Mental Health Services Act

Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan

November 4, 2008
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## MENTAL HEALTH SERVICES ACT (MHSA)
### PREVENTION AND EARLY INTERVENTION COMPONENT
#### OF THE THREE-YEAR
##### PROGRAM AND EXPENDITURE PLAN

**Fiscal Years 2007-08 and 2008-09**

<table>
<thead>
<tr>
<th>County Name</th>
<th>San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>November 4, 2008</td>
</tr>
</tbody>
</table>

### COUNTY’S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):  

<table>
<thead>
<tr>
<th>County Mental Health Director</th>
<th>Project Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Robert Cabaj</td>
<td>Name: James Stillwell</td>
</tr>
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<td>Telephone Number: (415) 255-3401</td>
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</tr>
</tbody>
</table>

Mailing Address: 1380 Howard Street, 4th Floor, San Francisco, CA 94103

### AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for “very small counties”), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _________________________                                        ______________________

County Mental Health Director                                                           Date

Executed at _______________________, California
1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

Robert Cabaj, the Director of the County’s Department of Public Health's Community Behavioral Health Services, or County Mental Health Director, was responsible for the overall Community Program Planning. He worked closely with Alice Gleghorn, Deputy Director of CBHS, who oversees MHSA implementation in San Francisco to select co-chairs for the community planning process. They chose James Stillwell, County Alcohol and Drug Program Administrator and Nancy Rubin, CEO of Edgewood Children’s Center, both leaders in the prevention-focused mental and behavioral health work in the county. Mr. Stillwell, as lead on the prevention planning efforts around substance abuse and other prevention efforts throughout the Department of Public Health, understands the principles of prevention and how to apply them, especially as part of a system of care. Ms. Rubin participated in the initial MHSA planning process and is a long-time expert in children and youth services of all types and currently CEO of a community based agency that is heavily involved in prevention work across many sectors, including mental health, education, early childhood, family support, foster care, and suicide prevention. As the PEI planning necessitated meaningful collaboration with sectors not traditionally considered part of the mental health system, her experience was invaluable.

b. Coordination and management of the Community Program Planning Process

The County developed a team to coordinate and manage the planning process, which included:
• James Stillwell, Co-Chair of the Committee and County Alcohol and Drug Program Administrator
• Nancy, Rubin, Co-Chair of the Committee and CEO of Edgewood Children’s Center
• Maria Iyog-O'Malley, MHSA Program Coordinator
• Tom Bleecker, Assistant Director of Research & Evaluation, CBHS
• Kathleen Minioza, Assistant Health Educator, CBHS
• Nathaniel Mitchell, MHSA, Implementation Specialist/Youth & Family
• Stephanie Romney, Senior Research Associate, CBHS

We also contracted with a Bay Area consulting company, Hatchuel Tabernik & Associates, to assist with facilitating the PEI planning process, and writing the final plan. The planning team met bi-weekly to plan, prepare and manage the process.

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The planning team shared responsibility for ensuring that stakeholders had an opportunity for meaningful participation in the planning process. We designed the planning process to include maximum feedback from all participating stakeholders, Planning Committee members and public alike. Ms. Minioza was the primary point of contact for all emails and phone calls, and included her
contact information – along with that of the co-chairs and planning consultant – on agendas and handouts.

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations

The County began outreach for the PEI community planning process by targeting the unserved and underserved populations that were identified in the 2004-05 Community Services and Supports (CSS) planning process. The CSS plan identified all age groups as underserved, with the widest service gaps (pre-CSS implementation) being among young children, transitional aged youth, and older adults. The most underserved ethnic groups were Latinos and Asians, although the CSS Plan stated that “the rates are obviously influenced by [San Francisco’s] large Asian and Latino populations response to stigma, preventing treatment-seeking in these populations in contrast to the small (7%) population of African Americans with high rates of substance abuse, criminal justice, and trauma producing mental health system involvement. These numbers are misleading if used to estimate true need.” In addition, City and County data showed that the Native American population was underserved, as Native Americans in SF were four times more likely to be homeless and mentally ill than average San Franciscans, and five times more likely to commit suicide. CSS planning found that females were less likely to be served than males, across age ranges. The plan also identified special populations, i.e., gay, lesbian, bisexual, transgender, queer and questioning (LGBTQQ) youth and adults, homeless, youth in foster care and juvenile probation, non-English speaking individuals and households, and those uninsured or insured without mental health coverage. Therefore, the County attempted to engage mental health providers, community-based organizations, consumers, and community leaders from all our ethnic groups, sectors, special populations, and neighborhoods in this effort to transform the way we think about and collaborate with one another to deliver mental health services.

San Francisco has a long history of engaging the community in public policy and planning efforts. As such, the CSS planning process was very successful in involving representatives of underserved populations, and laid extensive groundwork for the PEI outreach effort. The starting point for PEI outreach was the master list of the many organizations and individuals who participated in the CSS process. While far too extensive to summarize here, highlights of the CSS community engagement process include:

- trilingual outreach, in English, Spanish, and Cantonese;
- Behavioral Health Innovations Task Force, with 42 members from every underserved and special population listed above, and all required PEI sectors;
- 11 subcommittees, including an Early Intervention and Prevention subcommittee, co-chaired by two Task Force members, at least one of whom was a consumer;
- peer-to-peer family and consumer interviews, and consumer lunches;
- special topic focus groups;
- service provider survey;
- 15 briefing papers and best practice analyses; and
- 80 position papers submitted by community members/organizations
Building from the CSS list, the planning team employed the following strategies to include members of unserved and underserved populations in the PEI planning process:

- Drs. Cabaj and Gleghorn structured the PEI Planning Committee to include representatives from underserved populations and required stakeholder groups.
- Initial outreach for participation in the community planning process included emails to everyone who participated in the original extensive CSS planning process in 2004-05. Emails were then sent to an expanded list of stakeholders interested in the mental health system, compiled from participation in any DPH-sponsored activity. This included participation in other MSHA planning, such as Workforce Development Education and Training; MHSA Advisory Board meetings; trainings (e.g. 2-4 mental health and/or substance abuse trainings per month); and the CBHS database of contractors of supportive services, such as social services and health. Service providers and advocacy organizations working with unserved or underserved populations have been engaged with the County for many years and constituted a large portion of this outreach.
- MHSA Implementation Specialists delivered flyers to mental health providers.
- The PEI planning process was announced in the CBHS Director's Report which is widely distributed to all mental health and substance abuse agencies and the Mental Health Board members.
- Announcements of the planning process and of Planning Committee meeting were made via email, newspaper, and newsletters to ensure they were open to a diverse group of stakeholders.
- Co-chairs facilitated the Planning Committee meetings using an “integrated discussion” format, meaning that both committee members and the public were invited to comment and be a part of the discussion throughout.
- Planning Committee meetings were held at different locations around the city, housed in familiar and accessible community buildings:
  - Edgewood Family Center in South of Market/Potrero Hill (2 meetings)
  - Neighborhood House in the (inner) Mission District
  - Baha’i Center in the (inner) Mission District
  - Clinica de la Raza in the (outer) Mission District
  - Southeast Community College in Bayview/Hunter’s Point
  - West Bay Conference Center in the Western Addition (3 meetings)
  - Cameron House in Chinatown
- The majority of Planning Committee meetings were held in the morning, as requested by Committee members, with 20% of meetings in the evening to maximize diverse participation.
- Announcements publicized that interpreters were available for any meeting.
- All meetings were recorded, transcribed and posted on the DPH MHSA PEI website, along with the agenda, minutes, and handouts.
- Co-chairs conducted a feedback session at the end of every Planning Committee asking people (1) what went well, and (2) what could be improved for the next meeting or overall.
- The planning team offered to facilitate and incentivize focus groups with any populations that Planning Committee members or public participants felt were underrepresented. This resulted in one focus group with the Native American community and additional data collection from the Youth Caucus. The focus group at the Native American Health Center helped inform a number
of questions that surfaced across subcommittees. Findings from the focus group are detailed under the project description for Holistic Support in a Community Setting.

- Members of the planning team consulted with key informants, including the following representatives: Nathan Israel, Director of Evidence Based Practice Academy, CBHS-DPH; Ethan Nebelkopf, Director of Family & Child Guidance Clinics of the Native American Health Center and architect of the Holistic Support in an Urban Setting model.

- The first four Planning Committee meeting included training for all participants on understanding core PEI requirements, principles, priorities, and opportunities, identifying risk and protective factors; interpreting data, and designing desired outcomes.

- Each of the PEI Planning Committee workgroups had facilitators to guide the participants through examining the data, identifying and prioritizing desired outcomes, discussing existing capacity, and choosing up to five PEI programs to recommend to the full group.

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

San Francisco is a very diverse county and values the importance of involving representative groups in all planning efforts, especially ones related to meeting people’s needs and to systems change.

Race/Ethnicity. The overall demographic breakdown of the County is 44.3% White, 32.2% Asian/Pacific Islander; 14.1% Latino; 6.6% African American, 0.2% Native American, and 2.7% Multi-Racial or Other. The breakdown of the Committee was somewhat reflective of the County demographics: 60% White, 17% Asian/Pacific Islander; 6% Latino; 14% African American, and 3% Native American. While we did not ask members of the public to report their ethnicity, it was a very racially diverse group that contributed to providing a well-rounded picture of the needs in SF.

Language. More than one quarter of SF households (28.6%) are linguistically isolated, meaning the household lacks any fluent, adult speaker of English. According to the U.S. Equal Employment Opportunity Commission, the following languages are spoken in San Francisco: Spanish, Chinese (Cantonese and Mandarin), Vietnamese, Tagalog, Hmong, Laotian, Khmer, Mien, Cambodian, Mixtecos (Native Mexican dialect), Korean, Arabic, Yemeni, Farsi, Hindi, and Russian. Almost 30% of Committee members represented organizations that serve linguistically isolated consumers, while about 65% work with consumers and/or families that speak English as a second language.

Socioeconomics. Although SF has a high median income, 45% of households have incomes below $50,000, including almost 15% making less than $15,000. Over 40% of the population is low income (at or below 200% of the federal poverty level) in four neighborhoods: Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% is low income in the Mission and North Beach.

Age. San Francisco has a relatively low proportion of children, with 16.4% of residents being under the age of 20. The vast majority of the population (69.9%) is between 20 and 64, and 13.7% of the population are 65 or older. However, various factors contributed to a stronger focus on recruiting representatives of children and youth. Firstly, young children and transitional aged youth were
identified as underserved populations during the CSS process. Secondly, successful, transformative prevention and early intervention approaches often engage the entire family. Finally, at least half of the PEI funds must be allocated to children and youth. Therefore the Committee was comprised of 57% representatives from organizations that serve families or consumers of all ages, 29% representing children and youth plus 9% specifically representing transitional aged youth, and 6% representing adult serving organizations.

As mentioned in the previous section, in addition to extensive outreach, the planning process was designed to ensure maximum participation from the diverse populations of San Francisco. The meetings used an “integrated discussion” format, meaning that Committee members and the public were engaged in the discussion throughout the process. The meetings included trainings and presentations on prevention and early intervention principles and strategies.

The County continued to encourage and support this diverse participation by holding the meetings throughout the city, during the time of choice (10am-12noon) with a few meetings in the evenings, always with refreshments. Meetings were wheelchair accessible, and the following offer was on all agendas: Assistive Listening Devices, materials in large print and other alternative formats, American Sign Language interpreters, and other accommodations will be made available upon request. Contact Kathleen Minioza at 415-255-3585 (V) or 255-3745 (TTY).

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families
- Providers of mental health and/or related services such as physical health care and/or social services
- Educators and/or representatives of education
- Representatives of law enforcement
Enclosure 3

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No2

• Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families

CBHS ensured the participation of required stakeholders as Committee members and as participants throughout the planning process in a number of ways. As previously mentioned, the initial outreach for participation in the community planning process included email notification to a broad spectrum of the community. Email addresses were compiled from prior participation in the CSS planning process, plus stakeholders that had participated in any DPH-sponsored activity. Persons interested in serving on the Planning Committee submitted their names to be considered for membership. CBHS Leadership selected members from those volunteers to represent the required stakeholder groups and underserved populations. Where gaps were noted, the Leadership and PEI planning team identified additional candidates and organizations, making numerous phone calls over the course of two months to follow-up on initial outreach and ensure that all sectors were represented. Service providers, other County departments and advocacy organizations publicized and recruited participants as well. After the first Committee meeting, when some representatives did not attend, the planning team followed up, in some cases recruiting additional Committee members to replace those that could no longer participate.

The Committee members, and public stakeholders, played the roles of key informants, as they were chosen for expertise and experience in their sector. They were asked to identify risk and protective factors for priority populations, and to report on existing capacity and gaps related to prevention and early intervention services. Later, stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations1. In workgroups, they prioritized desired outcomes for individuals and systems, and shared their expertise to identify programs and practices that would work with SF’s diverse community, and that would achieve the desired outcomes, increasing identified protective factors and mitigating risk factors.

Stakeholders were also asked to identify gaps in the needs data, and possible sources for finding or producing that data, including holding focus groups. The planning team offered to provide staff and incentives for any focus groups that stakeholders felt would inform the process or fill a gap. The Native American Health Center organized one focus group, the results of which were incorporated into the planning process. The Youth Caucus used the focus group script to conduct more informal conversations with youth at some of their centers and shared the youth feedback in the workgroups.

The PEI planning process involved 35 Committee members and at least 80 public participants. Stakeholder group participation numbers are detailed in question 4b on page 8.

b. Training for county staff and stakeholders participating in the Community Program Planning Process.

The County took a two-pronged approach to the training component of the community planning process. It was important to build the capacity of the stakeholders to develop and sustain a viable, effective, and integrated PEI plan. However, the planning team also recognized that many of the participating stakeholders coming from non-traditional sectors had more experience with the prevention side of mental health. As mentioned before, the co-chairs represented innovative PEI

1 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects
work at both the County mental health and community-based organization levels. Therefore, the first two meetings were spent building a basic understanding and common language for the PEI planning work. The co-chairs provided training on the core PEI requirements, principles, priorities, and opportunities. And experts were invited to present on the strategic prevention framework (similar to that promoted by SAMHSA) for the PEI process, risk and protective factors, and the ecology and spectrum of prevention to build the capacity of all stakeholders to participate in a meaningful way. During these presentations, and throughout the process, the co-chairs drew on the knowledge and experience of the stakeholders to help the group continually re-focus their thinking “upstream,” on prevention instead of treatment, on building protective factors and resilience instead of addressing deficits.

Additionally, in meeting four, the Assistant Director of Research, Evaluation, and Quality Management at CBHS presented on understanding and using data. When the workgroups began developing desired outcomes for individuals/families and programs/system, the planning team put together a mini-training on crafting outcomes on both levels. In meeting six, at the request of one of the Planning Committee members, the co-chairs led a discussion around the definition of underserved cultural populations. For the planning purposes, the participants agreed to use the multi-faceted summary written by Dr. Lonnie Snowden, a nationally-recognized expert in this area. The summary was an excerpt from Mental Health: Culture, Race, Ethnicity, a supplemental report to Mental Health: A Report of the Surgeon General 1999. The supplemental report documents the existence of several disparities affecting mental health care of racial and ethnic minorities compared with whites:

1. Minorities have less access to, and availability of, mental health services.
2. Minorities are less likely to receive needed mental health services.
3. Minorities in treatment often receive a poorer quality of mental health care.
4. Minorities are underrepresented in mental health research.

Finally, in order to guide the workgroups in discussing and identifying possible PEI programs, the planning team developed criteria for determining a “local promising practice.” The criteria were:

At a minimum, the program should:
1. Be implemented for at least a year
2. Be grounded in research or literature on effective practices in the PEI field
3. Have clear goals and objectives
4. Have identified indicators and measures of success
5. Include a written curriculum, or description of the program’s key processes and strategies

Additional Areas to consider:
6. Early evidence of success, if any
7. Reaches population not covered by State-approved programs
8. Developed from direct feedback/input from consumers in SF

The other major component of capacity building was the use of facilitators for the workgroups. During the feedback session at the end of meeting 4, the participants expressed concern at being able to work through all of the tasks on their own. The planning team decided to provide facilitators for each of the workgroups moving forward. The Planning Consultant oriented and trained a team of facilitators for meetings 5, 6 and 7. Additionally, the County paid for the planning team and interested Planning Committee members to attend the PEI Regional Roundtable sponsored by CiMH, NHDA, MHSOAC, and CDMH in July 2008.
4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how these were applied in the PEI process.

The 2004-05 CSS process engaged a broad and diverse group of stakeholders and resulted in a relevant and concrete plan for providing mental health services and supports. However, there were lessons learned about how to improve a community planning process that we implemented for PEI planning. Specifically, these included:

- Create a diverse Planning Team to coordinate, manage and keep the process moving. In this case, we included various CBHS departments (i.e. substance abuse, MHSA, research and evaluation, and children youth and family system of care), a community-based provider, and a planning consultant with a prevention background.

- Achieve broad public input, understanding and buy-in for the Plan by including a wider variety of stakeholders (professions, organizational affiliations, sectors) in the planning process.

- Limit expert/panel presentations to a minimum to allow participants (Committee members and public) ample time to interact and bring their expertise to bear on the process and resulting plan.

- Whenever possible, integrate public comment, i.e. do not relegate public comment solely to the end of meetings.

- Bring data and research experts to meetings to facilitate the understanding and use of data in planning.

b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

Our program planning process reached representatives from the identified unserved/underserved populations and had strong representatives from all of the required sectors. The following participation numbers are based on sign-in sheets:

<table>
<thead>
<tr>
<th>Stakeholder Groups</th>
<th>Committee Members</th>
<th>Public Participants</th>
</tr>
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<tbody>
<tr>
<td>Consumers and family members (duplicates of some of the categories below)</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Providers</td>
<td>18</td>
<td>33</td>
</tr>
<tr>
<td>Education and Workforce</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other Organizations (Advocacy)</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Department of Public Health</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>80</strong></td>
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As mentioned previously, the process also successfully engaged representatives of all age groups, with an emphasis on those working with children, youth and transitional aged youth. Representatives of the issues and needs of Transitional Aged Youth formed a TAY Caucus as part of their participation in the PEI planning process. The Caucus included representatives from: Lavender Youth Recreation Information Center (LYRIC), Larkin Street Youth Services, Youth Leadership...
In terms of special populations identified during the CSS process, we recruited and outreached to agencies that could help represent their interests, specifically:

- Specific underserved ethnic groups were represented by many agencies:
  - Latino – Instituto Familiar de la Raza, La Casa de las Madres, Horizons Unlimited
  - Asian – APA Family Support Services, Japanese Community Youth Council
  - Native American – Native American Health Center
  - Refugees - Survivors International

- Lesbian Gay Bisexual Transgender Questioning Queer (LGBTQQ) community was represented by LYRIC, Lyon Martin Health Services, and Larkin Street.

- The homeless population was represented by Larkin Street and Family Service Agency.

- Juvenile probation had representation from Jail Health Services, Youth Justice Institute, and Superior Court.

- San Francisco has a large and diverse population of non-English speaking individuals and households, many of which were represented by community based organizations in this process, such as Instituto Familiar, APA Family Support Services, Japanese Community Youth Council, SF Welcome Back Center, and RAMS Fu Yau Project.

- Youth in foster care had a number of organizations representing their needs and priorities, including Aspira Foster and Family Services, Honoring Emancipated Youth, Larkin Street Youth Services, and DCYF.

- As a county, San Francisco is working on the issue of individuals who are uninsured or insured without mental health coverage. Every effort will be made to ensure that this population will be enrolled in Healthy SF. Healthy SF provides a Medical Home and primary physician, allowing a greater focus on preventive and specialty care. Representatives from Healthy SF and the SF Community Clinic Consortium were Committee members and public participants.

5. Provide the following information about the required county public hearing:

   a. The date of the public hearing: November 12, 2008

   b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

   c. A summary and analysis of any substantive recommendations for revisions.

   d. The estimated number of participants:

**Note:** County mental health programs will report actual PEI Community Program Planning expenditures separately on the annual MHSA Revenue and Expenditure Report.
<table>
<thead>
<tr>
<th>PEI Project Allocation</th>
<th>PEI Project Summary</th>
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| **1** School-Based Youth-Centered Wellness  
$947,400  
This project consists of two strategies:  
K-12 School Based Services – This project engages community-based organizations to provide school-based services that address non-academic barriers to learning. Using public schools as hubs, this approach brings together many partners to offer a range of supports and opportunities to children, youth and families before, during and after school. Lead agencies provide and coordinate mental health services with other supports available at the school. This project includes partial funding for the Wellness Center at School of the Arts, which was originally included in the MHSA Community Services and Supports Plan, and is now being transferred as it is more aligned with the prevention and early intervention principles.  
Supported Higher Education – This project supports two Student Centers at institutions of higher education to provide direct intervention when students experience educational problems as a result of mental illness or emotional disturbance. The Centers partner with community mental health agencies, bridging services that are focused primarily on academic capacity-building and psychological counseling and supports. |
| **2** Screening, Planning and Supportive Services for Incarcerated Youth  
$390,000  
This project addresses risk factors faced by incarcerated youth – e.g. mental illness, trauma, substance abuse, fractured support systems and poor access to appropriate mental health and basic needs services – by identifying their mental health needs and ensuring that information informs their case planning. The project funds administration of a mental health needs and strengths assessment for all youth entering Juvenile Hall, case planning and advocacy for those with mental health needs, and direct service and service linkages during and after detention. |
| **3** Re-Engagement of Truant and Out-of-School Youth  
$268,000  
This project is designed to support truant and out-of-school youth to re-engage with and be successful in school and to stabilize their lives. It will be based in a neighborhood with high truancy and related risky behaviors among youth, preferably at a local high school that does not already have a reentry program. The design has four components: outreach; reentry classes with academic support, enrichment opportunities, and mental health services; service linkages; and incentives. The program engages a cohort of youth for one semester of intensive services, after which students are placed in the most appropriate comprehensive or continuation high school. |
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<tr>
<th>PEI Project Allocation</th>
<th>PEI Project Summary</th>
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<tr>
<td>4 Holistic Wellness Promotion in a Community Setting $750,000</td>
<td>This project uses a holistic approach based on cultural values and traditions as a foundation for a healthy community, and is designed to address the breadth, depth and scope of trauma, including effects of historical trauma. The model includes community outreach and education, prosocial community building events, direct services, and service linkages. Funding will go to three separate providers, each grounded in a distinct cultural community in San Francisco.</td>
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<tr>
<td>5 Early Childhood Mental Health Consultation (ECMHC) $650,000</td>
<td>ECMHC seeks to prevent, identify, treat and reduce the impact of mental health challenges among children aged 0-5 and their families. Funds expand the ECMHC Initiative to 15 childcare classrooms (including five at Family Resource Centers), three family childcare networks, and six drop-in childcare programs within parental drug treatment programs. Mental health consultants provide professional development, child observation and individual and group consultation to teachers and staff, and service linkage and direct services to children and families. The project includes a Training Institute for the consultants to increase capacity and quality of service.</td>
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<tr>
<td>6 Mental Health Consultation for Providers Working with At-Risk Youth $425,000</td>
<td>This project funds mental health professionals to provide consultation services at community-based organizations that work with youth who are at-risk or already involved with the juvenile justice system. The consultants build staff capacity via group trainings and consultation, individual coaching, observation and case consultation and service linkages. They also provide short-term intervention with youth and families. The project fosters coordination across agencies (those involved in a similar DCYF initiative and those funded via this project), and documentation of the model and methods so it can be expanded in the future.</td>
</tr>
<tr>
<td>7 Depression Screening and Response $300,145</td>
<td>Building upon efforts to increase the capacity of community-based health care providers to serve clients with behavioral health issues, this project focuses on screening and serving older adults with depression. The project funds implementation of an evidence-based collaborative care model in three health centers. The model includes training for center staff, depression screening for all older adults, and a Care Manager to work with the patient and physician to develop care plans, provide immediate treatment, monitor progress, and provide service linkages and follow-up support.</td>
</tr>
<tr>
<td>PEI Project Allocation</td>
<td>PEI Project Summary</td>
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<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>8 Early Intervention and Recovery for Young People with Early Psychosis $1,200,000</td>
<td>This project serves young people with serious early psychosis. It builds capacity of the field to identify and intervene early and effectively with this vulnerable population, promoting their self-sufficiency and quality of life, and preventing future social and economic costs. The project has four components: outreach and consultation; intake and assessment; treatment; and training. It utilizes an integrated team approach in which all elements of the intervention are brought to the service of the client and family in a coordinated fashion.</td>
</tr>
<tr>
<td>9 Trauma Recovery Services $247,200</td>
<td>The project is being transferred from the MHSA Community Services and Supports Plan, as it is aligned with the prevention and early intervention principles. It is funded through augmented PEI funds that were not available during the original PEI planning process. This project consists of two similar but distinct community-based trauma recovery programs that serve youth and their families primarily in the Mission, Excelsior and Southeast Sector. Services include outreach, assessment, crisis and short-term counseling, case management and mental health consultation to community organizations and the Mission Community Response Network. It is administered by Instituto Familiar de la Raza and the Urban Services YMCA.</td>
</tr>
<tr>
<td>10 Crisis Response Team $348,157</td>
<td>The project is being transferred from the MHSA Community Services and Supports Plan, as it is aligned with the prevention and early intervention principles. It is funded through augmented PEI funds that were not available during the original PEI planning process. This project expands the Crisis Response Team (CRT), 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. Together with Comprehensive Child Crisis, the CRT facilitates debriefing and defusing services in communities and schools throughout the city. The project is funded in large part by the General Fund and is administered by CBHS.</td>
</tr>
<tr>
<td>11 Transitional Age Youth Multi-Service Center $200,000</td>
<td>TAY-SF recently released a document outlining four approaches to serving Transitional Age Youth through comprehensive multi-service centers. The model for this PEI project requires further exploration and development before undergoing the approval and subsequent Request for Proposals process.</td>
</tr>
</tbody>
</table>
**County:** San Francisco  
**PEI Project Name:** School-Based Youth-Centered Wellness  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
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<tr>
<td>4. Stigma and Discrimination</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>5. Suicide Risk</td>
<td>✔️</td>
<td>✔️</td>
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<td>☐</td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population (s)

Note: All PEI projects must address underserved racial/ethnic and cultural populations.

