San Francisco Health Network
Behavioral Health Services

San Francisco
Mental Health Services Act (MHSA)
FY2024-2025 Annual Update to the Integrated Program and Expenditure Plan

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

Pan American Unity Mural by Diego Rivera on display at SF Museum of Modern Art

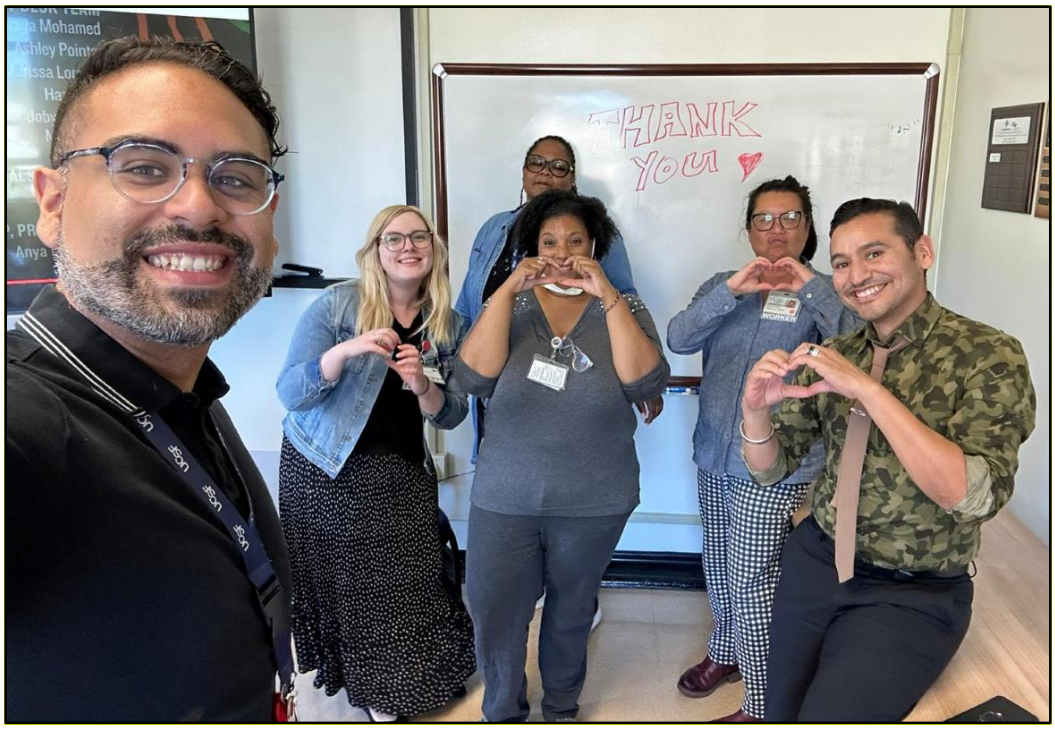
Table of Contents

Organization of this Plan

The San Francisco Mental Health Services Act Annual Update to the Program and Expenditure Plan provides information and outcomes of our work conducted during FY22-23, key updates from FY23-24, and our proposed plans for FY24-25. The plan's introductory section provides an overview of the Mental Health Services Act (MHSA), the general landscape of San Francisco, Community Program Planning (CPP) activities, MHSA program highlights from the past year, and the plan's formal review process.

In our section on activities from FY22-23, we present highlights for San Francisco Department of Public Health (SFDPH) MHSA's eight service categories. Each section includes a description of the overarching purpose of the service category, an overview of the programs within that category, and a description of the target population.

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



UCSFs WARD 86 Clinical Staff Luncheon 2022

MHSA County Compliance Certification

County: _____

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

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

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

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

All documents in the plan are true and correct.

_____ _____

Signature Date

Dr. Hillary Kunins

Local Mental Health Director/Designee

County: San Francisco County

Date: July XX, 2023

MHSA County Fiscal Accountability Certification

Placeholder page 1 of 2

Fiscal accountability placeholder page 2 of

Director's Message

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

I am proud to share the strides we have made in advancing our mission to provide comprehensive mental health services to the San Francisco community. The ongoing impacts of COVID-19 have underscored the urgent need for robust mental health and substance use support, and our team has responded with unwavering dedication and innovation. This year, we have significantly intensified our equity and inclusion efforts, placing a strong focus on addressing the diverse needs of our community. Our initiatives have included vital overdose prevention strategies and housing solutions, recognizing the critical role these factors play in the overall well-being of our clients. Understanding the unique challenges faced by our vulnerable populations, we have launched programs focused on those most in need within our San Francisco communities. Central to our efforts is the enhancement of our workforce to ensure it reflects the diversity of the communities we serve. We have prioritized the recruitment and training of behavioral health clinicians who bring professional expertise and lived experiences that resonate with our clients. By ensuring that our team includes multilingual staff and individuals who understand the cultural contexts of our clients, we are better equipped to deliver empathetic and effective care. We are committed to a holistic approach to mental health, addressing not only diagnoses and treatments but also the broader challenges our clients face such as job loss, housing instability and the impacts of systemic racism. Our goal is to provide comprehensive support that empowers our clients to overcome these obstacles and achieve lasting well-being.

The integration of our Justice, Equity, Diversity, and Inclusion (JEDI) team with the Mental Health Services Act teams has been a cornerstone of our strategy. This team, encompassing trauma-informed care, equity staff wellness and workforce development has enabled us to embed culturally responsive and equitable initiatives across our organization. With over 700 dedicated employees in Behavioral Health Services (BHS), we have created a supportive and inclusive environment that fosters continuous improvement and innovation. One of our proudest achievements this year the completion of two cohorts of staff members completing an Anti-Racist Fellowship. This program has built the leadership capacity of our managers and supervisors, particularly those overseeing clinics that predominantly serve Black/African American and Brown communities. This initiative aligns with San Francisco's Racial Equity Action Ordinance and our city's commitment to advancing racial equity. As we move forward, we remain dedicated to enhancing access to behavioral health services, including virtual care options, to meet the evolving needs of our clients. Our efforts are driven by a steadfast commitment to equity, inclusion and the holistic well-being of every individual we serve.

JEDI/MHSA works across Behavioral Health Services to support a wide range of behavioral health services provided by a culturally diverse network of community behavioral health programs and private psychiatrists, psychologists and other behavioral health clinicians. Merging our equity, trauma-informed and MHSA initiatives has allowed us to expand and improve our mental health and substance use services, including outpatient treatment, residential treatment, medication management, linkage services and an extensive array of more specialized treatment services. Since integrating our efforts, the JEDI/MHSA team achieved numerous accomplishments in FY22-23, as outlined below:

1. Sustaining funding for current programs and services with demonstrated impact;
2. Providing additional funding to strengthen population-focused: Mental Health Promotion and Early Intervention Programs;
3. Augmenting capital projects;
4. Growing Full-Service Partnerships (FSPs) by expanding treatment capacity;
5. Continuing the MHSOAC-approved innovation project for “Culturally Congruent Practices for Black/African American Communities”;
6. Sustaining a pilot project to bring culturally affirming patient navigation support to the City’s Chinatown North Beach Clinic;
7. Launching and Implementing a Maternal Mental Health Project for Birthing Parents; and
8. Providing Talk Therapy to Black/African American Clients throughout San Francisco.

As we enter FY24-25, we are preparing an implementation plan to adhere to California’s Proposition 1, which will change MHSA requirements. While meeting the new requirements for allocation of funding, we will aim to sustain programs vital to our community and support our culturally responsive and equity-focused community-based programs that provide innovative mental health and substance use services. Under Proposition 1, we will also collaborate with the California Department of Health Care Services on expanding workforce development programs.

Leading with race and prioritizing intersectionality, including sex, gender, sexual orientation, age, class, nationality, language and ability, JEDI/MHSA strives support our staff and programs that meet cultural and linguistic needs of our clients, so they can realize health, wellness, and recovery. Reducing mental health and substance use disparities and empowering our communities by incorporating their voices, conditions and ideas into our JEDI/MHSA programs and initiatives will be a focus for upcoming years. Thank you for your continued support and partnership as we strive to create a healthier, more equitable San Francisco.

In Community,

Jessica Brown

Jessica Brown, Director of SFDPH MHSA and JEDI

Introduction to MHSA

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

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

As dictated by the pre-Prop 1 law, the majority of San Francisco MHSA funding must be allocated to treatment services. In San Francisco, MHSA funding expands access to intensive treatment services, housing, employment services and peer support services for thousands of individuals with mental illness, 50 percent of whom are homeless or at-risk of becoming homeless. Promising outcomes from MHSA investments include declines in arrests, mental and physical health emergencies, school suspensions and expulsions, and the number of days in residential treatment, per data collected from the MHSA Year-End Reports. Proposition 63 also stipulates that 20 percent of the funds support programs "effective in preventing mental illnesses from becoming severe" and "reducing the duration of untreated severe mental illnesses."

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

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

In FY22-23, MHSA served a total of 55,915 individuals through outreach and engagement; screening and assessment; wellness promotion; individual and group therapeutic services; and service linkage efforts.

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

SF Nightlife and Entertainment Summit in 2022

California's MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

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

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

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

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

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

SF City Hall lighting in recognition of Pride Month, June 2023

Community Program Planning (CPP) & Stakeholder Engagement

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

Community Program Planning (CPP) & Stakeholder Engagement Activities

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

Exhibit 1. Key Components of MHSA CPP

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

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

MHSA Communication Strategies

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

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

Each Mind Matters outreach table at 1380 Howard

MHSA Advisory Committee & Our Commitment to Client Engagement

MHSA Advisory Committee

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

- Working collaboratively with BHS to support broad community participation in the development and implementation of MHSA initiatives
- Guiding MHSA resources to target priority populations as identified in existing MHSA plans
- Ensuring that San Francisco's behavioral health system adheres to the MHSA core principles
- Holding meetings every two months
- Encouraging community participation at meetings

The MHSA Advisory Committee's robust recruitment efforts focus on engaging community members, including those with behavioral health disorders, their family and friends, service providers, and other stakeholders, with an emphasis on the following underrepresented community members: those with lived experience with substance use disorder and the justice system, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of more than 25 active members. The 2023 MHSA Advisory Committee met on June 14th. The purpose of this meeting was to gather committee member feedback on MHSA programming and the needs of priority populations, specifically MHSA's Community Health Equity & Promotion Harm Reduction program and the Addiction & Recovering Counseling Certificate and Community Mental Health Certificate programs.

Increasing Client Engagement with the SF BHS Client Council

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

The BHS Client Council remains flexible in providing support to clients as they respond to the changing needs in the community. In 2023, the Council met on May 25th and October 17th to discuss unmet needs of the community and strategies to improve programming to meet these needs. The Behavioral Health Director has instituted quarterly meetings with the Council to provide updates and receive feedback.

Strengthening Relationships

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

Community Program Planning session

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

Recent Community Program Planning Efforts

Community Program Planning and the MHSA FY24-25 Annual Update to the Program and Expenditure Plan

The SFDPH MHSA team regularly engages with the community and conducts ongoing and extensive CPP efforts. SFDPH continued conducting extensive community outreach and engagement efforts to inform program planning for the MHSA FY24-25 Annual Update to the Program and Expenditure Plan. Community members' voices are critical in guiding MHSA program improvements and developing new programming. Beginning in 2020, due to the COVID-19 pandemic, community outreach, and engagement efforts moved to a virtual format and have continued in a hybrid virtual and in-person format since then. 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 FY22-23 programming, and our plans to integrate community feedback into MHSA programming. SFDPH remains committed to conducting

community outreach and engagement to ensure clients have the appropriate wellness tools and resources to support them in their recovery journey.

Community and Stakeholder Involvement

SFDPH strengthens the MHSA program planning by collaborating with behavioral health service clients, their families, peers, and providers to identify the most pressing behavioral health-related needs of the community and develop strategies to meet these needs. In 2023, **JEDI/MHSA hosted 5 community engagement meetings across the city** to collect community member feedback on existing programming and to better understand the needs of the community and to develop this plan. **More than 107 individuals attended these meetings**, including mental health and other service providers, clients of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders.

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

The 2023 CPP meetings are listed in the following table.

2023 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening**
5/25/23	Client Council Meeting Peer Wellness Center Improvements
6/14/23	Advisory Committee Meeting Stakeholder Input Gathering
7/13/23	Stakeholder Engagement Presentation Training on MHSA and Community Outreach
9/19/23	Wellness and Recovery Panel Transgender Pilot Project - Substance Use Forum

2023 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening**
10/17/2023	Client Council with Behavioral Health Services Director Consumer Input Collection Session

In each community meeting, SFDPH JEDI/MHSA staff presented an overview of the MHSA, including its core components, guiding principles, and highlights of existing programs and services. Staff also provided training on the equity framework and substance use/overdose prevention strategies. Staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health and strategies to address needs. These discussions also addressed how SFDPH can improve existing MHSA programming. SFDPH MHSA staff addressed how the feedback would be incorporated into the Annual Update and future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the FY24-25 MHSA Annual Update.

Community and Stakeholder Feedback

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

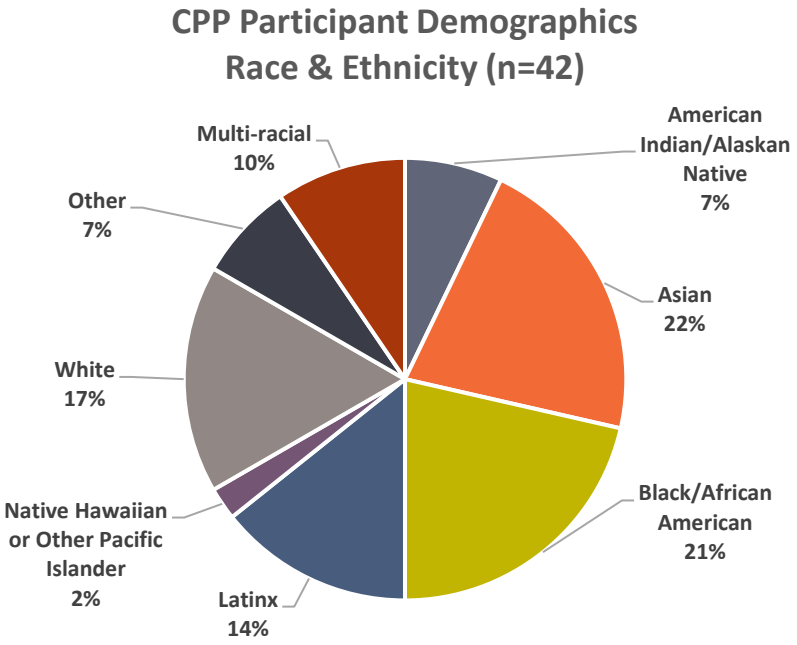
CPP meetings in 2023 built on existing community and MHSA programming meetings to understand the general behavioral health needs of the community, as well as specific program improvement planning and other feedback. The following notes highlight the key takeaways from these meetings. This feedback is incorporated into our continuous program improvement planning efforts.

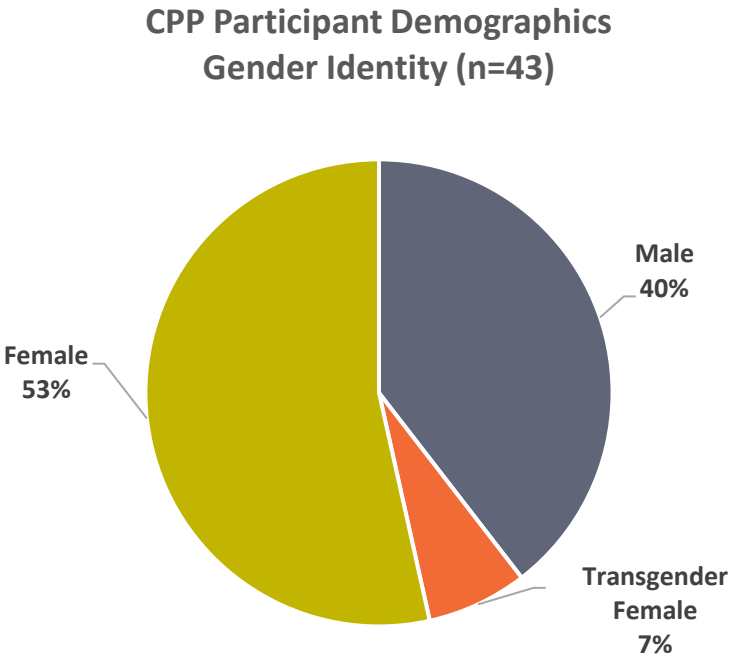
"Wellness and recovery services promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives."
- Service provider

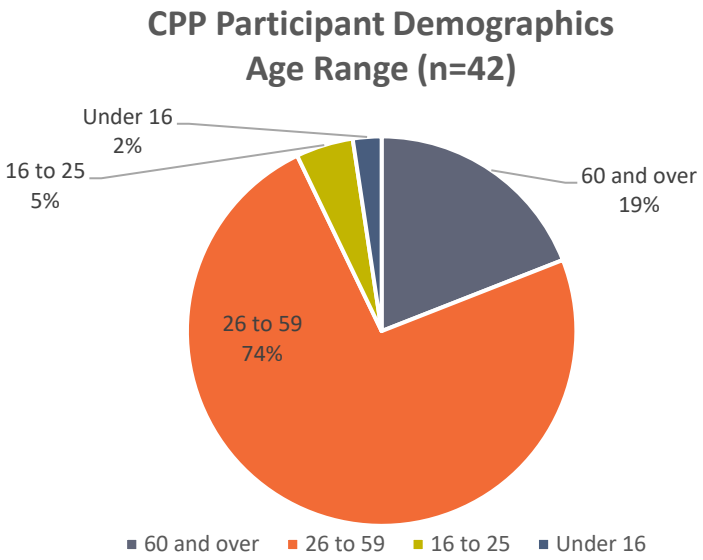
- Culturally responsive services reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access – this is of upmost importance in overcoming stigma, connecting clients to services, and successfully engaging with them.
- It is critical that mental health clinicians and staff are representative of the clients our programs serve, particularly when serving communities that are culturally, medically, economically, or otherwise isolated. This includes certain populations (e.g., TAY, LGBTQ+, racial and ethnic groups) as well as entire neighborhoods (e.g. Bayview/Hunter's Point).
- There is a need for additional services targeted towards populations with unique needs such as transgender and gender non-conforming individuals, mothers of small children and Native Hawaiian & Pacific Islander individuals.
- Additional training is needed to address race, gender and health disparities. Training should be offered in different languages and by people with lived experiences.

CPP Meeting Participation

More than 107 individuals attended a CPP meeting in 2023. CPP participant demographics (race/ethnicity, gender identity, age) for 2023 are included below. CPP events were primarily held virtually in 2023, which made the collection of meeting client demographic data more challenging to collect as clients often do not complete demographic survey requests.







Community Program Planning with Service Provider Selection

JEDI/MHSA includes elements of the CPP in developing and refining each of our programs. Frequently, this takes the form of an ad hoc committee or planning groups made of various stakeholders, including people with expertise or lived experience of specific populations. The MHSA principle of engaging clients and family members is applied to all programs. This process also includes 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 focus more generally on contracting with SFDPH JEDI/MHSA, as well as data collection and evaluation and service provider training initiatives. The MHSA team presents information to increase awareness among community members of these contracting opportunities and how our contracts are developed in collaboration with service providers, peers, service navigators, individuals with lived experience and family members.
We want to thank all our collaborative partners including San Francisco's community members, behavioral health clients, peer specialists, service providers and individuals with lived experience and family members.

Peer Services Holiday Party 2023

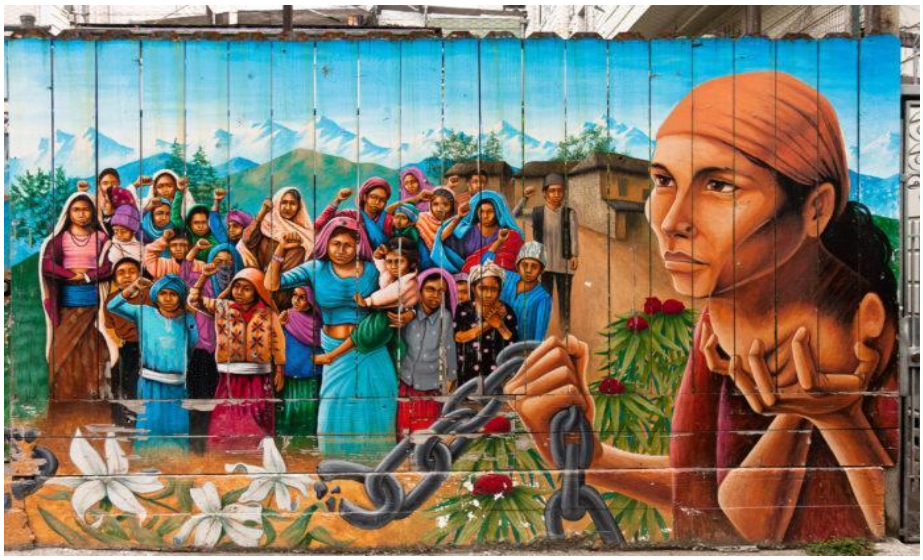
Assessment of San Francisco's Mental Health Needs and Capacity to Implement Proposed Services

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

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

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

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



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

CPP in Program Implementation

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

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

Peer Employment is a Critical Element of Community Program Planning

CA Proposition 63 emphasizes the importance of consumer participation in the mental health workforce. All MHSA-funded programs are encouraged to hire peers as members of program staff. Peers 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. **SF MHSA funded 224 peers in FY22-23** throughout our behavioral health system.

Spotlight on BHS Racial Equity Efforts

The San Francisco Department of Public Health, Behavioral Health Services' mission is to provide equitable, effective substance use and mental health care and promote behavioral health and wellness among all San Franciscans. This mission allows us to develop culturally responsive care that serve populations experiencing the most severe health inequities need and to receive the most resources.

We aim to improve client health outcomes through the following foundational objectives:

- Understand the impacts of racism and discrimination on our workforce and communities;
- Build workforce capacity to provide culturally congruent care for our communities with the greatest health inequities;
- Innovate, implement and improve systemwide anti-racist practices and policies.

Due to the severity of racism in our systems and communities, intensive foundational learning and interpersonal relationship building are necessary to ensure BHS leaders and staff are prepared to engage in meaningful and impactful antiracist practices and policy change. This begins with our 16-week, 80+ hour Antiracism Leaders Fellowship with facilitators Dante King and Robin DiAngelo. Fellowship participants learn and unlearn antiblackness, white supremacy, internalized superiority, internalized racism, white supremacy characteristics and moves, historical, and perpetual conditions. In FY22-23, nine BHS cabinet members, 14 BHS executives, and 9 JEDI managers participated in the fellowship, along with 1:1 executive coaching, racial affinity groups, a cabinet retreat, and cabinet Health Equity Antiracism Leadership Competencies, priorities, self-assessments, and action plans.

The Antiracism Leaders Self-Assessment is structured by foundational knowledge, emotional resources and communication, race consciousness, translating knowledge into action, and motivation and prioritization. In December 2023, during a BHS all staff town hall focused on racial equity, BHS cabinet members presented reflections from their experiences in the fellowship, along with their leadership competency priorities and commitments.

In FY24-25, BHS executives and cabinet members will participate in a combined all day in person retreat with Dante King, focused on self-assessments and action plans. Our Antiracism Leaders Fellowship cohort #2 will include direct reports of cabinet members and executives, who will all participate in a 360-Degree Antiracism Leadership Survey, in which leaders will receive and integrate feedback from staff on their antiracism behaviors and practices.

San Francisco's Integrated JEDI/MHSA Service Categories

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

Exhibit 2. MHSA Service Categories

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

Developing this Program and Expenditure Plan

The SFDPH MHSA FY24-25 Annual Update to the Program and Expenditure Plan was developed in collaboration with MHSA clients, peers, family members, service providers, local residents, and other stakeholders. The SFDPH JEDI/MHSA community outreach and program planning efforts were coordinated by a core team of JEDI/MHSA staff, which included the JEDI/MHSA Director and Program Managers. Independent consulting firms, HTA Consulting 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 FY24-25 Annual Update, the MHSA team incorporated the stated goals of the JEDI/MHSA, the mission of the SF DPH, newly expanding work in behavioral health funded under Mental Health SF, local data about community need, and revisited local MHSA priorities and needs identified in the 2023-26 Program and Expenditure Plan. 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 current and previous three-year MHSA Program and Expenditure Plan and MHSA Annual Update Reports submitted for each MHSA component. This was done to understand how priorities identified in those plans have been addressed and determine if all programs had been implemented as originally intended.
- Reviewing MHSA regulations, laws and guidelines released by the State (e.g., Department of Behavioral Health, Mental Health Services Oversight and Accountability Commission, California Housing Finance Agency, and new MHSA Innovations and Prevention and Early Intervention regulations) to ensure all required reporting information is incorporated in this plan.
- Reviewing informational materials produced by California Mental Health Services Authority, California Mental Health Director's Association, and Office of Statewide Health Planning and Development.
- Reviewing JEDI/MHSA Annual Year-End Program Reports and demographic data submitted by SFDPH contractors and civil service providers.
- Conducting program planning with service providers and clients through robust contracting efforts throughout the Department

Local Review Process

Our Community Program Planning process offers a number of opportunities for clients, peers, family members, service providers, community members, and other stakeholders to share their input in the development of our planning efforts, learn about the process of our MHSA-funded programs, including the role of the 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 the 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 FY24-25 Annual Update was posted on the MHSA website at www.sfdph.org/dph for a period of 30 days from MONTH DATE, 2024 through MONTH DATE, 2024.** Members of the public were requested to submit their comments either by email or by regular mail. The following is a summary of the public comments during the 30-day posting and Behavioral Health Commission:

Summary of Public Comments and BH Commission on the MHSA FY24-25 Annual Update		
Community Member	**Summary of Comments**	**SFDPH Response**

Following the 30-day public comment and review period, **a public hearing was conducted by the Behavioral Health Commission of San Francisco on MONTH DATE 2024.** The **San Francisco's MHSA FY24-25 Annual Update** was also presented before the **Board of Supervisors Audit and Oversight Subcommittee on MONTH DATE 2024** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted this MHSA FY24-25 Annual Update on MONTH DATE 2024.**

Public Hearing & Board of Supervisors Resolution

Placeholder

Resolution placeholder page

SFDPH JEDI/MHSA FY24-25 Annual Update

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

I. Recovery-Oriented Treatment Services

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

II. Peer-to-Peer Support Programs and Services

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

III. Vocational Services

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

IV. Housing

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

V. Mental Health Promotion and Early Intervention

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

VI. Innovation

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

VII. Behavioral Health Workforce Development

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

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

VIII. Capital Facilities and Information Technology - CF/TN

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

Peer to Peer Halloween Party 2023

1. Recovery-Oriented Treatment Services: CSS Funding

Service Category Overview

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

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

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

FSP Programs

Program Collection Overview

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

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

Target Populations

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

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

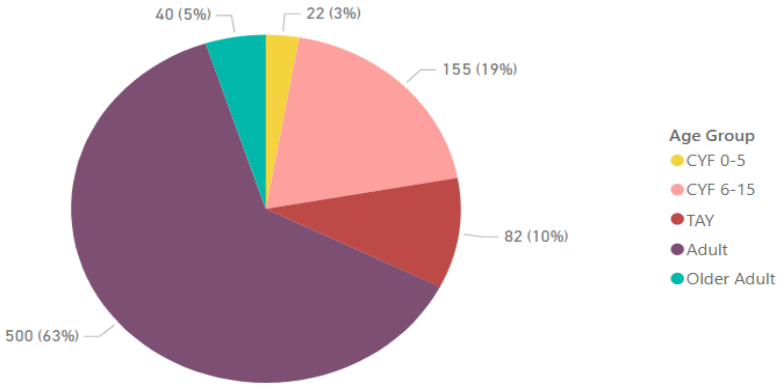
FSP Programs			
Target Population	Program Name *Provider*	Name Listed on ARER, Budget	Additional Program Characteristics
Adults/Older Adults	Assisted Outpatient Treatment (AOT) *SFDPH & UCSF Citywide Case Management*	CSS Full-Service Partnership 6. AOT	Outreach and engagement for individuals with known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

FSP Client Demographics, Outcomes, & Cost per Client

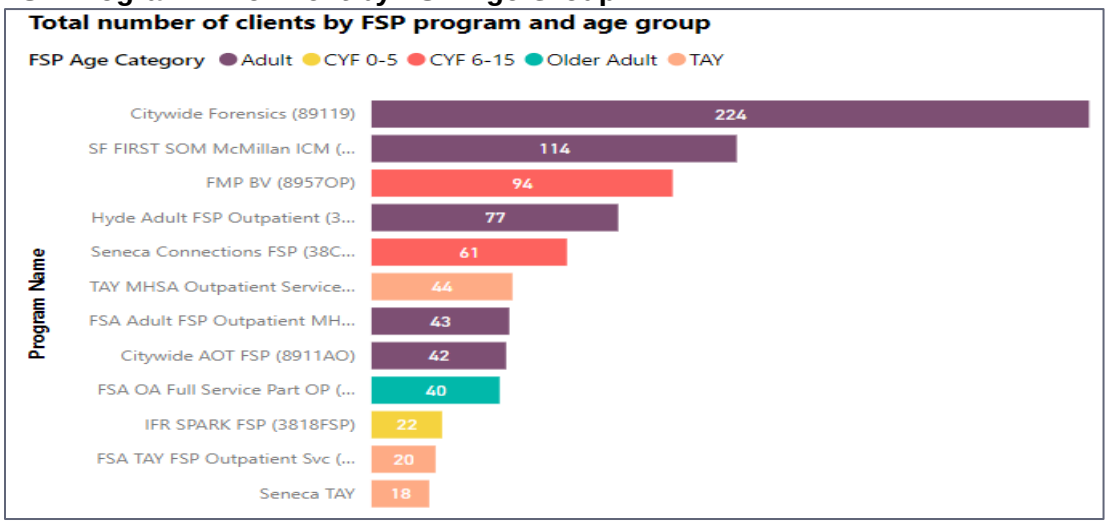
San Francisco funded twelve Full-Service Partnership (FSP) programs during FY22-23 serving a total of 787 number of clients. The tables and graphs below describe the demographic characteristics of clients served in the FSPs from July 1, 2022 through June 30, 2023. Demographic data are captured in the SFDPH Behavioral Health Services electronic health record program, Avatar. Sex, gender identity, race/ethnicity, and primary language are displayed by FSP Program and by FSP age group (as of July 1, 2022).

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

FSP Client Age Groups (n=787)



FSP Program Enrollment by FSP Age Group



Client Sex and Gender

Historically, client gender was entered into the electronic health record (Avatar) with only binary options: female and male. Under new Sexual Orientation and Gender Identity (SOGI) data recommendations, more options for gender identity are available; 55.9% of 787 clients identify

as male, 30.9% as female and 3.7% identified as trans female, trans male, or genderqueer/non-binary.

FSP Age Group by Gender Identity

Age group	Male	Female	Other	DTS/Unknown
CYF 0-15	52	65	<10	55
TAY	48	25	<10	<10
Adult	324	136	20	16
Older Adult	19	20	<10	<10
Total	**440**	**243**	**29**	**75**

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

Client Race/Ethnicity

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

Client Race/Ethnicity by FSP Program

Percentage race/ethnicity by FSP Program

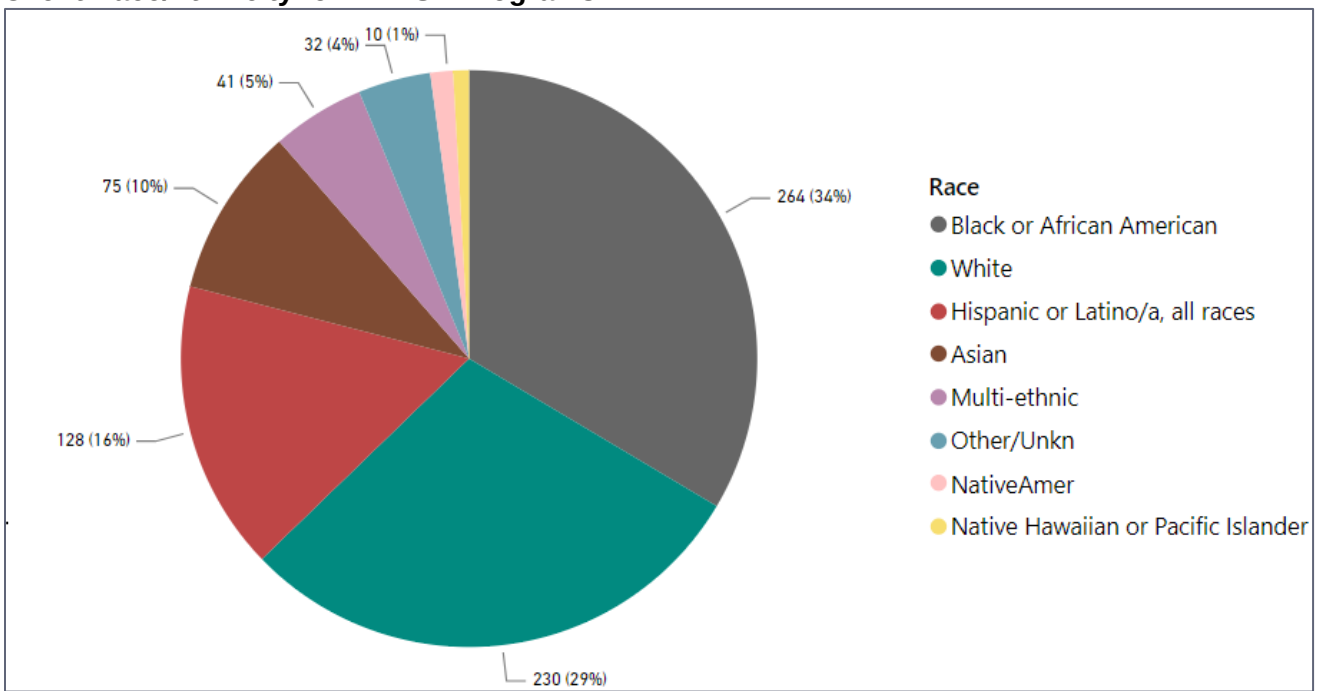
Program	Asian	Black or African American	Hispanic or Latino/a, all races	Multi-ethnic	Native American	Native Hawaiian or Pacific Islander	Other	Unknown	White	**Total**
BHS TAY FSP	11%	30%	27%	23%		2%	2%		5%	**100%**
Citywide AOT	7%	29%	14%	10%			2%		38%	**100%**
Citywide Forensics	10%	40%	8%	4%	2%	1%	2%		33%	**100%**
Family Mosaic Project (FMP)	14%	27%	34%	4%	2%	2%	12%	1%	4%	**100%**
FSA Adult FSP	16%	37%	12%	5%			2%		28%	**100%**
FSA Older Adult FSP	5%	35%	10%	3%	3%		3%		43%	**100%**
FSA TAY FSP	30%	30%	15%	10%		5%			10%	**100%**
Hyde Street FSP	5%	25%	9%	1%			3%		57%	**100%**
IFR SPARK FSP	5%	27%	45%				23%			**100%**
Seneca Connections	5%	49%	25%	5%	2%		5%	2%	8%	**100%**
Seneca TAY	22%	22%	28%	11%					17%	**100%**
SF FIRST FSP	7%	29%	12%	4%	2%	1%	1%		45%	**100%**
Total	**10%**	**34%**	**16%**	**5%**	**1%**	**1%**	**4%**	**0%**	**29%**	**100%**

Race/ethnicity by FSP program

Program	All Other Race/Ethnicity	Black or African American	Hispanic or Latino/a, all races	White
BHS TAY FSP	17	13	12	<10
Citywide AOT	<10	12	<10	16
Citywide Forensics	41	89	19	75
Family Mosaic Project (FMP)	33	25	32	<10
FSA Adult FSP	10	16	<10	12
FSA Older Adult FSP	<10	14	<10	17
FSA TAY FSP	<10	<10	<10	<10
Hyde Street FSP	<10	19	<10	44
IFR SPARK FSP	<10	<10	10	<10
Seneca Connections	11	30	15	<10
Seneca TAY	<10	<10	<10	<10
SF FIRST FSP	16	33	14	51
Total	**165**	**264**	**128**	**230**

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

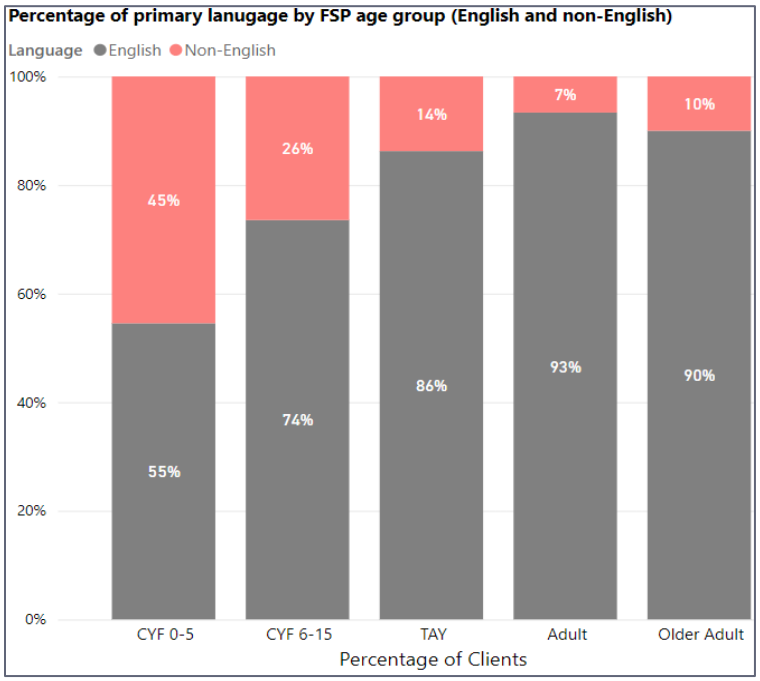
Client Race/Ethnicity for All FSP Programs



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 (88%).

Client Primary Language by Client Age Group



While English is reported as the primary language for 88% of FSP Clients, Spanish (8%) Cantonese (2%) and other language speakers (1%) are supported by FSP providers. Other languages included: Vietnamese, Filipino, Tagalog, Russian, German, and Arabic. As defined by DHCS Medi-Cal eligibility, the “threshold” languages for San Francisco are: Spanish, Cantonese, Mandarin, Vietnamese and Russian.

FSP Data Collection and Reporting (DCR) Outcomes

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

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

FSP Residential Outcomes

Data Collection. Residential settings data were extracted using the Enhanced Patient Level Data (EPLD) portal maintained by the Mental Health Data Alliance for DHCS and prepared for

reporting using Access and Excel. The graphs include all **clients** active in the FSP during FY22-23 with a completed Partnership Assessment Form (PAF), who have served in the **FSP partnership for at least one continuous year and up to four years.** These graphs exclude clients who have been active in the FSP for less than one year or more than four.

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

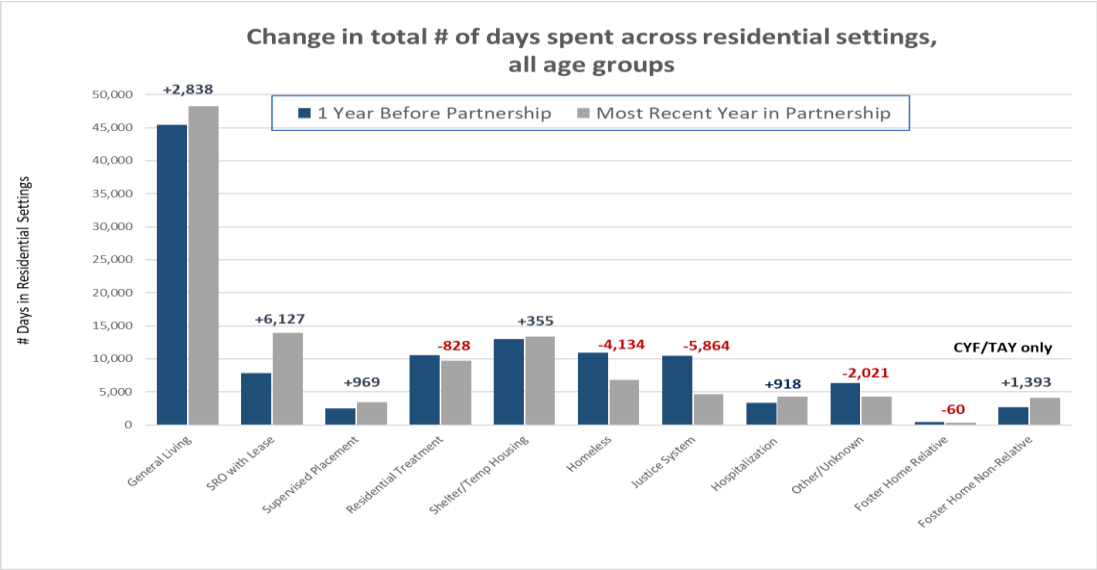
Residential settings are displayed from more desirable (i.e., generally more independent and less restrictive environments) to less desirable for clients. However, this interpretation varies by age group as well as for individuals. For example, while a supervised placement may represent a setback for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

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

Clients in All FSPs

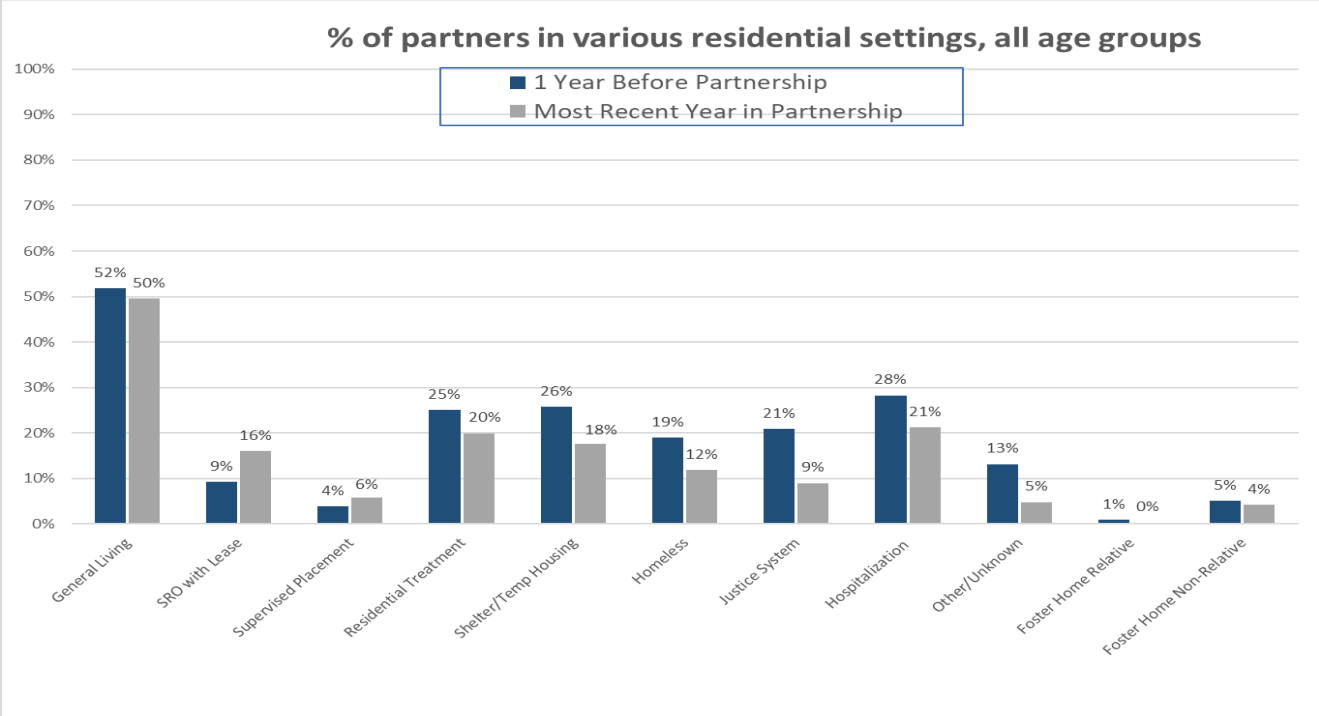
Across all age groups, the residential outcomes below (Exhibit RES-All-1) show reductions in the number of days that all clients enrolled between 1-4 years in an FSP program experienced homelessness and the justice system, but an increase in hospitalizations in their baseline year (pre-FSP) compared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

Exhibit RES-All-1. Change in time spent in residential settings, all clients (n=311)



Time spent in stable settings (General Living, SRO with lease, Supervised placement, Residential Treatment) increased from baseline to the most current year of FSP treatment and simultaneously decreased for less stable or more restrictive settings (Homeless, Justice System). Additionally, the number of clients experiencing these residential settings dropped or remained steady for most unstable or restrictive settings (Exhibit RES-All-2).

