



Edwin Lee
Mayor

San Francisco Department of Public Health
Community Behavioral Health Services
1380 Howard Street
San Francisco, CA 94103

MENTAL HEALTH SERVICES ACT



Fiscal Year 2011-2012

ANNUAL PLAN UPDATE

EXHIBIT LISTING AND INSTRUCTIONS

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B	Community Program Planning and Local Review Process
C	Overall Implementation Progress Report on FY 09/10 Activities
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D2	Previously Approved Program – WET
D3	Previously Approved Program – PEI
D4	Previously Approved Program – INN
E	MHSA Summary Funding Request
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San Francisco MHTA FY11-12 Annual Plan Update

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COUNTY SUMMARY SHEET

This document is for the County's use only and is intended to provide direction regarding the exhibits that should be included based on the type of request being submitted (i.e. annual update, update, etc.). This enclosure does not need to be included in an annual update/update request.

	Exhibits																						
	A	B	C ¹	D ²	D1	D2	D3	D4	E	E1	E2	E3	E4	E5	F1 ³	F2 ³	F3 ³	F4 ³	F5 ³	F6 ³	G ⁴	H ⁵	I ⁶
For each annual update/update:	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					<input checked="" type="checkbox"/>														
Component																							
<input checked="" type="checkbox"/> CSS					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> WET						<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input type="checkbox"/>							
<input checked="" type="checkbox"/> PEI							<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input type="checkbox"/>						
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¹Exhibit C is only required when submitting an annual update.
²Exhibit D is only required for program/project elimination.
³Exhibit F1 - F6 is only required for new programs/projects.
⁴Exhibit G is only required for assigning funds to the Local Prudent Reserve.
⁵Exhibit H is only required for assigning funds to the MHSA Housing Program.
⁶Exhibit I is only required for requesting PEI Training, Technical Assistance and Capacity Building funds.

COUNTY CERTIFICATION

County: San Francisco

Components Included:

- CSS WET
- CF TN
- PEI INN

County Mental Health Director	Project Lead
Name: Jo Robinson, MFT	Name: Marlo Simmons, MPH
Telephone Number: 255-3440	Telephone Number: 255-3915
E-mail: jo.robinson@sfdph.org	E-mail: Marlo.Simmons@sfdph.org
Mailing Address: 1380 Howard St., 5 th Floor San Francisco, CA 94103	

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, laws and statutes for this annual update/update, including all requirements for the Workforce Education and Training component. 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.

This annual update has been developed with the participation of stakeholders, in accordance with sections 3300, 3310, subdivision (d), and 3315, subdivision (a). The draft FY 2011/12 annual update was circulated for 30 days to stakeholders for review and comment and a public hearing¹ was held by the local mental health board of commission. All input has been considered with adjustments made, as appropriate.

The County agrees to participate in a local outcome evaluation for the PEI program(s) identified in the PEI component.²

The County Mental Health Director approves all Capital Facilities and Technological Needs (CFTN) projects.

The County has complied with all requirements for the Workforce Education and Training component and the Capital Facilities segment of the CFTN component.

The costs of any Capital Facilities renovation projects in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct.

All documents in the attached FY 2011/12 annual update/update are true and correct.

Jo Robinson, MFT
Mental Health Director/Designee (PRINT)

 2-22-12
Signature Date

¹ Public Hearing only required for annual updates.

² Counties with fewer than 100,000 residents, per Department of Finance demographic data, are exempt from this requirement.

**COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS**

County: San Francisco

30-day Public Comment period dates: 3/1/2011-3/31/2011

Date: 2/22/11

Date of Public Hearing (Annual update only): 4/13/2011

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update/update per Title 9 of the California Code of Regulations, sections 3300 and 3315.

Counties may elect to attach the Mental Health Board meeting minutes in which the annual update was discussed if it provides additional information that augments the responses to these questions.

Community Program Planning	
1.	<p>Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2011/12 annual update/update. Include the methods used to obtain stakeholder input.</p> <p>The FY11-12 Annual Plan Update developed provides the same amount of funding for all components as FY10-11. These programs were identified in the component plans and implemented through a competitive contractual process. It was posted on our website for 30 day public review and comment from March 1, 2011 to March 31, 2011. It was discussed with the MHSA Advisory Committee at their bi-monthly meeting held on February 16, 2011. The annual plan update was also discussed with MHSA funded agencies in their monthly meetings in February 2011. Other stakeholders were notified by email and a public notice posted in the San Francisco Chronicle. (State if there were comments received and if the comments were substantive to require action).</p> <p>Simultaneous with the 30 day public review and comment, the FY11-12 Annual Plan Update was submitted to the Health Commission and Board of Supervisors for their support and approval. Note dates here</p> <p>The Following the 30 day public comment and review period, a public hearing was conducted by the Mental Health Board on April 13, 2011. (State if there were comments received and if the comments were substantive to require action).</p>
2.	<p>Identify the stakeholder entities involved in the Community Program Planning (CPP) Process. (i.e., name, agency affiliation, population represented, age, race/ethnicity, client/family member affiliation, primary language spoken, etc.)</p> <p>The following were involved and appraised of the FY11-12 Annual Plan Update: Health Commission, Board of Supervisors, MHSA funded agencies, MHSA Advisory Committee, and the Mental Health Board. Members of the public and other stakeholders were notified by email and a public notice posted in the local newspaper.</p> <p>MHSA Advisory Committee – comprised of individuals representing various community-based organizations providing behavioral health and social services, consumer and family advocacy groups, residential care committee, educational institutions, housing, labor union, CBHS, and an interested citizen/student. Five of the twenty-four member committee have identified as consumers of mental health services.</p> <p>Mental Health Board – a 17 member board appointed by the Board of Supervisors; there are currently 6 vacant board member seats. Of the 11 active members, 2 are identified consumers and 5 are family members.</p>

**COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS**

3. If consolidating programs or eliminating a program/project, please include how the stakeholders were involved and had the opportunity to participate in the decision to eliminate the program/project.

Local Review Process

4. Describe methods used to circulate, for the purpose of public comment, the annual update or update.

The FY11-12 Annual Plan Update was posted on the DPH public website for public review and comment, wherein members of the public were requested to submit their comments either by email or by regular mail. It was circulated by email to approximately 600 community based mental health organizations, substance abuse organizations, housing agencies, prevention agencies, community and primary care clinics, consumer groups, and advocacy groups. A public notice was also posted in the local newspaper on [insert date published here].

5. Include substantive comments received during the stakeholder review and public hearing, responses to those comments, and a description of any substantive changes made to the proposed annual update/update that was circulated. The County should indicate if no substantive comments were received.

INCLUDE COMMENTS HERE

**OVERALL IMPLEMENTATION PROGRESS REPORT
ON FY 09/10 ACTIVITIES**

County: San Francisco

Date: 2/22/2011

Instructions: Welfare and Institutions Code section 5848 specifies that DMH shall establish requirements for the content of the annual update and updates including reports on the achievement of performance outcomes for services. Provide an update on the overall progress of the County's implementation of the MHSA including CSS, WET, PEI, and INN components during FY 2009-10. NOTE: Implementation includes any activity conducted for the program post plan approval.

CSS, WET, PEI, and INN

1. Briefly report on how the implementation of the MHSA is progressing: whether implementation activities are generally proceeding as described in the County's approved Plan, any key differences, and any major challenges.

Please check box if your county did NOT begin implementation of the following components in FY 09/10:

- WET
 PEI
 INN

Generally, CSS, WET, and PEI implementation activities proceeded as described in the individual approved plans, with some minor revisions for some programs within these components.

FY09-10 coincided with the five year anniversary of the enactment of MHSA, which occurred in January 2005. San Francisco made plans to publish a report of the progress of MHSA initiatives implemented since FY05-06. Keeping in mind that the CSS component was the only component that had been funded and implemented and robust data had been collected in the Data Collection and Reporting (DCR) system, the initial five year report was steered towards the implementation progress of the full service partnership programs. It was also decided to follow the FSP report with general system development and MHSA Housing implementation progress reports. A questionnaire was developed to request information from all CSS funded programs on the successes, challenges, benefits, and short-comings of MHSA funding, as well as the programs' adherence to the principles of the Act. Programs were also requested to provide vignettes that highlight the impact of MHSA on the lives of clients served. The questionnaires were distributed and completed in March 2010. Data from the DCR were extracted and analyzed to come up with outcomes in major life domains tracked through this system: financial, residential, and education. Service data were also analyzed to come up with primary diagnoses and co-occurring substance abuse status of FSP clients. By the end of FY09-10, data collected were very preliminary and data analysis continued well into the following fiscal year.

Start up programming for WET and PEI initiatives began in FY09-10 following a competitive process brought about by the release of a Request for Proposal on June 19, 2009. Twenty agencies were awarded contracts for eleven PEI programs and five WET programs. In addition, funding for one civil service operated crisis response team and two agencies delivering trauma and recovery services were moved from CSS to PEI as indicated in the PEI plan as these programs are more aligned to prevention and early intervention rather than treatment services. Services for all these newly funded and newly transferred programs between October 2009 and April 2010.

The Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations and requesting for budgeted positions and developing job descriptions for programs selected to be implemented by the County.

Finding safe and affordable housing outside of the Tenderloin and within desirable neighborhoods continue to be a challenge for housing partners funded through CSS. Moreover, some FSP clients were not able to meet eligibility requirements at two buildings wherein MHSA units were contracted due to their past criminal histories. This prompted CBHS to re-look at the housing contracts and renegotiate for additional sites that would give reasonable accommodations to the FSP clients' criminal histories. These new units would come on board in FY10-11. Consumer employment also presented challenges to CSS programs especially in the area of supervision and retention. All programs acknowledged the benefits of consumer employment in that it enhanced consumers' self-esteem, provided programs with resources to provide meaningful supports through the lens of someone who has had similar experiences as the clients, and helped alleviate stigma around mental illness. But the demands of the job brought on triggers that spun into relapses for some

**OVERALL IMPLEMENTATION PROGRESS REPORT
ON FY 09/10 ACTIVITIES**

and affected work performance and increased absenteeism for others. Supervision became more labor intensive than anticipated and continues to test programs to come up with the appropriate balance of support and expectation.

Implementation of WET initiatives progressed smoothly except for one agency, San Francisco State University (SFSU). Because SFSU has not had a contract with the City and County of San Francisco in the past, it took a long time to get this agency certified as a city vendor. As a result, no contract was awarded to this agency in FY09-10. The Program Coordinator pushed forward with getting this program off the ground with resolute determination despite the absence of city funding. Through the Program Coordinator's determination, an advisory board was created, preliminary recruitment of program personnel was attained, program informational materials were designed, and design drawings for the renovation of the student resource center was developed.

PEI programs moved forward with some hiccups along the way. The expansions of the school based wellness and the older adult behavioral health screening programs were not carried out. The school based wellness center was expected to be expanded to ten more schools. The older adult behavioral health screening was projected to include the clinics within the local consortium and other adult and senior community based centers. The implementation of the older adult behavioral health screening was fraught with difficulty with the identified partner that would have referred potential hires for placements, HIPAA compliance, and the unresponsiveness of other partners. In the end, both programs did not undergo the planned expansion because of lack of sufficient time for planning and the subsequent release of MHSA revenue projections, which were anticipated to significantly reduce in the coming two years. Expansions would have been unsustainable given these new revenue projections.

PEI programs served over 11,000 people in FY09-10. 4,429 people were served through Individual Encounters, consisting of outreach and drop-in services. 3,946 people were served through Group Activities, including workshops, trainings, and support Groups. 3,160 people were served through Large Community Events: cultural Events as well as celebrations. Demographic data of the total individuals served across all PEI programs is shown in the table on the following page. We are still working on data collection regarding LGTBQ and Veterans cultural groups.

The erosion of state general fund supports for mental health and social services, attempts to reassign these obligations to MHSA and the continued economic slump threatens the availability of MHSA revenues as a source for expansion of local mental health services and stability of MHSA funded programs, and increases the burden of local public mental health programs to serve more clients who have lost insurance coverage along with their jobs. San Francisco prides itself as one of the counties that immediately implemented CSS programs, thus limiting the availability of prior year unspent funds to tide through the coming years of decreasing MHSA revenues. As it stands now, local MHSA programs are projected to be sustainable for only two more years with the help of unspent funds. Beyond these years, San Francisco would have to redesign these programs to better meet the needs identified in each component and to deliver these services more cost-effectively.

2. During the initial Community Program Planning Process for CSS, major community issues were identified by age group. Please describe how MHSA funding is addressing those issues. (e.g., homelessness, incarceration, serving unserved or underserved groups, etc.)

CSS programs have been in operation since FY05-06. Programs identified in the CSS Plan were implemented as described in the plan so as to adequately address the issues highlighted in the planning process and meet the needs of the un-served and underserved groups.

The two CYF FSPs focus on ensuring that children with serious emotional disorders stay with their families or not placed in restrictive group settings. Included in the FSP are the services of the Family and Youth Involvement team who assist parents and youths navigate the complicated web of children and family services and a stress reduction program to improve the mental and physical health of families located in the south east sector of the city, which has a large number of low income residents. The CYF GSD programs provide: (1) integrated behavioral health and primary care services located in Chinatown to best address the behavioral needs of Asian families with autistic children; (2) enhance the capacity for culturally appropriate services located in the outskirts of the Tenderloin to Asian children and early adolescents especially those who have gender-specific issues; and (3) outreach and engagement services to prepare for the coming PEI programs in schools.

The two TAY FSPs focus on youths ageing out of foster care and children's' protective services, and homeless and runaway youths. Included in the TAY FSP is funding for rental subsidies for 12 units of housing in single room occupancy hotels and two shared single family houses. The TAY GSD programs provide: (1) integrated behavioral health services in a community clinic and the Juvenile Justice Institute; (2) 12 units of transitional residential housing for homeless youths not receiving mental health services through the FSPs; (3) supportive services for housing to help youths obtain and maintain

**OVERALL IMPLEMENTATION PROGRESS REPORT
ON FY 09/10 ACTIVITIES**

housing; and (4) peer based center that engages youths in socialization and positive recreational activities, as well as link them to employment opportunities. Included in the TAY GSD is GSD Housing funds to renovate a privately-owned building that would eventually house 40 youths via a master lease. This soon to be renovated building will centralize current GSD services in one site and will alleviate the dearth of housing available to youths.

Two adult FSPs focus on serving the homeless, one on residents of the Tenderloin where most of the low-income single room occupancy hotels are located and where most co-occurring clients tend to congregate, and one on clients with criminal justice involvement and have been mandated to receive mental health services by the behavioral health court. Also included in the FSP is funding for rental subsidies for 23 permanent housing (2 of which were emergency stabilization units that were converted to permanent housing at the request of the clients), 1 client in a skilled nursing facility, and 30 emergency stabilization units available for 90 days wherein clients could stabilize, establish residency, and secure all necessary documentation needed for permanent housing applications. Also included in the FSP is funding for a mobile wellness and recovery team that provides peer-to-peer services at clinics, single room occupancy hotels, and community based mental health provider sites. The adult GSD funds the following: (1) Behavioral Health Access Center (BHAC) located in the South of Market area, that provides centralized referral and linkage to mental health and substance abuse services, onsite pharmacy, and onsite opiate clinic; (2) two peer based centers, strategically located in the Tenderloin and Sixth Street corridor, neighborhoods with large numbers of homeless and individuals with multiple co-occurring disorders, that provide havens for homeless adults, low-threshold engagement activities, brief behavioral health services, and alternative relaxation activities; (3) residential treatment for dually-diagnosed individuals who are not eligible for MediCal; (4) supportive services for housing to help adults maintain and retain housing; and (5) vocational rehabilitation services to assist adults not linked to case management services with job readiness, job development and placement, and job coaching.

The Older Adult FSP serves seriously mentally ill seniors who have declining cognitive and physical abilities. Included in the FSP is funding for rental subsidies for 5 permanent housing units. Older adults also have access to the 21 permanent housing and 30 emergency stabilization housing funded through the Adult FSPs whenever available or when they become vacant. The older adult GSD funds the following: (1) integrated behavioral health services at primary care clinics; (2) supportive services for housing to help seniors maintain and retain housing; and (3) peer based center for socialization and recreational activities in a welcoming environment.

PEI

1. Provide the following information on the total number of individuals served across all PEI programs (for prevention, use estimated #):

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	3049	White	493	English	1983	LGBTQ	6
Transition Age Youth (16-25)	1085	African American	1314	Spanish	519	Veteran	
Adult (18-59)	1426	Asian	1052	Vietnamese	37	Other	
Older Adult (60+)	77	Pacific Islander	165	Cantonese	356		
		Native American	183	Mandarin	21		
		Hispanic	1179	Tagalog	3		
		Multi	114	Cambodian	0		
		Unknown	85	Hmong	0		
		Other	143	Russian	6		
				Farsi	0		
				Arabic	0		
				Other	470		

**OVERALL IMPLEMENTATION PROGRESS REPORT
ON FY 09/10 ACTIVITIES**

2. Provide the name of the PEI program selected for the local evaluation¹. N/A

PEI 4 – Holistic Wellness Promotion in a Community Setting

PEI Statewide Training, Technical Assistance, and Capacity Building (TTACB)

1. Please provide the following information on the activities of the PEI Statewide Training, Technical Assistance, and Capacity Building (TTACB) funds.

Activity Name; Brief Description; Estimated Funding Amount²

Target Audience/Participants³

1. Peer Outreach and Training - Sharing Our Lives: Voices and Experiences (SOLVE) officially began on November 1st, 2009. This program aims to increase the public's understanding of mental illness and to improve the capacity of behavioral health providers to deliver appropriate services and to implement consumer-run education that reduces stigma and focuses on recovery. SOLVE Speakers Bureau will consist of 15-20 Peer Educators who have completed the Mental Health Association of San Francisco's (MHA-SF) anti-stigma training curriculum which consists of 8 hours of formal training on public speaking and presentation skills related to anti-stigma education. These Peer Educators will also have the option to participate in a facilitated support group (to meet 12 times a year) designed to ensure that they are supported and that presentations are improved along the way.

In its first year, SOLVE was very successful, reaching over 600 members of the community at 36 presentations.

SOLVE Peer Educators represent the diversity of San Francisco as well as the complexity of mental illness. Peer Educators spoke on their experience with Schizophrenia, Depression, Bi-Polar Disorder, Borderline Personality Disorder, Obsessive Compulsive Disorder, and Dissociative Disorder. Peer Educators were asked to make an 8 month commitment to the program, and as of the end of the reporting period, no one had reached the 8 month period. However, almost all of the Peer Educators stated a desire to stay in the program past 8 months. SOLVE Peer Educators, under the direction of the Director of Programs and Training, gave 34 presentations over the reporting period and reached 602 individuals. Presentations were given to a wide variety of audiences.

MHA-SF's Mental Health Advocate will conduct a monthly support group for consumers working at CBHS (Community

The Mental Health Association of San Francisco was awarded this contract. SOLVE targets behavioral health consumers in recovery living productive lives who will serve as Peer Educators. Geographically, SOLVE will target communities that are severely under-served or traditionally susceptible to stigma, and therefore less likely to access support for prevention and recovery, including the Tenderloin, Mission, Bayview/Hunter's Point, Excelsior, Chinatown, and Visitacion Valley. SOLVE will work with community centers, religious institutions, and schools in each of these areas to deliver culturally-specific neighborhood-based presentations and provide linguistically appropriate referral materials.

Some of the venues that received presentations by peer educators of the SOLVE program include:

- Glide Memorial Foundation - Case Managers and Clinicians
- Supportive Housing Employment Collaborative (SHEC)
- Tenderloin Housing Clinic - Both Support Services and a series of trainings for all Property Management staff)
- Wells Fargo - Financial Analysts
- Chinatown Community Development Corporation
- San Francisco State University – students of the Introduction to Counseling Course
- University of California at San Francisco - First year medical students
- Trauma Recovery Center - Staff clinicians and psychologists
- La Casa de las Madres - One training for staff and one for consumers
- Ida B. Wells High School - Four trainings for all students in high school
- Jewish Home of San Francisco - Clinicians and Housekeeping Staff
- Jail Psychiatric Services - Clinicians

¹ Note that very small counties (population less than 100,000) are exempt from this requirement.

² Provide the name of the PEI TTACB activity, a brief description, and an estimated funding amount. The description shall also include how these funds support a program(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities.

³ Provide the names of agencies and categories of local partners external to mental health included as participants (i.e., K-12 education, higher education, primary health care, law enforcement, older adult services, faith-based organizations, community-based organizations, ethnic/racial/cultural organizations, etc.) and county staff and partners included as participants.

**OVERALL IMPLEMENTATION PROGRESS REPORT
ON FY 09/10 ACTIVITIES**

<p>Behavioral Health Services) and will also be available as part of an Employment Assistance Program (EAP) for peer and consumer workers at CBHS. Finally, the Mental Health Advocate will provide at least 2 trainings on the Mental Health Services Act during the year to members of the support group.</p> <p>The Mental Health Advocate provided a support group for implementation specialists at CBHS (Community Behavioral Health Services). This is a confidential group, so sign-in sheets are not kept to protect workers' confidentiality. The group was held on the following dates during the reporting period:</p> <ul style="list-style-type: none"> • January 21st, 2010 (6 attended) • February 18th, 2010 (6 attended) • March 18th, 2010 (7 attended) • April 22nd, 2010 (8 attended) • May 20th, 2010 (7 attended) • June 17th, 2010 (7 attended) <p>The estimated funding for this program combines PEI, WET, and PEI Statewide TTACB for a total of \$194,600. The breakdown of the funding by component is as follows: \$119,600 in PEI Statewide TTACB; \$50,000 PEI, and \$25,000 WET</p>	<ul style="list-style-type: none"> • Edgewood Center for Children and Families • Senior Action Network - Community meeting of seniors • Numerous other agencies and community presentations
<p>2.</p>	
<p>3.</p>	
<p>4.</p>	

**PREVIOUSLY APPROVED PROGRAM
Community Services and Supports**

C. Answer the following questions about this program.

1. Briefly report on the performance of the program during FY 09/10 including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities.

All MHSA CSS programs have adopted similar strategies to reach the un-served and underserved populations and reduce ethnic and cultural disparities. For MHSA clients, culture is not solely limited to racial and ethnic groupings, it could also be the social norms of particular groups of people these clients identify with, be they socio-economic class, gender identity, or homelessness. These strategies include: (1) hiring a diverse staff who understands the “culture” of the clients they serve; (2) hiring consumers and family members who have had similar experiences as the clients they serve and could serve as role models, build trust and establish rapport with difficult to engage clients; (3) participating in culturally relevant trainings to gain more skill and insight of specific groups; (4) doing “whatever it takes” to meet the clients where they are at geographically and in terms of their readiness in engaging in services.

Full Service Partnerships

Family Mosaic Program (FMP) – the program has continued with its original design of providing case management and wraparound services to clients who do not have MediCAL insurance and would not otherwise be served by this program without MHSA funding. FMP provides wraparound services such as tutoring for youth and parent education for the care givers, as well as mental health services. Family Mosaic operates at three sites that have large numbers of low income families: Bayview neighborhood which is predominantly African American and Asian; Mission neighborhood which is predominantly Latinos, and Chinatown which is predominantly Asian. This change in venue has allowed the program to extend their reach and serve clients beyond the Bayview neighborhood, thus enhancing their ability to provide services to un-served or underserved populations and other cultural and ethnic groups.

Hiring Diverse Staff - FMP reports having 2 African American and 1 Spanish Speaking case managers in their treatment staff.

Hiring Consumers/Family Members - Family Mosaic Project has initiated a pilot project jointly with a vocational training agency to provide paid work internships for older adolescents who are ready to transition out of the program. These internships are located typically in administrative offices of large agencies, such as the health department. A few clients have been placed for 3-4 month paid internships. These work internships can be a constructive way to help youth to consolidate their mental health gains and transition out of intensive case management program.

Training - FMP staff participated in cultural competency trainings, which included topics such as: Cultural Issues in CANS; Legal and Ethical Issues in providing mental health and substance abuse services in a multi-cultural settings; cultural issues in using the recovery model and harm reduction; supportive services for parents/caregivers of LGBTQ youth; and Multi cultural issues and services for sexually exploited person.

Whatever It Takes Approach – For FMP, whatever it takes means being flexible in making arrangements to meet with clients. Care Managers meet with clients at home, at school and after regular program hours as needed. Also, they are willing to perform tasks that are not within their normal job descriptions if it will be helpful to the client. For example, one care manager went to a client’s home and helped to clean out accumulated trash.

Seneca Connections – serves children and adolescents up to 18 with challenging behaviors in high level group homes and work with them to get them to live in a family setting. Among the service array that has been built in collaboration with county staff over the past three and one-half years are Intensive Support Services, Rapid Response, Family Finding, Supervised Visitation and Parent Partners.

Hiring Diverse Staff - Seneca has pursued recruitment through websites such as HispanicJobs.com, Asian-jobs.com, SanFranciscoDiversity.com and HBCUConnect.com (Historically Black Colleges and Universities in their effort to hire a diverse treatment and supportive services staff. They have also attended the following job fairs which are designed to promote a diverse work force: UC Berkeley – Diversity Job Fair (yearly), UC Santa Barbara – Diversity Job Fair (yearly) and Oakland Social Service Agency. They are on the mailing list for events in Historically Black Colleges and Universities that have MSW programs and have sent flyers and have visited or posted positions with the following universities: Bowie State University, Maryland, Towson University, Maryland, Temple University, Pennsylvania, and Jackson State University, Mississippi. As a result of these expanded recruitment strategies, the racial and ethnic backgrounds of staff working in the SF Connections programs over the past year are as follows: African American - 7.4%, Asian - 8.7%, Caucasian - 61.7%, Hispanic - 9.4%, Hawaiian/Pacific Islander - 2.0%, Native American/Alaskan - 1.3%, and Multi-Racial - 9.4%.

Hiring Consumers/Family Members - Seneca employs four Family Partners, who are parents and caregivers who have lived the experience of caring for someone

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with mental illness/severe emotional disorder and managed to navigate the system and then be able to use their experiences in the service of others.

Training - Seneca staff participated in the following trainings: How Cultural Issues Impacts the Supervision and Care of Youth; Best Practices in Cultural Competency; and Cultural Competency for Youth Placed in Intensive Treatment Foster Care

Whatever It Takes Approach - Seneca Center's practice philosophy of "unconditional care" aligns perfectly with the MHSA philosophy of "whatever it takes." Seneca Center sustains children and families through the most difficult times of their lives. In many cases, Seneca is the last hope for young people who have come to see failure and discouragement as a way of life. Seneca Center offers each child a simple but profound promise: You will be supported every step of the way, no matter what challenges you face. By supporting each child and family in identifying and building upon their resources and strengths, the program enables them to approach the future with renewed optimism and a stronger sense of the possibilities for creating a new and different story for their lives.

Included in the FSP is the Family and Youth Involvement Team (FYIT) which assists clients from Family Mosaic Project and the Children's System of Care navigate the network of services available to children, youth, and families.

Hiring Consumers/Family Members - FYIT has been fortunate to have the assistance of the Office of Cultural Competence and Client Relations within Community Behavioral Health Services partner with them as a placement site for consumers in the Peer Internship Program.

Training - FIT has sent staff to cultural sensitivity trainings on various topics such as: Trauma Focused and Community Violence; LGBTQ; African-American; API

Whatever It Takes Approach - For the Family and Youth Involvement team, whatever it takes signify thinking "outside of the box." Digital Storytelling is such case in point. Digital Storytelling is an intervention that not only addresses trauma but also allows for healing as well. Exploring promising practices as well as implementing evidence based practices is one interpretation of whatever it takes. Providing services in the community or where the client would like services as opposed to meetings only occurring in the office and supplying extensive outreach are other ways that the program ensures that due diligence has been conducted.

General System Development - funds one agency to enhance cultural competent services to API LGBTQ and behavioral health and primary care integration of services for autistic children. Trauma and Recovery services as well as the Wellness Center at the School of the Arts, initially funded through CSS, were continued for three months with GSD funding and moved to Prevention and Early Intervention (PEI) since these programs are more aligned with local PEI initiatives.

Chinatown North Beach Clinic and Chinatown Community Development Center - targets children identified within Asian families, ages 2 to 18, previously unidentified or identified but underserved, who, upon assessment, are found to have diagnoses of Autism or Pervasive Developmental Disorder. However, what began as a program that was originally focused on serving only children/youth with autism has expanded to services to children/youth with co-occurring disorders or other disabilities requiring similar treatment and follow-up. The integrated clinic staffing of this program includes a nurse practitioner, pediatrician, and child psychiatrist who speak the native languages of their clients and have special sensitivity and understanding to their clients' special medical and mental health needs and experience. They credit their long-established relationship with the community of Asian immigrants as the main factor for the success of their program and believe their roster of clinicians is unrivaled in the entire City and County of San Francisco.

Community Youth Center - was funded to Increase community resources & access to services & early identification for API youth & LGBTQ youth; increase numbers of A&PI youth to access early intervention services, especially those who are demonstrating symptoms of SED and other MH disorders and increase participation of youth & their families in peer-led activities & other support services. Being an Equal Opportunity organization, CYC has had a great deal of experience in recruiting and hiring individuals from underserved and un-served ethnic, racial and cultural communities. Since their organization focuses on Asian & Pacific-Islander communities, their staff has naturally represented ethnic minority groups.

Outreach and Engagement - funds two agencies to improve the mental and physical health of southeast sector residents, including Bayview Hunters Point, through leadership building, stress management activities and self help groups, nutrition and healthy eating education, and participation in physical activities and alternative healing practices. Five agencies were funded to outreach to schools and their communities to inform and engage them in the PEI planning efforts

Black Coalition on AIDS - was funded to improve the mental and physical health of southeast sector, a neighborhood that has a high number of low income residents impacted by community violence, with resulting chronic health problems, post-traumatic stress syndromes and sub-clinical depression. The program reports that about 80-90% of the staff and consultants are from underserved or un-served groups and that they have proven to be very committed and empathetic

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to the needs of the community members that attend its program. BCOA aspires to MHSA’s philosophy of “whatever it takes” by offering programs or activities that are very eclectic *and* geared to its specific clientele, to get them interested and engaged in stress reduction. For example, varied classes include yoga, line dancing, drumming and Soul Chi, (soulful movement).

Each of the programs funded to do school outreach have more than a decade of experience working with special education children with serious emotional disorders and in hiring diverse staff. One agency serving Latinos, **Horizons Unlimited**, have had a challenging time finding candidates that mirror its community & clients, most especially males who could be strong role models for other young men and women. Because of previous criminal histories, these young men find it difficult to get work and this in turn leads to a sense of disempowerment and results in low self-esteem. In contrast, **Edgewood** reports a diversified team with language capacities in Spanish, Cantonese, Mandarin, Thai, Cambodian, and Hindi. Another agency, **Richmond Area Multi Services Inc.**, reports that it actively recruits individuals from underserved communities but despite its effort, receive limited applicant pool from such communities. Once this agency is able to hire such staff, it provides supervision, mentorship, and other supports necessary to help retain these employees. And since this agency was also awarded the WET contracts for the Summer Bridge and Peer Counseling Certificate programs, it is able to recruit at an earlier level from these programs.

2. Describe any key differences and any major challenges with implementation of this program as a result of the fluctuation in MHSA funding and overall mental health funding.

CYF mental health experienced drastic cuts in services especially for children in special education classes and the federally mandated EPSDT program. These cuts, though not funded by MHSA, has had significant impact on MHSA as the only source of revenue that has been sheltered from diminishing state and local general funds. Plans from the state level to reassign MHSA to help with general fund deficits only serve to reduce mental health services that were put in place prior to MHSA. This leaves counties, including San Francisco, with recognizable service gaps for children, youth and families. San Francisco has done its best to maintain services funded through MHSA and services that were in existence prior to the enactment of MHSA. Some of these pre-existing services have been redesigned to match the principles of MHSA and continued with MHSA funding. As a result of funding reductions, CYF agencies have had significant challenges connecting their clients to outpatient services, transitioning clients to the adult system of care, and the lack of language assistance and capacities of other community agencies they have connected.