#### A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>☐</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>4. Children and Youth at Risk for School Failure</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>☐</td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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</tr>
</tbody>
</table>

#### B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach,
PEI PROJECT SUMMARY

which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations.2

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors and protective factors that are linked to positive outcomes. Community Behavioral Health Services (CBHS) Research and Evaluation staff prepared and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the Community Services and Supports (CSS) Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the School-Based Youth-Centered Wellness Project came from the following sources:

- Youth Risk Behavior Survey and California Healthy Kids Survey
- Adolescent Health Working Group *A Snapshot of Youth Health and Wellness in San Francisco, 2008*
- Department of Children Youth and their Families (DCYF)
- San Francisco Unified School District
- Research from SF State University School of Social Work (Mowbray et al., 2005; Mowbray & Collins, 2002; Cooper, 1993; Stanley & Manthorpe, 2001; Kadison & Digeronimo, 2004)
- Physicians for Human Rights, Health and Justice for Youth
- Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) survey conducted by the National Institute of Mental Health (NIMH)
- Department of Public Health (DPH) Population Health and Prevention Management Information Systems
- KidsData.org and Lucile Packard Foundation for Children’s Health
- UC Berkeley Child Welfare Research Center
- MHSA Community Services and Supports Plan

After examining the data, PEI stakeholders (Committee members and public participants) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The planning process identified the following risk and protective factors regarding *youth at risk for school failure*:

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2 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – *stigma and discrimination reduction* and *suicide risk*. The issue of *disparities in access* was integrated into all populations and proposed PEI Projects.
Risk Factors
- Stressors and unidentified issues, e.g. socioeconomic, family, behavioral health
- School stress
- Uncoordinated and disconnected systems
- Alcohol, tobacco or other drug use
- Violence and trauma
- Suicide risk
- Immigrant and undocumented youth face myriad of issues with limited support, e.g. isolation, language, legal status, acculturation
- Transitions, to kinder, high school, college
- Lack of awareness and common understanding among schools and agencies
- Lack of mental health and health education
- Disparities in access to services
- Suicide risk
- Onset mental illness and depression

Protective Factors
- Strength-based assessments and programs
- Services where the youth are in communities where they live
- Cross training for service providers
- Support from case managers, community based organizations and school personnel
- Positive culturally competent mentorship
- Strong, empowered support systems – family and community
- Opportunities to engage in meaningful activities
- Other youth
- Youth-friendly programs and systems
- Continuum of services

The stakeholders examined data about the at-risk youth population that further highlighted the need for school-based prevention services, also referred to as “supported education” at the college level. Relevant findings included:

- CBHS provided mental health services to over 4,800 youth under age 18 in 2007. In addition, the Wellness Centers provided counseling and behavioral health services to 3,837 high school youth during the 2006-2007 school year.

- At least 21% of young people have a diagnosable mental illness, i.e. DSM disorder (MECA). Roughly half of all lifetime mental disorders have been shown to start by the mid-teens and three-fourths by the mid-20s (Kessler et al, 2007).

- On the Youth Risk Behavior Survey (YRBS) administered to 9-12th graders in 2007: 13% had seriously considered suicide (6% attempted); 53% had tried alcohol and 22% had drunk alcohol in the last month; 26% were sexually active of which 29% had not used a condom the last time they had sex; 23% had been in a fight in the last year and 7% had felt unsafe going to school in the last month. On the California Healthy Kids Survey, more than half (53%) of 5th graders reported that ”kids at school spread mean rumors or lies about them at least some of the time,” and 57% report that “other kids hit or pushed them at school when they are not just playing around”.
College students contending with mental health issues exhibit retention rates far below those of the general population and at the same time frequently fail to use available services and academic supports (Cooper, 1993; Stanley & Manthorpe, 2001).

More than half of SFUSD students (57%) are enrolled in the USDA Free or Reduced Meal Program, compared with 51% statewide.

While 15% of all SF children live in poverty, that percentage varies depending on ethnicity: 29% of African-American children and youth live in poverty, followed by 27% of Latinos, 10% of Asian/Pacific Islanders, and 1% of Whites (kidsdata.org). In four SF neighborhoods, more than 40% of the population is low-income (at or below 200% of the federal poverty level): Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% of the population is low income in the Mission and North Beach. (DPH Population Health and Prevention Management Information Systems).

In 2006-07, SFUSD had a truancy rate of 27.47%, with truancy defined as 3 or more unexcused absences or tardies.

In 2006-07, the SFUSD four-year dropout rate was 17.6% (the percentage of high school freshmen that dropout by the end of their senior year). In the 2006-07 school year, 898 students in grades 7-12 dropped out of school and 53 students were expelled.

Over the last four years, 94% of San Francisco’s homicide victims under the age of 25 were high school drop-outs.

Homicide is the leading cause of death among youth ages 15 to 24 in San Francisco (30 per 100,000), almost twice the statewide rate of 18 per 100,000. There were 98 homicides in 2007, of which 93% were male. In 2007, 91% of young homicide victims were either African-American (54%) or Latino (37%).

The Mayor’s Office Communities of Opportunity Initiative released a report in 2006 focused on four high-risk street corners in Bayview-Hunters Point and Visitacion Valley. The report found: 8 out of 14 schools in this sector of the city rank in the bottom 20% of the state’s demographically similar schools; approximately 40% of residents in this area feel unsafe whenever alone, compared to the 16% city average; and homicides had increased 25% to 45% annually in the San Francisco police districts that encompass the area.

Approximately 1,800 or 2% of children and youth ages 0-17 in San Francisco were in the foster care system on July 1, 2007. This rate is twice the rate of California, Alameda County, and Contra Costa County.

In 2007, there were 5,094 referrals to Child Protective Services for maltreatment of children under 18, of which 21% were substantiated.

Twenty-eight percent of SFUSD K-12 students are English Language Learners (ELL), compared with 25% statewide.

The SFUSD identified over 1,700 students as homeless or marginally housed in 2006-07.
PEI PROJECT SUMMARY

the implementation of the proposed School-Based Youth-Centered Wellness Project. The summary of desired outcomes from all workgroups is attached.

The Planning Team synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, we selected the key community needs, priority population, and age group that this PEI project addresses:

- At-Risk Children, Youth and Young Adult Populations
- Children and Youth at Risk for School Failure
- Children and Youth At-Risk For Juvenile Justice Involvement
- Children and Youth in Stressed Families
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination
- Individuals At-Risk for Suicide
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Individuals Experiencing Onset of Serious Psychiatric Illness

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs, addresses needs identified during the community program planning process.

The PEI Planning Committee selected the School-Based Youth-Centered Wellness Project based on research and promising practices. The planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. There is a plethora of qualitative and quantitative research documenting the wide range of mental health and behavioral issues that surface in K-12 schools and the negative impact of mental health issues on academic success. There is equally robust research on the positive impact of school-based prevention activities on students’ academic, social-emotional, and healthy development. Similarly students facing mental health issues are an emerging population at postsecondary institutions, and meeting their needs has posed an increasing challenge. When students experience these kinds of difficulties without adequate support, it can negatively impact their academic and social functioning, and allow students with great potential to fall through the cracks. Students contending with mental health issues exhibit retention rates far below those of the general population and at the same time frequently fail to use available services and academic supports. These students are often reluctant to seek services labeled as “psychological counseling” or “disability resources” due to stigma, a lack of identification with these problem descriptions, or a conflict with cultural norms and expectations.
In the School Failure workgroup, stakeholders reviewed research and shared their expertise to identify programs and practices that would be effective with the diverse San Francisco community and that would achieve the desired outcomes, increasing identified protective factors and mitigating risk factors. Many of our Committee members and stakeholders have been providing school-based mental health prevention and early intervention activities for years. They utilize a wide range of models and strategies, many evidenced-based, others promising local practices. They are most easily summed up using the UCLA’s Center for Mental Health in Schools’ commonly used learning supports model, which identifies three levels of supports:

- **Systems for Promoting Healthy Development & Preventing Problems**, usually school-wide, universal prevention activities and some group-level indicated prevention activities;
- **Systems for Early Intervention**, usually individual interventions, either selected prevention or short-term, low intensity early intervention; and
- **Systems of Care**, intensive coordinated interventions and ongoing treatment.

The co-chair of SF’s MHSA Workforce Education and Training planning process also shared the findings and priorities from that process – including a Supported Higher Education project for consumers and family members. Supported higher education programs are a promising practice currently employed in community colleges across the country. There has been an increased interest at postsecondary institutions in “normalizing” supportive services to increase access, usage, and effectiveness. Based on the criteria given to workgroups for evaluating local, promising practices and as a result of all the planning activities described above, the School Failure workgroup identified the proposed School-Based Youth-Centered Wellness project, which was then chosen by the full Planning Committee vote.

The proposed project will address many of the needs identified for children and youth (and young adults) at-risk for school failure. It will provide prevention services that promote children’s healthy social and academic development, while also increasing the education and mental health systems’ ability to identify and address emerging mental health needs early and to prevent potentially severe mental health and/or social outcomes. Providing preventive mental health services in a school setting – K12 and higher education – will allow for activities that: build the capacity of teachers and other caring adults to support children’s wellness; improve school climate and help prevent or avoid crises; build protective factors in all students, not just those identified as having mental health issues; contribute to increased academic performance and graduation rates, and reduction of psychosocial stress; and increase access for all children and families in a non-stigmatized manner.

**b. Description of proposed PEI Intervention**

The proposed School-Based Youth-Centered Wellness Project consists of school-based best practices that address non-academic barriers to learning with strong collaboration with community-based organizations. The project consists of two programs: K-12 School-Based Services and Supported Higher Education.
**Program A: K-12 School-Based Services.** Using public schools as hubs, this approach brings together many partners to offer a range of supports and opportunities to children, youth, families before, during and after school. This is a coordinated approach that supports student success by combining mental health services with other supports already provided in the school setting. It builds on the strengths of community partners who incorporate a wide variety of philosophies that are often more rooted in a prevention or resiliency model, such as youth development, peer education, culture or ritual-based healing, and family support.

There are currently similar efforts in many of the SFUSD schools that can be coordinated and/or expanded as a part of this PEI project, such as Wellness Centers, Healthy Start, Learning Supports, and After-School Programs. In fact, this PEI project includes the transfer of funding for the Wellness Center at School of the Arts (SOTA) High School from the Community Services and Supports (CSS) Plan to the PEI Plan. Wellness Centers are an exemplary model of school-based prevention and early intervention services, and the Center at SOTA was funded originally under CSS because of the high priority San Francisco placed on PEI services. However, as it is a program under School-Based Services, it will be transferred as part of our PEI Plan. This PEI program specifically supports school-based services that fall under following categories:

*Promoting Healthy Development and Preventing Problems*
- Service coordination, e.g. coordinating Student Success Teams, Care Teams or coordination of services team, resource and referrals, and liaising with providers, school, and families
- Case management
- School climate improvement activities
- School-wide behavior systems/models, e.g. PBIS (Positive Behavioral Interventions and Supports), CHAMPs (Conversation, Help, Activity, Movement, and Participation), BEST (Building Effective Schools Together)
- Teacher training and coaching
- Family workshops and literacy
- Peer education/mentor programs
- Wellness promotion
- Well supervised clinical internship program

*Early Intervention*
- Case management
- Short-term individual, group, and family counseling
PEI PROJECT SUMMARY

- Crisis intervention
- Well supervised clinical internship program

In addition to the SOTA Wellness Center mentioned above, the proposed School-Based Services Project will serve four to six SF public schools with a combination of the types of services listed above. The majority (at least 75%) of project funding will go to prevention activities, with up to 25% allocated for early intervention. As part of the model, we will include school-wide activities, and we anticipate service at least 4,500 students, 1,500 families and all of the school staff each year. In addition to that, the Wellness Center will provide outreach and education to over 400 students, 100 families and 50 teachers and staff, and it will provide direct health and wellness services to approximately 150 students and 25 families.

Program B: Supported Higher Education. The Supported Higher Education program will be housed at a two San Francisco colleges or universities. It will augment and enhance the Supported Education project approved as part of the MHSA Workforce Education and Training plan. At the core of the design is a “student center” where the majority of services will be provided. Using a wraparound supported education model which over the last decade has proven successful at community colleges across the United States, this center will employ a multidisciplinary approach, bridging services primarily focused on academic capacity-building and the more explicit provision of psychological counseling and disability-related accommodations. The Center will be staffed by a Center Counselor, Peer Counselor/Advocate and Administrative Assistant. The Center will partner with the college and with community mental health agencies to provide direct intervention when students are experiencing educational problems as a result of mental illness or emotional disturbance.

While some of the specific partners and services will be determined by the needs of students and families at the chosen college, there are core components to the model:

1. Outreach - The Center will collaborate in its outreach to consumers and family members with a range of campus and community-based organizations. Recruitment will take place through posting flyers, presentations by peers and other representatives of the institution, consultation with staff at community-based organizations, and notices on listservs informing consumers and family members about educational opportunities and ways in which to liaise with the Center Counselor and staff. Examples of consumer and family-led organizations include Oasis Office of Self Help, Spiritmenders, Tenderloin Self Help, the National Alliance for the Mentally Ill, and the San Francisco Network of Mental Health Clients. Employment-based organizations serving consumers will also be included in the outreach process such as Community Vocational Enterprises, Toolworks, and Richmond Area Multi-Services (RAMS). SF’s wide network of community-based organizations serving consumers and family members will also be enlisted in the recruitment process.
Particular attention will be paid to the recruitment of consumers and family members from underserved and underrepresented communities. The Center will collaborate with such neighborhood organizations such as Instituto Familiar de la Raza, Positive Directions, Friendship House, Samoan Community Development Center, NICOS Chinese Health Coalition, Ella Hill Hutch Community Center, Chinatown Development Center, and the many other agencies providing culturally specific services. In addition, outreach and recruitment will build on the existing efforts of campus outreach and support organizations, and student-run organizations.

The Center will be staffed to serve students who may need to talk to someone immediately, a gap among typical disability resource and campus life programs. Public events and tabling opportunities will be organized at the Student Union and other campus sites. In this way, consumers, family members, and representatives of underserved communities will be engaged in educating the campus community about recovery.

2. **Enrollment and Assessment** - Supported education programs have been moving towards a universal model of services so that students do not need to prove that they have a preexisting psychiatric diagnosis in order to be eligible. Instead, the Center will utilize a recovery model assessment that evaluates levels of functioning within a specific context. In collaboration with the potential service recipients, Center providers will consider the students’ individual strengths and the challenges they face within the academic environment. A universalized approach is particularly important as one of the goals of supportive services is to link students to more intensive mental health or disability-related interventions when beneficial, especially among those who may have been reluctant to seek such services due to cultural barriers, stigma, or a lack of identification with psychiatric diagnoses. Thus, students would be accepted based on self-referral or referral by peers, faculty members, academic advisors, and university staff.

The development of adequate assessment tools would be one of the start-up tasks under this project. There are many assessment tools in use by various institutions of higher education providing supported education services. The college or university that is selected to implement this project would be expected to consult with consumers, County mental health, and community-based organizations in developing an assessment tool. Assessment would likely cover such areas as developmental history; personal, familial, and cultural relationships; immigration history; sense of ethnic identity and cultural values; critical life events; health and well-being; suicidality and other risks of harm to self or others; substance use; legal, educational, and employment history; recreational and religious or spiritual activities; and previous services received. And again, if it seems that students might benefit from more intensive mental health or disability-related services, they would be immediately referred to the appropriate County and/or campus resources where further assessment could be conducted.
3. **Individual Planning** – The Center Counselors work with an individual student, their family, and other involved providers as appropriate (therapist, mentor, faculty advisory, teacher, etc.) to conduct an assessment of the student’s learning goals, potential challenges to academic success, and types of supports that the group believes would be most helpful. The assessment will be used to develop an individualized educational or wellness plan that covers such areas as educational and wellness goals and strategies, self-care strategies, daily maintenance plan, child care, financial planning, basic needs, potentially triggering events and early warning signs, crisis management strategies, resources and contacts.

4. **Academic and Peer Counseling** – The Center Counselors is available to provide in individual academic counseling and coaching. They will develop a mentoring and buddy system to promote community building and socialization through peer-provided support. Peers mentors can accompany students to their first classes as well as other events that may engender anxiety or confusion. In addition, groups will be offered on such topics as time management, effective study techniques, communication skills, self-advocacy, employment, and stress management. Students receiving these supported education services have been shown to complete their studies in a manner commensurate with students not facing mental health issues. The Center provides a safe place to gather with a peer support person present, and engage in activities from social events to crisis intervention.

5. **Referrals and Linkages to Campus and Community Resources** – Students can be referred to existing campus resources such as learning assistance centers, tutoring programs, counseling centers, disability resource centers, educational and opportunity program, student health center, and campus support groups. They can also receive referrals (and follow-up support in accessing the services) to community resources including transfer and employment sites, mental health, legal aid, housing, domestic violence, and substance abuse treatment. Some of these service providers will be brought into the Center to provide outreach and direct support on campus. The Center Counselors act as a case manager, providing academically-oriented counseling and coordinating campus-wide and community-based supports. The Center will develop either a hard copy or web-based guide to resources on and off-campus. The center’s services will be confidential; however, at the students’ request, the Center Counselors can liaise with instructors, faculty advisors, and staff in order to create a better fit between students and their environment.

6. **Training** – In order for the Center to fully meet its goal of enhancing the academic achievement of students experiencing mental health challenges, ongoing services will also be provided to faculty in order to create an institution that nurtures academic success for students with mental health issues. In-service presentations and individual consultation will be provided to faculty and staff on issues related to mental health. Depending on the capacity of the higher education institution chosen, this project represents a possible opportunity for innovative program development, evaluation, and research. The Center can serve as a training site for social work, counseling, and psychology interns, as well as peer counselors and mentors. The expansion of internship and supervision opportunities reflects a need repeatedly identified during SF’s community planning process.
Two Centers will be funded under this proposed PEI project. Each Supported Higher Education Center will provide services to approximately 300 students per semester who are facing challenges in meeting their academic goals due to mental health issues or emotional disturbances.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The School-Based Youth-Centered Project will be operated under contract with CBHS by community based agencies and institutions of higher education chosen through a competitive RFP process.

For the K-12 School-Based Services program, implementation partners will include the SF Unified School District, the participating schools, and the community-based organizations, or lead agencies, that provide the school-based services. Eligible community based partners can have a wide range of prevention expertise, including but not limited to: youth development, leadership development, family support, violence prevention, health education, emotional and/or physical wellness promotion, arts, community development, social justice promotion, and culture or population specific approaches. However, lead agencies will be expected to have existing capacity to provide school-based services and participate in district-wide or citywide collaborative efforts. CBHS and the SFUSD currently have considerable infrastructure in place to support both the direct service and collaborative work inherent in providing school-based services. Therefore, this PEI project will fund increases in appropriate PEI services and not to duplicate the infrastructure already in place within individual organizations, such as the SFUSD’s School Health Programs Department.

For the Supported Higher Education program, partners include two higher education institutions that will house and implement the supported education model. They will be chosen through a competitive Request for Proposals (RFP) process under the MHSA Workforce Education and Training (WET) plan. The Center staff will be employees of the school, however it is important that they be able to act independently and in the sole interest of the consumer. While faculty and staff are critical partners in this effort, relying on traditional points of contact, such as faculty advisors, can pose an inherent conflict as the students’ advisors may also serve as their classroom instructors, evaluating and grading their efforts. In addition to their faculty and staff, partners will include campus departments and community agencies that can provide the wide range of mental health, health, family support, and basic needs services that this population might required.
For both programs, in instances where children, youth or their family members are identified as needing more intensive and long-term intervention for a serious and persistent mental illness, the project staff will work with school and agency resources, along with the County Behavioral Health Access Center (BHAC) to refer the consumer to appropriate services.

d. **Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.**

The target demographics vary by program. The K-12 School-Based Services program is heavily prevention focused and will target four to six schools with high proportions of mental health and/or behavioral needs, and strong existing or potential community partners. The ethnic and/or cultural populations to be served will depend on the schools and lead agencies that are selected through a competitive Request for Proposals (RFP) process. To ensure that this project reduces disparities in access, the RFP will include a competitive priority for applicants who demonstrate their capacity and intention to serve underserved populations and communities, as identified by the CSS planning process, PEI related needs assessment, and SF health disparities workgroup. The demographic profile of the consumers served by the SOTA Wellness Center we propose to transfer from CSS is as follows: 40% male, 60% female; 23% African American, 16% Asian/Pacific Islander; 8% White; 7% Latino; 1% Native American; and 32.5% other, and 12.5% declined to state. Since our capacity mapping revealed that all SFUSD high schools have some supportive mental health services via Wellness Centers, we expect the School Based Services program to primarily serve elementary and middle schools.

The Supported Higher Education program targets college students who are at risk for school failure and poor mental health outcomes. The ethnic and/or cultural populations to be served depends on the two colleges or universities that are selected through a competitive RFP process for the MHSA WET plan.

e. **Highlights of new or expanded programs.**

The proposed project will capitalize on the strengths of community based organizations, schools, and higher education institutions to best meet children and youth’s needs and the identified outcomes. Community based organizations are often rooted in the specific needs of their community and versed in prevention and early intervention approaches. Schools are uniquely positioned to identify needs and strengths of their students and families and to provide accessible, consistent and holistic services. Working in partnership, K-12 school-based prevention and early intervention services have a track record of positive social, emotional, and academic outcomes. The Coalition for Community Schools report *Making the Difference: Research and Practice in Community Schools* presents evaluation results from across the country (including California’s Healthy Start model) which link the work of these school-based partnerships to improve academic achievement, increase attendance, improve safety and behavioral outcomes, increase parent involvement, and support more stable families and communities. ([http://communityschools.org/mtdhomepage.html](http://communityschools.org/mtdhomepage.html)). The Supported Higher Education program will also build upon national successes, and local successes at the community college level, to create a model in San Francisco that can be expanded across the county...
and throughout the region. It will contribute directly to reducing stigma associated with “mental health” clinics and services among transitional age youth, young adults, and older adults – all underserved populations in our county.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program A: K-12 School-Based Services will require the following start-up activities

- Solicit proposals and select lead agencies and target schools
- Recruit, hire, and train staff
- Establish and/or refine partnerships between schools, lead agencies and additional partner agencies, using MOUs and contracts as appropriate
- Partners define the specific activities/scope of work for year one

The specific activities and strategies to be implemented will be determined by the lead agency and school. The following is an example of key ongoing activities at one site:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate coordination of services team</td>
<td>Ongoing – weekly meetings</td>
</tr>
<tr>
<td>Case management</td>
<td>Ongoing – average 10 students</td>
</tr>
<tr>
<td>School climate improvement activities</td>
<td>One per quarter</td>
</tr>
<tr>
<td>Lead team in choosing and implementing school-wide behavior system</td>
<td>Ongoing – biweekly meetings</td>
</tr>
<tr>
<td>Provide in-service for teachers on mental health and positive behavior management; follow-up coaching</td>
<td>Two inclusive trainings; follow-up coaching with two teachers/mo and as needed</td>
</tr>
<tr>
<td>Family workshops</td>
<td>One per quarter</td>
</tr>
<tr>
<td>Short-term individual and group counseling</td>
<td>Individual - target not to exceed eight students per year</td>
</tr>
<tr>
<td></td>
<td>Group – one group/quarter</td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>Ongoing - as needed, target not to exceed eight hrs/mo.</td>
</tr>
</tbody>
</table>

Program B: Supported Higher Education will require the following start-up activities

- Expand contract with colleges and/or universities selected under the WET RFP.
- Possibly recruit, hire, and train additional staff
- Establish additional partnerships with providers, using MOUs and contracts as appropriate

The project will include the following key ongoing activities
**PEI PROJECT SUMMARY**

### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach and recruitment via flyers, presentations by peers and other representatives of the institution, consultation with staff at community-based organizations, and notices on listservs and web-based social networks informing consumers and family members about educational opportunities and ways in which to liaise with the Center staff.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Hold social and informational events on-campus related to mental health.</td>
<td>Four events in year one at each site</td>
</tr>
<tr>
<td>Develop/maintain resource guide and informational materials for use on and off-campus.</td>
<td>Annually</td>
</tr>
<tr>
<td>Conduct individual assessment of strengths and needs with potential consumers.</td>
<td>Ongoing – approximately 300 students/semester at each site</td>
</tr>
<tr>
<td>Develop individualized educational or wellness plan based on assessment of students’ learning goals, challenges to academic success, and types of support.</td>
<td>Ongoing – Once per semester with estimated 250 students at each site</td>
</tr>
</tbody>
</table>

#### g. Key milestones and anticipated timeline for each milestone.

- Apr-May ‘09  RFP and contracting process
- June-July ‘09  Program start-up, including recruitment, hiring and training of staff
- Aug ‘09  Program launched by August 2009
- Aug-Sept ‘09  In-service for faculty and staff

#### 4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>K-12 School Based Services</td>
<td>Individuals: 4,500</td>
<td>Individuals: 300</td>
</tr>
<tr>
<td></td>
<td>Families: 1,500</td>
<td>Families: 200</td>
</tr>
<tr>
<td>Wellness Center</td>
<td>Individuals: 450</td>
<td>Individuals: 150</td>
</tr>
<tr>
<td></td>
<td>Families: 200</td>
<td>Families: 25</td>
</tr>
<tr>
<td>Supported Higher Education</td>
<td>Individuals: 4000</td>
<td>Individuals: 1000</td>
</tr>
<tr>
<td></td>
<td>Families:</td>
<td>Families: 200</td>
</tr>
<tr>
<td><strong>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</strong></td>
<td>Individuals: 8,950</td>
<td>Individuals: 1,450</td>
</tr>
<tr>
<td></td>
<td>Families: 1,700</td>
<td>Families: 425</td>
</tr>
</tbody>
</table>
5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

A major component of the School-Based Youth-Centered Project is to create and enhance linkages to county and community mental and behavioral health services. CHBS has a long history of working with the SFUSD and community based organizations to create a comprehensive and accessible system of care for children and youth. Experience has shown that housing programs at schools and community centers can dramatically improve the accessibility and penetration of services to high-need populations. For example, the established school-based service centers, such as Wellness Centers, are a core component of our county’s community behavioral health system. In instances when children, youth, or their family members demonstrate a need for further assessment or extended treatment, the lead agency program staff can refer them directly to the Behavioral Health Access Center (BHAC), or other community-based mental or physical health providers. Youth and families can also be referred to the County’s Comprehensive Child Crisis Services, a 24/7 multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress. The family can arrange to come to the clinic, or a crisis team can travel to the home or school to evaluate the problem.

For the School-Based Services program, the County also provides considerable services for students with special needs, both onsite at the schools and via the AB3632 Assessment Unit that assesses and links eligible SFUSD special education students to mental health services. Furthermore, the lead agencies implementing this project will be well-versed in the mental health resources available, both via the County and community service providers. Each of the agencies will be a community-based mental health agency that offers a variety of mental health and other core supportive services.

For the Supported Higher Education program, students who have been deemed by their Center Counselor to need more comprehensive assessment or more extended, in-depth treatment than is available through the Center will be referred to the college/university resources (Counseling and Psychological Services), County behavioral health services, or to other appropriate mental health service providers. Support will also be offered in following through on these referrals such as accompanying the student to the first appointment because students have sometimes demonstrated reluctance or anxiety about taking this next step on their own.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.
Program A: K-12 School Based Services. As mentioned above, this program is designed to capitalize on exactly such linkages by supporting multi-faceted community based organization to provide locally-determined, appropriate prevention and early intervention activities in collaboration with the schools. The school based services team provides limited short-term intervention services. This may involve case management, referrals, and partnerships with a wide range of mental and behavioral health services, violence prevention, and basic needs. Specific county services already identified as referral sources for this project include:

- Comprehensive child crisis services (described above)
- CBHS Violence Response Team
- Existing School-Based Community Behavioral Health Services for the general student population and/or students with special needs.
- The County currently provides over $71 million per year of substance abuse services. Services range from drug and alcohol education, alternative healthy activities and peer educators to early intervention counseling and drop-in and medical detox. Substance abuse services are already integrated into the high schools via the Wellness Centers. Center staff and on-site behavioral health counselors have access to the system information and referral processes, including an online database of all programs, searchable by neighborhood, cultural/linguistic capacity, content, etc. In addition, CBHS funds 10-12 school-based substance abuse prevention programs for students in grades 4-12. The full range of programs will be available to providers of this PEI project.
- Another proposed PEI project is Early Intervention and Recovery for Young People with Early Psychosis. If funded, this project will also be available to youth as needed.

