San Francisco
Department of Public Health

San Francisco
Behavioral Health Services Act (BHSA)
FY2025-2026 Annual Update to the Integrated Program and Expenditure Plan

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

Mural celebrating Chinese American history in San Francisco, painted by K.S. Chan in 1987 at the Commodore Stockton School

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Organization of this Plan

The San Francisco Department of Public Health (SFDPH) Mental Health Services Act (B/MHSA) Annual Update to the Program and Expenditure Plan highlights the outcomes of our work during FY23-24, key updates from FY24-25, and proposed plans for FY25-26 and beyond.

The introduction provides an overview of the B/MHSA, the general landscape of San Francisco, Community Program Planning activities, key program highlights from the past year, and the formal review process for the plan.

SFDPH's B/MHSA-funded programs are organized into eight service categories, with each category covered in a dedicated section. Each section includes a description of services, target populations, and an overview of the programs within that category. The categories 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

B/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, 2026.

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, 2026

B/MHSA County Fiscal Accountability Certification

Placeholder

Director's Message

As we continue to evolve in the ever-changing landscape of behavioral health, I want to take a moment to acknowledge and honor the incredible work that our Behavioral Health Services Act (BHSA) programs have continued to do across San Francisco. Even in a post-COVID environment, our programs have remained steadfast, adapting, innovating, and meeting the needs of our most vulnerable community members with care, compassion, and cultural responsiveness.

This past year, we have witnessed the power of what it means to lead with equity and purpose. From embedding culturally congruent care within our civil service clinics, to launching our anti-racist fellowship and executive retreats that build leadership capacity around systemic racism, our work has been deeply rooted in transformation. We have also supported our workforce through equity-centered initiatives—addressing disparities and workforce challenges while creating pathways for healing and retention.

As new program changes take shape—especially with the implementation of Proposition 1—we remain committed to sustaining the essence of the Behavioral Health Services Act: to provide equitable, culturally grounded, and community-informed behavioral health services. Our team has worked tirelessly to ensure this vision remains a reality, even as we confront complex challenges such as homelessness and the ongoing overdose epidemic.

In response, we have launched targeted programs that not only address substance use and overdose prevention but also incorporate cultural factors and lived experience as essential elements of care. We have continued to strengthen partnerships—both internally across SFDPH and externally with community-based organizations—to ensure a coordinated and holistic approach to wellness for our clients.

I want to thank our staff, providers, and community partners for their dedication, courage, and brilliance. It is because of your collective efforts that our programs remain successful and resilient. As we look toward the future—with expanded full-service partnerships, housing initiatives, and additional behavioral health supports—we do so with hope, intention, and a deep respect for the communities we serve.

In Community,

Jessica Brown

Jessica Brown
Director of SFDPH B/MHSA and JEDI

Introduction to B/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 Act 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.

California voters passed Proposition 1 in March 2024, a two-bill package that includes the Behavioral Health Services Act (BHSA) and the Behavioral Health Infrastructure Bond Act of 2024 (BHIBA). **Therefore, since we are in a transitional phase of moving from Mental Health Services Act (MHSA) to Behavioral Health Services Act (BHSA), you will see M/BHSA noted throughout this report.** The BHSA replaces the Mental Health Services Act of 2004. It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders, expanding housing interventions, and continued focus on increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels. Additionally, the Behavioral Health Services Act creates pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs. BHIBA establishes a $6.38 billion general obligation bond to develop an array of behavioral health treatment, residential care settings, and supportive housing to help provide appropriate care facilities for individuals experiencing mental health and substance use disorders.

SFDPH B/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 B/MHSA contributes to the wellness of the San Francisco community.

- B/MHSA integrated with the SFDPH BHS Office of Justice, Equity, Diversity and Inclusion (JEDI) to expand our system-wide equity efforts.
- JEDI/B/MHSA invests in the training, support, and deployment of peer providers throughout SFDPH. JEDI/B/MHSA partners with local service providers and community members to brainstorm ways to better support the peer provider community.
- JEDI/B/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.

SFDPH JEDI/B/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 or substance use disorders, and recognition that they are to be embraced as equal members of our community.

SF Nightlife and Entertainment Summit

California's B/MHSA Guiding Principles

Five B/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

Community Program Planning (CPP) & Stakeholder Engagement

The B/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 B/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 B/MHSA-funded programs.

Exhibit 1. Key Components of B/MHSA CPP

Communication Strategies	SFDPH BHS B/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, B/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 and the Mental Health Association SF's mental health awareness campaign, Stigma Busters.

B/MHSA Communication Strategies

San Francisco's B/MHSA and DPH staff keep stakeholders and other community members updated about B/MHSA through a variety of communication strategies, including the SFDPH BHS B/MHSA website, regular communication with community groups (e.g. B/MHSA Community Advisory Committee), the BHS Biweekly Newsletter, and providing regular updates to stakeholders (e.g. SFDPH Behavioral Health Services' Client Council).

The San Francisco BHSA webpage on the SFDPH website, https://www.sf.gov/information--behavioral-health-services-act provides up-to-date information about B/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 Newsletter provides another forum for sharing information about the implementation of B/MHSA with a broad group of stakeholders. Each month, B/MHSA provides updates about program implementation, upcoming meetings and other B/MHSA news. The BHS Director also provides a monthly Director's report to the Behavioral Health Commission and a quarterly update to the Client Council.

Each Mind Matters outreach table at 1380 Howard

B/MHSA Advisory Committee & Our Commitment to Client Engagement

B/MHSA Advisory Committee

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

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

The B/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 2024 B/MHSA Advisory Committee met on June 13th and December 11th. The purpose of this meeting was to gather committee member feedback on B/MHSA programming and the needs of priority populations, with presentations by RAMS' API Mental Health Collaboration, RAMS' Black Perinatal Wellness Program and BHS' Gender Health SF.

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 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 2024, the Council met on August 20th 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 them updates in real time on how SFDPH BHS improved programming is addressing their newly identified needs.

Strengthening Relationships

B/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 Mental Health San Francisco Leadership Committee, we ensure that programmatic areas funded or supported by B/MHSA complement and/or extend MHSF work, but do not duplicate efforts. The relationship between B/MHSA and these groups provides an ongoing channel of communication and support.

Community Program Planning session

B/MHSA partners with the SF Behavioral Health Commission to gather valuable feedback regarding B/MHSA strategies. The SF Behavioral Health Commission has been closely involved since the initial development of B/MHSA in San Francisco. The Commission works as an advisory body to provide education to B/MHSA leadership teams and to ensure that the needs of the community are met. B/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 behavioral health system.

Recent Community Program Planning Efforts

Community Program Planning and the B/MHSA FY25-26 Annual Update to the Program and Expenditure Plan

The SFDPH B/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 B/MHSA FY25-26 Annual Update to the Program and Expenditure Plan. Community members' voices are critical in guiding B/MHSA program improvements and developing new programming. This report provides a comprehensive overview of our community outreach and engagement efforts and key findings in FY23-24 programming, and our plans to integrate community feedback into B/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 B/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 2024, **JEDI/B/MHSA hosted 10 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 70 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.

JEDI and B/MHSA Retreat

All meetings were advertised on the SFDPH website, via word-of-mouth, and email notifications to providers in the SF BHS, JEDI/B/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 2024 CPP meetings are listed in the following table.

2024 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening**
2/15/2024	Innovation Project Planning Meeting with Stakeholders Latine/a/o/x and Indigenous communities of San Francisco
5/1/2024	Excelsior Family Connections Latinx Mental Health Needs
5/21/2024	Focus Group for Transgender Communities Behavioral Health Needs for the Trans Communities
6/13/2024	JEDI-B/MHSA Advisory Committee Mtg Culturally Congruent Services

2024 Community Program Planning (CPP) Meetings	
Date	**CPP Stakeholder Group/Convening**
8/20/2024	Client Council Stakeholder Meeting Gather input from clients and community stakeholder on upcoming behavioral health activities and resources
10/9/2024	Innovation Project Planning Meeting with Stakeholders Pacific Islander Communities
11/20/2024	Innovation Project Planning Meeting with Stakeholders Pacific Islander Communities
11/20/2024	Innovation Project Planning Meeting with Stakeholders Latine/a/o/x and Indigenous communities of San Francisco
12/17/2024	Innovation Project Planning Meeting with Stakeholders Pacific Islander Communities
12/11/2024	JEDI-B/MHSA Advisory Committee Mtg Stakeholder and community member feedback

In each community meeting, SFDPH JEDI/B/MHSA staff presented an overview of the B/MHSA, including its core components, guiding principles, and highlights of existing programs and services. Staff also provided meeting attendees with information 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 B/MHSA programming. SFDPH B/MHSA staff addressed how the feedback would be incorporated into the Annual Update and future B/MHSA programming. Community members were also provided with information on the 30-day local review process in approving the FY25-26 B/MHSA Annual Update.

Community and Stakeholder Feedback

The feedback and input shared by our community stakeholders, supports ongoing program improvement planning efforts. CPP meetings in 2024 built on existing community and B/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.

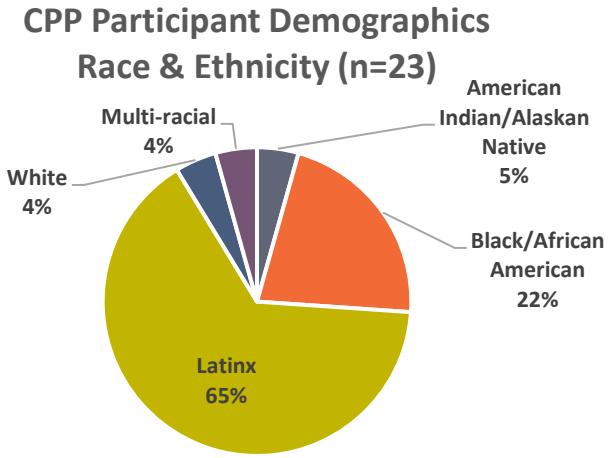
- Culturally responsive services reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access – this is of upmost importance in overcoming stigma, connecting clients to services, and successfully engaging with them.

- 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. The Latinx community has been facing challenges accessing care due to a shortage of programs serving individuals who speak Spanish or other Latin/Indigenous languages.
- There is a need for additional services targeted towards populations with unique needs such as transgender and gender non-conforming individuals, birthing people of color and transitional aged youth (TAY).
- Additional training is needed to address race, gender and health disparities. Training should be offered in different languages and by people with lived experiences.
- Stakeholders identified the high need to decouple Pacific Islander health data from Asian health data to reveal the true health needs of Pacific Islanders.
- Stakeholders also identified the need to develop more programming for the Pacific Islander mental health workforce, including mental health clinicians and peer staff. There should be a focus on outreach and programming geared toward Pacific Islander college students - who are studying to become mental health therapists and are planning to work in San Francisco's Pacific Islander communities who face financial pressures and various challenges in their efforts to complete degree programs.

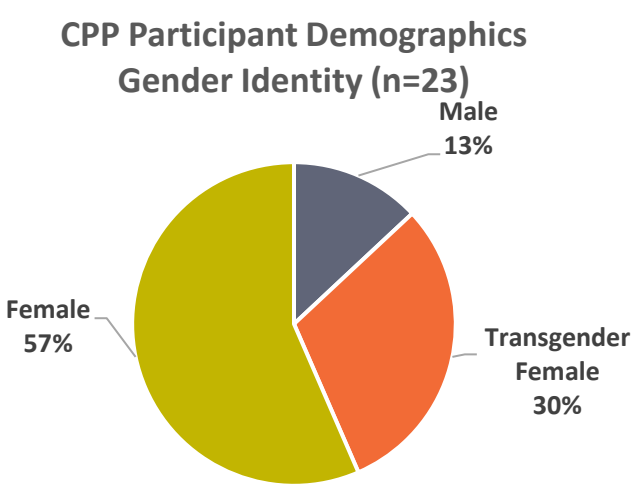
> ***"Wellness and recovery services promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives."***
> *- Service provider*

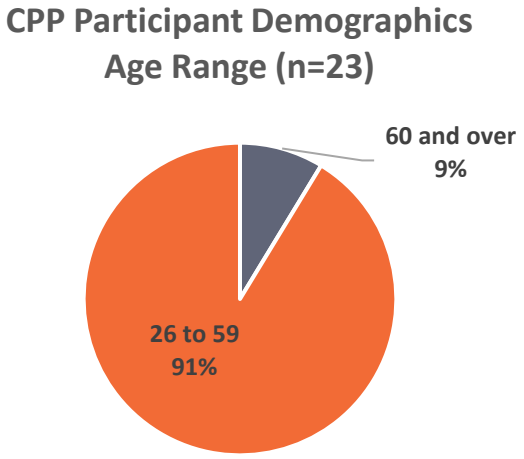
CPP Meeting Participation

More than 60 individuals attended a CPP meeting in 2024. Demographics of CPP participants (race/ethnicity, gender identity, age) for 2024 are provided below, when available[1]. CPP events were primarily held virtually in 2024, which made the collection of meeting client demographic data more challenging to collect as clients often do not complete demographic survey requests.



[1] Demographic data was only collected at 2 CPP meetings in 2024: 1) Excelsior Family Connections and 2) Focus Group for Transgender Communities.





Community Program Planning with Service Provider Selection

JEDI/B/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 up of various stakeholders, including people with expertise or lived experience of specific populations. The B/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/B/MHSA, as well as data collection and evaluation and service provider training initiatives. The B/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

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/B/MHSA units conducted a thorough analysis to determine the needs of the San Francisco community. This analysis identifies the shortage of qualified staff (e.g. licensed bilingual/bicultural Spanish speaking mental health therapists) to provide valuable services, and the staff needed to address the various mental health needs of our community. SFDPH JEDI/B/MHSA has a workforce program with dedicated funding to help remedy these personnel gaps. As a result of this analysis, we developed a report that discusses these mental health workforce shortages, the progress we have made over the past few years to gradually narrow these gaps, and plans to further increase the supply of professional staff and other staff that we anticipate will be needed to continue providing exceptional B/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/B/MHSA is planning to conduct another assessment. to better highlight the behavioral health needs of San Francisco and BHS/B/MHSA workforce's ability and capacity to address these needs.

"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/B/MHSA-funded agencies meet on a regular basis to discuss local B/MHSA program activities and to provide feedback.
- Providers participate in the regularly scheduled Impact Meetings that are facilitated by JEDI/B/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 a 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 B/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 B/MHSA funded over 200 peers in FY23-24** throughout our behavioral health system.

San Francisco's Integrated JEDI/B/MHSA Service Categories

As discussed in the introduction to this report, San Francisco's initial B/MHSA planning and implementation efforts were organized around B/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 B/MHSA, however, required that these plans be merged into a single Integrated Plan. Through our community planning efforts, B/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, B/MHSA simplified and restructured the B/MHSA funding components into seven B/MHSA Service Categories to facilitate streamlined planning and reporting (see Exhibit 2 below). These B/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. B/MHSA Service Categories

JEDI/B/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 Annual Update

The SFDPH B/MHSA FY25-26 Annual Update to the Program and Expenditure Plan was developed in collaboration with B/MHSA clients, peers, family members, service providers, local residents, and other stakeholders. The SFDPH JEDI/B/MHSA community outreach and program planning efforts were coordinated by a core team of JEDI/B/MHSA staff, which included the JEDI/B/MHSA Director and Program Managers. Independent consulting firms, HTA Consulting and Harder+Company Community Research, supported technical writing and program outcome data analysis and reporting.

In the planning work conducted for the FY25-26 Annual Update, the B/MHSA team incorporated JEDI/B/MHSA, SFDPH mission and goals, JEDI/B/MHSA goals, newly expanding work in behavioral health funded under local San Francisco initiatives, local data about community need, and revisited local B/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 B/MHSA team to identify and integrate direct program feedback from the individuals we serve, and the greater community, in planning for future B/MHSA programming. In addition to incorporating community feedback into our planning process, the B/MHSA team relied on several other strategies to inform future program improvements, including:

- Reviewing the current and previous three-year B/MHSA Program and Expenditure Plan and any subsequent B/MHSA Annual Update Reports. The team evaluates how effectively programs address the B/MHSA priorities and track the evolving needs of the community.
- Reviewing JEDI/B/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.
- Reviewing state regulations, laws and guidelines 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 the Office of Statewide Health Planning and Development.

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 B/MHSA-funded programs, including the role of the B/MHSA Advisory Committee, BHS Client Council, and other community engagement meetings. Please see the components on B/MHSA Communication Strategies and B/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 B/MHSA FY25-26 Annual Update was posted on the B/MHSA website for a period of 30 days from MONTH DATE YEAR through MONTH DATE YEAR.** 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 from the Behavioral Health Commission public meeting:

Summary of Public Comments and BH Commission on the B/MHSA FY25-26 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 2026.** The **San Francisco's B/MHSA FY25-26 Annual Update** was also presented before the **Board of Supervisors Audit and Oversight Subcommittee on MONTH DATE 2026** and was recommended to the full Board of Supervisors to approve. **The full Board of Supervisors adopted this B/MHSA FY24526 Annual Update on MONTH DATE 2026.**

Public Hearing & Board of Supervisors Resolution

Placeholder

Resolution placeholder page

SFDPH JEDI/B/MHSA FY25-26 Annual Update

As a result of feedback received during JEDI/B/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.

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

  - FSP Permanent Supportive Housing
  - Housing Placement and Support
  - TAY Transitional Housing
  - Supportive Housing
- **Mental Health Promotion and Early Intervention**
  - Peer Outreach and Engagement Services
  - Behavioral Health Services at Balboa Teen Health Center
  - School-Based Mental Health Services
  - School-Based Youth Early Intervention
  - School-Based Wellness Centers
  - Trauma and Recovery Services
  - FUERTE School-Based Prevention Groups Project
  - Senior Drop-In Center
  - Addressing the Needs of Socially Isolated Adults Program
  - Improving Maternal Mental Health for Black/African American Birthing People
  - Homeless Children's Network MA'AT Program
  - Kummba Program
  - Free Minds Initiative
  - Black African American Community Wellness & Health Initiative
  - 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
- **Innovation**
  - Culturally Responsive Practices for the Black/African American Communities
- **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
    - Fellowship for Public Psychiatry (Adult/Older Adult System of Care and Zuckerberg San Francisco General Hospital)
    - BHS Graduate Level Internship Program
    - Child and Adolescent Community Psychiatry Training Program (CACPTP)
- **Capital Facilities and Information Technology - CF/TN**
    - Expansion of Telehealth Kiosks – Capital Facilities
    - Consumer Portal – IT
    - Consumer Employment – IT
    - System Enhancements – IT
- **Equity and Evaluation Support Services**
    - Evaluation, Planning and Technical Assistance
    - Study Center Equity Consultants
    - Black/African American Faith-Based Peers

Peer to Peer Halloween Party

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/B/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 disorder supports 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 B/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 people 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 with mental illness and substance use disorders.
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

FSP Programs			
Target Population	Program Name *Provider*	Name Listed on ARER, Budget	Additional Program Characteristics
			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, and Cost per Client

FSP Client Demographics

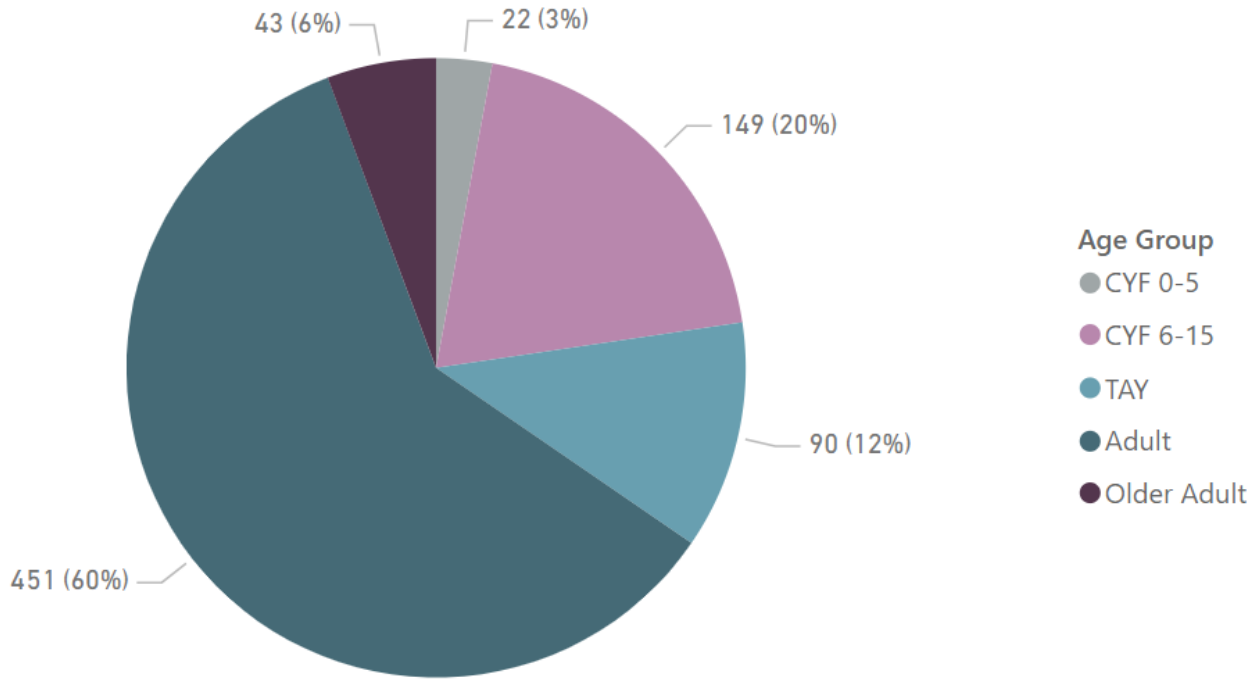
San Francisco funded twelve Full-Service Partnership (FSP) programs during FY23-24 serving a total of 743 unique clients. The graphs and tables below describe the demographic characteristics of FSP clients served between July 1, 2023 and May 21, 2024. Due to the transition of SFDPH Behavioral Health Services' electronic health record (EHR) system from Avatar to Epic, we currently do not have demographic data for unique clients served from May 22, 2024 through June 30, 2024.

For demographic reporting, age, sex/gender identity, race/ethnicity, and primary language are displayed by FSP program and/or FSP age group. Note that any table cell with fewer than 10 clients is displayed as "<10" to protect the privacy of FSP clients and not compromise individuals' identity.

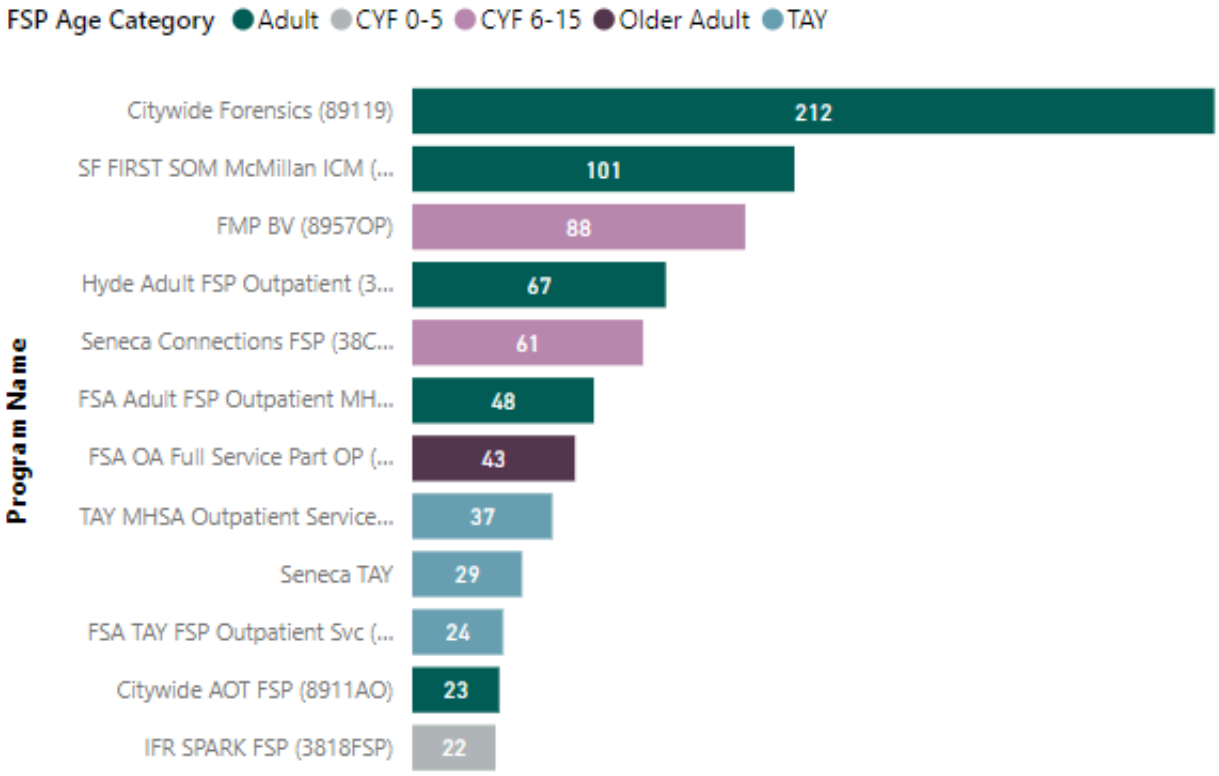
Client Age

Of 743 unique clients, two thirds are adults/older adults, and one third are younger clients (TAY and CYF).

Clients by Age Group



Program Enrollment by Age Group



Client Sex and Gender Identity

Historically, client sex was entered into the Avatar EHR with binary options: female and male. Under a county mandate on collection of Sexual Orientation and Gender Identity (SOGI) data, clients are able to more accurately reflect their gender identity with the inclusion of expanded reporting options.

Of 743 unique clients, 57% identified as male, 31% identified as female, and 5% identified as trans female, trans male, genderqueer or gender non-binary. Due to confidentiality considerations, the expanded categories are not included in the table below.

Age Group by Gender Identity

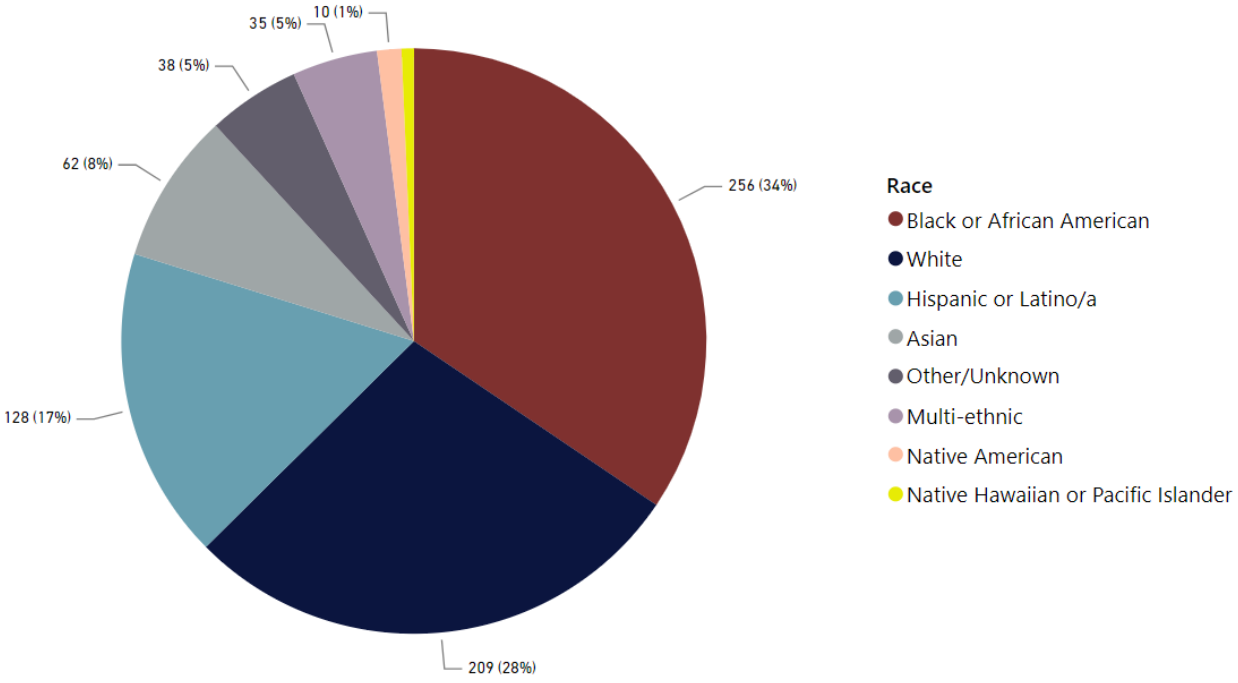
Age group	Female	Male	Other	Unknown
CYF 0-15	67	54	<10	42
TAY	26	50	<10	<10
Adult	121	300	17	<10
Older Adult	18	24	<10	<10

Client Race/Ethnicity

Race and ethnicity data are captured in Avatar and recoded into eight categories: Black or African American, Asian, Hispanic or Latino/a, Multi-ethnic, Native American, Native Hawaiian and Other Pacific Islander, White, and Other.

Client Race/Ethnicity for All FSP Programs

Overall, one third of FSP clients identified as Black/African American, and over a quarter identified as White. One third of younger clients identified as Hispanic/Latino/a, making them the largest demographic group in the respective age categories.



Client Race/Ethnicity by FSP Program

Percentage of Race/Ethnicity

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	14%	27%	46%	5%			8%			**100%**
Citywide AOT	13%	35%	13%	13%					26%	**100%**
Citywide Forensics	8%	43%	8%	6%	2%	1%	3%		29%	**100%**
Family Mosaic Project (FMP)	14%	24%	36%	5%	1%		14%	1%	6%	**100%**
FSA Adult FSP	13%	35%	8%	4%	2%		2%		35%	**100%**
FSA Older Adult FSP	5%	37%	9%	2%					47%	**100%**
FSA TAY FSP	21%	21%	21%	17%		4%			17%	**100%**
Hyde Street FSP	7%	25%	10%		1%		3%		52%	**100%**
IFR SPARK FSP		32%	50%				18%			**100%**
Seneca Connections	2%	51%	18%	2%	2%		10%	2%	15%	**100%**
Seneca TAY	17%	24%	28%	10%		3%			17%	**100%**
SF FIRST FSP	6%	30%	11%	4%	2%	1%	1%		46%	**100%**
Total	**8%**	**34%**	**17%**	**5%**	**1%**	**1%**	**5%**	**0%**	**28%**	**100%**

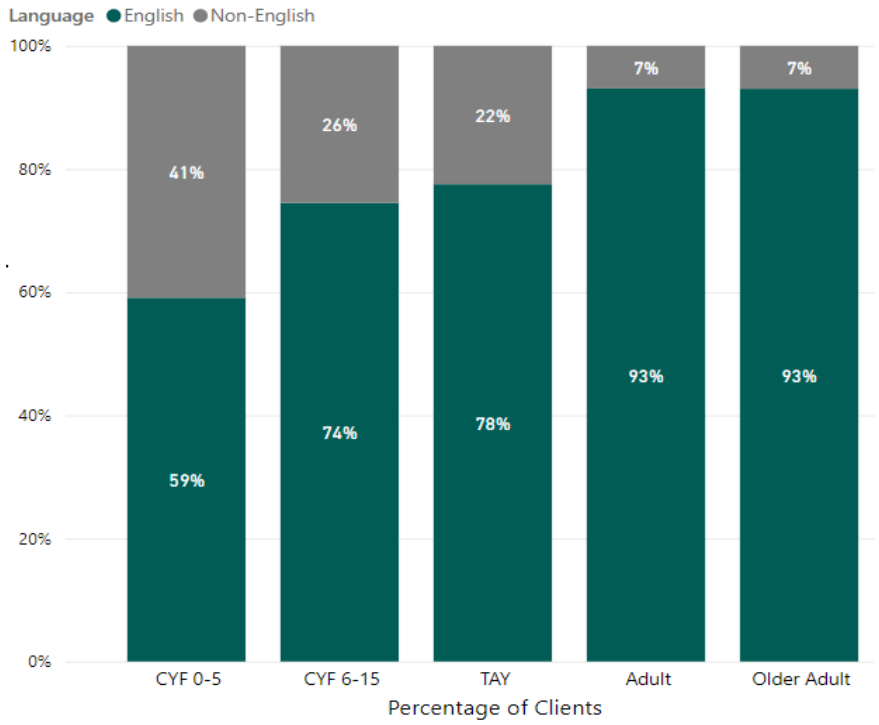
Count of Race/Ethnicity

Program	All Other Race/Ethnicity	Black or African American	Hispanic or Latino/a, all races	White
BHS TAY FSP	10	10	17	<10
Citywide AOT	<10	<10	<10	<10
Citywide Forensics	41	91	18	62
Family Mosaic Project (FMP)	30	21	32	<10
FSA Adult FSP	10	17	<10	17
FSA Older Adult FSP	<10	16	<10	20
FSA TAY FSP	10	<10	<10	<10
Hyde Street FSP	<10	17	<10	35
IFR SPARK FSP	<10	<10	11	<10
Seneca Connections	10	31	11	<10
Seneca TAY	<10	<10	<10	<10
SF FIRST FSP	14	30	11	46
Total	**150**	**256**	**128**	**209**

Client Primary Language

Client Primary Language is collected at FSP intake, and updated by case managers as part of the Client and Service Information (CSI) admission and treatment planning processes required by Medi-Cal. Most FSP clients (87%) indicated their primary language as English.