Family Mosaic Project, a full service partnership program, states that stepping MHSA clients down from Full Service Partnership services to a lower level outpatient care is problematic due to the paucity of outpatient services for which their clients can qualify.

Chinatown North Beach Clinic and Chinatown Community Development Center – has notably commented that absence of any other funding line to support resources for families they serve has been one of their major challenges. This falls, mainly, into three areas. The Disabilities Access Clinic is squarely aimed at serving a previously un-served but needy population of Asian-language speaking immigrants. Even with the unprecedented flexibility of MHSA’s funding, they were not able to put together funding sources (even considering blending funding) to fill the gap required to get behavioral consultants who could help train our parents to work with their children in their native language. This appears to be a by-product of the ceiling set on “vendor” or contracts fees by one of its lead partners (Golden Gate Regional Center) and the compensation required to attract these hard-to-find personnel to cross the Bay to work with their patients. Secondly, the aggression and violence experienced by families, as well as the level of stress that living with a seriously disabled child brings, means that many of parents are quite stretched. However, MHSA funding does not allow the program to take on the parents as the primary client---and sometimes, in retrospect, that is what would have made a bigger difference. Finally, the age restriction on the delivery of services to clients means that clients experienced an “aging out” of the children’s system. As they age out (leave the special education system/graduate/become adults), staff has had to leave their care to others, Not surprisingly, the adult primary care or mental health systems neither have the necessary resources to deal with the most difficult clients transitioning out of this program. The one possible adult referral, the “Anchor Project”, recently lost its director and has been re-staffed with personnel (based on seniority bumping) far less familiar with the needs and problems of this population. Ironically, when it was originally set up, the Anchor Project clinic was set up specifically because adult patients with special needs had become such high, repetitive---and therefore, expensive---users of emergency room services across the City---the least appropriate and effective place for them to receive services.

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Community Youth Center found that language assistance and capacity in other program services they connect with as their biggest challenge. Most of its clients are first-generation Americans, which makes their parents mostly immigrants to this country. Because they work with many monolingual families, the lack of language capacity in other agencies requires a lot more of their staff time to accompany family members to parent conferences at school, register them for government programs, and all other services these families need from other agencies. In their experience, they have not found a clinician who speaks Samoan. Therefore, they do not have the appropriate capacity to deal with some of the mental health issues that youth experience. **Richmond Area Multi-Services Inc.** echo the same concern and worry that some traditional service providers may “give up” on clients that are considered difficult to engage rather than explore the source of difficulty or provide flexibility in service provision.

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Is there a change in the service population to be served?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
2) Is there a change in services?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3) a) Complete the table below:	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>						
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<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?							
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.							

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F1.

A. List the estimated number of individuals to be served by this program during FY 11/12, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth	380	480	1,017	\$3,805
TAY				
Adults				
Older Adults				
Total				

Total Estimated Number of Individuals Served (all service categories) by the Program during FY 11/12: 1,877

NOTE: Family and Youth Involvement team is budgeted as part of FSP but reported as outreach and engagement because none of the clients served by this team are entered in DCR to avoid duplication (for FSP clients).

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<p>B. Answer the following questions about this program.</p>
<p>1. Provide a description of your previously approved program that includes the array of services being provided. Also provide information about targeted age group, gender, race/ethnicity and language spoken by the population to be served.</p>
<p>Two full service partnerships (FSPs) were funded for the children, youth and family age group. The full service partnerships work with children and adolescents up to 18 years of age who are at risk of out of home placements or who exhibit challenging behaviors in high level group homes. The FSPs provide services to enable these children to remain at home or stay in family settings within the community and achieve permanency and stability. A Family and Youth Involvement team, comprised of peer parents and youth development mentors, provides assistance to one of the FSPs. The peer parents work with parents who are consumers of the mental health system, and the youth peer mentors work with youth and young adults to provide outreach, support, mentoring, information, advocacy, and assistance in navigating the various child and family serving systems, including the school system.</p> <p>The General System Development agencies focused on integration of behavioral health services in a primary care setting and increasing capacity for culturally appropriate services especially for API LGBTQ.</p> <p>Outreach and Engagement services were developed to expand activities that address chronic disease (heart disease, stroke, and diabetes), subclinical depression and wellness and focused on families living in the south east sector neighborhoods. Services include stress reduction and promotion of well being through peer to peer support, grief and other support groups, and creative and culture-based activities which reduce stress, nutritional education and complimentary alternative healing practices. Additionally, five agencies were funded to outreach to schools and their communities to inform and engage them in the PEI planning efforts</p> <p>The targeted age groups are children and adolescents up to 18 years of age. 41% of clients served in FY09-10 were males and 59% females. 37% were African-Americans, 17% Asians, 18% Latinos, 16% Pacific Islander, 6% Caucasians, 2% Multi-Ethnic, 1% Native American, and 29% Other. English is the predominant language, represented by 72% of clients. Other preferred languages were: Spanish (8%), Cantonese (6%), Vietnamese (6%), Mandarin (1%), Tagalog (1%), and Other (5%). A small number of clients preferred to speak in Russian, Hmong, Farsi, Cambodian, and Arabic (each representing less than 1%).</p>
<p>2. If this is a consolidation of two or more programs, provide the following information:</p> <ul style="list-style-type: none"> a) Names of the programs being consolidated. b) How existing populations and services to achieve the same outcomes as the previously approved programs. c) The rationale for the decision to consolidate programs.
<p>3. If you are not requesting funding for this program during FY 11/12, explain how the County intends to sustain this program.</p>

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County: San Francisco

No funding is being requested for this program.

Program Number/Name: Work Plan #2: Transition Aged Youth

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

A. List the number of individuals served by this program during FY 09/10, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth				
TAY	85	407	228	\$12,527
Adults				
Older Adults				
Total				
Total Number of Individuals Served (all service categories) by the Program during FY 09/10:			720	

B. List the number of individuals served by this program during FY 09/10, as applicable.

Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
White	110	English	412	LGBTQ	101
African American	176	Spanish	26	Veteran	
Asian	19	Vietnamese	2	Other	
Pacific Islander	3	Cantonese	3		
Native American	7	Mandarin			
Hispanic	93	Tagalog	1		
Multi	20	Cambodian			
Unknown		Hmong			
Other	10	Russian	2		
		Farsi	2		
		Arabic	1		
		Other	1		

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C. Answer the following questions about this program.

1. Briefly report on the performance of the program during FY 09/10 including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities.

All MHSA CSS programs have adopted similar strategies to reach the un-served and underserved populations and reduce ethnic and cultural disparities. For MHSA clients, culture is not solely limited to racial and ethnic groupings, it could also be the social norms of particular groups of people these clients identify with, be they socio-economic class, gender identity, or homelessness. These strategies include: (1) hiring a diverse staff who understands the “culture” of the clients they serve; (2) hiring consumers and family members who have had similar experiences as the clients they serve and could serve as role models, build trust and establish rapport with difficult to engage clients; (3) participating in culturally relevant trainings to gain more skill and insight of specific groups; (4) doing “whatever it takes” to meet the clients where they are at geographically and in terms of their readiness in engaging in services.

Full Service Partnerships

Community Behavioral Health Services TAY – focus on youths transitioning out of foster care and children’s welfare system. Most often, these youths have a difficult time transitioning to adulthood and can be very fragile emotionally and psychologically.

Hiring Diverse Staff - CBHS TAY has four employees, 2 Latinos who are proficient in Spanish, 1 African-American and 1 Caucasian.

Hiring Consumers/Family Members - The Community Behavioral Health Services (CBHS) TAY FSP have hired 6 youth within a 2 year span. These youths were hired as a peer support to be present in its drop-in center and to monitor the snacks. In their observation of the dynamics of clients interacting with peer staff, program staff noted that consumers benefit from seeing peers in a responsible role and seeing their peers functioning in a healthy way.

Training - Four CBHS TAY FSP staff participated in the MHSA Immersion Training in San Jose, presented by Momentum and three went to the PREP-Early Psychosis training & treatment for TAY-Cultural Awareness.

Whatever It Takes Approach - “Whatever it takes” means that we are flexible, accessible, innovative, and creative in reaching out to difficult-to-reach youth. An example is, meeting a youth in a café for a soda or lunch to begin the engagement process. Many of these youths come from the Foster Care system, they are “burnt out” of the traditional therapy/group model. CBHS TAY meet youth where they are most comfortable.

Family Service Agency (FSA) – initially focused on homeless individuals but over time, referrals consisted of individuals who are high utilizers of the public health systems. By the very nature of these referrals, these clients have cycled in and out of several agencies but have not received appropriate services either because they refuse services or because their life circumstances are such that they could not engage in services. These individuals are very difficult to engage and at times, difficult to locate.

Hiring Diverse Staff - Family Service Agency reports that other than one peer worker who speaks Vietnamese, their current staffing do not have sufficient language capacity and it is currently working on expanding this area of its cultural competence.

Hiring Consumers/Family Members - Family Service Agency (FSA) hire consumers as Outreach Workers, In this capacity, workers assist the case manager in carrying out the treatment plan and perform a range of duties such as assisting with transportation to and from appointments, assisting with life skills, running socialization groups, and doing supportive counseling. These peer employees come with a lot of strengths. They are skilled in engaging clients in treatment. They are able to serve as a role model of someone in recovery. They can use their street knowledge and personal experiences to better understand where the client is coming from. They also contribute a different perspective to staff meetings and help everyone on the team remain sensitive to our clients’ needs. FSA has promoted two clients into case manager positions and both have been successful in their positions. Program employees have noted that consumers hired into responsible positions feel more solidified in their own recovery because of the work that they do with clients.

Training - FSA had 25 staff participating in cultural competency trainings and assessments provided by CBHS and within their own agency.

Whatever It Takes Approach - For FSA, “whatever it takes” means being creative from engagement all the way to treatment. During the engagement phase, FSA meets the client where they feel most comfortable, whether that is in the office, in their home, at a cafe, etc. They employ peer outreach workers who have personal experience with mental health and substance abuse issues. These peer workers are able to engage clients in a way a clinical staff cannot. Once the client is engaged in treatment, program staff begins talking to them about how they would like to see their life change, and how they could participate in that

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process. This may include unique interventions such as working on self care by taking the client to a salon to have their hair done. Besides meeting clients where they feel most comfortable, “whatever it takes” approach means advocacy and persistence and a willingness to work with the most behaviorally difficult clients. Their experience thus far has proved that when a clients’ behavior is successfully tolerated and limits are set, with time the behavior improves dramatically.

General System Development

One agency, Larkin Street Youth Services, was awarded four General System Development programs – Transitional Residential Housing for non FSP involved youths; Supportive Services for Housing to help with obtaining and retaining permanent housing and guide youth as they transition out of TAY housing; Peer Based Center for socialization and recreational activities, and employment development; and GSD Housing. Larkin has a long history of serving troubled youth, some with multiple behavioral and health issues. Larkin also operates several TAY housing within the city.

Hiring Diverse Staff - Larkin Street subjects its MHSA-funded programming to the same agency-wide standard for cultural competency and recruitment of underserved populations. Through targeted recruitment of personnel, Larkin works to ensure that its staff reflects the demographic diversity of San Francisco and of the youth served: 50% of their staff are people of color, and 40% are gay, lesbian, bisexual, or transgender. Every Larkin Street program strives to have at least one Spanish-English bilingual staff person on-site, and staff work closely with other community-based agencies to guarantee that services are available in multiple languages. Currently, onsite language capacity within Larkin Street’s team includes Spanish, Russian, Tagalog, and American Sign Language.

Hiring Consumers/Family Members - Larkin Street is committed to employing staff whose personal life experiences reflect those of the young adults it serve, be they drug addiction recovery issues, sexual identity issues, or homelessness. All employees are required to complete extensive training to promote and assure cross-cultural awareness and competency. Youth-focused, cultural and positive sexual orientation messages are reinforced continuously through the physical environment, the composition of staff, and referrals to culturally appropriate services offsite, in order to strengthen self-esteem and identity. The needs of gay, lesbian, heterosexual, bisexual, transgender, and questioning youth are addressed by providing positive peer and adult role models, groups on healthy sexual identification, and education of peers, family, and community. Larkin Street assesses its responsiveness to the cultural and linguistic needs of their clients in part through semi-annual anonymous client satisfaction surveys and ongoing focus groups.

Training - In FY09-10, 27 employees participated in the following trainings: MHSA Immersion training rendered by Momentum; Working with Latino youth (MECA model); Uneven Playing Field: Cultural Competence and Access; LGBTQ youth training; Gang Involved youth training; Clinicians for Change-Over Incidence of Psychosis Diagnosis

Whatever It Takes Approach – Larkin’s program has particularly benefited from the flexibility of MHSA funding as opposed to other funding streams for this population such as MediCal. MHSA’s “whatever it takes” philosophy matches its own “no wrong door” approach to positive youth development. Unlike the MediCal model, MHSA funds allow Larkin to continue to provide the highly individualized services that its long experience and expertise has taught us that youth need in order to stabilize and move toward independence. With MHSA, Larkin has been able to develop its program in response to youth’s real needs rather than in response to stringent and sometimes arbitrary funding requirements.

2. Describe any key differences and any major challenges with implementation of this program as a result of the fluctuation in MHSA funding and overall mental health funding.

MHSA funded programs did not suffer major set backs as a result of drastic cuts in the overall mental health funding. From the onset, San Francisco decided to fund new programs rather than leverage general funded programs with MHSA. As such, the county has been able to fund MHSA programs at the same level as FY07-08. However, with projections showing declines in MHSA receipts, these programs could potentially experience the same cuts as programs funded with general funds. Despite the current security around MHSA funding, several programs have voiced its limitations.

CBHS TAY recognizes that they need a vocational specialist to serve as a job coach since different issues come up for consumers when they are hired as part of the team. However, because of a hiring freeze within the city and limited MHSA and general fund funding, hiring a vocational specialist could not be done easily. Another barrier for this program was that they ran out of flex funds and were not able to pay stipends for more clients. They also worry that employing youths through their flex funds is not sustainable.

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Housing is a constant challenge especially for CBHS TAY clients. They serve youth that present with different levels of functioning and need to be placed in more appropriate housing that meets their needs. For example, it is difficult to place a youth that comes from a home environment and to move her/him to a SRO, when (s)he does not have any independent living skills to be able to live alone. Neither is it appropriate to place these youths in a board and care where the youth is expected to have a 20 hour structured day program upon moving in. Additionally, if a foster care youth needs to go into a 30-day residential treatment and are "burnt out" to go to groups, this youth is in jeopardy of losing the placement for lack of treatment compliance.

Family Service Agency - Accessing housing has been one of the biggest resource challenges for its FSP programs. The programs have often had to purchase single room occupancy hotel rooms for clients when no stabilization rooms have been available, which can get very expensive. Because of this, the programs had to be very strict about paying for housing, and have occasionally had to refer clients to a shelter. Many homeless clients are unwilling to use the shelter system, and have made the choice to sleep on the streets. Having clients in an MHSA program go homeless seems to go against the spirit of the program.

Larkin Street - The most challenging limitation has been Larkin's inability to find affordable stand-alone (not SRO or efficiency) housing units within the budget provided by its MHSA contract. The steep housing market in San Francisco, combined with landlords' hesitance to take on young, mentally ill tenants, has made it nearly impossible to place all of the youth in the types of units and the neighborhoods preferred by CBHS for its target population. Nevertheless, Larkin was successful in procuring leases with two shared single-family housing units in ideal locations but the cost per client is 1.5 to 2 times greater than single room occupancy hotels. Sustaining these housing options may not be possible because of declining MHSA revenue projections and biases of landlords against youths served by the FSPs and Larkin.

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Is there a change in the service population to be served?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
2) Is there a change in services?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3) a) Complete the table below:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>						
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c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.							

The FY10-11 budget included a one-time request to renovate an existing building that will house 40 TAY residents from both the FSP and Supportive Services for Housing program under GSD. Additionally in FY10-11, CBHS redid all its contracts following a mega-RFP for all behavioral health services. Within the mega-RFP, all TAY MHSa GSD services (supportive services for housing, peer based center, and transitional residential housing) were combined with the Housing Service Partnership (housing for FSP clients) with the intention of transferring all these services into the newly renovated site. Since the completion date was uncertain, we included budgets for both the existing services and the combined services in FY10-11 funding. We did this to ensure that services would have continued funding throughout the fiscal year, whether they are existing services or combined within one site. The above-mentioned activities account for the difference in budgeted amounts between FY10-11 and FY11-12. We are requesting an exception to the ±25% criteria because the change is due to one-time non-recurring expenditures.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F1.

A. List the estimated number of individuals to be served by this program during FY 11/12, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth				
TAY	90	420	220	\$9,023
Adults				
Older Adults				
Total				
Total Estimated Number of Individuals Served (all service categories) by the Program during FY 11/12:				730

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NOTE:

B. Answer the following questions about this program.

1. Provide a description of your previously approved program that includes the array of services being provided. Also provide information about targeted age group, gender, race/ethnicity and language spoken by the population to be served.

Two Full Service Partnerships (FSPs) were funded in FY10-11. One focused on youth transitioning out of foster care and child welfare systems and the other focused on homeless, runaway youths. Both FSPs were linked to the Housing Service Partner agency for permanent housing. The GSD agency provided supportive services for housing, transitional residential housing for GSD youth, and operated a peer based center.

50% of TAY clients were male, 48% female, and 2% transgender. 101 youth identified as LGBTQ. The race/ethnicity of youths served are as follows: 40% African American, 25% Caucasian, 4% Asian, 2% Latino, and 2% Other. A small number of youth identified as Native American, Pacific Islander and Multi-Ethnic (each with less than 1%). English is the preferred language of a large majority of youth served, representing 92% of all youth served followed by Spanish, spoken by 6% and Cantonese, spoken by 1% of youth served. A small minority spoke Arabic (n =1), Farsi (n =2), Russian (n =2), Tagalong (n =1), Vietnamese (n =2), and Other (n = 1).

2. If this is a consolidation of two or more programs, provide the following information:

- a) Names of the programs being consolidated.
- b) How existing populations and services to achieve the same outcomes as the previously approved programs.
- c) The rationale for the decision to consolidate programs.

3. If you are not requesting funding for this program during FY 11/12, explain how the County intends to sustain this program.

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County: San Francisco

No funding is being requested for this program.

Program Number/Name: Work Plan #3: Adults

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

A. List the number of individuals served by this program during FY 09/10, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth				
TAY				
Adults	458	4,966	3,803	\$8,660
Older Adults				
Total				
Total Number of Individuals Served (all service categories) by the Program during FY 09/10:			9,227	

B. List the number of individuals served by this program during FY 09/10, as applicable.

Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
White	1,719	English	1,599	LGBTQ	350
African American	2,557	Spanish	421	Veteran	11
Asian	244	Vietnamese		Other	
Pacific Islander	21	Cantonese	36		
Native American	50	Mandarin	1		
Hispanic	580	Tagalog	20		
Multi	12	Cambodian	12		
Unknown		Hmong			
Other	216	Russian	3		
		Farsi	1		
		Arabic	1		
		Other	6		

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C. Answer the following questions about this program.

1. Briefly report on the performance of the program during FY 09/10 including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities.

Full Service Partnerships

All MHSA CSS programs have adopted similar strategies to reach the un-served and underserved populations and reduce ethnic and cultural disparities. For MHSA clients, culture is not solely limited to racial and ethnic groupings, it could also be the social norms of particular groups of people these clients identify with, be they socio-economic class, gender identity, or homelessness. These strategies include: (1) hiring a diverse staff who understands the “culture” of the clients they serve; (2) hiring consumers and family members who have had similar experiences as the clients they serve and could serve as role models, build trust and establish rapport with difficult to engage clients; (3) participating in culturally relevant trainings to gain more skill and insight of specific groups; (4) doing “whatever it takes” to meet the clients where they are at geographically and in terms of their readiness in engaging in services.

Hyde Street Services –serves individuals who reside or who are homeless in the Tenderloin and who have been unable to link to outpatient services. The Tenderloin has become a magnet for homeless individuals who most often have multiple co-occurring disorders, diagnosed or undiagnosed. It is where the vast majority of single room occupancy hotels contracted by public health and social services agencies to house low-income San Francisco residents are situated. The neighborhood has also attracted drug sellers and users who have resorted to prostitution to support their drug habits. Hyde Street is located in the heart of the Tenderloin and is known to individuals who frequent this area.

Hiring Diverse Staff - Hyde Street has had little difficulty recruiting and hiring minority staff. Since the program began staff have included: African-American, Asian-American, gay and transsexual minorities.

Hiring Consumers/Family Members - Hyde St. employs three consumers. The housing specialist is a member of the FSP Team. The vocational specialist provides pre-vocational counseling, linkage to vocational and education programs, support groups and workshops. The peer counselor provides peer support and activity groups in the former Clubhouse.

Trainings - Seven Hyde Street employees went to the following trainings: Trauma and Healing Multi-Cultural Considerations; Transgender Issues; and Catholicism and the Filipino community.

Whatever It Takes Approach - To engage their clients, Hyde Street staff have become flexible and have used creative in interventions especially with regards to housing issues. Often saying no and setting limits when appropriate have worked in creating relationships with their clients.

Family Service Agency (FSA) – initially focused on homeless individuals but over time, referrals consisted of individuals who are high utilizers of the public health systems. By the very nature of these referrals, these clients have cycled in and out of several agencies but have not received appropriate services either because they refuse services or because their life circumstances are such that they could not engage in services. These individuals are very difficult to engage and at times, difficult to locate.

Hiring Diverse Staff - FSA has had success in hiring a diverse team that represents a variety of different cultural and ethnic groups. Its team represents all different races, socioeconomic status, and sexual orientation. The program currently does not have any language capacity (other than one peer worker, who speaks Vietnamese) so they would like to expand this area of their cultural competence.

Hiring Consumers/Family Members - FSA has consistently had 2 – 5 consumers across the TAY and Adult FSP programs. Their job title is Outreach worker, and they serve as an important part of the treatment team. The outreach workers assist the case manager in carrying out the treatment plan. Their job duties range from assisting with transportation to and from appointments, assisting with life skills, running socialization groups, and doing supportive counseling.

Trainings - Twelve employees from FSA attended the following trainings: Cultural Diversity Sessions 1 and 2; Consumers’ Experience-Training for Providers; and Recovery Model from Vision to Practice.

Whatever It Takes Approach - For FSA, “whatever it takes” means being creative from engagement all the way to treatment. During the engagement phase, FSA meets the client where they feel most comfortable, whether that is in the office, in their home, at a cafe, etc. They employ peer outreach workers who have

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personal experience with mental health and substance abuse issues. These peer workers are able to engage clients in a way a clinical staff cannot. Once the client is engaged in treatment, program staff begins talking to them about how they would like to see their life change, and how they could participate in that process. This may include unique interventions such as working on self care by taking the client to a salon to have their hair done. Besides meeting clients where they feel most comfortable, “whatever it takes” approach means advocacy and persistence and a willingness to work with the most behaviorally difficult clients. Their experience thus far has proved that when a clients’ behavior is successfully tolerated and limits are set, with time the behavior improves dramatically.

University of California San Francisco-Citywide Case Management Forensic (UC-CWCM) – serves individuals followed by the Behavioral Health Court and mandated to engage in mental health services. These individuals have very challenging time reintegrating into society because of their prior criminal histories.

Hiring Diverse Staff - UC-CWCM has made great efforts to recruit and hire a diverse staff. Currently it has 5 African-American, 3 Asian, 1 Iranian, 2 transgender, and 6 LGTB staff. The program also has fluent Spanish, Russian and Korean speaking staff members.

Hiring Consumers/Family Members - UC-CWCM has two active consumer positions: Life Coach who leads WRAP group, Dual Recovery Anonymous, performs duties of Job Coach and supported employment and Community Integration Specialist who leads clients in activities in the community including events from Tickets on the Town, links with other agencies such as Senior Ex-Offender Program and assist with housing. Trainings - Eight UC-CWCM staff participated in: Spirituality training; Race and Identity of Staff; and Race and Identity of Clients.

Whatever It Takes Approach - UC-CWCM has traditionally followed a “whatever it takes” philosophy and taken a creative and individualized approach to treatment with each client. Since implementation of its FSP program the necessity of a “whatever it takes” attitude has become even more apparent, especially in the realm of supported employment. Both case managers and employment specialists are extremely resourceful at motivating clients to change their belief system that they can work, and to find suitable and esteem-building work in the community. In one example, the program had a client who was once a very successful musician but had lost everything to his Bipolar Disorder and drug addiction. Over the years, his case manager and employment specialist have helped him get all the things necessary to re-engage with his music. They helped him budget and save money for a new instrument, get new teeth in order to properly play the instrument, find and audition for bands and eventually join several bands and perform in local venues, and maintain safe and permanent housing. This client continues to struggle with his substance use, but the FSP team believes his connection to his music and the clinic has helped keep him from completely de-compensating and returning to the streets. The FSP team continues to maintain caring hope for him and all its clients during both their ups and downs.

San Francisco Fully Integrated Recovery Services Team (SFFIRST) – previously an AB2034 funded program, focuses on individuals with serious mental illness who have been homeless for a long time. These individuals have adopted nomadic lifestyles and value their freedom fiercely. Engaging them in services and finding them a place to live is very demanding work.

Hiring Diverse Staff - SFFIRST finds it challenging to recruit from underserved ethnic, racial, cultural communities but it has been able to achieve it. The challenge for them is how to retain these clinicians with the program for an extended period.

Hiring Consumers/Family Members - SFFIRST has three former consumers in its team. It has been a challenge at times, but very satisfying to have them in its team. These employees have been engaged in creating groups, attending activities with clients, providing one-on-one peer level support to our clients, and taking clients to appointments.

Trainings - Twelve SFFIRST staff went to: Using Work as a Therapeutic Intervention; Harm Reduction in a Recovery Model; and Legal and Ethical training.

Whatever It Takes Approach - For SFFIRST, “whatever it takes” means providing innovative recovery oriented services to our clients, not just mental health treatment. They wrap the services as a package and all its clinicians from the support staff to the psychiatrist know all the clients. Staff just don’t take them appointments, they make a field trip out of it if necessary to make sure clients get from point A to point B.

Pathways to Discovery - Included in the FSP is a peer-run wellness and recovery team called Pathways to Discovery. Pathways to Discovery provides supports to the FSPs, mental health clinics, and housing providers by facilitating therapeutic art activities, one-on-one peer counseling, escorting clients to other services, assisting with activities of daily living, providing medication support, and facilitating group activities.

Hiring Diverse Staff - Recruiting and hiring has been a positive experience for Pathways to Discovery. Being a consumer run, consumer organized program, it

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really is very cultural competent program. It has the speaking capability of four different languages (Spanish, Tagalog, Cantonese, and English).

Whatever It Takes Approach - since Pathways works with other programs to support the client and the program staff, whatever it takes means helping the client to achieve their stated goal. Pathways staff advocate for them and help clients with empowering themselves..

General System Development

General System Development funds the operation of two peer based centers, vocational rehabilitation services with the Department of Rehabilitation and one local agency, a centralized access center, a mental health pharmacy, supportive services for housing, and dual diagnosis residential treatment.

Both peer based centers, operated by Central City Hospitality House and Office of Self Help, are consumer run centers. They both offer low threshold socialization services and provide safe haven from street life for homeless individuals.

Central City Hospitality House has two peer run centers, one in the Tenderloin and the other at Sixth Street. Services include massage therapy, brief behavioral health services, computer access and basic training on operating a computer, employment programs both volunteer and stipends, shower facilities, and food distribution. Central City Hospitality House also provides supportive services for housing, mainly through referrals from local shelters, to help individuals attain and maintain permanent housing.

Hospitality House is committed to hiring from its constituency to assure peer-based, culturally-diverse staff that is representative of its participant base, both ethnically and culturally. Employees are often hired from its volunteer and employment programs, and there is a commitment to promote from within for higher-level staff and management positions. Community meetings are held weekly to solicit suggestions from center participants about activities or events that they would like held within the centers

Office of Self Help, a peer membership program, is located on Market Street and offers group activities, free trips to out-of-town mental health facilities so family members could visit relatives, social activities for board and care residents, and a warm-line.

Behavioral Health Access Center (BHAC) relocated to a more centralized venue while also co-locating five separate behavioral health programs. These include Mental Health Access, for authorizations into the Private Provider Network, the Treatment Access Program, for assessment and placement into addiction and dual diagnosis treatment, the Offender Treatment Program, (formerly SACPA Prop 36), for placement of mandated clients into addiction and dual diagnosis treatment, COPE/OBIC for evaluation and placement into Opiate Replacement Therapy, and the CBHS Pharmacy.

Since the co-location of all the aforementioned programs within BHAC, the program has seen an increase in clients coming in for behavioral health services. Because of its proximity to the Mission district, BHAC has also witnessed an influx of Spanish-speaking clients.

Walden House provides dual diagnosis residential treatment for individuals without MediCal coverage. Prior to MHSA funding, these clients would have had to be on waitlists before receiving services. Walden's program staff work diligently with their clients and support them in their efforts of employment, recovery and family reunification. When there are positions available, Walden hires clients that are qualified to do the job. Many of the program staff are previous clients. Walden House provides in house trainings focusing on Cognitive-Behavioral best practices models for the treatment of severe mental illness to its entire staff, including frontline counselors and case managers, as well as therapists and psychologists with a strong focus on Dialectic Behavioral Therapy and Seeking Safety.

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2. Describe any key differences and any major challenges with implementation of this program as a result of the fluctuation in MHSA funding and overall mental health funding.

All MHSA funded programs were sheltered from budget cuts which affected mostly those programs funded by general funds. However, many of the programs that MHSA-funded programs collaborate with have been either defunded or pared down. Instability and budget cuts to the city's general fund funding have impacted MHSA programs due to reductions in the entire system of care. These reductions have caused some redirection of focus for some of the MHSA funded programs. For others, MHSA funding has allowed the programs to expand. Below are examples of the ways in which these programs have been affected.

Family Service Agency (FSP)

There are several significant ways in which the FSA Full Service Partnership program changed over time. In the beginning, the Adult (named CARE) and TAY (named MAP) FSP MHSA programs focused on specifically targeting homeless clients. The staff went into the community and conducted street outreach to target this population. However, over time, referrals came from the county, rather than from its own outreach, and most of these referrals are clients who are marginally housed or in treatment programs, but very few are homeless. This evolution seems to stem from a basic "capacity" issue and the need to focus attention on those clients who are the biggest "burden on the system." FSA's focus on the high end users of the system is still strong; however, the "underserved" homeless has gotten a lot less attention over time.

Pathways to Discovery (FSP Support)

The original concept for Pathways to Discovery was to be a Wellness and Recovery Center. Pathways to Discovery today is a program still looking for a home. The original site identified for this program was not approved by the Department of Building Inspection because of fire hazard concerns. The renovation of the other site identified has taken a long time to be renovated because of differing priorities between the Departments of Public Health and Public Works. With no dedicated funding for rental of space, Pathways does not have plenty of options. Pathways has adapted well to being a mobile program, offering the same programming in other programs or clinics instead of the individuals coming to a central place.

SFFIRST (FSP)

The SFFIRST team now is able to focus on the more acute and persistent mentally ill individuals that have been homeless for a long time. It is now able to provide wrap around services including housing, medical, and vocational services that it was not able to provide in the past.

UC-CWCM (FSP)

UC-CWCM was very much interested in developing an employment component to our services at the start of the FSP program. We started with one occupational therapist position and a peer job coach. In the years since, the employment team has grown tremendously and evolved into one of the cornerstones of its recovery-oriented treatment. It has been a huge struggle to maintain secure funding for the supported employment program. Last fiscal year, they lost funding for its occupational therapist and three employment specialists. Through a contract with the Department of Rehabilitation, they were able to save the Occupational Therapist and two employment specialist positions. The supported employment model has changed the attitude of the entire agency. Clients and staff who long ago thought that a "worker" identity was beyond their reach have been inspired by the success of other clients and now have renewed hope for their futures as employees. After the first years of the FSP program, it became very apparent the difficulty clients faced trying to integrate into the community at large. The program had been very successful linking clients to its own agency and developing a safe community in the clinic. Clients, however, needed to build a stronger base of support and identities that were not necessarily tied to their mental health service. Last year, UC-CWCM created a part-time consumer Community Integration Specialist position designed to help clients find and participate in various activities and services throughout the city. UC-CWCM also wanted to try and promote education and fight stigma against mental illness in the community. The program linked with NAMI and recruited clients to participate in NAMI's "In Our Own Voice" program. Clients were trained to develop presentations on their life stories and experiences and then hired to give presentations to myriad agencies and settings. This program has made significant contributions to the community but also the lives of participating clients. It has improved their self-esteem and feeling of empowerment.