In addition to the many County services available for referral, the lead agencies provide other social and basic need services directly. The following is a sampling of agencies that are currently part of CBHS's Child, Youth and Family System of Care and some of their services:

- SF Boys and Girls Club – Drop-in tutoring, enrichment, recreation, youth development and leadership, Second Step social skills, family support, and aggression replacement therapy.
- Edgewood Center of Children and Families – Parent-Child Interactive Therapy, family and kinship support, residential and in-home wrap-around services, community nursing, family resource centers, mental health services, and child abuse prevention.
- Instituto Familiar de la Raza – behavioral health care for consumers and family members, e.g. trauma, persistent mental illness, family conflict, immigration and reunification, mentoring, case management, parenting education/support groups, and violence prevention.
- Jewish Family and Children’s Services – individual, group and family counseling, parenting education and support groups, domestic violence prevention, advocacy and support, family mediation, resource library, and legal aid.
- Richmond Area Multi-Services, Inc – Parent-Child Interactive Therapy, mental health services, family support, life skills, in-home wraparound for severely mentally ill, and vocational training.
- Urban Services YMCA – school based mental health services, recreation, enrichment, health and fitness activities, family support, mentoring and violence prevention.
Program B: Supported Higher Education. Supported education programs are designed to be community partnerships which pool resources in order to maximize educational opportunities for people at-risk for mental health issues. Most colleges and universities have a range of internal resources to assist students which, with improved coordination, would provide a rich service environment for students experiencing mental health issues. These typically include:

- Student Resource Centers which offer information, referral, and assistance with academic advising, career counseling, crisis intervention, employment opportunities, financial aid, health care, and social networking.
- Student Health Services provide direct service and health education.
- Disability Resource Centers which provide disability management advising and “reasonable accommodations.”
- Educational Opportunity Program which provides support and retention services for students from economically and educationally disadvantaged backgrounds.
- Free Tutoring Programs.
- Resource Centers / Student Groups for various ethnic and cultural groups, such as
- Other specialized resource centers serving specific populations, e.g. LGBTQ, criminal justice involved, low-income, parents, etc.

Institutions of higher education also have a broad network of student-run organizations such as Queer-Straight Alliance for Queer, Asian Student Union, Black Student Union, First Nation Hawks, General Union of Palestinian Students, Indian Students Association, Iranian Culture Club, Korean Students Association, League of Filipino Students, Movimiento Estudiantil Chico de Aztlan, Queer People of Color, Student Council of Intertribal Nations and the Vietnamese Student Association. These organizations could be mobilized to reach out to potentially underserved populations and those in which stigma has impacted access to mental health services. Peer mentors from these organizations could be trained to disseminate information to their student cohort in relation to the risk factors and signs of mental illness and suicide as well as steps to take in addressing them.

The County services will also be accessible to individuals involved with the Center. BHAC can refer consumers to any number of mental health services, substance abuse treatment options, primary care services, and in the case of more severe or chronic mental health illness, to the MHSA-funded full service partnership. The proposed PEI Early Intervention and Recovery for Young People with Early Psychosis project will be another resource formally linked with this project.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

Program A: K-12 School-Based Services. The planning team researched local and comparable programs to ensure that the budget and program design for the proposed project includes sufficient programs and activities to achieve desired PEI outcomes at all levels. The average award of $100-125,000 per site per year is consistent with the California Healthy Start grants, as well as community school.
initiatives such as the district-wide effort in Chicago Public Schools. Through the RFP process, agencies will be required to demonstrate that they have sufficient infrastructure and relationships in place to implement the program as described.

Program B: Supported Higher Education. This project will leverage and support an effort the County has undertaken with MHSA Workforce Education and Training (WET) funds. It will augment and expand the Supported Education model at the two institutions selected by RFP as part of the WET plan, ensuring the project can achieve its desired individual and system level outcomes. It will increase the Center Counselor from 0.75FTE to a full-time position, increase the peer mentor from one half-time position to two half-time positions, and increase the administrative assistant from half-time to full-time, thereby increasing overall capacity, and specifically the linguistic and cultural competence. The County intends to apply for additional funding through the state-administered Student Mental Health Initiative to further support and expand this model.

6. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project

This project is, by design, a collaborative and system enhancing project. It builds on many, many years of partnership between the SFUSD, County public and mental health, and community based organizations. As described under the Project Description and Linkages sections, the proposed School-Based Services program will be delivered entirely by community-based organizations, onsite at public schools, in collaboration with the County and, in many cases, other community-based organizations. The Supported Higher Education program will be operated under a contract with two institutions of higher education selected through a competitive RFP process under the WET plan. The educational institutions will carry out the project as described here, collaborating with County behavioral health and community based organizations to provide the full range of support services their population needs.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Again, this project is designed to build upon and deepen the impact of the local community-based mental health system. It includes formal contracts with community-based agencies, both traditional mental health agencies and more prevention-based youth serving organizations, with institutions of higher education and all of their health and mental health resources, and the collaboration of the school district. Together this means that children, youth and families will participate in prevention and wellness promotion activities, schools will foster resilience and social skills, and behavioral health needs will be identified and addressed either onsite or through referrals for timely and
appropriate mental and behavioral health services. The project will also strengthen and formalize the referral processes between the institutions of higher education and the county and community behavioral and physical health systems.

c. Describe how resources will be leveraged.
This project will leverage access to considerable treatment resources because increased awareness and linking with services will lead to increased behavioral and physical health and basic needs services provided by the County and community agencies.

Program A: K-12 School-Based Services. The budget reflects leveraged resources that amount to 10% of the overall project budget. The exact resources will be dependent on the organizations that are selected to administer the project in the RFP process. In similar school based service programs within and outside the county, these resources often consist of:

- Medi-Cal reimbursement for short-term early intervention via EPSDT
- Medi-Cal reimbursement for outreach via MAA
- State funded programs such as Healthy Start, Tobacco Use Prevention and Education
- Federal funded programs such as Safe & Drug Free Schools, Safe Schools Healthy Students, Carol White Physical Education Program
- City funding, e.g. DCYF grants
- Foundation grants

This program also builds upon considerable existing infrastructure in the School District and County around school based health and mental health services, namely SFUSD’s School Health Programs Department, the Wellness Initiative (SFUSD, DPH, and DCYF), and the CBHS System of Care. As such, it leverages considerable resources such as:

- A history of school based collaboration on the ground and at a policy level;
- Extensive expertise among community-based organizations in working with children, youth and families overall, and in a school setting;
- Oversight and coordination, at the county and district levels and at the lead agencies; and
- Linkages and referral processes for follow-up services for at-risk children, youth and families.

Program B: Supported Higher Education. This program leverages MHSA Workforce Education and Training funds dedicated for launching two Supported Education Center. It will increase staffing at each Center, which increases the number of students and families served, and improve the quality and comprehensiveness of the services. The WET funding is reflected in the budget.

d. Describe how the programs in this PEI project will be sustained.
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.
7. Intended Outcomes
During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

Program A: K-12 School-Based Services
Individual Outcomes
- Fewer mental health crisis episodes
- Improved student mental health
- Improved capacity of teachers to support student wellness

Program Outcomes
- Students who need service coordination and case management services receive them
- Students participate in activities that improve school climate
- Schools use school-wide behavior systems/models
- Teachers participate in training and coaching activities
- Families participate in family and literacy workshops

System Outcomes
- Improved school climate among schools in San Francisco
- Increased student access to timely, non-stigmatizing mental health services
- Improved ability of schools to support student wellness

As a result of this program students will receive prevention services that promote healthy social and academic development. This will reduce disparities in access to mental health services by enabling the education and mental health systems to identify and address emerging mental health concerns among students early, which will prevent the development of more severe and chronic concerns.

Program B: Supported Higher Education
Individual Outcomes
- Students identify and achieve learning goals
- Students utilized peer mentors when needed
- Students view the center as a safe place to talk and receive guidance
- Students learn stress management, effective study techniques, communication skills, and other skills that will help them thrive academically and social at college
Program Outcomes

- Faculty receive training on mental health issues and how they impact the college experience for students
- The centers outreach to students who are mental health consumers and their family members
- The centers provide strength-based assessments of students support needs
- The centers provide academic counseling and coaching
- The centers provide referrals to academic supports and other community resources

System Outcomes

- College students who are mental health consumers are encouraged and supported in achieving their educational goals.

As a result of this program, more consumers of mental health services in San Francisco who wish to pursue higher education will enroll and work toward achieving their educational goals, which will reduce disparities in access to higher education.

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:
- Referral to CSS programs: when an individual or family is identified as needing more intensive and long-term intervention, the project staff will work with BHAC to refer them to appropriate services and/or placement.
- At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of and referral criteria for prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This framework will be folded into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project and population.
- The PEI Coordinator will be part of bi-weekly MHSA meetings.
- This, and all PEI projects, will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.
This project augments the WET project, Supportive Services for Consumers Enrolled in Public Universities or Private Colleges. WET funds are allocated for the staffing of student Centers at two institutions of higher educations.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.  Not applicable

9. Additional Comments (optional)
**PEI PROJECT SUMMARY**

**County:** San Francisco  
**PEI Project Name:** Screening, Planning and Supportive Services for Incarcerated Youth  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Suicide Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population (s)

Note: All PEI projects must address underserved racial/ethnic and cultural populations.

#### A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Children and Youth at Risk for School Failure</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).
Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach, which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the Supportive Services project came from the following sources:

- Department of Children Youth and their Families
- SF Mayors Office’s Communities of Opportunity Initiative
- Juvenile Offenders and Victims: 2006 National Report, produced by the Office of Juvenile Justice and Delinquency Prevention
- California Department of Social Services Child Welfare Reports 2006
- Physicians for Human Rights, Health and Justice for Youth
- Youth Risk Behavior Survey
- Community Services and Supports Plan

After examining the data, PEI stakeholders (Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for youth involved with the juvenile justice system:

**Risk Factors**
- Trauma and victimization

**Protective Factors**
- Positive culturally competent mentorship

---

3 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects.
Risk Factors
- Truancy and dropout from school
- Alcohol, tobacco or other drug use
- Immigrant and undocumented youth face myriad of issues, e.g. isolation, language barriers, legal status, trauma, acculturation
- Lack of appropriate interventions, esp. gender (and subpopulation) specific
- Fear/negative social perception of youth
- Stigma and invisibility
- Lack of formal and systematic mental health assessment
- Lack of information sharing and coordinated planning

Protective Factors
- Positive family relationships
- Opportunities to engage in meaningful activities
- Opportunity to learn new skills (school, vocational, recreational, community-oriented)
- Safe communities of support
- Other youth
- Youth-friendly programs and systems

The stakeholders examined data about the at-risk youth population that further highlighted the need for supportive wraparound services for young people involved with the juvenile justice system. Most notably, findings included:

- The California State Division of Juvenile Justice said parolees have a recidivism rate of 70% within three years of release. (Washington Crime News Service Sept 2006)

- Nationally, 63% of juveniles in detention had at least one prior commitment, and 23% had been convicted previously but not committed. Of those that had been in custody, 43% of girls and 39% of boys said they had been held five time or more before. Two in 10 of those had increased the seriousness of their offense. (Office of Juvenile Justice and Delinquency Prevention).

- The Mayor’s Office Communities of Opportunity Initiative released a report in 2006 focused on four high-risk street corners in Bayview Hunters Point and Visitacion Valley. The report found: approximately 40% of residents in this area feel unsafe whenever alone, compared to the 16% city average; homicides had increased 25% to 45% annually in the San Francisco police districts that encompass these areas; and at age 17, 70% of African American males and 44% of African American females had at least one referral to the juvenile probation system; and eight of 14 schools in this sector of the city rank in the bottom 20% of the state’s demographically similar schools.

- Federal studies estimate that 50-75% of incarcerated youth have diagnosable mental health disorders and nearly half have substance abuse problems; up to 92% of incarcerated girls have experienced one or more forms of physical, sexual and emotional abuse before entering the juvenile justice system (Physicians for Human Rights, Health and Justice for Youth).

- Last year, approximately 2.5% of the youth population in SF (2,030 young people) had at least one contact with the Juvenile Probation Department.
PEI PROJECT SUMMARY

- The majority of JPD referrals came from the following neighborhoods: Bayview/Hunters Point (22.6%), Outer Mission/Excelsior (11.1%), Inner Mission/Bernal Heights (10.7%), Visitacion Valley (10.6%), and the Western Addition (8.0%).
- On the Youth Risk Behavior Survey (YRBS) administered to 9th-12th graders in 2007: 9% had carried a weapon to school in the last month, 23% had been in a fight in the last year, 7% felt unsafe going to school in the last month, 13% had seriously considered suicide (6% attempted), 53% had tried alcohol and 22% had drunk in the last month, and 26% were sexually active of which 29% had not used a condom the last time they had sex.

Building on these conversations, a number of workgroups identified desired outcomes that would be addressed by the implementation of this PEI project - Screening, Planning and Supportive Services for Incarcerated Youth. A summary of desired outcomes from all workgroups is attached.

The Planning Team synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, the Planning Committee selected the key community needs, priority populations, and age groups that this PEI project addresses:
- At-Risk Children, Youth and Young Adult Populations
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Children and Youth At-risk for Juvenile Justice Involvement
- Children and Youth At Risk for School Failure
- Children and Youth in Stressed Families
- Stigma and Discrimination

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Planning Committee selected the Screening, Planning and Supportive Services for Incarcerated Youth project based on research and promising practices. Our planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. In workgroups, stakeholders reviewed research and shared their expertise to identify programs and practices that would work with our diverse community, and that would achieve the desired outcomes by increasing identified protective factors and mitigating risk factors. PEI workgroups were given criteria for evaluating local, promising
practices. Based on these criteria, and as a result of the planning activities described above, the Juvenile Justice workgroup identified this PEI project, which was then chosen by full Planning Committee vote.

The project is designed as a selected prevention and early intervention project, focused on young people already involved with the juvenile justice system. Currently, there is limited capacity in the juvenile justice and behavioral health care systems to screen and identify mental health issues among youth entering detention. Furthermore, even if the youth are screened, there is no guarantee that the information will be included in the case planning process or used to connect them to appropriate services. This project will leverage a recently funded collaborative project between the Department of Public Health (DPH) and the Juvenile Probation Department (JPD) - Assess, Identify Needs, Integrate Information, and Match to Services (AIIM). The proposed PEI project design expands on the AIIM model, serving more youth with less severe mental health issues. It also builds on the successful Youth Justice Institute (YJI) case planning project. YJI annually serves 200 girls in detention at the Youth Guidance Center. This model includes: comprehensive gender responsive intake and assessment; individual case plan development in collaboration with probation officers; referral to community-based services and aftercare resources and services. Evaluation results from 2002-06 show that the interventions have had a positive impact, e.g. the number of girls who spent over one month in custody decreased by 15% while the number of boys who spent over one month in custody increased by 25%, and the number of system contacts decreased for girls by 62%, almost twice the decrease for boys at 38%.

This PEI project will address risk factors faced by our incarcerated youth – e.g. mental illness, exposure to trauma, substance abuse, fractured support systems (e.g. family, school), and poor access to appropriate mental health and basic needs services. Services will be guided by identifying youths’ mental health needs using a standard screening and assessment procedure and ensuring that this information systematically informs their case planning. The proposed project will build the capacity of the juvenile justice system to identify and meet the mental health needs of incarcerated youth, enabling responsive and appropriate support that, in turn, will lead to youth reentering the community with increased wellness and self-sufficiency and will prevent future involvement with the juvenile justice system. It will also support families and communities to break the cycle of incarceration and support the success of their young people.

b. Description of proposed PEI Intervention

This PEI Project focuses on mental health assessment, case planning, and service linkage for incarcerated youth. While all detained youth are currently screened by Special Programs for Youth (SPY) with a semi-structured clinical interview, this project would take the next step by adding more comprehensive and standardized assessment, case planning and service linkages for youth determined to have moderate to high risk mental health needs. The project would support the administration of the Child and Adolescent Needs and Strengths (CANS) assessment in order to identify youth at juvenile hall that would benefit from selected or indicated prevention and short-term early intervention services. The complex needs and multi-system involvement of these youth requires a tool like CANS that can both assess and integrate information from multiple sources including youth, parents and families and all involved professionals. The CANS is a widely
used as a reliable measure of clinical and psychosocial needs\(^4\) and is especially useful for translating youth needs into an effective intervention plan. The CANS rates the needs and strengths of youth and their families across multiple domains (functioning, criminal and delinquent behaviors, substance abuse, other risk behaviors, mental health needs, child safety risks, caregiver capacity, strengths) in a way that directly maps to service planning. Additional individualized assessment modules can be added on as needed (e.g., developmental disability, sexuality, and trauma).

An advocate then ensures that the assessment results are linked to the disposition and inform the young person’s placement or referral. The advocate works with the youth and involved adults to implement a community-based action and services plan based on the CANS assessment. The plan both addresses the youths’ immediate needs as well as helping them move towards successful re-entry into the community by linking them to appropriate services while they are still in detention. The plan includes recommendations for the dispositional hearing (based on the CANS assessment), and the advocate is present at the hearing. They also advocate for the youth in the Multi-Disciplinary Team (MDT) meetings, where decisions are made about youths’ placements and dispositions by the involved child serving agencies (e.g. CBHS Child, Youth and Family System of Care and SPY, juvenile probation (JPD), child welfare, and community behavioral health organizations).

Service linkages are also a critical component of this project. The advocate will work closely with Child Youth and Family System of Care to secure appropriate mental health treatment, and with community-based organizations to connect youth to education, career and mentoring services in their neighborhood.

A representative from JPD’s Community Programs Division will be present at the daily MDT meeting and take part in the decision-making regarding placements and other post-discharge dispositions. The Community Programs Division currently funds over 40 different city-wide programs, including faith-based organizations, to provide ancillary social services to youth. A recent survey\(^5\) found that these programs provided a range of services. While the programs are too numerous to list, the table below offers an overview of the types of services available.

In addition, due to the lack of available, appropriate services for this high-risk population, this project includes funding for appropriate early intervention evidence-based practices like Multisystemic Therapy, Aggression Replacement Training, Functional Family Therapy, and Trauma-focused Cognitive Behavioral Therapy.

This project would screen approximately 500 incarcerated youth at Juvenile Hall, provide supportive services for an estimated 300 incarcerated and reentering youth with moderate mental health needs, and either provide services or referrals for an additional 200 with severe mental health needs.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The majority of direct services for this project will be provided on-site at Juvenile Hall, with linkages to community-based organizations for after care support. Implementation partners include the Juvenile Probation Department (JPD), CBHS (specifically the Special Programs for Youth), and community-based organizations providing supportive services for reentering youth. In cases when the screening identifies a need for more intensive and long-term intervention for a serious and persistent mental illness, the project staff will work with JPD and SPY, along with the County Behavioral Health Access Center (BHAC), to refer the young person to appropriate services and/or placement, both while in custody and once the young person reenters the community.
PEI PROJECT SUMMARY

d. **Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.**

This project targets detained youth who are identified as having moderate to high mental health needs, Medi-Cal eligible or uninsured, and have been detained for more than 72 hours. (According to JPD, approximately 27% of all detained youth are released within 72 hours.) Currently, standardized tools have not been in use long enough to make a reliable determination of the nature or severity of detained youths’ mental health needs. However, a rough projection can be made, based on the numbers detained at Juvenile Hall (N=709 youth detained for more than 72 hours in 2007), those informally diagnosed as needing mental health services and national prevalence studies.

In 2006, based on a semi-structured clinical interview, SPY reported that 71% of youth (N=659) had identified mental health needs. This is consistent with recent multi-state national prevalence studies (Shufelt & Cocozza), which have shown that 70.4% of young people in the system meet criteria for a mental health disorder. Of those who meet the criteria, an estimated 27% will have a serious mental illness that requires significant and immediate intervention. Based on this information, we estimate that this project will serve a total of 500 youth (300 with moderate needs and 200 with more significant needs). This population includes a number of underserved populations identified specifically in the CSS planning process, i.e. transitional aged youth, youth in juvenile probation (as well as homeless and youth in foster care, both represented in the juvenile justice system), and Latinos.

The ethnic and/or cultural populations to be served will reflect the demographics of youth detained at Juvenile Hall. The majority of youth detained at Juvenile Hall in 2007 (SF JPD Annual Statistical Report, July 2008) were male (72%) and from ethnic minority groups (95%). More than half (58%) were African American, 26% were Hispanic, 5% were Caucasian, 10% were Asian or Asian Pacific Islander (API), and <1% were Native American. Ages ranged from 12 to over 18, with 94% (N=915) 18 and under.

**e. Highlights of new or expanded programs.**

The proposed project expands a successful model of supportive services currently provided only to females via the Youth Justice Institute. It also strengthens a recent Department of Justice grant awarded to the Child, Youth and Family System of Care to conduct screening and case planning at Juvenile Hall. PEI funding will provide the opportunity to fully implement and connect these programs to build an effective continuum of services that include: screening, standardized assessment, systematic case planning, outreach and advocacy and linkage to appropriate early interventions. In addition, this PEI project will expand capacity from approximately 200 youth with the most serious mental health needs (funded by AIIM grant) to an additional 300 youth with more moderate mental health needs. Screening of a large percentage of young people entering the system will lead to more comprehensive assessment, earlier identification, and increased short-term intervention and treatment of mental health needs among incarcerated youth. The project will also dedicate two full-time advocates to create systemic connections to case planning for all 500 youth, in collaboration with probation officers, as well as providers of community services.
f. **Actions to be performed to carry out the PEI project, including frequency or duration of key activities. (can be narrative or in a table)**

This PEI project will require the following start-up activities:

- Solicit proposals and select providers for early intervention services (which will include appropriate evidence-based interventions).
- Build on already established partnerships with JPD personnel and service providers, using MOUs and contracts as appropriate.
- Establish partnership protocols, including collaborative meeting schedule and agreements, screening and assessment protocols, effective information sharing procedures, develop decision-making algorithms for collaborative and systematic case planning, develop outreach and advocacy, referral processes, and documentation/evaluation protocols.
- Recruit and train staff.

The project will include the following key ongoing activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer the Child and Adolescent Needs and Strengths (CANS) assessment to youth detained in Juvenile Hall for 72 hours or more</td>
<td>Ongoing - Average 10 youth per week</td>
</tr>
<tr>
<td>Case plan development, in conjunction with youth, family as appropriate, &amp; probation officer</td>
<td>Ongoing - Average 10 youth per week</td>
</tr>
<tr>
<td>Participate in daily meetings &amp; dispositional hearings as advocate for youth’s mental health needs</td>
<td>Ongoing - Average 10 hearings per week</td>
</tr>
<tr>
<td>Service linkage and general case management for youth with mental health needs identified via CANS</td>
<td>Ongoing - Average 10 youth per week</td>
</tr>
<tr>
<td>Short-term, intensive service for individual youth and families, e.g., Trauma-focused CBT, Multisystemic Therapy, Functional Family Therapy, Aggression Replacement Training</td>
<td>Ongoing – Average 40 youth per month, less than one year in duration</td>
</tr>
</tbody>
</table>

**g. Key milestones and anticipated timeline for each milestone.**

- **Apr-May ’09** RFP and/or MOU process, including detailing the participation of JDP personnel
- **June-Aug ’09** Program start-up, including recruitment, hiring and training of staff, and development of partnership protocols and decision-making algorithms
- **Aug-Sept ’09** Full program implementation begins by August 2009
4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Screening, Planning and Supportive Services</td>
<td>Individuals: 700</td>
<td>Individuals: 500</td>
</tr>
<tr>
<td></td>
<td>Families: 400</td>
<td>Families: 400</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDuplicated COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 700</td>
<td>Individuals: 500</td>
</tr>
<tr>
<td></td>
<td>Families:</td>
<td>Families: 400</td>
</tr>
</tbody>
</table>

5. Linkages to County Mental Health and Providers of Other Needed Services

a. **Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.**

This project consists of screening, comprehensive assessment, systematic case planning, and effective linkages to appropriate services. Therefore, formalizing strong linkages to county mental health and other community providers is critical to its success. This project will augment the existing services for detained youth (with diagnosed mental health issues) and coordinate them into a more cohesive network of care. Currently there are a number of loosely connected county and community services available, which will be formally linked through this supportive services project via the Multi-Disciplinary Team meetings and comprehensive case planning and advocacy. Existing programs include:

- Special Programs for Youth, which provides a range of behavioral health interventions for youth involved in the SF Juvenile Justice System who have identified mental health issues.
- Comprehensive Child Crisis Services has two Multi-Systemic Therapy teams that take referrals from Juvenile Hall.
- JPD Community Programs Division’s network of community providers.
- Child, Youth and Family System of Care community and school based mental health services and provider network that are not currently provided coordinated services to youth while in detention, e.g. the Family Mosaic Project in Bayview Hunter’s Point that provides intensive care management and wraparound services for seriously emotionally disturbed children, youth, and their families.
The Family Mosaic Project provides and/or coordinates an array of wrap around services designed to meet the mental health and related needs of the client and family, using a strengths-based, family-focused approach.

- County Behavioral Health Access Center (BHAC) provides assessment, referral and/or placement to county and community-based behavioral health providers.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

As described in the previous questions, this project will link incarcerated youth and their family members to the full range of needed services, either through County services or the network of community agencies participating via JPD and/or System of Care. From the point of initiation, the project staff will engage youth, and supportive adults, in case planning that involves community-based service organizations while they are in detention as well as for aftercare.

JPD and CBHS have been working in alliance with these community-based partners to identify and address gaps in the current system of care for juvenile justice involved youth, as defined in our Juvenile Justice Local Action Plan, and evidenced by the joint implementation of a Substance Abuse and Mental Health Services Administration (SAMHSA) Children’s System of Care grant. As a result the JPD/CBHS partnership has identified and worked with many community-based service providers representing a wide variety of treatment, mentoring, youth development, family support and basic needs services for high risk youth and their families.

While these networks are already in place to some degree, the proposed PEI project will develop a coordinated system that ensures appropriate and timely service linkages happen because service providers, family and youth are at the table with the JPD and CBHS when the plan is made. All detained youth will be assessed, and their needs will be advanced by an advocate whose primary responsibility is to work with the system and CBOs to ensure that the youth’s needs are met.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The proposed project builds on the research behind the AIIM proposal and on lessons learned by the YJI in their implementation of a similar program. The project includes two full-time clinical staff to implement the CANS, which is a reasonable allocation for 18 screenings, 8 comprehensive standardized assessments and systematic case planning each week. It includes two full-time advocates to lead the dispositional advocacy, family support and service coordination components. It also incorporates commitments from CBHS, JPD, SPY, and community agencies to participate in daily MDT meetings. Time for training and limited short-term early intervention are also included, ensuring sufficient capacity to achieve the desired outcomes.
6. Collaboration and System Enhancements

a. **Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.**

This project will operate under MOU/interagency agreements between DPH/CBHS and JPD, with subcontracts for the advocacy, linkage, and intervention services. As described under the Project Description and Linkages sections, the proposed project will be implemented onsite at Juvenile Hall. CBHS staff will be placed at the Hall to conduct the CANS assessment, case planning will happen onsite, as will the MDT meetings. The core partners – JPD, CBHS/SPY, and community agencies – will meet daily in a Multi-Disciplinary Team to review CANS findings, engage in systematic planning for appropriate services based on needs and strengths, formulate recommendations and case plans and ensure speedy and appropriate referrals and/or placement for services.

b. **Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.**

This project is designed to improve the mental health System of Care within the juvenile justice system. It strengthens existing services and connections to build a comprehensive network of care for this very high-risk population, to ensure that incarcerated youth are screened and provided with an array of appropriate, responsive behavioral health services while they are in detention and as they reenter their communities. Community providers will be included in the MDT case planning process and will in many cases begin working with youth while they are detained. This will lead to more effective transitions as youth leave detention with a thoughtful plan of action that has buy-in from the youth, their family, the system, and community partners.

c. **Describe how resources will be leveraged.**

The budget for this project leverages considerable cash and in-kind resources from the aforementioned AIIM Higher grant, most notably 0.7FTE of a social worker to administer the CANS. It also includes partial cost of a CANS training, program evaluation, and direct services for the youth identified as having severe mental health needs.

