IT staff, administrative staff and clinical staff who are responsible for EHR deployment • Ensuring that timelines and benchmarks are met by the entire EHR team • Manage dependencies by helping to ensure that equipment, personnel and other resources are deployed efficiently and according to timeline • Creating, maintaining and updating the Meaningful Use implementation plan • Managing EHR-related professional development for all BHS staff in an effective and timely manner to ensure smooth implementation across the Division. • Conduct data analysis related to the projects

Moving Forward in Capital Facilities

The Capital Facilities Plan stated in the FY17 – 20 Three-Year Integrated Plan will be a working plan dependent upon available funding. Several BHS mental health clinics in San Francisco have a significant need for Capital Improvements. This tentative plan calls for capital improvements at the Southeast Health Center. The balance of the annual capital investment will be made available pending additional CPP activities and available funding.

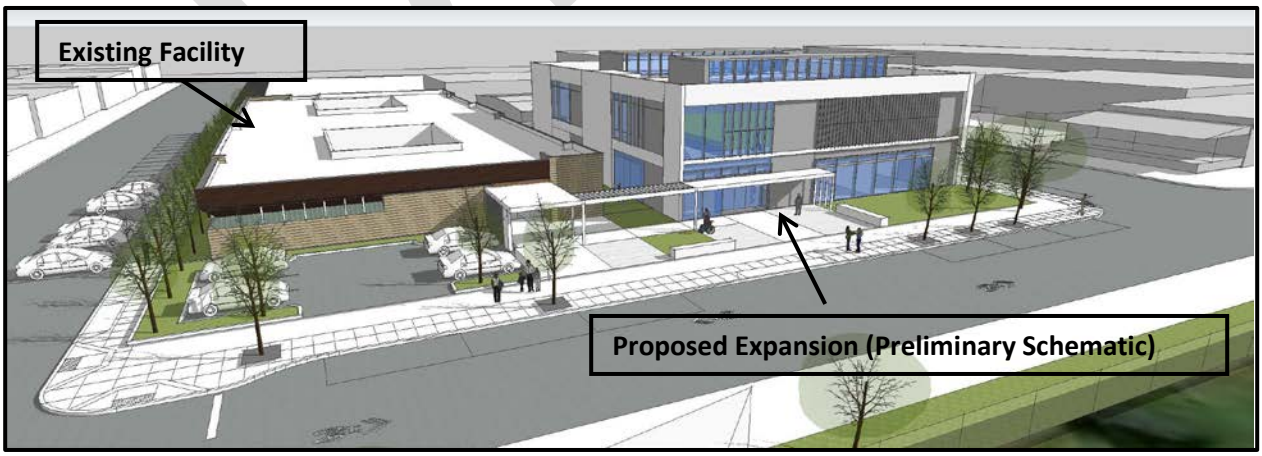
Southeast Health Center Expansion and Behavioral Health Integration Project

Project Location
Southeast Health Center is a DPH primary care clinic located at 2401 Keith Street serving San Francisco's historically underserved Bayview-Hunters Point neighborhood.

Project Summary
This project was included in the FY16/17 Annual Update and the FY17/18-19/20 Integrated Three Year Plan. With the goal of better and more holistically meeting the needs of Bayview-Hunters Point patients and their families, this priority DPH project renovates and expands upon the existing facility, bringing a fuller and more integrated complement of DPH's healthcare resources and programs to one convenient campus.

June 2018 Project Update
The project is being designed to implement a family-centered model of care that integrates DPH's primary care services, including office-based specialty services that target the most pressing health needs of the community, with behavioral health services and linkages to community resources. The new clinic will be a two-story 22,100 square foot facility, adjacent to the existing facility. The project is still targeting the start of construction for July 2019.

The San Francisco Department of Public Works (SFDPW) completed 100% of the schematic design phase in April 2018. A selection panel for the Public Arts Program will be convened this month to select local artists to provide original art for the clinic. Civic Design Review (Phase 1) has been approved (see rendering below) and Civic Design (Phase 2) is targeted for August 2018. DPH staff has continued to actively engage the clinic's community advisory board in the design process.



Program Evaluation for All MHSA Programs

In any given year, there are between 85-95 actively funded MHSA programs. MHSA -funded staff within the BHS Quality Management unit play an active role in supporting evaluation activities for MHSA, providing another opportunity to actively engage stakeholders. Several evaluation activities took place in the past year, however, we would like to highlight the following (5) five evaluation efforts:

1. The MHSA Evaluation Impact Group
2. Evaluation Efforts of Gender Health SF
3. Evaluation Efforts of the Peer-to-Peer Employment Program
4. Intensive Case Management to Outpatient Flow Solutions
5. Evaluation of SF-MHSA Program Reporting Practices
6. Statewide Evaluation Efforts

1. The MHSA Evaluation Impact Group

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

The Impact Group has created a collaborative, supportive forum for BHS to facilitate high quality evaluation activities in a peer discussion format. The program representatives have expressed their appreciation for technical training that is delivered in a conversational, understandable format, as well as the peer-to-peer support and engagement between programs. Impact Group meetings allow the MHSA program evaluation team from Quality Management to provide technical assistance (TA) on county or state requirements, evaluation and program improvement activities. Impact Group meetings also offer an opportunity for program providers and consumers to learn about various MHSA programs, share challenges to program implementation, lessons learned, evaluation plans, and consumer success stories with one another. Consumers are invited to present on their experience with the program, highlighting the program's successful impacts on their lives.

Impact Group meeting attendance usually ranges from 20-30 people, including program providers and consumers. A list of meeting topics in FY 2016-17 include:

- July: MHSA Orientation session for new MHSA funded staff
- August: TA session to Vocational Programs in preparation for the Vocational Summit
- September: Presentation by the Alleviating Anti-psychotic Induced Metabolic Syndrome Program
- December: Presentation by Community Youth Center's Asian Pacific Islander Youth and Family Support Services
- January: State regulations TA session and discussion with PEI Programs
- February: State regulations TA session and discussion with INN Programs
- March: How to do Focus Groups

- April: Collection of consumer social identity data
- May: Client Satisfaction & data-driven program improvement activities
- June: Completing MHSA Year-End Program Reports

2. Evaluation Efforts of Gender Health SF

In August 2013, the San Francisco Department of Public Health (SF-DPH) established Transgender Health Services, renamed Gender Health SF (GHSF), to provide access to gender affirming surgeries and related education and preparation services to eligible uninsured transgender or gender nonbinary adult residents. SF-DPH is the only publicly funded program in the nation to support gender affirming surgeries. Currently, SF-DPH provides a range of health services to transgender and gender nonbinary residents such as primary care, prevention, behavioral health, hormone therapy, chest and breast surgeries, and specialty and inpatient care. GHSF also serves to strengthen transgender health care competency among all SF-DPH staff at all access points. **MHSA funds the peer navigators and the program evaluator.** Since the program inception in 2013, GHSF has served 422 unduplicated individuals and averages over 130 client referrals to gender affirming surgeries per calendar year; in total, GHSF has received 638 referrals since 2013.

The four key indicators of the GHSF program evaluation include:

- Improvements in client surgery readiness
- Timely access to services
- Program satisfaction, and
- Three quality of life indicators (increased global quality of life, increased psychosocial functioning, and decreased gender dysphoria).

GHSF program activities towards ensuring client readiness and timely access to care include regular peer-led Client Education & Preparation Programs (EPPs) and various peer-led support groups (e.g., gender dysphoria, smoking cessation, weight and healthy nutrition). Also, whenever requested, peer navigators accompany clients to their surgical consultation appointments to assist with client advocacy and surgery preparation. Within the San Francisco Health Network, peer navigators also conduct regular provider in-service trainings to increase the background knowledge and LGBTQ cultural sensitivity among Behavioral Health, Primary Care, and various hospital staff throughout the San Francisco Health Network.

Since the start of program evaluation activities in 2016, participant satisfaction evaluations have been completed for attendees at one (1) community orientation, six (6) EPPs, and eight (8) SF-DPH provider education (in-service) sessions.

In the client education sessions, clients learn about possible surgical complications and how to have realistic post-operative expectations. Clients also learn how to plan ahead of their surgeries to have social support structures in place, and how to manage stress before, during, and after surgery. A majority of clients “agreed” or “strongly agreed” that the GHSF education programming was “valuable” and “worthwhile,” and helped clients feel “very” or “completely” ready for surgery, even when clients had to wait as long as 12 to 24 months for their surgery date.

Average attendance at the provider in-service trainings was approximately 13 providers per session, resulting in over 100 providers trained since 2016. Following the provider (in-service) education sessions, a majority of providers reported that they “agreed” or “strongly agreed” that they felt better able to take care of their transgender patients. In particular, providers noted that they “feel better prepared” to speak with clients about their upcoming surgeries. Many providers also indicated in their qualitative responses that they “want more” of these in-person types of

provider education and training sessions. When asked for qualitative feedback about how they hoped to change their clinical practices as a result of the trainings, many providers wrote that they hoped to "create a safe space" for their clients and to "use what [they] learned" in the training to "be more sensitive" and "more competent" when serving their transgender and gender nonbinary clients. Some providers noted that while the information provided in the in-service trainings wasn't particularly new to them, they felt "so grateful" that their other clinical team members received the training.

The GHSF peer navigators also work hard to ensure that clients remain engaged with their health care providers, which is one of the key standard of care requirements for assessing surgical readiness and achieving health plan approval for accessing gender affirmation surgery. Using standard scales as measurements (e.g., World Health Organization Brief Quality of Life Scale, Kessler-6 scale of psychological distress), and specific individual items regarding gender dysphoria, **outcome evaluation data revealed that client psychosocial wellbeing and gender dysphoria indicators improved after clients were able to access gender affirming surgeries**.

Qualitative interviews with 40 clients were conducted approximately 6 months after their surgeries during the 2017 calendar year to learn more about the role of the **peer navigators** in improving client outcomes and health care experiences. Clients often reflected on how important it was to have a peer advocate checking in on them and helping with the administrative paperwork for such an important and meaningful surgery. For example:

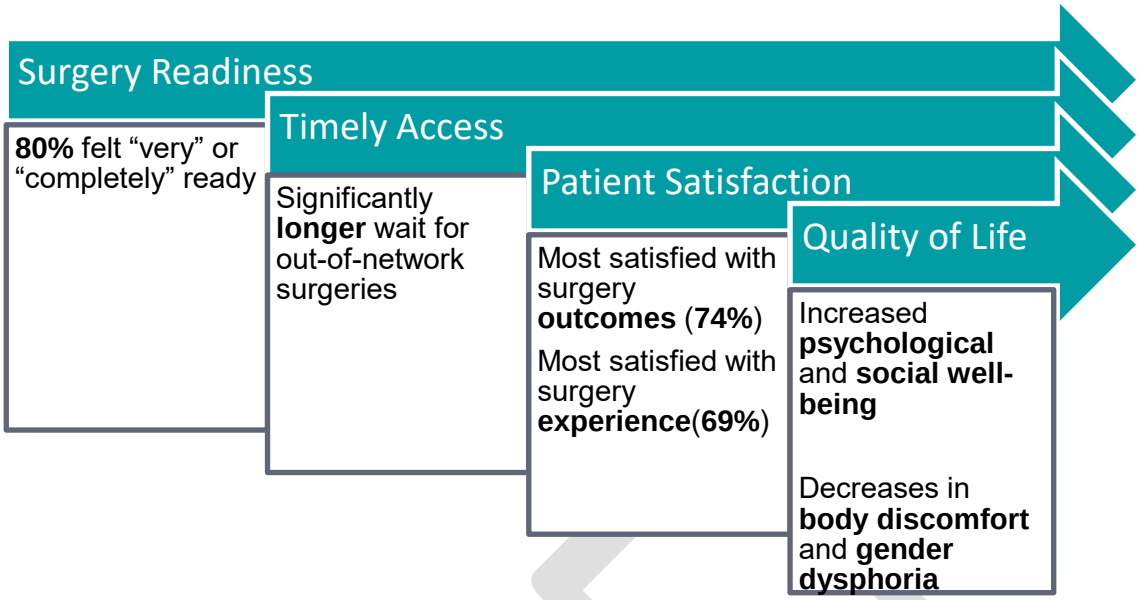
- "The [GHSF] staff were all excellent; they helped me with paperwork."
- "I was satisfied with the experience because everyone [at GHSF] kept checking in on me."
- "[GHSF] played a really helpful role in letting me know I had this option and doing a lot of work for me like helping me with paperwork, scheduling peer navigation and communication and liaisoning [sic] with my providers."

Clients also reflected on how important it was to have someone, especially an in-community peer, to walk them through this complex process so that clients both had a "better understanding of the process," from someone they trust, and that they had someone there to "help them through all the changes." The peers at GHSF truly understand their clients, and see them in their true identities. The clients reflected:

- "Calls from [my peer navigator] made me feel I had someone on my side before surgery. It's different talking to somebody vs reading a form. Calls from [GHSF] guided me to a better understanding of the process. [GHSF] advocated for my identity as gender queer. They validated my identity."
- "My experience was difficult. People changed and moved, but the [GHSF] care team was there for me through all the changes."

Finally, but no less importantly, through GHSF's ongoing peer-led community outreach activities throughout the BHS clinic network, GHSF is regularly asking and learning from the trans and gender nonbinary community members, as well as BHS staff, what the current needs of these communities are. From these outreach activities, GHSF is able to add or modify their ongoing programming to meet the current needs of community members and the clients that they serve.

The below graphic describes the impact of peer navigation on transgender and gender nonbinary patients served by GHSF:



3. Evaluation Efforts of the Peer-to-Peer Employment Program

SF-MHSA is committed to funding behavioral health programs that support, train, and hire peers, in alignment with its guiding principles. The Peer-to-Peer Employment Program is a community-based project and one of several MHSA-funded programs that aim to provide a positive employment experience to peers.

Working with program administrators and peer representatives, staff in Quality Management (QM) designed a survey to better understand peer employees' experience with four outcomes of interest:

a. Feeling integrated into the team (inclusion, contribution, appreciated, recognized, valued)
b. Professional development (opportunities for learning and applying what is learned)
c. Career advancement (opportunities for moving "up and out")
d. Supported in wellness and recovery (in supervision)

Currently active peer employees (n=53) were invited by email and with flyers to complete the survey online or on paper. Surveys were received by QM from September through October 2017. Out of 53 peer employees, 37 completed a survey for a response rate of 70%.

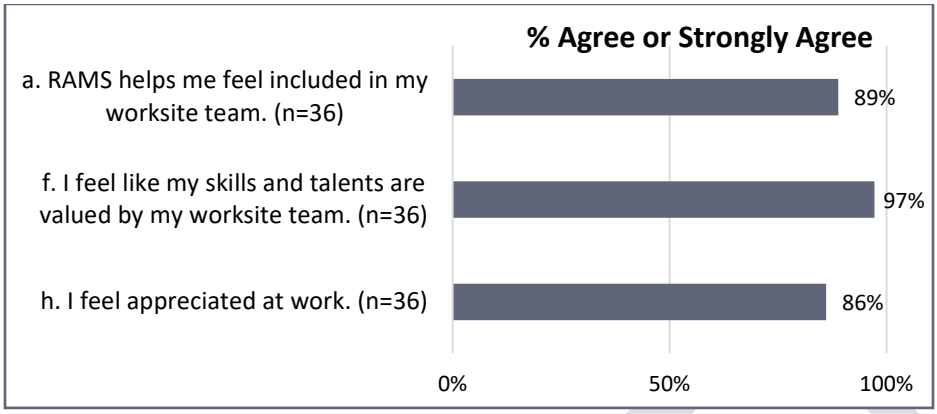
After initial review of the data, further clarification was needed on two topics. Hence, a focus group with 6 peer employees was convened to better understand responses to the 'most important skill learned' survey question and how peer employees manage Social Security benefits with their employment.

Results

Overall, the majority of peer employees report positive responses in the four outcomes of interest stated above. Each item had 36 respondents, except items g and i for which 35 individuals responded.

a. Feeling integrated into the team

The majority of survey respondents indicate that they feel supported in feeling integrated into their worksite team, and feel especially strong that their "skills and talents are valued by my worksite team."

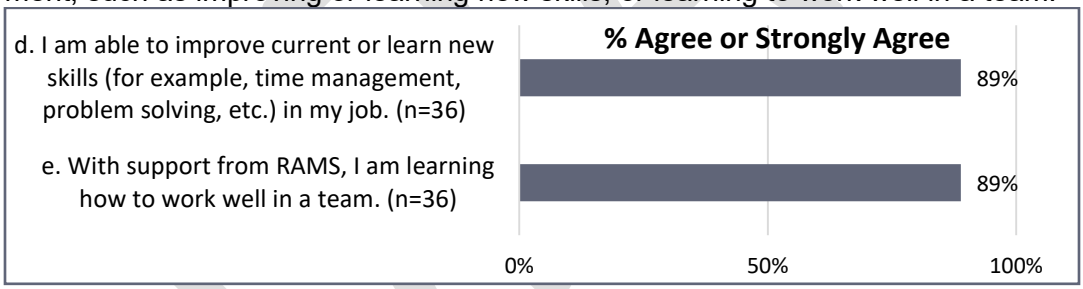


However, each of the above items had at least one respondent who gave a 'strongly disagree' or 'disagree' response. The following are comments from those respondents who indicate they disagree with item h:

- *"Financial promises made was not fulfilled on my behalf but was fulfilled to other(s) makes me feel un-appreciated"*
- *"My salary does not reflect it."*

b. Professional Development

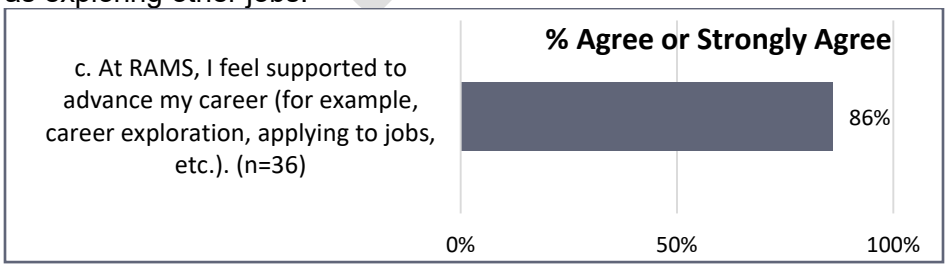
The vast majority of survey respondents report feeling supported in their professional development, such as improving or learning new skills, or learning to work well in a team.



For each item above, two respondents replied 'not applicable'.

c. Career Advancement

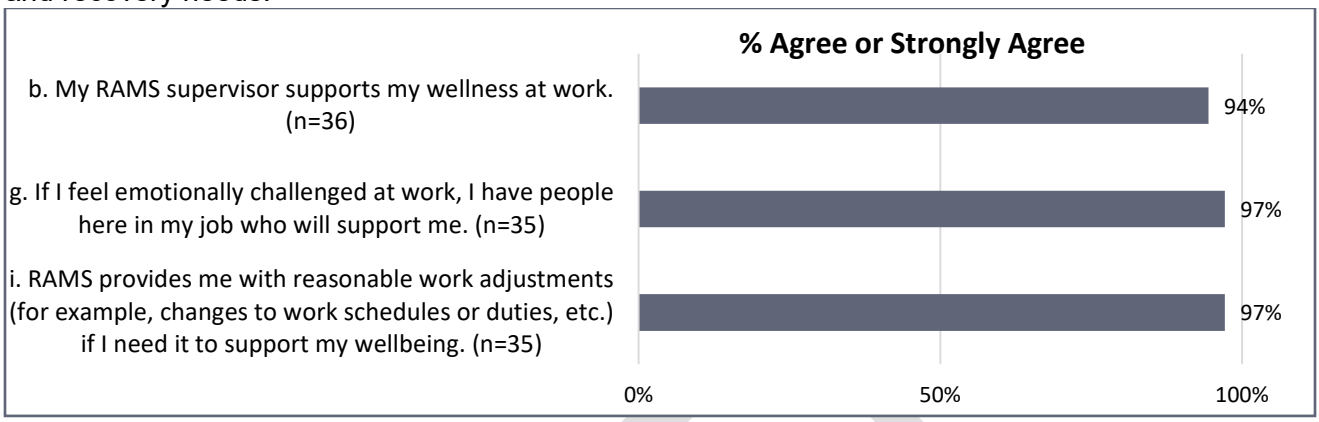
The majority of survey respondents report feeling supported in their career advancement, such as exploring other jobs.



Five individuals selected 'not applicable' for this item.

d. Wellness and Recovery

Items that capture feeling supported in one's wellness and recovery show the highest scores of all items overall. Most peers reported that their supervisors and others support their wellness and recovery needs.



However, one 'strongly disagree' response indicates at least one person does not feel as well-supported in wellness and recovery by their supervisor.

Overall, employees scored the survey items highly, suggesting broad levels of satisfaction with the support they receive from RAMS. Five respondents strongly disagree/ disagree with items in the 'feeling integrated into the team' and 'supported in wellness and recovery' outcomes. In addition, one respondent made a comment, "my [not applicable] answers aren't exactly I agree, but they aren't disagree answers either…they're kinda more like middle of the road."

4. Intensive Case Management to Outpatient Flow Solutions

Transitioning clients from intensive case management (ICM) to standard appointment based outpatient (OP) services has been a challenge for many years. In the SF Behavioral Health System (BHS) of care, fewer than 20% of clients discharged from ICM programs subsequently connect to outpatient mental health clinics, as evidenced by services accessed within three months post-discharge. There is widespread consensus that this represents a missed opportunity for quality care.

In 2017, Intensive Case Management (ICM), including Full Service Partnership (FSP) programs, and Outpatient (OP) providers, consumer advocates and peer employees, and BHS administrative staff, facilitated by a consulting group convened several times to examine this concern. The goals of the convenings were to:

- Build relationships between providers of ICM/FSP and Outpatient programs
- Clarify the problem to address (clients getting lost between ICM and outpatient services)
- Identify barriers and potential solutions to supporting clients in the referral and linkage to outpatient

The result of the convenings was a set of **potential solutions to test and implement** to improve client transitions from ICM to outpatient.

From November 2017 to the present, stakeholders have convened and formed three workgroups to address these three action areas. Each workgroup consists of representatives from the ICM programs, OP clinics, peer support organizations, as well as BHS administrators from the System of Care, Quality Management (QM) and MHSA. The objective for each group is to prioritize and test out proposed solutions, then with data and feedback from diverse providers

and clients, make recommendations for system and practice improvements. MHSA funded staff in QM act as quality improvement "coaches" for each of the following three workgroups.

