San Francisco Health Network
Behavioral Health Services

San Francisco
Mental Health Services Act (MHSA)
2021-22 Annual Update

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

Family Life Mural at Leonard Flynn Elementary School by Susan Kelk Cervantes

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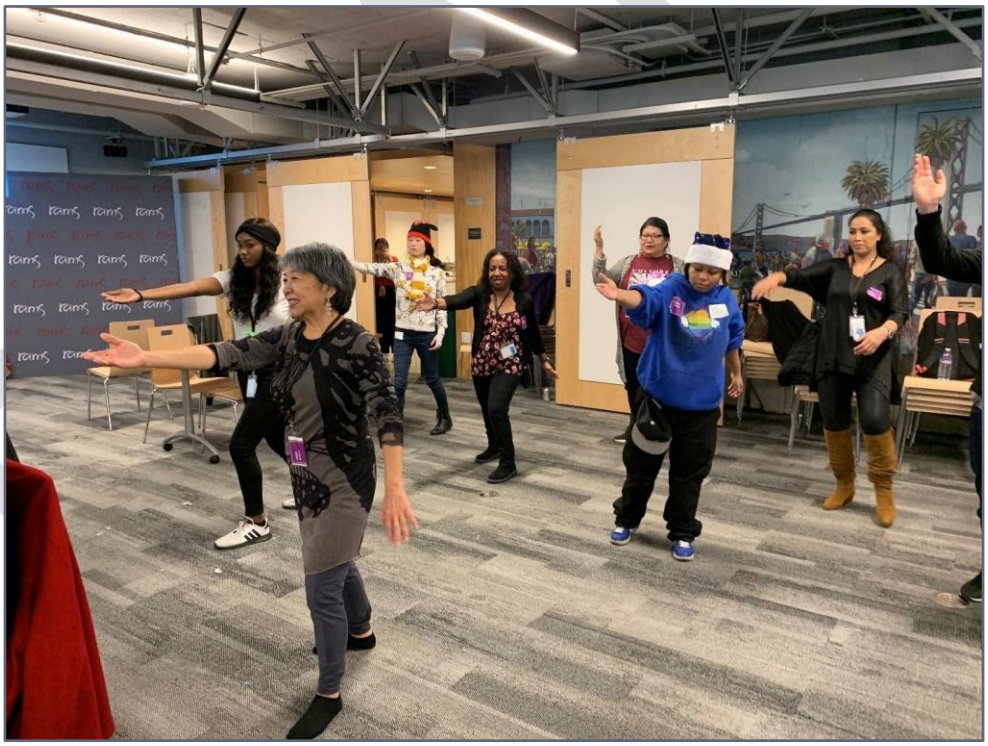
Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date, as well as our planning efforts for programs moving forward.

The report's introductory section provides an overview of the Mental Health Services Act (MHSA), the general landscape of San Francisco, our department's response to the COVID-19 pandemic, our Community Program Planning (CPP) activities, MHSA program highlights from the past year, and the report's formal review process.

The remainder of the report details program highlights and successes from FY2019-20 for SF DPH MHSA's seven service categories, as well as our Mental Health Promotion and Early Intervention (MH PEI) Programs and Innovation (INN) Programs. Each section also includes a description of the overarching purpose of the service category, an overview of the programs within that category, and a description of the target population.

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



MHSA County Compliance Certification

County: _____

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

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

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

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

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

_____ _____

Signature Date

Irene Sung, MD

Local Mental Health Director/Designee

County: San Francisco County

Date: XX XX, 2021

MHSA County Fiscal Accountability Certification[1]

PLACEHOLDER PAGE

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

MHSA County Fiscal Accountability Certification

PLACEHOLDER PAGE

Director's Message

Since 2004, The Mental Health Services Act (MHSA) is responsible for transforming public mental health services through funding innovative and traditional mental health programs and services across San Francisco. MHSA's guiding principles of community collaboration, recovery & wellness, health equity, client & family member involvement, and integrated client-driven services allows us to focus our efforts in ensuring that San Franciscans have equitable and culturally adaptive high quality mental health care. By partnering with a variety of programs throughout San Francisco, MHSA has continued to provide mental health care through an equity and social justice framework that serves and cares for the most vulnerable and marginalized communities. During this past year, the need of equitable and high-quality mental health care was even more apparent as the country dealt with the uncertainties and tragedies due to COVID-19, to unpacking our country's unresolved history of systematic racism. San Franciscans were and continue to be drastically impacted by the effects of COVID-19. From loss of economic resources, housing, social connectedness, isolation, and the impacts of civil unrest, San Franciscans have undergone adverse mental and behavioral health outcomes related to COVID-19 and our Behavioral Health System experienced high acuity in adverse mental health outcomes such as anxiety, depression, increase in substance use, and trauma-related disorders.

MHSA has upheld principles of racial equity and social justice by ensuring that our programs received that support needed to serve our communities during 2020. Our MHSA programs demonstrated resilience, collaboration, empathy, and diligence that allowed us to be innovative in our approach to care during one of the most challenging times since our inception. From providing telehealth services for our school-based PEI programs; hosting and developing community health wellness webinars with the Board of Supervisors; collaborating with our COVID Command Center to develop a suicide preventing and behavioral health campaign; maintaining our peer support programs through virtual methods; expanding funding for our PEI programs; developing a culturally congruent mental health intervention for Black/African Americans; partnering with the SF Human Rights Commission on reallocating police funding for mental health services; collaborating with the Latinx COVID Tasks Force on providing COVID Testing and contract tracing; providing funding for the Shelter in Place (SIP) Hotels; and the deployment of MHSA staff, our MHSA programs and staff were pivotal in ensuring that our communities continued to receive quality mental health care.

As we enter a new year, MHSA continues to reflect on the hardships we overcame in the previous year and we are grateful for what we accomplished. This 2021-22 MHSA Annual Update will showcase MHSA program outcomes achieved in Fiscal Year 2019-20 and gives an overview of future program plans for the coming year. In developing this plan, the San Francisco Department of Public Health (SFDPH) MHSA team prioritized collecting community input and feedback - from consumers, providers, peers, family members, and other stakeholders – to guide program improvements, implementation, and evaluation. This plan will illustrate our efforts to improving the quality of life for individuals with mental illness, as well as their friends and families, and the challenges we faced with COVID-19. This plan will focus on our continuous efforts to collaborate across systems, both public and private, to accomplish our goals of increasing awareness, reducing stigma, increasing equitable access, promoting prevention and early identification and intervention of mental health symptoms, and improving quality of care.

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

Jessica Brown, MPH
Director, San Francisco Mental Health Services Act

Introduction to MHSA

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

WELLNESS • RECOVERY • RESILIENCE

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

As dictated by the law, the majority of 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 and better serve all San Franciscans. The following examples illustrate some of the many ways in which MHSA contributes to the wellness of the San Francisco community.

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

SF MHSA strongly promotes a vision of outreach and engagement, a 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 staff at the MHSA Consumer Peer and Family Conference December 2019.

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 metropolis, 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 most densely populated major city in California (with a population density of 17,352 residents per square mile) and the second most densely populated major city in the United States, after New York City. Between 2011 and 2018, San Francisco's population grew by almost 8% to 888,817, outpacing California's population growth of 6% during this same period. In 2019, City officials estimated that San Francisco's population would grow to more than 980,000 by 2030; however, the COVID-19 pandemic has brought dramatic changes to the city.

Following a decade-long population increase driven by the local tech industry boom, the City is now seeing a dramatic population decline. With a limited supply and high demand for housing, San Francisco has been nation's most expensive rental market for several years, with nearby cities in the South and East Bay Area also ranking in the top ten. When Mayor London Breed issued the nation's first Shelter-in-Place order on March 17, 2020 in response to COVID-19, most workplaces shifted to remote work for the foreseeable future. Many workers could no longer justify paying such high rents to stay in the city for their job and others reportedly moved to out of the city to afford larger homes, backyards, and avoid crowds during the pandemic. Population data was not available at the time of this report, but judging by the decrease in sales tax revenue San Francisco's population loss in 2020 may be the worst in the state.

While many have taken advantage of this newfound mobility to leave the City, others have not had the same opportunity. San Francisco is home to approximately 8,035 individuals experiencing homelessness, a number that has grown steadily over the past ten years. During her time in office, Mayor Breed has demonstrated her commitment to helping San Franciscans who suffer from mental health and substance use disorders, including those experiencing homelessness. To protect these and other vulnerable residents, including marginally housed seniors and individuals with underlying health conditions, Mayor London Breed issued a Public Health Order to reduce risk of COVID-19 exposure and allocated $5 million in new investments. These funds were used to expand cleaning in shelters, resource centers, and SROs, and to increase meal offerings and shelter hours. Mayor Breed also opened a new homeless shelter, approved funds for the city to provide temporary shelter for individuals who need to quarantine for COVID-19 exposure, announced a moratorium on residential evictions, allocated $10 million to provide sick leave for private sector workers impacted by COVID-19, expedited the hiring of healthcare professionals, and convened an economic recovery task force.

"Public health comes first in this crisis, but we know that many people have less flexibility to stay home and keep paying their rent if they do get sick. We want everyone to know that staying home to take care of themselves and their families is the most important thing they can do, not only for their own health but also to slow the spread of this virus in our community," - Mayor Breed.

For additional background information on population demographics, health disparities, and inequalities, see the 2019 San Francisco Community Health Needs Assessment located at https://www.sfdph.org/dph/hc/HCAgen/2019/May%207/CHNA_2019_Report_041819_Stage%204.pdf.

SFDPH MHSA Response to COVID-19

During the COVID-19 pandemic, San Francisco and its residents have faced intersecting public health, mental health, and economic crises. Recognizing that the pandemic itself has strained San Franciscans' mental health, the SFDPH MHSA team has intensified its efforts to address residents' mental health needs. The team quickly adapted to make programs accessible virtually and has also assisted the San Francisco pandemic response effort in a more hands-on manner. Team members have been redeployed to different roles in the Department of Public Health to lend immediate support to COVID-19 response efforts, including peer support, contact tracing, and task force leadership and guidance.

Innovative Approaches and Leadership

- Community and Employee Wellness Activities were developed and implemented in collaboration with the Office of Equity and Workforce Development (OEWD), the Training Unit, Trauma-Informed Systems, Heal SF, the Human Rights Commission, the SF Board of Supervisors, and other partners
- The Peer Programs Manager was deployed to provide additional support to peers and peer specialist staff, who are a cornerstone in providing mental health, community, and wellness services within San Francisco's systems of care
- The Interim MHSA Director was a part of the Behavioral Health System COVID-19 Leadership Team and COVID-10 Employee Support Team
- MHSA supported Mental Health Association SF staff to participate in a Suicide Prevention Summit and provided suicide prevention training during COVID-19

Heal SF

Heal SF was developed as a comprehensive effort to provide immediate and coordinated mental health services for health care providers amid COVID-19. The Heal San Francisco Rapid Response Team, coordinated by Our Children Our Families (OCOF) Council, provides mental and behavioral resources to frontline workers, caregivers, educators, and communities. Resources include a '5'Cs of COVID-19' trauma informed clinical guidelines, a frontline workers counseling project, stress management for educators, and happy, healing, holistic classes. Heal SF focuses on aligning resources and strategies while addressing policies and practices that promote healing, centering equity, reparation, and social justice. Heal SF also coordinates between different health plans and services to ensure access to resources and collaboration across public, nonprofit, and volunteer efforts. Lastly, Heal SF connects health providers to suicide prevention resources and has expanded its services to provide community support during COVID-19.

Telehealth

MHSA programs are providing virtual services during the pandemic. Peer services rapidly transitioned to provide an array of online supports. Prevention and Early Intervention (PEI) programs transitioned to offer remote services for clients, including school-based mental health promotion (K-12 students and their families), priority population prevention and early intervention, early childhood mental health consultation, and comprehensive crisis intervention services. Some essential programs, such as the Curry Senior Center, Wellness in The Streets (WITS), and Transgender Pilot Project (TPP), continue to provide socially distant programming following PPE guidelines. Our suicide awareness and prevention programs and activities have also ramped up their outreach and education efforts. The San Francisco Suicide Prevention Felton Institute has provided a 24-hour Crisis Line for immediate intervention and emotional support for SF residents; a Drug and Relapse Line that refers clients to specialized treatment

programs, crisis intervention, recovery information, and emotional support; and an outreach initiative to business, schools, and hospitals, mental health agencies, and community venters to raise awareness and provide training on crisis intervention and de-escalation. The WITS program and TPP are conducting ongoing outreach to homeless populations. Hospitality House has been delivering hygiene kits, masks & hand sanitizers to homeless encampments and discussing COVID-19 with community members. Instituto Familiar de la Raza has been working with the Latino Task force to get information out to the Spanish, Maya and English-speaking SF communities about COVID and related resources. MHSA has also contributed to the development of telehealth surveys. These will be distributed to both providers and consumers in the BHS system to gather information on effectiveness of telehealth, and accessibility for underreached populations.

MHSA Advisory Board

The MHSA Advisory Board transitioned to virtual meetings in March 2019, before shelter in place mandates, in order to protect participant safety. This shift away from in-person meetings is allowing participation of community members who otherwise would not have been able to attend meetings.

Social Distancing in SF's Dolores Park, 2020.

Community Program Planning (CPP) & Stakeholder Engagement

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

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 (WET)** 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 Mental Health Services Oversight and Accountability Commission (MHSOAC) for their review and approval in February 2009. The plan was approved in April 2009.

- **Capital Facilities and Information Technology (CF/TN)** 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 (INN)** community meetings were held from April through August 2009. The Plan was submitted in March 2010 and approved in May 2010.

Community Program Planning (CPP) & Stakeholder Engagement Activities

Exhibit 1 provides an overview of San Francisco's ongoing CPP activities. San Francisco MHSA employs a range of strategies 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 MHSA CPP

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

In addition to the ongoing CPP activities listed in Exhibit 1, MHSA hosts activities and events throughout the year to promote mental health awareness. In 2020, these activities have moved to virtual and socially-distanced settings but remain effective in engaging the community.

In honor of "May is Mental Health Awareness Month," SF DPH BHS' Stigma Busters worked with the City of San Francisco to light up San Francisco City Hall green on May 6, 2020, as lime green is recognized as the official color of mental health awareness. Stigma Busters is a consumer-led committee that meets regularly to plan and promote stigma reduction activities throughout the San Francisco community.

The SF DPH BHS Stigma Busters also campaigned in honor of Suicide Awareness Month in September, Stigma Busters disseminated Each Mind Matters' "Know the Signs" campaign materials to service providers and at clinics, as well as electronically through the MHSA listserv and on our partners social medial channels. The materials were shared to promote awareness and inform the public on how to identify the signs of suicide and what resources are available to those in crisis.

MHSA Communication Strategies

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

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

SF MHSA Consumer, Peer, and Family Conference December 2019

MHSA Advisory Committee & Our Commitment to Consumer Engagement

MHSA Advisory Committee

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

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

The MHSA Advisory Committee's robust recruitment efforts focuses on engaging members from the mental health community, with an emphasis on the following underrepresented community members: those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of over 25 active members. For 2020, the MHSA Advisory Committee meeting schedule was as follows: 3/11/20, 6/17/20, 9/30/20 and 12/9/20. The purpose of these meetings is 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:

- MHSA Workforce Development Programs (WDET) Population-Focused Networking, Field Building, and Vision Session
- Consumer input on MHSA activities
- Exploration to Strengthen Vocational Programming
- Consumer and Stakeholder Input Meetings
- Input on how to best respond to COVID-19
- Culturally Responsive Practices for Black/African American Communities
- MHSA FY2020-23 Three-Year Integrated Plan
- Stakeholder Meeting to Improve ICM/FSP Programming
- Exploration to Strengthen Vocational Programming
- Stakeholder Meeting to Explore Evaluation Practices
- Focus Group on API Communities

Increasing Consumer Engagement with the SF BHS Client Council

MHSA has been working to foster a stronger collaboration with the San Francisco Behavioral Health Services Client Council. The Client Council is a 100 percent consumer/client driven and operated advisory body. The mission of the Client Council is to 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.

In 2020, MHSA and the BHS Client Council have continued to partner to better serve our clients but have been faced with new and diverse challenges related to the COVID-19 pandemic. The BHS Client Council developed S.M.A.R.T. goals and objectives at the beginning of the year, which quickly were revised and timelines extended once Mayor London Breed issued the country's first Shelter-In-Place order in response to the pandemic. As the pandemic continued into the summer, the Client Council worked with MHSA program managers to understand how to continue to conduct outreach to and engage the community in MHSA program planning. The Client Council also worked to provide direct feedback to service providers on how to keep clients engaged in services. The Client Council continues to meet virtually each month but is eager to be able to meet in-person again.

Strengthening Relationships

MHSA engages with various oversight bodies, including the SF Behavioral Health Commission 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 MHSA and these groups provide an ongoing channel of communication and support.

Community Program Planning session in 2019.

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

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

Recent Community Program Planning Efforts

Community Program Planning and the MHSA 2021-22 Annual Update

SFDPH continued our extensive community outreach and engagement efforts to inform program planning for the MHSA 2021-22 Annual Update. Community members voices are critical in guiding MHSA program improvements and developing new programming. In 2020, due to the COVID-19 pandemic, our community outreach and engagement efforts became virtual. While the nature of virtual community meetings can pose new barriers to engagement, such as access to technology, it also allowed us to continue to build connections with our community during the COVID-19 pandemic. Virtual meetings also provided opportunities for us to reach new audiences who may otherwise have faced barriers to attending in-person meetings, such as transportation. This report provides a comprehensive overview of our community outreach and engagement efforts and key findings in 2021-21, and our plans to integrate community feedback into MHSA programming. SFDPH remains committed to conducting community outreach and engagement to ensure consumers have the appropriate wellness tools and resources to support them in their recovery journey.

The SFDPH MHSA team is committed to engaging with the community and conducts ongoing and extensive CPP efforts. In 2020, the MHSA team demonstrated organization and efficiency in meeting the needs of our community members so that their feedback is captured and integrated into our program improvement efforts through a transparent process. Meeting announcements, participant registration, open communication, thorough and transparent note-taking, and follow-up efforts have led to successful and meaningful community participation in our program planning efforts. When CPP efforts moved to virtual community meetings in March 2020, demographics data collection of our CPP participants became more challenging. The team has since identified a solution to collect the data but data for the year is limited.

MHSA staff presents at 2019 CPP meeting on SF Housing Needs

Community and Stakeholder Involvement

SF DPH strengthens our 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 2020, **MHSA hosted 21 community engagement meetings across the City** to collect community member feedback on existing MHSA programming and better understand the needs of the community and to develop this MHSA Three-Year Plan. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders. In recent years, the MHSA team identified certain groups that had not been involved in previous CPP. We are happy to report

that we have since increased our outreach efforts to include more involvement with certain stakeholder groups, including local veterans, Transition Age Youth, vocational program participants, the Older Adult community, the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) community, primary care and medical staff, employees of municipal agencies and law enforcement.

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

The 2020 CPP meetings are listed in the following table.

2020 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening** ***(most meetings held virtually due to COVID-19)***
1/9/20	Workforce Development and Population-Focused Program CPP: Stakeholder Input Meeting (part one)
1/10/20	Workforce Development and Population-Focused Program CPP: Stakeholder Input Meeting (part two)
2/18/20	Client Council Meeting Consumer Input Meeting regarding MHSA Activities
2/24/20	Department of Rehabilitation Vocational Stakeholder Meeting: Exploration to Strengthen Vocational Programming
3/11/20	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
4/17/20	MHSA PEI Providers CPP: Input on how to best respond to COVID-19
4/30/20	Innovation Proposal CPP Meeting: Culturally Responsive Practices for Black/African American Communities
5/20/20	Behavioral Health Commission Public Hearing: MHSA FY2020-23 Three-Year Integrated Plan
6/17/20	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
7/6/20	Peer-to-Peer Forum: Input Gathering from Peer Specialists and Consumers
7/7/20	Peer Stakeholder Meeting Input Gathering from Peer Specialists and Consumers

2020 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening** ***(most meetings held virtually due to COVID-19)***
8/3/20	Innovation Proposal CPP Meeting: Culturally Responsive Practices for Black/African American Communities
8/18/20	ICM/FSP Providers Meeting: Stakeholder Meeting to Improve ICM/FSP Programming
9/21/20	Department of Rehabilitation Vocational Stakeholder Meeting: Exploration to Strengthen Vocational Programming
9/30/20	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
9/30/20	Innovation Proposal CPP Meeting: Culturally Responsive Practices for Black/African American Communities
10/5/20	Impact Meeting: Stakeholder Meeting to explore Evaluation Practices
10/20/20	Client Council Meeting Consumer Input Meeting regarding MHSA Activities
11/5/20	Mo'MAGIC Community Meeting – Innovation Proposal CPP Culturally Responsive Practices for Black/African American Communities
12/16/2020	Advisory Committee Meeting: Consumer and Stakeholder Input Meeting
12/29/2020	Peer Focus Group: Innovation Project for the Asian/Pacific Islander Communities

In each community meeting, MHSA staff presented an overview of the Mental Health Services Act, including its core components, guiding principles, and highlights of existing programs and services. Staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health needs and strategies to address these needs. These discussions also addressed how DPH can improve existing MHSA programming. Feedback from community members at the meetings was captured live, on flip charts and via transcription, to maintain a high-level of transparency. MHSA staff addressed how the feedback would be incorporated into the MHSA 2021-22 MHSA Annual Update and inform future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the MHSA 2021-22 MHSA Annual Update.

Community and Stakeholder Feedback

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

> ***"I really appreciate uplifting Black Trans folk and am curious about making sure to uplift Black Migrants."***
>
> **- Community Member**

Community and stakeholder feedback in 2020 was scheduled around existing community meetings with service providers, the MHSA Advisory Committee, and other community partners. Community feedback collected in recent years continues to frame MHSA outreach and engagement efforts. For example, as noted in the FY20-21 MHSA Annual Update report, San Franciscans continue to express a desire for diverse service providers and more intentional efforts to address systemic barriers related to housing, workforce development, and education. Given the importance of these social determinants of health for the mental health of our communities, the key findings below focus on some of the main systemic barriers to economic stability and mental well-being, particularly around housing, and the workforce. MHSA community outreach and engagement in 2020 also focused on the needs of specific populations who had previously reported substantial additional barriers affecting mental health. These include certain racial and ethnic populations, gender and sexual minorities, and individuals affected by homelessness.

The below feedback was collected from service providers, SFDPH consumers, community members, and other stakeholders in 2020. As described above, the conversations that solicited this feedback were designed based on feedback collected in recent years. MHSA went directly to service providers, consumers, and stakeholders who work with these specific populations to ask for their perspective and suggestions on MHSA programming and the needs of our community. Additionally, many strategies for improving mental health that arose from these meetings addressed specific populations or facets of the life course (e.g., aging, education). For this reason, the feedback below is organized into different categories based on the setting in which the feedback was solicited and the cross-cutting social determinants of health identified at these meetings.

Needs of Certain Racial and Ethnic Populations

> ***"[Mental health] is kept secret until things are way out of control…only then people will seek help."***
>
> **- Community Member**

Asian and Pacific Islanders

- Language diversity is increasing and there is a resulting need for translation services and cultural sensitivity trainings.
- Continuing barriers for these community groups relate to language barriers, lack of trust with government systems, and fear of losing immigration status.
- Clients prefer appointments with a community member, advocate, or translator who speaks and understands their language and culture. Language barriers persist especially for the South Asian communities.
- Mental health is still a stigma in the API community. The common saying "don't shame the family" is still prevalent which has influenced residents neglecting their mental health.

- Traumatic events experienced in this country and internationally have had a huge impact in residents receiving much needed care. Two big examples of this are violence against the elderly (specifically the North Beach neighborhood), and time previously spent in refugee camps.
- Due to the impact of traumatic events in the API community, CPP participants prioritized the need for trauma-informed care over government-based services.

> ***"It would be amazing if training can be available, to train people in our community for potential jobs for mental health."***
>
> **- Community Member**

- Clients indicated a need for a safe environment to host cultural events/activities.

Black/African Americans

- The greatest need is for mental health providers and diversity in the mental health workforce. Community members brainstormed about the need to incentivize people of color working in the mental health sector.
- In particular, beyond recruitment, the community advocated for funding projects to resolve retention issues at all position levels.
- Providers need to diversify their outreach efforts and expand to cultural strongholds such as barbershops and beauty salons.
- Meeting attendees mentioned the need to include more members of the community, such as parent leaders, and churches in MHSA services and activities.
- A few ways to empower community members include: providing training for community members on potential job opportunities in the mental health industry, providing scholarship and/or grant opportunities, offering Healing Circles.

Needs of Gender and Sexual Minorities

- The African American and API transgender communities continue to experience high instances of body dysmorphia and are in need of more transparency from providers.
- Nontraditional methods of engagement are needed.
- There is a need for more representation of sexual minorities and communities of color in certificate classes.

Needs Related to Workforce and Educational Development

Workforce Development Programs (WDET) Population-Focused Networking, Field Building and Visioning Session

- From this event, nine themes emerged that will be a focal point for enhancing MHSA activities:
  - Workforce development
  - Pipeline Development
  - Partnerships
  - Equity
  - Work Capacity
  - Financial Incentives
  - Supporting Individuals
  - Supporting Systems
- SF MHSA Staff will create a "SF Population Centric Community Mental Health Competencies Guide" which will include ethnic/linguistic/cultural considerations from each Population Focus program that will be provided to SFDPH: BHS Workforce Development, Education and Training (WDET) programs; with a goal to inform and update their curricula development and delivery

- Staff will work with population-focused, Mental Health Promotion & Early Intervention (PEI) programs to collect their respective communities preferred cultural consideration that will be shared with the SFDPH BHS Workforce Development programs.

Other General Needs Shared in CPP Meetings

- There is a need for peer liaisons in adult probation and other release programs.
- There is a need for more cultural competency for grievance officers. There should be soft handoffs to those in need of additional support, and therapy without medication stipulation
- There is a need for providers to understand how to conduct outreach to their clients.
- Examples of culturally congruent interventions include: wellness groups, skill-building groups, telehealth services to expecting/new mothers, emotional emancipation circles, drumming, acupuncture, singing, and family-based groups, and Healing Circles.

Feedback that was Consistent in Previous Years

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.

- Community members from all different cultures and backgrounds expressed a need for a more diverse workforce addressing mental health needs. This would address existing language barriers and provide more culturally responsive care for diverse San Franciscans.
- Service providers need to understand where trainings are available for the LGBTQ+ (lesbian, gay, bi-sexual, transgender, queer, questioning, and more) community. Both

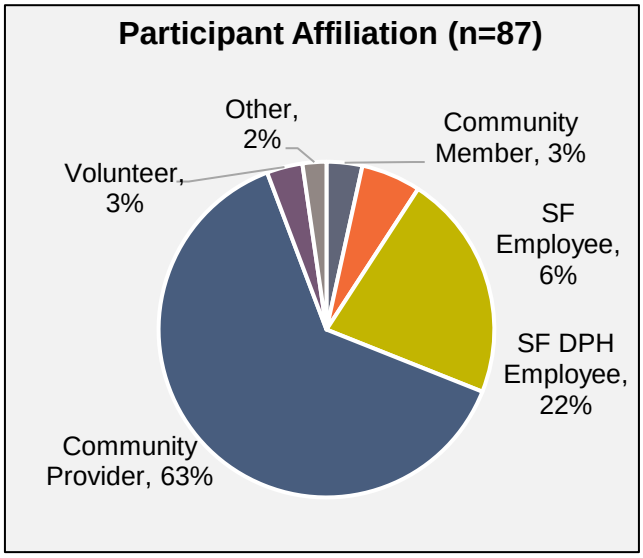
service providers and clients want a better understanding of navigating referral and service linkage.

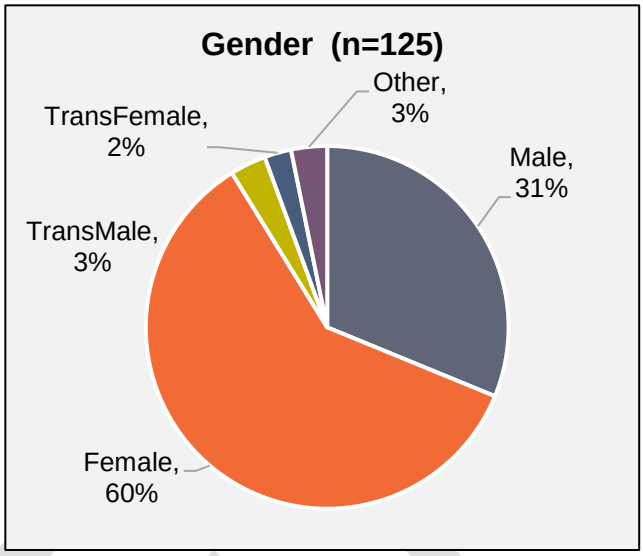
- Community members continue to ask service providers where they can get housing support and providers have limited resources to share.
- The need for community education and stigma reduction around behavioral/mental health is important, particularly regarding cultural and linguistic needs.
- The need for a clear understanding of what behavioral/mental health (MHSA-funded) programs and services already exist and improved methods for navigating these resources.
- More intentional collaboration is needed across different city departments to make it easier for clients to access necessary services, especially for people experiencing homelessness.

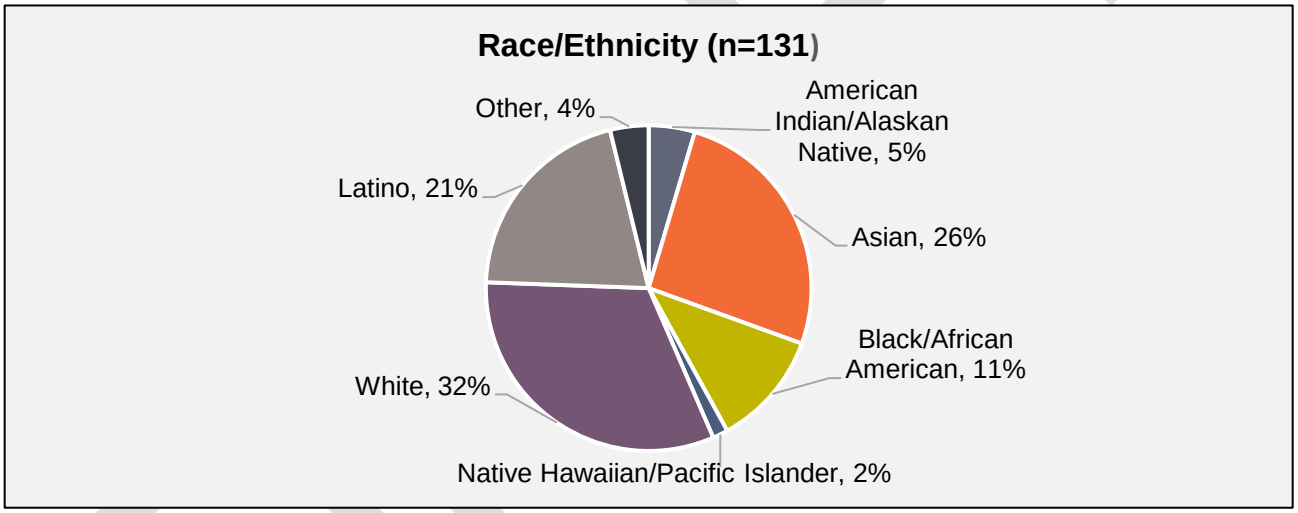
CPP includes a focus on the Needs of Trans Women of Color

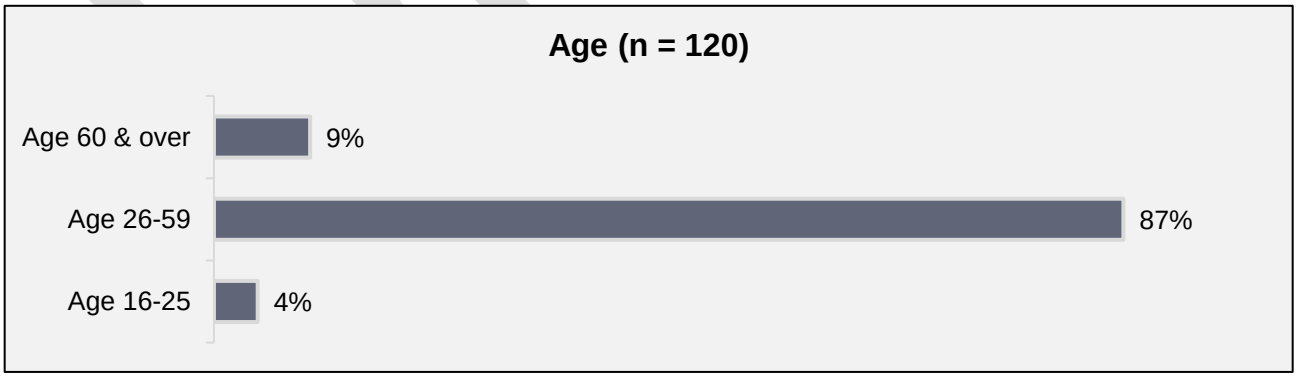
CPP Meeting Participation

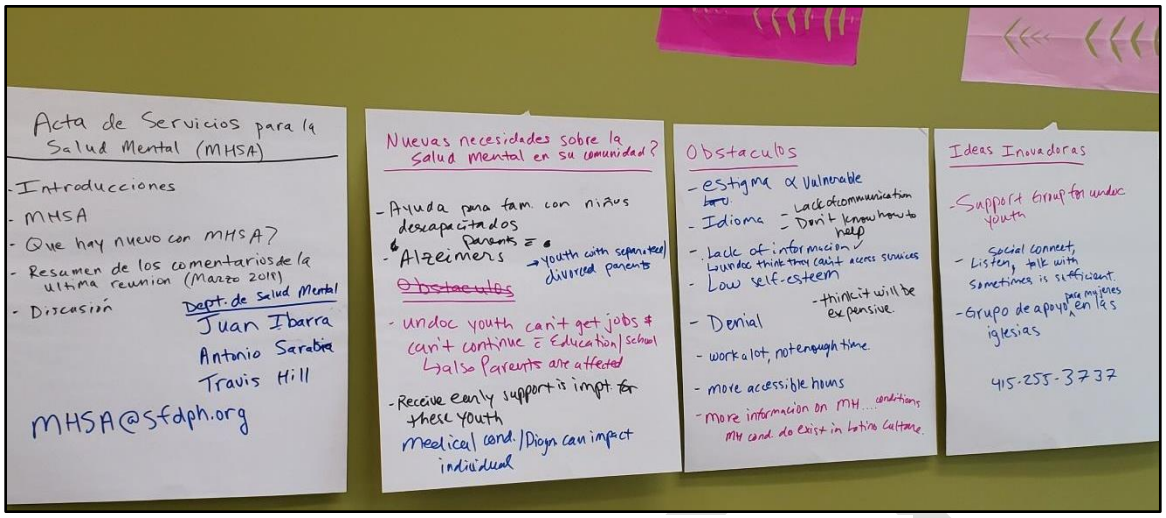
Over 200 people participated in the MHSA community meetings held in 2020.
Of those attendees, MHSA staff collected demographic data on 207 individuals and those data are reflected in the charts below. Please see participant demographics for 2020 below.


Participant Affiliation (n=87)
Other, 2%
Community Member, 3%
Volunteer, 3%
SF Employee, 6%
SF DPH Employee, 22%
Community Provider, 63%


Gender (n=125)
Other, 3%
TransFemale, 2%
Male, 31%
TransMale, 3%
Female, 60%


Race/Ethnicity (n=131)
Other, 4%
American Indian/Alaskan Native, 5%
Latino, 21%
Asian, 26%
Black/African American, 11%
White, 32%
Native Hawaiian/Pacific Islander, 2%


Age (n = 120)
Age 60 & over
9%
Age 26-59
87%
Age 16-25
4%



Flip charts with community feedback captured in a CPP meeting in 2019.

CPP with Service Provider Selection

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

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

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

- Black/African American Wellness and Peer Leaders (BAAWPL)
- Culturally Congruent and Innovative Practices for the Black/African American communities

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

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

The County must include a narrative analysis of its assessment of the County's mental health needs and its capacity to implement proposed programs/services. Below is a brief summary of our work to meet these regulations.

Wellness activity at SF MHSA Consumer, Peer, Family Conference, December 2019.

In 2019, SFDPH BHS/MHSA identified the goal of understanding the current composition of the BHS civil service workforce and progress made towards the aims of the 2017-2022 Workforce Needs Assessment and Strategic Plan. An initial data crosswalk was completed to identify data needs and gaps, while checking against MHSA regulations to ensure County compliance. Quantitative workforce and consumer data were then identified, collected, and analyzed. Qualitative data on progress towards the Plan's four goals was collected through interviews and review of secondary program documents.

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

A summary of the data described above can be found in Appendix A, as the "2019 BHS Workforce Needs Assessment and Development Plan Update". Please also see our Community Program Planning (CPP) section for a detailed summary of the mental health needs identified by San Francisco community members and stakeholders.

In the coming years, SF-MHSA is planning to conduct another assessment, although, this new assessment will be more thorough and robust. This new assessment will better highlight the mental health needs of San Francisco and the BHS/MHSA workforce's ability and capacity to address these needs. This robust new assessment is intended to be a component of our next Three-Year Program and Expenditure Plan.

Celebrating a Successful MHSA State Review!

The San Francisco Mental Health Services Act (SF-MHSA) team participated in a thorough State Review conducted by the California Department of Healthcare Services (DHCS) on February 10-12, 2020. This was the first triennial audit that consisted of an extensive review of program documents, a sample review of our FSP charts and site visits to various MHSA-funded programs. SF-MHSA submitted over 500 documents pertaining to program implementation, evaluation, policy development, budgeting and our community program planning process, in which we gather extensive community and stakeholder feedback. In addition, we toured nine MHSA sites, allowing DHCS to interview staff and participants about best practices and areas of opportunities.

We are pleased to announce that the State Review was a huge success. DHCS representatives were very pleased with SF-MHSA programming and the outcomes we achieved. They were most impressed with our community planning process, in which we hosted 23 community engagement meetings during FY 18-19 to solicit broad input from communities and stakeholders most impacted by current systems. They also noted that, “San Francisco MHSA is a model County Program” and DHCS representatives asked if they can point other counties to San Francisco for guidance on implementation, policies and evaluation. Lastly, they commended our successful integration of 352 MHSA-funded peer specialists working in various roles throughout the entire behavioral health system in FY18/19.

DHCS identified only ten findings, all of which are administrative and easy to resolve. Every County is issued a Corrective Plan within 60 days after the review, which will include our ten findings. SF-MHSA will have a further 60 days to submit a response and plan to resolve these issues. We are confident that we will be able to correct all ten of these minor administrative items within the timeline provided.

We would like to thank the MHSA Director, Jessica Brown, MPH, for her outstanding leadership and guidance through our first State Review. We could not have had such a successful review without her support.

MHSA Director, Jessica Brown, presents at the SF-MHSA Consumer, Peer and Family Conference in December 2019.

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

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Proposition 63, an emphasis was placed on the importance of consumer participation in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. **SF-MHSA funded 335 peers in FY19/20** throughout our behavioral health system. Consumers can be found working in almost all levels and types of positions, including: peer counselors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management.

San Francisco's Integrated MHSA Service Categories

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

Exhibit 2. MHSA Service Categories

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

Developing this Annual Update

The SF DPH MHSA 2021-22 Annual Update developed in collaboration with MHSA consumers, peers, family members, service providers, local residents, and other stakeholders. The SF DPH MHSA community outreach and program planning efforts were coordinated by a core team of MHSA staff, which included the MHSA Director and Program Managers. Independent consulting firms, Hatchuel Tabernik & Associates and Harder+Company Community Research, provided assistance with program planning and implementation, project management, coordination, community outreach, technical writing, and program outcome data analysis and reporting.

In the planning work conducted for the 2021-22 Annual Update, the MHSA team incorporated the stated goals of the Mental Health Services Act, the mission of the San Francisco Department of Public Health, and revisited our local MHSA priorities and needs identified in our 2017-2020 Program and Expenditure Plan and subsequent Annual Update Reports. Most importantly, the Community Program Planning (CPP) strategies outlined in the previous section of this report enabled the MHSA team to identify and integrate direct program feedback from the individuals we serve, and the greater community, in planning for future MHSA programming. In addition to incorporating community feedback into our planning process, the MHSA team relied on several other strategies to inform future program improvements, including:

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

SF-MHSA Program Successes in Responding to COVID-19

MHSA Peer-to-Peer Service Programs have been very innovative in transitioning their services virtually. The Prevention and Early Intervention programs, in particular, have been successful in proving wellness activities to the community. Such activities included but are not limited to: virtual beading circles, creating masks, and a sewing program. Activities that were not able to be done virtually, were successfully conducted following PPE guidelines at locations such as the Curry Senior Center, Wellness in the Streets Program (WITS), and Transgender Pilot Program.

In addition, the **Wellness in The Streets program** continues to conduct outreach to people that are unhoused at the Shelter-in-Place (SIP) hotels as well as on the street. The Hospitality House has been going to homeless encampment to deliver hygiene kits, masks, and hand sanitizer while providing awareness around COVID-19. For hard-to-reach populations, Instituto Familiar de la Raza has been working with the Latino Task force to get information out to the Spanish, Maya and English-speaking residents about COVID and related resources.

Since August 2020, the **RAMS Shelter in Place (SIP) Phone Team** has spoken with a total of 103 clients, of which 23 were new. Approximately 87 of these clients requested and are now receiving weekly phone calls from their assigned Peer Counselor. The team has since expanded their capacity in personnel and service frequency. This expansion proved to be very successful as seen in one example, where a client who was referred to the WITS team by the Peer Counselor, was met at a hotel the following day where he was then able to set up an email account and apply for general assistance. In addition, two RAMS Peer Counselors from the WITS team and SIP Phone Team presented their work at a virtual BHS Town Hall meeting in August 28th 2020. In their presentation, they spoke about the value of Peer support and how they have heard from multiple clients that the weekly peer support phone calls have helped reduce isolation and improve their quality of life.

Lastly, over Labor Day weekend **San Francisco's 42nd annual Carnival/ Latino Covid-19 Health and Recovery Street Fair** took place. While Latinx dance hits played and dance troupes showcased their moves, members of the Health Community and Behavioral Health Services, handed out health information to residents. The slogan for this year's health fair, *"Salud es Poder, Health is our Wealth",* was reflective of the fair's purpose to assist families in the Mission District who have been disproportionately affected by the Covid-19 pandemic. The health fair section of Carnival provided free Covid-19 testing, groceries, employment information, acupressure, BHS education information, and a myriad of other services from a wide array of other health providers. The Behavioral Health Services (BHS) booth handed out a variety of information ranging from; tips for dealing with Covid-19 stress, to leaflets on how to help our children deal with the pandemic. Despite the record-breaking heat, the community came out to enjoy the festival. Everyone practiced social distancing and other PPE guidelines making the event a great success.

Local Review Process

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

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA FY2021-22 Annual Update was posted on the MHSA website at www.sfdph.org/dph. **The MHSA FY2021-22 Annual Update was posted for a period of 30 days from March 22, 2021 to April 21, 2021.** 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:

Summary of Public Comments on the FY21-22 MHSA Annual Update		
Community Member	**Summary of Comments**	**DPH Response**

Following the 30-day public comment and review period, **a public hearing was conducted by the Behavioral Health Commission of San Francisco on XXXX.** The FY21-22 Annual Update was also presented before the **Board of Supervisors Budget and Finance Subcommittee on XXXX** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted the FY21-22 Annual Update on XXXX.**

Public Hearing & Board of Supervisors Resolution

Insert Resolution Here

Resolution placeholder page

Highlights of MHSA

***In FY19-20**, **MHSA served a total of 36,807 individuals** through our outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic services; and service linkage efforts.*

10th Annual MHSA Awards Ceremony

This year marks the 10th annual MHSA Awards Ceremony which was held December 18th, 2020 and hosted by the Mental Health Association of San Francisco. This year's event was held via Zoom. The community was able to spend a few hours together to acknowledge the participants of MHSA funded programs in San Francisco. The event is held annually to honor, recognize and celebrate the clients' achievements in their journey of mental health recovery.

National Suicide Prevention Month, September 2020

National Suicide Awareness and Prevention Month & Week, World Suicide Prevention Day, and National Recovery Month all occurs in the month of September. In honor of World Suicide Prevention Day on September 10th, the SF MHSA Team partnered with San Francisco City Hall to have the civic landmark illuminated in purple and teal, the colors which symbolize suicide awareness and prevention. This lighting of city hall purple and teal took place during Suicide Prevention Week, the week of September 6, and was part of the City's efforts to bring awareness to the issue of suicide prevention. During Suicide Prevention Week, MHSA also shared with providers and partners daily communications with resources from Each Mind Matters (EMM) which included webinars, virtual events, and activity ideas that reflected this year's theme of "Hope, Resilience and Recovery." EMM also encouraged a special focus on the intersection between suicide prevention, alcohol and drug use in their events and activities given that research has shown there's a strong co-morbidity and overlap among risk and protective factors for substance use and suicide.

Staff Updates

In FY19-20, a number of staffing changes occurred in the MHSA division, including:

- Teresa Yu served as MHSA Interim Director March-August 2020 during Jessica Brown's maternity leave, and then as co-Director from August-October 2020.
- Juan Ibarra, Epidemiologist and MHSA Evaluator was deployed to assist with San Francisco's COVID-19 response efforts.
- Anthony Sarabia began working as the RAMS Vocational Specialist (Health Worker I), a civil service position.
- Victoria Khofri joined on February 2020 as a RAMS intern to support both the Vocational Team and the larger MHSA Team.

Spotlight on Community Wellness Activities

With the first Shelter in Place order in March 2020, SFDPH BHS quickly recognized the immediate need for community wellness activities geared toward BHS clients, BHS employees, and the wider San Francisco community. Beginning in April, our community wellness efforts included:

Flyers and Webinars Focusing on Mental Health and Wellness for Priority Populations
BHS disseminated "10 Tips for Mental Health and Wellness" across the city in San Francisco's key threshold languages. In addition to highlighting mental health tips that can be implemented at home and available community resources, the flyers advertised a BHS webinar series. A total of six webinars included presentations by mental health clinicians who are also cultural experts in the Black/African American, Latinx, Chinese, Pacific Islander, Tongan and Samoan, and Southeast Asian communities. These webinars covered culturally-responsive mental health practices and provided information about available resources.

BHS collaborated with City staff and Supervisors and community partners to conduct outreach for these webinars and wellness promotion campaigns. Successful collaborations included:

- Collaborating with District 4 Supervisor Gordon Mar to reach the Sunset and surrounding neighborhoods.
- Working with the Human Rights Commission (HRC), the EOC, Health SF, and other community partners to deliver three webinars on community needs and mental health and wellness that focused on Transgender and Gender-Non-Conforming communities and LGBTQQ+ communities.
- Working with Instituto Familiar de la Raza (IFR) and HRC to deliver a Spanish language webinar on Mental Health and Wellness to Latinx communities, which received 909 views on Facebook to date.

Prevention and Early Intervention (PEI) Programs
Our PEI programs aimed to increase wellness support during the COVID-19 State of Emergency, using accessible methods that support BHS clients while sheltering in place. Activities were conducted by video or over the phone for clients without access to video technology.

Activities included: video conference calls for clients to check in, with opportunities for drumming, singing, deep breathing/mindfulness, and other cultural activities; helping clients manage stress and develop new coping mechanisms for this challenge; and helping clients learn how to make their own face masks.

Peer-to-Peer Programs
Our peer programs were active in supporting BHS clients to meet holistic needs. Some highlights from the year include:

- Moving many support groups online and increasing the frequency of some groups.
- Handing out care packages at the peer wellness center (while following social distance guidelines).
- Implementing an eight-week Wellness Recovery Action Plan group online
- Leveraging funding from other programs to provide iPads to BHS clients, so they can participate in online programming.
- Offering video conferencing support to peer specialist staff on how to transition to offering online groups, covering topics such as mindfulness and wellbeing, professional development, peer learning, setting boundaries, and personal safety.

SF DPH MHSA FY2020-21 Annual Update

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

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

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

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

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

- **Capital Facilities and Information Technology (IT)**
  - Expansion of Telehealth Kiosks– Capital Facilities
  - Consumer Portal - IT
  - Consumer Employment – IT
  - System Enhancements – IT

1. Recovery-Oriented Treatment Services: CSS Funding

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.

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

FSP Programs

Program Collection Overview

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

FSP services at all programs consist of the following:

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

Target Populations

Nine FSP programs have served a diverse group of clients, in terms of age, race/ethnicity, and stage of recovery, since 2006. In 2015-16, two new programs began to enroll clients: Instituto Familiar de la Raza (IFR) created the Strong Parents and Resilient Kids (SPARK) program to serve families with a child or children aged 0-5 with attachment disorders; and Citywide Case Management 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 Programs			
Target Population	**Program Name *Provider***	**Name Listed on ARER, Budget**	**Additional Program Characteristics**
Children 0-5 & Families	Strong Parents and Resilient Kids (SPARK) *Instituto Familiar de la Raza*	CSS Full-Service Partnership 1. CYF (0-5)	Provides trauma focused dyadic therapy, intensive case management, and wraparound services to the population of 0-5-year-old and their caregivers.
Children & Adolescents	SF Connections *Seneca Center*	CSS Full-Service Partnership 2. CYF (6-18)	Through close partnerships with 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 (FMP) *SFDPH*		
Transitional Age Youth (TAY)	TAY FSP *Felton Institute*	CSS Full-Service Partnership 3. TAY (18-24)	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 *SFDPH*		
	TAY FSP *Seneca Center*		
Adults	Adult FSP (Bayview, Oceanview, and Western Addition neighborhoods) *Felton Institute*	CSS Full-Service Partnership 4. Adults (18-59)	Offers an integrated recovery and treatment approach for individuals with serious 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 (Tenderloin neighborhood) *Hyde Street Community Services*		Provides culturally relevant services to the diverse ethnic and racial populations residing in the Tenderloin, especially Arab-speaking, Southeast Asian, African American, and Latinx individuals living with co-occurring disorders.

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

FSP Participant Demographics, Outcomes, & Cost per Client

San Francisco engaged eleven Full-Service Partnership (FSP) programs during fiscal year 2019-20, logging a total of nearly 1,000 client FSP episodes (n=924), experienced by 912 unduplicated enrolled clients.

The demographic tables and graphs below represent client served in the FSPs. Sex, Gender Identity, Race/Ethnicity, and Primary Language are reported in tables by FSP Program and by Client Age Group. Stacked bar charts show the percentage distribution across Client Age Groups. Also displayed is a matrix count of Client Age by FSP Age Category.

Demographic data are pulled from the Behavioral Health Services electronic health record system, Avatar, for all client episodes active in any FSP program, for any length of time between July 1, 2019 and June 30, 2020.

Client age is calculated from date of birth to July 1, 2019. A small number of clients (n=12) were opened in two different FSPs during the fiscal year, due to "aging up" or transferring programs for other reasons. For age reporting, clients are represented only once. Where demographics are displayed by FSP program, all clients served in the program in the fiscal year are represented.

Client Sex, Gender Identity and Sexual Orientation

The eleven FSPs in San Francisco served nearly twice as many males (63%) as females (37%), especially in the adult programs.

