

SAN FRANCISCO MENTAL HEALTH BOARD



Edwin Lee
Mayor

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Adopted Minutes

Mental Health Board
Wednesday, [June 18, 2014](#)
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
San Francisco, CA
6:30 PM – 8:30 PM

BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co-Chair; David Elliott Lewis, PhD, Co-Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Sgt. Kelly Kruger; Terence Patterson, EdD, ABPP; Harriette Stevens, EdD;; and Idell Wilson.

BOARD MEMBERS ON LEAVE: Vanae Tran, MS; and Errol Wishom.

BOARD MEMBERS ABSENT: Melody Daniel, MFT, Kara Chien, Andre Moore

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of CBHS; Marlo Simmons, MHSA Director; Michael Gause, Deputy Director of MHA-SF; Debra Hardy; Brian Tseng, Physicians Organizing Committee; and [four](#) members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:45 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

Mr. Joseph said the approval of the minutes for the Mental Health Board meeting of April 9, 2014 has been added to Item 3.0 Action Items as it was tabled from the May 2014 meeting.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Ms. Robinson suggested board members visit Ocean Mission Ingleside (OMI) Family Center's Wellness Program to see their great work.

She reported that in the proposed budget, the Mayor had restored about \$8.8 million for fiscal years 2014 - 2015 and 2015 - 2016. For the first time in many years, there are no service cuts in the Department of Public Health (DPH) programs and services. However, there could be cuts in the delivery of healthcare per the Affordable Care Act.

At the Health Commission meeting on Tuesday June 17, 2014, commissioners were informed about assisted outpatient treatment (AOT) as stated in Laura's Law. If AOT were approved, this would be a \$15 million program and would not be implemented until the fiscal year 2016. Furthermore, federal grants would be needed to meet the cost of \$15 million.

She announced that there are two people retiring: Director of Chinatown Community Center Nancy Yim-Lee and Deputy Director of CBHS James Stillwell who went from being a consumer to deputy director of CBHS.

1.2 Public Comment

Ms. Hardy asked for an explanation of the RFP acronym.

Ms. Robinson said "Request for Proposals."

Mr. Tseng from the Physicians Organizing Committee stated that the implementation of AOT would be beneficial for San Francisco. He met with the judge of Nevada County who explained that AOT is less restrictive than conservatorship. Turning Point runs the program in Nevada County. Many stakeholders in the county are involved to keep people out of psychiatric emergency services (PES), jail, dying on streets, or sent to prisons. Turning Points operates from the perspective of reach out before an acute psychotic outbreak sets in. The program treats the people who need the most help.

Mr. Gause from MHA-SF stated that Laura's Law would not be appropriate for San Francisco because psychiatric medications do not work for everyone with severe mental illness, because involuntary treatment is akin to coercive treatment, and because Nevada County and San Francisco County population are very fundamentally different. MHA-SF believes that full service partnerships are more appropriate for San Francisco.

Ms. Robinson commented that San Francisco is still in the process of evaluating AOT to get the facts straight. A fair comparison of apples-to-apples is needed. For example, What is going on in Los Angeles may not be applicable to San Francisco, since LA is not really implemented AOT and since LA's plan only has about 100 participating women who were incarcerated and too incompetent to stand trial.

Ms. Hardy wondered if the public is aware of a NY State study of Kendra's Law.

Ms. Robinson pointed out that the NY study does not have MHSA funding to support full service partnerships.

A member of the Public member voiced that there is an inherent fallacy in AOT being the solution for hard to engage people with severe mental illness (SMI) because, usually, many SMI people often are homebound or shut-ins, and they don't have the wherewithal, let alone reliable transportation, to participate in treatment.

Monthly Director's Report
June2014

1. MHSA Integrated Plan At-A-Glance

The San Francisco Mental Health Services Act (MHSA) Integrated Plan is now available to review and comment on the SFDPH website at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp>

The Community Behavioral Health Services (CBHS) unit of the Department of Public Health is inviting all stakeholders to review and comment on the San Francisco Mental Health Services Act Integrated Plan for a period of 30 days from May 16, 2014 to June 16, 2014. Attached is the Integrated Plan At-A-Glance.

This 30-day stakeholder review and comment is in fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848.

Please help us spread the word and forward this announcement to your networks.

Please email your comments to Marlo.Simmons@sfdph.org or send by mail to:

Marlo Simmons
Mental Health Services Act
Community Behavioral Health Services
1380 Howard Street, Room 210b
San Francisco, CA 94103

(See Attachment 1)

2. O.M.I. Family Center's Wellness and Recovery Rollout

It has been a year since OMI Family Center launched its three-phase wellness and recovery treatment model. The three phases are: Phase I – Welcoming / Engagement and Early Treatment; Phase II – Strengths Based Treatment; and Phase III – Late Treatment Consolidation and Graduation. The program was also designed to align with the Affordable Care Act Triple Aim of improving healthcare, improving population health and reducing costs.

Dr. Michael Marcin and Gloria Frederico, MFT, OMI Medical Director and Program Director, respectively, provided preliminary outcomes data to the CBHS Executive Committee, which showed that the program redesign resulted in improvements in OMI's client retention rates, including OMI surpassing National Institute of Health national average retention rates reported for mental health clinics.

The redesign involved the introduction of a Welcome Class for all clients, and a Medication Orientation Class for those referred for medication services. The Welcome Class resulted in a 22% increase in the percent of clients keeping their subsequent appointments with OMI clinicians. Staff reported increased feelings of effectiveness.

The implementation of the Medication Orientation Class serves to educate and engage patients, as well as effectively match patient commitment to available psychiatric services. The class resulted in a 37% reduction in wait-time to see a psychiatrist. There was also a 62% reduction in wait-time to see O.M.I.'s nurse, who plays an active role in psychiatric evaluations. This was because less of the psychiatrists' time was wasted on no shows, resulting in more open appointments utilized by those clients most likely to benefit from and engage medication treatment. The no-show rate for initial medication evaluation appointments was reduced by 53%. Interestingly, the proportion of people who chose to call to cancel or change appointments versus simply not showing up nearly doubled, which is believed to be a marker for a more fruitful treatment engagement. The data analysis shows that these changes are both statistically significant and clinically effective.

3. Strengthen Your Role in Suicide Prevention

The Bay Area Suicide & Crisis Intervention Alliance (www.bascia.org), with the San Francisco Suicide Prevention Center, the San Francisco Mental Health Education Fund and NAMI San Francisco, hosts a regional meeting of the State Suicide Prevention Network on June 17, 2014 from 9am to 3pm at the Seven Hills Conference Center at San Francisco State University (1600 Holloway, San Francisco 94132).

This meeting presents current best practices in suicide prevention and welcomes staff and volunteers in schools, workplaces, youth, ethnic and LGBTQ community groups, religious organizations, first responders, providers in mental health and primary care, military and VA, and mental health and suicide prevention advocates. For a detailed agenda, full list of discussion groups/workshops and registration information, visit www.basica.org.

4. Nancy Lim-Yee, Director of Chinatown Child Development Center to Retire

Ken Epstein and Max Rocha want to express our thanks and gratitude for the quality of Nancy's 39-year tenure at Chinatown Child Development Center. It is an incredible honor to have gotten to know Nancy over the last few years. She is a gifted leader whose vision has helped build a true community based program. She has managed to navigate in three important areas as a representative to SFDPH. She has built a quality program and hired and trained excellent staff, she has contributed to CCDC being a true community clinic embedded in the community it serves and she has been an advocate for access for a community that has been underserved, poorly served and/or unserved in the past. She has accomplished these three goals with grace and humility while never backing down and always pushing for excellence and equity. San Francisco Public Health, CYF Behavioral Health and the community have been blessed to benefit from all the Nancy has done and she will be missed. However, we know that the legacy she has built lives well and strong in CCDC and in the community and I believe this will drive the system to continue to advance her vision and for her staff to continue to improve the services to the community. Good luck Nancy and somehow we believe that you will continue to advocate for all you have built but hopefully in a restful way.

5. Chinatown Child Development Center, submitted by Nancy Lim-Yee

Since this will be the last time I will be writing this monthly report on behalf of the Chinatown Child Development Center (CCDC), I hope you will indulge me and excuse the lengthier than usual entry. This is something I have already written in an email to the CYF System of Care providers but I also wanted to include what I wrote in this monthly report.

It is with both great excitement and a bit of sadness that I am writing to let you know that I will be retiring at the end of June. I have loved the entire 39 years that I have been at CCDC, and have greatly appreciated working with such passionate and incredible people in the mental health/behavioral health community! I have learned so much from all of you over the years.

CCDC is being left in good hands! Some of you have already met Joe Lai who will be taking over as the interim program director as the City goes through its hiring process. I know that you will continue to see great work from the CCDC team in the coming years!

My last day as Program Director will be June 27th. After that, please feel free to keep in touch via my personal e-mail: nanlimyee@aol.com. I will continue to be active with my volunteer activities in the community, so I hope to see you around.

Some of you, I have known for many years; others I have met more recently. Nevertheless, I want to thank you for your friendship and support throughout my years at CCDC. It has been an honor – and an amazing journey. I want to end with a poem that I shared with some of you two Thanksgivings ago.

Weather Report
by: BJ Gallagher

Any day I'm vertical is a good day... that's what I always say.
And I give thanks for my health.
If you ask me "How are you?", I'll answer "Great!" because, in saying so, I make it so.
And I give thanks I can choose my attitude.

When Life gives me dark clouds and rain, I appreciate the moisture that brings a soft curl to my hair.
When Life gives me sunshine, I gratefully turn my face up to feel its warmth on my cheeks.
When Life brings fog, I hug my sweater around me & give thanks for the cool shroud of mystery that makes the familiar seem different and intriguing.
When Life brings snow, I dash outside to catch the first flakes on my tongue, relishing the icy miracle that is a snowflake.

Life's events and experiences are like the weather - they come & go, no matter what my preference.
So, what the heck?! I might as well decide to enjoy them.
For indeed, there IS a time for every purpose under Heaven.
Each season brings its own unique blessings...
And I give THANKS.

6. Comprehensive Child Crisis Services (CCCS)

The Comprehensive Child Crisis Services (CCCS) team continued to be busy in May 2014, helping to stabilize individuals and families in crises and to do our due diligence to keep children, adolescents, adults and the community safe. Our teams remained dedicated, flexible, and creative while providing out of the box solutions mental health care to protect the well-being of difficult to place youth that needed around the clock care for over 48 hours due to a shortage of child crisis beds within our system of care. And our teams provided this seamless mental health services while dealing with a broken internal air system, with at times, unbearably warm office conditions. We are very grateful for our team member's patience and resolve to provide excellent care under stressful circumstances and in difficult working conditions.

Two of our clinical interns completed their internship here at CCCS and went onto to accept great positions. Jenny Ireland, MFTi, was hired as a residential counselor at Fred Finch Youth Center, which provides housing and counseling services to at-risk youth and adolescents in the East and South San Francisco Bay Area. Nicholas Grant, PhD Candidate, was hired at Tulane University in New Orleans, LA as a Pre-doctoral Intern in their medical and school counseling clinics. We were fortunate to have had them work with us for the past nine months and are very proud of their achievements!

7. LEGACY (Formerly CSOC)

In May, CSOC/ L.E.G.A.C.Y. saw two of its Youth Development Team staff graduated from certification programs. Victor Damian graduated from San Francisco State University with a Core Strengths Coaching Certificate. This will further his work with youth and young adults in empowering them to thrive, flourish, set goals, get results, flow, and obtain a better sense of well-being. Inez Love graduated from Community College of San Francisco with a certificate in Trauma Prevention and Recovery. This certificate will enhance the current work she does with youth and young adults who have been effected by and are healing from violence.

Our Family Involvement Team (FIT) has been busy doing outreach in the Southeast community. On May 23rd, the FIT team participated in the Walgreens Health Fair on 3rd and Williams Street. On Friday June 6th, they will be assisting families in the Sunnydale area at the SF Families Connect Day.