Exhibit RES-All-2. Percentage change in residential settings, All Clients (n=311)



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 Key Event Tracker (KET) is a form in the DCR application designed for case managers to enter events as they occur, or the first opportunity thereafter. Key events were logged for 648 of the 787 clients who were active in FSP programs for FY22-23.

Report Methodology. The graphs below compare Emergency Events for **all FSP clients active any time in FY22-23** from the one-year baseline to an **average of emergency events over all years while in the FSP.**

Note that the number of active clients reported for emergency events (n=648) exceeds that for the residential outcomes (n=311), due to the narrower criteria for the latter, which require a minimum of one full year of partnership and no more than 4 years, for inclusion.

Among child clients, fewer emergency events were reported after entering FSP (Exhibit EE-CYF). Compared to baseline trends, there were marked declines across all types of

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

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

Exhibit EE-All. Emergency Events: Comparison of Events from Baseline (pre-FSP) to FSP, all ages (n=648)

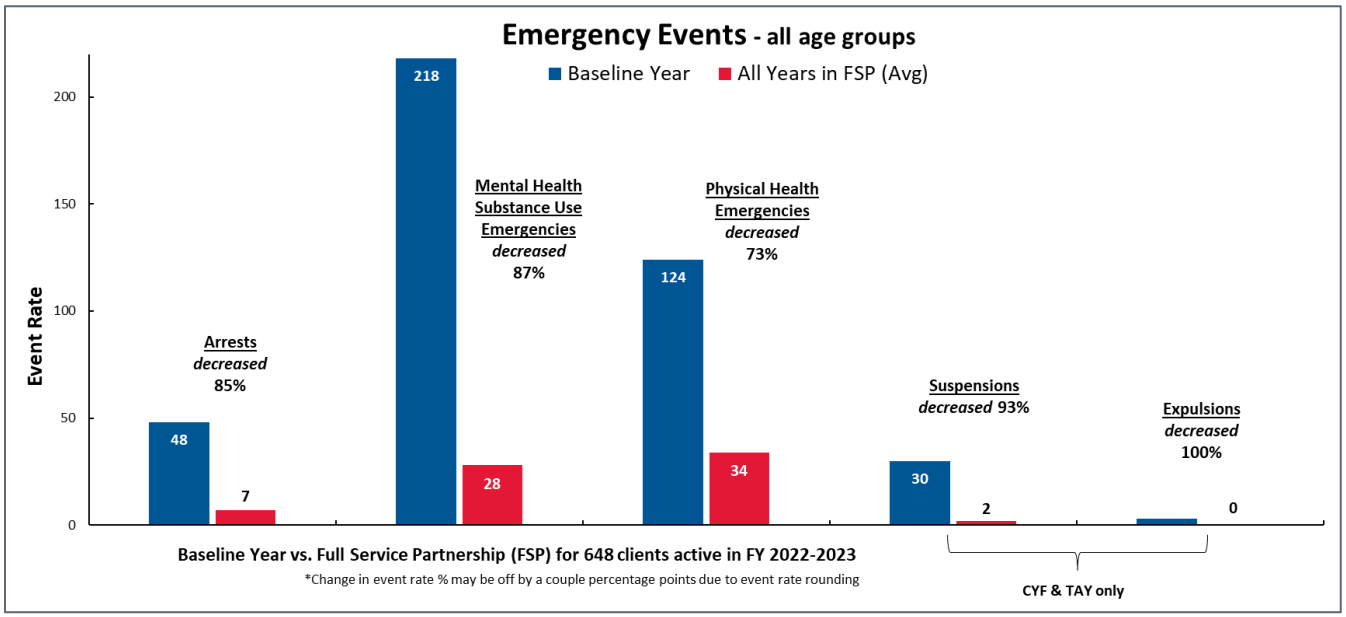
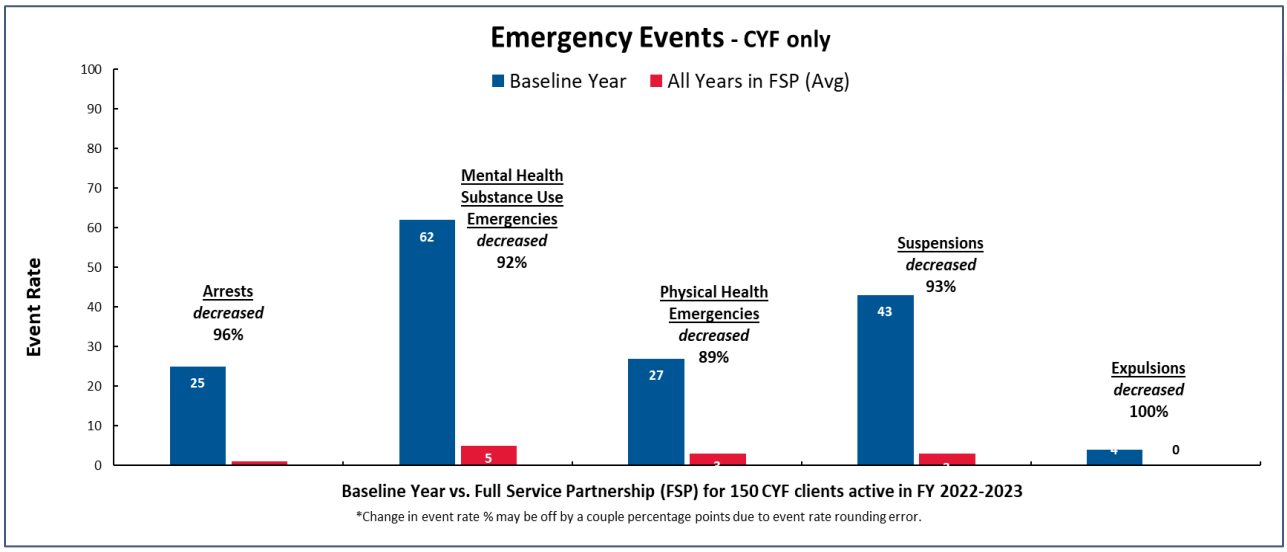


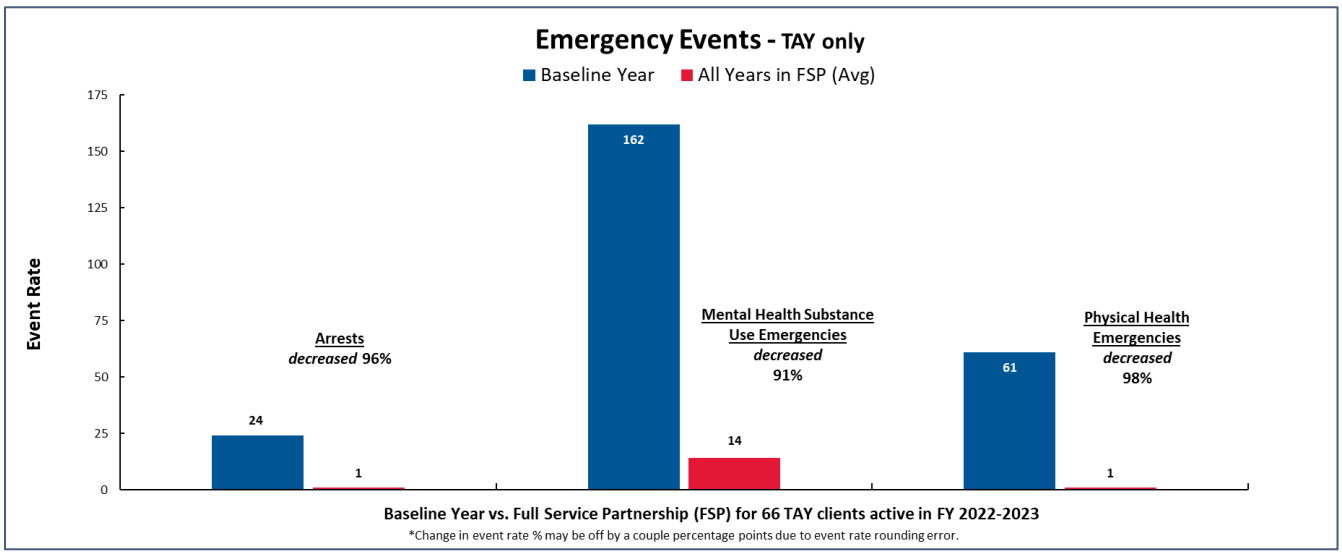
Exhibit EE-CYF, Emergency Events, Comparison of Events from Baseline (pre-FSP) to FSP, CYF only (n=150)



Among TAY clients, fewer emergency events were reported (Exhibit EE-TAY). Declines appear across all emergency events experienced by TAY clients.

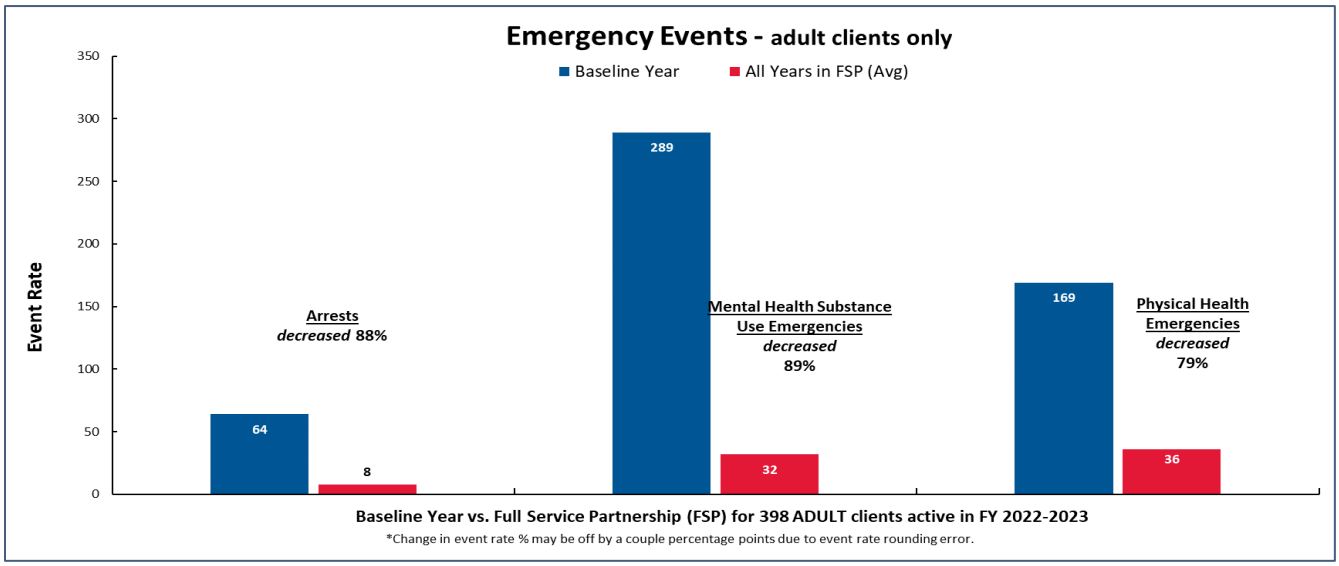
Discharge data also suggest that TAY engagement may be a major challenge (see Exhibit RFD, page 18). Data suggest that TAY clients often leave the FSP programs within the first year of service. Due to challenges in follow-up with the clients, the full sample of TAY clients served may be underestimated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

Exhibit EE-TAY. Comparison of Events from Baseline (pre-FSP) to FSP, TAY only (n=66)



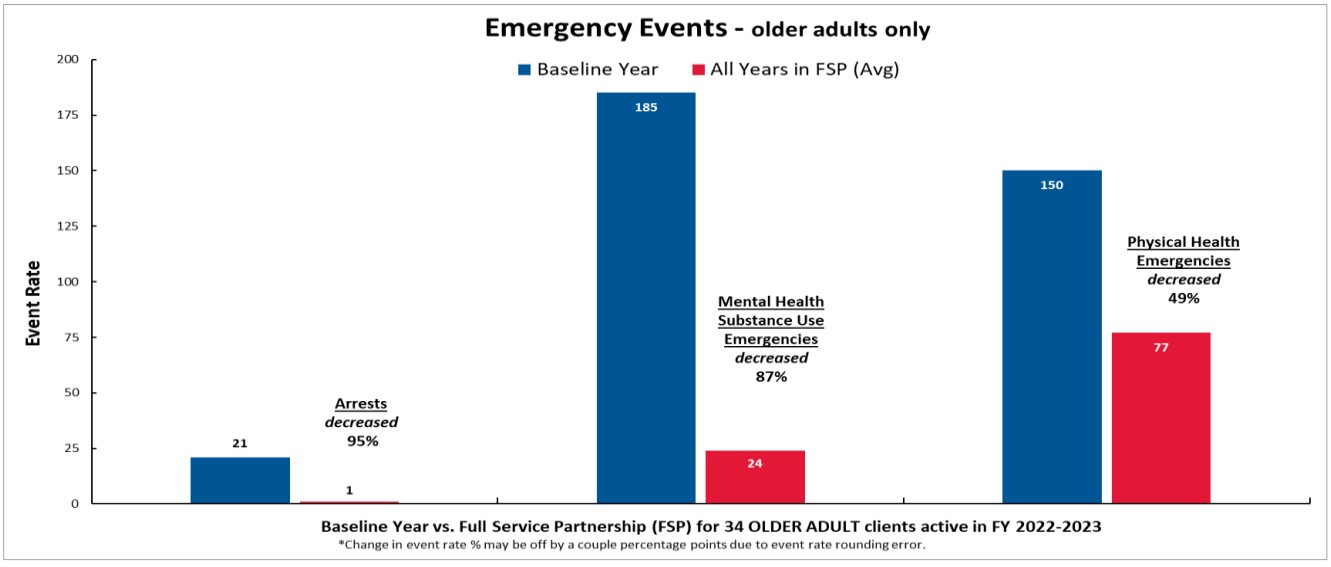
Among Adult clients, fewer emergency events were reported compared to baseline FSP data (Exhibit EE-A). Declines occurred across all emergency events experienced by adult FSP clients. The event rates per client for incidences related to mental/substance abuse health, physical health, and arrests declined by 88%, 89%, and 79%, respectively.

Exhibit EE-A. Comparison of Events from Baseline (pre-FSP) to FSP, Adult Clients only (n=398)



Older Adult clients. While physical health emergencies may be common among older adults, particularly those served by FSP programs, the number of physical health emergencies decreased 49% after at least one year of FSP service. The positive effect may be that FSP case management increases attention to previously untreated medical issues.

Exhibit EE-OA. Comparison of Events from Baseline (pre-FSP) to FSP, Older Adults only (n=34)

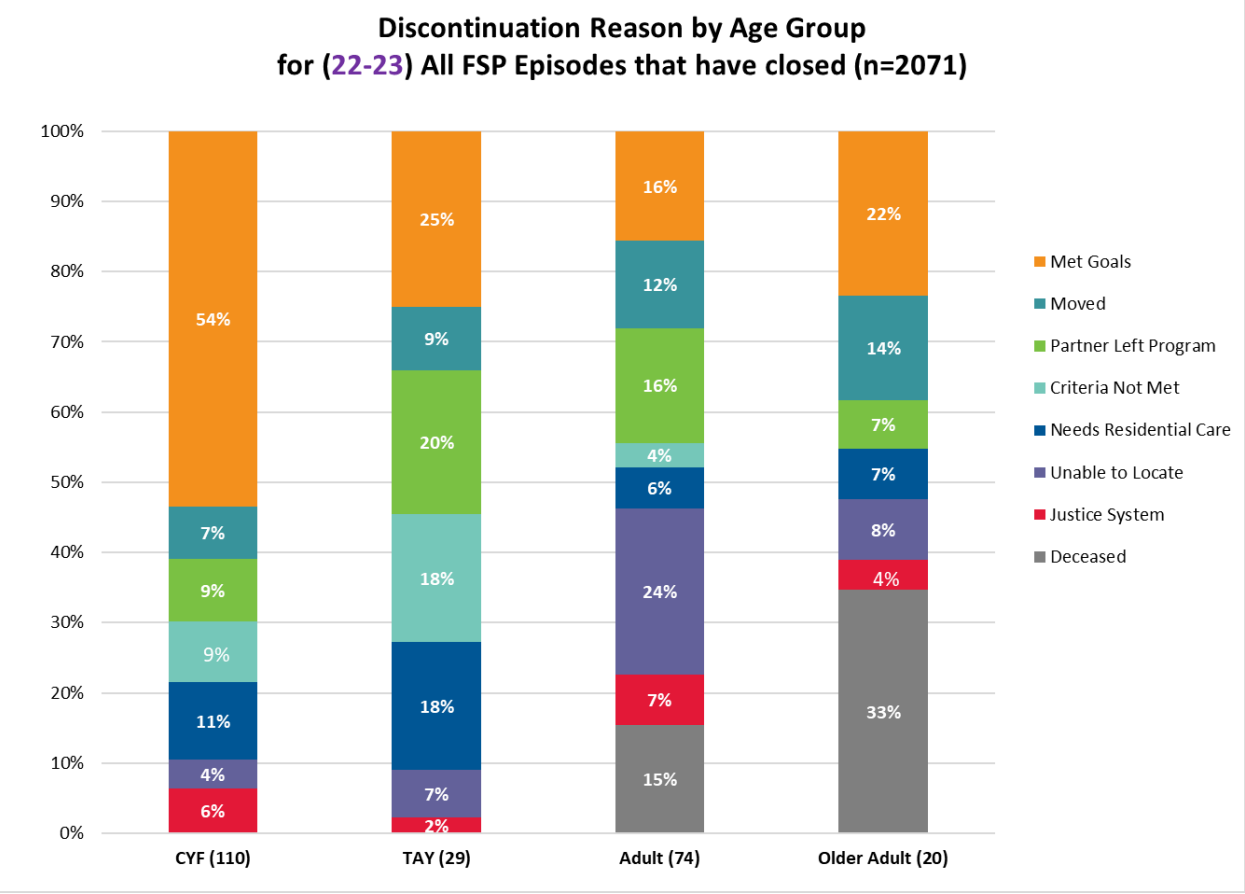


Reason for Discontinuation

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 services are not meeting client needs or clients not ready to engage in treatment.

A total of 2,071 discontinuations have been logged for since FSP inception. Reasons for Discontinuation from FSP varied widely (Exhibit RFD), with the most often reported reason being “Met Goals” (40%).

Exhibit RFD. Reason for Discontinuation for Clients, by Age group



Improving DCR Data Quality

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

San Francisco continues to manage DCR activity through the DCR Workgroup, comprised of MHSA evaluators from BHS Quality Management and an IT staff person. The Workgroup works

with FSP programs to support accurate and timely client data entry into the DCR, in part by generating several data quality and data outcome reports shared frequently with the FSP programs. These reports and data discussions help monitor and increase the level of completion for KETs and Quarterly Assessments.

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

In FY22-23, the DCR Workgroup provided bimonthly virtual DCR user training for new FSP case managers and ongoing support in both data entry and reporting. As has been the case since the inception of the DCR, more communication and support are needed to increase the completion rate of DCR data.

FY22-23 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[1]
Full-Service Partnership (Children)	177 Clients	$1,208,677	$6,829
Full-Service Partnership (TAY)	82 Clients	$1,662,486	$20,274
Full-Service Partnership (Adult)	500 Clients	$4,667,424	$9,335
Full-Service Partnership (Older Adult)	40 Clients	$1,562,152	$39,054

FSP Three-Year Projection

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

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

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

Behavioral Health and Juvenile Justice System Integration

Program Collection Overview

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

Target Populations

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

Behavioral Health and Juvenile Justice System Integration Programs

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

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

Program	FY22-23 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher – Seneca Center and DPH	100% (n<10) of clients with an identified need were referred to behavioral health services and 85% of those referred (n<10) attended three appointments/sessions with community-based providers.

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

Program Overview

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

Target Populations

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

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

Program	FY22-23 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP): also known as (re)MIND – Felton Institute	79% (n=19) of clients enrolled for 12 months or more increased their capacity to cope with challenges.

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

Program Overview

1) BHAC was designed with the goal of ensuring more timely access to behavioral health services and better coordinating intake, placement authorization and referral processes for individuals seeking behavioral health care. BHAC was one of the first projects funded by MHSA. BHAC is a portal of entry into San Francisco's overall system of care and co-locates the following services access support to BHS mental health treatment services including Private Provider Network, outpatient services and intensive services.
2) The Treatment Access Program (TAP) provides assessment, authorization and placement into residential substance use disorder treatment.
3) These services support justice mandated clients with accessing substance use and dual diagnosis treatment
4) BHAC provides co-location with the following programs:
    a. Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opioid Treatment.
    b. The BHS Pharmacy provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol withdrawal management medications for TAP clients, naloxone for opioid overdose prevention, specialty behavioral health medication packaging and serves as a pharmacy safety net for all BHS clients.

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

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

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

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

Target Populations

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

Outcomes, Highlights, and Cost per Client

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

Program	FY22-23 Key Outcomes and Highlights
Behavioral Health Access Center (BHAC) – DPH	Staff provided support to 17,560 San Francisco resident callers seeking access to mental health services.

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

Program Collection Overview

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

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

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

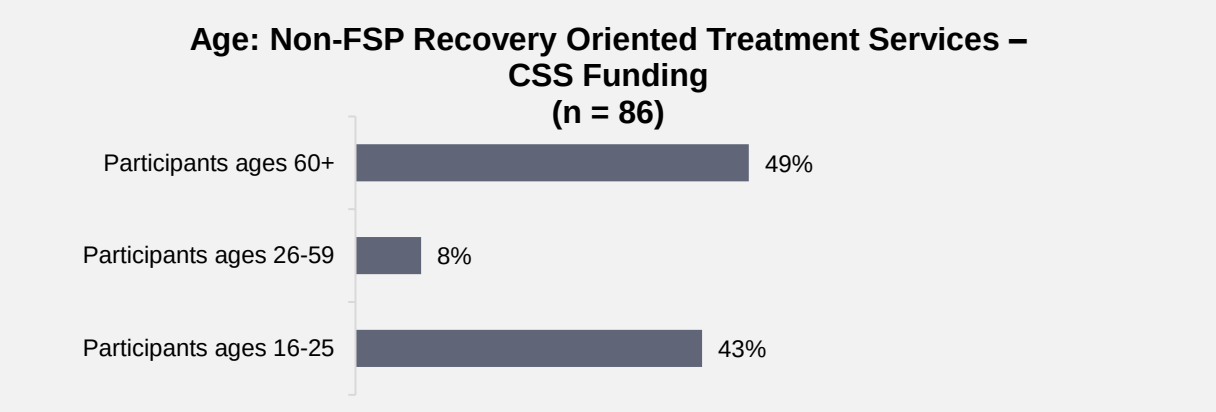
Target Populations

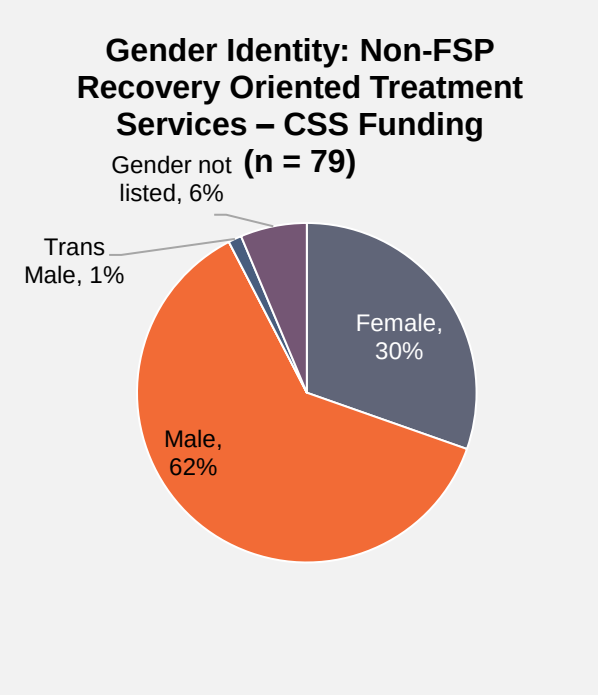
The target populations for these services are individuals and families served in primary care clinics with behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

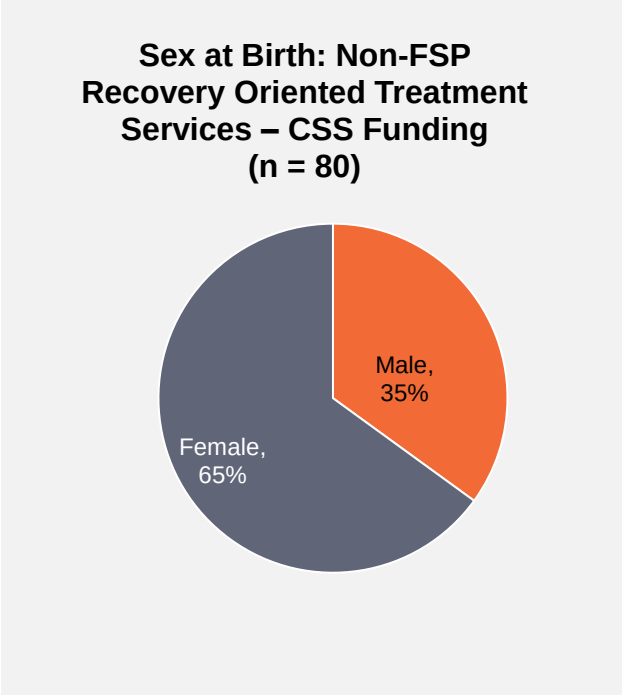
In the following table, numeric values represent the number of units (e.g., participants, events, etc.) reported in providers' year-end reports and percentages represent the portion of the stated goal for the fiscal year that those service units comprise.

Program	FY22-23 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – Curry Senior Center	86% (n=43) of clients who were evaluated by a Curry Clinic Nurse Practitioner for Behavioral Health issues were referred to a Curry Case Manager.

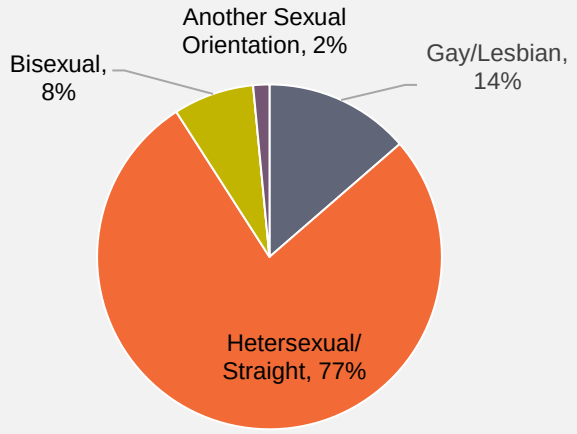
Demographics: Non-FSP Recovery Oriented Treatment Programs



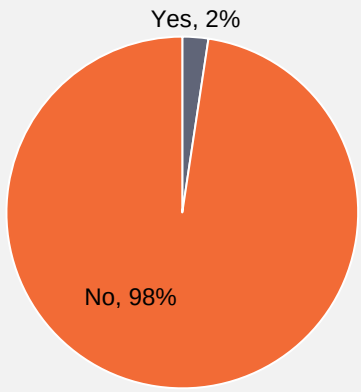




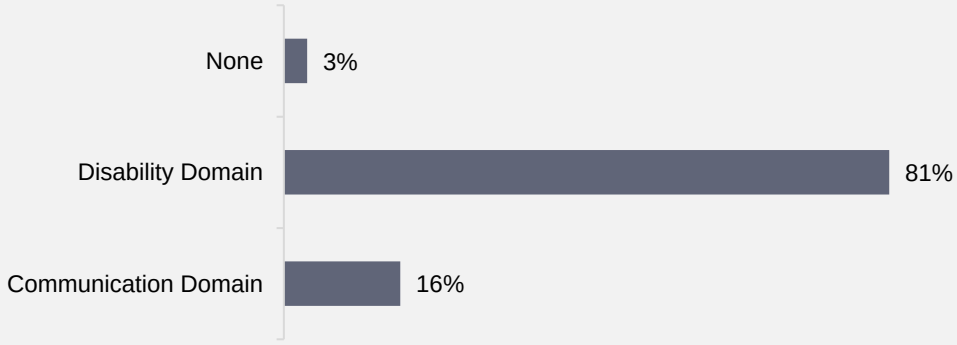
Sexual Orientation: Non-FSP Recovery Oriented Treatment Services – CSS Funding (n = 66)



Veteran Status: Non-FSP Recovery Oriented Treatment Services – CSS Funding (n = 84)



Disability Status: Non- FSP Recovery Oriented Treatment Services – CSS Funding (n = 32)



Race	n	%
Black, African American, or African	18	43%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	10	24%
Native Hawaiian or Pacific Islander	<10	0%
White	13	31%
Other Race	<10	2%
Total	41	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	16	89%
Non-Hispanic/Non-Latina/e/o	<10	0%
More than one Ethnicity	<10	11%
Total	16	100%

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

Primary Language	n	%
Chinese	<10	1%
English	66	84%
Russian	<10	1%
Spanish	<10	11%
Tagalog	<10	1%
Vietnamese	<10	1%
Another Language	<10	0%
Total	66	100%

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

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[2]**
Non-FSP Recovery Oriented Treatment Programs	2,535 Clients	$3,857,203	$1,522

Moving Forward in Recovery-Oriented Treatment Services

Behavioral Health Access Center (BHAC)

Recent changes and project updates for the Behavioral Health Access Center:

- In August 2023, BHAC expanded its hours of operation into the evenings and weekends; with office hours of 8AM-7PM Monday through Friday and 9AM-4PM Saturday and Sunday local Proposition C dollars.
- In November 2023 BHAC and Behavioral Health Access Line (BHAL) both were early adoptees of the EPIC electronic medical record in advance of systemwide implementation in May 2024.
- BHAC and BHAL implemented the use of State mandated screening tools for access to specialty and non-specialty mental health.
- BHAL implemented the use of a new purpose-built telecommunications platform, thus modernizing a system that had not been updated in over 20 years. The new system offers analytic capabilities and assists in triaging and distributing calls efficiently and in threshold languages.
- BHAC implanted the use of a new Customer relations Management system that tracks the total number of present at the program, for any purpose, including anonymous engagements for the distribution of Narcan, fentanyl test strips, hygiene kits, or safer use supplies.
- Through additional funding from the local Proposition C dollars, both BHAC and BHAL were able to hire an additional staff person to support expanded hours of operation.

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

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

Service Category Overview

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

Trans March Resource Fair 2021

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

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

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

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

Target Populations

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

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

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

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

Spotlight on State Peer Certification Training

SF BHS, in partnership with City College of San Francisco (CCSF), was approved as a training site for the **Medi-Cal Peer Support Certification Training**. This training qualifies graduates to apply for the State examination to become State Certified Peer Support Specialists (PSS).

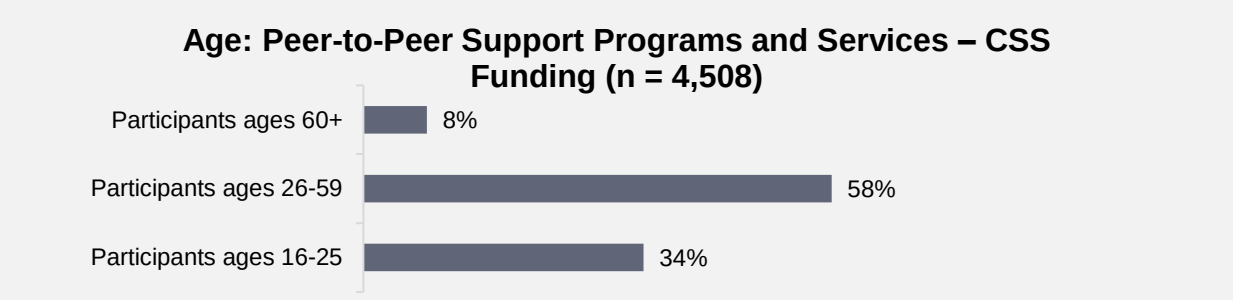
We are now entering our second year as certified PSS trainers and have graduated 70 individuals with another 25 students enrolled for the upcoming semester. In addition to completing the training, graduates earn 5 college credits which they may use towards an associate degree or as electives when transferring to a four-year university. Approximately 90% of our graduates are working in the field, have received a promotion or are furthering their educational journey.

CCSF also developed the first PSS Test Preparation Workship for the PSS State examination and will be offering two additional workshops in the next semester. The workshop covers:

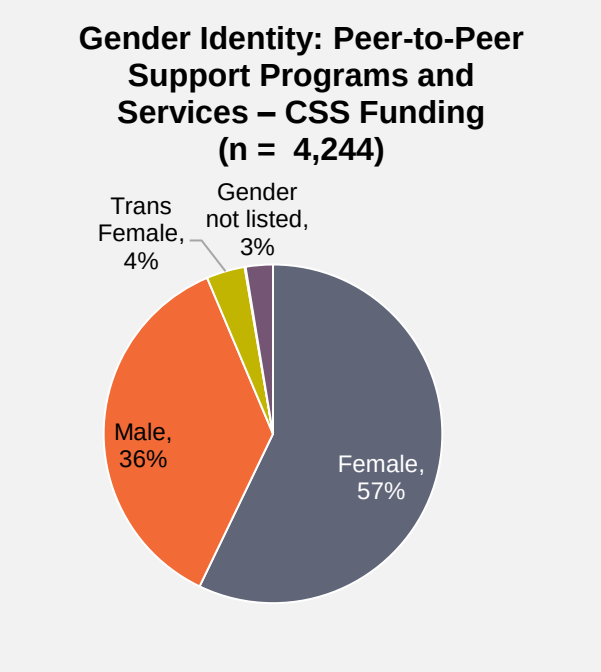
- How to apply for the PSS State Examination
- How to prepare for the examination
- An overview of the 17-core competencies
- Multiple choice exam taking strategies and practice
- Managing test anxiety
- What to expect if taking the test from home (online)
- What to expect when arriving at the testing site (in-person)

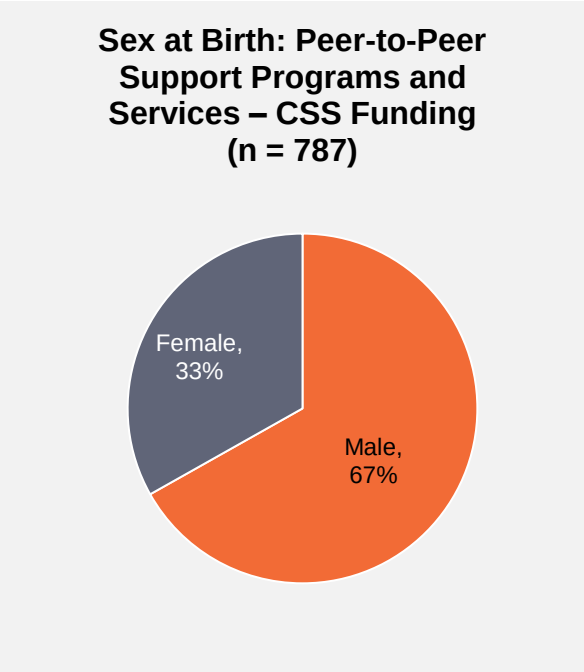
Richmond Area Multi-Services (RAMS) Peer Specialist Mental Health Certificate Program was also certified as a vendor for the **Medi-Cal Peer Support Specialist Core Competency Training** in the summer of 2022. As of December 2023, RAMS has 19 Peer Counselors who have completed and passed the State examination. For the upcoming year, RAMS intends to apply for the Continuing Education Entity component so that our state certified peers are able to gain access to required CEU's for their certification.

Demographics: Peer-to-Peer Support Programs

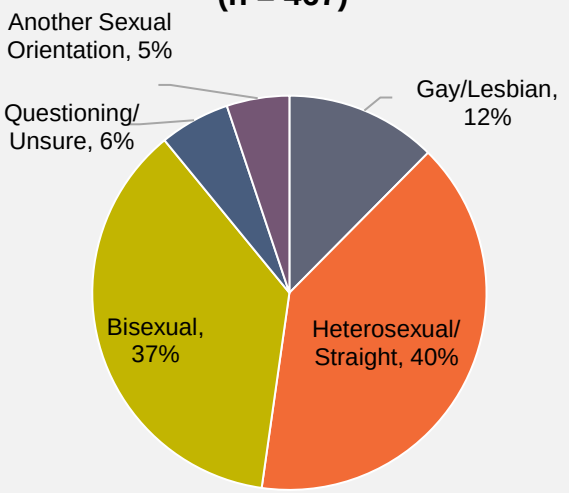


*<1 percent of clients reported data for 0-15; Age

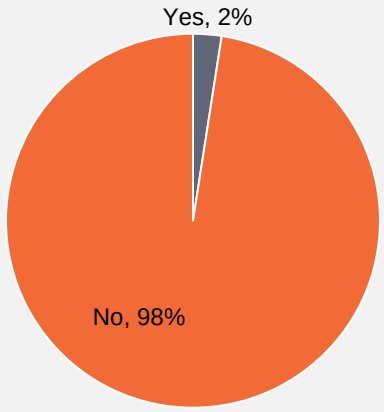




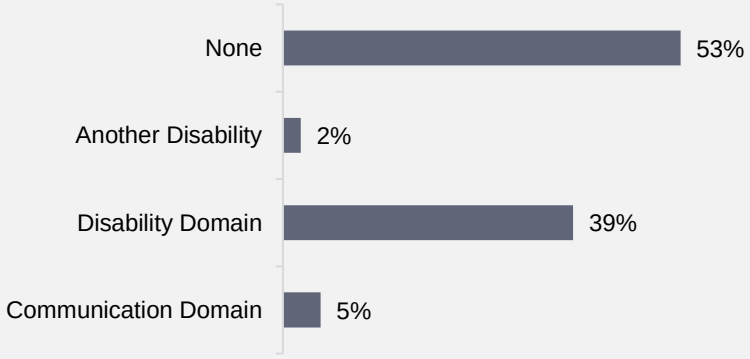
Sexual Orientation: Peer-to-Peer Support Programs and Services – CSS Funding (n = 467)



Veteran Status: Peer-to-Peer Support Programs and Services – CSS Funding (n = 570)



Disability Status: Peer-to-Peer Support Programs and Services – CSS Funding (n = 374)



Race	n	%
Black, African American, or African	393	22%
American Indian, Alaska Native, or Indigenous	31	2%
Asian or Asian American	318	18%
Native Hawaiian or Pacific Islander	21	1%
White	643	36%
Other Race	404	22%
Total	1,810	100%

Primary Language	n	%
Chinese	14	2%
English	622	75%
Russian	<10	1%
Spanish	178	21%
Tagalog	<10	0.2%
Vietnamese	<10	0.2%
Another Language	<10	1%
Total	814	100%

Ethnicity	n	%
Hispanic/Latina/e/o	385	44%
Non-Hispanic/Non-Latina/e/o	395	45%
More than one Ethnicity	89	10%
Total	869	100%

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

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

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Program	FY22-23 Key Outcomes and Highlights
Lifting and Empowering Generations of Adults, Children and Youth (LEGACY) - DPH	75% (n=46) of clients successfully completed at least one self-identified goals.
Peer to Peer, Family to Family - NAMI	95% (n=21) of Peer-to-Peer participants reported an increased understanding of their mental illness and felt better able to recognize signs and symptoms.
Peer Specialist Certificate, Leadership Academy and Counseling – Richmond Area Multi-Services (RAMS)	98% (n=43) of graduates reported they increased their skills and knowledge of peer counseling in the behavioral health field.
Gender Health SF – DPH	95% (n=59) of clients reported the programming was worthwhile.
Peer to Peer Employment - Richmond Area Multi-Services (RAMS)	80% (n=10) of graduates reported improvements in their abilities to manage stress in the workplace.
Peer-to-Peer Linkage Services (RAMS)	96% (n=22) of clients reported they agree the Service Coordinator helped them achieve their agreed upon task/goal.
Transgender Pilot Project – DPH	100% of clients (n=22) reported feeling more hopeful and less alone.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[3]**
Peer-to-Peer Programs	7,436 Clients	$6,312,874	$849

Moving Forward in Peer-to-Peer Support Programs

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

The Peer Specialist Mental Health Certificate Program, ran by Richmond Area Multi-Services, Inc. (RAMS, Inc.) received approval for an Advanced Level Course to become a 3-credit course at SFSU. Historically, only the Entry Level Course has been approved at SFSU. This change will provide additional incentives for peers to enroll and provide a consistent and accessible space conducive to the learning needs of students where the course can take place for each cohort going forward. In addition, the program was approved for additional funding to support increased cost of guest lectures in the program, curriculum development, staff training, increased space rental, cost for the Advanced Course classes and development of improved marketing materials for the program.

SFDPH MHSA's new "Peer Work Investments" project is being launched as a sub-program of the SFMHSA Peer Services to expand peer counseling services. SFMHSA received start-up funds from the State for a Medi-Cal eligible program to launch a new peer billing project.

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

Memorial for Peer Counselors

SF-MHSA Peer Services experienced the loss of five beloved Peer Specialists:

Grace Kwasniak worked as a Peer Counselor across multiple teams during her time at RAMS. She served as a disaster service worker at the TLC Living Room; supported patients with the DPH Whole Person Integrated Care team; and was a beloved member of the team at the Peer Wellness Center. Colleagues of Grace described her as a fierce, uncompromising, authentic, hilarious and relentless advocate for the clients she served.

Thomas Asuncion served as a part of the Peer Division's Operations Team at RAMS for many years. Thomas was described as a good teammate, who was always reliable, responsible and collaborative. His warmth, kindness, and even-keeled temperament will be sorely missed by those working closest to him.

Jacey McDaid was an exceptional peer counselor on the Street Crisis Response Team, the Street Overdose Response Team, and the Post Overdose Engagement Team at RAMS. Jacey's presence was everything that we would hope from a peer counselor on the team: a thoughtful advocate for clients, knowledgeable about navigating the community and system of care, a clear and honest communicator, engaged and attentive, resilient, reflective, empathic, genuine.