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Central City Hospitality House – Supportive Services for Housing

The most significant evolution for Central City Hospitality House occurred in its Support Services for Housing Program. The original intention of the funding was to support participants in obtaining housing through access to the Mayor's housing pipeline, but when no access was provided, we had to shift the focus to maintaining and retaining housing. Through ongoing advocacy and CBHS support, Hospitality House was provided access to short-term temporary housing assistance through DPH's Emergency Stabilization Units. Yet, lack of decent affordable housing has been the greatest challenge to meeting clients' needs. Specifically for this program, demand for support has exceeded available funding.

Behavioral Health Access Center – centralized access to referrals and linkages to behavioral health services

The integration of mental health and substance abuse access and referral programs within one site, along with the CBHS Pharmacy and OBIC clinic, has brought challenges to monitoring of visitors within the building. BHAC is located in the same building as the administrative offices of CBHS. With dedicated funding from MHSa for consumer employment, CBHS has hired system navigators to man the lobby, assist clients to where they are supposed to go so that they do not roam around the building, and provide de-escalation assistance to BHAC staff in crisis or tense situations. System navigators have been trained on First AID and CPR, Motivational Interviewing, Conflict Resolution and De-escalation, Burnout Prevention, and Customer Service on the job. Placements of system navigators who identify as consumers of mental and substance abuse services, at the lobby were initially met with resistance. But over time, building occupants understood the merits of hiring consumers to man the lobby as they witnessed the difficult nature of some of the clients who present at BHAC and the ability of these navigators to negotiate with these difficult clients.

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Is there a change in the service population to be served?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
2) Is there a change in services?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3) a) Complete the table below:	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>						
<table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="text-align: left;">FY 10/11 funding</th> <th style="text-align: left;">FY 11/12 funding</th> <th style="text-align: left;">Percent Change</th> </tr> </thead> <tbody> <tr> <td>\$7,392,929</td> <td>\$7,494,848</td> <td>1%</td> </tr> </tbody> </table>		FY 10/11 funding	FY 11/12 funding	Percent Change	\$7,392,929	\$7,494,848	1%
FY 10/11 funding		FY 11/12 funding	Percent Change				
\$7,392,929		\$7,494,848	1%				
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,							
For <u>Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?							
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.							

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F1.

A. List the estimated number of individuals to be served by this program during FY 11/12, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth				
TAY				
Adults	773	5,040	3,800	\$7,142
Older Adults				
Total				

Total Estimated Number of Individuals Served (all service categories) by the Program during FY 11/12: 9,613

NOTE: Family and Youth Involvement team is budgeted as part of FSP but reported as outreach and engagement because none of the clients served by this team are entered in DCR since the services are non-treatment related and to avoid duplication (if already an FSP client)

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<p>B. Answer the following questions about this program.</p>
<p>1. Provide a description of your previously approved program that includes the array of services being provided. Also provide information about targeted age group, gender, race/ethnicity and language spoken by the population to be served.</p>
<p>Four full service partnerships were funded: Hyde Street Services focus on clients within the Tenderloin; Family Service Agency on homeless individuals; UC-CWCM on behavioral health court mandated clients; and SFFIRST, previously an AB2034 funded program. General System Development funds the following services:</p> <ul style="list-style-type: none"> ▪ Centralized Access services provided by BHAC, a combination of mental health and substance abuse access, referral and placement programs, CBHS Pharmacy, and Opiate Clinic ▪ Supportive Services for Housing provided by Central City Hospitality House to assist individuals with maintaining/retaining housing ▪ Vocational Rehabilitation services through the Department of Rehabilitation and Community Vocational Enterprise to provide job training, placement, and coaching ▪ Dual Diagnosis Residential Treatment through Walden House for people without MediCal coverage ▪ Peer Based Centers operated by Central City Hospitality House and San Francisco Study Center to provide a milieu of low threshold socialization and recreational services and a haven from street life for homeless individuals <p>75% of adult clients served in FY09-10 were males, 24% female, and 1% transgender. Ten individuals identified as LGBTQ. 47% were African Americans, 32% Caucasian, 11% Latino, 5% Asian, 1% Native American, and 4% Other. Multi-Ethnic and Pacific-Islanders comprise less than 1% of clients seen. 75% speak English, 20% Spanish, 2% Cantonese, 1% Cambodian, 1% Tagalog, and a very small number speak Farsi (n=1), Russian (n=3), Arabic (n=1), Mandarin (n=1), and Other (n=6).</p>
<p>2. If this is a consolidation of two or more programs, provide the following information:</p> <ol style="list-style-type: none"> a) Names of the programs being consolidated. b) How existing populations and services to achieve the same outcomes as the previously approved programs. c) The rationale for the decision to consolidate programs.
<p>3. If you are not requesting funding for this program during FY 11/12, explain how the County intends to sustain this program.</p>

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County: San Francisco

No funding is being requested for this program.

Program Number/Name: Work Plan #4: Older Adults

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

A. List the number of individuals served by this program during FY 09/10, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth				
TAY				
Adults				
Older Adults	42	1,221	1,440	\$17,067
Total				
Total Number of Individuals Served (all service categories) by the Program during FY 09/10:			2,703	

B. List the number of individuals served by this program during FY 09/10, as applicable.

Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
White	398	English	278	LGBTQ	10
African American	536	Spanish	30	Veteran	4
Asian	94	Vietnamese	1	Other	
Pacific Islander	8	Cantonese	10		
Native American	12	Mandarin	8		
Hispanic	149	Tagalog	24		
Multi	3	Cambodian	4		
Unknown		Hmong			
Other	24	Russian	5		
		Farsi			
		Arabic			
		Other	4		

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C. Answer the following questions about this program.

1. Briefly report on the performance of the program during FY 09/10 including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities.

All MHSA CSS programs have adopted similar strategies to reach the un-served and underserved populations and reduce ethnic and cultural disparities. For MHSA clients, culture is not solely limited to racial and ethnic groupings, it could also be the social norms of particular groups of people these clients identify with, be they socio-economic class, gender identity, or homelessness. These strategies include: (1) hiring a diverse staff who understands the “culture” of the clients they serve; (2) hiring consumers and family members who have had similar experiences as the clients they serve and could serve as role models, build trust and establish rapport with difficult to engage clients; (3) participating in culturally relevant trainings to gain more skill and insight of specific groups; (4) doing “whatever it takes” to meet the clients where they are at geographically and in terms of their readiness in engaging in services.

Family Service Agency (FSA) is the only Full Service Partnership serving older adults.

Hiring Diverse Staff - Family Service Agency strives to recruit and hire from a broad range of underserved ethnic, racial, and cultural communities, and their staff’s diversity fully reflects this. Its staff currently consists of two bilingual and bicultural staff people (a Mexican-American Spanish-speaking clinician and a Japanese clinician), one Latino man, one African-American woman, one white woman, and one queer white man who speaks fluent Spanish, Latvian, and Russian.

Hiring Consumers /Family Members - FSA has had extensive experience and success in recruiting and hiring from underserved communities. Three members of its treatment team are former consumers. Since the inception of the program, consumers have played key roles in the treatment team. One of the Peer Case Aides successfully transitioned to a Case Manager position. She is currently completing a Masters in Community Mental Health, and is a perfect example of FSA’s experience and success in hiring, supporting, and promoting consumers.

Training - 24 staff participated in the following cultural sensitivity trainings in FY09-10: Cultural Diversity-Sessions 1 and 2; Consumers’ Experience-Training for Providers; and Recovery Model From Vision to Practice.

Whatever It Takes Approach - At the Senior Full Service Wellness Program (SFSWP), the philosophy of “whatever it takes” is the cornerstone of all its practice and treatment strategies. The treatment teams meet clients on the streets, in their homes, at senior centers, in hospitals and clinics, and anywhere the client might be. As examples, several of its clients are severely alcohol and drug dependent, and can only be served after extensive outreach and engagement efforts. Clinicians and peer case aides often scour the streets of the Tenderloin to find these clients and, regardless of their level of intoxication, provide such basic services as assistance with personal hygiene and clothing, food, health and wellness checks, peer companionship, and referrals to detoxification and harm reduction programs, often while outside on the street with the client.

As another example, many of the SFSWP clients are homebound, due to their advanced age, early signs of dementia, and, oftentimes, features of mental illness such as severe paranoia and disordered thinking. For these clients, the FSP team collaborates to provide daily visits, where fresh food is brought and sometimes prepared, medications are monitored, and wellness checks are conducted. As a final example, one of its most challenging clients is an older adult with schizophrenia, paranoid type, who is only ever willing to engage with the team in the early morning hours (before 7 am). Alternating team members make time to visit with this client on her schedule, bringing her weekly payments from her payee, and conducting wellness checks. The program peers also engage the client in much-needed socialization, taking her for coffee and breakfast long before most other agencies have even opened their doors. These examples illustrate only a few of the myriad ways in which the SFSWP team is willing and able to do whatever it takes to provide clients with essential services.

General System Development – funds a peer based center and supportive services for housing.

The Peer Based Center at Curry Senior Center, operated by Family Service Agency (FSA), has been very successful in serving underserved and un-served ethnic, racial and cultural communities because the Tenderloin is the most culturally diverse in the city. The biggest challenge is to engage guests who have mental health issues and who have had negative results with their medications. They tend to be very paranoid and refuse the help the program offers them. Program staff tries to establish a long and persistent relationship with them that is relaxed. There are no fixed rules; staff only tries to remind them of their options and consequences for

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not addressing their specific barriers. FSA has hired consumers with Mental Health and Substance Abuse backgrounds but had better results with substance abuse consumers. They have been hired as senior peer aide and peer aides. They have helped run groups and activities at the center. They have also taken guests to appointments, helped them to connect with other providers and established rapport with them. They also are extremely reliable and dedicated. A consumer working with other consumers appears to be beneficial for them as well. It gives them a sense of accomplishment and pride.

Curry Senior Center provides supportive services for housing to assist seniors in maintaining and obtaining housing. Curry has been very successful in hiring staff from underserved and un-served ethnic communities. Currently Curry Senior Center provides services in eight different languages and cultures – Cantonese, English, Lao Mandarin, Russian, Spanish, Tagalog, and Vietnamese. In addition to the health care, nutrition and support services (provided in eight languages) the agency also provides at least one cultural celebration each month to acknowledge the various cultural landscape of the city. During the past year the following cultural celebrations and events have been sponsored (partial list): Martin Luther King Day, Chinese/Vietnamese New Year, Pride Celebration, Filipino Independence Day, Cinco de Mayo, Juneteenth, Kwanzaa and others.

Curry has had mixed experience working with consumers. The first consumer hired for this program did very well working with clients, but had significant personal challenges resulting in frequent absences. This staff eventually left the program. A subsequent consumer is currently excelling at their job, and currently Curry is in a position to hire an additional consumer. Curry has witnessed the benefits of having a consumer in their staff. Some of the new clients have been engaged and attracted to Curry’s services as they’ve been referred by the consumer staff. Having this direct peer-to-peer referral and engagement process has been very beneficial for engaging new clients and maintaining supportive relationships with these clients, in-between counseling and health appointments. From the consumer employee’s perspective, being a member of a service team brings about an increased sense of self-worth especially when the employee is successful in engaging clients (their peers) to receive services that (eventually) improve the clients’ lives. In addition, the employee receives good, consistent income and coming to work has reduced isolation and has benefitted socially and personally from being part of a team.

2. Describe any key differences and any major challenges with implementation of this program as a result of the fluctuation in MHSA funding and overall mental health funding.

Full Service Partnership

MHSA funded programs for older adults were protected from department-wide budget cuts specifically because these programs were funded by MHSA, not local general funds.

FSA’s FSP program, thanks largely to the successful functioning of its original design, has seen little substantive change in terms of design over the past five years. Being the only FSP program for older adults, the original planned caseload has remained static and a waitlist now exists. Another major challenge is housing clients with prior sexual offenses. These clients could not qualify for MHSA contracted housing through CBHS, but most privately-owned hotels are willing to take these clients. The limited flex funds that the program had are not sufficient to house these clients in privately-owned single room occupancy hotels.

General System Development

Both GSD programs were protected from cuts because the source of their funding is MHSA. Peer based centers and mental health outpatient programs funded through general funds were subject to budget reductions, some were even totally defunded.

But having MHSA as the programs’ sole source of funding has its drawbacks as well. The peer based center operated by FSA was unable to meet the needs of frail and disabled people in going out in the community and participating in events, mainly because they do not have appropriate means of transportation like a van. The funds they received from MHSA were not enough to allow them to purchase a vehicle. Also, the Department of Public Health has issued a moratorium on

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Community Services and Supports**

purchasing vehicles to contain costs department-wide.

Curry Senior Center has also seen their MHSa flexible funds run out. After initially being able to use “client assistant funds” for such items as clothing, bedding, beds, TV’s, in addition to first, last month’s rent and security deposits, those funds dried up. Many elders, who are seeking a permanent home, benefited from these “extra essentials” and it has been difficult to find replacement funding.

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Is there a change in the service population to be served?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
2) Is there a change in services?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3) a) Complete the table below:	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>						
<table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="text-align: left;">FY 10/11 funding</th> <th style="text-align: left;">FY 11/12 funding</th> <th style="text-align: left;">Percent Change</th> </tr> </thead> <tbody> <tr> <td>\$2,175,755</td> <td>\$2,246,524</td> <td>3%</td> </tr> </tbody> </table>		FY 10/11 funding	FY 11/12 funding	Percent Change	\$2,175,755	\$2,246,524	3%
FY 10/11 funding		FY 11/12 funding	Percent Change				
\$2,175,755		\$2,246,524	3%				
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,							
For Consolidated Programs, is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?							
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.							

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F1.

A. List the estimated number of individuals to be served by this program during FY 11/12, as applicable.

Age Group	# of individuals FSP	# of individuals GSD	# of individuals OE	Cost per Client FSP Only
Child and Youth				
TAY				
Adults				
Older Adults	85	1,330	1,500	\$10,536
Total				
Total Estimated Number of Individuals Served (all service categories) by the Program during FY 11/12:				2,915

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Community Services and Supports**

B. Answer the following questions about this program.
1. Provide a description of your previously approved program that includes the array of services being provided. Also provide information about targeted age group, gender, race/ethnicity and language spoken by the population to be served.
<p>One FSP program was funded to serve older adults. Two GSD programs were funded to provide behavioral health services in primary care setting and supportive services in housing, and operate a peer based center that delivers socialization and recreational activities to seniors on a daily basis.</p> <p>75% of clients served in FY09-10 were males, 24% females, and 1% transgender. 10 clients identified as LGBTQQ. The race/ethnicities were as follows: 44% African American, 33% Caucasian, 8% Asian, 12% Latino, 1% Native American, and 2% Other. Pacific Islander and Multi-Ethnic represent less than 1% of total clients served. English is the preferred language, represented by 76% of clients served, followed by Spanish (8%), Tagalog (7%), Cantonese (3%), Mandarin (2%), Russian (1%), Cambodian (1%), and Other (1%). Less than 1% of clients spoke Vietnamese.</p>
2. If this is a consolidation of two or more programs, provide the following information: a) Names of the programs being consolidated. b) How existing populations and services to achieve the same outcomes as the previously approved programs. c) The rationale for the decision to consolidate programs.
3. If you are not requesting funding for this program during FY 11/12, explain how the County intends to sustain this program.

PREVIOUSLY APPROVED PROGRAM
Workforce Education and Training

County: San Francisco

No funding is being requested for this program.

Program Number/Name: WET A: Workforce Staffing and Support

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

1. Describe progress on the objectives achieved in this program during FY 09/10 (e.g. administrative and workforce policy support, the provision of financial relief, established partnerships among education and training that are connected to service needs, etc).

WET Action 1: Workforce Staffing and Support San Francisco implemented all the WET contracts for the Mental Health Career Pathways and the Training and Technical Assistance Programs in the second quarter of FY09-10. Six new contracts were awarded to five agencies to implement these initiatives. The WET Coordinator, who also is CBHS' Director of Cultural Competency, served on the advisory boards of the supported education program at San Francisco State University and the community certificate program at City College of San Francisco. Towards the end of the fiscal year, we began an information sharing conversation with the Mayor's Office of Economic and Workforce Development to discuss the MHSA WET efforts and how we could work collaboratively to promote these efforts within the Health Care Sector Academy that they have developed.

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Does the work detail or objective of the existing program(s) or activity(s) remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						
2) Do the activities and strategies remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						
3) a) Complete the table below:								
	<table border="1"> <thead> <tr> <th>FY 10/11 funding</th> <th>FY 11/12 funding</th> <th>Percent Change</th> </tr> </thead> <tbody> <tr> <td>\$410,447</td> <td>\$0</td> <td>-100%</td> </tr> </tbody> </table>		FY 10/11 funding	FY 11/12 funding	Percent Change	\$410,447	\$0	-100%
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$410,447	\$0	-100%						
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or,	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						

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Workforce Education and Training**

<p><u>For Consolidated Programs</u>, is the FY 11/12 funding requested outside the $\pm 25\%$ of the sum of the previously approved amounts?</p> <p>c) If you are requesting an exception to the $\pm 25\%$ criteria, please provide an explanation below.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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We are requesting an exception to the $\pm 25\%$ criteria because the WET funding is a one-time carve out from receipts in FY06-09. The requested funds in FY10-11 were to add more money from unapproved WET funding to support Workforce Staffing and Support, the costs for which have increased from the Three Year Plan. The increase is attributed to the addition of a WET Evaluator and assignment of the Director of Cultural Competency as the County WET Coordinator whose job classification is much higher than the budgeted Coordinator. The budgeted expenses for FY11-12 will come from unexpended prior years' funds.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F2.

A. Type of Funding by Category

WET Funding Category	Check the Box that Applies
Workforce Staffing Support	<input checked="" type="checkbox"/>
Training & Technical Assistance	<input type="checkbox"/>
Mental Health Career Pathway	<input type="checkbox"/>
Residency & Internship	<input type="checkbox"/>
Financial Incentive	<input type="checkbox"/>

B. Answer the following questions about this program.

<p>1. If there have been changes to this program within the scope of what was originally proposed, describe any new objectives, actions, or strategies.</p>
<p>There have been no changes in the scope of the workforce staffing and support functions from the original proposed plan.</p>
<p>2. If this is a consolidation of two or more previously approved programs, provide the following information:</p> <p style="margin-left: 20px;">a) Name of the programs.</p> <p style="margin-left: 20px;">b) The rationale for the decision to consolidate programs.</p> <p style="margin-left: 20px;">c) How the objectives identified in the previously approved programs will be achieved.</p>
<p>N/A</p>

PREVIOUSLY APPROVED PROGRAM
Workforce Education and Training

County: San Francisco

No funding is being requested for this program.

Program Number/Name: WET B: Training and Technical Assistance

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

1. Describe progress on the objectives achieved in this program during FY 09/10 (e.g. administrative and workforce policy support, the provision of financial relief, established partnerships among education and training that are connected to service needs, etc).

WET Action 2: CBHS Training Initiatives: - provide culturally and community appropriate trainings to staff from CBHS and community-based organizations on such topics as wellness and recovery, family support, intensive case management, and the integration of primary care and mental health services utilizing subject matter experts, some of whom may be consumers, family members, and members of underserved communities. Trainings will also cover hiring and integration of consumers, family members, and members of underserved and underrepresented communities into the behavioral health system and include topics such as: stigma, job performance standards, supporting professional development, reasonable accommodations, boundaries, ethical decision making, as well as effective strategies for providing supervision, support, and the enhancement of professional development and vocational success.

In FY09-10 CBHS provided the following trainings:

Consumer and Family Workshop: One Voice We Unite – This workshop focused on providing key strategies to assist families in their recovery, delivered by experts in the field, consumers, and family members who shared their knowledge and experience. Part of the workshop focused on how to develop and maintain the Wellness Recovery Action Plan (WRAP) and showcased some of the Digital Stories produced by the Children Youth and Families section of CBHS which showed youths’ and caregivers’ personal experience in dealing with mental illness, substance abuse, and trauma. There were 83 attendees of this workshop.

Therapeutic Value of Work – This conference provided testimonials from consumers who talked about the ways in which vocational and employment activity have changed their lives to one that have greater purpose and enhanced meaning and examined how clinicians can support them around specific situations which present challenges. The conference included a discussion of a landmark study showing that consumers’ utilization rate of acute inpatient psychiatric services correspondingly decreased as work activity increased and educated attendees about existing vocational practice models. There were 152 attendees of this conference.

Family to Family Training – this 12 week NAMI course provided families with information and resources that will better prepare them to understand and interact with the person in their life who is mentally ill and tools to strengthen their coping skills. 18 family members graduated from this course.

Integrating Mental Health and Substance Abuse Within a Recovery Model – this training was designed to explore the emerging issues and practices of integrated behavioral health services through a combination of lecture, interactive exercises, and discussion and focused on three areas: 1) Practicalities of services at

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Workforce Education and Training**

various stages - Engagement, Persuasion, Active Treatment, Relapse Prevention, 2) Our emotional reactions - forming relationships, deserving of help, dealing with frustration, stigma, and 3) Designing truly integrative services - Welcoming Center, Sanctuary, Refugee Center, and Healing Center. There were 124 attendees of this training.

WDET Action 3: Community Based Organization Training: Education Empowerment, Support, and Cross-Training: will aim to build community capacity through trainings that promote: understanding and improved service for specific cultural and ethnic groups; learning and collaboration between licensed and unlicensed providers; provide cross-training between agencies and reciprocal training between licensed and unlicensed providers.

FY09-10 was the first year of implementation for the Community Based Organization Training: Education Empowerment, Support, and Cross-Training. Community Behavioral Health Services contracted with the Harm Reduction Therapy Center to provide cultural sensitivity training and workforce development and education training and technical assistance (WDET) to consumers and family members in the workforce and their respective supervisors. Training Institute was formed comprised of 24 members including trainers, community based organization representatives, CBHS staff, and consumers. The committee held its first meeting in November 2009. The full Training and Evaluation Committee met quarterly in the 2009/10; the Cultural Sensitivity sub-committee met monthly from November 2009 till March 2010 to complete development of curricula and training structure; the WDET sub-committee met quarterly starting in March 2010 as a larger group and then met in smaller groups specific to the training topic.

An electronic system-wide survey was conducted in January 2010 to develop training topics and curricula for the Cultural Sensitivity trainings. By the end of the first contract year, 2009/10, HRTC delivered six training events (total of 44.0 hours) to 161 participants on the topics of cultural sensitivity in working with: Asian and Pacific Islanders, Older Adults, Russian-speaking populations, LGBTQIQ, and Transition Age Youth. Lead trainers are reaching out to participating agencies to assess if they would like further technical assistance.

Training curricula for WDET trainings on Consumer Professional Development and Crisis Intervention was approved June 30, 2010. Curricula will be completed for the other half of the trainings (Community Violence and Family Friendly Policies) by January 2011. No WDET trainings were held in FY09-10.

Several challenges were identified in the first year of training with regards to low attendance rates, need for expanded outreach, and scheduling of all planned trainings. Attendance were low compared to the number of registrations, which then had an impact on the appropriateness of the site chosen for the trainings (some are too big for the numbers attending while others are too small). Outreach for planned trainings were expanded with the combined help of the CBHS Training Unit and efforts of lead trainers. Scheduling of trainings was lengthened to another year to better spread time spent on trainings and to help with increasing attendance rates.

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Does the work detail or objective of the existing program(s) or activity(s) remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2) Do the activities and strategies remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3) a) Complete the table below:	

**PREVIOUSLY APPROVED PROGRAM
Workforce Education and Training**

FY 10/11 funding	FY 11/12 funding	Percent Change	
\$0	\$0	0%	
b) Is the FY 11/12 funding requested outside the $\pm 25\%$ of the previously approved amount, or , For Consolidated Programs, is the FY 11/12 funding requested outside the $\pm 25\%$ of the sum of the previously approved amounts?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
c) If you are requesting an exception to the $\pm 25\%$ criteria, please provide an explanation below.			
NOTE: If you answered <u>YES</u> to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F2.			

A. Type of Funding by Category

WET Funding Category	Check the Box that Applies
Workforce Staffing Support	<input type="checkbox"/>
Training & Technical Assistance	<input checked="" type="checkbox"/>
Mental Health Career Pathway	<input type="checkbox"/>
Residency & Internship	<input type="checkbox"/>
Financial Incentive	<input type="checkbox"/>

B. Answer the following questions about this program.

1. If there have been changes to this program within the scope of what was originally proposed, describe any new objectives, actions, or strategies.
There have been no changes in the scope of the Training and Technical Assistance programs from the original proposed plan.
2. If this is a consolidation of two or more previously approved programs, provide the following information: a) Name of the programs. b) The rationale for the decision to consolidate programs. c) How the objectives identified in the previously approved programs will be achieved.
N/A

PREVIOUSLY APPROVED PROGRAM
Workforce Education and Training

County: San Francisco

No funding is being requested for this program.

Program Number/Name: WET C: Mental Health Career Pathway Programs

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

1. Describe progress on the objectives achieved in this program during FY 09/10 (e.g. administrative and workforce policy support, the provision of financial relief, established partnerships among education and training that are connected to service needs, etc).

FY09-10 was the start up year for all Mental Health Career Pathway Programs. The following programs were implemented following a Request for Proposal in July 2009 and contract negotiations for services starting in October 2009.

Action 4: Summer Bridge Program is an eight-week summer mentoring program for 4 hours a day and three days a week, targeting high school and transitional aged youth (ages 16-20), currently enrolled in or recently graduated from SFUSD high schools. The program is designed to promote awareness of psychological well-being and foster an interest in pursuing a career in the behavioral health field. This summer program provides participating students with classroom learning, field trips to various providers and agencies, guest speakers, and networking opportunities with future schools and potential employers. Students receive \$250 for successfully completing the program. Richmond Area Multi-Services Inc. (RAMS) was awarded this contract. The first year was focused on curriculum development, convening of an Advisory Board, creating collaborative partnerships, and outreach for enrollment into the program.

Curriculum Development included extensive research regarding evidence- and practice-based models for effective program design structures. Research activities included reviewing San Francisco MHSA WET Plan and other related background documents, ongoing discussions with youth services staff, meetings with community partners and organizations, and reviewing curriculum/designs of other similar programs out of the area. Five focus groups with 30 youths in attendance and one care-giver group with two adults in attendance were held at high school wellness centers and community based youth organizations to obtain additional insight & understanding of what adolescents are interested in for a summer program. The curriculum was designed based on input from these focus groups and various providers with significant experience working with youth and workshop speakers were identified based on the topics covered in the curriculum.

Advisory Board An advisory board was created comprised of community youth organizations serving Latino, Asians & Pacific Islander and Samoan populations. Quarterly meetings were scheduled among these organizations in order to collaboratively plan the program. In addition, more frequent meetings were held between the Program Coordinator and the Director of the program where the Summer Bridge sessions were held once the program was underway in order to address site-specific issues, as they arose.

Outreach A flyer was created advertising the program which was translated and made available in three languages (English, Chinese and Spanish). The flyers were posted in all of the SFUSD high schools and distributed to all Wellness Centers, Beacon Center, Youth Task Force, and a Youth Wellness Academy for targeted outreach and promotion especially to youths from under-represented communities. The announcement and application forms, which were due at the end

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Workforce Education and Training

of April, were made available on the RAMS website. RAMS received 55 applications representing 12 public schools and extended offers to over 30 students; not all of the students offered spots in the program were able to accept them. Ultimately, 23 students were enrolled and the first Summer Bridge program was held between June 14th and August 6th, 2010.

Successes and Challenges Although this was the pilot year of the program, RAMS enjoyed many successes with Summer Bridge 2010. One of the highlights of the program was the quality of students who participated in the program. The agency was consistently impressed with the way in which the individuals worked well as a group, challenging while also supporting each other in their learning and development. The participants exhibited a level of maturity that was felt in their focus and their openness to new ideas and experiences. RAMS believes the participants were well-suited for the program because many of the participants were referred by providers in the community. This most likely helped in recruiting youth who were specifically interested in what the program had to offer and able to fully participate in all aspects of the program.

Another success of the program was the level of expertise and experience of the program staff. Leveraging its existing relationships with employees, past and present, RAMS was able to assemble a team that truly represented the diversity that can be found in the mental health field. The depth of clinical experience the team brought to their positions in the program enabled them to work proactively with the participants in order to manage group dynamics, as well as provide individualized support for those participants who were struggling with personal issues to ensure that the vast majority of the students were able to complete the program successfully.

Also, RAMS strives to recruit a more diverse group of program participants (both in terms of ethnicity and schools attended). Although 100% of the cohort was from the target population, the overwhelming majority of the students were of Asian descent. This made it somewhat difficult for the non-Asian members of the group to integrate into the cohort. RAMS will strategically plan to target specific schools that were under-represented this year so that the program can have a more balanced representation of San Francisco's diverse population.

Action 5: Peer Specialist Mental Health Certificate Program is a 12-week program, held twice a week, at the San Francisco State University Downtown Campus. This program targets individuals who are in early recovery but not ready for continuing education or not yet able to work in higher sectors of the labor force, to address basic skills and knowledge for entry-level employment in the behavioral health care system. The program is available in the Spring and Fall of each year. Students will receive \$250 stipends after successfully completing the free course. Successful completion of the course is equivalent to three transferrable credits to San Francisco State University. Richmond Area Multi-Services Inc. (RAMS) was awarded this contract. FY09-10 primarily focused on program and curriculum development and organizing an Advisory Board.

Curriculum Development The development of the curriculum was done in collaboration with the San Francisco State University's (SFSU) Department of Counseling. Curriculum development for this course included a review of materials from similar types of courses and various practices and models including, but not limited to: Supported Employment Model, Livneh's Model of Psychosocial Adaptation to Chronic Illness and Disability, and Social Cognitive Career Theory as well as the Recovery Model, which is the primary basis of the curriculum. Additional curriculum tools included textbooks, professional journal articles, attended workshops, and psychiatric rehabilitation materials. Significant feedback, suggestions, and recommendations on the curriculum came from the three focus groups (potential students, potential employers, community) that were held as well as the Advisory Committee of RAMS and SFSU. The final draft of the curriculum was completed on July 30, 2010

Advisory Committee Members of the RAMS Advisory Board include multi-disciplinary, mental health experts/professionals (social work, marriage & family counseling, psychologist, nursing, case management), educators, and consumers, as well as a cross ethnic/cultural representation (e.g. African American, Asian & Pacific Islander American, LGBTQQ, communities). In addition, San Francisco State University Department of Counseling also developed a separate Advisory Board, which is comprised of faculty members from the Department of Counseling, peer counseling supervisors, and coordinators from Bay Area peer counseling training programs. The goals for the advisory board are to ensure peer specialists are being trained to work in the field and have appropriate classroom experiences that will make them more marketable to social service agencies in the city of San Francisco. These goals were discussed in the context of curriculum design and development. In total, there were 16 Advisory Committee Meetings in FY09-10, which primarily focused on strategy and outreach planning in addition

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Workforce Education and Training

to curriculum development.

Outreach

Three focus groups were conducted, which were organized to specifically target members of the community to gather input for the curriculum, program design & structure, and recommended outreach strategies. The first focus group targeted potential applicants, potential employers, and the community at large. A total of 66 individuals participated in the focus groups. During the Community Focus Group, staff presented the application form and course topic outline to participants. Feedback and suggestions that were gathered during this meeting were then utilized to further improve both documents. Suggestions also included identified resources, time frames, and application requirements as well as suggested locations for promotions.