8. Therapeutic Behavioral Services (TBS)

We are pleased to report that the Department of Health Care Services commended our policy and procedures during the triennial audit regarding the issuance of EPSDT/TBS Notices to Medi-Cal beneficiaries as required by state mandate. The audit team praised the organization and levels of detail that were included in the binder that was presented to them by Chris Lovoy, TBS Coordinator, and they even took the binder back to Sacramento as a model for other counties state-wide. TBS continues to go strong with a regular influx of referrals, and the positive feedback about TBS from our system of care's mental health providers has been very much appreciated.

9. Family Mosaic Project

Family Mosaic Project is now accepting referrals. The referrals must come through one of 3 ways: A.I.I.M Higher, M.A.S.T. or Level II Risk.

Family Mosaic Project is a part of San Francisco's Department of Mental Health - Children, Youth and Family Services that provides intensive care coordination within the wraparound model to children, youth and their families.

Since 1998, Family Mosaic Project has provided wraparound services to children, youth and families in an effort to avoid out-of-home placement or a higher level of care.

Our mission is to support children and families in their communities by providing extraordinary outreach and innovative approaches to mental health services. We bring the services to you and your family at home, school and/or the community.

10. Foster Care Mental Health

In May, Foster Care Mental Health (FCMH) welcomed two new 2930 Psychiatric Social Workers, Niki Smith and Emily Meneses. They will be conducting CANS screens and assessments for children and

youth, and working closely with the Child Advocacy Center to ensure timely mental health assessment and linkage to services when needed. Also, FCMH is pleased to announce that Dr. Karen Finch will be joining our team in early September. Dr. Finch is currently completing her child psychiatry fellowship at UCSF and will be a wonderful addition to our team of child psychiatrists at FCMH.

11. Mission Family Center

As of May 27th Mission Family Center has filled all of our vacant positions! We are very pleased to welcome Eleana Arizaga, Psychiatric Social Worker, who comes to us from the Human Services Agency and with experience as therapist in her native Peru. Maureen Gammon is a Health Worker III, with an exemplary tenure at Family Mosaic and experience as a professional coach. Gilma Cruz-Montes, ASW who began at the end of April, comes to MFC from CSOC-Legacy where she was a renowned Parent Advocate. MFC is thrilled to have these three amazing therapists on board with us! With these vacancies filled we will be able to better serve our community and further decrease our waitlist which has already been reduced by 52% since January 2014. We are also proud to share our efforts in piloting new clinical flow processes, including planning for a parent psycho-educational orientation group this summer.

12. School Based Mental Health

DPH & SFUSD embarked on a series of planning meetings with goals of identifying concrete ways in which DPH's Children, Youth & Families System of Care, and SFUSD's Special Education (SPED) and Students, Families & Community Support Services (SFCSS) can work together to effectively support the highest need students. Examples of upcoming collaboration plans for mental health services amongst the three groups include prioritizing pre-referral support for teachers and schools so that they have the skills to support African American, Latina/o, English Learners, and socio-economically disadvantaged students; mapping and analyzing mental health resources across school sites; and aligning common evaluation and services outcomes. This plan will coordinate efforts for the next two to three academic years.

13. Southeast Child/Family Therapy Center

In May we have been saying good-bye to our fabulous interns and have been planning an African American Parent support group and a summer community activity group for teens. We also wrapped up our Adventure-based Psychotherapy group which was featured on the front page of the Chronicle. One of the members said he always wanted to be famous and now he is. We are also planning to say good-bye to Shirley Leong who has worked for us for almost 14 years. She will be retiring on June 21st, 2014. We wish her a happy retirement.

14. Alternative Family Services (AFS)

AFS is a mental health and foster care agency. We strive to provide coordinated, integrated and individualized care to children and families involved in the foster care system.

AFS works with CBHS to deliver a range of services including “Therapeutic Visitation Services” (TVS), an innovative strengths-based, family-focused therapeutic program for children and youth who are recently removed from their families. TVS is a time-limited program that utilizes intensive community based or in-home family therapy and parent-child interventions to increase the support and skills families need to safely reunify and maintain family attachment. These services are intended to promote safety,

well-being, and permanency for children and families. TVS also helps to integrate key players from Child Welfare, Family Courts, Panel Attorneys, CASA Workers, etc.

Recently, AFS participated in CBHS' Katie A Planning Workgroup to develop implementation recommendations. Currently, we are beginning to support Foster Care Mental Health's efforts to conduct "front-end" CANS assessments for children who are removed from their home.

Internally, AFS is looking to working to improve the effectiveness and efficiency of our services through an "integrated model of care" (i.e., integrated foster care and mental health care). We are focusing on the Intensive Treatment Foster Care (ITFC) program, where coordinated EPSDT services and social services reduce both mental health problems and the need for higher-level care. This is an amazing time to be working with child-welfare involved families—there are many changes at the federal and state levels that should help expand access and involvement for clients.

15. A Better Way

A Better Way provides mental health, parent training, foster care, adoption and housing services to children and youth throughout the Bay Area. In San Francisco County we offer specialty mental health services to clients aged birth to 21 and their families. In addition to standard outpatient mental health care, we provide two specialized services: Therapeutic Visitation (for families pursuing reunification) and early childhood mental health care (for children aged birth to five and their caregivers). Therapeutic Visitation consists of family therapy, parent training and clinical case management specifically aimed at: (a) developing stronger parent/child connections; (b) helping children heal from past trauma; (c) helping parents understand and address Child Welfare concerns; & (d) helping families develop and demonstrate improved protective factors in progressively "real-life" settings. Our Early Childhood mental health program offers screening/assessment/dyadic therapy, Parent Child Interaction Therapy (PCIT), and infant massage training to parents and caregivers of infants and young children. Our treatment teams include Mental Health professionals and Family Partners and Child & Family Team Facilitators.

16. Mandatory DPH Annual Compliance Training – 2014

The Department of Public Health (DPH) of the City and County of San Francisco is committed to providing health care services in compliance with all federal, state, and local laws and regulations. DPH encourages and expects all employees, contractors, and agents to abide by a high standard of ethical behavior and integrity, to maintain the highest standard of clinical and business conduct, and to exercise good judgment when conducting business with or on behalf of DPH.

The DPH Compliance Office oversees a program designed to educate the workforce regarding the key compliance issues that impact their jobs, and works diligently to prevent and detect fraud, abuse, and waste. This training is part of our robust compliance program which focuses on preventing, promptly addressing, and correcting any violations of the laws, code of conduct, conflict of interest, DPH policy, etc.

The Compliance Training is **mandatory** and is delivered annually through DPH on-line training modules. **The deadline to complete the training is July 3, 2014.** Please review the attached handout carefully for additional information on how to register for the compliance training course.

(See Attachment 2)

17. User Electronic Signature Form

The Department of Public Health (DPH) Compliance Office is updating its database to include "User Electronic Signature Agreement," as required under state and federal laws. An electronically signed record is a "financial program, or medical record that (1) is required to be signed under California or Federal law, California or Federal regulation, or organizational policy or procedures, and (2) may be requested during an audit by a state or federal auditor." As such, we are asking your help to update our records by completing the attached **User Confidentiality, Security and Electronic Signature Agreement Form**. Please return the completed signed form to our office by Friday, **July 11th, 2014**.

Mailing Options:

- 1) Scan and e-mail the completed form to Carla.Love@sfdph.org OR
- 2) Fax to 415-252-3032, attn: DPH Compliance Office

(See Attachment 3)

18. SanaMente Fact Sheets Highlight California's Mental Health Movement with the Latino Community in Mind

New English- and Spanish-language fact sheets outline SanaMente, the Spanish-language companion to Each Mind Matters. The fact sheets describe the SanaMente tagline and provide information, tools and resources that are specific to English- and Spanish-speaking Latino communities across the state. View these fact sheets and learn.

Do you have news to share? Send submissions to Jenna Thompson at Jenna@paschalroth.com. The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities. Contact: Each Mind Matters at info@eachmindmatters.org.

19. Behavioral Health Homes

See the attachment on Behavioral Health Homes which highlights the opening of Mission Mental Health integrated clinic as well as the many systemic changes we are succeeding in making towards integration like:

- Team based care approach at all the mental health clinics
- Implementation of primary care EMR with improved ability to share information back and forth at Mission Mental Health and South of Market
- Creating behavioral health/primary care partnerships allows us to develop a spectrum of medical and behavioral health care that we can easily guide our patients through and match the level of intensity of services to their clinical need

(See Attachment 4)

Tell us your clinic story and we will add it to the upcoming Director's Reports.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT ANNUAL UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Annual Update: Marlo Simmons, Director, San Francisco Mental Health Services Act Programs

Mr. Joseph introduced Marlo Simmons, Director of the San Francisco Mental Health Services Act programs who will present the Annual Update and three-year plan. The MHSA legislation requires that the MHB hold a public hearing 30 days after the plan is publicly released, and publicly comment on the plan.

The Integrated Plan 2014-2017 presentation is at the end of the minutes

Ms. Simmons provided a brief overview of Proposition 63 that was enacted into law in 2005. She said the guiding principles of MHSA for San Francisco are consumer and family involvement, community collaboration, cultural competence, integrated service delivery and the wellness and recovery model.

She said the integrated plan has an expansion of services and programs for District -10, or the southeast sector of the City. Many Bayview Hunters Point, including Western Addition clients are traumatized by community violence.

The State requires 20% of the fund be allocated to prevention and early intervention. Although San Francisco is only 49 square miles in area, the City embraces and celebrates diversity. There is a coexistence of many groups from Asian Pacific Islanders, African American, Native American, Latino/Mayan, Arab Refugees, transitional age youth, to people who are homeless and the LGBTIQ community. Most of the disenfranchised people were stigmatized, marginalized, oppressed and exposed to and induced by traumas during their formative years. Their mental health issues are met through outreach and engagement and screening and assessment and service linkage.

Ms. Bohrer asked for clarification about adult full service partnership program cost per clients, who most likely participate in the MediCal program.

Ms. Simmons explained that that is not the full cost because it is not duplicated and because the overall budget is based on the number of actual clients being served. Furthermore, MHSA serves people who are homeless, who often do not receive MediCal.

Ms. Bohrer suggested that there needs to be a mention if that full cost is more because it includes MediCal billing clients. She also suggested a collaboration between MHSA and MHB to join together with the Advisory Board Committee for site visits and program reviews.

Ms. Simmons said she will talk with MHB staff.

Ms. Bohrer suggested future reports include sub-programs too and would like to know if there is a registry itemizing all services

Ms. Robinson stated that the list of contracts would show CBO's and their contracts with funding.

Ms. Bohrer inquired about the annual budget for CBHS.

Ms. Robinson stated that the City annual budget shows funding allocation for CBHS.

Dr. Patterson asked about the MHSA loan assumption program. As a University of San Francisco professor of master and PhD levels, he noticed a lack of enthusiasm in African American and Asian American students due to cost prohibition on tuition.

Ms. Simmons explained the MHSA loan assumption programs are administered by the Statewide Health and Planning Department. The department gives out funds for local programs. She shared that she has been looking at specific data about San Francisco's MHSA workforce. There were discussions of people hired full time with 20 hours for professional education. Another discussion concerned recruiting high school students to think about a career in social service fields.

Ms. Bohrer said that there is no shortage in human resources just a shortage in financial assistance to offset tuition expenses and the high cost of living in San Francisco.

Ms. Robinson believed graduate degrees tend to earn much lower wages than IT graduates.

Ms. Stevens wondered who the consumers are and what qualifications are needed to get MHSA services. She pointed out that housing for loved ones is itself a crisis in San Francisco.

Ms. Simmons said it depends on a client's needs. Some clients need an FSP. Some clients are severely mentally ill and that impacts their daily function.

There is an income requirement for housing support. Permanent housing is for FSP clients, while stabilization and transitional housing are for others. Income requirements are based on actual housing programs that set maximum incomes and residents pay rents that can range from 30%-50% of the client's income.

Ms. Stevens wanted to know how parents access services for their children.