Client Primary Language by Age Group



While English is reported as the primary language for the majority of FSP clients, FSP providers also support a range of languages such as Spanish (spoken by 10% of clients), Cantonese

(1%), and other languages (2%). Other languages include Mandarin, Vietnamese, Russian, Filipino, Tagalog, Italian, and Arabic. As defined by DHCS Medi-Cal eligibility, the "threshold" languages for San Francisco are Spanish, Cantonese, Mandarin, Vietnamese and Russian.

FSP Client Outcomes

The B/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. San Francisco regularly downloads this data from the DHCS server into a San Francisco County SQL server data warehouse. From this, we generate datasets, sharing them regularly with FSP programs.

Key outcomes reported here for FSP clients include time spent in different residential settings, the occurrence of emergency events requiring intervention, and reasons for discontinuation of partnership. Data were entered into the DCR system using the Partnership Assessment Form (PAF) completed at the start of the partnership, and the Key Event Tracking (KET) form completed as key or major events occur.

Residential Outcomes

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 FY23-24 with a completed Partnership Assessment Form (PAF), who have served in the FSP partnership for at least one continuous year but no more than four years. Clients who have been active in the FSP for less than one year or more than four are excluded from this data.

The following charts compare active clients' baseline year (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 12-month year for all currently active clients. Typically, clients spend time in more than one setting in one year.

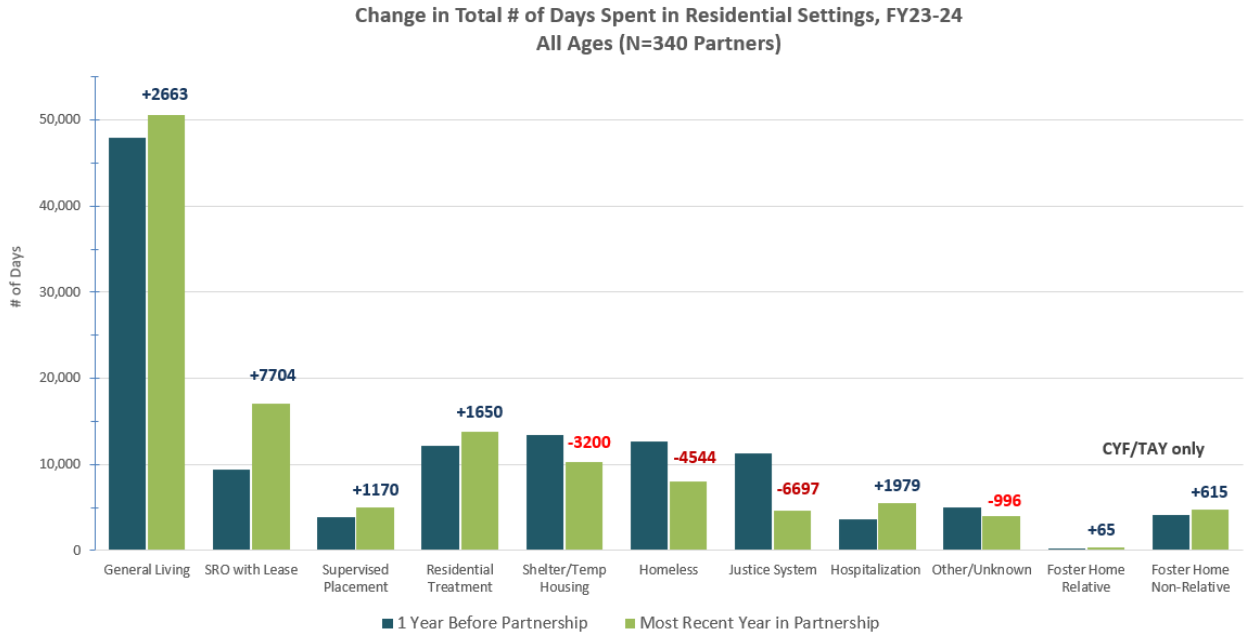
Residential settings are displayed from least restrictive (i.e., generally more independent and less restrictive environments) to most restrictive. However, while a supervised placement may represent a setback for one client, for others, this may represent receiving much needed care. For older adults, 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

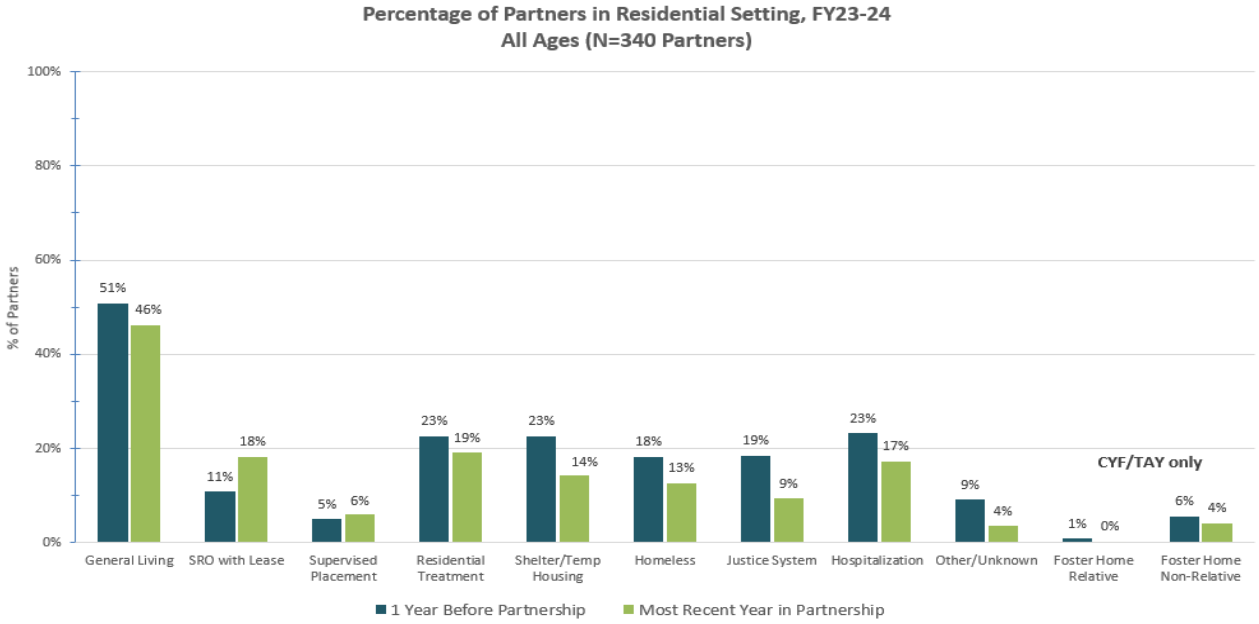
Residential outcomes across all age groups (Exhibit RES-All-1) show an increase in the number of days clients spent in stable settings, such as General Living, Single Room Occupancy (SRO) with Lease, i.e. tenant's rights, Supervised Placement, and Residential Treatment, from baseline year to the most recent year of FSP treatment. Simultaneously, there was a decrease in days spent in less stable or more restrictive settings, such as Homeless and Justice System. The most significant increase was in SRO with lease, which rose by 6.2%, followed by General Living settings, which rose by 2.1%. On the other hand, hospitalizations also increased by 1.6%.

Exhibit RES-All-1. Change in time spent in residential settings, All clients (N=340)



The percentage of clients experiencing unstable or restrictive settings during the most recent FSP year decreased (Exhibit RES-All-2), with the most significant drop being 9.1% among those involved in the justice system.

Exhibit RES-All-2. Percentage of clients in residential settings, All Clients (N=340)



Emergency Events

Emergency events, documented as key events using the KET form, include arrests, mental

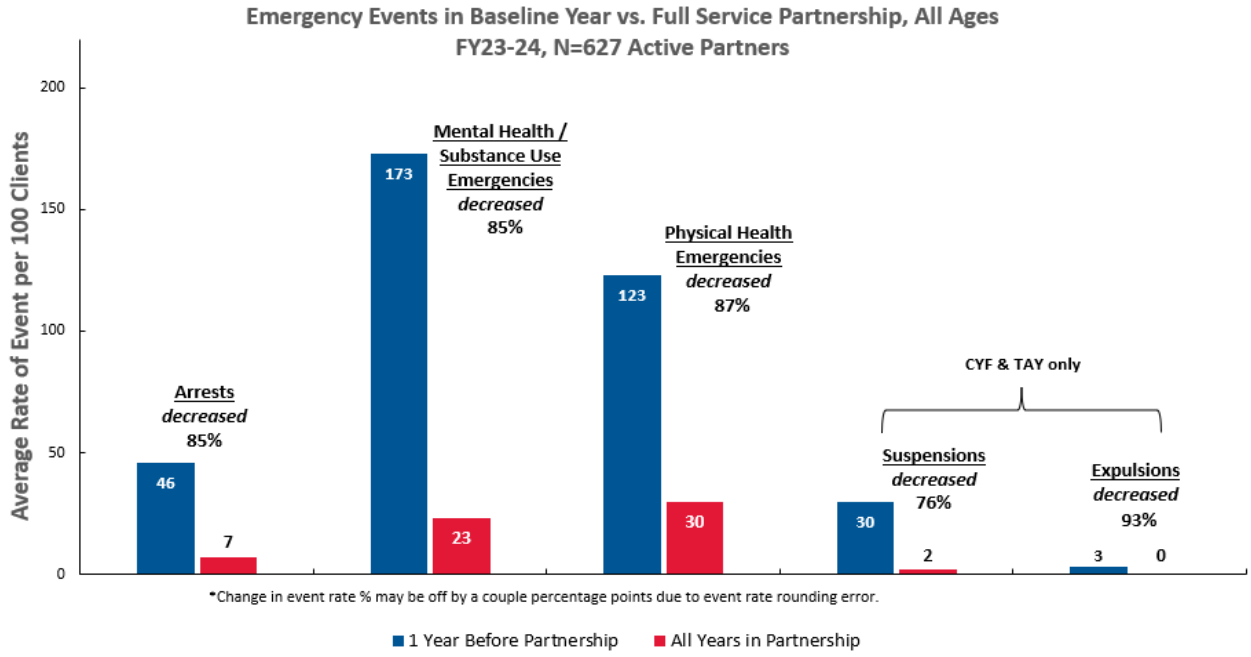
health or psychiatric emergencies (including substance use events), and physical health emergencies, as well as school suspensions and expulsions for children and TAY. Physical health emergencies are those which require emergency medical care (usually a visit to a hospital emergency department), not those of a psychiatric nature. Key events were logged for 627 of 743 unique clients who were active in FSP programs for FY23-24.

The graphs below compare the number of emergency events for all FSP clients active at any time during FY23-24 in the one-year baseline period before entering FSP to the average number of emergency events per 100 clients across all years in the FSP.

Note that the number of active clients included in the emergency events data (N=627) exceeds that for the residential outcomes data (N=340), due to the narrower inclusion criteria for the latter, which only includes clients who have served in a partnership for one to four years.

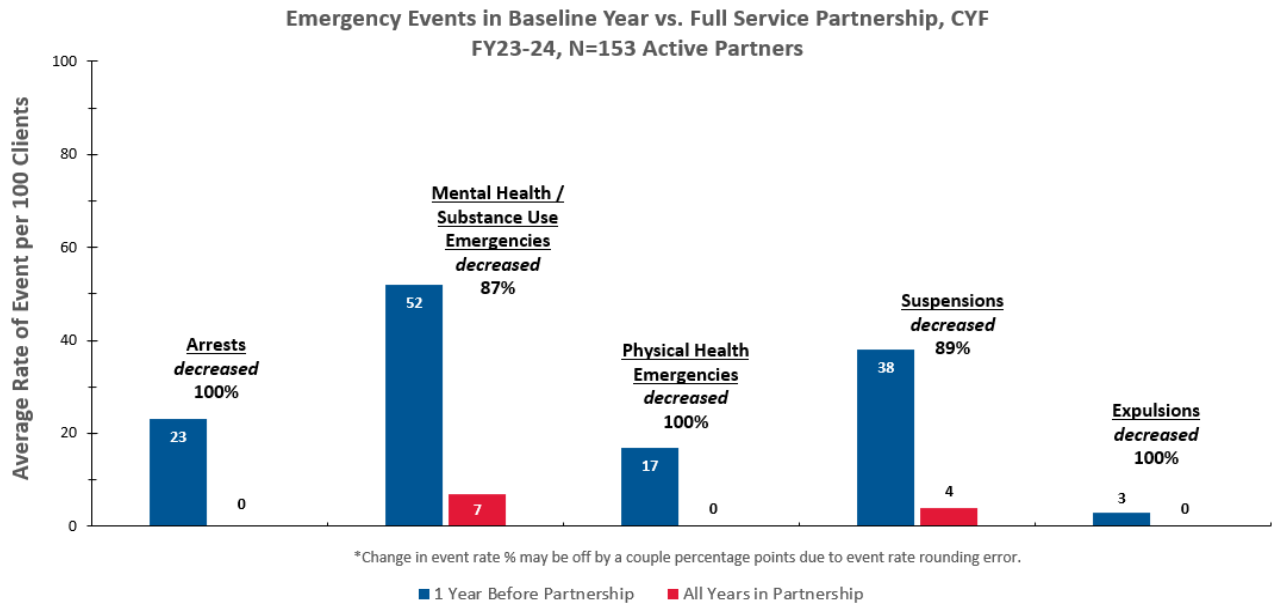
Overall, the occurrence of all types of emergency events decreased for all FSP clients during partnership as compared to their baseline (Exhibit EE-ALL)**.** Declines of arrests, mental health/substance use emergencies, physical health emergencies, school suspensions and school expulsions ranged from 76% to 87%.

Exhibit EE-ALL. Comparison of Emergency Events: Baseline vs. FSP, All ages (N=627)



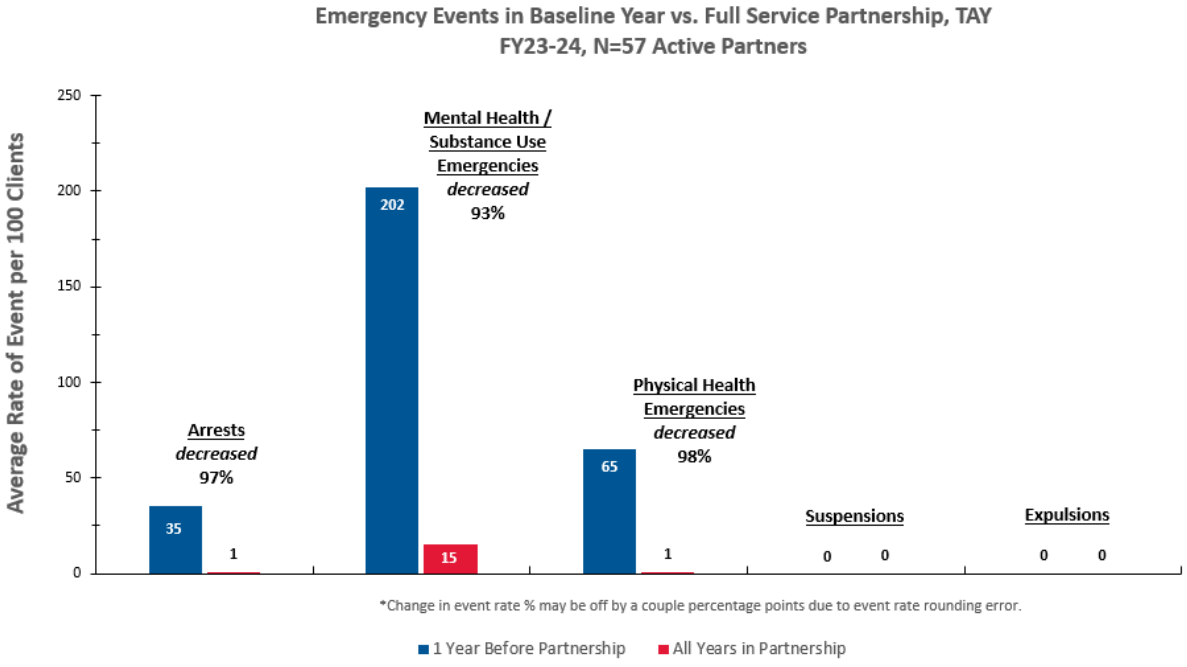
Among child clients, the number of emergency events reported decreased after entering FSP (Exhibit EE-CYF). Compared to the baseline period, only mental health/substance use emergencies and suspensions occurred. One contributing factor to reduced expulsion is that the San Francisco Unified School District (SFUSD) established a policy that severely limits 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.

Exhibit EE-CYF. Comparison of Emergency Events: Baseline vs. FSP, CYF (N=153)



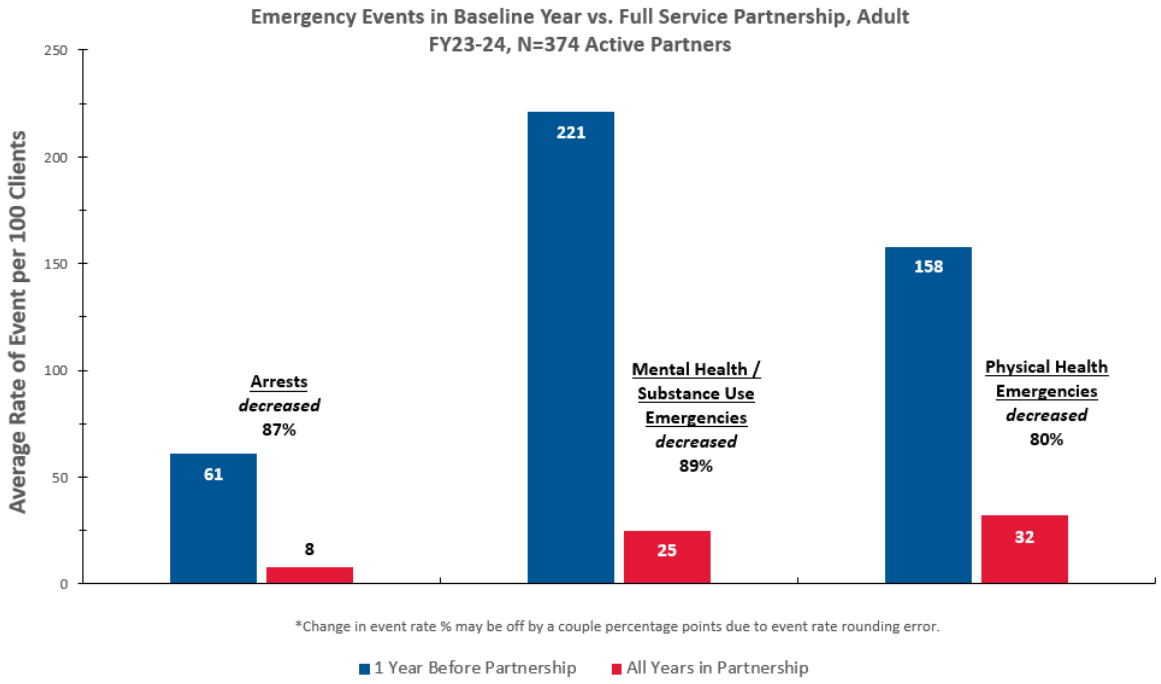
Among TAY clients, fewer emergency events were reported during their partnership (Exhibit EE-TAY). Declines over 90% appeared across all non-school emergency events experienced by TAY clients.

Exhibit EE-TAY. Comparison of Emergency Events: Baseline vs. FSP, TAY (N=57)



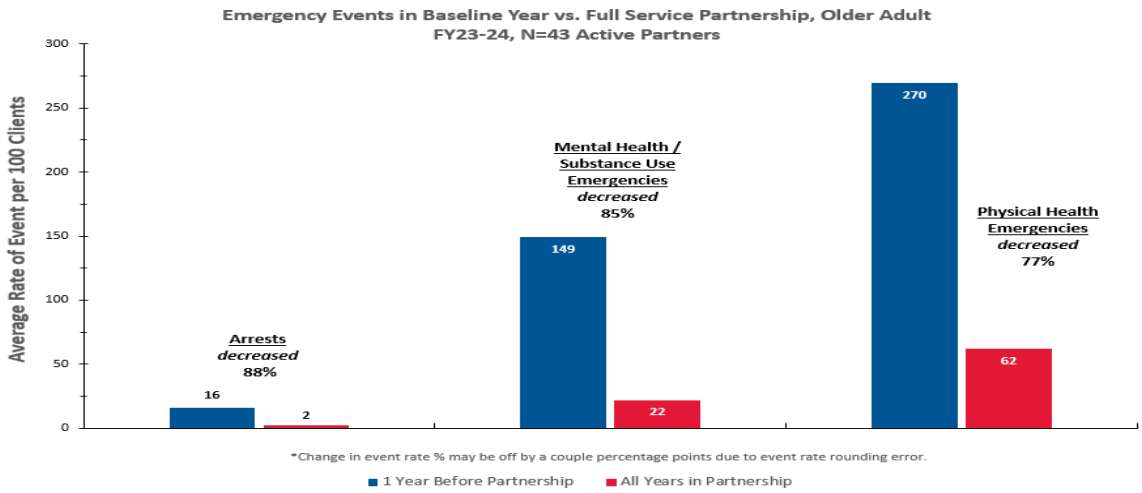
Among adult clients, fewer emergency events were reported during FSP compared to baseline data (Exhibit EE-A). Average event rates per 100 clients decreased 80% or more across all types of emergency events experienced by adult FSP clients.

Exhibit EE-A. Comparison of Emergency Events: Baseline vs. FSP, Adult (N=374)



While physical health emergencies may be common among older adults, particularly those served by FSP programs, the number of physical health emergencies decreased 80% after at least one year of FSP service (Exhibit EE-OA). The positive effect may be that FSP case management increases attention to previously untreated medical issues.

Exhibit EE-OA. Comparison of Events: Baseline vs. FSP, Older Adults (N=43)



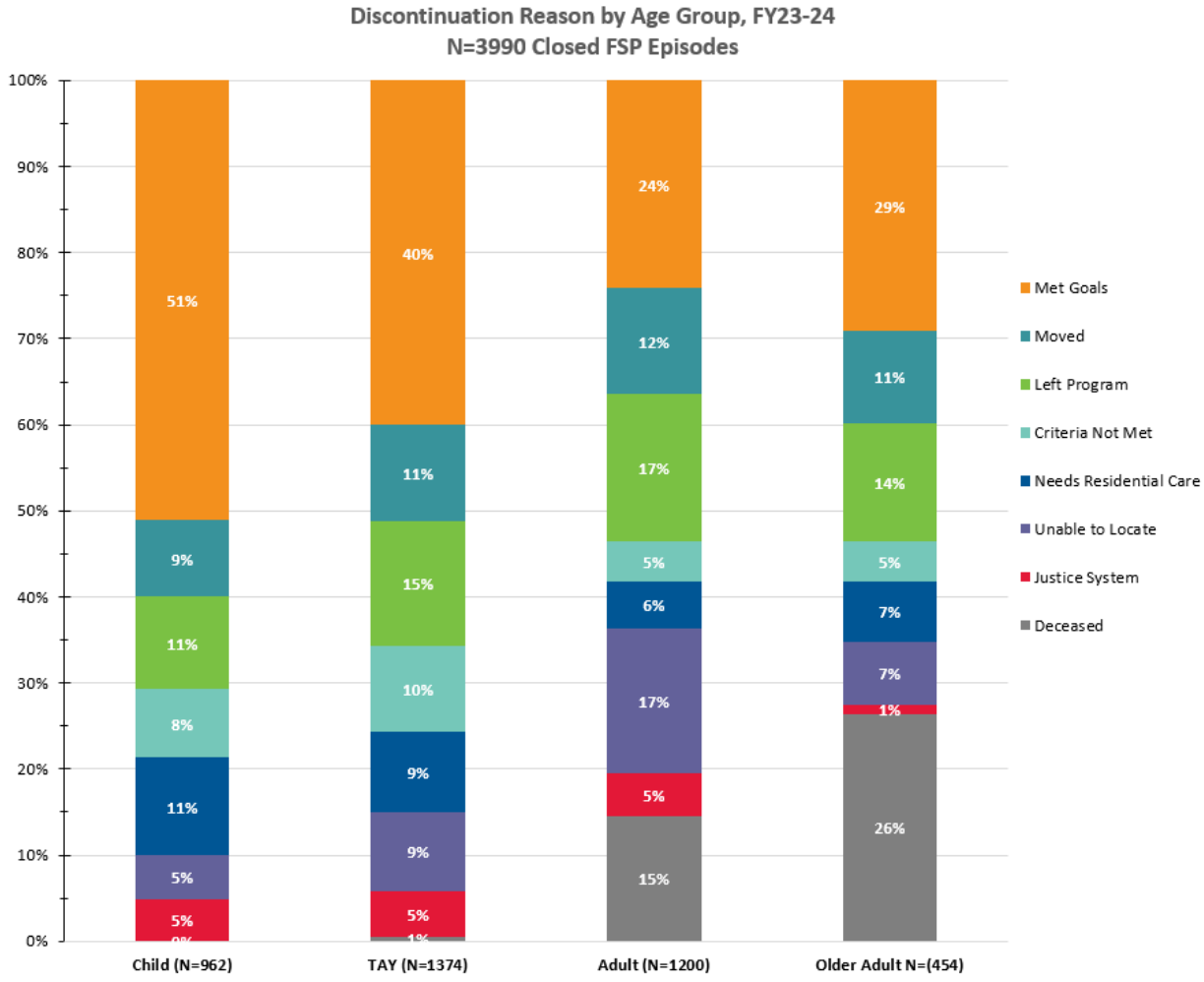
Reason for Discontinuation

Discontinuation events are 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, suggesting that the services provided may not meet their needs or that they are not yet ready to engage in treatment.

A total of 3,990 closed FSP episodes or discontinuations have been logged for all FSP clients since the inception of FSPs. The reasons for discontinuation varied for each age group (Exhibit RFD), with the most commonly reported reason being having met goals, accounting for 37% of cases overall.

Exhibit RFD. Reason for Discontinuation by Age group



Limitations

This report has several limitations related to the collection and quality of KET data in the DCR application. The KET form, designed for case managers to record key client events, such as residential changes and emergency events, is intended to be completed as events occur or at the earliest opportunity thereafter. However, data quality reports suggest that key events data may be incomplete due to challenges in following up with clients. Additionally, the ongoing transition between EHR systems during the past fiscal year affected the unique CSI identifier, creating difficulties for providers in locating clients in the DCR application. These issues have likely led to delayed or missed KET submissions. These limitations should be considered when interpreting trends in this report.

Since the inception of the DCR, capturing 100% of residential changes, emergency events, and other life events through KETs has proven challenging. Case managers face difficulties in being informed of all relevant details of those events, and in having the capacity to record them in the DCR.

Ongoing and Future Steps

San Francisco continues to manage DCR activity through the DCR Workgroup, comprised of B/MHSA evaluators from BHS Quality Management and IT. The Workgroup partners 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 of 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 into the DCR at a later time.

In FY23-24, the DCR Workgroup provided bimonthly virtual DCR user training for new FSP case managers and ongoing technical assistance for data entry and navigation of the DCR application. Training will continue to be held in FY24-25.

In the upcoming year, we will collaborate with our IT department to build a Behavioral Health Services-centered data infrastructure. Informed by the needs of our system of care and our JEDI team, this infrastructure will expand our capacity to track metrics related to outcomes and gaps, including health equity, and to provide timely feedback to programs

This will result in improved efficiency with which analysts can use DCR data by integrating within the same architecture as the Epic EHR system. By streamlining access to centralized client data, we will improve our reporting capabilities with more accurate information that uses multiple data sources.

FY23-24 Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[2]
Full-Service Partnership (Children)	171 Clients	$1,079,240	$6,311
Full-Service Partnership (TAY)	90 Clients	$3,209,948	$35,666
Full-Service Partnership (Adult)	451 Clients	$5,583,002	$12,379
Full-Service Partnership (Older Adult)	43 Clients	$1,740,679	$40,481

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.

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

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

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 clients. These programs and 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	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*	Justice System	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 B/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	FY23-24 Key Outcomes and Highlights
Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher – *Seneca Center and DPH*	63% (n<10) of clients referred to behavioral health services attended three appointments 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 transitional 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 of 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	FY23-24 Key Outcomes and Highlights
Prevention and Recovery in Early Psychosis (PREP): also known as (re)MIND – *Felton Institute*	86% (n=12) participants with at least one acute hospital admission within 12 months demonstrated a decrease in the total number of acute patient episodes or decrease in acute setting days.

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

Program Overview

The Behavioral Health Access Center (BHAC) is one of the first SF B/MHSA funded programs. It serves a walk-in central entry point into the behavioral health system of care, connecting individuals to outpatient mental health and substance use services, withdrawal management, substance use residential treatment, and the private provider network. Its goal is to promote timely access to behavioral health services and improve coordination of screening, intake, and referral processes for individuals seeking services. BHAC provides clinical screening, referral to residential substance use disorder and mental health treatment, crisis intervention and referral to urgent services, and referrals to outpatient SUD and mental health services. BHAC is part of the Office of Coordinated Care (OCC) which supports access to care, care coordination, and seamless transitions across systems and levels of care.

BHAC is co-located with several critical behavioral health services to streamline care coordination and improve access, including:

a. Centralized BHS Eligibility Unit, ensures that clients entering the system of care are properly screened for insurance coverage, linked to appropriate services, and supported through the verification, documentation, and troubleshooting of eligibility across centralized access points and contracted provider sites to promote accurate enrollment and billing.

b. Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC), which provide evaluation and placement into Opioid Treatment programs.

c. The BHS Pharmacy, which provides buprenorphine, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol withdrawal management medications for BHS clients, naloxone distribution for opioid overdose prevention, specialty behavioral health medication packaging, and serves as the safety-net pharmacy for all BHS clients.

d. Bringing Expanded Access to Medications (BEAM) provides telemedicine support to connect clients to medications treatment for heroin, fentanyl, or opioids, with warm handoffs to BHAC for in-person assessments and linkage to ongoing services.

BHAC was instrumental in the implementation of Proposition 47 in San Francisco. Through funding allocated by DHCS, Proposition 47 supports access to community-based behavioral health care for eligible individuals formerly incarcerated. Proposition 47 funding has allowed SFDPH to increase the amount of residential treatment capacity in the community and interrupt cycles of re-incarceration for justice-involved individuals. Additionally, 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-4pm) starting in July 2023.

In parallel, the BHS Pharmacy also extended its operating hours to weekday evenings and weekends, ensuring medication access aligns with BHAC's expanded availability.

Target Populations

BHAC primarily serves underserved and vulnerable populations, including:

- People with serious mental illness,
- People with substance-use disorders, or co-occurring diagnoses.
- People who are experiencing homelessness, uninsured or underinsured, or have low-to-no income
- People who are monolingual or non-English speaking, and/or members of racial or ethnic minority groups.

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	FY23-24 Key Outcomes and Highlights
Behavioral Health Access Center (BHAC) – *DPH*	448 clients were provided with eligibility assistance services.

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

Program 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).

B/MHSA has also made investments to bridge Behavioral Health Services and Primary Care in other ways. B/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 wraparound 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

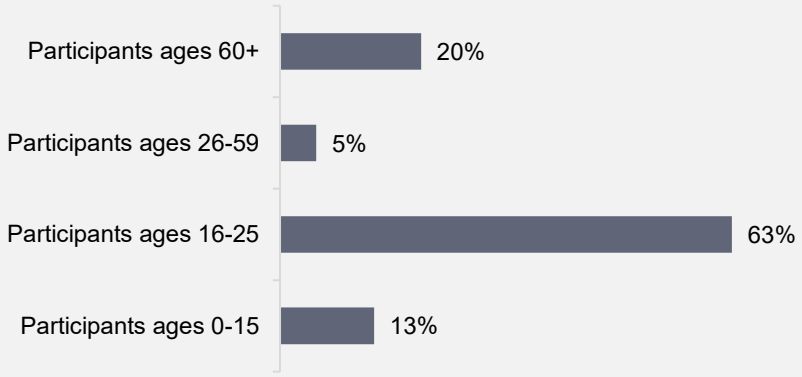
The target populations for these services are individuals and families served in primary care clinics with behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

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.

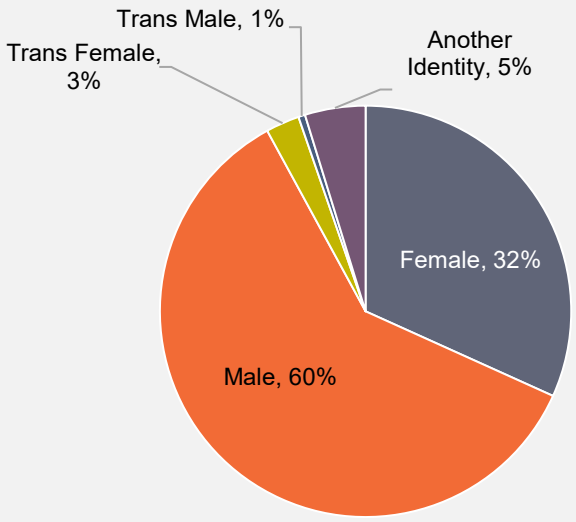
Program	FY23-24 Key Outcomes and Highlights
Integration of Behavioral Health and Primary Care – *Curry Senior Center*	100% (n<10) of patients diagnosed with clinical depression were offered assistance in obtaining an appointment for evaluation with a Behavioral Health Services provider.