Client Sex by FSP Program and Age Group

FSP Program	Female	Male	Total
BHS TAY FSP	22	34	**56**
Citywide AOT	13	30	**43**
Citywide Forensics	58	204	**262**
Family Mosaic Project (FMP)	47	64	**111**
FSA Adult FSP	21	25	**46**
FSA Older Adult FSP	25	21	**46**
FSA TAY FSP	11	21	**32**
Hyde Street FSP	24	29	**53**
IFR SPARK FSP	13	12	**25**
Seneca Connections	69	77	**146**
SF FIRST FSP	37	67	**104**
Total	**340**	**584**	**924**

Client Age Group	Female	Male	Total
1 CYF (0-5)	7	7	**14**
2 CYF (6-15)	75	103	**178**
3 TAY (16-24)	78	99	**177**
4 Adult (25-59)	123	283	**406**
5 Older Adult (60+)	55	82	**137**
Total	**338**	**574**	**912**

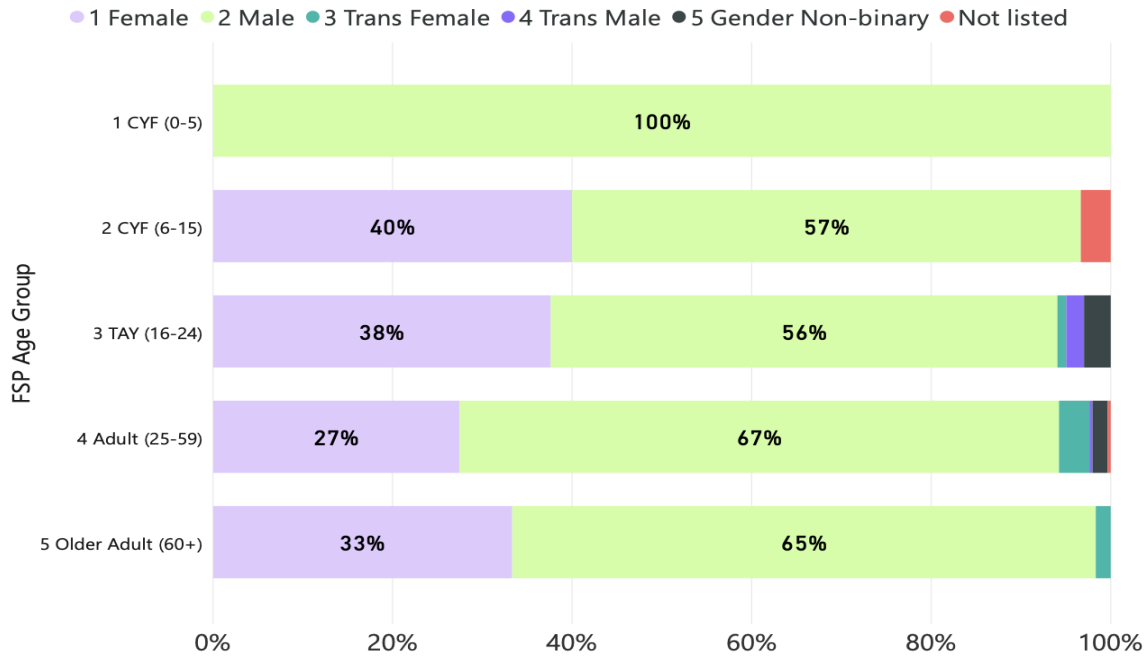
San Francisco recently initiated expanded data collection in Avatar for Sexual Orientation and Gender Identity (SOGI), however missing data are still highly prevalent (47%; reported below as "No Data").

Client Gender by Client Age Group

Client Age Group	1-Female	2-Male	3-Trans Female	4-Trans Male	5-Gender Non-binary	6-No Data	Not listed	Total
1 CYF (0-5)		1				13		**14**
2 CYF (6-15)	12	17				148	1	**178**
3 TAY (16-24)	38	57	1	2	3	76		**177**
4 Adult (25-59)	81	197	10	1	5	111	1	**406**
5 Older Adult (60+)	20	39	1			77		**137**
Total	**151**	**311**	**12**	**3**	**8**	**425**	**2**	**912**

Of those clients for whom Gender Identity data were available, 5% of clients identified as Trans Female, Trans Male or Genderqueer/Non-binary.

Client Gender by Client Age Group (excludes "No Data")



Similarly, as the SOGI data collection policies and practices continued to be adopted, data on client Sexual Identity (SI) were still underreported. Approximately 38-100% of clients had missing SI, depending on client age group. Available data show 5-52% of clients as Straight/Heterosexual, <1- 5% identifying as Gay or Lesbian, and 1-5% Bisexual, Questioning or Unsure, depending on age (no graph).

Race/Ethnicity

Race and Ethnicity data are captured in Avatar and recoded into seven categories: African America/Black, Asian, Latinx, Multi-ethnic, Native American, Native Hawaiian and Other Pacific Islander (NHOPI), White and Other. African American/Black and Latinx clients are over-represented compared to the general population of San Francisco. Asians are under-represented, and Whites are very much under-represented in the younger client populations.

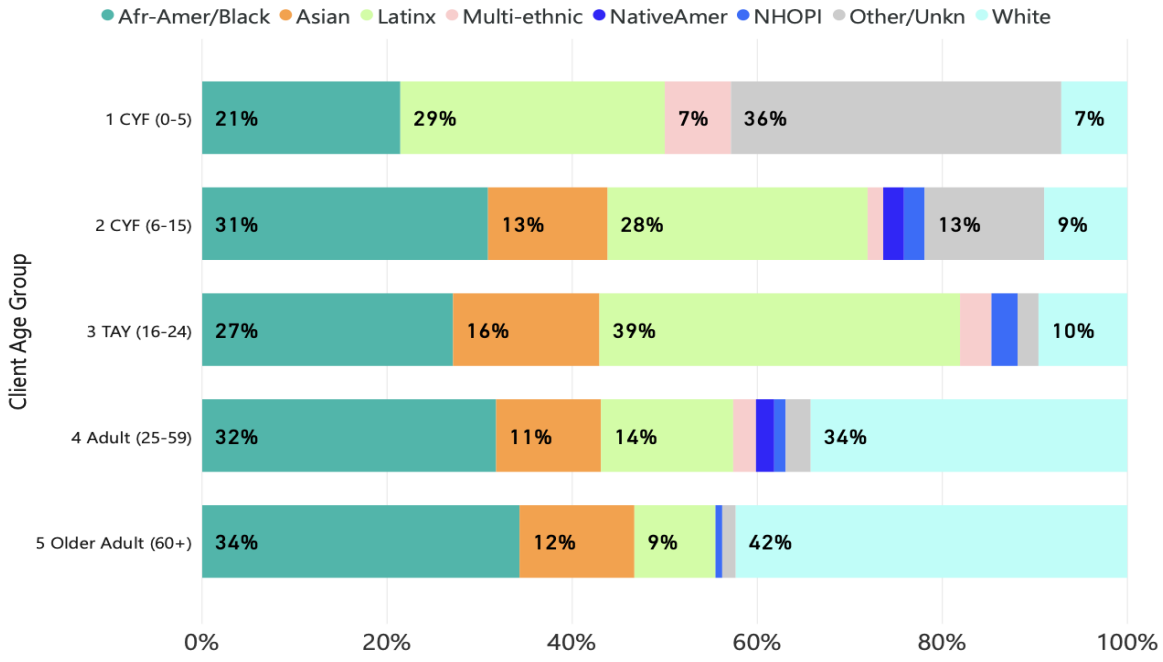
Client Race/Ethnicity by FSP Program

FSP Program	Afr-Amer/Black	Asian	Latinx	Multi-ethnic	Native Amer	NHOPI	Other/ Unkn	White	Total
BHS TAY FSP	14	7	25	1		3		6	**56**
Citywide AOT	10	6	7	1			2	17	**43**
Citywide Forensics	90	30	34	5	7	3	9	84	**262**
Family Mosaic Project (FMP)	24	23	39	3	2	3	9	8	**111**
FSA Adult FSP	16	10	9		1			10	**46**
FSA Older Adult FSP	16	5	3					22	**46**
FSA TAY FSP	9	6	8	4				5	**32**
Hyde Street FSP	21	5	3	1		2	2	19	**53**
IFR SPARK FSP	5	2	9			1	8		**25**
Seneca Connections	56	11	45	2	2	2	15	13	**146**
SF FIRST FSP	25	9	15	3		1	1	50	**104**
Total	**286**	**114**	**197**	**20**	**12**	**15**	**46**	**234**	**924**

Client Race/Ethnicity by Client Age Group

Client Age	Afr-Amer/Black	Asian	Latinx	Multi-ethnic	Native Amer	NHOPI	Other/ Unkn	White	Total
1 CYF (0-5)	3		4	1			5	1	**14**
2 CYF (6-15)	55	23	50	3	4	4	23	16	**178**
3 TAY (16-24)	48	28	69	6		5	4	17	**177**
4 Adult (25-59)	129	46	58	10	8	5	11	139	**406**
5 Older Adult (60+)	47	17	12			1	2	58	**137**
Total	**282**	**114**	**193**	**20**	**12**	**15**	**45**	**231**	**912**

Client Race/Ethnicity by Client Age Group



Client Primary Language

Client Primary Language is collected at FSP intake, and updated by case managers, as part of the Client Services Information (CSI) admission and treatment planning processes required by Medi-Cal. Most FSP clients indicate their primary language as English (83%).

Client Primary Language by FSP Program

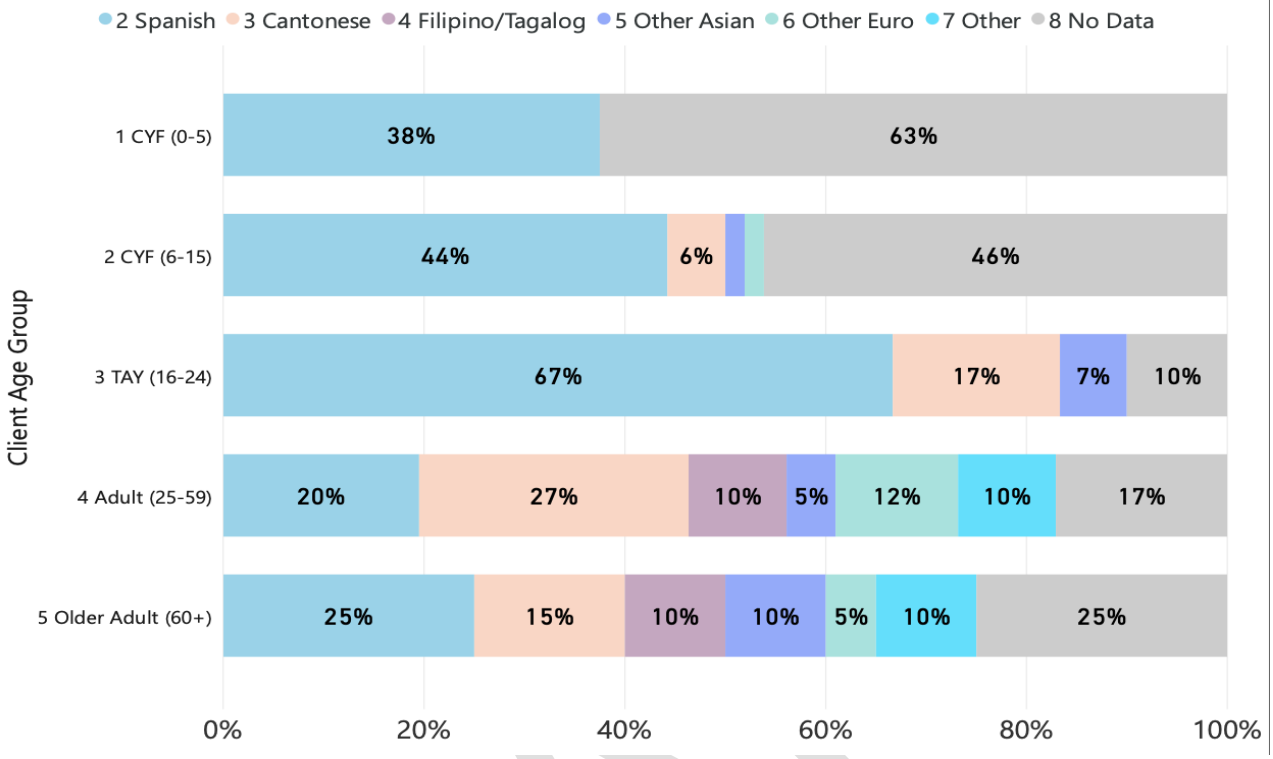
FSP Program	1 English	2 Spanish	3 Cantonese	4 Filipino/ Tagalog	5 Other Asian	6 Other Euro	7 Other	8 No Data	**Total**
BHS TAY FSP	48	8							**56**
Citywide AOT	38	1	2		1			1	**43**
Citywide Forensics	241	1	5	3	4	1	3	4	**262**
Family Mosaic Project (FMP)	77	20	5					9	**111**
FSA Adult FSP	40		3			2		1	**46**
FSA Older Adult FSP	40		2	1			1	2	**46**
FSA TAY FSP	27		3		1			1	**32**
Hyde Street FSP	50	1					1	1	**53**
IFR SPARK FSP	10	7						8	**25**
Seneca Connections	118	13			1	1		13	**146**
SF FIRST FSP	84	9	2	2		3	1	3	**104**
Total	**773**	**60**	**22**	**6**	**7**	**7**	**6**	**43**	**924**

Client Primary Language by Client Age Group

Client Age Group	1 English	2 Spanish	3 Cantonese	4 Filipino/ Tagalog	5 Other Asian	6 Other Euro	7 Other	8 No Data	**Total**
1 CYF (0-5)	6	3						5	**14**
2 CYF (6-15)	127	23	3		1	1		23	**178**
3 TAY (16-24)	147	20	5		2			3	**177**
4 Adult (25-59)	365	8	11	4	2	5	4	7	**406**
5 Older Adult (60+)	117	5	3	2	2	1	2	5	**137**
Total	**762**	**59**	**22**	**6**	**7**	**7**	**6**	**43**	**912**

Of those clients not reporting English as a primary language for whom data were available (n=107), Spanish (55%), Cantonese (21%) and Filipino and Tagalog (6%) were most common. Other Asian languages included: Vietnamese, Japanese, and Mandarin. Other European languages included: Russian, French, German and Portuguese. Arabic and Samoan were reported under Other. As defined by DHCS Medi-Cal eligibility, the “threshold” languages for San Francisco are: Spanish, Cantonese, Mandarin, Vietnamese and Russian.

Client Primary Language Other than English, by Client Age Group



Client Age and FSP Program Focus

FSP programs in San Francisco typically orient their services according to target age group. Clients can "age up" or "age out" of age-focused programs when developmentally appropriate and the client is ready. For example, TAY-aged clients were seen in CYF, TAY and Adult FSPs, depending on their age and readiness to transition. Increasingly, adult clients advancing into older age do not necessarily "age up" to the one Older Adult FSP, but instead stay within their Adult program, needing more older age-related services such as transportation, medical care and attention to cognitive impairment where they are. In fact, more clients over 60 years old are served by the four adult FSPs (n=92, 67%) than by the single Older Adult FSP (n=46, 33%).

FSP Data Collection and Reporting (DCR) Outcomes

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

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

FSP Residential Outcomes

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

Reporting Methodology. Residential Settings graphs include all **clients** active in the FSP during FY19-20 with a completed PAF, who have served **in the FSP partnership for at least one continuous year and up to four years**. These graphs exclude clients who have been active in the FSP for less than one year or more than four.

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

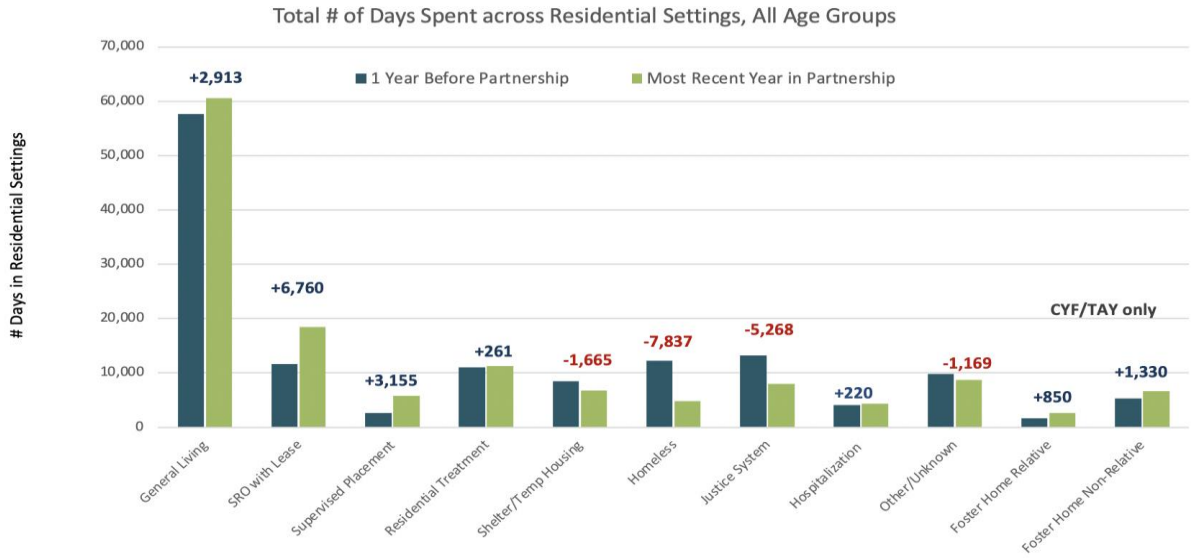
Residential settings are displayed from more desirable, i.e. generally more independent and less restrictive, to less desirable. However, this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for one client, for many the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

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

Clients in All FSPs

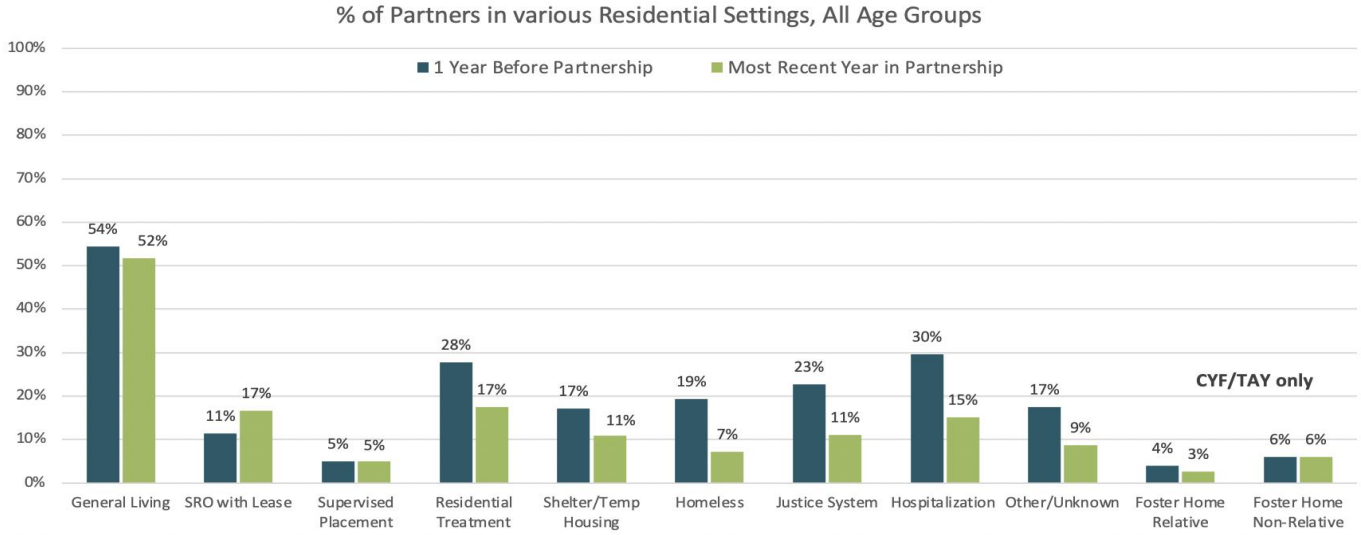
Across all age groups, the residential outcomes below (Exhibit RES-All-1) show reductions in the number of days that all clients enrolled between 1-4 years in an FSP program experienced homelessness and the justice system, but an increase in hospitalizations in their baseline year (pre-FSP) compared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

Exhibit RES-All-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=379)



While time spent in stable settings increased, and simultaneously decreased for less stable or more restrictive settings, the number of clients experiencing these residential settings dropped or remained steady for most unstable or restrictive settings (Exhibit RES-All-2). Looking at the above and below graphs together, it's helpful to notice the direction of days spent and the direction of percentage of clients experiencing that setting. For example, a smaller percentage of clients experienced Residential Treatment and Hospitalizations in the most recent year (17% down from 28%, and 15% down from 30%, respectively). However, those fewer clients spent more days in Residential Treatment and Hospitalization in the most current year, compared to the baseline year (up 261 and 220 days, respectively).

Exhibit RES-All-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, All Clients (n=379)



Child, Youth and Family Clients (CYF)
CYF client data show movement from residential treatment into home-based settings during FSP treatment (Exhibit RES-CYF-2). For Foster Home with Relative, however, fewer clients logged more time than for the baseline. (Exhibit RES-CYF-1). Justice involvement remained stable at 7%, however clients spent greater time (+817 days) in justice settings in FY19-20.

Exhibit RES-CYF-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, CYF only (n=134)

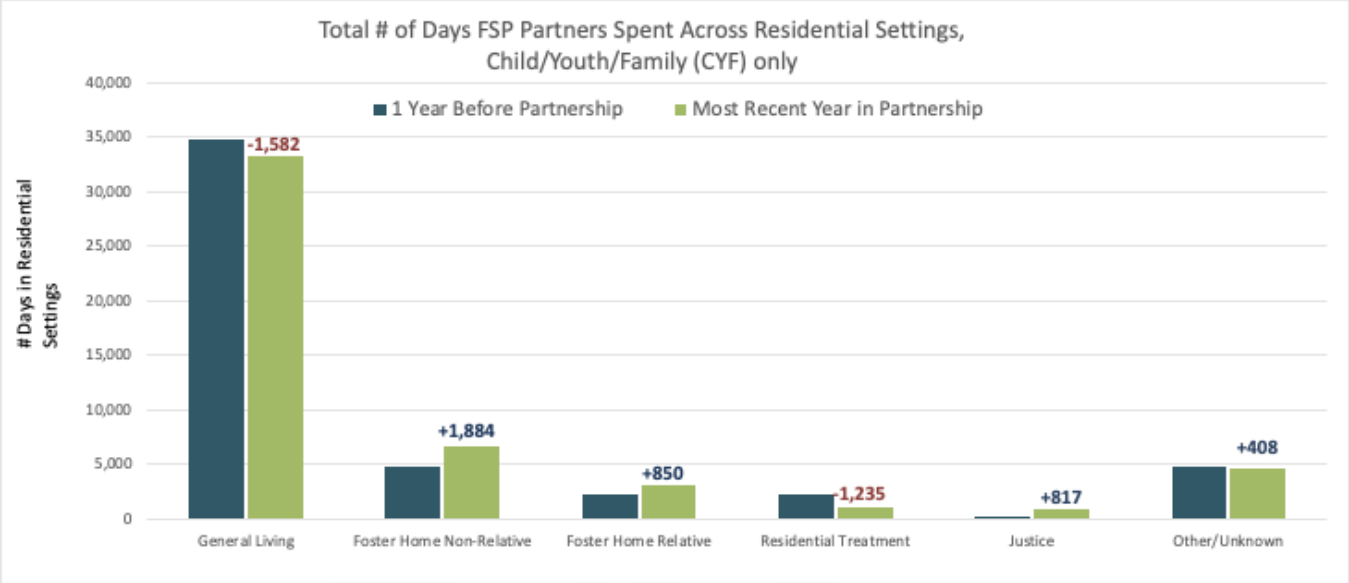
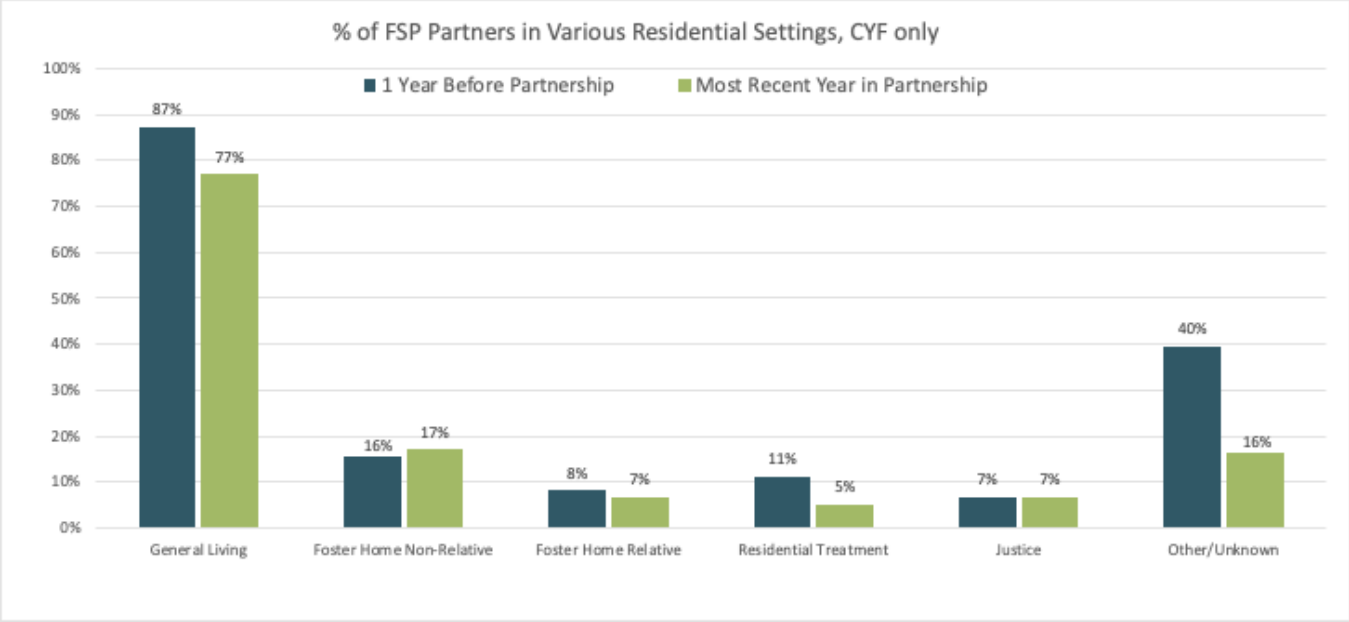


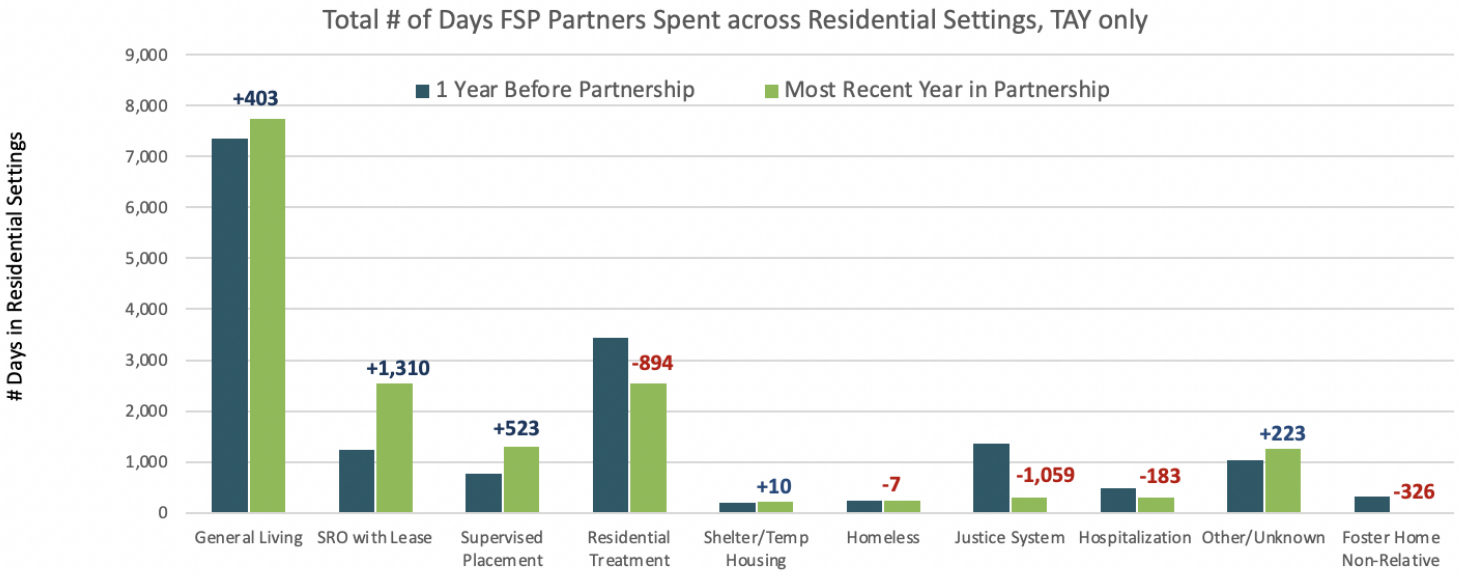
Exhibit RES-CYF-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, CYF only (n=134)



Transition Age Youth (TAY)

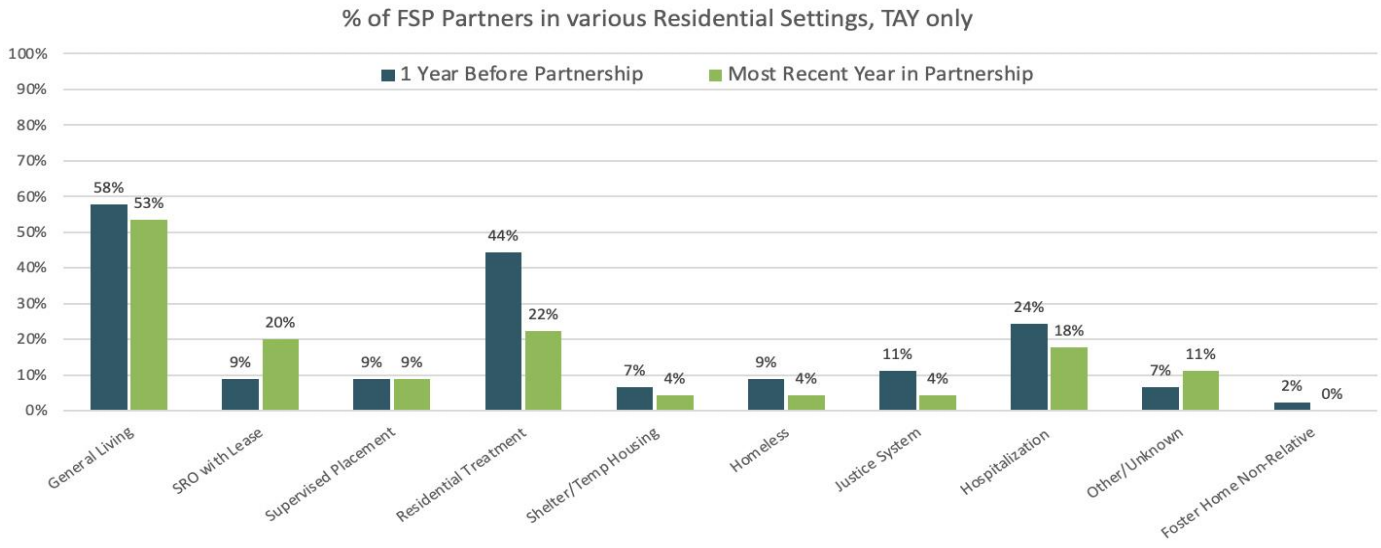
From the baseline year to the most current year in FSP, TAY clients spent more time in stabilizing settings like General Living, SRO with Lease and Supervised Placement; and less time in foster homes with non-relatives, hospitalized and in the justice system (Exhibit RES-TAY-1).

Exhibit RES-TAY-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, TAY only (n=45)



For more unstable or restrictive settings (i.e. homeless, justice system, hospitalization), TAY logged fewer days (Exhibit RES-TAY-2) than in their baseline year. This suggests that TAY clients are gaining access to housing or maintaining more stable housing.

Exhibit RES-TAY-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, TAY only (n=45)



Adult Clients

Adult clients saw an increase in General Living, SRO with Lease, and Supervised Placement in both the amount of time spent in each setting (Exhibit RES-A-1), and the number of clients (Exhibit RES-A-2). The small number of clients (1%) that moved into Supervised Placement were responsible for a substantial increase (+2,764) in the number of days spent in Supervised Placement. The proportion of Homeless clients and the days spent homeless decreased dramatically (by 23% and 6,162 days). The proportion of clients in involved in the Justice System decreased nearly two-fold (49%); however, a smaller proportion of people spent longer time (+1187) being justice involved. Similarly, Hospitalizations decreased by more than two-fold, but a smaller proportion of clients spent a greater number of days (+282) hospitalized. Fewer clients spent time in Residential Treatment (-13%), but those few clients spent more days (+1876) days in this setting, which may represent an advancement in recovery for FSP clients who have not previously accessed care.

Exhibit RES-A-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Adult Clients only (n=168)

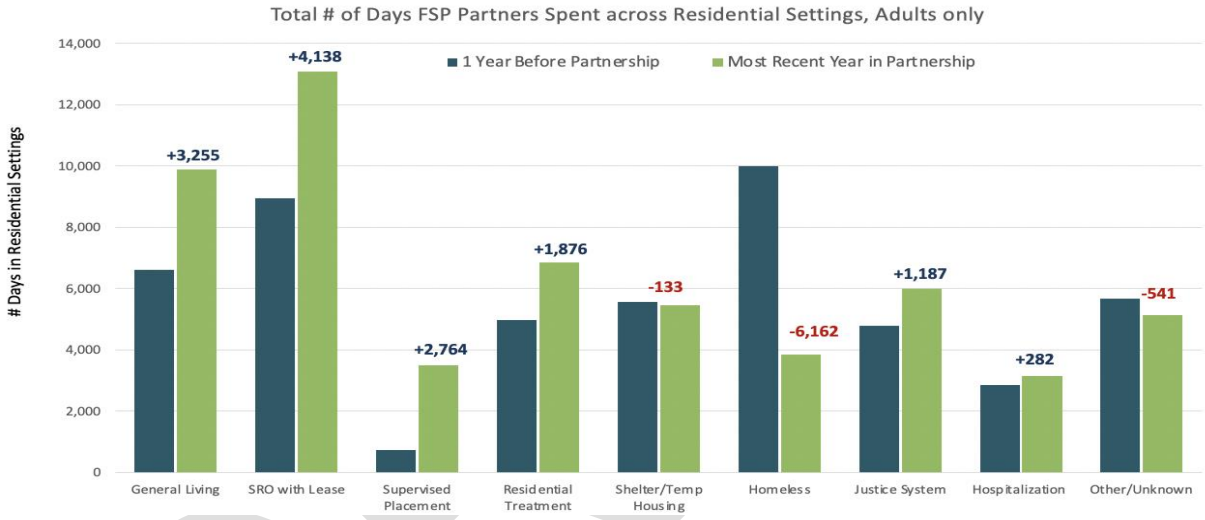
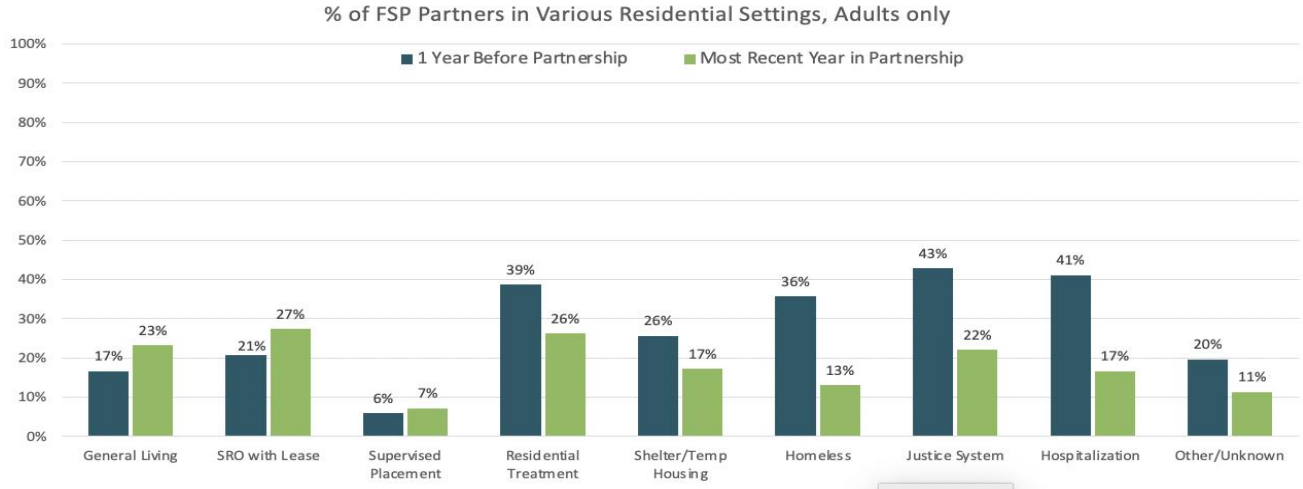


Exhibit RES-A-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Adult Clients only (n=168)



Older Adult Clients

Compared to the year prior to entering FSP programs, Older Adult FSP clients spent less time overall in unstable settings (Exhibit RES-OA-2), and more time in stable housing settings. For example, the number of days spent in General Living arrangements (+1,279 days), SRO with Lease (+666) and Residential Treatment (+183) were all higher compared to the year prior to entering FSP programs. Moreover, both the proportion of clients and days spent in Shelter/Temporary Housing and Homelessness decreased substantially. It is important to note that while the *number of days* in Residential Treatment increased across all Older Adult FSP clients compared to the year prior to entering the FSP, proportionally *fewer clients* spent time in Residential Treatment (-3%), which may represent an advancement in recovery for FSP clients who have not previously accessed care (Exhibit RES-OA-2). Finally, hospitalization rate remained stable at 40%; however, the number of days (+331) hospitalized increased slightly.

Exhibit RES-OA-1. Change in Time (days) Spent across Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Older Adults only (n=30)

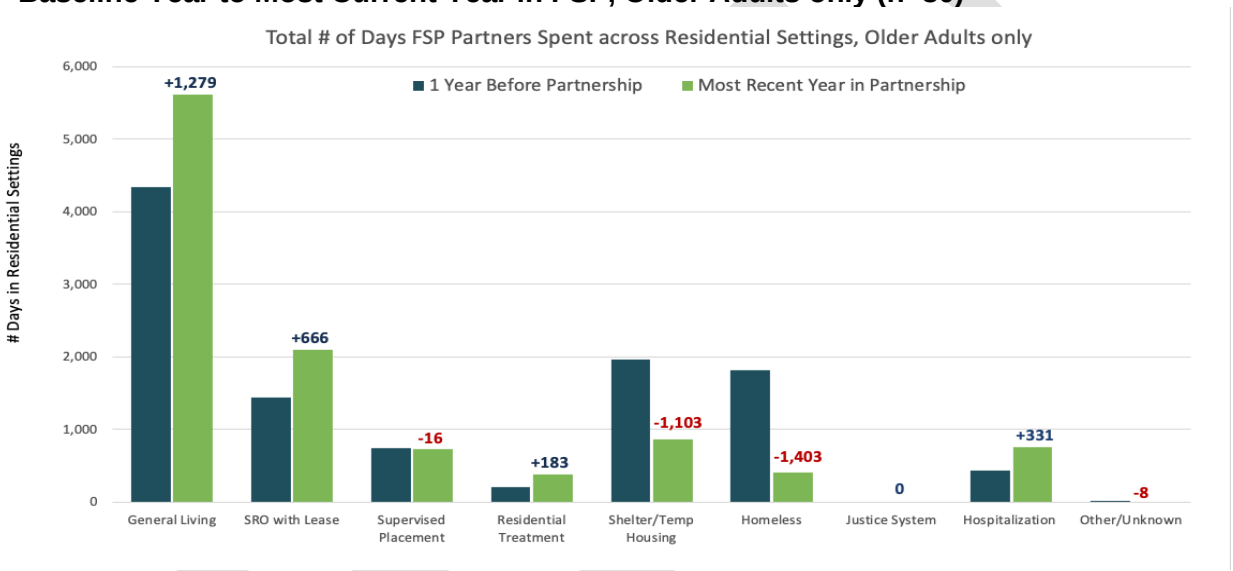
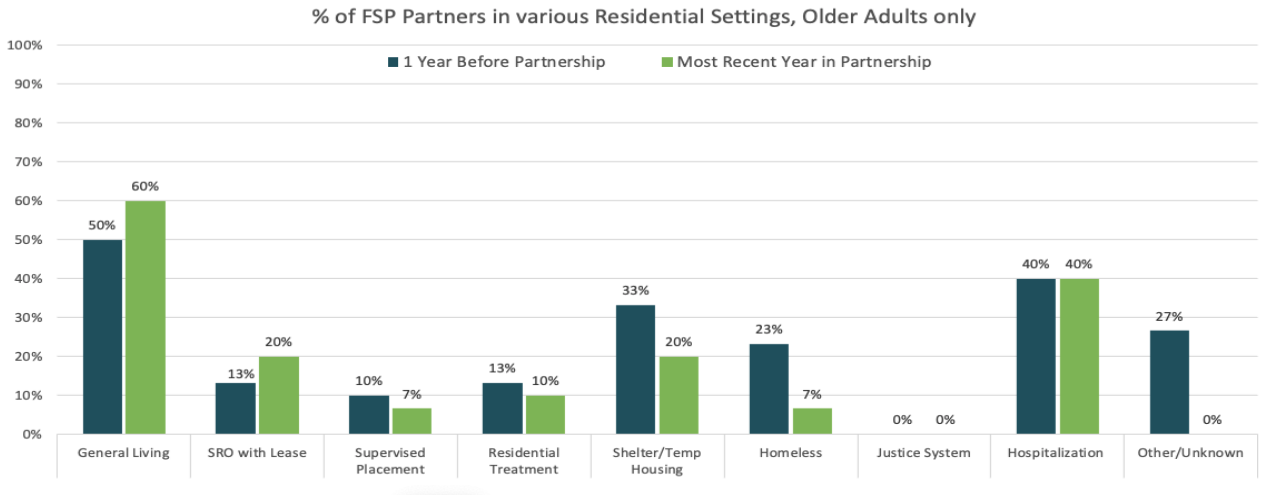


Exhibit RES-OA-2. Percentage of FSP Clients in Various Residential Settings, Comparing Baseline Year to Most Current Year in FSP, Older Adults only (n=30)



Emergency Events

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

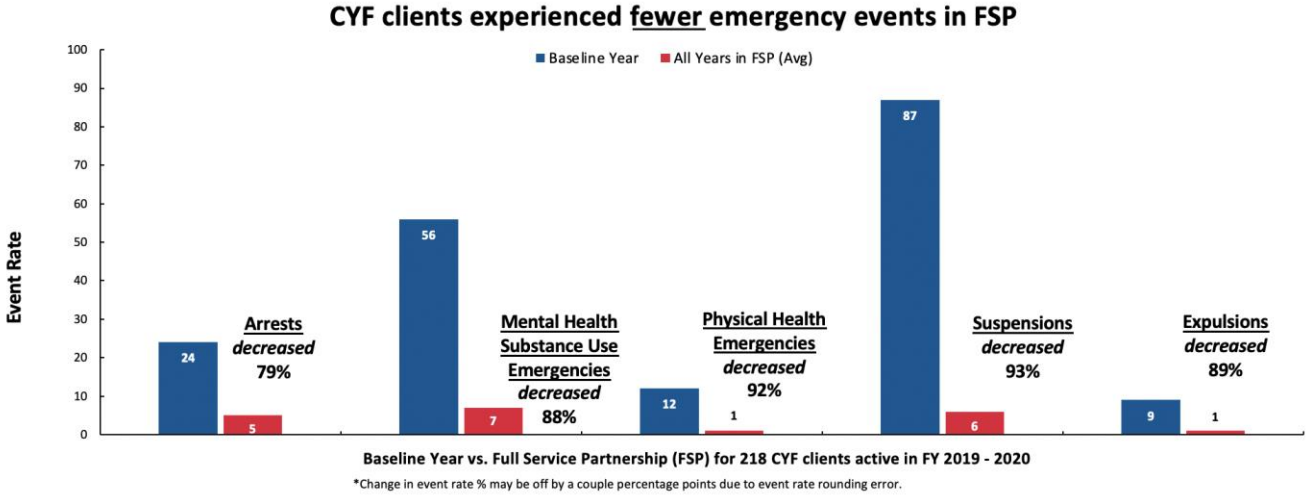
Report Methodology. The graphs below compare Emergency Events for **all FSP clients active any time in the fiscal year 2019-20** from the one-year baseline to an **average of emergency events over all years while in the FSP**. Event rates are reported here, for simplicity, as number of Emergency Events per 100 clients for each one-year period.

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

Among child clients, fewer emergency events were reported after entering FSP (Exhibit EE-CYF)**.** Compared to baseline trends, there were marked declines across all types of emergency events reported for child clients. One contributing factor to reduced expulsions is that the San Francisco Unified School District (SFUSD) established a policy that disallows expulsions. Since some clients' baseline and follow up years were prior to this policy change, or they are students outside the SFUSD, small numbers of expulsions do still appear in the graph.

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

Exhibit EE-CYF. Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, CYF only (n=218)

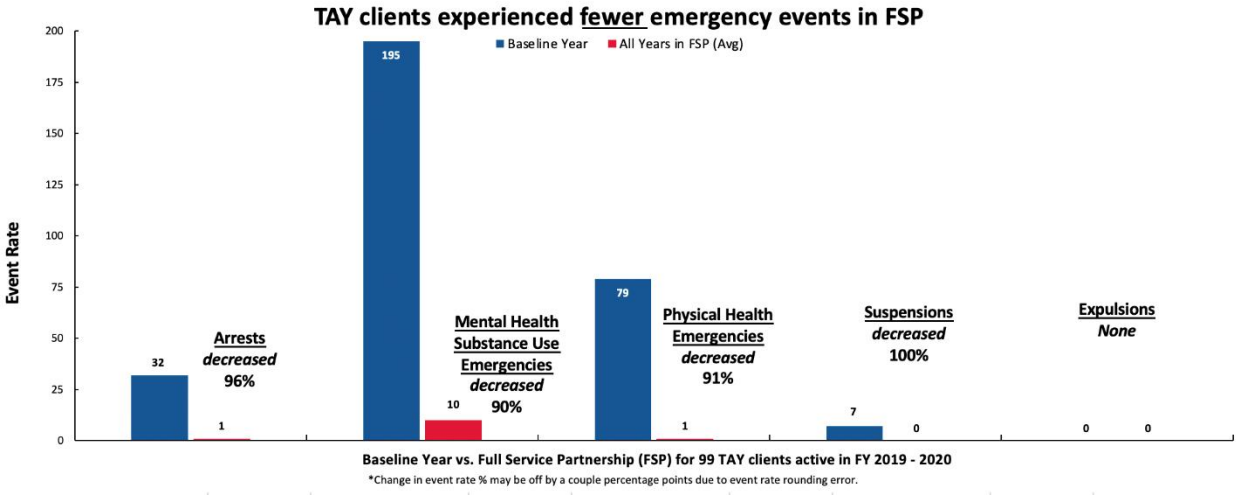


Among TAY clients, fewer emergency events were reported (Exhibit EE-TAY)**.** Marked declines appear across all emergency events experienced by TAY clients. For example, arrests, mental health, substance use, and physical health emergencies all decreased by 90% or more.

Discharge data also suggest that TAY engagement may be a major challenge (see Exhibit RFD, page 18). Up to 17% of TAY clients are "Unable to Locate" or "Partner Left Program." Data suggest that TAY clients may leave the FSP programs within the first year of service. Due to loss to follow up, the full sample of TAY clients served may be under-represented in the follow-up rates displayed here for our FSP programs.

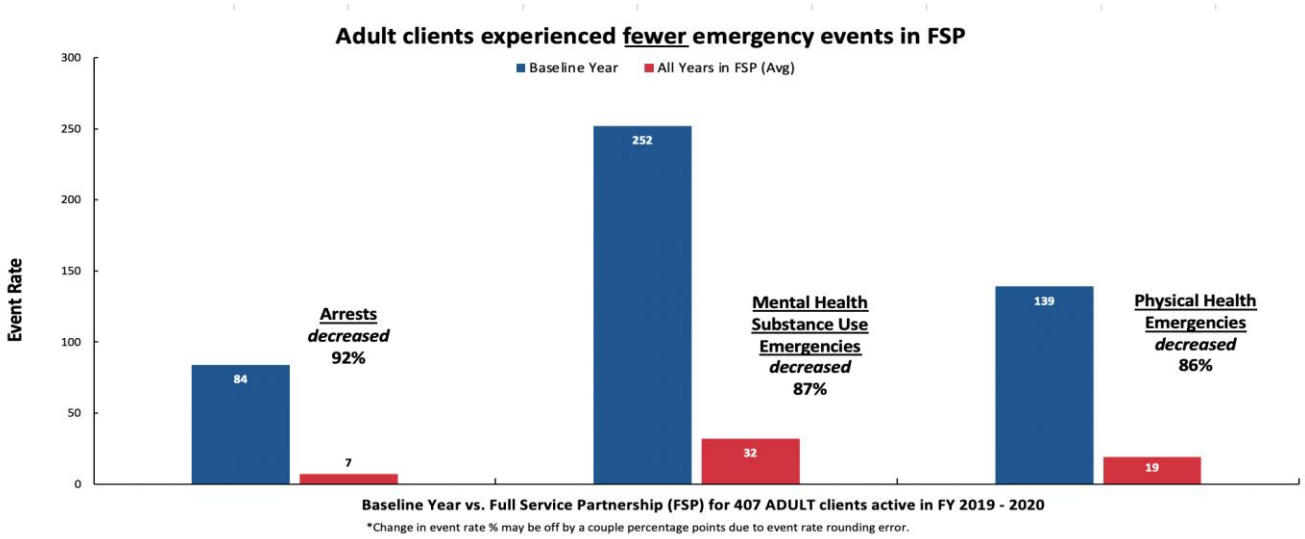
School Suspensions declined from 7 to 0 per 100 clients, and there were no School Expulsions reported across all TAY clients who were active in 2019-20. Either expulsions are under-reported, or this decrease reflects a policy in the school district, as mentioned for Exhibit EE-CYF, student expulsions are extremely rare.

Exhibit EE-TAY. Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, TAY only (n=99)



Among Adult clients, fewer emergency events were reported compared to baseline FSP data (Exhibit EE-A)**.** Marked declines appear across all emergency events experienced by adult FSP clients. For example, arrests, mental health, substance use, and physical health emergencies all decreased by over 85%.