Ms. Simmons said the MHSA-SF website provides the information.

Ms. Virginia Lewis asked about the waiting list for housing.

Ms. Simmons said the housing waiting list is very long and just re-opened recently.

Dr. David Elliott Lewis commented that there are allegations of mission drift and not addressing the needs of people with severe mental illness.

Ms. Robinson clarified that re-duplicating services and programs is not the purpose of MHSA. MHSA is designed to change the way CBHS deliver services, meaning not the same way as we have been doing before.

Unfortunately, there are vocal opponents against early intervention and prevention and reducing stigma. For example, FSPs have flex funds to help with special needs, but the stigma of mental illness deters people from seeking help. So, if the stigma of mental illness were reduced, then more clients would want to sustain engagement in mental health services. In another example, loving parents attempt to shield their children from the stigma but fail their children in the long run because they don't appreciate the value of early intervention and prevention of mental illness.

The use of peers in peer programs has been a profound additional asset, because peers not only can immediately relate to a person in crisis without much explanation but also inspire hope in recovery and wellness. Yet, when peer staffers asked for a \$200 yoga program for stress reduction and burn-out prevention during lunch, there was heavy media coverage calling for legislation and investigations. The opponents keep reminding us how we spend MHSA dollars on a \$200 yoga program, yet we remind our opponent that the \$200 yoga investment helps our peer staffers stay employed.

She added that MHSA funds cannot be used for forced treatment. Also, MHSA is not mission drifting but MHSA is mission exploring for stigma reduction, for early intervention and prevention!

Ms. Simmons said in San Francisco we have award ceremonies, but critics do not understand that most people with mental illness are disenfranchised by institutional stigmatization and discrimination. Any validation of wellness and recovery is itself an achievement for people with mental illness!

2.2 Public comment

Mr. Gause thanked Jo Robinson for her support of MHA-SF work. He recommended more public hearings and more support for peer respite care.

Member of the public commented that for critics who say MHSA-SF is not addressing the needs of people with severe mental illness, he wondered, according to Ms. Robinson statement that MHSA does not fund any forced treatment, if AOT constitutes forced treatment then proponents of AOT might not realize that MHSA funding has already precluded any services for AOT.

Member of the public said "Depression invokes doubt and suspicion and the implication that it can be overcome by personal will-power.

Clinical depression is caused by a chemical imbalance in the brain that, in turn, causes all consuming emotional pain which others who have not experienced it cannot fathom and ought not judge. Nor have they any standing to judge such awful outcomes as occurred here. There are prescription medications which work

to right the tipping ship, but many would rather suffer the falling into the cold dark abyss than face the fact and admit that they suffer a mental illness - such is the ignorant societal stigma which remains attached to this physical disease/defect.

And, it is extremely difficult talking to people about it, especially those who I was just getting to know, because they instantly look at you and your family so much differently and think that we all must be complete psychopaths, on drugs, or just straight up nuts. From the note my brother left, it was more like he thought we'd be better off without him, and was in such a low place that I don't even think he thought he was worth missing. That was one of the toughest things...to know that is how he felt, because he was really a good person. Through the years, I have become 'comfortable' with telling people about it, and if they judge me then I know then and there it's not anyone I want in my life anyway."

Mr. Tseng mentioned that there is a movement in Sacramento to reduce stigma, and wondered if there is any amendment of Proposition 63 at the legislature level to allow MHSA to provide more services.

Ms. Robinson said she has not heard of any discussion on amending the MHSA.

Ms. Bohrer asked if it is true that SF is "skewed" in MHSA fund allocation.

Ms. Simmons said that, unfortunately, the formula does not consider the homelessness in San Francisco. Thus the fund allocation did not take into account the number of people who are homeless.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION Be it resolved that the minutes for the Mental Health Board meeting of April 9th, 2014 be approved as submitted

Unanimously approved

3.3 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of May 21, 2014 be approved as submitted.

Unanimously approved

ITEM 4.0 REPORTS

For discussion

4.1 Discussion of internal functioning of the board, including attendance and participation: Terence Patterson, EdD, ABPP.

Dr. Patterson led a discussion about board attendance and participation. He would like to increase board attendance and interactions with stakeholders and community leaders to enhance the board efficacy.

4.2 Report from the Executive Director of the Mental Health Board.

Ms. Brooke reminded the board about the following:

- Watch the two hour Sunshine video then take test and sign off on the Sunshine form
- SFMHEF board meeting on Wednesday June 25, 2014 at 6 PM
- Besides the supervisor seat, four mental health seats available are: mental health professional, consumer, family member, public interest
- Conard House commendation letter of Sgt Kelly Kruger who is a Mental Health Board member

4.3 Report from the Chair of the Mental Health Board and the Executive Committee.

Mr. Joseph announced that the Executive Committee has changed its meeting time to the daytime. The next regular meeting is Thursday, June 19, 2014 at 11:00 AM in Room 424 at 1380 Howard Street. All board members as well as members of the public are welcome to attend.

Dr. David Elliott Lewis reported briefly on Laura's Law. He personally believes that the full service partnership approach is more conducive to wellness and recovery than coercive treatment of Assisted Outpatient Treatment (AOT) as proposed in the law. He added that at the May 23, 2014 Board of Supervisor meeting, Supervisor Jane Kim is offering an alternative bill to Laura's Law that will be on this November 2014 ballot. There will be a public debate on the issue on July 10th, 2014 at 301 Battery Street in the 3rd floor conference Center at 7 PM.

4.4 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Sgt. Kruger proposed board recognition of Jason Albertson from the Homeless Outreach Team (HOT).

Ms. Robinson proposed board recognition of Sandy Robison of the Pathways Program.

4.5 Report by members of the Board on their activities on behalf of the Board.

Ms. Virginia Lewis said she has been actively lobbying for the passage of Laura's Law. She dispelled the myth that Laura's Law uses coercive treatment. In fact, Laura's Law is not mandated to use involuntarily forced treatment. She believes Laura's Law is incredibly effective as corroborated and cited in recent research.

On a personal level and with her daughter's consent, (who was diagnosed with bi-polar disorder at the age of ten), she shared that her daughter wished Laura's Law had existed during her time to help her with her wellness and recovery.

Below is Ms. Virginia Lewis's recent letter to an editor

Laura's Law Saves Lives San Francisco is fortunate to have a number of fierce advocates speaking out on behalf of the cities' underserved - including the chronically mentally ill and homeless. Particularly incisive is Jennifer Friedenbach's (Director, Coalition on Homelessness) analysis concerning the public sector's woefully inadequate services available for these citizens.

However, there are other, equally concerned advocates who while agreeing with Jennifer Friedenbach and Eduardo Vega (Director, Mental Health Association of SF) on many issues (e.g., shameful lack of hospital beds, low-income housing, the private sector non-profit medical groups unwillingness to fund needed services as part of their give-back for the considerable benefits received through their non-profit status, etc.) there are other advocacy organizations who strongly disagree regarding the need for a Laura's Law (LL) /Assisted Outpatient Treatment (AOT) (AB1421, WIC 5345) program. Most importantly, the SF National Alliance on Mental Illness (NAMI), the oldest and most established advocacy group of families (parents, offspring and relatives of the seriously mentally ill) has voted to support a LL/AOT program, a voluntary program which mandates client participation in and agreement with the treatment plan. Individuals with severe and persisting mental illness (SPMI) who do not agree to participate in the program are ineligible for its considerable services such as intensive case management, housing, job training, and regular contact with a mental health professional. LL/AOT requires counties to commit to services before clients suffer multiple psychiatric hospitalizations and incarcerations. Involuntary medications are not part of Laura's Law. Per Section 5348(5) (c) of Laura's Law, "involuntary medications shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336." These sections refer to other laws already on the books which dictate how and when there can be medication over objection. (E.g. in a Riese Hearing, WIC §5345 et. seq.) Laura's Law adds no forced treatment of any kind. The program has proven in practice to break the cycle of continuous incarceration, psychiatric hospitalization or life on the streets. The 2012 Nevada County, California study of 43 SMI's 12 months before vs. 12 months after AOT noted reductions in homelessness (93.5%), hospitalization (64.2%), incarceration (21.2%); and emergency interventions (87.1%). Savings were \$213,300 – hospitalization and \$75,600 in incarceration costs. The relatively new LL program in Los Angeles County has already resulted in reductions in incarcerations (78%), hospitalizations 86% and cut taxpayer costs 40%. Consumer opposition to LL/AOT programs, as stated for example in the June 5th SF Chronicle article by Mr. Vega and Ms. Blakemore, is rooted for many members in negative and very painful 'lived experiences' with the mental health and criminal justice systems. Understandably, many members of consumer advocacy groups are suspicious and wary of any approaches which they believe are coercive. From these fears comes the belief that better outcomes result exclusively from voluntary programs, which may be true for many participants. However, there is no evidence that this is true for the small portion of the SPMI population for whom LL/AOT is designed. (e.g. Mr. Vega's letter cites 'outcomes' for persons participating in voluntary services funded through MHSA, but since eligibility for services does not depend on evidence of a diagnosis, we have no way to know if any participants can be considered people with SPMI.) Empirical evidence of positive outcomes in urban, NY State populations under Kendra's Law from 2009 and 2010 reports of long term studies of AOT confirm earlier NY OMH data – fewer, shorter psychiatric hospitalizations, a reduction in the likelihood of arrest, higher social functioning, less stigma and no increase in perceived coercion. State funding was authorized in 2013(Prop 63); hence SF County can now afford the costs of required services

under Laura’s Law. There is no reason to delay implementation of this much needed law. Virginia Lewis, LCSW Secretary, San Francisco Mental Health Board NAMI, Member SF Night Ministry (former Board member) Physician’s Organizing Committee, Member John Rouse, M.D. Associate Clinical Professor UCSF Department of Psychiatry Psychiatrist, San Francisco General Hospital Valerie Gruber, Ph.D., MPH Co-chair Northern California Commission on Psychiatric Resources

4.6 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Sgt Kruger proposed a presentation from Mark Leary on changes in the new program at San Francisco General Hospital.

Ms. Bohrer would like the July meeting be dedicated to reviewing the 2013 Retreat.

4.7 Public comment.

No comments were made.

ITEM 5.0 PUBLIC COMMENT

Ms. Brooke read two letters submitted by members (Ms. Maytte Colorado and Mr. Michael Lukso) of the public. The letters are at the end of the minutes.

ADJOURNMENT

Meeting adjourned at 8:42 PM.

Ms. Marlo Simmons’ San Francisco Mental Health Service Act Annual Update – Integrated Plan 2014-2017 presentation

June 3, 2014

Mental Health Board of
San Francisco
1380 Howard St., 2nd floor
San Francisco, CA 94103

Dear Mental Health Board:

I send you warm greetings. Mental illness runs in my family. We have never been homeless, but we have suffered suicides, divorces, domestic violence, alcohol and drug abuse and hospitalizations.

I read with interest the enclosed article where the DA seeks extra cash for a legal mental health unit. It may be part of the answer, but only a part. There needs to be training for police to de-escalate situations and handle better those suffering from mental illness. The police are the front lines. And there needs to be follow-up support, more funds for mental health caseworkers to help people committing non-criminal crimes get out of the legal revolving door.

It seems to me that the legal funding without support and housing funding will be like fashioning three new doors: the behavioral health court, the drug court, and the community justice center: to the same exits; an empty room, a jail cell or even forced institutionalization. I hope the CARES program comes into being as planned. (I saw it on your website.)

\$500,000 seems like a good investment. Can't Mayor Lee find funds for police training, attorneys and case workers, just a little? It would go a long way to solve our cities' problems.

Can it be so complicated? On the SF.Gov I see your faces. You are good people. Please find the way to work operationally across disciplines to advocate for funding and implementing an integrated approach to serve our needs.

Please support us.