A program flyer containing general course information was distributed to the public over the course of the promotion period. In addition, an Open House flyer was also created to disseminate information to the public. These were sent out via email blasts, posted on the RAMS website, and distributed during various community presentations. In addition, there were consultative meetings conducted between RAMS, Community Behavioral Health System's (CBHS) Office of Cultural Competence & Client Relations, and the Mayor's Office of Economic and Workforce Development (MOEWD) to discuss possible collaborations between programs.

RAMS outreached to 46 various agencies/networks to promote the program. Many agencies were specifically targeted, as their constituents are those of the underserved and underrepresented communities identified in the contract. Other outreach for the program also included media exposure through the SFSU Golden Gate Press; NAMI Newsletter; Radio Talk Show with Clear Channel and aired on multiple radio stations; Bay Area Ascertainment Meeting Alliance Group, a coalition of major Bay Area media entities such as Clear Channel, KTSF, KGO; and the National Minority Mental Health Awareness Webinar Conference.

The deadline for application submission was on August 16, 2010 for the course starting on September 14, 2010.

Success and Challenges

Through its fund raising efforts, RAMS was able to secure additional funding and donations for matching scholarships equivalent to the stipend amount for Filipino/American students, donated lunches and bottled water for student events. The extensive outreach to promote this program resulted in 80 applicants from the community for 20 student slots in the Fall 2010. In these applications, the following language capacities were noted: Tagalog, Vietnamese, Chinese Dialects (Cantonese, Mandarin, Toisan, Chiu Chow), Vietnamese, Spanish, French, Polish, Italian, Russian Hebrew, Romanian, Farsi, Darija, German and Japanese. This varied language representation clearly indicates the wide reach this program hopes to achieve.

Action 6: Mental Health Certificate Program – a multi-semester, 16 unit certificate program for consumers/family members from underserved/underrepresented groups, including those with cultural and linguistic capacity needed in the public mental health system, to obtain skills and training necessary for providing clinical and other supportive services to individuals with serious mental illness. Admission to the program is based on the completion of the prerequisite course HLTH 91D, Introduction to Recovery Model in Mental Health (1 unit) with a grade of C or higher. City College of San Francisco was awarded this contract. FY09-10 primarily focused on curriculum development, creation of a Community Advisory Board, identifying potential internship sites, and enhancing the supportive services and Peer Care Management team. The program will be launched in the Fall 2010. Scholarships and vouchers for text books will be offered.

Curriculum Development

All course outlines for the Community Mental Health Certificate Program (CMHC) have been completed and approved by the City College of San Francisco's curricula committee. All courses are founded on the Recovery and Wellness Model and integrate competencies articulated in DACUMS, focus groups, community meetings, and forums with consumer groups, family members, service providers, and employers. Project staff has secured approval for all curricula at the district level, and are currently working on securing curriculum approval at the regional and state level. Due to budget cuts and summer recess, the approval of curricula at the regional and state level are pending; however the documentation is in process and approval of the curricula at the regional and state level are anticipated before the end of this Fall semester.

Advisory Committee

A Community Advisory Board has been established comprised of eight (8) individuals representing consumers of mental health services, family members, and

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community allies. The program is still recruiting and expanding this committee's membership.

Supportive Services

The CMHC program incorporates supportive services designed to enhance student retention, access, and success and have developed direct links and personal contacts with on campus supportive services to achieve these goals. In addition, the program has also enhanced the Peer Care Management (PCM) team to support all CMHC students. The PCM team consists of two advanced CCSF certificate students, one graduate student, and the Program Coordinator. The peer care managers and behavioral health specialist offer peer-based outreach, linkage, mentoring, and care management services to new and continuing students in the CMHC. They facilitate "survival tips" workshops and on-going individual peer counseling and social-support groups, drawing on student centered and motivational interviewing skills to collaboratively support students. The PCM also help students develop personalized and comprehensive wellness and recovery action plans tailored to address needs, which may include tutoring, computer literacy skills, financial aid, parenting classes, academic counseling, health care, and any other services.

Outreach

Currently, the CMHC program is developing collaborative partnerships with community based organizations and educational institutions. These stakeholders may function as internship sites, pathway programs leading into the CMHC, post certificate extended training programs, and undergraduate degree and graduate program for those interested in further education. Additionally, the program is continuing its effort to expand on internship sites, creating all program student manuals, and completing scholarship and voucher procedures for the program.

Successes/Challenges

Taught two program prerequisite Health 91D, Introduction to the Recovery Model in Mental Health, courses and 32 students have successfully completed the introductory course. Currently recruiting for approximately 23-30 students for the summer session in July 2010, with approximately 15 students already enrolled for the course.

The development of our comprehensive program has required significant networking within and outside of the College. The infrastructure, collateral organizational, and peripheral systemic aspects of program development have demanded a significant contribution of time, planning, and extensive community outreach beyond the scope of a limited team. The inaccessibility to capital access has been challenging and resulted in overextending resources including human.

Action 7: Supportive Services for Consumers Enrolled in Public Universities or Private Colleges - to increase the enrollment in and graduation rates of consumers, family members, and members of underserved and underrepresented communities from post-secondary institutions – with concentration on service in the public mental health system. San Francisco State University and California Institute of Integral Studies were awarded the contracts for this initiative.

San Francisco State University (SFSU)

The College of Health and Human Services will offer a new set of services, called the Student Success Program (SSP) through the existing Student Resource Center. The goals of the Student Success Program are to increase access and enrollment, enhance retention, and maximize graduation rates among students with lived mental health experience, as well as community members who are underserved and underrepresented in the public behavioral health system. Due to contractual and administrative delays, the new Student Success Program (SSP) had not received funding in FY09-10 from either the City and County of San Francisco's Department of Public Health or SFSU. Expenses paid to date were largely covered by the personal funds of the Program's Coordinator and the lack of funding limited completion of some of the objectives.

Advisory Committee

The 30-member Student Success Program Advisory Committee has been established and includes representatives from various departments within San Francisco State University and students who identify as consumers, family members, and members of underserved and underrepresented communities. Community members on the SSP Advisory Committee include representatives from state rehabilitation agencies, statewide and regional workforce initiatives, local colleges, CiMH, CMHDA, California Mental Health Planning Council, vocational programs, CBHS, and community based mental health organizations. The committee has

PREVIOUSLY APPROVED PROGRAM
Workforce Education and Training

been apprised of the progress of the new SSP program as well as the purpose and potential ongoing roles of the committee. The Advisory Committee meets on a quarterly basis to discuss outreach; recruitment; marketing and promotion; position descriptions for the student assistants, peer mentors, and educational specialists; and public events and campaigns. A sub-committee of the full Advisory Committee has been formed to focus on program evaluation.

Evaluation Design

The Program Coordinator has been working with the Evaluation Subcommittee of the Student Success Program Advisory Committee, Department of Public Health and representatives of the Information Technology office at S.F. State University to identify the most appropriate evaluation procedures, data collection tools, and data to be collected within the context of the services to be provided. It is anticipated that data will be drawn from such sources as university records; the SSP's intake, assessment, and service plans; documentation of groups; consumer satisfaction surveys; suggestions from the publicly posted suggestion box; attendance reports and pre-and post-test materials related to public events and trainings; focus group discussions; a count of the number of students availing themselves of the SSP's drop-in services and socialization activities; and personal accounts from program participants.

Outreach

Materials for the SSP website are being generated along with additional materials advertising the new set of services. The Program Coordinator has created a brochure which was finalized based on feedback by the SSP Advisory Committee, the College of Health and Human Services, S.F. State University administrators and its development department, faculty, students, consumers, and community members. Printing will be completed when the funds become available. Multiple outreach, planning, and collaborative meetings have been held with SFSU campus partners and students who are consumers, family members, and representatives of underserved and underrepresented communities. The Project Director has met with the San Francisco State University Office of Community Development to set up a process for receiving private and in-kind donations and has established a collaborative agreement with SFSU's Office of Community Service Learning to recruit peers into providing services through the SSP. Presentations have been done on the SSP's program in 13 orientation sessions and classes, three transitional/articulated classes for community college students, three first-year experiences classes, and the Richmond Area Multi-Services (RAMS) Summer Bridge Program to an approximate total of 600 students and community members. She has also contacted approximately 200 members of the target communities and their providers in her individual outreach efforts.

Staffing

The Program Coordinator has developed job descriptions for the Peer Counselors (Educational Specialists) and Peer Mentors. Both were finalized based on feedback from the SSP Advisory Committee, the College of Health and Human Services, and SFSU's Human Resources and administrative staff and were distributed to the Schools of Social Work at UC Berkeley, as well as San Jose, San Francisco, and Sacramento State Universities. Eight intern candidates were interviewed and two interns from UC Berkeley have been selected for Academic Year 2010-2011. They will be providing services for 24hrs/week from September 2010 to May 2011.

Success and Challenges The contract process was the most difficult challenge this program faced in FY09-10. Despite the unavailability of funds due to the delay in processing the contract, the Program Coordinator has accomplished a lot of the necessary foundational work to implement this program. She has shown incredible determination, positive outlook, and tremendous goodwill to successfully lead this effort without the much-needed funding.

California Institute of Integral Studies (CIIS) – will expand student support services within its School of Professional Psychology (SPP) program in order to increase recruitment and retention of students from underrepresented groups while actively promoting the mandates of MSHA and career opportunities in the public sector of mental health services. The expansion will cover an on-campus student enrollment and assessment services, as well as academic and peer counseling services and will focus on students who have lived experiences as mental health consumers or family members of consumers, students from underrepresented minority groups, and LGBTQ students.

Student Support Services Department

In FY 09/10, CIIS implemented an on campus MSHA Student Support Services Department (SSSD) that provides new and prospective student intake

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assessments, post enrollment individualized wrap around educational success plans and learning difference assessments. SSSD offers psycho-educational testing services at no additional cost to students from the target populations. Additional staff members were hired and SSSD now has a bilingual and bicultural Community Outreach, Peer Counseling and Writing/Study Skill services. The addition of these staff members allows CIIS to better reach desired target populations in the language and cultures that they communicate in, create a welcoming campus that is free of Stigma for Consumers and Family Members who desire to pursue their MFT license and that supports an atmosphere of inclusion and respect around student’s sexual orientation and gender identity spectrum.

Advisory Group

To further address retention risk, the CIIS MHSA Advisory Group has been formed and serves a key function in our overall Retention Plan. The Advisory Group is comprised of staff, faculty, students and community members, and provides a forum for students to share their challenges in a non-judgmental environment which includes key faculty and administrative decision makers who can address solutions and support with students in a measurable, real-time manner.

Outreach

The Program Manager has outreached to 1,119 potential students, 312 of whom have requested application information from our 5 masters in Counseling Psychology Programs, our Bachelor’s Completion Program and our PsyD Program. Of that number, 112 have completed intake processes and 15 have followed through with a formal application. Subsequently, we now have 11 new students recruited from these 3 target populations, enrolled for academic year 2009/2010.

Trainings

CIIS has rolled out the first phase of a multi-level training and education program for Staff and Faculty, Students and the Community of San Francisco in general that addresses stigma and the dangers of stereotypes, creating a mindfulness and safety toolkit for students in crisis, sexual and gender identity, consumer and familial relationships in the context of higher education, and background and general information about MHSA and NAMI.

Successes and Challenges

SSSD has received powerful testimonials from students as to the benefit of these new services. Students who considered dropping out due to the academic, social or personal challenges they faced in their first semester of adjusting to Master’s level scholarship, have credited Student Support Services for their decision to continue and are now committed to completing their Master’s in Psychology programs. As a result of the summer series training and education programs, CIIS Staff, Faculty, Students and the extended Community have experienced an 80% increase in awareness of the Mental Health Services Act, its guiding principles and desired outcomes in the arena of Public Mental Health. 284 people participated in training and community outreach events over the past 6 months and post workshop surveys indicated that 94% of participants experienced an increased understanding of the challenges facing Consumers and Family Members, Underrepresented Cultural, Ethnic and Linguistic Minorities and LGBTQ Students enrolled in CIIS’ School of Professional Psychology Programs and in the community in general. Participants also demonstrated and increased awareness of the need to diversify the Public Mental Health Workforce in the County of San Francisco.

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Does the work detail or objective of the existing program(s) or activity(s) remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2) Do the activities and strategies remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

**PREVIOUSLY APPROVED PROGRAM
Workforce Education and Training**

3) a) Complete the table below:

FY 10/11 funding	FY 11/12 funding	Percent Change
\$33,636	\$0	-100%

b) Is the FY 11/12 funding requested outside the $\pm 25\%$ of the previously approved amount, **or**,

For Consolidated Programs, is the FY 11/12 funding requested outside the $\pm 25\%$ of the sum of the previously approved amounts?

Yes No

Yes No

c) If you are requesting an exception to the $\pm 25\%$ criteria, please provide an explanation below.

We are requesting an exception to the $\pm 25\%$ criteria because the WET funding is a one-time carve out from receipts in FY06-09. The requested funds in FY10-11 were to add more funding from unapproved WET funding to the Summer Bridge Program, which was very much under-funded in the original Three Year Plan request and is only one of the five MH Career Pathways program included in the Plan. The budgeted expenses for FY11-12 will come from unexpended prior years' funds.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F2.

A. Type of Funding by Category

WET Funding Category	Check the Box that Applies
Workforce Staffing Support	<input type="checkbox"/>
Training & Technical Assistance	<input type="checkbox"/>
Mental Health Career Pathway	<input checked="" type="checkbox"/>
Residency & Internship	<input type="checkbox"/>
Financial Incentive	<input type="checkbox"/>

B. Answer the following questions about this program.

1. If there have been changes to this program within the scope of what was originally proposed, describe any new objectives, actions, or strategies.

None

2. If this is a consolidation of two or more previously approved programs, provide the following information:

a) Name of the programs.

b) The rationale for the decision to consolidate programs.

c) How the objectives identified in the previously approved programs will be achieved.

N/A

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Workforce Education and Training**

County: San Francisco

No funding is being requested for this program.

Program Number/Name: WET D: Residency, Internship Programs

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

This program did not exist during FY 09/10.

1. Describe progress on the objectives achieved in this program during FY 09/10 (e.g. administrative and workforce policy support, the provision of financial relief, established partnerships among education and training that are connected to service needs, etc).

WDET Action 8: Internships for Hard-To-Fill Positions and Underrepresented

The goal of this program is to address mental health workforce shortages and diversity needs by creating a more comprehensive workforce that is culturally competent and staffed by professionals from the targeted service communities who meet the cultural competency needs of Community Behavioral Health Services (CBHS). The program is designed to include a coordinated and centralized recruitment and placement of the following disciplines at various sites: MSW; Counseling/Psychology; Nurse Practitioner; Mental Health Certificate.

This program has been revised several times since the approval of the original WET Three Year Plan. The additional allocation for WET (FY 08/09) gave us the opportunity to expand this program to include recruitment and hiring of full-time personnel, instead of only providing stipends for interns. This expansion was included in the Annual Plan Updates for FY09-10 and FY10-11. With the capacity to hire, came the decision that the goals and funding for this program complimented the PEI Older Adult Behavioral Health Screening program. The *Older Adult Behavioral Health Screening and Response Project* was designed to improve behavioral health outcomes for older adults, aged 55 and up, by expanding early identification efforts and improving access to appropriate care. The project funds two components. WET funds (Residency/Internship) were allocated to support the expansion of an evidence-based collaborative care model, currently implemented at one San Francisco primary care clinic, to all 14 DPH primary care clinics. The model incorporates training for staff, screening for older adults, and a care manager to develop care plans, provide immediate short-term intervention and/or referrals, monitor progress, and provide service linkages and follow-up support. PEI funds were allocated to expand and adapt this model to two community-based older adult centers. The Institute on Aging (IOA) was awarded the contract for the program in November 2009.

In the intervening period between the development of the initial program design (2007) and IOA's initial implementation activities (2010), DPH launched a system-wide initiative to integrate primary care and behavioral health services. Implementation of IOA's model in primary care has faced many challenges, not the least of which is the difference between the IOA model and the new DPH Behaviorist: model. These challenges have resulted in a significant impact on the logistical, clinical and operational aspects of this program. Hiring of behavioral health staff has also proved to be a significant challenge for Institute on Aging. Due to these and other challenges, IOA has staff placed at only two clinics.

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These challenges and the Department’s growing commitment to the evidenced-based Behaviorist model resulted in a decision to transfer funding from the IOA contract to internal efforts to hire, supervise, train, and place Behaviorist at DPH Primary Care Clinics. The goal of the program remains the same - to address mental health workforce shortages and diversity needs by creating a more comprehensive workforce that is culturally competent and staffed by professionals from the targeted service communities.

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1) Does the work detail or objective of the existing program(s) or activity(s) remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						
2) Do the activities and strategies remain consistent with what was previously approved?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						
3) a) Complete the table below:								
<table border="1"> <thead> <tr> <th>FY 10/11 funding</th> <th>FY 11/12 funding</th> <th>Percent Change</th> </tr> </thead> <tbody> <tr> <td align="center">\$654,743</td> <td align="center">\$0</td> <td align="center">-100%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$654,743	\$0	-100%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$654,743	\$0	-100%						
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.								

We are requesting an exception to the ±25% criteria because the WET funding was a one-time carve out from receipts in FY 06-09. The requested funds in FY10-11 were to add more funding from unapproved WET funding to the Residency and Internship Program, which was under-funded in the original Three Year Plan. Since there is no WET allocation for FY 11/12, the funding above is \$0. The actual budgeted expenses for FY11-12 will come from unexpended prior years’ funds.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Please complete an Exhibit F2.

A. Type of Funding by Category

WET Funding Category	Check the Box that Applies
Workforce Staffing Support	<input type="checkbox"/>
Training & Technical Assistance	<input type="checkbox"/>
Mental Health Career Pathway	<input type="checkbox"/>

**PREVIOUSLY APPROVED PROGRAM
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Residency & Internship	<input checked="" type="checkbox"/>
Financial Incentive	<input type="checkbox"/>

B. Answer the following questions about this program.

<p>1. If there have been changes to this program within the scope of what was originally proposed, describe any new objectives, actions, or strategies.</p> <p>There have been no changes in the scope of the workforce staffing and support functions from the original proposed plan.</p>
<p>2. If this is a consolidation of two or more previously approved programs, provide the following information:</p> <ul style="list-style-type: none"> a) Name of the programs. b) The rationale for the decision to consolidate programs. c) How the objectives identified in the previously approved programs will be achieved.
<p>N/A</p>

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 1: School-Based Youth-Centered Wellness
local evaluation

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	519	White	67	English	528	LGBTQ	
Transition Age Youth (16-25)	31	African American	237	Spanish	131	Veteran	
Adult (18-59)	76	Asian	67	Vietnamese		Other	
Older Adult (60+)	4	Pacific Islander	41	Cantonese	20		
		Native American	6	Mandarin			
		Hispanic	224	Tagalog	1		
		Multi	11	Cambodian			
		Unknown	31	Hmong			
		Other	2	Russian			
				Farsi			
				Arabic			
				Other	4		

**PREVIOUSLY APPROVED PROGRAM
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B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The ***School-Based Youth-Centered Wellness Program*** promotes the use of school-based best practices that address non-academic barriers to learning in strong collaboration with community-based organizations at K-12 school sites. Using public schools as hubs, this initiative brings together multiple partners to offer a range of supports and opportunities to children, youth, and their families before, during and after school. This coordinated approach is designed to support student success by combining the full spectrum of prevention, early intervention, and linkage to behavioral health services with other supports already provided in the school setting. It builds on the strengths of community partners which incorporate a wide variety of philosophies that are often rooted in a prevention or resiliency model, such as youth development, peer education, culture or ritual-based healing, and family support. The activities supported through the *School-Based Youth-Center Wellness Program* generally involve:

- Crisis intervention
- Family engagement and support
- Wellness promotion workshops
- School climate activities (e.g. Anti-Bullying and Good Citizen Campaigns)
- Student leadership and peer education
- Teacher training and support
- Mental health consultation services
- Case management
- Short-term individual and group behavioral health services (e.g. screening and assessment and early intervention)

The School-Based Youth-Centered Wellness programs are ongoing at 15 school sites by 5 community agencies.

- **Edgewood Center for Children and Families** *School-Based Well-Being at Charles Drew College Preparatory Academy (K-3) was funded* to build the capacity of teachers to handle behavioral issues as they arise, the capacity of families to provide the support their children need to succeed, and the capacity of children to deal with issues that may be impeding their academic and social progress.
- **Institutito Familiar de la Raza** *Consultation, Affirmation, Resources, Education & Empowerment Program (CARE) at Paul Revere School (K-8) was funded* to provide comprehensive mental health consultation services including prevention and early intervention services. The CARE Program serves as an integrative bridge between teachers, out-of-school time providers, students, and parents in order to facilitate the building of positive, esteem building relationships for students in the classroom, at home, and during after school programming.
- **Bayview Hunters Point Foundation** *at Balboa High School Health Center was funded* to provide prevention and early intervention behavioral health services including (1) prevention activities that address stigma, and increase awareness of and access to services, (2) short-term crisis and individual/group counseling services to students and their families.
- **Bayview YMCA** *at Burton High School was funded* to provide academic guidance, youth development, and family support services in order to help teens be successful in school, avoid truancy, build resiliency and self-esteem, and strengthen their social support systems (including their families).

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- **Richmond Area Multi-Services to provide *Enhanced Support Services for High School Wellness Centers*** serves schools disproportionately impacted by violence. Services include clinical case management and trauma/grief & loss group counseling. The Clinical Case Manager (CM) provides case management with persistent follow-up; outreach & liaison (e.g. primary care, vocational, community programs); consultation & workshops for students, teachers & parents (e.g. behavioral health issues, resources); and prevention activities (e.g. organizing health fairs, school parent meetings). The Trauma/Grief & Loss Group Counselor provides crisis intervention; mediation & de-escalation; individual & group counseling (ongoing & immediate response); case management & liaison (e.g. primary care, counseling); consultation & workshops for teachers & parents (e.g. issues of trauma/grief & loss); consultation & workshops for other providers (e.g. School Health); outreach & prevention (e.g. school assemblies, health fairs, parent groups); and consultation on school climate activities.

The PEI School-Based Youth-Centered Wellness Program also includes a grant to support the existing *Wellness Center at School of the Arts (SOTA) High School* (\$82,400). These funds were transferred from CSS to PEI in FY 2009-10 to support counselors conducting behavioral health assessments; individual & group counseling (short- and long-term); crisis intervention; substance use/abuse services; case management, referral & liaison (e.g. primary care, vocational, community clinics, afterschool programs); consultation & workshops for teachers & parents (e.g. awareness of behavioral health issues); and outreach & prevention (e.g. workshops, school assemblies, health fairs, parent meetings, Wellness Newsletter).

Reaching Underserved Communities and Addressing Health Disparities

By design, the *School-Based Youth-Centered Wellness Program* is primarily prevention focused and focuses on schools with high proportions of students with risk factors and/or behavioral needs and strong existing or potential community partners. The ethnic and/or cultural populations served represent high priority communities as documented by data and information on risk factors such as community violence/trauma, gang activity, social isolation, lack of support services, teenage pregnancy, substance abuse, unmet behavioral health needs, unsafe or lack of housing, lack of food security, and health inequities. A few highlights from specific programs are listed below.

- **Balboa High School Teen Health Center services** are available to all Balboa High School and Denman Middle School students, and after school to any SFUSD student by appointment. Generally, the target population is youth from diverse ethnic backgrounds, 12-19 years of age, serving slightly more females than males. The program makes a special effort to target students in English Language Learners (ELL) classes. These recently arrived immigrant youth come from a variety of countries and many have significant issues in their lives that affect their mental health. BTHC's ability to provide services in English, Spanish and Chinese has significantly supported the projects ability to reach these youth. Students who are recently released from the Youth Guidance Center, and pregnant and parenting teens.
- **Enhance Supports for Wellness Centers** primarily works in school sites in San Francisco's Southeast Sector, a high need and under-resourced geographic area of the City where tremendous health disparities exist in mental health. Richmond Area Multi-Service focuses on students with behavioral health issues with many being referred for concerns relating to mood, behavior, and other adverse circumstances. Outreach is also to those who may benefit from intensive case management, who are dealing with trauma/grief & loss, or families with limited resources.
- **Charles Drew College Preparatory Academy** serves the entire Charles Drew student body, which is 76% African American, 7% Latino, 5% Pacific Islander, 4% Multi-Racial or no response, 3% Asian, 3% White, 1% Filipino, and 1% Native American. Eighty-five percent will qualify for free or reduced-price lunches.
- **School Of The Arts (SOTA)** The demographic profile of the student community served by the SOTA Wellness Center is: 40% male, 60% female; 23% African American, 16% Asian/Pacific Islander, 8% White, 7% Latino, 1% Native American, 32.5% other, and 12.5% declined to state.
- **Paul Revere Elementary School** targets low-performing students who have experienced trauma, immigration, and poverty. Particular emphasis will be placed on Latino and African-American students and their families who have been marginalized and disempowered by the system. Of the 470 students currently enrolled at Paul Revere School, 54% are Latino and 25% African American. 60% are bused in from the Bay View District; 60% are English Second Language

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Learners, and more than 80% qualify for free or reduced-price lunch.

- **Phillip and Sala Burton Academic High School** Outreach and promotion efforts will be inclusive of all Burton students and parents in accordance with the guidelines and parameters established by the school principal and San Francisco Unified School District. Specific outreach strategies will include referrals from faculty and staff, flyer distribution, and multi-language mailings. The Prevention Services Coordinator (PSC) will personally contact parents to invite them to participate in workshops, brief presentations during advisory meetings, Beacon programs, club meetings, faculty/staff meetings, and ads placed in the weekly Beacon newsletter and school paper

Key Program Differences or Challenges in Implementation

Parent engagement has been an ongoing concern at Burton High School. Although parents did attend the workshops, the program is geared to serving more parents.

Another challenge was finding the most effective way to integrate in the school community and staff. Building relationship with existing services on campus was a challenge due to the concern of PEI program providing the same services as the Wellness Center. In addition the PEI program began in the middle of the school year and programs and services were already developed and implemented. Collaborations with other agency took a slow a start because PSC(what is PSC?) had to actually find out what agency provided the services needed to enhance the effectiveness of the PEI program.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

Working in FY 10/11 to identify a set of program goals and objectives for the program as a whole.

A. Select Person/Family-level and Program/System-level Outcomes

- Work with students and teachers around behavior intervention and social skills capacity building resulted in noticeable and in some cases, rapid and significant improvement in student behavior.
- Of the students surveyed, 100% reported overall satisfaction with services.
- Teachers consistently reported that the consultant's support increased their understanding of the social-emotional and behavioral needs of their students. For example, one teacher stated that she felt much better equipped to look at her student's individual needs and to respond to his distress differently as a

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

**PREVIOUSLY APPROVED PROGRAM
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result of consultation support.

- Parent participation during parent conference week reflected an increase in attendance for families receiving services, families who historically were more difficult to engage.
Of the 85% of referred students, 70% were linked with community services. There were significant external reasons for non-linkage such as: parents disapproved of mental health care, school year ended with students not being able to continue follow-through, and student deciding not to pursue services.

B. 09/10 Participant Data

Prevention – 4838 individuals served

Early Intervention services – 684 individuals served

C. Evaluation Methods

Select Program Goals and Outcomes

- Decrease mental health crisis episodes
- Students receiving behavioral health services will report feeling better about themselves (e.g. self-esteem, improved quality of life)
- Staff receiving consultation services will report that consultation helped them learn to communicate more effectively with parents of children where there were concerns about the child's behavior
- Increase parent participation at school activities
- Parents receiving services from the early childhood mental health consultant will report that the consultant was attentive and responsive to their needs
- Students receiving services and enrolled in groups will complete the group counseling cycle
- Successful linkages services

Select Evaluation Tools

- Child PTSD Symptom Scale (CPSS 1 & 2) to evaluate effectiveness trauma group services
- Pre/post measures on the WMS (Walker McConnell Scale) Assessment for behavior coaching
- Staff satisfaction surveys and anonymous consumer evaluation survey
- Sign-in sheets
- Attendance records
- Case management logs and clinician notes

D. Engaging Consumers

Balboa Teen Health Center's Youth Advisory Board (YAB) did an exceptional job in working with clinic staff this last school year, engaging in significant training and development, creating a power point on positive mental health, accessing mental health services at our clinic and an overview on minor consent laws and services; in classroom sessions several YAB members told their own stories about accessing MH services at BTHC and how it helped them. The YAB Assembly was an awesome event. Created by the YAB, with assistance from the SF Mime Troupe, the assembly told both a political story (current issues around health care at the Federal level) as well as bringing it down to the student level through a second story of the Congressman's niece who subsequently needed mental

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health services and was unable to access due to lack of access/insurance. It was well received by the students at Balboa.

E. Program Changes

N/A

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1"> <thead> <tr> <th>FY 10/11 funding</th> <th>FY 11/12 funding</th> <th>Percent Change</th> </tr> </thead> <tbody> <tr> <td>\$1,947,400</td> <td>\$1,168,400</td> <td>-40%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$1,947,400	\$1,168,400	-40%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$1,947,400	\$1,168,400	-40%						
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.								

In FY10-11 we had planned to expand the School-Based Youth-Centered Wellness program to ten additional schools. However, because MHSA revenue projections are expected to decline substantially in the next two-three years, the expansions would have been unsustainable. In FY11-12 we are excluding this expansion. Therefore the budget difference between FY10-11 and FY11-12 exceeds the +/- 25% limitations.

We are requesting an exception to the ±25% criteria (exhibit F3) because no programs were ever implemented.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

N/A

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation

**PREVIOUSLY APPROVED PROGRAM
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c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)		
N/A		
B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	4,500	600
Total Families:	1,500	250

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Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 2- Screening, Planning and Supportive Services for Incarcerated Youth

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	48	White		English	18	LGBTQ	
Transition Age Youth (16-25)	5	African American	24	Spanish	5	Veteran	
Adult (18-59)		Asian		Vietnamese		Other	
Older Adult (60+)		Pacific Islander	1	Cantonese			
		Native American		Mandarin			
		Hispanic	20	Tagalog			
		Multi	4	Cambodian			
		Unknown		Hmong			
		Other	2	Russian			
				Farsi			
				Arabic			
				Other			

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Prevention and Early Intervention**

B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The ***Screening, Planning and Supportive Services for Incarcerated Youth Program*** seeks to build the capacity of the juvenile justice system to identify and meet the behavioral health and wellness needs of incarcerated youth, enabling responsive and appropriate support that, in turn, will lead to youth reentering the community with increased emotional stability and self-sufficiency and will prevent future involvement with the juvenile justice system. The program also supports families and communities to break the cycle of incarceration and support the success of their young people. The program includes the following components.

1. Assessing all youth detained at Juvenile Hall (+72hrs) with the Child and Adolescent Needs and Strengths Assessment.
2. Developing treatment/case plans based on behavioral health needs.
3. Facilitating the wraparound planning process (individualized, family-centered, strength-based, and needs-driven).
4. Linking youth and families with a wide range of culturally competent services and supports provided by community partners in San Francisco and the East Bay.
5. Providing reentry support and follow-up with an emphasis on linkages to community resources.

Through a competitive request for proposal (RFP) process, Community Behavioral Health Services (CBHS) awarded new grants to the following organizations in October 2009.

- Seneca Center
- Youth Justice Institute (YJI)

The program was officially launched in March 2010. In the last three months of the fiscal year, program accomplishments included:

- Through the FY 09/10 contract with YJI, 33 young men were identified and served for advocacy/supportive services. Staff connected these youth to a myriad of community resources including advocacy to resolve school problems and get IEPs; YMCA; Samoan Community Development Center; Brothers Against Guns; Transition Age Youth; Boxing Gym; New Directions; Larkin Street; New Doors Ventures; Golden Gate Regional Center; Evening Reporting Centers; Jamestown Community Center; and Bayview Community Response Network.
- Through the FY 09/10 contract with Seneca Center, 16 young men and 4 young women were served. 10 youth were connected to individual mental health services; 6 youth to substance abuse treatment services; one youth to group therapy; 4 families to family therapy, 8 families to Wraparound Services and 3 families to Multi-Systemic Services. These services were offered by Asian American Recovery Services, Community Mental Health clinics, CBT Trauma Informed Violence workgroup, Westside Community Services, Family Mosaic and Seneca Center.
- Staff for bother programs also connected parents, as indicated by their individual situations, to parenting classes, the Homeless Perinatal Program, Family Advocates and church programs. Parents were also provided contact information regarding Child Crisis as part of families' safety plans.