Demographics: Non-FSP Recovery Oriented Treatment Programs

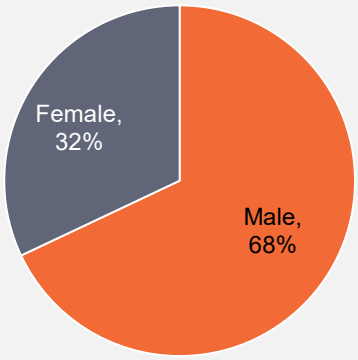
Age: Non- FSP Recovery Oriented Treatment Services – CSS Funding (n = 200)



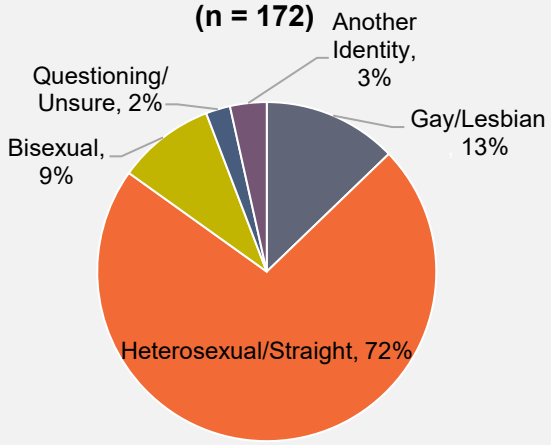
Gender Identity: Non- FSP Recovery Oriented Treatment Services – CSS Funding (n = 189)



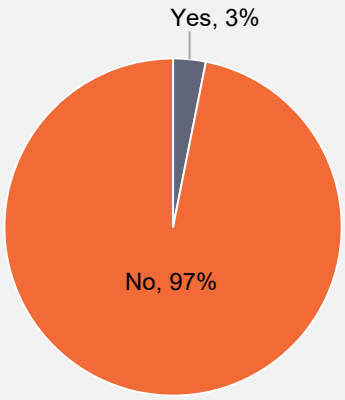
Sex at Birth: Non- FSP Recovery Oriented Treatment Services – CSS Funding (n = 278)

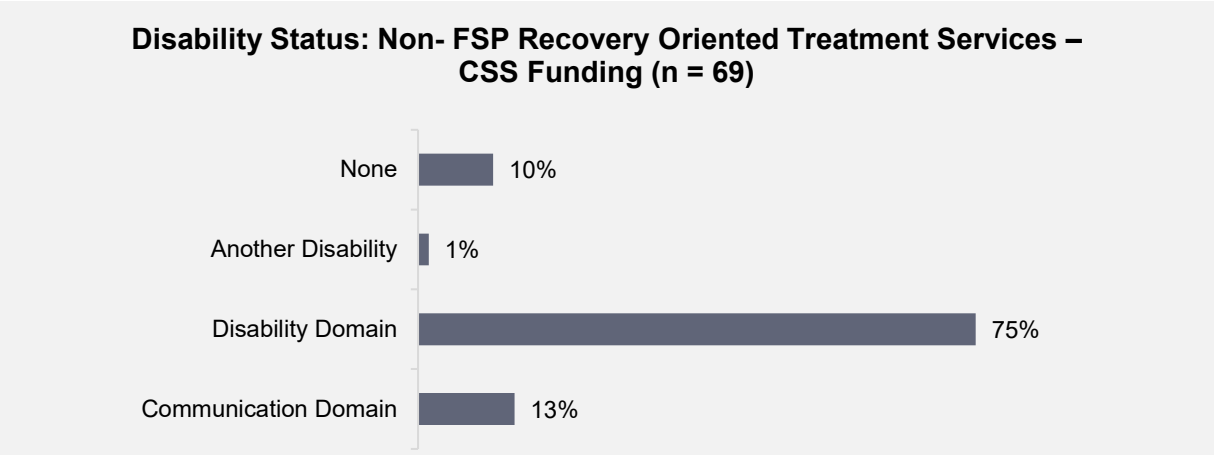


Sexual Orientation: Non- FSP Recovery Oriented Treatment Services – CSS Funding (n = 172)



Veteran Status: Non- FSP Recovery Oriented Treatment Services – CSS Funding (n = 128)





Race	n	%
Black, African American, or African	52	35%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	25	17%
Native Hawaiian or Pacific Islander	<10	3%
White	44	29%
Other Race	23	15%
Total	150	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	46	94%
Non-Hispanic/Non-Latina/e/o	<10	0%
More than one ethnicity	<10	6%
Total	49	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	176	89%
Russian	<10	1%
Spanish	16	8%
Tagalog	<10	0%
Vietnamese	<10	1%
Another Language	<10	0%
Total	197	100%

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

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[3]**
Non-FSP Recovery Oriented Treatment Programs	3,766 Clients	$3,933,314	$1,044

Moving Forward in Recovery-Oriented Treatment Services

Behavioral Health Access Center (BHAC)

Recent changes or updates to the project(s), including updated timelines and plans for FY25-26.

- During this reporting period, a redesigned, consumer-focused web page for Behavioral Health Services was launched, prominently featuring BHAC and its services: https://www.sf.gov/location/behavioral-health-access-center-bhac
- BHAC operated with expanded hours for a full year, providing a total of 66 hours of client-facing services over 7 days per week.
- BHAC transitioned to a new Electronic Medical Record, Epic, in May 2024, along with all SFDPH mental health services.
- BHAC added scheduling capabilities for outpatient specialty mental health services, improving timeliness and coordination of care.
- Implemented a newly established workflow for access to non-specialty mental health services for mild-to-moderate mental health conditions for eligible clients.
- Continued its co-location and collaboration with the BHS Eligibility Unit, facilitating rapid enrollment, including inter-county transfer for Medi-Cal members.
- A revised substance use disorder screening tool was piloted and fully implemented following proof-of-concept testing. While not a diagnostic tool, it is used to guide referrals and placement decisions for individuals seeking substance use treatment, improving consistency in assessment and service matching.
- Implemented the use of a new Customer Relations Management (CRM) system to better track BHAC visits and services.
- The transition of Utilization Management responsibilities from BHAC to the BHS Utilization Management (UM) team improved organizational efficiency, allowing BHAC to refocus on access and care linkage functions.
- The Office-Based Induction Clinic (OBIC) partnered with BHAC for an evening clinic, providing seamless access to buprenorphine treatment for individuals with opioid use concerns. BHAC also remains an active participant in the BHS Clearing House, providing naloxone and overdose prevention materials to clients and the public.

Through its role in the Office of Coordinated Care (OCC), BHAC supports individuals transitioning back into the community after a behavioral health crisis. This includes coordination with the Bridge and Engagement and Services Case Management Team (BEST-CM) and Triage teams. These partnerships provide warm handoffs, linkage to services, and stabilization support.

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

BHAC continues to work closely with B/MHSA-funded system navigation and consumer engagement initiatives, including hosting interns and peer navigators who play critical roles in daily operations and client support.

The Living Proof Campaign, a public education initiative aimed at addressing the opioid overdose epidemic—especially prevalent among people of color—will launch in November 2024. The campaign will raise awareness about available services for those who wish to reduce or stop substance use, positioning BHAC as a key resource for accessing care. This initiative is expected to increase client contacts at BHAC.

Through the above initiatives and ongoing services, BHAC continues to strengthen access to the behavioral health system of care in San Francisco County.

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 behavioral health system. Individuals who have participated in behavioral 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 behavioral health system. Peers also support clients in dealing with stigma and facing economic and social barriers to wellness and recovery. These B/MHSA-funded services are largely supported through the Community Services and Supports and INN funding streams.

Trans March Resource Fair

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 use, 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 B/MHSA continues to fund peer providers in civil service positions throughout our system of care. We currently fund civil service peer providers at Mission Mental Health, OMI Family Center, Mission Family Center and South of Market Mental Health.

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.

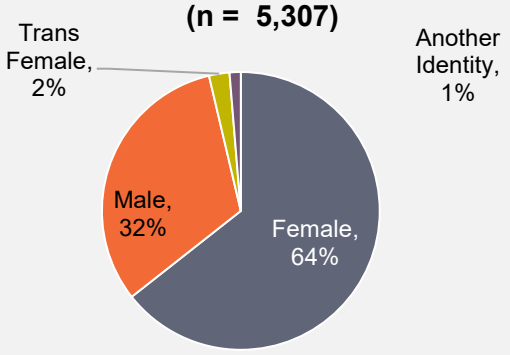
Population Served by Peers: Peers conduct culturally and linguistically congruent outreach, education and peer support to clients of residential, community, mental health care and primary care settings within SFDPH.

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 (CYF) 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 requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the client by meeting weekly for one hour and assisting the client with their wellness and recovery journey. Mentors also act as a community resource for helping a client direct their own path to wellness and recovery.
Peer Specialist Mental Health Certificate and Leadership Academy *Richmond Area Multi-Services (RAMS)*		Prepares BHS clients and/or family members with skills and 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. Training will also focus on building skills for participation in a variety of activities that request peer provider/client input (e.g., boards and

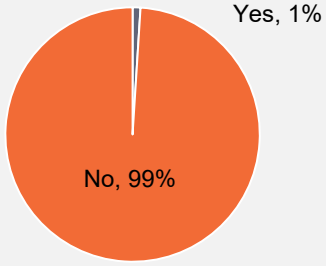
Peer-to-Peer Support Programs		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
		advisory committees, review panels, policy development, advocacy efforts, etc.).
Gender Health SF (formerly known as Transgender Health Services) *SFDPH*		Provides access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. B/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 and 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 and 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 B/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.

Demographics: Peer-to-Peer Support Programs

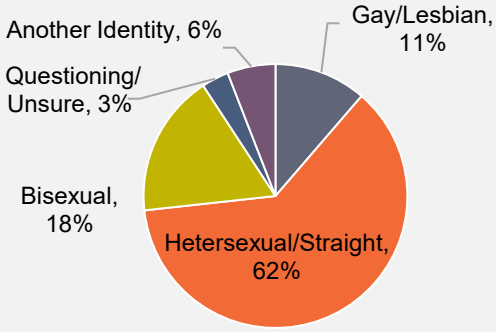
Gender Identity: Peer-to-Peer Support Programs and Services – CSS Funding (n = 5,307)



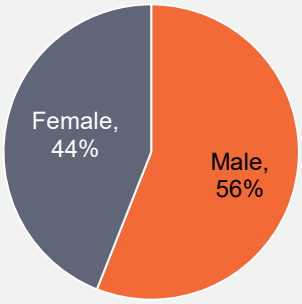
Veteran Status: Peer-to-Peer Support Programs and Services – CSS Funding (n = 4,143)



Sexual Orientation: Peer-to-Peer Support Programs and Services – CSS Funding (n = 1,051)

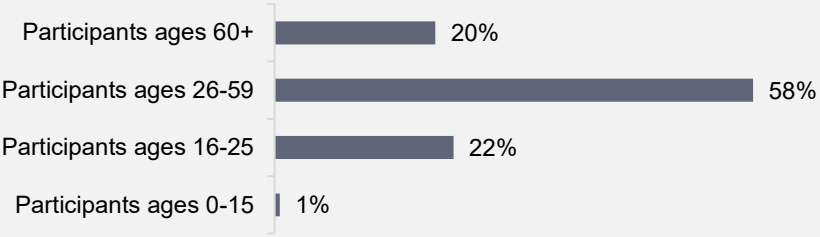


Sex at Birth: Peer-to-Peer Support Programs and Services – CSS Funding (n = 1,460)

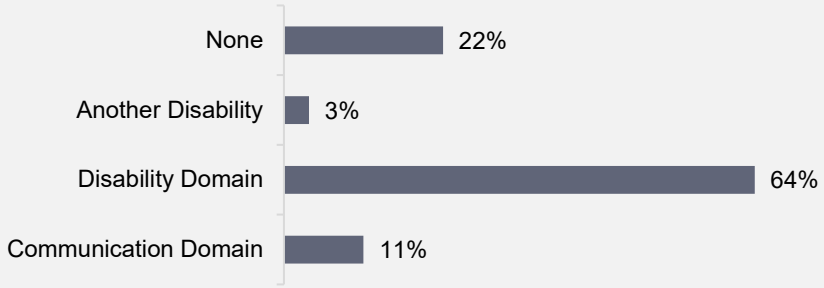


*< 1 percent of participants reported data for Trans Male; Gender

Age: Peer-to-Peer Support Programs and Services – CSS Funding (n = 5,726)



Disability Status: Peer-to-Peer Support Programs and Services – CSS Funding (n = 674)



Race	n	%
Black, African American, or African	542	21%
American Indian, Alaska Native, or Indigenous	40	2%
Asian or Asian American	673	26%
Native Hawaiian or Pacific Islander	34	1%
White	1,099	42%
Other Race	198	8%
Total	2,586	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	574	35%
Non-Hispanic/Non-Latina/e/o	976	60%
More than one Ethnicity	75	5%
Total	1,625	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	209	6%
English	2,659	80%
Russian	25	1%
Spanish	375	11%
Tagalog	42	1%
Vietnamese	<10	0%
Another Language	19	1%
Total	3,332	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	FY23-24 Key Outcomes and Highlights
Lifting and Empowering Generations of Adults, Children and Youth (LEGACY) - *DPH*	79% (n=62) of clients successfully completed at least two self-identified goals.
Peer to Peer, Family to Family - *NAMI*	100% (n=23) of Peer-to-Peer participants reported feeling better able to manage their mental health symptoms.
Peer Specialist Certificate, Leadership Academy and Counseling – *Richmond Area Multi-Services (RAMS)*	98% (n=52) of graduates reported they increased their skills and knowledge of peer counseling in the behavioral health field.
Gender Health SF – *DPH*	100% (n=32) of clients reported the programming was worthwhile.
Peer to Peer Employment – *Richmond Area Multi-Services (RAMS)*	89% (n=<10) of graduates reported improvements in their abilities to manage stress in the workplace.
Transgender Pilot Project – *DPH*	93% of clients (n=37) reported feeling less alone when hearing stories from others.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[4]**
Peer-to-Peer Programs	7,436 Clients	$6,420,455	$863.43

Moving Forward in Peer-to-Peer Support Programs

Peer-to-Peer Services remain an important and strong component of SFB/MHSA programs. Our B/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.

BHS Legacy:

- LEGACY filled two vacant positions - Operations manager and Cantonese-speaking family specialist position, both which had been vacant for 20 months plus. Since hiring for the two positions, services can now be offered to monolingual Cantonese speaking families in San Francisco, with a plan to host a Chinese support group in Cantonese. LEGACY Family Support Night is now 100% in person and although attendance was initially low, it improved over time especially when the program offered further incentives, such as taxi rides home.

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

Peer Specialist Mental Health Certificate and Leadership Academy:

- Three Peer Certificate Interns or "Peer Mentors" completed their internships, two in the summer of 2023 with an Advanced course and one in June 2024. The Entry Course for the program is already approved as a San Francisco State University (SFSU) course, however the RAMS Peer Internship worked with SFSU to get the Advanced course also approved as an official 3 credit SFSU course. . Two of the interns were thus able to get class credit for their internships. In addition, the Advanced Course and Leadership Academy training courses were approved as Continuing Education Units (CEU) for all state certified Peer Support Specialists and official certificates of completion with CEU hours are now provided for all participants.

Peer to Peer Employment

- **Peer Wellness Centers:** Post-covid, the Peer Wellness Centers have shifted to a hybrid modality. With an emphasis on in-person social connection and support, the group attendance numbers for onsite participation have almost doubled. Six new groups were added to Saturday programming in March 2023, including a weekend Dual Recovery Support (DRS) Group and the program is shifting to pre-covid hours by staying open an hour later Tuesday and Thursdays. In addition, 1:1 peer counseling support was expanded and staff trained on tools that document client progress.
- **Community-based Peer Support Groups:** With a move to 100% in person work schedules at peer counseling clinics, staff needed reviews, training and supervision as well as assistance and support in adjusting to **the return to in-person work**. One new dual-recovery support group was started at La Posada (Progress Foundation) and a second socialization group was added at Belen's Residential Care Home. Eight community-based, in-person groups in total were **established** by the end of FY23-24, with a plan to add a Peer Coordinator for community-based peer support groups plus additional group facilitators in FY24-25.
- **Peer Internships:** Monthly in-person group supervision sessions commenced along with weekly group supervision over zoom. Thirteen new interns were accepted into the program and offered a combination of street-based and site-based peer internship opportunities across multiple RAMS, DPH, and community partner sites.

Peer-to-Peer Linkage Services

- The service coordinators continue to facilitate and support groups at their sites including an Outdoor Wellness group, Art group, Cantonese Tech group as well as other social and wellness groups. Four Service Coordinators became approved to take the state peer certification exam during FY23-24, with 1 Service Coordinator successfully becoming state peer certified in December 2023. The Service Coordinator at Chinatown/North Beach MH continued live billing in Avatar using Targeted Case Management and Individual Rehabilitation billing codes and became the first peer to write billable Group Rehabilitation notes in August 2023. Quarterly contact is made with each clinic, by phone, email, virtually or in person in order to offer support and maintain strong partnerships with the clinics.

Wellness in the Streets:

- RAMS was awarded a Low-Threshold Case Management contract. Peer Counselors have shifted to weekly scheduled street outreach and visits to other community centers and non-congregated traditional housing sites throughout the city. Increased quantities of naloxone were ordered to address the increasing need for overdose prevention.

ICM-OP Peer Transition Team

- Two peer counselors became state certified as Medi-Cal peer support specialists and, despite some employment changes among the peer counselors, a core team of four 1.0 FTE Peer Counselors continued to provide services under the supervision of the Community Partnerships manager. The team has participated in more cross-clinic collaborative case conferences. With a change in care tools from Avatar to Epic, the team has stopped the use of the Referral Form and Readiness Questionnaire but continues to accept referrals from providers through other means including phone, email and an online referral form. Clinical view access to Epic continued for care coordination.

Gender Health SF

- Staff turnover has affected the program's capacity and operations. A major focus for the fiscal year has been to expedite the hiring process and stabilize the team to ensure continued effective service delivery. Additionally, interim supervision structure provided essential staff support and operational stability, and the UCSF's Alliance Health Project provided clinical consultation and support for peer navigators as the program navigated these staffing transitions. A clinical psychologist provided weekly consultation support for the clinical director, the program's monthly consultation group and support for the program's peer navigators. In terms of programming, patients are now reviewed using a collaborative clinical case review with weekly navigator clinical case review rotations which has streamlined the case review process and case assignments, while offering structure and support for the peer navigators
- In Summer of 2022, Gender Health SF collaborated with community stakeholders and the SF Health Plan to align with the newly updated guidelines for gender-affirming care released by the World Professional Association for Transgender Health (WPATH). A key outcome was the introduction of the Quality Care Form (QCF), aimed at establishing medical necessity with insurers. The QCF is used throughout various aspects of patient care including referral review, navigation assignment, care coordination, and referrals to surgeons and is relied on by patient navigators to understand psychosocial support needs and to address service gaps, such as discrepancies in housing or substance use information.

3. Vocational Services: CSS Funding

Service Category Overview

Through JEDI/B/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.

Peer-to-Peer Programming in Action

In collaboration with t 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 B/MHSA-funded services are largely supported through the Community Services and Supports and INN funding streams.

Target Population

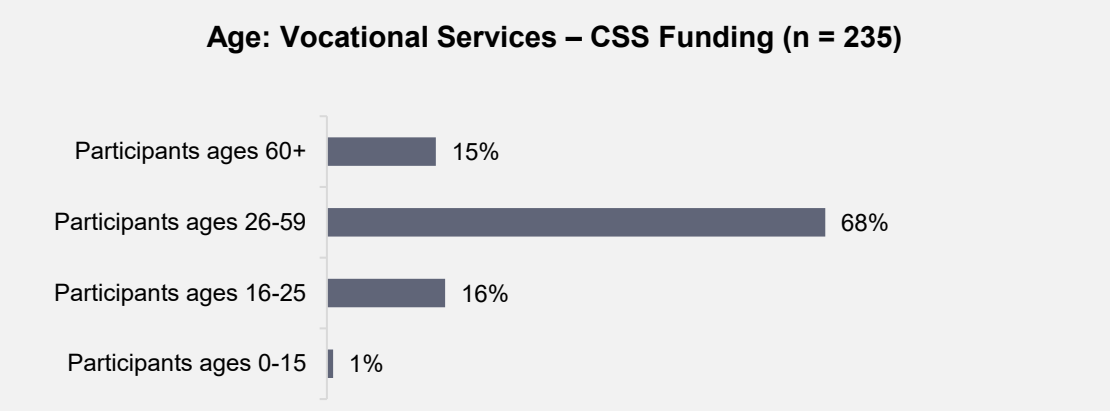
The target population consists of clients with behavioral health needs as well as other community residents in need of employment assistance. In particular, outreach is made to underserved populations and those interested in job readiness programs, on-the-job training, internships, competitive employment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

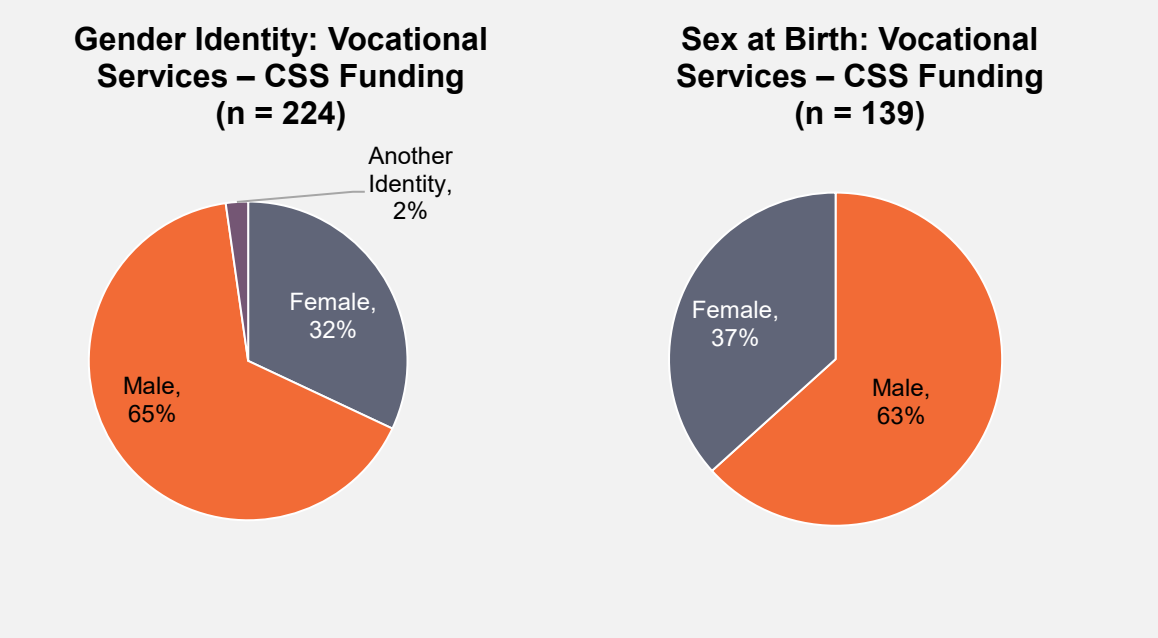
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
Department of Rehabilitation Vocational Coop (The Coop) *SFDPH and State of California*	CSS Other Non-FSP 8. Vocational Services (45% FSP)	San Francisco Department of Rehabilitation (DOR) and 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 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 seeking careers in the horticulture and landscaping field. Clients gain 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.

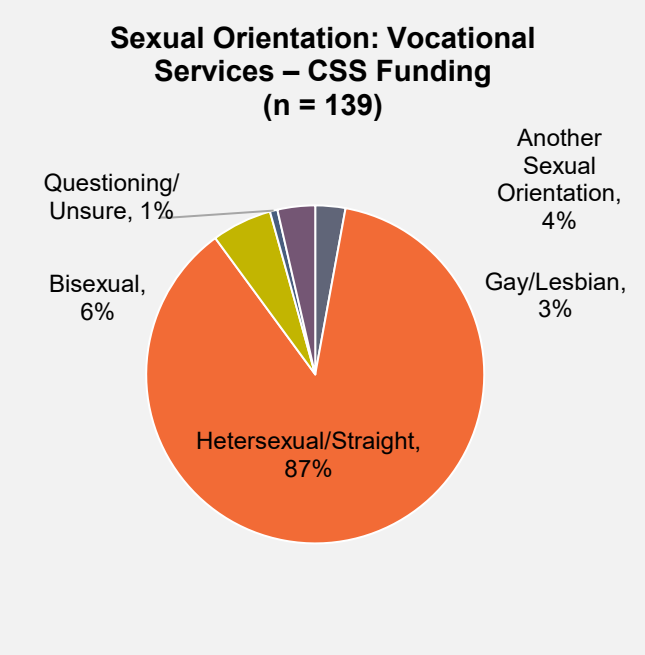
Vocational Services		
Program Name ***Provider***	**Name Listed on ARER and Budget**	**Services Description**
i-Ability Vocational IT Program *Richmond Area Multi-Services (RAMS)*		Prepares clients to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at 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 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 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.

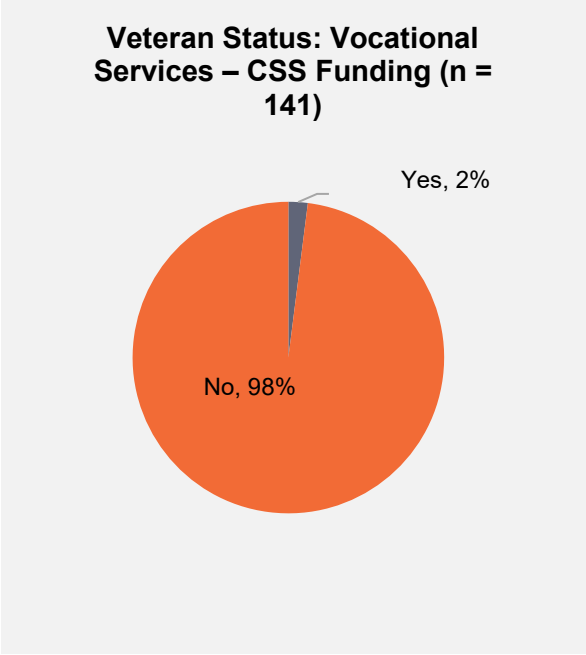
Client Demographics, Outcomes, and Cost per Client

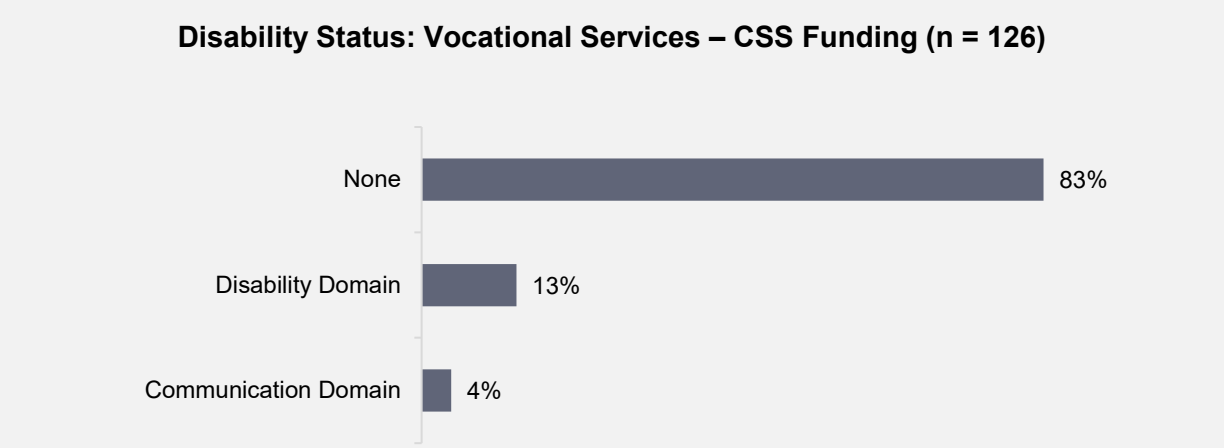




*< 1 percent of participants reported data for Trans Female, Trans Male; Gender







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

Race	n	%
Black, African American, or African	62	27%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	47	20%
Native Hawaiian or Pacific Islander	<10	1%
White	108	47%
Other Race	<10	4%
Total	230	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	44	26%
Non-Hispanic/Non-Latina/e/o	119	70%
More than one Ethnicity	<10	5%
Total	171	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	4%
English	142	81%
Russian	<10	2%
Spanish	16	9%
Tagalog	<10	2%
Vietnamese	<10	0%
Another Language	<10	3%
Total	176	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	FY23-24 Key Outcomes and Highlights
Department of Rehabilitation Co-op – *DPH and California State*	41% (n=45) of consumers were placed in employment.
i-Ability Vocational IT Program – *Richmond Area Multi-Services (RAMS)*	100% (n=17) of trainee graduates reported 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*	Of the 20 participants, n<10 doubled their hours, were hired into a transition job, or continued to do independent day labor jobs.
Janitorial Services – *Richmond Area Multi-Services (RAMS)*	100% (n=17) of clients reported improved workplace coping skills.
Café and Catering Services – *UCSF Citywide Employment Program*	100% (n=16) of graduates reported improved work readiness skills and confidence to use their new skills.
Clerical and Mailroom Services – *Richmond Area Multi-Services (RAMS)*	83% (n<10) of clients reported improved workplace coping skills.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH) – *UCSF Citywide Employment Program*	100% (n<10) of graduates reported improved work readiness skills and confidence to use their new skills.
Transitional Age Youth Vocational Program – *Richmond Area Multi-Services (RAMS)*	100% (n=16) of graduates reported improved workplace coping skills.
Employee Development Program – *Richmond Area Multi-Services (RAMS)*	100% (n<10) of graduates moved on to another Hire-Ability program.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[5]**
Vocational Programs	346 Clients	$2,398,392	$6,932

[5] 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. The following are key program highlights for the FY25-26 Fiscal Year:

- **I-Ability Vocational Information Technology (IT) Program:** The former vocational rehabilitation counselor (VRC) was promoted to the program manager role. Although the VRC role remained vacant for five months, the program is now fully staffed and is working to increase participant numbers post-covid. As of July 1, 2023, the hourly rate for all program participants increased from $17.90 an hour to $18.93 an hour due to changes in the San Francisco Minimum Compensation Ordinance (MCO).

- **First Impressions (Building Maintenance, Construction and Remodeling) Program:** Two new certification processes have been introduced for program participants including one that trains participants on a filament shredder that recycles thread for 3D printers and a 10-hour OSHA general industry certification. The 10-hour OSHA certification is a federally recognized lifetime certification that covers critical workplace safety topics for entry-level workers.

- **SF First Vocational Project:** A new position was filled this year, the Employment and Training Specialist. This position enabled the program to expand by re-starting a former vocational training program, Syringe Access Services (SAS) whereby clients assembled harm reduction kits. Eight clients were provided with stipends to join SAS as trainees. The Employment and Training Specialist also provided support to five other stipend trainees who were engaged as “clinic greeters” at the South of Market Mental Health Services clinic.

- **Janitorial Services:** There have been staffing changes this past year at Janitorial Services. In June 2024, a new program assistant was hired to provide administrative and job coaching support to interns. In addition, the Janitorial Business Services Manager resigned in December 2023 and the Janitorial Environmental Services Manager was promoted to cover many of the tasks previously assigned to this role. A Janitorial Services Coordinator position was also added to provide support for the primary administrative tasks of the janitorial program.

- **Café and Catering Services:** Slice of Life (SOL) Cafe and Catering was approved to take over the commercial kitchen at the Behavioral Health Center (BHC) at 887 Potrero Ave. The space was cleaned and updated with new appliances and a walk-in refrigerator freezer and passed the health department facility inspection on May 24, 2024.The new space increases SOL’s capacity for larger events and production and as such the need for training more workers. The Cafe at 1380 Howard expanded its training program to include baking, resulting expanded preparation for participants to work in both cafes and baking jobs.

- **Clerical and Mailroom Services**: In June 2024, a new program assistant was hired to provide administrative and job coaching support to interns. The position started as a part-time one and transitioned to a full-time position in July 2024.

- **Growing Recovery and Opportunities for Work Through Horticulture (GROWTH):** Growth increased the amount of hands-on, in-the-field experience in the program this fiscal year. The first 3 months of the 9-month program continued to be focused on a hybrid hands-on classroom and in-the-field training learning experience. The final 6

months of the program were held almost exclusively in the field working in a variety of landscaping and horticultural settings. This diverse, real-world work experience gives participants the best foundations to obtain similar work after they graduate. One of the field sites is working with San Francisco's Parks and Recs in Golden Gates' botanical garden and two graduates of the program were able to secure ongoing employment with Parks and Recs this year.

- **TAY Vocational Program:** Career Connections is now fully in person with enrollment at pre-pandemic levels. The vocational training curriculum was updated to allow for more individualized pacing to accommodate youth who were more work-ready vs. youth who need more preparation. This significantly increased the retention rate to 75%. Starting in FY24-25, Career Connections staff will utilize year-round recruiting to hold tours of the site for youth interested in the program and to build rapport.

- **Employees Development (ED) Program:** The ED program experienced its largest singular enrollment since the COVID-19 pandemic in June of 2024 (eight participants). The location of the program has stayed stable during the fiscal year. Staffing changes included the Vocational Rehabilitation Counselor being promoted to the role of Vocational Rehabilitation Coordinator I and assuming additional administrative and supervision responsibilities within the program. Additionally, ED was able to partner with RAMS Peer Division to have a peer intern onsite to provide additional support to participants.

4. Housing Services: CSS Funding

Service Category Overview

B/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 B/MHSA Housing Services.

No Place Like Home (AB 1618)
The No Place Like Home (NPLH) Program, signed into law in 2016, dedicates $2 billion in bond proceeds to develop permanent supportive housing for persons who are living with serious mental illness (SMI) and are in need of mental health and/or substance use services and are experiencing chronic homelessness, or are at-risk of chronic homelessness, or homelessness. The bonds are repaid by funding from the B/MHSA fund.