In addition to the resources included in the budget, the project will also leverage treatment resources since increased screening, comprehensive and standardized assessment, systematic case planning and linkage services will lead to increased behavioral and physical health and basic needs services provided by the County and community agencies. While this project will leverage existing evidence-based services for the highest risk youth (e.g. Multi-Systemic Therapy and Therapeutic Behavioral Services), it also includes funding to expand
evidence-based services to adequately meet the prevention and early intervention needs of the many youth detained each year in San Francisco who have substantial needs but do not have a severe mental health issue.

d. **Describe how the programs in this PEI project will be sustained.**
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

7. **Intended Outcomes**
During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

**Individual Outcomes**
- Incarcerated youth receive a comprehensive assessment of their strengths and needs
- Based on this assessment, youth receive the appropriate type and intensity of mental health services
- Incarcerated youth receive community-based service linkages following exit from incarceration

**Program Outcomes**
- An advocate works with incarcerated youth and involved adults to ensure timely assessment and implement a community-based action and services plan based on the assessment
- The advocate secures appropriate mental health treatment and connects youth to education, career and mentoring services in their neighborhood.
- The program serves 500 incarcerated youth at Juvenile Hall, provides supportive services for 300 incarcerated and reentering youth with moderate mental health needs, and provides services to or referrals for an additional 200 with severe mental health needs.

**System Outcomes**
- Youth at juvenile hall that would benefit from selected or indicated prevention and short-term early intervention services are connected to these services in a timely manner, which reduces recidivism.

As a result of this program, incarcerated youth in need of mental health prevention or early intervention services are identified, advocated for, and connected to appropriate and timely services. These efforts are expected to reduce disparities in access to care and youth recidivism.
8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:

- Referral to CSS programs: when a young person is identified as needing more intensive and long-term intervention, the project staff will work with SPY and the BHAC to refer the youth to appropriate services and/or placement.
- At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project.
- The PEI Coordinator will be part of bi-weekly MHSA team meetings, where s/he can discuss and troubleshoot coordination of this and other PEI projects.
- This and all other PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
**County:** San Francisco  
**PEI Project Name:** Reengagement of Truant and Out-of-School Youth  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Suicide Risk</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population (s)

Note: All PEI projects must address underserved racial/ethnic and cultural populations.

#### A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Children and Youth at Risk for School Failure</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach, which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the Reengagement project came from the following sources:

- California Department of Education, Educational Demographics Office and Safe & Healthy Kids Program Office (DataQuest)
- Department of Children Youth and their Families
- SF Mayors Office’s Communities of Opportunity Initiative
- Youth Risk Behavior Survey
- California Department of Social Services Child Welfare Reports 2006
- Physicians for Human Rights, Health and Justice for Youth
- Community Services and Supports Plan

After examining the data, PEI stakeholders (Planning Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for youth at-risk of school failure:

---

6 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects.
PEI PROJECT SUMMARY

Risk Factors
- Stressors and unidentified issues, e.g. socioeconomic, family, behavioral health
- Uncoordinated and disconnected systems
- Truancy and dropout from school
- Lack of or inconsistent reengagement strategies and programs
- Alcohol, tobacco or other drug use
- Violence and trauma
- Issues associated with immigrants, e.g. isolation, language barriers, legal status, trauma, acculturation
- Lack of awareness and common understanding among school personnel and agencies
- Lack of mental health education
- Disparities in access to services

Protective Factors
- Strength based assessments and programs
- Services where the kids are or in community where they live
- Cross training for service providers
- Strong, empowered support systems – family and community
- Positive culturally competent mentors and case managers
- Opportunities to engage in meaningful engagement activities
- Other youth

The stakeholders examined data about the at-risk youth population that further highlighted the need for a comprehensive, community based school reengagement strategy for out-of-school youth. Most notably, findings included:

- In 2006-07, the SFUSD four-year dropout rate was 17.6% (the percentage of high school freshmen that dropout by the end of their senior year). During that same year, 898 students in grades 7-12 dropped out of school and an additional 53 students were expelled.

- Of the high school students who dropped out in 2006-07, 30% were Asian/Pacific Islander, 29% were Latino, 15% African American, 6% White, <1% Native American, and 18% other or declined to state. Another way of looking at this data is that the dropouts represented 7% of all Latino high school students, 7% of Native American students, 5% of African American students, 3% of White students, and 2.5% of Asian/Pacific Islander students.

- In 2006-07, SFUSD had a truancy rate of 27.47%, with truancy defined as 3 or more unexcused absences or tardies. The rate at high schools was 27% and at middle schools 21%. There were 3,400 habitual and 2,100 chronic truants in the SFUSD, with the largest percentages in the 9th and 10th grades.

- Over the last four years, 94% of homicide victims under the age of 25 were high school drop-outs. Homicide is the leading cause of death among youth ages 15 to 24 in San Francisco (30 per 100,000), almost twice the statewide rate of 18 per 100,000. There
were 98 homicides in 2007, of which 93% were male. In 2007, 90% of young homicide victims were either African-American (54%) or Latino (37%).

- The Mayor’s Office Communities of Opportunity Initiative released a report in 2006 focused on four high-risk street corners in Bayview Hunters Point and Visitacion Valley. The report found: 8 out of 14 schools in this sector of the city rank in the bottom 20% of the state’s demographically similar schools; approximately 40% of residents in this area feel unsafe whenever alone, compared to the 16% city average; homicides had increased 25% to 45% annually in the San Francisco police districts that encompass the area; and at age 17, 70% of African American males and 44% of African American females had at least one referral to the juvenile probation system.

- On the Youth Risk Behavior Survey (YRBS) administered to 9-12th graders in 2007: 9% had carried a weapon to school in the last month, 23% had been in a fight in the last year, 7% felt unsafe going to school in the last month, 13% had seriously considered suicide (6% attempted), 53% had tried alcohol and 22% had drunk in the last month, and 26% were sexually active of which 29% had not used a condom the last time they had sex.

- The majority of JPD referrals came from the following neighborhoods: Bayview/Hunters Point (22.6%), Outer Mission/Excelsior (11.1%), Inner Mission/Bernal Heights (10.7%), Visitacion Valley (10.6%), %), and the Western Addition (8.0%).

Building on these conversations, a number of workgroups identified desired outcomes that would be addressed in some part by the implementation of this PEI project – Reengagement for Truant and Out-of-School Youth. The summary of desired outcomes from all workgroups is attached. The Planning Team synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, the Planning Committee selected the key community needs, priority population, and age group that this PEI project addresses:

- At-Risk Children, Youth and Young Adult Populations
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Children and Youth At Risk for School Failure
- Children and Youth At-risk for Juvenile Justice Involvement
- Children and Youth in Stressed Families
- Stigma and Discrimination
3. PEI Project Description

a. **Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.**

We selected the Reengagement project based on research and promising practices. Our planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. In workgroups, stakeholders reviewed research and shared their expertise to identify programs and practices that would work with our diverse community, and that would achieve the desired outcomes, increasing identified protective factors and mitigating risk factors. Based on the criteria given to workgroups for evaluating local, promising practices and as a result of all the planning activities described above, the At-Risk for School Failure workgroup identified this PEI project, which was then chosen by the full Planning Committee vote.

The project is designed as a “selected prevention” project, focused on truant and out-of-school youth that have disengaged from the school system and are at heightened risk for violence, incarceration, substance abuse, and other negative health and mental health outcomes. This project will build on a reentry program that has been piloted at two sites over the past two years by the San Francisco Unified School District (SFUSD) – at John O’Connell High School and later at a community based “CARE” Center (Center for Academic Reentry and Empowerment). These reentry programs target 9th and 10th graders who are chronically truant or even disengaged completely from school. At O’Connell, 20-30 students per semester participate in an intensive reentry program on the campus, including academic instruction and learning supports, credit recovery, enrichment, life skills and counseling. Of the 25 youth that participated in the first cohort, 20 improved their attendance and 14 passed their reentry classes. (In the previous semester, 47% of the students had a GPA under 0.05 and 47% had a GPA 0.06-1.0.) The CARES program grew out of several discussions among the SFUSD, Department of Children Youth and their Families, Police Department, Juvenile Probation, and community based organizations around the need for a facility where street outreach workers, parents, community based organizations and police officers could take youth who were truant and needed additional support to reenter school. The urgency to engage these youth and provide them with positive adult interactions came on the heels of several violent incidences which occurred in May and June of 2007 and involved youth during school hours. The participating agencies met for months to develop the framework and secure funding for a pilot truancy drop-off center. The result was a collaborative team approach, involving the Bayview/ Hunters Point YMCA, parents, schools, other community based organizations and public safety entities. Their model mirrors that of the O’Connell program, including outreach, assessment, individual academic success planning, placement, incentives and travel support for attendance, and direct academic support, counseling, and enrichment and life skills activities.

The proposed Reengagement Project will expand the reentry program to another school and community. It will address risk factors faced by out-of-school youth by re-engaging them with the school system and providing supportive services that build their abilities to succeed in school, employment and life. It will build capacity of schools, CBOs and families to work collaboratively to engage and support this
population, promoting their healthy development and preventing potential future involvement with violence, substance abuse, and the juvenile or criminal justice system.

b. Description of proposed PEI Intervention

The Reengagement project is based on the early success of the SFUSD programs and effective practices across the county, namely:

• Wilder Research Center surveyed best practices in truancy reduction and cited intensive school-based interventions. Examples include mentors, individualized plans, a team approach, learning circles, efforts by teachers to provide education relevant to the cultural background of the community, and providing a controlled environment emphasizing academics and discipline. (Wilder, 2003)

• The federal Office of Juvenile Justice and Delinquency Prevention evaluations of model programs emphasized incorporating several components of promising truancy reduction efforts, such as developing a “continuum of prevention and intervention services, focus on transition years, and include incentives.” (OJJDP 2004)

• Recommendations of the District-led Stay in School Coalition, whose overall mission is to improve school attendance and reduce the number of habitual and chronic truants in the district. The Stay in School Coalition is made up of key representatives of the SFUSD, City Departments and community based organizations.
  o While most of the three year effort has focused on reaching individual truant students and their families and developing individualized plans, there is a need to improve capacity for group and classroom work that helps students stay and thrive in school.
  o The Coalition has found that at least two adults are critical, one to supervise attendance, homework and connection with positive alternatives, and one who inspires, teaches and engages the youth in their academic work.
  o Effective reentry strategies require intermixing intensive and frequent supports and some ongoing reminder of sanctions and consequences.
  o National research tells us that school “attachment” drives school achievement, more so than directed curriculum or wraparound services coordination.

The proposed project will be based in a neighborhood with high truancy and related harmful behaviors among youth, preferably at a local high school that does not already have a reentry program. The project is designed to support youth to re-engage with and be successful in school and to stabilize their lives. The core team includes a full-time SFUSD teacher, a full-time SFUSD counselor, a half-time case manager, a part-time Learning Support Professional, and the school’s Wellness Coordinator. The program engages a cohort for one semester, after which students are placed in the most appropriate comprehensive or continuation high school. The design has four core components:
1. **Outreach**. School and district personnel (e.g. attendance liaisons, Student Assistance Programs and/or Care Team staff), street outreach workers, CBOs, and police and probation officers will outreach to truant youth to encourage them to attend the program and to reengage with school. The first tier of outreach will focus on students enrolled in the host school with serious cutting, attendance and related academic problems. The next tier will target the 700 high school students who are on the SFUSD enrollment list but never attended a single day of school. Police, probation officers and street outreach workers will also target out-of-school youth on the street.

2. **Reentry Classes**. Each semester, the Reengagement Project will serve up to 30 young people in a reentry program. This is a self-contained cohort that will participate in individual assessment and academic planning, academics, enrichment, life skills, peer mentoring, and counseling. There will be a full-time teacher and counselor working with the cohort, plus a part-time case manager and a Learning Support Professional (LSP) to ensure linkages and follow-up to any needed services (more detail below).

**Academics**. In the morning, young people work in core content areas as identified in their needs and strengths assessment. Core classes will be delivered by a district teacher, tailored to individual levels, and count for high school credit. In addition, all students will attend Cyber High, a standards-aligned, accredited “electronic high school” that is self-paced and allows students to complete more courses and earn more credits than in an average semester. Cyber High is currently available at both SFUSD reentry programs and two additional high schools, and will soon be incorporated into all high schools’ course offerings.

**Enrichment**. In the afternoon, young people will be engaged in a whole host of enrichment and life skills activities, such as physical education, arts, music, health and nutrition, service learning, career exploration, and a life skills class led by the counselor. The life skills class content incorporates various sources, including the best practice Reconnecting Youth from Duke University, and guest speakers from the community.

The core team, in collaboration with the youth, family, and other involved adults (e.g. probation officer, mentor, advocate) will create an individualized Academic Success Plan, which will be used to make appropriate community referrals and class and school assignments while in the program and after matriculation to an appropriate high school.

**Mental Health Support**. In addition to the counselor and case manager, a Learning Support Professional (LSP) will dedicate one day per week to the cohort of 30 youth. The LSP is a masters-level social worker with a PPS credential. They will provide direct services to the youth and their family, as well as contribute mental health expertise to the team. Specific supports may include: assessment, one-on-one and group counseling, support groups (e.g. Anger Management, Grief/Loss), supporting the teacher in developing an optimal learning environments for students, e.g. developing behavior and classroom management interventions/plans, working with families to develop learning and behavioral interventions for students at home, and linking students and families with necessary services, via the school/Wellness Center, CBHS, primary care and CBO networks.
3. **Service Linkages**: The project will utilize the capacity in the school (e.g. Wellness Center) and community, and existing services within the mental health, public health, and probation fields to ensure that participating youth receive appropriate services, while they are in the program and once they transition to their school placement. Partnering organizations will provide a range of services, such as mental health, health, youth employment; family support, computer skills/training, college preparation, and enrichment. The case manager, with support from the LSP will provide the referrals, logistical support, and follow-up for the youth.

4. **Incentives and Support**: A core component of the incentive system will be field trips that reinforce academic and/or life skills instruction. This may include trips to local colleges and universities, as part of career exploration, or trips to local museums with a related project-based lesson. Participating youth will also receive monthly incentives for full participation in the program, in addition to social incentives such as group trips or celebrations planned collaboratively with the whole cohort. There will also be bus tokens or passes available to assist with transportation costs.

The proposed Reengagement Project will serve approximately 50 young people annually who are at high risk for school failure, and related poor mental health outcomes, incarceration, homelessness, injury and/or early death. It will engage their families/guardians in being more present and active in their children’s education and well-being.

c. **Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.**

This project will be operated under contract with CBHS by the San Francisco Unified School District. Implementation partners will be the agencies described above, namely the SFUSD and host school, police department and juvenile probation, and other community service providers. Partnering organizations include, but are not limited to, the following service areas: mental health; youth employment; college preparation; family support; health and wellness; computer skills/training; mentoring; enrichment and youth development; and legal aid.

In instances where youth are identified as needing more intensive and long-term intervention for a serious and persistent mental illness, the project staff will work with school, district and agency resources, along with the County Behavioral Health Access Center to refer the consumer to appropriate services and/or placement.

d. **Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.**

This project targets youth who are already disengaging with the school system and are at-risk for poor mental health outcomes and potential future involvement with violence, substance abuse, and the juvenile or criminal justice system. The ethnic and/or cultural
populations to be served will depend in part on the school selected to host the program and accompanying student population. In conjunction with CBHS, the SFUSD will invite high schools to apply to host the program.

There are currently reentry programs running in the Bayview/Hunters Point and Mission neighborhoods. As a result, this project will likely be housed in a different community. In order to ensure that this project contributes to decreasing disparities in access for underserved populations, the application process and selection criteria will examine schools’ demographics, location, and capacity to serve these populations, as identified by the Stay in School Coalition and PEI related needs assessment.

e. Highlights of new or expanded programs.
The proposed PEI project would expand reengagement services to another high-need neighborhood in San Francisco. It would strengthen existing partnerships between CBHS, the SFUSD, and other City departments, as well as with our extensive network of community based organizations. Most importantly, through these partnerships and with PEI support, it would extend a critical safety net for one of our highest-risk population of young people, those that are disengaging from school and are in danger of giving up on a healthy and successful future. The Reengagement Project will ensure that the mental health needs of these disconnected youth are being met – dealing with the effects of trauma, substance abuse, educational failure, and emotional disturbances with appropriate assessment, supports and services that ameliorate the challenges to reconnecting with school.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
This PEI project will require the following start-up activities

- Detail the partnership with SFUSD using MOUs and contracts as appropriate
- Solicit proposals and select a location to implement the project
- Establish partnership protocols, including collaborative meeting schedule and agreements, referral processes, and documentation/evaluation protocols
- Recruit and train staff
- Set-up the Center (although it will be in an existing space, it will be likely to need some set-up)

The project will include the following key ongoing activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach to truant &amp; disengaged youth by project staff and partners, e.g. attendance liaison, street workers, probation officers, community based organization staff</td>
<td>Ongoing - Average 25 youth per semester-long cycle</td>
</tr>
</tbody>
</table>
## PEI PROJECT SUMMARY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and development of academic success plan in conjunction with youth, family, and involved adults</td>
<td>One per youth: 25 youth per cycle</td>
</tr>
<tr>
<td>Reentry class: Academic activities</td>
<td>3 hrs/day for one semester, 25 youth per cycle</td>
</tr>
<tr>
<td>Reentry class: Enrichment and life skills activities</td>
<td>3 hrs/day for one semester, 25 youth per cycle</td>
</tr>
<tr>
<td>Service linkage and general case management for participating youth</td>
<td>Ongoing - Average 25 youth per cycle</td>
</tr>
<tr>
<td>Early Intervention mental health services, e.g. assessment, short-term counseling, psychosocial groups, behavior contracts</td>
<td>Ongoing – one day/week</td>
</tr>
<tr>
<td>Consultation and support to the teacher and staff regarding mental health and positive behavior management and classroom climate</td>
<td>Ongoing – one day/week</td>
</tr>
</tbody>
</table>

### g. Key milestones and anticipated timeline for each milestone.
- Apr-June '09 Contracting and application process
- June-Aug '09 Program start-up, including set-up, recruitment, hiring and training of staff
- Aug-Sept '09 Outreach begins by August 2009
- Sept-Oct '09 First cycle begins by October 2009

### 4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>reengagement of Truant and Out-of-School Youth</td>
<td>Individuals: 50</td>
<td>Individuals: 25</td>
</tr>
<tr>
<td>FAMILY: 30</td>
<td>Families: 10</td>
<td>Families: 10</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDUPPLICATED COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 50</td>
<td>Individuals: 25</td>
</tr>
<tr>
<td>FAMILY: 30</td>
<td>Families: 10</td>
<td>Families: 10</td>
</tr>
</tbody>
</table>
5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

CHBS has a long history of working with the SFUSD and community based organizations to create a comprehensive and accessible System of Care for our children and youth. High School Wellness Centers have become a core component of our county's behavioral health care system. In instances when young people demonstrate a need for further assessment or extended treatment, the school-based program staff will refer them directly to the host school's Wellness Center, the Behavioral Health Access Center (BHAC), or other community based mental or physical health providers. Youth and families can also be referred to the County's Comprehensive Child Crisis Services, a 24/7 multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress. The young person can arrange to come to the clinic, or a crisis team can travel to the home or school to evaluate the problem. The County also provides considerable services for students with special needs, both onsite at the schools and via the AB3632 Assessment unit that assesses and links eligible special education students to mental health services.

The core team implementing this project will be well-versed in the mental health resources available, both via the County and community service providers.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

As mentioned above, this project is designed to capitalize on exactly such linkages by engaging high-risk youth in a supportive learning community in collaboration with the schools and community partners. The school’s Wellness Center Coordinator will be a part of the team, supporting seamless linkages to the array of behavioral health and other support services offered on-site. The counselor, LSP and case manager will provide limited short-term intervention services along with significant individualized case management and referrals to a wide range of mental and behavioral health services, violence prevention, youth development and basic needs providers in the community. Specific city and county services already identified as referral sources for this project include:

- Comprehensive child crisis services (described above)
- CBHS Violence Response Team
- Existing school-based community behavioral health services for the general student population and students with special needs.
PEI PROJECT SUMMARY

- CBHS provides over $71 million of substance abuse services annually. Services include drug and alcohol education, alternative healthy activities and peer education, early intervention counseling and drop-in, and medical detox. Substance abuse services are already integrated into the high schools via the Wellness Centers. Center staff and on-site behavioral health counselors have access to the CBHS system information and referral processes, including an online database of all programs, searchable by neighborhood, cultural/linguistic capacity, content, etc. In addition, CBHS funds 10-12 school-based substance abuse prevention programs for students in grades 4-12. The full range of programs will be available to providers in this PEI project.

- In addition to the Wellness Centers, a number of SFUSD departments are involved in the Stay in School Coalition and have been instrumental in designing and providing services to truant youth. These include: Pupil Services, School Health Programs, Parent Relations, School Operations and Instructional Support, Attendance Office, County Schools and Office of Public Engagement. They will provide direct services and referrals to youth involved in the PEI Project.

- Many city departments have also been involved in the Stay in School Coalition and supporting this high-risk population. These include: Department of Children, Youth and Their Families, Juvenile Probation Department, SFPD/School Resource Officers, Human Services Agency, District Attorney’s Office and the Housing Authority. They will also provide direct services and referrals for youth involved in the Reengagement Project.

- Proposed PEI project - Early Intervention and Recovery for Young People with Early Psychosis

In addition to the many City and County services available for referral, community agencies provide other social and basic need services in partnership with SFUSD schools. The following is a sampling of agencies that have been active in the existing reentry and truancy prevention programs and some of the services they provide:

- Urban Services YMCA – school-based mental health services, recreation, enrichment, health and fitness activities, family support, mentoring and violence prevention.

- Mission Neighborhood Centers – community centers with programs including case management, education programs, job training, parenting, recreation, and legal aid.

- Brothers Against Guns – Teen Center that prevents youth violence and incarceration through education, intervention, recreation, youth development, case management and mentoring.

- Community Youth Center – works with high need Asian youth and families, providing behavioral health, case management and intervention, education, employment training, leadership development, advocacy, and street outreach programs.

- Sunset Youth Services – youth drop-in center and range of community and school-based services including case management, family support and basic needs, gender-based groups, skill building, mentoring, recreation activities, and community events.
PEI PROJECT SUMMARY

- Vietnamese Youth Development Center - engages immigrant youth in the Tenderloin with urgently needed support and practical assistance including communication skills and problem solving, enrichment, recreation, excursions, cultural gatherings, and community services.

- Ella Hill Hutch Community Center - offers mentoring, enrichment, GED courses, employment services, and more.

- Bayview/Hunters Point YMCA – a cornerstone of the community that administers the CARE reentry program and provides a host of services to youth and families in the community, e.g. recreation, girls and boys mentoring and life skills groups, and after-school programs.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

As mentioned in the project description, this model is based on research in the field and our local experience in San Francisco. Perhaps most importantly, the research led to the creation of a core team model, comprised of two dedicated adult staff. To this core team of teacher and counselor, we have added a part-time case manager, LSP and support from the Wellness Coordinator to ensure timely short-term interventions, strong service linkages and follow-up. The proposed project also includes individual and group incentives.

6. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.

This project is collaborative by design. It builds on many years of partnership between the SFUSD, County public and mental health, and community based organizations. As described under the Project Description and Linkages sections, the proposed project will occur on-site at a high school, and be delivered by staff from the SFUSD and/or CBOs. It will utilize the expertise of the public and community agencies that have been working together to address the varied behavioral health, educational, and other needs of truant and disengaged youth via the Stay in School Coalition.

b. Describe how the PEI component will strengthen and build upon the local community based mental health and primary care system including community clinics and health centers.

The proposed PEI project builds upon the mental health and primary care system in high schools, namely the Wellness Centers. It expands young people’s service options to include other community based agencies, both traditional mental health agencies and more prevention-based youth serving organizations, in collaboration with the SFUSD and County mental health.
c. Describe how resources will be leveraged.
The budget reflects considerable leveraged resources from the SFUSD. A number of District personnel at the host school will be involved in the identification of and outreach to truant and disengaged youth. Most notably, this includes the school’s Attendance Liaison, who is typically hired from the community and is therefore culturally and/or linguistically competent, the Wellness Coordinator, and other members of the Student Assistance Program or Coordinated Care Team, i.e. assistant principal, school counselor, case manager and LSP. Finally, the SFUSD will provide space, core curricula and materials for the reentry classes.

In addition to the resources in the budget, this project will leverage other efforts happening in the city to prevent and reduce truancy. As mentioned previously, the Stay in School Coalition is putting sizable resources into such efforts, including: outreach at key schools with the greatest need; involving CBOs to support school sites and put together comprehensive Care plans for students; better use of technology to inform parents and students about resources; and use of incentives and sanctions by the District Attorney’s truancy mediation program. Finally, the project will also leverage treatment resources, as increased support and service linkage with this population will lead to increased behavioral and physical health and basic needs services provided by the County and community agencies.

d. Describe how the programs in this PEI project will be sustained.
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

Individual Outcomes
- Chronically truant youth receive outreach services
- Chronically truant youth attend re-entry classes that include academic and enrichment activities
- Chronically truant youth receive mental health support, including incentives and services linkages

Program Outcomes
- Program provides outreach, re-entry classes, and mental health support to 25 youth per cycle.
- Youth participating in the program return to school
PEI PROJECT SUMMARY

- Youth participating in the program graduate

System Outcomes
- The proposed PEI project expands reengagement services to another high-need neighborhood in San Francisco.
- It also strengthens existing partnerships between CBHS, the SFUSD, and other City departments, as well as with our extensive network of community based organizations.
- These efforts are expected to lead to improved long-term outcomes for youth who become chronically truant and, as a result, are at risk of school failure, poverty, and exposure to and/or participation in violence.

As a result of this program, youth who have become disengaged from their schools will be supported in their re-entry, leading to reduced disparities in educational attainment.

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:
- Referral to CSS programs: When an individual is identified as needing more intensive and long-term intervention, the project staff will work with BHAC to refer them to appropriate services and/or placement.
- At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a youth will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration other county and community mental health services that are available and appropriate for that particular population.
- The PEI Coordinator will be part of bi-weekly MHSA team meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.
- This and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
## 1. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
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<tr>
<td>4. Stigma and Discrimination</td>
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<tr>
<td>5. Suicide Risk</td>
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<td>☑</td>
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</tr>
</tbody>
</table>

## 2. PEI Priority Population (s)

Note: All PEI projects must address underserved racial/ethnic and cultural populations.