Reaching Underserved Communities and Addressing Health Disparities

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The target populations for this program are detained youth and transitional age youth involved in the juvenile justice system from underserved and underrepresented populations who are identified as having behavioral health needs, are Medi-Cal eligible or uninsured, and have been detained for more than 72 hours. Youth of color are highly overrepresented, particularly African Americans, who make up roughly 69% of the detained youth. These youth reside primarily in the Bayview, Visitation Valley, Mission, Outer Mission/Excelsior and Western Addition neighborhoods. About 75% of the target youth in the program have been charged with felony offenses and will spend an average of one year incarcerated or in placement. Approximately 50% of the youth were once involved in the dependency system. A significant number of the youth meet the criteria for at least one DSM-IV diagnosis. However, many of these youth are disconnected from mental health services prior to and most will not have been attending school regularly.

One of the core strategies of the program is to create sustainable support systems in the community that will enable clients and families to maintain the achievements made during the time they were in the program. These strategies have been demonstrated to be highly effective in engaging, retaining, and supporting San Francisco youth and families who formerly were distrustful of and resistant to services offered by both public and private agency providers.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program’s implementation, if any, and the reason(s) for the changes

A. Select Person/Family-level and Program/System-level Outcomes

- Of the 33 YJI clients connected with support services, 8 young men (26%) exited probation successfully with no additional violations or charges. This is in comparison to a 33% recidivism rate for males detained in juvenile hall.
- There were four Seneca youth discharged during the fiscal year who received direct behavioral health services for two months or more. Of these, 1 completed all of his treatment goals and 3 partially met their treatment goals. Seneca staff was able to engage youth and families in treatment planning and thereby gained buy-in for implementing treatment goals. Of the four youth who have discharged, all four were living with parents or relatives and attending school or working.

As the program progresses, more information on outcomes will be available.

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

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B. 09/10 Participant Data

In addition to the participant data above. Seneca reported that 80 youth received individual services and 45 youth received group services. The language data in section A is incomplete. Seneca did not report this information.

C. Evaluation Methods**Select Program Outcomes and Methods for Evaluation**

- Increase families' ability to support youth, youths' pro-social behavior and family and youth functioning.
- Clients with an open episode, for whom two or more contacts had been billed within the first 30 days, should have both the initial CANS assessment and treatment plans completed in the online record within 30 days of episode opening.
- Retention of youth in services a) internal, b) external as collected in YJI data base.
- Number of youth who accomplish goals set in advocacy as measured by exit form.
- Recidivism rates of youth receiving services will decrease by 40% in six and 12 months compared to the two years prior to the grant period as assessed by Juvenile Probation Department data.
- 100% of family members are referred to parenting classes, housing or employment support services, support groups, kinship services, faith based services or other community resources.
- 100% of youth are referred to housing resources, work or school support, recreational activities or other community services.

D. Engaging Consumers

Both programs employ evaluation strategies that engage consumers in providing feedback. Seneca administers the Peabody Client Satisfaction Survey to all clients discharging from AIIM Higher in order to find out what they think of the services they receive. The survey stresses that their honest feedback is critical for helping Seneca to continually improve. All responses are confidential and anonymous.

E. Program Changes

None

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="padding: 2px;">FY 10/11 funding</th> <th style="padding: 2px;">FY 11/12 funding</th> <th style="padding: 2px;">Percent Change</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$412,000</td> <td style="padding: 2px;">\$409,000</td> <td style="padding: 2px;">-1%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$412,000	\$409,000	-1%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$412,000	\$409,000	-1%						
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.								

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

N/A

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation
- c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)

N/A

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B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	150	65
Total Families:	150	65

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County: San Francisco

Program Number/Name: PEI 3: Re-engagement of Truant and Out-of-School Youth Please check box if this program was selected for the local evaluation

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

Due to a restructuring of the Student Support Division at the San Francisco Unified School District, a contract was never executed for FY 09/10. Implementation of the program is expected in Summer 2011.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)		White		English		LGBTQ	
Transition Age Youth (16-25)		African American		Spanish		Veteran	
Adult (18-59)		Asian		Vietnamese		Other	
Older Adult (60+)		Pacific Islander		Cantonese			
		Native American		Mandarin			
		Hispanic		Tagalog			
		Multi		Cambodian			
		Unknown		Hmong			
		Other		Russian			
				Farsi			
				Arabic			
				Other			

**PREVIOUSLY APPROVED PROGRAM
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B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:

- a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
- b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
- c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
- d) Specific program strategies implemented to ensure appropriateness for diverse participants
- e) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1" style="width: 100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="padding: 2px;">FY 10/11 funding</th> <th style="padding: 2px;">FY 11/12 funding</th> <th style="padding: 2px;">Percent Change</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$268,000</td> <td style="padding: 2px;">\$268,000</td> <td style="padding: 2px;">0%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$268,000	\$268,000	0%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$268,000	\$268,000	0%						
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the ±25% criteria, please provide an								

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

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explanation below.		
<p>NOTE: If you answered <u>YES</u> to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.</p>		
<p>A. Answer the following questions about this program.</p>		
<p>1. Please include a description of any additional proposed changes to this PEI program, if applicable.</p>		
None		
<p>2. If this is a consolidation of two or more previously approved programs, please provide the following information:</p> <ul style="list-style-type: none"> a. Names of the programs being consolidated b. The rationale for consolidation c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s) 		
N/A		
<p>B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.</p>		
	Prevention	Early Intervention
Total Individuals:	50	25
Total Families:	30	10

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County: San Francisco

Program Number/Name: PEI 4: Holistic Wellness Promotion in a Community Setting

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	110	White	16	English	306	LGBTQ	
Transition Age Youth (16-25)	175	African American	145	Spanish		Veteran	
Adult (18-59)	107	Asian	51	Vietnamese		Other	
Older Adult (60+)	46	Pacific Islander	1	Cantonese			
		Native American	131	Mandarin			
		Hispanic	8	Tagalog			
		Multi		Cambodian			
		Unknown		Hmong			
		Other	1	Russian			
				Farsi			
				Arabic			
				Other			

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B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The ***Holistic Wellness Promotion in a Community Setting*** is designed to address the needs of individuals, families and communities exposed to violence and trauma of all types. The development of the project was based on research and promising practices and was strongly informed by the best practice model developed here in the SF Bay Area – *Holistic System of Care (HSC)* – for Native Americans in an urban environment. The model includes community outreach and education, pro-social community building events, direct services, and service linkages to reduce risk factors and build protective factors. It draws heavily on traditional cultural or community wellness practices, peer support, family and community work, and evidence based treatment. While the exact menu of services depends on the lead agency and partners, as well as the specific needs and cultural practices of the community, the *Holistic Wellness Promotion in a Community Setting* Project generally supports activities that fall under Community Wellness Promotion and/or Cultural and Traditional Healing.

Wellness Promotion

- Family engagement and support
- Peer counseling/mentoring
- Support groups
- Positive parenting programs
- Leadership development
- Wellness promotion workshops
- Short-term individual and group behavioral health services (e.g. screening and assessment and early intervention)

Cultural and Traditional Healing

- Cultural events and festivals
- Drumming circles
- Naming Ceremonies and Coming of Age Ceremonies
- Arts activities such as oral traditions, quilting, Tai Chi, and theater
- Talking circles – facilitated community discussion groups with varying topics

Due to the great response to the Request for Proposals (RFP) and to the number of and diversity of communities in need of these services, the decision was made to award four contracts. This is one more award than the three originally proposed. In October 2010, 4 community-based organizations were selected to support implement Holistic Wellness Promotion in a Community Setting. The following list provides a brief overview of the four Holistic Wellness Programs with select implementation highlights from FY 09/10.

Bayview YMCA’s African American Holistic Wellness Program is designed to build a stronger sense of community among African American individuals and families in San Francisco, as well as decrease the impact of trauma and increase the holistic wellness of these individuals. The program has three primary programmatic areas: fellowship, oral tradition, and creative arts. In FY 09/10 Community Cultural Events happened at least once a month and celebrated African American culture, traditions, heroes, and societal contributions. Bayview YMCA partnered with other organizations to put on large scale events (such as Kwanzaa, Black Cuisine, and Juneteen) as well as several monthly smaller events. The goals of the cultural events were to involve the community in cultural activities, build awareness, and connect community members to cultural traditions and relevant services in the neighborhood. One project within the Oral Tradition programming

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was the Video Project, an intergenerational media project in which young people interviewed seniors about their experience living and working in San Francisco.

Central City Hospitality House's Holistic Violence Prevention and Wellness Promotion Project targeting the homeless population in the Tenderloin Neighborhood of San Francisco is designed to increase the community's capacity to ameliorate the negative impact of trauma exposure on community members through increasing access to a range of services. Prevention Activities are intended to strengthen positive social and psychological development to assist participants in maintaining a more stable level of functioning. Examples of prevention activities include, Violence Prevention and Civic Participation Program; Cultural connections and community-building through community violence prevention events, drumming, social activities, and the Community Arts Program; Drop-in Groups; Integration with the existing continuum of Hospitality House services. Early Intervention Activities are intended to support participants in meeting their mental health needs through an individualized range of services, varying in intensity, in order to prevent the need for more intensive mental health services. These activities include, Peer Advocate Screening; Mental Health Assessment; Harm Reduction Therapy (Integrated Mental Health and Substance Use Treatment). While 2009-10 was mostly a year of planning, the implementation has since begun and we look forward to providing updates on the outcomes and impact of the program. A program kickoff event was held for the community on Friday, August 20, 2010 (after the end of the fiscal year), and it was an overwhelming success with roughly 150 community members attending. In addition, 36 participants received a mental health screening during the 2009-10 fiscal year.

Instituto Familiar de la Raza's Indigena Health and Wellness Collaborative targeting Mayan Community is a **partnership** between Instituto Familiar de La Raza and Ascoacion Mayab that has the goal of improving the health and wellbeing of Indigena immigrant families by increasing access to health and social services, supporting spiritual and cultural activities that promote community building, strengthening social networks of support, and providing opportunities for healing as well as creating opportunities for early identification and interventions in families struggling to overcome trauma, depression, addictions, and other health and mental health problems. There are two components to the IHWC. The Cultura y Salud component focuses in providing opportunities for spiritual and emotional healing by organizing and sponsoring ceremonial, cultural and social gatherings and providing group education to families and individuals. Cultura y Salud also provides individual health education and risk reduction services to individual and families needing additional support. The Indigena Health Promoters Program component relies on a team of 6 Mayan speakers who have received training on outreach techniques, interpretation and health education. These promoters/promotores organize and facilitate activities ranging from cultural events, workshops on traditional arts and health education sessions to outreach, interpretation services and information and referral to community members as needed. The Promotores organize their outreach activities and provide services such as information and referral, workshops and group education about health related topics. Promotores also provided system navigation and interpretation services to clients as needed. In FY 09/10, Promotores reached 598 individuals with information and education during community events, health fairs, ceremonies and through street outreach. In addition, a total of 285 individuals identified through outreach, during events and activities or simply those who walked into our facilities received information and referral services. The program organized a community forum on trauma and a summit of cultural organizations that provided the space for healers and educators to address the issues of trauma and historical trauma among participants. A total of 137 individuals participated in these two activities. Close to 650 individuals participated in the 6 ceremonies and cultural activities sponsored by the program. During ceremonies and cultural activities healers also addressed issues of health and mental health with participants.

Native American Health Center's Living in Balance targeting the Native American community is designed to link culturally appropriate mental health prevention and early intervention services to Native people in San Francisco in a holistic approach congruent with Native American values and traditions. The program provides community outreach and education, pro-social community building events, direct services, and service linkage to reduce risk factors, build protective factors, and address and prevent trauma in this community. The Native Wellness Center's grand opening occurred on May 4, 2010. Sixteen people participated and the event included a blessing of the Living In Balance (LIB) project by a Traditional Healer. All staff members have been trained on the HSC wellness promotion model and have been oriented to the goals and structure of the MHSA program and the Native Wellness Center. During FY 09/10, program staff facilitated 19 individual sessions with Traditional Healers (19 participants), 23 early intervention sessions with a Mental Health Specialist (5 participants), and 22 direct prevention sessions with a Mental Health Specialist (7 participants). Additional program activities included, 4 Positive Indian Parenting Classes (13 participants), 23 Drum groups (35 participants), 19 beading groups (18 participants), 13 Regalia groups (41 participants), and 3 talking circles (52 participants).

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Select Program Differences or Challenges in Implementation

African American Holistic Wellness Program One challenge in the beginning of this project was having staff that was new to the community. Though the YMCA has a long history in the Bayview community, staff in the program were new to the Bayview YMCA. Many in the community view “outsiders” with great suspicion, which means a lot of staff time in FY 09/10 was spent simply getting to know others and having them get to know the staff.

Holistic Violence Prevention and Wellness Promotion Project Intern recruitment and interviews did not occur until after the end of the fiscal year. In addition, the database networking is not yet complete, so while data was collected, it has not been entered into the system yet.

Indigena Health and Wellness Collaborative The original design of the program included co-locating the Promotores at different “host” organizations. Unfortunately, by the time the Promotores had completed their training, the program had the commitment of only one agency to host one of the Promotores. Instead, the program decided to co-locate them at IFR and Asociacion Mayab’s new office.

Living in Balance Although many community members have accessed and utilized PEI services through the program, there is insufficient information to demonstrate progress towards targeted outcomes. We anticipate that progress will become more apparent once additional data is collected.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program’s implementation, if any, and the reason(s) for the changes

Select Person/Family-level and Program/System-level Outcomes

The overall goal for this program is for San Francisco communities, whose members have been disproportionately exposed to traumatic events, are able to ameliorate the negative effects of these events on mental health and to develop protective and resiliency factors at the community, family, and individual levels. More specific person/family-level and program/system-level outcomes are as follows.

Individual Outcomes

- Community members are exposed to cultural activities and traditional healing experiences.
- Community members experiencing emotional distress related to trauma exposure are able to reduce distress and improve functioning through increased access to counseling and/or case management services.

Program Outcomes

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

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- The program provides a comprehensive menu of culturally-appropriate services designed to support community members in coping with the effects of historical trauma and other forms of trauma-exposure.
- The program is perceived by community members as being a safe, healing, and non-stigmatizing place to connect with other community members, receive support, and address the effects of historical and other traumas within the community.
- Community members who participate in mental health services (e.g., counseling, case management) experience improvement in mental health functioning and decreases in trauma-related symptoms.

System Outcomes

- Increased community capacity to ameliorate the negative impact of trauma exposure on community members and improve community member coping and mental health.
- Increased community capacity to support the healthy development of children and youth.
- Increased community capacity to provide cultural activities and traditional healing experiences to community members who wish to participate in them.

09/10 Participant Data

Please See demographic data in Section I, Part A.

Individuals: 871

Groups: 173

Events: 3053

Local Evaluation of a PEI Program

The Holistic Wellness Promotion in a Community Setting was selected for the Local Evaluation of a PEI Program. As indicated above, FY 09/10 was spent primarily conducting start-up activities. Planning for a multi-site evaluation of the four Holistic Wellness programs included the following activities.

- Conducting individual site visits with the four individual Holistic Wellness contractors and discussing each agency's program designs, and refined work plans.
- Soliciting and reviewing proposals for contracted evaluation support (March 2010); awarded to LFA Group
- Convened the 4 programs for a 2-day training conducted by LFA Group on Theories of Change and developing Logic Models (4/26/10 and 5/5.10)
- Developed HR requisition with a goal of hiring a full-time PEI evaluator. After repeated delays, efforts to hire evaluator culminating in new hire as of 12/1/2011

While the planning for the Multi-Site Evaluation is still ongoing, the following evaluation questions suggest the likely focus of the evaluation.

Evaluation Questions:

- HOW EFFECTIVE ARE THE PROGRAMS IN RECRUITING and ENGAGING THEIR TARGETED POPULATIONS (i.e. community members exposed to violence and/or experiencing trauma) IN MENTAL WELLNESS ACTIVITIES?
- HOW ARE THE PROGRAMS BEING IMPLEMENTED?
- TO WHAT EXTENT HAVE HOLISTIC WELLNESS PROGRAMS IMPROVED COMMUNITY RESILIENCE TO TRAUMA AND VIOLENCE? (e.g. increased knowledge of MH information and services; increased social connectedness; increased community leadership capacity)?

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Next steps include, continued efforts to finalize logic models, preparing survey tools and outlining data collection procedures, including the engagement of community advocates, at the program sites, and convening the 4 programs for multi-site evaluation kick off meeting. As details relating to Data Sources and Resources, Sampling and Analytic Strategies Outcomes of interest will be shared as they become finalized.

Reaching Underserved Communities and Addressing Health Disparities

The African American Holistic Wellness Program targets African American families living in the 94124 zip code (Bayview), a high need and under-resourced geographic area of the City where tremendous health disparities exist in mental health. The program also supports programming at satellite service sites in the zip codes of 94112 (Oceanview) and 94115 (Western Addition). We will also consider (94134) Visitacion Valley.

The Holistic Violence Prevention and Wellness Promotion Project primarily targets multi-diagnosed, multiply traumatized, homeless and at risk adult residents of the Tenderloin. Hospitality House serves 600 people annually, which includes individuals and “families,” understood as a primary social group sharing common beliefs and activities, as defined by its members. Demographics of this population reflect the diversity of the community, with roughly 38% African American, 3% American Indian, 10% Asian, 26% Caucasian, 16% Latino, and 8% other; 28% female, 70% male, 2% transgender; 10% veterans; 50% housed; 21% age 55 and older. Services are located in San Francisco’s Tenderloin community, the 94102 zip code.

Indigena Health and Wellness Collaborative targets Indigena immigrant families in San Francisco: comprised of mostly newly arrived young adults. The nearly 15,000 Maya-Yucatecos in San Francisco represent the largest and fastest growing Mayan immigrant community in the City. Other emerging Maya communities, including Mam and Quiché from Guatemala and Tzeltal and Chol from Chiapas account for an additional 4,000 to 6,000 more individuals. Many of these individuals have relocated to the Mission and Tenderloin Districts and to the Geary Boulevard and Clement Street corridors in recent years. For the vast majority of these immigrants, their native languages are their primary and preferred means of communication at work, home, and in many other community settings. A survey conducted by Mayan students at San Francisco’s City College in 2003 showed that the vast majority of Mayans were solo males between the ages of 14-35 years old and that many of them had immigrated to the US less than five years ago. In recent years, more and more Indigena women have come to San Francisco to join their partners, bringing with them their children.

The Living in Balance program targets Native American/Alaska Native children, youth, transition age youth, adults, and older adults who have been exposed to trauma or are at risk for trauma, as well as children, youth, and transition age youth who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system in San Francisco.

Program Changes

None

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="padding: 2px;">FY 10/11 funding</th> <th style="padding: 2px;">FY 11/12 funding</th> <th style="padding: 2px;">Percent Change</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$1,000,000</td> <td style="padding: 2px;">\$1,000,000</td> <td style="padding: 2px;">0%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$1,000,000	\$1,000,000	0%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$1,000,000	\$1,000,000	0%						
b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, or ,	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.								

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

None

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation
- c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)

N/A

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	1600	200
Total Families:	400	50

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 5: Early Childhood Mental Health Consultation Initiative (ECMHCI)

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10							
<input type="checkbox"/> Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.							

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	1245	White	152	English	508	LGBTQ	
Transition Age Youth (16-25)		African American	155	Spanish	273	Veteran	
Adult (18-59)	364	Asian	722	Vietnamese	35	Other	
Older Adult (60+)		Pacific Islander	96	Cantonese	317		
		Native American	35	Mandarin	21		
		Hispanic	302	Tagalog			
		Multi	47	Cambodian			
		Unknown	54	Hmong			
		Other	46	Russian			
				Farsi			
				Arabic			
				Other	455		

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

ECMHC Model

The initiative seeks to prevent, identify, and reduce the impact of mental health challenges among children aged 0-5 and their families. It is a prevention-based model as the presence of mental health professionals in childcare and shelter settings provides staff and parents the opportunity to identify and address mental health issues or developmental delays before children enter school. The following are examples of typical ECMHCI activities:

- Child observation;
- Individual/group consultation and training for teachers and staff;
- Modeling and coaching for staff and care givers;
- Regular contact with programs of an average duration of 6-12 hours per week;
- Facilitating linkages to and coordination of services;
- On-call services (for Family Child Care Networks).
- Limited low intensity direct services to children and families, less than one year in duration, such as therapeutic groups, individual or family sessions and service linkage.

ECMHCI Initiative Training Institute

Under this initiative, MHSA PEI funding is supporting the development and implementation of a NEW CBHS administered *ECMHCI Training Institute*. The intent of the Institute is to build the capacity of mental health clinicians to undertake the unique and complex work of providing early childhood mental health consultation services to early care and education providers caring for San Francisco's youngest children. The Training Institute will focus on the core competencies that have been developed by *California's Infant, Preschool and Family Mental Health Initiative*. It will incorporate a peer learning model to foster the sustainability of a citywide learning and support network. The development of the Training Institute is still underway. Job descriptions have been developed and requests for budgeted positions for coordination of the initiative were recently approved.

Reaching Underserved Communities and Addressing Health Disparities

The ECMHCI targets settings in which young children receive care in San Francisco. The goal of the initiative is to nourish the positive mental health and well-being of young children through the promotion of healthy and supportive relationships with their caregivers. It primarily targets young children, aged 0-5, and their families who are at risk for poor behavioral health outcomes and later school failure due to poverty, family stressors, and exposure to violence and trauma. This includes low income families receiving subsidized child care, individuals and their families who are receiving substance abuse treatment, and children with special needs. ECMHCI also targets children whose families are homeless, newly-housed, victims of domestic violence, and/or whose parents have a substance abuse problem that often puts the child at very high risk for emotional/behavioral problems. Families are self-defined in this project and include non-custodial parents and guardians. The ethnic and/or cultural populations to be served depend on the child care programs that are selected to receive mental health consultation.

Key Program Differences or Challenges in Implementation

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Prevention and Early Intervention**

Because these funds supported the expansion of a proven model delivered by five organizations with a long history providing ECMHC services, the implementation was seamless. The only challenge for this initiative is that the demand for ECMHC services far exceeds the available resources.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
- a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

A. Select Person/Family-level and Program/System-level Outcomes

The Early Childhood Mental Health Consultation Initiative continues to make a lasting impact of the lives of young children in California. As a result of the MHSA funding we have successfully expanding the reach and scope of our service to include families being served through family child care networks, family resource centers, and substance abuse treatment centers. **Each of the PEI funded programs providing early childhood mental health has met or exceeded the following performance objectives for FY 09/10.**

Objective #1 (Understanding of Emotional and Developmental Needs)

Of those staff who received consultation, a minimum of 75% will report that meeting with a consultant increased their understanding and response to a child's emotional and developmental needs, and will report an increased understanding on how to administer developmental screenings.

Objective #2 (Communication with parents)

Of those staff who received consultation, a minimum of 75% will report that consultation helped them learn to communicate more effectively with parents of children where there were concerns about the child's behavior.

Objective #3 (Response to children's behavior)

Of those staff who received consultation, a minimum of 75% will report that the consultant helped them to respond more effectively to children's behavior and to communicate more effectively with them.

Objective #4 (Overall satisfaction)

A minimum of 75% will of staff working in sites served by the ECMHCI will report that they were satisfied with the services they received from the consultant.

Objective #5 (Responsiveness to Needs)

Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that the

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

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consultant was attentive and responsive to their needs.

Objective #6 (Linkage to Resources)

Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that consultant assisted them in linking to needed resources.

Objective #7 (Understanding of Child's Behavior)

Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that they have a better understanding of their child's behavior.

Objective #8 (Improvement of Child's Behavior)

Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that their child's behavior has improved.

B. 09/10 Participant Data

See participant demographic data above.

C. Evaluation Methods

Early Childhood Mental Health Consultation Initiative provider and parent surveys are administered annually, during the third quarter of each fiscal year and are used in the Annual Program Monitoring Report for that year. 100% of unduplicated clients who received a face-to-face billable service (consultation to staff and direct service to parents) during the survey period will be given and encouraged to also complete a Citywide Client Satisfaction Survey.

D. Engaging Consumers

The ECMHCI considers all children, families and staff to be participants in our program.

In addition to the annual staff and parent survey, providers interact with families informally, as well as formally by appointment, making themselves available as a resource to parents. At sites, the consultants meet regularly with site managers and staff as required by the ECMHCI Standards of Practice. They have a regular presence at each program and become acquainted with families by dint of their very presence. Working from a stance of unconditional positive regard, they build relationships wherever and however possible, making themselves available to chat with families, answer questions and concerns and provide resources. Parents receive an announcement of our services when they enroll their child by means of Consent to Consultation form and a flyer posted prominently at each site. Consultants and the Project Director offer parenting and kindergarten readiness workshops for families.

E. Program Changes

None

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Prevention and Early Intervention**

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="padding: 2px;">FY 10/11 funding</th> <th style="padding: 2px;">FY 11/12 funding</th> <th style="padding: 2px;">Percent Change</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$651,816</td> <td style="padding: 2px;">\$609,874</td> <td style="padding: 2px;">-6%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$651,816	\$609,874	-6%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$651,816	\$609,874	-6%						
b) Is the FY 11/12 funding requested outside the \pm 25% of the previously approved amount, or ,	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the \pm 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the \pm 25% criteria, please provide an explanation below.								

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

None

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation
- c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)

N/A

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	1,000	
Total Families:	250	250

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 6: Mental Health Consultation for Providers Working with Youth At-Risk for Juvenile Justice Involvement

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10							
<input type="checkbox"/> Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.							

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	33 (received direct services) 708 (served by agencies receiving onsite consultation)	White	111	English	57	LGBTQ	6
Transition Age Youth (16-25)	34 (received direct services) 698 (served by agencies receiving onsite consultation)	African American	571	Spanish	9	Veteran	
Adult (18-59)	687 (staff attended trainings) 31 (staff received onsite consultation)	Asian	143	Vietnamese		Other	
Older Adult (60+)		Pacific Islander	13	Cantonese	1		
		Native American	1	Mandarin		Male	39

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	Hispanic	471	Tagalog		Female	28
	Multi	12	Cambodian			
	Unknown		Hmong			
	Other	84	Russian			
			Farsi			
			Arabic			
			Other	1		

B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

Similar to the more established Early Childhood Mental Health Consultation Project, this project uses mental health professionals to provide mental health consultation services at community-based organizations that work with youth who are either at-risk or already involved with the juvenile justice system, as well as to the youth themselves. The consultants focus on building the capacity of the staff via group trainings and consultation, individual coaching, observation and case consultation, and service linkages, including connection with school-day supports where possible. The consultants also provide limited, short-term intervention with youth and families.

As collaborative partners in the Juvenile Justice Mental Health Consultation and Training Program (JJMHC), Edgewood Center for Children and Families, Larkin Street Youth Services and Huckleberry Youth Programs have been working together toward the common goal of building the capacity of providers to assess and meet the behavioral health needs of the at-risk and system-involved youth they serve. Since the inception of this program, which began officially on October 1, 2010, we have successfully been able to leverage the strengths of our respective programs to achieve the following outcomes:

- on-site short term mental health consultation for community agencies provided by Edgewood;
- monthly trainings open to all S.F. county youth-serving-agency staff;
- direct-services from Edgewood, Larkin, and Huckleberry;
- creation of an outcome measure for Larkin Street clients;
- individual training and consulting opportunities at each agency;
- implementation of a model for mental health consultation to youth-serving agencies, developed through the Learning Circle.

Huckleberry Youth Programs and Larkin Street Youth Services provide access to at-risk youth in our target population; a broad array of services for youth; connections with other youth-serving agencies; a recognized and respected public face; and sometimes the last opportunity for support before entering the Juvenile Justice System. Edgewood is the lead agency for the JJMHC program and serves as an on-site mental health consultation resource for community agencies, provides monthly trainings for staff working with at-risk youth on specific topics to support their work, and a research team that supports program measurement and evaluation. Edgewood uses the School-Based and Early Childhood Mental Health Consultants as a foundation to provide the basis for the mental-health/systems-approach consultation model created and implemented to support a range of youth-serving agencies.

PREVIOUSLY APPROVED PROGRAM
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Training

Conducted 5 training events

Consultation

Staff from 32 San Francisco community-based agencies attended training events. Also provided mid-level, on-site consultation services to three agencies (Precita Center, Mission Girls, & Jewish Vocational Services).

Learning Circle

Three monthly Learning Circle meetings were conducted with Edgewood Mental Health Consultants (MHCs) across all Edgewood MHC programs (JMMHC, Early Childhood, and School-based). During these meeting we utilized the expertise of an Organizational Development consultant to assist us in the creation of our Mental Health Consultation model. We have since developed a working model that we are beginning to implement across all of our mental health consultation programs. Over the next few months, we hope to gather input from non-Edgewood mental health consultation programs across San Francisco to further adjust our model. We ultimately hope to create a model that can be utilized by all Mental Health Consultation programs across San Francisco. After completing a cycle of 6 Learning Circle meetings, we will administer pre-post self self-efficacy measure to assess the degree to which participants are utilizing information learned during the meetings.

Reaching Underserved Communities and Addressing Health Disparities

The agencies we are targeting through this program serve very diverse communities and specialize in serving youth at-risk or already involved in the juvenile justice system. This population experiences some of the worst health disparities and risk factors, especially trauma and other behavioral health issues The Consultation and Training Program will provide on-site mental health consultation to at least 20 providers who serve at-risk youth who may benefit from mental health consultation. These agencies will be recruited from San Francisco agencies that currently serve youth involved in the Juvenile Justice system and agencies who serve youth who are at risk of becoming involved in the Juvenile Justice system.

The 200 youth receiving short-term early intervention and direct services will be enrolled at Huckleberry Youth Programs, including Community Assessment & Referral Center (CARC), Larkin Street Youth Services, and agencies enrolled in the Mid Level consultation portion of the program. Huckleberry's CARC provides an alternative to 600 young people, ages 11-17, who have been arrested for non-violent offenses and who would otherwise be brought directly to Juvenile Hall. Most youth come to CARC from Bayview-Hunter's Point, Visitation Valley, Excelsior, and the Mission—all of which are CBHS-priority, high-need neighborhoods. Larkin Street will target justice system involved youth ages 12-24 from throughout its programs, with services provided from their Tenderloin location.

Key Program Differences or Challenges in Implementation

Despite the collaborative intention of the program design, our achievements to-date are clearly attributable to individual program strengths and do not seem to reflect a collaborative and coherent multi-agency model. There are gaps between our individual agency activities, and we are not taking collective advantage of what we each have to offer this program.

- Define a clear referral process for community agencies requesting mental health consultation services that includes a joint effort with subcontractors to reach out to and recruit community agencies.
- Disseminate short-term therapeutic interventions to all agencies we consult with in the community.
- Create additional opportunities for subcontracts with other community agencies serving at-risk youth who are not currently represented in our work.
- Convene the Youth Mental Health Advisory Council to include all contracted agencies and representatives of the community who can assist us in our work with youth.
- Share and/or create trainings between all contracted agencies and make them available both internally and to the community.
- Investigate assessment and outcome opportunities, and assist in implementing structures in collaboration with research/evaluation departments at each agency

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

if available.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program’s implementation, if any, and the reason(s) for the changes

Program Outcomes and Evaluation Methods

Objective 1: At least 20 agencies serving youth at-risk for involvement in the juvenile justice system or involved in the juvenile justice system will participate in the Consultation and Training Program.

Measure: Monthly Training sign-in sheets. # of MOUs. Training Evaluation forms.

Summary: Conducted 5 training events. Staff from 32 San Francisco community-based agencies attended training events. Also provided mid-level, on-site consultation services to three agencies (Precita Center, Mission Girls, & Jewish Vocational Services).