Jon Bugatto was a vital member of the Peer Wellness Center leadership teaming, serving as a Peer Supervisor. He was also a part of the first group of staff members deployed to help launch the Tenderloin Linkage Center (TLC) in 2022. Jon's "gentle giant" presence created a sense of safety for clients and staff alike, and his authentic, direct, and non-judgmental communication style built immediate trust and connection in such a refreshing and honest way.

Ivory Nicole Smith was a beloved member of the Gender Health SF community in her role as a Peer Patient Navigator. Ivory was more than just a member of our team; she was a guiding light for those navigating the complexities of transgender healthcare, centering the lived experiences of our most vulnerable community members, Black transgender women. Her dedication to improving the lives of GHSF clients was evident in her tireless efforts to provide peer guidance, support, and resources.

SFMHSA is proud of the dedication that each of these individuals committed to this work. They will be greatly missed.

3. Vocational Services: CSS Funding

Service Category Overview

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

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

Target Population

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

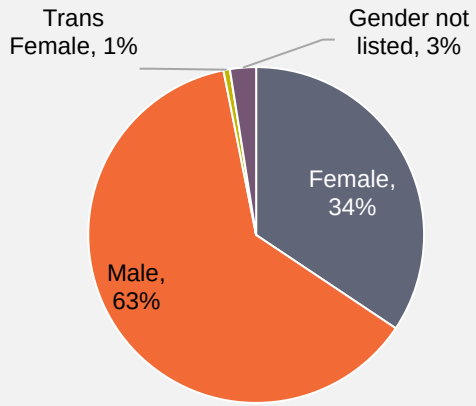
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Department of Rehabilitation Vocational Coop (The Coop) *SFDPH and State of California*	CSS Other Non-FSP 8. Vocational Services (45% FSP)	The San Francisco Department of Rehabilitation (DOR)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

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

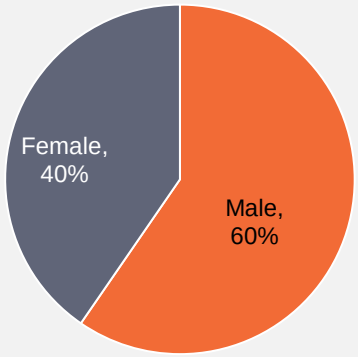
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
i-Ability Vocational IT Program *Richmond Area Multi-Services (RAMS)*		Prepares Clients to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at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

Client Demographics, Outcomes, and Cost per Client

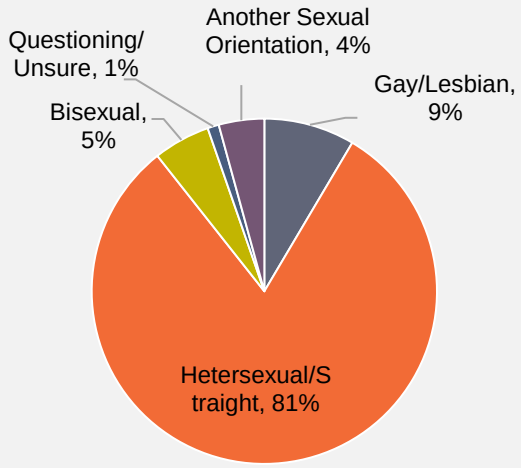
Gender Identity: Vocational Services – CSS Funding (n = 160)



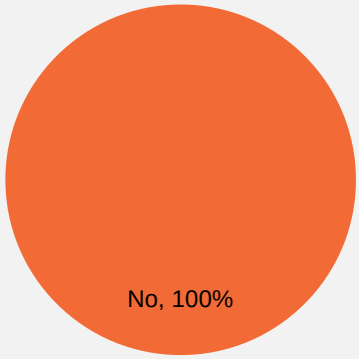
Sex at Birth: Vocational Services – CSS Funding (n = 99)



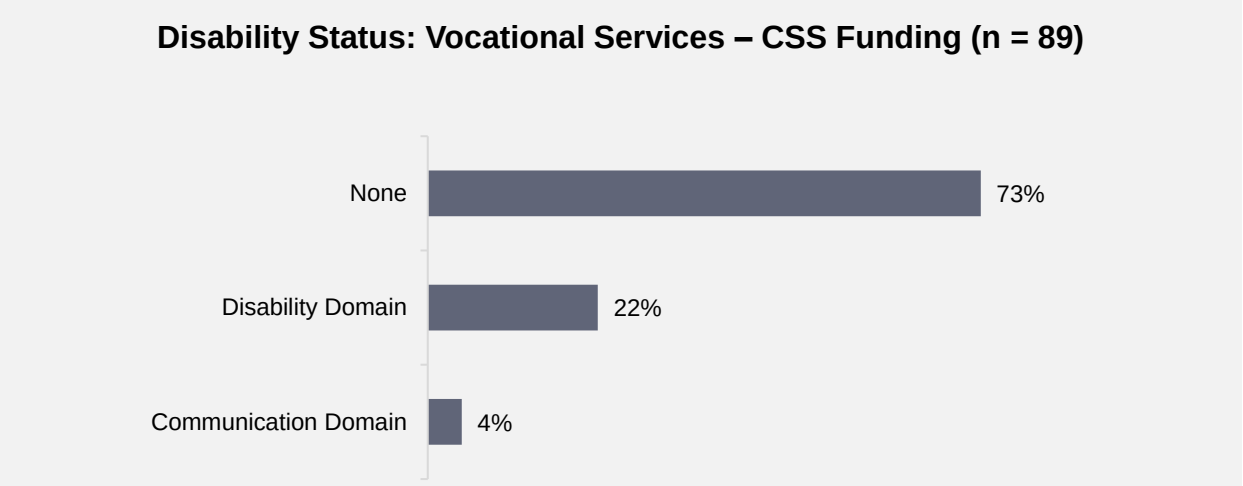
Sexual Orientation: Vocational Services – CSS Funding (n = 94)



Veteran Status: Vocational Services – CSS Funding (n = 101)



Vocational



Race	n	%
Black, African American, or African	39	28%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	35	25%
Native Hawaiian or Pacific Islander	<10	1%
White	43	31%
Other Race	19	14%
Total	136	100%

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

Ethnicity	
Hispanic/Latina/e/o	28
Non-Hispanic/Non-Latina/e/o	112
More than one Ethnicity	<10
Total	140

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

Primary Language	n	%
Chinese	<10	5%
English	114	79%
Russian	<10	1%
Spanish	17	12%
Tagalog	<10	2%
Vietnamese	<10	0%
Another Language	<10	1%
Total	131	5%

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

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

Program	FY22-23 Key Outcomes and Highlights
Department of Rehabilitation Co-op – DPH and California State	41% (n=45) of consumers were placed in employment and 14% (n=15) remained in employment for at least three months.
i-Ability Vocational IT Program - Richmond Area Multi-Services (RAMS)	100% (n=15) of trainee graduates indicated improvements to their coping abilities and an increase in readiness for additional meaningful activities related to vocational services.
First Impressions– UCSF Citywide Employment Program	100% (n<10) of graduates reported improved work readiness skills and confidence to use their new skills.
SF Fully Integrated Recovery Services (SF First) Vocational Project - DPH	85% of enrolled clients were permanently housed and 80% were connected to primary care.
Janitorial Services - Richmond Area Multi-Services (RAMS)	100% (n<10) of clients reported improved workplace coping skills, increased readiness for additional activities related to vocational services, and were interested in engaging in future vocational related activities.
Café and Catering Services - UCSF Citywide Employment Program	100% (n=11) of clients reported an improvement in development of work readiness skills and improved confidence.
Clerical and Mailroom Services - Richmond Area Multi-Services (RAMS)	100% (n<10) of clients reported improvement in their workplace coping skills, readiness for additional activities related to vocational services, and were interested in engaging in future vocational related activities.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) - UCSF Citywide Employment Program	100% (n<10) of participants reported an improvement in work readiness skills and were confident about being able to use the new skills they learned.
Transitional Age Youth Vocational Program - Richmond Area Multi-Services (RAMS)	100% (n<10) of graduates reported their coping abilities improved and an increase in readiness for additional meaningful activities related to vocational services.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[4]**
Vocational Programs	273 Clients	$2,298,106	$8,418

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

Moving Forward in Vocational Services

Vocational service providers will continue to provide robust services moving forward. We have highlighted the following programs to provide updates for the FY24-25 FY:

- UCSF's Citywide Employment Program, Café and Catering Services, is now providing daily baking training to onsite interns to enhance the training program and generate additional revenue. Additionally, the program has been able to attract new clients such as BHSA, UCSF, and the Department of Rehabilitation, due to changes in COVID precautions which allow for food to be provided at departmental meetings.
- UCSF's Citywide Employment Program, First Impressions, now offers a First Impressions Advanced program which provides opportunities for participants to further hone their skills in machine maintenance, work more independently, and shape the direction of their learning to fit their specific skill set. The Advanced program will give the trainees more transferable work skills and experience for their resumes/portfolios.
- Richmond Area Multi-Services, Inc. (RAMS) Hire-Ability TAY Vocational Services Program was limited due to COVID-19 restrictions which delayed the launching of the '22-23 cohorts. As a result, these participants will graduate in FY '23-24 along with the fall '23 and spring '24 cohorts.
- UCSF's Citywide Employment Program, GROWTH (Growing Recovery and Opportunities for Work through Horticulture) Program has prioritized strengthening community partnerships as they allow clients to obtain resources and multiple paths forward to integrate themselves in a productive and meaningful way. One key partnership that is being developed is with the Sutro Stewards, a non-profit that aims at building community through land stewardship and ecological restoration. In partnership with UCSF, Sutro Steward has been hosting the GROWTH Project for the pilot program called Health in Nature. The project aims to increase access to underrepresented and vulnerable communities on Mount Sutro.
- The Department of Rehabilitation Vocational Program plans to hold an Annual Meeting in July 2024 with the DOR and the Co-Op Partners. In FY24-25, the program will prioritize increasing collaboration with new partners, including UCSF and Kaiser.

4. Housing Services: CSS Funding

Service Category Overview

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

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

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

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

<u>Coordinated Entry</u>

Coordinated Entry (CE) is a key component of this response system. CE is a consistent, communitywide process to match people experiencing homelessness to available community resources that are the best fit for their situation. This CE process covers the CoC's entire geographic area. CE constitutes physical access points, a standardized method to assess and prioritize persons needing assistance, and a streamlined process to rapidly connect people to a housing solution. All people experiencing homelessness in San Francisco complete a standardized assessment that considers the household's situation, and prioritizes its HRS placement based on vulnerability, barriers to housing, and chronicity. The most intensive housing interventions are provided to those people in highest need. Permanent housing programs—including permanent supportive housing (PSH) and rapid rehousing (RRH) fill all vacancies from a community pool of Housing Referral Status households generated from the standard assessment process.

The Coordinated Entry System of Record is the Online Navigation and Entry System (ONE), San Francisco's implementation of the Homeless Management and Information System (HMIS). The assessment is entered directly into ONE and referrals to transitional and permanent

housing are made through ONE. This coordinated process drastically reduces the burden on people experiencing homelessness, sparing the rigor of seeking assistance from every individual provider and instead streamlining access to all resources in the HRS.

Emergency Stabilization Units (ESU)

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

FSP Permanent Supportive Housing (PSH)

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

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

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

Housing Placement Services

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

Supportive Services

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

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

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

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

Transitional Housing

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

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

MHSA-Funded Housing for TAY

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

for TAY with serious mental illness such as intake and assessment, life skills training, wrap-around case management, mental health interventions, and peer-based counseling.

Mercy Housing Property Management partners with TAY Support Service Provider, First Place for Youth to provide TAY with 6 MHSA Housing slots at 1100 Ocean Ave Apartments. First Place for Youth supports TAY tenants by offering wrap-around case management, external referrals to behavioral health services, housing retention support, education, and employment services. In November 2023, First Place for Youth began partnering with DPH's Permanent Housing Advanced Clinical Services (PHACS) team to offer TAY tenants on-site mobile care solutions and connections to longer-term medical and/or behavioral health service support.

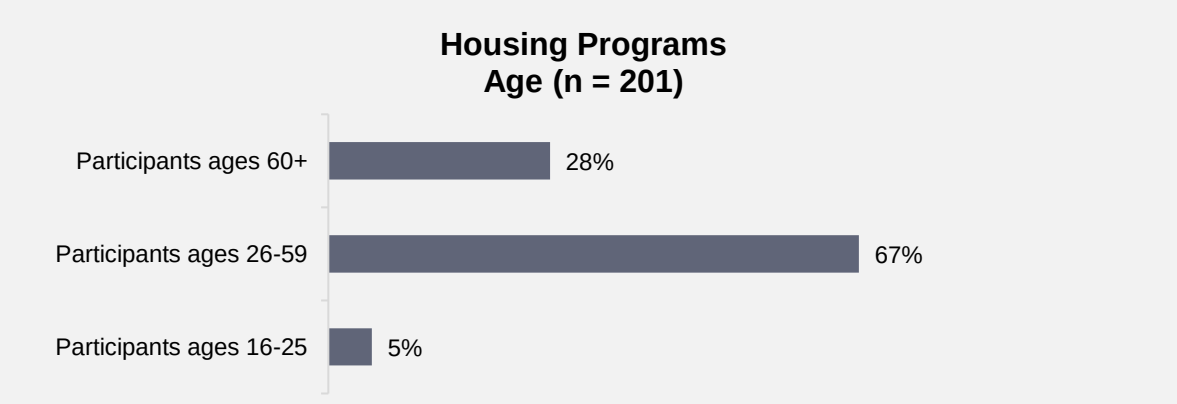
Program Names	Name Listed on ARER and Budget
Emergency Stabilization Housing	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)
Full-Service Partnership Permanent Supportive Housing	CSS FSP Permanent Housing (capital units and master lease)
Housing Placement and Support	CSS Other Non-FSP 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)

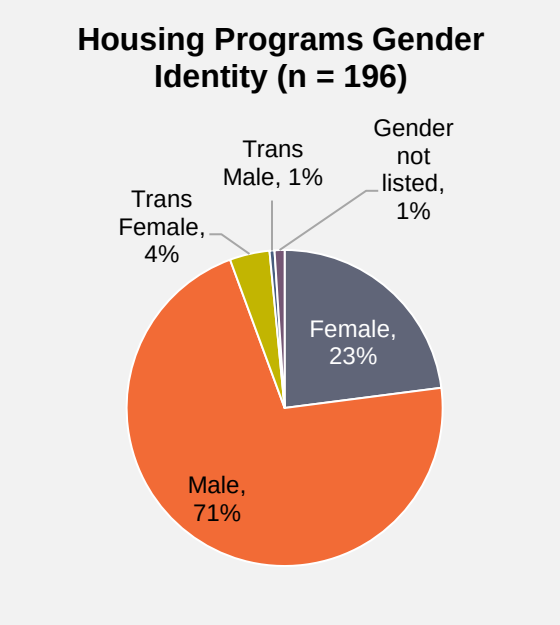
MHSA-Funded PSH Housing: FY22-23						
MHSA Housing Site	**Operator**	**MHSA Units**	**Target Population**	**Services**	**Type of Project**	**Referral Source**
Cambridge	CHP	7	Adults	CHP + FSP	HSH Supportive Housing	CE
Iroquois	CHP	10	Adults	CHP + FSP	HSH Supportive Housing	CE
Rene Cazenave	CHP	7	Adults	Citywide + FSP	MHSA Capital	CE
Richardson	CHP	13	Adults	Citywide + FSP	MHSA Capital	CE
San Cristina	CHP	9	Adults	CHP + FSP	HSH Supportive Housing	CE
Senator	CHP	6	Adults	CHP + FSP	HSH Supportive Housing	CE
Camelot	DISH	4	Adults	HSH + FSP	HSH Supportive Housing	CE
Empress	DISH	4	Adults	HSH + FSP	HSH Supportive Housing	CE
LeNain	DISH	8	Adults	HSH + FSP	HSH Supportive Housing	CE

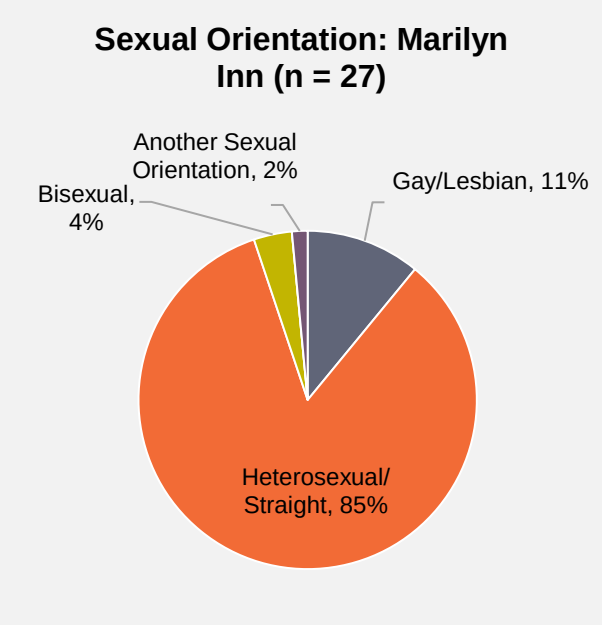
Star	DISH	6	Adults	HSH + FSP	HSH Supportive Housing	CE
Aarti/ Routz	Larkin St.	29	TAY	Larkin - All	MHSA GF – TH	BHS Placement
1100 Ocean	Mercy	6	TAY	FPFY + FSP	MHSA Capital	BHS Placement
Veterans Commons	Swords	12	Veterans	Swords/VA + FSP	MHSA Capital	BHS Placement
Ambassador	TNDC	9	Adults	TNDC + FSP	HSH Supportive Housing	CE
Dalt	TNDC	13	Adults	TNDC + FSP	HSH Supportive Housing	CE
Kelly Cullen	TNDC	17	Adults	TNDC + FSP	MHSA Capital	CE
Polk Senior	TNDC	9	Seniors	LSS + FSP	MHSA Capital	CE
Ritz	TNDC	2	Adults	TNDC + FSP	HSH Supportive Housing	CE
Willie B. Kennedy	TNDC	3	Seniors	NCHS + FSP	MHSA Capital	CE
TOTAL UNITS		**173**				

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

Demographics and Length of Stay: Housing Programs[5]

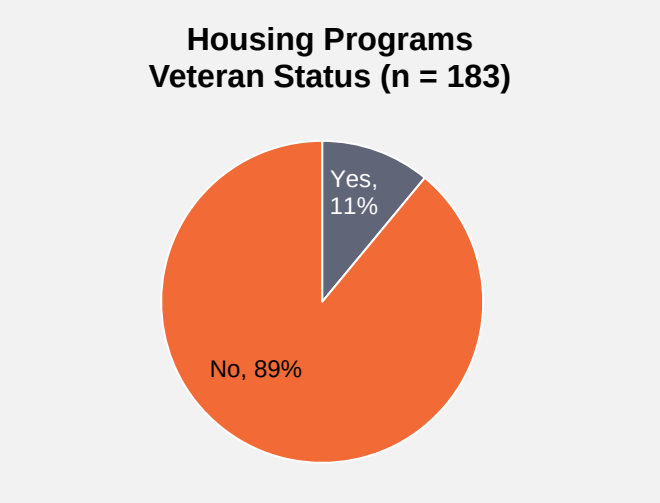






Sexual orientation data was not available for 1100 Ocean, 990 Polk Aarti, Ambassador Hotel, Cambridge, Camelot Hotel. Dalt Hotel, Empress, Iroquois Hotel, Kelly Cullen Community, Le Nain Hotel, Rene Cazenave Apartments, Richardson Apartments, Ritz Hotel, San Cristina, Senator Hotel, Star Hotel, Veterans Commons, and Willie B. Kennedy.

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



Race/Ethnicity	n	%
Black, African American, or African	64	34%
American Indian, Alaska Native, or Indigenous	<10	2%
Asian or Asian American	13	7%
Native Hawaiian or Pacific Islander	<10	2%
White	64	34%
Hispanic/Latina/e/o	<10	4%
Multi-Racial	29	15%
Other Race	<10	3%
Total	170	100%

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

Length of Stay

	n	%
Less than a Year	31	18%
1 Year	23	13%
2 Years	11	6%
3 Years	14	8%
4 Years	18	10%
5+ Years	76	44%
Total	173	100%

*6/30/23 was used as reference date for current residents.

Please note: Length of Stay data was not available for Marilyn Inn.

ESU Housing Programs[6]

Emergency Stabilization Units (ESUs)[7]
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)

Moving Forward in Housing Services

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

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

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

[6] In the demographic charts, "n" sizes vary if data was not fully available for any individual variable(s).
[7] There is no new ESU housing data to report in FY22/23 as the provider changed data tools.

expanded into the first NPLH supportive housing site that opened in winter 2022 and is currently serving over 40% of PSH programs.

In Fall 2022, 1064-1066 Mission completed construction by adding two adjacent new permanent supportive housing sites with 153 units of housing for adults experiencing homelessness and 103 units for seniors experiencing homelessness. The Round 1 NPLH award was disbursed in its entirety to this project, including 76 units for adults and 51 units for seniors (127 total NPLH units). The building completed lease-up in January 2023. It provides 256 studio apartments with a continuum of on-site services including intensive case management, nursing, the IHSS CCST program and community engagement activities.

Moving forward, there are new NPLH projects under development. Construction began in summer 2022 on 600 7th Street. The building is expected to open in summer 2024 and will include 70 NPLH units for adults and families experiencing homelessness. 730 Stanyan Street will include 12 NPLH units for transition age youth (TAY) and families experiencing homelessness and started construction in summer 2023. 78 Haight Street will include 15 NPLH units for TAY experiencing homelessness. This project is expected to begin construction in 2023 and should be completed in late 2025. 71 Boardman Place, a new PSH site that will include up to 45 NPLH units, is expected to start construction in spring 2025. Lastly, the Mayor's Office of Housing and Community Development (MOHCD), HSH and SFDPH meet regularly to plan for future PSH projects that are a good fit for NPLH funding.

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

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

Service Category Overview

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

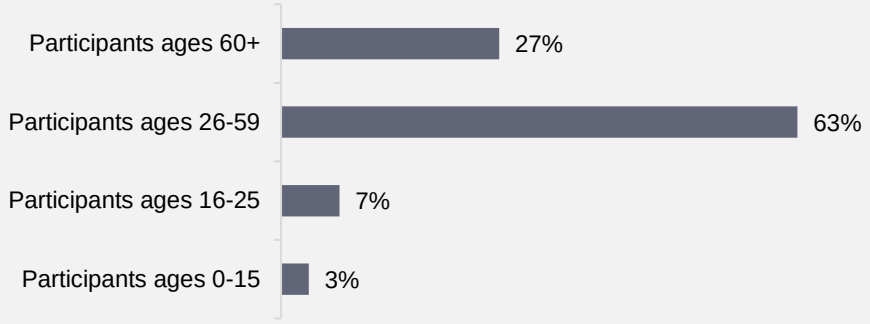
1. Stigma Reduction
2. School-Based Mental Health Promotion;
3. Population-focused Mental Health Promotion;
4. Mental Health Consultation and Capacity Building; and
5. Comprehensive Crisis Services

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

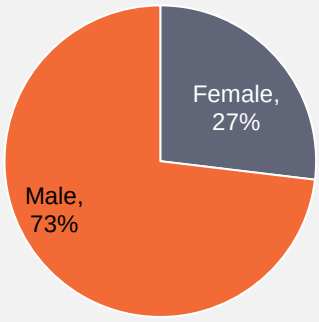
CALIFORNIA MHSA PEI Category	SF-MHSA PEI Programming
1. Prevention Programs	All Population-Focused Programs and School-Based Programs are Prevention Programs
2. Early Intervention Services	All Population-Focused Programs and ECMHCI are Early Intervention Programs.
3. Outreach for Increase Recognition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

Demographics: All PEI Programs

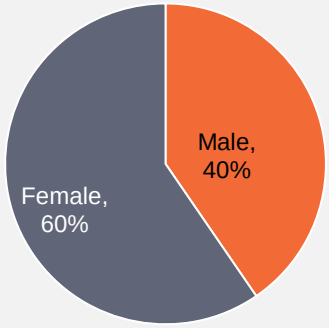
Age: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 51,673)



Gender Identity: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 49,721)

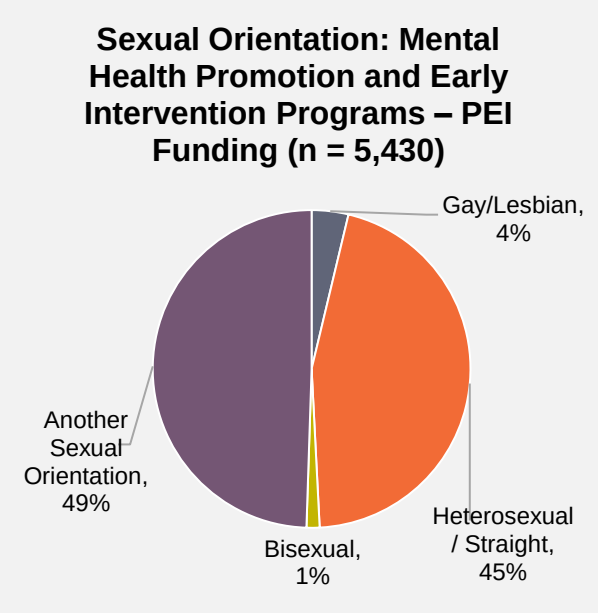


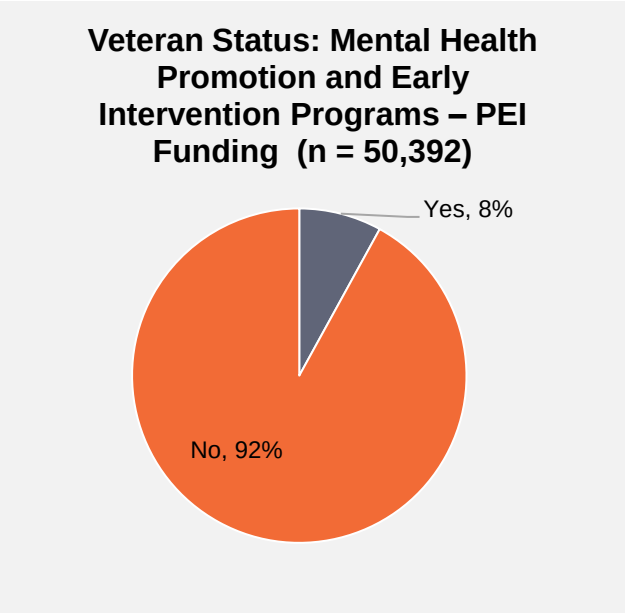
Sex at Birth: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 5,430)



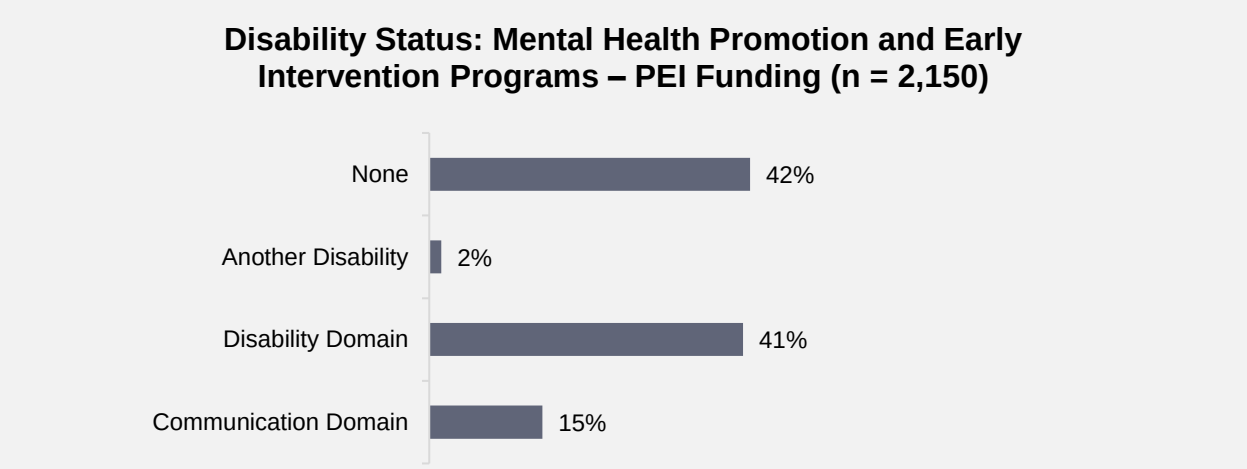
*< 1 percent of clients reported data for Another gender identity not listed, Trans Male; Gender

PEI





*< 1 percent of participants reported Questioning/Unsure; Sexual Orientation



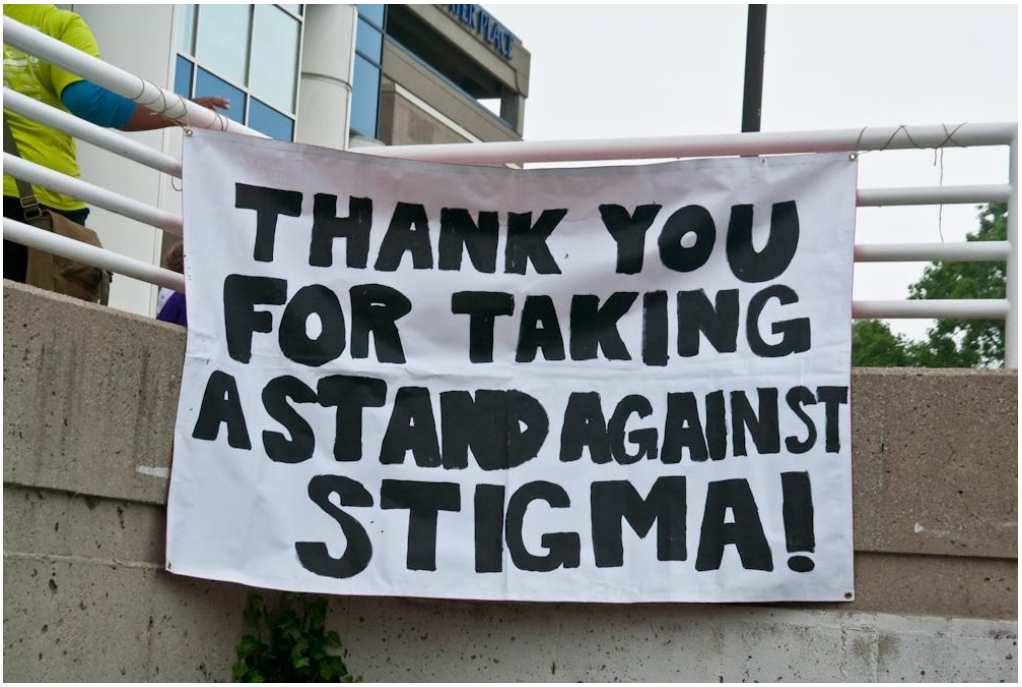
Disability status data was not available for Mental Health Promotion and Early Intervention – Comprehensive Crisis Services.

Race	n	%
Black, African American, or African	14,694	30%
American Indian, Alaska Native, or Indigenous	1,062	2%
Asian or Asian American	7,052	14%
Native Hawaiian or Pacific Islander	545	1%
White	16,805	34%
Other Race	9,188	19%
Total	49,346	100%

Ethnicity	n	%
Hispanic/Latina/e/o	7,636	88%
Non-Hispanic/Non-Latina/e/o	796	9%
More than one Ethnicity	264	3%
Total	8,696	100%

Primary Language	n	%
Chinese	323	6%
English	3,462	63%
Russian	<10	0%
Spanish	933	17%
Tagalog	41	1%
Vietnamese	572	10%
Another Language	152	3%
Total	5,483	6%

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



PEI

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

Program Overview

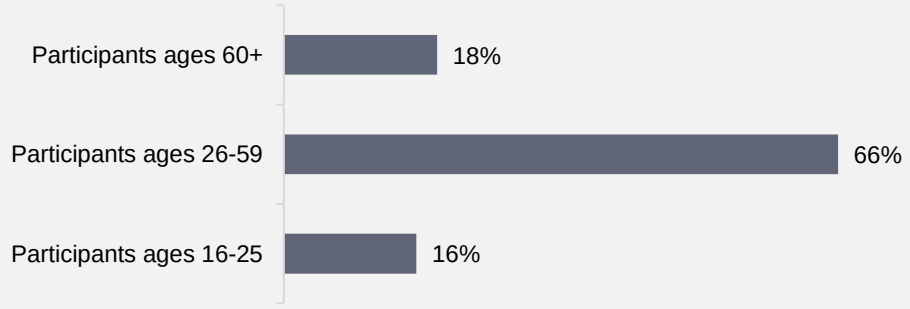
Peer Outreach and Engagement Services – Mental Health Association of San Francisco is funded by both CSS and PEI funding. The program is divided into three components:

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

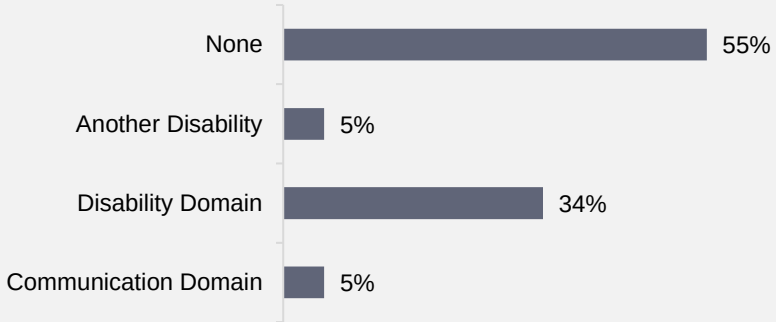
Client Demographics, Outcomes, and Cost per Client

Demographics: Stigma Reduction

Age: Mental Health Promotion and Early Intervention Programs - Stigma Reduction (n = 488)

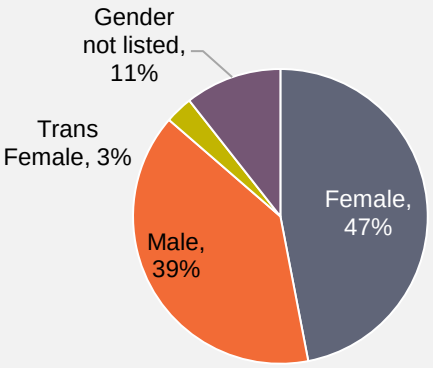


Disability Status: MH PEI - Stigma Reduction (n = 56)

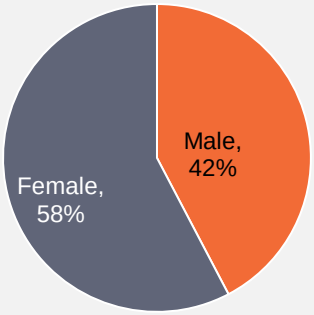


PEI

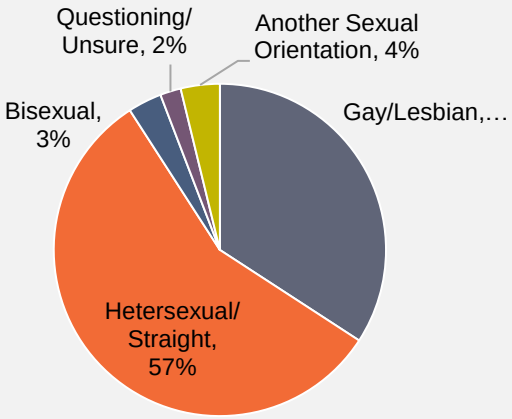
Gender Identity: Mental Health Promotion and Early Intervention - Stigma Reduction (n = 66)



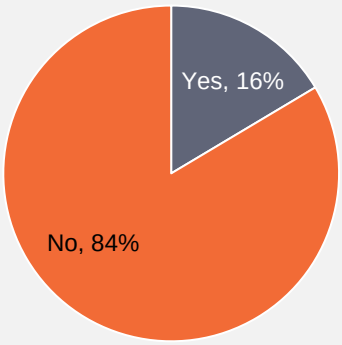
Sex at Birth: Mental Health Promotion and Early Intervention Programs - Stigma Reduction (n = 26)



Sexual Orientation: Mental Health Promotion and Early Intervention – Stigma Reduction (n = 395)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Stigma Reduction (n = 73)



PEI

Race	n	%
Black, African American, or African	48	26%
American Indian, Alaska Native, or Indigenous	<10	5%
Asian or Asian American	21	12%
Native Hawaiian or Pacific Islander	<10	4%
White	82	45%
Other Race	15	8%
Total	166	100%

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

Primary Language	n	%
Chinese	<10	0%
English	43	100%
Russian	<10	0%
Spanish	<10	0%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	43	0%

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

Ethnicity	n	%
Hispanic/Latina/e/o	29	48%
Non-Hispanic/Non-Latina/e/o	19	31%
More than one Ethnicity	13	21%
Hispanic/Latino	61	100%

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

Program	FY22-23 Key Outcomes and Highlights
Peer Outreach and Engagement Services – Mental Health Association of San Francisco	85% (n=24) of Support and Wellness participants reported feeling less isolated.

PEI

FY22-23 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[8]
Stigma Reduction	654 Clients	$143,838	$220

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

School-Based Mental Health Promotion (K-12)

Program Overview

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

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

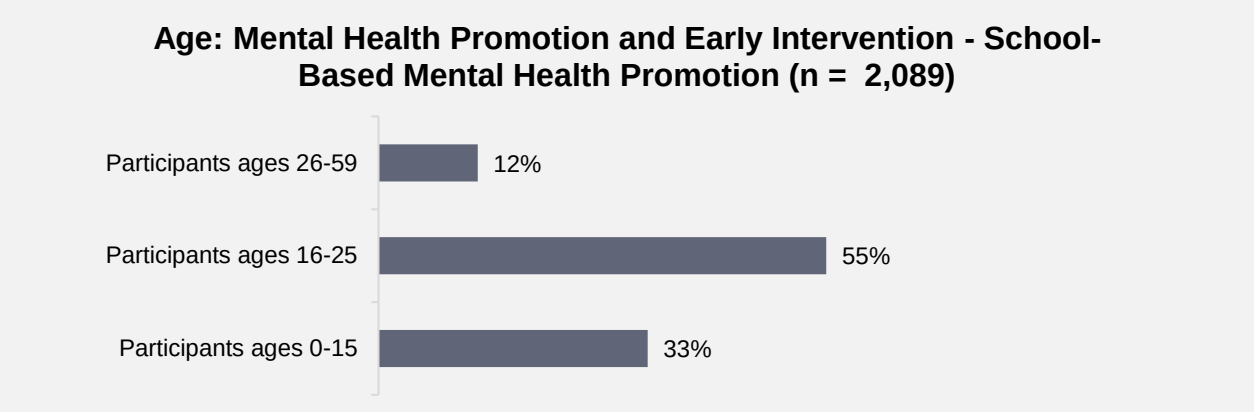
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To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

Target Populations

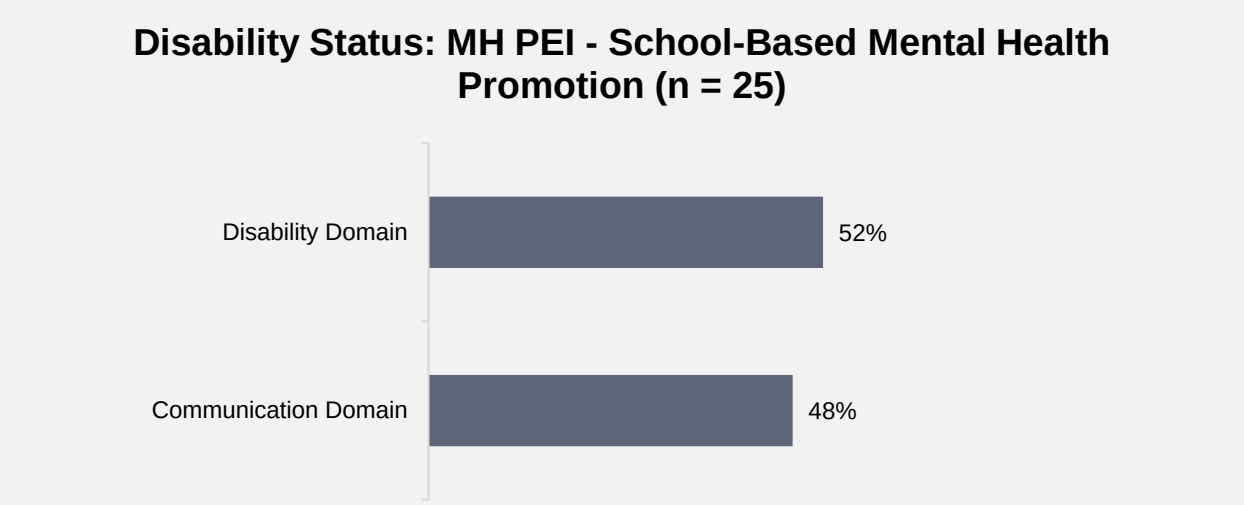
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

Client Demographics, Outcomes, and Cost per Client

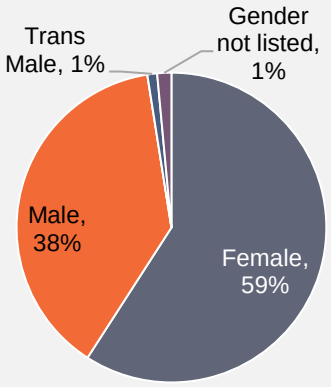
Demographics: School Based Prevention (K-12)



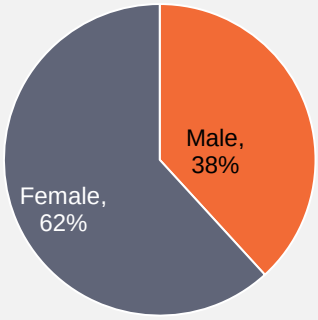
*< 1 percent of participants reported data for ages 60+; Age



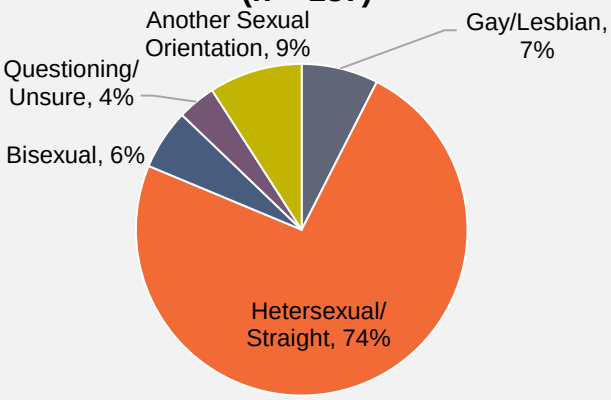
Gender Identity: Mental Health Promotion and Early Intervention - School-Based Mental Health Promotion (n = 883)



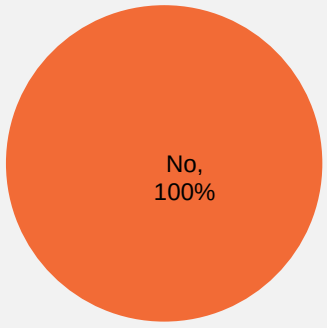
Sex at Birth: Mental Health Promotion and Early Intervention Programs - School-Based Mental Health Promotion (n = 793)



Sexual Orientation: Mental Health Promotion and Early Intervention – School-Based Mental Health Promotion (n = 187)



Veteran Status: Mental Health Promotion and Early Intervention Programs - School-Based Mental Health Promotion (n = 2,353)



PEI

Race	n	%
Black, African American, or African	146	27%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	208	38%
Native Hawaiian or Pacific Islander	<10	1%
White	85	16%
Other Race	95	18%
Total	534	100%

Primary Language	n	%
Chinese	54	4%
English	1,182	83%
Russian	<10	0%
Spanish	183	13%
Tagalog	<10	0%
Vietnamese	<10	0.1%
Another Language	<10	0.2%
Total	1,419	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	298	60%
Non-Hispanic/Non-Latina/e/o	128	26%
More than one Ethnicity	73	15%
Total	499	100%

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

Program	FY22-23 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - Bayview Hunter's Point Foundation	100% of vacant positions were filled ensuring the program was operating at full staff capacity.
Mental Health Services – Edgewood Center for Children and Families	67% (n<10) of classroom teachers reported feeling more successful in dealing with challenging student behaviors.
Youth Early Intervention – Instituto Familiar de la Raza	81% (n<10) of staff who received consultation services reported being satisfied with the services they received from the consultant.
Wellness Centers – Richmond Areas Multi-Services (RAMS)	97% (n=186) of students reported they would recommend therapy to a friend, 75% (n=207) reported learning ways to cope with stress, and 53% (n=150) reported improvements in their relationships with friends and/or family.