Sincerely, 
Ms. Maytte Colorado
Native San Franciscan
1147 Shotwell St.
SF, CA 94110-4021

TO: THE MENTAL HEALTH BOARD OF SAN FRANCISCO,
ATTN: DR. DAVID ELLIOTT LEWIS, PH.D.,
1380 HOWARD ST., 2ND FL. 94103

TO: THE SAN FRANCISCO EXAMINER
ATTN: JONAH OWEN LAMB
225 BUSH ST. 17TH FL. 94104

CC: THE OFFICE OF THE SHERIFF OF SAN FRANCISCO
ATTN: ROSS MIRKARIMI
ROOM 456 CITY HALL 94102

CC: SAN FRANCISCO COUNTY JAIL 5
ATTN: CAPTAIN IOTA
1 MORELAND DRIVE, SAN BRUNO 94066

CC: JAIL PSYCHIATRIC SERVICES
ATTN: JANE LOVELL
850 BRYANT ST. 94103

FROM: MICHAEL LUKSO, INMATE #608533
1 MORELAND DRIVE 5M1B8T
SAN BRUNO, CA 94066

RE: COMPASSIONATE EFFECTIVENESS & HARM REDUCTION

DATE: 6-12-2014

WITHIN ONE WEEK'S TIME, BOTH THE MENTAL HEALTH BOARD OF SAN FRANCISCO (MHBSF) AND THE SAN FRANCISCO EXAMINER (SFE) VISITED THE PSYCHIATRIC UNIT OF SAN FRANCISCO'S COUNTY JAIL IN SAN BRUNO. THE REASON I'M ADDRESSING THIS LETTER TO BOTH OF THE VISITORS

IS THAT I HEARD THE SAME QUESTIONS FROM EACH AND I'D LIKE TO ANSWER THEM.

MY NAME IS MICHAEL LUKSO AND, FIRST OF ALL, I WANT TO THANK YOU FOR VISITING THE JAIL. I FOUND YOUR VISITS TO BE ENCOURAGING BECAUSE THEY INDICATE THAT THE BOARD, THE EXAMINER, THE SHERIFF'S DEPARTMENT AND JAIL PSYCHIATRIC SERVICES (JPS) ARE CONCERNED WITH THE WELL-BEING OF INMATES. I SPOKE BRIEFLY WITH THE MHBSF IN POD 3A, PSYCHIATRIC'S ADMINISTRATIVE SEGREGATION UNIT, WHILE I WAS WORKING THERE CLEANING THE POD ON FRIDAY, MAY 30, 2014. SUBSEQUENTLY, I ATTENDED THE MEETING ON WEDNESDAY, JUNE 4TH, 2014, HELD BY THE EXAMINER IN POD 1B, JAIL'S PSYCHIATRIC UNIT WHERE I CURRENTLY RESIDE. IN THIS LETTER, I'D LIKE TO ANSWER TWO QUESTIONS:

1. 'WHAT IS A TYPICAL DAY LIKE FOR AN INMATE IN THE PSYCHIATRIC POD?' AND,
2. 'WHAT OTHER PROGRAMS COULD BE ADDED TO THE CURRENT CURRICULUM OF REHABILITATION?'

EVERY DAY BEGINS AT 3:30 AM WITH BREAKFAST. THEN, WE ARE LOCKED IN OUR CELLS FROM 4 AM TO 8 AM. LUNCH IS SERVED AT 9:30 AM AND WE ARE LOCKED IN OUR CELLS FROM 10 AM TO 11 AM. NEXT, WE HAVE AN 11 AM THERAPY GROUP LIKE SOCIAL SKILLS OR DIALECTICAL BEHAVIOR

THERAPY (DBT). THESE GROUPS ENCOURAGE BUILDING INTERPERSONAL SKILLS THROUGH ROLE-PLAYING OR GAMES LIKE BASKETBALL. BETWEEN 12 AND 1, WE TYPICALLY HAVE A CLASS THAT PROMOTES A HEALTHY MIND/BODY CONNECTION. ON MONDAYS, A VOLUNTEER FROM THE BUDDHIST CENTER LEADS A MEDITATION CLASS. ON TUESDAYS AND THURSDAYS, WE HAVE A YOGA CLASS. FROM 1 PM TO 2 PM WE HAVE CLASSES THAT ADDRESS ISSUES ~~ARE~~ OF MENTAL HEALTH AND SUBSTANCE USE. ON MONDAY, WE HAVE A MATRIX MODEL GROUP AND ON THURSDAYS WE HAVE A GROUP THAT DISCUSSES 12-STEP IN THE CONTEXT OF MENTAL HEALTH. WE ARE LOCKED IN OUR CELLS FROM 2 PM TO 4 PM, UNTIL OUR DINNER TRAYS ARRIVE. AFTER DINNER, AROUND 4:30, WE HAVE FREE TIME TO PLAY GAMES, OR WATCH A MOVIE UNTIL WE ARE LOCKED IN FROM 6 PM TO 7 PM. OUR LAST STRETCH OF ~~A~~ FREE TIME IS FROM 7 PM TO 9:30 PM. DURING THIS TIME, INMATES CALL LOVED ONES, PLAY A GAME OR WATCH A MOVIE. I'LL OFTEN PLAY SCRABBLE BUT I ALSO USE THE TIME TO WRITE LETTERS SUGGESTING THAT HARM REDUCTION BECOME PART OF JAIL'S CURRICULUM.

THE REASON I PROMOTE HARM REDUCTION IS THAT IT IS PART OF ~~A~~ WHAT I CALL A COMPASSIONATELY EFFECTIVE SOLUTION. COMPASSIONATE EFFECTIVENESS IS

A TERM I COINED AROUND 2005 TO DESCRIBE MY EXPERIENCE WITH BEHAVIORAL HEALTH COURT AND HARM REDUCTION. THAT COMPASSIONATE AND EMPOWERING PROGRAMS SAVE TAXPAYERS' MONEY IS THE STARTLING DISCOVERY I MADE WHILE PRACTICING HARM REDUCTION IN BEHAVIORAL HEALTH COURT. FOR SOMETHING TO BE COMPASSIONATELY EFFECTIVE IT MUST MEET THREE CONDITIONS:

1. IT MUST DIRECTLY OR INDIRECTLY RESULT IN REDUCING COSTS TO TAXPAYERS OR AN ORGANIZATION. FOR EXAMPLE, IT IS COMPASSIONATELY EFFECTIVE TO REHABILITATE INMATES TO THE HIGHEST LEVEL OF MENTAL HEALTH AND AUTONOMY THEY CAN SUSTAIN WITH THE LEAST AMOUNT OF CITY/COUNTY FUNDED PROGRAM SUPPORT. THIS, OF COURSE, HAS A DIRECT IMPACT ON TAXPAYER COST. AN EXAMPLE OF AN INDIRECT IMPACT IS ANY ACTIVITY OR PROGRAM THAT GENERATES A SENSE OF SELF RESPECT AND MENTAL HEALTH THAT IMPACTS THE BOTTOM LINE. FOR INSTANCE, WHEN A DEPUTY TREATS ME WITH RESPECT, I'M REMINDED TO DO THE SAME TO MYSELF. WHEN I DO THAT, I MAKE BETTER CHOICES AND DECISIONS, NOT SELF-DESTRUCTIVE ONES THAT NECESSITATE A COSTLY CITY/COUNTY INTERVENTION.
2. THE SECOND CONDITION IS THAT IT MUST BE ROOTED IN COMPASSION, ~~OR~~ EMPATHY OR RESPECT. THE POINT

HERE IS TO ENCOURAGE RENABILITATION AND REDUCE THE NEED FOR COSTLY CORRECTIONAL OR PUNITIVE ACTIVITIES. FOR EXAMPLE, DEPUTIES WITH A BROADER UNDERSTANDING FOR A DIVERSITY OF MENTAL HEALTH ISSUES HELP REDUCE UNNECESSARY INTERVENTIONS OR RE-ASSIGNMENTS OF ~~AD~~ INMATES TO A SAFETY CELL WHICH INCREASES THE OPERATING COSTS OF ~~THAT~~ ^{THOSE} INMATES.

3. LASTLY, IT MUST EMPOWER THE INDIVIDUAL AND LAY IN PLACE A BEHAVIOR CHANGE THAT IS WILLINGLY SUSTAINED OR REPEATED. INTRAVENOUS DRUG USERS, FOR INSTANCE, MAY NOT WILLINGLY EMBRACE ABSTINENCE, BUT THEY OFTEN EMBRACE NEEDLE EXCHANGE. THEY'LL REPEATEDLY VISIT A NEEDLE EXCHANGE FACILITY TO TAKE CHARGE OF THEIR HEALTH. AT THE SAME TIME, NEEDLE EXCHANGE SAVES THE CITY/COUNTY SIGNIFICANT SUMS OF MONEY BECAUSE IT REDUCES THE COST OF CITY FUNDED HEALTHCARE PROGRAMS THE IV DRUG USERS OFTEN ACCESS, BY PREVENTING BLOOD BORN DISEASES LIKE HEPATITIS AND HIV.

BEGINNING IN 2007, UNTIL 2013, I WAS ON COVARD HOUSE'S COMMUNITY SUPPORTED SELF MANAGEMENT COMMITTEE WITH RICHARD HEASLEY, THE ORGANIZATION'S EXECUTIVE DIRECTOR. THERE, I LEARNED THAT ANY PROGRAM THAT UTILIZES SAN FRANCISCO

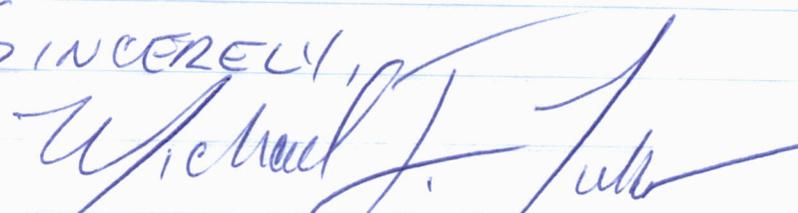
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CITY/COUNTY TAXPAYER DOLLARS HAD TO PROVIDE A HARM REDUCTION OPTION FOR CLIENTS. SINCE COUNTY JAIL UTILIZES TAXPAYER DOLLARS, IT SEEMS TO ME THAT THEY NEED TO PROVIDE A HARM REDUCTION OPTION FOR INMATES AS WELL. BUT EVEN IF I'M INCORRECT ABOUT THE REQUIREMENTS, IT IS STILL THE COMPASSIONATELY EFFECTIVE THING TO DO.

BUT FOR THOSE WHO WOULD STILL DISAGREE, I WOULD ASK THE FOLLOWING QUESTION: 'WHO IN JAIL WITH A HISTORY OF SUBSTANCE USE PROBLEMS WOULD YOU WILLINGLY BET YOUR ENTIRE LIFE'S SAVINGS ON STAYING SOBER WHEN RELEASED? THEN WHY DO WE PRETEND THAT IS GOING TO HAPPEN? WHY DON'T WE TEACH INMATES HARM REDUCTION TECHNIQUES THAT WILL HELP KEEP THEM OUT OF JAIL?'. IN THIS CONTEXT, COMPASSIONATE EFFECTIVENESS IS EXPRESSED THROUGH HARM REDUCTION'S ABILITY TO REDUCE RECIDIVISM. WITHOUT A HARM REDUCTION OPTION FOR INMATES, A LARGE SUM OF TAXPAYER MONEY IS LITERALLY BEING WASTED ON HIGHER RATES OF RECIDIVISM AND CITY/COUNTY HEALTHCARE INTERVENTIONS.

SO, TO ANSWER THE MHBSPF'S AND THE EXAMINER'S QUESTIONS, I BELIEVE IT WOULD BE TO EVERYONE'S ADVANTAGE IF HARM REDUCTION TECHNIQUES WERE TAUGHT WITH EQUAL TIME AND DEPTH AS 12 STEPS. THAT WOULD MEAN HAVING TWO INFORMAL HARM REDUCTION SUPPORT GROUPS, ONE FOR ALCOHOL AND ONE FOR CRYSTAL METH, AS WELL AS A FORMAL THERAPY GROUP LED BY A JPS STAFF MEMBER THAT SPECIFICALLY TEACHES WHAT HARM REDUCTION IS AND HOW IT APPLIES TO DUALY DIAGNOSED INMATES.