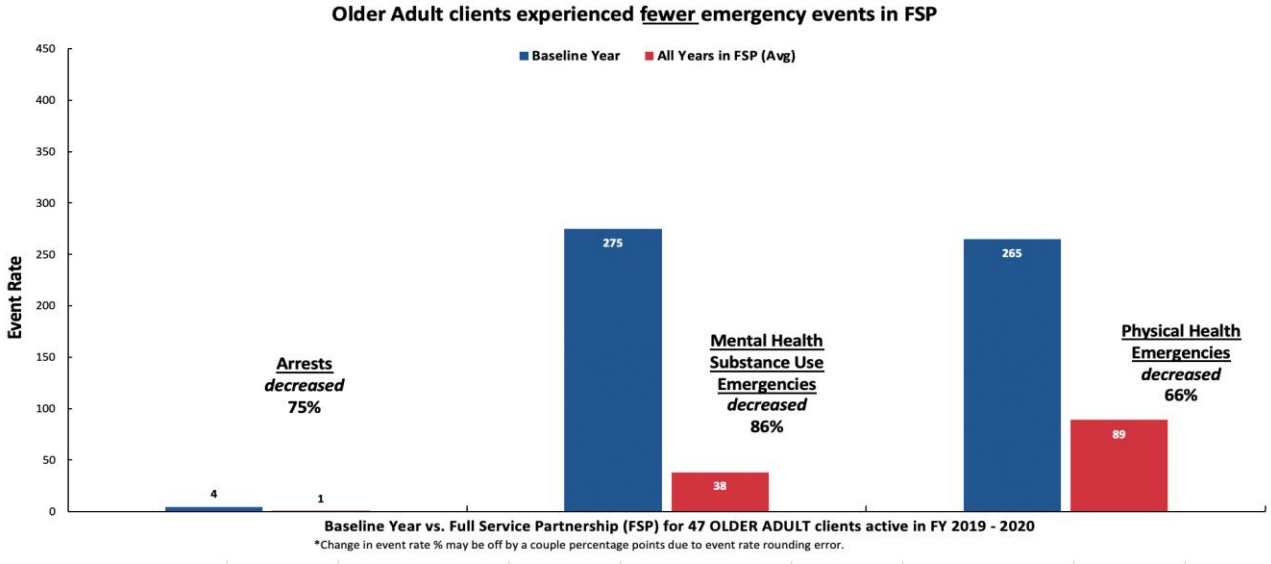
Exhibit EE-A. Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Adult Clients only (n=407)



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

While, physical health emergencies may be common among older adults, particularly those served by FSP programs, the rate of physical health emergencies (285 per 100 clients at baseline), compared to the first year in an FSP, dropped 66% to 89 events per 100 clients after at least one year of FSP service. The positive effect may be related to FSP case management increasing attention to previously untreated medical issues.

Exhibit EE-OA. Change in Rate of Emergency Events, Comparing the Baseline Year to an Average of All Years in FSP, Older Adults only (n=47)

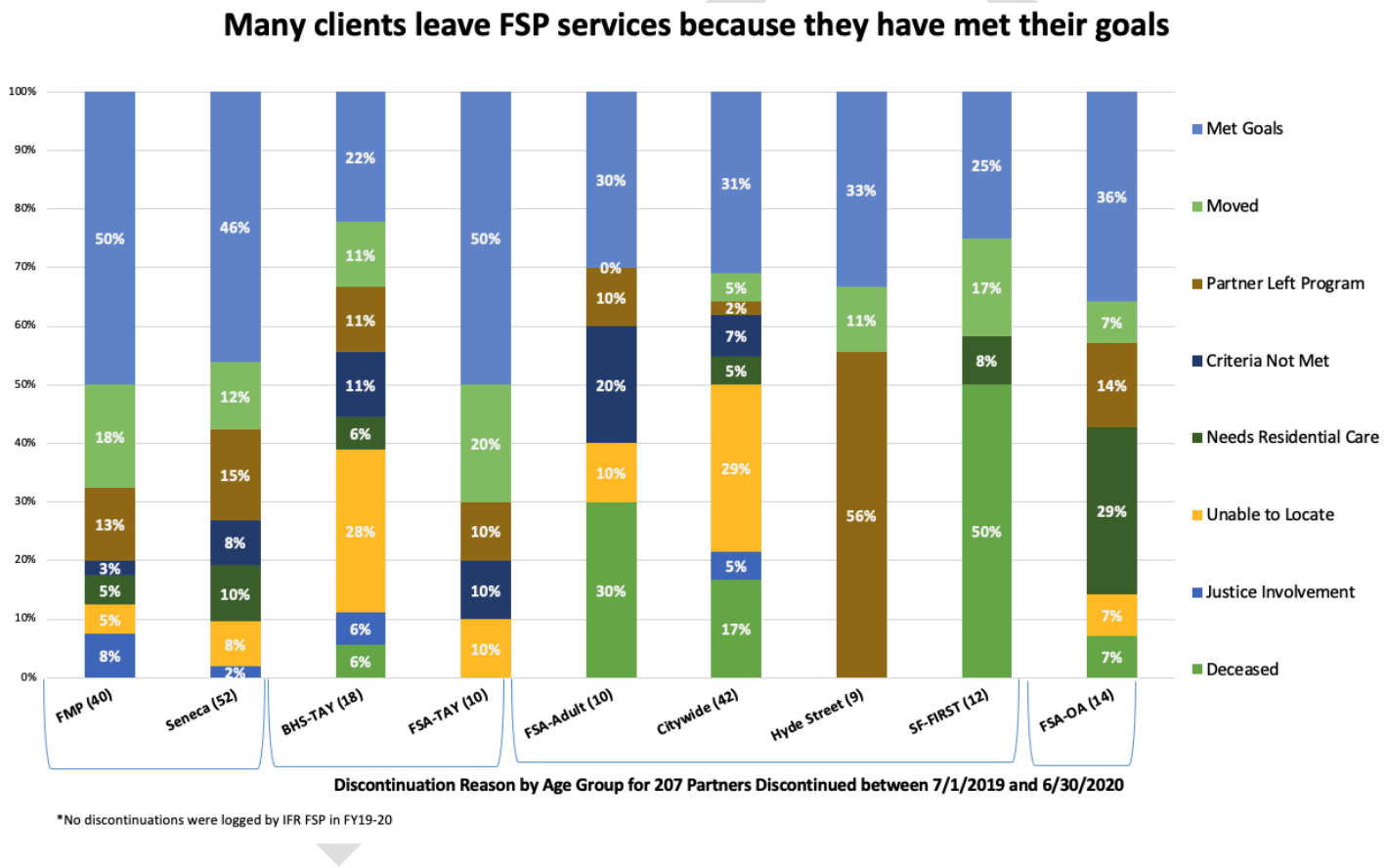


Reason for Discontinuation

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

Reasons for Discontinuation from FSP varied widely in FY 2019-20. The client reason for discontinuation reported most often across all age groups was "Met Goals" and represented 39% of discharges across the whole FSP system of care. Concerningly, 12% of discontinuations among Adults were due to death, often premature and complicated by long-term substance overuse, chronic medical conditions, homelessness, and poor access to medical care. Additionally,10% of discontinuations among TAY were due to justice involvement.

Exhibit RFD. Reason for Discontinuation for All Clients, by Program and Age Group



*No discontinuations were logged by IFR FSP in FY19-20

Improving DCR Data Quality

Since the inception of the DCR, ensuring high quality KET data to capture 100% of residential changes, emergency events, and other life events has proven a formidable challenge.

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

The Workgroup also provides a KET tracking template as a tool to help case managers record KETs as the events occur and remember to enter them in the DCR later. Data quality and completion appear to be impacted or enhanced, depending on the staff capacity of the program to prioritize DCR data entry.

The DCR Workgroup also provides one-on-one and group trainings on DCR online during COVID-19 and visits individual programs, as needed, when safe to do so. In FY19-20, the DCR Workgroup provided virtual DCR user trainings and ongoing support in both data entry and reporting. Based on these trends, more communication and support are needed to increase the completion rate of DCR data.

How the FSP programs and clients have been impacted by the COVID-19 pandemic

The following is a very brief summary of narrative reports to MHSA from the FSP programs for FY19-20 which included the months of March through June when San Francisco was under a series of health orders to Shelter-In-Place (SIP) to mitigate transmission of the virus.

Observations/Challenges:

- Several programs note a decrease in Medi-Cal billable services due to COVID-19, SIP, and a shift to telehealth.
- Several programs also describe difficulties engaging clients during SIP due to homelessness/transient housing, technological challenges (lack of phone or laptop, unreliable Wi-Fi for both clients and staff), reduced face-to-face interactions, and Zoom burnout. Difficulty in outreach has led to increased isolation for some clients. One program, in particular, notes a 17x increase in client deaths due to overdose (meth/fentanyl) and isolation. This has been particularly hard on clients and providers alike. Deaths from overdose during the pandemic have been three times higher than deaths from COVID-19.
- Access to housing and basic needs remains a challenge, and exacerbates mental health symptoms when not met.
- Nearly all programs note staffing challenges that have resulted in extremely high case loads for existing providers. Salary disparities, in combination with budget cuts and the high cost of living in San Francisco, make it difficult to recruit or retain qualified staff.

Adaptations:

- Programs have adapted tremendously in light of the COVID-19 pandemic, by providing services outdoors and via various models of telehealth. Some programs report this has increased outreach.
    - Leveraging meal delivery services to deliver medications as well
- Identifying high-risk clients, and increasing outreach to them specifically

- One program (SF FIRST) developed a COVID-19 protocol for client outreach, that can serve as a guideline for other programs
- Providing flip and smart phones and demonstrations of how to use tech
- Shorter, but more frequent calls have been implemented to combat Zoom fatigue
- "Para-telehealth" where providers and clients connect virtually (by phone or computer) in a pair of physical rooms near each other at the program site
- Zoom games to increase engagement

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[2]
Full-Service Partnership (Children)	192 Clients	$1,300,533	$6,774
Full-Service Partnership (TAY)	177 Clients	$1.200,834	$6,784
Full-Service Partnership (Adult)	406 Clients	$4,788,881	$11,795
Full-Service Partnership (Older Adult)	137 Clients	$1,060,514	$7,741

Behavioral Health and Juvenile Justice System Integration

Program Collection Overview

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

Target Populations

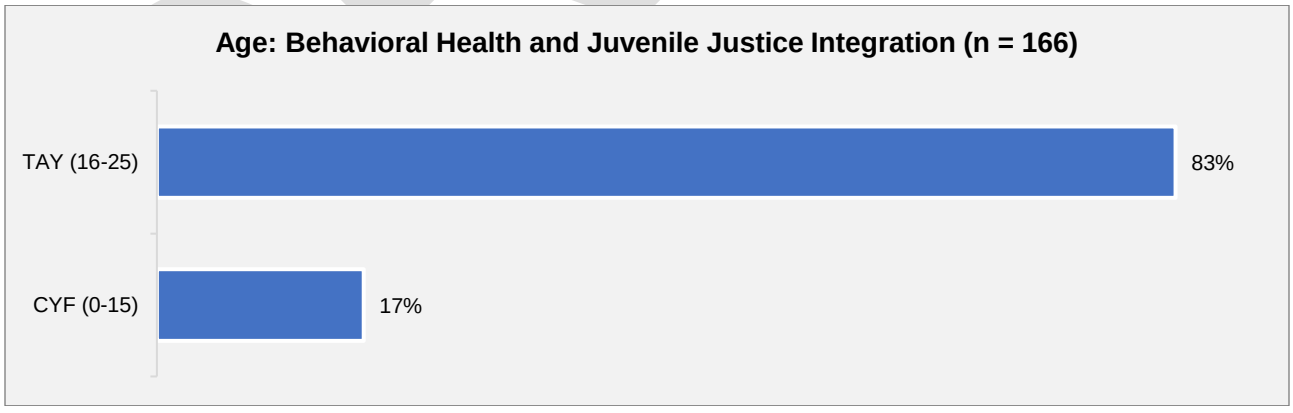
The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11- 21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. These programs and their affiliated programs operate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

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

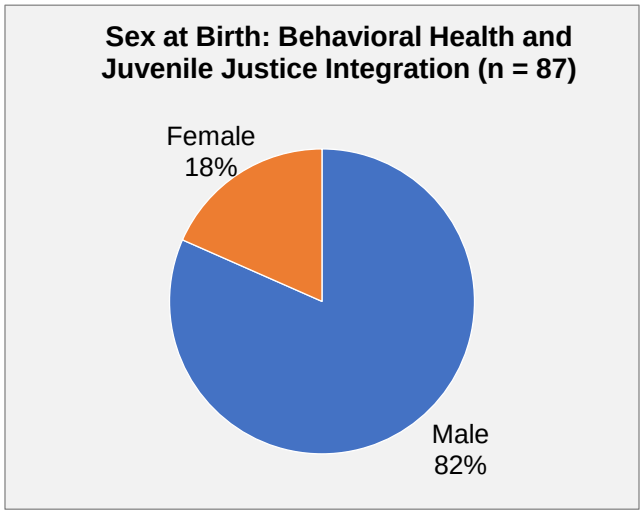
Behavioral Health and Juvenile Justice System Integration Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Assess, Identify Needs, Integrate Information & Match to Services (AIIM) Higher *Seneca Center and SFDPH*	CSS Other Non-FSP 5. Integration of Behavioral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

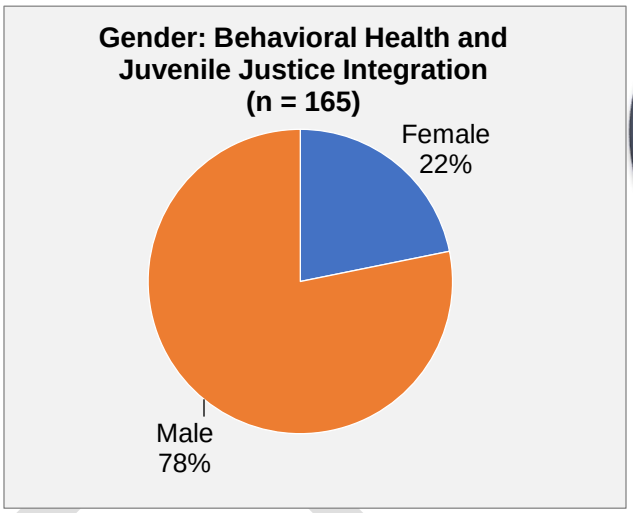
Participant Demographics, Outcomes, and Cost per Client

Demographics: Behavioral Health and Juvenile Justice Integration

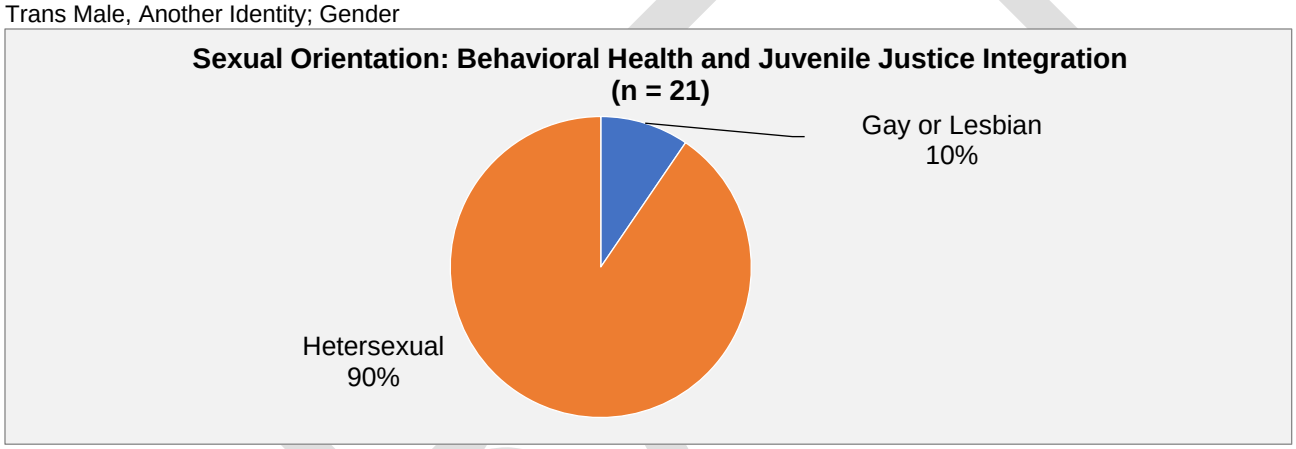


*< 1 percent of participants reported Adult (26-59), Older Adults (60+); Age





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



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

Primary Language	n	%
Black/African American	62	43%
American Indian or Alaska Native	0	0
Asian	3	0%
Native Hawaiian or Pacific Islander	7	1%
White	8	1%
Other Race	5	0%
Hispanic/Latino	49	34%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	11	8%
Total	145	100%

Primary Language	n	%
Chinese	1	1%
English	154	94%
Russian	0	0%
Spanish	8	5%
Tagalog	0	0%
Vietnamese	0	0%
Another Language	0	0%
Total	163	100%

Program	FY19-20 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher – Seneca Center and DPH	• 166 youth (111% of goal) received consultation, information and referral or Linkage services 36 youth received the full scope of AIIM Higher services (assessment planning, and linkage and engagement services). • 36 clients (100%) linked to appropriate community-based services. • 31 youth (86%) participated in warm handoff meetings facilitated by AIIM Higher staff and additional face-to-face services with the identified long-term provider, indicating successful linkage and engagement. • 10 youth (32%) submitted surveys after successfully participating in warm handoff meetings. • 9 surveys (90%) stated that they either agree or strongly agree that their "family was link to the services they needed".

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[3]
Behavioral Health & Juvenile Justice Integration	166 Clients	$396.350	$2.388

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

Program Overview

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

Target Populations

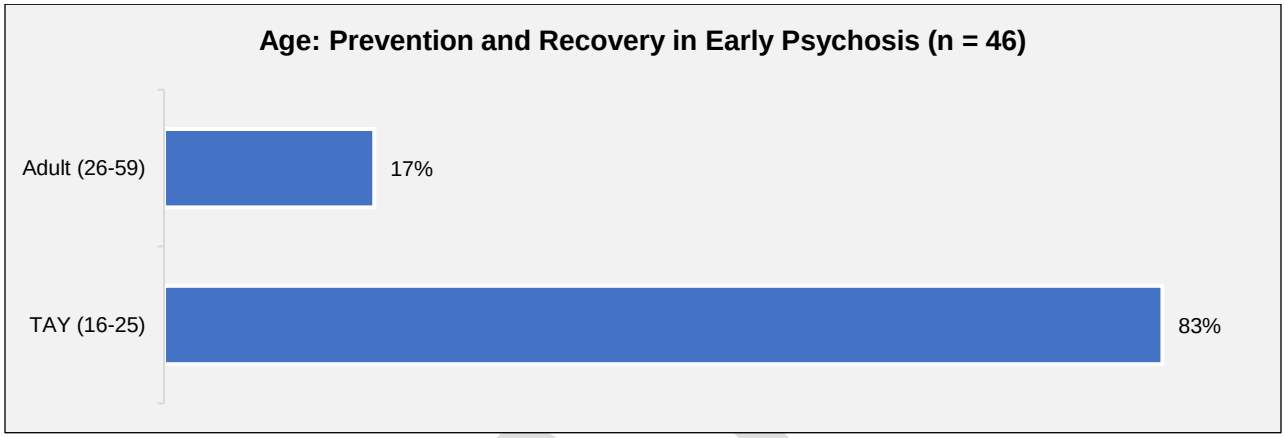
PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as

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

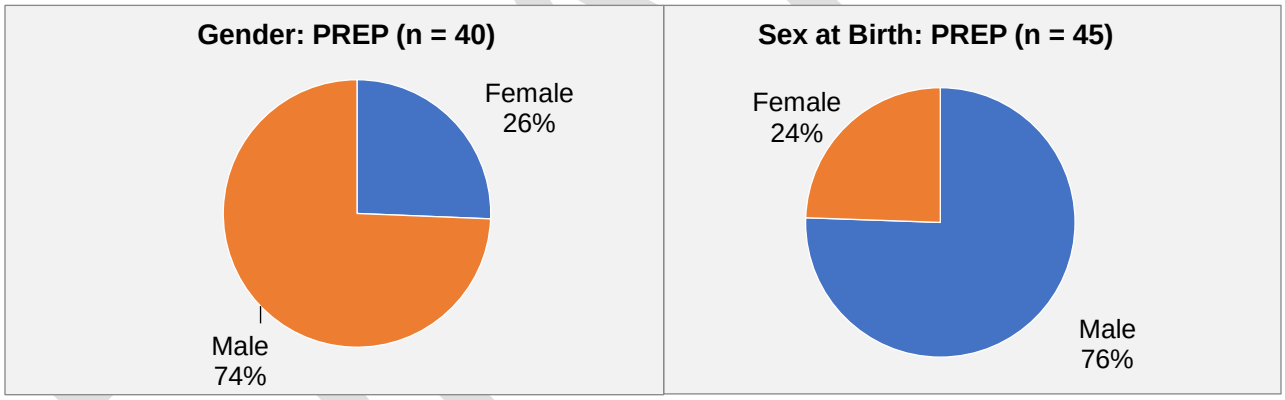
identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years.

Participant Demographics, Outcomes, and Cost per Client

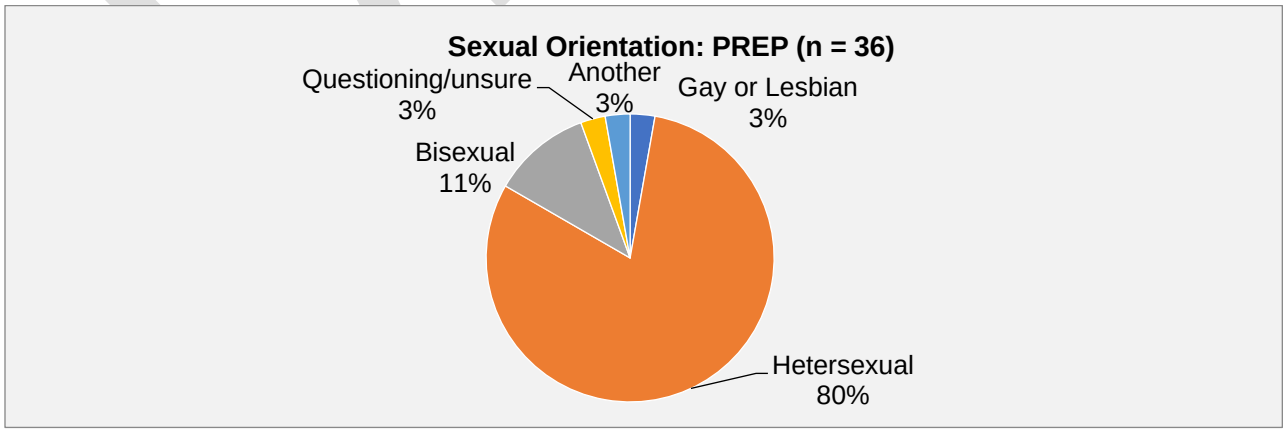
Demographics: Prevention and Recovery in Early Psychosis (re)MIND



*< 1 percent of participants reported data for CYF (0-15) and Older Adults (60+); Age



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



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

Race/Ethnicity	n	%
Black/African American	7	8%
American Indian or Alaska Native	0	0%
Asian	12	13%
Native Hawaiian or Pacific Islander	2	2%
White	10	11%
Other Race	14	15%
Hispanic/Latino	10	11%
Non-Hispanic/Non-Latino	36	40%
More than one Ethnicity	0	0%
Total	91	100%

Primary Language	n	%
Chinese	0	0%
English	39	91%
Russian	0	0%
Spanish	2	5%
Tagalog	0	0%
Vietnamese	2	5%
Another Language	0	0%
Total	43	100%

Program	FY19-20 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP) – Felton Institute	● 31 programs and stakeholder groups (207% of goal) received 1:1 outreach. ● 84 phone screenings (240% of goal) and/or consultations regarding potential referrals. ● 26 diagnostic assessments (173% of goal) conducted. ● 18 psychoeducational presentation and engagement activities (120% of goal) held. ● 1,549.28 hours total of direct and indirect service hours (77% of goal) provided. ● 4 outreach activities (22%) focused on community stakeholders serving the Southeast Sector of San Francisco. ● 10 participants (37%) represented residents of the Southeast Sector. ● 8 (50%) of participants enrolled for at least 12 months, engaged in new employment and/or education activities. ● 7 participants (70%) had a decrease in acute inpatient episodes and 10 (100%) had a decrease in days hospitalized. This is a 59% reduction in inpatient setting days during the first 12 month of program enrollment. ● 6 program participants (38%) enrolled in the program for at least 12 months had no acute inpatient setting episodes within the 12 months prior to their enrollment. Among these 6 clients, 4 (67%) remained with zero acute inpatient episodes during the first 12 month of program enrollment. ● 16 participants (100%) enrolled for at least 12 months showed an increase of at least 1PCI (Standardized Performance Change Index) point on clinician ratings on the ANSA in Life Domain Functioning or Strengths domains OR a decrease of at least 1PCI on Behavioral Health Needs or Risk Behaviors domains. ● 92.9% of SFDPH Consumer Experience Survey participants reported an average score of 3.5 or greater (average participant satisfaction score was 4.27).

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[4]**
Prevention and Recovery in Early Psychosis (PREP)	46 Clients	$637,811	$13,856

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

Program Overview

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

1) Mental health access for authorizations into the Private Provider Network
2) The Treatment Access Program for assessment, authorization, and placement into residential treatment
3) The Offender Treatment Program to place justice mandated clients into addiction and dual diagnosis treatment
4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy
5) The BHS Pharmacy that provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol 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 appoints 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

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

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.

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	FY19-20 Key Outcomes and Highlights
Behavioral Health Access Center (BHAC) – Department of Public Health	• 22.680 calls received from residents of San Francisco seeking access to mental health services. • 799 face-to-face contacts conducted with clients accessing behavioral health services, and also in need of primary care medical services.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[5]
Behavioral Health Access Center	1,788 Clients	$1,020,752	$571

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

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

Program Collection Overview

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

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

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

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

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

In addition, MHSA has made investments to bridge Behavioral Health Services and Primary Care in other ways. We have supported 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:

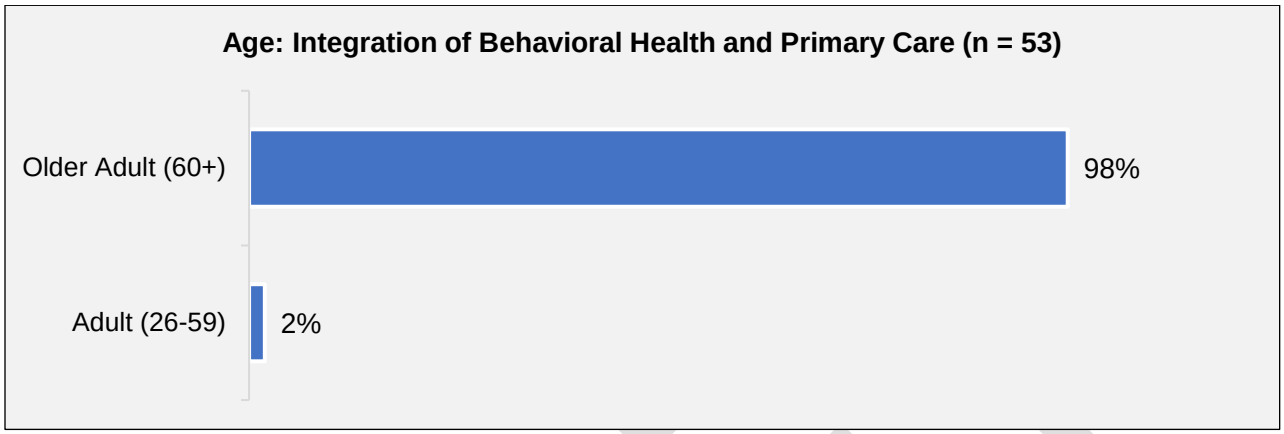
- The SPY Project
- Disability Clinic
- Hawkins Village Clinic
- Cole Street Youth Clinic
- Balboa High School Health Center

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

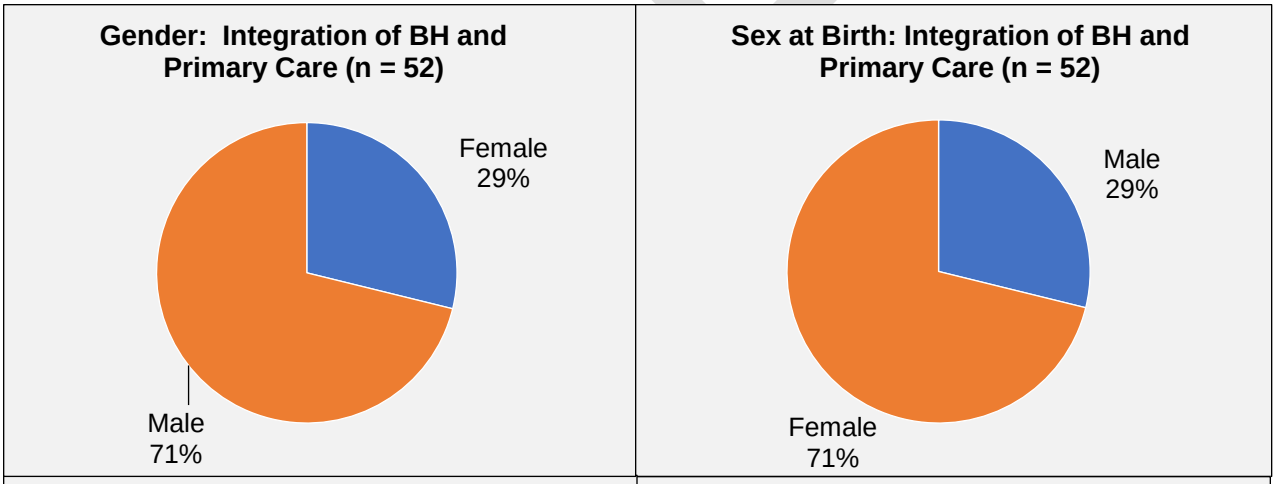
Target Populations

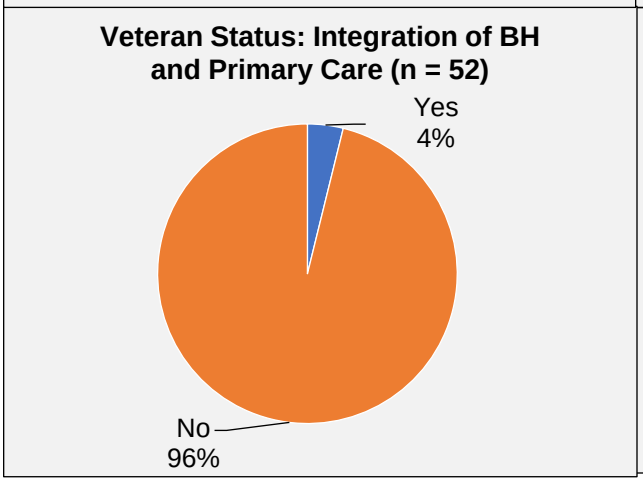
The target populations for these services are individuals and families served in primary care clinics with unidentified behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

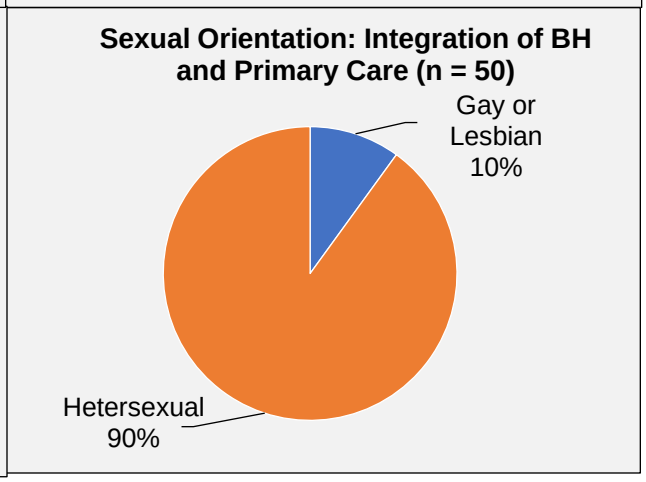
Demographics: Integration of Behavioral Health and Primary Care



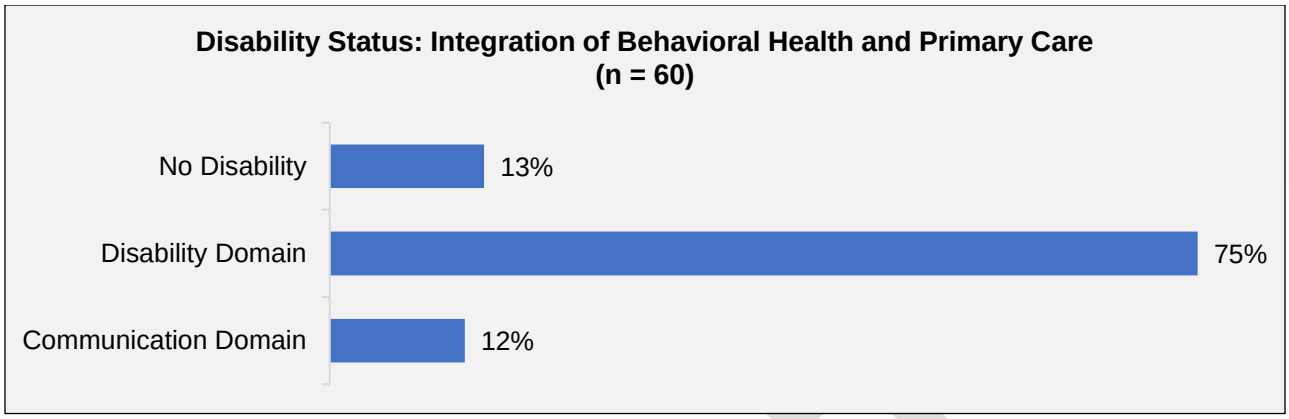
.*< 1 percent of participants reported data for CYF (0-15) and TAY (16-25); Age







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



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

Race/Ethnicity	n	%
Black/African American	13	13%
American Indian or Alaska Native	0	0%
Asian	3	3%
Native Hawaiian or Pacific Islander	0	0%
White	30	29%
Other Race	6	6%
Hispanic/Latino	5	5%
Non-Hispanic/Non-Latino	46	44%
More than one Ethnicity	1	1%
Total	104	100%

Primary Language	n	%
Chinese	0	0%
English	48	92%
Russian	0	0%
Spanish	4	8%
Tagalog	0	0%
Vietnamese	0	0%
Another Language	0	0%
Total	52	100%

Program	FY19-20 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – Curry Senior Center	• 1004 Face to Face encounters (200% of goal) completed by Behavioral Navigator. • 104 PHQ-9 (104% of goal) completed. • 55 clients (101% of goal) underwent case manager screening to assess mental health needs.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[6]
Integration of Behavioral Health and Primary Care	433 Clients	$1,485,246	$3,430

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

Moving Forward in Recovery-Oriented Treatment Services

Behavioral Health Services in Primary Care

While no program changes occurred in FY2019-20, the FY2020-21 will bring new changes to the Behavioral Health Services in Primary Care program. These changes will include increased funding to support the program's Behavioral Health Navigator. These will be reallocated funds from the recently eliminated registered nurse positions.

A part-time Peer Navigator position will also be added, working 22.5 hours per week and providing up to 300 face-to-face client encounters per year. This change is a result of the success of the current Peer Navigator position.

Full-Service Partnership (FSP) Programs

SF-MHSA plans to increase collaborate with the BHS Office of Equity and Workforce Development (OEWD) to revisit FSP programming and outcomes through an equity lens. BHS/SF-MHSA has renewed its commitment to equity, and in the coming year(s) will identify service and outcome disparities, and address how our FSPs can improve by working toward reducing these disparities.

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

Service Category Overview

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

2020 Trans Peer Event Poster

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

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

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

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

Target Populations

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

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

Peer-to-Peer Support Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Lifting and Empowering Generations of Adults, Children, and Youth (LEGACY) *SFDPH*	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	LEGACY program offers family and youth navigation services and education with a focus on stigma reduction.
Peer to Peer, Family-to-Family *National Alliance on Mental Illness (NAMI)*		NAMI Peer-to-Peer, Family-to-Family program utilizes trained peers to provide outreach, engagement, navigation in the community. Peer mentors meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the participant by meeting weekly for 1 hour and assisting the participant with their wellness and recovery journey. Mentors also act as a community resource for helping a participant direct their own path to wellness and recovery.
Peer Specialist Mental Health Certificate and Leadership Academy *Richmond Area Multi-Services (RAMS)*		The Certificate Program (Entry and Advanced courses) prepares BHS consumers and/or family members with skills & knowledge for peer specialist/counseling roles in the systems-of-care. In addition, the program offers the Leadership Academy which is a monthly training series designed to support and educate peer providers in the behavioral health field. Trainings will also focus on building skills for participation in a variety of activities that request peer provider/consumer input (e.g., boards and advisory committees, review panels, policy development, advocacy efforts, etc.).

Peer-to-Peer Support Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Gender Health SF (formerly known as Transgender Health Services) *SFDPH*	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	Gender Health SF program provides access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. MHSA began funding the peer counselor positions only, to support this program as a supplemental enhancement. Peer counselors ensure proper coordination of behavioral health services and ensure all behavioral health needs are addressed.
Peer-to-Peer Employment Program *Richmond Area Multi- Services (RAMS)*		The Peer Counseling & Outreach facilitates wellness activities and enhances treatment services by providing peer counseling and supportive case management & resource linkage to clients of BHS clinics/programs. The services, offered by individuals with lived experience, aim to improve the level of engagement with clients, foster feelings of hope, and promote recovery & wellness. The Peer Internship offers entry-level placements in peer direct services and administrative support roles. In a collaborative learning and supported environment, peer interns work with other peer providers in a variety of DPH programs. The paid internships are nine months (20 hours/week) in duration.
Peer Wellness Center *Richmond Area Multi-Services (RAMS)*		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 *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 INN 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.

Spotlight on Transgender Pilot Project Outcomes

Completed this year, the Transgender Pilot Project (TPP), funded by the MHSA Innovations program, aimed to increase access to mental health services and improve a sense of connectedness within the transgender community, specifically for trans women of color.

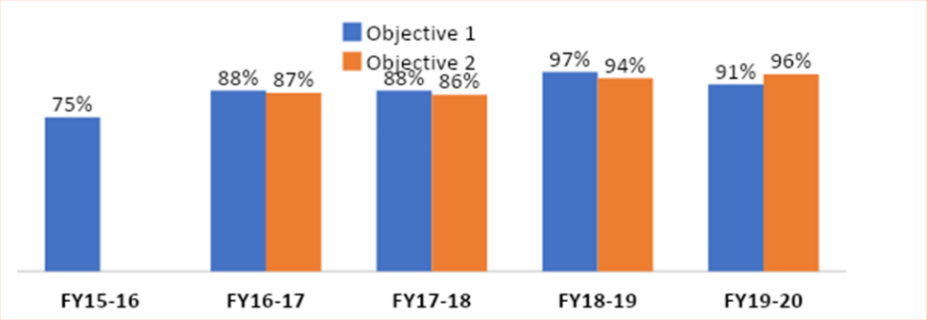
The TPP utilizes a peer support services model, in which peer specialists (primarily trans women with lived mental health experiences) engage trans women into the Behavioral Health Services system of care, eliminating as many barriers to engagement as possible. The overarching goals of the program are to 1) increase social connectedness within the trans community and 2) increase health, wellness, recovery, and overall quality of life for trans individuals.

TPP staff implemented this program with several core activities:

- Four weekly peer-led, strength-based and resiliency-focused support groups
- Peer-led outreach and education
- An annual peer-run Transgender Health Fair

Within the least five years, TPP has exceeded its objectives. At least 75% of participants each year reported an increase in social connectedness resulting from their participation in the peer-led groups (goal 1). Also, over 75% of Health Fair participants reported improvements in their health, wellness, and recovery as a result of attending the fair each year (goal 2).

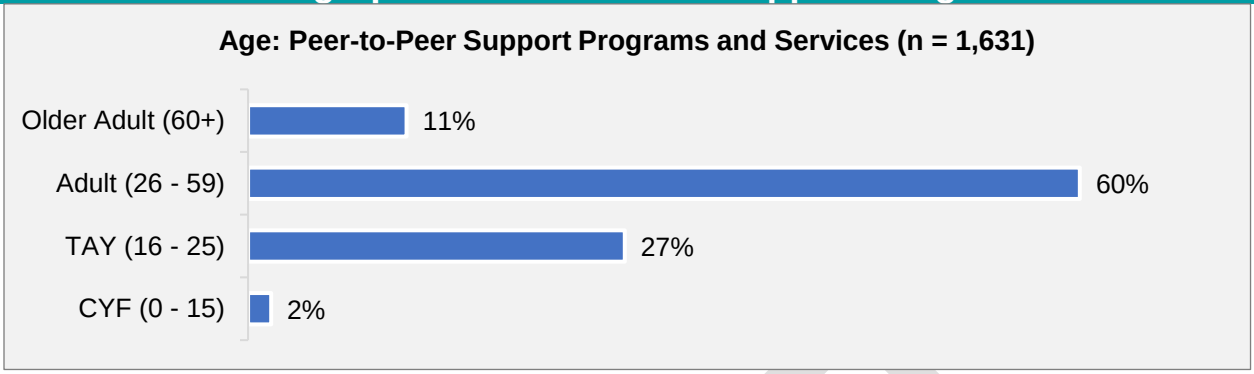
These successful outcomes demonstrate the efficacy of a peer-led, culturally competent model that emphasizes community in promoting wellness and health. We are pleased to announce that this successful programming will continue under alternate funding sources.



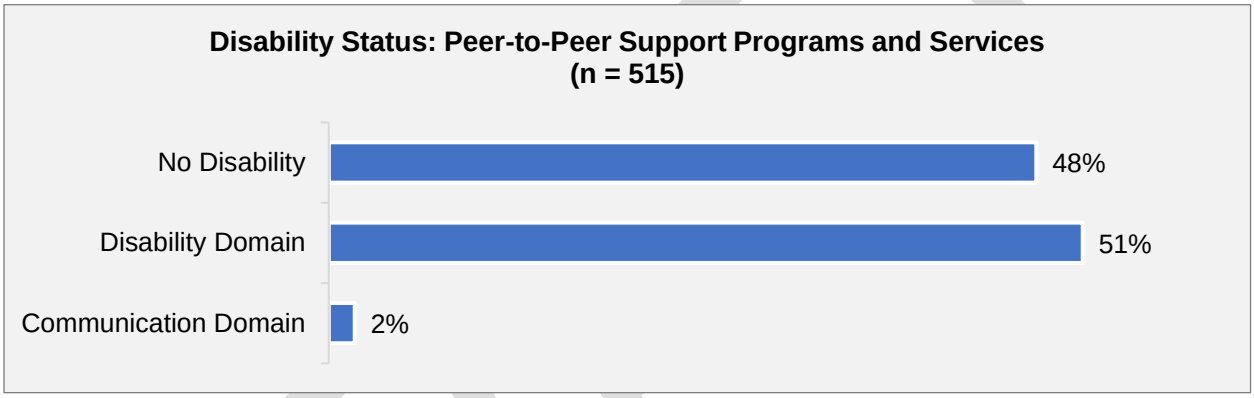
1. TPP Participants Meeting Annual Performance Objectives
Note: FY2015-16 data for Objective 2 is not available.

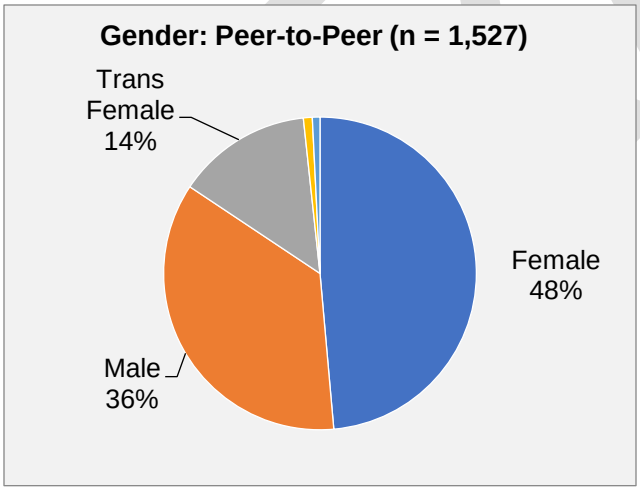
Participant Demographics, Outcomes, and Cost per Client

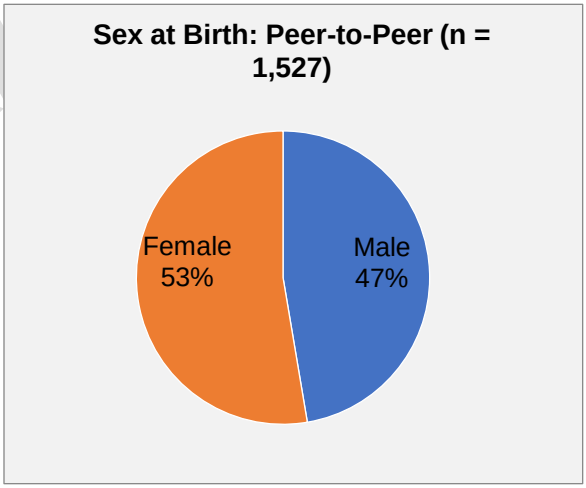
Demographics: Peer to Peer Support Programs

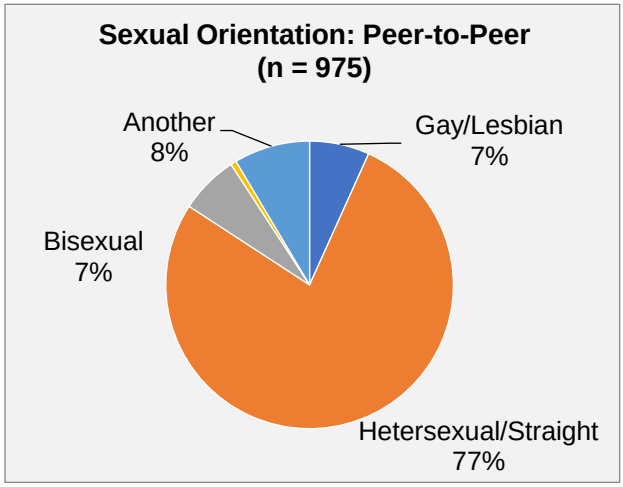


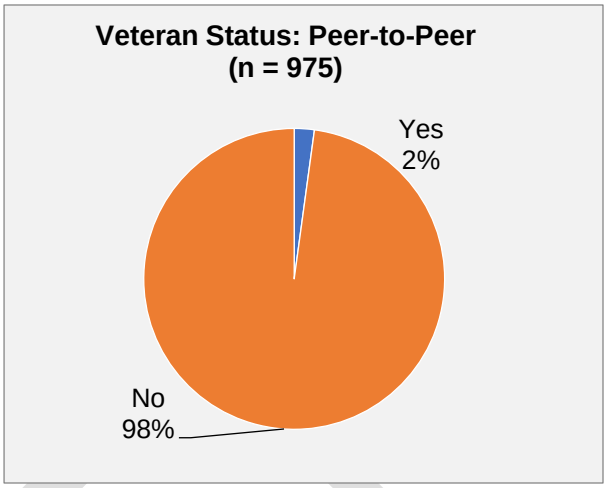
*< 1 percent of participants reported data for Trans Male, Another Gender; Gender Identity
*< 1 percent of participants reported data for Questioning/Unsure; Sexual Orientation
*< 1 percent of participants reported data for Another Disability; Disability Status











Race/Ethnicity	n	%
Black/African American	258	6%
American Indian or Alaska Native	19	0%
Asian	203	5%
Native Hawaiian or Pacific Islander	26	1%
White	401	9%
Other Race	31	1%
Hispanic/Latino	292	7%
Non-Hispanic/Non-Latino	3,210	72%
More than one Ethnicity	3	0%
Total	4,443	100%

Primary Language	n	%
Chinese	75	10%
English	507	67%
Russian	6	1%
Spanish	148	20%
Tagalog	13	2%
Vietnamese	4	1%
Another Language	4	1%
Total	753	100%

Program	FY19-20 Key Outcomes and Highlights
Transgender Pilot Project - DPH	• 88-94% of participants report an increase in social connection as evidenced by the client survey administered by SFDPH. • 100% of participants reported improvements to health, wellness and recovery as a direct result of the program. • Over 60 people attended the 9th Annual MHSA Trans Health and Wellness Fair including representation from two hospitals and a variety of community-based agencies. • 100% of surveyed attendees reported that they are more aware of and more likely to access services as a result of the event.
Lifting and Empowering Generations of Adults, Children and Youth (LEGACY) - DPH	• 3 community health fairs and outreach events (43% of goal) held. • 21 adult consumers (70%) provided valid phone numbers. and 2 (9.5%) accessed services through LEGACY. • 61 referred individuals (100%) screened to receive culturally and linguistically appropriate services through one-on-one peer-to-peer support to address their and/or their children's mental health needs. • 49 consumers (44%) completed at least one type of self-identifying behavioral health goal. • 70 consumers (350% of goal) participated in at least one of the 7 hosted LEGACY's Family Support Night groups. • 19 survey participants (90%) reported feeling empowered to share their experiences as a consumer of Behavioral Health Services. • 91 consumers (82%) participated in at least one type of peer-to-peer support group, workshop, or Family Support Night (FSN).
Peer to Peer, Family to Family - NAMI	• 16 Peer to Peer participants (89%) reported an increased understanding of their mental illness as a diagnostic medical condition, and felt better able to recognize signs and symptoms as evidenced by the completion of a relapse prevention plan. • 51 Family to Family participants (93%) (51) reported feeling more prepared to solve future problems with their loved one living with a mental health condition and better connected to the community and available resources. • 20 Peer to Peer participants (85%) understand what action steps to take when symptoms reoccur. 15 Peer to Peer Participants (88%) reported an increased awareness and skills to better practice self-care.
Peer Specialist Certificate, Leadership Academy and Counseling – Richmond Area Multi-Services	• 28 students (93%) plan on pursuing a career in the field of health and human services. • 30 Summer Advanced Course students (88%) successfully graduated from the program. • 29 students (96%) reported an increase in skills and knowledge due to participation in the program. • 4 social networking events (100% of goal) held in addition to 2

Program	FY19-20 Key Outcomes and Highlights
(RAMS)	Alumni Reunions.
Gender Health SF – DPH	• 2 surgical Education and Preparation Programs groups conducted. • 13 patient EPP participants (100%) reported feeling satisfied with the information gained during the EPP sessions. • 18 providers (86%) rated their cultural competency training as excellent.
Peer to Peer Employment - Richmond Area Multi-Services (RAMS)	• 33 staff (89%) attended four or more trainings. • 26 surveyed clients (81%) reported improvement in their overall quality of life. • 24 surveyed clients (75%) reported that as a result of participating in services, they feel socially connected. • 10 enrolled interns (100%) successfully completed the Peer Internship training. • 7 interns (78%) reported an improvement in their ability to manage stress in the workplace.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[7]
Peer-to-Peer Programs	4,852 Clients	$4,685,887	$966

Moving Forward in Peer-to-Peer Support Programs

Peer-to-Peer services remain a strong component of SF-MHSA programs. This year, all programs made a transition to virtual and hybrid models, taking major strides to find new and creative ways to tackle client isolation, increased levels of familial conflict, and stress resulting from the pandemic. Most programs saw an increase in demand and adapted to new engagement methods, which will continue into the coming year and beyond.
NAMI initially struggled with low enrollment, moving the program to shift outreach and engagement strategies that built on a growing volunteer base and develop public education presentations geared toward various target audiences. Programs such as LEGACY and NAMI, which provide peer-led support groups, found new and creative ways to support families, such as offering games, cooking, art workshops, and other interactive activities virtually. Ultimately, these peer-led efforts create and maintain critical safe spaces for community. LEGACY, for example, is adding a Girls' Support Group for transitional-aged youth, and peer support groups for caregivers, which will continue into the coming year.

RAMS' peer program developed a phone outreach program to unhoused individuals, expanded services, and further integrated peers as leaders in every level of the system of care, from direct service provision to program support and development. There were several staff changes in the

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

Gender Health SF program, which ultimately had to put some services on pause due to the Shelter in Place and associated orders. However, the program has done excellent work to resume programming and continue to make its services accessible for gender diverse clients. On November 19, 2020, the SFDPH Health Commission awarded Gender Health SF an employee recognition award for exceptional services and excellent performance of the program and staff. The award speaks to the program's mission and goal of serving San Francisco's most vulnerable trans and nonbinary communities to ensure quality care and increasing quality of life.