SFDPH B/MHSA, the Department of Homelessness and Supportive Housing (HSH), Mayor's Office of Housing and Community Development (MOHCD), and other agencies work in partnerships to implement this program. Collaborating stakeholders meet monthly to discuss the integration of new NPLH units into San Francisco's pipeline of permanent support housing. SFDPH works in partnership with MOHCD and HSH to develop and implement the supportive services portion of the NPLH program.

Housing

Coordinated Entry
Coordinated Entry (CE), a key component of the homelessness response system, is a community wide process that matches people experiencing homelessness to available and best-fitting resources. TCE includes physical access points, a standardized method to assess and prioritize people 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. 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 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 reduces the burden on people experiencing homelessness, 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 B/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 B/MHSA-funded stabilization units.. Procedures for the use of B/MHSA-funded ESUs are continuously shared and discussed with all FSP Programs.

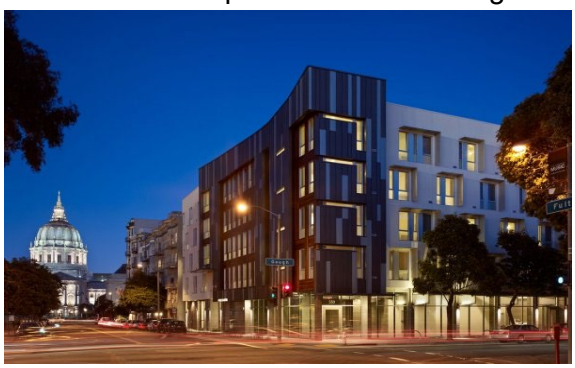
FSP Permanent Supportive Housing (PSH)

In 2007, the state provided counties with a one-time allocation of B/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 B/MHSA clients. In addition, San Francisco added $2.16 million from Community Services and Supports (CSS) to housing in FY 07-08. B/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 B/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 B/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 B/MHSA-funded permanent supportive housing (PSH) units dedicated to people with mental health challenges. Of these 191 PSH units, 152 units are for FSP clients from the TAY, and AOA Systems of Care, while the remaining 39 units are for non-FSP clients. B/MHSA-funded housing units include a mix of units developed with B/MHSA capital funding, located throughout San Francisco. Through partnership with HSH, B/MHSA-funded PSH sites are managed by the HSH Supportive Housing Programs Team.

Housing Placement Services

B/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 B/MHSA-funded units is conducted through the CE process. Beyond the B/MHSA inventory of 191 units, clients served by B/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/B/MHSA team in San Francisco collaborates with HSH to coordinate the provision of supportive services at properties with B/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), HomeRise—formerly known as Community Housing Partnership (CHP), Lutheran Social Services (LSS), UCSF Citywide and the HSH Support Services team provide supportive services for 137 B/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 First Place for Youth.

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 B/MHSA Program Manager for Housing Programs, HSH Program Manager for B/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 stakeholders.

Transitional Housing

The Marilyn Inn, operated by Conard House, is a new B/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.

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.

B/MHSA-Funded Housing for TAY

While TAY served by B/MHSA who are age 18 and up can access adult housing, they can also be placed at youth-centered housing sites. 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 B/MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street) since 2011. S LSYSA LSYS provides supportive services for TAY with serious mental illness. These services include: intake and assessment, life skills training, wraparound 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 B/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.

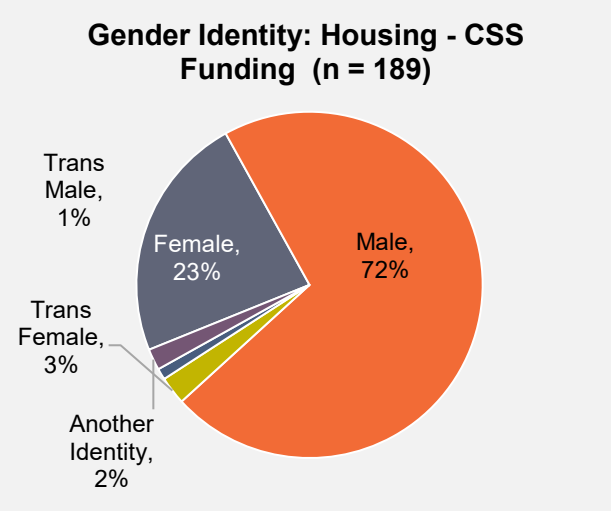
Larkin Street’s Aarti Hotel will begin partnering with DPH’s PHACS team in Winter 2024.

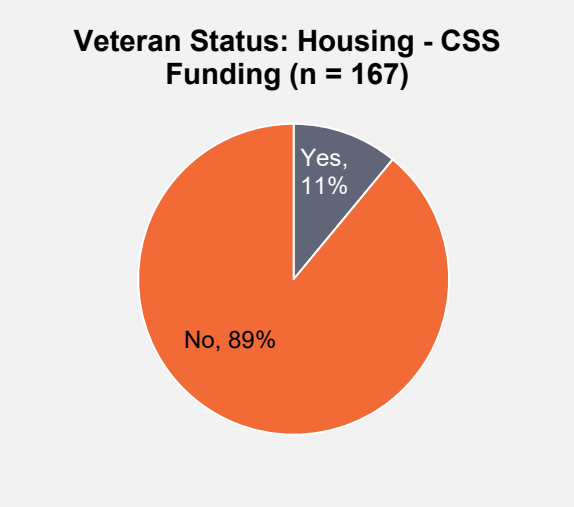
Program Names	Name Listed on ARER and Budget
Emergency Stabilization Housing	Emergency Stabilization Housing
CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)
Full-Service Partnership Permanent Supportive Housing	Full-Service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

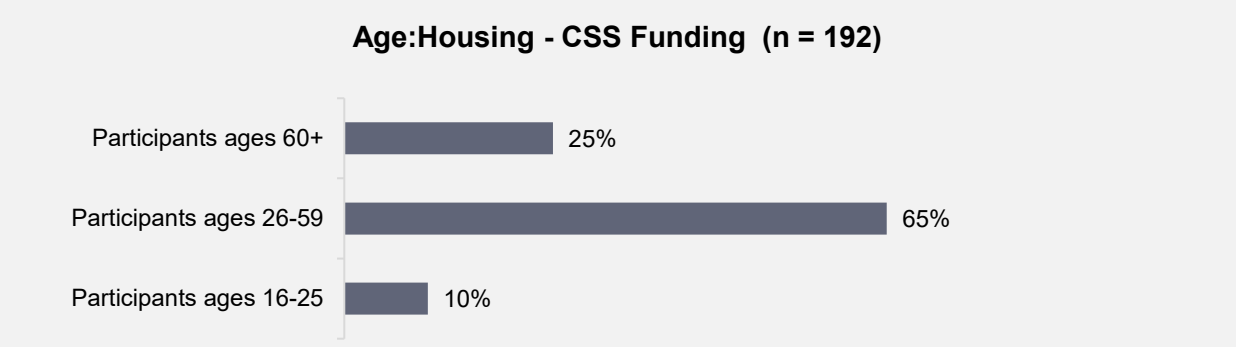
B/MHSA-Funded PSH Housing: FY23-24						
B/MHSA Housing Site	***Operator***	***B/MHSA Units***	***Target Population***	***Services***	***Type of Project***	***Referral Source***
Cambridge	*CHP*	*6*	*Adults*	*CHP + FSP*	*HSH Supportive Housing*	*CE*
Iroquois	*CHP*	*8*	*Adults*	*CHP + FSP*	*HSH Supportive Housing*	*CE*
Rene Cazenave	*CHP*	*3*	*Adults*	*Citywide + FSP*	*B/MHSA Capital*	*CE*
Richardson	*CHP*	*9*	*Adults*	*Citywide + FSP*	*B/MHSA Capital*	*CE*
San Cristina	*CHP*	*7*	*Adults*	*CHP + FSP*	*HSH Supportive Housing*	*CE*
Senator	*CHP*	*4*	*Adults*	*CHP + FSP*	*HSH Supportive Housing*	*CE*
Camelot	*DISH*	*3*	*Adults*	*HSH + FSP*	*HSH Supportive Housing*	*CE*
Empress	*DISH*	*2*	*Adults*	*HSH + FSP*	*HSH Supportive Housing*	*CE*
LeNain	*DISH*	*2*	*Adults*	*HSH + FSP*	*HSH Supportive Housing*	*CE*
Star	*DISH*	*3*	*Adults*	*HSH + FSP*	*HSH Supportive Housing*	*CE*
Aarti/ Routz	*Larkin St.*	*21*	*TAY*	*Larkin - All*	*B/MHSA GF – TH*	*Youth CE*
1100 Ocean	*Mercy*	*6*	*TAY*	*FPFY + FSP*	*B/MHSA Capital*	*Youth CE*
Veterans Commons	*Swords*	*8*	*Veterans*	*Swords/VA + FSP*	*B/MHSA Capital*	*VA and CE*
Ambassador	*TNDC*	*8*	*Adults*	*TNDC + FSP*	*HSH Supportive Housing*	*CE*
Dalt	*TNDC*	*9*	*Adults*	*TNDC + FSP*	*HSH Supportive Housing*	*CE*
Kelly Cullen	*TNDC*	*16*	*Adults*	*TNDC + FSP*	*B/MHSA Capital*	*CE*
Polk Senior	*TNDC*	*8*	*Seniors*	*LSS + FSP*	*B/MHSA Capital*	*CE*
Ritz	*TNDC*	*2*	*Adults*	*TNDC + FSP*	*HSH Supportive Housing*	*CE*
Willie B. Kennedy	*TNDC*	*4*	*Seniors*	*NCHS + FSP*	*B/MHSA Capital*	*CE*
TOTAL UNITS		*128*				

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[6]







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

Race	n	%
Black, African American, or African	55	30%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	13	7%
Native Hawaiian or Pacific Islander	<10	2%
White	69	38%
Other Race	<10	4%
Total	28	15%

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

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

Length of Stay	n	%
Less than a Year	27	17%
1 Year	21	14%
2 Years	12	8%
3 Years	<10	4%

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

ESU Housing Programs[7]

Emergency Stabilization Units (ESUs)[8]
These B/MHSA-funded ESU rooms are limited to referrals from 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/B/MHSA continues to make strides in the B/MHSA program by improving the coordination and implementation of administrative matters to meet client needs, as well as continued planning efforts to expand programming. In 2023, the Department of Homelessness and Supportive Housing (HSH) created the Coordinated Entry (CE) Redesign Implementation Committee that includes representation from community stakeholders and people with lived experience of homelessness.

The Redesign implementation Committee partners with HSH to inform operationalizing the CE recommendations identified in the 2022-2023 CE evaluation and redesign process. 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 B/MHSA and NPLH-eligible clients in the homeless response system.

SFDPH and HSH are partnering to implement the locally funded Permanent Housing Advanced Clinical Services (PHACS) program to bring clinical consultation, coaching, and training support

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

directly to PSH service providers through a referral triage system and development training activities. This program provides 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.

The CCST has shown a significant impact including a higher approval rate for IHSS services to PSH residents who need assistance with activities of daily living, streamlined approval of IHSS service hours, resolution of hygiene and unit habitability issues that can often lead to housing instability, and positive client feedback. The CCST expanded into the first NPLH supportive housing site that opened in winter 2022 and is currently serving over 40% of PSH programs.

In Fall 2022, 1064-1066 Mission completed construction by adding two adjacent new permanent supportive housing sites with 153 units of housing for adults experiencing homelessness and 103 units for seniors experiencing homelessness. The Round 1 NPLH award was disbursed in its entirety to this project, including 76 units for adults and 51 units for seniors (127 total NPLH units).
The building completed lease-up in January 2023. It provides 256 studio apartments with a continuum of on-site services including intensive case management, nursing, the IHSS CCST program and community engagement activities. Moving forward, there are new NPLH projects under development. Construction began in summer 2022 on 600 7th Street. The building is expected to open in fall 2024 and will include 70 NPLH units for adults experiencing homelessness.

730 Stanyan Street will include 20 NPLH units for transition age youth (TAY) and families experiencing homelessness; the building began construction in summer 2023 and is expected to be complete in fall 2025. 78 Haight Street will include 15 NPLH units for TAY experiencing homelessness.

This project began construction in 2023 and is expected to be completed in late 2025. 1979 Mission, a new 150-unit PSH site, will include 74 NPLH units for adults experiencing homelessness. The project is expected to start construction in fall 2026. 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.

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

Service Category Overview

San Francisco's B/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
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. B/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 B/MHSA PEI Category	SF-B/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-B/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.

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 Outcomes 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	FY23-24 Key Outcomes and Highlights
Peer Outreach and Engagement Services – *Mental Health Association of San Francisco*	100% (n=146) of Peer Connections participants receiving 1:1 peer counseling completed one personal wellness goal.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[9]**
Stigma Reduction	727 Clients	$137,224	$189

[9] 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

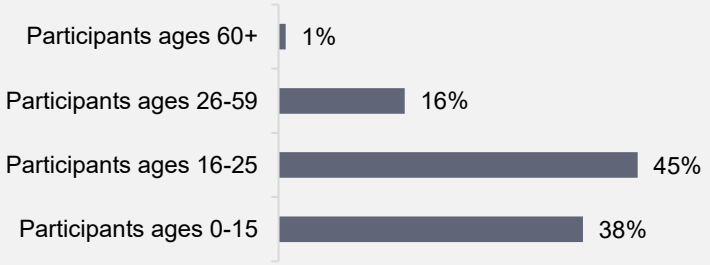
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to

students' families and caregivers. School-Based Mental Health Promotion programs also provide mental health consultation to school personnel.

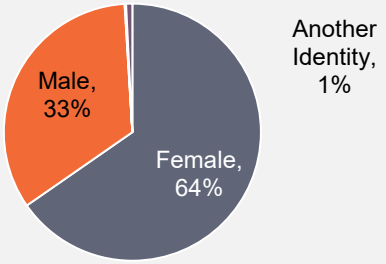
Client Demographics, Outcomes, and Cost per Client

Demographics: School Based Prevention (K-12)

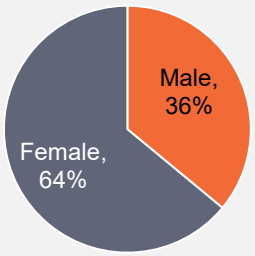
Age: Mental Health Promotion and Early Intervention - School-Based Mental Health Promotion (n = 335)



Gender Identity: Mental Health Promotion and Early Intervention - School-Based Mental Health Promotion (n = 320)

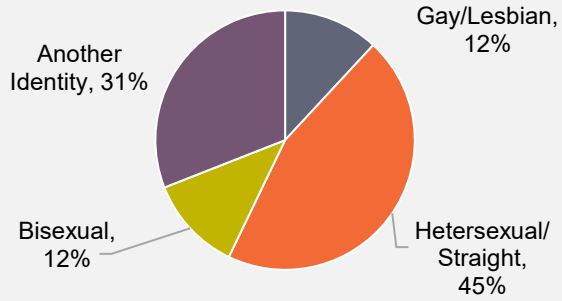


Sex at Birth: Mental Health Promotion and Early Intervention Programs - School-Based Mental Health Promotion (n = 708)

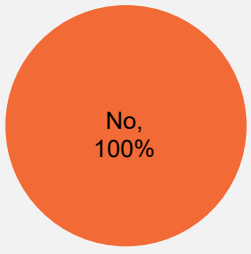


*< 1 percent of participants reported data for Trans Female, Trans Male; Gender

Sexual Orientation: Mental Health Promotion and Early Intervention – School-Based Mental Health Promotion (n = 42)



Veteran Status: Mental Health Promotion and Early Intervention Programs - School-Based Mental Health Promotion (n = 189)



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

*< 1 percent of participants reported Another Disability, Disability Domain, Communication Domain; Disability Status

Race	n	%
Black, African American, or African	80	52%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	42	27%
Native Hawaiian or Pacific Islander	<10	1%
White	28	18%
Other Race	<10	2%
Total	155	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	97	49%
Non-Hispanic/Non-Latina/e/o	72	36%
More than one Ethnicity	31	16%
Total	200	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	271	81%
Russian	<10	0%
Spanish	57	17%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	333	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	FY23-24 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - *Bayview Hunter's Point Foundation*	78% (n=21) of students re-engaged in school.
Mental Health Services – *Edgewood Center for Children and Families*	94% (n=18) of students who received Behavior Coaching reported an increase from pre to post.
Youth Early Intervention – *Instituto Familiar de la Raza*	97% (n=86) of staff who received consultation services reported being more knowledgeable about mental health and the socio-emotional needs of students and families.
Wellness Centers – *Richmond Areas Multi-Services (RAMS)*	94% (n=180) of students reported they met or somewhat met the goals they set in therapy.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[10]**
School-Based Mental Health Promotion (K-12)	1,509 Clients	$1,346,455	$892

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

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

SF B/MHSA Service Provider, Hospitality House Self-Help Center

B/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.

B/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 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 challenging barriers to service, including but not limited to language, culture, poverty, stigma, exposure to trauma, homelessness and substance use. As a

result, the B/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.

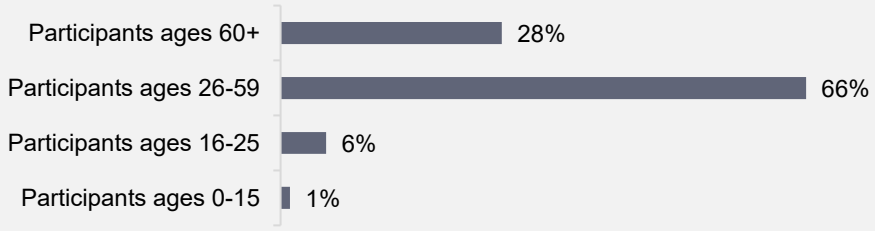
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Blacks/African Americans	Ajani Program Westside *Community Services*	Helps to build strong families by providing an understanding how healthy families function and by encouraging them 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 work group is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative 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.

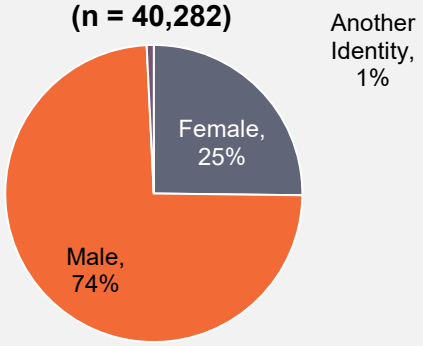
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name *Provider***	**Services**
Black/African American TAY	Population Specific TAY Engagement and Treatment – Black/African American *Third Street Youth Center*	Provide flexible, relationship-focused, and culturally responsive 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.

Demographics: Population Focused Mental Health

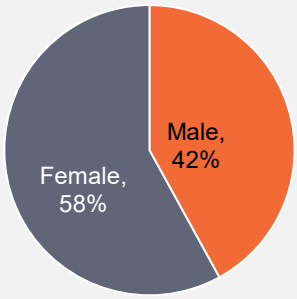
Age: Mental Health Promotion and Early Intervention - Population-Focused Mental Health Promotion (n = 42,411)



Gender Identity: Mental Health PEI Pop-Focused MH Promotion (n = 40,282)

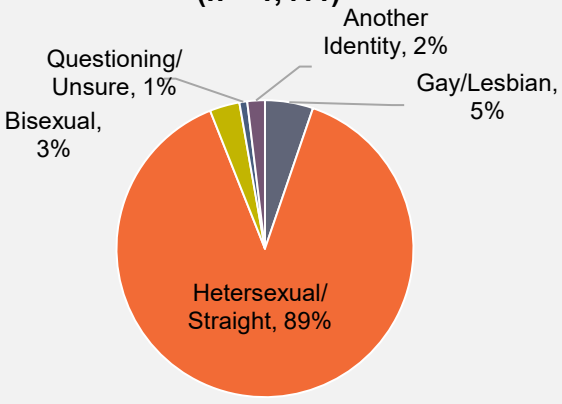


Sex at Birth: Mental Health PEI - Pop-Focused MH Promotion (n = 3,652)

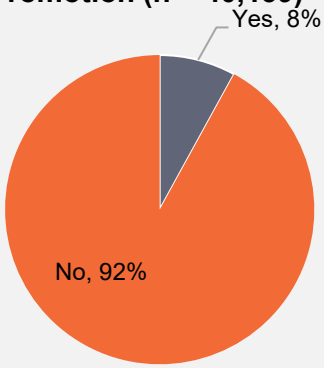


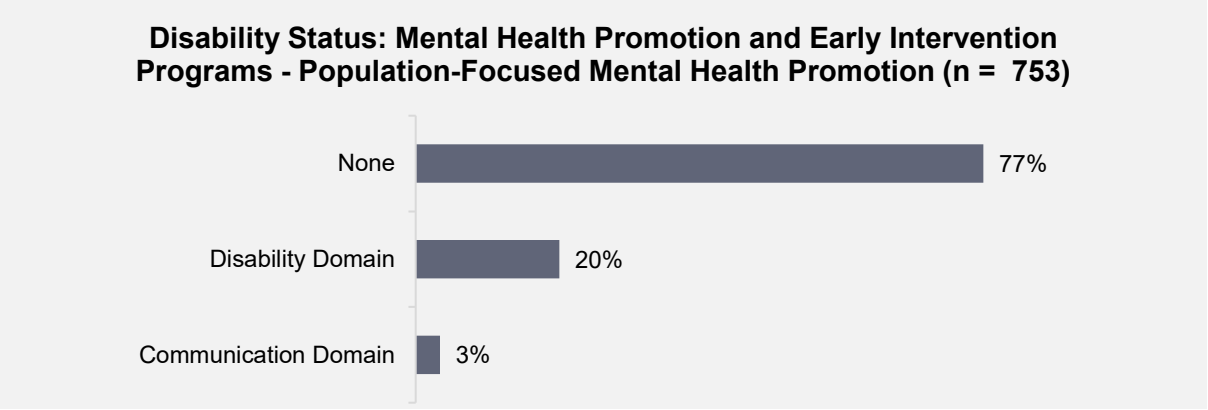
*< 1 percent of participants reported data for Trans Female, Trans Male; Gender

Sexual Orientation: Mental Health PEI - Pop-Focused MH Promotion (n = 1,411)



Veteran Status: Mental Health PEI - Pop-Focused MH Promotion (n = 40,139)





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

Race	n	%
Black, African American, or African	13,263	33%
American Indian, Alaska Native, or Indigenous	987	2%
Asian or Asian American	4,487	11%
Native Hawaiian or Pacific Islander	477	1%
White	14,828	36%
Other Race	6,666	16%
Total	40,708	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	4,657	69%
Non-Hispanic/Non-Latina/e/o	710	10%
More than one Ethnicity	1,407	21%
Total	6,774	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	737	16%
English	2,767	61%
Russian	78	2%
Spanish	599	13%
Tagalog	78	2%
Vietnamese	104	2%
Another Language	183	4%
Total	4,546	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	FY23-24 Key Outcomes and Highlights
Senior drop-in Center – *Curry Senior Center*	85% (n=165) of participants who attended at least three activities reported increased socialization.
Addressing the Needs of Socially Isolated Older Adults – *Curry Senior Center*	100% (n=74) of isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services.
Improving Maternal Mental Health for Black/African American Birthing People - *UCSF, RAMS, Rafiki, Homeless Children's Network*	25% (n<10) of families were connected to mental health services or a higher level of specialized Black perinatal mental healthcare.
Homeless Children's Network MA'AT Program - *UCSF, RAMS, Rafiki*	56% (n=14) of unduplicated clients in need received 12,538 minutes of Ma'at case management services.
Kuumba - *DPH Southeast Child and Family Therapy Center*	This is a new initiative provides culturally relevant community and school-based services around the psychosocial and academic needs of disenfranchised Black/African American families. We expect to have outcome data next year.
Black African American Community Wellness & Health Initiative – *Rafiki Coalition for Health & Wellness (Co-funded by CHEP & B/MHSA)*	100% (n=75) of participants reported an increase in feelings of social connections.
Black African American Community Wellness & Health Initiative - *Bayview Hunters Point YMCA (Co-funded by CHEP & B/MHSA)*	This is a new initiative that links individuals to wellness services (e.g. food insecurity support, peer group support). We expect to have outcome data next year.
Black African American Community Wellness & Health Initiative – *Booker T Washington (Co-funded by CHEP & B/MHSA)*	100% (n=50) of individuals were connected to mental health care from trusted Black healers and Practitioners.
Asian/Pacific Islander Mental Health Collaborative – *Richmond Area Multi-Services (RAMS)*	97% (n=306) 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=68) of individuals receiving non-clinical case management achieved at least one goal in their case/care plan.
Living in Balance – *Native American Health Center*	100% (n=23) of clients completed a behavioral health service goal.
South of Market Self-Help Center (6th Street) – *Central City Hospitality House*	77% (n=13) of participants achieved at least one case plan goal.
Tenderloin Self-Help Center - *Central City Hospitality House*	62% (n=70) of participants achieved at least one case plan goal.

Program	FY23-24 Key Outcomes and Highlights
Community Building Program - *Central City Hospitality House*	81% (n=42) of participants achieved at least one case plan goal.
Homeless Outreach and Treatment Program – *Central City Hospitality House*	100% (n=37) of participants achieved at least one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - *Instituto Familiar de la Raza*	97% (n=59) 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*	80% (n=17) of transition age youth receiving case management services successfully attained at least one of their treatment goals.
Population Specific TAY Engagement and Treatment – *LGBTQ+ - SF LGBT Center*	91% (n=10) of transition age youth who received program treatment and healing services demonstrated an intended treatment outcome.
Population Specific TAY Engagement and Treatment – Black/African American – *Larkin Street Youth Services and Third Street Youth Center*	71% (n=112) of transition age youth who were referred for internal or external behavioral health services attended an initial appointment or meeting with a behavioral health provider.
Population Specific TAY Engagement and Treatment – *Juvenile Justice/Others - Huckleberry Youth Programs*	96% (n=26) of transition age youth referred to behavioral health services participated in at least one initial appointment.
TAY Homeless Treatment Team – *Larkin Street Youth Services*	71% (n<10) of transition age youth who received treatment and healing services demonstrated an intended outcome.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[11]**
Population-Focused Mental Health Promotion	21,962 Clients	$7,470,069	$340

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

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 [12] 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)
- Homeless Children's Network
- Instituto Familiar de la Raza (IFR)

Target Populations

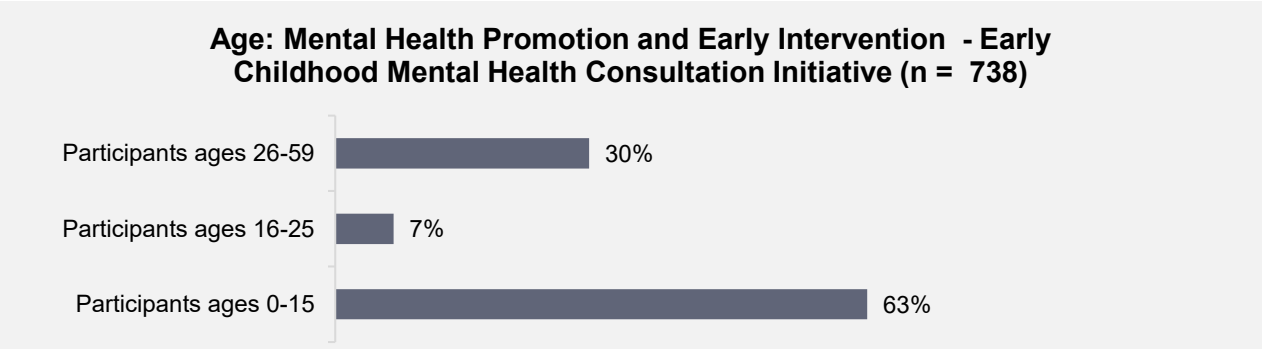
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents, and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients and families who experienced trauma, substance use disorders, homelessness, early developmental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

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

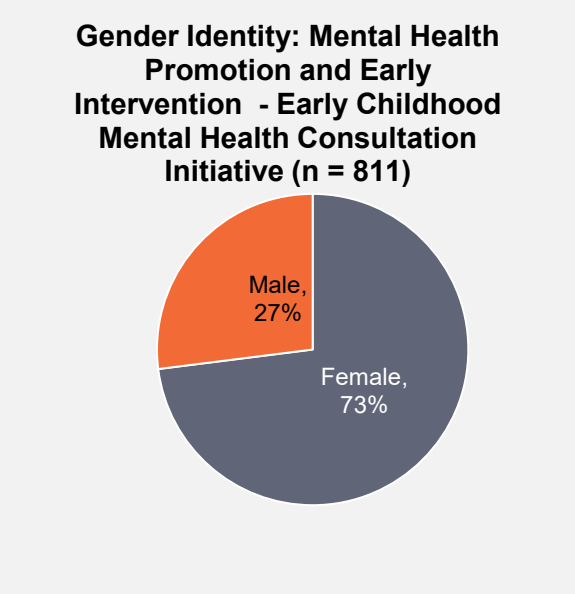
1. Early Childhood Mental Health Consultation Initiative (ECMHCI) - Infant Parent Program (IPP)/Day Care Consultants - *UCSF*
2. Early Childhood Mental Health Consultation Initiative (ECMHCI) - *Edgewood Center for Children and Families*
3. Early Childhood Mental Health Consultation Initiative (ECMHCI) - Fu Yau Project - *Richmond Area Muli-Services*
4. Early Childhood Mental Health Consultation Initiative (ECMHCI) – *Homeless Children's Network*

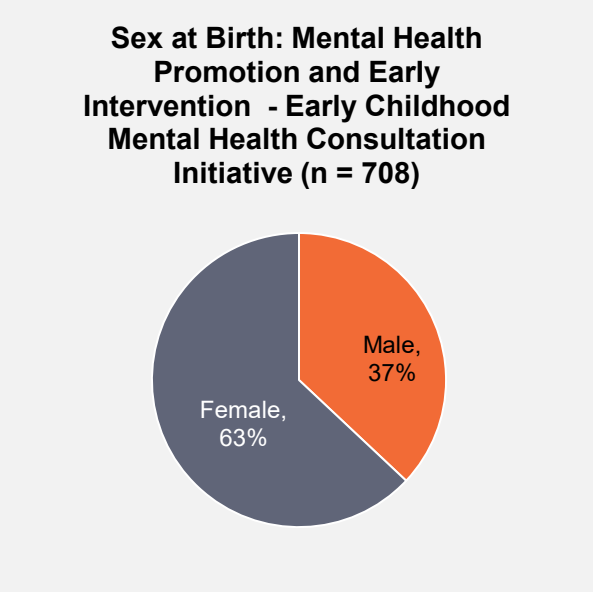
Client Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative

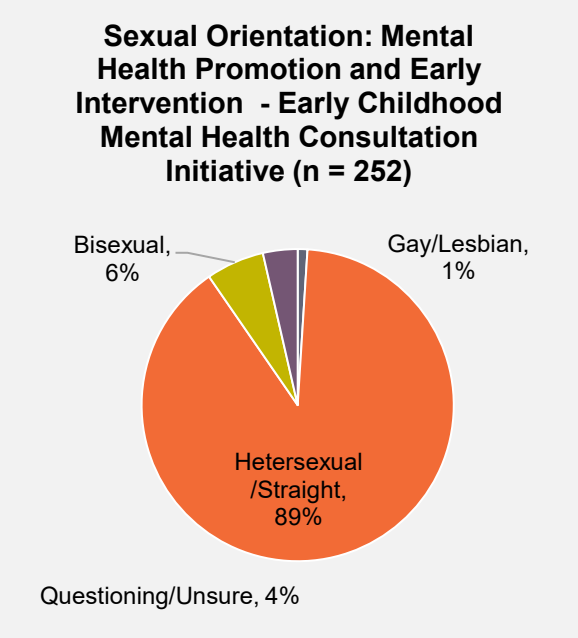


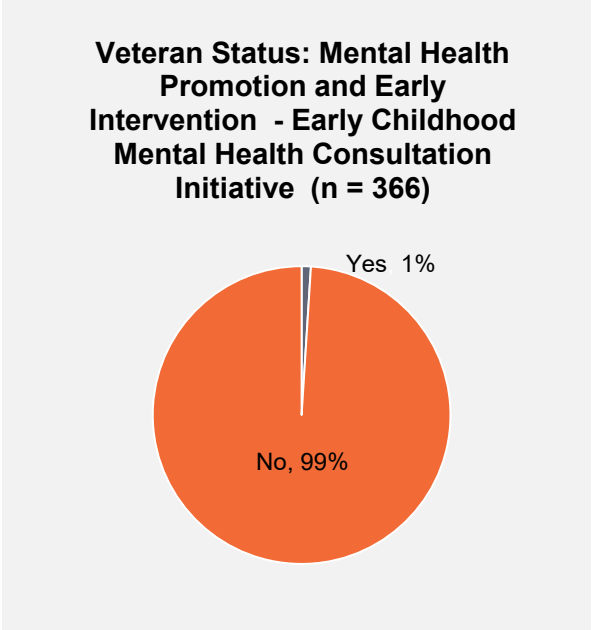
*< 1 percent of participants reported data for ages 60+; Age



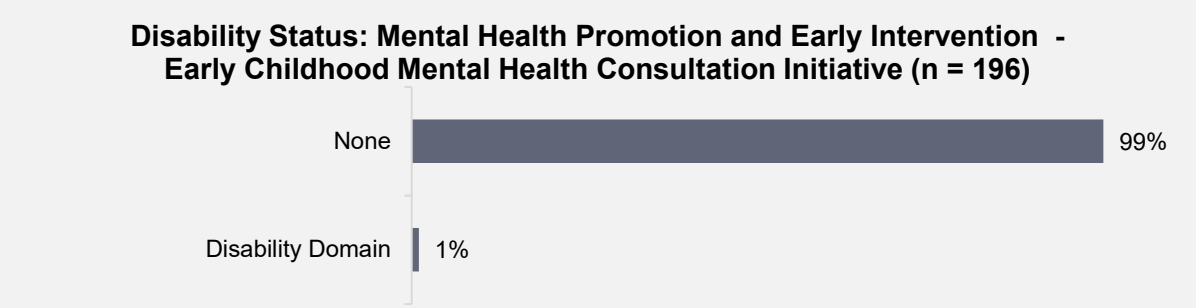


*< 1 percent of participants reported data for Another gender identity not listed, Trans Female, Trans Male; Gender





*< 1 percent of participants reported Another Sexual Orientation; Sexual Orientation



*< 1 percent of participants reported Another Disability, Communication Domain; Disability Status

Race	n	%
Black, African American, or African	509	29%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	286	16%
Native Hawaiian or Pacific Islander	13	1%
White	356	20%
Other Race	583	33%
Total	1,749	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	809	77%
Non-Hispanic/Non-Latina/e/o	146	14%
More than one Ethnicity	99	9%
Total	1,054	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	289	13%
English	1,246	55%
Russian	<10	0%
Spanish	735	32%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	2,282	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	FY23-24 Key Outcomes and Highlights
ECMHCI – *Infant Parent Program/Day Care Consultants*	86% of direct services were provided onsite.
ECMHCI – *Richmond Area Multi-Services*	100% of assigned hours were fulfilled.
ECMHCI – *Homeless Children's Network*	80% of allocated hours were assigned to direct service with sites.
ECMHCI – *Instituto Familiar de la Raza*	100% of assigned hours were fulfilled by the IFR consultant.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[13]**
Mental Health Consultation and Capacity Building	1,485 Clients	$1,790,016	$1,205

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

Comprehensive Crisis Services

Background and Community Need

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

Program Overview

Funded by B/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.