Objective 2: Programs participating in Mid-Level Consultation services will show improvement (reduction in gaps) in areas identified during the Gap assessment.

Measure: Pre-post Organization Needs Gap Survey administered to agency staff - measured in 6-month intervals. Retrospective pre-post self efficacy measures administered to agency staff (in development) - measured at 6-month intervals. Goal-attainment scales.

Summary: Unable to report - have not been providing on-site consultation services for the minimum of six-months required to administer our outcome measures.

Objective 4: Attendees of the (monthly) Training Program will find it useful, related to their daily work, and culturally relevant.

Measures: Training evaluation forms.

Summary: This objective was partially achieved. Respondents provided the following ratings for our monthly training events (aggregated across 5 training events): average rating of 3.9 out of 5 for “overall evaluation”; average rating of 3.77 out of 5 for “improving and/or developing job related skills”; average rating of 4.29 out of 5 for “effectively appreciated across cultures”; and average rating of 3.75 out of 5 for “usefulness of the teaching method”; average rating of 4.12 out of 5 for “instructor evaluation”. Respondent data was broken down according to the following: 72% of respondent provided an overall evaluation of 4 or 5 (out of 5) across all trainings. (JMHHC goal of 90% was not achieved) 56% of respondents rated the trainings as 4 or 5 (out of 5) in “improving and or developing job related skills”. (JMHHC goal of 90% was not achieved) 86% of respondents rated the trainings as 4 or 5 (out of 5) in “effectively appreciated across cultures”. (JMHHC goal of 75% was achieved)

Objective 5: Within two months following Trainings, attendees will find that they are using new information in their daily work.

Measures: Transfer of training evaluation (administered online to training attendees two months following training).

Summary: Due to technical difficulties managing our online survey software, we were unable to administer transfer of training evaluations to attendees of our April,

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

May, and June trainings. Our technical issues have since been resolved, and moving forward we are prepared to distribute transfer of training evaluations to attendees of our trainings beginning with our July trainings.

Objective 6: Youth and family functioning will improve as a result of direct service provision.

Measures: Clinical outcome measures; Huckleberry Youth Programs will administer CANS at 6-month intervals. Larkin Street Youth Services will administer Ansell Casey Life Skills Assessment at 6-month intervals.

Summary: Neither Huckleberry Youth Programs nor Larkin Street Youth Services has been tracking outcome data for the six-month time period required to generate pre-post data. Therefore, we do not yet have outcome data to measure improvement in youth and family functioning. Reliable outcome data should be available in 3 to 6 months.

Objective 7: Members of the Learning Circle will demonstrate increased levels of self-efficacy regarding specific activities in their work with clients and agencies.

Measures: Retrospective pre-post self efficacy measures administered to Learning Circle Participants, measured at 6-month intervals.

Summary: To date, we have conducted 3 monthly Learning Circle meetings with Edgewood Mental Health Consultants (MHCs) across all Edgewood MHC programs (JJMHC, Early Childhood, and School-based). During these meeting we utilized the expertise of an Organizational Development consultant to assist us in the creation of our Mental Health Consultation model. We have since developed a working model that we are beginning to implement across all of our mental health consultation programs. Over the next few months, we hope to gather input from non-Edgewood mental health consultation programs across San Francisco to further adjust our model. We ultimately hope to create a model that can be utilized by all Mental Health Consultation programs across San Francisco. After completing a cycle of 6 Learning Circle meetings, we will administer pre-post self self-efficacy measure to assess the degree to which participants are utilizing information learned during the meetings.

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?

Yes No

2. Is there a change in the type of PEI activities to be provided?

Yes No

3. a) Complete the table below:

FY 10/11 funding	FY 11/12 funding	Percent Change
\$425,000	\$425,000	0%

b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, **or**,

Yes No

For Consolidated Programs, is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?

Yes No

c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

NOTE: If you answered <u>YES</u> to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.		
A. Answer the following questions about this program.		
1. Please include a description of any additional proposed changes to this PEI program, if applicable.		
None		
2. If this is a consolidation of two or more previously approved programs, please provide the following information: a. Names of the programs being consolidated b. The rationale for consolidation c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)		
N/A		
B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	1100	
Total Families:	200	100

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 7: Older Adult Behavioral Health Screening and Response

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10							
<input type="checkbox"/> Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.							

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)		White		English		LGBTQ	
Transition Age Youth (16-25)		African American		Spanish		Veteran	
Adult (18-59)		Asian		Vietnamese		Other	
Older Adult (60+)		Pacific Islander		Cantonese			
		Native American		Mandarin			
		Hispanic		Tagalog			
		Multi		Cambodian			
		Unknown		Hmong			
		Other		Russian			
				Farsi			
				Arabic			
				Other			

**PREVIOUSLY APPROVED PROGRAM
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B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

As a result of a competitive RFP process, two agencies were awarded contract to implement this program. FY 09/10 primarily consisted of start-up activities including, staff recruitment and training.

Central City Hospitality House (CCHH)

The Hospitality House Older Adult Behavioral Health Screening and Response Project is designed to improve behavioral health outcomes for older adults by expanding early identification efforts and improving access to appropriate care through increasing access to a range of integrated services. Program staff were identified to early in the new fiscal year, including two nurse practitioners, one more medically-based, and the other focused on behavioral health needs. In addition, collaboration was outlined with the Curry Senior Center, with two Curry staff dedicated to spend several days each week conducting programming with Hospitality House older adult participants at the Sixth Street Senior Drop-in, with the idea being to build a bridge between the programs to offer an enriched service package. The newly forming Older Adult team established weekly case conference meetings in order to strategize about outreach and engagement in order to welcome interested participants into the program; everyone is looking forward to ongoing implementation in the new year.

Institute on Aging (IOA)

The goal of IOA program is to prevent and reduce behavioral health risk factors and issues in diverse adults aged 55+ years by providing evidence based behavioral health screening and treatment within the context of a community senior center. IOA partnership with the WASC has moved forward slowly but surely since September, 2009. Staff training has been a major project activity in FY 2009-2010—and continues to date including, efforts to coordinate some training pieces with UCSF and Family Service Agency. All project staff have received comprehensive training.

In March, 2010, IOA collaborated with UCSF to provide a series of 3 Medication Consultation clinics at the Western Addition Senior Center. Clinics were staffed by UCSF Pharmacy students and their preceptor, Kirby Lee, Ph.D. Participants received information about their current medication regimens, responses to any questions about medications, and referral for medication management services and information in the community. Participants were also offered Blood Pressure screening and feedback on Blood Pressure levels. These large clinics were well attended---serving a total of 93 unduplicated clients (by report of UCSF Pharmacy Department). IOA played a key role in initiating, developing, and coordinating these events at the WASC. Unfortunately, UCSF reported that they will not be able to maintain these clinics in the future. Weekly clinics will not be possible as previously planned. Instead, In FY 2010-2011, IOA will work with UCSF, Senior Center Staff, and possibly also Family Service Agency, to plan and organize 1-2 large all-day “Health Fairs” at the Senior Center which will include medication management consultations, blood pressure screenings, glucose level screenings, and health-related information.

Reaching Underserved Communities

A review of the data collected during the planning for this program suggests, over half of older adults are foreign born and that 45 percent of older adults report limited English proficiency. One strategy employed to ensure the linguistic needs of older adults are addressed is the intentional recruitment and hiring of multi-lingual staff. Of the seven (7) Institute on Aging staff hired, three (3) were bilingual Chinese/English and one (1) bilingual in Russian/English.

Key Program Differences or Challenges in Implementation

**PREVIOUSLY APPROVED PROGRAM
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Central City Hospitality House (senior center)

The program was not staffed until the end of the fiscal year.

Institute on Aging (IOA)

Communication with Western Addition Sr. Center (WASC) presented numerous challenges due to unavailability of WASC staff for periods of time, unexpected changes in plan from the WASC end of things, and lack of consistent follow-up on agreements on the part of WASC staff.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

09/10 Participant Data

Because neither program was staffed until the end of the fiscal year, programming was not implemented in FY 09/10. As a result, no participant data is available.

Program Outcome and Evaluation Methods

Institute on Aging (IOA at Western Addition Senior Center)

- IOA will provide mental health screening for 108 consumers at the WASC, and provide evidence-based interventions **32**.
- Of the consumers who received interventions, at least 50% will have a reduction of symptom levels from baseline or a reduction from clinical to sub-clinical scores within 6 months on relevant validated measures.

IOA began development of an excel-based Project Database system in February, 2010. After review from DPH Primary Care Medical Directors, beta-testing with project staff, and a series of revisions to the database---it is now fully operational and ready for use. The database, as structured, will capture all data needed for future reporting on the project, evaluation of clinical outcomes, and patient tracking by project staff.

Central City Hospitality House (CCHH at 6th Street Senior Center)

- 50 older adult participants will receive a mental health screening, and 50% of those screened will return to access therapy or medical services, to strengthen positive social and psychological development to assist in maintaining a more stable level of functioning, as measured by engagement in services, and documented in the mental health and/or case management needs assessment survey.

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

**PREVIOUSLY APPROVED PROGRAM
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- The program will hold 10 events and 100 older adult participants will reduce risk factors or stressors and increase protective factors to help prevent the initial onset or worsening of mental illness through participation in a range of services as measured by engagement, and documented in sign-in sheets.

Program Changes

None

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<p>3. a) Complete the table below:</p> <table border="1" data-bbox="157 836 955 901"> <thead> <tr> <th>FY 10/11 funding</th> <th>FY 11/12 funding</th> <th>Percent Change</th> </tr> </thead> <tbody> <tr> <td>\$1,997,418</td> <td>\$319,290</td> <td>-84%</td> </tr> </tbody> </table> <p>b) Is the FY 11/12 funding requested outside the $\pm 25\%$ of the previously approved amount, or, <u>For Consolidated Programs</u>, is the FY 11/12 funding requested outside the $\pm 25\%$ of the sum of the previously approved amounts?</p> <p>c) If you are requesting an exception to the $\pm 25\%$ criteria, please provide an explanation below.</p>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$1,997,418	\$319,290	-84%	<p>Yes <input checked="" type="checkbox"/></p> <p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$1,997,418	\$319,290	-84%						

We planned to expand the Older Adult Behavioral Health Screening and Response program to Community Consortium Clinics and other Community Based Agencies in FY 10/11. However, unanticipated implementation challenges left the program with insufficient time to implement the expanded services. Additionally, with MHSAs revenue projections declining over the next few years, the expansions would have been unsustainable. As a result of these factors, a decision was made to cancel the expansion for the foreseeable future.

We are requesting an exception to the $\pm 25\%$ criteria (exhibit F3) because no programs were ever implemented.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

A. Answer the following questions about this program.		
1. Please include a description of any additional proposed changes to this PEI program, if applicable.		
None		
2. If this is a consolidation of two or more previously approved programs, please provide the following information:		
<ul style="list-style-type: none"> a. Names of the programs being consolidated b. The rationale for consolidation c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s) 		
N/A		
B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	500	300
Total Families:	200	100

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 8: Early Intervention and Recovery for Young People with Early Psychosis

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	189	White	57	English	195	LGBTQ	
Transition Age Youth (16-25)	29	African American	68	Spanish	22	Veteran	
Adult (18-59)	9	Asian	24	Vietnamese		Other	
Older Adult (60+)	0	Pacific Islander	6	Cantonese	7		
		Native American	0	Mandarin			
		Hispanic	58	Tagalog	1		
		Multi	10	Cambodian			
		Unknown		Hmong			
		Other		Russian	2		
				Farsi			
				Arabic			
				Other			

**PREVIOUSLY APPROVED PROGRAM
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B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The Early Intervention and Recovery for Young People with Early Psychosis Project has four core components: outreach and education, intake and assessment, treatment, and training. It funds two teams, using an approach in which all elements of the intervention are brought to the service of the client and family in a coordinated fashion. Comprehensive initial and ongoing diagnostic assessments and careful monitoring of medication outcomes and side effects are key elements of success. Culturally competent engagement and persistent relapse prevention are also key elements. Rigorous staff training, clinical supervision, and fidelity monitoring are essential to ensure that effective treatment practices are really being offered to those suffering with these devastating diseases. To be optimally effective, outreach workers, case managers and therapists will all work together as an interdisciplinary team.

While two teams support the project – Comprehensive Child Crisis (civil service program) and PREP (a contracted community collaboration led by Family Service Agency of San Francisco).

Comprehensive Child Crisis is a 24 hours 7 days a week, mobile crisis response unit. All children and youths needing a comprehensive psychiatric assessment from CCCS are provided with a face to face assessment on the same day of request made. All CCCS staff responds to crisis evaluation requests wherever clients are located; these locations include but not limited to home, school, primary care office, police station, hospitals' emergency department, day treatment and residential settings, jail, etc.

The **Prevention and Recovery in Early Psychosis (PREP)** program is a community partnership between The University of California, The Family Services Agency of San Francisco, The Mental Health Association of San Francisco, Sojourner Truth Foster Family Service Agency and Larkin Street Youth Services. Although there is no known cure for psychosis, our goal is stable remission that will allow the individual to live a normal, prosperous, and fulfilling life. In addition to intervention services, PREP is the contracted provider for the outreach and training components of the program.

The following provides implementation highlights for the outreach, training and intervention components of the Early Psychosis Program.

Outreach

The program provided 704 hours of direct outreach and education services, including information and/or formal presentations to over 1,700 individuals from approximately 400 organizations, including 84 schools, 59 primary care service providers, 92 mental health care providers, 42 community groups and 108 clinician training providers. PREP developed and distributed two brochures (one for youth and one for service providers) and two one-page information sheets (one for family members and one for primary care providers). In total, approximately 5,000 brochures and flyers were printed and approximately 4,500 were distributed by the end of the reporting period.

Training

PREP provided five series of trainings in the assessment and treatment of early psychosis. Trainings were attended by a total of thirty individuals from the PREP partner agencies (Family Service Agency of San Francisco (FSA), Larkin Street Youth Services, Mental Health Association of San Francisco (MHA), Sojourner Truth Foster Family Service Agency, and the University of California, San Francisco (UCSF)) and from CBHS programs (Comprehensive Child Crisis Services and Transitional Age Youth). Participants received between 3 and 117 hours of training, receiving 43 hours of training on average. Evaluation of knowledge and skill acquisition was tailored to each training goal. Participant satisfaction with all training sessions was assessed using a standardized survey used for all Family Service

**PREVIOUSLY APPROVED PROGRAM
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Agency/Felton Institute training activities. Participants rate the quality of 10 aspects of training on a 5-point scale that ranges from 1=poor to 5=excellent. Aggregate satisfaction ratings are presented in relation to each training objective (see below. For additional details).

Intervention

Much of the initial start-up period (FY 09/10) has been devoted to assembling the staff needed to deliver specialized early psychosis services. As discussed above, two teams support the intervention component of the project – Comprehensive Child Crisis and PREP.

PREP provided:

- 1,414 hours of treatment services were provided to a total of 44 consumers (see above for demographic data).
- Of the 44 participating in-depth assessment, 31 met PREP eligibility criteria and enrolled in ongoing services, participating in one or more of the available treatment components.
- Of those, twenty-three (74%) participated in care management; 23 (74%) participated in CBT for Psychosis, 19 (61%) participated in medication management, and 13 (42%) participated in multifamily groups.
- Twenty-three family members also participated in multifamily groups.
- 704 hours of direct outreach and education services, including information and/or formal presentations to over 1,700 individuals from approximately 400 organizations, including 84 schools, 59 primary care service providers, 92 mental health care providers, 42 community groups and 108 clinician training providers.

Child Crisis provided:

- Assessments for 183 children and youth, and all the 183 were screened with ESP. (see above for demographic data).
- Out of the 183 assessments, 53 indicated positive on the ESP, which means further comprehensive assessment for prodromal symptoms is warranted.

Key Program Differences or Challenges in Implementation

Delays in hiring and training, as well as staff turnover in key outreach positions, limited staffing available to conduct as many outreach activities as originally planned.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program’s implementation, if any, and the reason(s) for the changes

A. Select Person/Family-level and Program/System-level Outcomes

The overall goal for the Early Psychosis program is to reduce disparities in access to care through early identification, outreach, engagement, and referrals to

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

services for young people with early psychosis.

Person/Family-level Outcomes

- Young people exhibiting signs or symptoms of early psychosis are identified by clinicians, family members, or others and receive an evaluation by a trained clinician.
- If appropriate, clients receive early intervention services and experience symptom reduction and improved functioning.

Program/System Outcomes

- Program provides outreach and education to community clinicians, family resource center staff, faith-based organizations, school counselors, juvenile probation, transitional housing staff, and primary care clinicians.
- Program provides a clinician, who meets clients wherever they are (e.g., home, school, primary care office, jail, etc.) in order to conduct an initial screening evaluation.
- Program provides early intervention services to clients.
- Program provides training to clinicians who work with clients exhibiting signs and symptoms of early psychosis.
- Increased community capacity to identify and provide appropriate early intervention services for young people exhibiting symptoms of early psychosis and reduce the community, family, and individual burden associated with untreated or under-treated psychotic disorders.

B. 09/10 Participant Data

See Section I. A for demographic data on participants.

C. Select Program Outcomes and Evaluation Methods

Family Service Agency (contracted PREP team)

Objective 1: Increase core clinical and scientific knowledge about early psychosis. Training Series 1 - Basic Didactics

- 6 sessions, 24 hours, 19 participants
- Statistically significant increases in knowledge about early psychosis were observed.
- Correct responses increased by 37%.
- Participants' average satisfaction was 4.5.

Objective 2: Develop clinical competence in cognitive-behavioral therapy (CBT) for early psychosis. Training Series 2 - Cognitive Behavioral Therapy (CBT)

- 4 sessions, 20 hours, 6 participants
- Statistically significant increases were observed both in knowledge about the specific techniques of CBT for Psychosis and confidence in implementing them.
- Knowledge increased by 35% and confidence increased by 41%.
- Participants' average satisfaction rating for the CBT Psychosis series was 4.8.
- Evaluation of clinician competence is ongoing.
- Clinicians providing CBT participate in weekly group case conferences and receive weekly individual supervision for 12 months and bi-weekly supervision thereafter.
- Fidelity to the CBT model is formally assessed during the first six months following training by having the supervisor rate recordings of 25% of each clinician's CBT sessions.

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Objective 3: Develop clinical competence in evidence-based medication management for early psychosis. Series 5 - Medication Management

- 1 session, 3 hours, 7 participants
- Statistically significant increases in knowledge about medication management for early psychosis were observed.
- The number of correct responses increased by 25%.
- Participants' average satisfaction rating for the Medication Management training was 4.9
- Supervision of medication management is ongoing, via monthly in-person supervision and regular review of prescribing to insure adherence to evidence-based guidelines.

Objective 4: Develop clinical competence in diagnostic assessment of psychosis and risk of psychosis. Series 4 - Diagnostic Assessment

- 6 sessions, 42 hours, 15 participants
- Group training in the use of the Structured Clinical Interview for DSM Disorders (SCID) (5 sessions)
- Quick Scale for the Assessment of Negative Symptoms (QSANS) & Quick Scale for the Assessment of Positive Symptoms (QSAPS) (1 session) was conducted.
- Clinician competence in the use of the SCID, QSAPS and QSANS was evaluated in relation to gold-standard ratings of video-taped interviews.
- Participants demonstrated near perfect concordance with the gold-standard ratings.
- Participants' average satisfaction rating for the Diagnostic Assessment series was 4.5
- Group training in the use of the Structured Interview for Prodromal Symptoms (SIPS) has been completed since the reporting period ended. Individual training in the use of these assessment tools is ongoing. An expert trainer observes all assessments, rates competency on a standardized rating scale, and provides individualized feedback until competency is achieved.

Objective 5: Develop clinical competence in multifamily psychosis and risk of psychosis. Series 3 - Multifamily Group (MFG)

- Group training was conducted by expert trainers from the Portland Identification and Early Referral (PIER) program where the evidence-based group intervention model was developed.
- Participants' average satisfaction rating for the Multifamily Group training was 4.7
- Assessment of clinician competence will be continuously assessed through self-assessment in local case conferences and through monthly telephone supervision with trainers from the PIER program.
- PIER program trainers will also review four video tapes from each multifamily group.
- Self and expert assessment will use a standardized evaluation form developed by the PIER program.

Comprehensive Child Crisis Services (CCCS)

Objective 1: Training Outcome - All CCCS staff will be trained in administering the Early Screener for Psychosis (ESP) that was produced by John Lyons, Ph. D.

- CCCS staff were trained to administer the ESP in late February after the CANS-based instrument was developed.
- It was then rolled out in Child Crisis on March 1st, 2010.

Objective 2: Individual Outcome - Young people exhibiting signs or symptoms of early psychosis are identified by clinicians, family members, or others and receive an evaluation by a trained clinician.

- After the development and training of all the CCCS staff on the ESP, Child Crisis implemented this screening tool in March.
- For the period of March 1st to June 30th, a total of 183 assessments were conducted, and all the 183 were screened with ESP.
- Out of the 183 assessments, 53 indicated positive on the ESP, which means further comprehensive assessment for prodromal symptoms is warranted.

Objective 3: Program Outcome - Program provides a clinician, who meets clients wherever they are (e.g., home, school, primary care office, jail, etc.) in order to conduct an initial screening evaluation.

Objective 4: Program Outcome - Program provides training to clinicians who work with clients exhibiting signs and symptoms of early psychosis.

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- Four CCCS staff received the Basic Didactics & Diagnostic Assessment provided by PREP.
- CCCS staff will participate in live training of the SIPS in the fall, and four case conferences in which each CCCS staff will present on how the SIPS is administered and the results of their assessment.
- CCCS staff will also participate in the training on K-SAD whenever it will be available for training by the PREP program.

Objective 5: System Outcome - 100% of publicly-funded clients (MediCal, Healthy Families, uninsured) that are identified as positive on ESP receive case management linkages to appropriate behavioral health treatment and/or intensive case management services.

- CCCS staff provides case management services up to 30 days to all publicly funded clients after completion of the crisis assessment. During this period, the clients are linked to outpatient intensive case management services, additional behavioral health services (i.e. individual therapy, family therapy, medication support, if any of these has not been in placed already) at the outpatient clinics that the clients are being seen, or any educational related supports that are identified by the CCCS case managers.

D. Outreach Strategies

Under the lead of the Mental Health Association, PREP provides outreach across all of SF's diverse communities to provide outreach and education on the PREP program, behavioral health, stigma, wellness, and signs of early psychosis. The goal of outreach is to create awareness, reduce stigma, and recognize signs of early psychosis and to educate about the PREP program. Extensive outreach is conducted across San Francisco in settings where youth and their families typically spend time (e.g., neighborhood centers, schools, churches, after-school organized sports activities, libraries and shopping centers). Outreach methods also include social media venues such as Twitter, Facebook, YouTube, Google Video and other online methods. Special efforts are taken to engage and reach out to traditionally underserved population groups through our partnerships with Sojourner Truth and Larkin Street – reaching out to those who would not typically receive or who would experience a delay in services due to such factors as limited access, stigma, poverty, and cultural and linguistic barriers.

E. Program Changes

None

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1" style="width: 100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="text-align: left; padding: 2px;">FY 10/11 funding</th> <th style="text-align: left; padding: 2px;">FY 11/12 funding</th> <th style="text-align: left; padding: 2px;">Percent Change</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$1,290,000</td> <td style="padding: 2px;">\$1,294,184</td> <td style="padding: 2px;">.32%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$1,290,000	\$1,294,184	.32%		
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\$1,290,000	\$1,294,184	.32%						
b) Is the FY 11/12 funding requested outside the \pm 25% of the previously approved amount, or ,	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the \pm 25% of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
c) If you are requesting an exception to the \pm 25% criteria, please provide an explanation below.								

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

N/A

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation
- c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)

N/A

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B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	1200	100
Total Families:	300	75

**PREVIOUSLY APPROVED PROGRAM
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County: San Francisco

Program Number/Name: PEI 9: Transitional Age Youth (TAY) Multi-Service Center
selected for the local evaluation

Please check box if this program was

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	40	White		English	106	LGBTQ	
Transition Age Youth (16-25)	88	African American	37	Spanish	6	Veteran	
Adult (18-59)		Asian	14	Vietnamese		Other	
Older Adult (60+)		Pacific Islander	2	Cantonese	1		
		Native American	3	Mandarin			
		Hispanic	20	Tagalog			
		Multi	20	Cambodian			
		Unknown		Hmong			
		Other	3	Russian	1		
				Farsi			
				Arabic			
				Other	3		

**PREVIOUSLY APPROVED PROGRAM
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B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The concept of serving Transition Age Youth in a multi-service center has been in various stages of development and implementation in SF for many years. This PEI project supports the first ever multi-service center designed to address the complex needs of the TAY population. Huckleberry Youth Programs, in partnership with Larkin Street Youth Services and Community Health Programs for Youth (CHPY), provide community outreach and education, direct services and service linkage to reduce risk factors and build protective factors to improve outcomes for TAY.

Funded activities include:

- Client Multi-Service Center Governing Board Meetings
- Review Team Meetings
- Ongoing outreach
- Intake and screening of TAY
- Coordinated behavioral health prevention services to youth and their families
- Coordinated case management services to youth and their families
- Academic & Employment Support
- Art Group
- Young Women's & Young Men's Leadership Group
- Family Education Groups
- Track and follow up within agencies to ensure comprehensive service delivery to program participants

The Cole Street Clinic is the temporary *center and has been re-named the Huckleberry Multi-Service Center (HMC)*. Signage and stationary for the Multi-Service Center replaces previous signage and stationery for Huckleberry's Cole Street Clinic. Other Huckleberry locations, Larkin Street Youth Services locations, Third Street Clinic in the Bayview, and Hawkins Youth Clinic in Visitacion Valley will serve as satellite sites.

Select implementation/program highlights from FY 09/10 are listed below.

- Program service delivery began in April 2010.
- Inter - and intra-agency referrals to the Multi-Service Center ensure that wherever a young person enters the agency stream, s/he knows about and is connected to the breadth of available services and supports.
- Referrals include those to HYP's young women's and young men's groups; LSYS's LARK INN housing services and Hire Up employment program; Arriba Juntos' job readiness training; Homeless Prenatal Care for housing help; a cancer caregiver's support group; English and Spanish-speaking therapists; dental care; the Metro Health Academy at City College; and HYP's education, employment and academic support specialists. We continue our outreach efforts to engage more families of youth in our services.

Reaching Underserved Communities and Addressing Health Disparities

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The target population for this project includes low-income African American, Latino, API TAY, ages 16-24, exposed to trauma and at risk or involved in juvenile/criminal justice system. Within this target youth community, we also prioritize working with youth aging out of public systems, pregnant and parenting TAY, high school dropouts, and runaway/homeless youth. Extensive outreach activities are conducted to reach underserved TAY. Activities include:

- Outreach about Multi-Service Center services and community resources through tabling events, workshops, community meetings, and personal interactions at their respective sites.
- 300 “Pocket cards” with program information were distributed by HYP Multi-Service Center, LSYS, and 3rd St. Clinic at their respective sites.
- Prevention Specialists reached out to youth at educational settings throughout San Francisco, including International High School, the CARE program, Wallenberg High School’s Health Fair, June Jordan School for Equity, and Downtown High School.
- Staff conducts a bi-monthly presentation at the San Francisco County jail, orienting the information for those in custody within the 18-23 year age range.

Key Program Differences or Challenges in Implementation

The Huckleberry Multi-Service center was developed by enhancing the type and number of services provided by an existing primary care clinic for youth. With the PEI funded expansion of staff and services, the size of the space has become inadequate. Multiple organizations involved in this project have been searching for a new space large enough to co-locate multiple services. Due to the cost of real estate in San Francisco, this has not been possible. Huckleberry Programs for Youth is continuing to look for a new larger location, but it is unlikely the space will be large enough to accommodate other providers.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program’s implementation, if any, and the reason(s) for the changes

A. Select Person/Family-level and Program/System-level Outcomes

Because this is a new type of service for CBHS to fund, no set of standard outcome objectives for school-based programs exists. Program planning goals for FY 10/11 include partnering with funded agencies and community partners to develop standard goals and objectives for the program. The following are an example of the program outcomes reported by Huckleberry in FY 09/10.

- During April-June, 43 Multi-Service Center clients completed a client satisfaction survey. Of those, 95% (41 clients) expressed satisfaction with the services they received.
- During the 3-month reporting period, of the 294 youth who received information about Multi-Service Center services, 91% have improved knowledge of Multi-Service Center services and locations as measured by surveys.
- Highlighting the efficacy of our efforts is the story of one client who relayed to LSYS staff that he had lost his housing and was considering suicide. Following

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

a formal suicidal assessment, the staff confirmed the client's need for further intervention and engaged Mobile Crisis. The client was offered safe housing options, and most importantly, caring support as he negotiated his crisis. He remained engaged and willing, and continues to utilize LSYS, connect with staff members and access support.

- In addition to the monthly TAY meetings each partner attends, we are using every opportunity to build collaborative relationships within the broader TAY-service community.

B. 09/10 Participant Data

- During the 3-month reporting period, 103 TAY and 17 families were screened for and integrated into Multi-Service Center prevention services
- During the 3-month reporting period, 26 TAY and 4 families were received early intervention services

C. Evaluation Methods

Select Outcomes and Evaluation Methods

- Huckleberry will collect and report quarterly on the number of individuals served through funded activities.
- 80% of TAY receiving outreach will have improved knowledge of Multi-Service Center services and locations as measured by surveys.
- 250 TAY and 50 families will be screened for and integrated into Multi-Service Center prevention services as measured by client records
- 130 TAY and 20 families will be screened for and integrated into Multi-Service Center early intervention services as measured by client records.

D. Engaging Consumers

A new Youth Advisory Board was created to ensure meaningful youth involvement in project planning, implementation, and evaluation. A Youth Advocate was hired to lead the Youth Advisory Board and 6-10 TAY receive stipends for their participation in the Youth Advisory Board. This group meets once a month.

E. Program Changes

N/A

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. a) Complete the table below:		

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

FY 10/11 funding	FY 11/12 funding	Percent Change		
\$200,000	\$200,000	0%		

b) Is the FY 11/12 funding requested outside the $\pm 25\%$ of the previously approved amount, **or**,
For Consolidated Programs, is the FY 11/12 funding requested outside the $\pm 25\%$ of the sum of the previously approved amounts?

c) If you are requesting an exception to the $\pm 25\%$ criteria, please provide an explanation below.

Yes No

N/A Yes No

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

None

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation
- c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)

N/A

B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.

	Prevention	Early Intervention
Total Individuals:	300	100
Total Families:	100	25

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 11: Trauma and Recovery Services
evaluation

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	157	White	2	English	84	LGBTQ	
Transition Age Youth (16-25)		African American	24	Spanish	67	Veteran	
Adult (18-59)		Asian		Vietnamese		Other	
Older Adult (60+)		Pacific Islander		Cantonese			
		Native American	6	Mandarin			
		Hispanic	119	Tagalog			
		Multi	4	Cambodian			
		Unknown		Hmong			
		Other		Russian			
				Farsi			
				Arabic			
				Other	6		

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The **Trauma and Recovery** project was selected during the CSS planning process to address the need for community-based, client-driven prevention and early intervention for individuals, families and communities impacted by violence. It was based in part on a successful local model that had been operating in the Latino community in SF for years. The Trauma and Recovery project consists of two similar but distinct community-based trauma and recovery programs: (1) La Cultura Cura Trauma Recovery and Healing Services administered by the Instituto Familiar de la Raza and (2) YMCA Trauma and Recovery Services administered by the Urban Services YMCA. Both provide selected and indicated prevention services along with short-term, low intensity early intervention services to those affected by trauma and violence.

La Cultura Cura. Instituto Familiar de la Raza's (IFR) La Cultura Cura program provides trauma recovery and healing services to youth under 18 years old and their families with an emphasis on Latinos and multicultural youth and families living in the Mission district. La Cultura Cura established a behavioral health team within the Community Response Network (CRN), a partnership of agencies serving youth and their families affected by street and gang violence.