3. Vocational Services: CSS Funding

Service Category Overview

The San Francisco Department of Public Health incorporates vocational services within its mental health programming through MHSA funding. These vocational services 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.

In collaboration with The California Department of Rehabilitation, DPH 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 include vocational skill development and training, career/situational assessments, vocational planning and counseling, service coordination, direct job placement, ongoing job coaching, and job retention services. These MHSA-funded services are largely supported through the Community Services and Supports and INN funding streams.

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

Target Population

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

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

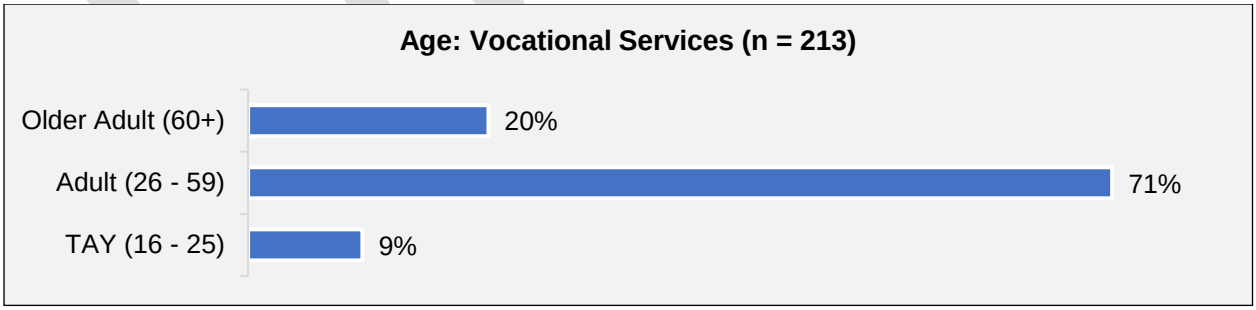
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
		coaching, vocational training, sheltered workshops, job placement, and job retention services.
First Impressions *UCSF Citywide Employment Program*		First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls, ceilings, and doors; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, vocational planning, job coaching, vocational training, workshops, job placement, and job retention services.
SF Fully Integrated Recovery Services Team (SF FIRST) *SFDPH*		The SF FIRST Vocational Training Program offers training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitator, as well as other positions. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal setting and hygiene maintenance for the workplace.
Janitorial Services *Richmond Area Multi-Services (RAMS)*		The Janitorial Services program provides janitorial and custodial vocational training to behavioral health consumers.
Café and Catering Services *UCSF Citywide Employment Program*		The Café and Catering Services program provides café, barista, catering and customer service vocational training to behavioral health consumers. Consumers learn café and catering related skills while working towards competitive employment.

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

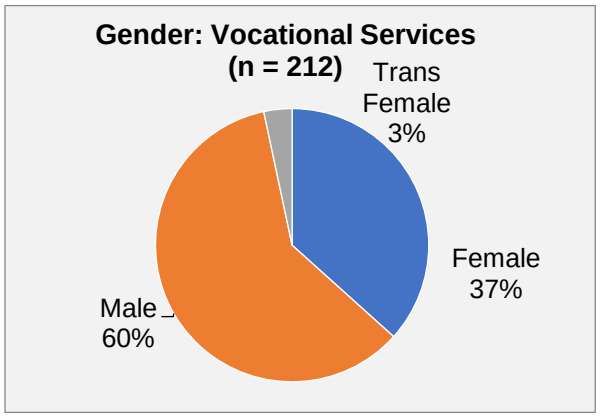
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
		• Help Desk: Participants learn customer and application support skills through the staffing Avatar Electronic Health Record (EHR) help desk, a call center. Skills learned include application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

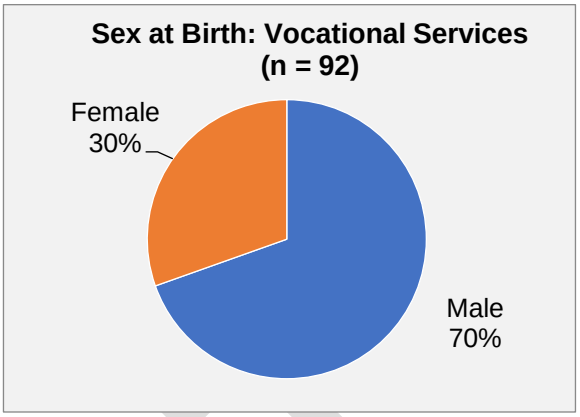
Participant Demographics, Outcomes, and Cost per Client

Demographics: Vocational Services

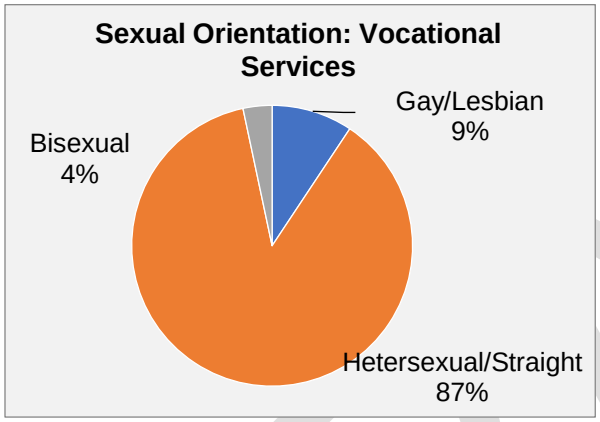


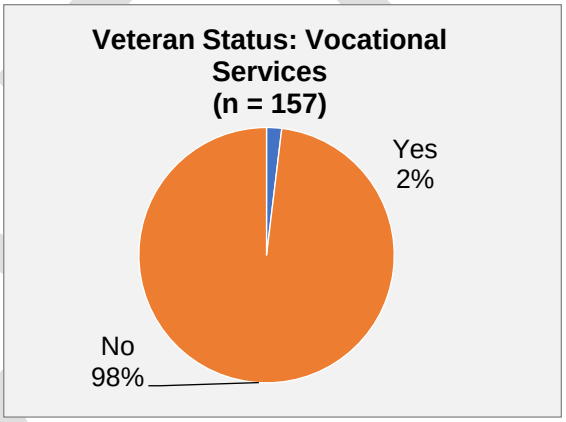
*< 1 percent of participants reported data for CYF (0-15); Age



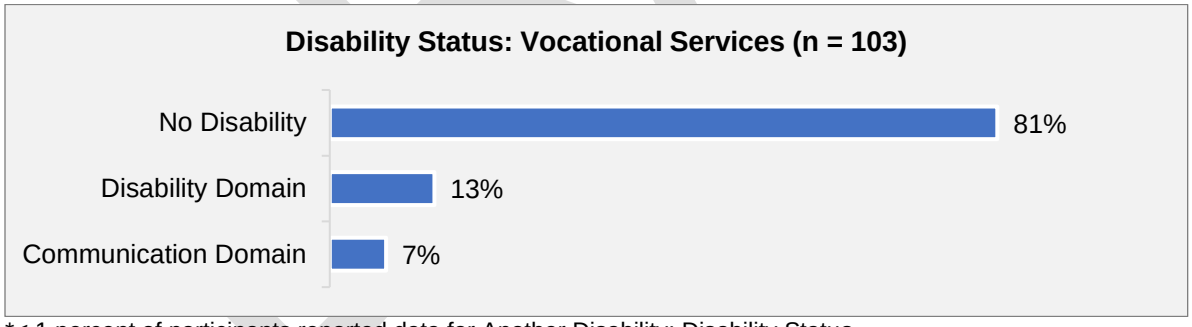


*< 1 percent of participants reported data for Trans Male, Another Identity; Gender





*< 1 percent of participants reported data for Questioning, Another Orientation; Sexual Orientation



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

Race/Ethnicity	n	%
Black/African American	51	15%
American Indian or Alaska Native	1	0%
Asian	56	16%
Native Hawaiian or Pacific Islander	3	1%
White	52	15%
Other Race	27	8%
Hispanic/Latino	73	21%
Non-Hispanic/Non-Latino	61	18%
More than one Ethnicity	22	6%
Total	346	100%

Primary Language	n	%
Chinese	15	8%
English	152	79%
Russian	1	1%
Spanish	15	8%
Tagalog	5	3%
Vietnamese	4	2%
Another Language	4	2%
Total	192	100%

Program	FY19-20 Key Outcomes and Highlights
Department of Rehabilitation Co-op – DPH and California State	• 400 Total Clients Served in DOR Co-Op. • 177 Job Placements. • 143 Job Placements that remained after 90 days.
i-Ability Vocational IT Program - Richmond Area Multi-Services (RAMS)	• 21 enrolled trainees (53%) completed the program. • 19 surveyed graduates (95%) indicated improvement to their coping abilities. • 20 surveyed graduates (100%) reported an increase in readiness for additional meaningful activities related to vocational services. • 20 enrolled trainees (50%) (participated in an exit interview in which they completed the program feedback tools.
First Impressions– UCSF Citywide Employment Program	• 15 BHS consumers (100% of goal) enrolled in the First Impressions Program. • 8 enrolled consumers (100% of goal) graduated from the program. • 8 graduates (100%) reported an improvement in development of work readiness skills. • 8 graduates (100%) reported an improvement in confidence to use the new skills learned. • 8 graduates (100%) reported improvement in both confidences to use the new skills learned and development of work readiness skills to use toward future opportunities (such as work/education/volunteering.
SF Fully Integrated Recovery Services (SF First) Vocational Project - DPH	• 81% of SF FIRST's enrolled clients are permanently housed. • 74% of enrolled clients are connected to primary care. • Several clients connected to stipend positions, training opportunities and other meaningful activities.
Janitorial Services - Richmond Area Multi-	• 2 clients (100%) successfully completed closure. • 2 survey respondents (100%) indicated improvement in their

Program	FY19-20 Key Outcomes and Highlights
Services (RAMS)	coping abilities in the workplace. ● 2 survey respondents (100%) indicated increased readiness for additional meaningful activities related to vocational services ● 2 graduates (100%) expressed motivation in being engaged in vocational / educational-related activities and referred to Hire-Ability's Employment Services program.
Café and Catering Services - UCSF Citywide Employment Program	● 24 BHS consumers (120% of goal) enrolled in the Slice of Life Café and Catering Program. ● 14 BHS consumers (100% of goal) graduated the Slice of Life Café and Catering Program. ● 14 graduates (100% of goal) reported an improvement in development of work readiness skills. ● 14 graduates (100% of goal) reported an improvement in confidence to use the new skills learned.
Clerical and Mailroom Services - Richmond Area Multi-Services (RAMS)	● 9 clients (90%) successfully completed closure. ● 7 respondents (100%) indicated improvement in their coping abilities in the workplace. ● 7 respondents (100%) indicated increased readiness for additional meaningful activities related to vocational services ● 9 graduates (100%) expressed motivation in being engaged in vocational / educational-related activities.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) - UCSF Citywide Employment Program	● 20 enrolled consumers (167% of goal) enrolled in The GROWTH Project. ● 5 consumers (83% of goal) graduated from The GROWTH Project. ● 5 graduates (100%) reported an improvement in development of work readiness skills. ● 5 graduates (100%) reported an improvement in confidence to use the new skills learned.
Transitional Age Youth Vocational Program - Richmond Area Multi-Services (RAMS)	● 8 of 8 participants (100%) enrolled in the program. ● After three months of programming, participants could not participate in internships due to social-distancing guidelines and were held-over pending easing of COVID-19 restrictions. Outdoor project work was developed to allow participants to receive vocational training safely and participants will graduate at the end of 2020 pending available opportunities to participate in additional training programs, resume education or apply for competitive work.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[8]
Vocational Programs	248 Clients	$1,303,740	$5,257

Moving Forward in Vocational Services

Building from the momentum, outreach efforts, and program development efforts in the previous year, MHSA partnered with several new and innovative vocational programs, as well as bolstered existing partnerships and placements. Vocational programs overall were hit hard by the pandemic, with a significant learning curve to adapt programs and some remaining with major limitations. However, despite these challenges, all programs were able to adapt to some degree and continue operating.

Department of Rehabilitation

Due to the pandemic, the Department of Rehabilitation had to initially cancel or postpone all in-person meetings, including monthly Administrative Co-op and Vocational Intake Coordinator's meetings and the annual Vocational Summit (May 2020), and Annual Co-op Meeting in July 2020. However, the DOR had some significant successes this year. The DOR started accepting referrals from BHS clients with or without a BIS number, as long as the client is receiving services from a civil-service or contracted BHS site/program/clinic, which greatly reduces barriers to services. Additionally, DOR partnered with the Adult Probation Department as a partner of UCSF Citywide Employment Team to pilot a program allowing the Co-op to accept referrals for clients through the Community Assessment and Services Center, which provides services for formerly incarcerated individuals.

RAMS programs – Clerical and Mailroom Services, IT, TAY Career Connections, Janitorial

Internships were put on hold due to shelter-in-place, resuming on-site internships as programs increase their on-site staffing and services. There were some program elements that could be adapted during COVID-19, including trainings that were transitioned to remote, loaning electronic devices to ensure access as needed, and arranging outdoor project work. For employees who are not able to return on-site and cannot work from home, RAMS maintained individual supervision and employee wellness, focusing on professional development and career growth from home. Despite these challenges, RAMS employment programs had increased employee satisfaction in all categories, compared to FY 18-19. As job placement sites reopen in the coming year and more staff are needed, these programs will be able to resume full vocational services.

SF FIRST Vocational programs

Unfortunately, due to the SIP order, SF FIRST programs had to be put on hold because none of the vocational opportunities allowed for social distancing that would guarantee the safety of clients they interact with in their stipended positions. This came as quite a blow for many, who rely on the income, community, and structure of the program. In lieu of regular direct placements from the training program into competitive-wage employment, SF FIRST has been using a "scaffolding" approach, slowly adding more hours or increasing complexity of duties to help stipended participants increase vocational skills and stamina. Moving forward, the

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

program will re-open vocational programs when the pandemic eases, and try to find alternatives and additional scaffolding opportunities when available.

UCSF Citywide Employment Programs

Due to restrictions around COVID-19, the GROWTH Administrative Team developed a strategy to shift to online learning while ensuring digital equity amongst participants. GROWTH purchased and loaned participants all the equipment needed to participate in the classroom training online. Once selected for the program, each participant received a high-speed internet hotspot with enough data for class, as well as an Amazon Fire tablet loaded with Zoom for live lectures from the program instructor, a library of books on horticulture, access to their professional email and YouTube for learning videos. To account for "Zoom fatigue", GROWTH classes were restructured with shorter, more frequent sessions. A large effort during the change to online learning was focused on working one-on-one with students to increase their technological knowledge of the equipment to encourage participation. Also, during the online classroom portion, participants received multiple deliveries of items to supplement their online learning with hands on practice. These learnings will continue when providing the GROWTH program to participants.

First Impressions had recently completed its classroom portion of the program when the SIP order was enacted. The program shifted its focus to job readiness skills and search, with program staff working on-on-one with clients to support individualized job placement and support.

Café and Catering Services (Slice of Life) was able to have 100% participation in their new online culinary training, ensuring that all interns passed their Serve Safe Food Handlers Certificate. The program staff also produced and delivered 100 meals per day to BHS clients throughout the city to promote safety and address food insecurity during the pandemic. The Slice of Life Culinary training program's enhanced curriculum includes a workbook and online instruction. Each topic area has instructional video. In addition to preparing our interns for work in the food service industry, we've included instruction on nutrition, healthy eating on a limited budget, and cooking with limited kitchen appliances. Given the program staffs' hard work during this pandemic, it is now poised to quickly pivot instruction from onsite training to remote learning, as needed. Slice of Life is also positioned to make this training available to a larger audience of people with mental illness throughout our community.

4. Housing Services: CSS Funding

Service Category Overview

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

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

On July 1, 2016, California Governor Jerry Brown signed legislation enacting the No Place Like Home (NPLH) Program to dedicate $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are living with 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 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.

State funding for NPLH was delayed by the passage of Proposition 2 during the November 6, 2018 California General Election. In San Francisco, NPLH has inspired an immense amount of cross-departmental collaboration to create permanent supportive housing for people with SMI/SED. The Department of Homelessness and Supportive Housing (HSH), Mayor's Office of Housing and Community Development (MOHCD), DPH, and other agencies are working in partnership to facilitate this program. Collaborating stakeholders meet monthly to discuss the integration of new NPLH units into San Francisco's pipeline of permanent support housing. MOHCD and HSH, will be taking the lead on this project. DPH will work in partnership with MOHCD and HSH, to develop and implement the supportive services portion of the NPLH program.

Since NPLH requires the provision of supportive services for people housed in NPLH units, a needs assessment is being conducted by HSH and will be finalized in April 2019. This assessment will explore the supportive services needed, best practices for providing supportive services in permanent supportive housing for people with SMI/SED, and gaps in existing supportive services. A diversity of stakeholders will give input on supporting people living with mental illness to retain their housing, including those working in mental health, permanent supportive housing, and homelessness.

<u>Coordinated Entry</u>

The NPLH program mandates that to qualify to live in a NPLH unit, people must have been assessed with a standard assessment tool that ensures people with the greatest need for and most barriers to housing are prioritized. Starting in 2017 and continuing in 2018, HSH launched three Coordinated Entry (CE) processes to centralize the housing referral and placement

process throughout the county. There are now CE processes for Adult (18+), Family, and Youth (18-24) to evaluate and prioritize the needs of people experiencing homelessness. Launching CE of each population is an iterative process and will continue to develop as older systems of housing assessment and placement are discontinued.

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

To ensure that the primary assessment tool was relative, equitable, and prioritized the most underserved communities, the Access Points (AP) funded by HSH conducted an Assessment Blitz. The goal was to assess a significant portion (20%) of the population experiencing homelessness. Through collaboration with providers like FSP, Intensive Case Management, and outpatient programs, the APs exceeded the goal of assessing at least 2,000 people.
The implementation of CE is an exciting change that will impact housing programs managed by MHSA, while simultaneously expanding housing access to clients who are otherwise not served in MHSA-funding housing programs. The MHSA program will continue to monitor the development of the NPLH program and its impact on the County's Annual MHSA Revenue Allocation due to the bond repayment.

Emergency Stabilization Units (ESU)

Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. MHSA-funded ESUs are managed by a DPH team called Transitions. The twenty-five ESUs are located within several single room occupancy (SRO) hotels in San Francisco. The units are available to FSP clients. In the 2018-2019 Fiscal Year, referral and discharge procedures were created for MHSA-funded stabilization units, to refine the efficiency of the program operations. Procedures for the use of MHSA-funded ESUs were shared and discussed with all FSP Programs on November 9, 2018. In recent years, the amount of ESUs being contracted with SFDPH have decreased. This is due in part to buildings leasing out individual units or entire buildings for higher amounts, comparable with the expensive rental market in San Francisco. Though interim housing options for MHSA clients are increasingly limited, the Transitions team has worked to increase the ESU inventory for MHSA by five units in the past fiscal year.

FSP Permanent Supportive Housing (PSH)

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

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

Through partnership with HSH, MHSA-funded PSH sites are managed by the HSH Supportive Housing Programs Team. MHSA-funded units are available to transition-aged youth, adults, and seniors.

Housing Placement Services

With the launch of the Adult, Youth, and Family CE processes, assessment and placement into all supportive housing are now standardized. The goal of streamlining processes is to ensure that people are prioritized for housing based on their barriers to housing, vulnerability (including disabling and medical conditions), and amount of time homeless (scaled for equity across age groups). HSH developed San Francisco's CE and an integrated database (called the Online Navigation and Entry [ONE] system) with ongoing input from a diversity of stakeholders.

MHSA-funded PSH units will continue to be reserved for FSP clients at adult housing sites, and TAY experiencing mental health challenges at TAY housing sites. Prioritization for MHSA-funded units are conducted through the Coordinated Entry process. Beyond the MHSA inventory of 191 units, clients served by MHSA programs can be accessed and prioritized for housing in the general pools of housing for homeless youth, adults, and families. HSH has valuable experience that will continue to be an asset in providing permanent housing to people experiencing homelessness with serious behavioral health and/or complex physical health needs.

Supportive Services

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.

The MHSA team in San Francisco collaborates with HSH to coordinate the provision of supportive services at properties with MHSA-funded PSH units. HSH contracts with several supportive housing stakeholders to support people living with mental health illness in retaining their housing. Tenderloin Neighborhood Development

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

MHSA-Funded Housing for TAY

While TAY served by MHSA who are age 18 and up can access adult housing, they can also be placed at youth-center housing sites. Youth with mental health and substance 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). 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.

Supportive Services

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.

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

MHSA-Funded PSH Housing: FY19-20							
MHSA Housing Site	**Operator**	**MHSA Units**	**Target Population**	**Services**	**Type of Project**	**Referral Source**	**% of FSP Clients**
Cambridge	**CHP**	9	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**	111%
Hamlin	**CHP**	0	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**	0%
Iroquois	**CHP**	10	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**	33%
Rene Cazenave	**CHP**	10	Adults	**Citywide + FSP**	MHSA Capital	**CE**	90%
Richardson	**CHP**	12	Adults	**Citywide + FSP**	MHSA Capital	**CE**	125%
San Cristina	**CHP**	15	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**	93%
Senator	**CHP**	3	Adults	**CHP + FSP**	HSH Supportive Housing	**CE**	100%
Camelot	**DISH**	11	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**	82%
Empress	**DISH**	7	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**	86%
LeNain	**DISH**	3	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**	100%
Pacific Bay Inn	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**	75%
Star	**DISH**	4	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**	150%
Windsor Hotel	**DISH**	6	Adults	**HSH + FSP**	HSH Supportive Housing	**CE**	100%
Aarti/Routz	**Larkin St.**	40	TAY	**Larkin - All**	MHSA GF - TH	**BHS Placement**	8%
1100 Ocean	**Mercy**	6	TAY	**FPFY + FSP**	MHSA Capital	**BHS Placement**	100%
Veterans Commons	**Swords**	8	Veterans	**Swords/VA + FSP**	MHSA Capital	**BHS Placement**	100%
Ambassador	**TNDC**	9	Adults	**TNDC + FSP**	HSH Supportive Housing	**CE**	89%
Dalt	**TNDC**	10	Adults	**TNDC + FSP**	HSH Supportive Housing	**CE**	110%
Kelly Cullen	**TNDC**	17	Adults	**TNDC + FSP**	MHSA Capital	**CE**	94%
Polk Senior	**TNDC**	10	Seniors	**LSS + FSP**	MHSA Capital	**CE**	80%
Ritz	**TNDC**	2	Adults	**TNDC + FSP**	HSH Supportive Housing	**CE**	100%
Willie B. Kennedy	**TNDC**	3	Seniors	**NCHS + FSP**	MHSA Capital	**CE**	33%
TOTAL UNITS		**191**					

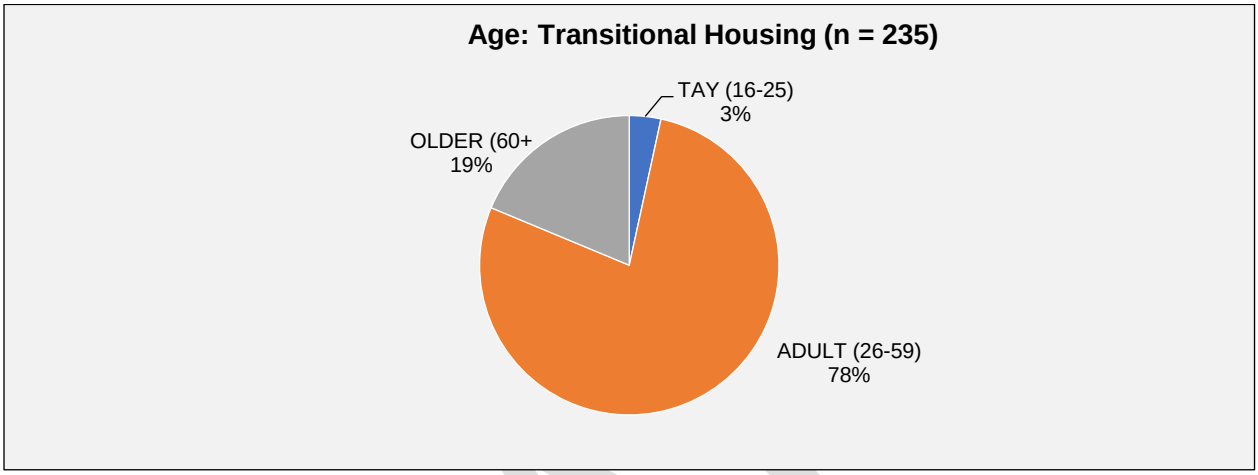
UNITS BY SUPPORTIVE SERVICE PROVIDER	
Total Units Supported by Community Housing Partnership (CHP)	51
Total Units Supported by Delivering Innovative Supportive Housing (DISH)	35
Total Units Supported by Mercy Housing	6
Total Units Supported by Larkin Street Youth Services (LSYS)	40
Total Units Supported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

MHSA-Funded ESU Housing: FY19/20			
Name of Housing Site	**Address of Housing Site**	**Property Management Provider**	**Count of MHSA Units in FY 19-20**
16th Street Hotel	3161 16th Street San Francisco, CA 94103	Danny and Alisha Patel	44
Crystal Hotel	2766 Mission St. San Francisco, CA 94110	Manager-Peter Morari Nisheet Shah-Owner	12
Eddy Hotel	640 Eddy St. San Francisco, CA 94109	Asmin "Bibi" Bibi	26
Oak Tree Hotel	45 6th Street San Francisco, CA 94103	Jay Devdhara	10
TOTALS			**92**

Participant Demographics and Outcomes

Demographics: Housing Programs[9]

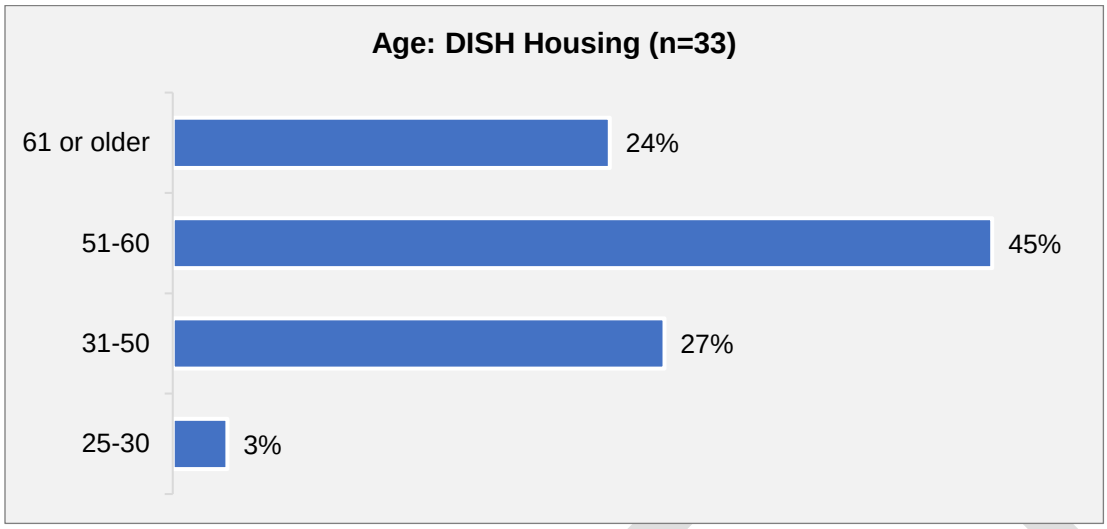
Emergency Stabilization Units

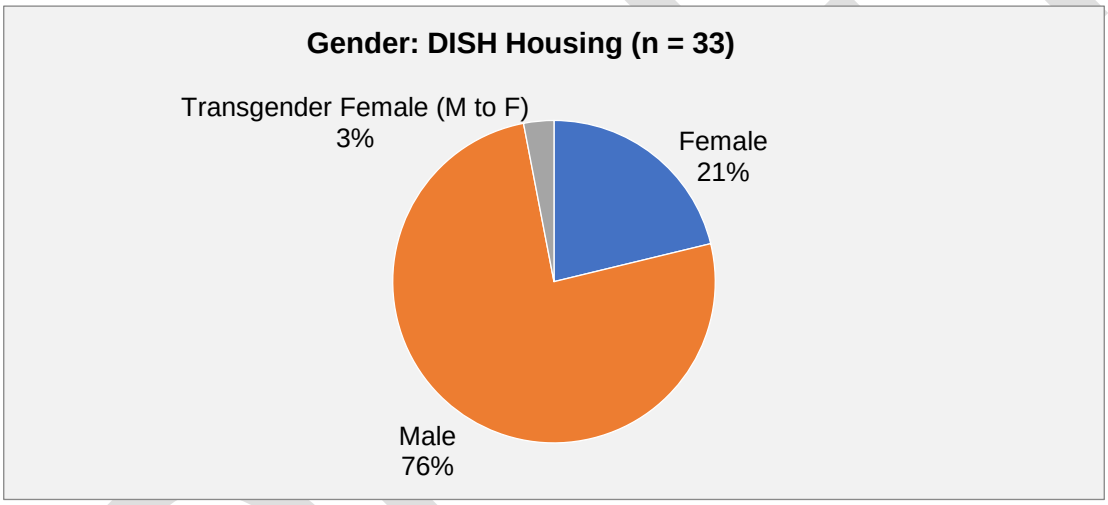


Race/Ethnicity	n	%
Black/African American	75	32%
American Indian or Alaska Native	4	2%
Asian	7	3%
Native Hawaiian or Pacific Islander	2	1%
White	93	40%
Other Race	7	3%
Hispanic/Latino	38	16%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	7	3%
Total	**233**	**100%**

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

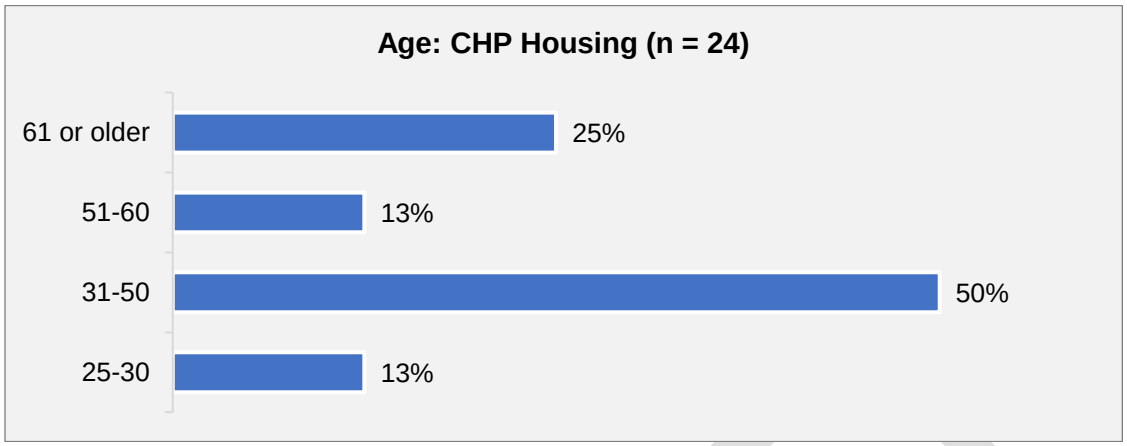
Delivering Innovative Supportive Housing (DISH) Housing

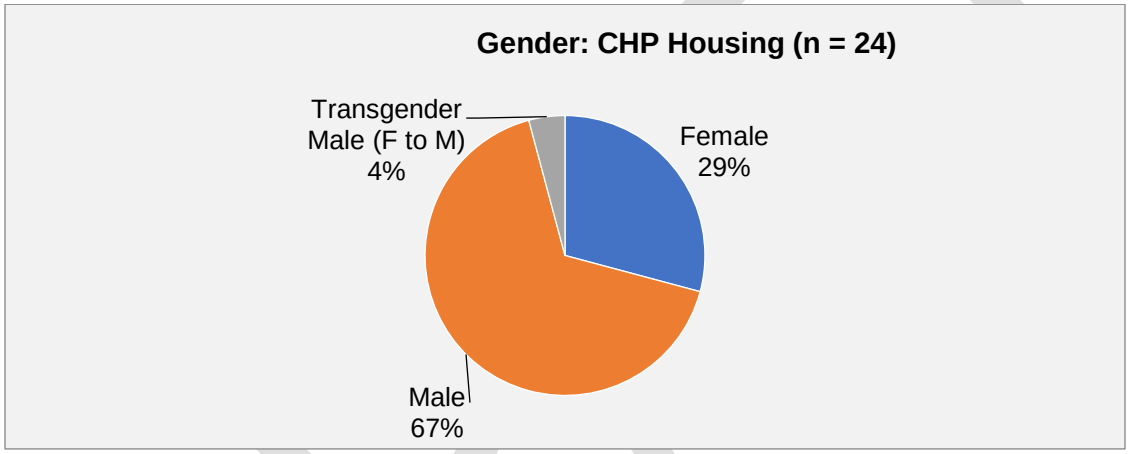




Ethnicity	Clients	Client %
African American / Black	8	24%
Asian	1	3%
Asian / Pacific Islander	4	12%
Latino/a	6	18%
White	14	42%
Grand Total	**33**	**100%**

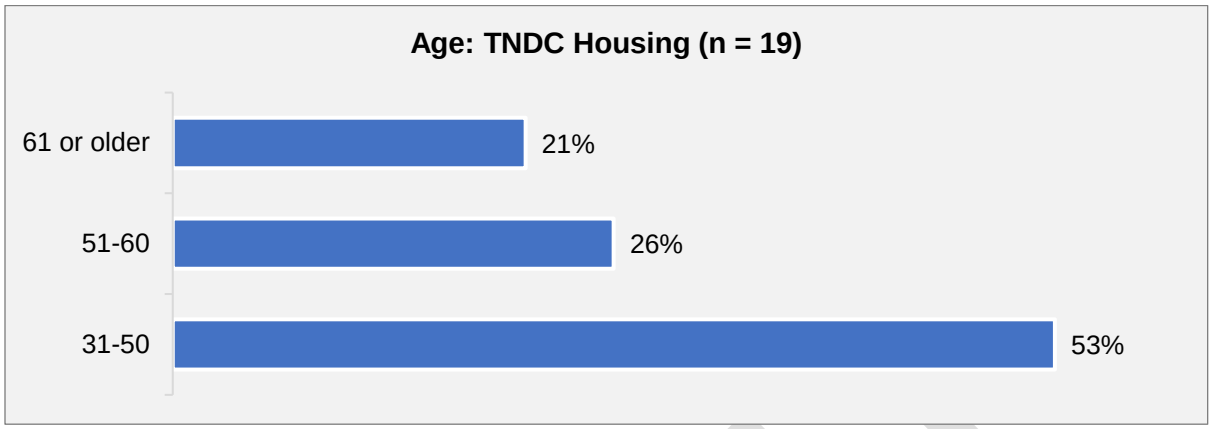
Community Housing Partnership (CHP) Housing

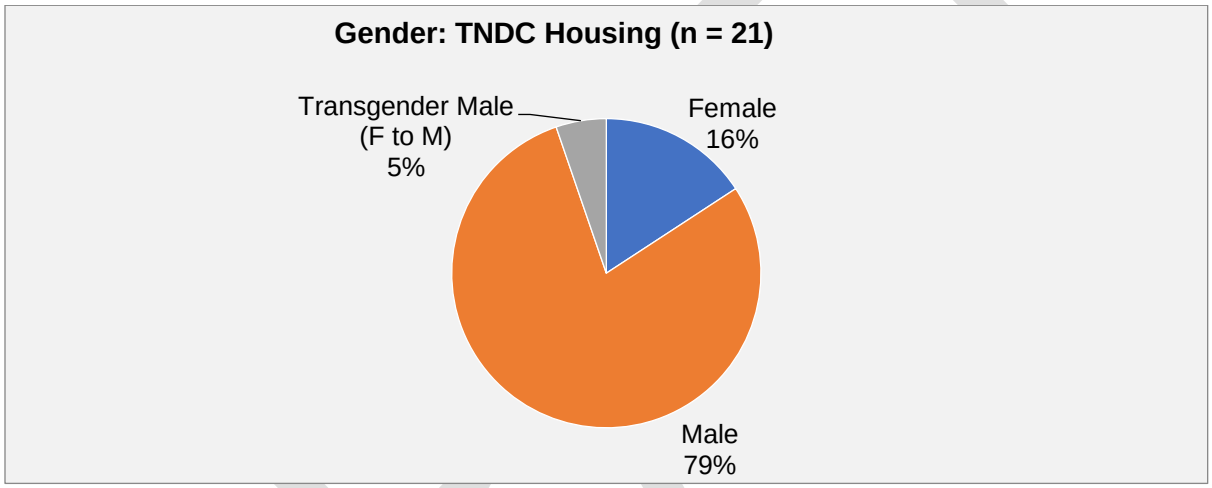




Ethnicity	Clients	Client %
African American / Black	9	38%
Filipino/a	1	4%
Latino/a	2	8%
White	11	46%
Native Hawaiian-Other Pacific Islander (NHOPI)	1	4%
Total	24	100%

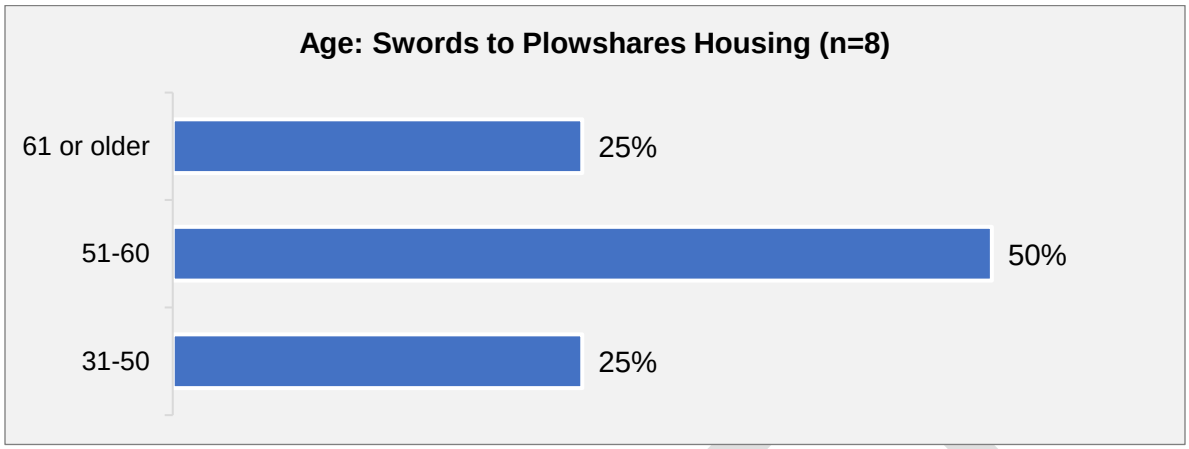
Tenderloin Neighborhood Development Corporation (TNDC) Housing





Ethnicity	Clients	Clients %
African American / Black	8	42%
Asian	1	5%
Asian / Pacific Islander	2	11%
Latino/a	3	16%
White	5	26%
Grand Total	19	100%

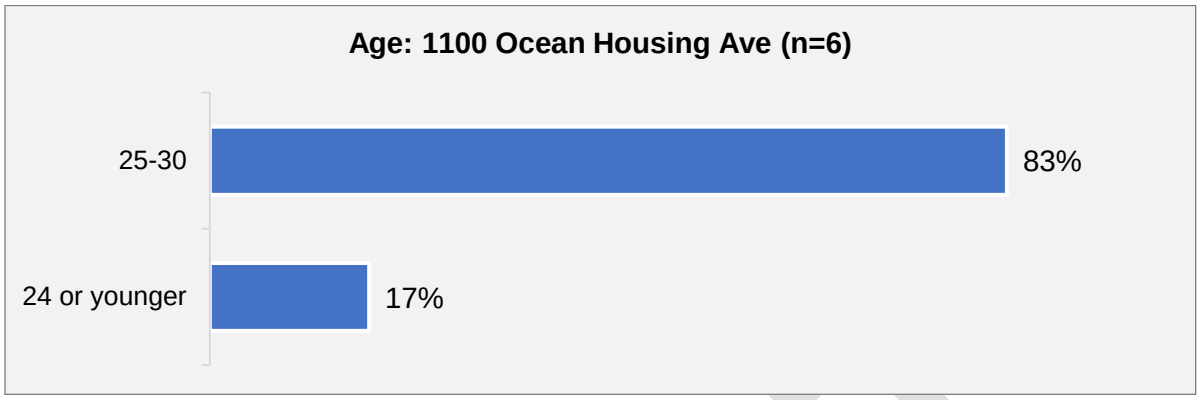
Swords to Plowshares Housing

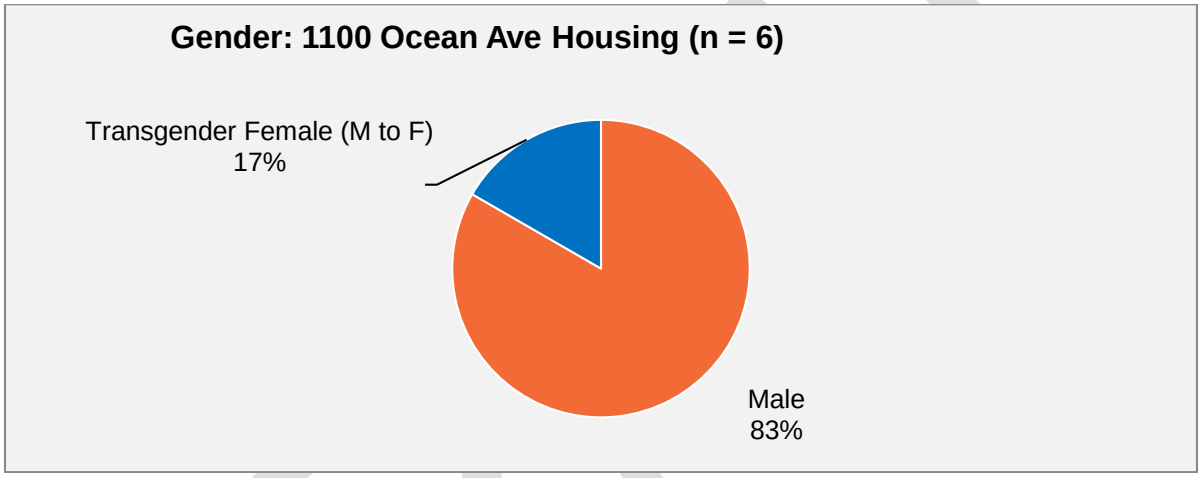


Gender	n	%
Male	8	100%

Race/Ethnicity	n	%
African American / Black	4	50%
White	4	50%
Total	8	100%

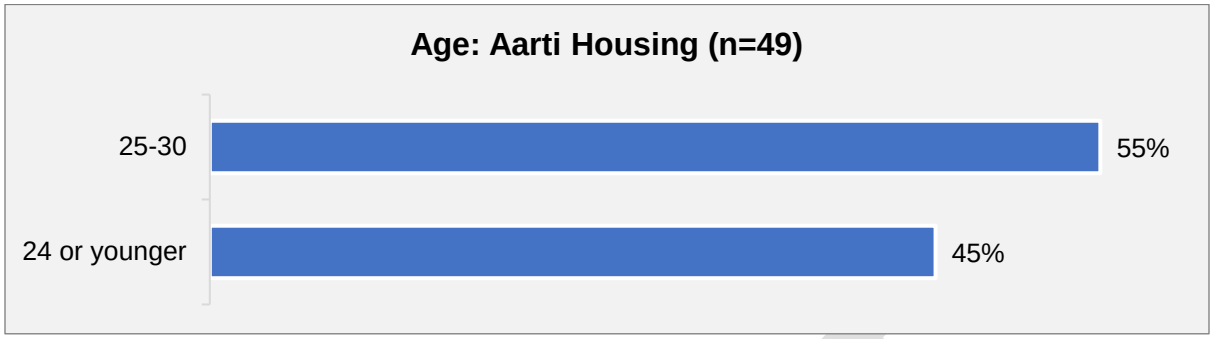
1100 Ocean - TAY Housing

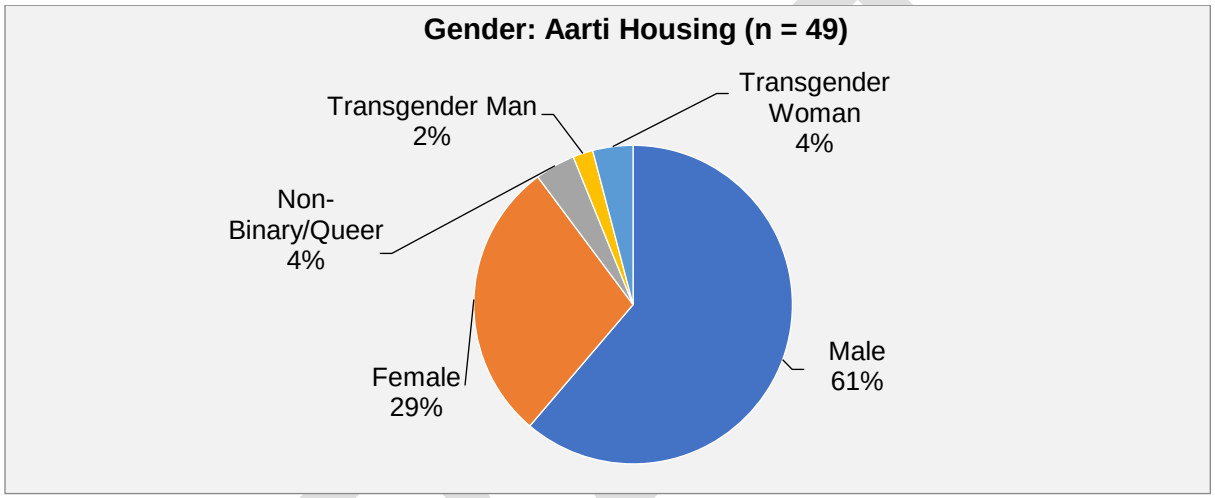




Race/Ethnicity	n	%
African American / Black	2	33%
Asian	1	17%
Latino/a	1	17%
White	1	17%
Other (Middle eastern)	1	17%
Grand Total	6	100%

Aarti Housing





Ethnicity	n	%
African American / Black	19	39%
Asian	1	2%
Asian / Pacific Islander	1	2%
Latino/a	7	14%
White	8	16%
Multiracial	8	16%
Other	2	4%
Unknown	3	6%
Grand Total	49	100%

Outcomes: Housing Programs[10]

Emergency Stabilization Units (ESUs)

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

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

Count of Stay	MHSA Rooms
Other	11
SF General Emergency Dept.	5
SF General Inpatient	3
CLEAD/CASC/ Probation	58
ICM/FSP	58
Grand Total	**135**

For FY 19-20, 108 clients stayed a total of 4,793 days in ESUs. Out of these 108 clients, 58 (53.70%) clients were FSP clients.

DISH Housing		
Length of Stay	**Clients**	**# Exits**
Under 12 months	4	
1 year	9	
2 years	4	
3 years	2	
4 years	5	
5 years or more	9	
Grand Total	**33**	**5**

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

CHP Housing		
Length of Stay	**Clients**	**# Exits**
1 year	10	
2 years	6	
3 years	2	
4 years	1	
5 years or more	5	
Grand Total	**24**	**2**

Swords to Plowshare Housing		
Length of Stay	**Clients**	**# Exits**
3 years	1	
4 years	1	
5 years or more	6	
Grand Total	8	**1**

TNDC Housing		
Length of Stay	**Clients**	**# Exits**
Under 12 months	1	
1 year	5	
2 years	3	
3 years	1	
4 years	2	
5 years or more	7	**1**

Moving Forward in Housing Services

The SFDPH MHSA is planning to receive funding allocations from the California No Place Like Home initiative. Our first funding allocation of $27.7 million was used to build 127 adult and senior units at 1064-1068 Mission Street. SFDPH MHSA is projecting these projects to be completed in the fall/winter of 2021. SFDPH MHSA will request a second funding allocation of $36.4 million over the next two fiscal years.

The NPLH requires the provision of supportive services for people housed in NPLH units and to better identify and understand the needs of the individuals to be housed in the proposed units, the Department of Homelessness and Supportive Housing conducted a needs assessment in the last year. With input from diverse consumers and other stakeholders, his assessment explored the supportive services needed, best practices for providing supportive services in

permanent supportive housing for people with severe mental illness and severe emotional disorders, and gaps in existing supportive services.

Additionally, several cross-county project planning meetings with BHS Systems of Care, MHSA, and HSH were held to address coordination of care needs. Through these planning sessions, partners identified the most common issues that lead to eviction and other adverse housing outcomes for people with SMI. These include behavioral issues, psychiatric crises and decompensation, being disconnected from mental health and SUD services, payment issues, and property damage and cleanliness issues.

Moving forward, future areas of planning include: care coordination, data and information sharing, practices for determining medical necessity, NPLH unit eligibility and integration into the Coordinated Entry System, Medi-Cal and billing, protocols and staff expectations, and training and capacity building. To facilitate improved coordination of care, EPIC is currently in the process of rolling out as the new electronic health record system for all of BHS. This system change will have implications for the way we use the Data Collection and Records (DCR) and the ONE System to optimize health and housing outcomes. Therefore, the MHSA Program Manager will be a ONE System liaison for people served through MHSA housing programs and BHS clients in general to support division needs for housing assessment, navigation, and care coordination in partnership with BHS leadership and providers.

Governor Newsom's most recent state budget and MHSA reform package adds $2.33 billion, after $61 million was transferred to pay for the NPLH bond debt. As part of this reform, NPLH is being expanded to reach individuals with a primary substance use disorder diagnosis, people with mental illness experiencing homelessness, people involved in the criminal justice system, and youth. Additionally, these funds will go toward improving performance measures and outcomes, funding for on-site supportive services, and increased collaboration between providers, led by BHS and DPH.

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

Service Category Overview

San Francisco's MHSA has shaped its PEI programs into an extended canopy of Mental Health Promotion and Early Intervention programs that cover four major categories:

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

The focus of all PEI programs is to raise people's awareness about mental health conditions; address the stigma tied to mental health; and increase individuals' access to quality mental health care. MHSA investments build the service delivery capacity of programs and grassroots organizations that typically don't provide mental health services (e.g. schools, cultural celebrations, and cultural epicenters).