### A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>☑</td>
<td></td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
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<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td></td>
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<tr>
<td>4. Children and Youth at Risk for School Failure</td>
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<td></td>
<td></td>
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<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>☑</td>
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<td></td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
<td>☑</td>
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</tbody>
</table>

### B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach,
which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations. This proposed PEI project came out of the work of the Trauma-Exposed Individuals and Families workgroup.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. In addition, we conducted a focus group at the Native American Health Center to provide more comprehensive and relevant data for this underserved population. This was especially relevant considering the lack of reliable data on the Native American population and the fact that Native Americans in SF are four times more likely to be homeless and mentally ill than the average San Franciscan, and five times more likely to commit suicide. The data that contributed to the development of the Holistic Wellness Promotion in a Community Setting project came from the following sources:

- PEI Focus Group with Native American population
- Public Policy Institute of CA
- California Healthy Kids Survey and Youth Risk Behavior Survey
- Department of Children Youth and their Families
- Mayor’s Office Communities of Opportunity
- Community Services and Supports Plan
- UC Berkeley Child Welfare Research Center, 2006
- DPH Population Health and Prevention Management Information Systems

After examining the data, PEI stakeholders (Planning Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for trauma exposed individuals, families and communities:

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7 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects
The stakeholders examined data about the trauma-exposed population and communities that further highlighted the need for a community-based holistic approach to wellness promotion. Relevant findings included:

- The overall demographic breakdown of the County is 44.3% White, 32.2% Asian/Pacific Islander; 14.1% Latino; 6.6% African American, 0.2% Native American, and 2.7% Multi-Racial or Other.

- More than one quarter of SF households (28.6%) are linguistically isolated, meaning the household lacks any fluent, adult speaker of English. According to the U.S. Equal Employment Opportunity Commission, the following languages are spoken in San Francisco: Spanish, Chinese (Cantonese and Mandarin dialects), Vietnamese, Tagalog, Hmong, Laotian, Khmer, Mien, Cambodian, Mixtec (Native Mexican dialect), Korean, Arabic, Yemeni, Farsi, Hindi, and Russian. At least 30% of young children in SF are immigrants (CPS 200, Foreign born); as many as 54% of children under age six live in immigrant families where at least one parent was born abroad. (Public Policy Institute of CA calculations from the US Census, ACS, 2005).

- While 15% of all SF children live in poverty, that percentage varies depending on ethnicity: 29% of African-American children and youth live in poverty, followed by 27% of Latinos, 10% of Asian/Pacific Islanders, and 1% of Whites (kidsdata.org). Over 40% of four SF neighborhoods’ population is low income (at or below 200% of the federal poverty level): Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% of the Mission and North Beach population is low income. (DPH Population Health and Prevention Management Information Systems).
- Homicide is the leading cause of death among youth ages 15 to 24 in San Francisco (30 per 100,000), almost twice the statewide rate of 18 per 100,000. There were 98 homicides in 2007, of which 93% were male. In 2007, 90% of young homicide victims were either African-American (54%) or Latino (37%).

- On the Youth Risk Behavior Survey (YRBS) administered to 9-12th graders in 2007: 13% had seriously considered suicide (6% attempted); 53% had tried alcohol and 22% had drunk in the last month; 26% were sexually active of which 29% had not used a condom the last time they had sex; 23% had been in a fight in the last year and 7% had felt unsafe going to school in the last month. On the California Healthy Kids Survey, over half (53%) of 5th graders report that ‘kids at school spread mean rumors or lies about them at least some of the time,’ and 57% report that ‘other kids hit or pushed them at school when they are not just playing around’.

- The Mayor’s Office Communities of Opportunity Initiative released a report in 2006 focused on four high-risk street corners in Bayview Hunters Point and Visitacion Valley. The report found: eight of 14 schools in this sector of the city rank in the bottom 20% of the state’s demographically similar schools; approximately 40% of residents in this area feel unsafe whenever alone, compared to the 16% city average; homicides had increased 25% to 45% annually in the San Francisco police districts that encompass the area.

- Approximately 1,800 or 2% of children and youth ages 0-17 in San Francisco were in the foster care system on July 1, 2007. This rate is twice the rate of California, Alameda County, and Contra Costa County.

- In 2007, there were 5,094 referrals to CPS for maltreatment of children under 18, of which 21% were substantiated.

The focus group conducted with Native Americans helped inform a number of questions that surfaced in this (and other) workgroups, namely: how do people define family; what are the major issues and strengths in the community (risk and protective factors); if some of these problems could be prevented, what would be different (desired outcomes); and ideas for activities that would help prevent problems.

Feedback included:

- **How do people define family?**
  - Responses (high frequency responses in normal type face):
    - Immediate family (parents, children, siblings, nieces and nephews)
    - Tribe
    - People, neighborhood, SF
    - Friends
    - People at work
    - People at the Clinic

- **What are the major issues and strengths in the community (risk and protective factors)?**
PEI PROJECT SUMMARY

Responses (high frequency responses in normal type face):
Risk Factors - What are the issues that have negative impact on wellbeing?
  o Health issues - diabetes, alcoholism, drugs, maintaining fitness
  o Lack of role models/positive self identity/sense of belonging
  o Lack of resources, school budget cuts
  o Incarceration and reentry
  o Unemployment
  o Homelessness
  o Violence

Protective Factors - What are the strengths among peers and community
  o Community
  o Family
  o Social gatherings
  o Encouragement from community

• If you could prevent some of these problems, what would be different? How would a person’s life be better? What would a healthy community look like? (desired outcomes)
  Responses (high frequency responses in normal type face):
    o Safe place to go that builds a sense of belonging and positive self identity
    o Self-sufficiency
    o Mentorship ➔ positive role models for young people to follow
    o Students continue their education
    o Community without gangs, violence or drugs
    o Healthy and safe elders
    o An open forum to know what is going on within our community

• Ideas for activities that would help prevent problems?
  Responses (high frequency responses in normal type face):
    o Activities and workshops with traditional activities for youth (jewelry making, basket making, beading, trips to different reservations…)
    o Social events
    o Indian Community Center
    o Outreach services
Building on these conversations, and due to the impact of trauma across many of the key community mental health needs and priority populations, almost all of the workgroups identified desired outcomes that would be addressed in some part by the implementation of the proposed Holistic Wellness project. The summary of desired outcomes from all workgroups is attached.

The Planning Team synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, the Planning Committee selected the key community needs, priority population, and age group that this PEI project addresses:

- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- At-Risk Children, Youth and Young Adult Populations
- Children and Youth at Risk for School Failure
- Children and Youth At-Risk For Juvenile Justice Involvement
- Children and Youth in Stressed Families
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination
- Individuals At-Risk for Suicide

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

We selected the Holistic Wellness in a Community Setting project based on research and promising practices. The Planning Team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project.
The resulting project was strongly informed by the best practice model developed here in the SF Bay Area – Holistic System of Care for Native Americans in an Urban Environment. The model was developed as a result of a multiyear strategic planning process that included a needs assessment based on the community-readiness model. The strategic plan links substance abuse, mental health, HIV/AIDS, and social services in a holistic approach congruent with Native American values and traditions. The plan also links prevention with treatment in a continuum of care. It draws heavily on traditional cultural or community wellness practices, peer support, family and community work, and evidence based treatment. The model provides a system of care which is family-focused, and treats mental and behavioral health as connected to the social, economic and spiritual health of children, family and the community. This success of this approach was documented in Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities (Cross et al. 2000), and has been successfully delivered in SF by a collaboration of Native American community-based organizations and public agencies.

In the Trauma-Exposed workgroup, stakeholders reviewed research and shared their expertise related to this and other approaches. They applied the core principles of the Holistic System of Care more broadly, and proposed a PEI project that would be applicable outside the Native American community, yet still rooted in cultural wellness practices and PEI principles.

Based on the criteria given to workgroups for evaluating local, promising practices, and as a result of the planning activities described above, the Trauma-Exposed workgroup identified this PEI project, which was then chosen by the full Planning Committee vote. The proposed Holistic Wellness project will address many of the needs identified for individuals, families and communities exposed to violence. It is designed to be community and culturally based and to achieve the desired outcomes by increasing identified protective factors and mitigating risk factors.

**b. Description of proposed PEI Intervention**

Holistic Wellness Promotion in a Community Setting is a project that uses a holistic approach based on cultural values and traditions as a foundation for a healthy community. It is informed by the Holistic System of Care described above, and grounded in research by SAMHSA, the Surgeon General’s Office, and others in the field that recognize the importance of culture in designing mental health programs for people of color and the value of community-based programs as an alternative to the medical model. The proposed PEI project addresses the breadth, depth and scope of trauma, including effects of historical trauma.

The model includes community outreach and education, pro-social community building events, direct services, and service linkages. The proposed PEI project will fund three separate providers, each grounded in a distinct cultural community in San Francisco. While the exact

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menu of services provided by each subcontractor will depend on the lead agency and partners, as well as the specific needs and cultural practices of the community, this project supports activities that fall under the following core areas:

**Community Wellness Promotion**
- Individual group and family counseling
- Case management
- Peer counseling / mentoring
- Support groups
- Home visits to individuals and families
- Positive parenting programs using evidence-based curriculum (e.g., Incredible Years, Triple P)
- Safety planning and risk reduction counseling
- After-school programming

**Cultural Activities and Traditional healing**
- Cultural events and festivals
- Drumming circles
- Naming Ceremonies and Coming of Age Ceremonies
- Sweat lodges
- Arts activities such as quilting, Tai Chi, mural arts, theater
- Talking circles – facilitated community discussion groups with varying topics designed to heal historical and recent trauma, foster resiliency and self-esteem, and inform and create a safe space to address community concerns.

The proposed Holistic Wellness project will serve three distinct communities in SF with a combination of the types of services listed above. The majority (at least 75%) of project funding will go to prevention activities, with up to 25% allocated for early intervention.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

This project will be operated, under contract with CBHS, by three community based agencies chosen through a competitive RFP process. Implementation partners will include the lead agency and additional service providers working in collaboration with each lead agency. The lead agency will have a history of serving and existing relationships with the target community.

In instances where children, youth, adults or family members are identified as needing more intensive and long-term intervention for a serious and persistent mental illness, the project staff will work with agency resources, along with the County Behavioral Health Access Center (BHAC) to refer the consumer to appropriate services and/or placement.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.
The target populations for this project are currently being identified as part of a comprehensive needs and capacity assessment of prevention and early intervention in the county. The need for a more in-depth assessment was a direct result of the community planning process, which highlighted the need for a deeper understanding of the scope and nature of mental health needs in the county and really mapping the existing capacity for providing prevention and early intervention services. This needs and capacity assessment will identify three communities that would most benefit from this holistic wellness promotion in a community setting. The need for and success of this approach are well known for the Native American community, and the research base is applicable to other historically underserved and trauma-exposed populations. This process will also identify existing culture-based strategies that have shown success in non-Native American communities in order to prioritize three groups to be served initially by this project. The lead agencies will then be selected through a competitive Request For Proposals (RFP) process.

e. Highlights of new or expanded programs.
The proposed project will take the core principles behind a successful approach to providing holistic support and behavioral health intervention for the Native American population and apply them to other communities facing multiple risk factors and high exposure to trauma of all forms, including historical trauma. This is a transformational and prevention-based approach that embodies many of the PEI principles. It offers much promise in building our capacity to serve all underserved communities more appropriately and effectively.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
This PEI project will require the following start-up activities
- Identify three target communities
- Publish RFP, solicit proposals and select lead agencies
- Recruit, hire, and train staff
- Establish partnerships lead agencies and additional partners, using MOUs and contracts as appropriate
- Define the specific activities/scope of work for year one

The specific activities to be implemented will be determined by the lead agency. However, the following is an estimated breakdown of key ongoing activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration per Award (there will be three awards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach – individual and at community events</td>
<td>Ongoing – monthly events, outreach to at least 600 individuals and families/year</td>
</tr>
<tr>
<td>Community events</td>
<td>1 event/ year</td>
</tr>
<tr>
<td>Talking Circles</td>
<td>3-4/ year, average 2 hours/event</td>
</tr>
</tbody>
</table>
PEI PROJECT SUMMARY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration per Award (there will be three awards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arts activities</td>
<td>2-4/year, varying in duration from one-time workshop to 4 week series.</td>
</tr>
<tr>
<td>Other cultural wellness/healing activities</td>
<td>2-4 year</td>
</tr>
<tr>
<td>Family activities</td>
<td>2-4/year, varying in duration from one-time workshop to 4-8 wk series</td>
</tr>
<tr>
<td>Provide or refer to counseling services</td>
<td>Ongoing – 15 people/year</td>
</tr>
<tr>
<td>Provide or refer to support groups</td>
<td>Ongoing – 15 people/year</td>
</tr>
<tr>
<td>Referrals to culturally appropriate behavioral health and basic needs services</td>
<td>Ongoing – 40 individuals and families per year</td>
</tr>
</tbody>
</table>

**g. Key milestones and anticipated timeline for each milestone.**

- May-June '09  RFP and contracting process
- June-Aug '09  Program start-up, including recruitment, hiring and training of staff
- Aug-Sept '09  Program fully implemented by September 2009

**4. Programs**

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Holistic Wellness Promotion in Community Setting – Outreach and Community events</td>
<td>Individuals: 300 Families: 300</td>
<td>Individuals: Families:</td>
</tr>
<tr>
<td>Holistic Wellness Promotion in Community Setting – Direct Services and Referral</td>
<td>Individuals: 50 Families: 50</td>
<td>Individuals: 30 Families: 30</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDUPIALIZED COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 300 Families: 300</td>
<td>Individuals: 30 Families: 30</td>
</tr>
</tbody>
</table>
5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The lead agency of each of the three awards will be well-versed in the mental health resources available, both via the County and community service providers. They will provide some short-term services as part of this project, and they may have capacity in their agencies to provide more intensive treatments via other funding resources. They will refer participants to County, primary care and other appropriate community mental health service providers as necessary. In instances when children, youth, or their family members demonstrate a need for further assessment or extended treatment, the lead agency program staff can refer them directly to the Behavioral Health Access Center (BHAC), or other community-based mental or physical health providers. Youth and families can also be referred to the County’s Comprehensive Child Crisis Services, a 24/7 multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress. The family can arrange to come to the clinic, or a crisis team can travel to the home or community center to evaluate the problem.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

This project is designed to embed such linkages in high need communities by supporting multi-faceted community based organizations to provide locally-determined, appropriate prevention and early intervention activities. The lead agencies will provide very limited short-term intervention services, along with many other needed services, such as violence prevention, food pantry, housing assistance, substance abuse intervention and treatment, domestic violence services and more. They will also work in partnership with other community and public agencies to provide a full scope of support and treatment services. This includes, but is not limited to: CBHS community based substance abuse services; community response network; CBHS Violence Response Team; teen and youth centers; after-school programs; family resource centers; employment and training programs, and recreation and fitness programs.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The Planning Team conducted research on local and comparable programs to ensure that the budget and program design for the proposed project includes sufficient resources, programs and activities to achieve desired PEI outcomes at the all levels. Applicant agencies will be required to demonstrate that they have sufficient infrastructure and relationships in place to implement the program as described.
6. Collaboration and System Enhancements

a. **Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.**

This project will be operated under contract with CBHS by three community based organizations chosen through a competitive RFP process. This project is a collaborative and system enhancing project. It will be delivered entirely by community-based organizations, at their and their partners’ locations in the community. CBHS will be a referral source and provide oversight for the project. San Francisco has a long history of working collaboratively, and as such, many of our communities have existing collaboratives, often organized around a cultural population and/or pressing issues.

b. **Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.**

Again, this project is designed to build upon and deepen the impact of community-based wellness promotion. It will be implemented by community-based agencies, and include referrals to and/or on-site service delivery by other health and mental health organizations, public and non-profit, including both traditional mental health agencies and more prevention-based youth and adult serving organizations.

c. **Describe how resources will be leveraged.**

The budget reflects leveraged resources that amount to 10% of the overall project budget. The exact resources will be dependent on the organizations that are selected to administer the project in the RFP process. Given the nature of the services described, and the capacity of our community-based organizations, these resources will likely consist of:

- Medi-cal reimbursement for short-term early intervention via EPSDT
- Medi-cal reimbursement for outreach via MAA
- Federal funding, e.g. Substance Abuse and Mental Health Services Administration
- State funding, e.g. After School Education and Safety grants
- City funding, e.g. DCYF grants
- Foundation grants

In addition, the project will also leverage considerable treatment resources, since increased outreach, education and service linkages will lead to increased behavioral and physical health and basic needs services provided by the County and community agencies.
d. Describe how the programs in this PEI project will be sustained.
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

7. Intended Outcomes

Please see the local evaluation for a more detailed description of the outcomes for this program.

**Individual Outcomes**
- Caregivers are able to provide consistent nurturing environments for their children, have positive interactions them, and to address problematic child behaviors effectively
- Children and youth are able to participate in safe, culturally-appropriate afterschool activities that develop positive self-esteem and self-efficacy, including youth development and anti-oppression activities
- Community members are exposed to cultural activities and traditional healing experiences
- Community members increase their knowledge of safety planning and risk reduction strategies related to family and community violence
- Community members experiencing emotional distress related to trauma exposure have increased access to counseling and/or case management services.

**Program Outcomes**
- Program provides counseling and case management services
- Program provides peer counseling / mentoring services
- Program provides home visits to individuals and families
- Program provides safety planning and risk reduction counseling
- Program provides safe, culturally-appropriate afterschool activities and
- Program provides classes designed to increase caregiver knowledge and use of effective parenting practices

**System Outcomes**
- Increased community capacity to ameliorate the negative impact of trauma exposure on community members through:
- Increased community capacity to support the healthy development of children and youth by
- Increased community capacity to provide cultural activities and traditional healing experiences to community members who wish to participate in them
As a result of this program, San Francisco communities whose members have disproportionately been 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.

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:
- Referral to CSS programs: when an individual or family is identified as needing more intensive and long-term intervention, the project staff will work with BHAC to refer them to appropriate services and/or placement.
- At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration other county and community mental health services that are available and appropriate for that particular project.
- The PEI Coordinator will be part of bi-weekly MHSA team meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.
- This and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
**County:** San Francisco  
**PEI Project Name:** Early Childhood Mental Health Consultation  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>PEI Key Community Mental Health Needs</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>Children and Youth</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>Transition-Age Youth</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>Adult</td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>Older Adult</td>
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<tr>
<td>5. Suicide Risk</td>
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</tr>
</tbody>
</table>

### 2. PEI Priority Population (s)

**Note:** All PEI projects must address underserved racial/ethnic and cultural populations.

A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>PEI Priority Population (s)</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>Children and Youth</td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>Transition-Age Youth</td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td>Adult</td>
</tr>
<tr>
<td>4. Children and Youth at Risk for School Failure</td>
<td>Older Adult</td>
</tr>
<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td></td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
<td></td>
</tr>
</tbody>
</table>

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach,
which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the Early Childhood Mental Health Consultation project came from the following sources:

- SF Mayors Office of Community Development
- First 5 San Francisco
- Early Childhood Mental Health Consultation Initiative
- California Department of Social Services Child Welfare Reports 2006
- Medi-Cal Eligibles, CY2006
- Public Policy Institute of CA
- Community Services and Supports Plan

After examining the data, PEI stakeholders (Planning Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for at-risk young children:

**Risk Factors**
- Uncoordinated and disconnected systems
- Lack of understanding of mental health issues and strategies among early care professionals
- Visible but unidentified behavior problems and mental health issues among 0-5 year olds
- Lack of understanding of what constitutes trauma – the types

**Protective Factors**
- Strong, empowered support systems – family and community
- Resiliency
- Strengths based assessments and programs
- Services where the kids are or in the communities where they live

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9 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects.
PEI PROJECT SUMMARY

Risk Factors

and impacts – within all support systems for young children

- Difficulty of transitions, e.g. from family to early care and into kindergarten
- Growing population of refugee children with family adjustment issues and limited support
- Poverty and family stressors
- Community and family norms of silence
- At risk for institutionalization and/or removal from family
- Disparities in access to services
- Lack of mental health education among families

Protective Factors

- Cross training for service providers

The stakeholders examined data about the birth-to-five population that further highlighted the need for increased mental health capacity at childcare programs. Most notably, these data included:

- 35% of young children in SF live in poverty. (Medi-Cal Eligibles, CY2006)
- 58% of our children ages five and under are being raised in families where all the parents are in the workforce. (2000 Census)
- At least 30% of young children in SF are immigrants (CPS 2000, Foreign born); as many as 54% of children under age six live in immigrant families where at least one parent was born abroad. (Public Policy Institute of CA calculations from the US Census, American Community Survey, 2005)
- In 42% of households, a language other than English is spoken at home (SF Mayors Office of Community Development 2005-2010 Consolidated Plan, SF Demographic Profile) and 29% of SF households are linguistically isolated. (2000 Census).
- In 2006, there were 1,908 child abuse referrals in the county for children 0-5 years old; 443 of them were substantiated, and 239 were inconclusive. (CDSS 2006)
- The High Risk Infant Interagency Council of SF published a report in 2004 (Young Children with Special Health Care Needs in San Francisco: Assessing Our Reach) that found that an estimated 7,400 children under age six (16% of all children at the time) had special health care needs, including social and emotional delays, but fewer than 1,600 had been seen by providers.
- Data from 3,611 children (age four) who receive childcare services at one of 80 sites served by the current Early Childhood Mental Health Consultation (ECHMC) Initiative shows that 11% have aggressive problems, 10% have communication delays, 10% have attention problems, 7% have anxiety related problems, 5% have depression related problems, 5% have attachment issues, and 4% have PTSD related symptoms.
Building on these conversations, three different workgroups identified desired outcomes that led to the selection of this PEI project – expansion of the Early Childhood Mental Health Consultation (ECMHC) Initiative. The summary of desired outcomes from all workgroups is attached.

We synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, we selected the key community needs, priority population, and age group that this PEI project addresses:

- At-Risk Children, Youth and Young Adult Populations
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Children and Youth in Stressed Families
- Children and Youth at Risk for School Failure
- Stigma and Discrimination

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Planning Committee selected the Early Childhood Mental Health Consultation expansion project based on research and promising practices. Our planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. In workgroups, stakeholders reviewed research and shared their expertise to identify programs and practices that would work with our diverse community, and that would achieve the desired outcomes, increasing protective factors and mitigating risk factors.

The Early Childhood Mental Health Consultation (ECMHC) is a promising practice that has been implemented in San Francisco and across the nation for over 10 years. Based on the criteria given to workgroups for evaluating local, promising practices and as a result of all the planning activities described above, three workgroups identified this PEI project. It will address many of the risk factors faced by our young children growing up in stressed families with high levels of poverty, violence, and poor access to mental health services and information. It will build the capacity of providers to meet the mental health needs of young children in their communities, improving the quality of care they provide and building their own understanding of trauma and other mental health issues. It will support families and communities to help nurture and support the healthy development of our youngest children.
b. Description of proposed PEI Intervention

The proposed PEI Project uses child-trained, mental health professionals to provide on-site mental health consultation to community-based childcare programs. Activities typically include providing professional development, child observation and individual/group consultation to teachers and staff; service linkage; and direct services to children and families. ECMHC seeks to prevent, identify, treat and reduce the impact of mental health challenges among children aged 0-5 and their families. It is a prevention-based model; 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.

PEI funds would support the expansion of ECMHC to 16 childcare classrooms (including four at Family Resource Centers), four family child care networks, and six drop-in childcare programs within parental drug treatment programs. Depending on the size of the individual classrooms, this would result in approximately 550-600 children who benefit from mental health consultation, and 250-300 who receive more intensive consultation with teachers and families per year. Funds would also support formal training and capacity building among mental health providers.

This project builds upon the success of a number of existing local programs around early childhood mental health consultation in childcare sites. Currently, First 5 SF, the Department of Children Youth and their Families, and the Human Service Agency co-fund an ECMHC Initiative, provided through 13 community-based organizations, that serves 158 childcare centers and family child care homes and 11 homeless and domestic violence centers. However, there are many more childcare providers in need of mental health consultation, 12 on the ECMHC Initiative’s waitlist and many more that yet to be engaged. ECMHCI evaluation results are promising. Highlights include:

1. Between 81% and 85% of participating childcare providers “strongly agreed” that the mental health consultant helped (1) increase their understanding of children’s emotional needs, (2) add to their understanding of children’s development, and (3) respond more effectively to children’s behavior and (4) communicate more effectively with parents of children who have challenging behaviors. (n=383).

2. Children showed increased socio-emotional resiliency and decreased behavioral concerns after ECMHC services while in preschool.

3. Children who attended a childcare center with access to ECMHC services developed the social and emotional competence needed in kindergarten.

4. The effectiveness of ECMHC services was sustained into kindergarten. Children who received ECMHC services in preschool showed a comparable level of kindergarten performance as their peers.
This project also includes funding to develop and deliver a year-long Training Institute for mental health consultants to increase capacity and quality of service across the County. The intent of the Institute is to educate and prepare mental health clinicians for 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. The Institute will build the foundation on which consultation services are delivered regardless of the agency providing the service. Samples of training topics on which the consultants will receive instruction are as follows:

- Relationship-based consultation practices to child care settings
- Infant, toddler, preschool development
- Parenting and family functioning
- Adult learning themes and strategies
- Interdisciplinary collaboration

Supervisors will also be encouraged to participate in the training so that they have an in-depth understanding of the service model and the scope of practice. Ultimately, when the training is complete, these supervisors will be the ones who support and supervise their consultants based on the instructional guidelines of the Training Institute.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Implementation partners for this project include qualified community mental health agencies that provide the consultants, and the community-based child care programs and childcare programs within parental drug treatment programs that are not already receiving mental health consultation. Childcare programs will be self-contained childcare centers, childcare programs within a Family Resource Center or other community organization, and family childcare homes.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

This project targets young children, and their families, who are at risk for poor mental health outcomes and later social and/or school failure due to poverty, family stressors, and exposure to 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. 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 childcare programs that are selected to receive mental health consultation. There is an undeniable need for early childhood mental health consultation throughout the city; there are 12 childcare
programs presently on the ECHMC Initiative’s waitlist, plus identified need at Family Resource Centers, Family Child Care Networks, and substance abuse treatment centers. A portion of this project will be targeted to reaching the highest-risk children, those whose parent(s) has a substance abuse problem. Parental substance abuse is associated with adverse health and developmental outcomes for children. For example, children of addicted parents exhibit depression, anxiety, and related symptoms more frequently than do children from non-addicted families. And they are at high risk for elevated rates of psychiatric and psychosocial dysfunction, as well as for alcoholism.

e. Highlights of new or expanded programs.
This project will both provide new services and expand on existing services within the County. Because we will be including Family Child Care programs, we will address a relatively hard to reach group of providers who often lack technical assistance and capacity building services due to their small size and isolation. The expansion will also focus on highest risk youngsters and their families, by addressing the childcare providers who are working in substance abuse treatment programs – serving children who have been exposed to highly stressed family life due to addiction and its sequelae. In addition, we will target childcare programs at Family Resource Centers because these programs have been developed to serve the most stressed families who access a variety of services while their children are being cared for at the site-based childcare.