- **Recovery Culture and Identifying Client Readiness for Graduation from ICM/FSP:** The objective of workgroup #1 is to come up with practice recommendations and proposed provider agreements on how to integrate the expectation of recovery and eventual graduation into the culture and programming of services at ICM/FSPs. Workgroup 1 also aims to achieve consensus between ICM/FSPs and OP MH programs on what client readiness to step-down looks like.
- **Referral, Intake, and Linkage Processes from ICM/FSP to OP MH:** The objective of workgroup #2 is to agree upon a clear and consistent process by which ICM/FSPs and OP MHs are to communicate and work with each other, in partnership with clients, to effect a priority referral, warm handoff, and a carefully orchestrated and assured successful transition of ICM/FSP clients into OP MH level-of-care.
- **OP MH Program Flexibility to Meet Needs of Clients Graduated from ICM/FSP:** The objective of workgroup #3 is to identify what OP MH programs will do differently in the way they provide services to clients stepped-down from ICM/FSP level-of-care, in order to mitigate important service gaps precipitated by the steep drop in the high frequency, intensity, and quantity of services which clients had been receiving at ICM/FSP programs.

Workgroups have met twice per month since early December, conducting small tests of change and generating experience and learning. On March 5th, the all workgroup participants will reconvene to share progress thus far with each other, and solicit feedback and volunteers from the other groups for further testing of prototypes. Workgroups will continue to meet twice monthly and refine tools and recommendations until a final convening in June when formal recommendations will be prepared for implementation.

These efforts are intended to strengthen the infrastructure in the system of care to support clients' advancement of their recovery. It will also lay groundwork for the integration of a proposed peer transition support team, as outlined in the Innovations plan approved by the MHSOAC on 3/22/18. Please see Appendix A for more details on this new Innovations project.

5. Evaluation of SF-MHSA Program Reporting Practices

The Quality Management (QM) department began a new process of reviewing the MHSA Year End Reports that are submitted from SF-MHSA programs annually and at mid-year. QM reviewed 51 MHSA FY16/17 Year End Reports to evaluate the following activities:

- Were the program objectives SMART (specific, measureable, achievable, relevant and time-bound)?
- Does the program have both process and outcome objectives?
- What is the quality of the data collection efforts?
- What is the quality of the data storage/management efforts?
- Is the analysis and reporting clear and accurate?
- Is the client satisfaction or feedback data utilized?

QM rated the programs as RED, YELLOW or GREEN, depending on the degree of technical assistance needed for programs to address all the concerns above. In the coming months, QM will collaborate with the MHSA program managers of the red and yellow rated programs and offer supportive technical assistance to the programs with the aim of strengthening data collection and reporting for the FY17/18 Year End Reports. QM also reviewed 40 MHSA FY17/18 Mid-Year Reports and collated similar results. This evaluation activity will be on-going until it is determined that sufficient TA has been provided to warrant better reporting outcomes.

In addition to the activities described above, QM and the Director of SF-MHSA collaboratively assessed the evaluation tools in place to collect all annual and mid-year data from programs. The findings showed that some programs may have reported duplicated counts in FY14/15 and FY15/16 while others reported unduplicated counts. Therefore, the number of "client served" in previous Annual Updates that reported on outcomes for FY14/15 and FY15/16 are likely a mixture of both duplicated and unduplicated client counts.

In FY16/17, due to SF-MHSA's ongoing efforts to strengthen our outcomes evaluation and reporting, we revised the evaluation tool to gather information for both "unduplicated counts" and "total served". Therefore the "clients served" numbers in this report may appear slightly lower than previous years, which is a result of our efforts to consistently improve evaluation practices.

6. Statewide Evaluation Efforts

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

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

2018 MHSA CPP Meeting at Excelsior Family Connections

"Looking Ahead for SF-MHSA"

In the years ahead, we will continue in our mission of transforming San Francisco's public mental health system. The MHSA will play an important role in strengthening and expanding the provision of mental health services locally, and throughout the state of California. Our future efforts will include the dissemination of the 2018/19 Annual Update, which brings together a vision for implementation of all the MHSA components.

In the coming year, SFDPH MHSA will work to implement and enhance the programming described in detail in this report. We will also strive to integrate all of the valuable feedback received in CPP meetings and other stakeholder engagements. We are committed to weaving this feedback into the core of MHSA programming.

In implementing the MHSA components over the next year, we will also focus efforts in a number of key areas. These areas of focus are detailed below:

- **We will take measures to respond to the upcoming No Place Like Home (NPLH) bond.** NPLH re-purposes statewide MHSA funds, and will provide $2 billion for the construction and rehabilitation of permanent supportive housing for homeless individuals with severe and persistent mental illness. In the coming months, we will monitor the roll-out of this legislation, and will prepare to participate in the competitive funding process. In the years ahead, we will work to develop and implement effective NPLH programming and services.

- **We will place a strong emphasis on program evaluation across the MHSA components.** In the year ahead, we will work to enhance our monitoring and evaluation activities, in order to effectively meet the performance objectives of our MHSA-funded programs. SFDPH MHSA is committed to pursuing innovative and dynamic methods of data-informed evaluation. We will implement our new and streamlined electronic data-collection and reporting tool that allows programs to submit mid-year and year-end reports online that include demographics data, measurable outcomes, client success stories and more. This electronic system is HIPAA compliant.

- **We will place a strong emphasis on expanding our collaborative efforts with multiple counties.** In the year ahead, we will work to enhance our relationships and networking capabilities with multiple counties in order to effectively work together, share common goals, exchange best practices and lessons learned and leverage resources. We plan to partner with multiple counties on an technology-based Innovations project that is spotlighted below. We also started a regular convening with neighboring counties to share ideas and strategize more effectively.

- **We will introduce new and innovative initiatives in programming.** These initiatives represent the only additional expenditures planned for the SFDPH MHSA budget, and are spotlighted below.

SF-MHSA Innovations

Innovations funding is integrated throughout our seven (7) MHSA Service Categories. Innovations funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes. As described in detail above, the current three (3) Innovations Learning Projects with SF-MHSA include:

1. First Impressions
2. Transgender Pilot Project
3. Addressing the Needs of Socially Isolated Older Adults

SF-MHSA plans to continue supporting these current Innovations projects while emphasizing the lessons learned and making sure we continue to implement robust evaluation efforts. The First Impressions Construction and Remodeling Vocational Program now has approval from the MHSOAC to operate as an Innovations Learning Project until June 30, 2019. SF-MHSA recently received approval from the MHSOAC for a one-year extension for First Impressions to extend both the time and budget of this project. This one year extension from July 1, 2018 to June 30, 2019 will help us accomplish two goals: better analyze transferable work skills and analyze the longevity of impact. SF-MHSA also submitted a request for a one-year extension and budget for the Addressing the Needs of Socially Isolated Older Adults program and the Transgender Pilot Program. These requests were approved by the MHSOAC. We would like additional time to focus on analyzing current data in order to determine the efficacy and successful components of these projects and to better answer our learning questions.

Launching Three New Innovations Initiatives

As a result from our Community Program Planning efforts, we will introduce three (3) new and innovative initiatives in programming in the next year. These three Innovations initiatives represent the only additional expenditures planned for the SFDPH MHSA budget.

On 3/22/18, the MHSOAC approved our Innovations proposal titled **Intensive Case Management/Full-Service Partnership to Outpatient Transition**. This project involves an autonomous peer linkage team providing both wraparound services and a warm hand off when transitioning from intensive case management services or full-service partnership services to outpatient treatment. The team will consist of five culturally and linguistically diverse peers and one clinician. Peers will serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow-up, and communicate with providers. The team will outreach to transitional clients in order to support them to have successful linkages to outpatient services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge. Please see Appendix A for more details on this exciting new Innovations project.

In the spring of 2018, we will submit two new innovations proposals to the MHSOAC. The **Wellness in the Streets** Innovations project will help increase access to underserved populations, specifically San Francisco residents who are homeless that do not typically access mental health services despite experiencing behavioral health needs. The proposed project would involve a roving support team of formerly homeless peer counselors that would engage this population in peer counseling directly on the streets of San Francisco in areas where individuals are unhoused. The primary objectives of the project will be to increase feelings of social connectedness, increase awareness of mental health resources and increase wellness. Please see Ap-

pendix B for more details on this exciting new Innovations project.

The **Technology-Assisted Mental Health Solutions** Innovations project will be a collaborative effort with other counties. This project will utilize innovative technology approaches to overall public mental health service delivery in order to increase access to mental health care and support for San Francisco residents. The components of this project will include Peer-to-Peer Chat Interventions and Virtual Evidence-Based Support Utilizing an Avatar that will be accessible from a computer, cell phone or tablet. The primary goals will be to provide alternate modes of engagement, support and intervention and to increase access to peer-to-peer interventions. Please see Appendix C for more details on this exciting new Innovations project.

Exploring One New Innovations Initiative

FUERTE Groups Project

A new Innovations prospect is currently being explored and vetted through our Community Planning Process to see what components of this project could be a new Innovations learning project in San Francisco. The innovative project being considered would be a modification of an existing evidence-based practice with an expansion to include new populations.

Latino newcomer adolescents (foreign born youth with five years or less post migration to the U.S.) are a rapidly growing youth population nationwide and remain the leading growing demographic in California urban centers such as San Francisco. These youth are at high risk of marginalization and poor societal outcomes, in part due to a range of health disparities including poverty, language barriers, and documentation status. These youth are also at a disproportionately higher risk for behavioral health problems compounded by the fact that they are at high risk of having experienced traumatic stressors.

The Family Unification and Emotional Resiliency Training (FUERTE) program is one of the few existing interventions culturally tailored to address the needs of Latino newcomer adolescents with Limited-English proficiency and health literacy. FUERTE is a school-based group prevention program which uses a sociocultural, ecological lens and an Attachment Regulation and Competency (ARC) framework with the aim of engaging Latino newcomer adolescents.

Although the FUERTE curriculum is built on evidence-based concepts, FUERTE's delivery model is innovative and to our knowledge does not exist elsewhere. **Our FUERTE model would be expanded to also include parent and caregiver interventions, which would consist of 2 hours of evening activities including education and the provision of supplemental materials. Our FUERTE model would also build out its peer development model, where former group members would be trained to provide peer-to-peer services as peer recovery support coordinators integrated into the new model.**

In order to rigorously evaluate the modified FUERTE program, the program expansion would be paired with a delayed intervention model randomized controlled trial. Annually, new participants will be randomized to participate in the fall or spring semester FUERTE groups at each school. We will employ a combination of quantitative and qualitative methods as part of our evaluation.

A final aim of our new project is to develop a framework on the cultural adaptation of FUERTE to different groups of newcomer Latino adolescents, as well as newcomers from other ethnic groups with similar concerns and needs (e.g., youth from Arabic-speaking countries). The framework will allow us to develop a "playbook" that will be used alongside the FUERTE manual to guide clinicians and community partners on how to adapt the main components of FUERTE

to be used with different populations of newcomer immigrant youth. Please see Appendix D for more details about this exciting new Innovations concept.

2018 Innovations Funding Reversion Plan

Introduction and Overview

Mental Health Services Act (MHSA), as authorized by Proposition 63 that was approved by California voters in November 2004, is a funding source that supports fundamental changes to the access and delivery of mental health services in California. MHSA Innovations funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes.

On December 28, 2017 the City and County of San Francisco Behavioral Health Services received Information Notice (IN) 17-059 from California Department of Health Care Services (DHCS) and Mental Health & Substance Use Disorders Services (MHSUDS).

The purpose of Information Notice 17-059 was to inform counties of the following:

- The process the Department of Health Care Services (DHCS) will use to determine the amount of unspent Mental Health Services Act (MHSA) funds subject to reversion as of July 1, 2017;
- The appeal process available to a county regarding that determination; and
- The requirement that by July 1, 2018, counties have a plan to expend the reverted funds by July 1, 2020.

Information Notice 17-059 specified the following instructions for counties to plan to spend the funds:

- Every county must develop a plan to spend its reallocated funds and post it to the county's website; *(This document constitutes the required Reversion Plan for the City and County of San Francisco. This plan will be posted to the county's website. Please see more information below.)*
- The county must submit a link to the plan to DHCS via email at MHSA@dhcs.ca.gov by July 1, 2018; *(The City and County of San Francisco will submit a link to this plan in June of 2018.)*
- Each county's Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county's website; *(The City and County of San Francisco anticipates this will occur by September 30, 2018.)*
- Each county must submit its final Plan to Spend to DHCS and the MHSOAC within 30 days of adoption by the county's BOS; *(The City and County of San Francisco anticipates this to occur by October 2018.)*
- A county may not spend funds that are deemed reverted and reallocated to the county until the county's BOS has adopted a plan to spend those funds;
- The expenditure plan must account for the total amount of reverted and reallocated funds for all impacted FYs, as indicated in the applicable notice of unspent funds subject to reversion or in the final determination on an appeal;
- The county must include the Plan to Spend in the County's Three-Year Program and Expenditure Plan or Annual Update, or as a separate plan update to the County's Three-Year Program and Expenditure Plan, and comply with WIC Section 5847(a*); and (This docu-*

ment meets the requirement as a separate plan update. This plan will also be included in the FY18/19 MHSA Annual Update.)

- Reallocated funds must be expended on the component for which they were originally allocated to the county. *(This only impacts Innovations funds for the City and County of San Francisco.)*

Background

Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) became effective July 10, 2017. The bill amended certain Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds. AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017 were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)). Funds that could be subject to reversion as of July 1, 2017 were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15.

For the City and County of San Francisco, this includes $1,733,351 of Innovations funds as follows:

Fiscal Year	Innovation Funds Reverted/Reallocated
FY 2008-09	$825,035
FY 2009-10	-
FY 2010-11	$908,316
FY 2011-12	-
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
Total	**$1,733,351**

No Community Services & Supports (CSS) funds or Prevention & Early Intervention (PEI) funds are included in the above calculation or at risk for reversion

In response to the Information Notice 17-059, the City and County of San Francisco has developed the following Reversion Plan.

San Francisco Mental Health Services Act (SF-MHSA) 2018 Innovations Reversion Funds Plan

The City and County of San Francisco has $1,733,351 in Mental Health Services Act (MHSA) Innovations reversion funds remaining to expend by July 1, 2020. Our current plan for expending Innovations reversion funds includes the following:

- Launching our Intensive Case Management/Full-Service Partnership to Outpatient Transition Support project on October 1, 2018, which was approved as an Innovations project by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on March 22, 2018. The budget for this project is $562,500 for the first year and $750,000 for the second year which totals $1,312,500 to be expended by July 1, 2020.

- Implementing a one-year extension for the First Impressions Construction and Remodeling Vocational Innovations project to strengthen our evaluation efforts by using new validated evaluation tools and testing methods in order to better address our learning ques-

tions. A formal approval of this extension was granted by the MHSOAC on April 20, 2018. The proposed extension dates with the extended budget includes:

- extending 7/1/18 to 6/30/19 with a budget of $202,500

- Continuing to implement our active and approved Innovations Project titled Transgender Pilot Project (TPP) and our active and approved Innovations Project titled Addressing the Needs of Socially Isolated Older Adults in order to expend the remaining $218,351 that is subject to reversion. This amount will be included in the previously MHSOAC approved total budgets of the projects.

Summary of Innovations Reversion Plan			
Expenditure Item	**Year to be Spent**	**Amount to be Spent**	**Total to be Spent**
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support project	FY18/19	$562,500	$1,733,351
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support project	FY19/20	$750,000	
First Impressions Construction and Remodeling Vocational program	FY18/19	$202,500	
Transgender Pilot Project Addressing the Needs of Socially Isolated Older Adults	FY18/19	$218,351	

All of the projects and activities described in this plan have been vetted through our Community Program Planning and stakeholder process as identified in WIC Section 5848, including the San Francisco Mental Health Board, the SF-MHSA Advisory Committee and various community members. This plan will also be included in our MHSA FY18/19 Annual Update.

Brief Program Descriptions

As noted above, four (4) Innovations Projects that were previously approved by the MHSOAC will be used to expend the reverted Innovations Funding. The following includes a brief program description of each project:

1. **Intensive Case Management/Full-Service Partnership to Outpatient Transition Support Project**

   This project involves an autonomous peer linkage team providing both wraparound services and a warm hand off to support clients transitioning from Intensive Case Management/Full-Service Partnership programs to outpatient behavioral health services. The team consists of five culturally and linguistically diverse peers and one clinician. Peers will serve as transitions specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers. The team will outreach to clients in transition in order to support them to have successful linkages to outpatient services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

2. First Impressions Construction and Remodeling Vocational Program

First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, job coaching, training and job placement.

3. Transgender Pilot Project (TPP)

The Transgender Pilot Project is designed to increase evaluation planning in order to better collect data on the strategies that best support Transgender women of color with engaging in behavioral health services. TPP entered the pilot year of operations in FY15-16 as a MHSA Innovations Project. The two primary goals involve increasing social connectedness and providing wellness and recovery based groups. The ultimate goal of the groups is to support clients with linkage into the mental health system and services.

4. Addressing the Needs of Socially Isolated Older Adults

The Addressing the Needs of Socially Isolated Older Adults program provides peer outreach and engagement services along with screening and assessment services to reduce isolation among the older adult population.

Local Review Process

SF-MHSA plans to spend the Reverted Funds starting October 1, 2018. This SF-MHSA 2018 Innovations Reversion Plan will be made available on the SFDPH MHSA website at www.sfdph.org/dph and www.sfmhsa.org in June of 2018.

This plan will be made available for public review and feedback with the FY18/19 SF-MHSA Annual Update. Notification of the public review dates and access to copies of the Innovations Reversion Funds Plan will be made available through email distribution to MHSA community members and providers, communication through the MHSA Advisory Committee Meeting, communication through the MHSA Provider Meeting and communication through the San Francisco Mental Health Board. Members of the public will be requested to submit their comments either by email or by postal mail to the following:

Alyssa Zachariah
Budget Analyst, Mental Health Services Act
San Francisco Department of Public Health
1380 Howard Street
San Francisco, CA 94103
(415) 255-3637

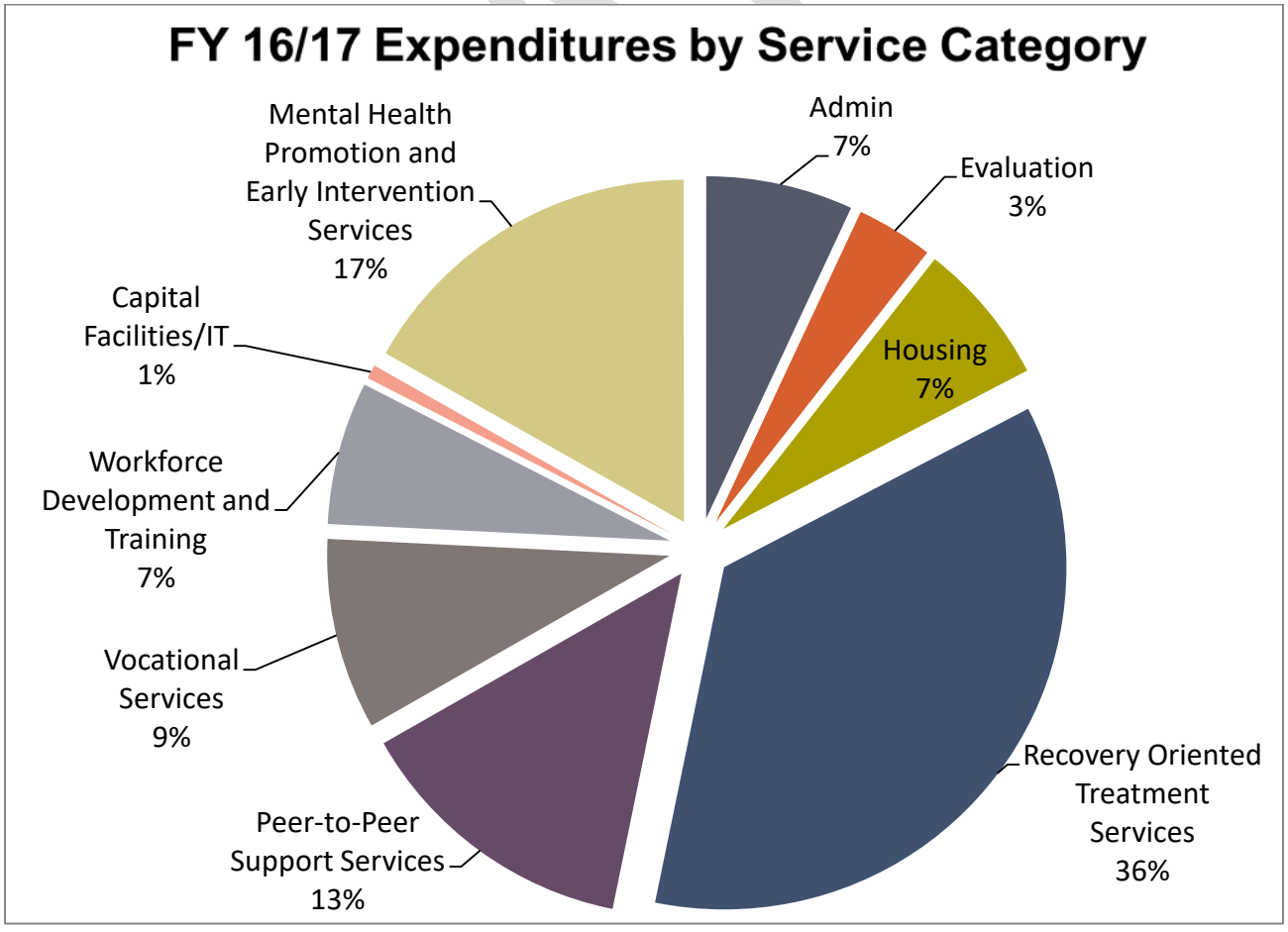
The public comments will be added following the 30 day public review and comment period.