FY22-23 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[9]
School-Based Mental Health Promotion (K-12)	3,545 Clients	$1,114,066	$314

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

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

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

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

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

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SF MHSA Service Provider, Hospitality House Self-Help Center

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

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

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

PEI

Target Populations

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

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

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

through culturally tailored outreach and services. These population-focused services acknowledge and incorporate clients' cultural backgrounds, including healing practices, rituals and ceremonies, 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 the programs emphasize outreach and engagement to a very specific population group.

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

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name *Provider***	**Services**
	Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional 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)*	Serves Filipino, Samoan and Southeast Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Latinx including Indigenous Mayan communities	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	Serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance *Native American Health Center*	Serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.

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

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

Spotlight on Black/African American Maternal Health Program

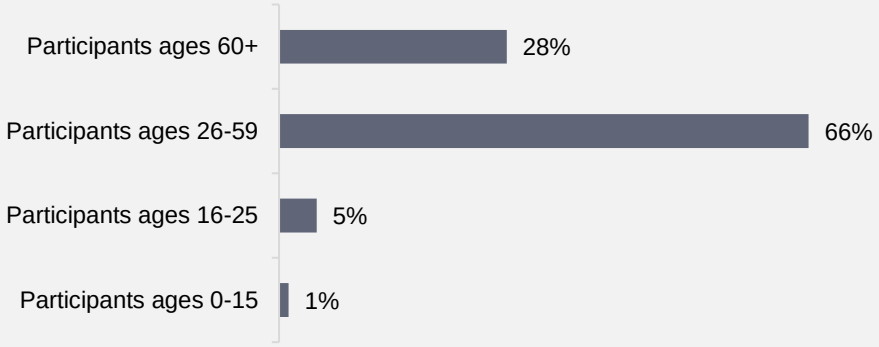
The Black/African American Mental Health Program is a collaboration between MHSA and the San Francisco Department of Public Health's Maternal, Child Adolescent Health Section. It focuses on providing equitable, trauma-informed, and culturally responsive mental health prevention and treatment care. Through the provision of outreach and promotion, mental health services, linkage, and workforce training, this program builds and expands the capacity of the behavioral health system to serve a population that has experienced disparities in care and health outcomes.

In FY24-25, UCSF, RAMS, Rafiki and Homeless Children's Network will collaborate to implement holistic mental health prevention and promotion services and trauma-informed, culturally congruent approaches to pregnancy, perinatal and postpartum mental health care. They will also be providing workforce development and training to ensure a culturally appropriate peer and mental health practitioner workforce equipped to serve this population and establish peer support networks. This program will work on building partnerships with health providers, both hospital and community-based, and providing comprehensive culturally congruent support to clients, including mental health therapy, childbirth education, prenatal and postpartum groups, doula and lactation support, and father support groups.

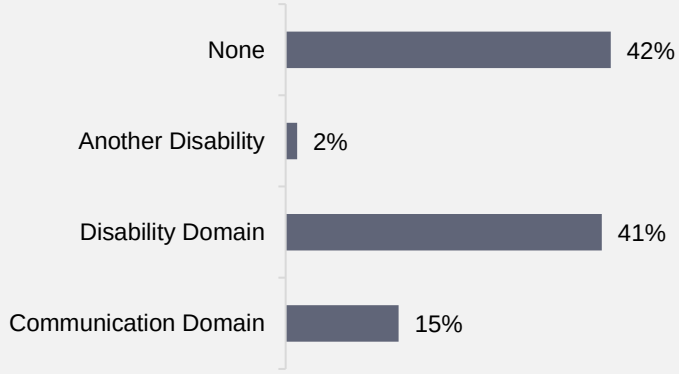
Client Demographics, Outcomes, and Cost per Client

Demographics: Population Focused Mental Health

Age: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion Programs (n = 47,915)

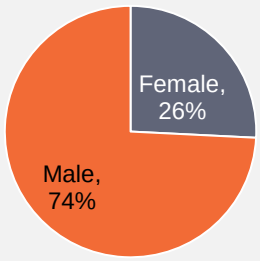


Disability Status: MH PEI - Population-Focused Mental Health Promotion Programs (n = 2,066)

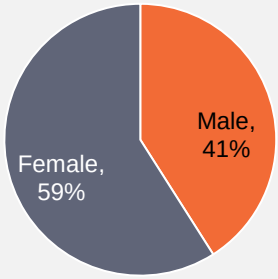


PEI

Gender Identity: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion (n = 48,059)

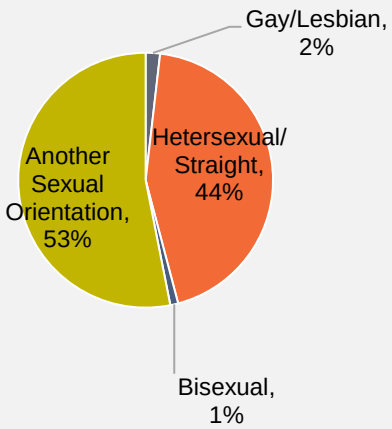


Sex at Birth: Mental Health Promotion and Early Intervention – Population-Focused Mental Health Promotion (n = 3,984)

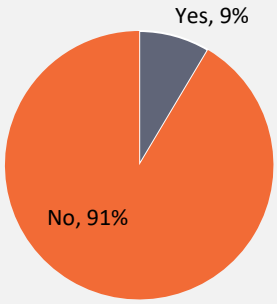


*< 1 percent of participants reported data for Another gender identity not listed, Trans Female, Trans Male; Gender

Sexual Orientation: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion Programs (n = 6,708)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Population-Focused Mental Health Promotion Programs (n = 46,904)



*< 1 percent of participants reported Questioning/Unsure; Sexual Orientation

PEI

Race	n	%
Black, African American, or African	14,205	30%
American Indian, Alaska Native, or Indigenous	1,048	2%
Asian or Asian American	6,606	14%
Native Hawaiian or Pacific Islander	520	1%
White	16,334	34%
Other Race	8,810	19%
Total	47,523	100%

Ethnicity	n	%
Hispanic/Latina/e/o	298	60%
Non-Hispanic/Non-Latina/e/o	128	26%
More than one Ethnicity	73	15%
Total	499	100%

Primary Language	n	%
Chinese	166	6%
English	1,282	49%
Russian	<10	0.2%
Spanish	437	17%
Tagalog	<10	2%
Vietnamese	569	22%
Another Language	131	5%
Total	2,585	100%

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

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

Program	FY22-23 Key Outcomes and Highlights
Senior drop-in Center – Curry Senior Center	87% (n=150) of participants who attended at least three activities reported increased socialization.
Addressing the Needs of Socially Isolated Older Adults – Curry Senior Center	97% (n=61) of isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services (including case management, substance use, mental health, and social support groups).
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	92% (n=77) of participants who received short-term, time-limited therapeutic services agreed they felt better as a result of participating in therapeutic activities.
Indigena Health and Wellness Collaborative	100% (n=67) of individuals receiving non-clinical case management achieved at least one goal in their case/care plan.

Program	FY22-23 Key Outcomes and Highlights
– Instituto Familiar de la Raza	
Living in Balance – Native American Health Center	60% (n=27) of individuals who received one-on-one therapeutic counseling services completed at least one behavioral health service goal.
South of Market Self-Help Center (6th Street) – Central City Hospitality House	72% (n=78) of participants with a written case plan achieved at least one case plan goal.
Tenderloin Self-Help Center - Central City Hospitality House	58% (n=62) of community members with a written case plan achieved at least one case plan goal.
Community Building Program - Central City Hospitality House	77% of participants (n=53) of clients achieved at least one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - Instituto Familiar de la Raza	100% (n=27) of transition age youth who were connected by program staff to internal behavioral health services attended an initial appointment or meeting.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander - Community Youth Center	91% (n=21) of Asian/Pacific Islander transition age youth who participated in at least three case management sessions successfully attained at least one of their treatment goals.
Population Specific TAY Engagement and Treatment – LGBTQ+ - SF LGBT Center	100% (n=53) of transition age youth enrolled in Mental Health services were connected to internal behavioral health related treatment services.
Population Specific TAY Engagement and Treatment – Black/African American – Larkin Street Youth Services and Third Street Youth Center	81% (n=75) of transition age youth who were referred for internal or external behavioral health services attended at least one initial appointment or meeting with a behavioral health provider.
Population Specific TAY Engagement and Treatment – Juvenile Justice/Others - Huckleberry Youth Programs	89% (n=50) of transition age youth referred to behavioral health services participated in at least one initial appointment.
TAY Homeless Treatment Team – Larkin Street Youth Services	73% (n=11) of transition age youth who received treatment and healing services demonstrated an intended outcome.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[10]**
Population-Focused Mental Health Promotion	36,422 Clients	$5,076,296	$139

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 evidence-based [11] and delivered in the following settings: center-based and family childcare, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. Four county entities provide funding and partnership to deliver ECMHCI: SFDPH/BHS; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco.

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

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

- Infant Parent Program - Day Care Consultants
- Edgewood Center for Children and Families
- Richmond Area Multi-Services (RAMS)

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

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

- Homeless Children's Network
- Instituto Familiar de la Raza (IFR)

Target Populations

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

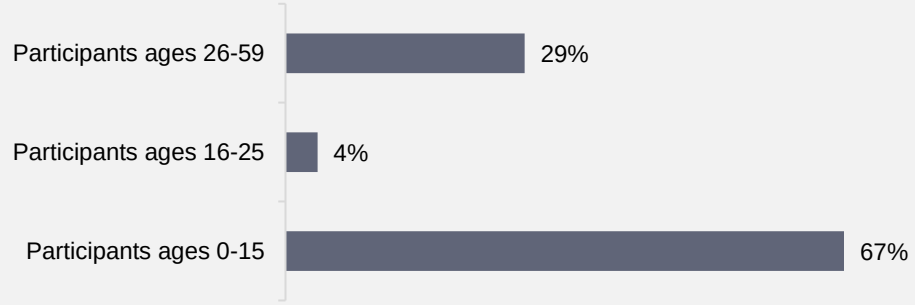
Early Childhood Mental Health Consultation Initiative	
Program Name	**Services Description**
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Infant Parent Program/Day Care Consultants ***UCSF***	Focuses on relationships between young children and their adult caregivers. The IPP embeds perinatal mental health specialists in the Obstetric 5M Clinic at Zuckerberg San Francisco General Hospital. In-clinic mental health treatment is provided to high risk, mostly immigrant, and indigent pregnant people. The aim of the program's intervention is to reduce psychiatry symptoms in those about to be parents, thereby improving their parental functioning and, in turn, the outcomes for their children. Families seen in this program are overseen through labor and delivery, and, if needed, the Neonatal Intensive Care Unit and Pediatric Clinics to ensure continuity of care.
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Edgewood Center for Children and Families	Works to tailor services to meet the unique and common needs of all clients, including conversations with struggling students, which yields a more focused understanding of the obstacles they are encountering and taking a collaborative approach to remedy the problem and put them on a positive path. Parental support is also provided by asking questions to better understand their challenges, concerns, and needs, helping them to better understand what works and what does not work as it relates to getting support. For this program, it is important to meet parents "where they are" without judgement and drawing from shared/common experiences to best support them. These services promote resiliency for students, staff, and the families we serve.
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Fu Yau Project ***Richmond Area Muli-Services***	One of five grantees of ECMHCI, which has combined five funding sources. In 2021, we connected with the Family Child Care Association of San Francisco's leadership to help foster their role in the program services as co-facilitators. During FY2022, we made changes to the program; instead of having two different topics per month, our two facilitators work together on one topic. These groups were facilitated in Cantonese and Mandarin, two core languages spoken by our clients. During COVID-19, virtual services were available, allowing the Mental Health Consultant the ability to continue monthly support groups focused on parent/caregiver support with an average of 12 clients per meeting.
Early Childhood Mental Health Consultation	Due to COVID-19, all discussions and work surrounding the redesign of this program were placed on hold, given the high demand for mental health support in FY20-21. Joining funders,

Early Childhood Mental Health Consultation Initiative	
Program Name	**Services Description**
Initiative (ECMHCI) – Homeless Children's Network	including Clarity Consulting Group, are working in partnership to gather data and client feedback as the beginning stages of the redesign take shape. Many consultation sites have slowly reopened following the pandemic, and guidance on how best to provide support has been coordinated at each site. Additionally, the program received three new consultation sites, increasing the overall program budget. Our diverse team of consultants hold a strong, relationship-focused, equitable, and trauma-informed approach to services, maintaining high standards of care.

Client Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative

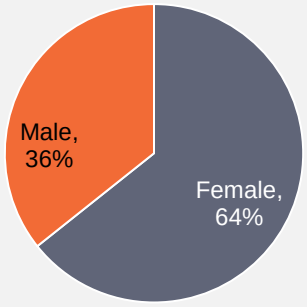
Age: Mental Health Promotion and Early Intervention - Early Childhood Mental Health Consultation Initiative (n = 517)



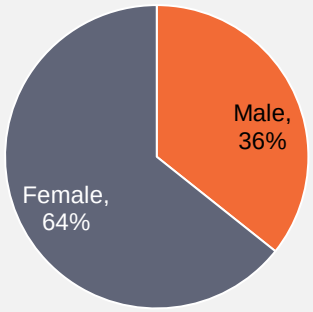
Disability Status: MH PEI - Early Childhood Mental Health Consultation Initiative (n = 105)

PEI

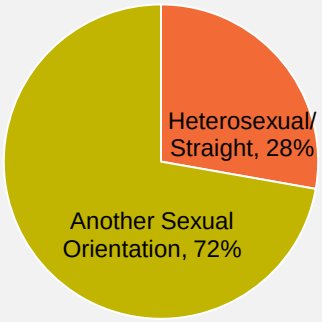
Gender Identity: Mental Health Promotion and Early Intervention - Early Childhood Mental Health Consultation Initiative (n = 521)



Sex at Birth: Mental Health Promotion and Early Intervention – Early Childhood Mental Health Consultation Initiative (n = 521)



Sexual Orientation: Mental Health Promotion and Early Intervention - Early Childhood Mental Health Consultation Initiative (n = 236)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Early Childhood Mental Health Consultation Initiative (n = 521)

*< 1 percent of participants reported Gay/Lesbian and Bisexual; Sexual Orientation

PEI

Race	n	%
Black, African American, or African	155	24%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	87	13%
Native Hawaiian or Pacific Islander	14	2%
White	225	34%
Other Race	174	27%
Total	655	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	320	86%
Non-Hispanic/Non-Latina/e/o	48	13%
More than one Ethnicity	<10	1%
Total	368	100%

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

Primary Language	n	%
Chinese	<10	1%
English	652	67%
Russian	<10	0%
Spanish	290	30%
Tagalog	<10	0%
Vietnamese	<10	0.2%
Another Language	16	2%
Total	958	100%

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

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

Program	FY22-23 Key Outcomes and Highlights
Infant-Parent Program/SPRING Project - UC San Francisco	100% (n=21) of parents who had four or more treatment sessions reported a stronger relationship with their infants, stronger identity as one who feels capable of parenting, more confident as a mother and advocating for their child and themselves.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[12]**
Mental Health Consultation and Capacity Building	950 Clients	$1,808,807	$1,904

Comprehensive Crisis Services

Background and Community Need

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

Program Overview

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

Target Populations

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

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

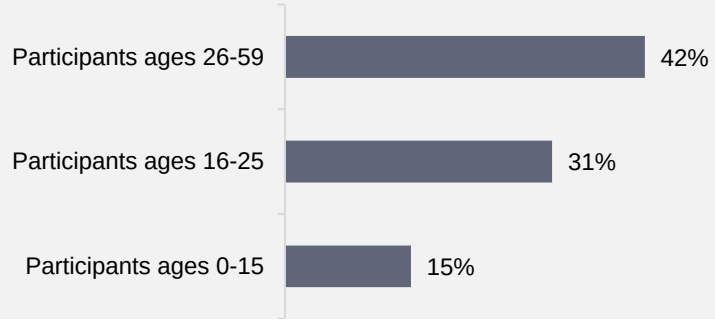
[12] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

	support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

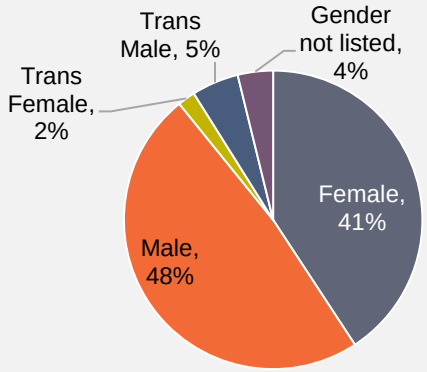
Program Outcomes, Highlights and Cost per Client

Demographics: Comprehensive Crisis Services[13]

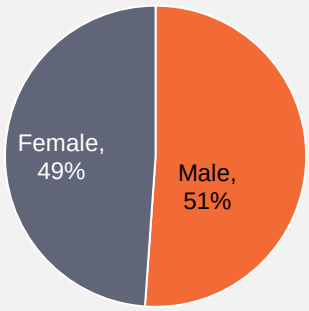
Age: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 618)



Gender Identity: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 157)



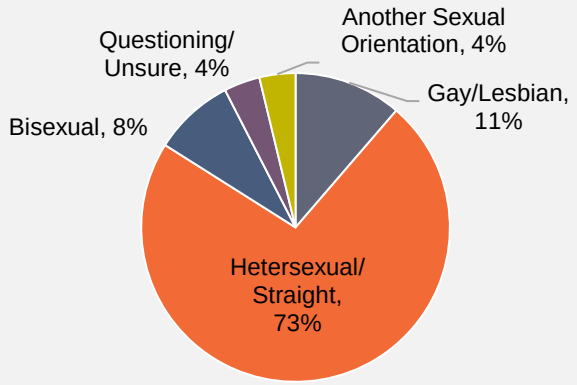
Sex at Birth: Mental Health Promotion and Early Intervention – Comprehensive Crisis Services (n = 133)



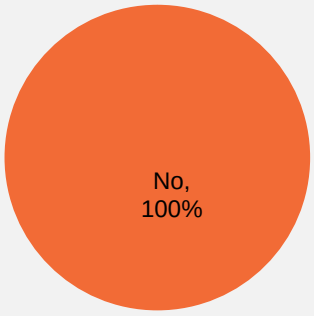
PEI

[13] Disability status data was not available for Mental Health Promotion and Early Intervention – Comprehensive Crisis Services.

Sexual Orientation: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 106)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Comprehensive Crisis Services (n = 495)



Race	n	%
Black, African American, or African	140	39%
American Indian, Alaska Native, or Indigenous	<10	0.3%
Asian or Asian American	41	12%
Native Hawaiian or Pacific Islander	<10	0.3%
White	79	22%
Other Race	94	26%
Total	354	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	69	81%
Non-Hispanic/Non-Latina/e/o	<10	0%
More than one Ethnicity	16	19%
Total	85	100%

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

Primary Language	n	%
Chinese	<10	3%
English	300	90%
Russian	<10	0%
Spanish	23	7%
Tagalog	<10	0.3%
Vietnamese	<10	0%

Primary Language	n	%
Another Language	<10	1%
Total	323	100%

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

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

Program	FY22-23 Key Outcomes and Highlights
Comprehensive Crisis Services (Mobile Crisis, Child Crisis, and Crisis Response)- DPH	35% (n=142) of individuals seen in the crisis clinics were sent to Psychiatric Emergency Services or were hospitalized on the same day.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[14]**
Comprehensive Crisis Services	709 Clients	$557,565	$786

Moving Forward in Mental Health Promotion (PEI)

Substance Use and Overdose Prevention Education for Black/African Americans

In partnership with the Population Behavioral Health Section, SF-MHSA is funding the Homeless Children's Network to provide an Equity-Based Substance Use Service that includes equitable and culturally responsive services to the Black/African American community. The intended outcome of this funding is to expand capacity of local community-based organizations to prevent and mitigate harmful health outcomes associated with substance use, and to reduce overdose death disparities through novel and innovative approaches. These approaches must be culturally relevant and defined by the Black/African American community. This funding aims to reach Black/African American individuals who do not already receive services through the San Francisco Department of Public Health and to provide culturally relevant substance use and overdose prevention outreach, engagement, and education. Overdose Settlement and MHSA dollars will support this project.

The Kuumba Healing Project

the Kuumba Healing Project (KHP) of Southeast Child Family Therapy Center continues to serve disenfranchised families of Black/African descent living in San Francisco. KHP provides culturally relevant community and school-based services around the psychosocial and academic needs of our targeted population. KHP is embedded in San Francisco's Unified School District (SFUSD) and collaborates closely with community-based programs. KHP provides behavioral health services including school based individual and group therapy, as well as implementing restorative circles and Social Emotional Learning (SEL) focused curriculum

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

throughout SFUSD. KHP also provides clinical consultation to SFUSD instructors and administrators and provides classroom observation and clinical assessment services.

The Kuumba Healing Project collaborates with NAMI (National Alliance on Mental Illness) by creating relevant psycho-educational content and co-facilitating classes targeting the Mental Wellness of youth and families of Black/African descent in San Francisco. The positions of the new Kuumba Fellow (Peer Specialists) provide paraprofessional support to KHP's clinical team in schools and community. The Kuumba Fellows additionally support and co-facilitate the provision of SEL curriculum, restorative circles, psycho-education and outreach within SFUSD and local community organizations.

The Free Minds Initiative

The San Francisco Mental Health Services Act, in partnership with the San Francisco Human Rights Commission (HRC) launched a culturally congruent mental health and wellness program to support the mental health needs of Black/African American communities. This initiative especially focuses on communities that currently face disparate access to essential services. The urgency of this matter cannot be overstated, and HRC is poised to make a significant impact through its groundbreaking *Free Minds Initiative*. At the heart of this endeavor is a collective impact approach, which is a strategic framework that recognizes the complexity of the challenges at hand and underscores the necessity for collaboration.

The Free Minds Initiative is envisioned as an innovative and comprehensive effort designed not only to reduce existing mental health disparities but also to foster increased cooperation and trust among key stakeholders. This includes forging stronger connections between city agencies, community-based organizations and individuals navigating mental health crises within these communities. The emphasis on culturally congruent services within the initiative underscores a commitment to recognizing and respecting the diverse needs of the communities involved. By tailoring mental health and wellness services to align with the cultural contexts of these communities, the Free Minds Initiative seeks to break barriers and ensure that individuals can access support in a way that is meaningful and relevant to their unique experiences. Ultimately, the Free Minds Initiative is not just a project; it is a vision for a transformed mental health landscape in San Francisco. Through collaborative efforts, trust-building and a sustained commitment to innovative practices, HRC envisions tangible improvements in mental health outcomes for the communities it serves. The initiative stands as a testament to the power of collective action in creating positive, lasting change in the lives of those who need it most. By the end of 2024, the program aims to provide innovative and necessary early intervention to sustain optimal health/mental health for vulnerable populations. In partnership with the HRC, the program's success will be closely monitored to ensure its effectiveness in meeting the community's needs. The Mental Health Services Act Prevention and Early Intervention (PEI) section will provide one-time funding for this project for a total of three years.

6. Innovations Projects: INN Funding

Service Category Overview

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

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

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

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

Program Overview

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

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

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

Family Unification and Emotional Resiliency Training (FUERTE) - UCSF

Program Overview

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

Target Populations

This program serves recently immigrated Latinx youth.

Wellness in the Streets - RAMS

Program Overview

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

Target Populations

This program serves people experiencing homelessness.

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

Program Overview

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

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

Target Populations

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

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

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

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

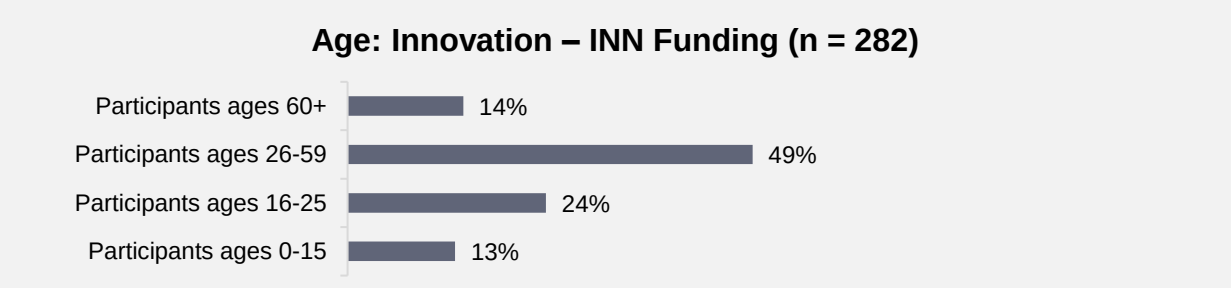
- Mission Mental Health Clinic Alternatives Case Management
- South of Market Mental Health
- DPH TAY Clinic
- OMI Family Center

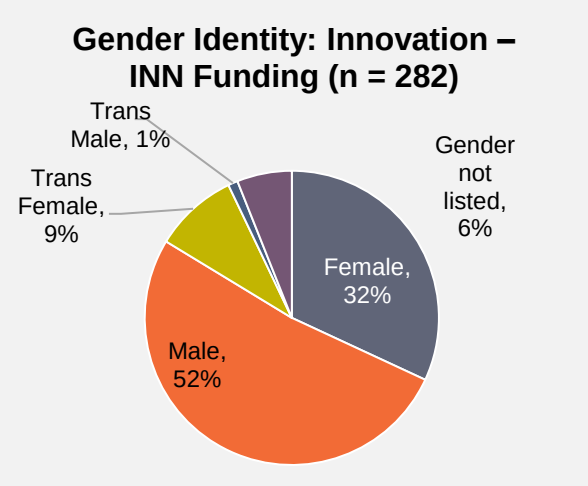
We are currently working with a provider and listening to community feedback on how to better market this program. Recently, an evaluator was selected for this project, providing additional oversight and programmatic development. A cultural liaison will be working on ensuring community input and feedback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

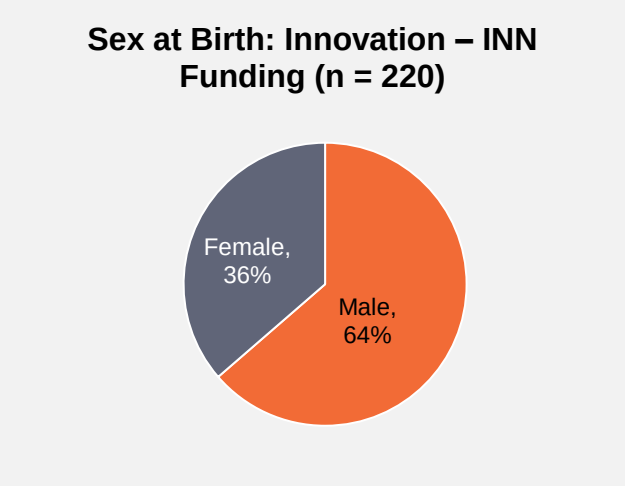
Client Demographics, Outcomes, and Cost per Client for all Innovation Programs

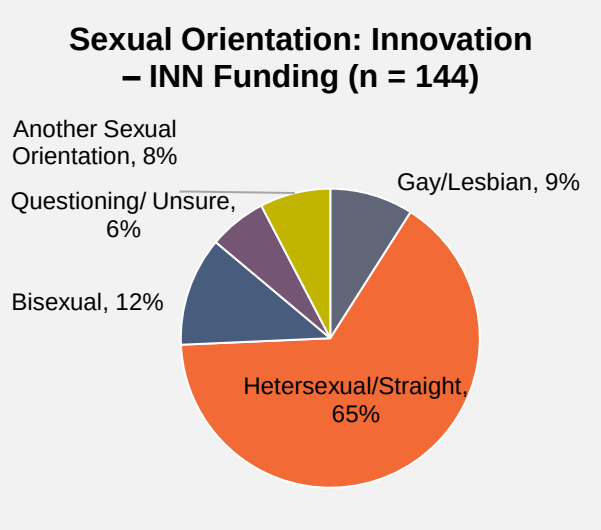
Service Indicator	Program Results for FY22/23
Total family members served	N/A
Potential responders for outreach activities	Responses included: Clinical psychology interns, family liaisons, mental healthcare providers, mental health facilitator/clinicians, community health outreach workers, librarians, school social workers, case managers, and senior clinical research coordinators.
Total individuals with severe mental illness referred to treatment	N/A
Types of treatment referred	N/A
Individuals who followed through on referral	N/A
Average duration of untreated mental illness after referral	N/A
Average interval between referral and treatment	N/A
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	90; average 45 individuals across two reporting programs.
Types of underserved populations referred to prevention program services	Latinx newcomers (last five years or less in the U.S.) Immigrant youth between the ages of 12-20 Individuals experiencing homelessness Transition age youth Socially isolated transgender adults
Individuals who followed through on referral	N/A
Average interval between referral and treatment	3-4 weeks
How programs encourage access to services and follow-through on referrals	Responses are summarized below: • Groups are co-facilitated by professionals in the mental health field 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

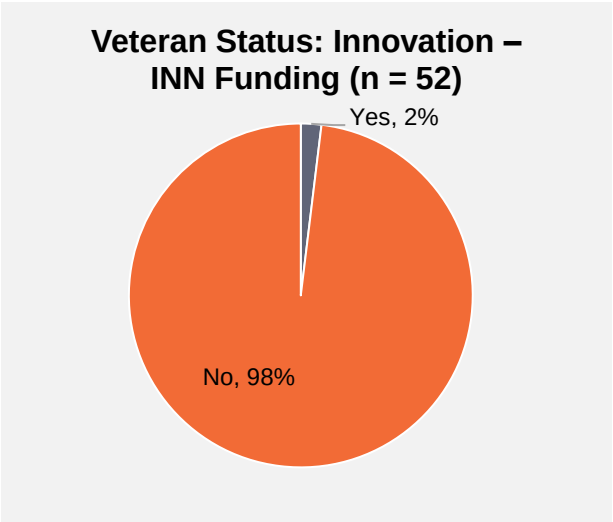
Service Indicator	Program Results for FY22/23
	mental health services providers, who will be leading psychoeducation on mental health and help decrease stigma against seeking mental health support. Program staff reach out to screen participants for socioemotional functioning and utilization of services prior to the start of the program, at the end of the program, and 3 months following program completion. • During coaching and peer support, Peer Navigators listen to participant needs and suggest referrals. Peer Navigators follow up via meetings and phone calls to inquire about the referral and if any additional support is needed.

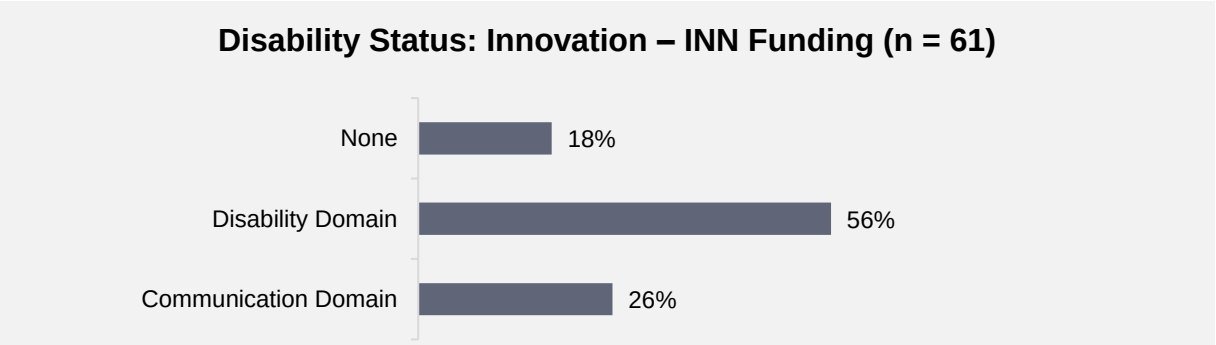












Race	n	%
Black, African American, or African	53	22%
American Indian, Alaska Native, or Indigenous	<10	3%
Asian or Asian American	11	5%
Native Hawaiian or Pacific Islander	<10	2%
White	71	30%
Other Race	91	38%
Total	226	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	107	46%
Non-Hispanic/Non-Latina/e/o	117	51%
More than one Ethnicity	<10	3%
Total	224	100%

Primary Language	n	%
Chinese	<10	0.4%
English	190	68%
Russian	<10	0.4%
Spanish	87	31%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	1%
Total	277	100%

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

Program	FY22-23 Key Outcomes and Highlights
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support – Richmond Area Multi-Services (RAMS)	94% (n=16) of clients reported they felt heard and understood by their Peer Counselor, and 92% (n=12) reported feeling more comfortable with their new provider.
FUERTE – University of California San Francisco (UCSF)	91% (n=19) of participants who attended at least three sessions reported an increase in social connectedness when sharing their favorite aspects of the program, and 52% (n=11) reported an increase in mental health literacy.
Wellness in the Streets - Richmond Area Multi-Services (RAMS)	94% (n=142) of individuals who identified an immediate need reported their need was addressed by a WITS team member, and 96% (n=103) reported feeling supported by the team member.
Technology Assisted Mental Health Solutions – Mental Health Association of San Francisco	89% of participants reported they feel somewhat or very comfortable using a tablet, and 83% of participants who attended support hours reported that Tech Support Hours helped increase their understanding of digital literacy.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[15]**
Innovations	341 Clients	$2,089,226	$6,127

Moving Forward in Innovations

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

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

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

Culturally Congruent and Innovative Practices for San Francisco's Black/African American Communities

The Culturally Congruent and Innovative Practices for Black/African American Communities project continues to ramp up and support the San Francisco communities. We are proud to announce that almost all positions have been filled. This includes the hiring of clinicians and health educators. Health educators have been providing groups to the community, including expressive arts groups and a hip hop therapy group for Transitional Age Youth. Training on the Sankofa model for providers has been provided.

This project is being implemented within the following four civil service clinics:

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

The following Innovation programs will no longer be funded by MHSA INN starting in FY24-25.

- ICM/FSP to OP Program (INN funding ended December 2023)
- FUERTE (INN funding ended February 2024)
- Technology Program (INN funding will end June 2024)
- Wellness in the Streets (INN funding will end June 2024)

After meeting with the community to discuss sustainability planning, SF-MHSA will use CSS funding to sustain the ICM/FSP to OP Program, use CSS funding to sustain the Wellness in the Streets Program, and use either CSS or PEI funding to sustain the FUERTE program. We would like to highlight the work of MHA-SF that was conducted for the INN Technology Program and highlight their plan to publish their work. SF-MHSA is still looking into sustainability planning for this program. The following highlights the work done by each of these programs in FY22-23:

Intensive Case Management and Full-Service Partnership to Outpatient Programs

The RAMS Peer Transitions Team is a five-year MHSA Innovations Project designed to assist clients as they transition from Intensive Case Management (ICM) to Outpatient (OP) care. This program began in 2019 and wrapped up at the end of December 2023. Community Program Planning meetings were conducted to determine which aspects of the ICM to OP Transition Support Project have been the most beneficial to clients in determining the continuation of funding for certain program elements. Feedback was also collected to determine the need for future programmatic improvements in the future. Feedback included suggestions to have more peers stationed onsite at outpatient clinics, more financial and programmatic supports for clients who are transitioning to outpatient programs, and support for vocational opportunities for clients involved in this project.

FUERTE

Outreach, recruitment and initial data collection were held in-person for the first time since before the COVID pandemic. To attain maximum student engagement and feedback, it is critical that school personnel are supportive and encourage students to attend. The program had full support from most Wellness Centers, but not all school personnel were familiar with the program's logistics. Some teachers expressed concerns about participants missing class time to complete surveys and attend group sessions, thus impacting their learning time. This concern was addressed by coordinating data collection and groups during lunch and/or advisory time. Additionally, to address the increased need for newcomer supports, the program expanded the allowance of personnel to include interested Spanish-speaking school staff such as librarians.

Wellness in the Streets

The WITS team continued to be deployed as Disaster Service Workers, working with clients in the city's Shelter in Place (SIP) hotels through the end of the COVID-19 public health emergency in March 2023. The team received client referrals from the BHS SIP team for peer support, interim case management, resource linkage and appointment navigation. When the COVID-19 public health emergency order was rescinded in March 2023, the WITS team continued to work with the BHS Shelter & Navigation Center team, accepting referrals to support individuals who were unhoused and in need of peer support, linkage and system navigation.

The WITS team also pivoted back to its originally intended mission following the end of the public health emergency, restarting general outreach to unhoused individuals to provide in-the-moment peer counseling to reduce isolation and help build/repair trust with the system of care for those who have been reluctant to engage in services. The team continued to collect data from these engagements, finding out what was most helpful from their clients and working collaboratively with them to identify any areas of need.

In an effort to build the infrastructure to best provide support and oversight for the quickly evolving slate of innovative programs, RAMS Peer Division created a new Associate Director of Crisis Response & Street-Based Services position to directly supervise the WITS team and to manage the larger growing ecosystem of street-based peer counseling services.

Technology-Assisted Mental Health Solutions (TAMHS) Project

SFDPH partnered with the Mental Health Association of San Francisco (MHASF) for the Technology-Assisted Mental Health Solutions (TAMHS) project. The project includes the Tech Borrowing and Distribution Program, which offers free devices, internet service, digital literacy education and peer support for community members. In 2021, San Francisco was selected to pilot TakemyHand™. This program was adopted because their behavioral health clients expressed an interest in an anonymous chat to support and overcome feelings of social isolation. TakemyHand ™ experienced significant delays during this period because of San Francisco County's delays in approving LiveChat. Due to LiveChat not being approved, the program has been unable to launch. This resulted in MHASF and SFDPH reallocating funds from TakeMyHand™ to Tech@Hand.

Due to the COVID-19 pandemic, MHSASF implemented an online digital literacy course. However, levels of engagement remained persistently low, even with the addition of incentives. MHASF pivoted from the online digital literacy courses to in person digital skills workshops. This has resulted in an increase in enrollment, retention and participant success rates.