FINALLY, I'D LIKE TO ONCE AGAIN THANK THE MENTAL HEALTH BOARD, THE SF EXAMINER, THE SHERIFF'S DEPARTMENT AND ESPECIALLY JPS FOR DEMONSTRATING YOUR CONCERN FOR OUR WELL-BEING.

SINCERELY,

 MICHAEL F. YUKSO

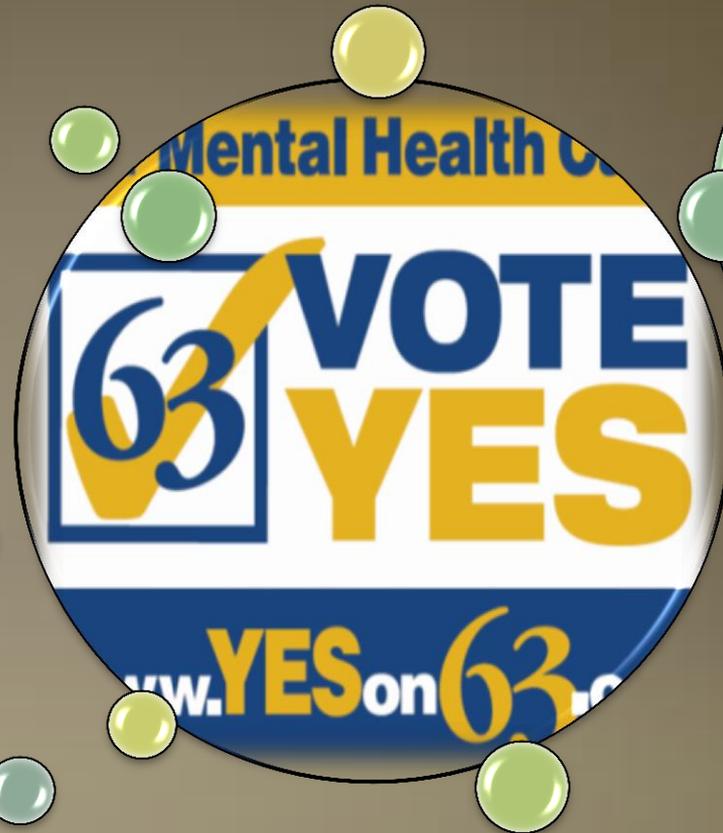
San Francisco
Mental Health
Services Act



MHSA

INTEGRATED
PLAN
2014-2017

Enacted
into law
in 2005



1% tax on
income
over \$1
million

Designed to
transform
the mental
health
system

*“As my life got bigger,
my illness got smaller”*

- MHSA Program Participant

Guiding Principles

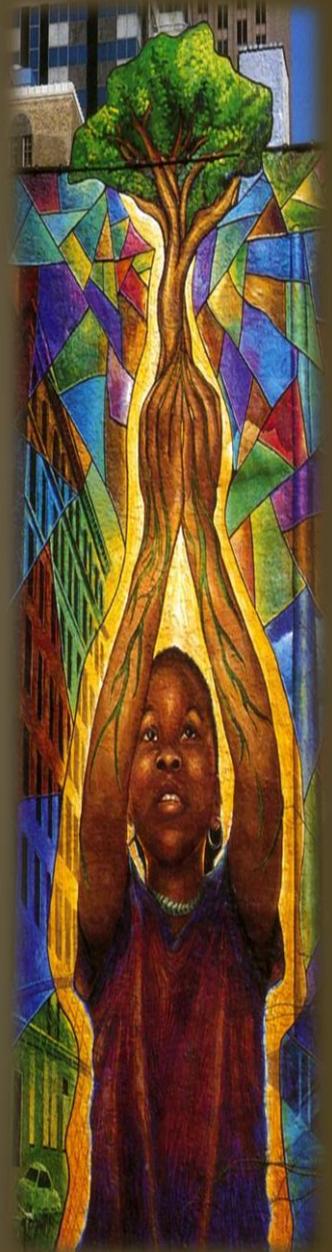
Consumer and Family Involvement

Community Collaboration

Cultural Competence

Integrated Service Delivery

Wellness and Recovery Model



A single plan that brings together all MHSA components

Guided by State regs, MHSA principles and Community Planning Process (CPP)

**MHSA
Integrated
Plan**

Identifies new investments planned for fiscal year 2014-15 and beyond

Describes service categories, programs, target populations, cost per client and outcomes

Community Program Planning

MHSA Communication Strategies

- Make information available on MHSA website
- Provide regular updates to stakeholders
- Share implementation highlights in monthly CBHS Director's Report

MHSA Advisory Committee

- Identify priorities
- Monitor implementation
- Provide feedback

Program Planning and RFP Selection Committees

- Assess needs and develop service models
- Review program proposals and interview applicants
- Select most qualified providers

Program Implementation

- Collaborate with participants to establish goals
- Promote peer and family employment
- Promote the engagement of peers in program governance

Evaluation

- Promote peer and family engagement in evaluation efforts
- Collect data on participant satisfaction

MHSA Service Categories



#1: Recovery-Oriented Treatment Services

#2: Mental Health Promotion & Early Intervention Services

#3: Peer-to-Peer Support Services

#4: Vocational Services

#5: MHSA Housing Program

#6: Behavioral Health Workforce Development

#7: Capital Facilities/Information Technology

*** All categories include programs funded with Innovation (INN) funding.**



Behavioral Health Access Center (BHAC)

Full Service Partnership (FSP) Programs

- 0-5 FSP
- Expand TAY and Adult FSPs

Recovery Oriented Treatment Services

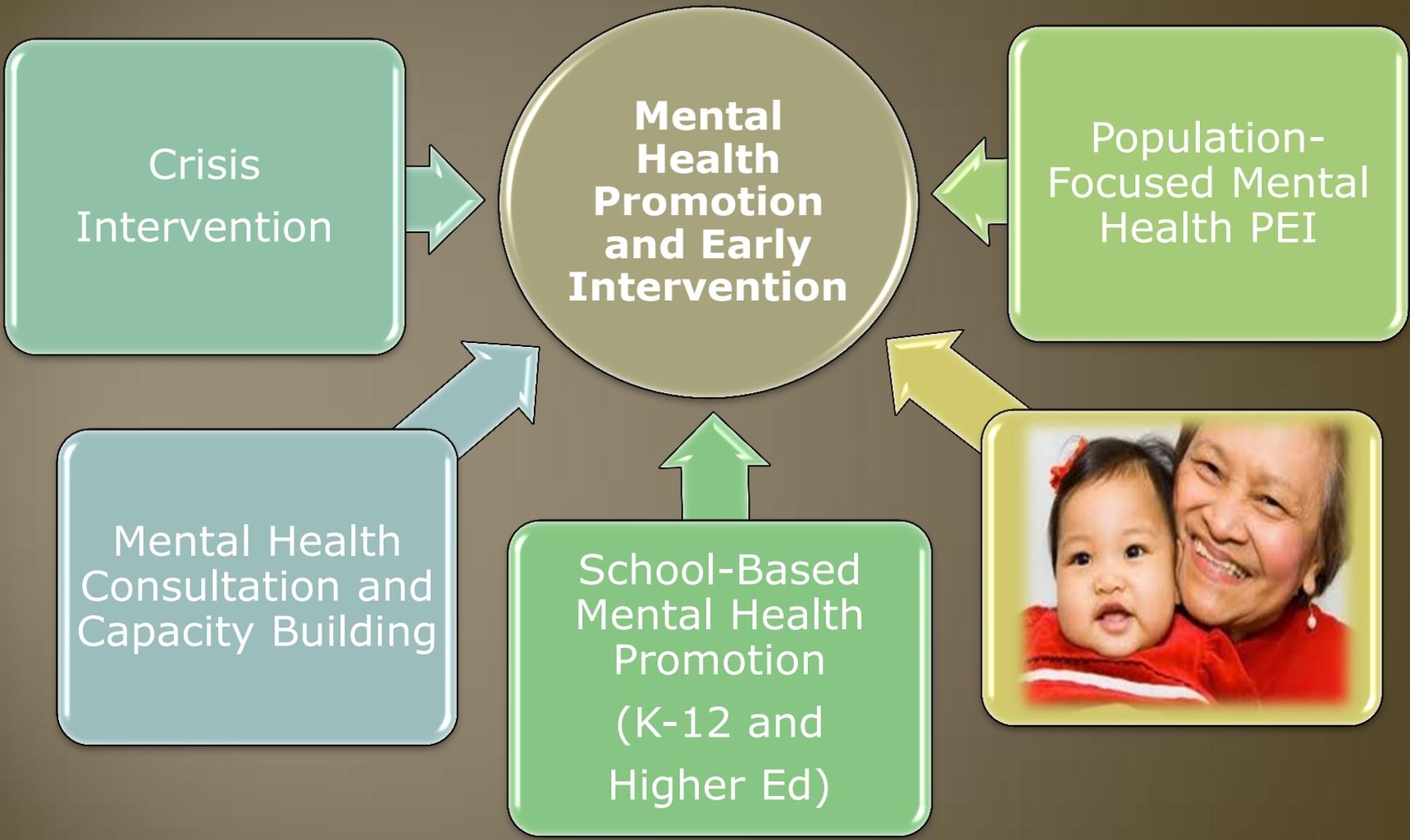
Trauma Recovery Programs

- Expand treatment in D-10

Dual Diagnosis Residential Treatment

Primary Care and Juvenile Justice Integration

Early Psychosis Program



- Asian and Pacific Islander (API)
- African American
- Native American
- Latino/Mayan
- Arab Refugees
- Homeless Adults
- Homeless or System Involved TAY (18-24)
- LGBTQ



Population-Focused Mental Health Promotion and Early Intervention



- Outreach and Engagement
- Screening and Assessment
- Wellness Promotion
- Individual and Group Therapeutic Services (short-term)
- Service Linkage