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

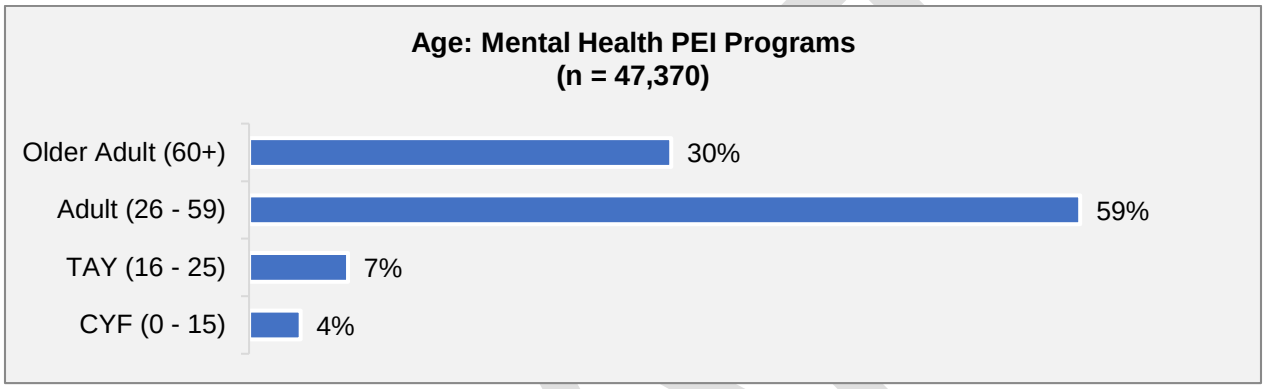
<u>Regulations for Statewide PEI Programs</u>

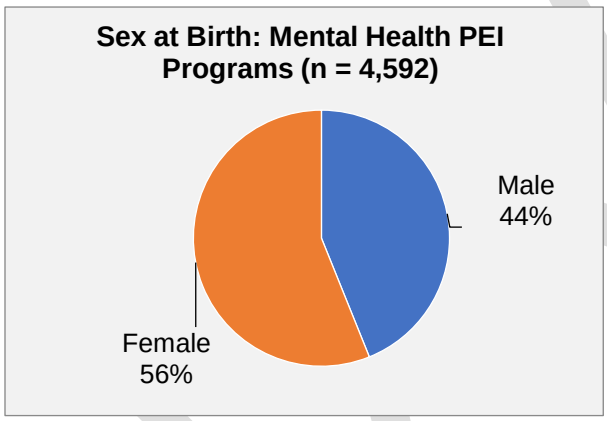
To standardize the monitoring of all California PEI programs, the MHSOAC crafted regulations with respect to counties' data collection and reporting. Key areas of attention are given to the number of people served by a program; the demographic background of program participants [e.g. age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)]; and the interval of time passed from an initiated referral to when the client first participates in referred services. The MHSOAC calls this "referral-to-first participation in referred services period" a successful linkage; and successful linkages are one indicator among many that signifies clients' timely access to care. Given the need for the MHSOAC to know and better understand the communities being served by MHSA resources, it is extremely important for MHSA to develop processes and instruments that will afford programs the ability to capture regulated data in a

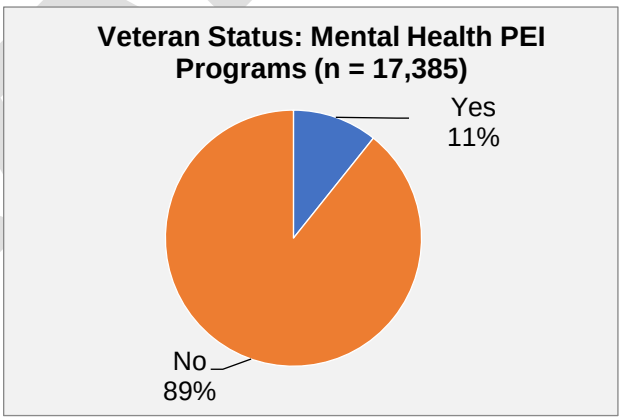
manner that is respectful and does not offend, discourage or alienate individuals who are seeking help. All counties are required to include their regulated demographic data in their Annual PEI Report to the MHSOAC, which is part of a county's Annual Update or 3-Year Program and Expenditure Plan.

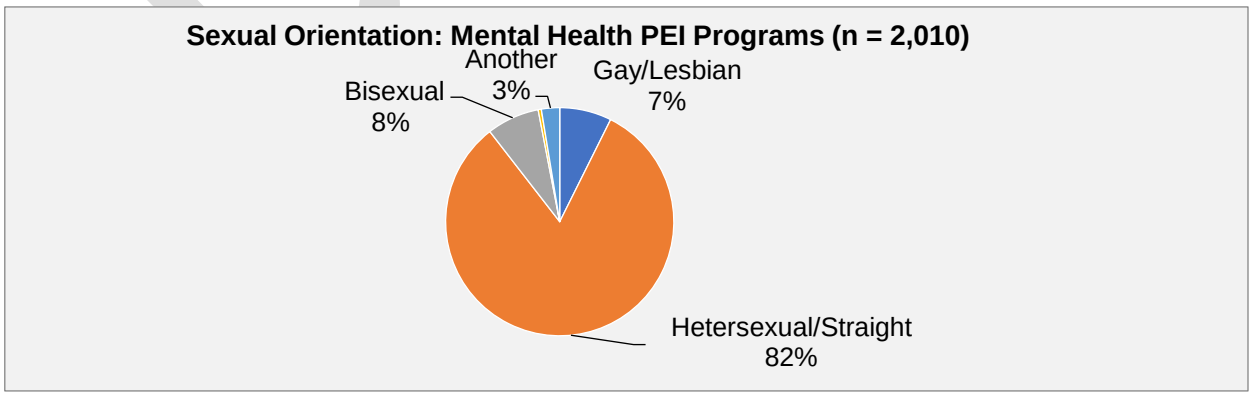
Demographics: All PEI Programs

Total Served: 110,980
Total Unduplicated: 22,642
Served for Early Intervention: 5,314
Served for Mental Illness Prevention: 1,426





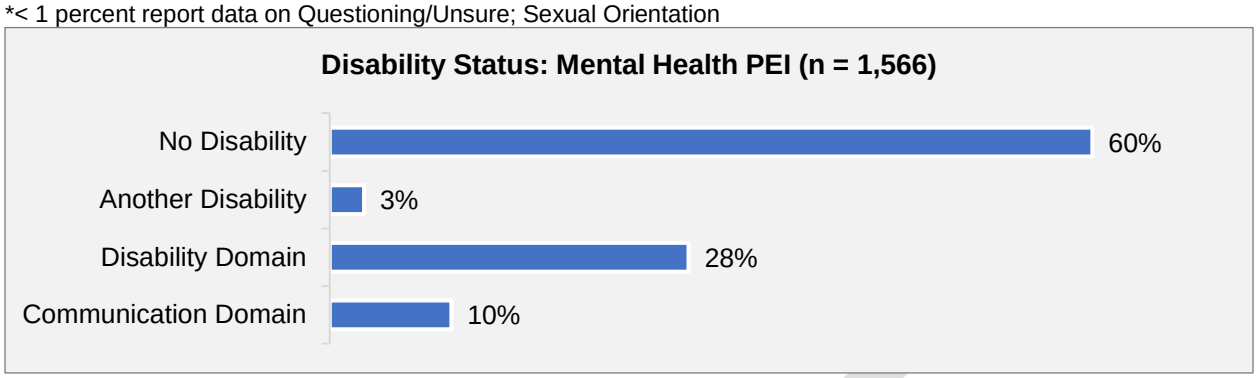




*< 1 percent report data on Trans Female, Trans Male, and Another Identity; Gender Identity

PEI

*< 1 percent report data on Questioning/Unsure; Sexual Orientation



Race/Ethnicity	n	%
Black/African American	6,689	18%
American Indian or Alaska Native	459	1%
Asian	4,594	13%
Native Hawaiian or Pacific Islander	269	1%
White	3,566	10%
Other Race	3,678	10%
Hispanic/Latino	3,633	10%
Non-Hispanic/Non-Latino	12,758	35%
More than one Ethnicity	675	2%
Total	36,321	100%

Primary Language	n	%
Chinese	1,013	11%
English	6,466	73%
Russian	5	0%
Spanish	991	11%
Tagalog	127	1%
Vietnamese	225	3%
Another Language	370	4%
Total	8,827	100 %

Service Indicator Outcomes for all PEI Programs

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

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

Service Indicator	Program Results
	first aid, de-escalation, conflict resolution, etc.; street level outreach; building trust by offering basics such as coffee and water, snacks, use of phone and computer, use of bathroom; employing Spanish-speaking staff who can assist monolingual Spanish speakers ● Our Intake Coordinator contacts referrals sources and potential clients within 48 hours of receiving services, offering a timely access appointment within 10 days of receipt of referral. Potential Clients are outreached to while waiting to be assigned to a therapist and advised of the wait to obtain services, and are offered linkages to other services when appropriate. ● Our agency provides warm handoffs to agencies that have capacity. We will accompany clients to meeting if there is a desire and capacity. We will also encourage family or other acting support systems to encourage or accompany clients. We keep our caseloads open for clients whom have trouble engaging and adjust our services to meeting them where they are. ● Staff often times make calls alongside youth participants to support initial connection and check-in informally. If a young person returns to drop-in programming to ask if the young person has accessed the referred program/agency. ● Mental health consultants are placed at early learning centers and residential programs serving families with young children in SF and are regularly present at these sites, building relationships with families and staff; these relationships enable the consultant to be embedded in trusted settings where families are served. ● Services were provided on site facilitating the referral process and decreasing barriers to access ● We assist clients with connecting to referrals and we keep the case until they have made their first appointment.

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

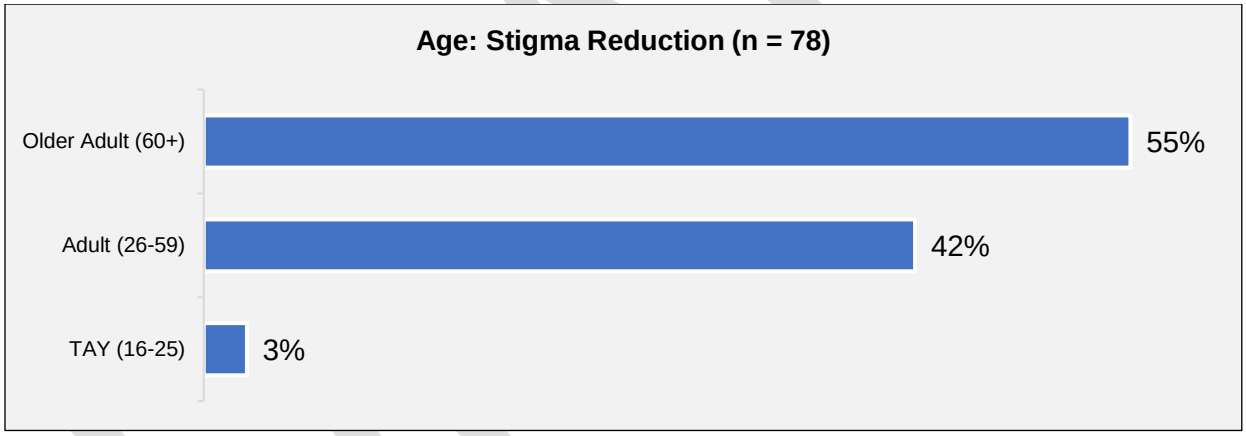
Program Overview

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

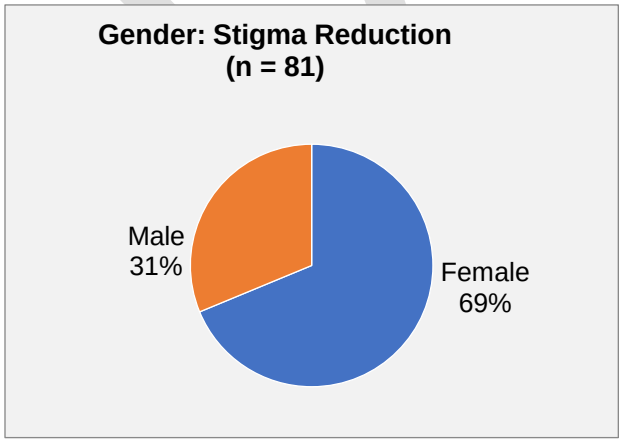
- SOLVE aims to reduce stigma (including self-stigma, structural stigma, and societal stigma) discrimination and bias, related to mental illness/mental health conditions as well as to empower those affected by stigma to advocate for their communities' needs.
- SUPPORT (previously known as Peer Response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

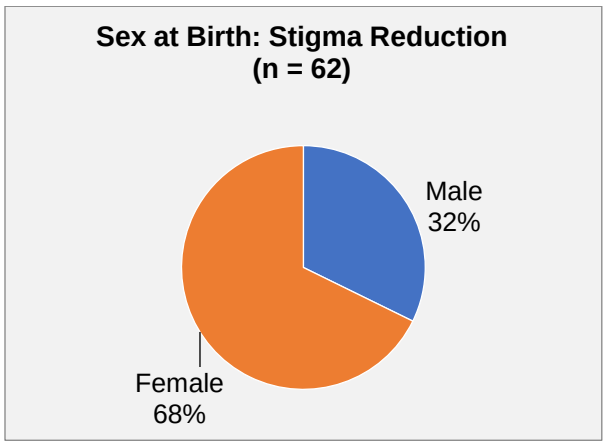
Participant Demographics, Outcomes, and Cost per Client

Demographics: Stigma Reduction



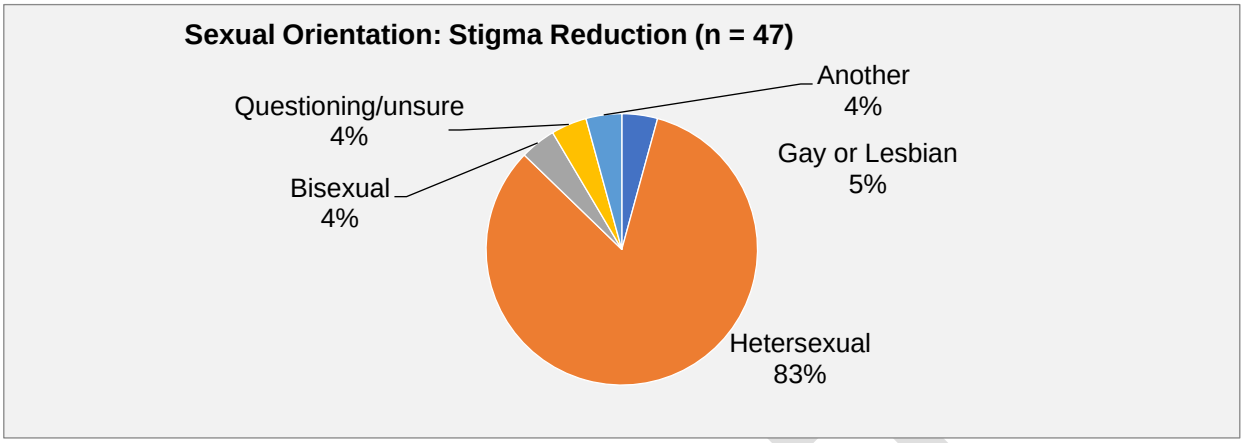
*< 1 percent reported data on CYF (0-15); Age

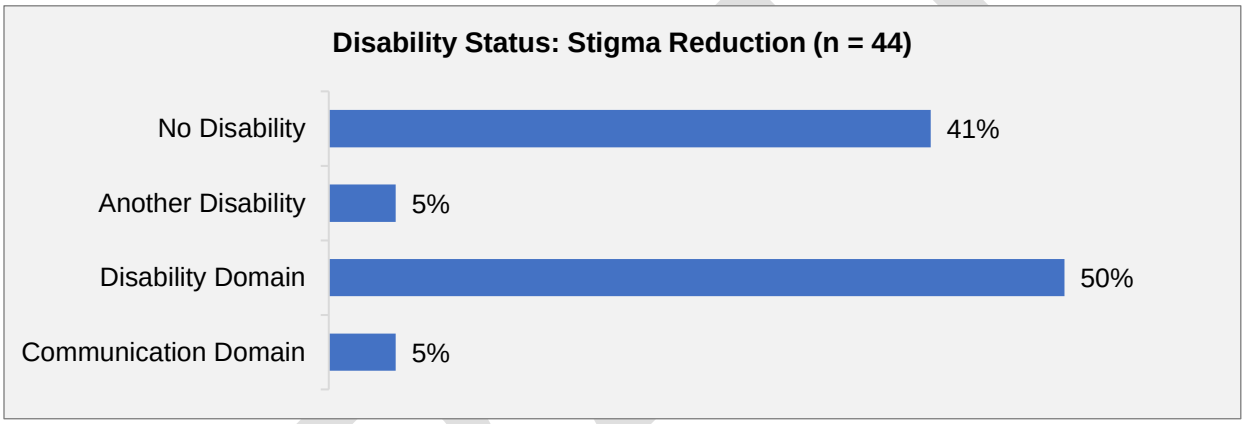




*< 1 percent reported on Trans Female, Trans Male, Another Identity; Gender

PEI





Race/Ethnicity	n	%
Black/African American	7	5%
American Indian or Alaska Native	2	1%
Asian	12	9%
Native Hawaiian or Pacific Islander	1	1%
White	38	28%
Other Race	12	9%
Hispanic/Latino	15	11%
Non-Hispanic/Non-Latino	47	35%
More than one Ethnicity	1	1%
Total	135	100%

Primary Language	n	%
Chinese	0	0%
English	58	91%
Russian	0	0%
Spanish	6	9%
Tagalog	0	0%
Vietnamese	0	0%
Another Language	0	0%
Total	64	100%

Program	FY19-20 Key Outcomes and Highlights
Stigma Reduction: Peer Outreach and Engagement Services – Mental Health Association of San Francisco	• The program delivered 45 presentations reaching 635individuals as measured by submitted evaluations, sign in sheets, and weekly updates. • Of the 353 completed evaluations, 90% of audience members reported decreased mental health stigma. • 98% of Peer Educators reported a decrease in mental health stigma. Peer educators also noted a decrease in self-stigma and risk factors. They noted improved mental health, resilience and protective factors as well as increased access to care and overall self-empowerment.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[11]
Stigma Reduction	117 Clients	$145,016	$1,239

School-Based Mental Health Promotion (K-12)

Program Overview

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

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

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

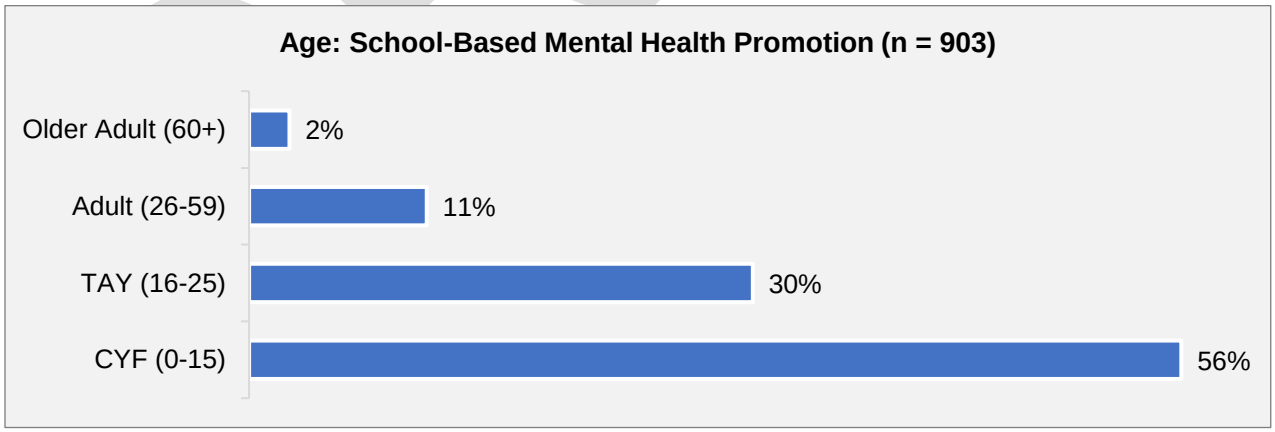
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To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

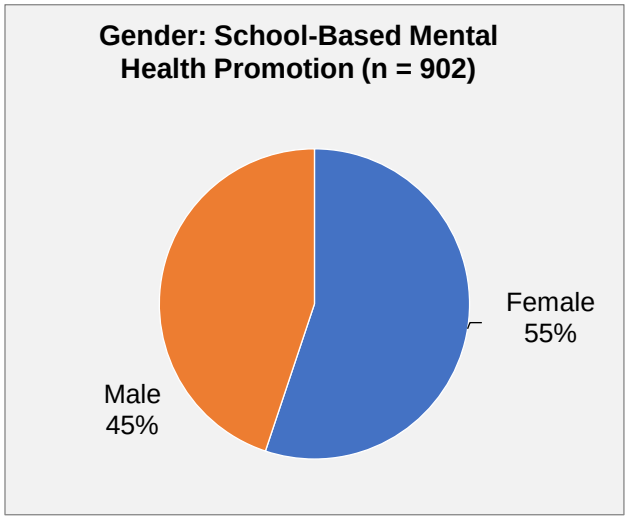
Target Populations

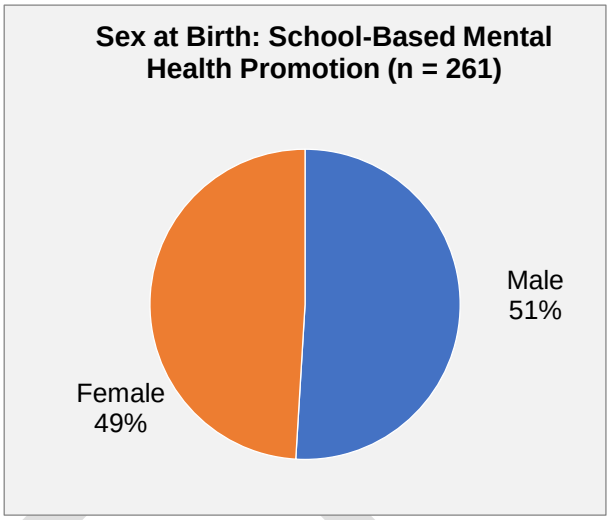
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

Participant Demographics, Outcomes, and Cost per Client

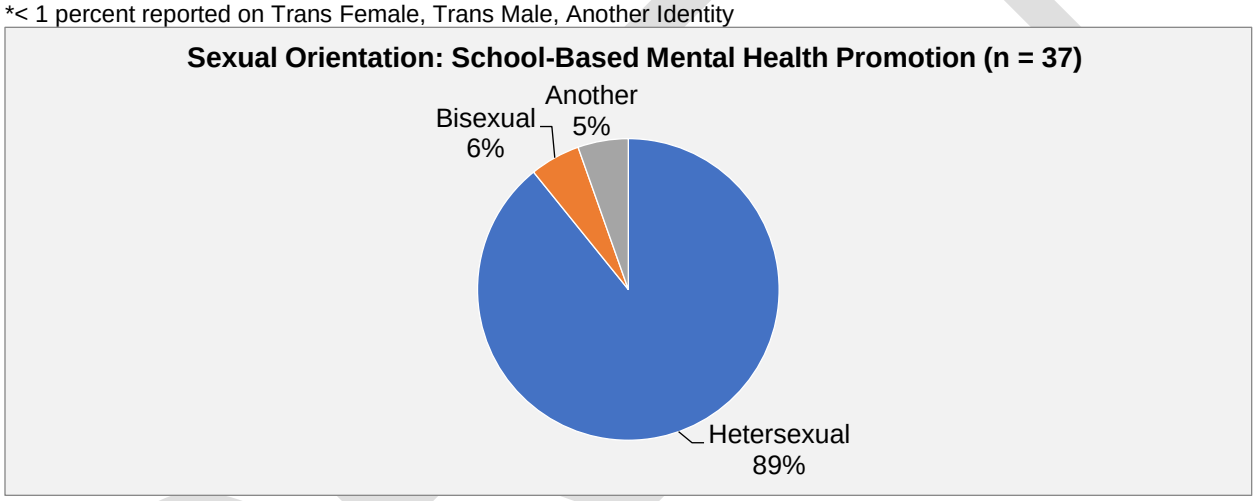
Demographics: School Based Prevention (K-12)



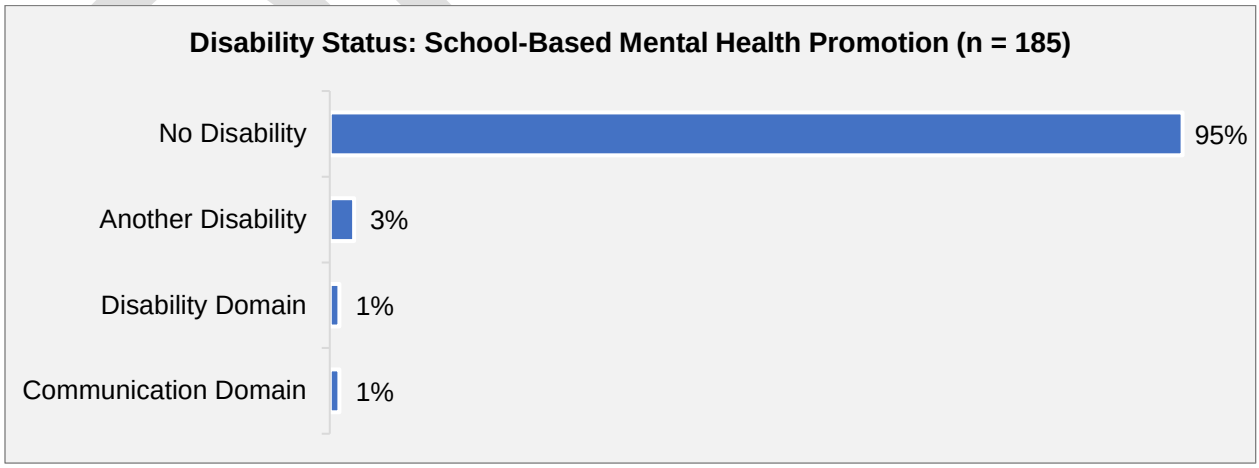




*< 1 percent reported on Trans Female, Trans Male, Another Identity



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



Race/Ethnicity	n	%
Black/African American	183	18%
American Indian or Alaska Native	1	0%
Asian	156	15%
Native Hawaiian or Pacific Islander	8	1%
White	69	7%
Other Race	26	3%
Hispanic/Latino	391	38%
Non-Hispanic/Non-Latino	89	9%
More than one Ethnicity	105	10%
Total	1,028	100%

Primary Language	n	%
Chinese	19	2%
English	521	66%
Russian	3	0%
Spanish	239	30%
Tagalog	5	1%
Vietnamese	1	0%
Another Language	17	2%
Total	788	100%

Program	FY19-20 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - Bayview Hunter's Point Foundation	• Starting in the beginning of this school year, the partnership guiding behavioral health programming transitioned, as they are now co-located within an SFUSD staffed wellness center. • With the onset of the COVID-19 Shelter-in-Place starting Citywide on March 16th, 2020, Balboa High School has been closed, with students continuing their studies remotely. This has created a decline in programming.
Mental Health Services – Edgewood Center for Children and Families	• 92% of classroom teachers reported being able to handle the challenges of teaching. • 90% of classroom teachers reported feeling the desire to continue working as a teacher in the school. • 75% of classroom teachers reported feeling more successful (from beginning to the end of the year) in dealing with challenging student behaviors.
Youth Early Intervention – Instituto Familiar de la Raza	• 20 teachers at Hillcrest and 25 teachers at James Lick received at least one Mental Health Consultant to support them to respond to stressors in the school. • 18 James Lick teachers (85%) satisfied or greatly satisfied with their Mental Health Consultation. • 12 Hillcrest teachers (85%) satisfied or greatly satisfied with their Mental Health Consultation. • 17 James Lick teachers (82%) reported having increased their understanding of childhood mental health and behavioral issues at Hillcrest. • 11 students (73% of goal) received regular push-in support at the two schools. • 30 students (200% of goal) received push-in support at James Lick through the Re-Mix room. • 18 teachers at Hillcrest (92%) and 21 teachers at James Lick (85%) reported improved relationships and increased empathy

Program	FY19-20 Key Outcomes and Highlights
	with parents.
Wellness Centers – Richmond Areas Multi-Services (RAMS)	• 451 outreach hours (281% of goal) provided. • 1,195 individuals (80% of goal) served. • 249 Screening and Assessment services (118% of goal) provided. • 117 youth (65% of goal) received Screening and Assessment. • 307 hours (84% of goal) of Mental Health Consultation provided. • 804 individuals (268% of goal) received Mental Health Consultation. • 815 hours (69% of goal) of individual services provided. • 157 individuals (87% of goal) received individual services. • 408 hours (170% of goal) of Group services provided. • 38 individuals (48% of goal) received Group services.
Trauma and Recovery Services – YMCA Urban Services	• 15 participants (75%) increased their engagement in school as a result of our case manager and clinician's work with them. • 14 clients (70%) engaged in the pass program have re-engaged in their academic experience. • 20 clients (100%) completed a family needs assessment. • 14 clients (70%) completed the program. • 8 clients (57%) who closed within fiscal year improved their CANS ratings more than 50%. • 43% (6 out of 14 clients) completed the entirety of the program, successfully transitioned out of PASS, and improved their CANS ratings more than 50%.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[12]
School-Based Mental Health Promotion (K-12)	912 Clients	$1,192,265	$1,307

PEI

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

Spotlight on Suicide Prevention Planning Efforts

SFDPH MHSA Prevention and Early Intervention (PEI) programs provide suicide prevention, outreach, and educational activities throughout the year. MHSA partnered with the SFDPH BHS Stigma Busters, a consumer-led committee, to lead a campaign for Suicide Awareness Month and Suicide Prevention Week in September. Stigma Busters disseminated Each Mind Matters's "Know the Signs" campaign materials to providers, cafes, businesses, and community members. The materials were shared at tabling events all over the City to promote awareness and inform the public on how to identify the warning signs of suicide and what resources are available to those in crisis. MHSA also funds and supports peer-based programs such as **National Alliance on Mental Illness (NAMI)** that currently provide family-to-family suicide prevention classes online. **Richmond Area Multi-Services, Inc (RAMS),** another MHSA peer-based program, also provides suicide prevention and awareness classes. MHSA also supports the **Mental Health Association SF (MHA-SF),** which recently had staff participate in a Suicide Prevention Summit and provided staff with suicide prevention training during COVID-19.

Suicide Prevention Center Programs
San Francisco's Suicide Prevention Center Programs include

- a 24-hr phone and text line that provides immediate crisis intervention and emotional support.
- an HIV Nightline addressing mental health concerns during peak nighttime hours.
- a Drug Line and Relapse Line focused on referrals to specialized information and interventions related to addiction and recovery.
- Grief support (groups and drop-in) for people who have lost a loved one to suicide and suicide survivors.
- Youth risk reduction program aimed at parents and caregivers.

San Francisco Suicide Prevention Felton Institute
The San Francisco Suicide Prevention Felton Institute has provided an array of suicide prevention services. The 24-hour Crisis Line has provided immediate crisis intervention and emotional support to city residents. So far, more than 150 volunteers have been trained to provide peer support crisis intervention, as well as new developments and interventions on suicide prevention. The Felton Institute also provides a Drug and Relapse Line that refers clients to specialized treatment programs, crises intervention, information on addiction and recovery, and emotional support along the recovery continuum. In addition, the institute has developed an outreach initiative to businesses, schools, hospitals, mental health agencies, and community centers to raise awareness and provide training in crises intervention and de-escalation.

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SF MHSA Service Provider, Hospitality House Self-Help Center

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

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

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

PEI

Target Populations

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

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

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

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

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Socially Isolated Older Adults	Senior Drop-In Center *Curry Senior Center*	The Curry Senior Drop-in Center is a multi-service center located in the Tenderloin neighborhood. It provides drop-in peer-led wellness-based services, including primary and behavioral health care, case management services, and socialization opportunities.
	Addressing the Needs of Socially Isolated Older Adults *Curry Senior Center*	The program provides peer-based outreach and engagement services to socially isolated older adults with mental health concerns living in the central neighborhoods of San Francisco.
Blacks/African Americans	Ajani Program Westside *Community Services*	The Ajani program helps to build strong families by providing an understanding how healthy families function and by encouraging them to develop leadership, collective responsibility and mentoring skills.
	Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional Initiative*	The Black/African American Wellness & Peer Leadership (BAAWPL) initiative takes a collective impact approach where the City, community, and two lead community-based organizations – the YMCA Bayview and the Rafiki Coalition – that are intent on decreasing the physical and mental health disparities of San Francisco's Black/African American populations.
Asians/Pacific Islanders (API)	API Mental Health Collaborative *Richmond Area Multi-Services (RAMS)*	The program serves Filipino, Samoan and 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.

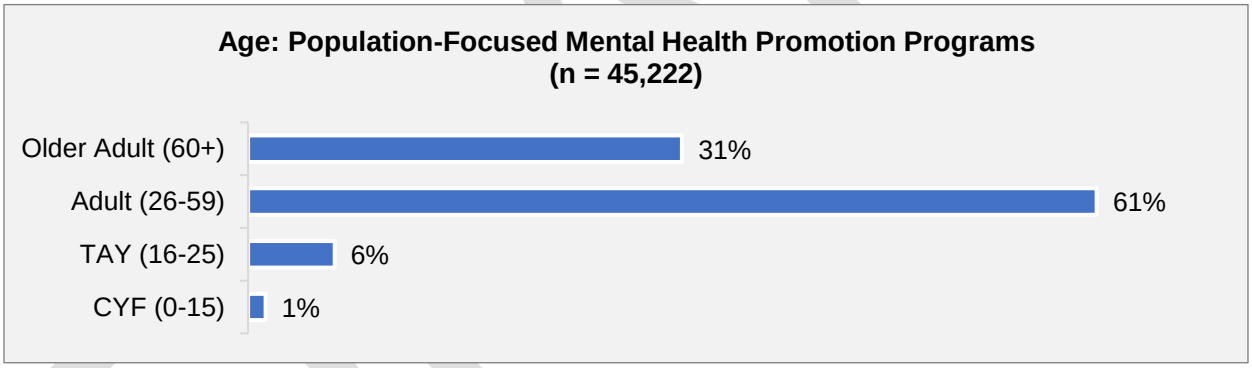
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name *Provider***	**Services**
Latinx including Indigenous Mayan communities	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	The program serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance *Native American Health Center*	The program serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.
Adults who are Homeless or At-Risk of Homelessness	South of Market Self-Help (6th Street) Center *Central City Hospitality House*	The program serves adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs.
	Tenderloin Self-Help Center *Central City Hospitality House*	The program serves adult residents facing behavioral health challenges and homelessness in the Tenderloin neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs.
	Community Building Program *Central City Hospitality House*	The program serves traumatized, homeless and dual-diagnosed adults in the Tenderloin neighborhood. The program conducts outreach, screening, assessment, and referral to mental health services. It also conducts wellness

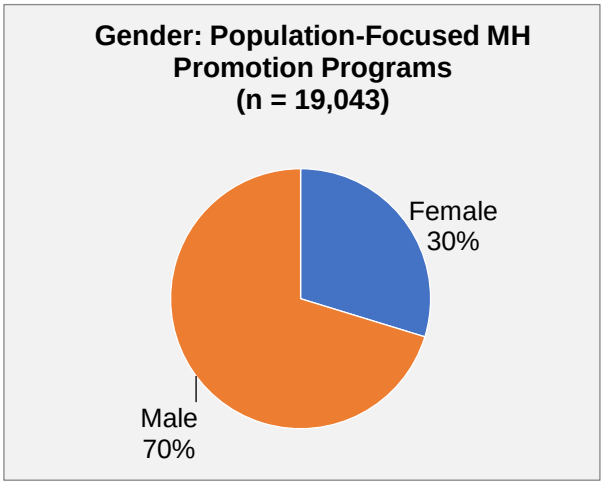
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name *Provider***	**Services**
		promotion and includes an 18-week peer internship training program.
Latinx/Mayan TAY	Population Specific TAY Engagement and Treatment – Latinx/Mayan *Instituto Familiar de la Raza*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Latino/Mayan community.
Asian/Pacific Islander TAY	Population Specific TAY Engagement and Treatment – Asian/Pacific Islander *Community Youth Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Asian/Pacific Islander community.
Black/African American TAY	Population Specific TAY Engagement and Treatment – Black/African American *Third Street Youth Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the Black/African American community.
TAY who are LGBTQ+	Population Specific TAY Engagement and Treatment – LGBTQ+ *SF LGBT Center*	TAY population specific programs provide flexible, relationship-focused, and culturally responsive engagement and treatment services for TAY. Services are low threshold/low barrier to entry and are designed to meet a wide range of behavioral health needs. This program serves transition age youth with a focus on the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and more) community.

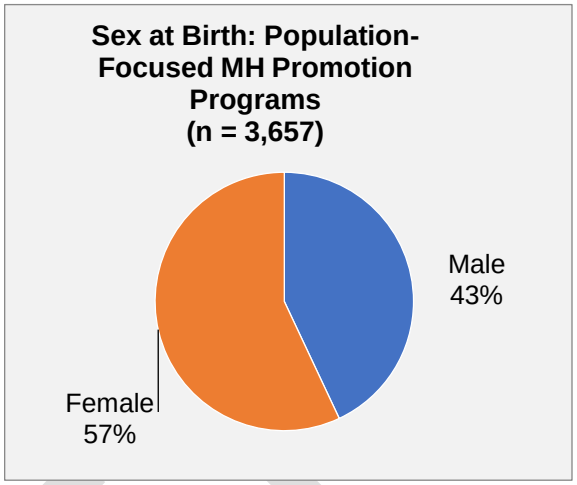
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
TAY who are Homeless or At-Risk of Homelessness or Justice Involved	Population Specific TAY Engagement and Treatment *Huckleberry Youth Programs*	The program serves low-income African American, Latino, Asian Pacific Islander, or LGBTQ TAY (ages 16-24) who have been exposed to trauma, are involved or at-risk of entering the justice system and may have physical and behavioral health needs. Program participants may be involved with the City's Community Assessment and Resource Center (CARC) which focuses on 16 and17 year old youth. The program conducts street outreach, mental health assessments and support, case management and positive youth development services.

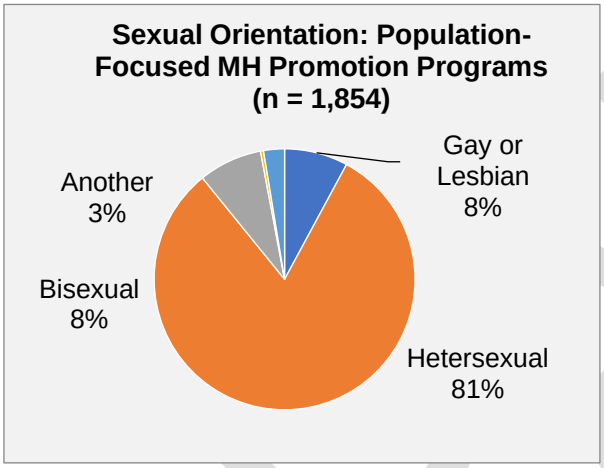
Participant Demographics, Outcomes, and Cost per Client

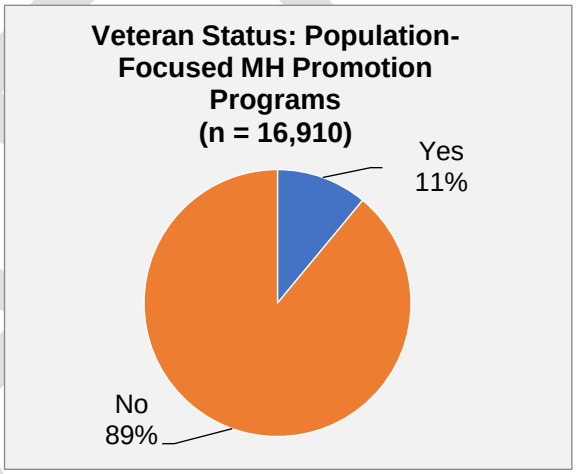
Demographics: Population Focused Mental Health



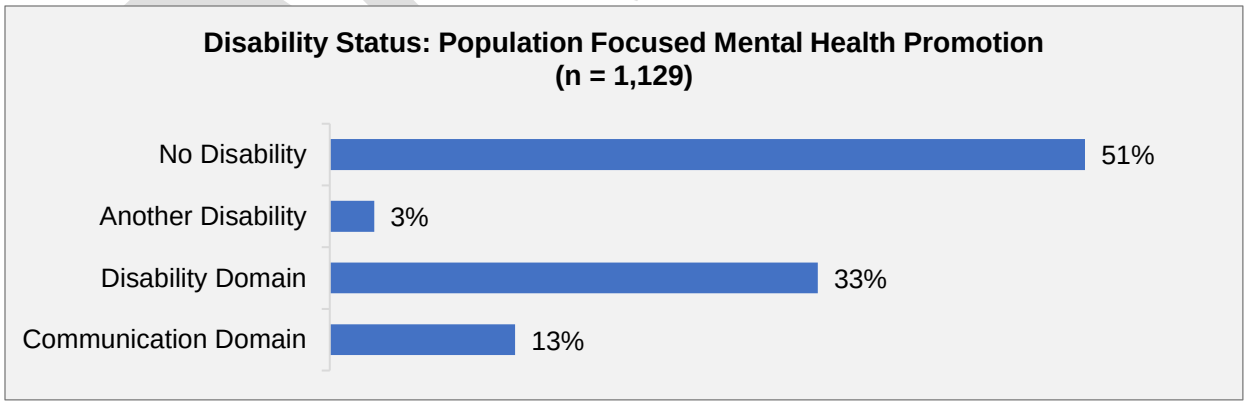








*< 1 percent of participants reported data for Trans Female, Trans Male, and Another Identity; Gender
*< 1 percent of participants reported data for Questioning; Sexual Orientation



Race/Ethnicity	n	%
Black/African American	6,258	19%
American Indian or Alaska Native	450	1%
Asian	4,137	12%
Native Hawaiian or Pacific Islander	251	1%
White	3,294	10%
Other Race	3,318	10%
Hispanic/Latino	2,814	8%
Non-Hispanic/Non-Latino	12,420	37%
More than one Ethnicity	490	1%
Total	33,432	19%

Primary Language	n	%
Chinese	838	12%
English	5,139	76%
Russian	2	0%
Spanish	443	7%
Tagalog	120	2%
Vietnamese	198	3%
Another Language	322	5%
Total	6740	100%

Program	FY19-20 Key Outcomes and Highlights
Senior Drop-in Center – Curry Senior Center	● 32 seniors (128% of goal) assessed. ● 18 limited English-speaking seniors (90% of goal) assessed. ● 32 seniors (100% of goal) referred to services. ● 18 limited English-speaking seniors (100% of goal) referred to services. ● 366 seniors (244% of goal) attended wellness-based activities. ● 42 seniors (98% of goal) attended 3 activities or more, 41 reported an increase in socialization.
Addressing the Needs of Socially Isolated Older Adults – Curry Senior Center	● 274 older adults (91% of goal) reached by peer outreach specialists. ● 142 isolated older adults (189% of goal) screened for behavioral health needs. ● 32 isolated older adults (23% of goal) referred to behavioral health services. ● 11 isolated older adults (37% of goal) attended 5 group activities. 6 isolated older adults attended 4 group activities. while 14 isolated older adults attended 3 group activities. ● 100% of isolated older adults attending 5 group activities reported equal or increased levels of social connectedness. ● 142 isolated older adults (236% of goal) screened for individual or group therapy. ● 97 isolated older adults (162% of goal) screened for non-behavioral health needs.
Black/African American Wellness and Peer Leadership Program – DPH Inter-Divisional Initiative (collaborative of AA Holistic Wellness and	● 2,008 contacts (200% of goal) engaged from target population. ● 106 program participants (141% of goal) have reported an increase in their feelings of social connectedness as measured by our activity feedback surveys, 141% of the stated goal. ● 57 nature hike and survey participants (87%) reported a significant increase in social connection. ● 40 participants (100% of goal) completed the biomarker health screening. ● 20 screened individuals (50%) improved biomarkers.

Program	FY19-20 Key Outcomes and Highlights
SF Live D10 Wellness)	● 150 participants (231% of stated goal) attended at minimum one (1) community event or social /cultural enrichment activity, one (1) movement class, and one (1) mental health or healing circle as tracked through event sign-in sheets. ● 50% of participants reported an improvement in their overall physical health/mobility, or increased awareness of mental health. ● 22 participants (88% of goal) completed the Rafiki intake, identified for Individual and Group Therapy, and completed a Wellness Action Plan. ● 22 clients (100% of goal) completed at least one (1) goal from their Wellness Activation Plan. ● 27 clients (54% of goal) received referrals for linkage and support. ● 11 referrals (41%) completed with a linked provider.
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	● 28,656 individuals (1,433% of goal) outreached and engaged via cultural festivals (5,282) social media (23,374) and over the phone. ● 115 individuals (192% of goal) completed screening and assessment forms. ● 477 individuals (1,136% of goal) screened, assessed, and referred. ● 8,215 individuals (2,054% of goal) participated in APIMHC culturally-relevant mental health promotion activities. ● 669 individuals surveyed (96%) demonstrated increased knowledge about mental health issues. ● 68 individuals (162% of goal) received case management. ● 68 individuals (162% of goal) completed basic written case/care service plans. ● 66 individuals (157% of goal) achieved at least one goal in their case/care plan.
Indigena Health and Wellness Collaborative – Instituto Familiar de la Raza	● 2491 individuals (346% of goal) have participated in calls, community walk-throughs, and open community events. ● 54 participants (146% of goal) screened and/or assessed for practical, emotional and mental health concerns. ● 154 participants (100%) referred to internal & external services received attempts for follow up, and completed one successful internal or external referral. ● 333 individuals (111% of goal) participated in cultural/ceremonial/social events (e.g. Día de los Muertos, Water Walk). ● 102 individuals (102% of goal) participated in small psychosocial peer support groups/Talleres. ● 51 individuals/families (102% of goal) received non-clinical case management and 100% of them have been referred to behavioral health and/or social services. ● 51 individuals (102% of goal) created a written case/care plan

Program	FY19-20 Key Outcomes and Highlights
	goal upon meeting with Case Manager and becoming Case Management clients. ● 51 individuals (100%) achieved at least 1 goal noted in their case/care plan.
Living in Balance – Native American Health Center	● 19 individuals (190% of goal) screened and assessed. ● 16 members (89% of goal) referred to behavioral health treatment after screening and assessment. ● 372 UOS (95% of goal) offered for Wellness Promotion groups, reaching 94 UDC (209% of goal). ● 24 survey respondents (88%) report a maintained or increased feeling of social connectedness. ● 21individuals (300% of goal) achieved at least one case management goal.
South of Market Self-Help Center (6th Street) – Central City Hospitality House	● 6,159 Community Members (616% of goal) contacted through participation in a range of socialization and wellness services as documented in sign-in sheets. ● 90 participants (150% of goal) screened for behavioral health concerns. ● 90 community members (100% of goal) screened and referred to behavioral health services. ● 46 community members (61% of goal) attended HRTC support groups. ● 38 community members (83%) reduced risk behaviors. ● 90 community members (225% of goal) referred to behavioral health services. ● 76 community members (304% of goal) achieved at least one case plan goals. ● 90 community members (300% of goal) wrote a case plan.
Tenderloin Self-Help Center - Central City Hospitality House	● 8,055 community members (320% of goal) contacted through participation in a range of socialization and wellness services. ● 65 community members (81 of goal) screened and/or assessed for behavioral health concerns. ● 65 community members (100%) referred, assessed and screened. ● 103 community members (59% of goal) attended Harm Reduction support groups. ● 70 community members (68%) reduced risk behaviors. ● 65 community members (81% of goal) referred to behavioral health services. ● 17 community members (34% of goal) achieved one case plan goal. ● 63 participants (103% of goal) wrote a case plan.
Community Building Program -	● 395 community members (264% of goal) engaged through 16 events. ● 61 community members (101 % of goal) screened and/or

Program	FY19-20 Key Outcomes and Highlights
Central City Hospitality House	assessed for behavioral health concerns. ● 46 community members (75% of goal) screened and/or assessed for referral to behavioral health services. ● 8 community members (100% of goal) enrolled in wellness promotion activities. ● 5 community members (125% of goal) increased their social connectedness. ● 46 community members (92% of goal) participated in individual therapy. ● 43 community members (93% of goal) completed at least one case plan as measured by HRTC. ● 46 participants (56% of goal) referred to behavioral health services. ● 61 community members (101% of goal) wrote a case plan ● 43 community members (172% of goal) achieved one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - Instituto Familiar de la Raza	● 300 community participants (1000% of goal) attended one community ceremony. ● 123 TAY (975% of goal) referred to TAY Program Services received follow up, screening and assessment for eligibility during the reporting period. ● 14 youth (82%) decreased MH symptoms and impairments as indicated by a 1-point reduction in items rated a 2 or 3. ● 6 TAY (75%) participated in Cargas y Regalos (Gifts and Burdens) a grief and healing psycho-educational group for TAY impacted by community and interpersonal violence. ● 6 TAY (75%) engaged in a weekly cultural affirmation group. 9 Service Delivery Partners from multiple agencies present to share their experience a healing space for service providers impacted by the killing of Sean Monterrosa.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander - Community Youth Center	● 112 TAY participants (224% of goal) screened. ● 98 A&PI youth (87.5%) reported agree or strongly agree in experiencing fewer conflicts with others. ● 97 A&PI youth and families (194% of goal) enrolled in case management service have successfully attained at least one of their treatment goals. ● 102 A&PI youth (91%) reported agree or strongly agree in an increase of participation in meaningful activities.
Population Specific TAY Engagement and Treatment – LGBTQ+ - SF LGBT Center	● 122 youth (61% of goal) served through our drop-in program. ● Fifty-eight (58) of the 122 youth accessed Navigation Services (96% of target for the year). ● 18 youth who had completed a program intake referred to mental health services from our Navigation Services. ● 24 youth (23%) referred to mental health services internal or external. All youth identified as needing mental health services referred to services. ● 25 TAY (166% of goal) received individual counseling. 18 of whom were seen more than once. 24 TAY received drop-in mental health services, 11 of whom also received individual

Program	FY19-20 Key Outcomes and Highlights
	counseling sessions, but utilized drop-in mental health hours due to availability in their scheduling. ● 18 youth (72%) engaged with ongoing mental health services.
Population Specific TAY Engagement and Treatment – Black/African American – Larkin Street Youth Services and Third Street Youth Center	● 75 youth (187% of goal) screened. ● Clients (120% of goal) identified with a behavioral health need referred to behavioral health services. ● 739 Instagram followers (100% of goal) received bi-monthly health related (food and other) social media messages. ● >200 views (100% of goal) on 3rd Street's health related messages. ● 215 youth (215% of goal) received individual or group mental health counseling services. ● 75% of youth (105% of goal) attending at least one therapy session and reported improvement in their quality of life. ● 78% of youth (103% of goal) reported feeling more connected to their network of peers at 3rd Street. ● 3 organizations (100% of goal) identified for a Southeast San Francisco convener group.
Population Specific TAY Engagement and Treatment – Juvenile Justice/Others - Huckleberry Youth Programs	● 238 TAY (198% of goal) screened and/or assessed, for behavioral/mental health concerns. ● 100 TAY (167% of goal) wrote a plan of care. ● 116 TAY (464% of goal) received individual therapeutic services. ● 115 TAY (144% of goal) referred for or received on-site behavioral health services. ● 85 TAY and/or their families (189% of goal) achieved at least one case/care plan goal. ● 42% of TAY (60% of goal) scored at least a 9 (out of 10; 1 = low sense of well-being, 10 = high sense of well-being) for their Overall Experience (general sense of well-being) on the evidenced-based Partners for Change Outcome Rating Scale (ORS). ● 12 TAY Frontline Workers meetings (120% of goal) facilitated to provide program updates, discuss trends, policy issues, facilitate referrals, and provide trainings. ● 100% of providers (125% of goal) who attended a Frontline Workers meeting stated that they found the meetings to be useful to their work with TAY. ● 100% of providers (125% of goal) stated that the Frontline Workers meeting increased resource sharing and/or network development.
TAY Homeless Treatment Team – Larkin Street Youth Services	● 18 youth (60%) demonstrated an ability to manage their mental health. ● 274 youth (94%) continued services with an internal Larkin Street Clinician or an external provider. ● 6 trainings (50% of goal) and professional development sessions held with non-clinical Larkin Street staff. ● 56 staff surveyed (93%) responded that the training increased their knowledge and skills in the training topic.