This project will greatly enhance the quality of existing services by providing a structured, ongoing training institute for mental health consultants to share and learn best practices. This strategy will build the capacity of the most influential parties in the ECHMC system – the consultants – and will raise the level of practice citywide.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
This PEI project will require the following start-up activities
- Identify, assess and match participating childcare programs and mental health consultants
- Establish partnerships with childcare programs and mental health consultants, using MOUs and contracts as appropriate
- Finalize consulting tools, e.g. staff training materials, observation protocols, group and individual consultation documents, and resources guides.
- Recruit, hire, and train staff

The project will include the following key ongoing activities

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PEI PROJECT SUMMARY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with 27 childcare programs per year, including child observations and individual and group consultation to teachers and staff about children of concern.</td>
<td>Ongoing – weekly contact with programs; average duration 6-12 hours/week</td>
</tr>
<tr>
<td>Direct service to 250-300 children and their families, i.e., therapeutic groups, individual or family sessions, and service linkage.</td>
<td>Ongoing – low intensity, less than one year in duration</td>
</tr>
<tr>
<td>Training Institute for early childhood mental health consultants.</td>
<td>10 months, biweekly didactic trainings and biweekly small group discussion sessions.</td>
</tr>
</tbody>
</table>

**g. Key milestones and anticipated timeline for each milestone.**
- May-June ’09  Contracting process to identify the community based mental health providers and participating childcare sites
- June-July ’09  Program start-up, including recruitment, hiring and training of staff
- July ’09  Program implementation begins by July 2009
- Sept ’09  Launch Training Institute

**4. Programs**

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Early Childhood Mental Health Consultation</td>
<td>Individuals: 600 Families:</td>
<td>Individuals: 250 Families: 250</td>
</tr>
<tr>
<td>Training Institute</td>
<td>Individuals: 25 Families:</td>
<td>Individuals:</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 625 Families:</td>
<td>Individuals:</td>
</tr>
</tbody>
</table>
5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The ECMHC project builds upon an existing initiative which is overseen by the Community Behavioral Health Services (CBHS) Department and has established linkages with county and community providers of mental health, childcare, and other services. County services are coordinated through the Behavioral Health Access Center (BHAC). In instances when children or their family members demonstrate a need for further assessment or extended treatment, the consultant can refer them directly to BHAC or to other community-based mental or physical health providers. Families can also be referred to the County’s Comprehensive Child Crisis Services, a 24/7 multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress. The family can arrange to come to the clinic or a crisis team can travel to the home or childcare center to evaluate the program.

The mental health consultants will be well-versed in the mental health resources available, both via the County and contracted service providers. Each of the agencies providing the mental health consultation services are and will be community based mental health agencies that offer varying degrees of mental health and other core services.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

As mentioned above, this project is designed to create exactly such linkages. The mental health consultants provide very limited short-term intervention services. The majority of their work is to build the capacity of childcare staff and families to identify and respond to the behavioral health needs of their young children. This involves training, modeling and coaching, and a significant amount of linking and referral to a range of services. In addition to the many County services available for referral, the consultants are part of multi-service community based agencies that provide other social and basic need services directly. The following is a sampling of agencies that provide mental health consultants and the services they provide:

- Instituto Familiar de la Raza – behavioral health care, e.g. trauma, persistent mental illness, family conflict, immigration and reunification issues, mentoring, case management, parenting education and support groups, violence prevention, and HIV/AIDS education and prevention.
- Jewish Family and Children’s Services – individual, group and family counseling, parenting education and support groups, domestic violence prevention, advocacy and support, family mediation, resource library, and legal aid.
c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

This PEI project builds on the existing ECMHC Initiative, which has proven to be very successful at the proposed level of intensity.

6. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.

This has been described in detail under the Project Description and Linkages sections. The proposed ECMHC project is delivered entirely by community-based mental health organizations, onsite at childcare programs and in family homes as needed. The PEI funded component will be integrated into the existing initiative, to which CBHS will continue to provide support and oversight.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Again, this project is designed to build upon and expand the impact of the local community-based mental health system. The creation of the proposed Training Institute will build capacity among the mental health consultants and their agencies to understand and deliver high quality mental health consultation services to this young and vulnerable age group.

c. Describe how resources will be leveraged.

The budget reflects the extensive resources this proposed project leverages, namely over $4,700,000 in city, county, and Medi-Cal funding that support the Early Childhood Mental Health Consultation Initiative. This project will build upon, expand and strengthen the existing ECMHC infrastructure and service delivery in the County. As such, in addition to financial capital, it leverages considerable resources in terms of:
PEI PROJECT SUMMARY

- outreach to childcare providers (this project will serve 12 centers that were already on a waitlist), and mental health agencies;
- training of mental health consultants (the Training Institute will further enhance capacity and best practices among currently practicing mental health consultants);
- oversight and coordination, at both the county level and at mental health agencies that provide the consultants; and
- linkages and referral processes for follow-up services for young children and their families.

d. Describe how the programs in this PEI project will be sustained.
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

Individual Outcomes

- Children at childcare sites receiving ECMHC services will be exposed to age-appropriate learning materials, positive child-teacher interactions, and other elements of a healthy environment.
- Children will develop social competence and exhibit age-appropriate behaviors.
- Children with emerging mental health and/or developmental problems will learn new skills and strategies to address and ameliorate these problems.

Program Outcomes

- Mental health clinicians are prepared for the unique and complex work of providing early childhood mental health consultation (ECMHC) services through participation in the training institute
- The ECMHC program is expanded to 15 childcare classrooms (including five at Family Resource Centers), 3 family child care networks, and 6 drop-in childcare programs within parental drug treatment programs.
- Mental health professionals provide on-site early childhood mental health consultation to community-based childcare programs.
- Consultants provide an array of services, including professional development, child observation and individual/group consultation to teachers and staff, service linkage, and direct services to children and families.
System Outcomes

- Increased ability to identify and treat emerging mental health disorders in young children in San Francisco before the disorders become more severe, chronic, and disabling.

As a result of this program, mental health disorders in children ages 0-5 will be prevented or identified early and treated, thus reducing the burden of mental illness within San Francisco families.

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:

- Referral to CSS programs: when a child or family is identified as needing more intensive and long-term intervention, the project staff will work with and the BHAC to refer the consumer to appropriate services and/or placement.

- At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project.

- The PEI Coordinator will be part of bi-weekly MHSA team meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.

- This and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
**PEI PROJECT SUMMARY**

**County:** San Francisco  
**PEI Project Name:** Mental Health Consultation for Providers Working with Youth At-Risk or Involved with the Juvenile Justice System  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Youth</td>
</tr>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
</tr>
<tr>
<td>5. Suicide Risk</td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population(s)

**Note:** All PEI projects must address underserved racial/ethnic and cultural populations.

**A.** Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Youth</td>
</tr>
<tr>
<td>1. Trauma Exposed Individuals</td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
</tr>
<tr>
<td>4. Children and Youth at Risk for School Failure</td>
</tr>
<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
</tr>
</tbody>
</table>

**B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).**

Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach,
which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations12.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the Mental Health Consultation Project came from the following sources:

- Department of Children Youth and their Families
- SF Mayors Office's Communities of Opportunity Initiative
- Juvenile Probation Department 2005 Annual Report
- California Department of Social Services Child Welfare Reports 2006
- Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) survey conducted by the National Institute of Mental Health (NIMH)
- DPH Population Health and Prevention Management Information Systems
- Physicians for Human Rights, Health and Justice for Youth
- Youth Risk Behavior Survey
- Adolescent Health Working Group *A Snapshot of Youth Health and Wellness in San Francisco, 2008*
- Community Services and Supports Plan

After examining the data, PEI stakeholders (Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for **children and youth at-risk of juvenile justice involvement:**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trauma and victimization</td>
<td>• Positive culturally competent mentorship</td>
</tr>
<tr>
<td>• Truancy and dropout from school</td>
<td>• Opportunities to participate in meaningful</td>
</tr>
</tbody>
</table>

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12 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects.
PEI PROJECT SUMMARY

Risk Factors

- Alcohol, tobacco or other drug use
- Growing population of immigrant and undocumented youth face myriad of issues, e.g. isolation, language barriers, legal status, trauma, acculturation
- Lack of appropriate interventions, especially gender- and subpopulation-specific services
- Fear/negative social perception of youth
- Stigma and invisibility

Protective Factors

- Engagement activities
- Safe communities of support
- Other youth
- Youth-friendly programs and systems

The stakeholders examined data about the at-risk youth population that further highlighted the need for increased mental health capacity among all types of providers who work with young people, e.g. after-school programs, community centers, youth development programs, crisis and violence prevention. Most notably, findings included:

- 16.4% of San Francisco’s population is under the age of 20.
- The Mayor’s Office Communities of Opportunity Initiative released a report in 2006 focused on four high-risk street corners in Bayview Hunters Point and Visitacion Valley. The report found: approximately 40% of residents in this area feel unsafe whenever alone, compared to the 16% city average; homicides had increased 25% to 45% annually in the San Francisco police districts that encompass these area; and at age 17, 70% of African American males and 44% of African American females had at least one referral to the juvenile probation system; and 8 out of 14 schools in this sector of the city rank in the bottom 20% of the state’s demographically similar schools.
- Federal studies estimate that 50-75% of incarcerated youth have diagnosable mental health disorders and nearly half have substance abuse problems; Up to 92% of incarcerated girls have experienced one or more forms of physical, sexual and emotional abuse before entering the juvenile justice system (Physicians for Human Rights, Health and Justice for Youth).
- At least 21% of young people have a mental illness, i.e. DSM disorder
- Last year, approximately 2.5% of the youth population in SF (2,030 young people) had at least one contact with the Juvenile Probation Department (JPD).
- The majority of JPD referrals came from the following neighborhoods: Bayview/Hunters Point (22.6%), Outer Mission/Excelsior (11.1%), Inner Mission/Bernal Heights (10.7%), Visitacion Valley (10.6%), %), and the Western Addition (8.0%).
PEI PROJECT SUMMARY

- Homicide is the leading cause of death among youth ages 15 to 24 in San Francisco (30 per 100,000), almost twice the statewide rate of 18 per 100,000. There were 98 homicides in 2007, of which 93% were male. In 2007, 90% of young homicide victims were either African-American (54%) or Latino (37%). Over the last four years, 94% of San Francisco’s homicide victims under the age of 25 were high school drop-outs.

- On the Youth Risk Behavior Survey (YRBS) administered to 9-12th graders in 2007: 9% had carried a weapon to school in the last month, 23% had been in a fight in the last year, 7% felt unsafe going to school in the last month, 13% had seriously considered suicide (6% attempted), 53% had tried alcohol and 22% had drunk alcohol in the last month, and 26% were sexually active of which 29% had not used a condom the last time they had sex.

- 200 young adults per year age out of the foster care system, with varying degrees of support; 270 youth aged 6-17 entered foster care in 2007

- Over 40% of the population in four SF neighborhoods is low income (at or below 200% of the federal poverty level): Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% is low income in the Mission and North Beach. (DPH Population Health and Prevention Management Information Systems).

Building on these conversations, a number of workgroups identified desired outcomes that would be addressed in some part by the implementation of this PEI project – Mental Health Consultation for Providers Working with Youth At-Risk for Juvenile Justice Involvement. The summary of desired outcomes from all workgroups is attached.

We synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, we selected the key community needs, priority population, and age group that this PEI project addresses:

- At-Risk Children, Youth and Young Adult Populations
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Children and Youth At-Risk for Juvenile Justice Involvement
- Children and Youth in Stressed Families
- Children and Youth at Risk for School Failure
- Individuals At-Risk for Suicide
- Stigma and Discrimination
3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

We selected the Mental Health Consultation for Providers Working with Youth At-Risk for Juvenile Justice Involvement project based on research and promising practices. Our planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. In workgroups, stakeholders reviewed research and shared their expertise to identify programs and practices that would work for our diverse community, and that would achieve the desired outcomes, increasing identified protective factors and mitigating risk factors. Based on the criteria given to workgroups for evaluating local, promising practices and as a result of all the planning activities described above, the Juvenile Justice workgroup identified this PEI project, which was then chosen by the full Planning Committee vote.

Mental Health Consultation is a promising practice that has been implemented in San Francisco and across the nation with various target populations, including childcare providers and after-school programs. Building on the Early Childhood Mental Health Consultation Initiative – which has demonstrated great success and the expansion of which is another proposed PEI project – the Department of Children Youth and their Families (DCYF) has recently funded a pilot program to provide mental health consultation in after-school programs for children aged 6-13. This grew out of consistent feedback from the after-school field that more support was needed to meet the mental health needs of children in their care and to manage challenging behavior and meet special needs in the after-school hours. In addition, DCYF has added mental health consultation as a minimum compliance standard for providers working as part of the Community Response Network (CRN), making this a timely project to leverage other efforts in the county.

This PEI project will work with dedicated youth service providers to address many of the risk factors faced by our young people growing up in the most stressful environments, e.g. high levels of violence, substance abuse, school failure, and poor access to appropriate mental health services. It will build the capacity of a wide range of youth service providers to assess and meet the mental health needs of the young people in their communities, preventing future involvement with the juvenile justice system and improving the overall quality of support they provide. And it will support families and communities to break the cycle of incarceration and support the success and healthy development of their youth.

b. Description of proposed PEI Intervention

Similar to the established Early Childhood Mental Health Consultation Project, this project will use 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 and their families. The consultants will 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 will also provide limited, short-term intervention with youth and families.

Providers receiving consultation may include County Court and Community Schools, but, since this project is a prevention strategy, we will prioritize community centers and community-based organizations working with youth at-risk for involvement with juvenile justice. We will focus on agencies that target community hot spots for juvenile crime, such as those at the “seven street corners” in SF where 70% of African American males and 44% of African American females have had at least one referral to the juvenile probation system by age 17. Creating a pool of culturally competent mental health consultants will be a critical component of the success of this program.

This project would provide mental health consultation at an estimated 20 sites in year one, representing approximately 100 individual staff. We anticipate that at least 1,000 youth would benefit from the mental health consultation, with approximately 200 of those participating in more intensive short-term early intervention, at least 100 with their families.

We anticipate that the consultants will be working with a variety of youth workers, many of whom will lack advanced degrees and backgrounds in mental health. However, these youth workers will be likely to have highly sophisticated understanding of the context, conditions and stressors faced by the youth that they serve. The role of the consultants will be to build staff understanding about basic mental health diagnoses and the impact of trauma and exposure to violence on the mental health of youth and their families, increase their knowledge of intervention strategies and resources available, and helping to address and dispel the stigma and discrimination connected to being identified as mentally ill in many communities.

This project includes funding for coordination across agencies (those involved in the DCYF initiative and agencies funded for this project), and documentation of the consultation model and methods so it can be expanded in the future.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

This project will be operated under contract with CBHS by agencies chosen through a competitive RFP process. Implementation partners will include qualified mental health providers and community based organizations working with youth at-risk for, or already involved with,

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13 The Communities of Opportunity’s report on the Four Corners was based on a more extensive study by SF Human Service Agency that identified seven street corners in the city with a geographic concentration of children and families interacting across the mental health, foster care and juvenile justice systems.
the juvenile justice system. The organizations receiving consultation can include county court and community schools, but the primary target will be CBOs providing youth programming in neighborhoods with high proportion of at-risk youth. The programs can be independently run or part of a larger community-based organization, community or resource center, after-school program, or network.

In instances where children, youth or their family members are identified as needing more intensive and long-term intervention for a serious and persistent mental illness, the project staff will work with agency resources, especially the County Behavioral Health Access Center, to refer the consumer to appropriate services and/or placement.

d. **Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.**

This project targets youth who are at risk for poor mental health outcomes and subsequent or continued involvement with the juvenile justice system. The ethnic and/or cultural populations to be served depend on the neighborhoods that are selected through a competitive Request for Proposals (RFP) process. However, data reviewed during the planning process indicates that there is a high need in specific SF neighborhoods, namely Bayview/Hunters Point, Outer Mission/Excelsior, Inner Mission/Bernal Heights, Visitacion Valley, and the Western Addition. Data also illustrate that African-American and Latino youth are overrepresented in the juvenile justice system, and that girls are the fastest growing segment of the juvenile justice population. These factors will be taken into consideration when writing and reviewing the RFP. Additionally, as a result of this PEI planning process, the County is undertaking a comprehensive needs and capacity assessment of community mental health needs and services. In conjunction with DCYF, we will look at the results of the gap analysis to ensure that the PEI funds expand and do not duplicate existing mental health consultation services.

In order to ensure that this project contributes to decreasing disproportionate minority contact with the juvenile justice system and corresponding disparities in access to mental health services for underserved populations, the RFP will include a competitive priority for applicants who demonstrate their capacity and intention to serve these populations – as identified by the CSS planning process, PEI needs assessment, and SF health disparities workgroup.

e. **Highlights of new or expanded programs.**

This project creates a new service for community-based providers working with at-risk youth that will build their understanding of and ability to respond to mental health issues among their clients. It utilizes a prevention approach that is new for the juvenile justice field, looking to identify and address mental health issues among youth who are at high-risk for involvement (or deeper involvement) with the juvenile justice system while those youth are engaged with caring adults in the community. It also capitalizes on the opportunity to leverage emerging efforts in the county to provide mental health consultation in non-traditional settings, namely after-school programs and the community response network organizations.
f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
This PEI project will require the following start-up activities
- Solicit proposals and select agencies to deliver the services
- Establish partnerships with providers, using MOUs and contracts as appropriate
- Establish partnership protocols among consultants (those funded by this PEI project and others working on DCYF initiatives), including collaborative meeting schedule and agreements and documentation/evaluation protocols
- Finalize consulting tools, e.g. consulting agreements, staff training materials, observation protocols, group and individual consultation documents, and resources guides
- Recruit, hire, and train staff

The project will include the following key ongoing activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with providers in 20 community-based settings per year, including professional development, individual and group consultation to staff, and service coordination/linkages.</td>
<td>Ongoing - weekly contact with providers; average duration 1-3 hours</td>
</tr>
<tr>
<td>Direct service to 100-200 youth and their families, i.e., therapeutic groups, individual or family sessions, and service linkage.</td>
<td>Ongoing – low intensity, less than one year in duration</td>
</tr>
<tr>
<td>Learning network meetings for contracted mental health consultants to coordinate and improve the approach, build linkages and document the consultation model and methods.</td>
<td>Ongoing – monthly meetings</td>
</tr>
</tbody>
</table>

g. Key milestones and anticipated timeline for each milestone.
- Apr-May ’09 RFP and contracting process to identify the community based mental health providers and participating providers
- June-Aug ’09 Program start-up, including recruitment, hiring and training of staff
- August ’09 Program implementation begins by August 2009
4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Mental Health Consultation – services for providers</td>
<td>Individuals: 100 Individuals: 11</td>
<td></td>
</tr>
<tr>
<td>Mental Health Consultation – services for youth</td>
<td>Individuals: 1,000 Individuals: 200 Families: 100</td>
<td>11</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 1,100 Individuals: 200 Families: 100</td>
<td>11</td>
</tr>
</tbody>
</table>

5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The Mental Health Consultation Project is designed to increase the capacity of many youth service providers to meet the minor mental health needs of their participants, identify more serious needs, and to link their youth to appropriate mental, behavioral and physical health services. County services are coordinated through the Behavioral Health Access Center (BHAC). In instances when young people or their family members demonstrate a need for further assessment or extended treatment, the mental health consultant or program staff can refer them directly to BHAC, or other community-based mental or physical health providers. Youth can also be referred to the County’s Comprehensive Child Crisis Services, a 24/7 multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress. The young person can arrange to come to the clinic or a crisis team can travel to the home or program/center to evaluate the problem. Further, youth can also be referred to the Wellness Center, or other school-based community behavioral health services, at their high school or middle school.
The mental health consultants will be well-versed in the mental health resources available, both via the County and community providers. Similar to the Early Childhood Mental Health Consultation Project, each of the agencies providing the mental health consultation services will be community based mental health agencies that offer varying degrees of mental health and other services.

b. **Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.**

As mentioned above, this project is designed to create exactly such linkages. The mental health consultants provide very limited short-term intervention services. The majority of their work is to build the capacity of program staff, and families, to identify and respond to the behavioral health needs of their young people. This involves training, modeling and coaching, and also a significant amount of linking and referral to a range of services. Specific county and city services that are already identified as referral sources for this project include:

- Comprehensive child crisis services (described above)
- CBHS Violence Response Team
- School-Based Community Behavioral Health Services for general student population and students with Severe Emotional Disorders.
- Special Programs for Youth/SF Youth Guidance Center, which provides a full range of behavioral health services for youth involved in the SF Juvenile Justice System.
- The County provides over $71 million of substance abuse services. Services range from drug and alcohol education, alternative healthy activities and peer educators to early intervention counseling and drop-in and medical detox. Information on available programs and referral processes is available in an online database, searchable by neighborhood, cultural/linguistic capacity, content, etc. The extensive network of CBOs providing substance abuse services accept referrals from all sources, such as other CBOs, self-referrals, family members, and specialty services and programs. The full range of programs and access persons will be available to mental health consultants and participating providers for this PEI project.
- Proposed PEI project - Early Intervention and Recovery for Young People with Early Psychosis
- The Community Youth Center, which provides trauma-focused services to a traditionally underserved population: Asian/Pacific Islander LGBTQQ youth.

In addition to the many County services available for referral, the mental health consultants are part of multi-service community based agencies that provide other social and basic need services directly. The following is a sampling of agencies that provide mental health consultants under the Department of Children Youth and their Families’ (DCYF) pilot programs for mental health consultation in after-school programs and with the Crisis Response Network:
PEI PROJECT SUMMARY

- Instituto Familiar de la Raza – behavioral health care, e.g. trauma, persistent mental illness, family conflict, immigration and reunification issues, mentoring, case management, parenting education and support groups, violence prevention, and HIV/AIDS education and prevention.
- Edgewood Center – family and kinship support, residential and in-home wrap-around services, community nursing, family resource centers, mental health services, and child abuse prevention.
- Richmond Area Multi-Services, Inc – Mental health services, family support services, life skills, in-home wrap-around services for severely mentally ill, and vocational training.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The proposed Mental Health Consultation Project builds upon the demonstrated success of the ECMHC model and on the promising local project to provide mental health consultation to after-school programs and the Community Response Network. The project design and budget were developed with those models in mind, and, based on their success, include sufficient resources to be successful. Similar to the DCYF-funded project, this Mental Health Consultation Project allows for variation in the intensity of the consultation, based on the approach of the mental health agency and the specific needs of the participating providers. As part of the RFP, applicants will justify the level of intensity they feel best matches their capacity and the needs of their partners. Applicants will need to show they have the resources and infrastructure to supervise their consultants and provide linkages to necessary services; and that the providers working with youth have the infrastructure, programming and cultural competence to engage at-risk young people. Consultation can involve services along a continuum of intensity, such as:
- group training for staff on understanding and responding to mental health issues
- series of targeted workshops that build knowledge and skills
- peer-based learning circles
- on-site technical assistance, observation, coaching, etc.
- technical assistance with actual consultant placed on-site for 1 day/week
- short-term direct services with youth and families

However we have set a threshold for the minimum resources needed to ensure that the project can achieve the desired outcomes based on the existing efforts in the County and similar efforts nationally. Specifically, the minimum per site amount will be $10,000 for a menu of the less intensive services, e.g. group training, workshops, and on-site technical assistance as needed.
6. Collaboration and System Enhancements
   a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project

   This project will be operated under contract with CBHS by agencies chosen through a competitive RFP process. As described under the Project Description and Linkages sections, the proposed project will be delivered entirely by community-based mental health organizations, onsite at youth serving programs and in other community settings.

   PEI funds will also foster collaboration of community mental health agencies and of DPH/CBHS and DCYF. Currently, one of the CBOs funded by DCYF to provide mental health consultation to after-school programs acts as a convener of all of the providers involved in the initiative. They meet monthly in a peer Learning Circle to discuss their approaches, share best practices, develop citywide trainings, troubleshoot and build overall capacity. DCYF also convenes a quarterly meeting of after-school stakeholders to share information and report on progress. This proposed PEI project includes additional funding to support this model of collaboration, ensuring that all of the mental health consultants - those involved in the DCYF initiative and those funded through PEI – will coordinate and improve their approaches, build linkages and document the consultation model and methods so that it can be expanded in the future.

   The other partners will be the providers working with youth who are at-risk for or already involved with the juvenile justice system. Agencies who respond to the RFP will have the option of identifying their community based youth service partners, and supplying data to support that these groups are already working with the target population of youth.

   b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

   Again, this project is designed to build upon and expand the impact of the local community-based youth services and mental health system. It includes formal contracts with community-based mental health agencies and youth serving community based organizations to ensure that the needs of this high-risk group of young people are identified and addressed either by the program staff, through short-term intervention by the consultant, and/or with referrals for timely and appropriate mental and behavioral health services.

   c. Describe how resources will be leveraged.

   The budget does not reflect leveraged resources at this point. The project builds upon an existing infrastructure in the County providing mental health consultation in non-traditional settings – namely the ECMHC initiative, DCYF’s mental health consultation in after-school programs pilot, and DCYF’s inclusion of mental health consultation in their case management standards for Community Response Network lead agencies. The specific monetary amount this project will leverage depends on the sites selected to be served. Providing
consultation to an after-school program, Beacon or other youth serving organization would leverage between $100,000 and $200,000 per site in funding from DCYF, SF Parks & Recreation, SFUSD, California Department of Education, and the SF Public Library in direct services to youth, e.g. outreach, prevention and asset building activities, family support, and service linkage and/or case management. In addition, the project leverages considerable other resources such as:

- awareness of and interest in mental health consultation services among child and youth serving providers;
- an existing pool of trained mental health consultants;
- oversight and coordination, at both the county level and at mental health agencies that provide the consultants; and
- linkages and referral processes for follow-up services for at-risk young people and their families.

In addition, the project will also leverage considerable treatment resources, since increased awareness and service linkages will lead to increased behavioral and physical health and basic needs services provided by the County and community agencies.

d. Describe how the programs in this PEI project will be sustained.