YMCA Trauma and Recovery Services. The goal for this program is to guarantee comprehensive behavioral health, case management, and outreach services to youth and their families affected by violent events in order to identify and reduce the impact of trauma. The trauma and recovery Clinical Case Managers (CCMs) collaborate with the YMCA's existing network of behavioral health counselors, case managers, community organizers and family advocates to provide youth and their families with appropriate behavioral health services. The CCMs maintain dual counselor/case manager relationships with clients to identify any symptoms of a traumatic response as a result of exposure to violent events and in some instances locate appropriate crisis response services and facilitate referrals to these services in the event that more intensive treatment is needed.

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
 - a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

PREVIOUSLY APPROVED PROGRAM
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Outcomes and Evaluation Methods

La Cultura Cura

- 70% of youth who receive behavioral health services for a minimum of 3 months will demonstrate improvements in symptoms of depression, anxiety, self-concept and/or behavior as measured by pre and post T-scores on the UCLA PTSD RI Trauma Checklist and CPSS Trauma Symptoms, client self-report, and/or observations as reflected in the client's charts.
- 85% of youth and families referred for TR & HS will receive follow-up as demonstrated by client referral and disposition log maintained at the program.
- A minimum of 10 Care Development Meetings will be convened and facilitated by TR & HS staff with Mission partner agencies of the NWCRN to improve the coordination of case management and mental health services to the target population. Staff will maintain a sign-in-sheet, attendance log, and maintain records of the meeting.
- 75% of VP workers who participate in the Healing Circle will report a decrease in a minimum of one symptom of vicarious trauma and increase their knowledge of self care as evidenced by a pre and post survey measured on a likert scale. The pre and post measurement will be developed by the Director and Senior Clinical Case Manager in consultation with the CBHS Evaluation Team.

YMCA Trauma and Recovery Services

- 35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI. Data Source: Avatar Living Situation Codes.
- 70% of treatment episodes will show three or more service days of treatment within 30 days of admission for CYF mental health treatment providers. Data Source: Avatar indicating clients engaged in the treatment process.

09/10 Participant Data

Total individuals served: 165

Outreach contacts: 87

See participants' demographic data above.

Reaching Underserved Communities and Addressing Health Disparities

La Cultura Cura is driven by a core understanding that Latino youth and their families face unique social, cultural, and linguistic barriers in accessing behavioral health care services. Latino children and youth in particular face disproportionate levels of poverty coupled with a lack of health care benefits. They exhibit more depression and anxiety, and are more likely than their white counterparts to drop out of school and to consider suicide. Latino children and youth who engage in negative street activity and violence face serious risk for multiple health and social problems including physical injury, traumatic responses to violence and loss, incarceration and social isolation. Attitudinal barriers coupled with the lack of bilingual/bicultural behavioral health care providers constitute major obstacles to providing effective interventions once services are sought. Cultural, linguistic and socially relevant services, such as those in this proposed PEI project, serve as a critical factor in the assessment and engagement of Latino youth and families affected by violence.

The **YMCA** System of Care is grounded in the philosophy, principles, and practices of the Recovery Model that holds that each individual can achieve optimal recovery through the pursuit of personal goals, the development of skills, and the provision of supports to achieve those goals; as well as an emphasis on prevention and early intervention approaches and services. Through comprehensive clinical services, they aim to reduce the likelihood of further intervention in the future. The YMCA works with existing partners such as other CBOs, SFUSD, and the Probation Department so that those services not provided by Urban Services will be accessible to eligible youth in targeted communities.

PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?

Yes

No

2. Is there a change in the type of PEI activities to be provided?

Yes

No

3. a) Complete the table below:

FY 10/11 funding	FY 11/12 funding	Percent Change
\$247,200	\$247,200	0%

b) Is the FY 11/12 funding requested outside the ± 25% of the previously approved amount, **or**,

Yes

No

For Consolidated Programs, is the FY 11/12 funding requested outside the ± 25% of the sum of the previously approved amounts?

Yes

No

c) If you are requesting an exception to the ±25% criteria, please provide an explanation below.

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

N/A

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation
- c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)

None

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	200	100
Total Families:	100	75

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

County: San Francisco

Program Number/Name: PEI 12: Community Behavioral Health Services Crisis Response Team

Please check box if this program was selected for the local evaluation

Date: 2/22/11

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10
<input type="checkbox"/> Please check box if your county did not begin implementation of this PEI program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

A. List the number of individuals served by this program during FY 09/10, as applicable. (NOTE: For prevention, use an estimated number.)

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	0	White	88	English	181	LGBTQ	
Transition Age Youth (16-25)	25	African American	53	Spanish	6	Veteran	
Adult (18-59)	152	Asian	31	Vietnamese	2	Other	
Older Adult (60+)	27	Pacific Islander	5	Cantonese	10		
		Native American	1	Mandarin			
		Hispanic	15	Tagalog	1		
		Multi	6	Cambodian			
		Unknown		Hmong			
		Other	5	Russian	3		
				Farsi			
				Arabic			
				Other	1		

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

B. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

FY 09/10 Implementation and Program Performance

The CBHS Crisis Response Team (CRT) provides caring and culturally competent assistance to the families and loved ones of victims of gun violence and homicides. The CRT provides immediate crisis care and follow-up case management services to those affected by violence, in conjunction with the SFPD and other city agencies. The CRT services include: crisis support; short term case management; and brief therapy to victims and families who have been impacted by violence.

Case management services depend on the need of each family and can encompass a host of services such as: debriefing sessions for families and loved ones; organizing neighborhood donation drives to provide financial assistance to the victim's family; linking families to grief support and therapy; educating the community about the impact of violence and trauma; and connecting families to services within the neighborhood where the incident occurred. The CRT also assists families with funeral services and arrangements and with securing general assistance through federal- and state-funded programs. An important component of the CRT approach is facilitating the involvement of additional community-based agencies or response organizations to wrap supportive services around the family. The CRT also participates in a variety of community healing events to support positive efforts leading to a healthier community.

Reaching Underserved Communities and Addressing Health Disparities

The team will respond to all violence-related incidents after receiving a call from the SF Police Department. These incidents occur throughout the city. However, the greatest numbers of violent incidents occur in neighborhoods that have historically been economically depressed, have high rates of truancy among youths, and have active territorial gang rivalries. Violent incidents have occurred in the Tenderloin, Bayview-Hunters Point/Visitation Valley, South of Market, and Chinatown neighborhoods, where 40% of the residents are low income (at or below 200% of the federal poverty level): CRT has also responded to incidents in the Mission and North Beach neighborhoods, where over 30% of these neighborhood populations is low income. Our data also shows that in 2007, 90% of young homicide victims were either African-American (54%) or Latino (37%). Therefore, it is not surprising that the vast majority of families served are African-American and Latino, followed by Asian/Pacific Islander.

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

2. Please provide any available data on program outcomes. If this program was selected for the local evaluation of a PEI program¹, please provide an analysis of results or progress in the local evaluation. The analysis shall include, but not be limited to:
- a) A summary of available information about person/family-level and program/system-level outcomes from the PEI program
 - b) Data collected, including the number of program participants under each priority population served by age, gender, race, ethnicity, and primary language spoken
 - c) The method(s) used in this evaluation, including methods to ensure that evaluation results reflect the perspectives of diverse participants
 - d) Specific program strategies implemented to ensure appropriateness for diverse participants
 - e) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

Select Person/Family-level and Program/System-level Outcomes

Still working to develop the procedures and supports needed to collect, track, and analyze the data.

As a result of this intervention, communities in San Francisco that are most affected by violence and trauma-exposure will have better access to effective and timely crisis and case management services, which will reduce disparities in access to care and prevent the development of more chronic and severe impairment in trauma-exposed individuals.

09/10 Participant Data

Provided direct crisis intervention services to 205 individuals and additionally provided 504 individuals (family members, etc.) with support.

Evaluation Methods

Still working to develop the procedures and supports needed to collect, track, and analyze the data.

Select Program Goals and Outcomes

Individual Outcomes

- Participants learn and use effective coping strategies to address grief, loss, and trauma exposure
- Participants access entitlements and services related to their trauma exposure
- timely and appropriate crisis intervention
- Prevents participants who have been exposed to traumatic events from developing post-traumatic stress disorder and other trauma-related mental health disorders

Program Outcomes

- CRT staff arrive at the scene of a violent incident within 30 minutes of receiving a call from the San Francisco Police Department and/or General Hospital

¹ Note that very small counties (population less than 100,000) are exempt from this requirement

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

- CRT staff provide effective crisis intervention services to trauma-exposed individuals, including crisis support; short term case management; and brief therapy
- CRT staff provide crisis support and debriefing services to affected school personnel and students following violent incidents

System Outcomes

- Individuals in need of mental health services related to trauma exposure are identified and referred by the San Francisco Police Department and San Francisco General Hospital. This early identification and referral leads to timely intervention and a reduction in the burden of suffering caused by delay in or lack of access to services.

Engaging Consumers and the Community

The CRT works closely with the Community Response Network, a group of neighborhood-based providers that coordinate services and resources to address gang violence and to enable families of victims of violence seamless access to services. The CRT also works in close collaboration with the Comprehensive Children’s Crisis Team to address issues surrounding the effects of violence on children and their families. The CRT facilitates debriefing and defusing services in communities and schools throughout the city, using protocols that have been developed with the San Francisco Unified School District to supply crisis staff following a school-based violent incident. Debriefings are opportunities for psycho-education and processing of trauma resulting from community exposure to gun violence. Further, as part of this expansion, CRT will link with SF’s Suicide Prevention for 24 hour phone and on-line crisis intervention and emotional support.

Program Changes

N/A

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the Priority Population or the Community Mental Health Needs?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
2. Is there a change in the type of PEI activities to be provided?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
3. a) Complete the table below:								
<table border="1" style="width: 100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="text-align: left; padding: 2px;">FY 10/11 funding</th> <th style="text-align: left; padding: 2px;">FY 11/12 funding</th> <th style="text-align: left; padding: 2px;">Percent Change</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$374,020</td> <td style="padding: 2px;">\$366,945</td> <td style="padding: 2px;">-2%</td> </tr> </tbody> </table>	FY 10/11 funding	FY 11/12 funding	Percent Change	\$374,020	\$366,945	-2%		
FY 10/11 funding	FY 11/12 funding	Percent Change						
\$374,020	\$366,945	-2%						
b) Is the FY 11/12 funding requested outside the $\pm 25\%$ of the previously approved amount, or ,	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>						
<u>For Consolidated Programs</u> , is the FY 11/12 funding requested outside the $\pm 25\%$ of the sum of the previously approved amounts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
c) If you are requesting an exception to the $\pm 25\%$ criteria, please provide an explanation below.								

NOTE: If you answered YES to any of the above questions (1-3), the program is considered Revised Previously Approved. Complete Exhibit F3.

A. Answer the following questions about this program.

1. Please include a description of any additional proposed changes to this PEI program, if applicable.

The project is being transferred from the MHSA CSS Plan using augmented PEI funds that were not available during the original PEI planning process. This project expands the CRT, funded in large part by the SF General Fund, which provides caring and culturally competent assistance to families and loved ones of victims of gun violence and homicides. In partnership with the police, General Hospital, and a host of city and community agencies, the CRT provides immediate crisis intervention, short-term stabilization and case management, and follow up services to victim’s families and friends. The CRT facilitates debriefing and defusing services in communities and schools throughout the city.

2. If this is a consolidation of two or more previously approved programs, please provide the following information:

- a. Names of the programs being consolidated
- b. The rationale for consolidation

**PREVIOUSLY APPROVED PROGRAM
Prevention and Early Intervention**

c. Description of how the newly consolidated program will aim to achieve similar outcomes for the Key Priority Population(s) and Community Mental Health Need(s)		
N/A		
B. Provide the proposed number of individuals and families to be served by prevention and early intervention in FY 11/12.		
	Prevention	Early Intervention
Total Individuals:	200	60
Total Families:	200	60

PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN-1 Adapt the WRAP

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

¹ The term “essential purpose” has been replaced with the term “primary purpose” for INN.

PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 2: Mindfulness Based Intervention for Youth and their Providers

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

¹ The term “essential purpose” has been replaced with the term “primary purpose” for INN.

PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 3: Supported Employment and Cognitive Training (SECT) Project

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

¹ The term “essential purpose” has been replaced with the term “primary purpose” for INN.

PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 4: Digital Storytelling for Adults

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

¹ The term “essential purpose” has been replaced with the term “primary purpose” for INN.

**PREVIOUSLY APPROVED PROGRAM
Innovation**

County: San Francisco

Program Number/Name: INN 5: Youth Led Evaluation of Health Assessment Tools

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

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PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 6: Peer Education/Advocacy on Self-Help Movement and Consumer Rights

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

¹ The term “essential purpose” has been replaced with the term “primary purpose” for INN.

PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 7: Peer Led Hoarding and Cluttering Support Team

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

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SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

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PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 8: Collaboration with the Faith Community

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

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PREVIOUSLY APPROVED PROGRAM
Innovation

County: San Francisco

Program Number/Name: INN 9: Community Mini Grants

Date: 2/22/2011

SECTION I: PROGRAM SPECIFIC PROGRESS REPORT FOR FY 09/10

Please check box if your county did not begin implementation of this INN program in FY 09/10. Please provide an explanation for delays in implementation and then skip to Section II: Program Description for FY 11/12.

San Francisco County's Three Year Program and Expenditure Plan for Innovation was submitted in March 2010, revised on May 14, 2010 and approved by MHSOAC on May 27, 2010. The remainder of FY09-10 was spent developing a Request for Qualification for Innovation programs that were selected to be implemented by community based organizations as well as requesting for budgeted positions and developing job descriptions for programs selected to be implemented by the County.

A. Please complete the following questions about this program during FY 09/10.

1. Briefly report on the performance of the program during FY 09/10, including progress in providing services to unserved and underserved populations, if applicable, with emphasis on reducing ethnic and cultural disparities. Please describe any key differences and major challenges with implementation of this program, if applicable.

2. Please provide an analysis of how the program is meeting its learning goals to date. The analysis shall include, but not be limited to:
- a) A summary of what has been learned from the program, to date, including how the program affected participants, if applicable
 - b) Primary methods used to determine how the Innovation program is meeting its learning goals, including methods to ensure that evaluation results reflect the perspectives of stakeholders
 - c) Data collected, including data available on program outcomes and elements of the programs that contributed to successful outcomes. Please also include the number of program participants served by age, gender, race, ethnicity, and primary language spoken, if applicable
 - d) Changes and modifications made during the program's implementation, if any, and the reason(s) for the changes

PREVIOUSLY APPROVED PROGRAM
Innovation

SECTION II: PROGRAM DESCRIPTION FOR FY 11/12

1. Is there a change in the primary purpose ¹ ?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Is there a change to the learning goals?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NOTE: If you answered <u>YES</u> to any of the above questions (1-2), the program is considered Revised Previously Approved. Complete Exhibit F4.		
3. Please include a description of any additional proposed changes to this INN program, if applicable.		

¹ The term “essential purpose” has been replaced with the term “primary purpose” for INN.

County: San Francisco

Date: 2/22/2011

	MHSA Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. FY 2011/12 Component Allocations						
1. Published Component Allocation	\$13,557,900			\$3,638,800	\$904,300	
2. Transfer from FY 11/12 ^{a/}	\$3,000,000		\$3,000,000			
3. Adjusted Component Allocation	\$10,557,900					
B. FY 2011/12 Funding Request						
1. Requested Funding in FY 2011/12	\$15,833,483	\$0	\$3,000,000	\$6,494,129	\$1,018,056	
2. Requested Funding for CPP				\$108,810	\$50,902	
3. Net Available Unexpended Funds						
a. Unexpended Funds from FY 09/10 Annual MHSA Revenue and Expenditure Report	\$5,139,236	\$0		\$2,629,433	\$618,859	
b. Amount of Unexpended Funds from FY 09/10 spent in FY 10/11 (adjustment)	\$5,139,236			\$2,629,433	\$618,859	
c. Unexpended Funds from FY 10/11	\$5,275,583			\$2,964,139	\$164,658	
d. Total Net Available Unexpended Funds	\$5,275,583	\$0		\$2,964,139	\$164,658	
4. Total FY 2011/12 Funding Request	\$10,557,900	\$0	\$3,000,000	\$3,638,800	\$904,300	
C. Funds Requested for FY 2011/12						
1. Unapproved FY 06/07 Component Allocations						
2. Unapproved FY 07/08 Component Allocations						
3. Unapproved FY 08/09 Component Allocations						
4. Unapproved FY 09/10 Component Allocations ^{b/}						
5. Unapproved FY 10/11 Component Allocations ^{b/}						
6. Unapproved FY 11/12 Component Allocations ^{b/}	\$10,557,900		\$3,000,000	\$3,638,800	\$904,300	
Sub-total	\$10,557,900	\$0	\$3,000,000	\$3,638,800	\$904,300	
7. Access Local Prudent Reserve						
8. FY 2011/12 Total Allocation ^{c/}	\$10,557,900	\$0	\$3,000,000	\$3,638,800	\$904,300	

NOTE:

- Line 3.a and 3.b. should be completed if annual update is being submitted prior to the end of FY 10/11.
- Line 3.a., 3.b., 3.c., and 3.d. should be completed if annual update is being submitted after the end of FY 10/11.
- Line 3.a. should be consistent with the amount listed on the FY 09/10 Annual MHSA Revenue and Expenditure report, Enclosure 9, Total Unexpended Funds line.
- Line 3.c. should be consistent with the amount listed on the FY 10/11 Annual MHSA Revenue and Expenditure report, Total Unexpended Funds line.
- Line 3.c. will be verified upon receipt of the FY 10/11 Annual MHSA Revenue and Expenditure report and adjustments will be made as necessary.

^{a/}Per Welfare and Institutions Code Section 5892(b), in any year after 2007-08, Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve in an amount not to exceed 20% of the average amount of funds allocated to that County for the previous five years. The 20% limits are included in Enclosure 8.

^{b/}For WET and/or CFTN components, enter amount of unapproved funds being requested for use from any of the years a transfer from CSS was made.

^{c/} Must equal line B.4. for each component.

CSS FUNDING REQUEST

County: San Francisco

Date: 2/22/2011

CSS Programs			FY 11/12 Requested MHSA Funding	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group				
No.	Name	Full Service Partnerships (FSP)		General System Development	Outreach and Engagement	MHSA Housing Program	Children and Youth	Transition Age Youth	Adult	Older Adult		
Previously Approved Programs												
1.	1A/B	Children, Youth and Families (CYF)	\$1,966,746	\$1,445,783	\$520,963		\$1,966,746					
2.	2A/B	Transitional Age Youth (TAY)	\$2,467,070	\$1,057,079	\$1,409,991			\$2,467,070				
3.	3A/B	Adults	\$7,494,848	\$5,521,079	\$1,973,769				\$7,494,848			
4.	4A/B	Older Adults (OA)	\$2,246,525	\$895,586	\$1,350,939					\$2,246,525		
5.			\$0									
6.			\$0									
7.			\$0									
8.			\$0									
9.			\$0									
10.			\$0									
11.			\$0									
12.			\$0									
13.			\$0									
14.			\$0									
15.			\$0									
16.	Subtotal: Programs ^{a/}		\$14,175,189	\$8,919,527	\$5,255,662	\$0	\$0	\$1,966,746	\$2,467,070	\$7,494,848	\$2,246,525	Percentage
17.	Plus up to 15% Indirect Administrative Costs		\$1,658,295									12%
18.	Plus up to 10% Operating Reserve		\$0									0.0%
19.	Subtotal: Programs/Indirect Admin./Operating Reserve		\$15,833,484									
New Programs/Revised Previously Approved Programs												
1.			\$0									
2.			\$0									
3.			\$0									
4.			\$0									
5.			\$0									
6.	Subtotal: Programs ^{a/}		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	Percentage
7.	Plus up to 15% Indirect Administrative Costs											#VALUE!
8.	Plus up to 10% Operating Reserve											#VALUE!
9.	Subtotal: Programs/Indirect Admin./Operating Reserve		\$0									
10.	Total MHSA Funds Requested for CSS		\$15,833,484									

a/ Majority of funds must be directed towards FSPs (Cal. Code Regs., tit. 9, § 3620, subd. (c)). Percent of Funds directed towards FSPs=

62.90%

Additional funding sources for FSP requirement:

County must provide the majority of MHSA funding toward Full Service Partnerships (FSPs). If not, the county must list what additional funding sources and amount to be used for FSPs. [In addition, the funding amounts must match the Annual Cost Report.] Refer to DMH FAQs at http://www.dmh.ca.gov/Prop_63/MHSA/Community_Services_and_Supports/docs/FSP_FAQs_04-17-09.pdf

**CSS Majority of Funding to FSPs
Other Funding Sources**

	CSS	State General Fund	Other State Funds	Medi-Cal FFP	Medicare	Other Federal Funds	Re-alignment	County Funds	Other Funds	Total	Total %
Total Mental Health Expenditures:	\$8,919,527	\$0	\$0	\$634,000	\$0	\$0	\$0	\$0	\$0	\$9,553,527	67%

Revised 12/29/10

County: San Francisco

Date: 2/22/2011

Workforce Education and Training			FY 11/12 Requested MHSA Funding	Estimated MHSA Funds by Service Category				
No.	Name	Workforce Staffing Support		Training and Technical Assistance	Mental Health Career Pathway	Residency and Internship	Financial Incentive	
Previously Approved Programs								
1.	A	Workforce Staffing and Support	\$0					
2.	B	Trainings and Technical Assistance	\$0					
3.	C	Mental Health Career Pathways	\$0					
4.	D	Internships for Hard-to-Fill Positions	\$0					
5.			\$0					
6.			\$0					
7.			\$0					
8.			\$0					
9.			\$0					
10.			\$0					
11.			\$0					
12.			\$0					
13.			\$0					
14.			\$0					
15.			\$0					
16.	Subtotal: Programs ^{al}		\$0	\$0	\$0	\$0	\$0	Percentage
17.	Plus up to 15% Indirect Administrative Costs		\$0					#DIV/0!
18.	Plus up to 10% Operating Reserve		\$0					#DIV/0!
19.	Subtotal: Programs/Indirect Admin./Operating Reserve		\$0					
New Programs								
1.			\$0					
2.			\$0					
3.			\$0					
4.			\$0					
5.			\$0					
6.	Subtotal: WET New Programs ^{al}		\$0	\$0	\$0	\$0	\$0	Percentage
7.	Plus up to 15% Indirect Administrative Costs							#VALUE!
8.	Plus up to 10% Operating Reserve							#VALUE!
9.	Subtotal: New Programs/Indirect Admin./Operating Reserve		\$0					
10.	Total MHSA Funds Requested		\$0					

Note: Previously Approved programs to be expanded, reduced, eliminated and consolidated are considered New.

Revised 12/29/10

PEI FUNDING REQUEST

County: San Francisco

Date: 2/22/2011

PEI Programs		FY 11/12 Requested MHSA Funding	Estimated MHSA Funds by Type of Intervention		Estimated MHSA Funds by Age Group					
No.	Name		Prevention	Early Intervention	Children and Youth	Transition Age Youth	Adult	Older Adult		
Previously Approved Programs										
1.	1	School-Based Youth-Centered Wellness	\$1,168,400	\$876,300	\$292,100	\$918,400	\$169,500	\$80,500		
2.	2	Screening, Planning & Supportive Services for Incarcerated Youth	\$409,000	\$306,750	\$102,250	\$122,700	\$286,300			
3.	3	Re-Engagement of Truant and Out-of-School Youth	\$268,000	\$174,200	\$93,800	\$214,400	\$53,600			
4.	4	Holistic Wellness Promotion in a Community Setting	\$1,000,000	\$500,000	\$500,000		\$1,000,000			
5.	5	Early Childhood Mental Health Consultation Expansion	\$609,874	\$475,702	\$134,172	\$609,874				
6.	6	Involved with Juvenile Justice System	\$425,000	\$395,250	\$29,750	\$127,500	\$297,500			
7.	7	Older Adult Behavioral Health Screening and Response	\$319,290	\$319,290				\$319,290		
8.	8	Early Intervention and Recovery for Young People with Early Psychosis	\$1,294,184	\$1,203,591	\$90,593	\$394,184	\$900,000			
9.	9	Transition Aged Youth Multi-Service Center	\$200,000	\$142,000	\$58,000		\$200,000			
10.	11	Trauma and Recovery Services	\$247,200	\$165,624	\$81,576	\$173,040	\$74,160			
11.	12	Crisis Response Team	\$366,945		\$366,945		\$366,945			
12.										
13.		\$0								
14.		\$0								
15.		\$0								
16.	Subtotal: Programs*		\$6,307,893	\$4,558,707	\$1,749,186	\$2,560,098	\$1,981,060	\$1,447,445	\$319,290	Percentage
17.	Plus up to 15% Indirect Administrative Costs		\$186,236							3%
18.	Plus up to 10% Operating Reserve		\$0							0.0%
19.	Subtotal: Programs/Indirect Admin./Operating Reserve		\$6,494,129							
New/Revised Previously Approved Programs										
1.		\$0								
2.		\$0								
3.		\$0								
4.		\$0								
5.		\$0								
6.	Subtotal: Programs*		\$0	\$0	\$0	\$0	\$0	\$0	\$0	Percentage
7.	Plus up to 15% Indirect Administrative Costs									#DIV/0!
8.	Plus up to 10% Operating Reserve									#DIV/0!
9.	Subtotal: Programs/Indirect Admin./Operating Reserve		\$0							
10.	Total MHSA Funds Requested for PEI		\$6,494,129							

*Majority of funds must be directed towards individuals under age 25. Percent of funds directed towards those under 25 years 72%

Note: Previously Approved Programs that propose changes to Key Community Health Needs, Priority Populations, Activities, and/or funding as described in the Information Notice are considered New.

INN FUNDING REQUEST

County: San Francisco

Date: 2/22/2011

INN Programs			FY 11/12 Requested MHSA Funding	
No.	Name			
Previously Approved Programs				
1.	1	Adapt the WRAP	\$0	
2.	2	Mindfulness Based Intervention for Youth and their Providers	\$0	
3.	3	Supported Employment and Cognitive Training (SECT) Project	\$0	
4.	4	Digital Storytelling for Adults	\$0	
5.	5	Youth Led Evaluation of Health Assessment Tools	\$0	
6.	6	Peer Education/Advocary on Self-Help Movement and Consumer Rights	\$0	
7.	7	Peer-Led Hoarding and Cluttering Support Team	\$0	
8.	8	Collaboration with the Faith Community	\$0	
9.	9	Mini Grants	\$0	
10.				
11.				
12.				
13.				
14.				
15.				
16.	Subtotal: Programs		\$0	Percentage
17.	Plus up to 15% Indirect Administrative Costs		\$0	#DIV/0!
18.	Plus up to 10% Operating Reserve			#DIV/0!
19.	Subtotal: Previously Approved Programs/Indirect Admin./Operating Reserve		\$0	
New Programs				
1.	10	Community Garden	\$160,000	
2.	11	WAIST Nutrition Project	\$188,256	
3.	12	Clinic/School Linking Project	\$669,800	
4.				
5.				
6.	Subtotal: Programs		\$1,018,056	Percentage
7.	Plus up to 15% Indirect Administrative Costs		\$0	0%
8.	Plus up to 10% Operating Reserve		\$0	0.0%
9.	Subtotal: New Programs/Indirect Admin./Operating Reserve		\$1,018,056	
10.	Total MHSA Funds Requested for INN		\$1,018,056	

Note: Previously Approved Programs that propose changes to the primary purpose and/or learning goal are considered New.

Revised 12/29/10

CFTN FUNDING REQUEST

County: San Francisco

Date: 2/22/11

Capital Facilities and Technological Needs Work Plans/Projects				TOTAL FY 11/12 Required MHSA Funding	Funding Requested by Type of Project		
No.	Name	New (N) Existing (E)	Capital Facilities		Technological Needs		
1.	Consumer Connect	Existing (E)	\$0		\$0		
2.	South East Health Center	New (N) Existing (E)	\$3,000,000	\$3,000,000			
3.			\$0				
4.			\$0				
5.			\$0				
6.			\$0				
7.			\$0				
8.			\$0				
9.			\$0				
10.			\$0				
11.			\$0				
12.			\$0				
13.			\$0				
14.			\$0				
15.			\$0				
16.			\$0				
17.			\$0				
18.			\$0				
19.			\$0				
20.			\$0				
21.			\$0				
22.			\$0				
23.			\$0				
24.			\$0				
25.			\$0				
26.	Subtotal: Work Plans/Projects			\$3,000,000	\$3,000,000	\$0	Percentage
27.	Plus up to 15% Indirect Administrative Costs			\$0			0.0%
28.	Plus up to 10% Operating Reserve			\$0			0.0%
29.	Total MHSA Funds Requested			\$3,000,000			

Revised 12/29/10

NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: San Francisco

Completely New Program

Program Number/Name: INN 10: Seeding Resilience

Revised Previously Approved Program

Date: 2/22/2011

Complete this form for each new INN Program. For existing INN programs with changes to the primary¹ purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- Increase access to underserved groups**
- Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

The primary purpose of this project is to increase access for individuals with mental health issues, by providing an alternative to indoor clinical services at community gardens throughout the city and county. To this end, the *Seeding Resilience* project will provide opportunities for community members facing mental health challenges to engage in community building, nutrition education, food preparation and job skills training through participation in a community garden.

2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.

The *Seeding Resilience* project seeks to learn how to best utilize garden spaces to promote mental health care through the use of: 1) skill shares; 2) employment training; and 3) citywide events that provide free whole body care. Focusing on the skill shares, which come out of the disability community, participants are able to learn and share information and learn how to problem solve. Because skill shares encourage underserved populations and stakeholders to lead and share information as equals in a safe environment, we expect to learn that skill shares enable individuals who are unable to access clinical forms of mental health care to become more invested in their health, to increase their self sufficiency, to become more engaged in community and to participate more often.

More specifically, this project seeks to:

- Learn what types of skill building, health and education programming underserved groups are willing to participate in, in a community garden environment.
- Learn what types of skill building, health and education programming city and non profit organizations are able and willing to collaborate on and provide in a community garden environment.
- Learn how utilize and empower the existing network of urban agriculture leaders to support community members with mental health challenges and create opportunities for employment training and skill sharing in community gardens throughout the city.

2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

The GHCG project will apply the following general standards.

- Community Collaboration.** This strategy is inherently collaborative, involving city agencies, CBOs, neighborhood businesses and community members. The following are just a few examples existing GHCG collaborations:
- The Zen Center, located one block from the GHCG site will provide volunteers to assist with gardening, skilled landscape architect, nutrition and cooking education classes. Their long-standing farm, Green Gulch Garden, located in Marin will provide seeds and plant starters.
 - Tom Waddell Health Center will provide program support, technical advice, peer counseling and nutritional and self-

¹ The term "essential purpose" has been replaced with the term "primary purpose" for INN.

NEW/REVISED PROGRAM DESCRIPTION

Innovation

healing herbal education.

- Hayes Valley Neighborhood Association members will assist with the gardening and work side by side with homeless members to create and expand a sense of community absent in many of the homeless and formerly homeless members lives.
- The SF Refresh project will encourage and create a framework for city agencies, CBOs, neighborhood businesses and community members to volunteer and work together to provide free whole body care activities at community garden's throughout the city.

Cultural Competence. We plan to engage a diverse group of consumers to participate. The garden will also incorporate vegetables and plants commonly used by various cultures.

Client Driven Mental Health System. Participants will be individuals who choose to join the project and will be in charge of determining which project resources they utilize. Engaging consumers as garden employees and volunteers will promote the development of client driven programming.

2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

75% of our project will focus on the Growing Home Community Garden (GHCG). The other 25% will focus on developing educational opportunities and connecting urban agricultural leaders at community gardens across the city. GHCG is primarily tended by the homeless, formerly homeless, veterans and dual diagnosed individuals of diverse backgrounds. The SF Refresh project will provide diverse skill shares citywide to the general public with strong outreach to mental health consumers.

3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.

Beginning in April 2011 and continuing for three months, we will collect feedback from stakeholders and begin attending meetings of the San Francisco Urban Agriculture Alliance (SFUAA). Following this period, we will hire and train peer staff to outreach to mental health consumers. Citywide events, workshops, and skill shares will be held to provide free whole body self-care at the gardens. Collaboration and networking with SFUAA will enable the project to continue after Project Homeless Connect has ended its relationship with the project.