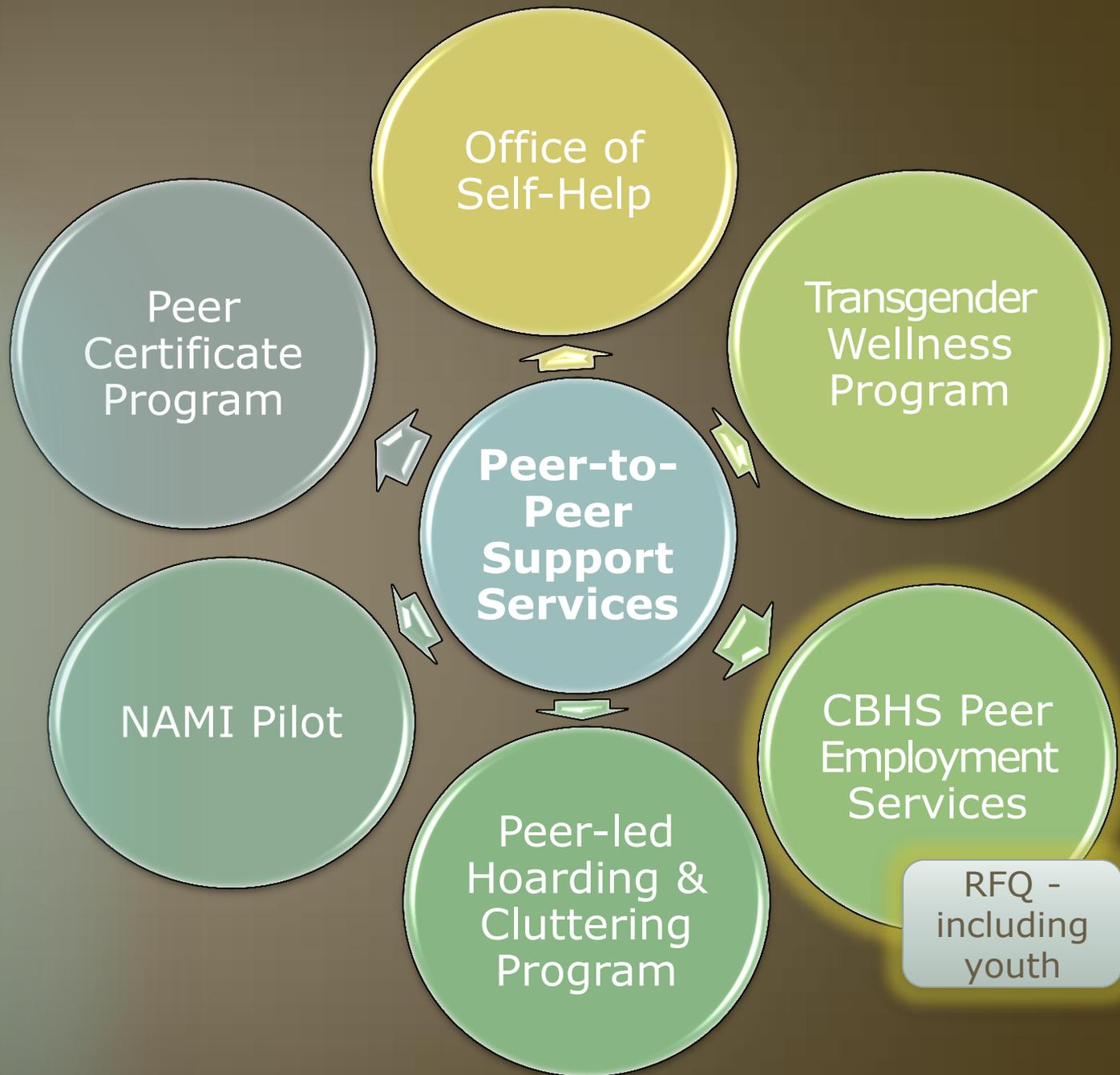


PEOPLE MAY
DOUBT

WHAT YOU SAY,
BUT THEY WILL

believe,

WHAT YOU DO.



RFQ -
including
youth



Remodeling



Information Technology (IT)

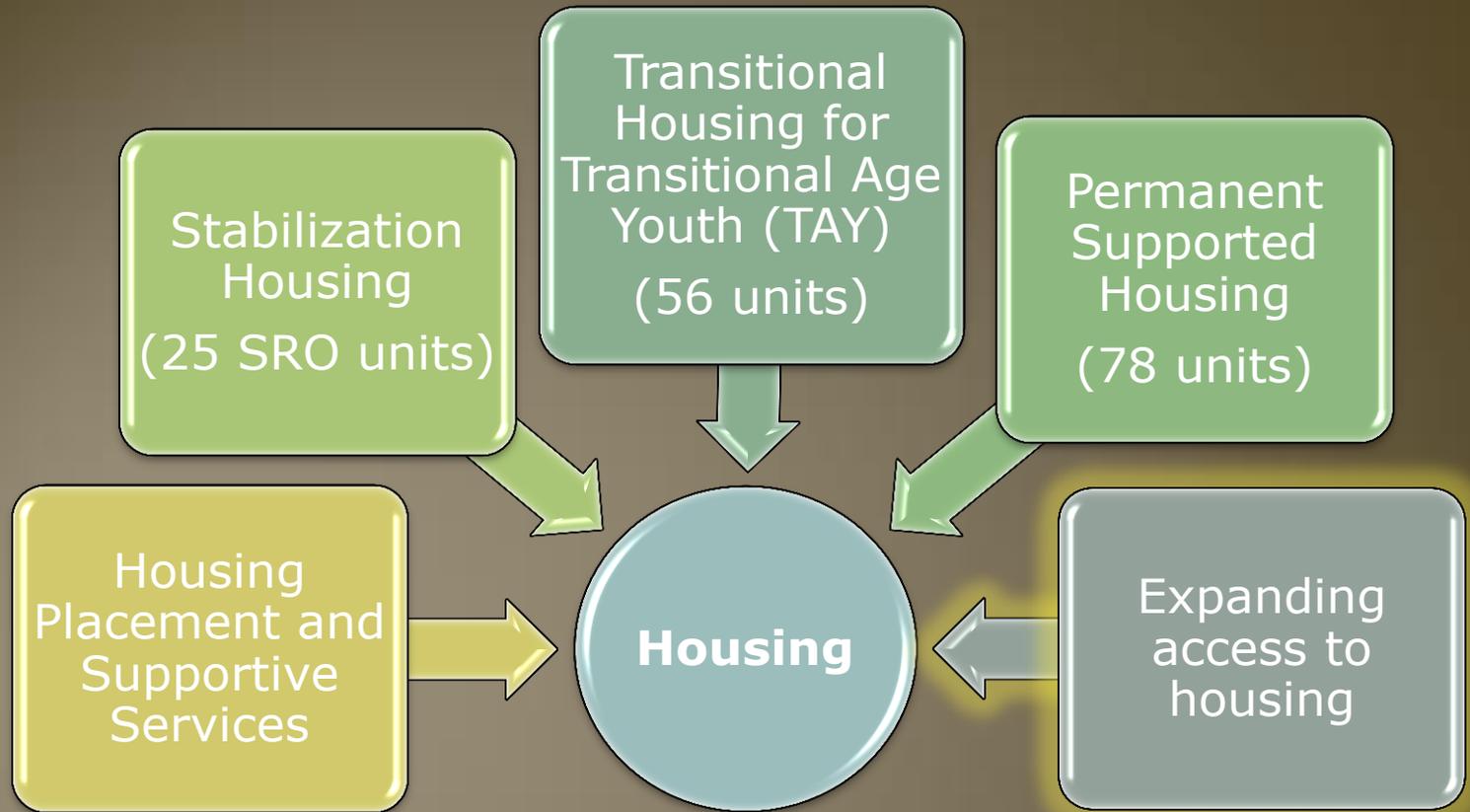


Peer-to-Peer Behavioral Health Services



Nutrition and Cooking

Vocational Services



Workforce Development

Financial Incentive Programs (state funded)

Mental Health Loan Assumption

Licensed Mental Health Service Provider Education Program

Residency and Internship Programs

Child and Adult Psychiatry Fellowship

Intern Coordinator

Mental Health Career Pathway

Summer Bridge

City College Certificate Program

John O'Connell

Address workforce disparities

Training and Technical Assistance

Seeking Safety, WMR, Medicinal Drumming

Capacity Building for Youth Providers and 12N

Trauma Training Institute

MH Training Program for Outreach Workers

Capital Facilities



- Silver Ave
- Redwood Center
- Sunset Mental Health
- Tom Waddell Urban Health Clinic