Program	FY19-20 Key Outcomes and Highlights
	• 49 staff surveyed (82%) responded that they would put skills learned into practice in their work.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[13]
Population-Focused Mental Health Promotion	20,969 Clients	$2,702,621	$129

Early Childhood Mental Health Consultation Initiative

Program Overview

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

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the evidence-based work[14] of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and are delivered in the following settings: center-based and family childcare, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. The Initiative is made possible through a partnership between four county agencies: DPH/BHS; 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. The cycle of this initiative began on January 1st, 2019. As a result, the five providers became flexible in administering their services, given the small timeframe of January to June 2019.

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

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

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

occupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic play groups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families. These services are meant to underscore the importance of early intervention and enhance the child's success. Due to the short timeframe, data is limited at this time.

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

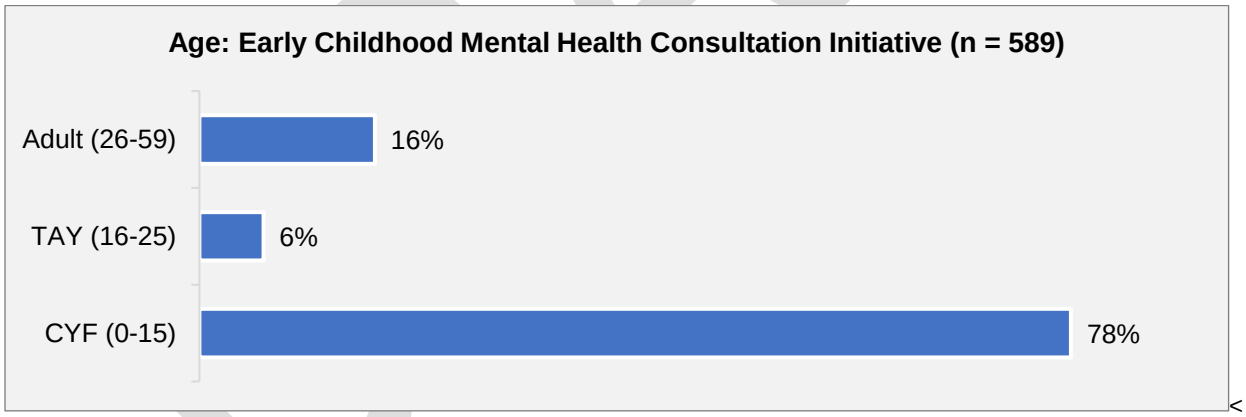
- Infant Parent Program - Day Care Consultants
- Edgewood Center for Children and Families
- Richmond Area Multi-Services
- Homeless Children's Network
- Instituto Familiar de la Raza

Target Populations

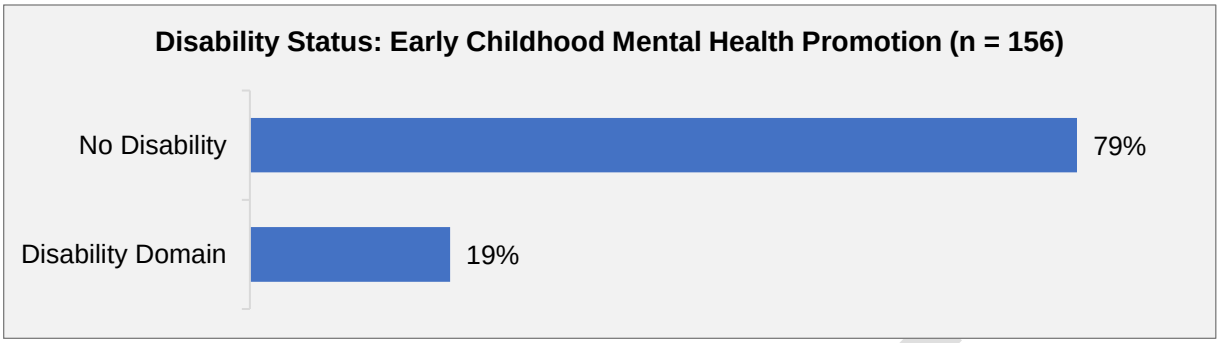
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients who experienced trauma, substance abuse, homelessness, and other challenges. The program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

Participant Demographics, Outcomes, and Cost per Client

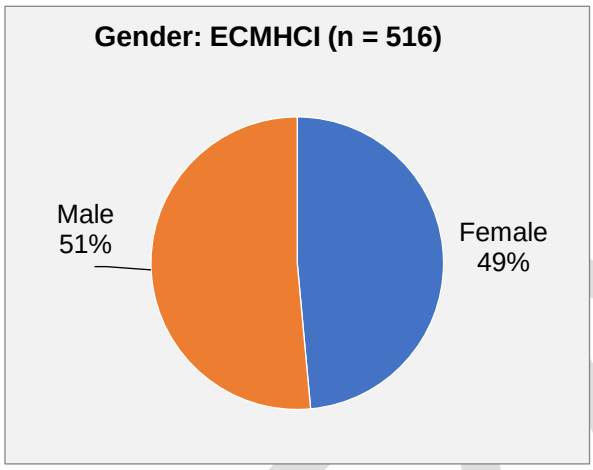
Demographics: Early Childhood Mental Health Consultation Initiative

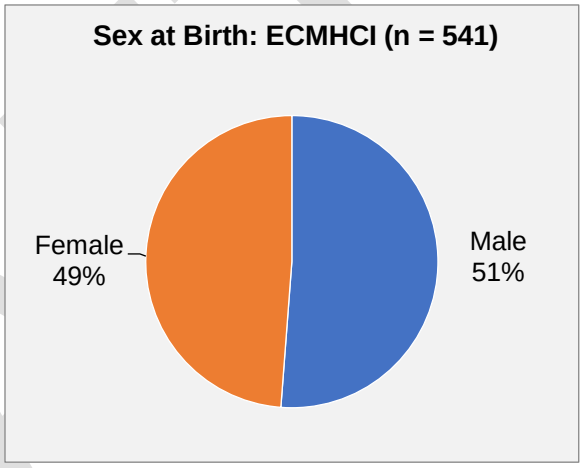


1 % of participants reported data for Older Adult (60+) for Age



*< 1% of participants reported data for Trans Female, Trans Male, Another Identity; Gender
*100% of participants reported Heterosexual; Sexual Orientation





*<1% of participants reported Yes; Veteran Status
*< 1% of participants reported data for Gay/Lesbian, Bisexual, Questioning, Another Orientation; Sexual Orientation
*< 1% of participants reported Another Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	141	11%
American Indian or Alaska Native	2	0%
Asian	228	18%
Native Hawaiian or Pacific Islander	7	1%
White	84	7%
Other Race	267	21%
Hispanic/Latino	269	21%
Non-Hispanic/Non-Latino	182	15%
More than one Ethnicity	74	6%
Total	1,254	100%

Primary Language	n	%
Chinese	136	17%
English	437	53%
Russian	0	0%
Spanish	225	27%
Tagalog	1	0%
Vietnamese	24	3%
Another Language	27	3%
Total	823	100%

Program	FY19-20 Key Outcomes and Highlights
Infant Parent Program Day Care Consultants **Edgewood Center for Children and Families** **Wellness Centers – Richmond Areas Multi-Services (RAMS)** **Homeless Children's Network** **Instituto Familiar de la Raza**	• During the period covered by the MHSA funding, this programming continued to provide a range of supports to childcare administrators, teachers and families. • Once the COVID-19 Shelter in Place period started, Early Childhood Mental Health Consultation services shifted to become entirely virtual, via telephone or video conference. Consultants' time was shifted to provide individual consultation to teachers and families to address increased anxiety and depression, encourage self- care and also respond to concerns arising as a result of risk factors that had already been present.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[15]
Mental Health Consultation and Capacity Building	858 Clients	$655,808	$764

Comprehensive Crisis Services

Background and Community Need

Comprehensive crisis response and stabilization services are considered a crucial element of public behavioral health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. Crisis response to incidents of violence can reduce the long-term impact of complex trauma exposure. 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 efforts – PEI funding supported a significant expansion of crisis response services in 2009.

Program Overview

Comprehensive Crisis Services (CCS) is a mobile, multidisciplinary, multi-linguistic agency that provides acute mental health and crisis response services. CCS is comprised of four different teams (see Exhibit 20). These teams provide caring and culturally competent assistance throughout the San Francisco community. Services include: follow up contact within a 24-48-hour period of the initial crisis/incident; short -term case management; and therapy to individuals and families that have been exposed to trauma. MHSA funds four members of the crisis response team.

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

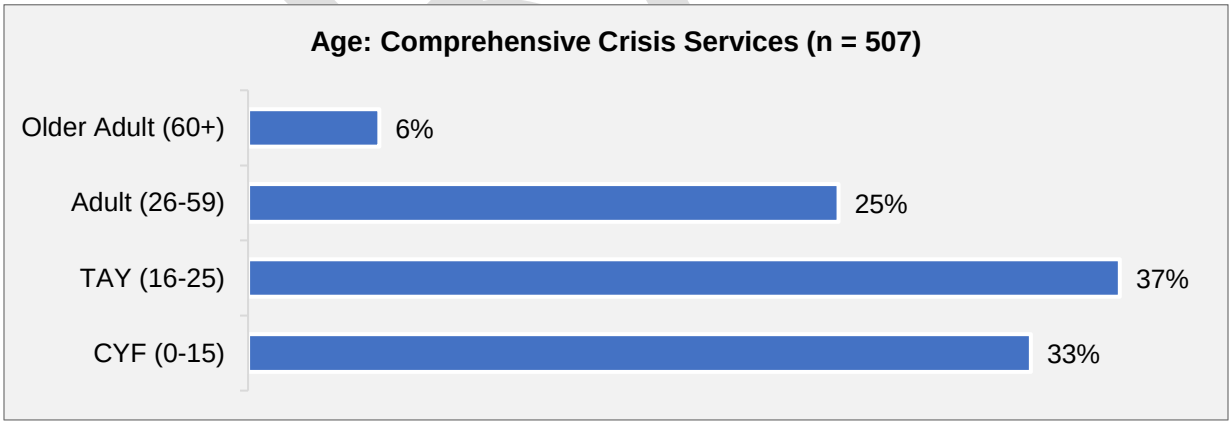
Target Populations

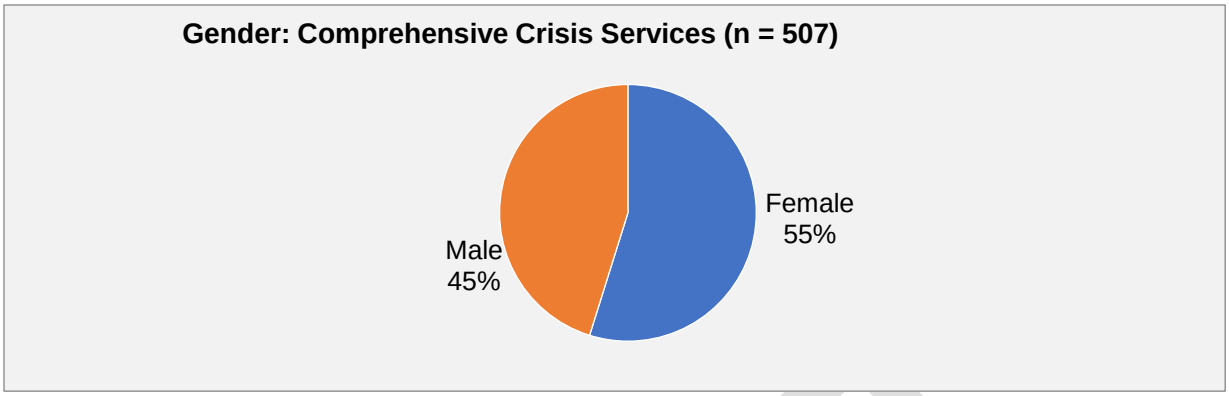
The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and in need of support.

Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals age 18 years or older.
Child Crisis Team	Offers 24/7 mobile 5150 assessments & crisis intervention for suicidal, homicidal and gravely disabled children and adolescents regardless of health insurance status. Clients with publicly-funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response Team	Provides 24/7 mobile response to homicides, critical shootings, stabbings, suicides and pedestrian fatalities; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

Program Outcomes, Highlights and Cost per Client

Demographics: Comprehensive Crisis Services





*< 1% of participants reported data for Trans Female, Trans Male, Another Identity; Gender
*<1% of participants reported Yes; Veteran Status
*< 1% of participants reported data for Gay/Lesbian, Heterosexual, Bisexual, Questioning, other Orientation
*<1% of participants reported data; Disability

Race/Ethnicity	n	%
Black/African American	95	29%
American Indian or Alaska Native	2	1%
Asian	55	17%
Native Hawaiian or Pacific Islander	2	1%
White	76	23%
Other Race	0	0%
Hispanic/Latino	93	28%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	5	2%
Total	328	100%

Primary Language	n	%
Chinese	20	6%
English	285	83%
Russian	0	0%
Spanish	36	11%
Tagalog	1	0%
Vietnamese	0	0%
Another Language	3	1%
Total	342	100 %

Program	FY19-20 Key Outcomes and Highlights
Comprehensive Crisis Services	• A total of 3,004 clients were served by this program in FY19/20. • This program has a very diverse staff and does their best to provide cultural humility when servicing clients. • The program increased collaborations with the Mayor's Office of Housing to advocate and ensure MHSA clients have the best opportunities to live in a safe environment. • The program also increased collaborations with SFUSD to ensure that students' mental health does not impact their education.

FY19/20 Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[16]
Comprehensive Crisis Services	3,004 Clients	$259,859	$87

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

Moving Forward in Mental Health Promotion and Early Intervention

Early Childhood Mental Health Consultation Initiative (ECMHCI)
The ECMHCI issued a Request for Qualifications (RFQ) for program service providers, which offered an opportunity to revise our program contracts and open the contracting opportunity to new service providers in the community. The RFQ was developed with input from our clients and staff and was then published and distributed among the community to invite a number of qualified applicants. In the end, the same set of service providers were selected due to their qualifications and the new contracts were awarded to initiate January 1, 2020.

Mental Health Promotion and Early Intervention's Response to COVID-19
During the month of April 2020 and during the subsequent months with the shelter-in-place Order, SF-MHSA quickly shifted gears to provide community wellness activities for behavioral health consumers and our San Francisco community members. These activities were primarily conducted through our MHSA Prevention and Early intervention (PEI) programs. The focus of these efforts were to increase access to wellness support during this State of Emergency, provide support through alternative means and ensure that community members are being well supported. Here is an update on the PEI-funded community wellness activities provided:

- Providing video conferencing calls for clients to check in and provide wellness support. These activities included:
    - Drumming activities
    - Singing activities
    - Deep Breathing and Mindfulness activities
    - Cultural activities
- Providing phone calls for clients that cannot access internet/technology
- Helping clients develop new coping mechanisms within the current COVID-19 climate
- Helping clients to manage stress levels
- Teaching/helping clients to make their own face masks to prevent the spread of COVID-19 and proactively focus on one's health and wellness

Expanded Programming for the Asian/Pacific Islander Communities
As stated above in the Community Program Planning section of this report, SF-MHSA received a significant amount of input requesting the need for increased programming and modalities for the Asian/Pacific Islander communities of San Francisco. Here is a brief summary of what stakeholders suggested about these communities:

- Some community members prefer to visit traditional/cultural temples for blessings and some simply do not want to visit mental health resource centers.
- Continuing barriers for these community groups relate to language accommodations, lack of trust with government systems, and fear of losing immigration status.
- Clients prefer appointments with a community member, advocate, or translator who speaks and understands their language and culture. Language barriers persist especially for the Vietnamese and Laotian communities.
- Other early intervention solutions included home visits by social workers and quality drop-in services to gain skills and basic support.

San Francisco MHSA (SF-MHSA) staff are meeting regularly with other stakeholders to review the CPP input and explore ways to increase services for the Asian and Pacific Islander San Francisco residents who may be experiencing mental health distress and are in dire need of

culturally affirming mental health supports and services, especially during this time of increased discrimination and violence towards the Asian/Pacific Islander communities of San Francisco.

The SF-MHSA team has been examining the life challenges faced by our city's Asian and Pacific Islander communities, as well as taking a closer look at their culturally-rooted mental health restoration and wellness practices.

In FY20/21, SF-MHSA will continue gathering input from stakeholders to identify the various needs of this diverse community. SF-MHSA is digging deeper to learn about the specific modalities of mental wellness and care — within the context of ethnic-specific cultures — that resonate closer with the city's Asian and Pacific Islander communities. This work will involve SF-MHSA a) improving its community engagement efforts with people and community-based organizations from the intended communities to be served; b) examining the discrete communities' cultural views and practices around mental wellness and care; and c) codifying this new knowledge to SFDPH BHS so that it can inform future program planning.

In FY21/22, SF-MHSA will expand PEI programming for the Asian and Pacific Islander communities based on the additional CPP input we receive.

6. Innovations Projects: INN Funding

Service Category Overview

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

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

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

In FY18-19 and 19-20, three INN projects' five-year INN funding sunsetted and, due to the strengths and positive outcomes they achieved, were re-funded through other MHSA funding streams. The First Impressions INN program ended in FY18/19 and is now funded under CSS funding and is housed in our Vocational programs. Addressing the Needs of Social Isolated Older Adults INN funding ended in FY19/20 and is now funded by PEI funding and is housed in our Peers programs. The Transgender Pilot Project INN funding ended in FY19/20 and is now funded by CSS funding and is housed in our Peer programs.

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

Program Overview

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

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

The major goals of this project are to increase client engagement in behavioral health outpatient services among those stepping down from ICM/FSP services, improve the overall client experience for those in transition, and support and further develop a peer-driven model of care. The team 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 mental

health outpatient services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

On July 6, 2018, MHSA published RFQ 22-2018 for the project, which has been renamed the Peer Transition Team (PTT). For this RFQ, the selected service provider will be required to select, employ, train and support five peer specialists to perform the peer duties described in this document. At least one of these five peers must be a peer who is a Transition Age Youth (16-24 years of age) and at least one of these five peers must be either a bilingual Spanish-speaking peer or a bilingual Chinese-speaking peer. The selection team reviewed proposals and awarded the contract to the Richmond Area Multi Services agency (RAMS), based on agency qualifications. RAMS launched the program start-up on January 1, 2019. This start-up period included the hiring of peer staff, the purchasing of items for the program, introductions to all the relevant program sites, and development of forms and brochures needed by the programs. Full operations of the programming began July 2019.

Family Unification and Emotional Resiliency Training (FUERTE) - UCSF

Program Overview

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

Target Populations

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

Wellness in the Streets - RAMS

Program Overview

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

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

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

Program Overview
The primary purpose of this INN Tech Suite Project is to increase access to mental health care and support and to promote early detection of mental health symptoms. Through the utilization of multiform-factor devices, such as smart phones, tablets and laptops, as a mode of connection and treatment to reach people who are likely to go either unserved or underserved by traditional mental health care, project services will focus on prevention, early intervention, family and social support to decrease the need for psychiatric hospital and emergency care service. The Innovations Technology-Assisted Mental Health Solutions project (Tech Suite) has been preparing for multi-county marketing efforts. With input from all counties, a brand, logo, and outreach materials are being created. A formal name for the Tech Suite has been adopted, which is Help@Hand. Help@Hand is being envisioned as a multi-city and county collaborative whose vision is to improve the well-being of Californians by integrating promising technologies and lived experiences. Please see Appendix B titled, “Technology-Assisted Mental Health Solutions Innovation Project Update” at the end of this report for more information.

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

MHSA staff and consumers at the SF Transgender Health Fair, 2019

Culturally Responsive Practices for Black/African American Communities

The SFDPH BHS has initiated a five-year, MHSA Innovations project to improve outcomes for San Francisco's Black/African American community – a community that is significantly underserved in the current behavioral health care system.

This project is utilizing and evaluating interventions that have not been previously offered to San Francisco's Black/African American communities. A cornerstone of this initiative is that it is led by a skilled and specialized team of behavioral health staff and peer specialists with backgrounds in culturally responsive interventions focused on the wellbeing of Black/African American communities. Staff implementing the project will be demographically representative of the priority communities served.

This project will include four (4) primary learning goals.

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

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

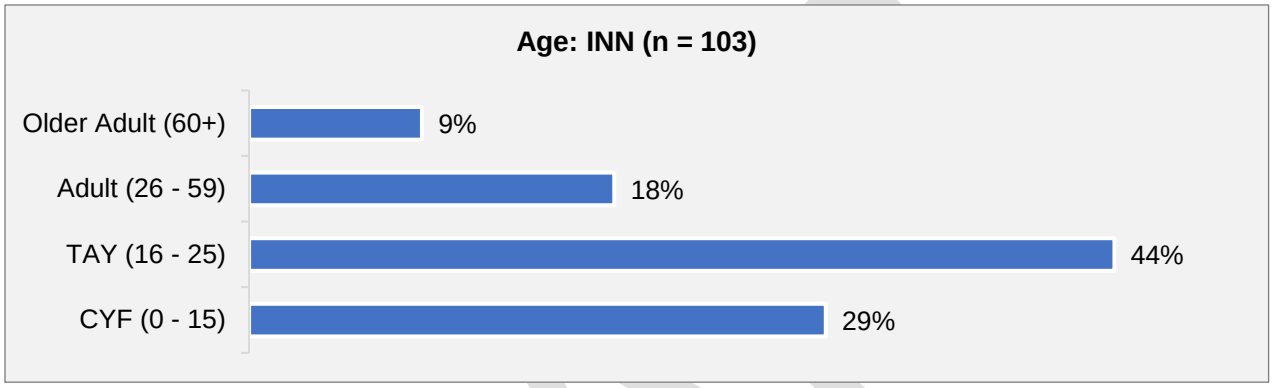
- Better **link consumers with someone who is representative of intersecting identities** such as race, gender, sexual identity and age.
- Implement **African Centered story-telling, expressive arts, community rituals and/or spirituality practices** based on the interest of the participants.
- Hold **trauma-informed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

This initiative will be presented to the MHSOAC on 3/25/21 and, if approved, will tentatively begin program planning shortly after.

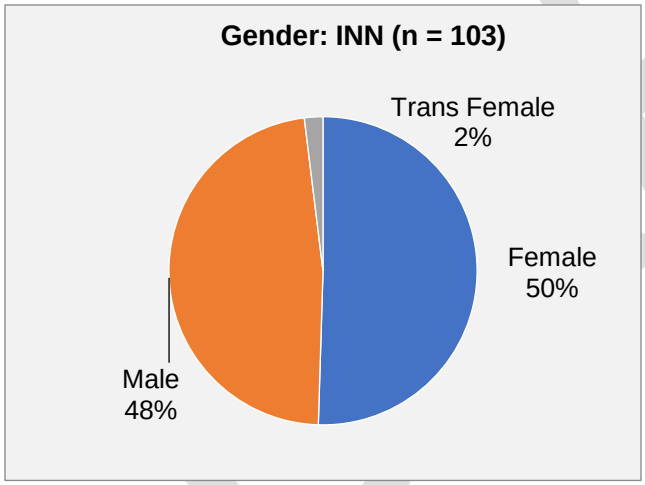
Participant Demographics, Outcomes, and Cost per Client for all Innovation Programs

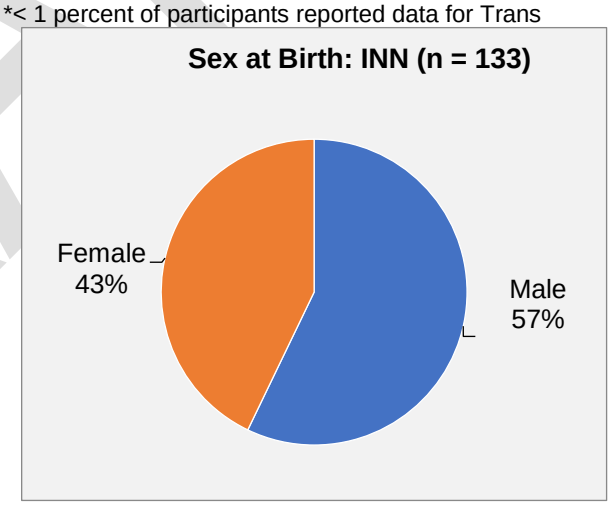
Service Indicator Type	Program Results
Total family members served	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Potential responders for outreach activities	Responses include: doctors, nurse practitioners, nurses, case managers, behavioral health specialists, social workers, psychiatry fellows, occupational therapists, police and fire department staff, and other community service providers.
Total individuals with severe mental illness referred to treatment	37 individuals by 1 reporting program.
Types of treatment referred	Responses include: mental health, substance use, and case management.
Individuals who followed through on referral	37 individuals by 1 reporting program.
Average duration of untreated mental illness after referral	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Average interval between referral and treatment	No INN programs were able to report these data. SFMHSA will provide technical assistance to providers to better capture these data in the future.
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	33 individuals; average 16.5 individuals across 2 reporting programs.
Types of underserved populations referred to prevention program services	Responses include: ● Homeless, immigrant, communities of color, isolated older adults, LGBTQA, low-income ● Latinx immigrant youth between 12-24 years of age ● Homeless
Individuals who followed through on referral	1 individual by 1 reporting program.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example response: 3 weeks.
How programs encourage access to services and follow-through on referrals	Responses include: ● Escort to visits, suggest need for visit, and remind participants of future visits. ● Each group is co-facilitated by two professionals in the mental health field, at least one who must be a terminal level

Service Indicator Type	Program Results
	provider of mental health services (i.e. MSW, MFT) who can identify and refer students who need additional services or may be in crisis. Additionally, the groups allow youth to build a supportive relationship with mental health services providers, who will be leading psychoeducation on mental health and helping decrease stigma against seeking mental health support. • In-person outreach and engagement; phone call follow up if phone numbers are obtained.



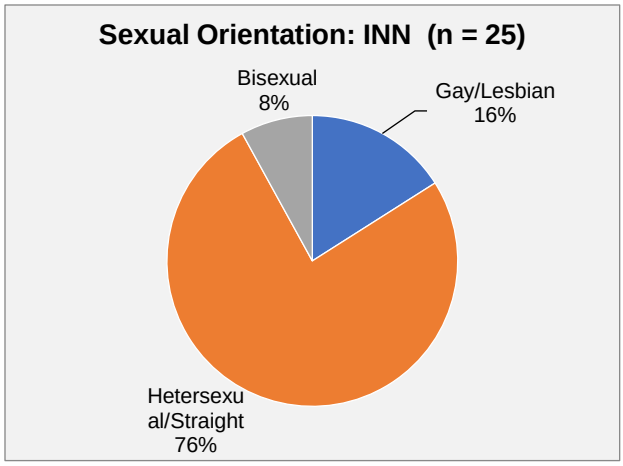
*< 1 percent of participants reported data for Trans

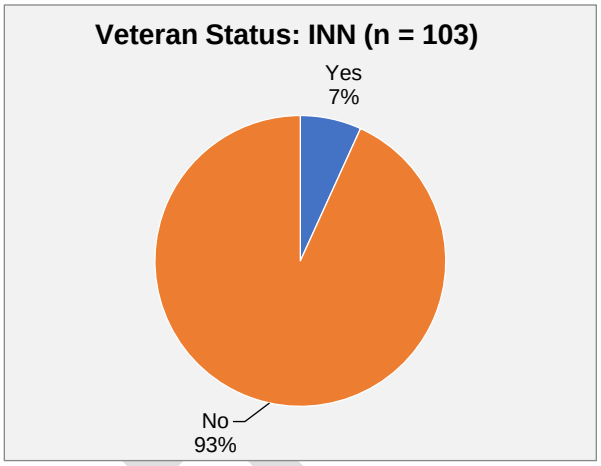




Male, Another Gender; Gender Identity; Gender

INN





*< 1 percent of participants reported data for Questioning/Unsure, Another Identity; Sexual Orientation
*100 percent of participants reported No Disability; Disability Status

Race/Ethnicity	n	%
Black/African American	10	7%
American Indian or Alaska Native	1	1%
Asian	4	3%
Native Hawaiian or Pacific Islander	0	0%
White	14	10%
Other Race	4	3%
Hispanic/Latino	78	57%
Non-Hispanic/Non-Latino	22	16%
More than one Ethnicity	3	2%
Total	**136**	**100%**

Primary Language	n	%
Chinese	0	0%
English	30	29%
Russian	0	0%
Spanish	72	70%
Tagalog	1	1%
Vietnamese	0	0%
Another Language	0	0%
Total	**103**	**100%**

Program	FY18-19 Key Outcomes and Highlights
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support – Richmond Area Multi-Services (RAMS)	●30 clients (118% of goal) enrolled with the Peer Transition Team met with a Peer Counselor within 30 days of date of enrollment. ●10 clients surveyed (121% of goal) reported "Agree" or "Strongly Agree" regarding feeling heard and understood by their peer counselor. ●8 clients surveyed (97% of goal) reported that they "Agree" or "Strongly Agree" regarding feeling more comfortable with their new provider.
FUERTE – University of California San Francisco (UCSF)	●12 schools (400% of goal) agreed to host Fuerte groups. 10 school (333% of goal) hosted groups. ●36 group facilitators in SF County (180% of goal) trained on the Fuerte curriculum. ●71 San Francisco Unified School District (SFUSD) students (284% of goal) enrolled in the Fuerte program. ●19 students who participated in Fuerte (30% of goal) screened using the PSC-35. ●1 student was identified as being at risk for behavioral health concerns and was referred and linked to specialty mental health services by their group facilitator.
Wellness in the Streets - Richmond Area Multi-Services (RAMS)	●The program was not able to work up to its full capacity due to the impact of COVID-19 and the temporary reduction of program services. ●This start-up program hired 3 full-time Peer Counselors. ●This program was initially intended to perform street outreach to homeless individuals living on the streets, however due to the pandemic, BHS requested from the State to adjust the services to provide in-person outreach to individuals who are homeless and temporarily housed in Shelter-In-Place (SIP) hotels. ●Clients were contacted by telephone or through virtual means by a peer to provide emotional support. ●Peer Counselors provided linkage services, assisting clients in completing necessary documents to qualify for health/food/housing benefits and assisting clients in connecting to primary care services.
Technology Assisted Mental Health Solutions – Mental Health Association of San Francisco	●45 presentations reached 635 individuals. ●353 completed evaluations (90%) received post community presentations reported decreased stigma. ●12 Peer Educators (98%) responded 'strongly agree 'or 'agree' to the End-of-Year Evaluation measuring "experiencing reduced self-stigma". ●60 consumers (120% of goal) received 1:1 wellness coaching support. ●53 individuals (110% of goal) achieved one personal wellness goal from their care plan, meeting and exceeding our goal by 110%. ●1,1076 evaluations (121% of goal) received by participants who engaged in group support reported an increase in social connectedness after attending support group sessions, meeting.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[17]
Innovations	133 Clients	$988,938	$7,435

Moving Forward in Innovations

As these four INN programs continue operations into FY2020-21, they are moving away from ramping-up new projects and starting to look at their outcomes, collecting feedback from staff and consumers, designing program improvements, planning for sustainability, and continuing to innovate.

The Intensive Case Management/Full-Service Partnership to Outpatient Transition Support intends to hire two additional full-time peer counselor positions, develop a clinician feedback survey, and expand client eligibility criteria to include clients who will be stepping down to the outpatient level of care within the next 12 months. Additionally, the program intend to update program outreach materials and gain access to Avatar data systems in effort to increase care coordination with clinicians. The program intends to continue collecting client feedback to incorporate into program improvement planning.

The FUERTE program faced many challenges in 2020 due to the COVID-19 pandemic, particularly with the closure of schools. Our first challenge after transitioning to remote work was the time spent to obtain district permission to continue groups through teleservices after school closures. Since teleservices present a unique challenge to maintaining student confidentiality, we were instructed to reconsent caregivers and participants for remote participation. Caregivers were not available via email and some schools placed restrictions preventing students receiving emails from outside of SFUSD. As a result, most of our outreach to caregivers and students was done by phone by program staff and some facilitators. Reaching families by phone was time intensive, which resulted in a lack of engagement for 3-4 weeks with most participants. Prior to the pandemic, contact with the students happened easily in-person during school hours. As a result, we did not have a need for an existing system to engage students via phone, email or text. To aid us in this challenge, we set up in June a HIPAA-compliant text messaging system for group reminders, text check-ins, and feedback collection that we hope will allow us to maintain student engagement throughout distance learning and beyond. To increase attendance, we plan to schedule groups during or immediately after the virtual school day and link FUERTE to the routine set up by the schools during distance learning.

The Wellness In the Streets program was initially intended to perform street outreach to homeless individuals living on the streets in San Francisco, with the intent of gathering real-time feedback on needs homeless individuals are experiencing. However, due to the pandemic, BHS requested from the State to adjust the services to provide in-person outreach to individuals who are homeless and temporarily housed in hotels due to limited space in shelters, as a result of the pandemic. Currently, clients in the hotels are being contacted by telephone or through virtual means by a peer to provide emotional support. When clients and their peer counselor have identified a specific task/linkage that needs to be attended to, the Peer Counselor will connect the client to the WITS Peer Counselors, who will meet with the client(s) at the hotel or at a specific location and assist the client in completing the task. Real examples are assisting clients

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

in completing necessary documents to qualify for health/food/housing benefits and assisting clients in connecting to primary care services.

Technology Assisted Mental Health Solutions (SOLVE) will continue to provide online and remote services, including the SOLVE Hangout for peer educators to meet in a virtual space to provide support for one another. Peer Engagement Services will be reassessed for modified service needs due to COVID-19 pandemic. Demand for services has dramatically increased since March 2020, when the San Francisco Shelter-in-Place order went into effect. Remote availability of these services, particularly our Zoom and phone services, have led to increase in availability for our group support services. These services have increased nearly 100% and we expect to see these trends continue.

FUERTE Program Staff 2019

7. Behavioral Health - Workforce Development: WET Funding

Service Category Overview

The Behavioral Health Workforce Development service category addresses the shortage of qualified individuals who provide services in San Francisco's public mental health system. This includes developing and maintaining a culturally humble and competent workforce that includes individuals who have experiences 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. 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.

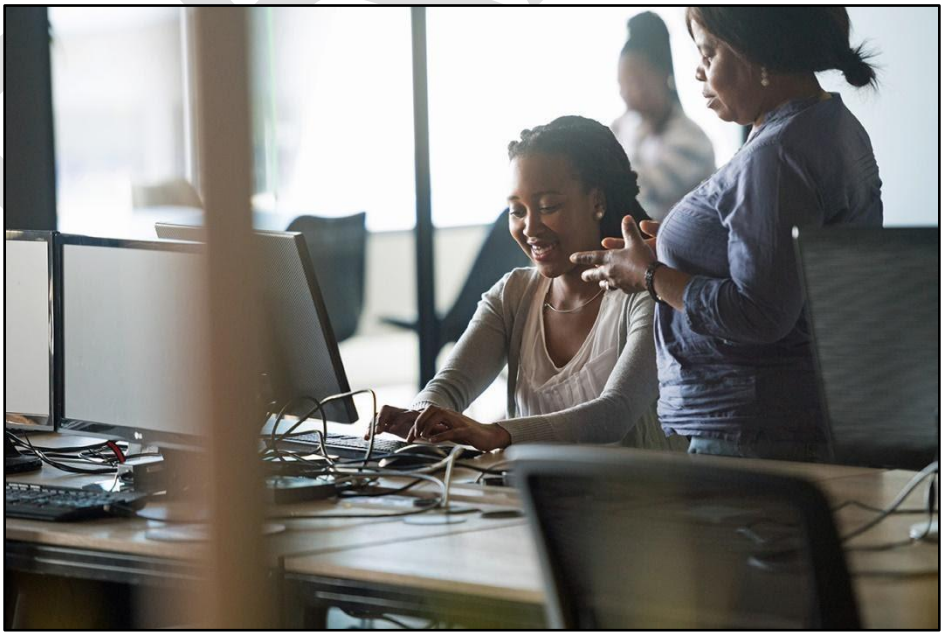
Target Populations

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

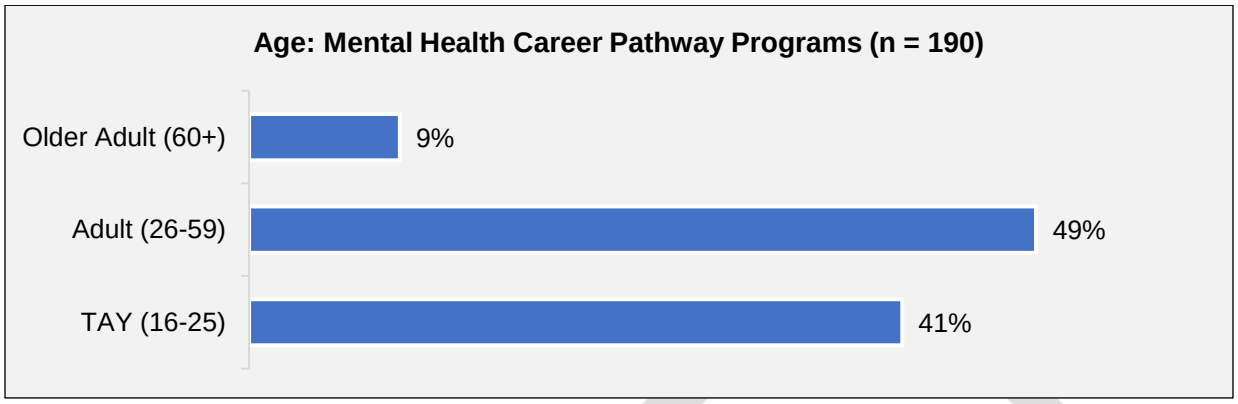
Workforce Dev

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

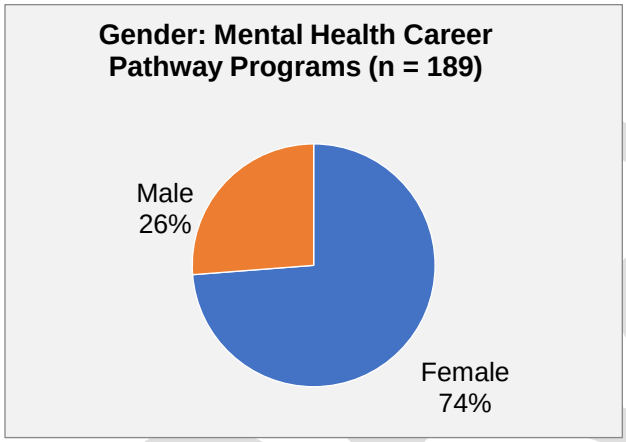


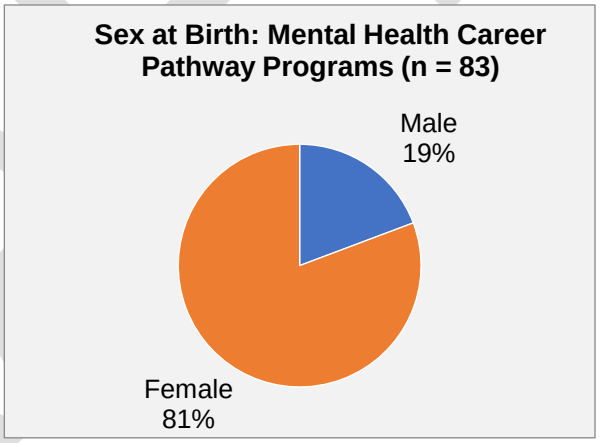
Participant Demographics, Outcomes, and Cost per Client

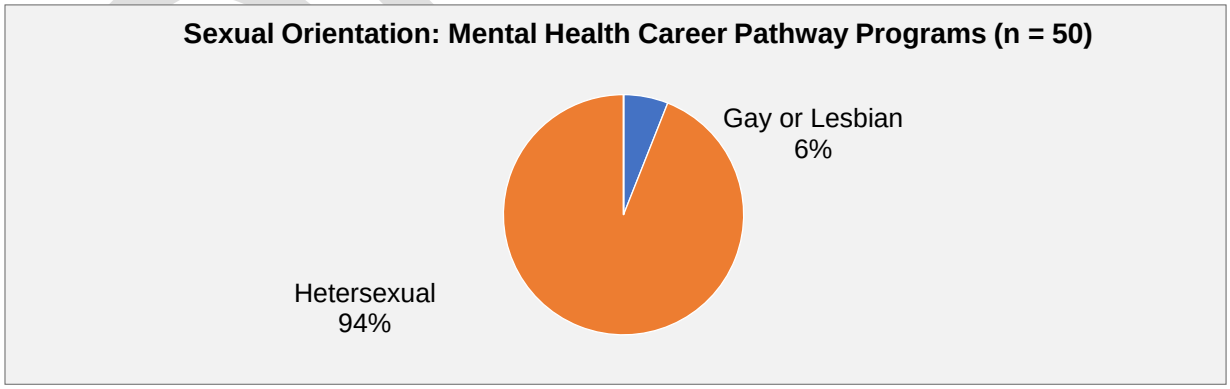
Demographics: Mental Health and Career Pathways



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

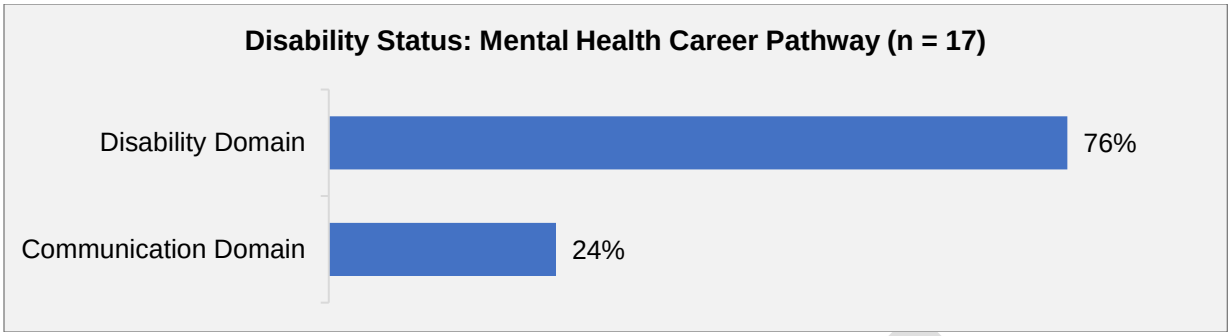






*< 1% of participants reported data for Yes; Veteran Status
*< 1% of participants reported data for Trans Male Trans Female Another Identity; Gender
*< 1% of participants reported data for Bisexual, Questioning/Unsure, Another Identify; Sexual Orientation

Workforce Dev



*< 1% of participants reported data for No Disability; Another Disability Not Listed

Race/Ethnicity	n	%
Black/African American	30	15%
American Indian or Alaska Native	3	2%
Asian	20	10%
Native Hawaiian or Pacific Islander	0	0%
White	60	30%
Other Race	1	1%
Hispanic/Latino	76	38%
Non-Hispanic/Non-Latino	0	0%
More than one Ethnicity	9	5%
Total	30	100%

Primary Language	n	%
Chinese	6	3%
English	97	54%
Russian	0	0%
Spanish	68	38%
Tagalog	10	6%
Vietnamese	0	0%
Another Language	11	6%
Total	181	100%

Program	FY19-20 Key Outcomes and Highlights
Community Mental Health Worker Certificate – City College of San Francisco	● 17 CMHC cohort students (77%) completed the certification program as evidenced by Argos student tracking system. ● 30 students (46%) of students enrolled in Health 91D successfully completed the course. ● 17 CMHC cohort students (77%) completed their internship. ● 17 graduating students (100%) expressed readiness to pursue subsequent work/educational opportunities. ● 17 graduating students (100%) expressed interest in pursuing health related careers. ● 17 graduating students (100%) expressed knowledge of pathways into health-related careers.
Community Mental Health Academy – Crossing Edge Consulting	● 18 individuals (100%) recruited and 15 (83%) attended the first session of the Community Mental Health Academy.14 individuals (77%) completed the program (Fall). ● 20 individuals (133% of goal) recruited and 19 attended the first session. 18 individuals (120% of goal) completed the program (Spring).

Workforce Dev

Program	FY19-20 Key Outcomes and Highlights
	● 32 participants (100%) shared contact information in their network, which included but not limited to housing, mental health clinics, substance use support, case management providers, foster care services, resources for LGBTQ youth, suicide prevention services and suicide hotlines, mental health counseling in school settings, and access to food and financial support during COVID-19. ● 32 participants (100%) learned about: a) mental health first aid, b) trauma informed care and recovery, c) crisis intervention, d) and wellness and recovery action planning ● 32 participants (100%) learned about: a) motivational counseling strategies, b) wellness and recovery interventions, c) de-escalation techniques, d) indigenous based stress reduction tactics, and grounding practices.
Faces for the Future Program – Public Health Institute	● 50 students (100%) enrolled in the FACES Program. ● 54 hours (180% of goal) of collaborative meetings completed. ● 50 students (125% of goal) completed 6, 2-hour internship training workshops. ● 50 students (183% of goal) received 22 hours of work-based learning at JOCHS. ● 38 students (100%) completed the mandatory health clearances.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[18]
Mental Health Career Pathways	78 Clients	$654,552	$8,392

Workforce Dev

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

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

Program Outcomes, Highlights and Cost per Client

Program	FY19-20 Key Outcomes and Highlights
Trauma Informed Systems Initiative - *SFDPH*	• 1,800 participants trained in FY19/20. • 2 TIS staff members began the process of become certified in "Search Inside Yourself Leadership Institute (SIYLI)," a yearlong learning and practice venture in emotional intelligence, neuroscience, mindfulness and leadership. They began offering SIYLI to DPH staff in the fall of 2019.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[19]
Training and Technical Assistance	1,800 Served	$747,803	$415

Workforce Dev

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

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

Program Outcomes, Highlights and Cost per Client

Program	FY18-19 Key Outcomes and Highlights
Fellowship for Public Psychiatry in the Adult/Older Adult System of Care and SF General Hospital - UCSF	• 2 MHSA-funded fellows. One fellow worked at Mission Mental Health Clinic and Comprehensive Crisis Services unit and he is now a first-year employee with Behavioral Health Services. The second fellow was a fourth-year psychiatry resident at UCSF who worked at Richard H. Fine People's Clinic at ZSFG, a position she has continued on a half-time basis as a faculty member of ZSFG Dept of Psychiatry. • Multiple external trainings attended: 1) a Mental Health Advocacy training at the Steinberg Institute and California Psychiatric Association and 2) various forensic field trips (Behavioral Health Court, Citywide Forensic, SFPD Ride Along, San Quentin Correctional Facility). • 2 fellows from FY19/20 continue to work at SFHN-BHS clinics. In July 2020, Dr. Matthew Goldman was selected to serve as the Associate Medical Director for the Comprehensive Crisis Services unit. Dr. Tamara Bendahan works part-time with the Behavioral Health Team within ZSFG's RFPC.
Child and Adolescent Community Psychiatry Training Program (CACPTP) - UCSF	• 4 second year Child and Adolescent Fellows, one fellow at each of the following clinics one afternoon a week: Southeast Child Family Therapy Center, Chinatown Child Development Center, Family Mosaic Project, and OMI Family Center.
BHS Graduate Level Internship Program - DPH	• In FY19/20, 19 MSW students were able to attend the monthly Intern Lecture Series. • There was a total of 29 scheduled training sessions. • A few intern placements ended early because of COVID-19 and intern trainings were moved to virtual format vs. in-person.

FY19/20 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[20]
Psychiatry Residency and Fellowships	180 Served	$563,998	$3,133

Workforce Dev

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

Moving Forward in Behavioral Health Workforce Development

BHS Training Unit

The BHS Training Committee was recently renamed to be the "BHS Workforce Development Employee Engagement Committee". This committee met several times in FY19/20 but then paused committee meetings once COVID-19 occurred in March of 2020, so staff members could focus on other priorities related to the pandemic response efforts. Prior to COVID-19-19, this committee met to focus on disseminating staff experience survey results and drafting a very comprehensive workplan. The committee leaders recently meet to discuss plans to revamp this committee post-COVID-19 and resume efforts, primarily to refocus on the comprehensive workplan.

BHS MSW Counseling Graduate Training Program

Teresa Yu filled in as an interim role of BHS Internship Program following the departure of Jonathan Maddox. Teresa Yu filled this role from August through January until we were able to hire a new staff member. Michelle Meier accepted the position as BHS Internship Coordinator and started in early January 2020. The program recently partnered with Rick Goscha from CIBHS to provide training on his Strengths Model - specifically the Strengths Assessment and Strengths-Based Group Supervision model which BHS is using for their monthly Case Conferences (part of the weekly didactic series).

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

Three MHSA-funded fellows completed the program this academic year. Dr. Michael Politis is a child and adolescent psychiatrist working in both the SFHN-BHS Foster Care Mental Health and the SFHN-BHS Comprehensive Crisis Services unit. Dr. Ricardo Lozano is a bilingual and bicultural Latino psychiatrist. Additionally, one fellow (Dr. Nathan Kyle Jamison) is placed at one of SFHN-BHS's affiliated clinics, HealthRight360. Fellows will complete all program activities as conducted in previous years, with "field trips" converted to virtual activities as often as possible due to COVID-19 restrictions. To supplement the Fellowship's curriculum, fellows will also attend virtual workshops on Mental Health Advocacy organized by the Steinberg Institute and California Psychiatric Association among others, and have an experiential exercise in advocacy. To expand the reach of the fellows' capstone projects, we are emphasizing collaboration with and dissemination to mental health services consumers from each clinical site. Specifically, fellows will identify a consumer partner from their sites' Community Advisory Board and work with them throughout the year, as well as disseminate their results to a broad group of stakeholders (e.g. consumers, clinic staff, leadership). These projects will be submitted to the annual meeting of the American Psychiatric Association meeting held in Los Angeles in the spring of 2021. In addition, we plan to launch the DPH Public Psychiatry Administrative Fellowship (PPAF), a two-year program with a mission to build community among emerging public psychiatry leaders within the SFHN-BHS. Fellows will complete a quality improvement project and participate in leadership workshops. We have already initiated recruitment for FY21/22. We have received several applicants, accepted our first fellow, and have interviews scheduled with three additional potential fellows.

Online Learning Management System

BHS/SF-MHSA received one response to our RFQ for an Online Learning Management System to support clinicians and staff with increased access to training. A panel of five reviewers was convened to review the proposal. Based on a thorough review by the panel, the proposal was accepted. Several planning and implementation meetings have been held with the selected

vendor and a series of issues were clarified (i.e. such as how many users the system can accommodate, who will handle user help requests, how the system will be evaluated, etc.). Based on these meetings, a contract was developed and is in the process of review by the Department of Public Health. We expect the contract review to be completed in 2020 in which we can start a formal program implementation process.

Child and Adolescent Community Psychiatry Treatment Program

The course in Community Psychiatry will take place in June 2021 and rotation at the Juvenile Justice Center has continued. The program is also creating a Community Psychiatry Track, which allows for one fellow to spend two afternoons a week in an SFPDH Clinic during FY 21/22.

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

Service Category Overview

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

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

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

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

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

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

Information Technology	
Program Name	**Services Description**
	• Preparation for the transition to the Epic system (Electronic Health Record) in 2021.

Moving Forward in Capital Facilities

Chinatown North Beach Clinic- 729 Filbert Street
The project entails:

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

BHS Pharmacy renovations that we approved in the FY2020-23 Three-Year Plan for FY20/21 is on track for completion by the end of FY20/21.

SF-MHSA plans to provide funding for capital facilities renovations at one of the BHS Hope SF sites in the Hunters Point district of San Francisco. These renovations will help create telehealth spaces and kiosks for telehealth services. In our CPP process, the San Francisco community has identified the need to continue with telehealth services even beyond the COVID-19 pandemic, as telehealth services significantly increase access to services for the underserved populations. We anticipate that these renovations may last beyond FY21/22 through FY22/23.