MHSA Budget – FY16/17 Actual Expenditures

MHSA Integrated Service Categories

MHSA Integrated Service Categories	Abbreviation	FY 16/17 Expenditure Amount	Percentage
Admin	Admin	2,248,502.62	7%
Evaluation	Evaluation	1,173,097.37	4%
Housing	H	2,190,215.91	7%
Recovery Oriented Treatment Services	RTS	11,597,516.04	36%
Peer-to-Peer Support Services	P2P	4,373,854.85	14%
Vocational Services	VS	2,916,656.05	9%
Workforce Development and Training	WD	2,184,851.86	7%
Capital Facilities/IT	CF/IT	212,968.37	1%
Mental Health Promotion and Early Intervention Services	PEI	5,435,089.80	17%
TOTAL		**32,332,752.87**	**100%**

FY16/17 MHSA Actual Expenditures



SF MHSA Integrated Services Categori	MHSA FY16/17 Expenditures by Funding Component	FY 16-17 Expenditure
	Community Services and Supports (CSS) 80% of total MHSA revenue (after INN calculated) In FY 16-17, 52% was allocated to serve FSP clients	
Admin	CSS Admin	1,769,287.86
Evaluation	CSS Evaluation	927,682.54
H	CSS FSP Permanent Housing (capital units and master lease)	768,388.36
RTS	CSS Full Service Partnership 1. CYF (0-5)	436,642.98
RTS	CSS Full Service Partnership 2. CYF (6-18)	931,690.68
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,060,067.18
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,500,127.81
RTS	CSS Full Service Partnership 5. Older Adults (60+)	968,653.74
RTS	CSS Full Service Partnership 6. AOT	383,513.72
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	770,964.10
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	164,847.69
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	1,016,497.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	82,714.45
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	227,419.62
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	976,672.80
RTS	CSS Other Non-FSP 3. Trauma Recovery	454,046.77
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,314,215.65
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	407,669.88
RTS	CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	83,116.64
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,784,209.38
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,622,713.99
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	240,482.86
	SUBTOTAL Community Services and Support (CSS)	**21,891,625.72**
	Workforce, Development Education and Training (WDET) $2M transferred from CSS to fund WDET activities in FY 16-17	
WD	WDET 1. Training and TA	758,037.80
WD	WDET 2. Career Pathways	776,837.56
WD	WDET 3. Residency and Internships	371,437.01
Admin	WDET Admin	73,266.08
Evaluation	WDET Evaluation	93,202.82
	SUBTOTAL Workforce, Development Education and Training (WDET)	**2,072,781.27**
	Capital Facilities/IT $1.2M transferred from CSS to fund Capital Facilities/IT activities in FY 16-17	
CF/IT	Cap 3. Sunset Mental Health	42.67
CF/IT	IT 1. Consumer Portal	31,401.91
VS	IT 2. Vocational IT	956,356.56
CF/IT	IT 3. System Enhancements	181,523.79
Admin	IT Admin	130,438.62
	SUBTOTAL Capital Facilities/IT	**1,299,763.55**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**25,264,170.53**
	Prevention and Early Intervention (PEI) 20% of MHSA revenue (after INN calculated)	
PEI	PEI 1. Stigma Reduction	225,425.97
PEI	PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	1,123,574.67
PEI	PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	180,892.82
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,579,482.50
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	779,902.16
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	445,811.68
PEI	PEI 7. CalMHSA Statewide Programs	100,000.00
Admin	PEI Admin	73,266.08
	SUBTOTAL Prevention and Early Intervention (PEI)	**5,508,355.88**

	Innovation (INN) 5% of total MHSA revenue	
VS	INN 14. First Impressions	337,585.50
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	256,250.00
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	333,395.47
WD	INN 17. Hummingbird Place - Peer Respite	278,539.49
Admin	INN Admin	202,243.99
Evaluation	INN Evaluation	152,212.01
	SUBTOTAL Innovation (INN)	**1,560,226.46**
	TOTAL FY 16-17 MHSA Expenditures	**32,332,752.87**

FY17/18 through FY19/20 Three-Year MHSA Expenditure Plan

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Francisco Date: 8/6/18

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. Estimated FY 2017/18 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	12,161,592	1,368,880	4,375,469	-	-		17,905,941
2. Estimated New FY2017/18 Funding	24,320,000	6,080,000	3,333,351				33,733,351
3. Transfer in FY2017/18a/	(5,150,975)			2,036,061	2,614,914	500,000	-
4. Access Local Prudent Reserve in FY2017/18						-	-
5. Estimated Available Funding for FY2017/18	31,330,617	7,448,880	7,708,820	2,036,061	2,614,914		51,139,291
B. Estimated FY2017/18 MHSA Expenditures	24,668,100	4,496,892	961,025	2,036,061	2,614,914		34,776,992
C. Estimated FY2018/19 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	6,662,517	2,951,987	6,747,795	-	-		16,362,299
2. Estimated New FY2018/19 Funding	24,320,000	6,080,000	1,600,000				32,000,000
3. Transfer in FY2018/19a/	(5,047,191)			1,922,561	2,624,629	500,000	-
4. Access Local Prudent Reserve in FY2018/19						-	-
5. Estimated Available Funding for FY2018/19	25,935,326	9,031,987	8,347,795	1,922,561	2,624,629		47,862,299
D. Estimated FY2018/19 Expenditures	22,167,884	3,878,064	3,286,549	1,922,561	2,624,629		33,879,688
E. Estimated FY2019/20 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	3,767,442	5,153,923	5,061,246	-	-		13,982,611
2. Estimated New FY2019/20 Funding	24,320,000	6,080,000	1,600,000				32,000,000
3. Transfer in FY2019/20a/	(5,047,191)			1,922,561	2,624,629	500,000	-
4. Access Local Prudent Reserve in FY2019/20						-	-
5. Estimated Available Funding for FY2019/20	23,040,252	11,233,923	6,661,246	1,922,561	2,624,629		45,482,611
F. Estimated FY2019/20 Expenditures	22,167,884	3,954,192	2,615,440	1,922,561	2,624,629		33,284,707
G. Estimated FY2019/20 Unspent Fund Balance	872,368	7,279,730	4,045,806	-	-		12,197,904

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	6,303,480
2. Contributions to the Local Prudent Reserve in FY 2017/18	500,000
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	6,803,480
5. Contributions to the Local Prudent Reserve in FY 2018/19	500,000
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	7,303,480
8. Contributions to the Local Prudent Reserve in FY 2019/20	500,000
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	7,803,480

Community Services and Supports (CSS) Estimated Budget – FY17/18 through FY19/20

FY17/18 Community Services and Supports (CSS) Estimated Budget	Fiscal Year 2017/18					
	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)	540,129	400,000.00	-	-	-	140,129
2. CSS Full Service Partnership 2. CYF (6-18)	3,863,969	991,220	76,334	162,884	1,495,606	1,137,923
3. CSS Full Service Partnership 3. TAY (18-24)	1,269,931	1,028,944	199,431	2,283	37,922	1,351
4. CSS Full Service Partnership 4. Adults (18-59)	11,315,351	3,981,951	1,410,967	2,016,690	204	3,905,539
5. CSS Full Service Partnership 5. Older Adults (60+)	1,347,604	974,986	276,975	77,147	-	18,495
6. CSS Full Service Partnership 6. AOT	606,018	606,018	-	-	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	1,041,725	1,041,725	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports (50% FSP)	3,402,911	2,321,826	4,293	135,627	-	941,165
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,130,704	901,073	9,218	342,638	-	877,776
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	253,906	253,906	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement (20% FSP)	49,157	49,157	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	632,918	632,918	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	897,160	745,483	136,346	-	-	15,331
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,383,494	993,404	63,936	13,832	64,115	248,207
3. CSS Other Non-FSP 3. Trauma Recovery	505,817	472,756	-	689	28,190	4,183
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,650,833	1,477,264	173,569	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	2,253,859	568,425	-	-	-	1,685,434
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	-	-	-	-	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,402,911	2,321,826	4,293	135,627	-	941,165
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,604,194	1,101,311	11,267	418,780	-	1,072,837
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	169,271	169,271	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	114,700	114,700	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	421,946	421,946	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	460,758	323,281	137,477	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	289,657	289,657	-	-	-	-
CSS Administration	1,663,673	1,663,673	-	-	-	-
CSS Evaluation	821,379	821,379	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	43,093,977	24,668,100	2,504,107	3,306,197	1,626,037	10,989,536
FSP Programs as Percent of Total	61%	estimated CSS funding over total CSS expenditures				

FY18/19 Community Services and Supports (CSS) Estimated Budget	Fiscal Year 2018/19					
	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)	540,129	400,000	-	-	-	140,129
2. CSS Full Service Partnership 2. CYF (6-18)	1,426,166	365,853	28,174	60,120	552,019	420,000
3. CSS Full Service Partnership 3. TAY (18-24)	1,222,322	990,370	191,954	2,197	36,500	1,301
4. CSS Full Service Partnership 4. Adults (18-59)	11,526,452	4,056,239	1,437,291	2,054,313	208	3,978,401
5. CSS Full Service Partnership 5. Older Adults (60+)	1,366,464	988,631	280,851	78,227	-	18,754
6. CSS Full Service Partnership 6. AOT	610,528	610,528	-	-	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	953,467	953,467	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports (50% FSP)	3,259,246	2,223,802	4,112	129,901	-	901,430
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,887,654	798,287	8,167	303,553	-	777,647
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	256,094	256,094	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement (30% FSP)	51,583	51,583	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	918,581	763,282	139,601	-	-	15,697
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	835,608	600,000	38,616	8,354	38,724	149,913
3. CSS Other Non-FSP 3. Trauma Recovery	150,437	140,604	-	205	8,384	1,244
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,699,400	1,520,724	178,676	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,888,952	476,395	-	-	-	1,412,557
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	-	-	-	-	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,259,246	2,223,802	4,112	129,901	-	901,430
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,307,132	975,684	9,982	371,009	-	950,458
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	170,730	170,730	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	120,361	120,361	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	240,156	240,156	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	389,442	273,244	116,199	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	232,284	232,284	-	-	-	-
CSS Administration	1,587,325	1,587,325	-	-	-	-
CSS Evaluation	788,205	788,205	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	38,048,197	22,167,884	2,437,734	3,137,781	635,835	9,668,963
FSP Programs as Percent of Total	61%	estimated CSS funding over total CSS expenditures				

FY19/20 Community Services and Supports (CSS) Estimated Budget	Fiscal Year 2019/20					
	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)	540,129	400,000	-	-	-	140,129
2. CSS Full Service Partnership 2. CYF (6-18)	1,426,166	365,853	28,174	60,120	552,019	420,000
3. CSS Full Service Partnership 3. TAY (18-24)	1,222,322	990,370	191,954	2,197	36,500	1,301
4. CSS Full Service Partnership 4. Adults (18-59)	11,526,452	4,056,239	1,437,291	2,054,313	208	3,978,401
5. CSS Full Service Partnership 5. Older Adults (60+)	1,366,464	988,631	280,851	78,227	-	18,754
6. CSS Full Service Partnership 6. AOT	610,528	610,528	-	-	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	953,467	953,467	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports (50% FSP)	3,259,246	2,223,802	4,112	129,901	-	901,430
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,887,654	798,287	8,167	303,553	-	777,647
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	256,094	256,094	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement (30% FSP)	51,583	51,583	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	918,581	763,282	139,601	-	-	15,697
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	835,608	600,000	38,616	8,354	38,724	149,913
3. CSS Other Non-FSP 3. Trauma Recovery	150,437	140,604	-	205	8,384	1,244
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,699,400	1,520,724	178,676	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,888,952	476,395	-	-	-	1,412,557
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	-	-	-	-	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	3,259,246	2,223,802	4,112	129,901	-	901,430
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,307,132	975,684	9,982	371,009	-	950,458
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	170,730	170,730	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	120,361	120,361	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	240,156	240,156	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	389,442	273,244	116,199	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	232,284	232,284	-	-	-	-
CSS Administration	1,587,325	1,587,325	-	-	-	-
CSS Evaluation	788,205	788,205	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	38,048,197	22,167,884	2,437,734	3,137,781	635,835	9,668,963
FSP Programs as Percent of Total	60.9%	estimated CSS funding over total CSS expenditures				

Prevention and Early Intervention (PEI) Estimated Budget – FY17/18 through FY19/20

FY17/18 Prevention and Early Intervention (PEI) Estimated Budget	Fiscal Year 2017/18					
	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	410,926	185,500	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	1,225,874	519,208	-	-	-	34,145
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	217,036	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,414,595	1,044,211	-	-	-	52,651
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,241,474	547,697	-	-	-	2,434,057
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	210,106	32,892	2,976	-	-	-
7. PEI 7. CalMHSA Statewide Programs	150,000	50,000	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	1,225,874	519,208	-	-	-	34,145
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	217,036	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,414,595	1,044,211	-	-	-	52,651
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	413,825	182,566	-	-	-	811,352
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	1,890,957	296,030	26,785	-	-	-
PEI Administration	222,440	75,370	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	12,254,737	4,496,892	29,761	-	-	3,419,001

FY18/19 Prevention and Early Intervention (PEI) Estimated Budget	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	185,500	185,500	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	555,044	520,795	-	-	-	34,249
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	759,246	722,801	-	-	-	36,445
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,019,025	554,543	-	-	-	2,464,482
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	36,914	33,851	3,063	-	-	-
7. PEI 7. CalMHSA Statewide Programs	50,000	50,000	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	555,044	520,795	-	-	-	34,249
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	759,246	722,801	-	-	-	36,445
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,006,342	184,848	-	-	-	821,494
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	332,229	304,663	27,566	-	-	-
PEI Administration	77,468	77,468	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	7,336,058	3,878,064	30,629	-	-	3,427,365

FY19/20 Prevention and Early Intervention (PEI) Estimated Budget	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	185,500	185,500	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	555,044	520,795	-	-	-	34,249
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	799,229	760,865	-	-	-	38,364
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,019,025	554,543	-	-	-	2,464,482
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	36,914	33,851	3,063	-	-	-
7. PEI 7. CalMHSA Statewide Programs	50,000	50,000	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	555,044	520,795	-	-	-	34,249
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	799,229	760,865	-	-	-	38,364
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,006,342	184,848	-	-	-	821,494
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	332,229	304,663	27,566	-	-	-
PEI Administration	77,468	77,468	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	7,416,025	3,954,192	30,629	-	-	3,431,203

Innovations (INN) Estimated Budget – FY17/18 through FY19/20

	Fiscal Year 2017/18					
	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 14. First Impressions	252,647	252,647	-	-	-	-
2. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	256,250	256,250	-	-	-	-
3. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	207,245	207,245	-	-	-	-
4. INN 17. Hummingbird Place - Peer Respite	42,639	42,639	-	-	-	-
5. INN 18. Intensive Case Management Flow	-	-	-	-	-	-
6. INN 20. Technology-assisted Mental Health Solutions	-	-	-	-	-	-
7. INN 21. Wellness in the Streets (WITS)	-	-	-	-	-	-
8. INN 22. FUERTE						
INN Administration	202,244	202,244	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	961,025	961,025	-	-	-	-

	Fiscal Year 2018/19					
	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 14. First Impressions	202,500	202,500	-	-	-	-
2. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	246,378	246,378	-	-	-	-
3. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	187,565	187,565	-	-	-	-
4. INN 17. Hummingbird Place - Peer Respite	-	-	-	-	-	-
5. INN 18. Intensive Case Management Flow	750,000	750,000	-	-	-	-
6. INN 20. Technology-assisted Mental Health Solutions	1,005,045	1,005,045	-	-	-	-
7. INN 21. Wellness in the Streets (WITS)	350,000	350,000	-	-	-	-
8. INN 22. FUERTE	300,000	300,000	-	-	-	-
INN Administration	245,061	245,061	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,286,549	3,286,549	-	-	-	-

	Fiscal Year 2019/20					
	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 14. First Impressions	-	-	-	-	-	-
2. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	170,250	170,250	-	-	-	-
3. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	159,000	159,000	-	-	-	-
4. INN 17. Hummingbird Place - Peer Respite	-	-	-	-	-	-
5. INN 18. Intensive Case Management Flow	750,000	750,000	-	-	-	-
6. INN 20. Technology-assisted Mental Health Solutions	636,477	636,477	-	-	-	-
7. INN 21. Wellness in the Streets (WITS)	350,000	350,000	-	-	-	-
8. INN 22. FUERTE	300,000	300,000	-	-	-	-
INN Administration	249,713	249,713	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	2,615,440	2,615,440	-	-	-	-

Workforce, Education and Training (WET) Estimated Budget – FY17/18 through FY19/20

FY17/18 Workforce, Education and Training (WET) Estimated Budget	Fiscal Year 2017/18					
	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	439,523	621,821	-	65,129	-	308,399
2. Career Pathways	-	862,710	-	-	-	-
3. Residency and Internships	150,863	406,575	-	-	-	-
WET Administration	75,760	75,370	-	-	-	-
WET Evaluation	93,000	69,585	-	-	-	-
Total WET Program Estimated Expenditures	759,146	2,036,061	-	65,129	-	308,399

FY18/19 Workforce, Education and Training (WET) Estimated Budget	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,005,732	628,308	-	65,808	-	311,616
2. Career Pathways	739,385	739,385	-	-	-	-
3. Residency and Internships	406,575	406,575	-	-	-	-
WET Administration	77,468	77,468	-	-	-	-
WET Evaluation	70,826	70,826	-	-	-	-
Total WET Program Estimated Expenditures	2,299,985	1,922,561	-	65,808	-	311,616

FY19/20 Workforce, Education and Training (WET) Estimated Budget	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,005,732	628,308	-	65,808	-	311,616
2. Career Pathways	739,385	739,385	-	-	-	-
3. Residency and Internships	406,575	406,575	-	-	-	-
WET Administration	77,468	77,468	-	-	-	-
WET Evaluation	70,826	70,826	-	-	-	-
Total WET Program Estimated Expenditures	2,299,985	1,922,561	-	65,808	-	311,616

Capital Facilities/Technological Needs (CFTN) Estimated Budget – FY17/18 through FY19/20

FY17/18 Capital Facilities/Technological Needs (CFTN) Estimated Budget	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center	-	-	-	-	-	-
2. Redwood Center Renovation	-	-	-	-	-	-
3. Sunset Mental Health	-	-	-	-	-	-
4. IHHC at Central YMCA (Tom Waddell)	-	-	-	-	-	-
5. Southeast Health Center	750,000	750,000	-	-	-	-
6. South of Market Mental Health	-	-	-	-	-	-
7. Behavioral Health Clinic Remodel	200,000	200,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	32,382	32,382.28	-	-	-	-
9. Vocational IT	1,337,748	1,337,748.00	-	-	-	-
10. System Enhancements	204,449	160,598.72	43,849.85	-	-	-
CFTN Administration	134,185	134,184.86	-	-	-	-
Total CFTN Program Estimated Expenditures	2,658,764	2,614,914				

FY18/19 Capital Facilities/Technological Needs (CFTN) Estimated Budget	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center	-	-	-	-	-	-
2. Redwood Center Renovation	-	-	-	-	-	-
3. Sunset Mental Health	-	-	-	-	-	-
4. IHHC at Central YMCA (Tom Waddell)	-	-	-	-	-	-
5. Southeast Health Center	750,000.00	750,000.00	-	-	-	-
6. South of Market Mental Health	-	-	-	-	-	-
7. TBD through Community Planning Process	200,000.00	200,000.00	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	33,283.39	33,283.39	-	-	-	-
9. Vocational IT	1,337,748.00	1,337,748.00	-	-	-	-
10. System Enhancements	210,915.74	165,678.82	45,236.92	-	-	-
CFTN Administration	137,919.12	137,919.12	-	-	-	-
Total CFTN Program Estimated Expenditures	2,669,866.25	2,624,629.33				

FY19/20 Capital Facilities/Technological Needs (CFTN) Estimated Budget	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center	-	-	-	-	-	-
2. Redwood Center Renovation	-	-	-	-	-	-
3. Sunset Mental Health	-	-	-	-	-	-
4. IHHC at Central YMCA (Tom Waddell)	-	-	-	-	-	-
5. Southeast Health Center	750,000.00	750,000.00	-	-	-	-
6. South of Market Mental Health	-	-	-	-	-	-
7. TBD through Community Planning Process	200,000.00	200,000.00	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	33,283.39	33,283.39	-	-	-	-
9. Vocational IT	1,337,748.00	1,337,748.00	-	-	-	-
10. System Enhancements	210,915.74	165,678.82	45,236.92	-	-	-
CFTN Administration	137,919.12	137,919.12	-	-	-	-
Total CFTN Program Estimated Expenditures	2,669,866.25	2,624,629.33				

INNOVATIONS PROJECT PLAN:

Intensive Case Management/Full-Service Partnership to Outpatient Transition Support

FY 2018/19 to FY 2022/23

INN community planning meeting on ICM/FSP-OP transition workflow - June 16, 2017

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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Local Review

The FY 18-19 MHSA Three-Year Plan for the City and County of San Francisco Community Planning Process (CPP) involved various opportunities for community members and stakeholders to share input in the development of our Integrated Planning effort, which included the Intensive Case Management/Full-Service Partnership (ICM/FSP) to Outpatient (OP) Transition Support Innovation Project. Please see the CPP meetings section below for details.

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA Three-Year Integrated Plan was posted on the SF MHSA website at www.sfdph.org/dph and www.sfmhsa.org. Our 2017-2020 Program and Expenditure Integrated Plan was posted for a period of 30 days from 7/17/17 to 8/16/17. Members of the public were requested to submit their comments either by email or by regular mail. The comments included feedback or questions on current programs, as well as one financial question. None of the comments were specifically focused upon the ICM/FSP to OP Transition Support Innovation Project.

Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board of San Francisco and on 9/20/17. The 3-Year Plan was also presented before the Board of Supervisors' Budget and Finance Committee on September 28, 2017 and recommended to be adopted. The San Francisco Board of Supervisors adopted the report on October 17, 2017. San Francisco Mayor Ed Lee approved the report on October 27, 2017 *(See Appendix)*.

Community Planning Process Meetings

The San Francisco Department of Public Health has strengthened its' MHSA program planning for the 2017-2020 Integrative Plan by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In early 2017, SF MHSA hosted eleven (11) community engagement meetings inviting participants from the City's eleven Supervisorial Districts to collect community member feedback on existing MHSA programming and better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders. Five of the eleven meetings were open to the public and all meetings were advertised on the SF DPH website and via word-of-mouth and email notifications to service providers in the SF BHS, MHSA, and San Francisco Health Network distribution networks. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed.

CPP Meetings	
Date	**CPP Location**
January 5, 2017	Samoan Community Development Center 2055 Sunnydale Ave San Francisco, CA 94134
January 19, 2017	Mo' Magic Meeting/African Arts Culture Complex 762 Fulton St San Francisco, CA 94102
February 10, 2017	Chinatown Child Development Center 720 Sacramento St San Francisco, CA 94108
February 13, 2017	Filipino Mental Health Initiative/Bayanihan Center 1010 Mission St San Francisco, CA 94103
February 15, 2017	MHSA Advisory Committee/Behavioral Health Services 1380 Howard St San Francisco, CA 94103
February 21, 2017	Client Council/Behavioral Health Services 1380 Howard St San Francisco, CA 94103
March 1, 2017	Chinatown community members at Cameron House 920 Sacramento St San Francisco, CA 94108
March 7, 2017	LEGACY Peer/Community Advisory 1305 Evans Ave San Francisco, CA 94124
March 15, 2017	MHSA Providers Meeting 1453 Mission St San Francisco, CA 94103
March 24, 2017	Latino and Mayan Community Meeting/ Instituto Familiar de la Raza 2919 Mission St San Francisco, CA 94110
April 12, 2017	The Village 1099 Sunnydale Ave San Francisco, CA 94134

ICM/FSP-OP Transition Support Community Planning Meetings

In addition to the CPP meetings, leadership from the Adult and Older Adult System of Care, Quality Management, and Mental Health Services Act staff, supported by facilitators from Learning for Action (LFA), a consulting group, organized a series of six meetings that consisted of ICM/FSP and outpatient program directors and clinicians, consumer/peer advocacy staff, and individual consumers with lived experience in mental health services. The forums were designed specifically to address client and program needs when a client is transitioning from an ICM/FSP to an appointment based outpatient clinic. Please see the Community Program Planning section of the Plan below.