7. Behavioral Health - Workforce Development: WET Funding

Service Category Overview

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

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

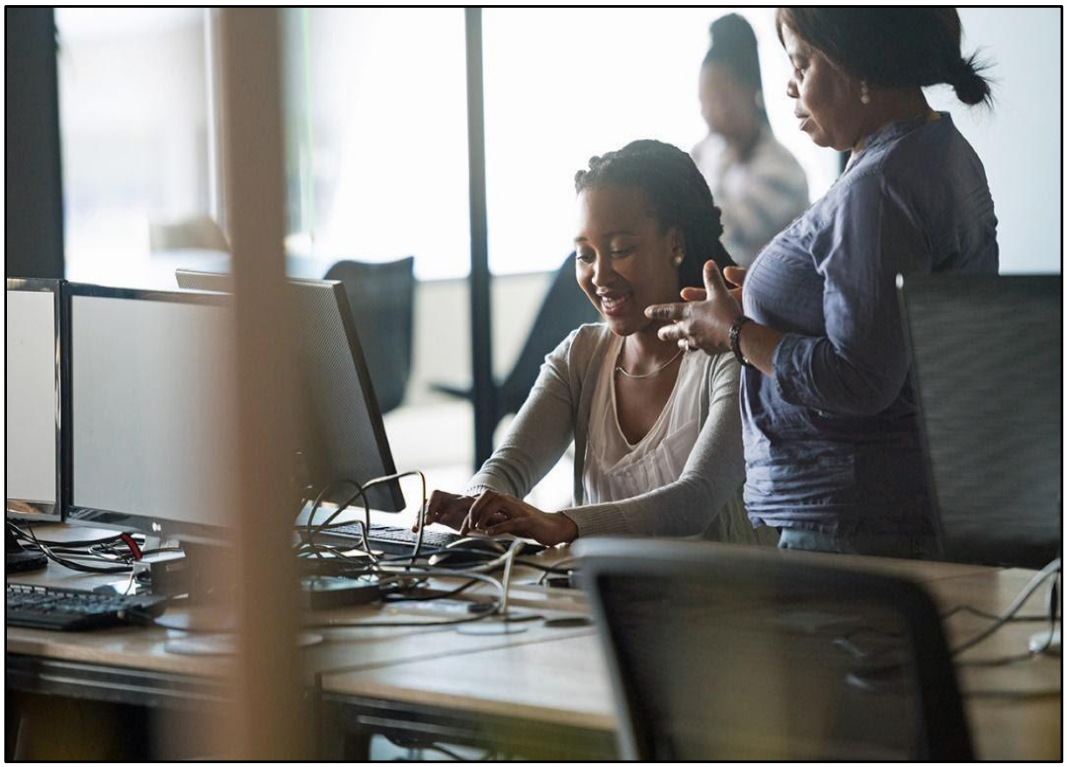
Target Populations

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

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

Workforce Dev

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



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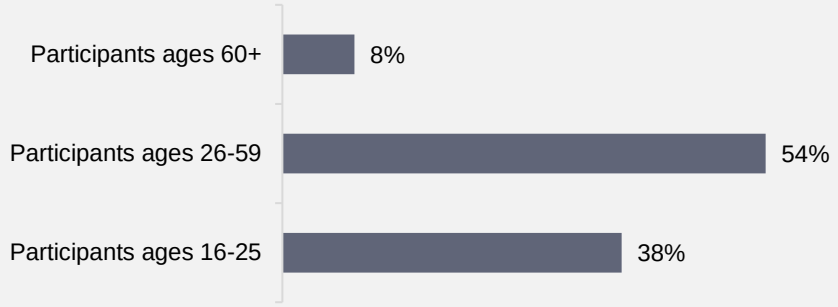
Client Demographics, Outcomes, and Cost per Client

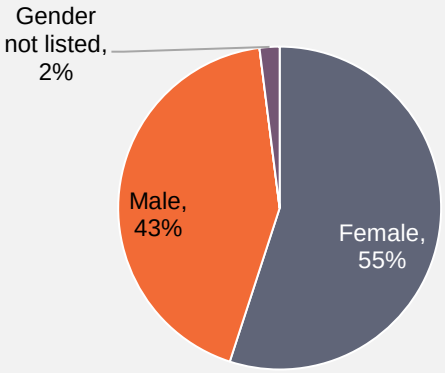
Demographics: Mental Health and Career Pathways

Age: Behavioral Health Workforce Development - Mental Health Career Pathway Programs (n = 298)

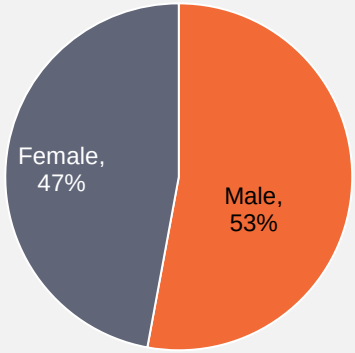


*< 1 percent of participants reported data for 0-15; Age

Gender Identity: Behavioral Health Workforce - Mental Health Career Pathway Programs (n = 287)



Sex at Birth: Behavioral Health Workforce – Mental Health Career Pathways Program (n = 155)



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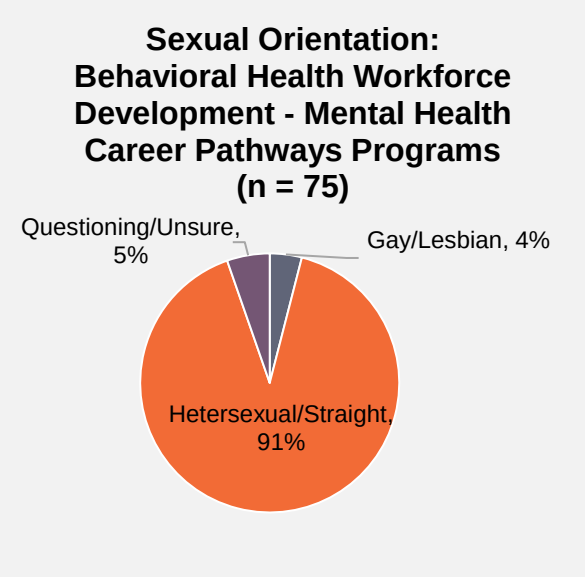
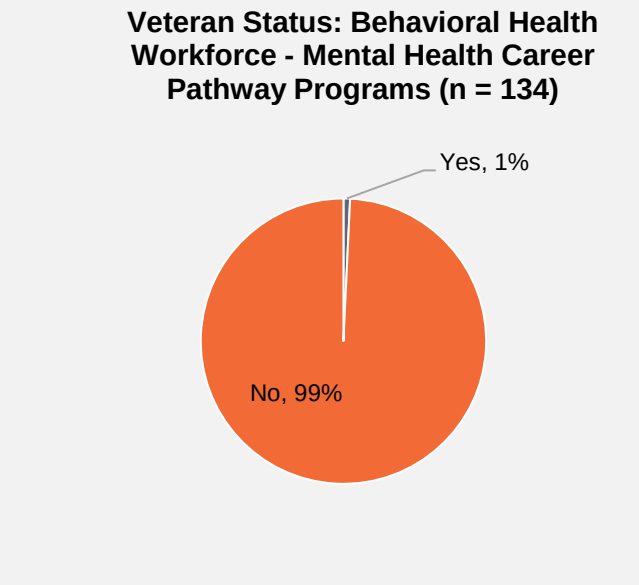
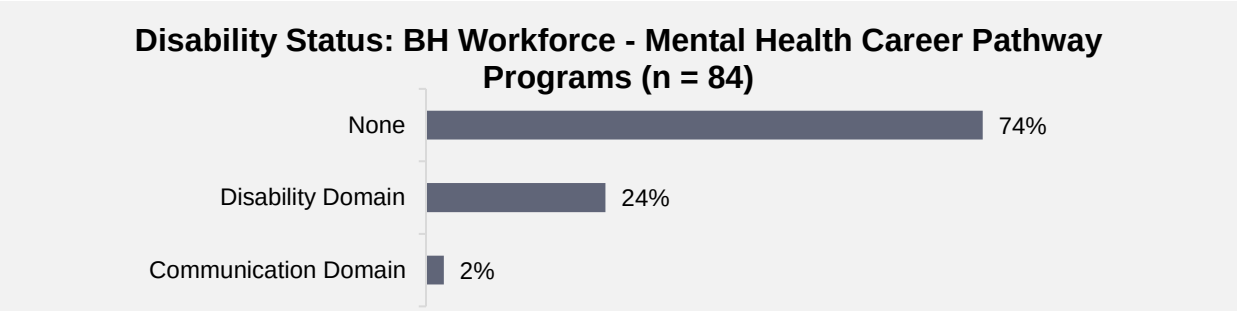






Race	n	%
Black, African American, or African	82	35%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	50	21%
Native Hawaiian or Pacific Islander	<10	2%
White	63	27%
Other Race	36	15%
Total	231	100%

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

Primary Language	n	%
Chinese	21	10%
English	117	55%
Russian	<10	0%
Spanish	51	24%
Tagalog	10	5%
Vietnamese	<10	0%
Another Language	15	7%
Total	214	100%

Ethnicity	n	%
Hispanic/Latina/e/o	93	95%
Non-Hispanic/Non-Latina/e/o	<10	2%
More than one Ethnicity	<10	3%
Total	93	100%

Program	FY22-23 Key Outcomes and Highlights
Community Mental Health Worker Certificate – City College of San Francisco	100% (n=14) of graduating students reported readiness to pursue their next work/educational opportunity, an interest in pursuing a health-related career, and knowledge of pathways into health careers
Community Mental Health Academy – Crossing Edge Consulting	75% (n=56) of staff and supervisors graduated from the Community Mental Health Academy.
Faces for the Future Program – Public Health Institute	70% (n=56) of students reported a sustained or increased interest in pursuing a health profession.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[16]**
Mental Health Career Pathways	300 Clients	$921,920	$3,073

Training and Technical Assistance Programs	
Program Name ***Provider***	**Services Description**
Online Learning Management System – *Relias*	The Online Learning Management System is an online and mobile training program that can be accessed by staff while at any location. This program offers multiple behavioral health courses that grant continuing education units and ongoing training to licensed and registered staff, interns, volunteers, peer specialists, paraprofessionals, administrative staff and other staff members. This program provides consistent and standardized training that is continuously updated and culturally congruent.
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.

[16] 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**
TAY System of Care Capacity Building – Clinician's Academy *Felton Institute*	The TAY System of Care Capacity Building trains providers such as SFUSD teachers and staff in assisting TAY students to address substance use. This program teaches harm reduction principles and other evidence-based models. This program also trains providers on improving TAY access to services and service delivery.

Program Outcomes, Highlights and Cost per Client

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

Program	FY22-23 Key Outcomes and Highlights
Online Learning Management System – Relias	800 civil service staff in Behavioral Health have been registered on the system and they have enrolled in a total of 1,994 courses.
Trauma Informed Systems Initiative - DPH	950 individuals were trained.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client**[17]
Training and Technical Assistance	1,750 Clients	$1,310,726	$749

Residency and Internship Programs	
Program Name ***Provider***	**Services Description**

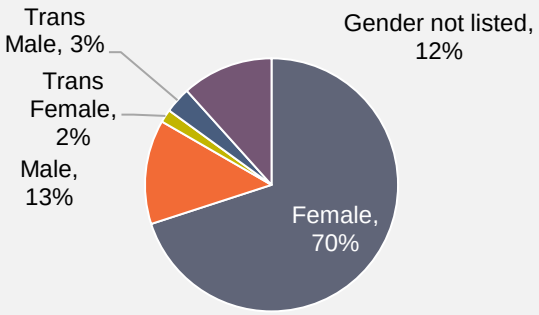
Workforce Dev

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

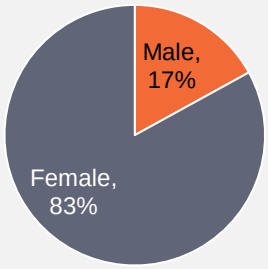
Fellowship Program for Public Psychiatry in the Adult System of Care - *UCSF*	Trains the next generation of public mental health care leaders who will provide patient-centered care to vulnerable populations with severe mental illness through 1) understanding and implementing relevant, evidence-based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

Demographics: Residency and Internship Programs

Gender Identity: Behavioral Health Workforce - Residency and Internship Programs (n = 60)



Sex at Birth: Behavioral Health Workforce – Residency and Internship Programs (n = 53)



Race	n	%
Black, African American, or African	<10	17%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	22	52%
Native Hawaiian or Pacific Islander	<10	2%
White	11	26%
Other Race	<10	2%
Total	33	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	18	100%
Non-Hispanic/Non-Latina/e/o	<10	0%
More than one Ethnicity	<10	0%
Total	18	100%

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

Sexual orientation data was not available for Behavioral Health Workforce Development: Residency and Internship Programs.

Veteran data was not available for Behavioral Health Workforce Development: Residency and Internship Programs.com

Disability status data was not available for Behavioral Health Workforce Development: Residency and Internship Programs.

Language data was not available for Behavioral Health Workforce Residency and Internship Programs.

Program Outcomes, Highlights and Cost per Client

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

Program	FY22-23 Key Outcomes and Highlights
Fellowship for Public Psychiatry in the Adult/Older Adult System of Care - UCSF Public Psychiatry Fellowship at SF General – UCSF	One fellow from FY22-23 is now one of the Co-Associate Program Directors at the Public Psychiatry Fellowship and four fellows disseminated their capstone project findings at the 2023 Annual Meeting of the American Psychiatric Association.
Child and Adolescent Community Psychiatry Training Program (CACPTP) - UCSF	This program had 5 fellows rotate in the clinics with 34 clients served.
BHS Graduate Level Internship Program – DPH	A total of 42 student interns were awarded Multicultural Student Stipends to support their workplace-based training and career development. Awardees included 14 clinical psychology students on track clinical degrees.

FY22-23 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[18]**
Psychiatry Residency and Fellowships	60 clients served by the Fellows	$650,465	$10,841

Moving Forward in Behavioral Health Workforce Development

BHS Training Program

FY22-23 was the Intensive Case Management (ICM) Academy's 2nd year of providing trainings that address the needs of Adult, Older Adult and Transitional Age Youth (TAY) ICM & Full-Service Partnerships (FSP) providers, peers, clinicians, and those working within the ICM system of care (SOC). In FY22-23, the ICM Academy expanded our audience to reach providers, peers, clinicians and BHS employees whose work includes case management. The ICM Academy provided 10 training courses to 101 unique attendees, with topics including Evidence-Based Practices, Dual Diagnosis, SUD, Forensics, Gerontology, Crisis Intervention, De-Escalation, and Harm Reduction among others. All training was recorded for future viewing. Goals for FY24-25 include setting up a California Association of Marriage and Family Therapist (CAMFT) program to provide CEUs for attendees, and to begin holding some in-person and hybrid offerings.

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

In 2023, BHS began strategizing for the TAY Academy. The TAY Foundational trainings were identified and organized using the Vimeo and Alchemer platforms. TAY SOC providers may now review training and complete quizzes as well as evaluations to complete the TAY Foundational Series. A variety of training courses have been planned for 2024 and 2025, including in-person and virtual cohorts as well as individual training. The TAY Academy will officially launch in Fall 2024.

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

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

This program is continuing the SFDPH Public Psychiatry Administrative Fellowship, a two-year program with a mission to build community among emerging public psychiatry leaders within BHS. SFDPH MHSA funds the training of two fellows in the San Francisco Health Network. Fellows completed all program activities as conducted in previous years. There are two new MHSA-funded fellows for the 2023-24 academic year who will be working at SFHN-BHS Mission Mental Health and the Southeast Child/Family Therapy Center.

Child and Adolescent Community Psychiatry Treatment Program (CACPTP)

In FY23-24, the program will have the first Child Psychiatry Public Track fellow rotating two afternoons a week in our Community Psychiatry clinic and working on a quality improvement project through the UCSF Public Psychiatry Fellowship. In FY24-25, there will be 6 second year Childa and Adolescent Psychiatry Fellows each working in a clinic for 4 hours a week in addition to the Child Psychiatry Public Track Fellow.

Trauma-Informed System (TIS) Initiative

The San Francisco workforce continues to be severely impacted by COVID-19, housing instability, high incidence of substance use/overdose, high workplace vacancy rates, and racial injustice within the workplace, which all contribute to increased burn out among staff. These factors highlight the importance of the work of TIS. However, the TIS team has also been hit by losses such as being constantly deployed and low rates of staff retention due to staff moving away and accepting other positions. Despite this, during FY22-23, TIS was able to hire 2 full-time staff for positions that were vacant for 3 years. Since their hiring and on-boarding, a cohort of 15 new TIS 101 trainers were trained and certified. Additionally, the Early Adopter work is back in full swing with 23 organizations committed to becoming a healing organization. We are also committed to integrating BHS into our early adopter network, ensuring that all of BHS is trauma informed.

Relias Online Learning Management System

FY22-23 was the first full year of operation for the Relias Online Learning Management System. The Relias system offers over 500 training courses on behavioral health topics, with most courses offering continuing education credit required for staff licensure or certification. Additionally, 58 courses sponsored by BHS – most focused on diversity and equity – have also been added, allowing users to access the training all in one place. A total of 800 civil service staff in Behavioral Health have been registered in the system and have enrolled in a total of 1,994 courses. Plans for FY23-24 include developing training plans on Relias that can be used

by supervisors for workforce development and integrating an Equity Learning Requirement into Relias that is mandatory for all staff to complete as part of their annual review.

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

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

SFUSD continues to be impacted COVID, with 4 out of the 6 teachers who serve as primary contacts for the program resigning from the teaching profession. This means that FACES must work to rebuild credibility and relationship with an entirely new group of teachers in 2023-24.

Work-based learning internships, traditionally offered to students by FACES in partnership with SFDPH, remained on hiatus during this reporting period per SFPDH policies. To adapt, FACES implemented a combination of field trips, off-site work-based learning experiences for students, and the FACES Public Health Youth Corps model. Students learned about public health, including health disparities and population health. They also completed workshops about the COVID-19 vaccine and examined the mental health impact of COVID for youth. They learned about youth advocacy skills, practiced case scenarios, and participated in lesson modules on de-escalation skills for challenging conversations and motivational interviewing. These workshops prepared students to conduct COVID-19 outreach in their communities, and they were deployed in their communities and at school as public health ambassadors with COVID-19 prevention as their primary focus.

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

Students also receive help with career development, internship placement and practice, student evaluation and wrap-around support services. The program supports recovery through peer mentorship, counseling, tutoring and socialization through an academic setting. The Community Mental Health Certificate program has expanded to include the Medi-Cal Peer Support Specialist Training to provide additional pathways to workforce development, State certification, and employment.

In addition, faculty members from the Community Mental Health Certificate program received a five-week intensive training to develop a CANVAS online platform hybrid training.

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

The program worked to return to in-person training. The program focused on overall skill development as well as personal growth, including providing a WRAP (wellness recovery action plan) book for each individual.

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

The program prioritizes economically disadvantaged communities of color, marginalized groups, and large numbers of individuals from isolated and/or economically/socially marginalized communities (e.g., LGBTQ+, formerly incarcerated, in recovery, people who are experiencing homelessness or marginally housed). As a result of COVID-19 and zero contact activities, the program integrated more online learning opportunities. Remote/online programming continued to improve and facilitate new training and computer skill building for students. However, many students of color had to drop from the program due to technological challenges. Therefore, the program has begun to implement more in-person instruction opportunities to foster the social and interpersonal skills necessary to be successful in the field. This also provides more opportunities to provide additional services to students.

The program developed an Associates of Science degree pathway for students who wish to further their careers and education. The new pathway will begin in January 2024.

Workforce Dev

SPOTLIGHT ON STAFF WELLNESS RETREATS

BHS acknowledges the impacts of professional caregiving and seeks to provide opportunities for personal and interpersonal relationship building, celebration, reflection, and healing among all levels of behavioral health staff. Each clinic/program has one day per fiscal year to hold a staff wellness retreat that is funded by MHSA workforce dollars, during which they are permitted to close facilities and programming for the entire day. It has been a goal that all levels of the clinic/program's staff participate in the retreat planning process to ensure an equitable process and meaningful outcomes.

Mission Mental Health (MMH) Clinic's retreat is a good example of attaining that goal. MMH received significant support planning their resiliency-themed retreat. The process included accessing the level of support needed to support a retreat that would address the needs of the staff to reconnect as a team, have an intersectional culturally congruent, and trauma-informed retreat, assist the team with exploring how to support staff wellness and sustainability, provide a healing experience to address past challenges with retreats that did not feel intersectional, cohesive or restorative, and address ongoing division within the agency comprised of several divisions. Staff feedback included:

- People appreciated how culturally rich, inclusive, and intersectional the retreat was and that it made space for their identities in a way they felt they couldn't speak to or share the same way in the past.
- People shared how important it was to meet and share this space with staff they only knew through zoom and that they no longer felt isolated as a team member and that they feel they can engage, access, and collaborate with each other differently now. This also applied to per-diem workers.
- Feedback was given that it truly felt like a retreat for everyone and not the result of one person centering their own needs or just the needs of some staff but that it really took everyone into consideration.

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

Service Category Overview

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

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

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

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

Information Technology	
Program Name	**Services Description**
Consumer Employment (Vocational IT)	The collaboration between BHS Ambulatory Applications and RAMS has resulted in significant opportunities for clients to attain gainful employment this past fiscal year. Five IT training program graduates were hired for peer positions within the BHS Ambulatory Applications team. The RAMS i-Ability IT training staff's trainers/supervisors now includes graduates of the training program. Furthermore, two graduates of the Avatar Help Desk were hired for full-time positions with the city. Other graduates attained full-time employment outside of SFDPH this past fiscal year. The Avatar Accounts team is comprised of several clients in the role of Onboarding/Offboarding the various administrative and clinical staff at the various mental health clinics that utilize Avatar as their Electronic Health Record (EHR) system. The clients working on this team will be critical to the transition from Avatar to Epic as the new EHR system. Important contributions of these employed clients include: ○ Processed 828 new Avatar account requests. ○ Collaborate with Server and Compliance Departments ○ Monitor and Maintain Avatar access and security
System Enhancements	The System Enhancements project provides vital program planning support for IT system enhancements. Responsibilities include the following: ● Ensuring that timelines and benchmarks are met by the entire EHR team ● Manage dependencies by helping to ensure that equipment, personnel and other resources are deployed efficiently and according to timeline ● Managing EHR-related professional development for all BHS staff in an effective and timely manner to ensure smooth implementation across the Division. ● Conduct data analysis related to the projects ● Three civil service Business Analyst positions funded by MHSA. These positions are dedicated to supporting the Avatar application and related projects that include the MHSA database. ● Preparation for the transition to the Epic system in 2024.

Moving Forward in Capital Facilities

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

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

The Hope San Francisco Sunnydale Project
This project is in the design and building phase in collaboration with the developer of the Sunnydale housing authorities. In fall 2024, $2 million will be utilized for site construction of the wellness clinic. The wellness clinic provides basic medical care and wellness programs onsite. Furthermore, it provides direct access for SFDPH staff to the largest four public housing site communities in San Francisco.

Consolidation of Older Adult Services
The $1.2 million dedicated construction funding for tenant improvements to support the consolidation of two older adult clinics is paused, as a real estate development opportunity did not materialize. The funding is still in place to support the tenant improvements once a suitable site is located and a lease is established.

Chinatown North Beach Clinic – 729 Filbert Street
Construction at the clinic's new location commences in 2023. The Chinatown Child Development Center will join the Chinatown Health Center as a city-owned property. The new location will be integrated with the upgraded primary care clinic supporting similar client communities. During 2024, the project will be under permit review and then bid out for construction.

Moving Forward in Information Technology (IT)

The San Francisco Department of Public Health selected the Epic Electronic Health Record (EHR) application as the primary EHR for the department, whenever possible. This journey began with Wave 1 implementation in August of 2019 which focused on hospital services and primary care clinics.

We launched Epic for Mental Health Services in May 2024. Epic will bring many benefits to our clients, including improved communication between providers within our network. Epic MyChart (the client portal) will allow clients to be more engaged in their care because they will be able to receive appointment reminders, lab results, and the ability to respond to questionnaires and communicate directly with their providers.

The Mental Health Services go-live date for Epic was May 22nd, 2024.

Highlights of what MHSA funded IT staff have been working on over the last year:

Epic MyChart Support

During 2023, SFMHSA funded IT staff participated in the development of a new support structure for Epic MyChart, the patient portal serving San Francisco SFDPH clients. The team worked with SFDPH stakeholders and various IT teams to ensure there was a smooth transition of client support. This implementation involved setting up a call center, a new call log system and developing additional training materials for IT staff assigned to the call center. This project took place in conjunction with our Richmond Area Multi-Services (RAMS) IT peer staff who began receiving support calls in April 2023. Staff have received over 3,000 client support calls since the new support structure went live. Our RAMS IT staff will expand their support to include outreach services that will assist clients to enroll in MyChart.

Avatar Document Extract for OnBase

To ensure that providers can access historic Avatar Mental Health documents via Epic, IT staff have been generating and exporting reports to be uploaded into a medical document viewer called OnBase. Staff worked with multiple IT and SFDPH Stakeholders to determine which documents needed to be available to Mental Health Providers at Epic go-live. Over 2,000,000 documents have been generated during 2023 and more are currently in development. This will ensure that Mental Health Providers will have seamless access to critical information about their clients.

Quarterly Avatar Technical Workgroup Meeting

To assist our contract providers' information technology, we have developed a partnership with these agencies to educate, train and prepare the system upgrades and/or Avatar modifications. We have regular meetings that serve as an opportunity to receive feedback, discuss successes and trouble-shoot challenges at various sites.

Data Collection and Reporting System (DCR)

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

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

CalAIM Support – Documentation and Payment Reform

During 2023, IT staff supported Avatar system changes to meet new documentation and payment requirements set by the state. Changes included updates to multiple forms in Avatar including the following: progress notes, care plan, and clinical assessments. Reports were also developed to track implementation efforts, capture units of service and monitor the use of new service codes.

MHSA Expenditures

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

MHSA Integrated Service Categories and FY22-23 Expenditures

MHSA Integrated Service Categories	Abbreviation	FY 22-23 Expenditure Amount	Percentage
Admin	Admin	2,995,850.77	6%
Evaluation	Evaluation	903,158.63	2%
Housing	H	3,562,198.57	8%
Recovery Oriented Treatment Services	RTS	13,897,456.41	30%
Peer-to-Peer Support Services	P2P	7,823,375.06	17%
Vocational Services	VS	3,762,781.93	8%
Workforce Development and Training	WD	2,883,111.92	6%
Capital Facilities/IT	CF/IT	1,765,016.13	4%
Mental Health Promotion and Early Intervention Services	PEI	9,396,010.51	20%
TOTAL		**46,988,959.93**	**100%**

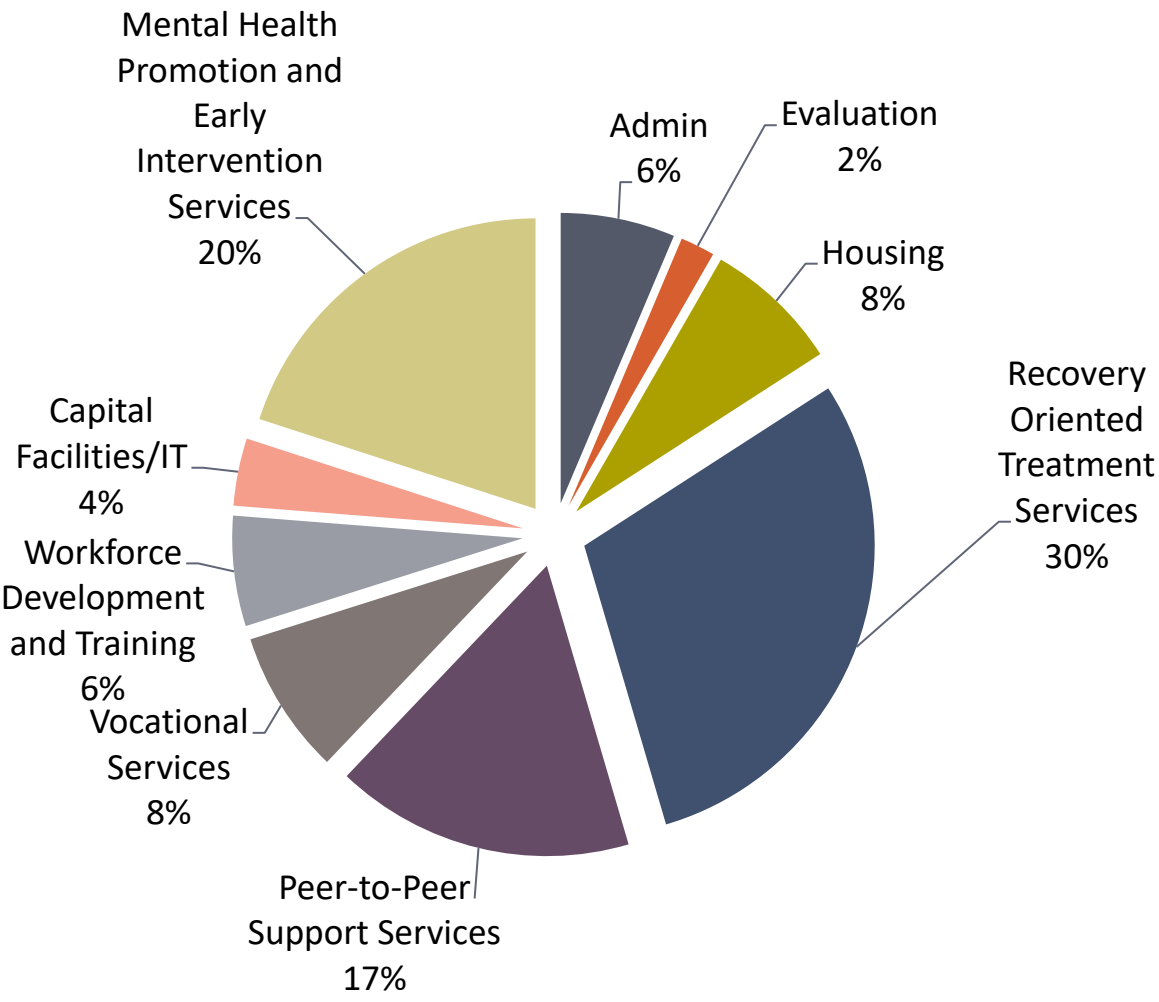
MHSA FY22-23 Actual Expenditures

SF MHSA Integrated Services Categori	Programs by Funding Component	FY 22-23 Expenditure
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 22-23, 53% was allocated to serve FSP clients	
Admin	CSS Admin	2,083,636.86
Evaluation	CSS Evaluation	738,776.80
H	CSS FSP Permanent Housing (capital units and master lease)	2,574,521.63
RTS	CSS Full Service Partnership 1. CYF (0-5)	424,360.00
RTS	CSS Full Service Partnership 2. CYF (6-18)	784,316.54
RTS	CSS Full Service Partnership 3. TAY (18-24)	1,662,486.26
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,075,882.27
RTS	CSS Full Service Partnership 5. Older Adults (60+)	1,562,151.66
RTS	CSS Full Service Partnership 6. AOT	1,591,541.80
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	1,024,113.24
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	651,000.53
RTS	CSS Other Non-FSP 3. Trauma Recovery	149,167.00
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,898,463.30
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	134,459.05
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	6,312,873.72
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,298,105.93
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	315,000.00
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	214,891.94
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	457,785.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	418,397.02
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	521,117.74
PEI	CSS Other Non-FSP 14. Overdose Prevention	81,951.81
	SUBTOTAL Community Services and Support (CSS)	**28,975,000.10**

	Workforce, Development Education and Training (WDET) **$3.2M transferred from CSS to fund WDET activities in FY 22-23**	
WD	WDET 1. Training and TA	1,310,726.49
WD	WDET 2. Career Pathways	921,920.26
WD	WDET 3. Residency and Internships	650,465.17
Admin	WDET Admin	184,160.12
Evaluation	WDET Evaluation	164,381.83
	SUBTOTAL Workforce, Development Education and Training (WDET)	**3,231,653.87**
	Capital Facilities/IT **$5.9M transferred from CSS to fund Capital Facilities/IT activities in FY 22-23**	
CF/IT	IT 1. Consumer Portal	184,655.36
VS	IT 2. Vocational IT	1,464,676.00
CF/IT	IT 3. System Enhancements	137,645.10
Admin	IT Admin	433,277.88
CF/IT	Cap 11 Southeast Family Therapy Services	96,805.72
CF/IT	Cap 14. Chinatown Child Development Center	1,331,123.54
CF/IT	Cap 15 TAY Clinic at 755 S. Van Ness	14,786.41
	SUBTOTAL Capital Facilities/IT	**3,662,970.01**
	Other	
	SUBTOTAL Other	**-**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**35,869,623.98**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	143,838.13
PEI	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	1,114,065.70
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,076,295.69
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,808,806.68
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	557,565.18
PEI	PEI 7. CalMHSA Statewide Programs	34,763.00
	SUBTOTAL Prevention and Early Intervention (PEI)	**8,735,334.38**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 18. Intensive Case Management Flow	614,259.92
P2P	INN 20. Technology-assisted Mental Health Solutions	526,618.44
P2P	INN 21. Wellness in the Streets (WITS)	369,622.98
PEI	INN 22. FUERTE	137,574.96
PEI	INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	377,411.64
PEI	INN 23. Culturally Responsive Practices for the Black/African American Communities	63,737.72
Admin	INN Admin	294,775.91
	SUBTOTAL Innovation (INN)	**2,384,001.57**
	TOTAL FY 22-23 MHSA Expenditures	**46,988,959.93**

FY22-23 Expenditures by Service Category

FY 22-23 Expenditures by Service Category



MHSA Funding Summary

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

County: San Francisco | Date: 6/30/23

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. Estimated FY23-24 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	32,686,060	18,348,014	7,466,637	574,010	10,373,616		69,448,337
2. Estimated New FY23-24 Funding (incl. interest)	60,978,597	15,534,855	4,142,879	222,138	8,786		80,887,255
3. Transfer in FY23-24	(9,250,735)			7,300,837	1,949,898	-	-
4. Access Local Prudent Reserve in FY23-24						-	-
5. Estimated Available Funding for FY23-24	84,413,922	33,882,869	11,609,516	8,096,985	12,332,301		150,335,593
B. FY23-24 MHSA Expenditures	35,546,197	21,301,516	3,847,047	7,300,837	5,566,796		73,562,392
C. Estimated FY24-25 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	48,867,725	12,581,354	7,762,469	796,148	6,765,505		76,773,201
2. Estimated New FY24-25 Funding (incl. interest)	48,861,770	12,215,442	3,214,590				64,291,802
3. Transfer in FY24-25	(10,906,832)			6,563,130	4,343,702	-	-
4. Access Local Prudent Reserve in FY24-25						-	-
5. Estimated Available Funding for FY24-25	86,822,662	24,796,796	10,977,059	7,359,278	11,109,207		141,065,003
D. Estimated FY24-25 Expenditures	36,722,372	23,468,447	2,557,516	6,563,130	6,372,814		75,684,279
E. Estimated FY25-26 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	50,100,290	1,328,349	8,419,543	796,148	4,736,393		65,380,723
2. Estimated New FY25-26 Funding (incl. interest)	32,281,063	8,070,266	2,123,754				42,475,083
3. Transfer in FY25-26	(12,024,990)			6,681,523	5,343,467	-	-
4. Access Local Prudent Reserve in FY25-26						-	-
5. Estimated Available Funding for FY25-26	70,356,364	9,398,615	10,543,297	7,477,671	10,079,860		107,855,806
F. Estimated FY25-26 Expenditures	37,736,261	23,493,878	2,211,493	6,681,523	6,071,176		76,194,331
G. Estimated FY25-26 Unspent Fund Balance	32,620,103	(14,095,263)	8,331,804	796,148	4,008,683		31,661,475

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

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

CSS Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	725,591	442,640	-	-	77,311	205,640
2. CSS Full Service Partnership 2. CYF (6-18)	1,375,489	952,284	317,863	-	48,107	57,235
3. CSS Full Service Partnership 3. TAY (18-24)	3,749,033	2,349,198	1,372,835	-	-	27,000
4. CSS Full Service Partnership 4. Adults (18-59)	10,675,466	5,953,136	3,074,500	-	-	1,647,830
5. CSS Full Service Partnership 5. Older Adults (60+)	2,461,388	1,635,511	450,401	294,270	-	81,207
6. CSS Full Service Partnership 6. AOT	2,096,350	1,809,674	275,922	-	-	10,754
7. CSS FSP Permanent Housing (capital units and master lease)	2,456,110	2,456,110	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,342,827	3,370,818	-	162,026	-	809,984
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,917,445	1,154,400	-	271,654	-	491,391
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	189,000	189,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	123,230	123,230	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	341,642	341,642	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,836,333	1,287,517	236,996	-	-	311,819
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,140,279	684,777	143,572	-	-	311,929
3. CSS Other Non-FSP 3. Trauma Recovery	209,383	142,667	36,309	-	-	30,407
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,631,121	2,274,891	356,230	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,045,412	215,345	-	-	-	830,068
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,342,827	3,370,818	-	162,026	-	809,984
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,343,544	1,410,933	-	332,021	-	600,589
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	126,000	126,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	287,537	287,537	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	227,761	227,761	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	790,700	333,402	457,298	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	728,845	728,845	-	-	-	-
14. CSS Other Non-FSP 14. Overdose Prevention	997,531	997,531	-	-	-	-
CSS Administration	2,128,683	2,128,683	-	-	-	-
CSS Evaluation	551,847	551,847	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-				
Total CSS Program Expenditures	49,841,375	35,546,197	6,721,927	1,221,996	125,418	6,225,836
FSP Programs as Percent of Total	58%					

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	747,359	455,919	-	-	79,631	211,809
2. CSS Full Service Partnership 2. CYF (6-18)	1,412,968	978,232	326,524	-	49,418	58,795
3. CSS Full Service Partnership 3. TAY (18-24)	3,858,198	2,417,602	1,412,810	-	-	27,786
4. CSS Full Service Partnership 4. Adults (18-59)	11,433,130	6,375,645	3,292,705	-	-	1,764,780
5. CSS Full Service Partnership 5. Older Adults (60+)	2,680,404	1,781,040	490,478	320,454	-	88,432
6. CSS Full Service Partnership 6. AOT	2,159,208	1,863,936	284,195	-	-	11,076
7. CSS FSP Permanent Housing (capital units and master lease)	2,503,196	2,503,196	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,436,533	3,443,550	-	165,522	-	827,461
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,903,228	1,145,841	-	269,640	-	487,748
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	189,000	189,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	125,031	125,031	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	341,642	341,642	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,887,145	1,323,143	243,554	-	-	320,448
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,174,487	705,321	147,880	-	-	321,287
3. CSS Other Non-FSP 3. Trauma Recovery	215,664	146,947	37,398	-	-	31,319
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,710,055	2,343,138	366,917	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,076,775	221,805	-	-	-	854,970
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,436,533	3,443,550	-	165,522	-	827,461
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,326,168	1,400,472	-	329,560	-	596,136
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	126,000	126,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	291,739	291,739	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	227,761	227,761	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	814,421	343,404	471,017	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	750,710	750,710	-	-	-	-
14. CSS Other Non-FSP 14. Overdose Prevention	1,027,457	1,027,457	-	-	-	-
CSS Administration	2,181,889	2,181,889	-	-	-	-
CSS Evaluation	568,402	568,402	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	51,605,103	36,722,372	7,073,478	1,250,697	129,049	6,429,508
FSP Programs as Percent of Total	59%					

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	769,780	469,597	-	-	82,020	218,163
2. CSS Full Service Partnership 2. CYF (6-18)	1,451,572	1,004,958	335,445.06	-	50,768	60,401
3. CSS Full Service Partnership 3. TAY (18-24)	3,970,637	2,488,058	1,453,983.03	-	-	28,596
4. CSS Full Service Partnership 4. Adults (18-59)	11,774,067	6,565,767	3,390,894	-	-	1,817,406
5. CSS Full Service Partnership 5. Older Adults (60+)	2,760,245	1,834,091	505,088	329,999	-	91,067
6. CSS Full Service Partnership 6. AOT	2,223,952	1,919,826	292,717	-	-	11,409
7. CSS FSP Permanent Housing (capital units and master lease)	2,551,695	2,551,695	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,567,300	3,545,049	-	170,400	-	851,850
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,954,483	1,176,699	-	276,901	-	500,883
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	189,000	189,000	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	126,886	126,886	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	341,642	341,642	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,943,759	1,362,837	250,861	-	-	330,061
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,209,722	726,480	152,316	-	-	330,926
3. CSS Other Non-FSP 3. Trauma Recovery	222,134	151,355	38,520	-	-	32,258
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	2,791,356	2,413,432	377,924	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,109,078	228,459	-	-	-	880,619
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,567,300	3,545,049	-	170,400	-	851,850
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,388,812	1,438,187	-	338,435	-	612,190
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	126,000	126,000	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	296,066	296,066	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	227,761	227,761	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	838,854	353,706	485,148	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	773,231	773,231	-	-	-	-
14. CSS Other Non-FSP 14. Overdose Prevention	1,058,281	1,058,281	-	-	-	-
CSS Administration	2,236,692	2,236,692	-	-	-	-
CSS Evaluation	585,455	585,455	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	53,055,759	37,736,261	7,282,895	1,286,136	132,788	6,617,680
FSP Programs as Percent of Total	59%					

PEI Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	200,646	200,645.78	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	686,552	620,918	-	-	-	65,633
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	6,966,734	6,941,840	26,001	-	-	(1,107)
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	12,919,638	2,408,522	-	-	-	10,511,116
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	71,403	62,166	9,237	-	-	-
7. PEI 7. CalMHSA Statewide Programs	41,388	41,388	-	-	-	-
8. PEI 9. Overdose Prevention	2,004,189	2,004,189	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	686,552	620,918	-	-	-	65,633
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	6,966,734	6,941,840	26,001	-	-	(1,107)
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	4,306,546	802,841	-	-	-	3,503,705
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	642,625	559,490	83,135	-	-	-
PEI Administration	96,758	96,758	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Expenditures	35,589,765	21,301,516	144,375	-	-	14,143,874

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	206,665	206,665.15	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	725,640	656,270	-	-	-	69,370
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	8,081,130	8,052,253	30,161	-	-	(1,284)
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	12,065,556	2,249,301	-	-	-	9,816,255
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	73,545	64,031	9,514	-	-	-
7. PEI 7. CalMHSA Statewide Programs	41,388	41,388	-	-	-	-
8. PEI 9. Overdose Prevention	2,064,315	2,064,315	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	725,640	656,270	-	-	-	69,370
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	8,081,130	8,052,253	30,161	-	-	(1,284)
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	4,021,852	749,767	-	-	-	3,272,085
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	661,904	576,275	85,629	-	-	-
PEI Administration	99,661	99,661	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	36,848,424	23,468,447	155,465	-	-	13,224,512

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	212,865	212,865	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	728,363	658,732	-	-	-	69,630
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	8,000,945	7,972,355	29,861	-	-	(1,271)
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	12,427,523	2,316,780	-	-	-	10,110,742
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	75,751	65,951	9,800	-	-	-
7. PEI 7. CalMHSA Statewide Programs	41,388	41,388	-	-	-	-
8. PEI 9. Overdose Prevention	2,126,244	2,126,244	-	-	-	-
PEI Programs - Early Intervention						
9. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	658,732	658,732	-	-	-	-
11. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Preventi	10,984,447	7,972,355	-	-	-	3,012,092
12. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,071,568	772,260	299,307	-	-	-
13. PEI 6. Comprehensive Crisis Services (10% Prevention)	593,563	593,563	-	-	-	-
PEI Administration	102,651	102,651	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	37,024,040	23,493,878	338,968	-	-	13,191,194

Program Name	Childhood Trauma Prevention and Early Intervention	Early Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	Culturally Competent and Linguistically Appropriate Prevention and Early Intervention	Strategies Targeting the Mental Health Needs of Older Adults	Early Identification Programming of Mental Health Symptoms	Fiscal Year 2023/24 MHSA Funds	Fiscal Year 2024/25 Estimated MHSA Funds	Fiscal Year 2025/26 Estimated MHSA Funds
PEI 1. Stigma Reduction	✓	✓	✓	✓	✓	✓	✓	$ 200,646	$ 206,665	$ 212,865
PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	✓	✓	✓	✓			✓	$ 1,241,837	$ 1,312,539	$ 1,317,465
PEI 4. Population Focused Mental Health (50% Prevention)	✓	✓	✓	✓	✓	✓	✓	$ 13,883,680	$ 16,104,506	$15,944,710
PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	✓	✓	✓	✓	✓		✓	$ 3,211,363	$ 2,999,069	$ 3,089,041
PEI 6. Comprehensive Crisis Services (10% Prevention)	✓	✓	✓	✓			✓	$ 621,656	$ 640,306	$ 659,515
PEI 7. CalMHSA Statewide Programs	✓	✓	✓	✓	✓	✓	✓	$ 41,388	$ 41,388	$ 2,126,244

INN Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. INN 18. Intensive Case Management Flow	556,719	556,719	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	804,681	804,681	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	395,936	395,936	-	-	-	-
4. INN 22. FUERTE	-	-				
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,796,982	1,796,982				
INN Administration	292,729	292,729	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Expenditures	3,847,047	3,847,047	-	-	-	-

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 21. Wellness in the Streets (WITS)	407,814	407,814	-	-	-	-
2. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,850,891	1,850,891	-	-	-	-
INN Administration	298,811	298,811	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	2,557,516	2,557,516	-	-	-	-

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,906,418	1,906,418	-	-	-	-
INN Administration	305,075	305,075	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	2,211,493	2,211,493	-	-	-	-

WET Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs						
1. Training and TA	6,471,582	4,245,133	-	-	-	2,226,449
2. Career Pathways	1,771,552	1,771,552	-	-	-	-
3. Residency and Internships	962,088	962,088	-	-	-	-
WET Administration	155,998	155,998	-	-	-	-
WET Evaluation	166,066	166,066	-	-	-	-
Total WET Program Expenditures	9,527,286	7,300,837	-	-	-	2,226,449

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	5,709,566	3,745,277	-	-	-	1,964,289
2. Career Pathways	1,746,457	1,746,457	-	-	-	-
3. Residency and Internships	741,170	741,170	-	-	-	-
WET Administration	160,678	160,678	-	-	-	-
WET Evaluation	169,548	169,548	-	-	-	-
Total WET Program Estimated Expenditures	8,527,419	6,563,130	-	-	-	1,964,289

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	5,776,295	3,789,048	-	-	-	1,987,246
2. Career Pathways	1,790,437	1,790,437	-	-	-	-
3. Residency and Internships	763,405	763,405	-	-	-	-
WET Administration	165,498	165,498	-	-	-	-
WET Evaluation	173,134	173,134	-	-	-	-
Total WET Program Estimated Expenditures	8,668,770	6,681,523	-	-	-	1,987,246

CFTN Estimated Expenditures for FY23-24 through FY25-26

	Fiscal Year 23-24					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CFTN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 11. Southeast Family Therapy Services	2,000,000	2,000,000	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	1	1	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	1	1	-	-	-	-
4. Cap 14. Chinatown Child Development Center	1,500,000	1,500,000	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	200,000	200,000	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	250,000	250,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
1. IT 1. Consumer Portal	196,662	196,662	-	-	-	-
2. IT 2. Vocational IT	1,327,302	1,327,302	-	-	-	-
3. IT 3. System Enhancements	57,070	57,070	-	-	-	-
CFTN Administration	35,760	35,760	-	-	-	-
Total CFTN Program Expenditures	5,566,796	5,566,796	-	-	-	-

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 11. Southeast Family Therapy Services	2,000,000	2,000,000	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	1	1	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	1,000,000	1,000,000	-	-	-	-
4. Cap 14. Chinatown Child Development Center	1,500,000	1,500,000	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	1	1	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	1	1	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	202,562	202,562	-	-	-	-
9. IT 2. Vocational IT	1,367,121	1,367,121	-	-	-	-
10. IT 3. System Enhancements	-	-	-	-	-	-
CFTN Administration	303,128	303,128	-	-	-	-
Total CFTN Program Estimated Expenditures	6,372,814	6,372,814	-	-	-	-

	Fiscal Year 25-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cap 11. Southeast Family Therapy Services	-	-	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	2,000,000	2,000,000	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	1	1	-	-	-	-
4. Cap 14. Chinatown Child Development Center	2,000,000	2,000,000	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	1	1	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	1	1	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	210,425	210,425	-	-	-	-
9. IT 2. Vocational IT	1,408,134	1,408,134	-	-	-	-
10. IT 3. System Enhancements	130,103	130,103	-	-	-	-
CFTN Administration	322,511	322,511	-	-	-	-
Total CFTN Program Estimated Expenditures	6,071,176	6,071,176	-	-	-	-

San Francisco Health Network
Behavioral Health Services

2021 and 2022 Workforce Needs Assessment

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

SF-MHSA Needs Assessment

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

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

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

2019 Analysis

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

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

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

San Francisco Health Network
Behavioral Health Services

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

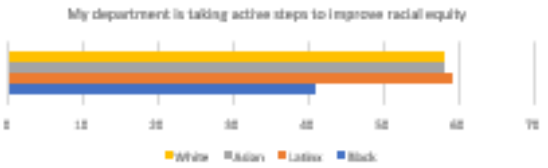
V: 5 | Date: 2/28/22

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

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

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

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



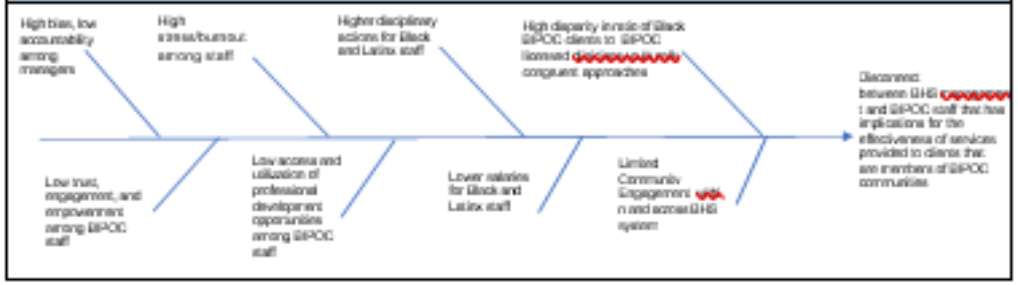
Problem Statement: What specific, measurable problem will serve as your baseline performance?