Moving Forward in Information Technology

System Implementation, Support, Maintenance and Reporting
System implementation, support, maintenance and reporting provides vital program planning and support for projects. Three civil service Business Analysts positions are funded by MHSA. These positions are dedicated to supporting MHSA IT initiatives and IT systems including the Avatar EHR application.
Responsibilities include the following:

- Implementation of MHSA projects
- Manage connectivity for our BHS contract providers to the Avatar EHR system
- Coordinate with the System of Care on BHS/MHSA IT related projects
- Conduct data analysis related to projects
- Ensure the Avatar EHR system is compliant with State mandates
- Support the Avatar EHR system for BHS providers
- Preparation for the transition to the Epic system (Electronic Health Record) in 2022
- Participate in the IT strategic goals for DPH, including MHSA and BHS
- Maintenance of MHSA reporting databases, including DCR

Program Evaluation for All MHSA Programs

MHSA Evaluation Staff and the COVID-19 Pandemic

The MHSA Evaluation Team holds four FTE epidemiologists, one of whom leads the group. This fiscal year brought extreme impacts to the staffing of the evaluation team. Starting the year with one vacant position, a second position was vacated in October when an epidemiologist left for the private sector. Hampered by an unusually slow hiring process, onboarding a candidate for the first position was beset by months of delays and setbacks. With two positions vacant, and the onset of COVID-19, the two active epidemiologists were deployed to the Covid Command Center full-time beginning in March 2020 and remained completely engaged in the pandemic response through the remainder of the fiscal year, leaving no evaluators available to MHSA for at least seven months. This greatly hampered the team's ability to support ongoing and emerging data and evaluation needs.

System Change: Integrating MHSA Principles into the Larger BHS System of Care

- **Integrated Service Delivery**
  Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.
- **Wellness and Recovery**
  Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

Intensive Case Management (ICM) programs, which include Full Service Partnership (FSP) programs, welcome higher acuity clients and provide "whatever it takes" to improve clients' wellbeing and recovery. Transitioning clients to appointment-based mental health outpatient clinics (OP), when they no longer need the intensity of ICM/FSP care, continues to present many challenges for clients and the Behavioral Health System of Care. However, with the implementation of new standards of work and supports for clients, we are better able to assess clients' transitions to OP care. These efforts strongly reflect the goals of integrating client care more seamlessly, and supporting and encouraging client wellness and recovery. Continuing the collaborative planning from recent years, several key initiatives were implemented in FY18-19, then tracked by Quality Management staff and improved upon in FY19-20. However, the COVID-19 virus outbreak and months-long shelter-in-place Orders imposed on March 13, 2020 grew into a global pandemic, and significantly impeded our progress toward transitioning clients out of ICMs in the remainder of the fiscal year.

ICM to Outpatient Referral Tracking

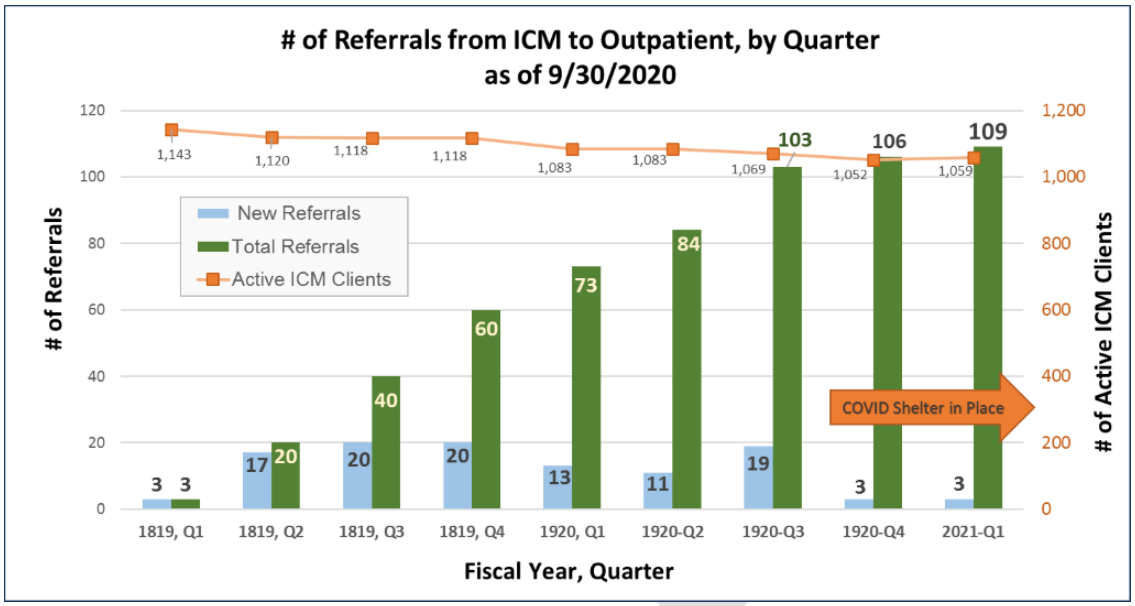
Monthly reporting to BHS Administration (QM) by the ICM/FSP programs has allowed us to monitor referrals and measure successful client linkages to Outpatient clinic services, opening up ICM slots for clients in higher acuity. These efforts were reported as part of an External Quality Review Non-clinical Performance Improvement Project (EQRO PIP) for 2020.

Successful Linkage from ICM to Outpatient is defined as ALL of the following:

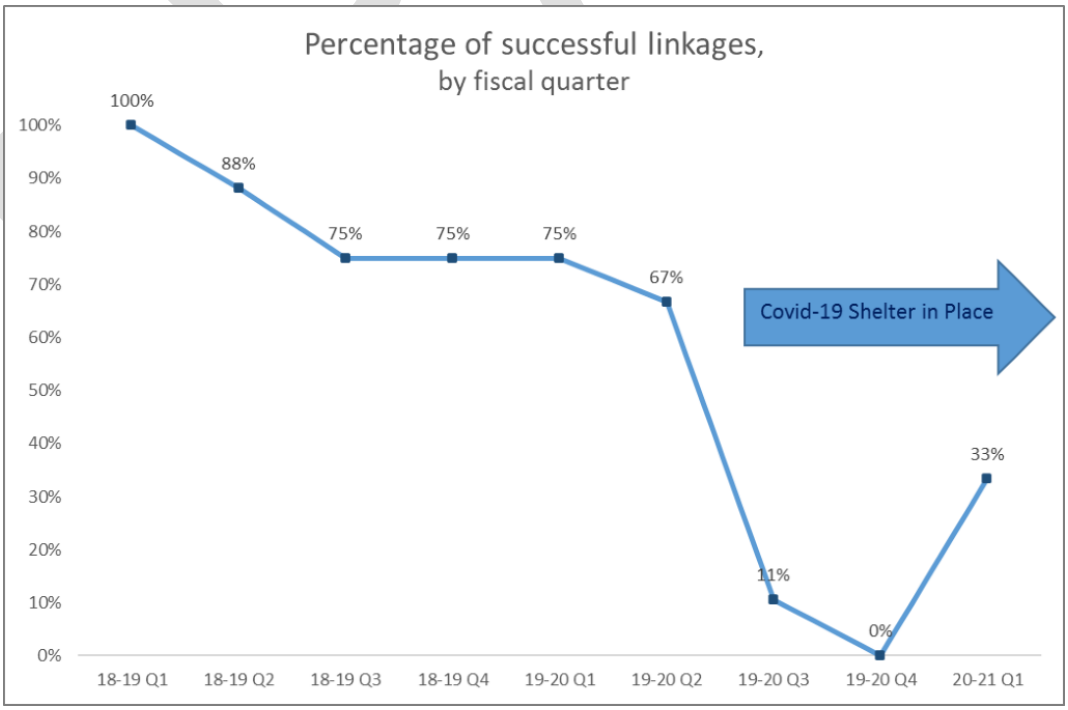
1. Evidence of a referral made from ICM to Outpatient;
2. New outpatient episode open for at least 60 days;
3. The referred ICM client attends at least 3 outpatient services; and
4. The ICM episode generating the referral is closed

The below displays numbers of referred clients from **ICM to Outpatient care**, including new referrals per quarter, cumulative referrals and across the top, the totals of active ICM clients.

New referrals to Outpatient each month generally ranged from 11-20 until the initiation of COVID-19 Shelter in Place orders, severely curtailing efforts to stepdown ICM clients.



The below figure provides point-in-time baseline data for the proportion of successful linkages from ICM to Outpatient, quarterly. The numerators and denominators are provided below the horizontal axis. The numerator is the number of clients who met the four criteria for successful linkages (see footnote to Indicators table above) that resulted from referrals during that quarter. The denominator is the number of referrals initiated in that quarter. Note that the events associated with the criteria may take place over more than one quarter following a referral.



Since 2018, many efforts have been tested and implemented with a goal to effectively and appropriately transition clients who no longer meet criteria for ICM to step down to a lower level of care more appropriate to their clinical needs. The ICM to Outpatient Flow PIP interventions included agreed upon guidance for making referrals and reporting data, a systematic utilization review (UM) process and the support of the RAMS Peer Transition Team. These efforts were either rolling out or already in place by March 2020. However, the COVID-19 Shelter in Place orders severely hampered most efforts to actively transition clients out of ICMs were suspended. That said, a few clients did transition to Outpatient care.

The mandatory SIP orders impacted care in BHS in the following ways:

- ICMs focus on client crisis stabilization
- ICMs and Outpatient programs grappling with newly essential TeleHealth service delivery, technology issues, privacy concerns, etc.
- Severe staff shortages due to mandatory deployments to Disaster Operations Command (now called the Covid Command Center) to support testing, mitigation and community support strategies
- Delays in identifying SIP service delivery options and protocols

ICM-OP Task Force

Throughout FY18-19, the SOC convened an ICM-OP Task Force, meeting monthly, to move the collaborative workgroup's recommendations forward. In FY19-20, the task force folded into system of care leadership and continues to monitor and advocate for progress on key priorities:

1. Ensures implementation of the ICM-OP Referral process requirements
2. Collect referral data centrally and evaluate the impact of the changes; also exploring the incorporation of the referral form(s) into the BHS electronic health record (Avatar)
3. Expand case management, outreach and supportive services at the Outpatient level to better engage and retain incoming ICM and FSP clients
4. Communicate regularly with ICM/FSP and OP providers updates and challenges on implementation of the ICM-Outpatient Flow task force's recommendations.

Innovations Project Evaluations

MHSA-funded staff within the BHS Quality Management (QM) unit play an active role in supporting evaluation activities for MHSA, especially Innovation projects. QM staff are routinely consulted for the development of evaluation plans, carrying out evaluation data collection, participant and stakeholder feedback, as well as supporting and/or writing Innovations Final Reports.

QM is particularly involved with the ICM-OP Peer Transition Team implemented by RAMS as it aligns well with, and in fact came out of, the ICM-OP Collaborative described briefly above. RAMS staff collect the data with technical support and oversight from QM. QM created an evaluation plan and drafted data collection tools to assess multiple perspectives of the Peer Transition project:

1. Client experience
2. Peer Specialist experience
3. FSP/ICM assessment
4. Outpatient assessment

Data collection is designed to capture from each: effectiveness of client support, communication between the PTT and the programs, support of the peer team, among other priorities. Interviews were conducted with PTT peer counselors in February and July of 2020, and a survey of ICM providers seeking data on their experience with the PTT is expected to roll out in FY 20-21. QM

also supported defining objectives and preliminary evaluation planning for Wellness in the Streets (WITS), FUERTE, and the Tech Suite project still in development. QM will play a major role in evaluating the WITS for its duration. However, the FUERTE program will have primary evaluation support from UCSF, with QM oversight. QM staff also provided input to the latest Innovations proposal, Congruent Care for African Americans, seeking to address inequities and access and engagement with this population, resulting in inappropriate or inadequate care. The proposal is expected to be reviewed (and hopefully approved) by MHSOAC in FY 20-21. Finally, QM supports MHSA in advising on and assistance in writing Innovations Final Leaning Reports, such as the Curry Isolated Seniors project (where data analysis was conducted primarily by UCSF evaluators) and the Transgender Pilot Project, documented elsewhere in this report.

Program Objectives and Evaluation Support

Improved Program Objectives for other MHSA programs

QM reviewed MHSA programs' contract process and outcome objectives for FY 19-20 in an effort to make them stronger. The careful review of objectives helped identify programs that still needed support in creating SMART objectives. With SMARTer objectives, SF MHSA can report more meaningful and accurate outcomes and impacts in MHSA Annual Update reports. Already strong, the programs' SMART objectives continue to get leaner and more meaningful.

Evaluation Frameworks for new RFQs and RFPs

As new programs are conceptualized, or Innovations funding gets approved, the County creates Requests for Qualifications (RFQs) and Requests for Proposals (RFPs) that give community based providers the opportunity to apply for funding to implement the services proposed. QM contributes to the RFQ/RFP development process in order to ensure that clear goals are articulated from the start and that evaluation expectations are well defined. Applicants are encouraged to design logic models for their proposals and articulate how they plan to measure their outcomes.

PEI Data Regulations: Access and Linkage to Treatment

In an ongoing effort to implement complex data requirements for PEI and INNOVATIONS programs to capture Access and Linkage to Treatment for previously unserved and underserved individuals in the population, Quality Management partners with MHSA staff to provide technical assistance to programs. QM offered one on one TA, with visits to the programs. Due to staff departures and deployments to work on COVID-19 response in SF, TA visits to programs were limited.

Gender Health San Francisco

One staff evaluator supports the Gender Health SF project. However, the pandemic and the deployment of this epidemiologist to the COVID-19 Command Center full time, limited their availability to the project. GHSF carried out data collection in a reduced capacity, as they too responded to citywide efforts to mitigate the virus in the community.

"Looking Ahead for SFDPH 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 FY21/22 Annual Update, which brings together updates and a vision for implementation of all the MHSA components.
In the coming year, MHSA will work to implement and enhance the programming described in detail in this report. We will also strive to integrate the valuable feedback received in CPP meetings and other stakeholder engagements. We are committed to weaving this feedback into the core of MHSA programming. Over the next year, we will also focus efforts on a number of key areas. These areas of focus are detailed below:

- **We will continue to take measures to respond to the No Place Like Home (NPLH) bond and requests.** NPLH re-purposes statewide MHSA funds, and will provide $2 billion Statewide for the construction and rehabilitation of permanent supportive housing for homeless individuals with severe and persistent mental illness. In the coming year, we will work to implement effective NPLH programming as outlined by the State.
- **We will place a strong emphasis on program evaluation across the MHSA components.** In the year ahead, we will work to enhance our monitoring and evaluation activities, in order to effectively meet the performance objectives of our MHSA-funded programs. We will continue to gather stakeholder feedback and make improvements to reporting tools that allow programs to submit mid-year and year-end reports that include demographics data, measurable outcomes, client success stories and more.
- **We will continue to implement our new projects/programs.** As stated in our FY21/22 Annual Update, we have several new projects/programs that were approved through our CPP process that we will continue to launch and implement for our community:
    - ICM/FSP to Outpatient Transition Support
    - Wellness in the Streets
    - Technology-Assisted Mental Health Solutions
    - Family Unification and Emotional Resiliency Training (FUERTE)
    - Online Learning Management System
    - New Innovation Project: Culturally Responsive Practices for the Black/African American Communities
    - New Innovation Project: Support for the Asian/Pacific Islander Communities
- **We will continue to adapt during COVID-19 pandemic.** As stated earlier, SF-MHSA has modified programming to ensure that safety and access to care are top priorities for our San Francisco communities. We will continue to assess these ever-changing needs and we will continue to adapt our programming, as needed, to meet the various and diverse needs of our community members, consumers and stakeholders.
- **We will fund the following mini-initiatives** based on stakeholder feedback:
    - Provide group facilitator support for the "Working While Black Support Group" for the Black/African American communities
    - Provide group facilitator support for Latinx and Asian/Pacific Islander support groups
    - Provide support for a T2 Leadership cohort
    - Provide support for MHSA's collaborative efforts with OEWD
    - Exploration of a project providing mini-grants for small innovation projects
    - Partner with Rafiki to support a new Wellness Application (app) that will allow clients to conduct a myriad of health and wellness activities
    - Possible expansion of telehealth kioks

Projected MHSA Expenditures

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

MHSA Integrated Service Categories

MHSA Integrated Service Categories	Abbreviation	FY 19/20 Expenditure Amount	Percentage
Admin	Admin	2,616,622.96	8%
Evaluation	Evaluation	477,095.01	1%
Housing	H	2,070,423.81	6%
Recovery Oriented Treatment Services	RTS	12,974,443.74	39%
Peer-to-Peer Support Services	P2P	5,391,392.48	16%
Vocational Services	VS	2,443,132.57	7%
Workforce Development and Training	WD	1,966,354.06	6%
Capital Facilities/IT	CF/IT	300,233.34	1%
Mental Health Promotion and Early Intervention Services	PEI	5,153,432.96	15%
TOTAL		**33,393,130.93**	**100%**

MHSA FY19/20 Actual Expenditures

SF MHSA Integrated Services Categori	Programs by Funding Component	FY 19-20 Expenditure
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 18-19, 53% was allocated to serve FSP clients	
Admin	CSS Admin	2,084,952.61
Evaluation	CSS Evaluation	400,031.94
H	CSS FSP Permanent Housing (capital units and master lease)	987,703.66
RTS	CSS Full Service Partnership 1. CYF (0-5)	400,000.00
RTS	CSS Full Service Partnership 2. CYF (6-18)	900,533.08
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,200,834.03
RTS	CSS Full Service Partnership 4. Adults (18-59)	4,054,179.87
RTS	CSS Full Service Partnership 5. Older Adults (60+)	1,060,513.57
RTS	CSS Full Service Partnership 6. AOT	734,700.83
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	1,020,752.42
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	637,811.45
RTS	CSS Other Non-FSP 3. Trauma Recovery	140,604.00
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,485,245.78
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	396,349.61
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,233,101.45
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,303,739.65
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	285,000.00
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	197,331.15
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	600,389.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	490,433.04
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	452,486.06
	SUBTOTAL Community Services and Support (CSS)	**23,066,693.20**

	Workforce, Development Education and Training (WDET) **$2.3M transferred from CSS to fund WDET activities in FY 18-19**	
WD	WDET 1. Training and TA	747,803.45
WD	WDET 2. Career Pathways	654,552.21
WD	WDET 3. Residency and Internships	563,998.40
Admin	WDET Admin	82,799.05
Evaluation	WDET Evaluation	14,227.73
	SUBTOTAL Workforce, Development Education and Training (WDET)	**2,063,380.84**
	Capital Facilities/IT **$3.0M transferred from CSS to fund Capital Facilities/IT activities in FY 18-19**	
CF/IT	Cap 8. Chinatown/Northbeach Exam Room	15,292.50
CF/IT	IT 1. Consumer Portal	150,660.75
VS	IT 2. Vocational IT	1,139,392.92
CF/IT	IT 3. System Enhancements	134,280.09
Admin	IT Admin	112,515.60
	SUBTOTAL Capital Facilities/IT	**1,552,141.86**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**26,682,215.90**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	145,015.92
PEI	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	1,051,660.63
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,702,621.43
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	655,807.88
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	259,859.10
PEI	PEI 7. CalMHSA Statewide Programs	66,471.70
Admin	PEI Admin	82,798.60
	SUBTOTAL Prevention and Early Intervention (PEI)	**4,964,235.26**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adults	211,404.38
P2P	INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	229,944.28
P2P	INN 18. Intensive Case Management Flow	428,698.80
P2P	INN 20. Technology-assisted Mental Health Solutions	153,995.77
P2P	INN 21. Wellness in the Streets (WITS)	134,247.80
PEI	INN 22. FUERTE	271,996.30
Admin	INN Admin	253,557.10
Evaluation	INN Evaluation	62,835.34
	SUBTOTAL Innovation (INN)	**1,746,679.77**
	TOTAL FY 18-19 MHSA Expenditures	**33,393,130.93**

MHSA Estimated Expenditures from FY21/22 to FY22/23

FY2020-21 Through FY2022-23 Three-Year Integrated Plan

Funding Summary

County: San Francisco | Date: 6/30/21

	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 2020/21 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	13,512,617	8,797,145	6,045,646	350,000	2,303,610		31,009,018
2. Estimated New FY2020/21 Funding	30,400,000	7,600,000	2,000,000				40,000,000
3. Transfer in FY2020/21	(4,516,242)			2,189,828	2,326,414	-	-
4. Access Local Prudent Reserve in FY2020/21						-	-
5. Estimated Available Funding for FY2020/21	39,396,375	16,397,145	8,045,646	2,539,828	4,630,024		71,009,018
B. Estimated FY2020/21 MHSA Expenditures	23,666,010	5,991,687	3,800,946	2,424,911	4,576,414		40,459,968
C. Estimated FY2021/22 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	15,730,364	10,405,459	4,244,700	114,917	53,610		30,549,050
2. Estimated New FY2021/22 Funding	30,400,000	7,600,000	2,000,000				40,000,000
3. Transfer in FY2021/22	(4,542,809)			2,929,300	1,613,509	-	-
4. Access Local Prudent Reserve in FY2021/22						-	-
5. Estimated Available Funding for FY2021/22	41,587,555	18,005,459	6,244,700	3,044,217	1,667,119		70,549,050
D. Estimated FY2021/22 Expenditures	23,861,210	8,806,750	2,831,076	2,929,300	1,613,509		40,041,845
E. Estimated FY2022/23 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	17,726,345	9,198,708	3,413,624	114,917	53,610		30,507,205
2. Estimated New FY2022/23 Funding	30,400,000	7,600,000	2,000,000				40,000,000
3. Transfer in FY2022/23	(4,633,017)			2,946,748	1,686,268	-	-
4. Access Local Prudent Reserve in FY2022/23						-	-
5. Estimated Available Funding for FY2022/23	43,493,329	16,798,708	5,413,624	3,061,665	1,739,878		70,507,205
F. Estimated FY2022/23 Expenditures	24,173,008	9,485,914	3,144,222	2,946,748	1,686,268		41,436,161
G. Estimated FY2022/23 Unspent Fund Balance	19,320,321	7,312,795	2,269,401	114,917	53,610		29,071,044

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

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

CSS Estimated Expenditures FY20/21 to FY22/21

	Fiscal Year 2020/21					
	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)	552,932	400,000.00	-	-	-	152,932
2. CSS Full Service Partnership 2. CYF (6-18)	1,132,313	926,389	45,839	-	-	160,085
3. CSS Full Service Partnership 3. TAY (18-24)	1,950,231	1,490,133	440,574	-	-	19,524
4. CSS Full Service Partnership 4. Adults (18-59)	9,940,576	4,132,495	1,834,969	1,309,296	2,743	2,661,073
5. CSS Full Service Partnership 5. Older Adults (60+)	1,564,092	1,081,391	406,492	-	-	76,209
6. CSS Full Service Partnership 6. AOT	759,985	759,985	-	-	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	987,704	987,704	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,500,366	2,126,856	-	111,480	-	262,031
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,681,294	599,193	6,988	265,304	-	809,809
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	171,000	171,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	59,199	59,199	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	360,233	360,233	-	-	-	-
Non-FSP Programs		-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,156,509	1,023,177	108,248	-	-	25,083
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,096,984	637,811	240,023	-	-	219,150
3. CSS Other Non-FSP 3. Trauma Recovery	190,938	140,604	39,461	-	-	10,873
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,740,773	1,544,972	195,801	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,676,935	396,350	3,774	1,129	50,610	1,225,073
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	2,500,366	2,126,856	-	111,480	-	262,031
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,054,915	732,347	8,541	324,261	-	989,767
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	114,000	114,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	138,132	138,132	-	-	-	-
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	772,721	509,405	263,316	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	436,147	436,147	-	-	-	-
CSS Administration	2,136,385	2,136,385	-	-	-	-
CSS Evaluation	395,091	395,091	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	36,309,978	23,666,010	3,594,026	2,122,949	53,353	6,873,640
FSP Programs as Percent of Total	55%					

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	800,000	400,000	-	400,000	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	1,632,191	942,297	368,196.64	289,170	32,527	-
3. CSS Full Service Partnership 3. TAY (18-24)	3,142,980	1,518,053	694,689	559,440	370,797	-
4. CSS Full Service Partnership 4. Adults (18-59)	9,560,996	4,156,107	1,508,783	1,560,670	1,362,943	972,493
5. CSS Full Service Partnership 5. Older Adults (60+)	2,560,584	1,097,270	510,231	553,303	399,779	-
6. CSS Full Service Partnership 6. AOT	1,179,101	768,091	156,789	254,221	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	2,010,873	987,704	-	1,023,170	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,081,756	2,135,183	233,374	1,616,250	-	96,949
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,145,434	595,969	51,359	326,428	4,406	167,272
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	288,120	171,000	-	117,120	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	111,616	59,199	-	52,417	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	720,467	360,233	-	360,233	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	2,122,335	1,048,467	799,540	171,587	102,741	-
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,514,073	637,811	-	636,669	239,593	-
3. CSS Other Non-FSP 3. Trauma Recovery	320,669	140,604	-	140,604	39,461	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,785,573	1,581,337	828,057	240,728	135,451	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	730,181	396,350	-	329,753	3,140	939
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,081,756	2,135,183	233,374	1,616,250	-	96,949
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,399,975	728,407	62,772	398,967	5,385	204,444
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	192,080	114,000	-	78,080	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	260,438	138,132	-	122,306	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	480,311	240,156	-	240,156	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	994,253	524,687	309,554	-	160,012	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	664,644	449,231	199,888	15,525	-	-
CSS Administration	3,671,138	2,128,794	1,185,694	356,650	-	-
CSS Evaluation	512,353	406,944	105,409	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	46,963,899	23,861,210	7,247,712	11,459,696	2,856,236	1,539,046
FSP Programs as Percent of Total	55%					

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	800,000	400,000	-	400,000	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	1,660,572	958,682	374,598.94	294,198	33,093	-
3. CSS Full Service Partnership 3. TAY (18-24)	3,202,519	1,546,811	707,849.02	570,038	377,821	-
4. CSS Full Service Partnership 4. Adults (18-59)	9,705,301	4,218,836	1,531,556	1,584,225	1,383,514	987,171
5. CSS Full Service Partnership 5. Older Adults (60+)	2,598,750	1,113,625	517,836	561,551	405,738	-
6. CSS Full Service Partnership 6. AOT	1,191,918	776,440	158,493	256,984	-	-
7. CSS FSP Permanent Housing (capital units and master lease)	2,010,873	987,704	-	1,023,170	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,098,154	2,143,761	234,312	1,622,743	-	97,338
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,150,359	598,532	51,580	327,831	4,425	167,992
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	288,120	171,000	-	117,120	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	111,616	59,199	-	52,417	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	720,467	360,233	-	360,233	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	2,175,063	1,074,516	819,404	175,850	105,294	-
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,514,073	637,811	-	636,669	239,593	-
3. CSS Other Non-FSP 3. Trauma Recovery	320,669	140,604	-	140,604	39,461	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,851,552	1,618,792	847,671	246,429	138,660	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	730,181	396,350	-	329,753	3,140	939
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,098,154	2,143,761	234,312	1,622,743	-	97,338
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,405,995	731,539	63,042	400,683	5,408	205,323
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	192,080	114,000	-	78,080	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	260,438	138,132	-	122,306	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	480,311	240,156	-	240,156	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	1,024,080	540,428	318,841	-	164,812	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	684,583	462,708	205,885	15,990	-	-
CSS Administration	3,759,855	2,180,238	1,214,348	365,268	-	-
CSS Evaluation	527,723	419,152	108,571	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	47,563,407	24,173,008	7,388,298	11,545,041	2,900,958	1,556,101
FSP Programs as Percent of Total	55%					

PEI Estimated Expenditures FY20/21 to FY22/21

	Fiscal Year 2020/21					
	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	140,472	140,472	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	565,752	528,608	-	-	-	37,144
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	1,950,695	1,874,871	-	-	-	75,824
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,069,224	466,174	-	-	-	2,603,049
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	27,420	27,016	404	-	-	-
7. PEI 7. CalMHSA Statewide Programs	66,472	66,472	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	565,752	528,608	-	-	-	37,144
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	1,950,695	1,874,871	-	-	-	75,824
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,023,075	155,391	-	-	-	867,683
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	246,776	243,144	3,632	-	-	-
PEI Administration	86,059	86,059	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	9,692,390	5,991,687	4,036	-	-	3,696,667

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	140,472	140,472.34	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	568,138	530,838	-	-	-	37,301
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,406,925	3,274,497	-	-	-	132,428
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,072,513	466,674	-	-	-	2,605,839
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	28,242	27,826	416	-	-	-
7. PEI 7. CalMHSA Statewide Programs	66,472	66,472	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	568,138	530,838	-	-	-	37,301
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,406,925	3,274,497	-	-	-	132,428
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,024,171	155,558	-	-	-	868,613
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	254,179	250,438	3,741	-	-	-
PEI Administration	88,640	88,640	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	12,624,815	8,806,750	4,157	-	-	3,813,908

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	140,472	140,472	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	570,596	533,134	-	-	-	37,462
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,751,767	3,605,935	-	-	-	145,832
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	3,075,901	467,189	-	-	-	2,608,712
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	29,089	28,661	428	-	-	-
7. PEI 7. CalMHSA Statewide Programs	66,472	66,472	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	570,596	533,134	-	-	-	37,462
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,751,767	3,605,935	-	-	-	145,832
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,025,300	155,730	-	-	-	869,571
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	261,805	257,951	3,853	-	-	-
PEI Administration	91,300	91,300	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	13,335,065	9,485,914	4,281	-	-	3,844,870

INN Estimated Expenditures FY20/21 to FY22/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	1,170,087	1,170,087	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	1,106,961	1,106,961	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	565,752	565,752	-	-	-	-
4. INN 22. FUERTE	388,004	388,004				
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1	1				
INN Administration	570,142	570,142	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,800,946	3,800,946	-	-	-	-

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	687,120	687,120	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	349,294	349,294	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	350,000	350,000	-	-	-	-
4. INN 22. FUERTE	420,000	420,000	-	-	-	-
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	600,000	600,000				
INN Administration	424,661	424,661	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	2,831,076	2,831,076	-	-	-	-

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	653,295	653,295	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	349,294	349,294	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	350,000	350,000	-	-	-	-
4. INN 22. FUERTE	420,000	420,000	-	-	-	-
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	900,000	900,000				
INN Administration	471,633	471,633	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,144,222	3,144,222	-	-	-	-

WET Estimated Expenditures FY20/21 to FY22/21

	Fiscal Year 2020/21					
	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	1,661,440	1,100,279	-	97,845	-	463,316
2. Career Pathways	654,552	654,552	-	-	-	-
3. Residency and Internships	569,794	569,794	-	-	-	-
WET Administration	86,059	86,059	-	-	-	-
WET Evaluation	14,228	14,228	-	-	-	-
Total WET Program Estimated Expenditures	2,986,072	2,424,911	-	97,845	-	463,316

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	2,282,622	1,511,653	-	134,427	-	636,542
2. Career Pathways	741,637	741,637	-	-	-	-
3. Residency and Internships	573,142	573,142	-	-	-	-
WET Administration	88,640	88,640	-	-	-	-
WET Evaluation	14,228	14,228	-	-	-	-
Total WET Program Estimated Expenditures	3,700,269	2,929,300	-	134,427	-	636,542

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	2,299,746	1,522,993	-	135,436	-	641,317
2. Career Pathways	741,637	741,637	-	-	-	-
3. Residency and Internships	576,591	576,591	-	-	-	-
WET Administration	91,300	91,300	-	-	-	-
WET Evaluation	14,228	14,228	-	-	-	-
Total WET Program Estimated Expenditures	3,723,501	2,946,748	-	135,436	-	641,317

CTFN Estimated Expenditures FY20/21 to FY22/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 5. Southeast Health Center	3,000,000	3,000,000	-	-	-	-
3. Cap 8. Chinatown/Northbeach Exam Room	15,293	15,293	-	-	-	-
4. Cap 9. Comprehensive Crisis Services/CTT Team Build Out	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
1. IT 1. Consumer Portal	156,635	156,635	-	-	-	-
2. IT 2. Vocational IT	1,148,198	1,148,198	-	-	-	-
3. IT 3. System Enhancements	139,600	139,600	-	-	-	-
CFTN Administration	116,689	116,689	-	-	-	-
Total CFTN Program Estimated Expenditures	4,576,414	4,576,414				

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 10. Expansion of Telehealth Kiosks	40,000	40,000				
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	161,334	161,334	-	-	-	-
9. Vocational IT	1,148,198	1,148,198	-	-	-	-
10. System Enhancements	143,788	143,788	-	-	-	-
CFTN Administration	120,190	120,190	-	-	-	-
Total CFTN Program Estimated Expenditures	1,613,509	1,613,509				

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. TBD	100,000	100,000				
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	166,174	166,174	-	-	-	-
9. Vocational IT	1,148,198	1,148,198	-	-	-	-
10. System Enhancements	148,101	148,101	-	-	-	-
CFTN Administration	123,795	123,795	-	-	-	-
Total CFTN Program Estimated Expenditures	1,686,268	1,686,268				

Appendix A: 2019 BHS Workforce Needs Assessment and Development Plan Update

San Francisco Department of Public Health

Prepared by
Jessica Lee-Burleigh, MPH, MSW
Sophie Lyons, MPH, MSW
Hatchuel Tabernik and Associates

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Introduction

Background and Context

In May 2017, the San Francisco Department of Public Health (SFDPH) Behavioral Health Services (BHS) completed the 2017-2022 Five-Year Workforce Development Strategic Plan (the Plan) to outline a process for the department to achieve their workforce development and retention goals. Prompting the development of this Plan was the identification of competing priorities and overlapping initiatives, along with the need to target limited resources within San Francisco Department of Public Health (SFDPH) Behavioral Health Services (BHS). The Plan was created through a collaborative and iterative process by the BHS Workforce Development Team in partnership with Learning for Action, an independent consulting firm. Plan development activities included steering committee meetings, stakeholder interviews, workforce and consumer data collection and analysis, and focus groups. The Plan has been used since its development to guide workforce development decision making.

In the Plan, BHS identifies department-specific goals, strategies, and objectives that complement wider SFDPH workforce development trainings and opportunities. These efforts were designed to supplement, not duplicate, any pre-existing workforce development efforts. There are two key strategies identified in the Plan, aimed at ensuring the BHS has the best possible workforce: 1) building the pipeline of qualified and interested members of the workforce, and 2) supporting the development of the current workforce. Under these overarching strategies are four goals, each with associated strategies and objectives.

Goal 1: Recruitment, Hiring, & Development – Transform our workforce so it better reflects our service populations	
Strategies • Reduce the impact of implicit bias in hiring decisions • Increase opportunities for certification/licensure for communities that need greater representation amongst our workforce • Focus pipeline development work, including incentives and supports, where there is high potential for reaching communities that need greater representation amongst our workforce • Provide incentives and supports to increase the language capability of current staff	**Objectives** • Increase the number of Latino, African American, Asian, Pacific Islander, and Native American behavioral health staff, with a focus on those that are certified and/or licensed • Increase the number of male behavioral health staff • Increase the number of behavioral health staff who speak Mandarin Chinese, Cantonese Chinese, Russian, Tagalog, Vietnamese, and Spanish
Goal 2: Training & Support – Ensure that our workforce has the training, skills, and tools to deliver high quality, responsive care.	
Strategies • Strengthen onboarding materials and practices • Build out training program with a focus on system of care priorities and meeting requirements for clinical licensure & certification • Improve clinical supervision practices • Build staff capacity to manage clinic operations • Improve wellness-based documentation	**Objectives** • Staff have the knowledge and skills to meet expectations as BHS employees • Staff have the knowledge and skills to deliver care according to BHS system of care priorities, e.g.: Trauma-Informed, Family-focused, True North, Cultural and Racial Humility, Wellness and Recovery

	• Staff have the knowledge and skills appropriate to thrive and grow within their roles as clinicians or administrators
Goal 3: Work Environment & Experience – Support and empower staff to be engaged at work and grow professionally within BHS	
Strategies • Deliver Trauma Informed Care trainings and provide support for vicarious trauma • Create and promote new staff wellness resources • Deliver trainings on cultural humility and crucial conversations • Clinic safety initiative • Improve supervision practices • Create opportunities for staff to expand leadership skills	**Objectives** • Increased staff wellness • Increased percentage of staff feeling safe in their clinics • Increased percentage of staff reporting a positive workplace culture • Increased opportunities for staff to grow professionally and be promoted
Goal 4: Incorporating Lived Experiences – Successfully integrate peers across the workforce	
Strategies • Ensure peers receive a minimum of 55 hours of training per year, including: ○ Training to increase supervisory skills ○ Peer-to-peer training ○ Peer specialist mental health certificate • Provide supports to peers interested in joining the workforce (e.g. peer-to-peer employment, ACE program) • Provide supports to peers interested in advancing within the workforce • Leadership academy • Improve supervision practices	**Objectives** • Increased capacity to provide youth-to-youth, parent-to-parent and family-to-family services • Peers have the knowledge and skills appropriate to thrive and grow within their roles • Double the number of qualified peers in supervisory or leadership roles within the BHS workforce • Improved peer supervision skills

Data Collection and Methodology

In 2019, SFDPH BHS partnered with Hatchuel Tabernik & Associates with the goal of understanding the current composition of the BHS civil service workforce and progress made towards the aims of the 2017-2022 Strategic Plan. An initial data crosswalk was completed to identify data needs and gaps. Quantitative workforce and consumer data was then identified, collected, and analyzed. Qualitative data on progress towards the Plan's four goals was collected through interviews and review of secondary program documents. A summary of all data is presented here as the 2019 BHS Workforce Needs Assessment and Development Plan Update.

Data for the Needs Assessment Update was collected on 680 BHS civil service staff from the internal Human Resources (HR) database, and on 18,190 BHS consumers from the SFDPH electronic health record system, Avatar. Publicly available demographic data on the Medi-Cal eligible population in the City and County of San Francisco was also used.[21] Finally, as recent data is unavailable, data from 2014 on BHS contractors was pulled from the *San Francisco Behavioral Health*

[21] California Department of Health Care Services, Certified Eligible Counts - Summary Tables: ACA Expansion Adult Age 19 to 64 as of April 2019, https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx, accessed 9/24/19

Services Workforce Disparities Analysis report prepared by Learning for Action, as part of the original planning process.[22] Data was analyzed to create a demographic profile of BHS Civil Service staff and to identify distinctions between civil service provider type. When possible, characteristics of the BHS contractor population (as of 2014) are outlined. The analysis also examines comparisons between workforce and consumer demographics.

Data Limitations

The data used for the analyses in these reports are limited in the following ways:

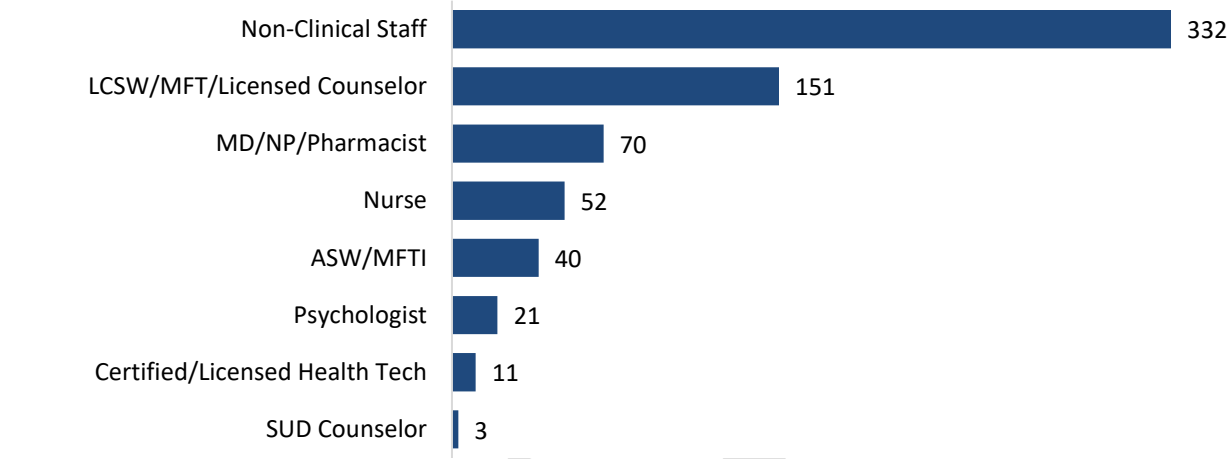
- The Medi-Cal Eligible data set is limited in its available age categories (0-18, 19-64, and 65+) and language fluency categories (English, Spanish, and Other/Unknown), so the possibility for in-depth comparisons is limited.
- No recent data on BHS contractors is available, so data from a previous report is used here, and it is unknown if analysis methods were the same as the present methods.

[22] Taylor, J. T., & Rivera, D. (2015). *San Francisco Behavioral Health Services Workforce Disparities Analysis*. *San Francisco Behavioral Health Services Workforce Disparities Analysis*. Prepared by Learning for Action for San Francisco Department of Public Health, Behavioral Health Services.

Needs Assessment Update

Civil Service and Contractor Workforce

Figure 2. Number of Civil Service Staff by Provider Type, N=680

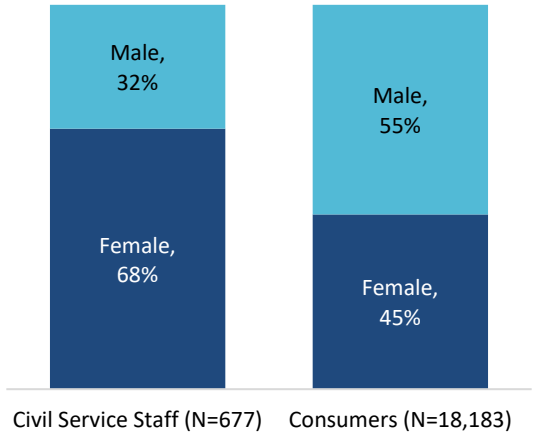


Source: SFDPH Human Resources, 2019

There are a total of 680 civil service staff working in the BHS. About half (49%) of these individuals are in non-clinical position (though some may hold a clinical license). Twenty-two percent are fully licensed masters-level mental health providers (LCSW/MFT/Licensed Counselor). In addition to BHS civil service staff, as of 2014, there are 1,138 mental health contractors working with SFDPH BHS. Among these contractors, 37% are masters-level mental health clinicians; 9% are psychologists; 6% hold medical (MD), nurse practitioner, or pharmacist licenses; and 48% are paraprofessionals (including peers).[23]

Gender

Figure 3. Gender of Civil Service Staff and BHS Consumers



Sources: SFDPH Human Resources, 2019; Avatar, 2019

Table 1. Number of Civil Service Staff by Gender and Provider Type

	Male	Female	Total
MD/NP/Pharmacist	29	41	**70**
Psychologist	8	12	**20**
Nurse	13	39	**52**
LCSW/MFT/Licensed Counselor	39	112	**151**
ASW/MFTI	13	26	**39**
SUD Counselor	2	1	**3**
Certified/Licensed Health Tech	4	7	**11**
Non-Clinical Staff	110	221	**331**
Total	**218**	**459**	**677**

Source: SFDPH Human Resources, 2019

[23] Taylor, J. T., & Rivera, D. (2015). *San Francisco Behavioral Health Services Workforce Disparities Analysis*. *San Francisco Behavioral Health Services Workforce Disparities Analysis*. Prepared by Learning for Action for San Francisco Department of Public Health, Behavioral Health Services.

Approximately two-thirds (68%) of the BHS civil service staff identify as female, while slightly less than half (45%) of the BHS consumers do. As of 2014, three-quarters of the contractor staff identified as female.[24]

This overrepresentation of female workforce can be seen among all civil service provider types, except among SUD counselors, where two of the three counselors are male. In addition, women are more likely than men to work as a civil service nurse or LCSW/MFT/Licensed Counselor compared to other positions, with approximately 75% of staff in those provider groups identifying as female. Data do not indicate the presence of any transgender or non-binary civil service staff, contractors, or consumers. It is unknown whether this indicates a lack of transgender and non-binary individuals or if current data systems do not include these categories.

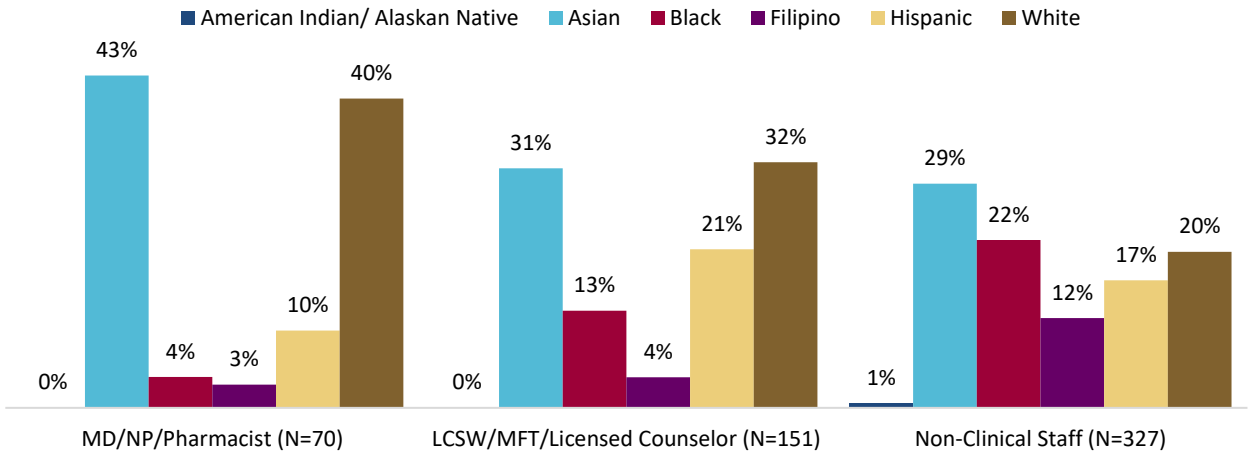
Race/Ethnicity

Table 2. Number of Civil Service Staff by Race/Ethnicity and Provider Type

	American Indian/ Alaskan Native	Asian	Black	Filipino	Hispanic	White	Total
MD/NP/Pharmacist	0	30	3	2	7	28	**70**
Psychologist	0	5	1	0	5	10	**21**
Nurse	1	14	4	8	10	15	**52**
LCSW/MFT/Licensed Counselor	0	47	19	6	31	48	**151**
ASW/MFTI	1	6	7	3	17	5	**39**
SUD Counselor	0	1	0	0	2	0	**3**
Certified/Licensed Health Tech	0	1	3	3	4	0	**11**
Non-Clinical Staff	2	96	71	38	54	66	**327**
Total	**4**	**200**	**108**	**60**	**130**	**172**	**674**

Source: SFDPH Human Resources, 2019

Figure 4. Race/Ethnicity of Civil Service Staff for the Three Most Populous Provider Categories



[24] Taylor, J. T., & Rivera, D. (2015). *San Francisco Behavioral Health Services Workforce Disparities Analysis*. *San Francisco Behavioral Health Services Workforce Disparities Analysis*. Prepared by Learning for Action for San Francisco Department of Public Health, Behavioral Health Services.

Source: SFDPH Human Resources, 2019

Thirty percent (30%) of BHS civil service staff identifies as Asian, making this the most well represented race/ethnicity. Twenty-six percent (26%) of the civil service workforce identifies as white, 19% as Hispanic, 16% as Black, 9% as Filipino, and 0.5% as American Indian/Alaskan Native. The racial/ethnic distribution is more balanced among non-clinical staff than among clinical staff. The racial/ethnic disparity is most pronounced among staff with a medical degree (MD), nurse practitioner, or pharmacist license. Forty-three percent of this provider group identifies as Asian and 40% as white, while only 4% identify as Black and 10% as Hispanic. In addition, there are only four civil service staff in total who identify as American Indian/Alaskan Native, none of whom hold doctoral or masters level license provider positions.

As of 2014, 45% of contracted direct service providers identify as white, 21% as Asian/Pacific Islander, 18% as African American, 10% as Latina/o, 5% as Biracial/Multi-ethnic, 1% as Native American/Alaskan Native, and 0.2% as Middle Eastern.

Table 3. Race/Ethnicity of Civil Service Staff, BHS Consumers, and Medi-Cal Eligible Individuals in San Francisco

	Civil Service Staff (N=680)	BHS Consumers (N=18,190)	Medi-Cal Eligibles (N=206,619)
African American/Black	16%	19%	9%
American Indian/ Alaskan Native	1%	1%	0%
Asian	38%	19%	37%
Hispanic	19%	21%	20%
Other/Unknown	1%	13%	23%
White	25%	26%	11%

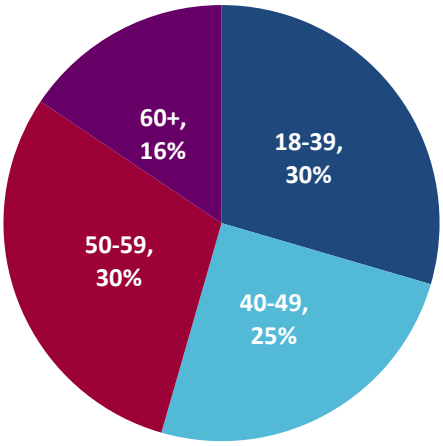
Note: In this table, Asian includes Native Hawaiian/Pacific Islander.
Sources: SFDPH Human Resources, 2019; Avatar, 2019; California Department of Health Care Services, Certified Eligible Counts – Summary Tables: ACA Expansion Adult Age 19 to 64 as of April 2019, https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx,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

The racial/ethnic distribution is similar between BHS civil service staff and consumers, though there is a higher percentage of staff (38%) who identify as Asian (which includes Native Hawaiian/Pacific Islander) compared to consumers (19%). The percentage of Asian staff does closely reflects that of the Medi-Cal Eligible population in San Francisco, however. In addition, the proportions of African American/Black civil service staff and consumers are relatively equivalent (16% and 19%, respectively), and are both higher than among the Medi-Cal eligible population (9%).

More data collection and analysis would need to be done in order to determine the reasons that the BHS consumer group does not more closely reflect the Medi-Cal eligible population of San Francisco. With the data currently available it cannot be determined if the discrepancy is due to a difference in need or a difference in access to services (including access that is afforded through a workforce that reflects the population).