We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

Individual Outcomes

- Youth who are either at-risk or already involved with the juvenile justice system will successfully participate in community-based activities
- Youth will improve social and behavioral functioning and reduce their rates of incarceration
- Staff in organizations receiving consultation services will learn skills and improve self-efficacy related to working with youth involved with the juvenile justice system

Program Outcomes

- Mental health professionals 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 and their families
8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:
• Referral to CSS programs: when a young person is identified as needing more intensive and long-term intervention, the project staff will work with the BHAC to refer the consumer to appropriate services and/or placement.
• At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be adapted into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project.
• The PEI Coordinator will be part of bi-weekly MHSA team meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.
• This and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
## County: San Francisco  
**PEI Project Name:** Depression Screening and Response  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs

**Select as many as apply to this PEI project:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Suicide Risk</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population(s)

*Note: All PEI projects must address underserved racial/ethnic and cultural populations.*

**A. Select as many as apply to this PEI project:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
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<td></td>
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<tr>
<td>3. Children and Youth in Stressed Families</td>
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<td></td>
<td></td>
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<tr>
<td>4. Children and Youth at Risk for School Failure</td>
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<td></td>
<td></td>
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<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Underserved Cultural Populations</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach,
which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations14.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the Depression Screening and Response pilot project came from the following sources:

- Medi-cal Eligibles, CY2006
- DPH Population Health and Prevention Management Information Systems
- City and County of San Francisco Five Year Consolidated Plan 2005-2009
- Community Services and Supports Plan

After examining the data, PEI stakeholders (Planning Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for seniors:

**Risk Factors**
- Isolation (loss of family and friends, cultural, physical impairment)
- Lack of knowledge of mental health issues by family and providers
- Access lethal methods
- Depression
- Stigma of mental health prevents access until it is too late
- Grief and loss
- Multiple Medication side effects
- Impaired communication skills in the elderly

**Protective Factors**
- Increased screening and treatment options
- Connectedness
- Education to providers and community
- Reduced access to methods

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14 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects.
The stakeholders examined data about the senior population that further highlighted the need for a depression screening and response program. Most notably, findings included:

- The 2000 Census reported that 22% of San Francisco’s population was 55 years or older. The 2006 Census CPS puts the number of seniors, over the age of 60, at almost 150,000.
- Between 2002-2004, 21% of older adults (65 years of age and older) in San Francisco committed suicide. Suicide rates among older adults are highest for white men, followed closely by Chinese women.
- Over 40% of the population is low income (at or below 200% of the federal poverty level) in four neighborhoods: Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% is low income in the Mission and North Beach. 30% of the county’s seniors (age 60 and over) live in poverty.
- In 2004, there were 1,500 elderly persons at-risk of becoming homeless and in need of supportive housing who were not being served as such.

Building on these conversations, a number of workgroups identified desired outcomes that would be addressed in some part by the implementation of a Depression Screening and Response project. The summary of desired outcomes from all workgroups is attached.

We synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, we selected the key community needs, priority population, and age group that this PEI project addresses:

- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination
- Individuals At Risk for Suicide Risk

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Planning Committee selected the Depression Screening and Response project based on research and promising practices identified in large part by Lisa Golden, MD at Ocean Park Health Center and Patricia Arcán, Professor at Langley Porter Psychiatric Institute, USCF. The planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. In workgroups, stakeholders reviewed research and shared their expertise to identify programs and
practices that would work with the diverse SF community, and that would achieve the desired outcomes, increasing identified protective factors and mitigating risk factors. Workgroups were given criteria in evaluating local, promising practices. Based on this criteria and as a result of the planning activities described above, the Suicide Risk workgroup identified this PEI project, which was then chosen by the full Planning Committee vote.

Initially the scope was larger and included college students and LGBTQ youth as additional target populations. However, the Committee selected two separate PEI projects that address the need for mental health services on college campuses (Supported Education) and for LGBTQ youth (Transition Aged Youth Multi-Service Center). Due to that, plus budgetary constraints and high level of need among older adults, the Depression Screening and Response project was narrowed to target seniors. The project will address many of the risk factors faces by our older adults, often facing the stressors and challenges of their lives in isolation, with chronic illness, and with poor or stigmatized access to mental health services and information.

b. Description of proposed PEI Intervention
The proposed Depression Screening and Response program combines the expertise and experience of a health care center with mental health professionals to reach, screen and serve older adults. It employs a collaborative care model that has been widely researched, evaluated and integrated into health care settings. At the heart of the collaborative care model is a Care Manager, who works with the patient and their primary care physician to develop, implement and monitor a care plan. The care plan goal is to reduce symptoms by half within 2-3 months, and is adjusted accordingly, e.g. “stepped care.” The plan can include various levels and types of medication, brief, evidence-based counseling, and more intensive treatments if needed.

The project will be implemented at three primary health clinics that serve high numbers of adults aged 55 years and older. Together the clinics will choose between the four nationally recognized coordinated care models, based on their expertise and patient needs. All of the models include the following core components:

1. **Training** – Training is an important component of the project. The Care Managers will be trained in depression in health care, the components of the model, treatment options (overview and in-depth options), and using psychiatric consult. Physicians, consulting psychiatrists and the administrative staff will participate in short overview training as well.

2. **Screening** – Screen older adults using evidence-based tool(s), i.e. PHQ2 and PHQ9. Both are easy to use and well suited to a health care setting because they can be administered during a typical 15 minute primary care visit. The PHQ9 is longer and used when the PHQ2 is positive. They are available in multiple languages and scored such that it is possible to track rates of improvement. The

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15 The four collaborative care models that inform this project are Impact, Prospect, PRISM-E and TCE-supported model.
screening tools will be administered by medical assistants and/or health workers, as well as being explained and self-administered by consumers who are literate.

3. **Care Manager** – This project creates a half-time Care Manager position at each of the participating health centers to work directly with seniors who screen positive for depression. The Care Manager will work with the consumer to educate them about depression and to develop a care plan, in consultation with their health care provider. The Care Manager offers two preliminary courses of action, antidepressant medication or short-term evidence-based therapy, e.g. Problem-Solving Treatment. They also coach the consumer in behavioral activation and events scheduling. They check in with the senior at least once a month to administer the PHQ9 and otherwise monitor their progress. The Care Manager will work closely with their health centers staff to provide quick, appropriate services for consumers, as well as linking with other providers as needed. Ideally, they should be a master’s level social worker with the linguistic and cultural competence to work with the specific clinic population.

4. **Follow-up/Stepped Care** – On average, one-third of seniors served through this type of coordinated care model improve dramatically within the first 6-8 weeks. At that point, they will continue to receive periodic phone check-ins from the Care Manager and PHQ9 screenings when they come into the health centers, but otherwise exit the program. Another third typically show some improvement but will require a next step of care, such as adding medication or short-term counseling, increasing or changing medication. At that point, the Care Manager will consult not only with the physician but with a partnering psychiatrist who can consult on prescriptions, medication management and possibly more intensive evaluation. The final third tend to need specialty mental health care. The Care Manager will link these consumers to mental health assessment and services. Each of the health centers participating in this PEI project will partner with a local mental health clinic that will provide the consulting psychiatrist and be the first line of referral for more intensive mental health services, as appropriate.

The project will be implemented at three health centers. As the project will be implemented for approximately nine months in year one, the centers will screen an estimated 2,500 seniors, of whom we expect 500 to receive support from a Care Manager and/or other follow up services.

c. **Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.**

The main implementation partners for this project will be three health centers. Primary care, community clinics and senior centers are a critical part of San Francisco's health care delivery system. They are community-based to increase access for people who are at greatest risk for poor health outcomes, due to such things as poverty, isolation, or homelessness. These types of health centers will implement the pilot in partnership with a local mental health clinic, which will provide a consulting psychiatric and direct services for seniors.
The centers will work closely with CBHS to improve integration of services for this vulnerable population. When a senior is identified as needing more intensive and long-term intervention, the project staff will work with the partner mental health clinic and the BHAC to refer the consumer to appropriate services and/or placement. The Care Manager will facilitate and follow-up on referrals for treatment to ensure a smooth handoff.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The target population for this project is older adults, aged 55 and up who are at-risk for suicide or worsening mental health. This older adult population has high incidence of depression, chronic illness and suicide risk. Older adults were explicitly identified as an underserved population during the CSS planning process. The proposed PEI project targets adults 55 years or older. The demographic breakdown will depend on the centers selected to participate in the project.

e. Highlights of new or expanded programs.

This project will greatly increase the capacity of community-based health centers to screen and serve older adults struggling with depression and other behavioral health issues. It expands an ongoing effort to integrate health and mental health services, ensuring the most appropriate and timely interventions. It builds upon evidence-based practices for serving seniors in a primary care setting that has been successfully implemented in surrounding counties and nationally.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

This PEI project will require the following start-up activities

- Issue RFP and select three health care centers, along with their partnering mental health clinics
- Establish MOUs and contracts as appropriate
- Establish partnership protocols, including collaborative meeting schedule and agreements and documentation/evaluation protocols
- Recruit, hire, and orient staff

The project will include the following key activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train health care center staff</td>
<td>Details TBD depending on model chosen</td>
</tr>
<tr>
<td>Screen older adults using evidence-based tool</td>
<td>Ongoing – 250-300 consumers/month</td>
</tr>
</tbody>
</table>
PEI PROJECT SUMMARY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop care plans with seniors who screen positive for depression</td>
<td>Ongoing – 50-60 consumers/mo</td>
</tr>
<tr>
<td>Medication support</td>
<td>Ongoing – approximately half of consumers with care plans</td>
</tr>
<tr>
<td>Short-term counseling</td>
<td>Ongoing – approximately half of consumers with care plans</td>
</tr>
<tr>
<td>Stepped care – make adjustments to care plan in consultation with</td>
<td>Ongoing – approximately 15-20 consumers/mo</td>
</tr>
<tr>
<td>consumer, physician and/or psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Link consumers with more specialty mental health care</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

4. Key milestones and anticipated timeline for each milestone.

- May-June ’09  RFP and contracting process
- June-July ’09  Program start-up, including recruitment and hiring
- Aug-Sept ’09  Staff training
- Oct ’09  Screening, care counselors and psychiatrist roles begin by Oct 2009

4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Depression Screening and Response</td>
<td>Individuals: 2,500</td>
<td>Individuals: 500</td>
</tr>
<tr>
<td></td>
<td>Families:</td>
<td>Families:</td>
</tr>
<tr>
<td></td>
<td>12 (direct service – 9 months)</td>
<td></td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDUPlicated COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 2,500</td>
<td>Individuals: 500</td>
</tr>
<tr>
<td></td>
<td>Families:</td>
<td>Families:</td>
</tr>
<tr>
<td></td>
<td>12 (direct service – 9 months)</td>
<td></td>
</tr>
</tbody>
</table>

5. Linkages to County Mental Health and Providers of Other Needed Services
PEI PROJECT SUMMARY

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

This project is a collaboration of health and mental health providers and therefore the linkages to services are core to the design. The project will be implemented at three health care clinics, with Care Managers placed on-site to provide short-term interventions and linkages to both primary care and mental health services, specifically at a local mental health clinic. County mental health services will be further coordinated by the Care Manager through the Behavioral Health Access Center (BHAC).

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

The Care Manager, health center and partner mental health clinic staff have extensive knowledge of services available through their agencies and/or other community-based organizations. The training element of this project will further increase their knowledge and ability to link consumers to a range of services, such as basic needs, substance abuse treatment, and senior center services.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

This project includes sufficient activities and staffing to achieve the desired outcomes. It creates a new position – Care Manager – to provide both direct services and linkages for consumers. It includes dedicated time from psychiatrists along with administrative support to ensure the project is well integrated into the processes and flow of the centers. The staffing structure and level is based on successful models around the Bay Area and the nation.

6. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.

This project will be operated under contract with CBHS by three health centers, who will implement the screening, care planning, direct PEI services and linkages to additional services. They will each work in partnership with a mental health agency that will provide psychiatric consultation and receive referrals for seniors who need specialty mental health care. This will increase both partners’ ability to serve seniors with depression and other mental health issues.
b. **Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.**

As described above, this project is designed to strengthen and build up on our local community-based mental health and health care systems. It is a collaborative project that will be implemented by CBHS, community-based health care providers and community-based mental health providers.

c. **Describe how resources will be leveraged.**

The budget for this project includes leveraged staff time of the health center staff that will administer the screening tools (e.g. health worker, intake workers, etc.). It also includes additional psychiatric time for client consultation/evaluation that can be billed to Medi-cal. In addition to those leveraged resources included in the budget, the project will also leverage considerable treatment resources, as increased screening and service linkage will lead to increased behavioral and physical health services provided by the clinics, County, and community agencies.

d. **Describe how the programs in this PEI project will be sustained.**

We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

### 7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

**Individual Outcomes**
- Older adults are screened for depression using a reliable and valid instrument during their routine primary care visits or at senior centers
- Older adults who screen positive receive coordinated responsive services
- As a result of these services, older adults with depression experience fewer depressive symptoms, improved functioning, and improved quality of life.

**Program Outcomes**
- The project provides training and education to health care staff on depression and treatment options, the screening tools, process for responding, communication systems, and resources
In year one, the project will screen an estimated 2,500 seniors.

System Outcomes
- Increased capacity of San Francisco’s community-based health care centers to screen and serve older adults (55 years of age and older) who have depressive disorders.

As a result of this program, older adults in San Francisco who have depressive disorders will be identified in a timely manner and receive services to improve functioning and prevent the development of more severe and chronic impairment.

8. Coordination with Other MHSA Components
a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:
- Referral to CSS programs: when a senior is identified as needing more intensive and long-term intervention, the project staff will work with and the BHAC to refer the consumer to appropriate services and/or placement.
- At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project.
- The PEI Coordinator will be part of bi-weekly MHSA meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.
- This and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
## County: San Francisco  PEI Project Name: Early Intervention and Recovery for Young People with Early Psychosis
Date: November 4, 2008

### 1. PEI Key Community Mental Health Needs
Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Youth</td>
</tr>
<tr>
<td>Disparities in Access to Mental Health Services</td>
</tr>
<tr>
<td>Psycho-Social Impact of Trauma</td>
</tr>
<tr>
<td>At-Risk Children, Youth and Young Adult Populations</td>
</tr>
<tr>
<td>Stigma and Discrimination</td>
</tr>
<tr>
<td>Suicide Risk</td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population(s)
Note: All PEI projects must address underserved racial/ethnic and cultural populations.

#### A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Youth</td>
</tr>
<tr>
<td>Trauma Exposed Individuals</td>
</tr>
<tr>
<td>Individuals Experiencing Onset of Serious Psychiatric Illness</td>
</tr>
<tr>
<td>Children and Youth in Stressed Families</td>
</tr>
<tr>
<td>Children and Youth at Risk for School Failure</td>
</tr>
<tr>
<td>Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
</tr>
<tr>
<td>Underserved Cultural Populations</td>
</tr>
</tbody>
</table>

#### B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).
Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach, which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2)
identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations.  

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of this project came from the following sources:

- Child, Youth, and Family System of Care (CYF-SOC), a division of the San Francisco Department of Public Health’s Community Behavioral Health Services
- Human Services Agency (January 2007)
- Community Services and Supports Plan

After examining the data, PEI stakeholders (Committee members and public) identified the top risk and protective factors related to each of the key community mental health needs and priority populations. The following list resulted for young people with early psychosis:

**Risk Factors**
- Mental health services disconnected from primary care in medical care settings
- Lack of awareness among mental health clinicians of early signs of serious mental illness
- Lack of timely prevention, early intervention and treatment for early serious mental illness
- Lack of culturally and linguistically competent and sensitive providers
- Lack of supports for families with seriously mentally ill member (e.g. coping strategies, etc.)
- Lack of public awareness of early signs of mental illness, what serious mental illness is, and what treatments work
- Stigma and discrimination

**Protective Factors**
- Improved access and engagement
- Increased awareness and understanding of early signs
- Informed community that understands and responds to early signs with respect and the ability to help youth access needed and appropriate resources.
- Family engagement and supports

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16 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects
The stakeholders examined data about the at-risk youth population that further highlighted the need for a comprehensive, coordinated and responsive early intervention and recovery strategy for young people with early psychosis. Relevant findings include:

- Nationally, 2.4 million American adults or about 1.1% of the population aged 18 and older in a given year have schizophrenia.
- 7% of the children and youth served by the Child, Youth, and Family System of Care (CYF-SOC), a division of the SF Department of Public Health’s Community Behavioral Health Services, had a serious mental illness, which accounted for over 21% of the total cost of services.
- Schizophrenia can be a debilitating disease that typically begins between the ages of 15 and 25.
- Intervention during the early stages of psychosis improves outcomes (Cannon et al. 2008); however, treatment is often not accessed until a number of years later.
- Young people who remain untreated or inadequately treated, likely show up in the adult system with more severe and persistent symptoms and greater functional impairments. In 2007, 32% (6,544) of the nearly 21,000 adults over 18 who received Community Behavioral Health Services, had a diagnosis of schizophrenia or another psychotic disorder.
- Of the 6,377 homeless individuals identified and surveyed by the SF Human Service Agency, nearly half (2,550) reported that a serious mental or addictive illness was the primary reason for their homelessness.

Building on these conversations, the early onset workgroup identified desired outcomes that would be addressed by the implementation of the Early Intervention and Recovery Project. They were:

1. Reduced rate of onset of serious psychiatric illness - decreased symptoms, increased functioning and improved quality of life.
2. Connection to the System of Care earlier in the course of an illness (e.g. prior to or immediately upon onset) with increased level of trust in the mental health system.
3. Mental health and primary care clinicians are more knowledgeable about early signs of serious psychiatric illness.
4. Fluid process of referral from community organizations (schools, juvenile justice, primary care, etc.) to specialized mental health services for early psychiatric illness.
5. Developmentally and culturally appropriate programs available to at-risk individuals/families across the lifespan.

The Planning Team synthesized and compiled the risk and protective factors and desired outcomes into a summary that was used by the workgroups to develop recommended PEI programs. As a result of this analysis, input and planning, the Planning Committee selected the key community needs, priority populations, and age group that this PEI project addresses:

- Individuals Experiencing Onset of Serious Psychiatric Illness.
PEI PROJECT SUMMARY

- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination
- At-Risk Children, Youth and Young Adult Populations
- Children and Youth At Risk for School Failure
- Children and Youth At Risk for Juvenile Justice Involvement
- Children and Youth In Stressed Families
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Individuals At Risk for Suicide

3. PEI Project Description

a. **Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.**

We selected the Early Intervention and Recovery Project based on research and promising practices. Our planning team and stakeholders analyzed demographic and service data described above to identify the community needs and priority populations addressed by this project. During the community planning process, addressing the needs of San Francisco children and youth who are at risk for developing a serious mental illness emerged as a discreet, key priority. In the *early onset* workgroup, stakeholders reviewed research and shared their expertise to identify programs and practices that would work with our diverse community, and that would achieve the desired outcomes, increasing identified protective factors and mitigating risk factors. While research shows that intervention during the early stages of psychosis improves outcomes (Cannon et al. 2008), treatment is often not accessed until a number of years later. In fact, roughly half of all lifetime mental disorders have been shown to start by the mid-teens and three-fourths by the mid-20s (Kessler et al, 2007). Severe disorders, like Schizophrenia are typically preceded by earlier behavioral, social and emotional signs and symptoms that seldom receive clinical attention. Missing this critical window for early intervention can lead to greater suffering, trauma and functional deterioration. The proposed model is based on established programs in Australia, the U.K., Maine, and other sites. It offers comprehensive identification and treatment for young people (and their families) who have recently experienced their first psychotic break or are diagnosed as being at high-risk for psychosis.

Based on the criteria given to workgroups for evaluating local, promising practices and as a result of all the planning activities described above, the *Early Onset* workgroup identified this PEI project as their sole recommendation, which was then chosen by the full Planning Committee vote. The proposed Early Psychosis Identification and Intervention project is an innovative solution to getting San Francisco’s high-risk youth and their families the immediate and comprehensive help they need to intervene as early as possible to mitigate the
PEI PROJECT SUMMARY

debilitating course of schizophrenia and psychosis. The main objective is to foster more resilient pathways for San Francisco’s children, youth and their families who are at the highest risk.

This PEI project will address risk factors faced by young people with serious early psychosis by engaging them early and with an intensive array of services. It will build our system’s capacity to identify and intervene early and effectively with this vulnerable population, their families, caregivers and friends. This early identification and engagement will promote youth self-sufficiency, enhance their quality of life, and prevent much more damaging social and economic costs down the road, such as school failure, hospitalization, incarceration, or homelessness.

b. Description of proposed PEI Intervention
The proposed 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 utilizes an integrated team approach in which all elements of the intervention are brought to the service of the client and family in a coordinated fashion. A comprehensive initial diagnostic assessment and ongoing assessment, 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. Details of the model follow:

1. Outreach & Education – Outreach and Education will strengthen the capacity of existing community programs and services to create awareness, reduce stigma and recognize early signs of serious mental health problems. Outreach includes educational talks given to community clinicians, family resource center staff, faith-based organizations, school counselors, juvenile probation, transitional housing staff, and primary care clinicians to educate them about early signs of serious mental illness, evidence-based practices for early diagnosis, instructions for making referrals and obtaining consultations. It can include public advertising to reduce stigma and presentations in health classes given directly in high schools, colleges, at juvenile hall, etc. Whenever possible, primary consumers and family members are employed to conduct culturally competent outreach and will join forces with existing outreach and advocacy efforts (e.g., Mental Health Association). The other PEI projects that work with this age group – specifically the Supported Services for Incarcerated or Reentering Youth, Mental Health Consultation for Providers and the Supported Higher Education projects – will be sources of outreach and directly linked with this project. A clinician who is also part of the early psychosis team (see below) would staff a dedicated phone line. The clinician responds to inquiries from young people, concerned friends, family members, clinicians, primary care providers, teachers, clergy, and other community members as appropriate.

2. Intake & Assessment – A clinician will be available to meet clients wherever they are (e.g., home, school, primary care office, jail, etc.) in order to conduct an initial screening evaluation. Collateral informants, such as a family member, friend, partner or advocate are
PEI PROJECT SUMMARY

encouraged to attend as often as possible. These evaluations can take 1-3 hours, depending on the consumer’s level of functioning. Consumers who meet intake criteria are then invited to receive treatment and are assigned a case manager. Those who do not meet intake criteria are referred to appropriate treatment and assisted to obtain that treatment. A full diagnostic assessment is completed after a client enrolls in the program. Many of these young people may have cognitive deficits as part of their illness and need neuropsychological assessment as well. Assessment results are shared with the clinical team for treatment planning purposes.

3. Early Intervention – This model requires a comprehensive, integrated treatment approach where specific components are offered based on an individual client’s needs. This person-centered care model relies on an interdisciplinary team that meets weekly to keep all staff members updated on client progress. The intervention package may includes the following interventions:

- Crisis intervention and stabilization.
- Environmental accommodations to reduce stress at home, school, or work.
- Individual or multi-family group psycho-education and support to help reduce blame, guilt, and a sense of helplessness.
- Therapy for the individual to teach coping skills (e.g., CBT for psychosis), promote adjustment to the illness, and support protective measures.
- Substance abuse counseling and support.
- Collaboration with school personnel or employers to develop strategies for a successful return to those environments.
- A low-dose medication regime to control the most troubling symptoms so the individual can think more clearly and cope with daily life. This regimen is developed with a psychiatrist.
- Psychological testing to better clarify diagnosis and specific functioning.

4. Training – This PEI project includes extensive training for all levels of staff, especially:

- All clinicians complete at least a 10-week training course on the basics of early psychosis, complemented by weekly case consultation meetings with the interdisciplinary team. Training can also be developed – building from other reputable expert clinicians in these areas.
- Intake clinicians receive formal training on the Structured Interview for Prodromal Symptoms (SIPS; Miller et al. 1999), which is the primary diagnostic measure used in the US, or the Comprehensive Assessment for At-Risk Mental States (CAARMS; Yung et al, 2003) and have extensive experience ascertaining DSM-IV diagnoses and dealing with crisis.
- Therapists complete training on and receive ongoing consultation for Multi-Family Groups
- Individual therapists should be experienced in working with young people, families and serious mental illness and substance abuse.
- Licensed psychologists or psychology trainees, who are available to provide diagnostic and neuropsychological assessment, receive supervision from a licensed psychologist.
The proposed project will fund two clinical teams, along with a subcontracted outreach and education team, trainers and early intervention service providers, reaching an estimated 1,200 individuals with outreach and education, of which 100 will receive assessment and early intervention services and an additional 200 referrals.

c. **Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.**

The two clinical teams will be located at Comprehensive Child Crisis Services. Child Crisis provides a 24-hour, multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress related to family violence, physical or emotional illness, school truancy, behavioral problems and other crises. Youth and families can access the clinic by public transportation or staff may travel to the home, school or other San Francisco location to evaluate the problem. Other implementation partners will include schools (and health and wellness centers), including high schools, vocational schools and colleges, faith-based organizations, child welfare, police and probation, transitional housing and shelters, primary and community-based behavioral health providers.

Extensive outreach activities will be 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, shopping centers, etc.).

d. **Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.**

This project targets transitional age youth with early psychosis who are at-risk for or in process of experiencing their first psychotic break. Outreach and education efforts will be extensive and occur throughout San Francisco. Given the evidence of the global consistency in symptoms and prevalence of schizophrenia and other psychotic disorders combined with family and genetic studies that indicate high heritability of these diseases, (NIMH, 1998, 2001), we expect a fairly even distribution of eligible youth across the county. However, additional efforts will be made to engage traditionally underserved population groups who would not typically receive or experience a delay in services due to such factors as limited access, stigma, cultural and linguistic issues, and poverty. Extensive outreach activities will be conducted across San Francisco in settings where youth and their families typically spend time.

e. **Highlights of new or expanded programs.**

Throughout San Francisco, the Outreach and Education Team will increase awareness and reduce the stigma surrounding psychosis and strengthen the capacity of individuals, families and community agencies and organizations to recognize and respond effectively to early signs of psychosis (or another serious mental illness). In addition, the Outreach and Education Team will provide clear, easy and concrete
instructions on how to access this program so that youth and those that care for them can be linked to an evidence-based screening and evaluation service for the early detection of psychosis. Youth who do not exhibit prodromal symptoms but who are identified as having another kind of behavioral health concern will be linked to existing community services by a case manager. The community-based intervention component will include evidence-based practices specifically designed to respond to the specific needs of impacted youth, their families, caregivers or friends to reduce stress, increase awareness, promote adjustment and enhance coping strategies.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
This PEI project will require the following start-up activities

- Solicit proposals and select agencies to implement portions of the outreach and education, training, wraparound and respite services, and neuropsych assessments.
- Establish partnerships using MOUs and contracts as appropriate
- Establish partnership protocols, including collaborative meeting schedule and agreements, referral processes, and documentation/evaluation protocols
- Recruit, hire, and orient staff
- Establish screening and referral procedures
- Design database and data entry protocol

The project will include the following key ongoing activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Outreach and Education</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Screening and Assessment</td>
<td>Ongoing - average 8 youth per week</td>
</tr>
<tr>
<td>Enroll clients and families, or refer and link young person to appropriate services</td>
<td>Ongoing - 100 consumers in year one, plus 200 referred for other services</td>
</tr>
<tr>
<td>Analyze and summarize data for immediate feedback to treatment team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Weekly interdisciplinary meeting</td>
<td>Ongoing – weekly</td>
</tr>
<tr>
<td>Intensive Intervention Phase (6 months -1 year)</td>
<td>100 consumers</td>
</tr>
<tr>
<td>Supervision to insure effective treatment practices</td>
<td>Ongoing – weekly</td>
</tr>
<tr>
<td>Semi-annual evaluation, summaries and reports</td>
<td>Semi-annual</td>
</tr>
</tbody>
</table>

g. Key milestones and anticipated timeline for each milestone.
PEI PROJECT SUMMARY

Apr-May ’09  RFP and contracting process
June-Sept ’09  Program start-up, including recruitment, hiring and training of staff
Aug-Sept ’09  Outreach begins by September 2009
Sept-Oct ’09  Clients enrolled by October 2009
Oct ’09  Treatment underway by October 2009

4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
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<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Early Intervention and Recovery for Young People with Early Psychosis</td>
<td>Individuals: 1200 Families:</td>
<td>Individuals: 100 Families:</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDuplicated COUNT OF INDIVIDUALS TO BE SERVED</td>
<td>Individuals: 1200 Families:</td>
<td>Individuals: 100 Families:</td>
</tr>
</tbody>
</table>

5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The proposed project will be administered by CBHS in close collaboration with other County and community services. The case manager will coordinate County mental health services through the Behavioral Health Access Center (BHAC). In instances when children, youth or their family members demonstrate a need for further assessment (e.g., neuropsychological evaluation) or extended treatment (e.g., substance abuse treatment), the case manager will connect families to community-based therapeutic services or assessment, family support and wraparound services contracted specifically to meet the needs of the consumers.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.
The project teams will serve as a hub to plan and coordinate all needed services for participating consumers. In addition to the intervention services provided at Child Crisis, we have access to an extensive network of formal (e.g., substance abuse treatment, occupational therapy) and informal (e.g., mentoring, tutoring) community-based services. The case manager will be employed full time to identify, build and maintain a network of services to meet the varying needs of children, youth and families. In addition, the case manager will help clients to navigate, access and engage in these services.

c. **Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.**

Locating this new prevention and early intervention service in an already existing and productive clinic guarantees that infrastructure and related resources will be in place (i.e. continuous quality improvement, protection of client rights such as confidentiality, linguistic access and billing mechanisms) to support the achieved outcomes. The PEI funds allocated will enable the creation of a well-staffed team of clinicians, psychiatrist, case manager, and outreach workers that can provide service to the client and family in a coordinated fashion.