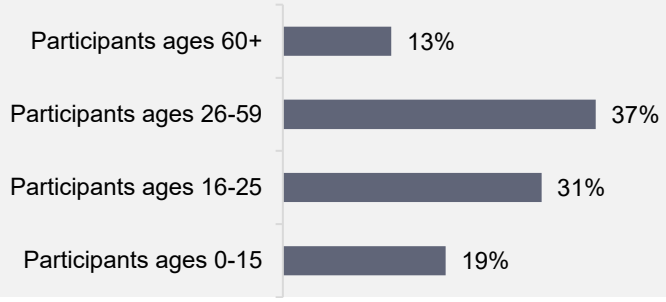
Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, and short-term crisis case management for individuals ages 18 years or older.
Child Crisis Team	Offers 24/7 mobile 5585/5150 assessments and 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.

Target Populations

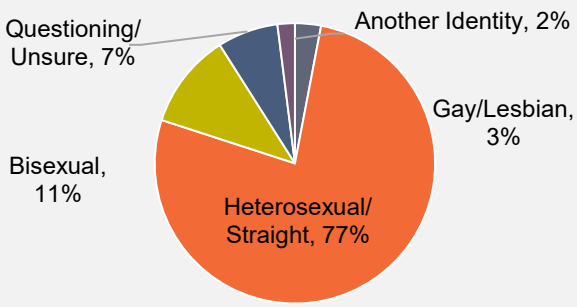
The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and in need of support.

Demographics: Comprehensive Crisis Services[14]

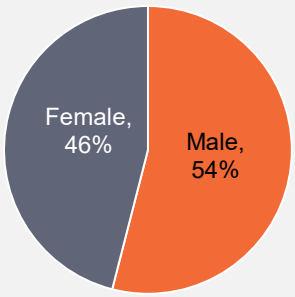
Age: Mental Health Promotion and Early Intervention - Comprehensive Crisis Services (n = 466)



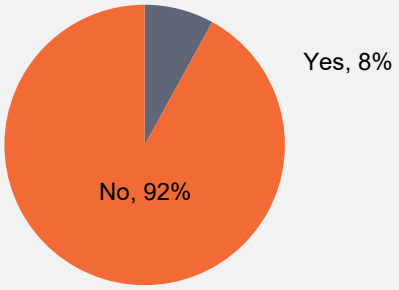
Sexual Orientation: Mental Health PEI- Comprehensive Crisis Services (n = 106)



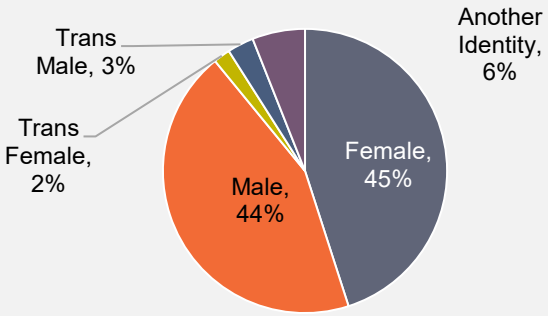
Sex at Birth: Mental Health PEI – Comprehensive Crisis Services (n = 133)



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



Gender Identity: Mental Health PEI - Comprehensive Crisis Services (n = 157)



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

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

Race	n	%
Black, African American, or African	93	35%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	32	12%
Native Hawaiian or Pacific Islander	<10	2%
White	70	26%
Other Race	68	25%
Total	269	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	56	93%
Non-Hispanic/Non-Latina/e/o	-	0%
More than one Ethnicity	4	7%
Total	60	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	2%
English	232	87%
Russian	<10	0%
Spanish	27	10%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	1%
Total	268	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	FY23-24 Key Outcomes and Highlights
Comprehensive Crisis Services (Mobile Crisis, Child Crisis, and Crisis Response) – *DPH*	40% (n=102) of individuals seen in the crisis clinics were sent to Psychiatric Emergency Services or were hospitalized on the same day.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[15]**
Comprehensive Crisis Services	569 Clients	$804,086	$1,413

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, B/MHSA is funding the Homeless Children's Network to provide an equity-based substance use service that includes proposed equitable and culturally responsive services to the focused priority population. 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 priority community. This funding aims to reach Black/African American individuals who do not already receive services through SFDPH and to provide culturally relevant substance use and overdose prevention outreach, engagement, and education. Overdose Settlement and B/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 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, psychoeducation, and outreach within SFUSD and local community organizations.

Black African American Community Wellness & Health Initiative (BAACWHI)
The BAACWHI operates programs at three locations: 1) Booker T. Washington Community Service Center, 2) Rafiki Coalition and 3) YMCA Bayview Hunters Point. Upcoming highlights moving forward for each location include:

- Booker T. Washington Community Service Center

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

    - 40 individuals will be screened for basic needs (e.g. food security, eviction prevention
    - Hire for a new violence prevention person to complement BAACWHI services
    - Host 5 events about mental health, how to care for your mental health, destigmatizing people's participation in therapy and mental health support
    - 20 individuals will receive individual therapeutic services
    - 20 individuals will participate in group therapeutic services by a cultural practitioner/healer/community elder that are culturally responsive healing circles and community-led wellness groups and Afro-centric communal healing
    - Connect 50 individuals to mental health care from trusted Black healers and Practitioners
    - 100 community members will be informed of BTWCSC support services
- Rafiki Coalition
    - Will reach out to 1,100 community members
    - Screen 50 individuals for basic needs and refer them to a Navigator who will guide them to resources and services
    - Assess 50 community members for mental health needs and refer them to mental health supports and services
    - 100 community members will participate in Wellness Promotion groups
    - 75 individuals participate in mental health services
- YMCA Bayview Hunters Point
    - Will reach out to 1,100 community members
    - Screen 50 individuals for basic needs and refer them to a Navigator who will guide them to resources and services
    - Assess 50 community members for mental health needs and refer them to mental health supports and services
    - 100 community members will participate in Wellness Promotion groups
    - 75 individuals participate in mental health services

<u>Rafiki's Black Maternal Mental Health Program – The Black Moms' Wellness Group</u>
The Black Moms' Wellness Group is a weekly skills and process group focused on nervous system self-regulation and parent-child co-regulation, maternal mental health, infant and early childhood mental health and development, as well as building community and solidarity from an African-centered, culturally concordant frame. The group is facilitated by a clinic-based therapists, who has a perinatal and trauma focus; and supported by two school-based therapists who both have early childhood and trauma focused backgrounds.

Since its inception in June 2024, the group has served 17 families, with six families that currently attend regularly, ranging from prenatal/expecting mothers to mothers with children up to the age of six years old. Families are encouraged to bring their children with them to: reduce barriers to attendance; practice self-regulation, co-regulation, communication, problem-solving and cooperative parenting skills in real-time and a real-world environment; and engage in community and village-building with additional child-care support from the two additional clinicians.

While this group was originally intended to be perinatally focused (prenatal to a year after birth), there was a request for support from mothers of all age groups and the group expanded to become more inclusive, the result being that mothers of different ages and stages have been able to share their wisdom and experience with newer mothers and provide support, community and solidarity.

The group alternates weekly between planned lessons that combine psychoeducation and practical independent living skills, including effective and age-appropriate communication, nervous system regulation, the eight dimensions of self-care, the physical/emotional/ psychological impacts of trauma and healing, etc.; and open weeks, which can include emotional processing and/or case management and troubleshooting by connecting families to resources in the community.

Since beginning the group in July 2024, group members have reported a greater sense of connectedness and community with each other and have named the group as a supportive factor in their lives, longer periods of calm and ease in their daily lives, a stronger sense of confidence in their parenting skills, greater attunement and closer connection with their children and partners (if applicable), and an overall higher quality of life.

Homeless Children's Network's (HCN) Black Maternal Mental Health Program - EMBRACE
The program has so far focused on laying a strong foundation for the Black Birthing Health Initiative (BBHI). This included brainstorming sessions with key stakeholders—healthcare providers, Black/African American community leaders, and cultural competency experts—to identify barriers to care and design culturally relevant solutions.

During this foundational period, hiring was a primary focus. We also formalized partnerships with local, Black-led organizations and healthcare providers to create a support network for Black birthing individuals. Additionally, we developed operational protocols, training materials, and outreach strategies in preparation for the program's launch.

6. Innovations Projects: INN Funding

Service Category Overview

B/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.

In FY23-24, SFDPH B/MHSA oversaw five INN Learning Projects integrated throughout the seven B/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 B/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, San Francisco Unified School District (SFUSD), and 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 (WITS) 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 SFB/MHSA 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.

Culturally Congruent and Innovative Practices for Black/African American Communities (INN) - SFDPH

Program Overview

The Culturally Congruent and Innovation Practices for Black/African American Communities Project seeks to create more diversity in the mental health workforce to better engage consumers and implement culturally responsive services that meet the need of these communities. This project is being implemented at four civil service sites in San Francisco.

- Mission Mental Health Clinic: African American Alternatives Intensive Case Management Program (AAAICM)
- South of Market Mental Health Integrated Service Center: ONYX Program
- Transitional Age Youth Civil Services Clinic: African Americans Inspiring Minds Program
- Outer Mission/Ingleside (OMI) Family Center: IMANI Program

This project is implemented by culturally congruent providers with lived experience with Black/African American Communities. A cultural liaison will be working on ensuring community input and feedback in each step of the project.

Project staffing includes seven clinicians as well as health workers and peer specialists who are providing the community with over 250 culturally congruent support groups a year in addition to one-on-one support. Group outings and special event activities around holidays, like Kwanza, and Black History Month provide an opportunity for clients to build social connections.

Target Populations

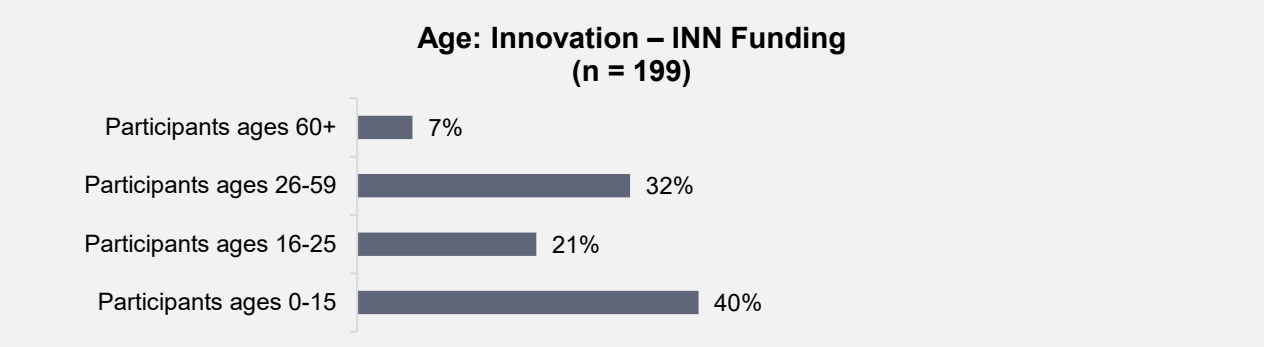
All Black/African American San Franciscans who experience behavioral health challenges.

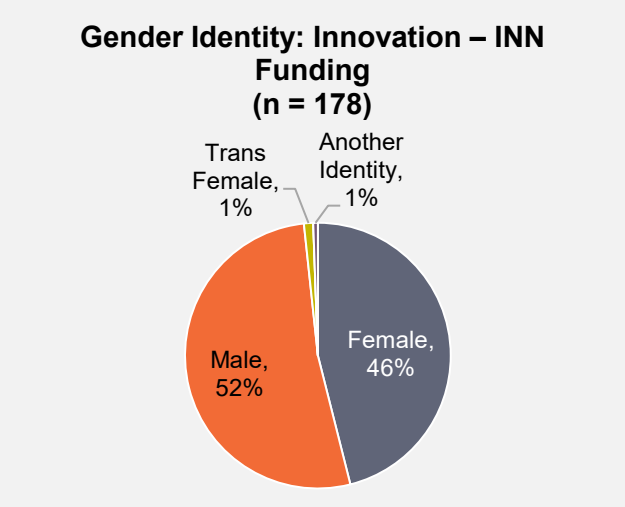
Client Demographics, Outcomes, and Cost per Client for all Innovation Programs

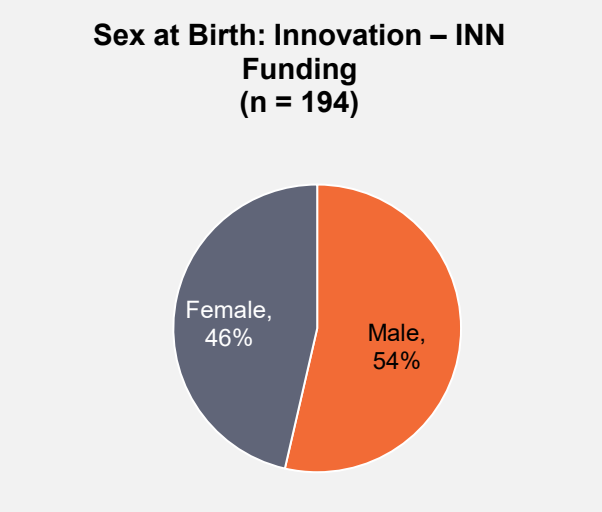
Service Indicator	Program Results for FY23-24
Total family members served	N/A

Service Indicator	Program Results for FY23-24
Potential responders for outreach activities	N/A
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	37
Types of underserved populations referred to prevention program services	Immigrant youth; Individuals experiencing homelessness; Latinx individuals who have been in the United States for five years or less.
Individuals who followed through on referral	N/A
Average interval between referral and treatment	N/A
How programs encourage access to services and follow-through on referrals	• 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 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.

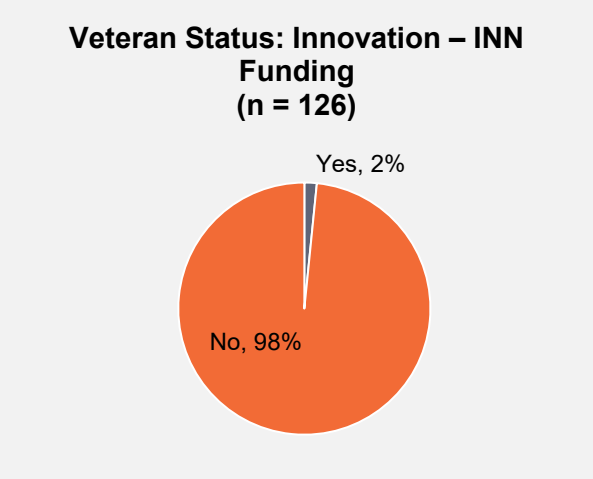
Demographics: INN Funding

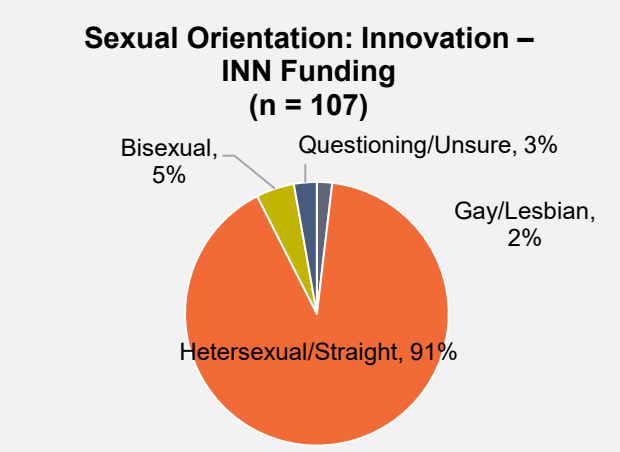


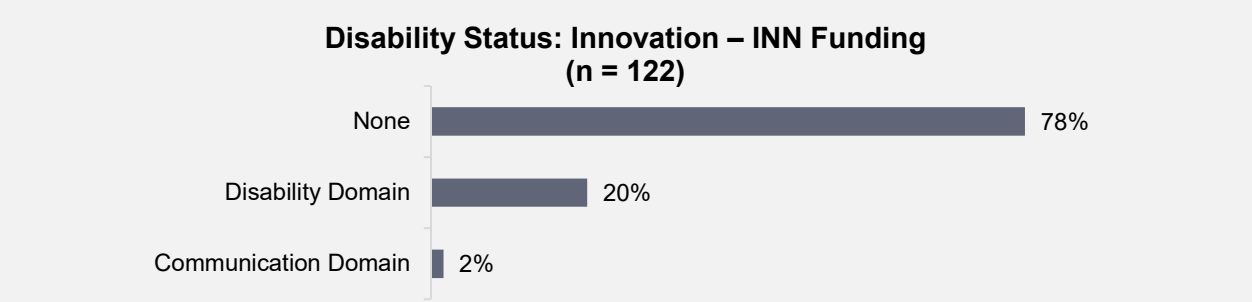




*< 1 percent of participants reported data for Another gender identity not listed; Gender
*< 1 percent of participants reported Another Sexual Orientation; Sexual Orientation







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

Race	n	%
Black, African American, or African	32	18%
American Indian, Alaska Native, or Indigenous	10	6%
Asian or Asian American	<10	2%
Native Hawaiian or Pacific Islander	<10	1%
White	31	18%
Other Race	99	56%
Total	176	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	125	37%
Non-Hispanic/Non-Latina/e/o	212	63%
More than one Ethnicity	<10	0%
Total	338	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	65	35%
Russian	<10	0%
Spanish	120	65%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	185	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	FY23-24 Key Outcomes and Highlights
Intensive Case Management/Full-Service Partnership to Outpatient Transition Support – *Richmond Area Multi-Services (RAMS)*	92% (n=22) of clients reported feeling more comfortable with their new provider.
FUERTE – *University of California San Francisco (UCSF)*	58% (n=37) of participants who attended at least three sessions reported an increase in social connectedness.
Wellness in the Streets - *Richmond Area Multi-Services (RAMS)*	96% (n=192) of individuals who identified an immediate need reported their need was addressed by a WITS team member.
Technology Assisted Mental Health Solutions – *Mental Health Association of San Francisco*	82% (n=16) of participants reported they agreed they accomplished at least one digital skill goal.
Culturally Responsive Practices for the Black/African American Communities - *DPH*	100% (n=5) of training sessions on culturally congruent topics were attended by providers from the clinics affiliated with the project.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[16]**
Innovations	338 Clients	$2,773,640	$8,206

Moving Forward in Innovations

Culturally Congruent and Innovative Practices for San Francisco's Black/African American Communities
Providers have been receiving training on culturally congruent topics and strategies to improve their ability to deliver services and reach Black/African American communities.

Peer specialists from NAMI SF are conducting outreach to Black/African American communities, including hosting mental health fairs, providing trainings and connections to community resources. They provide Mental Health 101 and In Our Own Voice presentations at faith centers and community organizations. They will also lead peer led support groups at churches, linking individuals to support at project sites.

INN Changes
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

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

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.

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

- ICM/FSP to OP Program (INN funding ended December 2023)
- FUERTE (INN funding ended February 2024)
- Technology Program (INN funding ended June 2024)
- WITS (INN funding ended June 2024)

After meeting with the community to discuss sustainability planning, SF-B/MHSA has decided to continue the successful programming of the ICM/FSP to OP Program, the Wellness in the Streets Program, the FUERTE program and the Technology Program using other B/MHSA funding sources throughout FY24-25.

The following highlights the work done by each of these programs in FY23-24:

Intensive Case Management and Full-Service Partnership to Outpatient Programs
In April 2024, based on interest from clients and Peer Counselors, the program began quarterly client group outings to increase socialization activities and opportunities for our clients to build community with one another. In partnership with BHS Leadership, the program has participated in more cross-clinic collaborative case conferences.

We continue to accept referrals from providers through email, phone, and our online RAMS Peer Division Centralized Referral Form and gained Clinical View access to Epic for continued care coordination. INN was successfully granted an extension to continue all services until June 30, 2024, when the RAMS Peer Transition Team B/MHSA Innovations Final Report was submitted.

In terms of staffing, INN maintains a core of four FTE Peer Counselors who continue to provide services under the supervision of the Community Partnerships manager. In December 2023, one FTE Peer Counselor left the program, and their position was covered by a Peer Counselor from another program. In April 2024, an intern from the Dual Recovery Support (DRS) team was hired as a full-time Peer Counselor. Finally, two Peer Counselors became State certified as Medi-Cal Peer Support Specialists.

FUERTE
There has been some staff turnover at the Fuerte INN Project this last year. In August 2023, a senior program coordinator left to attend graduate school, and her position was filled by a program coordinator the same month. In July 2023, another program coordinator left to attend graduate school.

In September, a new clinical psychology fellow joined our team. We also welcomed an Assistant Director of Evaluation/postdoctoral fellow in January 2024 as well as a project coordinator in February. In April, another program coordinator joined our team. Lastly, in June, a part-time .20

program coordinator left the program. We plan to fill this position in September 2024 with a .10 FTE social worker.

Wellness in the Streets (WITS)

An extremely positive change for the WITS program was the promotion of a longtime RAMS peer counselor to peer supervisor. This Peer Counselor had a strong connection to peer work and was able to offer an increased level of support and guidance to fellow peers. RAMS was also awarded a Low Threshold Case Management contract due to strong performance under the WITS contract, and with the need to hire more peers, it became integral to have the supervisor role to support both programs. Gradually, as the shelter in place (SIP) hotels closed and RAMS WITS staff were no longer deployed as Disaster Service Workers in FY 23-24, peer counselors shifted to weekly scheduled street outreach and visits to navigation centers, shelters, and non-congregate transitional housing sites throughout the city.

There was an increased need of drug intervention and prevention with the fentanyl crisis for the unhoused in the streets and encampments of San Francisco, so we increased the quantities of naloxone ordered and distributed by the WITS team in the community. With the creation of additional shelter options like tiny homes and converted hotels, the teams engaged with clients on-site at these locations to provide peer support.

Technology-Assisted Mental Health Solutions (TAMHS) Project

The program continues to shift from being a remote only program to a hybrid modeled program in order to increase engagement. Many of the participants needed in-person support to learn vital digital literacy skills, be supported while emotionally processing what they needed to learn, and to have some regular social connection.

This also improved our participant recruitment as we can build trust with the program and put a face to our work when participants see us regularly on-site. The shift to more person engagement in August 2023 has been showing great results in participant retention.

Based on feedback from cohort participants in May 2024, to encourage socialization and enhance community building among the cohort, we shifted to cohort member-only workshops in October 2024 instead of making these workshops available to the public/community. We continue to work with other community-based organizations to coordinate collaborative care for the folks we serve, table at each other’s events, support one another’s work, and recruit with one another.

In terms of staffing, there have been some changes in the last reporting period. Our program manager left the organization in June 2023 and a new coordinator was hired in July 2023. Based on performance and initiative, the new coordinator was promoted to be the new Program Manager. A Digital Peer Navigator was also promoted to take the coordinator position shortly after. New Digital Peer Navigators were hired in Feb 2024 and with the goal to hire a second DPN by July 2024 such that the team is fully staffed.

Training must be completed by all staff to be completed before they begin working with a participant one on one to improve the team's ability to provide competent support to community members. The training courses include Med-Cal Peer Support Specialist Certification, Community Tech Network Digital Equity Instructor Training, CPR, Naloxone, Harm Reduction training through the Wildflower Alliance, HIPPA, Salesforce, and General Program Admin. The manager also completed the training to reinforce learnings from mandatory SF DPH training and HR training.

The following INNOVATION programs are planned for 2025-26:

Two Innovation Project ideas are being explored and in the planning phases. Our goal is to present these Innovation project ideas to the Behavioral Health Oversight and Accountability Commission for approval in Spring 2026.

1. Innovation Project for Pacific Islander (PI) Communities

SF B/MHSA recognizes the need to deliver targeted support to the Pacific Islander (PI) community, noting their needs are often overlooked and the community experience with violence, trauma, and stigma against accessing behavioral health treatment services. In August 2024, SF B/MHSA began to closely assess the needs of the PI population and plan for innovative ways to meet those needs. This included (1) Reviewing San Francisco-based efforts serving PI communities and conducting a literature review on PI health locally and nationally, and (2) Assembling a project design team that includes various PI community leaders.

From this process, three main project themes emerged:

1. Supporting families grieving the loss of loved ones to community violence, including connecting them to resources for funeral costs.
2. Building on the long-standing, culturally rooted work of the PI Cultural District and S.A.L.T. (South Pacific Islander, All Islanders Gathering, Living in Peace, Tongans Rise Up), which collaborate with partners across housing, public health, crisis response, violence intervention, law enforcement, and universities.
3. Codifying and funding the volunteer work of PI leaders, compensating them for their frontline service to families experiencing trauma.

M/BHSA proposes piloting a project that strengthens these efforts, ensuring sustainable, culturally grounded behavioral health care for San Francisco's Pacific Islander communities.

2. Innovation Project for Latine/x/a/o Communities

This Innovation Project aims to integrate community-defined, culturally based interventions—traditionally practiced in community settings—into San Francisco's civil service Behavioral Health Services clinics. The goal is to institutionalize culturally rooted therapeutic approaches that promote long-term wellbeing for Latine/a/o/x and Indigenous communities.

Starting in 2024, M/BHSA began to assess the population needs and plan for innovative ways to meet these needs, by (1) Identifying current San Francisco initiatives serving Latine/a/o/x and Indigenous populations, (2) Researching community-defined interventions used nationwide, and (3) Meeting with potential providers to assess alignment of interventions with local needs.

The process was guided by a philosophy that healing lies in cultural values, traditions, and Indigenous practices as paths to restoration and lifelong health.
Stakeholder engagement has included:

- The Office of Equity and Community Engagement (Population Health Division), which shared its assessment of community needs.
- City College of San Francisco staff, who provided insights from the National Network to Eliminate Disparities in Behavioral Health's conference portfolio on Latino community-defined interventions.
- Longstanding community stakeholders who identified service gaps and priorities.
- Participation in Latino conferences and networking workshops focused on uplifting Latine/a/o/x and Indigenous voices.

- Collaboration with community providers already implementing elements of culturally defined practices.

These efforts underscore the demand for culturally specific models and the opportunity to embed them into public clinics. Through continued collaboration, the project will select and implement the most effective interventions to meet the needs of San Francisco's Latine/a/o/x and Indigenous residents.

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 experience as clients, family members of service recipients and practitioners who have experience providing client- and family-driven services that promote wellness and resilience. This service category includes 1) the Mental Health Career Pathways Program, 2) Training and Technical Assistance, and 3) Residency and Internship Programs.

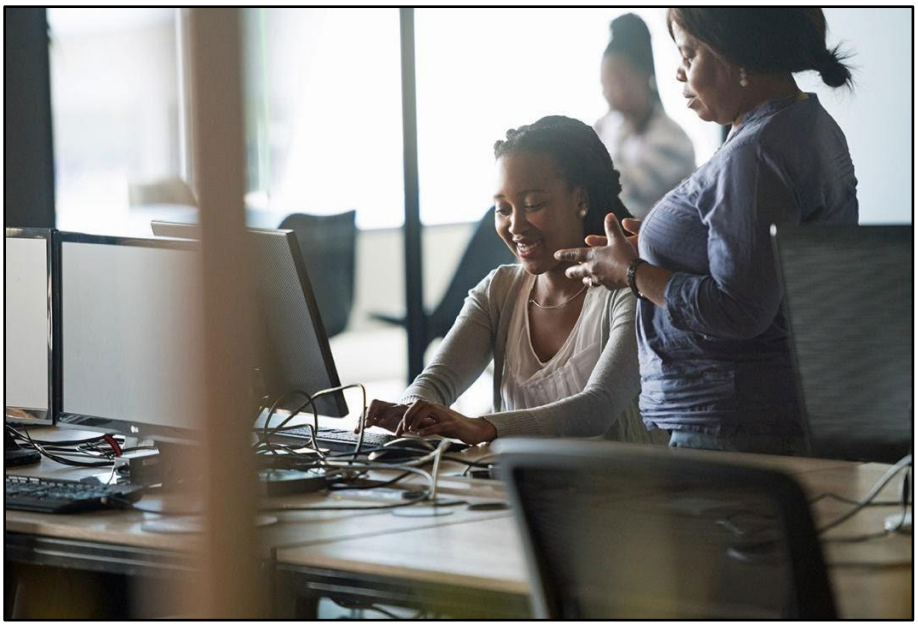
B/MHSA's goal is to develop an ethnically, linguistically and culturally diverse behavioral health workforce development pipeline to increase the number of individuals that are informed about, choose to prepare for, and are successful in entering and/or completing behavioral health training programs. To accomplish this goal, B/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

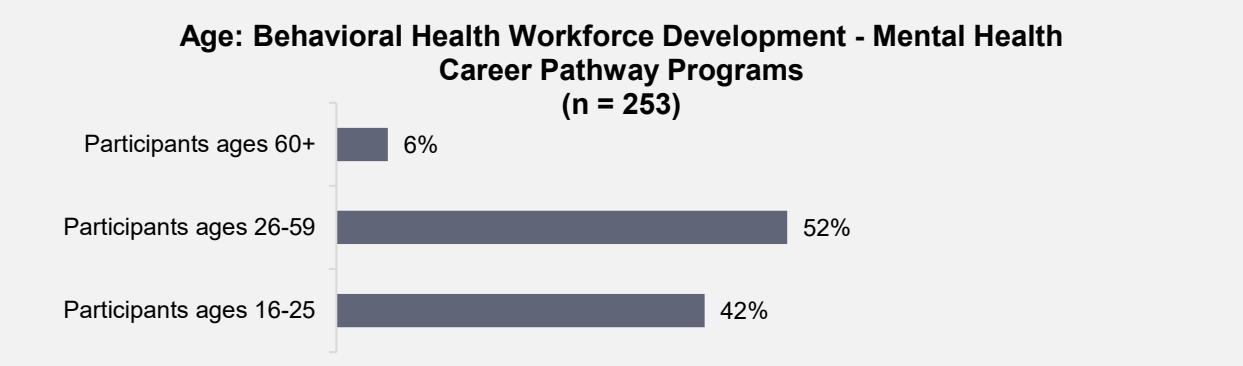
These programs work with populations who are currently underrepresented in licensed mental health professions. These include high school and college students who express career interests in the health care/behavioral health care professions and mental health clients, family members and individuals who 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

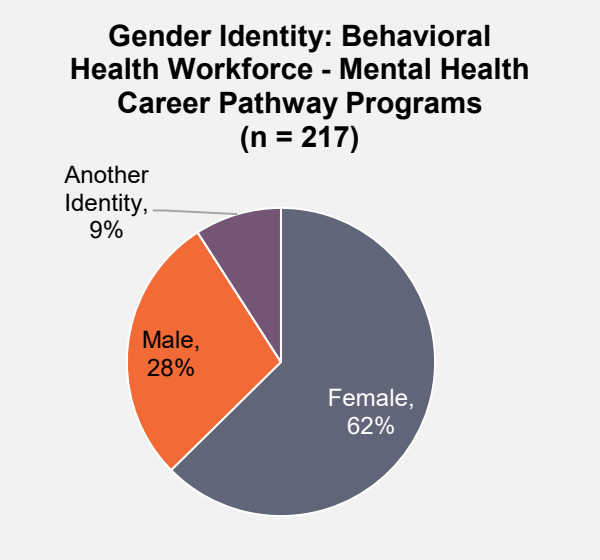
Mental Health Career Pathway Programs	
Program Name ***Provider***	**Services Description**
	need of mental health support; and efficient ways to link someone with mental health care.
FACES for the Future Program - *Public Health Institute*	This program is nationally recognized for healthcare career 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.