Phase I (04/11 – 06/11)

Phase I provides the time to meet with stakeholders who will provide feedback and input into the project, as well as attend meetings of the SFUAA to listen to their issues concerns and to begin forming a relationship.

Phase II (07/11 – 07/13)

Phase II provides time for mental health peer mentors to be hired and supervised, and additional homeless and formerly homeless peers will gain employment training with placement by SF FIRST. Peer mentors will learn employment skills and provide outreach to mental health consumers. Individuals will participate in skill share opportunities and workshops each year. Citywide events will be held to provide free whole body self care at the gardens. We will regularly attend SFUAA meetings to work on creating opportunities for promoting the goals of MHSA.

Phase III (08/13 – 11/13)

Phase III provides three months for stakeholder feedback, data analysis, report writing, and initial dissemination of findings. A final report will be provided at 24 months from project launch. The dissemination of the model will occur through journals (both peer reviewed and not), conference and other scholarly presentations.

4. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

We will measure and disseminate lessons learned from the project by:

- Recording data and oral narratives from stakeholders about the project and its participants.

NEW/REVISED PROGRAM DESCRIPTION

Innovation

- Writing a paper that outlines the lessons, challenges, outcome indicators (repeat attendance, amount of engagement in the project, outreach strategies, beneficial social connectedness, etc), the design of the project and how it evolved as lessons were learned throughout the project.
- Information about how to replicate the project will be made available online.

5. If applicable, provide a list of resources to be leveraged.

The *Seeding Resilience* project, through its partnership with GHCG will be able to leverage significant in-kind resources including:

- Close connection to a strong alliance that includes individuals, government agencies, private groups and community organizations.
- A volunteer coordinator will help manage and recruit volunteers. Over 30,000 volunteer hours have already been committed to this project and additional partnerships are being formed daily.
- A garden educator will be on site weekly to maintain the health and integrity of the project.

6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is \$1,000,000. The first year projected amount will be \$250,000, the second year projected amount is \$250,000, the third year is \$250,000 and the fourth year is \$250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

INN 10: Seeding Resilience Project's entire budget is \$134,098

7. Provide an estimated annual program budget, utilizing the following line items.

NEW ANNUAL PROGRAM BUDGET

A. EXPENDITURES

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel			80,000	80,000
2.	Operating Expenditures			24,462	24,462
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)			9,000	9,000
5.	Work Plan Management				
6.	Other Expenditures			46,538	46,538
	Total Proposed Expenditures				

B. REVENUES

1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues				

C. TOTAL FUNDING REQUESTED

160,000 160,000

NEW/REVISED PROGRAM DESCRIPTION
Innovation

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

This budget is for two years of operating the Seeding Resilience Project.

Personnel = **80,000**

Personnel include Program Manager at .63 FTE, Administrative Support at .25 FTE, and Garden Manager at .25 FTE. Program Manager will provide oversight to the entire project, develop program objectives and outcome measures, work with community partners, lead the evaluation, and write the final report. The Administrative Support will assist the program in purchasing supplies, process timesheets, process invoices for payment, and with correspondence. The garden manager will supervise gardeners and work closely with the GHCG volunteer coordinator in organizing gardening and community activities.

Operating Expenditures:

Supplies for garden and community activities	= 4,362
Internet Access at garden sites	= 2,500
Incentives for garden participants	= 10,000
Food for community activities/participants	= 6,000
Training and Staff Development	= 1,000
Local Travel	= 600
TOTAL OPERATING EXPENSES	= 24,462

Contracts:

Honoraria for trainers and Skill Shares speakers	= 6,000
Evaluation consultant	= 3,000
TOTAL CONTRACTS	= 9,000

Other:

Stipends for Peer Mentors (3 x .25 FTE @ \$11/hour incl. payroll taxes)	= 38,438
Indirect Costs – calculated at 12% of Personnel Costs	= 8,100
TOTAL OTHER	= 46,538

NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: San Francisco

Completely New Program

Revised Previously Approved Program

Program Number/Name: INN 11: Alleviating Antipsychotic Induced Metabolic Syndrome (AAIMS)

Date: 2/22/11

Complete this form for each new INN Program. For existing INN programs with changes to the primary¹ purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- Increase access to underserved groups
- Increase the quality of services, including better outcomes**
- Promote interagency collaboration
- Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

Consumers with mental illnesses such as schizophrenia, schizoaffective disorder, and bipolar disorder often require treatment with atypical antipsychotic medications. These medications carry a significant risk for the development of metabolic derangements which can lead to significant suffering and early death. This project focuses on a population of consumers that face the greatest barriers to successful community integration and to employment - seriously mentally ill consumers, many of whom have co-occurring substance abuse, a history of homelessness, and very limited financial resources.

Prior studies have shown that educating consumers about how to improve their diet and increase their exercise can significantly decrease the metabolic consequences of using these medications. That said, many of these programs target either consumers in a residential setting or those with generally good access to cooking facilities and fresh ingredients. The population served at the San Francisco Department of Public Health's Housing and Urban Health (HUH) Clinic is primarily homeless or marginally housed. With this innovative project, we seek to test a modified intervention designed to address the environmental realities of the clients served at the HUH Clinic.

We expect that we will be able to improve outcomes by helping this underserved group successfully learn how to shop, cook, and eat in a healthier fashion along with improving knowledge of and engagement in a regular exercise regime.

2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.

In the past ten years, a strong connection has been established between the second generation or "atypical" antipsychotics and the development metabolic derangements. Obesity, diabetes and lipid abnormalities - collectively referred to as "metabolic syndrome" - are strongly correlated with even short term use of these medications. These metabolic changes are also related to higher incidence of heart disease, stroke, and an increased risk for various types of cancer. Thus, evolving standards of psychiatric care now include monitoring of metabolic markers, such as blood glucose, cholesterol and triglyceride levels, weight and body-mass index (BMI).

The HUH Clinic patients on Atypical Antipsychotics face the additional hurdle of very poor access to adequate cooking facilities, exercise facilities, or nutritional counseling. We will develop a project which educates consumers on atypical antipsychotics about the connection between diet and health, how to shop based on what is locally available, cooking skills appropriate to their setting (i.e.: working with microwaves and crock pots), and how to exercise adequately to improve fitness and health. Project participants will be recruited both from SFDPH clinics serving residents of supportive housing sites and directly from single-room occupancy hotels (SROs), primarily in the Tenderloin, Mission, and South of Market

¹ The term "essential purpose" has been replaced with the term "primary purpose" for INN.

NEW/REVISED PROGRAM DESCRIPTION

Innovation

neighborhoods in San Francisco.

The educational component of this project will be based upon a protocol developed by Dr. Rohan Ganguli of the University of Toronto and Jaspreet Singh Brar of the University of Pittsburgh. This protocol ("A Behavioral Group-Based Treatment of Weight Reduction in Schizophrenia and Other Severe Mental Illnesses") is an approach designed to address the metabolic consequences of using atypical antipsychotics. The primary focus of this protocol is increasing exercise and decreasing caloric intake through portion control. The innovation in this case is the addition of a significant component focused on healthy cooking and shopping within the constraints that come with living in the Tenderloin, Mission, and South of Market neighborhoods. These individuals as a whole have little-to-no access to cooking facilities and a dearth of outlets for affordable fresh foods. We hope to **improve outcomes** by helping this underserved group successfully learn how to shop, cook, and eat in a healthier fashion along with improving knowledge of and engagement in a regular exercise regime.

In this Innovations project, we will: 1) Learn how to translate a successful nutrition and exercise training into a community mental health setting; 2) Increase its power by combining it with skills training around shopping and cooking using the limited resources available to our low-income population.

Expected Outcome/Positive Change:

- Improve metabolic markers for seriously mentally ill consumers on atypical antipsychotic medications.
- Improve self-confidence and nutritionally related skills in target consumers.

2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) will apply the following MHSA General Standards.

- **Community Collaboration.** AAIMS will involve collaboration between primary care providers, mental health providers, and nutritional educators. It will also involve working with case managers, social workers, farmer's market vendors, and small corner store operators.
- **Cultural Competence.** Multimodal nutrition and weight control projects have been developed in diverse communities with generally good results. We will work to engage local stake holders in the design of the nutritional component based on different cultural expectations of dietary needs.
- **Client Driven Mental Health System.** AAIMS will provide a specific array of supports for nutrition and exercise education and implementation, but the patient is inherently in charge of utilizing these resources.
- **Family Driven Mental Health System.** While a common problem for our consumers is the social isolation which often leads them to this community, insofar as AAIMS participants have available family supports, the project will actively involve these resources in helping to support participants and to provide formative feedback regarding the efficacy of the interventions and suggestions for improvement.
- **Wellness, Recovery and Resilience Focus** AAIMS is fundamentally aligned with the Wellness, Recovery and Resilience Focus because it is about empowering our consumers with both knowledge and skills which will enable them to make informed decisions about their diet and control for the unintended consequences of necessary medications.
- **Integrated Service Experience.** The AAIMS project will integrate primary, psychiatric, and nutritional counseling with the resources which are actually available in the community such as farmer's markets and small groceries. We will work with these community stake holders to promote improved awareness of nutrition and will encourage them to make more appropriate items available to our consumers.

2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

Consumers with mental illnesses such as schizophrenia, schizoaffective disorder, and bipolar disorder who receive treatment with atypical antipsychotic medications who reside in supportive housing sites and who live in SRO's in the Tenderloin, Mission, and South of Market neighborhoods if San Francisco.

3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.

We anticipate that we will require three months to train staff, 18 months to complete 3 training cycles with time between for assessment and modification of the protocol as indicated. And finally, three months to develop a summary of findings.

Phase I (10/11 – 01/12)

NEW/REVISED PROGRAM DESCRIPTION

Innovation

Phase I provides the time to ramp up the program, including training staff, purchasing equipment for the skills training, and establishing research protocols. This period will also be vital for discovery of any barriers to implementation and resolving these issues prior to start up of the project.

Phase II (02/12 – 06/13)

Phase II provides 3 cycles of intervention, including two 14-week cycles per cohort of skills training. Data on the project will be collected throughout the project period and analyzed. An interim report will be provided at 12 months.

Phase III (07/13 – 10/13)

Phase III provides three months for data analysis, report writing, and initial dissemination of findings. A final report will be provided at 24 months from project launch. The dissemination of the model will occur through journals (both peer reviewed and not), conference and other scholarly presentations.

4. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

- If AAIMS is successful, seriously mentally ill consumers will successfully integrate nutritional theory, cooking and shopping skills, and exercise training into their daily lives which we anticipate will lead to significant improvement in metabolic markers and overall health.
- The AAIMS project will also lead to significant improvement in our patients' psychological well being as assessed using standardized instruments. AAIMS participants will be asked for their perceptions of and satisfaction with the program as a way to gather formative feedback for program improvement. The evaluation will consider barriers to participation and will interview any consumers that drop out of the program as well as those that persist as feasible.
- The AAIMS project will work with both property management and support services at supportive housing sites to develop improved access to adequate kitchen resources and will also work to develop an ongoing training program for how to shop and cook given the limitations of locally available food items.

5. If applicable, provide a list of resources to be leveraged.

In-kind program oversight and staff supervision will be provided by Dr. Chris Hobart, a staff Psychiatrist at the HUH Clinic. In-kind space at DPH facilities will be used for holding groups and to house project staff.

6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is \$1,000,000. The first year projected amount will be \$250,000, the second year projected amount is \$250,000, the third year is \$250,000 and the fourth year is \$250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

INN 11: the entire project budget is \$188,255. The first year projected amount is \$94,128 and the second year projected amount is \$94,128.

7. Provide an estimated annual program budget, utilizing the following line items.

NEW ANNUAL PROGRAM BUDGET

A. EXPENDITURES

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel			\$91,000	\$91,000
2.	Operating Expenditures			\$41,700	\$41,700
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)			\$31,000	\$31,000

NEW/REVISED PROGRAM DESCRIPTION

Innovation

5.	Work Plan Management				
6.	Other Expenditures			\$24,556	\$24,556
	Total Proposed Expenditures			\$188,256	\$188,256
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues				
C. TOTAL FUNDING REQUESTED					
				\$188,256	\$188,256

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

The budget provided is for two years of operating the AAIMS program.

Personnel

- .5 FTE Project Coordinator (coordination, administrative and data collection duties) plus benefits at 30%
= \$45,500 x 2 **= 91,000**

Operating (\$28,850)

- Printed Project Materials (manuals, hand outs, etc.) - \$30 per 45 participants = \$1,350 x 2 = 2,700
- Office Support Equipment (computer, printer) = \$2,250 x 2 = 4,500
- SRO approved cooking equipment, etc. (pedometers, scales, microwave, slow cooker, refrigerator.)
\$270 per 45 participants = \$12,150 x 2 = 24,300
- Healthy snacks (and other incentives for attendance)
\$50 per session x 10 sessions x 3 cycles = \$1,500 x 2 = 3,000
- In-Session Cooking Expenses (ingredients & cooking equipment for demonstrations) –
\$8/participant x 15 participants x 10 sessions x 3 cycles = 3,600 x 2 = 7,200

TOTAL OPERATING**= 41,700****Consultants** (\$15,500)

- Nutrition Training Consultant = \$7,500 x 2 = 15,000
- Evaluation/CQI Consultant = \$8,000 x 2 = 16,000

TOTAL CONSULTANTS**= 31,000****Other Expenditures**

Total Salary, Operating and Consultants = \$81,850

Indirect (Fiscal Intermediary) 15% of direct costs (163,700 x .15)

=24,556

NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: San Francisco **Completely New Program**

Program Number/Name: INN 12: Building Bridges: *Linking Schools and Community Clinics*
Revised Previously Approved Program

Date: 2/22/ 2011

Complete this form for each new INN Program. For existing INN programs with changes to the primary¹ purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- Increase access to underserved groups
 Increase the quality of services, including better outcomes
 Promote interagency collaboration
 Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

Building Bridges will test a staffing model designed to promote **interagency collaboration** between DPH Community Health Programs for Youth (CHPY) clinics and San Francisco Unified School District. And, if successful, to study how stronger collaboration between these systems might serve to better meet the significant mental health needs of youth living in Southeast neighborhoods of San Francisco.

2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.

Youth living in neighborhoods like Hunter's Point, Sunnyside, and other neighborhoods in the Southeast section of San Francisco, are at significant risk for exposure to community violence, family upheaval and other factors that may cause and exacerbate behavioral health problems. Reaching many of these youth in the community is often difficult due to (1) stigma associated with accessing mental health services, (2) youth not knowing where to go if they are interested in services, and (3) fears around consent and confidentiality. Additionally, many youth with mental health issues go to primary care services with physiological complaints that are actually psychological in nature. For these youth, an **interagency collaborative** approach between schools where youth should be daily, community behavioral health providers and primary clinics potentially supports increased access for youth and a streamlined system for professional linkages and referrals for care.

San Francisco only has one comprehensive school-based health clinic, Balboa Teen Health Center, located in the City's southeast section. While sufficient resources and political will to expand this model to other High Schools does not currently exist, this proposal attempts to build on this proven model of school-based/linked health care delivery to youth by linking CHPY clinics to SFUSD Wellness Centers, supporting clinic staff time in Wellness Centers and increasing collaborative approaches to care.

This INN was developed in response to a desire to test ideas that improve collaboration, leverage resources and expand access to services.

2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

- **Community Collaboration.** Building Bridges will involve collaboration between primary care providers, school-based providers, and various CBOs, including Larkin Street Youth Services (fiscal agent for 3rd St, access to job training, housing), Bayview Hunter's Point Foundation (fiscal agent for Hawkins, Balboa, access to neighborhood youth and behavioral health services), other potential collaborators include the TAY Unit of Adult Probation, Juvenile Probation, the and other local neighborhood agencies and groups.

¹ The term "essential purpose" has been replaced with the term "primary purpose" for INN.

NEW/REVISED PROGRAM DESCRIPTION

Innovation

- **Cultural Competence.** The target schools/communities are in low-income, high crime areas of San Francisco which are disproportionately communities of color. Therefore, the staff recruited will have capacity for working with diverse groups of youth - taking into account language, culture, class and historical trauma.
- **Client Driven Mental Health System.** This innovative model was developed with significant input from the Balboa Teen Health Center Youth Advisory Board (YAB), many of whom are current consumers of mental health care.
- **Family Driven Mental Health System.** This project will incorporate an awareness of the important role of families in the wellness process for youth. Family members will also be included in the evaluation process to assess the efficacy of the model as it has affected their family.
- **Wellness, Recovery and Resilience Focus.** This model supports a continuum of care with an emphasis on prevention and early intervention as the first line of care. Clinically, it is built on a strengths-based approach to working with youthful clients, and supports a harm reduction model as well.
- **Integrated Service Experience.** Building Bridges is built on a fully integrated model of care, supporting collaboration and communication among primary care/reproductive health care providers, school-based services and other support services to provide maximum access to care for at-risk youth.

2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

Youth and their families; transitional age youth; youth living in the southeast neighborhoods of San Francisco. This project will serve in excess of 400 youth, ages 12-19 primarily, through prevention and early intervention efforts on an annual basis; the vast majority of clients are youth of color with a fairly even split between males and females. Languages most important in addition to English are Chinese and Spanish.

3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.

We anticipate that we will require three months to hire staff, 24 months to run the pilot with ongoing assessment and QI activities. And finally, three months to develop a summary of findings.

Phase I (07/11 – 10/11)

Phase I provides the time to ramp up the program, including training staff, purchasing equipment for the skills training, and establishing protocols. This period will also be vital for discovery of any barriers to implementation and resolving these issues prior to start up of the project.

Phase II (11/11 – 06/13)

Phase II provides 24 months of intervention. Data on the project will be collected throughout the project period and analyzed. An interim report will be provided at 12 months.

Phase III (07/13 – 10/13)

Phase III provides three months for data analysis, report writing, and initial dissemination of findings. A final report will be provided at 30 months from project launch. The dissemination of the model will occur through journals (both peer reviewed and not), conference and other scholarly presentations.

4. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

The proposed pilot will have an evaluation component to determine whether the intervention demonstrates an impact on collaboration between DPH and SFUSD and/or increase access to services for youth and their families.

The evaluator will also identify any barriers to implementation and provide formative feedback to the project team to overcome these barriers.

NEW/REVISED PROGRAM DESCRIPTION

Innovation

A final report will be written to document the results based on our project objectives and any lesson learned from the process. This information will be disseminated within to the State Department of Mental Health, and other county Departments. If successful, we plan to promote the use of the model in future DPH funding decision as well as to other funders of school based services in San Francisco.

5. If applicable, provide a list of resources to be leveraged.

In-kind program oversight and staff supervision will be provided by Michael Baxter, MSW, Director of Youth Oriented Primary Care. In-kind space at DPH facilities will be used for holding groups and to house project staff.

6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is \$1,000,000. The first year projected amount will be \$250,000, the second year projected amount is \$250,000, the third year is \$250,000 and the fourth year is \$250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

Program INN 12. The entire project is \$669,800. The first year projected amount will be \$334,900; the second year projected amount is \$334,900.

7. Provide an estimated annual program budget, utilizing the following line items.

NEW ANNUAL PROGRAM BUDGET

A. EXPENDITURES

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel	\$334,900			\$334,900
2.	Operating Expenditures				
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management				
6.	Other Expenditures				
	Total Proposed Expenditures	\$334,900			\$334,900
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues				
C. TOTAL FUNDING REQUESTED		\$334,900			\$334,900

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

The budget provided is for two years.

2930 Clinical Social Worker \$81,586 x 2	= 163,172
2931 MFT \$81,586 x 2	= 163,172
2575 Clinical Psychologist \$94,443 x 2	= 188,886
Benefits @ 30% \$77,285 x 2	=154,570
TOTAL PERSONNEL	=669,800

NEW/REVISED PROGRAM DESCRIPTION
Innovation

2931 MFT \$81,586
2575 Clinical Psychologist \$94,443

Benefits @ 30% \$77,285
Total Personnel \$334,900

**NEW AND EXISTING PROJECT DESCRIPTION
Capital Facilities**

County: San Francisco

Project Number/Name: South East Health Center Renovation

Select one:

New

Existing

Project Address: 2401 Keith Street, San Francisco, CA 94134

Date: 2/22/2011

Type of Building (Check all that apply)		
<input type="checkbox"/> New Construction	<input type="checkbox"/> Acquired with Renovation	<input type="checkbox"/> Acquired without Renovation
<input checked="" type="checkbox"/> Existing Facility	<input checked="" type="checkbox"/> County owned	<input type="checkbox"/> Privately owned
<input type="checkbox"/> Leasing (Rent) to Own Building	<input type="checkbox"/> Restrictive Setting	<input type="checkbox"/> Land only

NEW PROJECTS ONLY

1. Describe the type of building(s). Include (as applicable):
- Prior use and ownership.
 - Scope of renovation.
 - When proposing to renovate an existing facility, describe how the renovation will result in an expansion of the capacity/access to existing services or the provision of new services.
 - When renovation is for administrative services, describe how the offices augment/support the County's ability to provide programs/services.
 - If facility is privately owned, describe the method used for protecting the County's capital interest in the renovation and use of the property.

Southeast Health Center, located in the Bay view district of San Francisco, is a federally qualified health center owned and fully-operated by the Department of Public Health. The building, designed in 1975, is 14,154 square feet and is zoned for public use. The site has been improved to include paved parking for 48 stalls on a total of 1.21 acres. The site wraps around a privately owned .17 acre parcel that divides the parking area into two sections and contains a single-story warehouse.

Southeast Health Center (SEHC) currently provides primary and urgent care services to adults, teens, children and infants. In addition, SEHC provides dental care to children, initial screening for hearing/speech problems, pre-natal care, breast health services, limited behavioral health and psycho-social care, heroin detoxification services, trauma and violence focused children's mental health services, HIV early intervention program, and specialty clinics (cardiology, oncology, respiratory diseases, occupational health, and orthopedics). SEHC also runs a diabetes clinic and asthma clinic for children and adults. It partners with the 3rd Street Youth Center and Clinic for primary care, reproductive health care, and limited behavioral health services and HIV/STD testing.

SEHC served 3,425 unique individuals in 2009 - 10% of the total zip code population and 47% of those who have incomes under 100% of the federal poverty level; almost 30% of the patients are under 18 and a little less than 70% are between 18 and 64; 7% of the patients are over 65. 65% of the patients are African American, 11% are Asian Pacific Islander and 13% are Latino.

The expansion of Southeast Health Center has been a priority for the Bayview Hunters Point Project Area Committee (PAC) and the Bayview community for many years, and there have been a number of studies to analyze the need and feasibility of the project. The proposed expansion of SEHC will enlarge the usable square footage to 43,730 square feet. The proposed renovation will include space for the expansion of primary care and behavioral health services, enhancement of substance abuse services, addition of an outreach component, shared space, as well as a new facade. Health services at the expanded site will include the integration of behavioral health services, substance abuse services, crisis intervention and specialty services, as well as citywide behavioral health services, resulting in the formation of a **Southeast Health Campus**.

Five existing DPH programs will be co-located at this site: Comprehensive Child Crisis Services (including the City's Violence Response Team); Foster Care Mental Health; Family Mosaic Project; Children's System of Care; and the Health

NEW AND EXISTING PROJECT DESCRIPTION
Capital Facilities

and Environment Resource Center (HERC). Three of the five programs receive MHSA funding: Family Mosaic Project is a CYF full service partnership; Health and Environment Resource Center is an outreach and engagement program under Community Services and Support; and the Comprehensive Child Crisis Services program receive Prevention and Early Intervention funding for young people with early psychosis. These programs focus on the residents of the Southeast community and also have a special role in serving foster children citywide.

DPH is implementing a new system-wide approach to behavioral health-primary care integration, a “Behaviorists” model of care where immediate and short term interventions are the focus rather than long, office-based visits. This renovation will allow SEHC to implement this model by providing physical space for the co-location of existing children’s behavioral health programs. Planning discussions about this renovation also highlighted the expansion of some specialty medical services including diabetes, asthma, podiatry and vision services. The needs for more smoking cessation services and Alcoholics Anonymous services have also been discussed. With the co-location of HERC at this site, the clinic would have the ability to add community outreach components to the planned expanded specialty medical clinic. In conjunction with all these developments, the 3rd Street Youth Center and Clinic also has plans to relocate across the street from the park across SEHC. The close proximity of both clinics will further enhance their existing collaboration while at the same time preserve the autonomy of a youth clinic to maintain confidentiality and improve utilization especially among high-risk teens.

2. Describe the intended purpose, including programs/services to be provided and the projected number of clients/individuals and families and age groups to be served, if applicable.

The expanded site offers a wonderful opportunity to integrate behavioral health services for children and families into the primary care setting. This co-location will offer the community a more holistic approach to health. Health services at the expanded site will include the integration of behavioral health services, substance abuse services, crisis intervention and specialty services, as well as citywide behavioral health services, resulting in the formation of a **Southeast Health Campus**.

It is projected the expansion will give SEHC the capacity to increase its patient caseload to **1,250** additional children and families. It will also give SEHC the ability to operate on evenings and weekends, which will be a welcome service, especially to working parents.

3. Provide a description of project location. Include proximity to public transportation and type of structures and property uses in the surrounding area.

The Southeast Health Center (SEHC) is located in the Bayview Hunters Point district of San Francisco. To the west of the clinic is the Bay view Park and the Martin Luther King Pool, a publicly accessible pool operated by the San Francisco Parks and Recreation Department. Commercial businesses surround the clinic. The Charles Drew College Preparatory Academy and Nursery and the Rainbow’s End Pre-school are located ten blocks northwest of the clinic.

Public transportation is available less than two blocks away on 3rd Street and Carroll Avenue on the Muni Third Street (T) trolley line from the Metropolitan Transportation Agency (MTA). The entrance to the 101 freeway is a short distance away on 3rd Street. In addition to the parking available on the clinic’s property, plenty of street parking is available in the neighborhood.

4. Describe whether the building(s) will be used exclusively to provide MHSA programs/services and supports or whether it will also be used for other purposes. If being used for other purposes, indicate the percentages of space that will be designated for mental health programs/services and for other uses. Explain the relationship between the mental health program/services and other uses. (NOTE: Use of MHSA funds for facilities providing integrated services for alcohol and drug programs and mental health is allowed as long as the services are demonstrated to be integrated.)

The Southeast Health Campus will house an integrated primary care, behavioral health services for youth and families, and outreach services. The addition of the behavioral health services at this site is consistent with the CSS objective to integrate primary care and behavioral health services within the City’s system of care. Bringing together the expertise and experience of existing children’s behavioral health services and primary care within one campus will realize the MHSA principles of providing an integrated service delivery system to assure a seamless approach to services and delivering a client and family centered services that truly meet clients’ behavioral and medical needs in one setting. The renovations

NEW AND EXISTING PROJECT DESCRIPTION
Capital Facilities

will create space for 5 programs that will be co-located with the existing primary care services, shared space for integrated activities, and common areas (corridors, bathrooms, parking).
5. Describe the steps the County will take to ensure the property/facility is maintained and will be used to provide MHSA programs/services for a minimum of twenty (20) years.
The City and County of San Francisco's Dept. of Public Health intends to address the on-going staffing and maintenance needs of the South East Campus through annual appropriations in the City's budget process.
6. If proposing Leasing (Rent) to Own Building provide a justification why "leasing (rent) to own" the property is needed in lieu of purchase. Include description of length and terms of lease prior to transfer of ownership to the County.
N/A
7. If proposing a purchase of land with no MHSA funds budgeted for building/construction, explain this choice and provide a timeline with expected sources of income for construction or purchasing of building upon this land and how this serves to increase the County's infrastructure.
N/A
8. If proposing to develop a restrictive setting, submit specific facts and justifications that demonstrate the need for a building with a restrictive setting. (Must be in accordance with Welf. & Inst. Code §5847, subd. (a)(5).)
N/A
9. If the proposed project deviates from the information presented in the CFTN component approved in the Three-Year Program and Expenditure Plan, describe the stakeholder involvement and support for the deviation.
N/A
<u>EXISTING PROJECTS ONLY</u>
1. Provide a summary of the originally approved CF project.
N/A
2. Explain why the initial funding was insufficient to complete the project.
N/A
3. Explain how the additional funds will be used.
N/A

**NEW AND EXISTING PROJECT DESCRIPTION
Capital Facilities**

Provide an estimated annual program budget, utilizing the following line items.

NEW/EXISTING PROJECT BUDGET					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Pre-Development Costs		250,000		250,000
2.	Building/Land Acquisition		1,541,120		1,541,120
3.	Renovation				
4.	Construction	3,000,000	16,427,530		19,427,530
5.	Repair/Replacement Reserve		863,427		863,427
6.	Other Expenditures		360,000		360,000
	Total Proposed Expenditures		19,192,077		22,192,077
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues		19,192,077		19,192,077
	Total Revenues	0	19,192,077		19,192,077
C. TOTAL FUNDING REQUESTED		3,000,000	0		3,000,000

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed program expenditures for each line item. Please include a brief description of pre-development costs, building/land acquisition, renovation, construction, repair/replacement reserve, and other expenditures associated with this CF project.

The budget was developed with a consultant hired by the Department of Public Health to review current space, operational issues, financial data, explore development and financing options, and meet with various stakeholders to determine service needs. The pre-development costs will include development of site plans, conceptual design, and financing plan. The proposed renovation budget includes a projection for acquiring an adjacent warehouse to make room for the expansion should zoning laws prohibit the City from adding 2 new floors above the 1 story annex over the existing parking lot. The construction costs could be financed through bond issuance and/or tax credits. The reserve is for financing of the debt obligation and other expenditures is for issuance of a debt service loan. Other expenses are projected costs for project management.

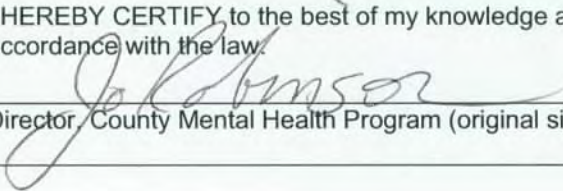
**Training, Technical Assistance and Capacity Building Funds Request Form
 (Prevention and Early Intervention Statewide Program)**

Previously approved with no changes
 New

Date:1/17/2011	County Name: San Francisco
Amount Requested for FY 2011/12: \$119,600	
<p>A. Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) and/or contractor(s).</p>	
<p>CBHS contracts with Mental Health Association of San Francisco to conduct Training, Technical Assistance and Capacity Building activities. This project aims to increase the public’s understanding of mental illness and to improve the capacity of behavioral health providers, partners and systems. The project offers high quality, consumer-run education about mental illness that reduces stigma and focuses on recovery. It includes a Speaker’s Bureau of trained consumers, Training of Trainers sessions, presentations in traditional and non-traditional settings, program and educational outreach, and the production and distribution of educational materials.</p> <p>MHA-SF Mental Health Advocate is the primary staff supported with this funding and provides the following.</p> <ul style="list-style-type: none"> ▪ A monthly support group for consumers working at CBHS. (Community Behavioral Health Services) ▪ Up to 5 hours per week as part of an Employment Assistance Program (EAP) for peer and consumer workers at CBHS ▪ At least 2 trainings on the Mental Health Services Act during the year to members of the support group. The target audience for these trainings may also include MHSA funded housing sites. <p>The Mental Health Association of San Francisco has been working within the mental health community for over 60 years, and has demonstrated experience in training, technical assistance and capacity building.</p> <p>This funding is combined with PEI and WDET funds to also support a Speaker’s Bureau.</p>	
<p>B. The County and its contractor(s) for these services agree to comply with the following criteria:</p> <ol style="list-style-type: none"> 1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County’s Three-Year Program and Expenditure Plan. 2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services. 3) These funds shall only be used to pay for the programs authorized in Welfare and Institutions Code (WIC) section 5892. 4) These funds may not be used to pay for any other program. 5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC section 5892. 6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities. 7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines. 	

Certification

I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.



Director, County Mental Health Program (original signature)