ICM/FSP-OP Transition Support Community Planning Meetings	
Date	**Community Planning Meeting Location**
April 7, 2017	Bank of America Building 1 South Van Ness Ave San Francisco, CA 94103
April 21, 2017	Department of Public Health 25 Van Ness Ave San Francisco, CA 94102
May 5, 2017	San Francisco Main Public Library 100 Larkin St San Francisco, CA 94102
May 19, 2017	Bank of America Building 1 South Van Ness Ave San Francisco, CA 94103
June 2, 2017	San Francisco Main Public Library 100 Larkin St San Francisco, CA 94102
June 16, 2017	San Francisco Main Public Library 100 Larkin St San Francisco, CA 94102

Project Overview

Primary Problem

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

The ICM/FSP-OP Transition Support project will focus upon transitions and the flow of clients from Intensive Case Management (ICM) programs, including Full Service Partnership (FSP) programs, to Outpatient (OP) services within Behavioral Health Services (BHS) in the City and County of San Francisco.

ICM services

Behavioral health ICM services are provided to clients with the most acute, severe and chronic behavioral health challenges resulting in the most serious and persistent functional impairments – including co-morbid health conditions such as substance use disorder, and serious and chronic diseases; repeated use of emergency services, acute and institutional care; homelessness; incarceration; and grave disability, and severe risk to themselves or others. These services offer a lifeline to some of the most vulnerable behavioral health system consumers with the goal of empowering individuals to remain safe in the community, preventing acute crisis or avoiding institutional care, and promoting wellness and recovery.

ICM programs are a particular type of intensive mental health outpatient services with low caseloads, multi-disciplinary team approach, and a comparatively richer array of wraparound services (such as relatively greater access to supportive housing, vocational rehabilitation and other health and human services), in order to be able to do whatever it takes to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery.

FSP services

Full Service Partnership (FSP) programs are a subset of ICM programs and reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Severe Mental Illness or Severe Emotional Disturbance to lead independent, meaningful, and productive lives. Services include integrated, recovery-oriented mental health treatment; intensive case management and linkage to essential services; housing and vocational support; and self-help.

Primary Problem

When clients no longer need the intensive level of care and service provided by ICM and FSP programs and they are discharged, many individuals do not link successfully to medically necessary regular Outpatient (OP) services.

The electronic health record system (EHR) discharge data from calendar years 2014-2015, 2015-2016, and 2016-2017 show that only 16% of clients discharged from an ICM or FSP have subsequent episodes opened in outpatient programs within four months, and fewer than 10% of those discharges result in

sustained care (a year or over) in the outpatient setting. Furthermore, 38% of discharged clients have no new episodes at all, suggesting that they are most likely disengaged from mental health care.

Unfortunately, several factors at various levels can impede a successful transition, defined as linkage and engagement, to outpatient care. Some examples are below:

- System- Large gap in service and support between ICM/FSP and Outpatient.
- Workflow- No agreed upon set of criteria or conditions agreed upon to assess client readiness.
- Administrative- No single checklist form in use for BHS.
- Clinician- ICM/FSP Case Managers worry about clients relapsing.
- Clients- Clients may feel attached to their ICM/FSP Case Manager.

With better resources in place, fewer clients will be lost from our care, and more will transition safely to outpatient care to continue their in recovery, living more self-directed lives that support their wellness and connection to a community that has meaning for them.

Why is it important to solve for your community.

All ICM/FSP programs must subscribe to the wellness-recovery and evidence-based principles as outlined for FSP programs funded under the Mental Health Services Act (MHSA). The "system transformation" envisioned by the MHSA is founded on the belief that all individuals - including those living with the challenges caused by mental illness – are capable of living satisfying, hopeful, and contributing lives.

In a Wellness and Recovery-oriented system, a grounding principle is that recovery is a "possible and expected outcome of treatment, and that the full range of comprehensive services and supports that an individual needs to meet his or her recovery goals be accessible, flexible, individualized, and coordinated." (Felton et al, 2010, p. 441) A belief in a client's ability to recover from mental illness is central to a Wellness and Recovery service philosophy and in order for a client to be successful in that recovery, they need to receive client-centered, coordinated support from both the program they are leaving and the program they are transitioning to in order to enable them to be successful.

In the past, both providers and clients assumed clients could receive ICM/FSP services indefinitely. In recent years, however, a 3-4 month-long waitlist has formed for ICM/FSP services so it is even more incumbent on the system to learn how to best support clients who are ready to successfully transition to a lower level of care to OP services.

The issue of transitions in various settings is a challenge across the system. Findings from this project can have implications for other areas where clients move from services in one part of the system to the next.

Development and Prioritization of the INN project

Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

The idea for this project emerged from Behavioral Health ICM/FSP program director meetings as an issue needing attention. This group expressed not knowing where clients were ending up after leaving their services. There was a realization that clients did not seem to be getting to or staying in OP services.

In recent years, a few system of care initiatives focused upon checklists, protocols, and measurements for transitions. The intake process varies widely across outpatient programs, causing confusion and miscommunication between ICM and OP providers. The lack of involvement of all levels of staff was identified as a barrier to organizational change.

However over time, investment, commitment, and passion for the issue of transitions has grown among leadership in the adult system. Recently, the Director of the Adult and Older Adult system engaged in a project examining transitions between Psychiatric Emergency Services at the Zuckerberg San Francisco General Hospital and Trauma Center and Behavioral Health Services.

Among the clinical staff as well, there is readiness for this project. Due to the impact of MHSA principles upon the system of care, there has been a cultural shift in the clinics, where the language of recovery and wellness is increasingly being used, and an openness to the idea that recovery is possible for clients is more commonly expressed.

Addressing the Primary Problem

Review of Existing Practices and Evidence-Based Models

Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

An extensive literature review of categories including patient navigation, peer programs, and transitions reveals the closest parallels between the ICM/FSP- OP transition and the transition of youth in the foster care system from youth services into the adult mental health system. These transitions have the following in common:

- Steep drop off in service delivery
- Loss of existing care team and need to transition to a new care team, posing a challenge to engagement
- Physical transitions: Clients seeking services may have to completely uproot from the geographic location of their clinics to obtain services.
- Possible loss of housing, case management, access to long existing relationships within clinics, frequency of available support meetings, and access to any and all social services provided through the originating clinic

The main limitation in exploring foster care youth transitions as a comparable model of service delivery is that the ICM/FSP- OP transition focuses on an adult population, while foster care transition models involve a population undergoing a significant life change in which complex legal issues are at play.

Review of Best Practices

Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

In reviewing literature focusing on practices specifically related to patient navigation, peer programs, and transitions, it was difficult to find a match that closely mirrored the ICM/FSP- OP transition. Some areas of interest include:

1. Patient Transitions - While there are a large number of studies focusing on patient transitions, the vast majority are written about care linkages in the field of medical care.

2. Patient Navigation for those with mental health issues- Some studies can be found addressing patient navigation in the mental health system, though they are related specifically to exiting institutions such as jail and inpatient facilities.

3. Utilizing peers within the mental health system - While there is a large body of work examining the efficacy of peers in mental health systems, specific information focused on step down of services was not found.

Unfortunately, these examples do not adequately capture the steep drop off in services between ICM/FSP and OP programs, and the mechanisms necessary to successfully link clients to services. The proposed project would address a hybrid of the three categories listed above: patient transitions, patient navigation for those with mental health issues, and utilizing peers within the mental health system.

The Proposed Project

Provide a brief narrative overview description of the proposed project.

The ICM/FSP-OP Transition Support project involves an autonomous peer linkage team providing both wraparound services and a warm hand off. The team will consist of five culturally and linguistically diverse peers and one clinician. Peers will serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers. The team will outreach to transitional clients in order to support them to have successful linkages to OP services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

With this Innovation project, some of the major goals are to increase client engagement in OP 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 model envisioned by stakeholders includes the following elements:

a. Peers to be situated in a cohort with each one being able to respond to any client referred to the peer team
b. As part of training and orientation, the peers do a “rotation” at each ICM/FSP program to gain familiarity with the programs and their staff, and vice versa
c. At their OP site, peers to participate in multidisciplinary group supervision, individual supervision, client case conferences, staff meetings, and clinical training (e.g., Motivational Interviewing, Cognitive Behavioral Therapy, Trauma-Informed Systems, as needed)
d. Clinical supervision to be provided by a licensed therapist or social worker at an agency supporting the peer cohort

e. Regular peer cohort meetings/trainings with all peer transition team members, i.e. weekly
f. As an ICM/FSP client nears readiness for a referral to OP, the peer is invited to the ICM/FSP by the ICM/FSP case manager to meet the client
g. Peer transition team member then conducts outreach with the client to facilitate connections, introduce client to community supports, conduct an orientation to the OP site, and together with the ICM/FSP case manager, connect the client to the new provider
h. Accommodation for the peer member if/when they feel challenged emotionally, re-traumatized, and/or destabilized at work

Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).

This innovation project will be a change to an existing practice. While linkage, peer services, navigation, and similar services exist within the system, having a cohesive peer transition team that works interdependently with a clinic is a new approach. In this new vision, transitions between the ICM/FSP and OP will be tailored to the needs of the client. Instead of a brief handoff period, we envision a bridge to the new service. In that frame, rather than having the transition be a loss for the client, the client is instead gaining a team of peer professionals that have flexibility in addressing the needs of the client.

Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.

Peer Navigation is a well-documented, successful practice in both behavioral and physical health settings; however, its efficacy has not been demonstrated in transitions from intensive, wraparound mental health settings to outpatient settings. Data-driven research conducted within the San Francisco Behavioral Health Services system has shown there is a demonstrated need for assistance given the very low rate of engagement in outpatient services after clients have stepped down from the ICM/FSP level. SF BHS has peers working within clinics but there are no peers dedicated to this particular function. Through the Community Planning Process for this project, clients, front line staff, clinic directors, and peer staff recommended peer linkage as a critical piece that could be added to more smoothly facilitate this step down transition process.

Innovation Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.

The ICM/FSP-OP Transition Support project will be adapting an existing mental health approach. While peers are being used all through public health systems for navigation, the specific design of an autonomous peer team that works interdependently with a clinic is a new design. In current models, one or two peers might be used as an extension of a particular clinic, and their roles and functions are designed around the needs of the clinic. In the proposed design, a peer team will be dispatched to work with the focus being the individualized needs of clients. Essentially, the client will be the spoke in a wheel of services designed to assist the client to move smoothly to the next stage of their transition. In this model, the peers will assist in the step down process by linking the client in transition to any and all necessary wraparound services without the constraints of determining what are Medi-Cal billable services. The wheel of support will also be flexible enough to move back and forward seamlessly if there are any client setbacks.

Learning Goals / Project Aims

This project will center on the development of a highly skilled peer transition team to help support behavioral health clients advancing in their recovery from an intensive wraparound case management program to an appointment-based outpatient clinic.

Intensive Case Management (ICM) programs modeled on the Assertiveness Community Treatment (ACT) and Full Service Partnership (FSP) models offer extensive services that are not usually available to support clients in the outpatient setting. As ICM/FSP clients grow in their recovery and no longer need the intensive services, outpatient settings can provide medication management and therapy needed on an ongoing basis.

Peer counselors can offer support to clients in many important ways. Peers model positive recovery through their work and sharing their personal struggles and successes, inspiring hope in clients that they can also recover.

As transition support, peers can offer a continuity of care and relationship during a transition of therapeutic care. Peers can accompany clients to the new site, as well as connect clients to critical community supports that interest them, such as a wellness center, community arts program, vocational training, spiritual center or church, sports or fitness groups, etc. Peers can offer a unique and personal kind of support that is qualitatively different from what a trained professional without lived experience can provide.

Logic Model for Peer Transition Support Team

Identified Concern:	**Contributing Risk Factors:**	**Strengths/Resources:**
Many individuals with serious mental illness experience significant advances in recovery while enrolled in an ICM/FSP wraparound program. Many of these clients could be served effectively in appointment based outpatient care (OP) with proper support. Unfortunately only about **8% of clients leaving ICM/FSP connect to OP care and receive ongoing support.**	• **Very large gap in services** and supports between wraparound ICM/FSP care (24/7 access, intensive outreach and case management, social milieu, groups, food, payee services, vocational programs, etc.) and appointment based therapy in the OP clinics. • Varied and **unclear processes for referral, intake and linkage** at OP sites. • **Provider and client apprehension.**	MHSA Innovations funding, dedicated and highly skilled professional and peer professional staff at BHS, MHSA Principles and practices, strong commitment to peer model of support for clients, community defined practices, consumer resiliency and desire to live a more fulfilling life.

Goals	**Potential Strategies**	**Expected Outcomes**			**Suggested Measurements**
		Short Term	**Intermediate**	**Long Term**	
1) Support clients to live lives increasingly independent of MH services, as appropriate 2) Serve clients at the lowest intensity of services that facilitates recovery 3) Provide seamless continuum of care to clients 4) Facilitate client connections to outpatient services when appropriate 5) Practice MHSA principles of peer-driven model of care	◊ **Hire and train a cohort of experienced peer specialists** to do outreach, mentoring, support and linkage of ICM/FSP clients to OP ◊ **Embed peer transition specialists in the OP clinics**, with in-service rotations and regular, ongoing contact with the ICM/FSP teams ◊ **Link ICM/FSP clients to peer team** members as they transition to OP care ◊ **Peers** to work closely with ICM/FSP clients to **connect to OP, community supports and meaningful activities** ◊ Support the Peer Transition Team with **clinical supervision** and **team bonding**	◊ More peer staff will be in outpatient settings ◊ ICM/FSP clients well be connected to peer transition team members for transition support ◊ Referrals from ICM/FSPs to OP will increase ◊ ICM/FSP clients arriving at the OP clinics will feel more welcome ◊ Clients coming from ICM/FSPs will engage in more OP services	◊ Transitioning clients will participate in more meaningful activities *(e.g. vocational training, employment, education program, social connection, family reunification)* ◊ Client will increase their self-management of life skills ◊ Client will increase their time in stable housing ◊ Client will increase their engagement in peer group activities ◊ Providers will report more confidence in the transition process	◊ More ICM/FSP clients will connect successfully to OP care ◊ Clients eligible for ICM/FSP will wait less time to enroll in an ICM/FSP program ◊ Peer Employees will be more valued and better utilized across the SOC ◊ MH service delivery will better align with client needs.	◊ # of client referrals from ICM/FSP to OP (EHR*, MDC**) ◊ % of referrals to OP that result in a new episode (admin/EHR) ◊ # days ICM/OP episodes overlap (EHR) ◊ # client services at OP w/in 90 days of ICM/FSP episode closing date (EHR) ◊ Client self-report on satisfaction of the transition process (TBD) ◊ Peer Transitions Support self-report of effectiveness of the peer team (TBD) ◊ ICM/FSP and OP provider assessment of Peer Transition Team value and effectiveness (TBD) **EHR=Electronic Health Record system* ***MDC= Manual Data Collection*

Learning Goals / Project Aims (Continued)

Learning Goals:

An expectation of a peer transition team is that clients paired with peers will transition from the ICM/FSPs to less intensive services more successfully than those clients who so not have access to a peer. That is, they will engage with the new provider and participate in OP services for at least 6 months.

Key Learning Questions:

1) How effective is a highly skilled peer transition team in helping clients from intensive wraparound services (e.g. ICM, FSP or ACT) engage in appointment based outpatient (OP) care?

   We hypothesize that a well-trained cohort of peer professionals will allow clients who are advancing in their recovery to transition from intensive case management services to periodic appointment based outpatient care with minimal relapse or interruption of services. Experienced health workers with lived experience can model self-care and self-management behaviors that support recovery. Clients can relate to peers sometimes more readily than to clinical providers, and trust their guidance and support more easily.

2) What program elements need to be in place for a peer transition support team to be successful?

   The plan calls for the peer transition team to have licensed clinical supervisor (such as an LMFT or other), preferably with lived experience. Also essential to the cohort's success will be leadership support from BHS, as well as from the ICM/FSP and OP directors. The peer cohort will also need to feel welcomed, respected and integrated into the OP teams in order to better facilitate new clients' engagement in those settings. Finally, the peer cohort should be provided with the appropriate support and accommodations should the pressure of the role, i.e. exposure to client trauma, threaten to destabilize their own recovery.

3) What factors create a resilient relationship between the client and peer transition team member (e.g., availability, modes of contact/communication, boundary setting)?

   It will be important to identify the specific ways in which clients are most helped by the peer transition team. Do clients respond best to outreach in the clinic, at their homes, or elsewhere in the community? Do clients prefer regular or periodic contact? To what extent does a peer's lived experience help a client find their way to more self-sustaining, independent living? What activities are most supportive in the transition period: sharing stories of recovery, providing transportation to an appointment (mental health or other), or doing activities together?

4) Which practices best support the peer transition team member's wellbeing and professional development?

We hypothesize that the peer cohort will benefit from camaraderie and support of a peer group, as well as from guidance and direction from a clinical supervisor. This can occur individually or in a group setting. At times, client experiences may challenge peers in their own mental wellness and at worse, trigger old memories or behaviors, risking a relapse of their own. It is important that the peer cohort be supported in their wellness and be provided accommodation as needed.

5) What programmatic elements facilitate collaboration and communication between providers at the ICM/FSP and OP programs during a referral and linkage process?

Currently, BHS is in a process to improve communication between providers of the ICM/FSP and OP programs and procedures regarding referrals and linkage to an OP site. A multisite, multidisciplinary workgroup, led by the adult system of care director and supported by Quality Management, is about to launch a structured improvement process (a series of "A3's") to address several aspects of referral and linkage from ICMs/FSPs to OP. From December 2017 through May 2018, improvement testing will focus on:

1) Creating a culture of transition and clarifying client "readiness" for referral to OP,
2) Standardizing protocols for intake at the OP sites, and
3) Clarifying service transition, provision and program flexibility.

Many of the improvements identified and tested are expected to be operational in spring of 2018, laying a foundation for the installation of the peer transition support team. Some processes will be continuously examined and revised as the peer team is established and more learning comes to light.

Evaluation/Learning Plan

The primary goal will be to increase successful linkages of clients from ICMs/FSPs to outpatient care. The San Francisco Health Network has taken up this challenge among its set of mission metrics called "True North" metrics and define the measure as **the percentage of clients who had a subsequent episode in an outpatient clinic where they received 8 or more services within 90 days of the ICMs/FSPs discharge date.**

Recent data from the SF BHS clinical and billing database (EHR) indicate the following discharge rates for the last two fiscal years:

Clients discharged from ICM who engage successfully in Outpatient Settings
(excludes those who died and those who moved out of the area)

	# of clients discharged from ICM with 8 or more OP services within 90 days of ICM discharge	# of clients discharged from ICM and eligible for services	Rate of **Successful Engagement** in Outpatient Setting
FY 2015-16	42	230	**18.3%**
FY 2016-17	43	227	**18.9%**

In order to understand the potential impact of the peer transition team on this outcome metric, we will continue to track ICMs discharge data and subsequent client services in outpatient care, as well as gather data to address the learning questions proposed above. The evaluation plan will address each of these learning questions with qualitative, survey and clinical data.

Learning Question	**Sources of Data**	**Data Collection Strategy**
1) How effective is a highly skilled peer transition team in helping clients from intensive wraparound services (e.g. ICM, FSP or ACT) engage in appointment based outpatient (OP) care?	Peer Staff Clients ICM/FSP and OP Staff	Interviews with Peer Staff Client feedback forms, focus group and/or interviews Surveys of ICM/FSP and OP staff
2) What program elements need to be in place for a peer transition support team to be successful?	Peer Staff Clients	Interviews with Peer Staff Client feedback forms, focus group and/or interviews
3) What factors create a resilient relationship between the client and peer transition team member (e.g., availability, modes of contact/communication, boundary setting)?	Peer Staff Clients	Interviews with Peer Staff Client feedback forms, focus group and/or interviews
4) Which practices best support the peer transition team member's wellbeing and professional development?	Peer Staff	Interviews with Peer Staff
5) What programmatic elements facilitate collaboration and communication between providers at the ICM/FSP and OP programs during a referral and linkage process?	ICM/FSP and OP Staff	Surveys of ICM/FSP and OP staff Interviews with ICM/FSP and OP directors

In addition, process measures will be gathered to track the progress of the implantation of the Peer Transition Team and the effort to link clients. For example,

- Number of peer transition staff hired, trained and their lengths of work stay (administrative)
- Number of days ICM/FSP and OP episodes overlap (EHR)

Finally, it will be useful to know how many referrals from ICMs/FSPs are initiated for new outpatient episodes. However, San Francisco does not currently track systematically in the EHR client referrals to new services. The benefit of this additional data (date referral initiated, referral destination, etc.) will provide sensitivity to detect efforts to link clients to OP that do not conclude in actual open episodes. Quality improvement efforts could focus on the challenges that arise in those scenarios.

It is proposed as part of this project we explore and test options to collect referral data manually from ICM/FSP clinicians as a PDSA (Plan Do Study Act) in the early stages of implementation and review its value. A high degree of usefulness of referral data could justify its incorporation into the EHR for ongoing performance tracking.

- Number of client referrals from ICM/FSP to OP (manual data collection)
- Percentage of ICM/FSP referrals to OP that result in a new outpatient episode (manual combined with the EHR)

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

CalOMS and Counselor Certification Regulations Compliance

The contractor must comply with applicable client data collection and reporting requirements of the California Outcomes Measurement System (CalOMS) as required by the State of California Department of Health Care Services (DHCS). Additionally the contactor must comply with applicable counselor, staff training, or certification requirements as mandated by DHCS.

Achievement of contract performance objectives and productivity

The contractor must have a record of continuously monitoring progress towards contract performance objectives and must have established information dissemination and reporting mechanisms to support achievement. All staff (including direct service providers) should be informed about objectives and the required documentation related to the activities and service delivery outcomes.

In regards to management monitoring, the Program Director should report progress/status towards each contract objective in the monthly report to executive management. If the projected progress has not been achieved for the given month, the Program Director will identify barriers and develops a plan of action. The data reported in the monthly report is continually collected, with its methodology

depending on the type of information. In addition, the contractor should monitor service delivery progress (engagement, level of accomplishing service goals/objectives), and termination reasons.

Documentation quality, including a description of any internal audits

The contractor must have a proven record of accomplishment of utilizing various mechanisms to review documentation quality. Case/chart reviews will be conducted by Division management; based on these reviews, determinations/recommendations are provided relating to frequency and modality/type of services, and the match to client's progress and needs. Feedback will be provided to direct staff members while general feedback and summaries on documentation and quality of programming are integrated throughout staff meetings and other discussions.

Mid-year and Annual reports, focusing on program objectives and consumer demographics, will be submitted to MHSA and reviewed by the relevant MHSA Program Manager, and technical assistance and support will be provided when needed. Annual contract monitoring and site visits will be conducted by the Department of Public Health Behavioral Health Services Business Office. Training and support around contract deliverables and evaluation is provided at monthly MHSA Provider Meetings and MHSA Impact Meetings.

The MHSA Impact meetings provide a forum where technical assistance (TA) on program assessment and improvement activities is provided in a collaborative and interactive manner to MHSA-funded programs. These meetings provide an opportunity for providers and consumers to learn about program services and provide feedback to MHSA programs.