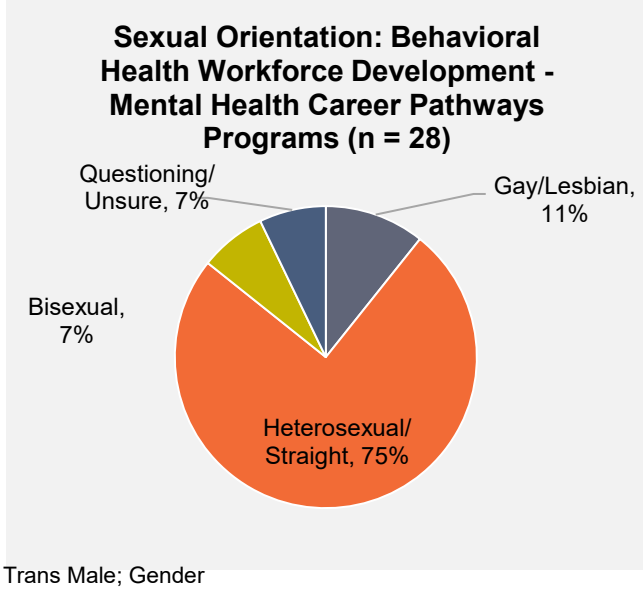


Demographics: Mental Health and Career Pathways

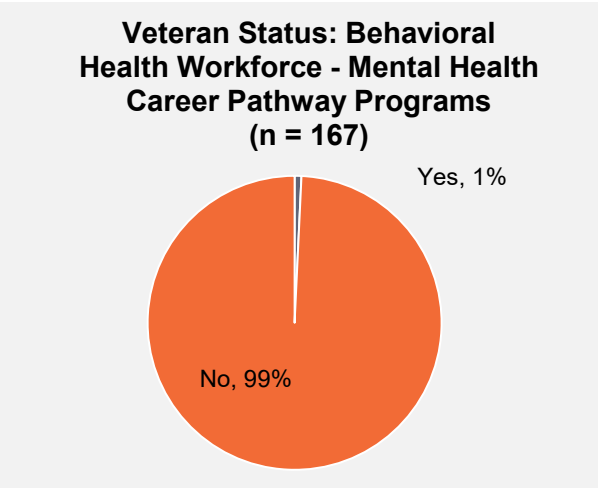


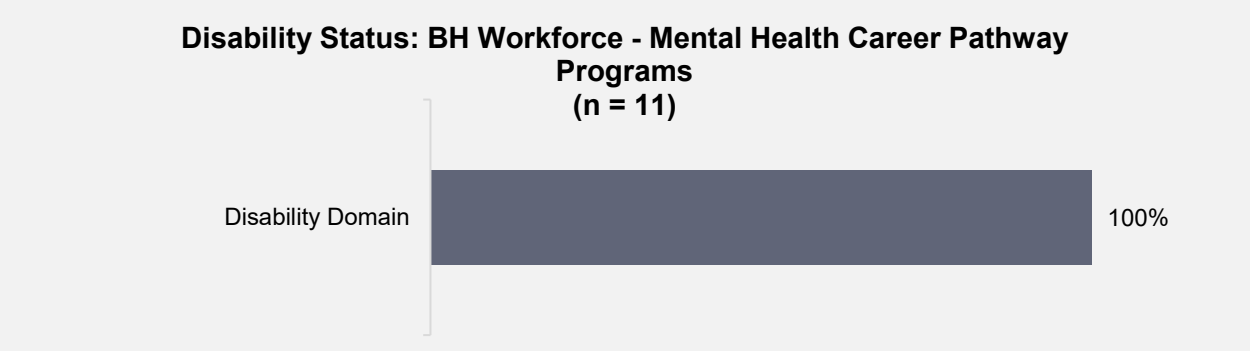
*< 1 percent of participants reported data for ages 0-15; Age





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





*< 1 percent of participants reported Another Disability, Communication Domain; Disability Status

Race	n	%
Black, African American, or African	52	24%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	40	18%
Native Hawaiian or Pacific Islander	<10	0%
White	31	14%
Other Race	98	44%
Total	221	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	71	80%
Non-Hispanic/Non-Latina/e/o	<10	6%
More than one Ethnicity	13	15%
Total	89	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	139	67%
Russian	<10	0%
Spanish	47	23%
Tagalog	<10	1%
Vietnamese	<10	0%
Another Language	12	6%
Total	208	100%

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

Program	FY23-24 Key Outcomes and Highlights
Community Mental Health Worker Certificate – *City College of San Francisco*	100% (n=15) of graduating students reported readiness to pursue their next work/educational opportunity.
Faces for the Future Program – *Public Health Institute*	60% (n=48) of students reported a sustained or increased interest in pursuing a health profession.
Addiction & Recovery Counseling Certificate Program - City College of San Francisco (formerly: Drug and Alcohol Studies)	100% (n=13) of graduating students expressed readiness to pursue their work/educational opportunity.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[17]**
Mental Health Career Pathways	260 Clients	$1,425,906	$5,484

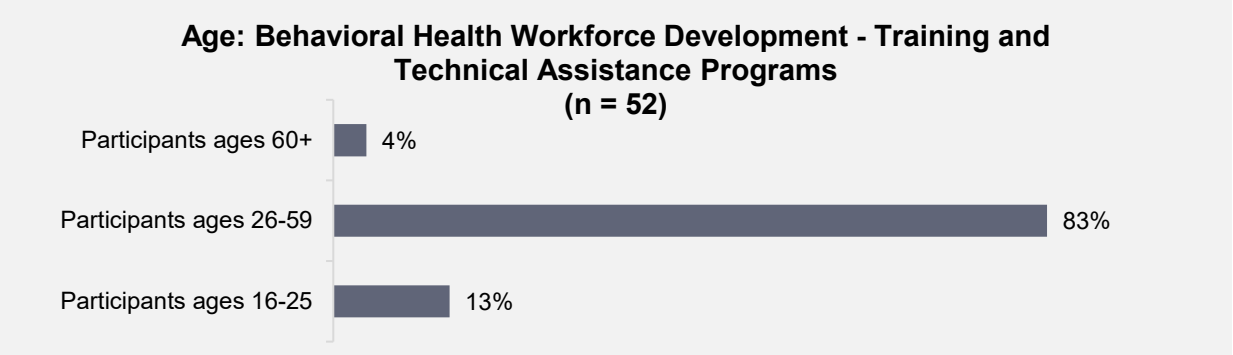
Training and Technical Assistance Programs	
Program Name *Provider*	**Services Description**
Online Learning Management System – *Relias*	The Online Learning Management System is an online and mobile training program that can be accessed by staff while at any location. This program offers multiple behavioral 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.
TAY System of Care Capacity Building – Clinician's Academy	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

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

Training and Technical Assistance Programs	
Program Name ***Provider***	**Services Description**
Felton Institute	other evidence-based models. This program also trains providers on improving TAY access to services and service delivery.

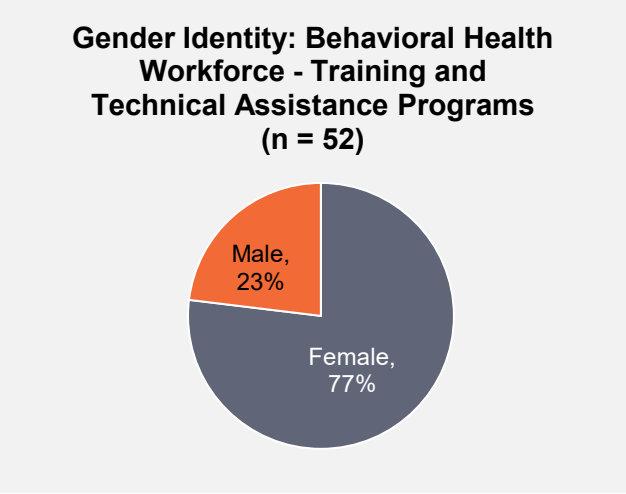
Client Demographics, Outcomes, and Cost per Client

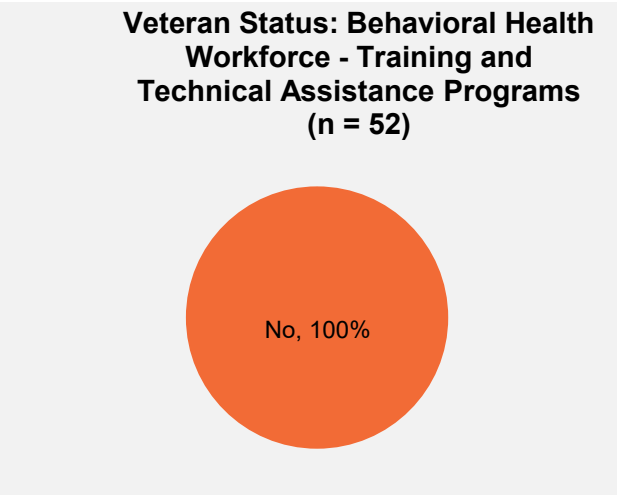
Demographics: Training and Technical Assistance Programs



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

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





Sex at birth data was not available for Behavioral Health Workforce - Training and Technical Assistance Programs.
Sexual orientation data was not available for Behavioral Health Workforce - Training and Technical Assistance Programs.
Disability status data was not available for Behavioral Health Workforce Development: Training and Technical Assistance Programs.

Race	n	%
Black, African American, or African	15	29%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	<10	2%
Native Hawaiian or Pacific Islander	<10	0%
White	<10	8%
Other Race	32	62%
Total	52	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	29	100%
Non-Hispanic/Non-Latina/e/o	<10	0%
More than one Ethnicity	<10	0%
Total	29	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	45	87%
Russian	<10	0%
Spanish	<10	12%
Tagalog	<10	2%
Vietnamese	<10	0%
Another Language	<10	0%
Total	52	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 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	FY23-24 Key Outcomes and Highlights
Online Learning Management System – *Relias*	The number of civil service behavioral health staff registered on the online learning management system increased to 810 and course enrollments increased to 1700.
Community Mental Health Academy – *Crossing Edge Consulting*	100% (n=22) of staff received six Community Mental Health Academy curricula sessions.
Trauma Informed Systems Initiative – *DPH*	23 organizations committed to becoming a healing organization.
TAY System of Care Capacity Building	43 participants were enrolled in the program.

(Clinician's Academy) – ***Felton Institute***	

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[18]**
Training and Technical Assistance	1,802 Clients	$3,470,566	$1,926

Residency and Internship Programs	
Program Name ***Provider***	**Services Description**
Fellowship Program for Public Psychiatry in the Adult System of Care - *UCSF*	Trains the next generation of public mental health care leaders who will provide patient-centered care to vulnerable populations with serious 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 serious 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 serious 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.

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

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	FY23-24 Key Outcomes and Highlights
Fellowship for Public Psychiatry in the Adult/Older Adult System of Care - UCSF **Public Psychiatry Fellowship at SF General – *UCSF***	100% (n=4) of fellows disseminated their capstone project findings at the 2024 Annual Meeting of the American Psychiatric Association.
Child and Adolescent Community Psychiatry Training Program (CACPTP) - *UCSF*	N<5 fellows at five unique clinical sites provided quality care to a total of 51 clients with behavioral health needs.
BHS Graduate Level Internship Program – *DPH*	42 interns were awarded Multicultural Student Stipend Program funds to support their workplace-based training and career development.
BHS Training Program – *DPH*	13 Intensive Clinical Case Management Academy training seminars were provided.

FY23-24 Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[19]**
Psychiatry Residency and Fellowships	115 Clients	$187,625	$1,631

Moving Forward in Behavioral Health Workforce Development

<u>BHS Training Program</u>
FY23-24 was the ICCM (Intensive Clinical Case Management) Academy's third year providing training addressing the needs of Adult, Older Adult and Transitional Age Youth (TAY) ICM & Full-Service Partnership (FSP) providers, peers, clinicians, and those working within the ICM system of care (SOC). Recently, the ICCM Academy expanded our audience to reach providers, peers, clinicians and BHS employees whose work includes case management. BHS offered 13 ICCM Academy training seminars throughout FY23-24. Our ICCM Academy training coordinator recently left the position so the ICCM Academy has been put on hold until we can hire this position.

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

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

Recent changes or updates to the project(s), including updated timelines

- We are working with SFHN-BHS to identify early career psychiatrists for the next cycle for the Public Psychiatry Administrative Fellowship, a two-year program with a mission to build community among emerging public psychiatry leaders within the SFHN-BHS.
- We continue to update our curriculum based on fellow feedback, the changing landscape of public psychiatry, and current research. This year, we made several evidence- and expert- informed changes to didactics on advocacy training, trauma-informed care, and social justice in the justice system.
- We finalized a contract with the Department of State Hospitals (DSH) and accepted our first early career psychiatrist employed by DSH
- Staffing changes
    - Dr. Brittany Bryant joined the faculty as the Capstone Project Director
    - Dr. Chuan Mei Lee joined the faculty as the Child and Adolescent Program Public Psychiatry Track director
    - Jessica Khaw joined our staff as the Research Data Analyst.
    - Anya Fang has changed roles on our staff to the Administrative Officer.

Future plans for FY24-25 and FY25-26

- FY23-24: We have two B/MHSA-funded fellows this academic year. Dr. Andrew Sudler is a Black psychiatrist working at SFHN-BHS Office of Coordinated Care and San Francisco County Jail. Dr. Nakisa Kiai is an Asian psychiatrist working at the Southeast Child/Family Therapy Center. Fellows will complete all program activities as conducted in previous years.
- FY24-25: We have matched one CAP-2 fellow in the public psychiatry track and will likely be accepting two additional applicants within the coming weeks. We anticipate having one more open position and are still conducting interviews for a position with the Department of State Hospitals.

Child and Adolescent Community Psychiatry Treatment Program (CACPTP)

In FY23-24, we had five fellows at five unique clinical sites. They saw 51 clients. We had a Public Psychiatry Fellow who spent two afternoons at one clinical site and completed a Quality Improvement project focusing on supporting the AA/API staff. For the first time, we had three fellows apply for Child Psychiatry positions in our clinics. As we only had two vacant positions, we were only able to hire two of the three fellows. All of our Child and Adolescent Psychiatry positions are full; this even allowed us to hire behind a staff that was leaving, so there was adequate staffing to cover the clients. In FY24-25, we have five fellows rotating at five sites. For FY25-26 there is an additional Child and Adolescent Fellow interested in participating in the Public Psychiatry Fellowship, spending two afternoons in our Community Psychiatry clinics. We are exploring whether there is enough funding to support this.

Trauma-Informed System (TIS) Initiative

The impact of the San Francisco housing crisis, substance use and overdose rates in our communities, high workplace vacancy rates, and racial Injustice on our Workforce has been severe. The burn-out rate of our workforce is palpable. Trauma-Informed Systems and training have never been more necessary. We are pleased to say that 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

This was the second full year of operation for the Relias Learning Management System. We added it to the new BHS Hiring Manager checklist and created a general BHS Training email address, increasing the number of civil service Behavioral Health staff registered on the system to 810 and course enrollments to 1700. Of the more than 500 courses on Relias, most relate to behavioral health clinical issues with many offering CEUs (continuing education units) which clinicians require for license renewal.

Other courses focus on skills needed for workforce development. In addition to the Relias courses, we began uploading our internal BHS training and currently have 68 of our own sponsored by BHS. This year was focused on Justice, Diversity, Equity and Inclusion with 10 new courses in diversity and equity added since October of 2023 bringing a total of 35 DEI courses.

A new tracking system was also implemented in Relias for a locally mandated ELR (Equity Learning Requirement) that is required of all staff as part of their annual performance review. Plans for next year include continued expansion, developing training plans on Relias that can be used by supervisors for workforce development.

BHS MSW and Counseling Graduate Training Program (BHS Internship Program)

For FY23-24 a total of 42 student interns were awarded Multicultural Student Stipend Program (MSSP) funds to support their workplace- based training and career development. For FY24-25 we have opened the MSSP applications, and they are due on November 1st. BHS has 22 interns this year, 4 working towards Master of Marriage and Family Therapy, 1 working toward Master of Counseling, 14 working toward Master of Social Work, and 3 working toward Doctorate in Psychology.

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.

In January 2024, a new Program Manager joined FACES for the Future as the current manager transitioned to another Program. In March 2024 a new Lead Coordinator joined the program to support students at two High Schools, John O'Connell Technical High School and Burt High School.

FACES for the Future experienced one primary challenge during the academic year. In January 2024, we became aware that Volunteer Services at Zuckerberg San Francisco was no longer able to onboard FACES students into their offsite health career-based learning opportunities due to capacity issues.

Instead, FACES worked with the SFDPH Human Resources to confirm our path to onboarding additional students. To address this challenge FACES is working proactively to identify a consistent pathway to onboard new students for the 2024-2025 Academic Year.

City College of San Francisco: Community Mental Health Worker Certificate Program
The Community Mental Health Certificate (CMH) at City College of San Francisco (CCSF), has added the Medi-Cal Peer Support Specialist (PSS) training as a sub-certificate to the program. In July 2023 an application was submitted to the CCSF curricula committee to convert the PSS training program into a Certificate of Accomplishment at the college.

The curricula committee approved the application and now students will be awarded a CCSF Certificate of Accomplishment upon completion of the PSS training. This certificate of accomplishment is a significant step toward professionalizing Peer Support Specialist as the title is now not only recognized by the State of California, but also by the California Community College System, which is comprised of 116 colleges statewide.

This is a significant milestone in advancing the Peer Support Specialist profession and acknowledging their value and contributions to the community and systems of care. The funding provided by the San Francisco Department of Public Health has helped facilitate this lengthy process to offer the PSS training every semester.

In addition, the funding has enabled the creation of the first Test Preparation Workshop for the State of California PSS examination. The workshop was launched in December 2023 and three separate training sessions were offered during the fiscal year. During the 23-24 fiscal year 7 (seven) students have taken and passed the State of California PSS examination and are now State certified as Medi-Cal Peer Support Specialists.

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.

Our program has remained consistent throughout the past fiscal year. The adjustments we made due to Covid-19 have been well integrated into programming and found effective as a pedagogical modality. The main adjustment involves a hybrid model of online (Zoom) and in-person training sessions.

BHS Training Consultant
In FY23-24, B/MHSA funded a contracted consultant role to provide coordination and support regarding our BHS training efforts.

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

Service Category Overview

B/MHSA funding for Capital Facilities allows counties to acquire, develop, or renovate buildings to support the delivery of B/MHSA programs. Funds may also be used to develop community-based, less restrictive settings that will reduce the need for institutionalization or incarceration. B/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.

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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 include 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. ○ Collaborated with Server and Compliance Departments ○ Monitored and maintained 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 B/MHSA. These positions are dedicated to supporting the Avatar application and related projects that include the B/MHSA database. ● Preparation for the transition to the Epic system in 2024.

Moving Forward in Capital Facilities

The Southeast Family Therapy Services
The funding dedicated to relocation of a leased site into a city owned location has begun construction planning and design. This year the San Francisco DPW completed design documents and submitted to the San Francisco Department of Building Inspection for the building permit. DPW will start the bid preparation, and the project will be bid out. The estimated start of construction is Spring 2025.

The development of the site will entail the repurpose of existing structures. The interior tenant improvements enable the existing Southeast Family Center to relocate in the next two to three years. This project will renovate and upgrade space to expand capabilities of the clinic to support the historically underserved neighborhoods in the Southeast of San Francisco.

The HOPE SF Sunnydale Project
This project is in final construction in collaboration with the developer of the Sunnydale housing authorities and Mercy Housing. $2,000,000 for the site construction of the wellness clinic supported the design and building of the site. The wellness clinic provides basic medical care and wellness programs onsite for clients. It provides direct access for DPH staff to the community in the largest of four public housing sites in the City of San Francisco.

Consolidation of Older Adult Services
The $1,200,000 of dedicated funding for construction of 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 the lease put in place.

Chinatown Child Development Center
Chinatown Child Development Center will join the Chinatown Health Center in a City owned property. The new location will be integrated with the upgraded Primary Care Clinic supporting the similar client communities. During 2025 the project will be in permit review and then bid out for construction.

Mental Health San Francisco Services Site
We have planned $10,000,000 in funds for purchase and build out of a new facility. San Francisco legislated a service site in 2019 to increase access to mental health and substance use services, for people experiencing homelessness. The site will provide access to the Behavioral Health Access Center, Expansion of access to substance use services, and house the Office of Coordinated Care.

This site will also serve as an administrative and service delivery site for Behavioral Health Services. This will expand services to include treatment for people with substance use disorders, prioritize care for individuals with the most serious mental illnesses, provide ongoing resources for housing interventions and workforce, and continue investments in prevention, early intervention, and innovative pilot programs.

Moving Forward in Information Technology (IT)

Information Technology

The San Francisco Department of Public Health migrated Mental Health services to a new Electronic Health Record (EHR), Epic on May 22nd, 2024.

During the last fiscal year, B/MHSA Funded IT Staff participated in the Epic migration by:

- Attending planning and discovery sessions.
- Providing guidance on Mental Health reporting to Epic team.
- Extracting over 3,700,000 documents from the previous EHR to Epic OnBase.
- Supporting Mental Health Contract Agencies migration to access Epic via PAG.

Data Collection and Reporting (DCR) system

B/MHSA staff continued to maintain, create, support, and manage all user accounts for PSCs (partnership service coordinators) of various B/MHSA programs and have managed user groups for FSPs and PCSs within the DCR system. This includes:

- DCR Account creation/deactivation.
- Partner assignments/transfers between PCS's.
- DCR support (email & phone).

B/MHSA Funded Staff

Over the last fiscal year, two B/MHSA became vacant. The positions moved to the Epic team in support of Mental Health.

B/MHSA Expenditures

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

B/MHSA Integrated Service Categories and FY23-24 Expenditures

MHSA Integrated Service Categories	Abbreviation	FY 23-24 Expenditure Amount	Percentage
Admin	Admin	2,920,210.37	5%
Evaluation	Evaluation	1,033,510.33	2%
Housing	H	3,381,420.66	6%
Recovery Oriented Treatment Services	RTS	17,787,687.11	30%
Peer-to-Peer Support Services	P2P	7,133,112.43	12%
Vocational Services	VS	3,662,761.36	6%
Workforce Development and Training	WD	5,084,096.61	9%
Capital Facilities/IT	CF/IT	3,242,874.73	6%
Mental Health Promotion and Early Intervention Services	PEI	14,197,322.10	24%
TOTAL		**58,442,995.70**	**100%**

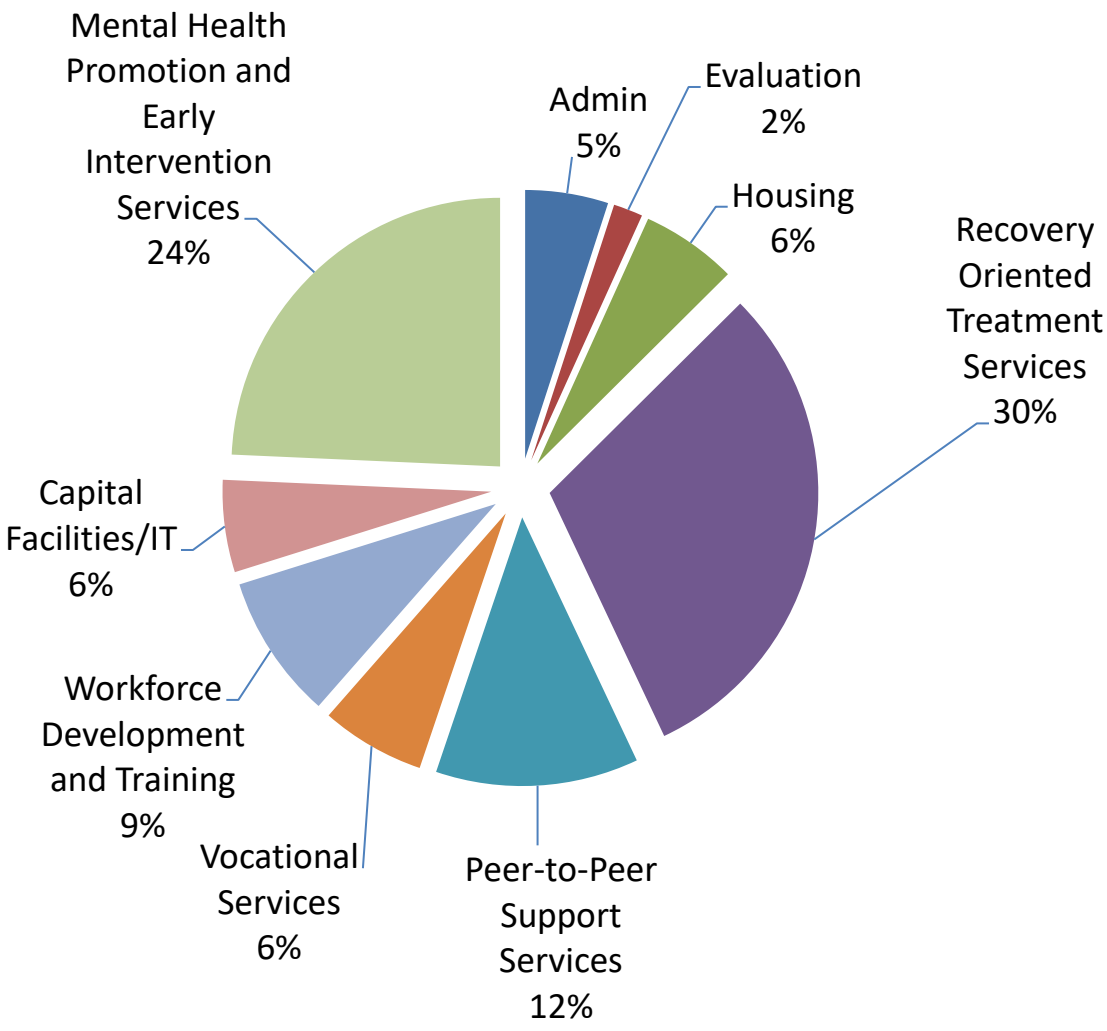
B/MHSA FY23-24 Actual Expenditures

SF MHSA Integrated Services Categori	Programs by Funding Component	FY 23-24 Expenditures
	Community Services and Supports (CSS) 76% of total MHSA revenue In FY 23-24, 53% was allocated to serve FSP clients	
Admin	CSS Admin	1,995,278.80
Evaluation	CSS Evaluation	916,356.80
H	CSS FSP Permanent Housing (capital units and master lease)	2,257,923.94
RTS	CSS Full Service Partnership 1. CYF (0-5)	369,619.19
RTS	CSS Full Service Partnership 2. CYF (6-18)	709,620.52
RTS	CSS Full Service Partnership 3. TAY (18-24)	3,209,947.79
RTS	CSS Full Service Partnership 4. Adults (18-59)	3,965,032.85
RTS	CSS Full Service Partnership 5. Older Adults (60+)	1,740,678.59
RTS	CSS Full Service Partnership 6. AOT	1,617,969.10
RTS	CSS Other Non-FSP 1. Behavioral Health Access Center	1,169,642.39
RTS	CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	643,816.02
RTS	CSS Other Non-FSP 3. Trauma Recovery	142,667.00
RTS	CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,798,180.00
RTS	CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	179,008.30
P2P	CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	6,420,454.95
VS	CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,398,391.91
H	CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	115,029.93
H	CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	408,077.79
H	CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	600,389.00
RTS	CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	1,058,367.88
RTS	CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,183,137.48
PEI	CSS Other Non-FSP 14. Overdose Prevention	588,488.89
	SUBTOTAL Community Services and Support (CSS)	**33,488,079.12**

	Workforce, Development Education and Training (WDET) **$5.3M transferred from CSS to fund WDET activities in FY 23-24**	
WD	WDET 1. Training and TA	3,470,565.67
WD	WDET 2. Career Pathways	1,425,906.25
WD	WDET 3. Residency and Internships	187,624.69
Admin	WDET Admin	185,078.94
Evaluation	WDET Evaluation	117,153.53
	SUBTOTAL Workforce, Development Education and Training (WDET)	**5,386,329.08**
	Capital Facilities/IT **$3.9M transferred from CSS to fund Capital Facilities/IT activities in FY 23-24**	
CF/IT	IT 1. Consumer Portal	89,374.29
VS	IT 2. Vocational IT	1,264,369.45
CF/IT	IT 3. System Enhancements	41,922.10
Admin	IT Admin	449,020.41
CF/IT	Cap 11 Southeast Family Therapy Services	1,224,161.07
CF/IT	Cap 14. Chinatown Child Development Center	1,887,417.27
CF/IT	Cap 15 TAY Clinic at 755 S. Van Ness	-
	SUBTOTAL Capital Facilities/IT	**4,956,264.59**
	Other	
	SUBTOTAL Other	**-**
	TOTAL Community Services and Support (CSS) (including WDET & Capital Facilities/IT)	**43,830,672.79**
	Prevention and Early Intervention (PEI) 19% of total MHSA revenue	
PEI	PEI 1. Stigma Reduction	137,223.44
PEI	PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	1,346,454.78
PEI	PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	7,470,068.88
PEI	PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,790,016.39
PEI	PEI 6. Comprehensive Crisis Services (10% Prevention)	804,086.30
	SUBTOTAL Prevention and Early Intervention (PEI)	**11,547,849.79**
	Innovation (INN) 5% of total MHSA revenue	
P2P	INN 18. Intensive Case Management Flow	430,083.31
P2P	INN 20. Technology-assisted Mental Health Solutions	-
P2P	INN 21. Wellness in the Streets (WITS)	282,574.17
PEI	INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	2,025,695.83
PEI	INN 23. Culturally Responsive Practices for the Black/African American Communities	35,287.59
Admin	INN Admin	290,832.22
	SUBTOTAL Innovation (INN)	**3,064,473.12**
	TOTAL FY 22-23 MHSA Expenditures	**58,442,995.70**

FY23-24 Expenditures by Service Category

FY 23-24 Expenditures by Service Category



B/MHSA Funding Summary

	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 FY24-25 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	54,435,896	21,542,019	8,607,603	(129,263)	9,606,456		94,062,712
2. Estimated New FY24-25 Funding (incl. interest)	59,538,091	15,193,770	4,115,270	11,795	216,214		79,075,140
3. Transfer in FY24-25	(9,264,503)			6,022,827	3,241,676	-	-
4. Access Local Prudent Reserve in FY24-25						-	-
5. Estimated Available Funding for FY24-25	104,709,484	36,735,789	12,722,874	5,905,360	13,064,346		173,137,852
B. FY24-25 MHSA Expenditures	50,725,337	16,455,460	2,230,375	6,022,827	3,745,518		79,179,517
C. Estimated FY25-26 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	53,984,148	20,280,329	10,492,499	(117,468)	9,318,828		93,958,335
2. Estimated New FY25-26 Funding (incl. interest)	46,274,075	11,568,519	3,044,347				60,886,940
3. Transfer in FY25-26	(10,871,493)			6,151,266	4,720,227	-	-
4. Access Local Prudent Reserve in FY25-26						-	-
5. Estimated Available Funding for FY25-26	89,386,730	31,848,847	13,536,846	6,033,798	14,039,055		154,845,275
D. Estimated FY25-26 Expenditures	53,064,643	15,659,950	3,374,744	6,151,266	7,620,880		85,871,483
E. Estimated FY26-27 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	36,322,086	16,188,897	10,162,102	(117,468)	6,418,175		68,973,792
2. Estimated New FY26-27 Funding (incl. interest)	55,226,545	13,806,636	3,633,325				72,666,506
3. Transfer in FY26-27	(12,482,615)			6,592,255	5,890,361	-	-
4. Access Local Prudent Reserve in FY26-27						-	-
5. Estimated Available Funding for FY26-27	79,066,016	29,995,533	13,795,427	6,474,787	12,308,536		141,640,299
F. Estimated FY26-27 Expenditures	55,395,278	17,158,805	3,446,590	6,592,255	6,489,930		89,082,857
G. Estimated FY26-27 Unspent Fund Balance	23,670,738	12,836,728	10,348,837	(117,468)	5,818,605		52,557,441

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	7,259,570
2. Contributions to the Local Prudent Reserve in FY24-25	0
3. Distributions from the Local Prudent Reserve in FY24-25	0
4. Estimated Local Prudent Reserve Balance on June 30, 2025	7,259,570
5. Contributions to the Local Prudent Reserve in FY25-26	4,409,123
6. Distributions from the Local Prudent Reserve in FY25-26	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	11,668,693
8. Contributions to the Local Prudent Reserve in FY26-27	0
9. Distributions from the Local Prudent Reserve in FY26-27	0
10. Estimated Local Prudent Reserve Balance on June 30, 2027	11,668,693

CSS Expenditures for FY24-25 through FY26-27

	Fiscal Year 24-25					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Progsumif						
1. CSS Full Service Partnership 1. CYF (0-5)	-	-	-	-	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	3,612,444	1,880,362	323,518	761	727,991	679,812
3. CSS Full Service Partnership 3. TAY (18-24)	4,982,315	4,626,073	632,578	28,613	19,000	(323,949)
4. CSS Full Service Partnership 4. Adults (18-59)	12,951,515	8,491,016	1,405,768	650,393	-	2,404,338
5. CSS Full Service Partnership 5. Older Adults (60+)	2,504,745	2,158,829	430,302	-	-	(84,387)
6. CSS Full Service Partnership 6. AOT	2,368,791	2,411,023	9,068	28,154	-	(79,454)
7. CSS FSP Permanent Housing (capital units and master lease)	1,755,360	1,755,360	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	4,914,470	3,894,848	-	232,194	5,722	781,706
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,652,315	1,235,953	-	-	-	1,416,361
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	-	-	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	126,121	126,121	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	-	-	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	2,838,357	2,419,469	181,217	-	-	237,671
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,989,046	1,073,030	253,437	2,919	25,211	634,447
3. CSS Other Non-FSP 3. Trauma Recovery	211,104	146,234	26,365	419	21,553	16,533
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	4,659,443	4,026,783	632,661	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,077,136	110,157	-	1,216	11,518	954,245
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	4,914,470	3,894,848	-	232,194	5,722	781,706
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	3,241,718	1,510,610	-	-	-	1,731,108
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	-	-	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	294,282	294,282	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	-	-	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	2,944,949	2,553,508	391,440	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,602,181	1,556,447	-	-	-	45,734
14. CSS Other Non-FSP 14. Overdose Prevention	1,007,214	1,007,214	-	-	-	-
CSS Administration	3,658,532	3,653,545	4,986	-	-	-
CSS Evaluation	1,899,624	1,899,624	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-				
Total CSS Program Expenditures	66,206,132	50,725,337	4,291,341	1,176,862	816,719	9,195,873
FSP Programs as Percent of Total	52%					