Southeast Health Center

Expanding Capital Improvements - SOMA

Information Technology



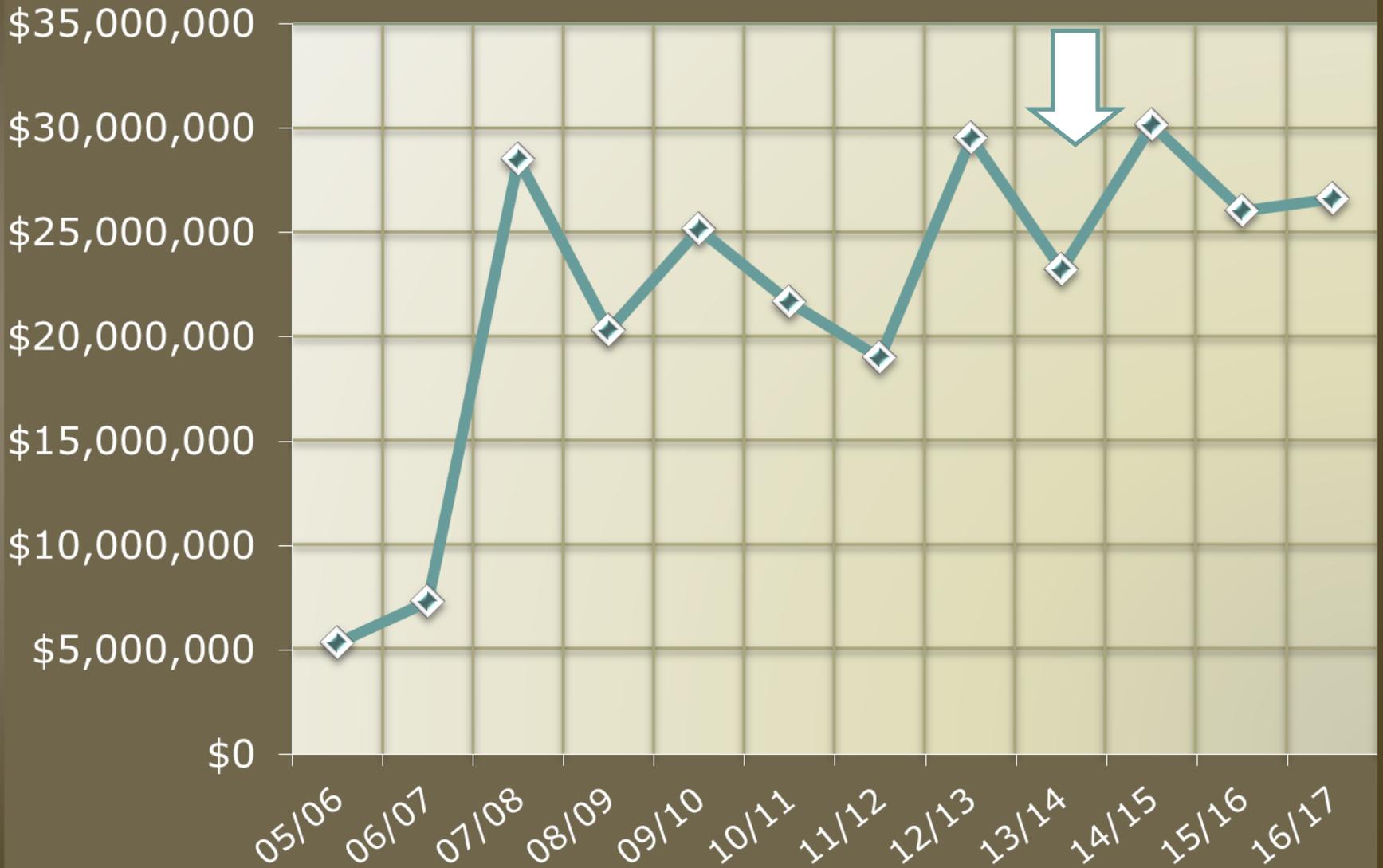
Vocational IT

Consumer Portal

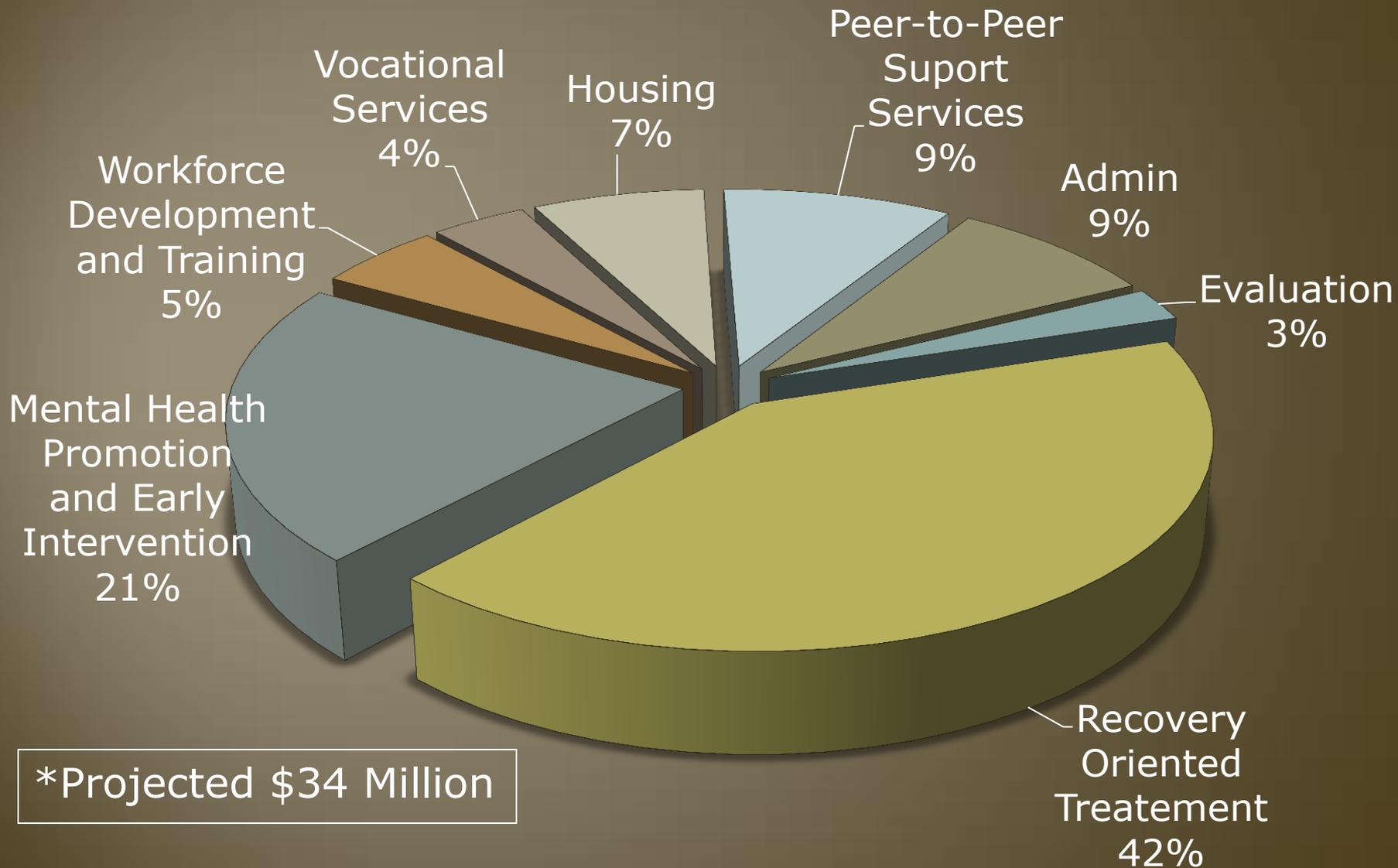
System Enhancements

San Francisco MHSR Revenue by FY

***13/14 and beyond are estimated**



MHSA 14/15 Budget* by Service Category



*Projected \$34 Million



**Questions?
Comments?**

Marlo Simmons, MPH

MHSA Director

255-3915 or marlo.simmons@sfdph.org

SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)
INTEGRATED PLAN *At-A-Glance*

S.F. MHSA INTEGRATED Service Categories	RFP likely Summer/Fall 2014	MHSA Program Name (by funding component)	MHSA Program Summary	Projected FY 14/15 Budget	Integrated Plan Highlights
Community, Services and Supports (CSS) <i>80% of total MHSA revenue (after INN calculated)</i> <i>51% must be allocated to serve FSP clients</i>					
				Total CSS Budget: \$21,427,522	
Recovery Oriented Treatment Services	X	CSS Full Service Partnership 1. CYF (0-5)	A central component of MHSA, Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing “whatever it takes” to assist individuals diagnosed with SMI or SED to lead independent, meaningful, and productive lives. Ten FSP programs serve a diverse group of clients in terms of age, race/ethnicity, and stage of recovery. Services include integrated, mental health treatment; intensive case management and linkage to essential services; housing and vocational support; and self-help support.	\$ 400,000	* Allocated \$400K (plus additional EPSDT revenue TBD) to develop new FSP program for children 0-5 and their families.
Recovery Oriented Treatment Services		CSS Full Service Partnership 2. CYF (6-18)		\$ 1,231,387	
Recovery Oriented Treatment Services		CSS Full Service Partnership 3. TAY (18-24)		\$ 1,076,468	* FSP expansion described below includes new Case Manager for TAY.
Recovery Oriented Treatment Services		CSS Full Service Partnership 4. Adults (18-59)		\$ 5,030,795	* Allocated \$600K (plus additional MediCal revenue TBD) to expand clinical capacity, housing access and peer supports. * Expansion includes Cantonese speaking Case Manager and two Case Managers to serve forensics population. * Transferred SF First FSP staff to new TRANSITIONS FSP focused on client transitions from hospital discharge to engagement in outpatient clinic care.
Recovery Oriented Treatment Services		CSS Full Service Partnership 5. Older Adults (60+)		\$ 688,328	

SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)
INTEGRATED PLAN *At-A-Glance*

S.F. MHSA INTEGRATED Service Categories	RFP likely Summer/Fall 2014	MHSA Program Name (by funding component)	MHSA Program Summary	Projected FY 14/15 Budget	Integrated Plan Highlights
Housing		CSS Full Service Partnership Housing Program	Available to Full Service Partnership clients, the FSP Housing Program provides access to emergency stabilization housing, transitional housing for TAY, permanent supportive housing and other supports designed to help FSP participants gain access to and maintain housing. 71 units currently occupied - 9 new units still in the pipeline.	\$ 614,548	<ul style="list-style-type: none"> * Conducting a feasibility study of different models to expand access to housing. * Evaluating the impact of housing with a focus on permanent placements. * Purchasing 3 new units (Rosa Parks Sr. Apts) with interest earned from initial housing allocation.
Recovery Oriented Treatment Services		CSS Other Non-FSP 1. Behavioral Health Access Center	The Behavioral Health Access Center (BHAC) is a portal of entry into San Francisco's overall system of care. BHAC co-locates the following five behavioral health programs: 1) Mental Health Access for authorizations into the Private Provider Network, 2) the Treatment Access Program for assessment and placement into addiction and dual diagnosis treatment, 3) the Offender Treatment Program to place mandated clients into addiction and dual diagnosis treatment, 4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy, and 5) the CBHS Pharmacy. The Pharmacy, among its many services, provides specialty behavioral health medication packaging and serves as a pharmacy safety net for all CBHS clients.	\$ 1,004,689	<ul style="list-style-type: none"> * Expanded bilingual (Cantonese) pharmacy capacity
Recovery Oriented Treatment Services	X	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with coworkers, peers, and family members. PREP treatment services include: 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.	\$ 931,770	<ul style="list-style-type: none"> * Plan to strengthen linkage between PREP program and SF General Hospital, Psych Emergency Services (PES) and outpatient clinics.
Recovery Oriented Treatment Services	X	CSS Other Non-FSP 3. Trauma Recovery	The Trauma and Recovery Project addresses the need for community-based, client-driven behavioral health intervention for individuals, families and communities who are impacted by violence. Services include outreach, assessment, crisis and short-term counseling, case management and mental health consultation to community organizations. The focus of treatment is recovery from traumatic response and the symptoms that stem from chronic and/or complex trauma.	\$ 647,225	<ul style="list-style-type: none"> * Planning to expand access to trauma treatment services in Southeast San Francisco (D-10) by working with a community coalition to develop a new program model. Partnering with Trauma Training Initiative staff to oversee this effort.

SAN FRANCISCO MENTAL HEALTH SERVICES ACT (SFMHSA)
INTEGRATED PLAN *At-A-Glance*

S.F. MHSA INTEGRATED Service Categories	RFP likely Summer/Fall 2014	MHSA Program Name (by funding component)	MHSA Program Summary	Projected FY 14/15 Budget	Integrated Plan Highlights
Recovery Oriented Treatment Services		CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	Behavioral health clinicians work as a member of a primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based and practical interventions, consultation to primary care team members, and self- and chronic-care management services. This program also supports primary care clinicians providing services in mental health clinics.	\$ 1,474,087	* Contributing to the development of Behavioral Health Homes (BHH), Behavioral Health Clinics where clients will receive an increased level of comprehensive team-based care.
Recovery Oriented Treatment Services	X	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	All youth detained for more than 72 hours at San Francisco’s Juvenile Justice Center are assessed for behavioral health needs. Any identified needs are presented to the Juvenile Probation Department to be addressed in case planning with local courts. The program connects and supports the engagement of youth and families in appropriate and effective mental health services. MHSA also funds psychiatric services in the Youth Guidance Center Clinic – a clinic providing free primary health care, case management and psycho-social services to incarcerated youth ages 8-18.	\$ 580,192	* Expanded to serve youth on probation attending Civic Center High School.
Recovery Oriented Treatment Services		CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	Dual diagnosis residential treatment and support is provided to individuals who do not have MediCal coverage and who would otherwise not be eligible for services. An integrated model of care allows clients to receive the full spectrum of services, including: substance abuse treatment, mental health services, primary medical care, case management, parolee services, workforce development, and gender-specific residential treatment homes for adults with co-occurring disorders.	\$ 85,309	* Will explore how ACA impacts need to fund services for non-MediCal population.
Peer-to-Peer Support Services	X	CSS Other Non-FSP 7. Peer-to- Peer Supports: Clinic and Community-Based	Peer-to-Peer Support Services provides individuals with lived experience in the mental health system the opportunity to assist their peers in developing the skills necessary to pursue meaningful roles in their lives. Many peer-support staff are graduates of the Peer Specialist Mental Health Certificate, a 12-week program designed to prepare consumers and/or family members with the skills & knowledge for entry-level employment in the behavioral/mental health system. In addition to the peer certificate programs, MHSA also funds a peer-run drop-in center and NAMI peer-led support and education groups in various CBHS clinics.	\$ 2,468,875	

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S.F. MHSA INTEGRATED Service Categories	RFP likely Summer/Fall 2014	MHSA Program Name (by funding component)	MHSA Program Summary	Projected FY 14/15 Budget	Integrated Plan Highlights
Vocational Services	X	CSS Other Non-FSP 8. Vocational Services	Vocational services assist consumers and family members in securing and maintaining meaningful employment. Vocational services include job coaching, situational assessment, trainings, and job placement services in the areas of 1) Information Technology 2) Basic Construction 3) Hospitality/Culinary and 4) Behavioral Health Services.	\$ 228,252	* First Impressions is a new (recently approved) INN project.
Housing		CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The 25 ESUs are located within three single room occupancy (SRO) hotels in San Francisco. The units are available to clients referred by Full Service Partnership programs, Intensive Case Management programs and Central City Hospitality House.	\$ 393,637	
Housing		CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (25% FSP)	MHSA funding has allowed for Direct Access to Housing to expand capacity to serve MHSA clients with the addition of an Intake Coordinator, focused on placing clients in the setting most appropriate to their needs, and a Nurse Practitioner.	\$ 260,508	
Housing		CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	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.	\$ 1,089,465	
Recovery Oriented Treatment Services		CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	In recognition of disparities in access for certain populations, this program expands the staffing capacity at outpatient mental health clinics to better meet the treatment needs of target populations such as older adults and monolingual communities.	\$ 338,323	* Planning to hire a Wellness and Recovery Program Manager to collaborate with providers and stakeholders to develop, implement and evaluate projects promoting wellness and recovery practices across the CBHS Systems of Care.
		CSS Admin	The Admin budget includes indirect administrative costs that are 'incurred for a common or joint purpose and cannot be readily identified as benefiting only one MHSA program or project'. These costs typically include salaries and benefits of employees 1) working to administer MHSA funding (e.g. accounting, contracts); 2) working to further the principles of MHSA (e.g. cultural competence); 3) managing program planning and technical assistance activities. Admin expenses also include Community Program Planning expenses as well as MHSA operating expenses not related to direct client services (e.g. rent, utilities)	\$ 2,222,592	