Additional Information for Regulatory Requirements

Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

Leadership from the Adult and Older Adult System of Care, Quality Management, and Mental Health Services Act staff, supported by facilitators from Learning for Action (LFA), a consulting group, organized a series of six meetings that consisted of ICM/FSP and outpatient program directors and clinicians, consumer/peer advocacy staff, and individual consumers with lived experience in mental health services. The forums were designed specifically to address client and program needs when a client is transitioning from an ICM/FSP to an appointment based outpatient clinic.

The meetings first focused upon refining our understanding of the problem as informed by data from QM, and then brainstorming and discussing possible solutions and INN project models. A consumer panel shared their experiences of transitions from ICM/FSP to Outpatient programs and additional consumers participated in small group discussions of improvement ideas for specific aspects of the transition. Peer representation was also provided through peer advocacy CBO organizations' (MHA-SF and NAMI) participation in meetings and the MHSA Peer Program Manager's participation in the planning team and ICM/FSP forums.

Training about MHSA Innovations funding took place during the second meeting, and Innovations guidelines were revisited at subsequent meetings as relevant to the discussion. At the second meeting, MHSA Program Evaluator, Diane Prentiss, presented on Innovations funding purposes and MHSA requirements for INN projects guidelines.

At the end of the series of meetings, the following had been created:

- A summary of an INN Transition/Linkage Team with Augmented Services project idea
- A list of interested parties in giving feedback to the project plan writing team
- A list of interested parties in addressing non-INN project ideas to improve communication and protocols between systems

Further feedback was collected from:

- QM conducted further interviews of front line staff using an A3 structured problem solving and continuous improvement tool. These interviews confirmed feedback previously collected
- MHSA Advisory Board presentation, which led to an individual interview with a consumer with relevant experience to this project
- MHSA Director presented ICM Flow INN project idea to SF Health Commission

- MHSA staff presented ICM Flow INN project idea at monthly FSP data meeting and quarterly ICM/FSP Directors meeting

Peers participating in the process included individuals from the black/African American, Hispanic/Latino, and transgender communities. The most recent MHSA Advisory Board members' demographic profile in FY 14-15 showed representation of consumers, service providers, and family members from diverse communities, such as the Asian, black/African American, Hispanic/Latino, American Indian/Alaskan Native, multi-lingual and LGBT communities. The ICM/FSP and Outpatient Clinical Directors, and the planning team reflect the ethnic demographics of the community to some degree, with leadership from the Asian American and Hispanic/Latino communities.

Primary Purpose

Select *one* of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

a) Introduces a new mental health practice or approach.
b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community. *Peer services, linkage, navigation.*
c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

Population

If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?

Estimate of clients served. The ICM/FSP programs serve approximately 500 Transitional Age Youth, adult and older adult clients per year and they are expected to discharge 20% (n= 100) of their clients annually to allow clients with high acuity access to the ICM/FSP. Clients are discharged for many reasons; some move out of the area, withdraw from the ICM/FSP or are lost to follow up without completing their treatment goals. The optimal outcome is for clients to complete treatment having met treatment goals and transition to less intensive services, such as appointment based outpatient clinic, for continued support as needed.

In a recent 3 year analysis, only 16% (average n=16) of discharged ICM/FSP clients have subsequent episodes opened at outpatient clinics, and half of those clients remained in the outpatient program for a year or more. The proposed innovation project is focusing not on time spent at the outpatient program but on **evidence of engagement** at the outpatient clinic. The measure to be improved will be the percentage of clients who had a subsequent episode in an outpatient clinic where they received 8 or more services within 90 days of the ICM/FSP discharge date.

Goal/Targets: Increase the percentage of clients who access 8 or more services in outpatient within 90 days of discharge from an ICM

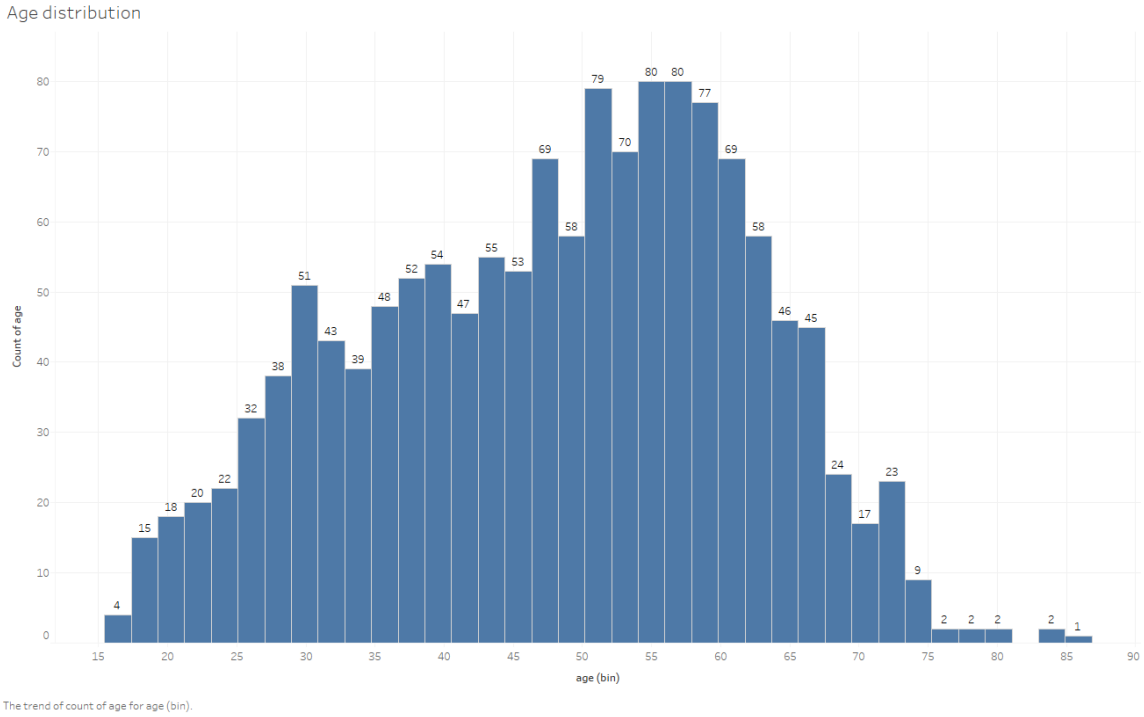
DATES	% of clients who engage successfully at outpatient
Year 1	19%
Year 2	22%
Year 2	25%

Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.

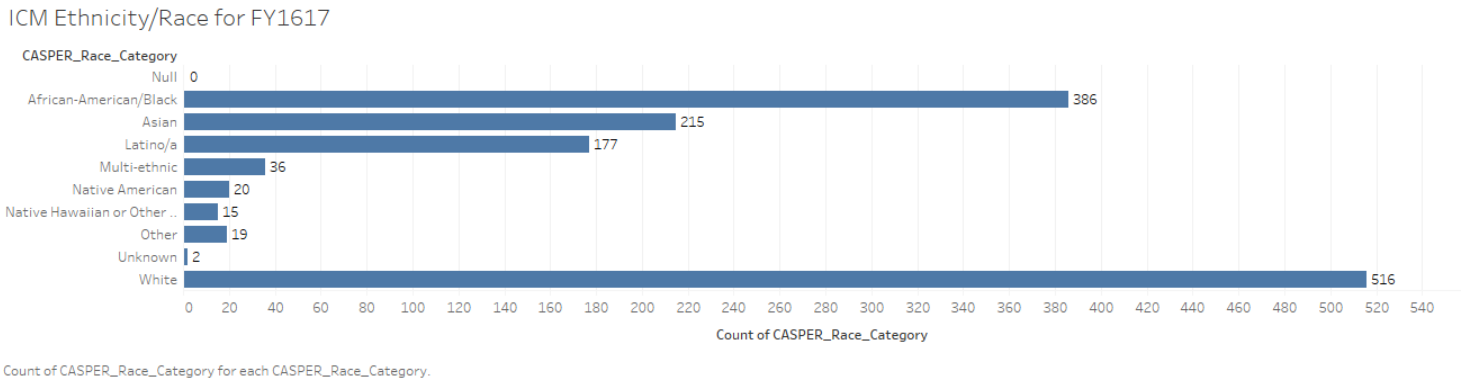
Population description. The project is designed to serve active ICM/FSP clients who are advancing in their recovery such that they no longer need or meet criteria for ICM/FSP services, and could effectively be treated at a less intensive level of care such as an outpatient program.

a. Demographic data of all ICM/FSP clients, active FY16-17.

AGE of Active ICM Clients, FY16-17



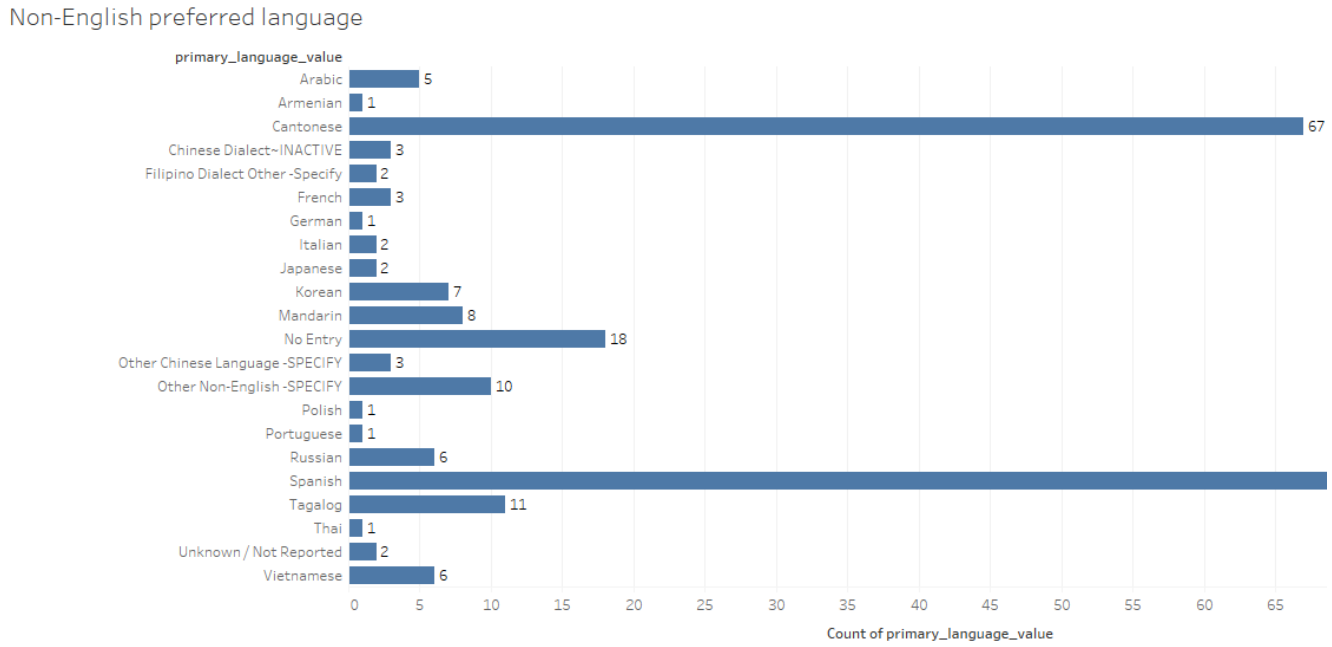
RACE/ETHNICITY of Active ICM Clients, FY16-17



Primary Language

English	83%
Other*	17%

*Other consists of the following:



Reasons for Discharge from ICM/FSP Episodes
(Clients discharged FY1617, n=299)

Unengaged:	**62**	21%
Cannot Locate	13	
Client Dissatisfied	3	
Client Withdrew: AWOL, AMA, No Improvement	23	
Client Withdrew: AWOL,AMA, Treatment Par	11	
No follow through	12	
Program Change/Administrative Reason	**92**	31%
Did Not Need Service	5	
Discharge/Administrative Reasons	29	
Ineligible for Services	1	
Program Transfer	19	
Referred to CBHS Clinic	1	
Referred to non CBHS Services	1	
Client moved out of service area	36	
Unknown/Other	**26**	9%
Other	21	
Unknown	5	
Progress Toward Goals	**61**	20%
Mutual Agreement/Goals Reached	35	
Mutual Agreement/Treatment Goals Partial	21	
Treatment Completed	5	
Client Died	34	
Client Discharged/Program Unilateral Dec	4	
Client Incarcerated	10	
Consumer Choice/Schedule	2	
Consumer Choice/Unspecified	6	
Mutual Agreement/Treatment Goals Not Rea	2	

When an ICM/FSP episode is closed, clinicians record a reason for discharge in the EHR. Some of the reasons are ambiguous and not applied consistently. That said, the data as such indicate very low percentages of clients discharging with “Treatment Goals Reached” (35/299) and “Treatment Completed” (5/299). Many more episode discharges suggest non-engagement, such as “Cannot Locate” (13/299), “Client Dissatisfied” (3/299), “Client Withdrew: AWOL, AMA…” (34/299), and “No Follow Through” (12/299). These 62 clients represent 21% of discharges.

Population (Continued)

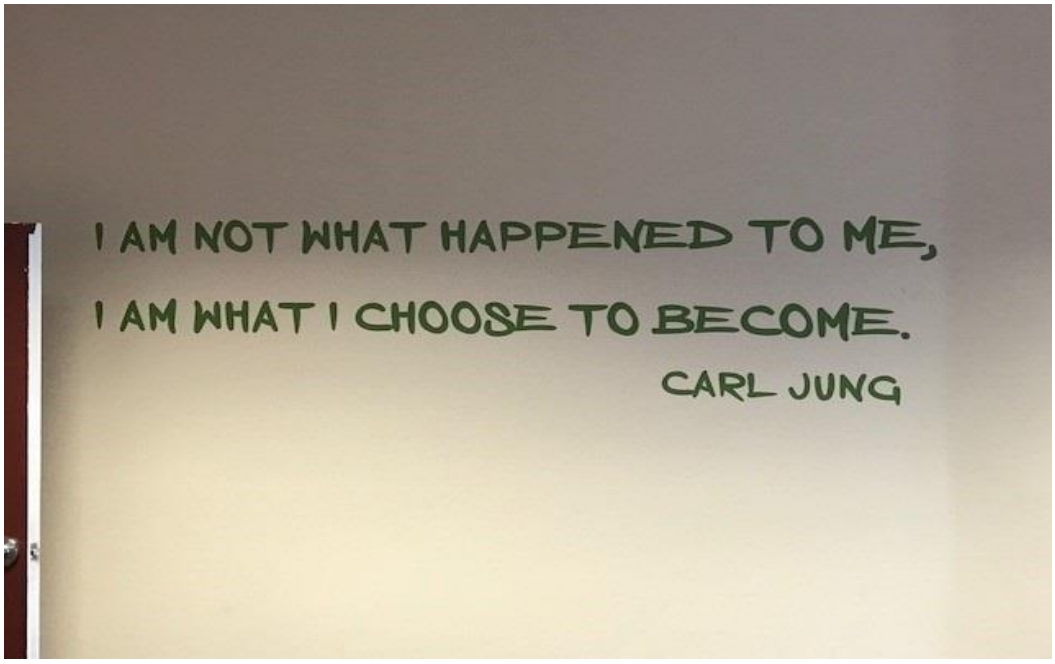
Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

The proposed project will focus on clients enrolled in intensive case management behavioral health programs who are experiencing increasing recovery such that they may soon manage well at a lower intensity of service delivery. Eligibility will include enrollment in an ICM and a degree of increasing recovery as arrived at by the client and the client's ICM case manager based on criteria that are currently in development.

Criteria for Transition

Criteria for "advancing recovery" will be identified by a stakeholder group working on client "readiness" to transition from ICM/FSP to Outpatient in a process taking place from November 2017 to June 2018. The workgroup will consider many of the following: client data in the EHR (e.g. Adult Needs and Strengths Adult/Older Adult outcomes), housing stability, medication self-management, appointment self-management, vocational training, meaningful connections/activities in the community, etc.). After PDSA improvement testing over several months, the workgroup will recommend best practices to be adopted by the system of care.

Connection with a peer transition support team to facilitate linkage and engagement in the outpatient setting, as described in this proposal, will a component of the aforementioned planning process.



MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320.

a) Community Collaboration

The project will be a collaboration between peer navigators, BHS, and community-based organizations, who will collaborate to fulfill their common vision and goal of successful transitions between FSPs/ICMs and Outpatient services.

b) Cultural Competency

The Peer Navigators will receive cultural humility training and reflect the diversity of the community they are serving.

c) Client-Driven/ Family-Driven

This project places peers and family members who have lived experience and who have been through transitions between FSPs/ICMs and Outpatient settings at the center of programming. The peer navigators will be a cohesive and highly skilled team who will use their expertise to meet each client where they are at.

d) Wellness, Recovery, and Resilience-Focused

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

e) Integrated Service Experience for Clients and Families

This project focuses on bringing a more seamless transition to clients moving from a high level of intensive services to a less structured and resources outpatient setting through the use of peer navigators, a greater level of coordination between providers and the provision of enhanced services in the later setting.

Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

Within the broader system of care, there is a network of peer providers that provide services for clients with severe mental illness. In addition, a segment of peer services exists within a wide variety of MHSA providers. These contractors are funded by MHSA to provide peer services for any BHS clients. The existing menu of services includes; support groups, individual and group counseling, wellness activities including outings, family to family classes, linkage, Dual Recovery Anonymous, Wellness Recovery Action Plan (WRAP) planning, cultural specific activities, services to those with hoarding and cluttering issues, and support for those interested in vocational activities.

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

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) Explain how you plan to ensure that the Project evaluation is culturally competent.

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

b) Explain how you plan to ensure meaningful stakeholder participation in the evaluation.

We have already established a large group of stakeholders that includes ICM/FSP and Outpatient providers, and peer advocates. As the Innovations program is established and the Peer Team identified and trained, the stakeholder group will expand to include members of the Peer Team as well as clients.

The stakeholder group will be consulted on Innovation project learning goals, data collection tools, methods and language for data collection, and how best to summarize and communicate findings to suit diverse audiences. San Francisco also has an active Mental Health Board that meets monthly and a Behavioral Health Services Client Council, where issues important to client representatives, including Innovations project findings, are presented and discussed. Both the Client Council and the Mental Health Board will be integral partners in designing the ICM/FSP-

OP Flow evaluation, interpreting and reporting the findings, and making recommendations for client-focused program improvement.

Deciding Whether and How to Continue the Project without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

Early partnership with the MHSA Quality Management team has resulted in a robust evaluation plan. The findings from evaluation objectives and outcomes will be reviewed by the MHSA team, BHS Executive Team, and the System of Care. Together, they will determine protocols and infrastructure that will be institutionalized to support and sustain cultural change, where they will be located and the appropriate streams of funding for the relevant service components.

Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

Project learnings and newly demonstrated successful practices will be shared within our county and to stakeholders. Successful elements of this project can be applied to other areas of the behavioral health system of care, especially given the project is focused on a population that is challenging to engage. Shared practices could change service delivery and the peer employment infrastructure, possibly expanding the focus areas of future peer programs to transitions in various settings.

Successful practices and lessons learned will be shared with the San Francisco Mental Health Board and San Francisco Board of Supervisors, as well as with the BHS Executive Team. Evaluation team members will present at the MHSA Advisory Committee and MHSA Provider Meetings, which include peer based organizations and community based agencies. Project successes and challenges will be presented on at the Client Council, a committee of consumers that perform an advisory role on BHS affairs. Finally, the findings could be presented at state MHSA meetings to provide insight to other counties working on similar projects.

a) **How will program participants or other stakeholders be involved in communication efforts?**

Feedback from project participants will be shared in communication efforts of the successes and lessons learned from this project. Peer navigators will be invited to co-present, along with other system of care staff, on progress, findings, and their experience of the project to stakeholders.

b) **KEYWORDS for search: Please list up to five keywords or phrases for this project that someone interested in your project might use to find it in a search.**

Linkage; Peers; Intensive care for mental health; Seamless transition; Warm hand off.

Timeline

a) **Specify the total timeframe (duration) of the INN Project: ____ Years ____ Months**

The duration of the project will be ***five years***, which will allow time to effectively recruit staff, engage participants, track data, and measure the outcomes of the transitions.

b) **Specify the expected start date and end date of your INN Project: ____ Start Date ____ End Date**
Note: Please allow processing time for approval following official submission of the INN Project Description.

April 2018 Start Date. ***March 2023*** End Date.

c) **Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for**
   i. **Development and refinement of the new or changed approach;**
   ii. **Evaluation of the INN Project;**
   iii. **Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;**
   iv. **Communication of results and lessons learned.**

ICM/FSP- OP Flow Timeline	
Timeframe	**Activities**
April 2018-September 2018	Recruitment, onboarding, and training of peer staff. Presentations to referring agencies and clients.
October 2018	Identification and recruitment of potential participants
July 2019	First data collection point for MHSA; Annual review of referrals and linkages
January 2020	Midyear MHSA outcomes report
July 2020	Data collection point for MHSA; Annual review of referrals and

	linkages
March 2020	Presentation for MHSA stakeholders on progress of the project including the MHSA Advisory Committee, the MHSA Providers Meeting, the Client Council, the Mental Health Board, and the Adult System of Care.
January 2021	Midyear MHSA outcomes report
July 2021	Data collection point for MHSA; Annual review of referrals and linkages
January 2022	Midyear MHSA outcomes report
March 2022	Presentation for MHSA stakeholders on successes/challenges of the project including the MHSA Advisory Committee, the MHSA Providers Meeting, the Client Council, the Mental Health Board, and the Board of Supervisors. Review project learnings and stakeholder feedback with Adult System of Care leadership and the BHS Executive Team. Possible decision-making point for sustainability of the project or elements of the project.
July 2022	Data collection point for MHSA; Annual review of referrals and linkages
January 2022	Midyear MHSA outcomes report
March 2023	Project End date
July 2022	Data collection point for MHSA; Annual review of referrals and linkages
October 2023	Final Learning Report Due
November 2023	Presentation on final report to key stakeholders

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The following is the budget narrative for the ICM/FSP-OP Transition Support Project:

- $473,009 for annual personnel direct costs and $55,000 for fringe, for 5 years $2,365,045 and 275,000, respectively. Personnel include:
    - 1.0 FTE for one Senior Peer Navigator,
    - 3.0 FTE for three Peer Navigators
    - 1.0 FTE for one bilingual Peer Navigator
    - 1.0 FTE for one Clinician
    - 0.5 FTE for one part-time Program Manager

- $70,000 for annual general operating, including supplies, transportation between sites, food for clients, and client incentives, for 5 years: Total $350,000.

- $97,951 for fiscal intermediary services, for 5 years: Total $489,755.

- $24,040 for annual staff training and development, including support services to prevent burnout among peer staff, for 5 years: Total $120,200.

- $30,000 for annual evaluation costs, for 5 years: Total $150,000.