	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)	-	-	-	-	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	4,316,479	2,246,828	386,569	909	869,871	812,301
3. CSS Full Service Partnership 3. TAY (18-24)	5,099,786	4,735,145	647,493	29,288	19,448	(331,587)
4. CSS Full Service Partnership 4. Adults (18-59)	13,283,376	8,708,584	1,441,788	667,058	-	2,465,945
5. CSS Full Service Partnership 5. Older Adults (60+)	2,570,197	2,215,243	441,547	-	-	(86,592)
6. CSS Full Service Partnership 6. AOT	2,425,798	2,469,046	9,286	28,832	-	(81,366)
7. CSS FSP Permanent Housing (capital units and master lease)	1,789,311	1,789,311	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	5,029,358	3,985,899	-	237,622	5,856	799,981
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,510,415	1,169,829	-	-	-	1,340,585
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	-	-	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	334,221	334,221	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	-	-	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	2,935,707	2,502,453	187,432	-	-	245,822
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	2,025,744	1,092,828	258,113	2,973	25,676	646,153
3. CSS Other Non-FSP 3. Trauma Recovery	207,962	144,057	25,973	413	21,232	16,287
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	4,847,319	4,189,148	658,170	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,077,136	110,157	-	1,216	11,518	954,245
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	5,029,358	3,985,899	-	237,622	5,856	799,981
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	3,068,285	1,429,791	-	-	-	1,638,493
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	-	-	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	779,849	779,849	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	-	-	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	3,047,026	2,642,018	405,008	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,631,059	1,584,500	-	-	-	46,558
14. CSS Other Non-FSP 14. Overdose Prevention	1,042,847	1,042,847	-	-	-	-
CSS Administration	3,946,048	3,940,670	5,378	-	-	-
CSS Evaluation	1,966,319	1,966,319	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	68,963,599	53,064,643	4,466,758	1,205,932	959,458	9,266,807
FSP Programs as Percent of Total	52%					

	Fiscal Year 26-27					
	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)	-	-	-	-	-	-
2. CSS Full Service Partnership 2. CYF (6-18)	5,053,014	2,630,212	452,530.80	1,064	1,018,300	950,907
3. CSS Full Service Partnership 3. TAY (18-24)	5,271,465	4,894,549	669,289.67	30,274	20,103	(342,750)
4. CSS Full Service Partnership 4. Adults (18-59)	13,752,305	9,016,014	1,492,686	690,607	-	2,552,998
5. CSS Full Service Partnership 5. Older Adults (60+)	2,651,862	2,285,629	455,576	-	-	(89,343)
6. CSS Full Service Partnership 6. AOT	2,511,723	2,556,504	9,615	29,853	-	(84,248)
7. CSS FSP Permanent Housing (capital units and master lease)	1,817,286	1,817,286	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and CBO (50% FSP)	5,166,244	4,094,385	-	244,089	6,016	821,754
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	2,814,777	1,311,659	-	-	-	1,503,118
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	-	-	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (30% FSP)	343,210	343,210	-	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	-	-	-	-	-	-
Non-FSP Programs						
1. CSS Other Non-FSP 1. Behavioral Health Access Center	3,053,491	2,602,854	194,952	-	-	255,685
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	2,074,361	1,119,055	264,308	3,045	26,293	661,661
3. CSS Other Non-FSP 3. Trauma Recovery	212,953	147,515	26,596	423	21,742	16,678
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	5,054,033	4,367,795	686,238	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,102,987	112,801	-	1,245	11,794	977,147
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	5,166,244	4,094,385	-	244,089	6,016	821,754
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	3,440,283	1,603,139	-	-	-	1,837,144
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	-	-	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	800,822	800,822	-	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	-	-	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	3,170,393	2,748,987	421,406	-	-	-
13. CSS Other Non-FSP 13. Building a Peer-to-Peer Support Network for Transgender Individuals	1,684,155	1,636,081	-	-	-	48,074
14. CSS Other Non-FSP 14. Overdose Prevention	1,084,837	1,084,837	-	-	-	-
CSS Administration	4,088,011	4,082,440	5,572	-	-	-
CSS Evaluation	2,045,119	2,045,119	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-	-	-	-	-
Total CSS Program Estimated Expenditures	72,359,577	55,395,278	4,678,770	1,244,688	1,110,263	9,930,578
FSP Programs as Percent of Total	52%					

PEI Estimated Expenditures for FY24-25 through FY26-27

	Fiscal Year 24-25					
	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	140,654	140,653.74	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	940,019	775,587	-	2,962	28,026	133,445
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	4,755,339	4,696,940	2,708	27	122	55,543
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	4,883,431	1,314,347	-	59	5,981	3,563,043
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	175,143	172,470	2,673	-	-	-
7. PEI 7. CalMHSA Statewide Programs	-	-	-	-	-	-
8. PEI 9. Overdose Prevention	1,700,793	1,700,793	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	940,019	775,587	-	2,962	28,026	133,445
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	4,755,339	4,696,940	2,708	27	122	55,543
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	1,627,810	438,116	-	20	1,994	1,187,681
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	1,576,284	1,552,228	24,055	-	-	-
PEI Administration	191,799	191,799	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Expenditures	21,686,630	16,455,460	32,145	6,056	64,270	5,128,700

	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	140,654	140,653.74	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	951,513	785,069	-	2,998	28,368	135,077
3. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,744,607	3,698,621	2,133	21	96	43,737
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	7,274,658	1,957,932	-	88	8,910	5,307,727
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	181,118	178,354	2,764	-	-	-
7. PEI 7. CalMHSA Statewide Programs	-	-	-	-	-	-
8. PEI 9. Overdose Prevention	1,760,690	1,760,690	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	951,513	785,069	-	2,998	28,368	135,077
9. PEI 3. School-Based Mental Health Promotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,744,607	3,698,621	2,133	21	96	43,737
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	2,424,886	652,644	-	29	2,970	1,769,242
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	1,630,063	1,605,187	24,876	-	-	-
PEI Administration	397,110	397,110	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	23,201,417	15,659,950	31,905	6,155	68,808	7,434,598

	Fiscal Year 26-27					
	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	144,029	144,029	-	-	-	-
2. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	978,342	807,205	-	3,082	29,168	138,886
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	3,922,376	3,874,206	2,234	22	100	45,814
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	9,896,315	2,663,536	-	120	12,121	7,220,538
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	188,390	185,515	2,875	-	-	-
7. PEI 7. CalMHSA Statewide Programs	-	-	-	-	-	-
8. PEI 9. Overdose Prevention	1,832,418	1,832,418	-	-	-	-
PEI Programs - Early Intervention						
9. PEI 2. School-Based Mental Health Promotion (K-12) (50% Prevention)	807,205	807,205	-	-	-	-
11. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	5,300,583	3,874,206	-	24	2,390	1,423,963
12. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	927,897	887,845	40,052	-	-	-
13. PEI 6. Comprehensive Crisis Services (10% Prevention)	1,669,636	1,669,636	-	-	-	-
PEI Administration	413,002	413,002	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	26,080,194	17,158,805	45,161	3,248	43,780	8,829,200

Program Name	Childhood Trauma Prevention and Early Intervention	Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	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 2024/25 MHSA Funds	Fiscal Year 2025/26 Estimated MHSA Funds	Fiscal Year 2026/27 Estimated MHSA Funds
PEI 1. Stigma Reduction	✓	✓	✓	✓	✓	✓	✓	$ 140,654	$ 140,654	$ 144,029
PEI 2. School-Based Mental Health Pomotion (K-12) (50% Pr	✓	✓	✓	✓			✓	$ 1,551,173	$ 1,570,139	$ 1,614,411
PEI 4. Population Focused Mental Health (50% Prevention)	✓	✓	✓	✓	✓	✓	✓	$ 9,393,880	$ 7,397,241	$ 7,748,413
PEI 5. Mental Health Consultation and Capacity Building (75	✓	✓	✓	✓	✓		✓	$ 1,752,463	$ 2,610,576	$ 3,551,382
PEI 6. Comprehensive Crisis Services (10% Prevention)	✓	✓	✓	✓			✓	$ 1,724,698	$ 1,783,541	$ 1,855,151
PEI 7. CalMHSA Statewide Programs	✓	✓	✓	✓	✓	✓	✓	$ -	$ -	$ 1,832,418

INN Estimated Expenditures for FY24-25 through FY26-27

	Fiscal Year 24-25					
	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	-	-	-	-	-	-
2. INN 20. Technology-assisted Mental Health Solutions	-	-	-	-	-	-
3. INN 21. Wellness in the Streets (WITS)	101,459	101,459	-	-	-	-
4. INN 22. FUERTE	-	-				
5. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,842,249	1,842,249				
6. INN 25. Pacific Islander Innovations Project	-	-				
7. INN 26. Innovations Project for the Latine/a/o/x and Indigenous Community of San Francisco	-	-				
INN Administration	286,667	286,667	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Expenditures	2,230,375	2,230,375	-	-	-	-

	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 21. Wellness in the Streets (WITS)	-	-	-	-	-	-
2. INN 23. Culturally Congruent and Innovative Practices for the Black/African American communities	1,881,155	1,881,155	-	-	-	-
3. INN 25. Pacific Islander Innovations Project	600,000	600,000				
4. INN 26. Innovations Project for the Latine/a/o/x and Indigenous Community of San Francisco	600,000	600,000				
INN Administration	293,589	293,589	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,374,744	3,374,744	-	-	-	-

	Fiscal Year 26-27					
	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	1,944,852	1,944,852	-	-	-	-
2. INN 25. Pacific Islander Innovations Project	600,000	600,000				
3. INN 26. Innovations Project for the Latine/a/o/x and Indigenous Community of San Francisco	600,000	600,000				
INN Administration	301,738	301,738	-	-	-	-
INN Evaluation	-	-	-	-	-	-
Total INN Program Estimated Expenditures	3,446,590	3,446,590	-	-	-	-

WET Estimated Expenditures for FY24-25 through FY26-27

	Fiscal Year 24-25					
	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	3,693,609	3,693,609	-	-	-	-
2. Career Pathways	1,787,329	1,787,329	-	-	-	-
3. Residency and Internships	196,667	196,667	-	-	-	-
WET Administration	224,974	224,974	-	-	-	-
WET Evaluation	120,249	120,249	-	-	-	-
Total WET Program Expenditures	6,022,827	6,022,827	-	-	-	-

	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	3,722,573	3,722,573	-	-	-	-
2. Career Pathways	1,765,508	1,765,508	-	-	-	-
3. Residency and Internships	203,589	203,589	-	-	-	-
WET Administration	335,222	335,222	-	-	-	-
WET Evaluation	124,374	124,374	-	-	-	-
Total WET Program Estimated Expenditures	6,151,266	6,151,266	-	-	-	-

	Fiscal Year 26-27					
	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	4,043,563	4,043,563	-	-	-	-
2. Career Pathways	1,858,802	1,858,802	-	-	-	-
3. Residency and Internships	211,738	211,738	-	-	-	-
WET Administration	348,832	348,832	-	-	-	-
WET Evaluation	129,320	129,320	-	-	-	-
Total WET Program Estimated Expenditures	6,592,255	6,592,255	-	-	-	-

CFTN Estimated Expenditures for FY24-25 through FY26-27

	Fiscal Year 24-25					
	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	-	-	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	-	-	-	-	-	-
4. Cap 14. Chinatown Child Development Center	413,779	413,779	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	-	-	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
1. IT 1. Consumer Portal	-	-	-	-	-	-
2. IT 2. Vocational IT	1,295,979	1,295,979	-	-	-	-
3. IT 3. System Enhancements	-	-	-	-	-	-
CFTN Administration	35,760	35,760	-	-	-	-
Total CFTN Program Expenditures	3,745,518	3,745,518	-	-	-	-

	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	5,838,680	5,838,680	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	-	-	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	-	-	-	-	-	-
4. Cap 14. Chinatown Child Development Center	486,221	486,221	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	-	-	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	-	-	-	-	-	-
9. IT 2. Vocational IT	1,295,979	1,295,979	-	-	-	-
10. IT 3. System Enhancements	-	-	-	-	-	-
CFTN Administration	-	-	-	-	-	-
Total CFTN Program Estimated Expenditures	7,620,880	7,620,880	-	-	-	-

	Fiscal Year 26-27					
	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	4,161,320	4,161,320	-	-	-	-
2. Cap 12. Hope SF Sunnydale Wellness Center	-	-	-	-	-	-
3. Cap 13. Southeast Mission Geriatric	-	-	-	-	-	-
4. Cap 14. Chinatown Child Development Center	1,001,528	1,001,528	-	-	-	-
5. Cap 15. TAY Clinic at 755 So Van Ness	-	-	-	-	-	-
6. Cap 16. Behavioral Health Services at 1380 Howard	-	-	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. IT 1. Consumer Portal	-	-	-	-	-	-
9. IT 2. Vocational IT	1,327,082	1,327,082	-	-	-	-
10. IT 3. System Enhancements	-	-	-	-	-	-
CFTN Administration	-	-	-	-	-	-
Total CFTN Program Estimated Expenditures	6,489,930	6,489,930	-	-	-	-

Appendix A Three-Year Prevention and Early Intervention (PEI) Evaluation Report FY21-22 through FY23-24

PEI Programming and Evaluation

Community Program Planning for Implementation of Prevention and Early Intervention Programming

SFDPH strengthens the B/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 2024, 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 B/MHSA groups its Mental Health Promotion and Early Intervention (PEI) programs into five major categories:

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

The focus of all PEI programs is to raise people's awareness about mental health conditions; reduce the stigma around mental illness; and increase individuals' access to quality mental health care. B/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 B/MHSA PEI Category	SF-B/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-B/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.

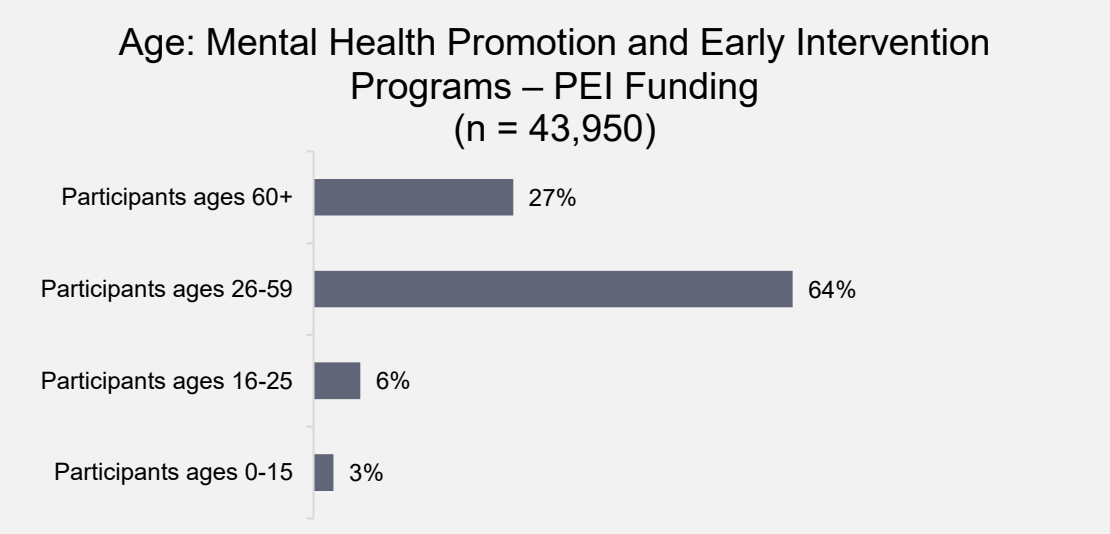
Given the need for the MHSOAC to know and better understand the communities being served by B/MHSA resources, it is extremely important for B/MHSA to develop processes and instruments that will afford programs the ability to capture required data in a manner that is respectful and does not offend, discourage 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.

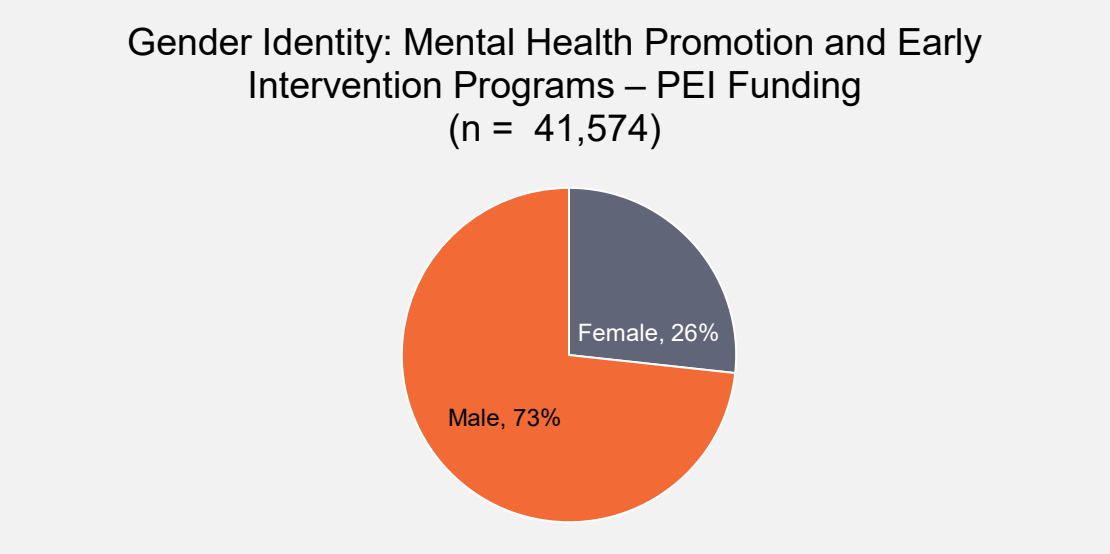
Total Served for all B/MHSA PEI Programs

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	141,643	24,351	2,444	488
Subcategory: Mental Health Promotion and Early Intervention – School-Based Mental Health Promotion (K-12)	1,509	335	229	16
Subcategory: Mental Health Promotion and Early Intervention – Population-Focused Mental Health Promotion	136,453	21,962	1,388	431

Subcategory: Mental Health Promotion and Early Intervention – Early Childhood Mental Health Consultation Initiative	2,907	1,485	258	41
Subcategory: Mental Health Promotion and Early Intervention – Comprehensive Crisis Services	774	569	569	N/A

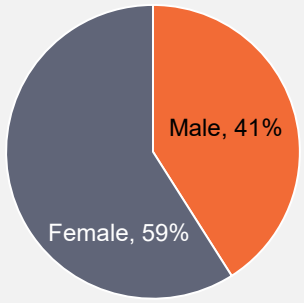
Demographics: All PEI Programs



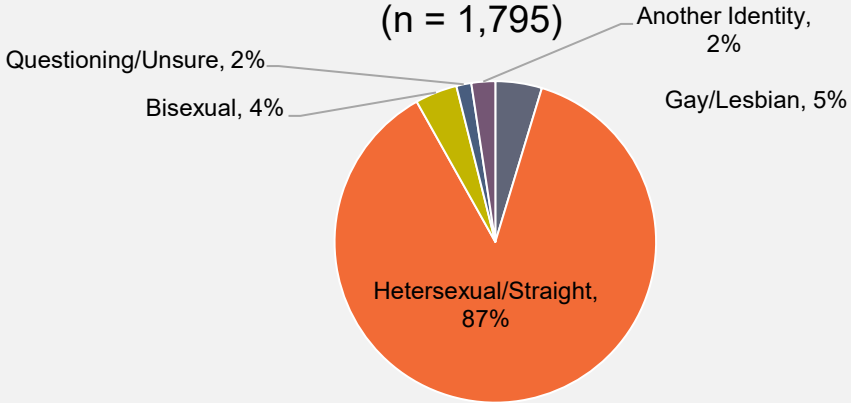


PEI

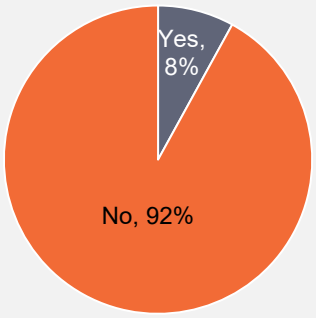
Sex at Birth: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 4,747)



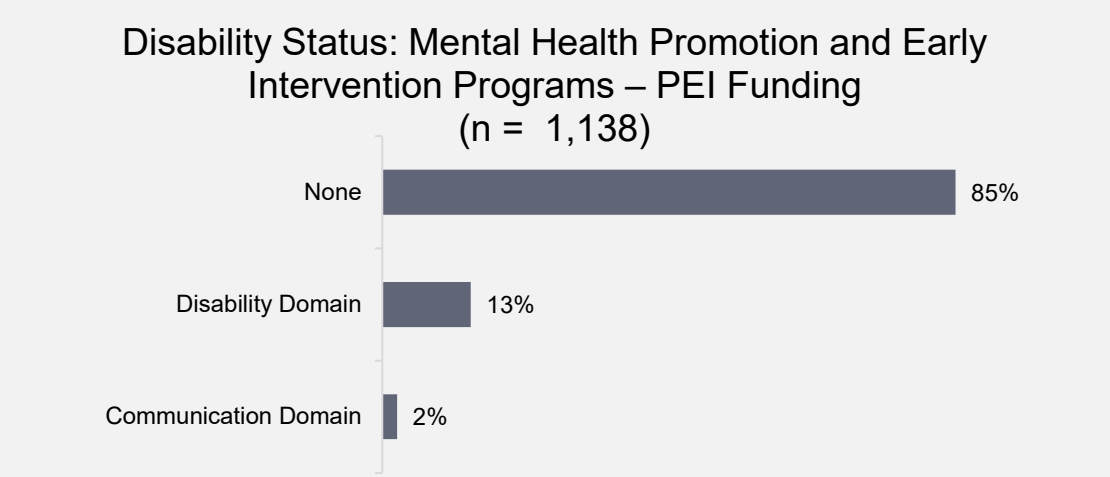
Sexual Orientation: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 1,795)



Veteran Status: Mental Health Promotion and Early Intervention Programs – PEI Funding (n = 40,707)



PEI



Primary Language	n	%
Chinese	1,036	14%
English	4,516	61%
Russian	78	1%
Spanish	1,418	19%
Tagalog	79	1%
Vietnamese	108	1%
Another Language	194	3%
Total	7,429	100%

Ethnicity	n	%
Hispanic/Latina/e/o	5,619	69%
Non-Hispanic/Non-Latina/e/o	928	11%
More than one Ethnicity	1,541	19%
Total	8,088	100%

Race	n	%
Black, African American, or African	13,945	33%
American Indian, Alaska Native, or Indigenous	990	2%
Asian or Asian American	4,847	11%
Native Hawaiian or Pacific Islander	497	1%
White	15,282	36%
Other Race	7,320	17%
Total	42,881	100%

Service Indicator Outcomes for all PEI Programs FY23-24

Service Indicator	Program Results for FY23/24
Total family members served	1,223 family members; average of 136 family members across the 9 reporting programs that served families.
Potential responders for outreach activities	**Community Organizations/Social Services**: Case managers, Home visitors, Non-profit agency staff, Outreach coordinators, Program Managers Social workers, Trusted community messengers, Wellness coordinators **Education and Youth Services**: College students, Educators, High school personnel, Teachers, Youth wellness specialists **General Support Services**: Basic needs service providers, Family childcare providers, Parents/caregivers, Property managers, Tribal agency staff **Mental Health, Healthcare, and Behavioral Support**: Behavioral health specialists, Clinical directors, Clinical supervisors, Counselors, Medical workers, Mental health therapists, Psycho-social service providers
Total individuals with severe mental illness referred to treatment	456 individuals; average 57 individuals across 8 reporting programs who referred individuals to treatment.
Types of treatment referred	**Healthcare Services:** Health clinics, Primary care, Emergency departments **Mental Health and Behavioral Support:** Behavioral health counseling, Individual counseling/therapy, Intensive TAY clinics, Family therapy services Substance abuse counseling, Substance treatment programs **Other support:** Case management, Housing, Support groups, Wrap-around services
Individuals who followed through on referral	220 individuals; average 37 individuals across six reporting programs.
Average duration of untreated mental illness after referral	10.7 weeks
Average interval between referral and treatment	3.8 days
Total number of referrals of underserved populations to services for prevention, early intervention, and treatment beyond early onset	1,365 referrals; average 98 referrals across 14 reporting programs.
Types of underserved populations referred to prevention program services	**Communities of Color**: Individuals who identify as Asian Indian, Black/African American, Cambodian, Filipino, Hmong, Indigenous, Japanese, Korean, Lao, Latinx, Native Hawaiian, Samoan, Thai, Two-Spirit community members, and Vietnamese. **Families**: Black pregnant and postpartum individuals/families, Families experiencing homelessness, housing instability, or limited

Service Indicator	Program Results for FY23/24
	resources, Families impacted by COVID-19; Families with young children, Immigrant families, LGBTQ+ families, and Monolingual families. **Immigrants and Refugees**: Asylum-seeking youth and mixed legal status families/clients; Immigrants **Other Underserved Populations:** Homeless individuals, Immigrants, Isolated adults, Limited English-speaking individuals, LGBTQ+ individuals, those in recovery, Low-income, non-English speaking, and functionally impaired individuals, marginally housed, poor/low-wealth, formerly incarcerated individuals, Older adults, and Single parents. **Youth and Young Adults**: Adolescents (ages 14-19), Asylum-seeking youth, chronically ill youth, Disabled and neurodivergent youth, Ex-gang-involved youth, Homeless and marginalized youth, medically transitioning youth, Parenting youth, Sex work-involved youth, Survivors of human trafficking, Transitional-aged youth and young adults, and Unaccompanied minors and youth involved in the foster care system.
Individuals who followed through on referral	780 individuals; average 71 individuals across 11 reporting programs.
Average interval between referral and treatment	13 days
How programs encourage access to services and follow-through on referrals	**Develop trusting relationships with individuals** through frequent sessions, assessments, and follow-ups; utilize peer-based staff who share similar backgrounds to foster trust, empathy, and non-judgmental support. **Inform individuals of available services** using different outreach methods and providing navigation services to ensure clients are aware of accessible resources. Programs also aim to ensure clients feel comfortable accessing services by offering advocacy and attending sessions when possible. **Collaborate with partner agencies,** including maintaining strong relationships with community organizations to coordinate referrals. **Provide warm handoffs and navigation services** where initial connections are made, followed by follow-up calls or in-person check-ins to ensure clients follow through with referrals. **Track referrals** through electronic health records and monitor follow-through, providing ongoing support as needed. **Follow-up** include making additional connections if necessary and providing ongoing support to overcome access barriers.

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 Promotoras, 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, supporting 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.

Service Indicator	Program Results for FY21-22
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 treatment beyond early onset	1,530 individuals; average 117.7 individuals across 13 reporting programs.
Types of underserved populations referred to prevention program services	Ethnic/racial groups: communities of color including American Indian and Alaskan Native, Black/African American, Cambodian, Filipino, Lao, Latinx, Mongolian, Native American, Samoan, and Vietnamese. Social Minorities/Resource-limited: adverse childhood experiences, functionally impaired, immigrant communities, indigenous, individuals suffering from complex trauma, individuals concerned about mental illness, LGBTQ+, low-income, non-English speaking, monolingual families, single parents, substance use, unhoused, and working parents with limited resources. Age Groups: immigrant youth, isolated older adults, Southeast Asian youth, transition age youth, and unhoused or marginal housed youth.
Individuals who followed through on referral	1,155 individuals; average 96.3 individuals across 12 reporting programs.

Service Indicator	Program Results for FY21-22
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 ● 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

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 Outcomes

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	FY23-24 Key Outcomes and Highlights
Peer Outreach and Engagement Services – *Mental Health Association of San Francisco*	100% (n=146) of Peer Connections participants receiving 1:1 peer counseling completed one personal wellness goal.

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.

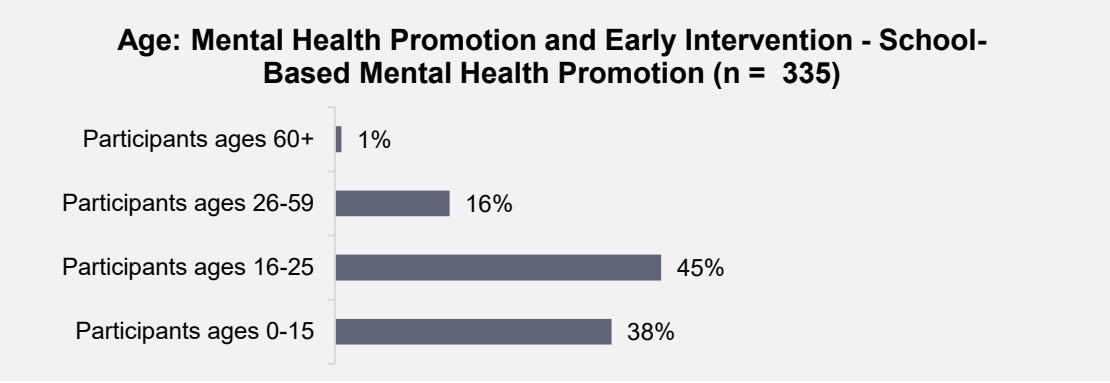
An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To 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.

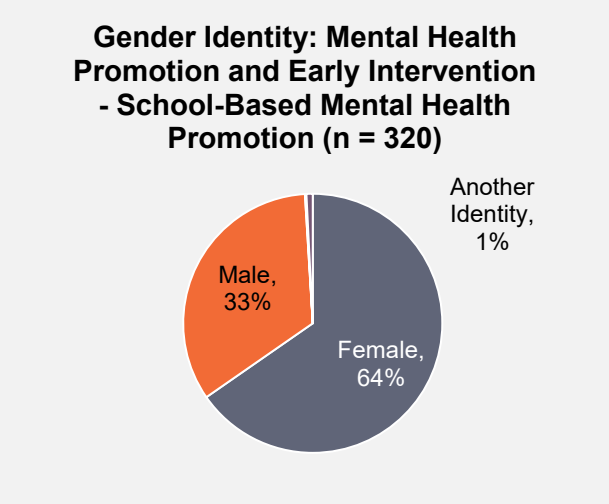
Target Populations

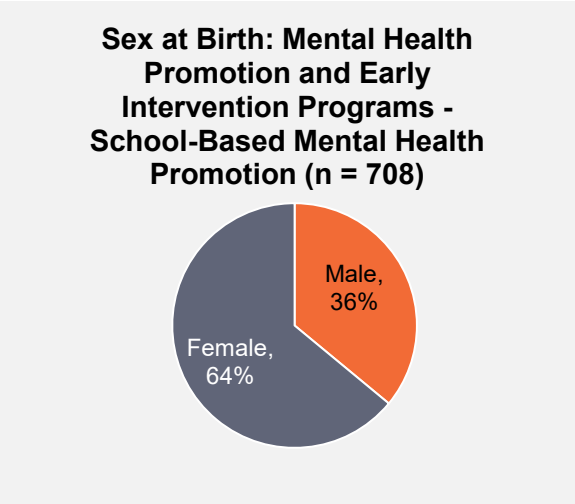
The target population for School-Based Mental Health Promotion Programs is students who are in kindergarten through 12th grade who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers.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

Client Demographics and Outcomes

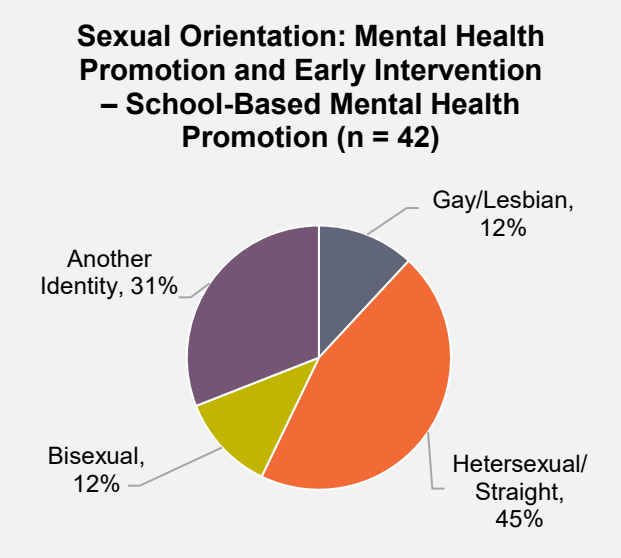
Demographics: School Based Prevention (K-12)

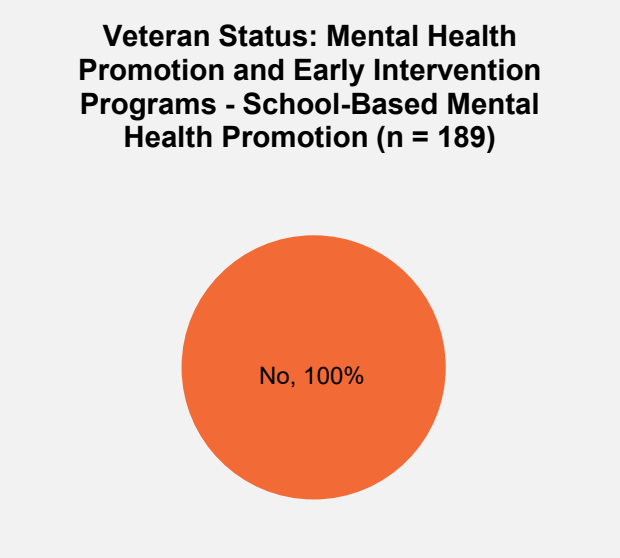






*< 1 percent of participants reported data for Trans Female, Trans Male; Gender





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

*< 1 percent of participants reported Another Disability, Disability Domain, Communication Domain; Disability Status

Race	n	%
Black, African American, or African	80	52%
American Indian, Alaska Native, or Indigenous	<10	1%
Asian or Asian American	42	27%
Native Hawaiian or Pacific Islander	<10	1%
White	28	18%
Other Race	<10	2%
Total	155	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	97	49%
Non-Hispanic/Non-Latina/e/o	72	36%
More than one Ethnicity	31	16%
Total	200	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	271	81%
Russian	<10	0%
Spanish	57	17%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	333	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	FY23-24 Key Outcomes and Highlights
Behavioral Health Services at Balboa Teen Health Center - *Bayview Hunter's Point Foundation*	78% (n=21) of students re-engaged in school.
Mental Health Services – *Edgewood Center for Children and Families*	94% (n=18) of students who received behavior coaching reported an increase from pre to post.