Age

Figure 5. Age of Civil Service Staff, 2019, N=674



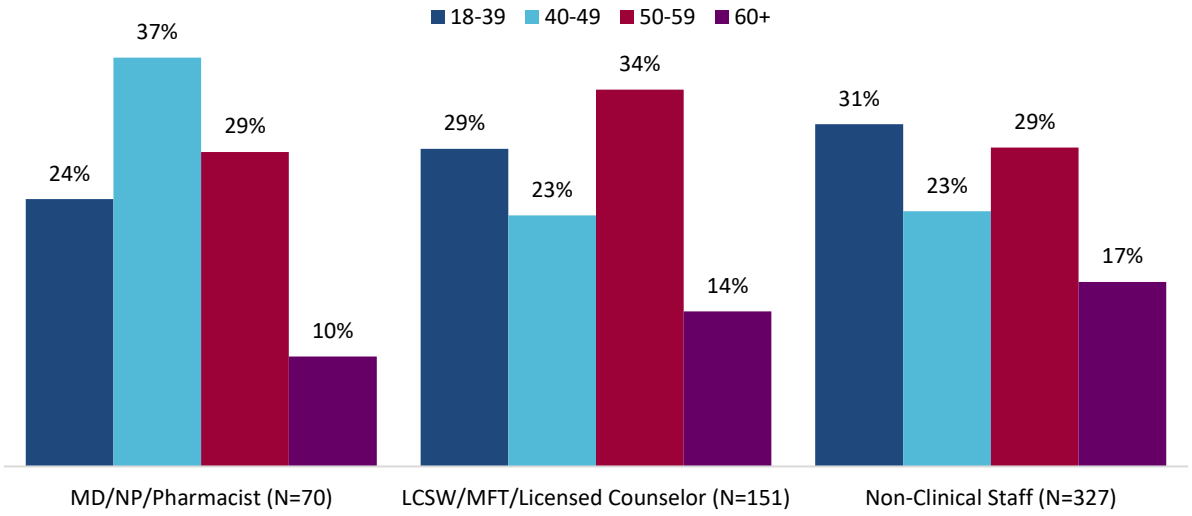
Source: SFDPH Human Resources, 2019

	Age				
	18-39	40-49	50-59	60+	Total
MD/NP/Pharmacist	17	26	20	7	**70**
Psychologist	2	6	6	7	**21**
Nurse	15	10	20	7	**52**
LCSW/MFT/Licensed Counselor	43	34	51	21	**149**
ASW/MFTI	17	13	5	5	**40**
SUD Counselor	1	1	1	0	**3**
Certified/Licensed Health Tech	2	2	4	3	**11**
Non-Clinical Staff	102	76	95	55	**328**
Total	**199**	**168**	**202**	**105**	**674**

Source: SFDPH Human Resources, 2019

Table 4. Number of Civil Service Staff by License Type and Age

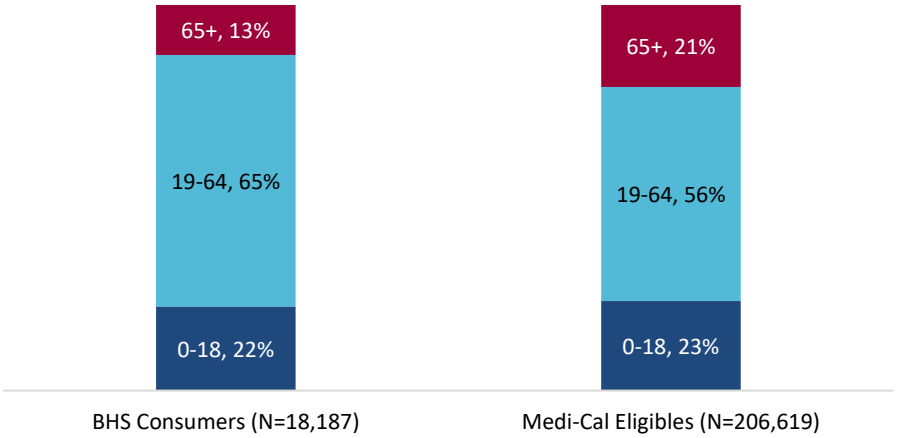
Figure 6. Age of Civil Service Staff for the Top Three Provider Type Categories



Source: SFDPH Human Resources, 2019

Sixteen percent (16%) of the BHS civil service workforce is over the age of 60, indicating that at least 105 staff members will reach retirement age within the next five years. The majority of these individuals are masters-level mental health providers (LCSW, MFT, Licensed Counselor) or non-clinical staff. The provider group with the largest proportion of young staff is the ASW/MFTI provider group with 43% between the ages of 18 and 39. Given that these are post-masters mental health provider trainees, we would expect this group to be younger on average.

Figure 7. Age of BHS Consumers and Medi-Cal Eligible Individuals in San Francisco



Sources: Avatar, 2019; California Department of Health Care Services, Certified Eligible Counts – Summary Tables: ACA Expansion Adult Age 19 to 64 as of April 2019, https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx, accessed 9/24/19

The percentage of BHS consumers who are 0-18 years old reflects the percentage of that age group in the Medi-Cal eligible population. Older adults make up 21% of the Medi-Cal eligible population, but only 13% of the BHS consumer population.

Language Fluency

Table 5. Number of Civil Service Staff with Non-English Language Fluency by Provider Type

	Language							Total Staff with Non-English Fluency	Total Staff
	Cambodian	Spanish	Vietnamese	Tagalog	Korean	Mandarin	Cantonese		
MD/NP/Pharmacist	0	9	1	0	0	3	3	16	70
Psychologist	0	5	0	0	0	2	3	10	21
Nurse	0	4	0	2	0	1	9	16	52
LCSW/MFT/Licensed Counselor	1	34	4	3	0	4	17	63	151
ASW/MFTI	0	14	1	1	0	1	4	21	40
SUD Counselor	0	0	0	0	0	0	0	0	3
Certified/Licensed Health Tech	0	0	0	0	0	1	1	2	11
Non-Clinical Staff	0	35	1	7	1	6	22	72	332
Total	**1**	**101**	**7**	**13**	**1**	**18**	**59**	**200**	**680**

Note: These counts include duplicate individuals as 11 civil service staff speak more than one non-English Language.
Source: SFDPH Human Resources, 2019

Table 6. Language Fluency of Civil Service Staff and Preferred Language of BHS Consumers

	Civil Service Staff (N=680)	BHS Consumers (N=16,358)
English	100%	73%
Spanish	15%	11%
Cantonese	9%	8%
Mandarin	3%	1%
Tagalog/Filipino	2%	1%
Vietnamese	1%	1%
Cambodian	0.1%	0.3%
Korean	0.1%	0.3%
Russian	0%	2%
Other Language	0%	2%

Note: Percentages for Civil Service Staff will not add up to 100% as staff may be fluent in more than one language. It is assumed that all staff speak English.
Sources: SFDPH Human Resources, 2019; Avatar, 2019

In total, 189 (28%) BHS civil service staff speak a language other than English, with 11 individuals speaking multiple non-English languages. A higher proportion of psychologists, nurses, licensed masters level mental health providers, and post-masters mental health provider trainees are fluent in a language other than English compared to other provider types. The majority of civil service staff with non-English fluency speak Spanish, with Cantonese as the second most commonly spoken language. Among Spanish speakers, 34% and 35% are masters-level mental health providers (LCSW, MFT, Licensed Counselor) or non-clinical staff, respectively. Among contracting providers (as of 2014), 32% speak a language in addition to English, with 28 languages represented. Spanish is the most commonly spoken among contractors with non-English language fluency, with 13% speaking the language. Cantonese (7%) is the second most common.[25]

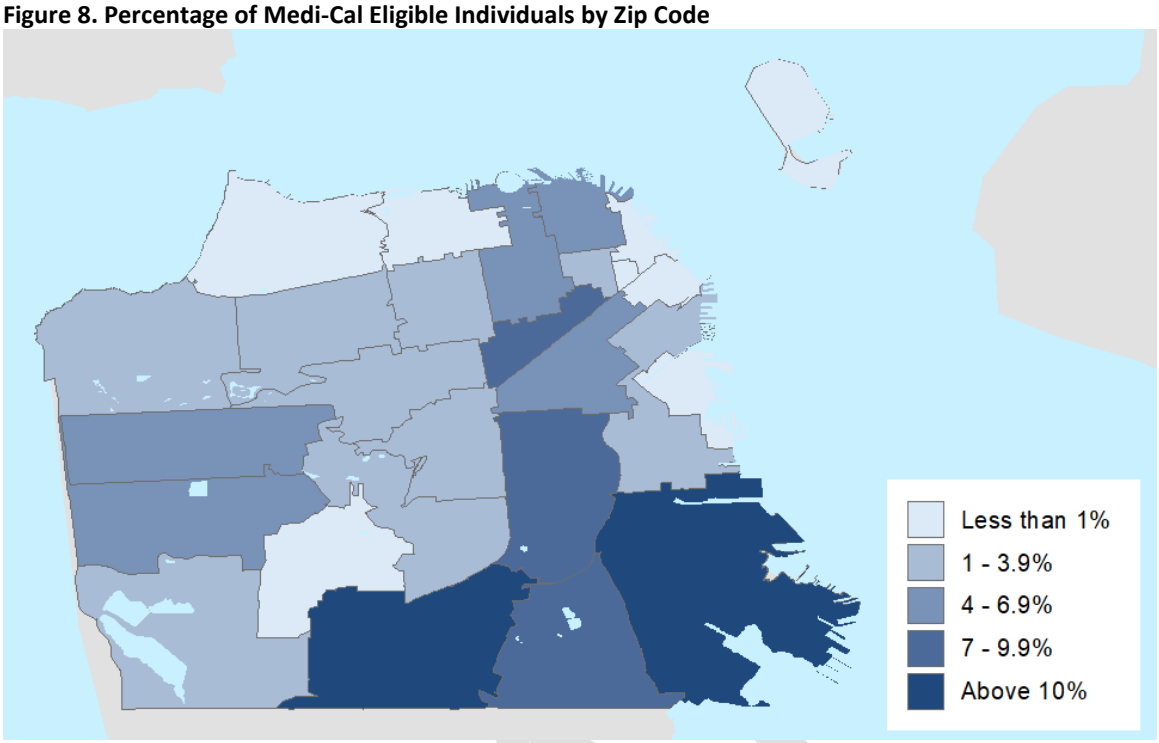
Among the most commonly spoken non-English languages, Spanish and Cantonese, the proportions of civil service staff who are fluent reflects that of consumers who prefer those languages. In addition, the proportion of Spanish speaking consumers is reflective of the Medi-Cal Eligible population, of which 17% speak Spanish. No civil service staff are fluent in Russian, though 2% of consumers report it as their preferred language.

Zip Code

As can be seen in the maps on the following page, there are higher proportions of both Medi-Cal eligible individuals and BHS consumers in the south-eastern areas of San Francisco, roughly covering the South of Market (SOMA), Mission, Bayview/Hunters Point, and Balboa Park/Excelsior/Outer Mission areas. It is noteworthy that the highest concentration (20%) of BHS consumers report 94103, SOMA and part of the Mission, as their zip code, which is not in alignment with the concentration of the Medi-Cal eligible population. Only 6% of Medi-Cal eligible individuals are recorded as living in this zip code. The zip codes with the highest concentrations of Medi-Cal eligible individuals are 94112 (15%) and 94124 (11%). These roughly represent the Balboa Park/Excelsior/Outer Mission and Bayview/Hunters Point areas, respectively.

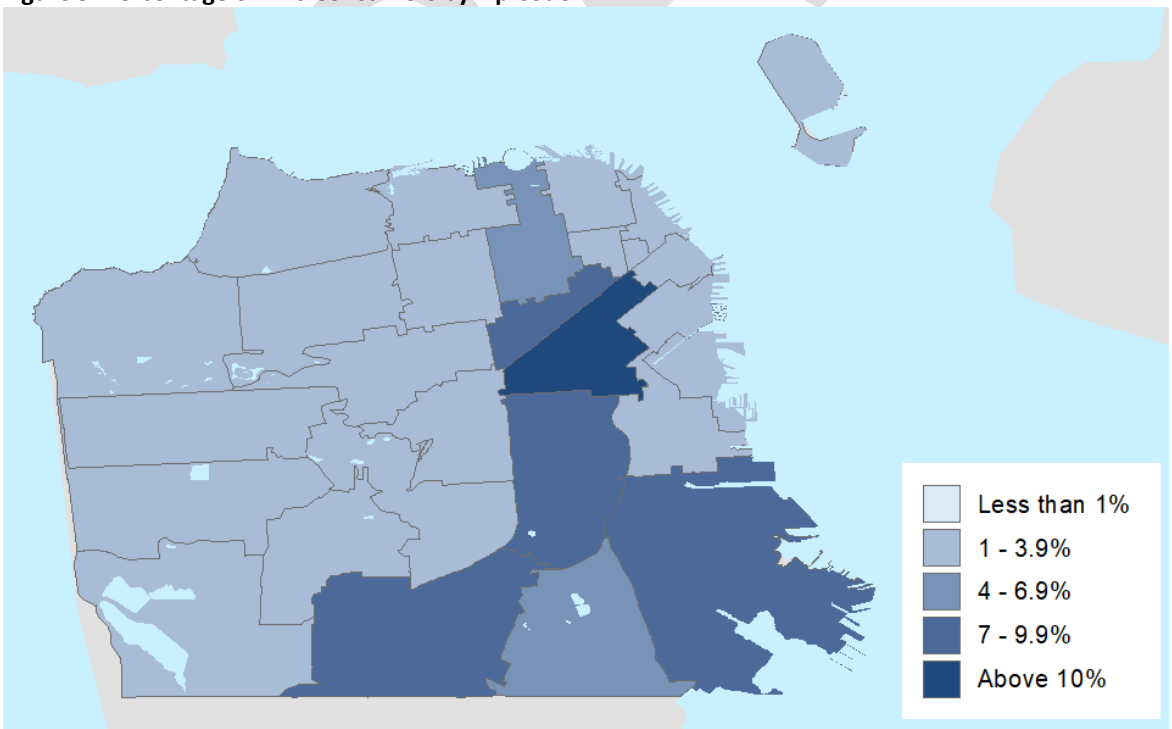
[25] Taylor, J. T., & Rivera, D. (2015). *San Francisco Behavioral Health Services Workforce Disparities Analysis*. *San Francisco Behavioral Health Services Workforce Disparities Analysis*. Prepared by Learning for Action for San Francisco Department of Public Health, Behavioral Health Services.

Figure 8. Percentage of Medi-Cal Eligible Individuals by Zip Code



Source: California Department of Health Care Services, Certified Eligible Counts – Summary Tables: ACA Expansion Adult Age 19 to 64 as of April 2019, https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx, accessed 9/24/19

Figure 9. Percentage of BHS Consumers by Zip Code



Note: Less than 1% of BHS consumers reported a non-residential San Francisco zip code (e.g. P.O. Box) and 5.8% reported a zip code outside of San Francisco.
Source: Avatar, 2019

Summary

There are several key take-aways from the data presented above:

- About half of the BHS civil service workforce hold non-clinical positions, while the other half occupy positions that require licensure or certification.
- Females are over-represented in the civil service workforce, when compared to consumers, particularly in nurse or LCSW/MFT/Licensed Counselor positions.
- Overall, the racial/ethnic distribution BHS civil service staff is similar to that of consumers, with the exception of staff who identify as Asian being higher than Asian consumers.
- There are greater racial/ethnic disparities among civil service staff with higher levels of licensure compared to non-clinical staff, with the disparity being most pronounced among staff with a medical, nurse practitioner, or pharmacist licenses.
- The racial/ethnic makeup of the civil service workforce is more aligned with the consumer population than the contractor workforce (according to the latest available data).
- The civil service workforce is generally well prepared to meet the language needs of consumers – although no BHS civil service staff speak Russian.
- A higher proportion of psychologists, nurses, licensed masters-level mental health, and post-masters mental health trainee providers are fluent in a language other than English compared to other provider types.
- A large proportion of BHS consumers reside in the SOMA neighborhood, an area with a relatively small proportion of Medi-Cal eligible individuals.

Workforce Development Plan Update

The table below outlines progress made on specific goals and strategies associated with the 2017-2022 Strategic Plan. All relevant data was gathered through interviews with key staff and review of secondary program documents.

Table 7: Behavioral Health Services 5-Year Workforce Development Plan 2017-2022 Update

GOAL 1: Recruitment, Hiring, and Development
Transform our workforce so it better reflects our service populations

Objectives:
A. Increase the number of Latino, African American, Asian, Pacific Islander, and Native American behavioral health staff, with a focus on those that are certified and/or licensed
B. Increase the number of male behavioral health staff
C. Increase the number of behavioral health staff who speak Mandarin Chinese, Cantonese Chinese, Russian, Tagalog, Vietnamese, and Spanish

Strategy	Tactics	Programs	Action Steps	Progress/Status	Intended Outcomes
Focus pipeline development work where there is high potential for reaching communities that need greater representation amongst our workforce Objective Contribution: A, B, C	*High School* • Recruit (specific) target populations (include youth inclined towards helping e.g. peer educators, health academies) • Curriculum includes educational content, exposure to BH professionals and Internships • Social supports are provided • Students are informed about and supported to take next steps in pipeline (e.g. CCSF certificate, college applications, internships, etc.)	*High School* • Public Health Institute (PHI) FACES for the Future Coalition program (sunsets FY 20/21) • Richmond Area Multi-Services, Inc. (RAMS) Program: Summer Bridge (sunset 12/31/17)	*High School* • Increase # of BHS intern placements available for FACES participants • Ensure program deliverables and desired outcomes for FACES align with this plan and demographic priorities • If indicated, consider re-investing funds to offer small stipends to high school students • Continue to build relationships between CCSF-CMHC Program & FACES for the Future	*High School* • RAMS Summer Bridge sunset at the end of 2017 as planned • FACES program continues to be implemented as planned	*High School* • % of students matching target populations after 'graduation' reporting interest in, or taking concrete steps towards, BH career in San Francisco

	Developing & Recruiting from the Paraprofessional Workforce • Support Mental Health Academies • Outreach • Support to enroll in career pipeline programs	*Developing & Recruiting from the Paraprofessional Workforce* • Mental Health Mini-Academies ○ 16/17 Street Violence Intervention Program (SVIP) Train the Trainer Pilot ○ SOMA Youth Collaborative • HOPE SF • Population Focused Programs (Latino/Mayan, Samoan. Southeast Asian, Filipino, African American, Native American)	• Explore alternate funding sources to support BHS HS programs *Developing & Recruiting from the Paraprofessional Workforce* • Provide limited ongoing technical assistance for SVIP efforts • Explore partnership with Roadmap to Peace in the Mission District to provide supportive services and job readiness training to its program participants • Ensure population-focused programs and participants receive education about career pipeline programs.	*Developing & Recruiting from the Paraprofessional Workforce* • Technical assistance for SVIP has grown substantially • As planned, collaboration with community-based initiatives and organizations has included the SOMA Youth Collaborative, HOPE SF Peer Health Leaders, Roadmap to Peace, and case managers and other front-line staff that work directly with program participants – all have participated in the Community Mental Health Academy • A total of 50 trainings were conducted with 2,716; a monthly webinar series was established for substance use treatment providers; year-long training academy for clinical supervisors was conducted; accreditation	*Developing & Recruiting from the Paraprofessional Workforce* • Interested paraprofessionals from these programs enroll in career pipeline programs • Increased language capacity of BHS staff

	Community College Certificate Programs • Fund community college certificate programs serving a high % of BHS target populations to educate & train students to enter front-line behavioral health workers using curricula grounded in the wellness & recovery & resiliency principles, community defined practices, evidence-based approaches, best practices & trauma recovery • Engage & recruit consumers of mental health services, their family members & community allies *Ambulatory Care: Bachelors Internship Program* • Program being designed to expose graduates to behavioral health careers and help them understand how graduate school can benefit them	*Community College Certificate Programs* • 20-25 graduates per year • Community Mental Health • Substance Abuse (sunset 12/31/17) • Medicinal Drumming *Ambulatory Care: Bachelors Internship Program* • None at start of development plan *Higher Education Partnerships*	*Community College Certificate Programs* • Include funding for both certificate programs in WDET RFQ • Sunset Medicinal Drumming due to more urgent workforce needs (e.g. shortage of child & adolescent psychiatrists, shortage of substance abuse counselors, etc.) • Increase evaluation efforts to ensure these investments are reaching preferred outcomes. *Ambulatory Care: Bachelors Internship Program* • Collaborate with Ambulatory Care Workforce Development Officer to clarify goals, expectations, and potential implementation • Review and continue to build out implementation	status for CME (physicians) and substance use counselors was added *Community College Certificate Programs* • Medicinal Drumming was sunset as planned, in order to divert resources to other workforce needs • Community Mental Health Certificate program has continued as planned, and meeting contract deliverables • The Drug & Alcohol Certificate program has continued as planned, and meeting contract deliverables *Ambulatory Care: Bachelors Internship Program*	*Community College Certificate Programs* • Graduates secure frontline positions in SF's public behavioral health sector (civil service or CBO) • Graduates go on to earn Drug & Alcohol Certificate, Associate's degree, Bachelor's degree, Master's degree or PhD with the goal of entering SF's public behavioral health sector (civil service or CBO) *Ambulatory Care: Bachelors Internship Program* • Achieve work experience to better prepare students for careers or graduate studies in behavioral health • The number of staff reflecting the ethnic, cultural & linguistic heritages of the communities being served increases

	Higher Education Partnerships • Develop and recruit more licensed and certified mental health practitioners, who reflect the ethnic, cultural & linguistic heritages of the communities we serve, into SF's public mental/ behavioral health workforce • Explore partnerships with programs in other parts of the country whose student profiles align with BHS's desired workforce profile *Graduate Level Internship Program* • BHS Internship and Training Coordinator recruits, trains and supports 80 Interns per year • Provide stipends for students from diverse communities to create a more diverse pool of interns *Psychiatry Fellowship Training Program*	• San Francisco State University (SFSU) Student Success Program (SSP) (sunset 12/31/17) • California Institute of Integral Studies (CIIS) Student Support Services (sunset 12/31/17) *Graduate Level Internship Program* • CYF and A/OA multi-cultural student stipends *Psychiatry Fellowship Training Program* • CYF and A/OA	*Higher Education Partnerships* • Include Higher Ed Partnership funding in WDET RFP • Increase evaluation efforts to ensure these investments are reaching preferred outcomes • Consider reallocation of funds to meet the changing workforce needs *Graduate Level Internship Program* • Foster additional or deeper partnerships with local postsecondary institutions (such as CSU East Bay) that have diverse student populations • Improve evaluation efforts to ensure these investments are reaching preferred outcomes	• This internship program has not yet been implemented due to staff transitions. A new position will be overseeing the implementation of this program as of January 2020 and it will be revisited at that time *Higher Education Partnerships* • Both the SFSU and CIIS programs were sunset as planned • This activity area has been removed from the 2017-2021 Strategic Plan, with no plans to reincorporate *Graduate Level Internship Program* • A partnership with CSU East Bay has been developed for recruitment of graduate level interns • Student stipends continue to be dispersed as planned	*Higher Education Partnerships* • Graduates secure clinical and professional positions in SF's public behavioral health sector (civil service or CBO) • The number of staff reflecting the ethnic, cultural & linguistic heritages of the communities being served increases *Graduate Level Internship Program* • Increase diversity of interns • Increase number of intern/placements • Increase the awareness of job opportunities within San Francisco County Behavioral Heath

	• Partnership with UCSF and ZGH *Mental Health Loan Assumption Program* • BHS staff promotes state funded loan forgiveness programs for priority populations	*Mental Health Loan Assumption Program* • No local funds • MHSA (state-MHSA) OSHPD 15/16 received 66 SF applications -35 awards ($5k -$ 10k) = $229,974	*Psychiatry Fellowship Training Program* • Work with UCSF to diversify their pipeline of medical students for placement in fellowship • Re-assess activities to ensure outcomes are being met and increase technical assistance as needed *Mental Health Loan Assumption Program* • Determine if other state or federal programs should be promoted • Provide more specific guidance to state re SF priorities • Monitor to ensure SF applicants are prioritized according to SFDPH BHS-determined priority demographics • Explore ways to assess long-term benefit of the program for recipients • Explore feasibility of a local loan assumption program,	*Psychiatry Fellowship Training Program* • Partnership with UCSF has continued as planned • Two new clinical sites were added: SFHN-BHS Comprehensive Crisis Services and Richard Fine People's Clinic at Zuckerberg General Hospital • Two fellows submitted their capstone projects for inclusion in the annual meeting of the American Psychiatric Association *Mental Health Loan Assumption Program* • The state-level program has ended and no local funds have yet been identified as a replacement • Discussions are ongoing and the search for local funds continues	*Psychiatry Fellowship Training Program* • Diversity of fellows matches our goals • Continue 80% success retaining fellows in public mental health workforce *Mental Health Loan Assumption Program* • Retention of diverse staff in the BHS workforce

			as the state-level program is projected to end		
Reduce the impact of implicit bias in hiring and promotion decisions Objective Contribution: A, B	*Hiring and Promotion Practices* • Support leadership staff to participate in the Implicit Bias Training offered by HR Department at DPH	*Hiring and Promotion Practices* • N/A	*Hiring and Promotion Practices* • Explore ways to further support BHS staff who are involved in hiring and promotion decisions to act on what they are learning about implicit bias through trainings and hiring process • Formalize and/or implement supports for BHS staff who are involved in hiring and promotion decisions to act on what they are learning about implicit bias through trainings and hiring process	*Hiring and Promotion Practices* • There is a dedicated training budget for FY 18-21, including trainings on culturally based implicit biases and racial humility	*Hiring and Promotion Practices* • Increased % of new hires reflect under-represented communities • Increased % of promotions reflect under-represented communities
Increase opportunities for certification/licensure for communities that need greater representation amongst our workforce Objective Contribution: A, B	*Professional Development Supporting Promotion* • Recruit frontline workers to be promoted via certification, licensure, or other education and training while they are employed	*Professional Development Supporting Promotion* • N/A	*Professional Development Supporting Promotion* • Research and evaluate other models (such as Riverside County, Seneca/USC School of Social Work) of "grow-your-own" programs • Secure and/or reallocate funds, establish program model, and develop infrastructure for program if indicated • Work with DHR to re-evaluate school-leave program to ensure staff	*Professional Development Supporting Promotion* • Research and exploration of "grow your own" programs in ongoing – the process is currently on hold because the staff member overseeing departed August 2019 and the role remains vacant	*Professional Development Supporting Promotion* • BHS will have an increase in the number of internal staff promotions and advancements • Promoting from within will strengthen the institutional knowledge of the BHS workforce

			have adequate time to obtain a degree and advance their career • Partner with DPH to provide education regarding HR resources that assist staff with obtaining a higher education.		
Provide incentives and supports to increase the language capability of current staff Objective Contribution: C	*Language Development Initiative* • Continuing education program for staff to increase language capacity in for priority languages in exchange for commitment to stay with BHS for a certain amount of time	*Language Development Initiative* • N/A	*Language Development Initiative* • Secure funds, (or reallocate funds) establish program model, and develop infrastructure for program if indicated • Review and continue to build out implementation	*Language Development Initiative* • Partnership with City College of San Francisco's Healthcare Interpreting Certificate Program has been developed	*Language Development Initiative* • Increase the language capacity in the BHS workforce for priority languages • Increase staff retention
Goal 2: Training and Support *Ensure that our workforce has the training, skills, and tools to deliver high quality, responsive care.* **Objectives:** A. Staff have the knowledge and skills to meet expectations as BHS employees B. Staff have the knowledge and skills to deliver care according to BHS system of care priorities, e.g.: i. Trauma-Informed ii. Family-focused iii. True North iv. Cultural Humility v. Wellness and Recovery C. Staff have the knowledge and skills appropriate to thrive and grow within their roles as clinicians or administrators					
Strategy	**Tactics**	**Programs**	**Action Steps**	**Progress/Status**	**Intended Outcomes**
Strengthen onboarding materials and practices	*BHS On-Boarding Checklists*	*BHS On-Boarding Checklists* • N/A	*BHS On-Boarding Checklists* • Finalize checklists • Train staff to use them	*BHS On-Boarding Checklists* • An online Clinic Director's Manual has been created,	*BHS On-Boarding Checklists*

Objective Contribution: A	• Provide guidance about activities to complete before or near start date *BHS On-Boarding Training* • After DPH and AC Orientation, provide staff with BHS Orientation and Training	*BHS On-Boarding Training* • N/A	• Use during on-boarding process • Increase operational capacity to complete tasks on checklist *BHS On-Boarding Training* • Create and pilot an orientation for BHS staff; solicit feedback from BHS Exec leadership and begin implementation, including Substance Use Disorder Services • Identify staffing and other resources needed to meet requirements • BHS on barding offered monthly • Evaluate for satisfaction and impact • Clinic specific onboarding developed	including hundreds of documents and resources *BHS On-Boarding Training* • Trainings for all systems of care (Children Youth and Families, Adults/Older Adults, and Transition Age Youth) will be rolled out in January 2020	• Ensure consistent onboarding and training practices for all new hires *BHS On-Boarding Training* • Expand staff knowledge of DPH and BHS priorities • Increase % of staff who feel they have the tools to do their jobs
Build out training program with a focus on system of care priorities and meeting requirements for clinical licensure & certification Objective Contribution: B, C	*Compliance Training* • Civil service staff complete mandatory trainings within the required timeline. (Examples include compliance trainings on privacy and harassment, Disaster Service Workers, 12N, Trauma Informed Systems)	*Compliance Training* • Some compliance trainings are monitored • Unclear if other resources are invested in this goal	*Compliance Training* • Map mandatory training requirements • Determine how to track completion/compliance • Identify staffing and other resources needed to meet requirements • Determine how DPH/BHS principles can be incorporated into this work	*Compliance Training* • SFDPH Human Resources is tracking compliance training completion and collaborating with BHS to ensure that all training requirements are met	*Compliance Training* • Staff have the knowledge and skills to deliver care according to BHS system of care priorities

	Clinical Skills Training Examples include: • Dialectical Behavioral Therapy • Strengths-Based Model Training • Wellness Recovery Action Program (WRAP) Trainings • Wellness Management and Recovery training (Illness Management and Recovery) • Family-focused Care • Substance Use Disorder Services training *QI and QA Skills* • Ensure that all clinicians are adequately able to perform clinical formulation and risk assessment for individuals and families	*Clinical Skills Training* • Collaborate with AC Workforce Director & System of Care leadership to identify, prioritize, and implement training priorities (Include Substance Use Disorder Services) *QI and QA Skills* • QI Learning Academy	*Clinical Skills Training* • Continue to map training needs • Provide opportunities to shadow service delivery sites • Explore creative ways to meet the needs of our clients with the current workforce *QI and QA Skills* • Continue to implement QI Learning Academy, monitor performance, and make adjustments as needed • Explore LEAN training for BHS	*Clinical Skills Training* • This project is pending. *QI and QA Skills* • The QI Learning Academy has been discontinued, with no plans to revive	*Clinical Skills Training* Staff have the knowledge and skills to deliver high quality clinical care *QI and QA Skills* • Increased quality of clinical formulation and risk assessment
Improve clinical supervision Objective Contribution: C	*Clinical Supervision Institute* • Institute designed to resource clinical supervisors within BHS to provide reflective, relational, and skill enhancing support to their supervisees • 10-month training program comprised of a 2-day	*Clinical Supervision Institute* • New program developed	*Clinical Supervision Institute* • Train 1 cohort of 60 Civil Service and CBO clinical supervisors	*Clinical Supervision Institute* • Training extended to CBO staff, in addition to civil service • The second cohort of 60 clinical supervisors from both civil services and BHS contractors across all BHS	*Clinical Supervision Institute* • Increased capacity of the Behavioral Health workforce to be increasingly reflective, relational, and skillful through improved clinical supervision

	foundational training; 3 specialized trainings			systems of care was completed in 2019	
Build staff capacity to manage clinic operations Objective Contribution: C	*Clinical Operations Support Academy* • Training academy to support Directors within BHS with tools/information that are unique to their leadership position • Bi-monthly seminars provided to Directors	*Clinical Operations Support Academy* • New program developed	*Clinical Operations Support Academy* • Provide 6 trainings to staff and plan didactic material for implementation • Continue as designed and alter as needed based on participant feedback	*Clinical Operations Support Academy* • An online Clinic Director's Manual has been created, including hundreds of documents and resources	*Clinical Operations Support Academy* • New directors within BHS are supported to manage the numerous tasks that they are responsible for
Improve wellness-based documentation Objective Contribution: C	*Documentation Training* • Train people to better understand Medi-Cal, and ensure clinical documentation meets Medi-Cal requirement	*Documentation Training* • New program developed	*Documentation Training* • Integrate clinical perspective into Avatar training • Deepen documentation training to maximize billing • Improve messaging related to documentation requirements	*Documentation Training* • This project is pending.	*Documentation Training* • Staff understand how to maximize use of Avatar to document and bill for their work • Staff bill at the top of their class
Goal 3: Work Environment and Experience *Support and empower staff to be engaged at work and grow professionally within BHS* **Objectives:** A. Increased Staff Wellness B. Increased % of staff feeling safe in their clinics (TN) C. Increased % of staff reporting a positive workplace culture D. Increased opportunities for staff to grow professionally and be promoted					
Strategy	**Tactics**	**Programs**	**Action Steps**	**Progress/Status**	**Intended Outcomes**
Deliver Trauma Informed Care trainings and provide	*TIS Trainings and Resources* • Deliver TIS trainings	*TIS Trainings and Resources* • TIS Framework and Training Program	*TIS Trainings and Resources*	*TIS Trainings and Resources* • TIS trainings have continued as planned, with	*TIS Trainings and Resources* • Increased staff wellness

support for vicarious trauma Objective Contribution: A	• Promote Trauma Informed Systems principles		• Continue TIS implementation across DPH including BHS • Re-assess activities to ensure outcomes are being met	2700 participants trained in FY 18-19 • "Search Inside Yourself" certification is offered on a monthly basis – this is a yearlong learning and practice venture in emotional intelligence, neuroscience, mindfulness, and leadership	• Increase the capacity of the Behavioral health workforce to cope with vicarious trauma
Create and promote new staff wellness resources Objective Contribution: A	*Staff Wellness Promotion* • Staff Wellness Coordinator • Staff acknowledgment system • Clinic staff retreats • Annual all staff meeting	*Staff Wellness Promotion* • N/A	*Staff Wellness Promotion* • Refine role of Staff Wellness Coordinator • Assess staff wellness needs and interest, including the need to address organizational vicarious trauma • Promote existing staff wellness resources • Critical Incident Debriefing (CID) - Assess current CID resources and develop CID protocol • Training in crucial conversations • Explore ways to acknowledge staff contributions • Training and TA for staff to develop skills	*Staff Wellness Promotion* • Activities were being implemented by the Staff Wellness Coordinator, a role that has been vacant since March 2019 – activities will resume when this role is filled	*Staff Wellness Promotion* • Increased staff wellness and job satisfaction

			• Staff retreats that incorporate wellness		
Deliver trainings on cultural humility & crucial conversations Objective Contribution: A, C	*Soul of Us* • Design and deliver cultural humility trainings focused on internal communications and relationships *Crucial Conversations Training* • Design and deliver crucial conversations trainings	*Soul of Us* • Currently offered through Ambulatory Care Workforce Development *Crucial Conversations Training* • Currently offered through Ambulatory Care Workforce Development	*Soul of Us* • Better integrate DPH/AC/BHS principles into all training curriculum • Assess to determine if projected outcomes are being met and modify plan as needed *Crucial Conversations Training* • Better integrate DPH/AC/BHS principles into all training curriculum • Assess to determine if projected outcomes are being met and modify plan as needed	*Soul of Us* • This project is pending. *Crucial Conversations Training* • This project is pending.	*Soul of Us* • Staff feel respected • Increased sense of belonging in the workplace *Crucial Conversations Training* • Increased capacity of staff to communicate effectively with each other • Reduced levels of staff conflict
Clinic safety initiative Objective Contribution: B	*Clinic Safety Initiative* • Effectively address and monitor staff's sense of safety in civil service clinics	*Clinic Safety Initiative* • Quarterly survey monkey sent to staff to assess 'Safety Climate' of staff. • Identify and implement enhancements to clinic environment to support increased sense of safety.	*Clinic Safety Initiative* • Administer baseline survey to assess safety climate and re-administer quarterly to determine impact of interventions. • Assess to determine if projected outcomes are being met and modify plan as needed	*Clinic Safety Initiative* • Personal safety alarms were distributed to civil service staff • De-escalation trainings were conducted in FY 17-18 and 18-19	*Clinic Safety Initiative* • Increase the % of staff feeling safe in their clinics
Improve supervision practices Objective Contribution: D	*Supervision* • Review and revise supervision guidelines, tools, and practices to shift the focus of supervision to	*Supervision* • N/A	*Supervision* • Review supervision protocols and make recommendations	*Supervision* • A best practices tool-kit is in development	*Supervision* • Increased motivation of staff to pursue professional development and promotion

	professional development and growth		regarding new supervision guidelines and practices • Determine viability of reforms to supervision and implement changes as indicated		
Leadership Academy Objective Contribution: D	*Leadership and Professional Development* • Leadership and Professional Development Initiative	*Leadership and Professional Development* • N/A	*Leadership and Professional Development* • Better integrate DPH/AC/BHS principles into all training curriculum • Explore initiative design and feasibility • Assess to determine if projected outcomes are being met and modify plan as needed	*Leadership and Professional Development* • This project is pending.	*Leadership and Professional Development* • Develop skills and tools staff need to succeed • Staff feel more supported
Goal 4: Incorporating Lived Experiences *Successfully integrate peers across the workforce* **Objectives:** A. Increased capacity to provide youth-to-youth, parent-to-parent and family-to-family services B. Peers have the knowledge and skills appropriate to thrive and grow within their roles C. Double the number of qualified peers in supervisory or leadership roles within the BHS workforce D. Improved peer supervision skills					
Strategy	**Tactics**	**Programs**	**Action Steps**	**Progress/Status**	**Intended Outcomes**
Ensure peers receive a minimum of 55 hours of training per year, including training to increase supervisory skills, peer-to-peer	*Peer Training* • Peer Specialist Mental Health Certificate • Advanced Level Training • Leadership Academy • NAMI Peer-to-peer training	*Peer Training* • RAMS peer training (NAMI)	*Peer Training* • Map current peers training efforts • Monitoring state level development for peer certification	*Peer Training* • NAMI training has continued as planned • Trainings address and incorporate children and family peers	*Peer Training* • Peers have the knowledge and skills appropriate to thrive and grow within their roles • Increased capacity to provide youth-to-youth,

training, and peer specialist mental health certificate Objective Contribution: A, B, D			• Ensure trainings address and incorporate children and family peers • Evaluate these programs to determine efficacy and ensure that training efforts align with state recommendations	• State-level development of peer certification is currently in flux	parent-to-parent and family-to-family services
Provide supports to peers interested in joining the workforce Objective Contribution: C	*Peer Employment* • Peer-to-Peer Employment Program • Support Access to City Employment (ACE) Program • Support applying for civil service employment	*Peer Employment* • LEGACY (Lifting and Empowering Generations of Adults, Children, and Youth) • RAMS Peer Employment Program	*Peer Employment* • Take inventory and map out the current number of active peer employees within all of BHS, including demographic data • Promote number of peer providers with an emphasis on programs that serve families and youth • Continue workshops re civil service hiring • Continue with collaborative efforts among BHS workforce, BHS Vocational Services and the ACE Program Coordinator to increase access to city employment for consumers • Collaborate with the Peer to Peer Employment Program, other peer projects, and family & consumer stakeholders to explore ways to increase capacity	*Peer Employment* • In FY 18-19 there were 352 peers recorded as occupying BHS contractor positions (HR does not track this data for civil service due to confidentiality issues)	*Peer Employment* • More peers in civil service positions • Expanded capacity to provide youth-to-youth, parent-to-parent and family-to-family services • More programs utilizing peers as a modality

			• Collaborate with the Peer to Peer Employment Program and consumer stakeholders to determine a plan for filling the gaps to ensure all BHS programs utilize peers as a modality • Outreach and recruit peer employees from community colleges, continuing education programs and adult schools.		
Provide supports to peers interested in advancing within the workforce Objective Contribution: C	*Peer Advancement* • Advanced Level Training • Workshops re civil service applications	*Peer Advancement* • Advanced Peer Certificate Program and Leadership Academy	*Peer Advancement* • Collaborate with Peer-to-Peer Employment Program and consumer stakeholders to determine next steps to increase advancement opportunities • Collaborate with the ACE Program Coordinator to break down system barriers and double the number of civil service supervisory positions for peers • Evaluate Advanced Level Training and Peer Specialist Mental Health Certificate programs to ensure that peers are prepared for supervisory positions	*Peer Advancement* • The Advanced Peer Certificate Program, Peer Specialist Mental Health Certificate Program, and the Leadership Academy are all being implemented as planned through RAMS	*Peer Advancement* • More peers in supervisory roles • Improves supervision skills

The table below outlines the alignment of SFDPH BHS Workforce Development Plan goals with MHSA priorities (MHSA priorities have been paraphrased here; full text can be found in the Mental Health Service Act, Part 3.1, Section 5822).

Strategic Plan Goals	(a) Expansion of postsecondary education pipeline	(b) Expansion of loan forgiveness and scholarship programs	(c) Creation of a stipend program modeled after the federal Title IV-E program	(d) Establishment of regional partnerships between the mental health system and the educational system	(e) Strategies to recruit high school students for mental health occupations	(f) Curriculum to train and retrain staff to provide services in accordance with MHSA provisions and	(g) Promotion of the employment of mental health consumers and family members	(h) Promotion of the meaningful inclusion of mental health consumers and family members in training and education programs	(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members	(j) Promotion of the inclusion of cultural competency in the training and education programs
GOAL 1: Recruitment, Hiring, and Development										
GOAL 2: Training and Support										
GOAL 3: Work Environment and Experience										
GOAL 4: Incorporating Lived Experiences										

APPENDIX B: FY19/20 Update on County Collaborative Efforts regarding the Technology-Assisted Mental Health Solutions Innovation Project

Overview

Help@Hand is a statewide collaborative project that began in 2018 with 14 counties and cities leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility outcomes to connect people with care across the state. Technology has many benefits, but there are also many challenges and questions. The participating jurisdictions are at the forefront of innovation to understand how technology is introduced and works, within the public behavioral health system of care. This means Help@Hand is not one project, but many projects across multiple cities and counties. The Collaborative offers the benefit of a shared learning experience that increases choices for counties/cities, accelerates learning, and adds in cost sharing. The focus of Help@Hand remains on pursuing a shared vision and common goals. Change at the scale of this project necessitates a robust readiness and change management approach. The project team has focused on building in activities to address these areas for both the project team and the community.

The Help@Hand project leads innovation efforts through factors such as:

- Peer Engagement - integrating those with lived experience of mental health issues/co-occurring issues throughout the project,
- Safety & Security - making sure we prioritize the safety and security of the users and their data,
- Incorporating Stakeholder Feedback - the project has a lot of stakeholders with different priorities. Help@Hand tries to find ways to meet the needs of most, but understanding with conflicting feedback it is not possible to meet the needs of everyone,
- Innovative Technology - always exploring if and how technology fits in the behavioral health system of care,
- Lessons Learned - applying the learnings and incorporating lessons learned as we continue and demonstrating progress and responsible use of resources.

Typically, we consider projects successful based on whether consumer welfare was directly improved by project activities. However, the test of success in an innovation project is more nuanced. Innovation is about transforming the system itself and therefore additional determinations of success include two questions:

1. Did participating Cities/Counties learn something proportionate to the investment they made in the project?
2. Have other Cities/Counties learned from what participants have done and implemented the elements that are valuable to that City/County?

Impact

During FY 19-20 the Help@Hand project had many successes and challenges. Some of the most notable impacts of the project during this time were work with the Peer community and the Cities' and Counties' exploration of mental health products to find those that best fit the needs of their stakeholder community.

Peers

Peers identified and raised the need for Digital Mental Health Literacy (DMHL) to empower California communities to make informed decisions about how they engage with technology. Listening sessions were held by the Peer and Community Engagement Manager to gather topics that would facilitate understanding and adoption of technology. There were 20 Digital Mental Health Literacy discovery sessions held in eleven different Counties with over 300 stakeholders from June – November 2019. These sessions led to the development of a DMHL video series, and a DMHL Curriculum that includes smaller coaching sessions (Q1-Q3 '19 & '20). Additionally, there were two Peer Summits held, in May and September 2019, to support Collaboration of Peer Leads from across the state for project learning, connection, and problem solving (Q1 2019). Monthly Peer Collaboration meetings were held to serve as a space for Peers to connect and share County/City project updates.

Technology Exploration

In early 2020 after the results of the Request for Statement of Qualifications (RFSQ) were released, the Collaborative Cities and Counties began engaging their community stakeholders and conducting focus groups to explore new technologies available to the project and receive additional feedback on products that would be a good fit for their communities.

Success Stories

The Help@Hand Collaborative worked on many activities in FY 19-20 laying the groundwork for implementing behavioral health solutions in their individual Cities and Counties. Some of the major successes during the 19-20 fiscal year include:

Using Working Groups to Move Forward

Roadmap Workgroup – One of the keys to success on any project is ensuring there is a consistent view of the result and the steps it will take to get there. A project with 14 unique Cities and Counties amplifies the need for consistency and alignment. In June 2019, the Roadmap workgroup was formed to help identify and document the shared expectations of project participants. The workgroup consisted of representation from large and small and regionally diverse Cities and Counties, as well as those with varying target audiences. The workgroup also included Peer participation. The group met several times throughout the fiscal year to develop the roadmap and present it to the overall Collaborative for feedback and approval. The workgroup held regular check-ins to monitor progress of the roadmap initiatives.

Risk and Liability Workgroup - In October of 2019, the Risk & Liability workgroup was established by the CalMHSA project management team. The goal of this workgroup is to review project management, implementation, and product feature updates that need to be considered for specific attention, or project pivots. This workgroup offers the time and space needed to prepare for any upcoming or potential hurdles that the project needs to address or prepare for.

Branding

During a series of working sessions stakeholders provided input on the artwork and theme for the Help@Hand project. It was important to all the Collaborative members that direction for the aesthetics of the project come from the communities they intended to serve. Once the artwork

and branding guidelines were finalized (including logos, colors, and illustrations) they were approved by the Help@Hand Leadership committee in quarter four, 2019.

More Technology Options

A Request for Statement of Qualifications (RFSQ) brought 93 new vendors for the Collaborative Counties and Cities to explore. The project opened a RFSQ process in September 2019 for technology companies to apply to be part of the suite of apps Help@Hand considers. Approving 93 additional products for the project opened new opportunities for Cities and Counties to select products that meet community interest and needs.

Stakeholder Engagement

During a CAMHPRO/ACCESS Webinar on November 12, 2019 the Peer and Community Engagement Manager presented an update on the Help@Hand Project. ACCESS, formerly known as CAMHPRO, is a statewide stakeholder group. The objective of this presentation was to provide background and Context on Innovation and the Help@Hand Project; share project lessons learned and respond to frequently asked questions; explain where the project is going and how to stay involved; and discuss the role and activities of Peers on the Help@Hand Project.

Help@Hand published the first Stakeholder Update report on September 30, 2019. This was an important step not only to improve visibility into the project and help answer questions for stakeholders, but it also created a channel for stakeholders to receive the latest updates on the project and have a voice into the work by submitting questions to be updated in the report that was updates in March 2020. In addition to the written reports, Help@Hand offered a webinar where stakeholders learned about more of the work that is happening throughout the project. The webinar was held on February 21, 2020.

In January 2020 helpathandca.org was launched, the website was a product of the Collaborative's vision and input for sharing project wide information. This site makes it easy for the Collaborative members to share updates and sources to stakeholders and their respective communities. Both Stakeholder Update Reports and Reports to the MHSOAC were included on the site, as well as a featured section for the Digital Mental Health Literacy video series.

Budget Structure

An updated budget structure was established to provide Collaborative Counties and Cities with clarity around expenses and local dollars. In December 2018, Cohort One approved a budget for the Collaborative. This is the budget that Help@Hand had been operating under since inception. As the project progressed, cohort members expressed a need to utilize project funds at the local level and so, a new DRAFT budget concept was developed. This concept was previewed with Cohort Members that attended the October 24, 2019 In-Person Collaborative meeting. The new concept was presented at the November 7, 2019 Leadership meeting and the motion to approve the new model was passed during the November 21, 2019 Leadership meeting.

Contract Management

In conjunction with the budget structure updates, Help@Hand recognized the need for enhanced contracting and contract management processes for engaging and managing technology vendors. The rapid advancements of the technology industry highlight the

importance of a procurement and vendor management process that addresses the nuances and challenges that may arise. Help@Hand partnered with an industry-recognized legal expert to update the contract template that enhances protections for the consumers who use the products as well as the financial interest of the Cities and Counties, and the Collaborative.

In-person Collaborative Events

Help@Hand facilitated two in Person-Collaborative events. In both August 2019 and October 2019, the project had the opportunity to bring the Collaborative Counties and Cities together to talk through project work, idea sharing, lessons learned, planning, and education. These events were an essential part of creating connections between Collaborative members. Unlike remote meetings, these in-person events reduced distractions, eliminated networking hurdles, and offered the opportunity to build more trust to boost creativity and involvement.

Collaborative Tools Developed

- Digital Behavioral Health Questionnaire - Understanding each technology product is very important to the Collaborative. During FY 19-20 a Digital Behavioral Health Questionnaire (DBHQ) was developed to assess the products from the RFSQ to help the Collaborative Counties and Cities define the needs of their consumers and what considerations need to be at the center of their assessment.
- Vendor Security Questionnaire - The Vendor Security Questionnaire was also created. This tool was used by Cities and Counties to better understand the security measures each vendor used and put in place to collect, store, and protect data. The information from both of these tools assisted Cities and Counties in making product selections that best fit their community's needs.

Challenges

There are many things to consider when integrating technology into existing systems of care. The Help@Hand Collaborative has addressed many challenges in this work. Some of the challenges experienced by the Collaborative during FY 19-20 include:

COVID-19

The beginning of 2020 brought significant challenges to Help@Hand Cities and Counties due to the COVID-19 pandemic. Many Collaborative members' capaCity changed quickly in March 2020 as they were asked to respond to evolving pandemic response request and care needs in their local communities.

Rapid Response - The early months of the pandemic saw Cities and Counties challenged to understand how they could quickly leverage mental health technology to meet growing community needs. Help@Hand worked quickly to develop a streamlined approach that supported Cities and Counties in launching a technology to their respective communities in direct response to growing mental health needs related to quarantine and COVID-19. Each step of the technology selection, readiness and deployment process is essential. Therefore, the rapid response approach did not reduce or eliminate critical steps but streamlined them by working to establish common features and functionality with the vendors and reducing variation among Cities and Counties. This effort is ongoing.

Collective Learning

During FY 19-20 Cities and Counties had the opportunity to select products from additional vendors and began developing implementation plans for their individual communities. As the project expanded, determining which decisions were to be made collectively and which should be taken locally was at times a challenge for the Collaborative. For example, different products presented opportunities and challenges for each City and County. A product that was a good fit for one, may not be for another. Through collective sharing of local efforts, lessons learned and the development of tools such as the Vendor Security Questionnaire, Digital Behavioral Health Questionnaire and the pilot process the Collaborative built a process that allowed for transparency and trust as each County determined their unique product selection. The Collaborative also asked whether risk incurred by one County could be transferred to the Collaborative or other Counties and appropriate Collaborative crisis response protocols and social media engagement strategies. While Collaborative decision-making processes have been established, the nuances of integrating behavioral health technology into Counties evolving systems of care continued to present unique questions to the Collaborative. The use of social media and crisis response protocols and expectations varied throughout the Collaborative.

Peer Chat Apps

Many Cities and Counties outlined their goal to use Peer Chat apps in their OAC plans for the Help@Hand project however, through the RFSQ process the Collaborative discovered there are few Peer chat apps that adequately meet the County's needs. Only 10 of the 93 RFSQ approved products were Peer chat apps and many did not share the same definition of Peer as defined by the project. This has posed challenges for the Cities and Counties to meet their community's interest in using Peer chat platforms. Additionally, during FY 19-20 the Collaborative ended their contract with the original Peer chat app vendor selected for the project.

Languages

A goal for many Help@Hand participating Cities and Counties was to reach monolingual communities across California. As the Collaborative began exploring new products during FY – 20 many discovered that most behavioral health technologies are not translated/ trans adapted and validated as culturally competent in the languages Counties need. An ongoing challenge for the Help@Hand Collaborative has been finding products that are adequately adapted in languages other than English and are ready to be implemented throughout diverse communities. The cost and time needed to translate products as well as the vendor community's interest in doing so has proven to be a challenge for the Help@Hand project.

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