Revenue

The total amount being requested for this project is ***$750,000 per year*** for a total of five years, hence, a ***total budget of $3,750,000***.

A. ICM/FSP-OP Transition Support Project Budget FY 18-19 to FY 22-23*							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1.	**Salaries**	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$2,365,045**
2.	**Direct Costs**						
3.	**Indirect Costs**	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$275,000**
4.	**Total Personnel Costs**	**$528,009**	**$528,009**	**$528,009**	**$528,009**	**$528,009**	**$2,640,045**
OPERATING COSTs		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
5.	**Direct Costs**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$350,000**
6.	**Indirect Costs**						
7.	**Total Operating Costs**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$350,000**

NON RECURRING COSTS (equipment, technology)		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
11.	**Direct Costs (Fiscal Intermediary)**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$489,755**
12.	**Indirect Costs**						
13.	**Total Consultant Costs**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$97,951**	**$489,755**

OTHER EXPENDITURES (please explain in budget narrative)	**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
14. Training	**$24,040**	**$24,040**	**$24,040**	**$24,040**	**$24,040**	**$120,200**
15. Evaluation	**$30,000**	**$30,000**	**$30,000**	**$30,000**	**$30,000**	**$150,000**
16. Total Other expenditures	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$270,200**

BUDGET TOTALS						
Personnel (line 1)	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$473,009**	**$2,365,045**
Direct Costs (add lines 2, 5 and 11 from above)	**$167,951**	**$167,951**	**$167,951**	**$167,951**	**$167,951**	**$839,755**
Indirect Costs (add lines 3, 6 and 12 from above)	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$55,000**	**$275,000**
Non-recurring costs (line 10)						
Other Expenditures (line 16)	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$54,040**	**$270,200**
TOTAL INNOVATION BUDGET	**$750,000**	**$750,000**	**$750,000**	**$750,000**	**$750,000**	**$3,750,000**

For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

Glossary

ACT- Assertive Community Treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together.

BHS- Behavioral Health Services is a division of the San Francisco Department of Public Health. Also known as the San Francisco Behavioral Health Plan, BHS offers a full range of specialty behavioral health services provided by a culturally diverse network of community behavioral health programs, clinics and private psychiatrists, psychologists, and therapists. Services are available to residents of San Francisco who receive Medi-Cal benefits, San Francisco Health Plan members, and to other San Francisco residents with limited resources.

EHR- An Electronic Health Record (EHR) is an electronic version of a patient's clinical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, and treatment goals.

FSP- Full Service Partnership programs are a subset of ICM programs and reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Severe Mental Illness or Severe Emotional Disturbance. Services include integrated, recovery-oriented mental health treatment; intensive case management and linkage to essential services; housing and vocational support; and self-help.

ICM- Intensive Case Management programs, which include Full Service Partnership (FSP) programs Provide services to clients with the most acute, severe and chronic behavioral health problems. ICM programs have low caseloads, a multi-disciplinary team approach, and a comparatively richer array of wraparound services in order to be able to do "whatever it takes" to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery.

OP- Outpatient services involve appointment-based mental health office visits for therapy and psychiatric medication management at community mental health agencies or civil service clinics. Select Outpatient services may have adult socialization programs.

PDSA- Plan Do Study Act is a tool for accelerating quality improvement. PDSA is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Warm handoff- a referral that is conducted in person, between two members of the health care team, in front of the client (and family if present)

Wraparound services- support aligned with the philosophy of "do whatever it takes" to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery (i.e. - relatively greater access to supportive housing, vocational rehabilitation and other health and human services)

FILE NO. 170904 RESOLUTION NO. 379-17

[Mental Health Services Act - Program and Expenditure Plan (Integrated Plan)]

Resolution adopting the Mental Health Services Act Program and Expenditure Plan (Integrated Plan) for FY2017-2018 through FY2019-2020.

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

WHEREAS, The MHSA specifies five major program components (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 Mental Health Board; and

WHEREAS, The San Francisco Mental Health Services Act Integrated Plan FY2017-2018 through FY2019-2020, a copy of which is on file with the Clerk of the Board of Supervisors in File No. 170904, complies with the MHSA requirements above, and provides an overview of progress implementing the various component plans in San Francisco and identifies new investments planned for FY2017-2018 through FY2019-2020; 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 MHSA Integrated Plan FY2017-2018 through FY2019-2020 is adopted by the Board of Supervisors.

City and County of San Francisco
Tails
Resolution

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

File Number: 170904 **Date Passed:** October 17, 2017

Resolution adopting the Mental Health Services Act Program and Expenditure Plan (Integrated Plan) for FY2017-2018 through FY2019-2020.

September 28, 2017 Budget and Finance Committee - RECOMMENDED

October 17, 2017 Board of Supervisors - ADOPTED

Ayes: 11 - Breed, Cohen, Farrell, Fewer, Kim, Peskin, Ronen, Safai, Sheehy, Tang and Yee

File No. 170904

I hereby certify that the foregoing Resolution was ADOPTED on 10/17/2017 by the Board of Supervisors of the City and County of San Francisco.

Alicia Somera

for Angela Calvillo
Clerk of the Board

Mayor

10/27/2017

Date Approved

Appendix B – Wellness in the Streets Innovations Learning Project (Pending MHSOAC Approval)

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Wellness in the Streets (WITS)

Background

San Francisco is part of the 9-county Northern Californian Bay Area, containing four of the ten most expensive counties in the United States. With a population exceeding 7 million, the San Francisco Bay Area has an increasingly expensive housing market that is difficult for many to afford. In San Francisco, a minimum wage worker would have to work approximately 4.7 full-time jobs to be able to rent a two-bedroom apartment (National Low Income Housing Coalition, 2017). According to the last homeless count conducted by the City and County of San Francisco, the city has 7,499 homeless individuals with a large percentage living with severe mental illness or at risk of experiencing mental health issues.

Community Planning Process

The San Francisco Department of Public Health (SF-DPH) has strengthened its MHSA program planning by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In late 2017 and early 2018, San Francisco Mental Health Services Act (SF-MHSA) hosted thirteen (13) community engagement meetings inviting participants from all over the city to collect community member feedback to better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders. All meetings were advertised on the SF-DPH website and via word-of-mouth and email notifications to service providers. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed. The community input gathered from these meetings helped to shape the Innovations Proposal for this project.

Community Needs Assessment

From April 1- July 14 2017 a diverse group of peers from various SF-DPH/BHS programs began the collection of information from homeless and marginally housed individuals. These information collection sessions occurred in multiple San Francisco neighborhoods including: South of Market, Castro, Bayview/Hunters Point, Tenderloin, Mid-Market, Mission, and the Haight Ashbury District. The information collection efforts were conducted in both English and Spanish. Peer specialists were selected to support this needs assessment based on personal lived experience with homelessness, previous history in the BHS Peer Certificate program or previous experience working with the San Francisco homeless population.

Peer counselors traveled in teams or pairs to various areas of the city with high concentration of unhoused individuals with the goal of engaging them in conversations related to mental health services in San Francisco. The peers provided outreach bags containing socks, snacks, and toiletries as an engagement strategy. The overarching goal was to collect statements related to both engagement and retention in services provided at BHS clinics. Conversations could be as brief as a few sentences or as long as the interaction felt comfortable to gain some insight into the needs of the population. Counselors were advised to create an open ended dialogue as opposed to any promises of services. After the encounters, summary notes were developed to capture the main points of the conversations and the primary needs of this specific population.

Primary Problem

The re-occurring themes to arise from the Community Planning Process and the Community Needs Assessment were feelings of isolation and disconnectedness for the City's homeless population. Homeless participants described **very little contact with social services**. A few respondents had the experience of **falling out of services because of their inability to keep track of appointments within their current living situation**. The overarching theme was the need to have contact with someone willing to connect with individuals at their current location. **"No one talks to us…"** was repeated frequently during the Needs Assessment as well as, "you are the only people that have come to speak with us." In addition, surveyed individuals were confused as to where to obtain mental health services. In two cases, respondents were within two blocks of identified service providers but were unsure where to go for support. Calling to ask information for services with no live receptionist to answer questions was also identified as a barrier.

<u>Community Need</u>

In a Wellness and Recovery-oriented system, a grounding principle is that recovery is a "possible and expected outcome of treatment, and that the full range of comprehensive services and supports that an individual needs to meet his or her recovery goals be accessible, flexible, individualized, and coordinated." (Felton et al, 2010, p. 441) A recommendation was formulated to have a peer-based mental health outreach team that would work directly with unhoused individuals on the streets, in their environment, in order for the individual to be successful in their personal recovery.

Review of Existing Practices and Evidenced-Based Models

An extensive literature review of categories including homeless engagement strategies, evidence-based treatment modalities when working with the homeless population, patient navigation, peer programs, and housing reveals the following:

- Street based mental health services are generally conducted as an extension of an Assertive Community Treatment (ACT) program, a street based medical program, or a program that encourages individuals who are homeless to come into a physical program.
- Few evidence-based and peer-based practices have been attempted in San Francisco directly on the streets.
- Individuals who are homeless may wait until symptoms become so severe that they need to be treated at psychiatric hospitals or inpatient facilities.
- Teaching about wellness tools and crisis planning can be implemented by peers and is proven to be effective with homeless individuals.

Proposed Project

The purpose of this Innovations Learning Project would be to increase access to underserved populations, specifically **San Francisco residents who are homeless that do not typically access mental health services despite experiencing behavioral health needs.** The proposed project would involve a roving support team of 4.5 Full-Time Equivalent (FTE) formerly homeless peer counselors that would engage in peer counseling directly on the streets of San Francisco in areas where individuals are unhoused. One of these peers will be a peer supervisor with lived experience.

A diverse team of peer counselors will go out in the community in pairs to engage unhoused San Francisco residents in meaningful connections, based on the needs of the residents. Small items will be used as engagement tools such as coffee or snacks. Peer workers will distinguish themselves by wearing a sweatshirt or other garment with a visible project logo.

Peers will meet unhoused individuals on the streets to engage and provide peer support. Peer counselors will spend time listening to personal stories, discussing wellness and recovery, and modeling hope. Peers will provide brief peer counseling activities including behavioral health education activities, wellness planning, crisis planning and other activities. Longer-term interventions will be provided including weekly support groups in a park or café. Below are some examples of these activities.

- **Peer support groups will take place in Civic Center Park that may include WRAP groups, Seeking Safety groups and general health and wellness groups based on the preferences of the participants.**
- **Peers will meet up with unhoused individuals at coffee shops for one-on-one social connection while using motivational interviewing and other evidenced-based peer interventions for support.**
- **Peers will help individuals develop a wellness toolbox directly on the street that can be used on a daily basis.**

<u>Peer Interventions</u>

The above objectives will be obtained through **one primary intervention; peer-to-peer activities directly on the street.** Peer specialists will provide peer counseling interventions to homeless individuals on the street including, but not limited to:

- Wellness planning – developing a list of things to do every day to maintain wellness
- Crisis planning – developing a plan to use when feeling distressed or in crisis
- Support system development – developing a list of support people when needs arise
- Mental health psycho-education - teach early warning signs of mental health problems
- Socialization skills development

- Harm reduction skills training
- Coping skills development
- Seeking safety support groups
- Support for managing appointments and medications
- Reconnection with friends or family members support

Participants will be able to set up appointments to meet with a peer. In addition, a 4-hour block of time will be available for community meet-ups with the peers. Programming will be entirely street-based and peer specialists will be setting up activities on street corners, in coffee shops or cafes based on the preferences of the participants.

Training for Peer Specialists

Peer specialists will be trained using the current 12-week BHS Peer Specialist Mental Health Certificate Program, the Advanced Peer Certificate Program, the Leadership Academy monthly training seminars for peers, and other training including, but not limited to:

- Wellness Recovery Action Plan (WRAP)
- Harm Reduction
- Psycho-education on mental health, coping skills and socialization skills
- De-escalation strategies
- CPR/First Aid
- Personal safety training
- Seeking Safety

Contribution to Learning

This project will center on the development of a highly skilled peer specialist team to help support San Francisco homeless residents advance in their recovery using a peer-to-peer counseling approach directly on the streets. The primary goals of the project would be to increase social connectedness of homeless individuals; increase awareness of mental health resources; and increase feelings of wellness and the overall quality of life of individuals who are homeless by using peer-to-peer interventions on the street.

Key Learning Questions

1. Do street-based peer-to-peer activities help to increase the personal wellness of individuals who are homeless (i.e. social connectedness, better quality of life, etc.)?
2. What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless?
3. What engagement strategies work best to facilitate collaboration and communication between peer specialists and homeless residents living on the street?

Evaluation/Learning Plan

SF-MHSA will work in close partnership with SF-DPH Quality Management (QM) to implement a comprehensive evaluation plan and tools to measure outcomes. The evaluation plan will include a logic model and guide the design and implementation of the Innovations Learning Project. An ethnically diverse group of consumers and community members will be involved in the design of the evaluation tools, particularly people with lived experience with homelessness, that will assess how this project impacts those participating. The use of surveys and key informant interviews will be used. Interactions with homeless residents will be periodically measured by survey

questions, with some questions to measure the effectiveness of the interaction and some to identify what community members suggest for future efforts and activities. SF-MHSA and QM will compile evaluation reports summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on stakeholder feedback.

Specific outcomes may include:

- Increased feelings of social connectedness
- Increased wellness
- Increased quality of life

Data collection tools include, but not limited to:

- Brief feedback instrument to be used for the short-term peer interventions to evaluate activities provided to individuals that are more transient
- Surveys to assess the longer-term peer interventions (i.e. weekly support groups in the park) to evaluate individuals engaged in ongoing activities
- Staff checklists that include a list of peer interventions to determine the peer activities being used

The results of this Innovations Learning Project will be disseminated through various modalities including the SF-MHSA webpage; regular communication with community groups including the MHSA Advisory Committee and the BHS Client Council; the monthly Behavioral Health Services Director's Report; the BHS Executive Team; and regular updates to key stakeholders.

Plan after the Innovations Learning Project Ends

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

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

Another approach involves an ongoing process of improving and enhancing citywide collaborations as a way to both expand services reimbursements and identify potential points of interaction or resource sharing that could create opportunities for alternate forms of continuation support.

Timeline

<u>Phase I- Start Up and Planning (10/1/2018-12/31/2019</u>)

Program staff and consumers will spend the first three months of this project selecting community partners that employ peers that can engage and serve San Francisco residents who experience homelessness. The program will also fine-tune the scope of work, hire needed staff, and establish the necessary infrastructure to operate the program.

<u>Phase II- Implementation (1/1/2019-6/30/2023)</u>

In this phase, the project will be fully operational and engaging with San Francisco residents who experience homelessness directly on the streets by considering their social and behavioral health needs, and implementing mutually-agreed upon peer activities. The evaluation plan will be refined and implemented throughout this phase.

Phase III – Reflection, Evaluation, and Dissemination (7/1/2023-9/30/2023)

In this phase, the evaluation data gathered in the implementation phase will be analyzed to determine best practices, lessons learned and the overall impact of the project. We will also assess the success of the community partnerships and the added value of their collaborative efforts.

Budget Narrative

The majority of spending for this project will go toward hiring 3.5 FTE County Contracted Peer Counselors at $18/hr to staff the project. There will also be a 1.0 FTE County Contracted Peer Supervisor who identifies as a consumer at $22/hr. There will be a 0.25 FTE SF-DPH Manager of the overall project who self-identifies as a consumer. This manager will be responsible for implementing the work plan for this project. We are requesting $14,402 annually for operating expenditures to engage participants and operate the program including food, coffee, clothing materials, blankets, travel, art supplies, office supplies and other items.

Leveraged Funding

The training for the peer counselors and the peer supervisor will be leveraged through existing funds allocated to the BHS Peer Specialist Mental Health Certificate program, the Advanced Peer Certificate Program and the Leadership Academy's monthly training seminars for peers. The additional annual training expenditures for this project are estimated at $6,600.

Annual Projected Budget

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	**$39,133**		**$254,865**	**$293,998**
2. Operating Expenditures			**$14,402**	**$14,402**
3. Non-recurring expenditures				
4. Training			**$6,600**	**$6,600**

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
5. Work plan management				
6. Evaluation	**$35,000**			**$35,000**
7. **Total proposed work plan- Year 1 expenditures**	**$74,133**		**$275,777**	**$350,000**
B. Revenues				
1. Existing revenues				
2. Additional revenues a. b.				
3. Total New Revenue				
4. Total Revenues				
C. Total Annual funding requirements	**$74,133**		**$275,777**	**$350,000**

Appendix C – Technology-Assisted Mental Health Solutions Innovations Project (Pending MHSOAC Approval)

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Innovations Learning Project - Technology-Assisted Mental Health Solutions

Background

Recent research demonstrates that technology can be used to directly impact the provision of health and mental health services. The City and County of San Francisco's Behavioral Health Services (BHS) department is seeking approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to use Innovation Funds to determine how technology can influence mental health delivery and possibly increase access to mental health care. This effort will take place in collaboration with multiple counties that have been recently approved by the MHSOAC. This project will bring interactive technology tools into the public mental health system through a highly innovative set or "suite" of applications designed to educate users on the signs and symptoms of mental illness, connect individuals seeking help in real time, and increase user access to mental health services when needed.

Community Planning Process

The San Francisco Department of Public Health (SF-DPH) has strengthened its MHSA program planning by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In late 2017 and early 2018, San Francisco Mental Health Services Act (SF-MHSA) hosted thirteen (13) community engagement meetings inviting participants from all over the city to collect community member feedback to better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders. All meetings were advertised on the SF-DPH website and via word-of-mouth and email notifications to service providers. Printed and electronic materials were translated into Spanish, Mandarin,

and other languages, and interpretation was provided at all public community meetings, as needed. The community input gathered from these meetings helped to shape the Innovations Proposal for this project.

Primary Problem

A re-occurring theme to arise from the Community Planning Process included **the need to increase access to mental health services for Transition Age Youth (TAY) and socially isolated transgender adults.**

Community Need

Behavioral health consumers and other stakeholders supported the idea to **use technology to increase access to support through the use of computers, tablets and phones**. The Community Planning Process data showed trends suggesting that BHS should create a virtual support system through chatrooms facilitated by peers. Some stakeholders noted the importance of virtual appointment reminders while others suggested that fun and interactive mental health games could be created to help improve cognition, reduce hallucinations and stimulate positive counter-thoughts when someone is going through a downward spiral. Several individuals suggested the need to have a public community space, like the San Francisco Public Library, where community members could access these technology-based services if the participant does not have a computer at home and the individual is not willing to physically come into a behavioral health clinic due to stigma or other reasons. Stakeholders emphasized the fact that some behavioral health clients do not frequently use technology and that training should be an important component to this project. It was noted that technology-based mental health services could be very beneficial for those who wish to increase social skills and reconnect with friends and family. "These tools could be a bridge to building stronger social skills and individuals can try to work up to more face-to-face time" and social time with peers. Many of our stakeholders were opposed to the idea of passive sensory data collection and digital phenotyping for early detection of mental health issues, therefore, the City and County of San Francisco will exclude this component of this collaborative Innovations Learning Project from our local implementation plan.

We also reviewed previous MHSA-funded project evaluation reports and interviewed staff members of programs that have overlapping characteristics to find that clients desire more frequent access to support and a longer duration of support. These findings also support the need to increase service access to the TAY population and diverse ethnic groups.

Review of Existing Practices and Evidenced-Based Models

An extensive literature review of categories including technology-based programs that increase access to mental health services, peer-to-peer engagement strategies, avatars in e-mental health interventions and evidence-based treatment modalities when working with isolated populations reveals the following:

- The potential to foster cohesive social networks in virtual worlds is cited as a strength
- Small sample size studies show that a creative platform with which to deliver individual and group therapies, peer support, and as a form of e-mental health augmentative intervention, avatar technology offers significant potential to engage a broad range of clients in need of psychological support who may otherwise be unable or unwilling to participate in traditional treatment models
- The Adult Transgender population in San Francisco has been identified as a hard-to-engage group that may benefit from technology-assisted mental health modalities

- Peer-to-Peer interventions through a technology-based platform may increase access to care, increase support and promote wellness activities

Proposed Project

The primary purpose of this Innovations Project is to utilize a new approach to overall public mental health service delivery in order **to increase access to mental health care and support for all individuals in San Francisco with a focus on transition age youth (TAY) ages 16-24 and socially isolated transgender adults.** We estimate that **500 clients will be served for the total duration of this project**. The primary goals of the project will include the following:

1. Intervene earlier to prevent mental illness and improve client outcomes
2. Provide alternate modes of engagement, support and intervention
3. Increase access to peer-to-peer interventions

This project will include one full-time equivalent manager who will oversee all aspects of this project. This manager will be in charge of all areas of implementation, staff training, community training, marketing and evaluation.

All of elements of this project will adhere to HIPAA (Health Insurance Portability and Accountability Act of 1996) legislation and we will only implement HIPAA compliant technology products with a high concern to safe-guarding client confidentiality. In addition, all components of this project will adhere to current San Francisco Department of Public Health emergency and crisis protocol (i.e. how to deal with suicidal ideation, self-harm, etc.) and develop new protocol, as needed, prior to the formal implementation of this project.

The components of this Innovations Learning Project will include Peer-to-Peer Chat Interventions and Virtual Evidence-Based Support Utilizing an Avatar that will be accessible from a computer, cell phone or tablet. These interventions can be accessed at home, in a clinic setting or in the community (i.e. the San Francisco Public Library).

1. Peer-to-Peer Chat Interventions

A web-based network of trained peer counselors will be available to chat with individuals, or their family members/caregivers, experiencing symptoms of mental illness. A peer is defined as an individual with personal lived experience who is a consumer of behavioral health services, a former consumer, or a family member of a consumer. Peer-to-peer services encourage peers to utilize their lived experience, when appropriate and at the discretion of the peer, to benefit the wellness and recovery of the clients being served. This project will create a safe place for clients to learn skills and gain support within an environment that uses empathy and empowerment to inspire recovery.

The project will involve a roving support team of 4.0 full-time equivalent peer counselors to provide peer counseling interventions to San Francisco residents who would benefit from technology-based interventions. The peer-to-peer counseling and evidence-based support activities may include, but are not limited to: peer relationship building, wellness planning, crisis planning, support system development, coping skills development, mindfulness support and system navigation.

Clients will be able to access the peer-to-peer chat counseling services through a link to the chatroom that will be available through the SF-MHSA website. This chatroom will be accessible from a computer, cell phone or tablet. Social media, clinician training and other dissemination efforts will be used to promote the service across San Francisco and to a very broad audience.

Peer counselors will be trained using the current 12-week BHS Peer Specialist Mental Health Certificate Program, the Advanced Peer Certificate Program, the Leadership Academy monthly training seminars for peers, and other training including, but not limited to:

- Wellness Recovery Action Plan (WRAP)
- Mindfulness
- Harm Reduction
- Seeking safety
- Psycho-education on mental health, coping skills and socialization skills

2. Virtual Evidence-Based Support Utilizing an Avatar

Virtual, evidence-based online treatment protocols using avatars to deliver clinical care have been proven to be effective in studies with small sample sizes. We would like to further test these theories by refining some of these virtual practices to fit the needs of our culturally-diverse San Francisco population.