Youth Early Intervention – *Instituto Familiar de la Raza*	97% (n=86) of staff who received consultation services reported being more knowledgeable about mental health and the socio-emotional needs of students and families.
Wellness Centers – *Richmond Areas Multi-Services (RAMS)*	94% (n=180) of students reported they met or somewhat met the goals they set in therapy.

Population-Focused Mental Health Promotion & Early Intervention

Program Collection Overview

B/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.

B/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 B/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.
	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.

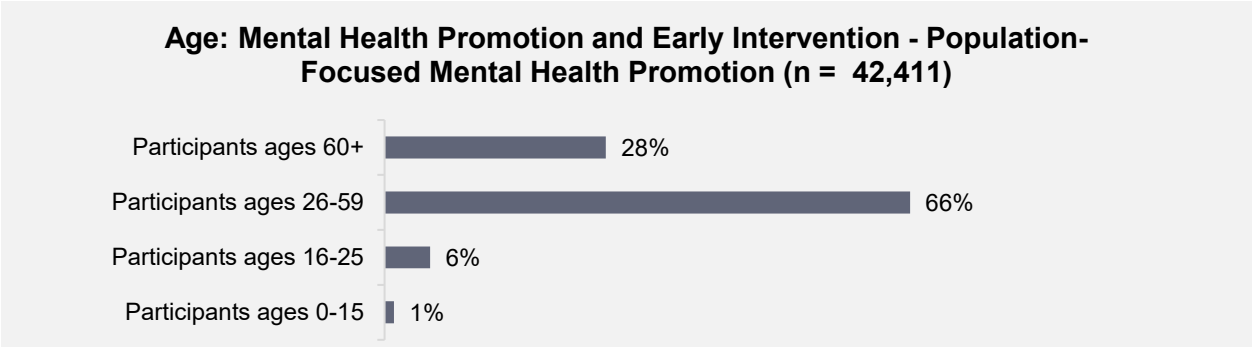
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
Asians/Pacific Islanders (API)	API Mental Health Collaborative *Richmond Area Multi-Services (RAMS)*	Serves Filipino, Samoan and Southeast Asian community members of all ages. The API 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 work group 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.
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.

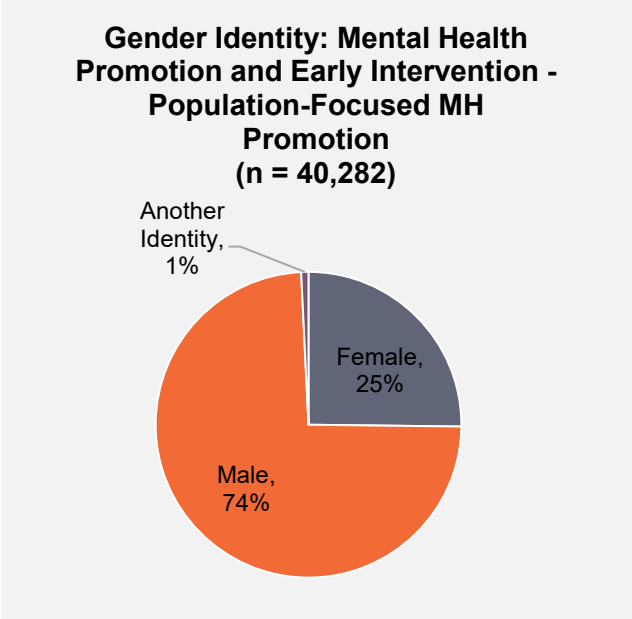
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
	Tenderloin Self-Help Center *Central City Hospitality House*	Serves adult residents facing behavioral health challenges and homelessness in the Tenderloin neighborhood. The self-help 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.
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.

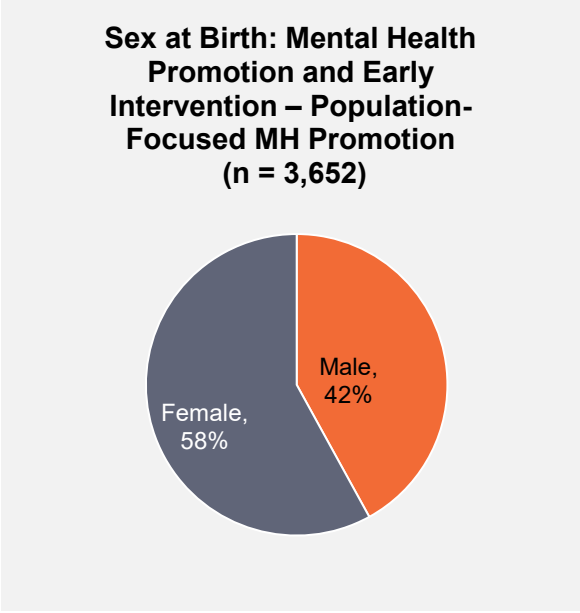
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name** ***Provider***	**Services**
TAY who are Homeless or At-Risk of Homelessness or Justice Involved	Population Specific TAY Engagement and Treatment *Huckleberry Youth Programs*	Serves low-income African American, Latino, 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 and Outcomes

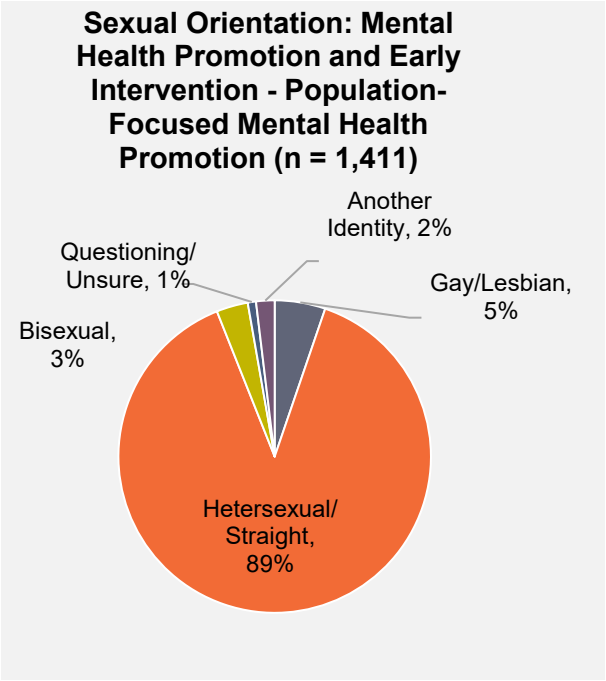
Demographics: Population Focused Mental Health

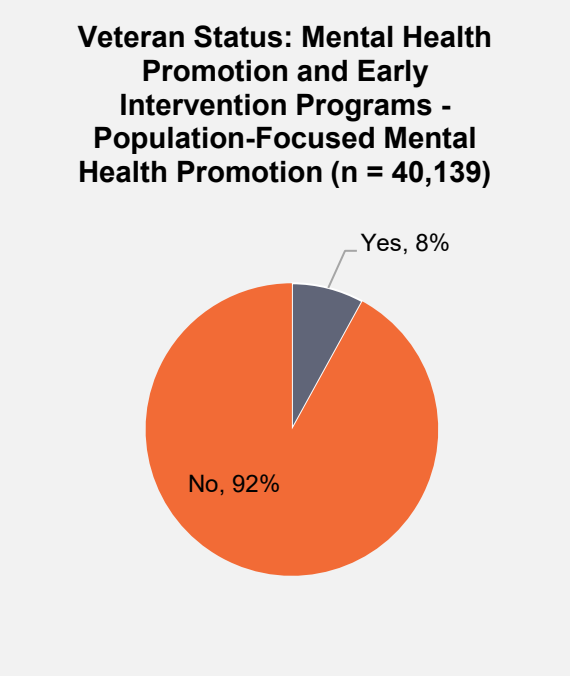


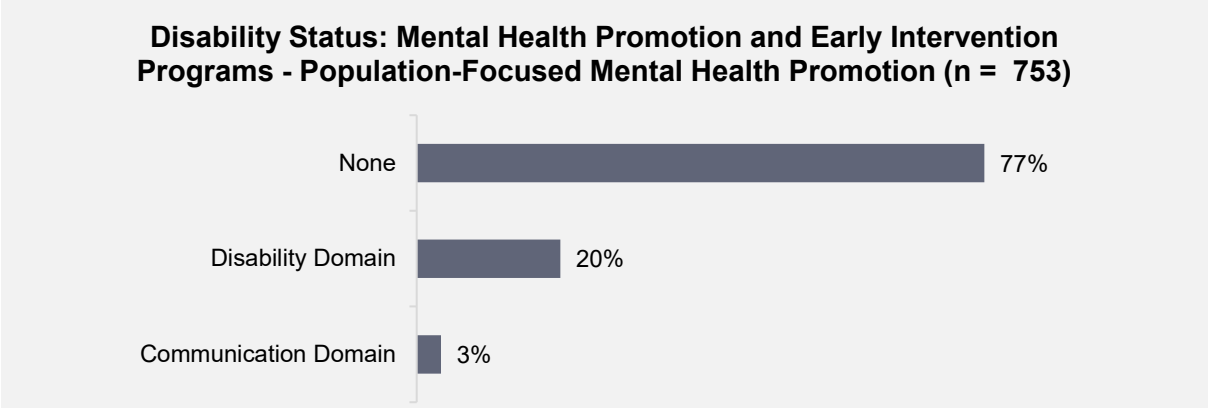




*< 1 percent of participants reported data for Trans Female, Trans Male; Gender







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

Race	n	%
Black, African American, or African	13,263	33%
American Indian, Alaska Native, or Indigenous	987	2%
Asian or Asian American	4,487	11%
Native Hawaiian or Pacific Islander	477	1%
White	14,828	36%
Other Race	6,666	16%
Total	40,708	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	4,657	69%
Non-Hispanic/Non-Latina/e/o	710	10%
More than one Ethnicity	1,407	21%
Total	6,774	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	737	16%
English	2,767	61%
Russian	78	2%
Spanish	599	13%
Tagalog	78	2%
Vietnamese	104	2%
Another Language	183	4%
Total	4,546	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	FY23-24 Key Outcomes and Highlights
Senior drop-in Center – *Curry Senior Center*	85% (n=165) of participants who attended at least three activities reported increased socialization.
Addressing the Needs of Socially Isolated Older Adults – *Curry Senior Center*	100% (n=74) of isolated older adults screened and identified as having a behavioral health need were referred to appropriate behavioral health services.
Improving Maternal Mental Health for Black/African American Birthing People - *UCSF, RAMS, Rafiki, Homeless Children's Network*	25% (n<10) of families were connected to mental health services or a higher level of specialized Black perinatal mental healthcare.
Homeless Children's Network MA'AT Program - *UCSF, RAMS, Rafiki*	56% (n=14) of unduplicated clients in need received 12,538 minutes of Ma'at case management services.
Kuumba - *DPH Southeast Child and Family Therapy Center*	This is a new initiative provides culturally relevant community and school-based services around the psychosocial and academic needs of disenfranchised Black/African American families. We expect to have outcome data next year.
Black African American Community Wellness & Health Initiative – *Rafiki Coalition for Health & Wellness (Co-funded by CHEP & B/MHSA)*	100% (n=75) of participants reported an increase in feelings of social connections.
Black African American Community Wellness & Health Initiative - *Bayview Hunters Point YMCA (Co-funded by CHEP & B/MHSA)*	This is a new initiative that links individuals to wellness services (e.g. food insecurity support, peer group support). We expect to have outcome data next year.

Program	FY23-24 Key Outcomes and Highlights
Black African American Community Wellness & Health Initiative – *Booker T Washington (Co-funded by CHEP & B/MHSA)*	100% (n=50) of individuals were connected to mental health care from trusted Black healers and Practitioners.
Asian/Pacific Islander Mental Health Collaborative – *Richmond Area Multi-Services (RAMS)*	97% (n=306) 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=68) of individuals receiving non-clinical case management achieved at least one goal in their case/care plan.
Living in Balance – *Native American Health Center*	100% (n=23) of clients completed a behavioral health service goal.
South of Market Self-Help Center (6th Street) – *Central City Hospitality House*	77% (n=13) of participants achieved at least one case plan goal.
Tenderloin Self-Help Center - *Central City Hospitality House*	62% (n=70) of participants achieved at least one case plan goal.
Community Building Program - *Central City Hospitality House*	81% (n=42) of participants achieved at least one case plan goal.
Homeless Outreach and Treatment Program – *Central City Hospitality House*	100% (n=37) of participants achieved at least one case plan goal.
Population Specific TAY Engagement and Treatment – Latino/Mayan - *Instituto Familiar de la Raza*	97% (n=59) 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*	80% (n=17) of transition age youth receiving case management services successfully attained at least one of their treatment goals.
Population Specific TAY Engagement and Treatment – *LGBTQ+ - SF LGBT Center*	91% (n=10) of transition age youth who received program treatment and healing services demonstrated an intended treatment outcome.
Population Specific TAY Engagement and Treatment – Black/African American – *Larkin Street Youth Services and Third Street Youth Center*	71% (n=112) of transition age youth who were referred for internal or external behavioral health services attended an initial appointment or meeting with a behavioral health provider.
Population Specific TAY Engagement and Treatment – *Juvenile Justice/Others - Huckleberry Youth Programs*	96% (n=26) of transition age youth referred to behavioral health services participated in at least one initial appointment.
TAY Homeless Treatment Team – *Larkin Street Youth Services*	71% (n<10) 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 [20] 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)
- Homeless Children's Network
- Instituto Familiar de la Raza (IFR)

Target Populations

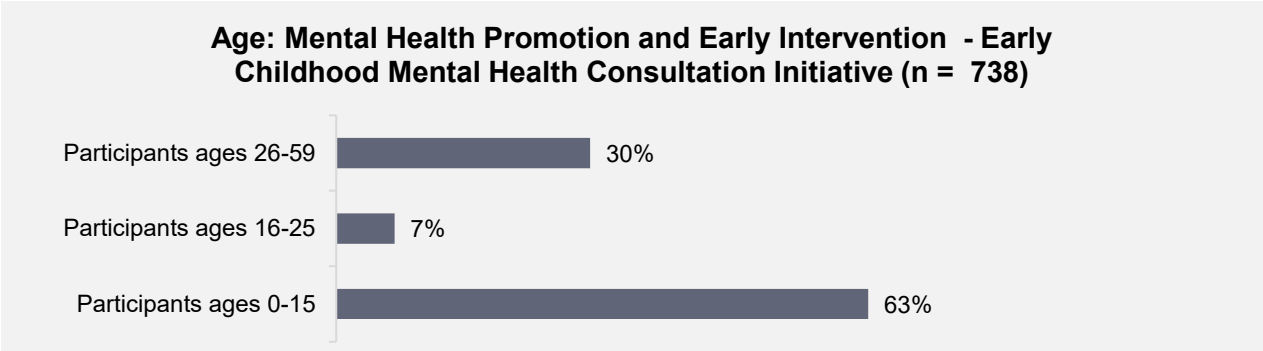
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients and families who experienced trauma, substance use disorders, homelessness, early developmental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

5. Early Childhood Mental Health Consultation Initiative (ECMHCI) - Infant Parent Program (IPP)/Day Care Consultants - *UCSF*
6. Early Childhood Mental Health Consultation Initiative (ECMHCI) - *Edgewood Center for Children and Families*
7. Early Childhood Mental Health Consultation Initiative (ECMHCI) - Fu Yau Project - *Richmond Area Muli-Services*
8. Early Childhood Mental Health Consultation Initiative (ECMHCI) – *Homeless Children's Network*

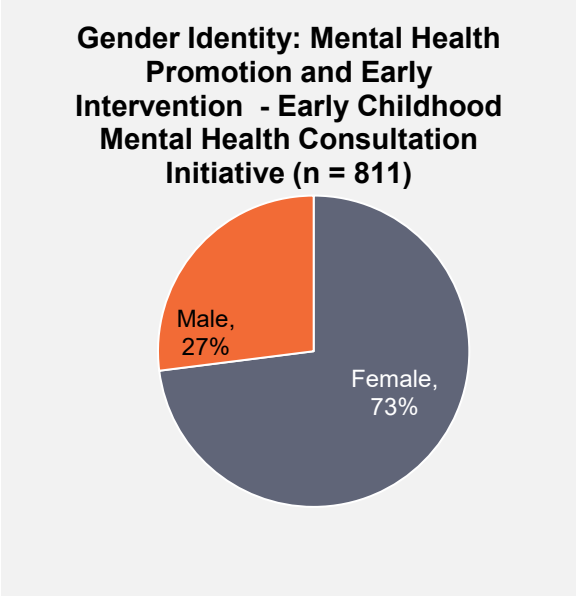
[20] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91

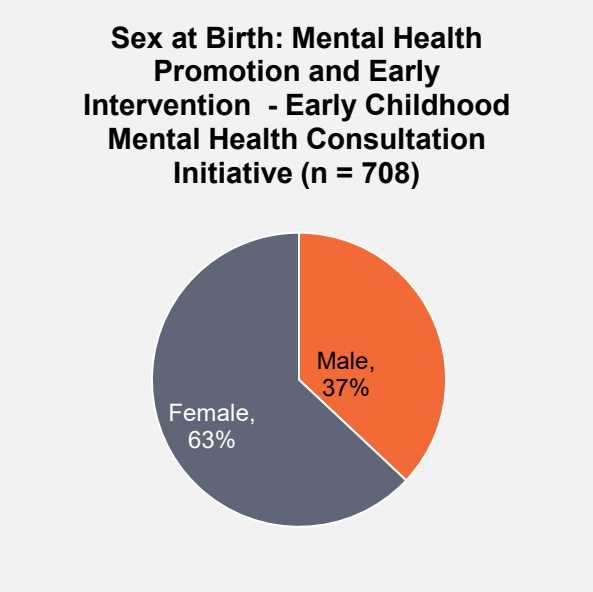
Client Demographics and Outcomes

Demographics: Early Childhood Mental Health Consultation Initiative

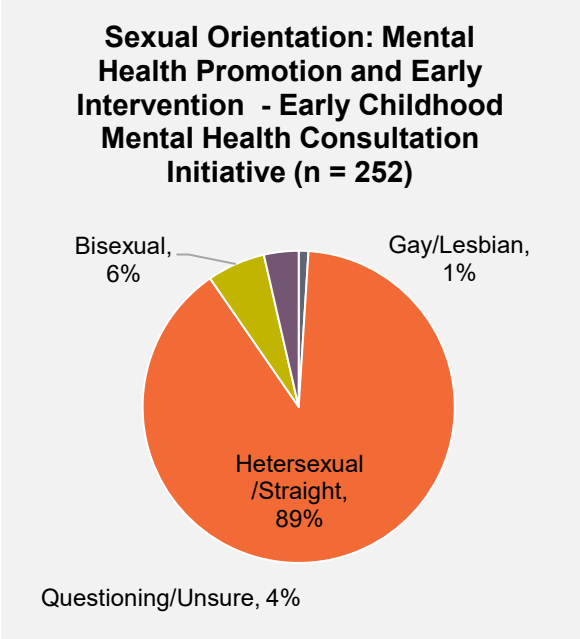


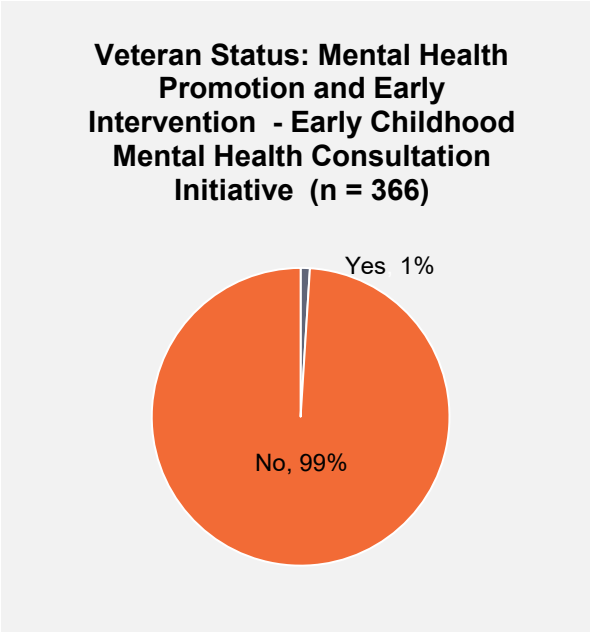
*< 1 percent of participants reported data for ages 60+; Age



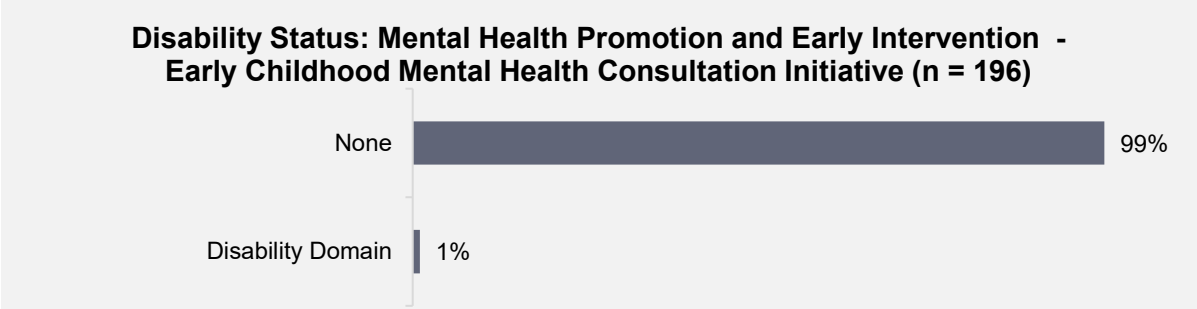


*< 1 percent of participants reported data for Another gender identity not listed, Trans Female, Trans Male; Gender





*< 1 percent of participants reported Another Sexual Orientation; Sexual Orientation



*< 1 percent of participants reported Another Disability, Communication Domain; Disability Status

Race	n	%
Black, African American, or African	509	29%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	286	16%
Native Hawaiian or Pacific Islander	13	1%
White	356	20%
Other Race	583	33%
Total	1,749	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	809	77%
Non-Hispanic/Non-Latina/e/o	146	14%
More than one Ethnicity	99	9%
Total	1,054	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	289	13%
English	1,246	55%
Russian	<10	0%
Spanish	735	32%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	0%
Total	2,282	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	FY23-24 Key Outcomes and Highlights
ECMHCI – *Infant Parent Program/Day Care Consultants*	86% of direct services were provided onsite.
ECMHCI – *Richmond Area Multi-Services*	100% of assigned hours were fulfilled.
ECMHCI – *Homeless Children's Network*	80% of allocated hours were assigned to direct service with sites.
ECMHCI – *Instituto Familiar de la Raza*	100% of assigned hours were fulfilled by the IFR consultant.

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 B/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.

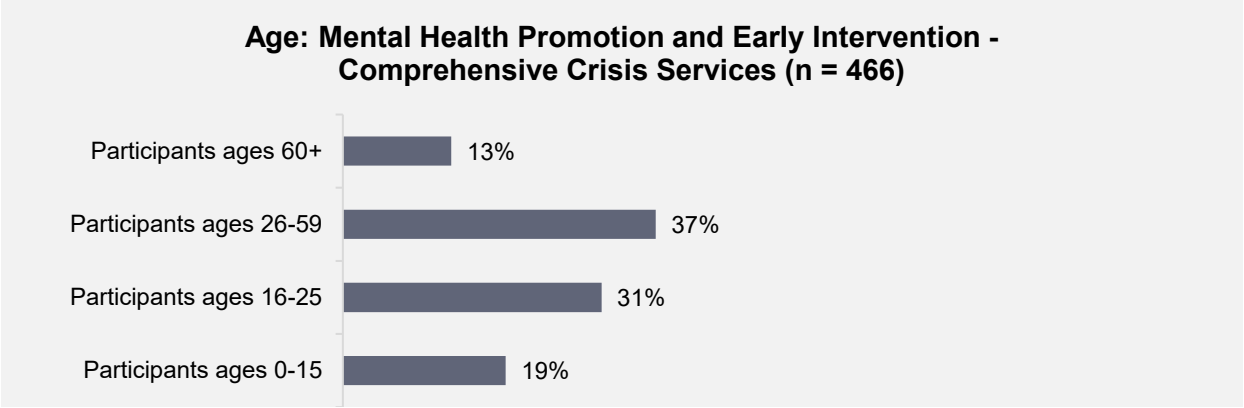
Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Team	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions, & short-term crisis case management for individuals ages 18 years or older.
Child Crisis Team	Offers 24/7 mobile 5585/5150 assessments & 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.

Target Populations

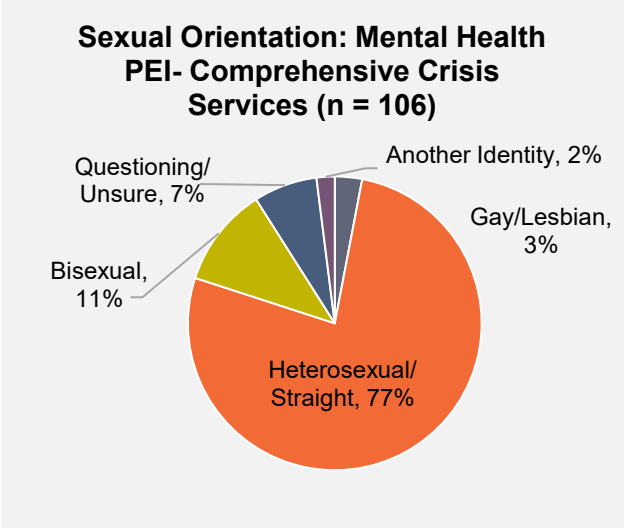
The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and in need of support.

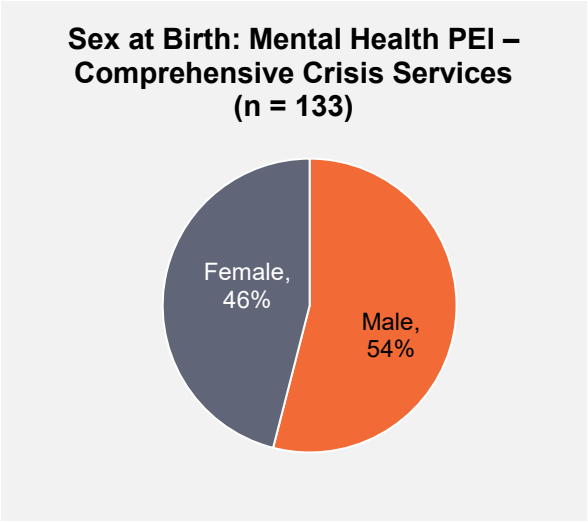
Program Demographics and Outcomes

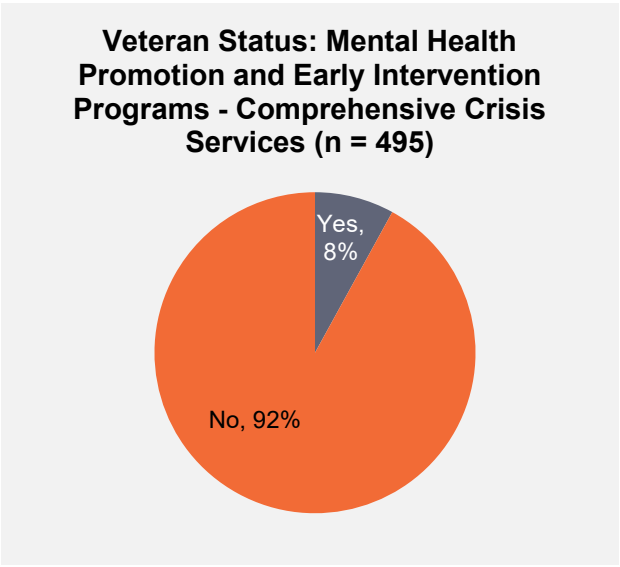
Demographics: Comprehensive Crisis Services[21]

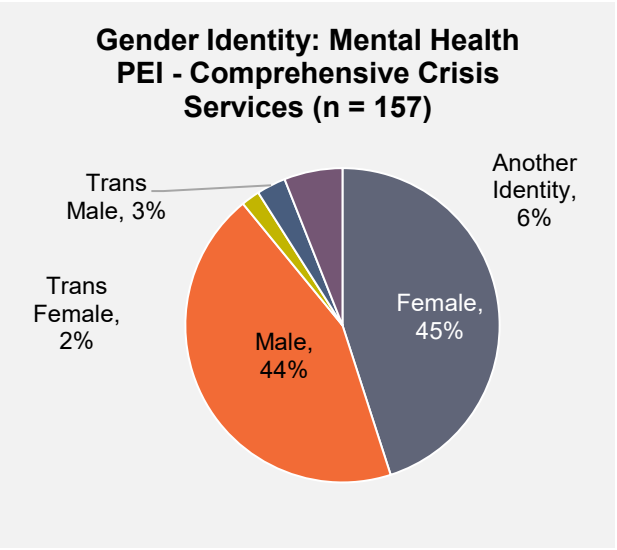


[21] Disability status data was not available for Mental Health Promotion and Early Intervention – Comprehensive Crisis Services.









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

Race	n	%
Black, African American, or African	93	35%
American Indian, Alaska Native, or Indigenous	<10	0%
Asian or Asian American	32	12%
Native Hawaiian or Pacific Islander	<10	2%
White	70	26%
Other Race	68	25%
Total	269	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	56	93%
Non-Hispanic/Non-Latina/e/o	-	0%
More than one Ethnicity	4	7%
Total	60	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	2%
English	232	87%
Russian	<10	0%
Spanish	27	10%
Tagalog	<10	0%
Vietnamese	<10	0%
Another Language	<10	1%
Total	268	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	FY23-24 Key Outcomes and Highlights
Comprehensive Crisis Services (Mobile Crisis, Child Crisis, and Crisis Response) – *DPH*	40% (n=102) 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	Psychosis and Mood Disorder Detection and Intervention	Suicide Prevention Programming	Youth Outreach and Engagement Strategies	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 2024/25 MHSA Funds	Fiscal Year 2025/26 Estimated MHSA Funds	Fiscal Year 2026/27 Estimated MHSA Funds
PEI 1. Stigma Reduction	✓	✓	✓	✓	✓	✓	✓	$ 140,654	$ 140,654	$ 144,029
PEI 2. School-Based Mental Health Pomotion (K-12) (50% Pr	✓	✓	✓	✓			✓	$ 1,551,173	$ 1,570,139	$ 1,614,411
PEI 4. Population Focused Mental Health (50% Prevention)	✓	✓	✓	✓	✓	✓	✓	$ 9,393,880	$ 7,397,241	$ 7,748,413
PEI 5. Mental Health Consultation and Capacity Building (75	✓	✓	✓	✓	✓		✓	$ 1,752,463	$ 2,610,576	$ 3,551,382
PEI 6. Comprehensive Crisis Services (10% Prevention)	✓	✓	✓	✓			✓	$ 1,724,698	$ 1,783,541	$ 1,855,151
PEI 7. CalMHSA Statewide Programs	✓	✓	✓	✓	✓	✓	✓	$ -	$ -	$ 1,832,418

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.

Behavioral/Mental Health Services Act (B/MHSA)

FY23-24 YEAR-END PROGRAM NARATIVE REPORT

July 1, 2023 through June 30, 2024

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

INSTRUCTIONS:

- This program report should include all MHSA-funded activities conducted from July 1, 2023 through June 30, 2024.
- 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.**

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 FY23-24 YEAR-END Report"**

PART 2: PROGRAM NARRATIVE

1. For each of your finalized program objectives for FY23-24, briefly describe your progress using a summary of the data collected.

For example: *Objective: By June 30, 2024, 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 FY23-24 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 23-24:	
TOTAL number of <u>FTEs</u> dedicated for peer employment in FY 23-24:	
TOTAL <u>number of peers</u> employed in those positions in FY 23-24:	

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, 2023 through June 30, 2024

Instructions: This program report should include program participants served by MHSA-funded activities conducted between July 1, 2023 through June 30, 2024. 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, 2024.
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, 2023 through June 30, 2024 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):	

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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:

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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

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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	

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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)	
Indígena (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	

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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, B/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.sf.gov/information--behavioral-health-services-act