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

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

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

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



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

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

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

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

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

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

Continuum on Becoming an Anti-Racist Multicultural Organization

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

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

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

San Francisco Health Network
Behavioral Health Services

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

2021-2022
BHS Racial Equity Action Plan Priorities

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

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

2022 Challenges & Needs

SF Emergency Hiring Order & BHS Hiring Extravaganza

Embedded equity team in recruitment, hiring, and onboarding process

Piloted equity interventions

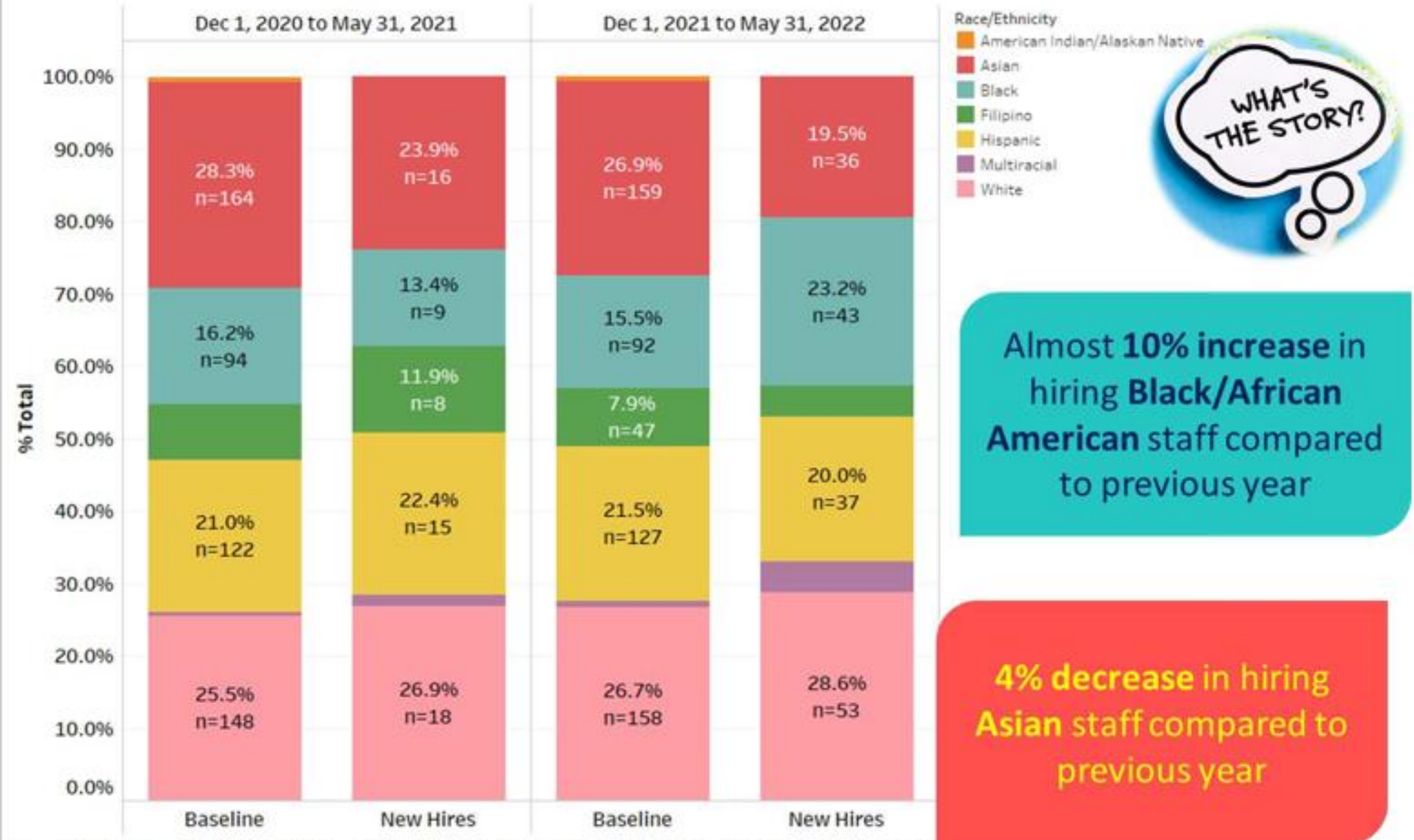
Hired 200 staff

Management and clinicians remain predominantly white and Asian despite equity interventions

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

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

BHS New Hires by Race/Ethnicity

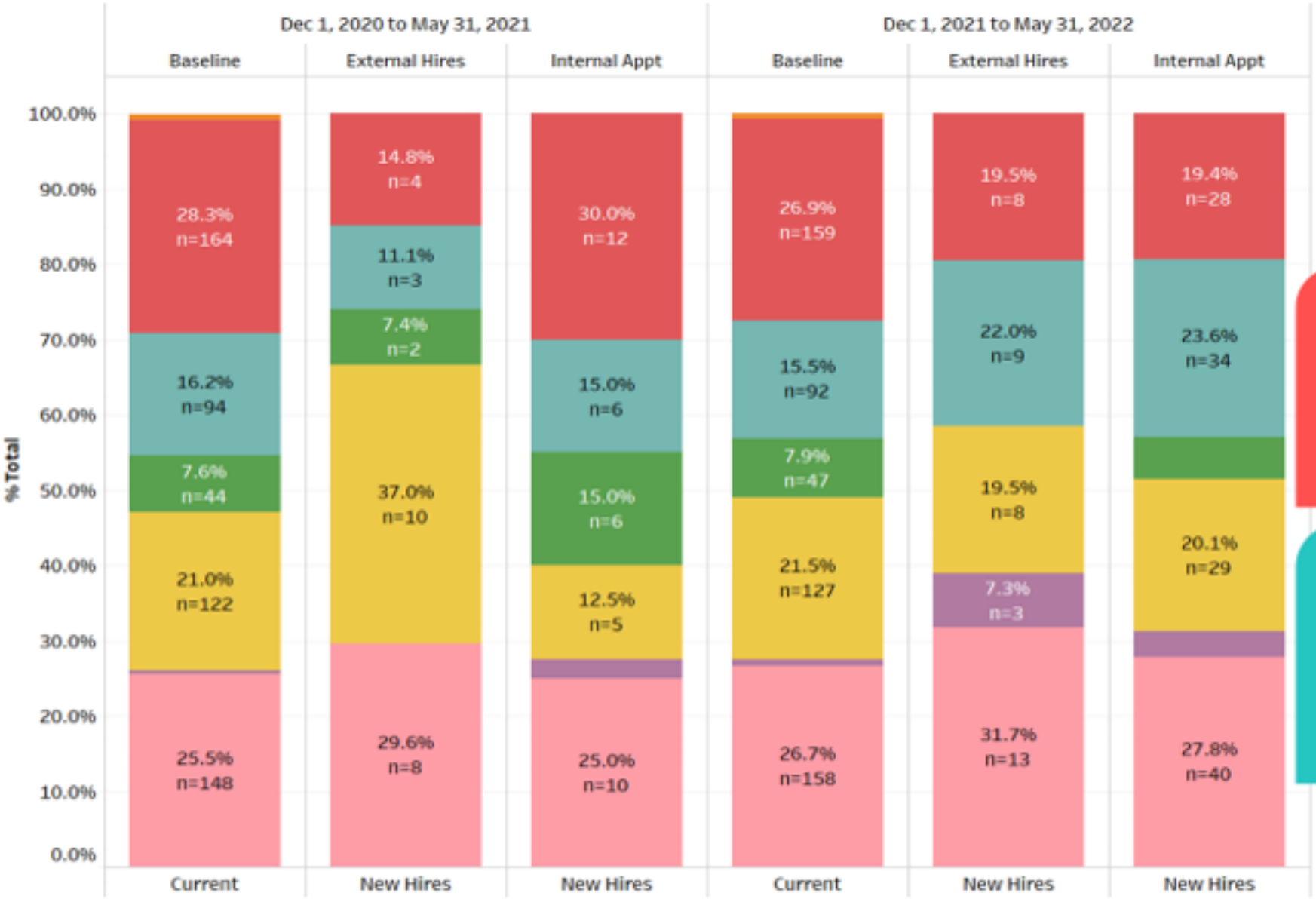


Almost **10% increase** in hiring **Black/African American** staff compared to previous year

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

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

BHS New Hires: External Recruitments and Internal Appointments



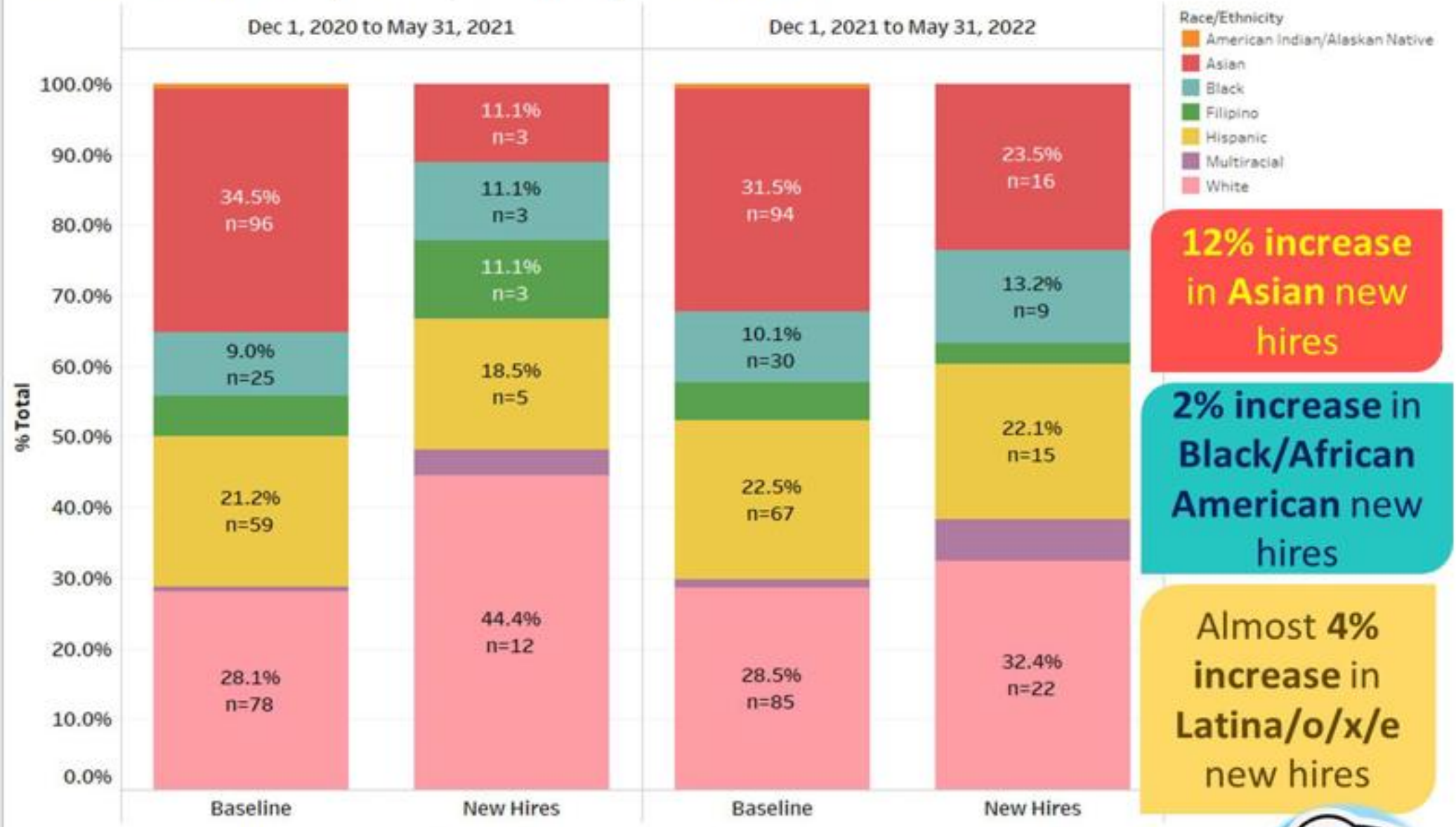
Almost **5% increase** in **Asian** external hires, and **11% decrease** in internal appts

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

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

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

BHS New Hires by Race/Ethnicity: Clinicians



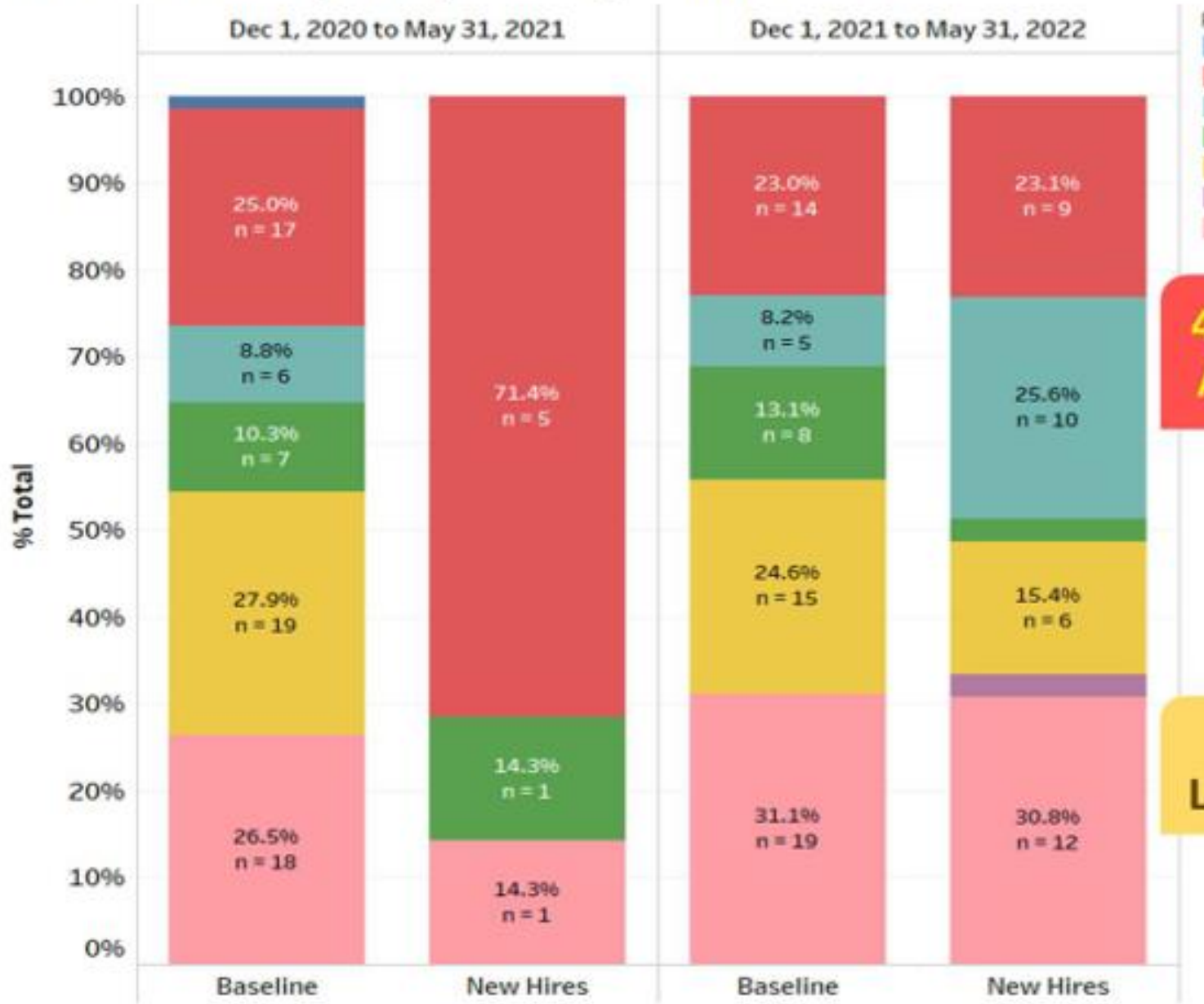
12% increase in **Asian** new hires

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

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

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

BHS New Hires by Race/Ethnicity: Administrators



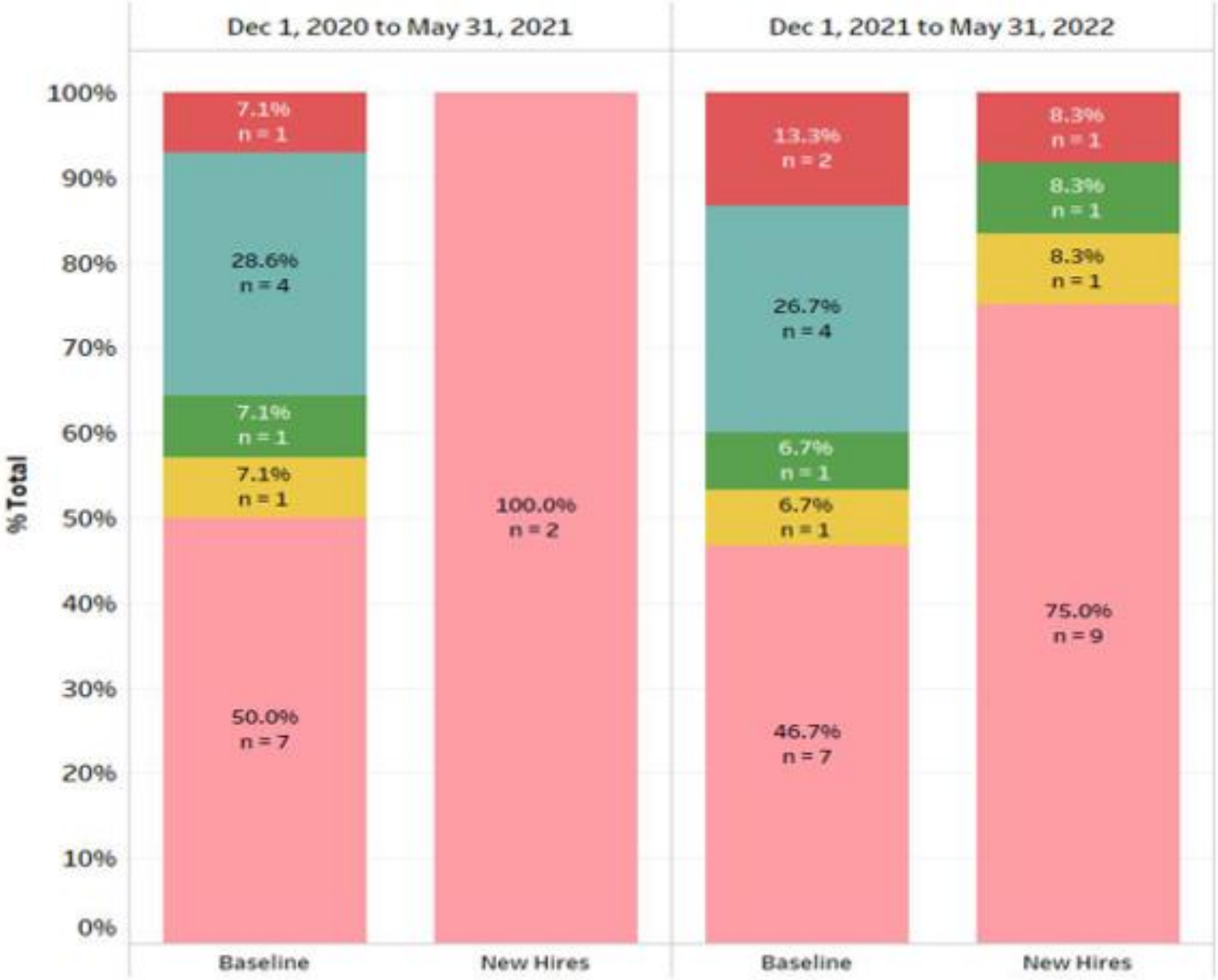
48% decrease in **Asian** new hires

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

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

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

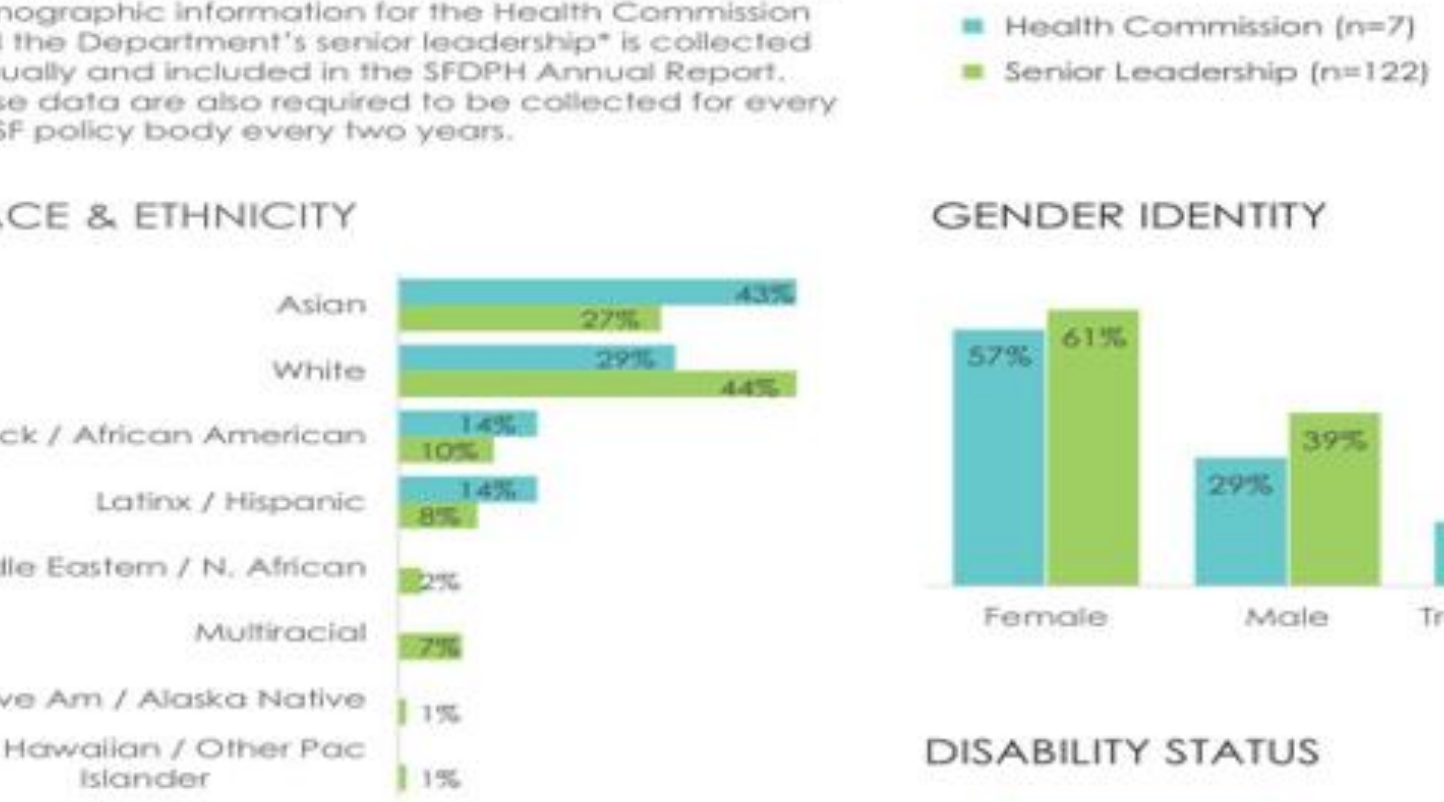
BHS New Hires by Race/Ethnicity: Directors/Managers



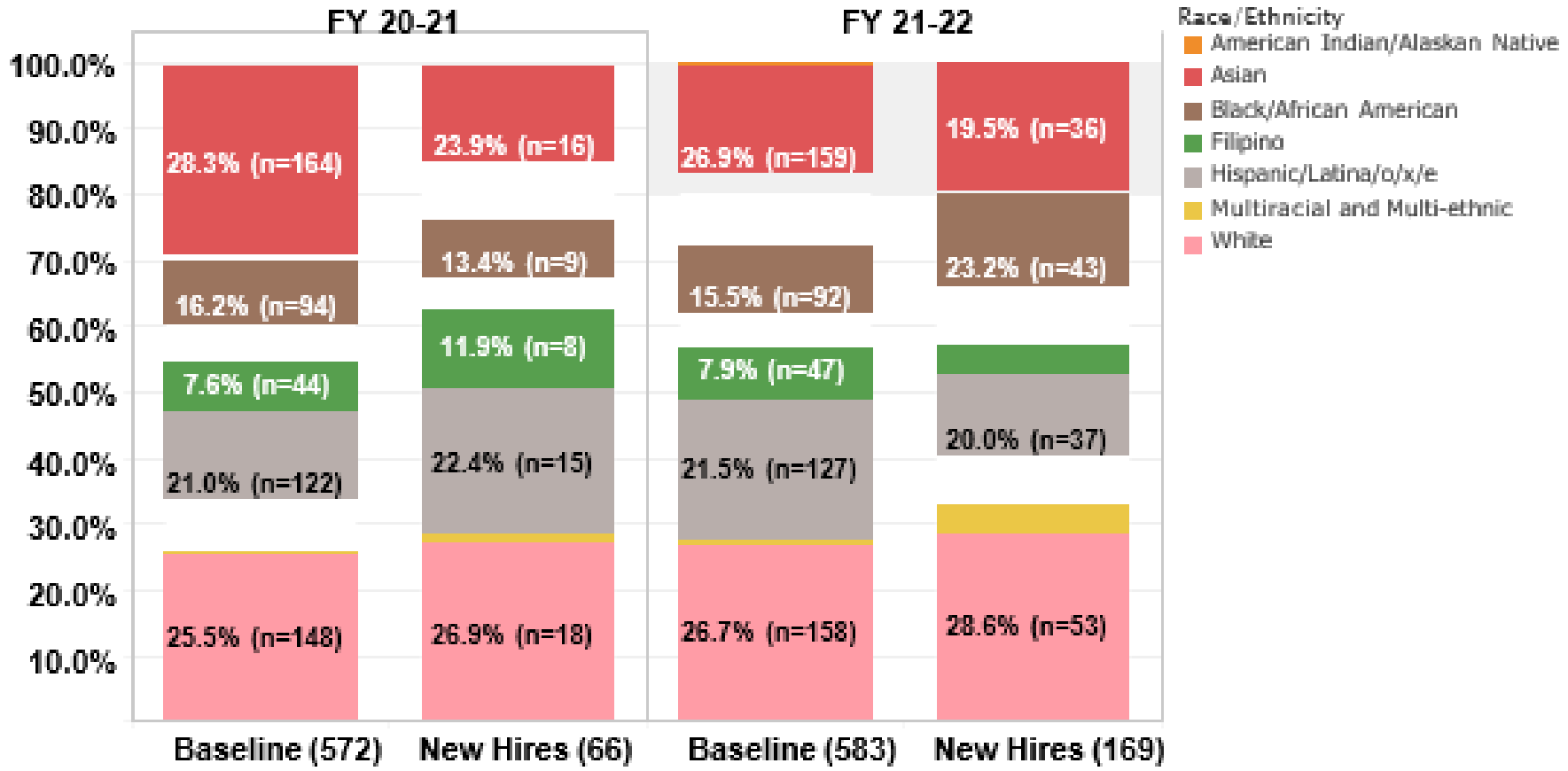
Behavioral Health Services (BHS) directors current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021,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

HEALTH COMMISSION & SENIOR LEADERSHIP DEMOGRAPHICS

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

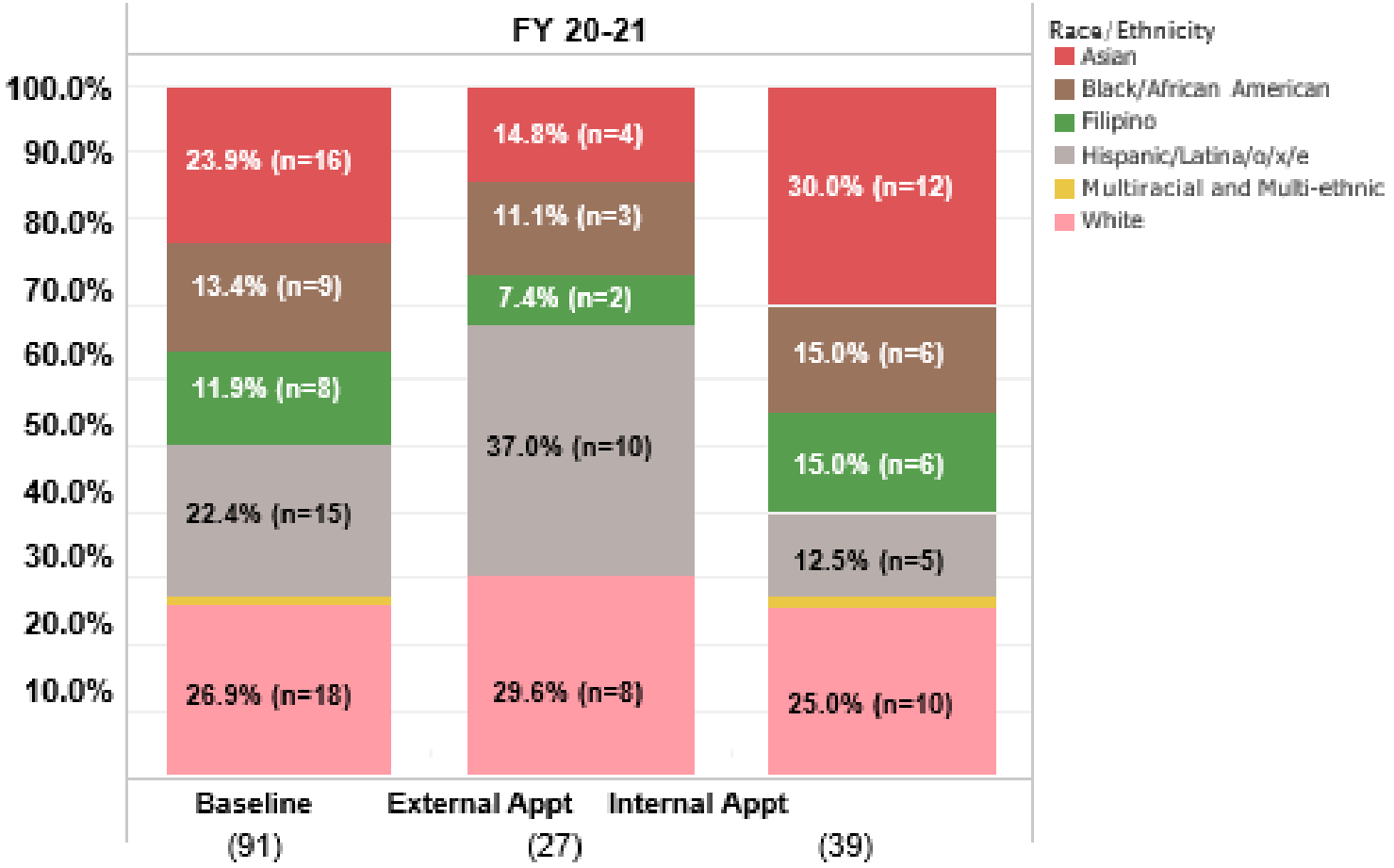


BHS New Hires by Race/Ethnicity



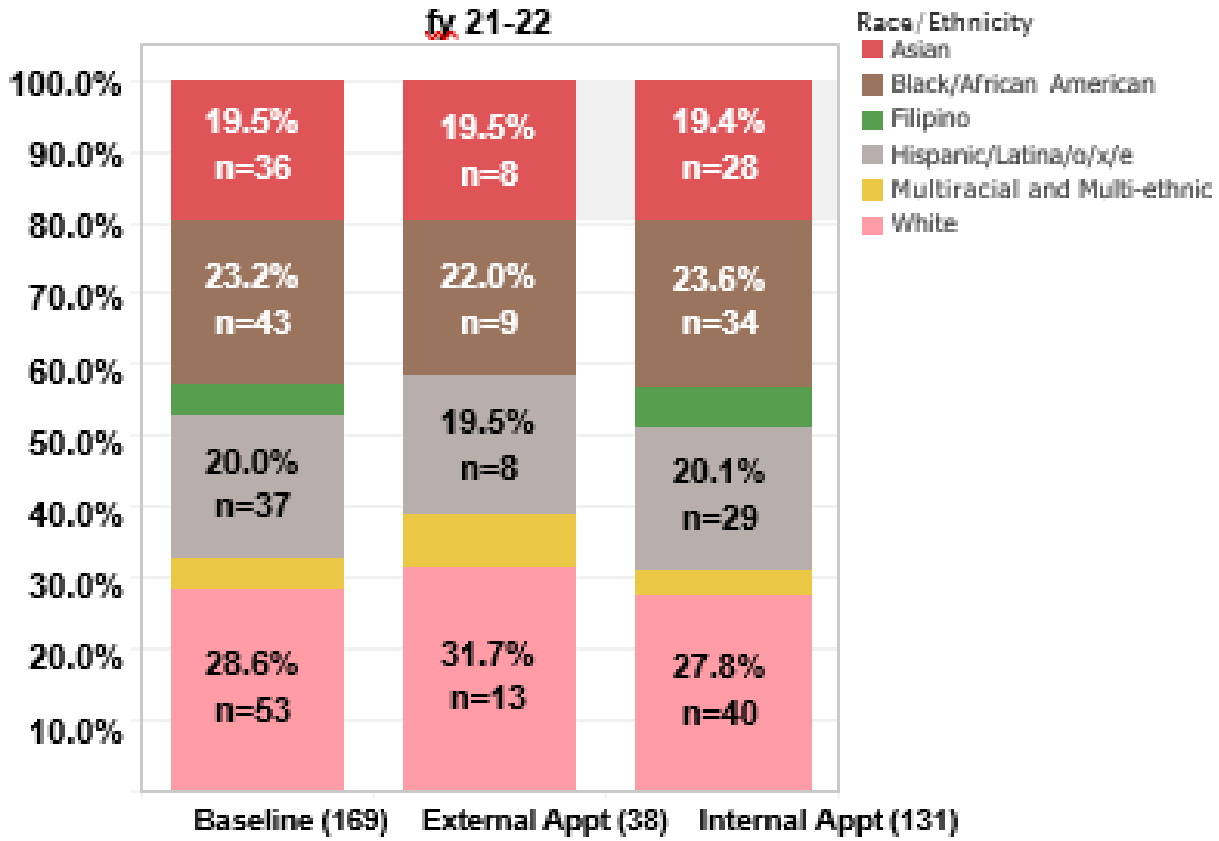
Behavioral Health Services (BHS) current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021,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

2020 BHS External Hires and Internal Appointments by Race/Ethnicity



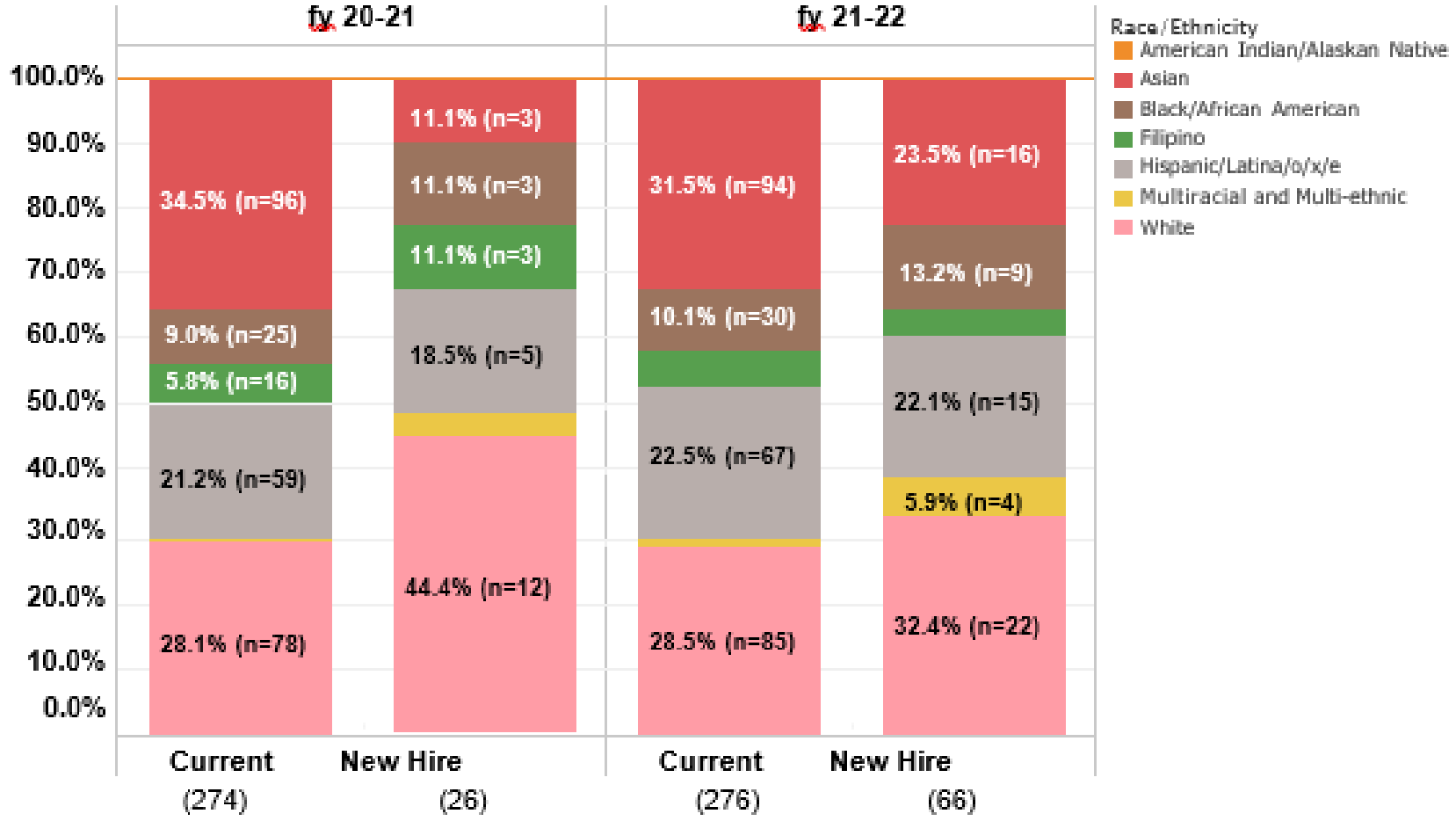
Behavioral Health Services (BHS) new hires versus external hires and internal appointments between 12/1/2020 and 5/31/2021 by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022,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

2021 BHS External Hires and Internal Appointments by Race/Ethnicity



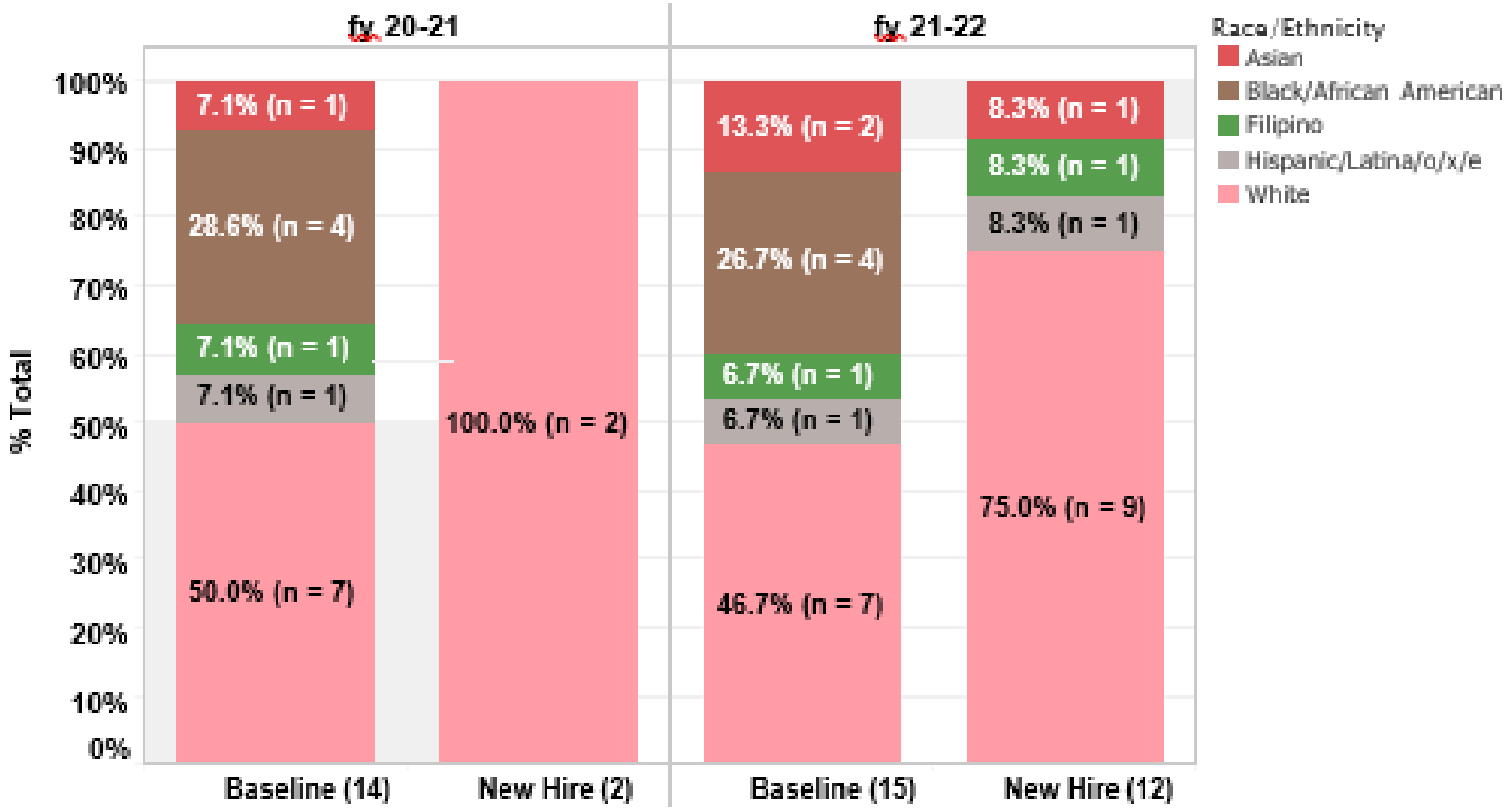
Behavioral Health Services (BHS) new hires versus external hires and internal appointments between 12/1/2021 and 5/31/2022 by race/ethnicity based on data accessed in HRiMS on 11/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021, 11/1/2021, 12/6/2021, 1/3/2022, 3/7/2022, 4/6/2022,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