San Francisco's Behavioral Health Services will partner with multiple counties regarding training materials and technology products that will help implement this project.

This component of the project includes computerized evidence-based support that is **constructed by clinical experts in the behavioral health field. Avatars can be used to teach mental health psycho-education, teach basic cognitive and behavioral support techniques, facilitate role-playing exercises to increase social skills, increase knowledge of strategies to increase mood and decrease depression, and teach relaxation and mindfulness techniques**. These virtual strategies can be implemented at home, in individual therapy sessions with a clinician and in group settings. This support will involve interactive interface with the capability of customization and modification based on user's feedback.

This computerized support can take place outside of the clinic setting or side-by-side with a therapist present for increased support. Virtual support at home can be beneficial for individuals that are low-risk of needing emergent and emergency care. This virtual evidence-based support can be accessed 24 hours a day, 7 days a week.

Utilizing various forms of avatar technology to facilitate or augment treatments that are delivered with the face-to-face support of a therapist could be beneficial as well. For example, a therapist can sit alongside and coach clients through virtual role-playing scenarios. In addition, avatars can offer clients a unique opportunity to address or confront their symptoms within a safe environment, with the support of a therapist. Therapeutic discussion can take place throughout the interactions with the avatars to use as a teaching tool.

Contribution to Learning

This project will center on the development of a highly skilled peer specialist team to help increase access and support to San Francisco residents. This project will also center on the training of behavioral health clinicians within the mental health system to advance their skills in using technology-based interventions to increase access to services.

Key Learning Questions

1. Will individuals who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?

2. Will the use of virtual peer chatting and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increased wellbeing?
3. What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?
4. What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations (i.e. transition age youth, socially isolated transgender adults, others)?
5. Will issues pertaining to privacy and/or data security present a barrier to the use of these applications?

Collaborative Efforts

This project is part of a statewide multi-county collaborative effort in which multiple counties will be developing their own technology strategies based on local needs and stakeholder feedback. The City and County of San Francisco will share technology products with the other counties on this project in order to provide our county with greater purchasing power than we would have on our own.

The City and County of San Francisco will buy into these developed technology products and buy into the use of the qualified vendors chosen to develop the products. A large scale evaluation plan will be implemented and counties will collaborate to share strategies, lessons learned, and best practices. Management of technology products, governance of the project and oversight over a formal statewide evaluation will be a multi-county effort. In addition, a marketing and outreach and peers/end user subcommittee will be overseen by multiple counties.

Evaluation/Learning Plan

SF-MHSA will work in close partnership with SF-DPH Quality Management (QM) to implement our local evaluation activities following the guidelines of the large-scale statewide and multi-county evaluation plan. The use of surveys and key informant interviews may be used. SF-MHSA and QM will compile evaluation reports summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on stakeholder feedback.

Specific outcomes may include:

1. Increased purpose, belonging and social connectedness for users
2. Increased quality of life
3. Increased access to services

The results of this Innovations Learning Project will be disseminated through various modalities including the SF-MHSA webpage; regular communication with community groups including the MHSA Advisory Committee and the BHS Client Council; the monthly Behavioral Health Services Director's Report; the BHS Executive Team; regular updates to key stakeholders; and regular updates to the state and multi-county collaborative.

Plan after the Innovations Learning Project Ends

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

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

Another approach involves an ongoing process of improving and enhancing citywide collaborations as a way to both expand services reimbursements and identify potential points of interaction or resource sharing that could create opportunities for alternate forms of continuation support.

Timeline

Phase I- Start Up and Planning (10/1/2018-12/31/2018)

The program will collaborate with all counties approved by the MHSOAC and participating in this multi-county effort regarding the use of the technology-based platforms and collaborative planning efforts. The program will fine-tune the scope of work, hire needed staff, and establish the necessary infrastructure to implement the project. Program staff and consumers will also spend the first three months of this project selecting community partners that employ peers that can engage and serve San Francisco residents who wish to utilize technology-based interventions.

Phase II- Implementation (1/1/2019-6/30/2021)

In this phase, the project will be fully operational and engaging with San Francisco residents who are seeking additional sources of support. The local evaluation activities will be refined and implemented throughout this phase.

Phase III – Reflection, Evaluation, and Dissemination (7/1/2021-9/30/2021)

In this phase, the evaluation data gathered in the implementation phase will be analyzed to determine best practices, lessons learned and the overall impact of the project. We will also assess the success of the community and governmental partnerships and the added value of their collaborative efforts.

As stated above, this Innovations project will be a collaborative effort with other counties in regards to program implementation and project evaluation. As more counties join this project, they will enter and exit in different phases in the life cycle of this project, based on their proposed timelines. The City and County of San Francisco is proposing a three-year timeline that will begin upon MHSOAC approval. The County plans to adopt all of the learning questions outlined above and collaborate with participating counties throughout its participation in this project. In the event that the collaborative county partners exit this project during the City and County of San Francisco's three-year timeframe, we plan to continue our evaluation of the learning questions and finish the evaluation accordingly.

Budget Narrative

The total requested budget is $1,005,045 for the first year, $636,477 for the second year and $631,477 for the third year for a total budget of $2,273,000 over three (3) years. If approved by

the MHSOAC, SF-MHSA will utilize FY18/19 Innovations Funding for the first year and will not utilize reversion funds.

SF-MHSA will make a contribution to buy into the multi-county collaborative in order to leverage funding and reduce costs. The total collaborative expenses for the three-year period will total $1,357,909. These collaborative costs will be the City and County of San Francisco's contribution towards the technology suite including one peer specialist with the state selected vendor 7 Cups for the peer chat component; collaborative evaluation activities to be carried out by the state selected vendor University of California Irvine; outreach and marketing efforts with the state selected vendor RSE; and access to application products specifically designed to meet the needs of the target populations previously identified.

The total local county expenses for the three-year period will total $915,091.These local costs will cover expenses including the local evaluation activities to measure local outreach, penetration and engagement; the local peers that will be hired; training for the peers; a SF-DPH manager to oversee this project; and a small operating budget for local expenses.

Leveraged Funding

The training for the peer counselors will be leveraged through existing funds allocated to the BHS Peer Specialist Mental Health Certificate program, the Advanced Peer Certificate Program and the Leadership Academy's monthly training seminars for peers. The additional annual training expenditures for this project are estimated at $11,772.

Projected Innovations Budget

Local Expenses	Year One	Year Two	Year Three	Innovation Total
Local Evaluation				
Measuring Outreach & Engagement	$ 25,000	$ 25,000	$ 25,000	$ 75,000
Personnel Expenses				
County Mental Health Department	$ 78,266	$ 78,266	$ 78,266	$ 234,798
County Contracted Providers	$ 176,906	$ 176,906	$ 176,906	$ 530,718
Operating Expenses	$ 13,087	$ 13,086	$ 13,086	$ 39,259
Local Training Expenses	$ 11,772	$ 11,772	$ 11,772	$ 35,316
TOTAL LOCAL EXPENSES	**$ 305,031**	**$ 305,030**	**$ 305,030**	**$ 915,091**

Collaborative Expenses	Year One	Year Two	Year Three	Innovation Total
CalMHSA Overhead (5%)	**$ 67,895**	**$ -**	**$ -**	**$ 67,895**
Collaborative Experts	**$ 46,000**	**$ 46,000**	**$ 41,000**	**$ 133,000**
7 Cups: Apps				
Start-Up Fee	$ 57,089	$ -	$ -	$ 57,089
Development Fund	95,149	-	-	95,149
Licensure/Annual Fees	133,209	133,209	133,209	399,626
Local Customization				-
7 Cups - Apps Subtotal	**$ 285,447**	**$ 133,209**	**$ 133,209**	**$ 551,865**
7 Cups: Paid Peers				
Start-Up Fee	$ 15,224	$ -	$ -	$ 15,224
Development Fund	-	-	-	-
Licensure/Annual Fees	57,089	57,089	57,089	171,268
Local Customization				-
7 Cups - Paid Peers Subtotal	**$ 72,313**	**$ 57,089**	**$ 57,089**	**$ 186,492**
Collaborative Evaluation				
Start-Up Fee	$ 133,209	$ -	$ -	$ 133,209
Development Fund	-	-	-	-
Licensure/Annual Fees		57,089	57,089	114,179
Local Customization	-	-	-	-
Evaluator Subtotal	**$ 133,209**	**$ 57,089**	**$ 57,089**	**$ 247,388**
Collaborative Outreach & Marketing				
Start-Up Fee	$ 38,060	$ -	$ -	$ 38,060
Development Fund	57,089	-	-	57,089
Licensure/Annual Fees		38,060	38,060	76,119
				-
Outreach & Marketing Subtotal	**$ 95,149**	**$ 38,060**	**$ 38,060**	**$ 171,268**
Collaborative Subtotals				
Start-Up Fee	$ 243,582	$ -	$ -	$ 243,582
Development Fund	152,239	-	-	152,239
Licensure/Annual Fees	190,298	285,447	285,447	761,193
Local Fees	-	-	-	-
Vendor Subtotals	**$ 586,119**	**$ 285,447**	**$ 285,447**	**$ 1,157,013**
TOTAL COLLABORATIVE EXPENSES	**$ 700,014**	**$ 331,447**	**$ 326,447**	**$ 1,357,909**

Total Expenses	Year One	Year Two	Year Three	Innovation Total
Total Collaborative Expenses	$ 700,014	$ 331,447	$ 326,447	$ 1,357,909
Total Local Expenses	$ 305,031	$ 305,030	$ 305,030	$ 915,091
TOTAL PROJECT EXPENSES	**$ 1,005,045**	**$ 636,477**	**$ 631,477**	**$ 2,273,000**

Local Review Process

This SF-MHSA Innovations Plan was made available on the SFDPH MHSA website at www.sfdph.org/dph and www.sfmhsa.org for 30-days requesting public comments from June 18, 2018 to July 17, 2018.

This plan is also made available for public review and feedback with the FY18/19 SF-MHSA Annual Update. Notification of the public review dates and access to copies of the Innovations Plan have been made available through email distribution to MHSA community members and providers, communication through the MHSA Advisory Committee Meeting, communication through the MHSA Provider Meeting and communication through the San Francisco Mental Health Board. Members of the public will be requested to submit their comments either by email or by postal mail to the following:

Imo Momoh, MPA
Director, Mental Health Services Act
San Francisco Department of Public Health
1380 Howard Street
San Francisco, CA 94103
(415) 255-3637

The public comments will be added following the 30 day public review and comment period.

Appendix D – MHSA Innovations Concept: FUERTE Groups Project

I. Introduction/Purpose

Our country is at the crossroads of an increasingly divided debate on immigration. Children and adolescents are more than ever caught in the crossfire. While often escaping dangerous and unsafe conditions in their country of origin they are surviving traumatic crossings, hostility and detention at the border and intentional or forced separation from family[1–4]. San Francisco (SF), a sanctuary city, continues to attract and support increasing numbers of newly immigrated youth. Latinx newcomer adolescents (ages 12y – 18y; five years or less post migration to the U.S.) are one of the largest immigrant demographics in California urban centers such as San Francisco[5]. These youth are at high risk of health disparities when compared to U.S. born youth, particularly European American youth, in part due to a range of health care access barriers, including poverty, limited English proficiency, and documentation status[6,7]. Latinx newcomer youth are also at disproportionately higher risk for behavioral health problems compared to their U.S. born counterparts as they often have pervasive histories of exposure to traumatic events, including events that occur pre-, during, and post-migration to the United States[2,3,8,9]. To address challenges in accessing services, culturally-tailored, school-based programs have been proposed to be the frontline for reducing behavioral health access disparities among this population[7].

The SF FUERTE program is one of few existing evidence-informed early intervention programs culturally-tailored to address the needs of Latinx newcomer adolescents with both limited English proficiency and health literacy. FUERTE is designed as a selective prevention, school-based approach to promote support around acculturation and behavioral health access for immigrant Latinx youth in San Francisco. Given the increasing tensions around immigration at the border and the separation of families we expect increasing numbers of children and youth that have experienced trauma to end up in San Francisco, particularly as it is a top destination in the U.S. for unauthorized immigrants[10].

While the FUERTE curriculum is built on theory and evidence-based practices, interventions of this type have not existed elsewhere nor has the FUERTE program been properly evaluated. The FUERTE program has been largely enacted due to high demand by both school district and San Francisco County public health officials for the need for early intervention programming, coupled with grassroots efforts led by the Department of Pediatrics at the University of California, San Francisco/Zuckerberg San Francisco General Hospital, and local behavioral health services providers. While the FUERTE groups were developed using evidence-based frameworks and guided by theory, no large-scale program evaluation has been conducted thus far. Pilot data provides some preliminary evidence that FUERTE has positive outcomes in youth. This proposal aims to iterate on lessons learned in the pilot, update the curriculum and examine the efficacy of FUERTE at increasing health literacy among this target population. In addition, we want to assess and address the goal of increasing engagement and service access for youth in need of specialty mental health services. To reach this aim, the FUERTE groups provide increased screening, referrals and engagement of youth in specialty mental health when applicable. In addition, the program evaluation will seek to understand how clinicians make decisions regarding tailoring the FUERTE curricula to different groups of Latinx newcomer adolescents. Specifically, we will

quantitatively and qualitatively examine how providers make these decisions with the goal of creating a "playbook" to inform subsequent adaptations of FUERTE for other populations of focus with similar concerns (e.g., Middle Eastern immigrants).

II. Background/Program Description

School-based, preventative programming has been proposed to be the frontline for reducing behavioral health access disparities among Latinx newcomer youth[7]. However, very few evidence-based, selective prevention programs exist that have been tailored to ensure cultural relevance for newcomer Latinx youth with limited English proficiency and low health literacy in under-resourced school settings. Like many urban school districts in California, San Francisco Unified School District is an especially relevant setting for the FUERTE program. The district has a high number of newcomer adolescents, with an average of over 500 newcomer adolescents coming into the school district per year, most from Central America and Mexico[11].

Newcomer immigrant youth are a high-risk and difficult to access population. In San Francisco, there is a shortage of adolescent mental health providers able to work with limited English proficiency youth, and access to services can be delayed due to availability of clinicians. Youth and caregivers may face numerous obstacles to attending appointments, including cost, transportation, and competing responsibilities like work or childcare[7]. This population may have fears relating to their documentation status, distrust of institutions, or attach stigma to mental health services[12]. Finally, they often lack resources to navigate the U.S. medical system and low literacy regarding mental health symptoms and appropriate care[7].

The FUERTE model has been innovatively designed to address the above barriers. In order to optimize the exposure of large number of immigrant youth with limited healthcare providers, FUERTE is designed as a group format, each group comprised of 4-8 participants. This has the additional benefit of fostering a sense of community and normalizing the therapeutic process in a supportive group setting. The intervention is targeted for youth ages 12 to 18 in the San Francisco Unified School District (SFUSD). Participants are recruited through referrals from educators and staff in the Wellness Initiative, health centers that are co-located in schools throughout the district. Group leaders are bilingual behavioral health providers from both the school district and community-based organizations with experience working with newcomer Latinx youth.

The FUERTE program is relatively brief, comprised of six sessions. The FUERTE curriculum was developed using various evidence-based frameworks and theory. The Attachment, Regulation, and Competency (ARC) framework[13] was used to develop the components associated with traumatic stress with the model emphasizing that in order to improve the behavioral health of these youth, there is a need for creating systemic changes (e.g., social connectedness). The ARC model was adapted to highlight three targets for prevention programming: 1) increased social connectedness; 2) adolescent self-regulatory capacity; and 3) developmental competency through building or restoring resilience. In order to adapt the ARC framework for use with newcomer Latinx youth, we incorporated an understanding of the sociocultural contexts that might be particularly salient for newcomer youth including the pre-migration experience, the experience during migration, as well as post-migration contexts. In addition, cognitive-behavioral principles

(e.g., cognitive restructuring, stress management) are used to assist with building group members' self-regulatory capacity.

The curriculum is comprised of five modules. Module 1 focuses on an orientation to the group, establishing goals, and beginning the development of a supportive group community. Module 2 focuses on routines, rituals, and traditions, and begins establishing routines and rituals for the group itself. Module 3 allows group members to reflect on the stress of immigration, provides psychoeducation to normalize stress reactions, and provides information on when stress reactions may need further intervention, including information on seeking behavioral health services. Module 4 develops emotional and affect literacy, and the development of effective coping skills using available resources. Finally, Module 5 seeks to foster attunement to the emotions of others to help group members increase their attachment to present caregivers and/or other supportive individuals in their lives.

Youth are screened for behavioral health symptoms both pre and post group completion. Youth who report at-risk symptoms at either screening time point are referred to a local community-based mental health provider for further assessment of their behavioral health concerns. FUERTE clinicians help facilitate these referrals and connections with local community providers, as these clinicians are also often employed by these same organizations.

Since its first iteration in 2014, pilot FUERTE groups have been implemented in nine SFUSD high schools and middle schools and served over 150 youth. Preliminary data on the FUERTE groups suggest that it may be effective with the population of focus. Quantitative analysis using the Pediatric Symptom Checklist-17, a validated self-reported mental and emotional well-being scale for use with this population, revealed that a significant number of students referred to the program screened positively for emotional and behavioral problems. Qualitative analysis of open-ended surveys given to FUERTE participants following the completion of the program revealed that one of the most-liked components included those related to social connectedness (e.g., meeting students with similar experiences). The students also identified a number of learning objectives of the FUERTE curriculum including building trust in others, such as sharing their own experiences as well as respecting the sharing of experiences by other group members. Additionally, they described effective ways of positively sharing their emotions. Finally, FUERTE participants also reported behavioral changes from participating in the curriculum including using coping strategies to relax and reduce stress, increasing patience when encountering stressful situations, and increasing their self-confidence.

Increased demand to deliver FUERTE from SFUSD will grow the program to serve over 75 youth annually. In addition, the program will include novel strategies to enhance the curricula. One is the inclusion of a parental component which will take the form of two hours of evening supplemental materials shared with parents. The FUERTE model will also build out its peer development model, where former group members will be trained to serve as peer recovery support coordinators and integrated into the model.

Currently, no formal program evaluation has taken place. The current proposal aims to use a crossover randomized control design to examine the efficacy of FUERTE. Youth who qualify for the FUERTE curricula will be randomized into a wait list control group or receive the FUERTE

program. In the following school semester, youth in the wait list control group will then participate in the FUERTE intervention. The program evaluation will allow us to assess whether youth are effectively screened for behavioral symptoms, and for those at risk, increase referrals to specialty mental health providers. In addition, the impact of FUERTE on increasing the health literacy of these youth will also be assessed. Finally, in order to initiate the process of developing FUERTE to be used with other immigrant groups, a framework on the tailoring of FUERTE will be developed. The framework will be informed by quantitative and qualitative perspectives on how clinicians make decisions on tailoring the FUERTE curricula. The framework will allow us to develop a "playbook" that will be used alongside the FUERTE manual to guide clinicians and community partners on how to tailor the main components of FUERTE to be used with different populations of newcomer immigrant youth.

III. Learning Objectives

1. Does FUERTE increase the health literacy of newcomer Latinx immigrant youth? Specifically, at the conclusion of FUERTE:
    a. Can youth identify common trauma-related symptoms?
    b. Can youth identify coping mechanisms for managing stress?
    c. Can youth identify how to seek services in San Francisco County?
    d. Does FUERTE increase youth's social connectedness?

2. Does FUERTE increase behavioral health access among Latinx newcomer youth?
    a. Does FUERTE effectively identify youth with mental health concerns?
    b. Does FUERTE increase referrals for specialty mental health services for youth in need?

3. How are decisions made regarding tailoring the FUERTE curriculum?

IV. Method

Participants

All newcomer Latinx youth ages 12 to 18 enrolled in participating SFUSD schools will be considered eligible for inclusion in the FUERTE program evaluation. Youth will be randomized into the FUERTE intervention or into a waitlist control group. Youth in the control group who are identified as exhibiting significant behavioral health symptoms on premeasures will be given referrals for specialty mental health services. Efforts will be made to have equal numbers of girls and boys represented across study conditions.

Procedure

The study will be carried out in participating SFUSD high schools and middle schools, with a goal of 6-8 schools per year and at least 75 participants per year. Each group will be comprised of at least four and no more than eight newcomer adolescents. A similar number of youth in each school will comprise the waitlist control group each semester, matched as much as possible by

gender and age of participants in the current FUERTE group. Youth in the waitlist control group will then participate in the FUERTE program the following semester.

A crossover, randomized control trial design will be used. Youth will be identified for the FUERTE groups by school staff each semester, and half will be randomized to receive the intervention, while the other half will be randomized to the waitlist control group. Premeasures will be completed with youth in both groups by early October. The FUERTE program will begin by late October and conclude late November/early December. Post measures of intervention and waitlist control groups will conclude by mid-December. Three-month follow-up measures will be collected in mid-March.

In the Spring semester, youth will be identified for FUERTE groups by March and these will become the new waitlist control group, while the waitlist control group from the Fall semester will now participate in the FUERTE program. Premeasures with both groups will be completed by early April. The FUERTE program will begin in mid-April and conclude by late May. Post measures of intervention and waitlist control groups will conclude by early June. Three-month follow-up measures will be collected from both groups in early September.

Measures

Evaluation Question #1. Does FUERTE increase the health literacy of newcomer Latinx immigrant youth?

Knowledge of trauma-related symptoms. A three-item measure will be created based on the FUERTE curricula that will examine youth's knowledge of trauma-related symptoms. One item will also assess whether youth are able to identify when there is a need for seeking specialty mental health services. The three-item measure will be administered to both FUERTE and control conditions at pre, post, and 3-month follow-up. Measures will be available in both Spanish and English.

Knowledge of coping mechanisms. A three-item measure will be created based on the FUERTE curricula that will examine youth's knowledge of coping mechanisms for traumatic stress. The three-item measure will be administered to both FUERTE and control conditions at pre, post, and 3-month follow-up. Measures will be available in both Spanish and English.

Knowledge of mental health system. A three-item measure will be created based on the FUERTE curricula that will examine youth's knowledge of mental health service access. The three-item measure will be administered to both FUERTE and control conditions at pre, post, and 3-month follow-up. Measures will be available in both Spanish and English.

Social connectedness. Two measures of social connectedness will be used in the present study. The first is the Social Connectedness scale[14] which is a 10-item scale that measure the degree of interpersonal closeness a youth experiences in their social world. The second measure will be comprised from items adapted from the Los Angeles Family and

Neighborhood Survey[15] asking youth to indicate how many acquaintances they have in their neighborhood (*How many of the kids in your neighborhood do you know*?) and how many acquaintances they have in school (*How many of the kids in your school do you know*?). Measures will be administered to youth in both FUERTE and control conditions at pre, post, and 3-month follow-up.

Evaluation Question #2. Does FUERTE increase behavioral health access among Latinx newcomer youth?