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		CSS Evaluation	Direct and indirect costs associated with collecting, analyzing, and using information to answer questions about MHSA projects, policies and programs, particularly regarding their effectiveness and efficiency and whether the program goals are appropriate and useful.	\$ 661,071	
Prevention and Early Intervention (PEI) <i>20% of MHSA revenue (after INN calculated)</i> <i>* Plan proposes allocating 2% of PEI funding to CalMHSA for statewide PEI programs</i>					
		Total PEI Budget: \$7,278,578			
Mental Health Promotion and Early Intervention	X	PEI 1. Stigma Reduction	Sharing Our Lives, Voices and Experiences (SOLVE) is a stigma elimination program. SOLVE trains people in the community who have been living with mental health challenges to share their personal experiences.	\$ 201,469	* Includes funding for 4th Annual MHSA Recovery Award Ceremony and consumer engagement activities and training for MHSA Advisory Committee.
Mental Health Promotion and Early Intervention	X	PEI 2. School-Based Mental Health Promotion (K-12)	School-Based Mental Health Promotion – a collaboration of community-based organizations and San Francisco K-12 campuses – applies school-based best practices that address non-academic barriers to learning. With public schools serving as hubs, this initiative offers a range of supports and opportunities for children, youth, and their families to support student success by combining the full spectrum of prevention, early intervention, and linkages to behavioral health services.	\$ 1,119,589	
Mental Health Promotion and Early Intervention	X	PEI 3. School-Based Mental Health Promotion (Higher Ed)	Student support services are designed to increase university access and enrollment, enhance retention and maximize graduation rates among those at risk for mental illness, particularly members of underserved and underrepresented communities, and their family members who are preparing for careers in the public behavioral health field.	\$ 417,226	

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Mental Health Promotion and Early Intervention	X	PEI 4. Population Focused Mental Health Promotion and Early Intervention	Population-focused mental health promotion services are typically delivered in community-based settings where mental health services are not traditionally provided. This program supports activities including, outreach and engagement, mental health promotion and psycho-social education, behavioral health screening and assessment, referrals and linkage, and short-term therapeutic services. Target populations include: * African American * Asian and Pacific Islander (API) * Native American * Latino/Mayan * Arab Refugees * Homeless Adults * Homeless or System Involved TAY (18-24) * LGBTQ * Socially Isolated Older Adults	\$ 3,597,372	* Working with providers to developing shared performance objectives for all population-focused mental health promotion programs. * Older Adult Peer-to-Peer program (INN-15) being developed in partnership with Curry Senior Center.
Mental Health Promotion and Early Intervention	X	PEI 5. Mental Health Consultation and Capacity Building	The Mental Health Consultation and Capacity Building PEI subcategory is comprised of the following two programs: (1) Early Childhood Mental Health Consultation Initiative (ECMHCI) and (2) Youth Agency Mental Health Consultation (YAMHC). The ECMHCI is grounded in the work of mental health professionals who provide support to children, parents, and caregivers of San Francisco's youngest residents between the ages of 0-5. ECMHCI services are delivered in a variety of settings, including center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers and substance abuse treatment centers. YAMHC provides consultation services to agencies who serve youth who are involved in the juvenile justice system or at-risk of being involved in the juvenile justice system.	\$ 1,131,855	
Mental Health Promotion and Early Intervention		PEI 6. Comprehensive Crisis Services	Comprehensive Crisis Services (CCS) is a multidisciplinary, multi-linguistic program that provides acute mental health and crisis response services to children and adults. In addition to responding to MH crisis, the team also responds to incidence of gun violence.	\$ 526,404	
		PEI Admin	see CSS Admin for description admin expenses.	\$ 141,261	

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		PEI Evaluation	See CSS Evaluation for description evaluation expenses.	\$ 143,401	* Activities include a focused evaluation of K-12 School-Based Programs.
Innovation (INN) <i>5% of total MHSA revenue</i>				Total INN Budget: \$2,766,085	
Peer-to-Peer Support Services		INN 7. Peer Response Team (part of Peer-to-Peer Support Services)	The Peer Response Team (PRT) was created to provide peer support and assistance navigating the community and systems of care for individuals dealing with hoarding and cluttering challenges.	\$ 215,735	
Mental Health Promotion and Early Intervention	X	INN 8. Collaboration with the Faith Community (part of Population Focused Mental Health Promotion)	Engages faith-based organizations and families in Bayview/Hunter's Point and Visitacion Valley in order to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers.	\$ 150,000	* Partnering with DPH Population Health and Prevention to explore developing a new model of peer support, recruiting peers from the African American churches in the Southeast.
	X	INN 9. Mini Grants	A community-run grant making program modeled on the funding methodology commonly employed by venture capitalists in the for-profit sector and donor advised funds in a community foundation. Approved through the original INN Plan, this program has yet to be implemented.	\$ 500,000	* Focused on priority populations * Details TBD though CPP.
Workforce Development	X	INN 11. Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) (part of Vocational Services)	This pilot program adapted an existing nutrition and exercise protocol into a community mental health setting and integrated shopping and cooking skills training. This program educates consumers on atypical antipsychotics about the connection between diet and health, how to shop based on what is locally available, healthy cooking, and how to exercise to improve fitness and health.	\$ 233,903	
Recovery Oriented Treatment Services		INN 12. Building Bridges Clinic/School of Linking Project (part of Primary Care and Behavioral Health Integration)	Building Bridges, now in its second year, was designed to test a staffing model designed to promote interagency collaboration between DPH Community Health Programs for Youth (CHPY) clinics and San Francisco Unified School District to develop a streamlined system for professional linkages and referrals for care to better meet the behavioral health needs of youth living in the southeast neighborhoods of San Francisco. Funding supports new mental health staff at Balboa Teen Health Center (BTHC), 3rd Street Youth Center and Clinic, and Hawkins Clinic.	\$ 405,361	

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Vocational Services		INN 14. First Impressions (part of Vocational Services)	First Impressions (FI) is a basic construction and remodeling vocational program that will assist mental health consumers in learning marketable skills, receive on-the-job training and mentoring, and secure competitive employment in the community.	\$ 300,000	
Mental Health Promotion and Early Intervention		INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults (part of Population Focused Mental Health Promotion)	This locally approved INN funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services in a network of organizations providing health, nutrition and social supports to seniors. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see Plan - Appendix B)	\$ 200,000	* (Updated) INN proposal.
Mental Health Promotion and Early Intervention		INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals (part of Population Focused Mental Health Promotion)	This locally approved INN funded pilot program seeks to learn how to develop and implement effective peer-to-peer support services across a network of organizations providing health and social supports to Transgender individuals. Due to changes to the budget and scope of the project, a revised INN Proposal will be submitted to the MHSOAC (see plan - Appendix A)	\$ 259,807	* (Updated) INN proposal.
Workforce Development	X	INN 17. MH Certificate for Outreach Paraprofessionals (part of Workforce Development)	This plan includes a proposal for a NEW INN project (see Appendix B). The Mental Health Outreach Workers (MHOW) Training program aims to train San Francisco street outreach workers, exposed to constant community trauma, on how to best meet the mental health needs of the clients that they encounter in the field, and also how to best deal with one's own experience with trauma. Three sub communities of outreach workers have been identified by our local CPP as frontline programs coming in contact with high rates of trauma. These are: Homeless Youth Outreach Workers Programs and Street Violence Outreach workers, and Asian Community Outreach workers. In total, a cohort of 60 outreach workers will be trained (20 per sub community).	\$ 300,000	* New INN proposal.
		INN Admin	see CSS Admin for description admin expenses.	\$ 201,279	
Workforce, Development Education and Training (WDET) * Plan proposes \$1.6 million per year of CSS funds will be transferred to WDET				Total WDET Budget: \$1,591,151	

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S.F. MHSA INTEGRATED Service Categories	RFP likely Summer/Fall 2014	MHSA Program Name (by funding component)	MHSA Program Summary	Projected FY 14/15 Budget	Integrated Plan Highlights
Workforce Development	X	WDET 1. Training and TA	The MHSA supports trainings for health and social service providers to improve their capacity to provide high quality, culturally competent, recovery oriented services. Key components of this work include the implementation of Seeking Safety and Illness Management Recovery (IMR) groups, capacity building for providers serving youth and system-wide (12N) LGBTQ sensitivity training. This program also supports the Trauma Training Institute.	\$ 648,653	* Launched Trauma Training Initiative * Funding evaluation of Wellness Management Recovery groups * New INN proposal for Mental Health Outreach Worker Training Program (see INN #17) * Continues Medicinal Drumming Pilot from another year
Workforce Development	X	WDET 2. Career Pathways	The Mental Health Career Pathways Program focuses on developing a workforce pipeline that will usher in the next generation of mental health and behavioral health practitioners and include members of underserved and underrepresented communities. Funded projects include a 'career exposure' program for high school students and a Community Mental Health Certificate program at City College.	\$ 269,365	* New partnership with SFUSD on pilot promoting behavioral health professions within the Health Academy at John O'Connell High School. * Updated goals from recent workforce disparities assessment.
Workforce Development		WDET 3. Residency and Internships	CBHS, in partnership with SFGH and UCSF, established a Public Psychiatry Fellowship Program to enable general psychiatry and child psychiatry fellows to work in CBHS community-based clinics, thereby providing experience and training on how to work in a community-based setting, with the goal of enticing them into future community-based employment. This program also includes funding for a CBHS Intern Coordinator to work collaboratively with CBHS staff, university and college graduate level (Master's level and PhD level) programs and graduate student interns to develop, implement and evaluate a centralized and coordinated public mental health internship/practicum program.	\$ 494,033	* New graduate level Intern Coordinator to be hired
		WDET Admin	see CSS Admin for description of admin expenses.	\$ 141,949	
		WDET Eval	See CSS Evaluation for description evaluation expenses.	\$ 37,150	* Evaluating implementation of Wellness Management and Recovery Groups
Capital Facilities/IT Plan proposes \$500k per year of CSS funds be transferred to CF				Total CF/IT Budget: \$1,555,312	

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Capital Facilities /Information Technology		IT 1. Consumer Portal	CBHS will provide consumers access to their CBHS EHR records via a new consumer portal.	\$ 121,654	* Not going to implement AVATAR's Consumer Connect as proposed in original IT Plan. DPH-wide consumer portal is under development. * DPH will cover cost of new portal yet other budget implications of implementation for CBHS clients are still TBD.
Capital Facilities /Information Technology	X	IT 2. Vocational IT (part of Vocational Services)	Prepares consumers to provide information technology (IT) support services (i.e., desktop, help desk) at the CBHS IT Department through its Vocational Information Technology Training Program.	\$ 545,000	
Capital Facilities /Information Technology		IT 3. System Enhancements	System Enhancements focus on improving the quality and efficiency of behavioral health services and include improving connectivity and IT infrastructure at behavioral health sites, supporting servers that host the Avatar application and other applications related to the delivery of services. System Enhancements also include the expansion of staff capacity to develop reports (clinical productivity, consumer outcomes, etc.) and maintain databases.	\$ 225,000	* Planning currently underway will result in detailed expenditure plan.
		IT Admin	see CSS Admin for description admin expenses.	\$ 163,658	
Capital Facilities /Information Technology		Cap 1. Southeast Health Center	Renovation will resulting in a new Southeast Health Campus that will provide integrated services, co-location of five CBHS mental health programs: Child Crisis, Foster Care Mental Health; Family Mosaic Project; Children's System of Care; and the Health and Environment Resource Center (HERC). MHSA is making a \$2M contribution of capital facilities funding to this project. The timeline for development and expenditures is still TBD.	TBD	
Capital Facilities /Information Technology		Cap 2. South of Market Mental Health	Renovations at South of Market Mental Health Clinic to better serve MHSA populations and their families. Funds will be allocated to create a peer-run Wellness Center, a more welcoming environment, improve patient flow and increase clinical/staff space. Planning for this project has just begun.	\$ 300,000	* Establish annual allocation of \$500K to make capital improvements at mental health clinics. * First new capital project at SOMA MH.
Capital Facilities /Information Technology		Cap 3. TBD through CPP		\$ 200,000	* Balance of (\$500K) Capital Facility allocation available for project TBD through community planning process.

TOTAL PROJECTED FY 14/15 MHSA Budget * \$ 34,618,648

* FY 15/16 and 17/18 expected to be comparable to FY 14/15.
Final budgets for future years will be provided in Annual Updates.