BHS New Hires by Race/Ethnicity: Clinicians



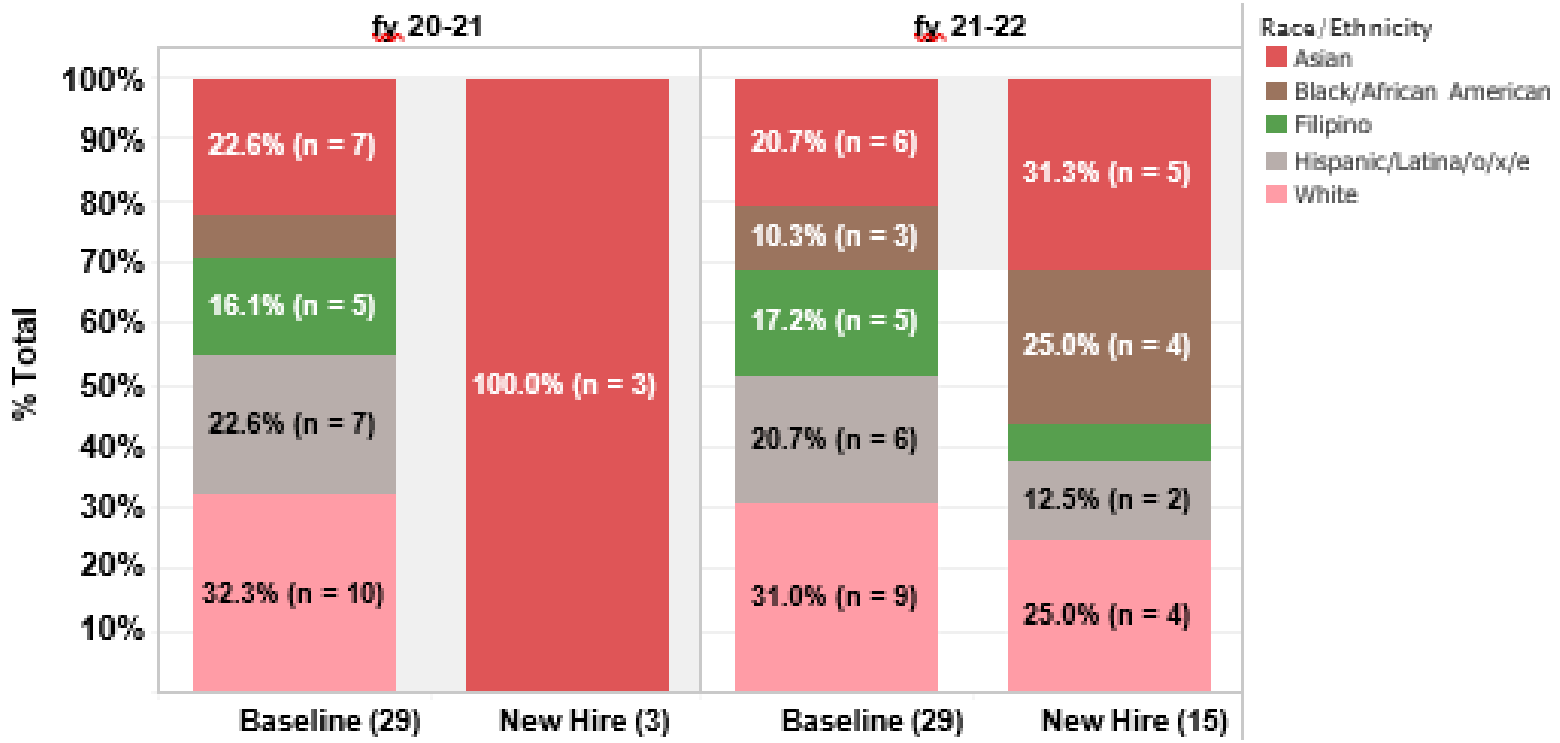
Behavioral Health Services (BHS) clinicians current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921, 6/2/2021,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

BHS New Hires by Race/Ethnicity: Directors/Managers



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

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

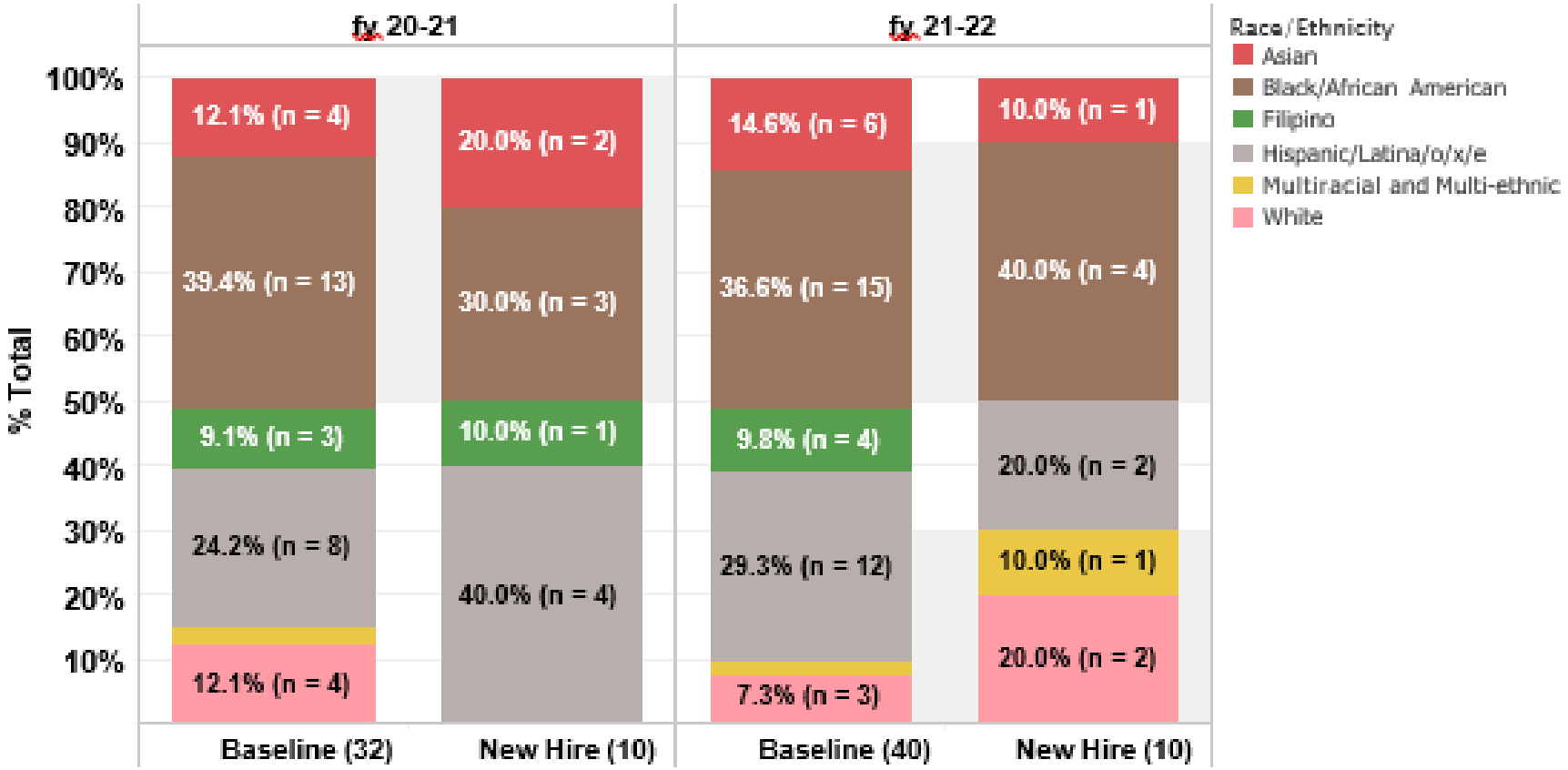


Behavioral Health Services (BHS) Health Program Coordinators I and II, Analysts, and Epidemiologists current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRIMS on 11/30/2020 and 12/6/2021 and PeopleSoft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

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

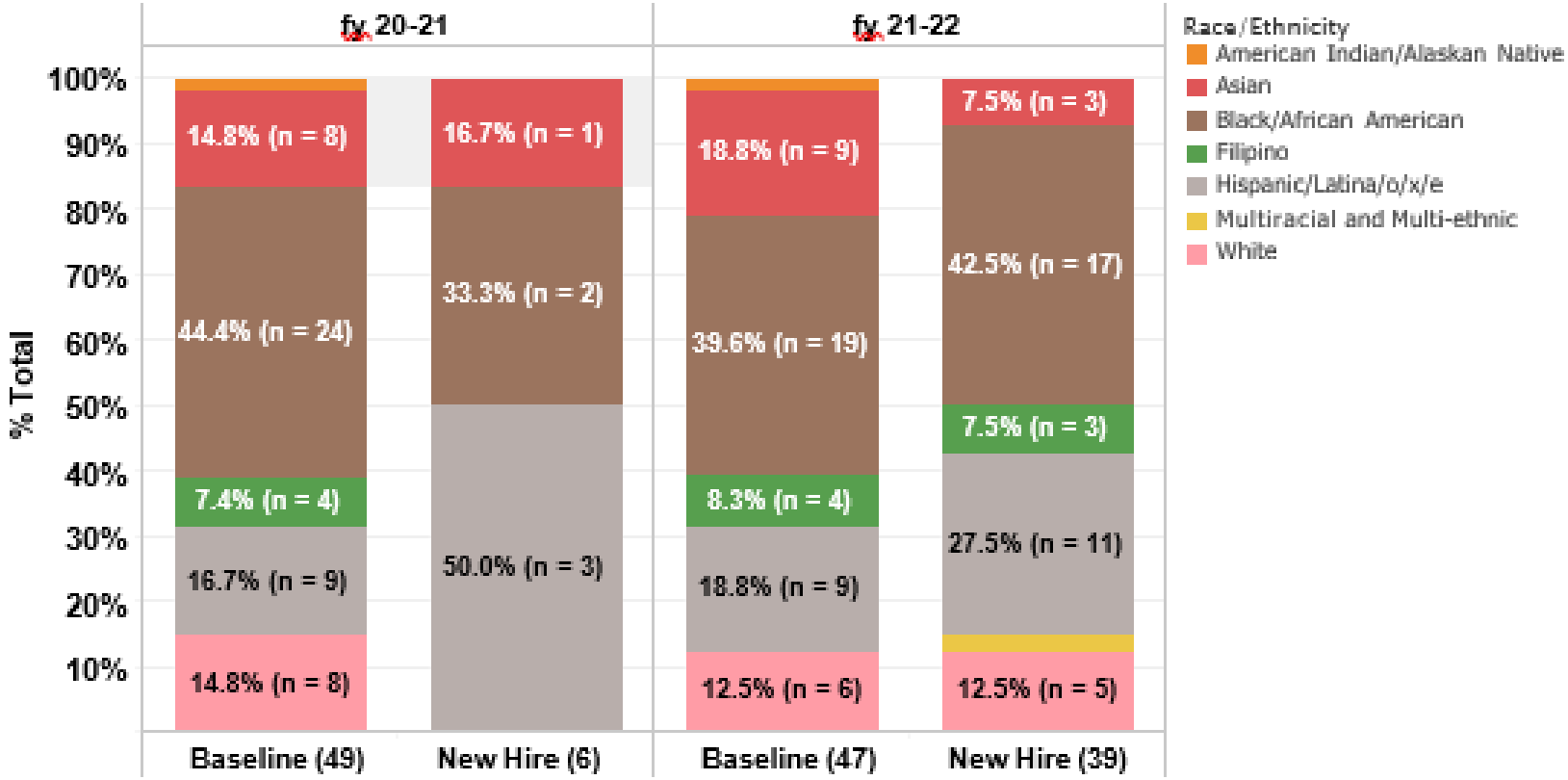
Behavioral Health Services (BHS) Health Program Coordinator IIIs current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021,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

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



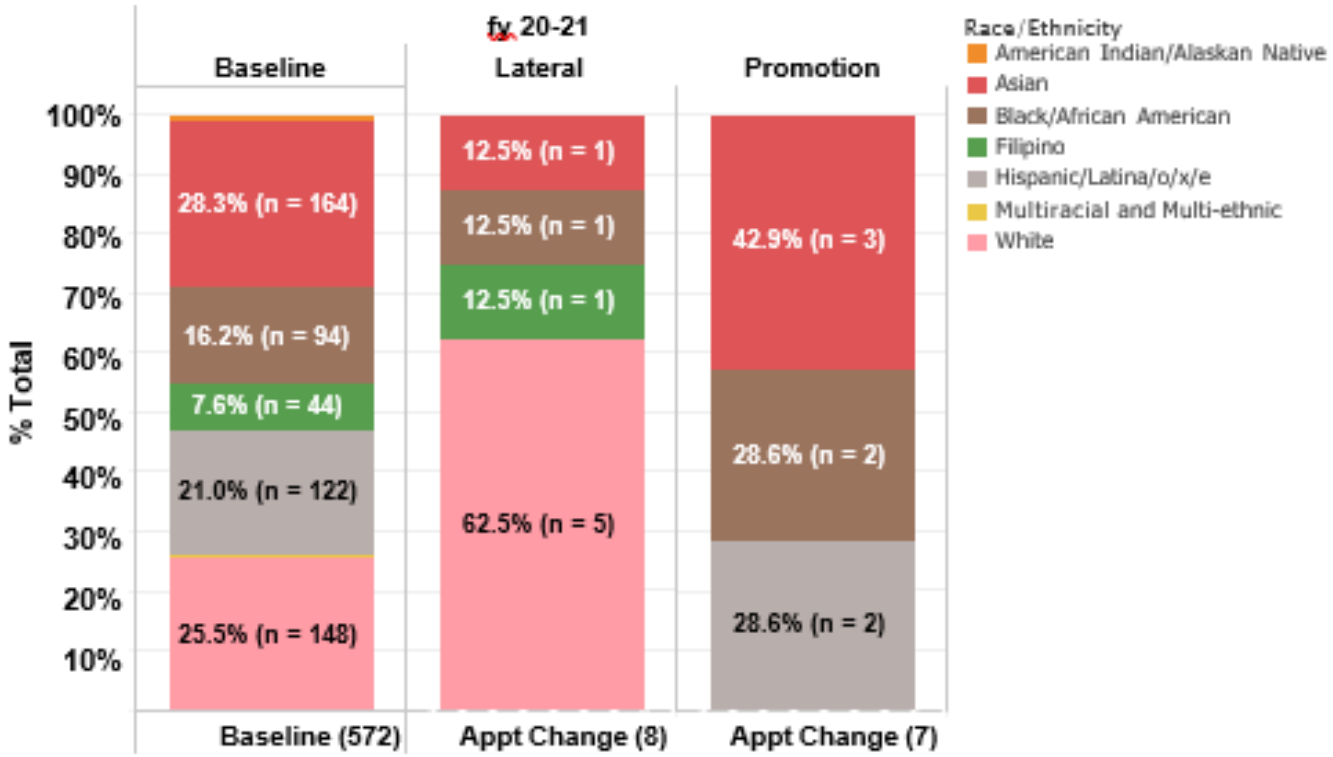
Behavioral Health Services (BHS) Health Workers I and II current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921,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

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



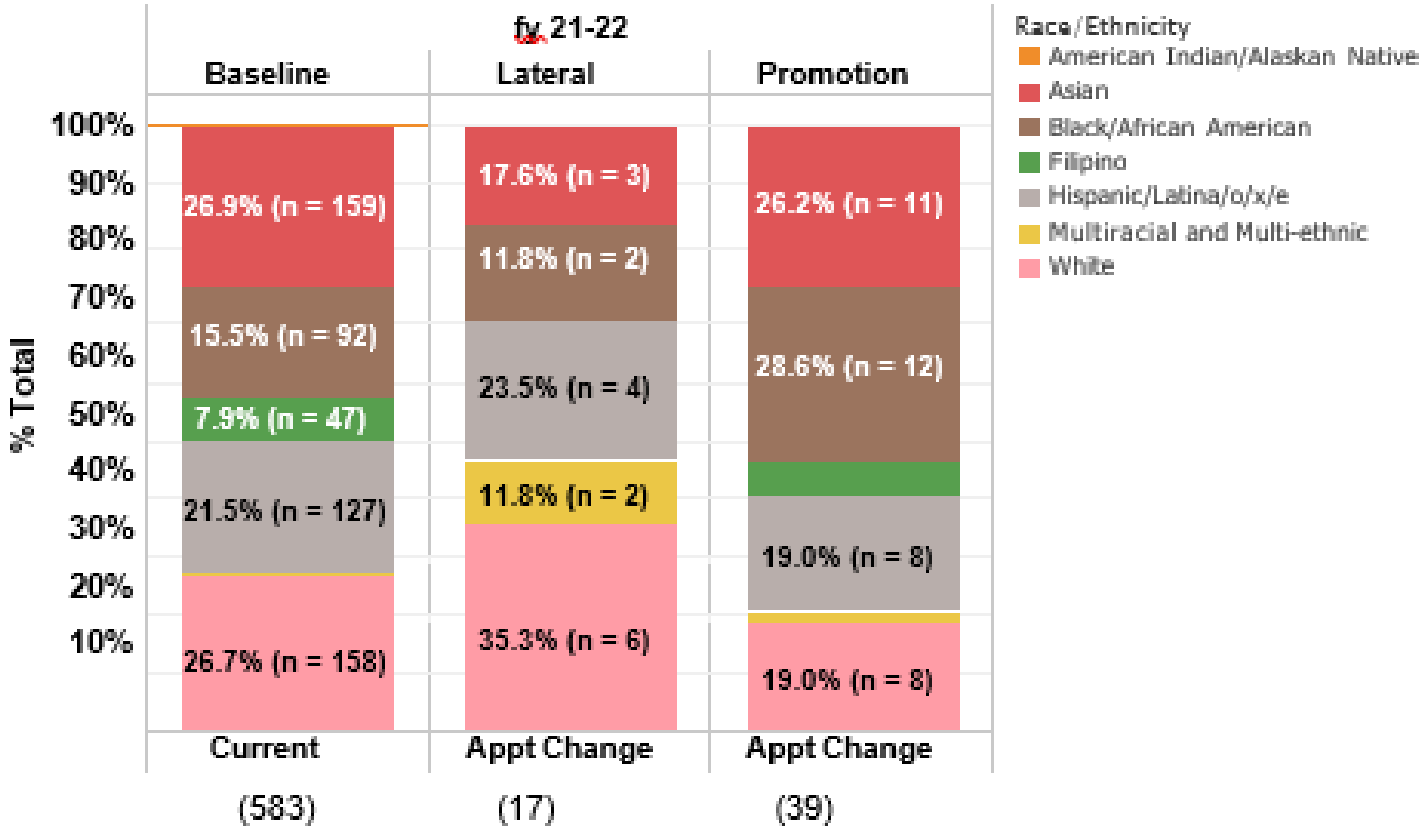
Behavioral Health Services (BHS) Health Workers III and IV current staff (12/1/2020 vs 12/1/2021) and new hires (12/1/2020 through 5/31/2021 vs 12/1/2021 through 5/31/2022) by race/ethnicity based on data accessed in HRiMS on 11/30/2020 and 12/6/2021 and PeopleSoft on 11/1/2020, 2/1/2021, 3/8/2021, 4/5/2921,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

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



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

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



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

Proposed Next Steps

Prevention, Early Intervention, and Response

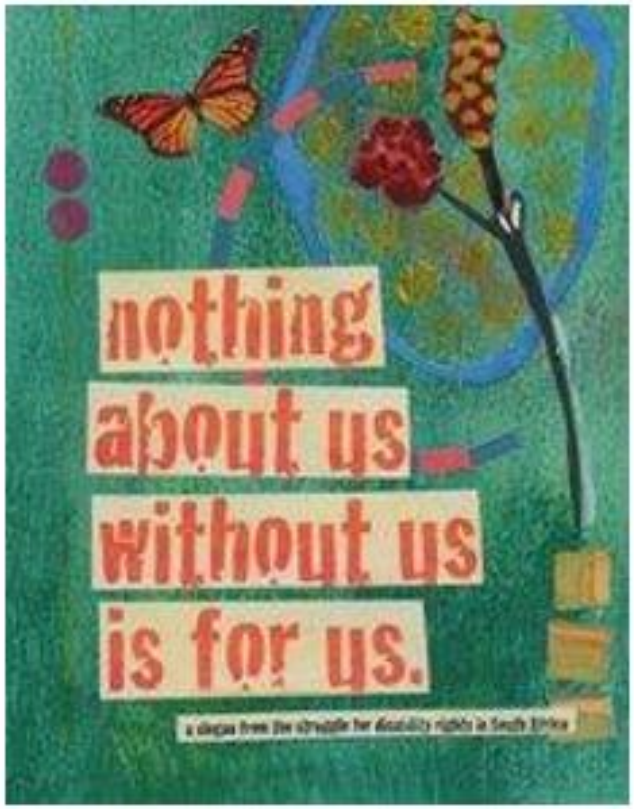
- Do no harm.
- When harm is done, acknowledge, apologize, and initiate racial reckoning at individual, interpersonal, and organizational levels.
- Support transparent and accountable measures for racial harm prevention, early intervention, and rapid response.

Proposed Next Steps

Recruitment and Hiring for all BHS Positions

BHS HR Pre-Approved Recruitment and Hiring Process and Procedures

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



Proposed Next Steps

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

- Include Equity Director and/or designated equity lead in **every stage of hiring process** from preparation to recruitment to final offer.
- Include equity introduction and **lived experience desired qualification** in all job announcements.
- Create **recruitment plans** that prioritize Black/African American, Latina-o-e-x, and SOGI applicants.
- Assess **applicant racial/ethnic and SOGI demographics** and related work experience before closing job announcements and conduct additional prioritized recruitment when needed.
- Include **weighted rating of lived experience** in application review form and notice of inquiry referral questionnaire rating.
- Include **lived experience interview question** and response guidelines in all interviews.
- Include **weighted assessment** of application, application review, notice of inquiry referral questionnaire, and interview.
- Base **merit** on organizational, positional, and lived experience, especially when considering internal candidates.

Proposed Next Steps

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

- Provide **onboarding warm welcome** with additional **culturally relevant supports** including DPH Working While Black group and BHS racial/ethnic affinity/accountability groups.
- Decrease racialized salary gaps for Black/African American and Latina-o-e-x staff including **acting assignments** and **acting pay** advancements, conversion of **TEX positions to PCS**, and **appointment above entrance** salary step requests.
- Reduce racialized disciplinary outcomes, including **probation**, for Black/African American and Latina-o-e-x staff.
- Increase transparent **accountability measures** for white and Asian directors/managers, higher admin, and clinical staff.

Appendix B Three-Year Prevention and Early Intervention (PEI) Evaluation Report FY20-21 through FY22-23

Figure – Mural in San Francisco

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

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

PEI Programming and Evaluation

Community Program Planning for Implementation of Prevention and Early Intervention Programming

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

In 2023, MHSA hosted several community engagement meetings across the city to collect community member feedback on existing PEI programming and better understand the needs of the community. All meetings were advertised via word-of-mouth and email notifications.

The community feedback is incorporated into our continuous program improvement planning efforts including program planning and implementation, monitoring, quality improvement, evaluation and budget allocations. A summary of the community feedback can be found in the Community Program Planning section above.

PEI Service Category Overview

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

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

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

CALIFORNIA MHSA PEI Category	SF-MHSA PEI Programming
1. Prevention Programs	All Population-Focused Programs and School-Based Programs are Prevention Programs
2. Early Intervention Services	All Population-Focused Programs and ECMHCI are Early Intervention Programs.
3. Outreach for Increase Recognition of Early Signs of Mental Illness Programs	All Population-Focused Programs are Outreach Programs.
4. Stigma and Discrimination Reduction	The Peer Engagement Program is our designated Stigma Reduction Program. All Population-Focused Programs are Discrimination Reduction Programs.

5. Access and Linkage to Treatment Programs	All Population-Focused Programs and Comprehensive Crisis Programs are Access and Linkage Programs.
6. Suicide Prevention Program	SF-MHSA does not provide PEI funding for a Suicide Prevention Program, as San Francisco County already has an established County-wide Suicide Prevention Program called “San Francisco Suicide Prevention” using alternate funding.

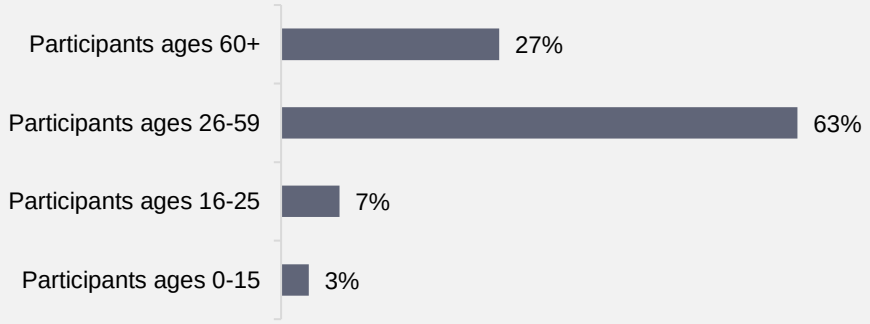
Regulations for Statewide PEI Programs

To standardize the monitoring of California PEI programs, the MHSOAC requires particular county data elements and reporting. These include number of people served by a program; the demographic characteristics of program clients [e.g., age, ethnicity, veteran status and SOGI (sexual orientation, gender identity)]; and the interval of time between a referral and client participation in referred services. The MHSOAC calls this “referral-to-first participation in referred services period” a successful linkage; and successful linkages are one indicator among many that signifies clients’ timely access to care. Given the need for the MHSOAC to know and better understand the communities being served by MHSA resources, it is extremely important for MHSA to develop processes and instruments that will afford programs the ability to capture required data in a manner that is respectful and does not offend, discourage or alienate individuals who are seeking help. All counties are required to include these demographic data in their Annual PEI Report to the MHSOAC, which is part of a county’s Annual Update or 3-Year Program and Expenditure Plan.

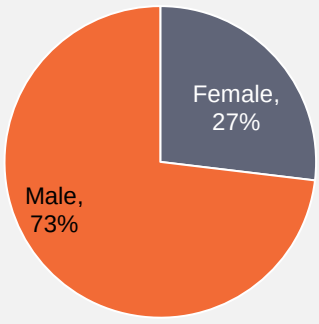
Service Categories	Total number of individuals served (including duplicates)	Total number of individuals served (unduplicated)	Total number of unduplicated individuals at risk of mental illness (Prevention Services)	Total number of unduplicated individuals with early onset of a mental illness served (Early Intervention Services)
Mental Health Promotion and Early Intervention Programs – PEI Funding	105,746	42,369	4,037	618
Subcategory: Mental Health Promotion and Early Intervention – Stigma Reduction	661	654	50	N/A
Subcategory: Mental Health Promotion and Early Intervention – School-Based Mental Health Promotion (K-12)	8,200	3,545	1,930	195
Subcategory: Mental Health Promotion and Early Intervention – Population-Focused Mental Health Promotion	94,037	36,422	1,226	332
Subcategory: Mental Health Promotion and Early Intervention – Early Childhood Mental Health Consultation Initiative	988	950	122	91
Subcategory: Mental Health Promotion and Early Intervention – Comprehensive Crisis Services	1,030	709	709	N/A

Demographics: All PEI Programs

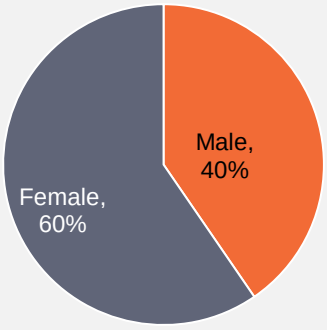
Age: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 51,673)



Gender Identity: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 49,721)

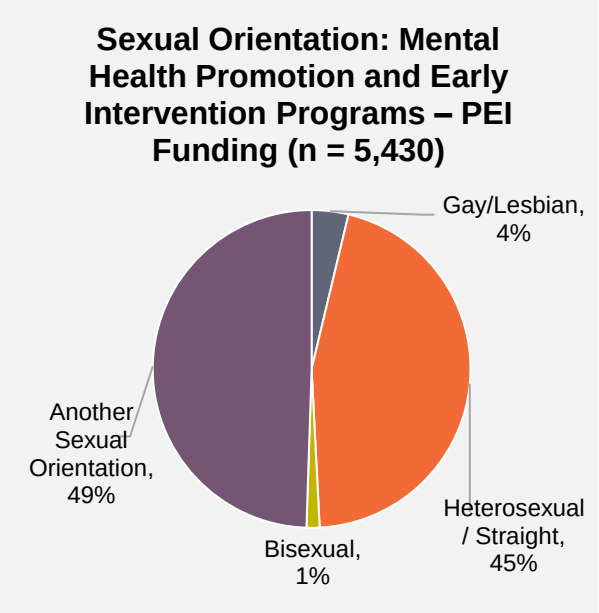


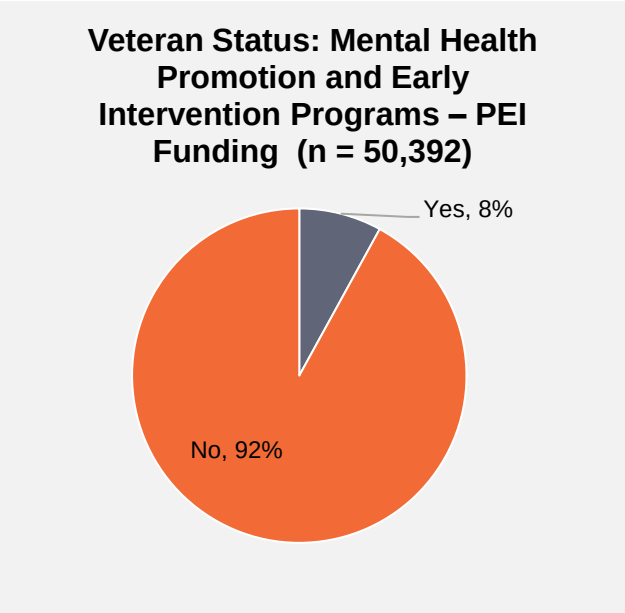
Sex at Birth: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 5,430)



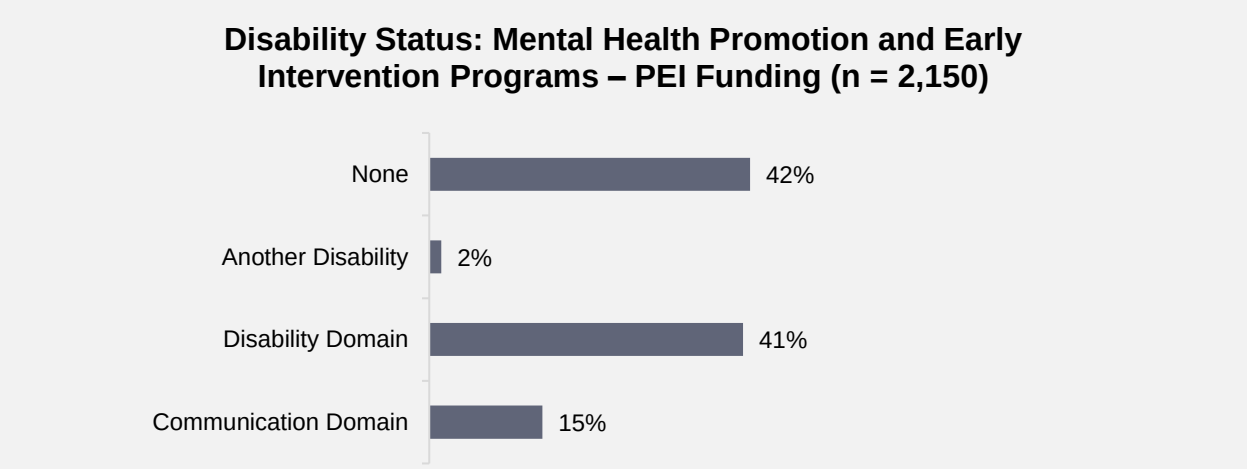
*< 1 percent of clients reported data for Another gender identity not listed, Trans Male; Gender

PEI





*< 1 percent of participants reported Questioning/Unsure; Sexual Orientation



Disability status data was not available for Mental Health Promotion and Early Intervention – Comprehensive Crisis Services.

Race	n	%
Black, African American, or African	14,694	30%
American Indian, Alaska Native, or Indigenous	1,062	2%
Asian or Asian American	7,052	14%
Native Hawaiian or Pacific Islander	545	1%
White	16,805	34%
Other Race	9,188	19%
Total	49,346	100%

Ethnicity	n	%
Hispanic/Latina/e/o	7,636	88%
Non-Hispanic/Non-Latina/e/o	796	9%
More than one Ethnicity	264	3%
Total	8,696	100%

Primary Language	n	%
Chinese	323	6%
English	3,462	63%
Russian	<10	0%
Spanish	933	17%
Tagalog	41	1%
Vietnamese	572	10%
Another Language	152	3%
Total	5,483	6%

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

Service Indicator Outcomes for all PEI Programs FY22-23

Service Indicator	Program Results for FY22-23
Total family members served	154 family members; average of 51 family members across the 3 reporting programs that served families.
Potential responders for outreach activities	Responses included: • Community based providers/staff: Drop-in center staff, peer outreach staff, case managers, program managers, health educators, community promotores, program coordinators, social workers, and resource specialists • First responders: Law enforcement officers, firefighters • Healthcare providers/staff: Nurses, medical providers, and health clinic staff • Mental health care providers/staff: Mental health care providers, harm reduction therapists, behavioral health specialists, psychiatric fellows, MFT students, and psychiatric unit staff • Parents • Peer advocates • School staff: assistant principals, principals, afterschool program directors, classroom teachers, school psychologists, and social-emotional specialists
Total individuals with severe mental illness referred to treatment	355 individuals; average 59 individuals across six reporting programs who referred individuals to treatment.

Types of treatment referred	Responses include: Case management, health care, housing, mental health, and substance use
Individuals who followed through on referral	225 individuals; average 38 individuals across six reporting programs.
Average duration of untreated mental illness after referral	12.5 weeks
Average interval between referral and treatment	34 days
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	869 individuals; average 67 referrals across 13 reporting programs.
Types of underserved populations referred to prevention program services	Responses included: • Communities of color including Latinx, Filipino, Samoan, Native Hawaiian, Cambodian, Lao, Vietnamese, Hmong, Asian Indian, Thai, Japanese, and Korean • Folks in recovery • Folks who are formerly incarcerated • Functionally impaired youth • Indigenous communities including Urban Native and Two-Spirit • Immigrants • Inner city teens • LGBTQ+ • Low-income • Non-English speaking, including monolingual Southeast Asian speakers • Older adults • Recently arrived families • Single parents • Unhoused families, families living in public housing, and marginally-housed individuals
Individuals who followed through on referral	487 individuals; average 49 individuals across 10 reporting programs.
Average interval between referral and treatment	13 days
How programs encourage access to services and follow-through on referrals	Responses are summarized below: • Build and maintain relationships with clients including hiring peer-based staff who come from similar backgrounds or have experienced similar challenges. • Connect clients to other needed services such as housing and employment. • Conduct warm hand-offs.

	• Provide care coordination, including accompanying clients to referral service, support clients to navigate through service systems, and conduct follow up phone calls to clients. • Provide follow-ups to clients waiting for services. • Provide on-site services to facilitate access. • Provide presentations from on-site case management and treatment services.

Indicator Outcomes for all PEI Programs FY21-22

Service Indicator	Program Results for FY21-22
Total family members served	197 family members; average of 16.4 family members across the 12 reporting programs.
Potential responders for outreach activities	Responses included: behavioral health specialists, case managers, community members and liaisons, family success and educational coaches, health and mental health providers, probation officers, school/after school staff, social services, and social workers.
Total individuals with severe mental illness referred to treatment	96 individuals; average 8.7 individuals across 11 reporting programs.
Types of treatment referred	Responses included: case management, housing, medical care, mental health/therapy, substance abuse, and women's health.
Individuals who followed through on referral	319 individuals; average 26.6 individuals across 12 reporting programs.
Average duration of untreated mental illness after referral	Many programs either did not offer these services or were not able to track and report this data. Of those who did, responses included: - 7 days - 132 days - 4.5 months - 12 months - During pregnancy, and flexibly up to 2-19 months postpartum depending on need.
Average interval between referral and treatment	Many programs either did not offer these services or were not able to track and report this data. Of those who did, responses included: - 1-2 weeks - 1 month - 1.5 months - 51.4 days - 2 months - 3-6 months
Total number of referrals of underserved populations to services for prevention, early intervention, and	1,530 individuals; average 117.7 individuals across 13 reporting programs.

Service Indicator	Program Results for FY21-22
treatment beyond early onset	
Types of underserved populations referred to prevention program services	Ethnic/racial groups: communities of color including American Indian and Alaskan Native, Black/African American, Cambodian, Filipino, Lao, Latinx, Mongolian, Native American, Samoan, and Vietnamese. Social Minorities/Resource-limited: adverse childhood experiences, functionally impaired, immigrant communities, indigenous, individuals suffering from complex trauma, individuals concerned about mental illness, LGBTQ+, low-income, non-English speaking, monolingual families, single parents, substance use, unhoused, and working parents with limited resources. Age Groups: immigrant youth, isolated older adults, Southeast Asian youth, transition age youth, and unhoused or marginal housed youth.
Individuals who followed through on referral	1,155 individuals; average 96.3 individuals across 12 reporting programs.
Average interval between referral and treatment	Some programs either did not offer these services or were not able to track and report this data. Of those who did, responses included: - 4 days - 1-2 weeks - 27 days - 26.29 days - 51.4 Days - 3-6 months - Case by case, and typically seen multiple times a week, weekly or biweekly depending on level of acuity and availability of the patient/client. If in-patient, a combination of in-person and telehealth visits may occur with more frequency.
How programs encourage access to services and follow-through on referrals	Responses are summarized below: ● Accept self-referrals ● Conduct warm handoffs ● Continuous communication, including reminders about future visits/meetings and wellness follow up calls ● Destigmatize mental health/create safe and confidential spaces ● Develop trusting relationships with families ● Escort individuals to referral services ● Hire peer advocates who have similar backgrounds or have experienced similar challenges ● Identify multiple portals to connect families to help ● Internal referrals

Service Indicator	Program Results for FY21-22
	• Partner/collaborate with other programs, services, and agencies • Provide care coordination • Stay in communication with youth waiting for available services. • Transportation, home visits, wrap around care, culturally and linguistically relevant services. • Use data to track participation • Use marketing/communication strategies

Service Indicator Outcomes for all PEI Programs FY20-21

Service Indicator	Program Results for FY20-21
Total family members served	723 family members; average 55.6 family members across 13 reporting programs.
Potential responders for outreach activities	Responses include: hospital fellows, community mental health students, law enforcement personnel, wellness program students/instructors, peer providers, support group members, high school faculty, partner agency staff, teachers, administrators, case managers, nurses and providers, school social workers, parent liaisons, school administrators and other personnel, community members, juvenile justice department staff, occupational therapists, social workers, HSA personnel, drop-in center staff, health clinic staff, therapists, program coordinators, community center staff, religious leaders, resource center staff, harm-reduction specialists, physicians, behavioral health specialists, probation officers, program directors, site supervisors, early childcare experts, family support specialists, and home visitation staff.
Total individuals with severe mental illness referred to treatment	551 individuals; average 55.1 individuals across 10 reporting programs.
Types of treatment referred	Responses included: specialty mental-health sites, individual or family mental health services, inpatient psychiatric assessment and care, substance use disorder treatment, housing, primary care, health clinics, suicide prevention, emergency care, psychiatry, medication access, case management, hospital and outpatient services, and longer-term services.
Individuals who followed through on referral	317 individuals; average 35.22 individuals across 9 reporting programs.
Average duration of untreated mental illness after referral	Majority of programs were not able to track and report this data. Example responses include: - 4 days - 2 weeks - 3 weeks - 3 months

Service Indicator	Program Results for FY20-21
	- 6-12 months
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include: - 1 week - 17 days - 3 weeks - 3 months (reported by 2 programs)
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	730 individuals; average 60.83 individuals across 12 reporting programs.
Types of underserved populations referred to prevention program services	Ethnic/Racial Groups, Black, Indigenous, People of Color (BIPOC), Latinx, Filipinos, Samoans, Cambodians, Lao, Vietnamese, Mongolians, Central American indigenous people (Mayan; Mexico, Guatemala, El Salvador, Nicaragua). Age Groups: transition-age youth, inner city teens, isolated older adults, southeast Asian youth, unaccompanied youth, unhoused elders, Social Minorities/Resource-limited: people experiencing homelessness, unstably or marginally housed people, families isolated by COVID, LGBTQ, gender affirming care clients, low-income, non-English speaking, functionally impaired, unemployed, refugee, 1st or 2nd generation immigrant, formerly incarcerated, Spanish speaking, under-insured, undocumented, systems-involved, those with a history of mental health needs or substance misuse, people housed in multifamily/crowded homes, those disconnected from services access for basic needs, survivors of community violence, educators impacted by COVID,
Individuals who followed through on referral	481 individuals; average 43.73 individuals across 11 reporting programs.
Average interval between referral and treatment	Majority of programs were not able to track and report this data. Example responses include: - 6 days - 1-2 weeks - 2 weeks (reported by 2 programs) - 17 days - 3 months

Service Indicator	Program Results for FY20-21
How programs encourage access to services and follow-through on referrals	Responses include: ● The audience receives an informational packet that provides a list of resources in San Francisco. We also discuss the Warmline and CALHOPE phone support as well as the many support groups we offer. ● An interdisciplinary team encourages access to mental health services, including coordinating tabling activities during student events, and partnering with student representatives to outreach their fellow peers. Upon assessing the student, the clinician will make the appropriate referrals to community-based organizations for specialty mental health treatment. ● Our program centers building relationships with all support staff at school sites who then can make a warm handoff to the mental health consultants. Additionally, MHCs make themselves available with flexible hours and through various mediums (in person, zoom, phone etc.) and meet families where they are at. ● Clients who do not meet medical necessity, do not qualify for full-scope MediCal or do not have any insurance, were able to receive mental health assessment, treatment or referrals if they had chronic school attendance challenges. ● Staff outreach and continuity of contact; events and weekly peer groups; internal referrals based on needs assessment. ● We have a mental health coordinator and announce our services weekly on Friday evenings in our call-em-all voice calls to all clients about services available and how to contact us. ● Partner coordinators work closely with clients to navigate them to services. Site coordinators are encouraged to conduct follow-up calls with clients to ensure they have followed through with their referrals/appointments. ● After a client is provided with a service referral and possibly a warm hand off or navigation support, staff will call the client up to 3 times to ensure that the client's need was met and also to confirm the connection was made. ● We track referrals and linkages in our program management system. Reminders are automatically generated for staff to conduct follow-up 3 days later. We have also been doing outreach through food box deliveries. ● Peer-based staff approach social work with knowledge, understanding, empathy and non-judgement. Over time and utilizing the principles of harm reduction, we build up trusting relationships with community members and are then better able to pinpoint specific needs and direct individuals to the appropriate services and resources.