Screening. Youth will complete the Pediatric Symptom Checklist (PSC)[16], which is a self-report symptom inventory of common behavioral health problems in youth. The PSC is available in both Spanish and English. The PSC will be administered to youth in the FUERTE and waitlist control conditions within the first week of the first FUERTE group meeting. The measure will also be administered to youth in the FUERTE condition and waitlist control groups within one week of the last FUERTE group. In addition, a three-month follow-up measure will be given to youth in both conditions. At each of these timepoints (pre, post, 3-month follow-up) youth who display clinically significant mental health symptoms will be referred for specialty mental health services.

Referrals. Youth in both the FUERTE and control conditions will be given a referral for specialty mental health services if they display clinically significant behavioral health symptoms on pre, post, and/or 3-month follow-up measures. At post and 3-month follow-up, youth will be asked if they are currently connected to a mental health provider in the form of a yes/no question. The question will be available in both Spanish and English.

Evaluation Question #3. How are decisions made regarding tailoring the FUERTE curriculum?

To examine how the FUERTE curriculum is tailored to different groups of newcomer Latinx youth, a mixed-methods approach will be used. At the end of each FUERTE group, clinicians will be asked to complete quantitative measures that assess how they delivered each of the components of the FUERTE intervention and their satisfaction with the intervention elements. In addition, qualitative interviews will be held to discuss implementation difficulties, difficulties with program content or activities, and suggestions for improvement. Furthermore, similar items will be completed by youth in the FUERTE condition, as well as input will be gathered from key stakeholders serving on community participatory boards. The framework developed by Barrera, Berkel, & Castro[17] for evaluation of cultural adaptations of prevention interventions will be used to help guide the development of quantitative and qualitative items. These items will be used to inform the development of a "playbook" that will be used to train and provide to support to clinicians leading future iterations of the FUERTE groups, particularly those doing so with other groups of newcomer youth with similar concerns.

V. Community Planning Process

The vision for FUERTE arose from a community needs assessment which took place in the summer of 2015. During this time, four separate stakeholder focus groups were convened, one

each with newcomer Latinx youth, their parents, educators, and community-based mental health providers. This needs assessment provided the qualitative support to support urgent increases in school-based mental health resources for this population, with the primary objective of developing skills to increase social connectedness, including family reunification skills and communication skills.

For the present program evaluation, FUERTE will develop a community participatory board of key stakeholders to guide the development and implementation of this project. A youth-led participatory action model developed by researchers at the University of California, Berkeley will inform the development of these boards[18]. Board members will include immigrant youth, their parents, teachers and educators, community-based mental health providers, faith-based organizations, and local activists. The boards will help inform program evaluation efforts during each step of the project and will hold meetings at least quarterly each year to inform the progress around the evaluation of the FUERTE curriculum so that it best meets the needs of the communities it is serving. All printed and electronic materials that are produced by these meetings will be available in both English and Spanish. All study data will be shared with participants in these boards, and in coordination with the youth-led board, will be disseminated by the youth among key stakeholders both locally and across the State of California.

VI. Products

The program evaluation of FUERTE will result in a number of products which will increase the ability to disseminate the FUERTE curriculum to other counties in need in the State of California. Products include the following:

1. The FUERTE curriculum, available in English and Spanish, will be made broadly available to schools and providers across California for free use and adaptation.
2. A network of trained FUERTE facilitators will be available to lead "train the trainer" sessions for other providers that are interested in undertaking this model.
3. Finally, in order to initiate the process of adapting FUERTE to be used with other immigrant groups, a framework on the adaptation and tailoring of FUERTE to different groups of newcomer Latinx adolescents will be developed based on examining how current clinicians make decisions on tailoring the FUERTE curricula. The framework will allow us to develop a "playbook" that will be used alongside the FUERTE manual to guide clinicians and community partners on how to adapt and tailor the main components of FUERTE to be used with different populations of newcomer immigrant youth.

VII. Budget

The estimated annual budget for this project will be $300,000 utilizing MHSA Innovations funding starting in FY18/19.

VIII. References

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2. United Nations High Commissioner for Refugees Regional Office for the United States and the Caribbean. Children on the run: Unaccompanied children leaving Central America and Mexico and the need for international protection. http://unhcrwashington.org/children. Published 2014.
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4. Allen B, Cisneros EM, Tellez A. The children left behind: The impact of parental deportation on mental health. *J Child Fam Stud*. 2015;24(2):386-392.
5. Pew Research Center Hispanic Trends. Hispanic Population and Origin in Select U.S. Metropolitan Areas, 2014. Pew Research Center. http://www.pewhispanic.org/interactives/hispanic-population-in-select-u-s-metropolitan-areas/. Published 2016.
6. Suárez-Orozco C, Yoshikawa H, Tseng V. Intersecting Inequalities: Research to Reduce Inequality for Immigrant-Origin Children and Youth. *William T Grant Found*. 2015. internal-pdf://228.60.152.102/Intersecting-Inequalities-Research-to-Reduce-I.pdf.
7. Alegría M, Green JG, McLaughlin KA, Loder S. Disparities in child and adolescent mental health and mental health services in the US. 2015.
8. Sawyer CB, Márquez J. Senseless violence against Central American unaccompanied minors: historical background and call for help. *J Psychol*. 2017;151(1):69-75.
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13. Blaustein ME, Kinniburgh KM. *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self-Regulation, and Competency*. Guilford Press; 2010.
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17. Barrera M, Berkel C, Castro FG. Directions for the advancement of culturally adapted preventive interventions: local adaptations, engagement, and sustainability. *Prev Sci*. 2017;18(6):640-648.
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Appendix E

San Francisco Assessor-Recorder
Carmen Chu, Assessor-Recorder
DOC- 2018-K584109-00
Acct 25-NO CHARGE DOCUMENT
Thursday, MAR 01, 2018 14:57:07
Ttl Pd $0.00 Rcpt # 0005768176
ofa/FT/2-12

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:
California Housing Finance Agency
Office of General Counsel
P.O. Box 4034
Sacramento, CA 95814

No fee for recording pursuant to
Government Code Section 27383

2/c
2-12

MHSA ASSIGNMENT AND ASSUMPTION AGREEMENT
(MHSA Loan and Related Loan Documents)

CalHFA Development No. 15-009-M

This Assignment and Assumption Agreement (the *"Agreement")* is entered into as of February 1, 2018, by and between the **California Housing Finance Agency**, a public instrumentality and political subdivision of the State of California (the *"Agency"* or *"Assignor")* and the **San Francisco Department of Public Health** ("*Assignee*"), and **Rosa Parks II, L.P.**, a California limited partnership (the "*Borrower*").

RECITALS

A. WHEREAS, pursuant to Chapter 6.3 of Part 3 of Division 31 of the California Health & Safety Code, the Agency has authority to provide for the financing of special needs housing, and the Agency participation in the MHSA Housing Program constitutes authorized financing for special needs housing. The Agency has agreed to originate and service loans from the Mental Health Services Fund (California Welfare & Institution Code Section 5890), created in accordance with the Mental Health Services Act of 2004, Proposition 63 and Executive Order S-07-06 (*"MHSA"),* as a contract administrator on behalf of the California Department of Health Care Services *("DHCS"),* formerly the California Department of Mental Health, pursuant to the Interagency Agreement dated May 30, 2008.

B. WHEREAS, the Agency made, a permanent loan (the *"MHSA Permanent Loan")* pursuant to the MHSA Housing Program to Borrower. The MHSA Permanent Loan is evidenced by a promissory note from the Borrower to the Agency in the face amount of Three Hundred Thousand and No/100s Dollars ($300,000.00), titled "California Housing Finance Agency, MHSA Promissory Note, CalHFA Development No. 15-009-M, (Permanent Financing/Residual Receipts)" (the *"MHSA Promissory Note")* and secured by a deed of trust. The deed of trust is being executed by Borrower, as trustor, to Old Republic Title Company, as trustee, in favor of the Agency, as beneficiary, and is titled "California Housing Finance Agency, MHSA Deed of Trust With Assignment of Rents, Security Agreement and Fixture Filing, CalHFA Development No. 15-009-M" dated July 1, 2017 (the *"MHSA Deed of Trust")* recorded on July 20, 2017 in the Official Records as Instrument No. 2017-K478988. The Development (defined below) shall also be regulated and encumbered by a regulatory agreement executed by Borrower and the Agency titled "California Housing Finance Agency, MHSA Regulatory Agreement (Mental Health Services Act Housing Program), CalHFA Development No. 15-009-M" dated as of July 1, 2017 (the *"MHSA Regulatory Agreement")* recorded on July 20, 2017, in the Official Records as Instrument No. 2017-K478987. Unless otherwise noted, references to

instruments recorded in *"Official Records"* refer to instruments recorded in the Office of the County Recorder of the County of San Francisco.

The MHSA Permanent Loan, MHSA Regulatory Agreement, MHSA Promissory Note, MHSA Deed of Trust and related unrecorded documents shall hereafter be collectively referred to herein as the *"MHSA Permanent Loan Documents"*.

C. WHEREAS, Borrower has obtained a commitment from the United States Department of Housing and Urban Development *("HUD")* pursuant to the HUD Section 202 Supportive Housing for the Elderly Program *("HUD 202 Program")* to finance a multifamily residential rental housing project on real property located in the City of San Francisco, County of San Francisco, California and more particularly described on Exhibit A attached hereto and incorporated herein by this reference (the *"Development"*).

D. WHEREAS, the Agency has, with the written approval of DHCS, determined that under the particular circumstances of this Development, an assignment to the Assignee of all rights and obligations pursuant to the MHSA Permanent Loan Documents and related obligations pursuant to the MHSA Housing Program with respect to the Development is appropriate.

E. WHEREAS, this assignment and assumption shall include all of the Agency's obligations related to the construction period activities, all MHSA post-closing requirements and all ongoing monitoring and servicing obligations for the Development under the MHSA Permanent Loan Documents and the MHSA Housing Program with respect to the Development.

F. WHEREAS, the Assignor and Assignee are entering into this Agreement in order to effectuate the assignment by Assignor and the acceptance and assumption by the Assignee, of all of Assignor's rights and obligations under the MHSA Permanent Loan Documents and the MHSA Housing Program with respect to the Development.

NOW THEREFORE, in consideration of the foregoing, of the mutual promises of the parties hereto and for other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, Assignor and Assignee agree as follows:

1. Assignment. Assignor hereby assigns to Assignee all of Assignor's right, title, and interest in and obligations under the MHSA Permanent Loan Documents and the MHSA Housing Program with respect to the Development.

2. Acceptance of Assignment. Assignee accepts the above assignment of Assignor's right, title and interest in, and assumes all obligations under, the MHSA Permanent Loan Documents and MHSA Housing Program with respect to the Development, and agrees to perform all of Assignor's obligations and covenants under the MHSA Permanent Loan Documents and MHSA Housing Program with respect to the Development as if Assignee were the original signatory thereto. Assignee acknowledges and agrees that upon execution of this Agreement, Agency shall have no further obligations under the MHSA Permanent Loan Documents and MHSA Housing Program with respect to the Development.

3. Representations.

(a) Assignee represents and warrants to Assignor that the execution and delivery by Assignee of this Agreement, the consummation of the transaction contemplated by this Agreement, and the performance and compliance by Assignee with the terms of this Agreement, the MHSA Permanent Loan Documents have been duly authorized by all necessary action on the part of Assignee. This Agreement has been duly executed and delivered by Assignee and constitutes a legal, valid and binding obligation of Assignee enforceable against Assignee in accordance with its terms.

(b) Assignor represents and warrants that it has not previously assigned, pledged, hypothecated or otherwise transferred any of its rights or obligations under the MHSA Permanent Loan Documents.

4. Reporting and Other MHSA Housing Program Requirements. Assignee hereby covenants and agrees to comply with all reporting and other requirements of the MHSA Housing Program as required by DHCS.

5. Indemnity.

(a) Indemnification of Assignor and Assignee by Borrower. The Borrower shall indemnify, defend (with counsel reasonably chosen by the Assignor and/or Assignee (together, the "Indemnitees"), at the Indemnitees' option), and hold the Indemnitees, and their employees, officers, agents, and board members harmless against all claims, losses, liabilities, judgments, and costs, including without limitation, reasonable legal fees, which arise out of or in connection with this Agreement, the MHSA Permanent Loan, including without limitation the underwriting, due diligence, lien priority, title insurance, inspections, closing and post-closing activities related to the MHSA Permanent Loan, the MHSA Permanent Loan Documents, the ownership or occupancy of or construction on or in connection with the Development (including, without limitation, rehabilitation) by the Borrower or the Borrower's contractors, subcontractors, agents, employees, or tenants, including claims resulting from the Borrower's failure to comply with Article XXXIV of the California Constitution, federal, state and local Fair Housing laws regarding discrimination in rental housing, handicapped accessibility, prevailing wage (California Labor Code Section 1720 et seq.) and/or Davis Bacon (40 U.S.C. 276(a) et seq.) (as applicable), and the relocation of persons displaced by the Development.

Notwithstanding the foregoing indemnification by Borrower to the Indemnitees, in the event of any conflicts or inconsistencies in the indemnity of the Indemnitees as provided in this Paragraph 5(a) and the limitations and restrictions with respect to indemnifications provided by the Borrower as set forth in Paragraph 6, Indemnification, of the HUD-Required Provisions Rider attached to and made a part of the MHSA Permanent Loan Documents (the "HUD-Required Provisions Rider"), the provisions as set forth in said Paragraph 6 of the HUD-Required Provisions Rider shall govern and prevail.

(b) Indemnification of Agency by Assignee. The Assignee shall indemnify, defend (with counsel reasonably chosen by the Agency, at the Agency's option), and hold the Agency, and its employees, officers, agents, and board members harmless against all claims, losses, liabilities, judgments, and costs, including without limitation, reasonable legal fees, which arise out of or in connection with this Agreement, the MHSA Permanent Loan, including without

limitation the underwriting, due diligence, lien priority, title insurance, inspections, closing and post-closing activities related to the MHSA Permanent Loan, the MHSA Permanent Loan Documents, the ownership or occupancy of or construction on or in connection with the Development (including, without limitation, rehabilitation) by the Borrower or the Borrower's contractors, subcontractors, agents, employees, or tenants, including claims resulting from the Borrower's failure to comply with Article XXXIV of the California Constitution, federal, state and local Fair Housing laws regarding discrimination in rental housing, handicapped accessibility, prevailing wage (California Labor Code Section 1720 et seq.) and/or Davis Bacon (40 U.S.C. 276(a) et seq.) (as applicable), and the relocation of persons displaced by the Development. The Assignee agrees that the Assignee, and not the Agency, is responsible for ensuring compliance with all such laws.

6. Remedies. In the event that the Assignee breaches any representation or warranty or fails to perform any of its obligations under this Agreement, the Assignor shall have all rights and remedies at law or in equity, including the right to seek specific performance, injunctive relief, or such other equitable relief as it may deem appropriate; provided, however, any actions by the Assignor hereunder is consistent with federal and State laws and regulations. Nothing herein shall be deemed to limit the Assignor's remedies at equity or in law, it being understood and agreed that the remedies available to the Assignor in the event that the Assignee breaches any representation or warranty or fails to perform any of its obligations are cumulative and not exclusive of any other remedies.

7. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

8. Waiver by Agency. No waiver by the Agency of any breach of or default under this Agreement shall be deemed to be a waiver of any other or subsequent breach thereof or default hereunder.

9. Amendments; Consents and Waivers; Entire Agreement. No modification, amendment or waiver of any provision of this Agreement shall be effective unless it shall be in writing and signed by each of the parties hereto. Any waiver or consent shall be effective only in the specific instance and for the purpose for which given. This Agreement embodies the entire agreement of Assignor and Assignee with respect to the assignment and assumption of the MHSA Permanent Loan and the MHSA Permanent Loan Documents and supersedes all prior agreements and understandings between the parties relating to the subject hereof.

10. Attorney Fees. In any action to enforce or defend any provision of this Agreement, the prevailing party or parties shall be entitled to costs and reasonable attorney fees.

11. California Law. This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

12. Invalidity. Any provision of the Agreement which is determined by a court to be invalid or unenforceable shall be deemed severed herefrom, and the remaining provisions shall remain in full force and effect as if the invalid or unenforceable provision had not been a part hereof.

13. No Inference. The parties hereto acknowledge and agree that this Agreement is the product of negotiation between Assignor and Assignee and that the language and terms of this

Agreement shall not be interpreted or construed in favor of or against any one party by reason thereof.

14. Counterparts. This Agreement may be signed in counterparts, each of which shall constitute one and the same instrument.

15. All Prior Versions of the Agreement As Void. This Agreement is the final agreement among the Assignor, Assignee and Borrower with respect to the assignment of the MHSA Permanent Loan and MHSA Permanent Loan Documents from Assignor to Assignee; and all prior agreements with respect to this subject matter, whether partially or fully executed, shall be construed as superseded in its entirety by this Agreement, and, thus, construed as null and void.

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Document continues on next page

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

ASSIGNOR:

CALIFORNIA HOUSING FINANCE AGENCY, a public instrumentality and political subdivision of the State of California

By: _____
Name: _____
Title: Donald Cavier
Chief Deputy Director
California Housing Finance Agency

ASSIGNEE:

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

By: _____
Name: _____
Title: _____

Approved as to Form:

Dennis J. Herrera
City Attorney

By: _____
Heidi Gewertz, Deputy City Attorney

BORROWER:

ROSA PARKS II, L.P.
a California limited partnership

By: Rosa Parks II GP LLC, a California limited liability company
Its: General Partner

By: Turk Street, Inc., a California nonprofit public benefit corporation
Its: Sole Member/Manager

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

ASSIGNOR:

CALIFORNIA HOUSING FINANCE AGENCY, a public instrumentality and political subdivision of the State of California

By: _____
Name: _____
Title: _____

ASSIGNEE:

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

By: _____
Name: BARBARA GARCIA
Title: Health Director

Approved as to Form:

Dennis J. Herrera
City Attorney

By: _____
Heidi Gewertz, Deputy City Attorney

BORROWER:

ROSA PARKS II, L.P.
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By: Rosa Parks II GP LLC, a California limited liability company
Its: General Partner

By: Turk Street, Inc., a California nonprofit public benefit corporation
Its: Sole Member/Manager

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

ASSIGNOR:

CALIFORNIA HOUSING FINANCE AGENCY, a public instrumentality and political subdivision of the State of California

By: _____
Name: _____
Title: _____

ASSIGNEE:

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

By: _____
Name: _____
Title: _____

Approved as to Form:

Dennis J. Herrera
City Attorney

By: _____
Heidi Gewertz, Deputy City Attorney

BORROWER:

ROSA PARKS II, L.P.
a California limited partnership

By: Rosa Parks II GP LLC, a California limited liability company
Its: General Partner

By: Turk Street, Inc., a California nonprofit public benefit corporation
Its: Sole Member/Manager

By: Donald S. Falk
Name: Donald S. Falk
Title: Chief Executive Officer

EXHIBIT A

Legal Description

The land referred to is situated in the County of San Francisco, City of San Francisco, State of California, and is described as follows:

Leasehold estate as created by that certain lease dated March 10, 2009, made by and between The Housing Authority of the City and County of San Francisco, a public body corporate and politic, as lessor, and Rosa Parks II, L.P., a California limited partnership, as lessee, for the term and upon the terms and conditions contained in said lease and subject to provisions contained in the lease which limit the right of possession, Memorandum of Ground Lease thereof recorded March 13, 2009 in Reel J847 of Official Records, Image 0093 under Recorder's Serial Number 2009-I732538-00.

An Amendment to the terms of said Lease was recorded on October 2, 2014 under Recorder's Serial Number 2014-J957486-00.

PARCEL ONE:

Lot 27, Parcel A, as shown on Parcel Map 5436, filed in the Office of the Recorder of the City and County of San Francisco, State of California on January 30, 2009 in Book 47 of Parcel Map, Pages 179 and 180, inclusive.

APN: Lot 027 (formerly Lot 025); Block 0757

PARCEL TWO:

A non-exclusive easement for ingress and egress, as defined in Section 2(c) (i) (ii) and (iii) of the Reciprocal Easement, Joint Use and License Agreement recorded June 20, 2014 in Official Records under Recorder's Serial Number 2014-J897103-00, over that portion of Parcel B as shown on Parcel Map 5436, filed in the office of the recorder of the City and County of San Francisco, State of California in Book 47 of Parcel Maps at page 179, described as follows:

Beginning at the northwesterly corner of Parcel B as shown on Parcel Map 5436, filed in the office of the recorder of the City and County of San Francisco, State of California in Book 47 of Parcel Maps at page 179; thence easterly along the northerly line of said Parcel B 49.67 feet to an angle point in the northerly line; thence northerly along the northerly line of said Parcel B 5.00 feet to an angle point in the northerly line of said Parcel B; thence easterly along the northerly line of said Parcel B 123.00 feet; thence at a right angle southerly 7.30 feet; thence at a right angle westerly 25.70 feet; thence at a right angle southerly 12.72 feet; thence at a right angle westerly 92.32 feet; thence at a right angle southerly 5.61 feet; thence at a right angle westerly 20.51 feet; thence at a right angle southerly 0.79 feet; thence at a right angle westerly 23.43 feet; thence deflecting 45°00'00" to the right 10.50 feet; thence deflecting 45°00'00" to the left 3.28 feet to the westerly line of Parcel B; thence northerly along the westerly line of said Parcel B a distance of 14.00 feet to the point of beginning.

ACKNOWLEDGEMENTS

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
) ss.
County of Sacramento)

On February 9, 2018, before me, Julie Dunann, a Notary Public, personally appeared DONALD CAVIER, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) **IS**/are subscribed to the within instrument and acknowledged to me that **HE**/she/they executed the same in **HIS**/her/their authorized capacity(ies), and that by **HIS**/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under penalty of perjury under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: Julie Dunann

Name: Julie Dunann

(Seal)

JULIE DUNANN
Notary Public - California
Sacramento County
Commission # 2177436
My Comm. Expires Jan 23, 2021

ACKNOWLEDGEMENT

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

COUNTY OF San Francisco

On February 15, 2018 before me, Frances Arnold, notary public *(insert the name and title of the officer)*, personally appeared Barbara A. Garcia *(insert name of signer)*, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

(Signature) *(Seal)*

FRANCES E. ARNOLD
COMM. # 2130893
NOTARY PUBLIC • CALIFORNIA
SAN FRANCISCO COUNTY
Comm. Exp. OCT. 19, 2019

ACKNOWLEDGEMENT

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

COUNTY OF San Francisco

On Feb. 8, 208 before me, Michelle Bolanos, Notary Public *(insert the name and title of the officer)*, personally appeared Donald S. Falk *(insert name of signer)*, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in his/~~her/their~~ authorized capacity(~~ies~~), and that by his/~~her/their~~ signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

(Signature) *(Seal)*

MICHELLE BOLANOS
COMM. #2167022
Notary Public - California
San Francisco County
My Comm. Expires Oct. 7, 2020

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