Service Indicator	Program Results for FY20-21
	● We have enhanced and streamlined our referral screening, assignment and follow-up process for the entire outpatient program. Staff are expected to respond to referral source within 48 hours/2 working days of assignment. ● Warm hand-offs; at least 3 follow up contacts after referral is made. ● Soft handoffs, engagement in WRAP Care, collateral sessions with other providers. ● Our program provided information of community resources to staff and families in meetings and through newsletters; we also facilitated linkage to other internal programs. ● Established ongoing relationships with many community organizations. When referrals are made, consultants follow up with parents, teaching staff, family advocates, or other managers on the status of the referral. ● Consultants provide individualized referrals to clients and families based on their needs and factoring for any barriers to access. Consultants will also follow up on referrals and, when possible, provide additional support to ensure access.

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

Program Overview

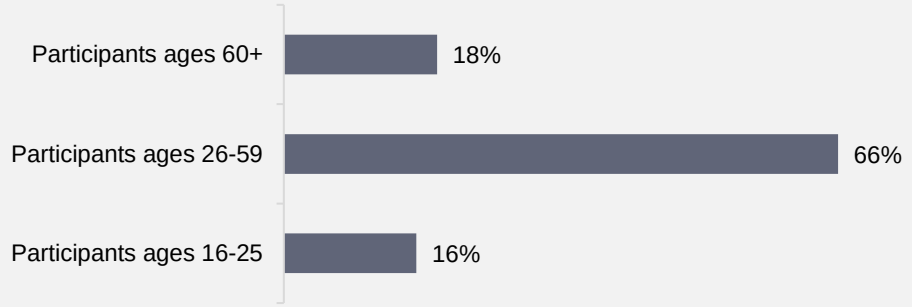
Peer Outreach and Engagement Services – Mental Health Association of San Francisco is funded by both CSS and PEI funding. The program is divided into three components:

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

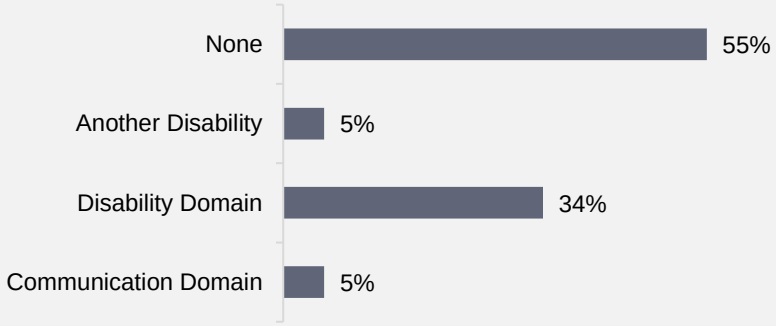
Client Demographics, Outcomes, and Cost per Client

Demographics: Stigma Reduction

Age: Mental Health Promotion and Early Intervention Programs - Stigma Reduction (n = 488)

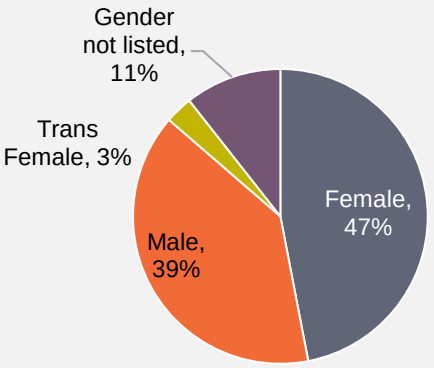


Disability Status: MH PEI - Stigma Reduction (n = 56)

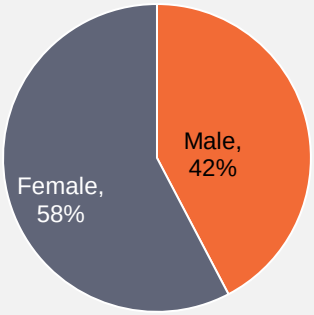


PEI

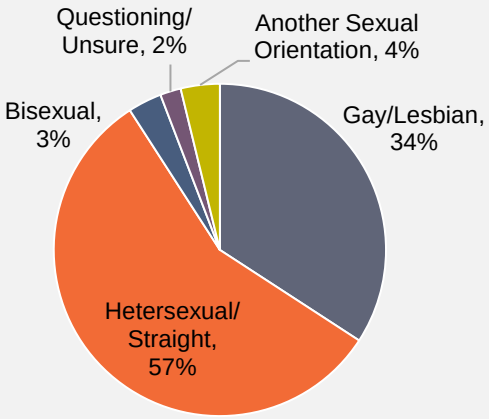
Gender Identity: Mental Health Promotion and Early Intervention - Stigma Reduction (n = 66)



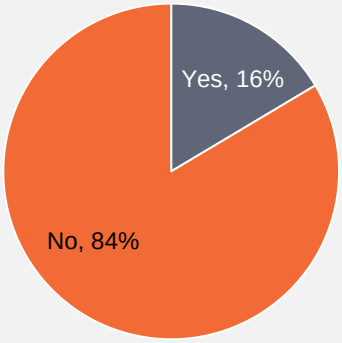
Sex at Birth: Mental Health Promotion and Early Intervention Programs - Stigma Reduction (n = 26)



Sexual Orientation: Mental Health Promotion and Early Intervention – Stigma Reduction (n = 395)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Stigma Reduction (n = 73)



PEI

Race	n	%
Black, African American, or African	48	26%
American Indian, Alaska Native, or Indigenous	<10	5%
Asian or Asian American	21	12%
Native Hawaiian or Pacific Islander	<10	4%
White	82	45%
Other Race	15	8%
Total	166	100%

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

Primary Language	n	%
Chinese	<10	0%
English	43	100%
Russian	<10	0%
Spanish	<10	0%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	43	0%

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

Ethnicity	n	%
Hispanic/Latina/e/o	29	48%
Non-Hispanic/Non-Latina/e/o	19	31%
More than one Ethnicity	13	21%
Hispanic/Latino	61	100%

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

Program	FY22-23 Key Outcomes and Highlights
Peer Outreach and Engagement Services – Mental Health Association of San Francisco	85% (n=24) of Support and Wellness participants reported feeling less isolated.

School-Based Mental Health Promotion (K-12)

Program Overview

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

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

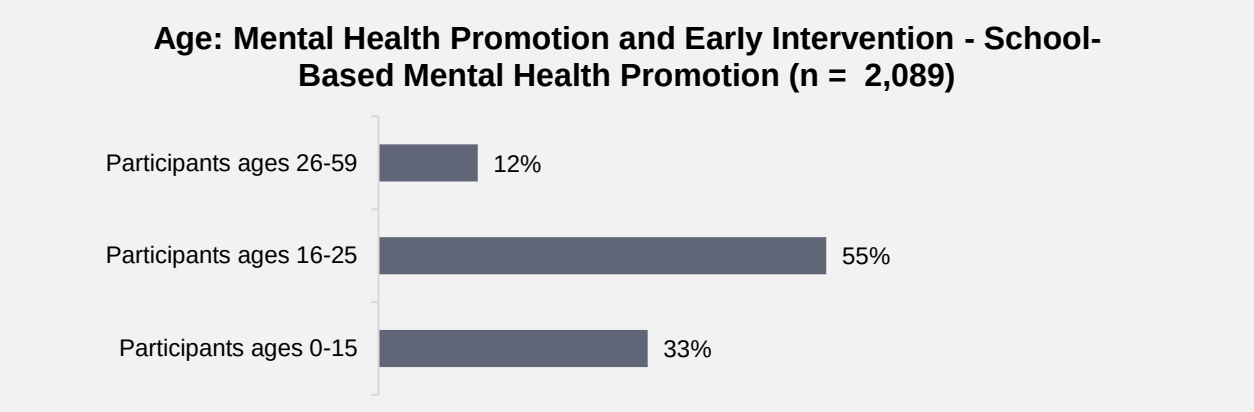
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To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

Target Populations

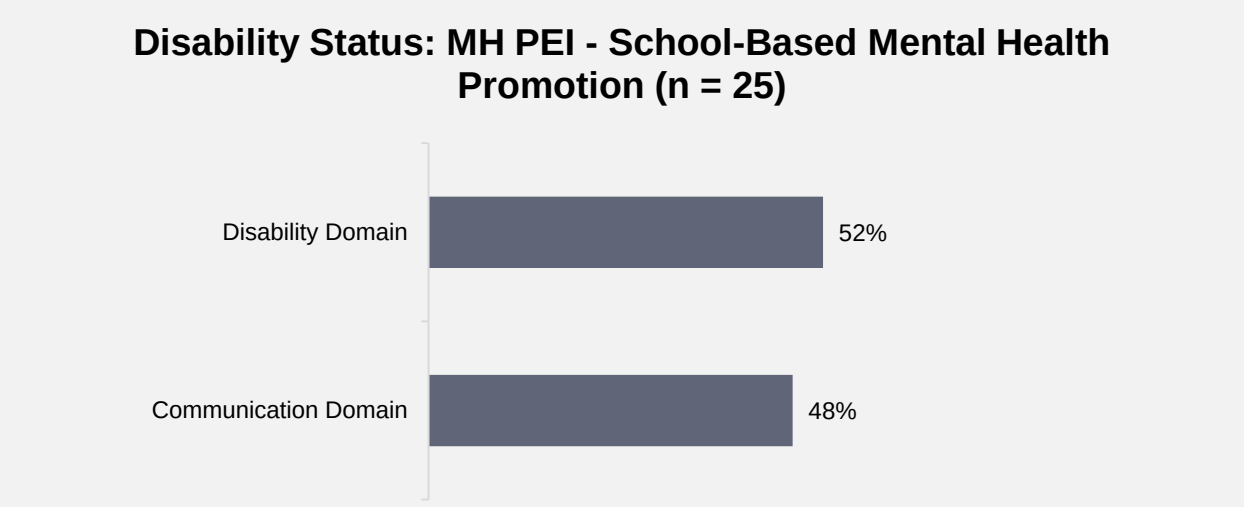
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

Client Demographics, Outcomes, and Cost per Client

Demographics: School Based Prevention (K-12)

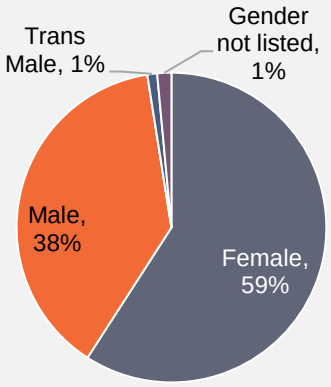


*< 1 percent of participants reported data for ages 60+; Age

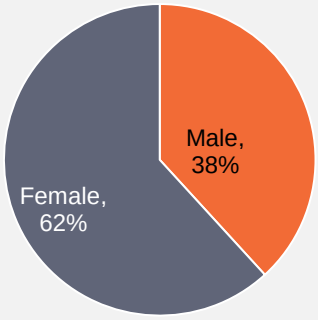


PEI

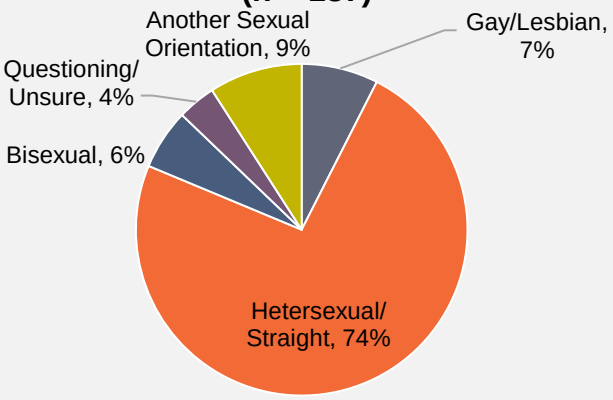
Gender Identity: Mental Health Promotion and Early Intervention - School-Based Mental Health Promotion (n = 883)



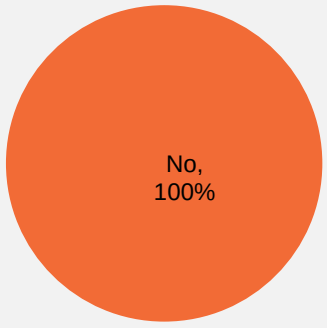
Sex at Birth: Mental Health Promotion and Early Intervention Programs - School-Based Mental Health Promotion (n = 793)



Sexual Orientation: Mental Health Promotion and Early Intervention – School-Based Mental Health Promotion (n = 187)



Veteran Status: Mental Health Promotion and Early Intervention Programs - School-Based Mental Health Promotion (n = 2,353)



PEI

Race	n	%
Black, African American, or African	146	27%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	208	38%
Native Hawaiian or Pacific Islander	<10	1%
White	85	16%
Other Race	95	18%
Total	534	100%

Ethnicity	n	%
Hispanic/Latina/e/o	298	60%
Non-Hispanic/Non-Latina/e/o	128	26%
More than one Ethnicity	73	15%
Total	499	100%

Primary Language	n	%
Chinese	54	4%
English	1,182	83%
Russian	<10	0%
Spanish	183	13%
Tagalog	<10	0%
Vietnamese	<10	0.1%
Another Language	<10	0.2%
Total	1,419	100%

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

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

Program	FY22-23 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - Bayview Hunter's Point Foundation	100% of vacant positions were filled ensuring the program was operating at full staff capacity.
Mental Health Services – Edgewood Center for Children and Families	67% (n<10) of classroom teachers reported feeling more successful in dealing with challenging student behaviors.
Youth Early Intervention – Instituto Familiar de la Raza	81% (n<10) of staff who received consultation services reported being satisfied with the services they received from the consultant.
Wellness Centers – Richmond Areas Multi-Services (RAMS)	97% (n=186) of students reported they would recommend therapy to a friend, 75% (n=207) reported learning ways to cope with stress, and 53% (n=150) reported improvements in their relationships with friends and/or family.

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SF MHSA Service Provider, Hospitality House Self-Help Center

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

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

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

Target Populations

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

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

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

services. As a result, all of the programs emphasize outreach and engagement to a very specific population group.

Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Socially Isolated Older Adults	Senior Drop-In Center *Curry Senior Center*	A multi-service center located in the Tenderloin neighborhood. It provides drop-in peer-led wellness-based services, including primary and behavioral health care, case management services, and socialization opportunities.
	Addressing the Needs of Socially Isolated Older Adults *Curry Senior Center*	The program provides peer-based outreach and engagement services to socially isolated older adults with mental health concerns living in the central neighborhoods of San Francisco.
Blacks/African Americans	Ajani Program Westside *Community Services*	Helps to build strong families by providing an understanding how healthy families function and by encouraging them to develop leadership, collective responsibility and mentoring skills.
	Black/African American Wellness and Peer Leadership Program *SFDPH Interdivisional 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)*	Serves Filipino, Samoan and Southeast Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Latinx including Indigenous Mayan communities	Indigena Health and Wellness Collaborative *Instituto Familiar de la Raza*	Serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, support spiritual and cultural activities and community building. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.

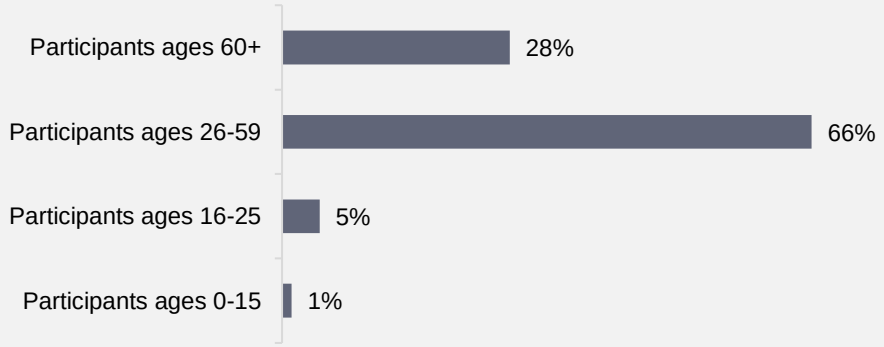
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Native Americans	Living in Balance *Native American Health Center*	Serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.
Adults who are Homeless or At-Risk of Homelessness	South of Market Self-Help (6th Street) Center *Central City Hospitality House*	Serves adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs This program now offers outreach and treatment support during extended hours to better engage with adult residents facing homelessness.
	Tenderloin Self-Help Center *Central City Hospitality House*	Serves adult residents facing behavioral health challenges and homelessness in the Tenderloin neighborhood. The self-help center offers a low-threshold engagement, including peer-run programming, case management, access to primary care, support groups and socialization. Many individuals who access the center are referred directly to mental health services prior to assessment, due to the acuity of their needs.
	Community Building Program *Central City Hospitality House*	Serves traumatized, homeless and dual-diagnosed adults in the Tenderloin neighborhood. The program conducts outreach, screening, assessment, and referral to mental health services. It also conducts wellness promotion and includes an 18-week peer internship training program.

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

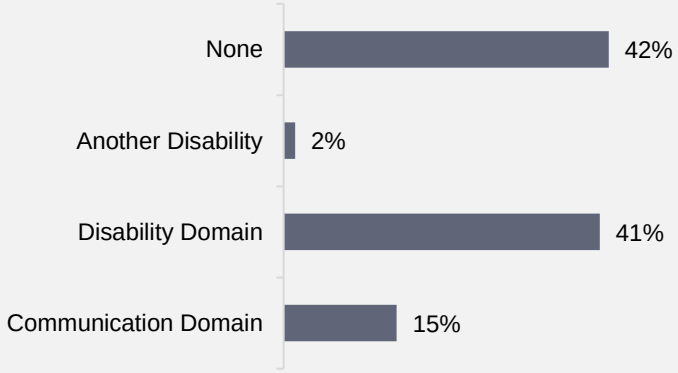
Client Demographics, Outcomes, and Cost per Client

Demographics: Population Focused Mental Health

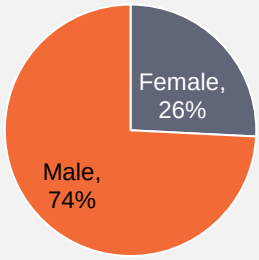
Age: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion Programs (n = 47,915)



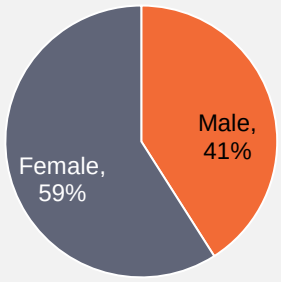
Disability Status: MH PEI - Population-Focused Mental Health Promotion Programs (n = 2,066)



Gender Identity: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion (n = 48,059)

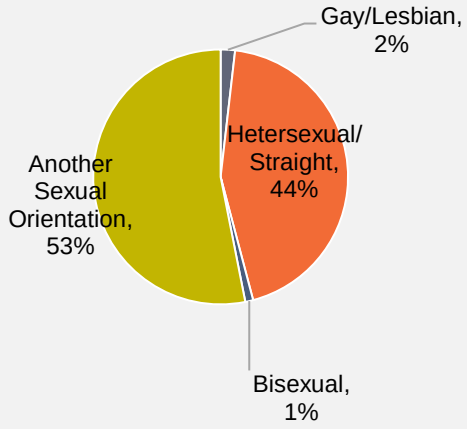


Sex at Birth: Mental Health Promotion and Early Intervention – Population-Focused Mental Health Promotion (n = 3,984)

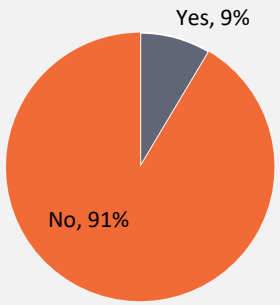


*< 1 percent of participants reported data for Another gender identity not listed, Trans Female, Trans Male; Gender

Sexual Orientation: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion Programs (n = 6,708)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Population-Focused Mental Health Promotion Programs (n = 46,904)



*< 1 percent of participants reported Questioning/Unsure; Sexual Orientation

Race	n	%
Black, African American, or African	14,205	30%
American Indian, Alaska Native, or Indigenous	1,048	2%
Asian or Asian American	6,606	14%
Native Hawaiian or Pacific Islander	520	1%
White	16,334	34%
Other Race	8,810	19%
Total	47,523	100%

Ethnicity	n	%
Hispanic/Latina/e/o	298	60%
Non-Hispanic/Non-Latina/e/o	128	26%
More than one Ethnicity	73	15%
Total	499	100%

Primary Language	n	%
Chinese	166	6%
English	1,282	49%
Russian	<10	0.2%
Spanish	437	17%
Tagalog	<10	2%
Vietnamese	569	22%
Another Language	131	5%
Total	2,585	100%

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

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

Program	FY22-23 Key Outcomes and Highlights
Senior drop-in Center – Curry Senior Center	87% (n=150) of participants who attended at least three activities reported increased socialization.
Addressing the Needs of Socially Isolated Older Adults – Curry Senior Center	97% (n=61) of isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services (including case management, substance use, mental health, and social support groups).
Asian/Pacific Islander Mental Health Collaborative – Richmond Area Multi-Services (RAMS)	92% (n=77) of participants who received short-term, time-limited therapeutic services agreed they felt better as a result of participating in therapeutic activities.
Indigena Health and Wellness Collaborative – Instituto Familiar de la Raza	100% (n=67) of individuals receiving non-clinical case management achieved at least one goal in their case/care plan.

Program	FY22-23 Key Outcomes and Highlights
Living in Balance – Native American Health Center	60% (n=27) of individuals who received one-on-one therapeutic counseling services completed at least one behavioral health service goal.
South of Market Self-Help Center (6th Street) – Central City Hospitality House	72% (n=78) of participants with a written case plan achieved at least one case plan goal.
Tenderloin Self-Help Center – Central City Hospitality House	58% (n=62) of community members with a written case plan achieved at least one case plan goal.
Community Building Program – Central City Hospitality House	77% of participants (n=53) of clients achieved at least one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan – Instituto Familiar de la Raza	100% (n=27) of transition age youth who were connected by program staff to internal behavioral health services attended an initial appointment or meeting.
Population Specific TAY Engagement and Treatment – Asian/Pacific Islander – Community Youth Center	91% (n=21) of Asian/Pacific Islander transition age youth who participated in at least three case management sessions successfully attained at least one of their treatment goals.
Population Specific TAY Engagement and Treatment – LGBTQ+ - SF LGBT Center	100% (n=53) of transition age youth enrolled in Mental Health services were connected to internal behavioral health related treatment services.
Population Specific TAY Engagement and Treatment – Black/African American – Larkin Street Youth Services and Third Street Youth Center	81% (n=75) of transition age youth who were referred for internal or external behavioral health services attended at least one initial appointment or meeting with a behavioral health provider.
Population Specific TAY Engagement and Treatment – Juvenile Justice/Others – Huckleberry Youth Programs	89% (n=50) of transition age youth referred to behavioral health services participated in at least one initial appointment.
TAY Homeless Treatment Team – Larkin Street Youth Services	73% (n=11) of transition age youth who received treatment and healing services demonstrated an intended outcome.

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 evidence-based [19] and delivered in the following settings: center-based and family childcare, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. Four county entities provide funding and partnership to deliver ECMHCI: SFDPH/BHS; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco.

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

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

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

Target Populations

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

Early Childhood Mental Health Consultation Initiative	
Program Name	**Services Description**
Early Childhood Mental Health Consultation Initiative (ECMHCI) - Infant Parent Program/Day Care Consultants *UCSF*	Focuses on relationships between young children and their adult caregivers. The IPP embeds perinatal mental health specialists in the Obstetric 5M Clinic at Zuckerberg San Francisco General Hospital. In-clinic mental health treatment is provided to high risk, mostly immigrant, and indigent pregnant people. The aim of the program's intervention is to reduce psychiatry symptoms in those about to be parents, thereby improving their parental functioning and, in turn, the outcomes for their children. Families seen in this

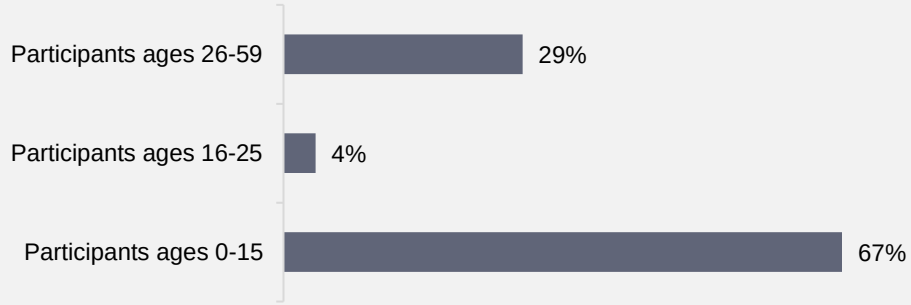
[19] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91

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

Client Demographics, Outcomes, and Cost per Client

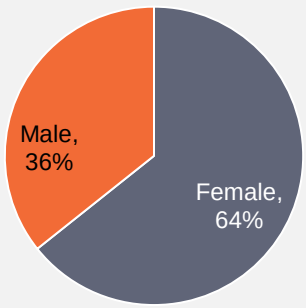
Demographics: Early Childhood Mental Health Consultation Initiative

Age: Mental Health Promotion and Early Intervention - Early Childhood Mental Health Consultation Initiative (n = 517)

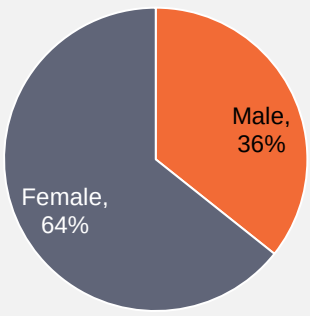


Disability Status: MH PEI - Early Childhood Mental Health Consultation Initiative (n = 105)

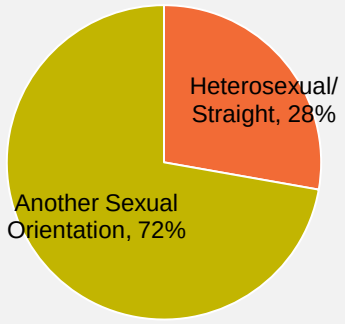
Gender Identity: Mental Health Promotion and Early Intervention - Early Childhood Mental Health Consultation Initiative (n = 521)



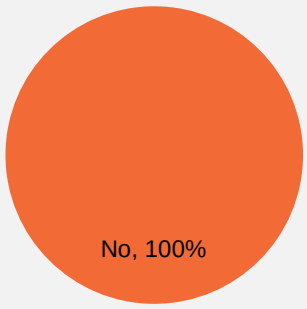
Sex at Birth: Mental Health Promotion and Early Intervention – Early Childhood Mental Health Consultation Initiative (n = 521)



Sexual Orientation: Mental Health Promotion and Early Intervention - Early Childhood Mental Health Consultation Initiative (n = 236)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Early Childhood Mental Health Consultation Initiative (n = 521)



Primary Language	n	%
Chinese	<10	1%
English	652	67%
Russian	<10	0%
Spanish	290	30%
Tagalog	<10	0%
Vietnamese	<10	0.2%
Another Language	16	2%
Total	958	100%

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

*< 1 percent of participants reported Gay/Lesbian and Bisexual; Sexual Orientation

Race	n	%
Black, African American, or African	155	24%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	87	13%
Native Hawaiian or Pacific Islander	14	2%
White	225	34%
Other Race	174	27%
Total	655	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	320	86%
Non-Hispanic/Non-Latina/e/o	48	13%
More than one Ethnicity	<10	1%
Total	368	100%

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

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

Program	FY22-23 Key Outcomes and Highlights
Infant-Parent Program/SPRING Project - **UC San Francisco**	100% (n=21) of parents who had four or more treatment sessions reported a stronger relationship with their infants, stronger identity as one who feels capable of parenting, more confident as a mother and advocating for their child and themselves.

Comprehensive Crisis Services

Background and Community Need

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

Program Overview

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

Target Populations

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

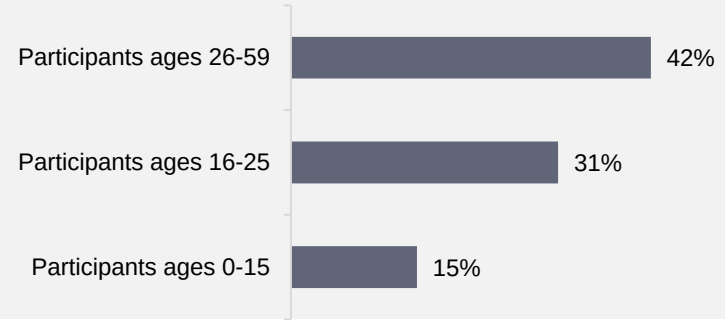
Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals ages 18 years or older.
Child Crisis Team	Offers 24/7 mobile 5585/5150 assessments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

	support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

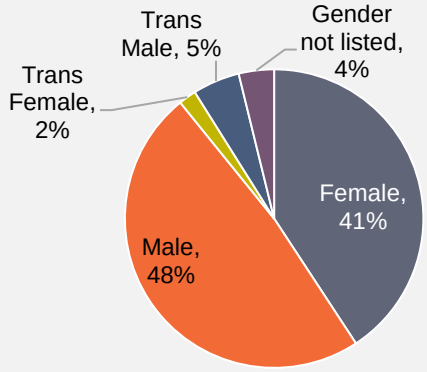
Program Outcomes, Highlights and Cost per Client

Demographics: Comprehensive Crisis Services[20]

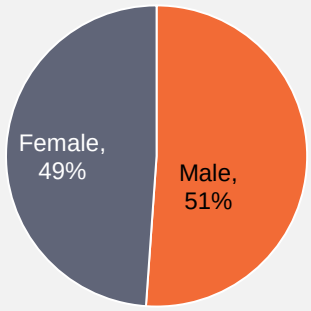
Age: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 618)



Gender Identity: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 157)

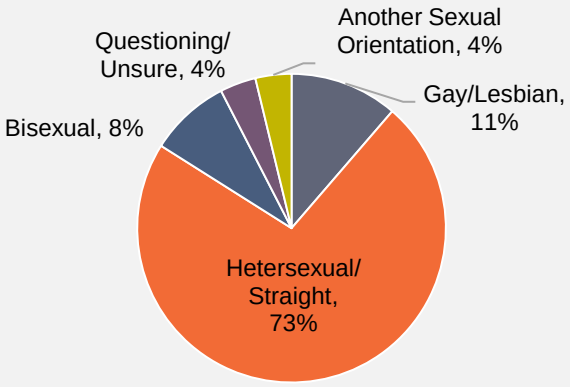


Sex at Birth: Mental Health Promotion and Early Intervention – Comprehensive Crisis Services (n = 133)

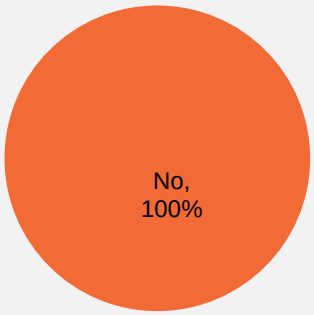


[20] Disability status data was not available for Mental Health Promotion and Early Intervention – Comprehensive Crisis Services.

Sexual Orientation: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 106)



Veteran Status: Mental Health Promotion and Early Intervention Programs - Comprehensive Crisis Services (n = 495)



Race	n	%
Black, African American, or African	140	39%
American Indian, Alaska Native, or Indigenous	<10	0.3%
Asian or Asian American	41	12%
Native Hawaiian or Pacific Islander	<10	0.3%
White	79	22%
Other Race	94	26%
Total	354	100%

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

Ethnicity	n	%
Hispanic/Latina/e/o	69	81%
Non-Hispanic/Non-Latina/e/o	<10	0%
More than one Ethnicity	16	19%
Total	85	100%

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

Primary Language	n	%
Chinese	<10	3%
English	300	90%
Russian	<10	0%
Spanish	23	7%
Tagalog	<10	0.3%
Vietnamese	<10	0%
Another Language	<10	1%
Total	323	100%

Primary Language	n	%

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

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

Program	FY22-23 Key Outcomes and Highlights
Comprehensive Crisis Services (Mobile Crisis, Child Crisis, and Crisis Response)- DPH	35% (n=142) of individuals seen in the crisis clinics were sent to Psychiatric Emergency Services or were hospitalized on the same day.

PEI Funding Table

Program Name	Childhood Trauma Prevention and Early Intervention	Early Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	Culturally Competent and Linguistically Appropriate Prevention and Early Intervention	Strategies Targeting the Mental Health Needs of Older Adults	Early Identification Programming of Mental Health Symptoms	Fiscal Year 2023/24 MHSA Funds	Fiscal Year 2024/25 Estimated MHSA Funds	Fiscal Year 2025/26 Estimated MHSA Funds
PEI 1. Stigma Reduction	√	√	√	√	√	√	√	$ 200,646	$ 206,665	$ 212,865
PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	√	√	√	√			√	$ 1,241,837	$ 1,312,539	$ 1,317,465
PEI 4. Population Focused Mental Health (50% Prevention)	√	√	√	√	√	√	√	$13,883,680	$16,104,506	$15,944,710
PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	√	√	√	√	√		√	$ 3,211,363	$ 2,999,069	$ 3,089,041
PEI 6. Comprehensive Crisis Services (10% Prevention)	√	√	√	√			√	$ 621,656	$ 640,306	$ 659,515
PEI 7. CalMHSA Statewide Programs	√	√	√	√	√	√	√	$ 41,388	$ 41,388	$ 2,126,244

Evaluation Tools

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

Mental Health Services Act (MHSA)

FY22-23 YEAR-END PROGRAM NARATIVE REPORT

July 1, 2022 through June 30, 2023

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

INSTRUCTIONS:

- This program report should include all MHSA-funded activities conducted from July 1, 2022 through June 30, 2023.
- A separate report must be submitted for each program.
- **Full Service Partnership (FSP) programs are exempt from the Demographic Data Report. FSP Programs are required to submit the FSP Narrative Report only.**
- This report needs to be completed and submitted via e-mail to Hannah Abarquez, hannah.abarquez@sfdph.org by **Friday, September 16, 2023**.

Report Type	Report Components	Program Type	Reporting Period	Due Date
Year-End Report	1) Demographic Data	All Programs except FSPs	07/01/2022 - 06/30/2023	09/16/2023
	2) Program Narrative	All Programs including FSPs	07/01/2022 - 6/30/2023	09/16/2023

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

- **PART 1** includes Head Count and Demographic Data.
  - **Demographic Data Report is NOT required for FSP programs**
- **PART 2** includes the Program Narrative and begins on page 2 of this document.
  - **FSP Programs should use the template titled "FSP - Program Narrative Report Template_MHSA FY22-23 YEAR-END Report"**

PART 2: PROGRAM NARRATIVE

1. For each of your finalized program objectives for FY22-23, briefly describe your progress using a summary of the data collected.

For example: *Objective: By June 30, 2023, 100 new participants will be screened for behavioral health issues, as measured by the assessment conducted by case managers and recorded in the monthly intake assessment forms. Results: 109 participants were screened, exceeding our goal (109%)*

Be sure to include both a number and percent.

Please ensure the Program Objectives that you are reporting on match with the MHSA FY22-23 Performance Objectives as they are listed on the CDTA website for your program: https://www.sfdph.org/dph/comupg/aboutdph/insideDept/CDTA/documents-PO.asp

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

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

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

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

TOTAL amount of <u>MHSA funding</u> allocated to hire peers in FY 22-23:	
TOTAL number of <u>FTEs</u> dedicated for peer employment in FY 22-23:	
TOTAL <u>number of peers</u> employed in those positions in FY 22-23:	

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

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

- Cultural Competence. Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
- Community Collaboration. Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
- Client, Consumer, and Family Involvement. Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.
- Integrated Service Delivery. Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.
- Wellness and Recovery. Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

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

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

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

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

7. Please share one of your participant success stories.

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

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

San Francisco Health Network
Behavioral Health Services

Mental Health Service Act (MHSA)
FY20-21 YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT
July 1, 2022 through June 30, 2023

Instructions: This program report should include program participants served by MHSA-funded activities conducted between July 1, 2022 through June 30, 2023. A separate report must be submitted for each program. All MHSA-funded programs, **except** Full Service Partnership (FSP) programs, are required to complete the Year-End Demographic Data Program Report. Fill in each blue box with the appropriate information. However, programs will be able to provide a brief explanation if your program is unable to collect data for any part of this report.

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

Please note that this Demographic Data Report is PART 1 of the Year-End Program Report, which consists of two parts. PART 2 includes the Program Narrative Report.

This report needs to be completed and submitted via e-mail by Friday, September 16, 2023.
We thank you for all your great work and continued service to the community!

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

Box A: Please provide the total number of individuals served July 1, 2022 through June 30, 2023 through MHSA funding. For any blue box left empty, please provide a brief reason explaining why the data was not collected.

A.1. Total number of individuals (including duplicates) served:	
A.2. Total number of unduplicated individuals served:	
A.3. Total number of unduplicated individuals at risk **(see endnote #1)** for mental illness (prevention) served:	
A.4. Total number of unduplicated individuals with early onset of a mental illness (early intervention) served:	

A.5. Please indicate a **percentage estimate** of clients this program served in FY22-23 who were experiencing homelessness **(see endnote #2)** at the time of service (if data is available):	

FY22-23 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

CURRENT GENDER IDENTITY	
Female	
Male	
Trans female*	
Trans male**	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**0**
If another identity is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**0**
If another disability is counted, please specify:	

SEX AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	**0**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

Box B: Please provide the numbers in the blue boxes for the demographic data as listed below:

FY22-23 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

AGE CATEGORIES	
0-15 yrs	
16-25 yrs	
26-59 yrs	
60+	
Declined to answer	
Unknown	
TOTAL	**0**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/straight	
Bisexual	
Questioning/unsure	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**0**
If another group is counted, please specify:	

***** Trans female – transgender women, transfeminine, or transwomen, sometimes referred to as male-to-female or MTFs

****** Trans male - transgender men, transmasculine, or transmen, sometimes referred to as female-to-male or FTMs

*** See endnote #3 for the definition of disability

FY22-23 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

Please report on the following major race/ethnic categories of participants (OK to choose more than one category).

RACE/ETHNICITY	
Black or African American	
American Indian or Alaska Native	
Asian	
Native Hawaiian or Other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	
TOTAL	0
If another race/ethnicity is counted, please specify:	

Hispanic or Latino	
Non-Hispanic or Non-Latino	
More than one ethnicity	
Declined to answer	

FY22-23 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

If appropriate to your program, please report on additional ethnicity categories for your participants.

Additional Ethnicity	
African	
Caribbean African	
Central American	
Chicano/Mexican American	
Mexican	
Puerto Rican	
South American	
Alaska Native	
First Nation (Canada)	
Indigena (Mexico, Central, & South America)	
Asian Indian	
Cambodian	
Chinese	
Filipino	
Hmong	
Japanese	
Korean	
Laotian	
Thai	
Vietnamese	
Native Hawaiian	
Pacific Islander	
Guamanian	
Samoan	
Tongan	
Eastern European	
European	
Middle Eastern	
Another ethnicity not listed	
If another ethnicity is counted, please specify:	

PRIMARY LANGUAGE	
Chinese	
English	
Russian	
Spanish	
Tagalog	
Vietnamese	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	0
If any other languages, please specify:	

For Chinese language total count above, please provide Dialect count (if data is available)	
Cantonese	
Mandarin	

FY22-23 MHSA YEAR-END DEMOGRAPHIC DATA PROGRAM REPORT

For any demographic data marked as unknown or not collected in Box B, please provide a brief reason why in the blue boxes below:	
Type of demographic data unknown or not collected	**Reason not collected**

Box C: If your program serves families, please provide the total number of family members served. For any blue box left empty, please provide a brief reason explaining why the data was not collected.	
Total number of unduplicated family members served:	

Box D: For programs that perform outreach activities, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness [see endnote #4], provide support, and or refer individuals who need treatment) reached. For any blue box left empty, please provide a brief reason explaining why the data was not collected.	
Types of responders (i.e., employers, nurses, school personnel, promoters, etc.) reached & types of settings (i.e., schools, senior centers, churches, etc.) where potential responders were engaged:	*Example: 2 nurses at schools, 15 parents at schools, 15 parents at community centers, 15 teachers at schools, 5 police officers at community centers, & 1 police officer at a school.*

Box E: For programs that refer (see endnote #5) individuals with severe mental illness, please provide information for the categories below (for any blue box left empty, please provide a brief reason explaining why the data was not collected):	
E.1. Unduplicated number of individuals with severe mental illness referred to treatment:	
E.2. Types of treatment individuals were referred to:	

E.3. For internal referrals only (see endnote #6). Unduplicated number of individuals who followed through on referral and participated at least one time in referred program:	

E.4. For internal referrals only. Average duration of untreated mental illness for persons who are referred to treatment and who have not previously received treatment:	
E.5. For internal referrals only. Average interval between referral and participation at least one time in referred treatment program:	

Box F: For programs that refer underserved populations to services, please provide information for the categories below (for any blue box left empty, please provide a brief reason explaining why the data was not collected):	
F.1. Please specify the types of underserved populations (i.e., homeless, immigrant, communities of color, isolated older adults, etc.) that were referred to prevention program services:	
F.2. Total number of referrals of underserved populations to prevention services (see endnote #7), early intervention services (see endnote #8), or to treatment beyond early onset:	
F.3. For internal referrals only. Number of unduplicated individuals who followed through on referral and participated at least one time in referred program:	
F.4. For internal referrals only. Average interval between referral and participation at least one time in referred treatment program:	
F.5. Please describe ways your program encourages access to services and follow-through on referrals:	

THANK YOU FOR COMPLETING THIS REPORT

Endnotes - Definitions as provided by the PEI Regulations

(1) Risk factors for mental illness: include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, traumatic loss (e.g. complicated, multiple, prolonged, severe), having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

(2) Literally Homeless (definition from U.S. Dept. of Housing & Urban Development): Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
(i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
(ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
(iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution**.**

(3) Disability: physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

(4) Severe mental illness: a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

(5) Referral: Process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral.

(6) Internal referral: A referral made to a program which is provided, funded, administered, or overseen by the City and County of San Francisco mental health system. This includes referrals to programs within your agency or others within San Francisco.

(7) Prevention services: a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

(8) Early intervention services: treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

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