### 6. Collaboration and System Enhancements

a. **Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.**

As mentioned above, the Early Intervention and Recovery project will be implemented in partnership with the Comprehensive Child Crisis Services. Child Crisis provides a 24-hour, multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress related to family violence, physical or emotional illness, school truancy, behavioral problems and other crises. Child Crisis will serve as a 24-hour triage and intake point for this program. In addition, Child Crisis is mobile which allows staff to go to children, youth and families wherever they are. Other implementation partners will include schools (and wellness centers), including high schools, vocational schools and colleges, faith-based organizations, child welfare, police and probation, transitional housing and shelters, primary and community-based behavioral health providers.

b. **Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.**

The Early Intervention and Recovery project will offer comprehensive evidence-based prevention and early intervention services to meet the needs of children, youth and their families at serious risk for or experiencing early signs of psychosis. A comprehensive and coordinated approach to early psychosis is the next step in building a Child, Youth and Family System of Care that reduces inequities in access to appropriate and effective prevention and early intervention services for diverse children and families. The Case manager will work...
c. Describe how resources will be leveraged.
In addition to partnering with other child-serving agencies in San Francisco, the proposed project will leverage the existing infrastructure of Child Crisis and the Child Youth and Family System of Care. The budget reflects that the project's clinical teams will be required to bill Medi-Cal for 20% of their services.

d. Describe how the programs in this PEI project will be sustained.
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.

7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

Individual 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 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
System Outcomes
- 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 undertreated psychotic disorders.

As a result of this program, the mental health system will reduce disparities in access to care through early identification, outreach, engagement, and referrals to services for young people with early psychosis.

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.
   This project will coordinate with CSS in the following ways:
   - Referral to CSS programs: when a consumer is identified as needing more intensive and long-term intervention, the project staff will work with and the BHAC to refer the consumer to appropriate services and/or placement.
   - At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project.
   - The PEI Coordinator will be part of bi-weekly MHSA meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.
   - This, and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.  Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.  Not applicable

9. Additional Comments (optional)
### 3. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th></th>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Disparities in Access to Mental Health Services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>Psycho-Social Impact of Trauma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>At-Risk Children, Youth and Young Adult Populations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>Stigma and Discrimination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>Suicide Risk</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
</tbody>
</table>

### 4. PEI Priority Population(s)

Note: All PEI projects must address underserved racial/ethnic and cultural populations.

A. Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th></th>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Trauma Exposed Individuals</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>Children and Youth in Stressed Families</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>Children and Youth at Risk for School Failure</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>6.</td>
<td>Underserved Cultural Populations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>□</td>
</tr>
</tbody>
</table>

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

This project was prioritized and selected as part of the original MHSA Community Services and Supports (CSS) planning process. The process included extensive stakeholder input and data analysis. The process is detailed in the County’s CSS Plan and summarized in the Community Planning Process description at the beginning of this document. The need for prevention and early intervention services was a
reoccurring theme in the CSS planning process, which included a PEI subcommittee. As a result, prevention and early intervention services were prioritized and three programs were included in the CSS plan, with the intention to incorporate them into the PEI plan at a later date if they were successful.

Based on the original PEI allocation for San Francisco, there did not appear to be enough funding for the Trauma Recovery project in addition to the projects being developed by the Planning Committee. Therefore it was not discussed during the Community Planning Process. This project was added when the County’s PEI allocation was augmented, and the County was authorized to transfer appropriate projects from the CSS Plan to the PEI Plan.

The Trauma & Recovery Services project was one of those originally funded through CSS. It addresses the following key community needs and priority populations:

- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- At-Risk Children, Youth and Young Adult Populations
- Children and Youth At Risk for School Failure
- Children and Youth At Risk for Juvenile Justice Involvement
- Children and Youth In Stressed Families
- Individuals At Risk for Suicide
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Trauma and Recovery project was selected during the CSS planning process to address the need for community based, client-driven 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.

b. Description of proposed PEI Intervention

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) Trauma and Recovery Services administered by the Urban Services YMCA.
Program A: 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 upon 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. 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 symptoms of 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, post traumatic stress syndrome, 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 delivery model integrates social learning theory and cultural identity development theory with best practices mental health approaches, e.g. Cognitive Behavioral Therapy, Family Psycho-Education, Parent-Youth Interventions, and Trauma Recovery Counseling. The model includes a multidisciplinary team approach staffed by clinicians, case managers, peer advocates, and street outreach workers. Services include:

- **Outreach** to community members to provide education and information on violence prevention strategies and resources. This includes educational outreach and community building events such as drumming for peace.

- **Psychosocial Assessment** may include a psychosocial, clinical and cultural formulation of the client including history, mental and behavioral status, relevant cultural issues and history, diagnosis, and the use of testing procedures.

- **Crisis debriefing and Grief and Crisis Counseling** to clients, family members and staff who have been affected by street and/or gang violence to support healthy functioning and reduce risk factors including retaliation following an incident of violence. This includes individual short-term crisis counseling, family counseling, youth and parent support groups, therapeutic drumming and healing circles. Interventions are part of a coordinated effort to protect the public in general and the individuals/families targeted with violence.

- **Case Management** means services that assist a client to access needed medical, educational, prevocational, vocational, rehabilitative, or other community services to increase community functioning. The services may include, but are not limited to, communication, advocacy, coordination, and referral, monitoring service delivery to ensure that the client achieves access to needed services and the service delivery system, monitoring the client’s progress, and plan development. This also includes case management support, which is
PEI PROJECT SUMMARY

direct and indirect activity with or on-behalf of an individual or family designed to support the stabilization of individuals/families who have been affected by street and/or gang violence.

**Systems Development and Consultation** are services and activities that build the capacity of the professionals that support individuals, families and communities affected by trauma. This includes training and ongoing consultation for the Mission Community Response Network (CRN) staff, and clinical supervision for IFR staff.

**Program B: YMCA Trauma and Recovery Services.** The goal for this program is to guarantee comprehensive mental health, clinical case management, and outreach services to youth and their families affected by violent events in order to reduce the levels of untreated trauma to San Francisco residents. The trauma and recovery Clinical Case Managers (CCMs) collaborate with the YMCA’s existing network of mental health counselors, case managers, community organizers and family advocates to provide youth and their families with appropriate mental health services. The CCMs maintain dual counselor/case manager relationships with clients to address any ongoing symptoms of post-traumatic stress disorder 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. Specific services include:

- **Outreach** to community members regarding trauma and wellness, available resources and programs.
- **Assessment**, meaning a clinical analysis of the history and current status of a consumer’s mental, emotional, or behavioral disorder, relevant cultural issues and history; diagnosis; and the use of treating procedures.
- **Targeted Case Management** that assists a consumer to access needed behavioral health, medical, educational, vocational, rehabilitative, or other needed service.
- **Short-term Therapy** delivered to an individual, group and/or family.
- **Outreach Services/Consultation Services** to professionals at the YMCA and other community organizations to expand staff knowledge and skills in relation to trauma, i.e. how trauma negatively impacts youth, families and the community and effective interventions for working with traumatized youth, family and communities to ameliorate effects and improve functioning.

The community-based program targets individuals in greatest need of mental health services in facilities that are both welcoming and non-threatening. 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.
c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

This project will be operated under contract with CBHS. It was awarded to IFR and the Urban Services YMCA through a competitive RFP process. For over 10 years, Urban Services YMCA has specialized in delivering school based mental health, trauma and recovery services, mentoring, truancy intervention, and case management to underserved communities. IFR was founded in 1978 as the first Chicano/Latino focused mental health center in San Francisco. Over the past 28 years, the agency has evolved into a multi-service community health and social service agency that serves approximately 4,000 clients and their families each year.

Both agencies will provide services in the community, at their clinics and centers, other centers of community, and in consumers’ homes. Within our targeted neighborhoods, the lead agencies have multiple facilities that provide access points for youth and their families. These include service centers in Bayview-Hunter’s Point (e.g., Beacon Center at Thurgood Marshall High School, Malcolm X Academy, KIPP Bayview, Willie Brown Academy), multiple service sites in the Western Addition (e.g., KIPP SF Bay Academy, Buchanan YMCA, Safe Haven, partner agency at the Ella Hill Hutch Community Center, Beacon Center at John Muir) and locations in the OMI/Excelsior (e.g., Beacon Center, FRC, Safe Haven, Leadership High School), and the IFR clinic, CRN office, schools, and youth centers in the Mission.

Both agencies will work with CBHS, other CBOs, the police and probation departments, and the schools to conduct outreach, receive referrals, and refer consumers for additional services. When a child, youth or their family is identified as needing more intensive and long-term intervention, the project staff will work with their own agencies, existing partner networks, and the County Behavioral Health Access Center (BHAC) to refer the consumer to appropriate services and/or placement.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

These two programs target five communities in San Francisco that are the most impacted by violence: Mission, Bayview-Hunters Point, Visitacion Valley, Western Addition, and the Excelsior. Services will be provided to youth under the age of 18 and their families who reside in these communities – with an emphasis on youth and families affected by street and gang violence.

IFR targets Latino youth and families in the Mission. As described earlier, Latinos are an underserved population that faces multiple stressors and barriers to behavioral health services. Language barriers, unstable housing and homelessness, cultural and racial discrimination, issues related to legal status and the re-emergence of anti-immigrant sentiment create severe and persistent stressors for Latino youth and their families. In addition to the youth and families, IFR provides mental health consultation services to the staff of the Mission CRN, including street outreach workers, care managers and crisis response workers.
The YMCA targets children, youth and families that have been seriously impacted by violence in the Southeast quadrant of SF, i.e. Bayview Hunters Point, Visitacion Valley, Potrero Hill, Excelsior, plus the Western Addition. These districts have high incidents of traumatic events such as homicides, assaults and gang violence. Outreach efforts are be made to offer services to historically underserved communities of African-American, Latino and Asian Pacific Islander descent.

e. **Highlights of new or expanded programs.**

This project is being transferred over from CSS and is already in operation. As such, there are no specific highlights.

f. **Actions to be performed to carry out the PEI project, including frequency or duration of key activities.**

As this PEI project is being transferred over from CSS and is already in operation, it will not require start-up activities. The project will include the following key ongoing activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program A: IFR La Cultura Cura</strong></td>
<td></td>
</tr>
<tr>
<td>Community Outreach to provide education &amp; information</td>
<td>Ongoing</td>
</tr>
<tr>
<td>on violence prevention strategies and resources</td>
<td></td>
</tr>
<tr>
<td>Drumming for Peace</td>
<td>1 community session per quarter</td>
</tr>
<tr>
<td>Community Healing Ceremonies (e.g. Fiesta de Colores;</td>
<td>4 ceremonies per year</td>
</tr>
<tr>
<td>Xilonen, Mayahuel, Dia de los Muertos)</td>
<td></td>
</tr>
<tr>
<td>Youth Therapeutic Drumming Group</td>
<td></td>
</tr>
<tr>
<td>Short-term crisis individual counseling</td>
<td>20 youth; up to 12 sessions each</td>
</tr>
<tr>
<td>Youth Support Group</td>
<td>2 per year; 6 sessions each</td>
</tr>
<tr>
<td>Parent Support Group</td>
<td>2 groups per year; 6 sessions each</td>
</tr>
<tr>
<td>Trauma and grief counseling (families)</td>
<td>3 families per quarter; 6-12 sessions each</td>
</tr>
<tr>
<td>Mental health training &amp; consultation to Mission CRN</td>
<td>3 trainings/year; ongoing biweekly consultation</td>
</tr>
<tr>
<td>staff</td>
<td></td>
</tr>
<tr>
<td>Healing Circle (crisis debrief for outreach staff/volunteers)</td>
<td>Monthly for 10 months</td>
</tr>
<tr>
<td>Supervision of care managers, peer counselor and crisis counselor</td>
<td>Monthly QA reviews and biweekly supervision</td>
</tr>
<tr>
<td><strong>Program B: Urban Services YMCA Trauma and Recovery</strong></td>
<td></td>
</tr>
<tr>
<td>Outreach, Recruitment, Promotion with children, youth</td>
<td>Ongoing</td>
</tr>
<tr>
<td>and families</td>
<td></td>
</tr>
<tr>
<td>Facilitate coordination of services team</td>
<td>Ongoing – weekly meetings</td>
</tr>
</tbody>
</table>
### PEI PROJECT SUMMARY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of the Child and Adolescent Needs and Strengths assessment</td>
<td>Ongoing - Average 10-12 youth per week</td>
</tr>
<tr>
<td>Direct PEI services to youth and families, including, Assessment, short-term individual or family therapy, groups and targeted case management</td>
<td>Ongoing – Average 20 youth/families per week</td>
</tr>
<tr>
<td>Program and Service Innovation &amp; Best Practice Coordination with CBHS</td>
<td>Ongoing - Attend all CBHS sponsored meetings - monthly</td>
</tr>
<tr>
<td>Outreach and consultation to staff of YMCA and other organizations to expand knowledge and skills in relation to trauma, i.e. how trauma impacts youth, families and the community and effective interventions for working to ameliorate effects and improve functioning</td>
<td>Ongoing as needed</td>
</tr>
<tr>
<td>Ensure participant satisfaction with services</td>
<td>Annual satisfaction surveys; ongoing monitoring during various phases of service delivery</td>
</tr>
</tbody>
</table>

### g. Key milestones and anticipated timeline for each milestone.

- Apr ‘09  Contracting process
- May’09  Program fully implemented

### 4. Programs

#### Target service numbers for 2009-10

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: IFR La Cultura Cura Trauma Recovery and Healing Program</td>
<td>Individuals: 1,000 Families: 100</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Individuals: 100 Families: 15</td>
<td></td>
</tr>
<tr>
<td>B: Urban Service YMCA Trauma and Recovery Program</td>
<td>Individuals: 250 Families: 120</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Individuals: 35 Families: 35</td>
<td></td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED <strong>UNDuplicated COUNT OF INDIVIDUALS TO BE SERVED</strong></td>
<td>Individuals: 1,250 Families: 220</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Individuals: 135 Families: 50</td>
<td></td>
</tr>
</tbody>
</table>
5. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

A major component of this project is the creation of linkages to county and community mental and behavioral health services. Both lead agencies operate in partnership with other community mental health providers and CBHS. In instances when young people or their family members demonstrate a need for further assessment or extended treatment, the mental health consultant or program staff can refer them directly to BHAC, or other community-based mental or physical health providers. Youth can also be referred to the County’s Comprehensive Child Crisis Services, a 24/7 multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress. The young person can arrange to come to the clinic or a crisis team can travel to the home or program/center to evaluate the problem. Case managers from the lead agencies will follow-up on referrals to these agencies to ensure successful links have been made and that participants are receiving appropriate services.

The agency staff is well-versed in the mental health resources available, both via the County and community service providers. Each of the agencies is a community-based mental health agency that offers varying degrees of mental health and other core services.

**Program A:** La Cultura Cura receives referrals from the Community Response Network, a collaboration of community based agencies providing street outreach, case management and crisis response services to youth and their families affected by street and gang violence. Youth and families served through the program will have access to Psychiatrist Consultations through IFR’s Outpatient clinic. IFR also has strong links with the Human Services Agency and the San Francisco Family Court system, advocating and serving youth and families interfacing with these systems.

**Program B:** Urban Services YMCA staffs no less than 20 case managers/counselors who are spread throughout the city and tied to centralized community locations including FRCs, Beacon Centers and Safe Havens. With this significant wellness and crisis and emergency services infrastructure already in place, they will be able to provide a seamless coordination of services and offer a comprehensive and holistic continuum of care for families. Urban Services will also utilize their integration partnerships with Balboa Teen Health Clinic and Bayview Child Health Center to provide appropriate behavioral health and substance abuse services.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.
As mentioned above, this project is designed to capitalize on exactly such linkages by supporting multi-faceted community based organizations to provide appropriate prevention and early intervention activities in collaboration with high-need communities. The project staff provide limited short-term intervention services, including crisis intervention and debriefing, short-term individual, group and/or family therapy, assessment and case planning. Another major component of their work is to make and follow-up on referrals and linkages for a wide range of mental and behavioral health services, violence prevention, and basic needs.

**Program A:** Youth and their families served through La Cultura Cura will have full access to other IFR programs including mentoring services, family development services, arts and cultural activities, school-based mental health services and the agency’s spiritual and cultural activities, in addition to a full array of mental health and harm reduction services provided through the child/outpatient clinic. Outside of their own resources, IFR has collaborative agreements with adolescent and adult programs citywide to link clients to the services they need. IFR has formal agreements with Latino Family Alcohol Counseling Center, Horizons’ substance abuse program, Walden House, Friendship House Residential Program, Latino Commission, the IRIS Center, and Casa de las Madres.

**Program B:** The CCMs have access to Urban Services programs as well as other community programs to provide the most comprehensive plan of care for each client. They link clients to other needed services either within the YMCA’s existing pool of resources or to partner CBOs in safe neighborhood locations. Urban Services YMCA provides comprehensive wraparound services including mentoring, truancy intervention, counseling services, gang intervention, citywide juvenile obesity prevention programming, afterschool academic and enrichment programs, parent education classes, family advocacy, emergency food distribution. In addition to their agency resource, the YMCA provides wraparound services through appropriate referral of clients to additional community based support services such as substance abuse treatment and prevention, food pantries, primary care, and health and fitness resources, whenever possible delivering services in the heart of the communities served. Specifically, they utilize well recognized, existing community service centers including three Neighborhood Beacon Centers (e.g., Bayview-Hunter's Point, OMI/Excelsior and Western Addition), two Family Resource Centers (e.g., OMI and soon to be opened Western Addition FRC) and two community Safe Havens (e.g., OMI and Western Addition). The SafeStart Initiative at the OMI FRC serves youth impacted by violent crime, including domestic, sexual and community violence.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

These programs are currently operational and have made good progress towards reaching their performance and outcome objectives.
6. Collaboration and System Enhancements
   a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project
   This project will be operated under contract with CBHS by the two agencies – IRF and Urban Services YMCA – that were chosen through a competitive RFP process. As described under the Project Description and Linkages sections, the proposed project will be delivered entirely by community-based mental health organizations. Both agencies are part of extensive networks of CBOs, schools, city and county that they will utilize to provide comprehensive support to the children, youth and families served by this project. These partners will refer consumers to the project, accept referrals for more intensive mental health or other needed services, and provide space for services (e.g. schools, CRN). CBHS will provide oversight for the project.

   b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.
   Again, this project is designed to build upon and expand the impact of the local community-based mental health system. It is implemented two community-based multi-service agencies, building their capacity to serve children, youth and families impacted by violence and trauma. Both agencies conduct this work in a bigger context of building the community’s capacity to address trauma. IRF is part of the Community Response Network; and the Urban Services YMCA has as part of their strategic plan the goal to “partner with organizations to expand community services and provide resources to strengthen other CBOs.” In offering trauma and recovery services, this project will strengthen the current mental health and primary care system by providing improved access to services as well as increased services to underserved populations. This project offers additional support to community clinics and health centers in that it can potentially serve as a “first-stop” for clients and assist clinics with assessment and treatment planning. In other words, clients who may not otherwise access community clinics may be referred to the programs at one of the school or community service locations, assessed for appropriate services and provided with education and referrals to community clinics and health centers which may better serve individual needs.

   c. Describe how resources will be leveraged.
   The project budget does not reflect leveraged resources. However, both agencies are leveraging considerable resources to provide infrastructure, supervision and staff development, additional outreach, and services to participants who require a more intensive plan of care. They leverage funding from the Department of Children Youth and their Families, Human Service Agency, along with Medi-Cal, private insurance and EPSDT billing.

   d. Describe how the programs in this PEI project will be sustained.
   We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes.
7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

**Individual Outcomes**

**Program A: IFR La Cultura Cura.**
- Increased knowledge about the impact of violence on the individual, family and community.
- Promote individual and family empowerment through group intervention that supports resiliencies, healthy communication skills, relationship building and problem solving skills as well as effective strategies to avoid victimization and re-victimization in the streets.
- Awareness and sensitivity to the symptoms and behaviors (anxiety, flashbacks, avoidance, isolation) associated with Post Traumatic Stress Disorder.
- Increased coping skills (emotional regulation, use of acceptance and tolerance strategies, healthy practices and help seeking behavior) among youth and parents.
- Decrease in stigma and isolation among families affected by street violence and/or whose children were affiliated with negative street activities.

**Program B: Urban Services YMCA.**
- Significantly reduce untreated trauma and the negative impact it poses on the social, emotional, mental and physical health and day-to-day functioning of impacted youth and families.
- Clients who have been served for two months or more will have met or partially met their treatment goals and improved functioning by at least 50% in at least one area at discharge.
- Clients will be satisfied with services received as evidenced by Consumer Satisfaction Surveys and continuous evaluation of program.

**System and Program Outcomes**

**Program A: IFR La Cultura Cura.**
- Foster cultural competency in delivery of services to targeted youth and their families in the Mission District.
- Improved coordination of crisis response, street outreach, case management and mental health services in the Mission District
- Promotes and ensures that programs providing case management and mental health in the MCRN network operate under common guidelines and effective interventions.
- Utilize traditional, conventional and contemporary practices to reach Latino community to promote critical thinking, communication skills and reducing risks for victimization and re-victimization.
Program B: Urban Services YMCA.
- Increase provision of prevention and ancillary services to underserved communities within the targeted service areas.
- Offer comprehensive, culturally competent, co-occurring capable and effective clinical and case management services to 25 youth and families affected by violence and trauma.
- Engage in continuous quality improvement measures and self-evaluation.

8. Coordination with Other MHSA Components
   a. Describe coordination with CSS, if applicable.
      This project will coordinate with CSS in the following ways:
      - Referral to CSS programs: when an individual or family is identified as needing more intensive and long-term intervention, the project staff will work with BHAC to refer them to appropriate services and/or placement.
      - At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be adapted into a referral protocol for each of the PEI projects, taking into consideration the CSS, and other county and community mental health services that are available and appropriate for that particular project.
      - The PEI Coordinator will be part of bi-weekly MHSA meetings, where s/he can discuss and troubleshoot coordination of this and other PEI project.
      - This, and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

   b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

   c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
County: San Francisco  
PEI Project Name: Community Behavioral Health Services Crisis Response Team  
Date: November 4, 2008

### 5. PEI Key Community Mental Health Needs

Select as many as apply to this PEI project:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>☐</td>
<td>☐</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
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<td>☐</td>
<td>☐</td>
<td>✔</td>
<td>☐</td>
</tr>
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<td>✔</td>
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<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>

### 6. PEI Priority Population (s)

**Note:** All PEI projects must address underserved racial/ethnic and cultural populations.

**A.** Select as many as apply to this PEI project:

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<tr>
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<td>✔</td>
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<td>☐</td>
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<td>✔</td>
<td>☐</td>
</tr>
</tbody>
</table>

**B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).**

Through a broad network of civil service and community-based programs, San Francisco has an established history of providing comprehensive behavioral health services for individuals exposed to trauma. The Crisis Response Team (CRT) was developed as part of...
the County’s commitment to provide immediate assistance and support to families and communities affected by gun violence, to reduce to long-term impact of complex trauma exposure, and to interrupt the cycle of violence in San Francisco. Due to the pressing need for services to address the needs of children, youth, adults and families impacted by violence – a need that was highlighted during the MHSA Community Services and Support Planning Process – the CRT was originally launched with General Funds in 2006. As PEI funds had not yet been released, the 2007-08 MHSA budget included a significant expansion of the CRT project. Citywide budget reduction measures delayed the planned expansion to 2008-09, which has allowed the CRT project to be included as part of the proposed PEI Plan.

Based on the original PEI allocation for San Francisco, there did not appear to be enough funding for the CRT project in addition to the projects being developed by the Planning Committee. Therefore it was not discussed during the Community Planning Process. The project was added when the County’s PEI allocation was augmented, and the County was authorized to transfer appropriate projects from the CSS Plan to the PEI Plan.

The Crisis Response Team Project addresses the following key community needs and priority populations:

- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- At-Risk Children, Youth and Young Adult Populations (in families)
- Children and Youth in Stressed Families
- Individuals At Risk for Suicide Risk
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The CSS planning process, along with other city and community planning processes, identified the impact of violence and trauma as a major priority for all public and non-profit organizations to address. Since 2004, Community Behavioral Health Services (CBHS) has implemented a number of new programs designed to specifically address this priority of responding to and breaking the cycle of violence. In partnership with many of these stakeholder agencies and organizations, the Crisis Response Team addresses the needs of families and communities impacted by violence by providing immediate crisis intervention, short-term stabilization and case management, and follow up services.
b. Description of proposed PEI Intervention
The CBHS Crisis Response Team (CRT) provides caring and culturally competent assistance to families and loved ones of victims of gun violence and homicides. The Crisis Response Team 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. The CRT responds to calls from the San Francisco Police Department and/or General Hospital and arrives at the scene of a violent incident within 30 minutes of the call. The CRT operates in teams of two – one licensed psychiatric social worker and an unlicensed or volunteer staff. At times, the CRT is present at the hospital where the victim and the victim’s family have been taken by the emergency medical services. After the initial response to an incident, the team follows up with families and victims within 24 hours with case management services, and crisis and short-term mental health services such as PTSD groups and individual therapy, as appropriate. 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 federally 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 services around the needs of the family. The CRT also participates in a variety of community healing events to support positive efforts leading to a healthier community.

The CRT works closely with the Community Response Network, a group of neighborhood-based providers that coordinate services and resources to addresses gang violence, to enable seamless access to services by families of victims of violence. 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 request 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.

The CRT meets weekly to discuss the incidents that team members have responded to, review outstanding cases, especially those that are still open 30, 60, and 90 days after the incidents, and provide a determination of these open cases.

Given the very demanding work and the emotional strain experienced by the CRT staff, there is a need to protect and take care of staff to prevent burn out. CRT staff have a debriefing session within 24 hours of responding to a violent incident, either by phone or in person. In addition, staff are provided with a maximum of 10 therapy sessions when needed.
The CRT currently has a staff of six employees (three health workers and three psychiatric social workers). PEI funds will fund an additional two psychiatric social workers and one health program coordinator to adequately staff the team for 24/7 on-call coverage, provide adequate supervisory personnel for all team members, including non-professional and volunteer staff, and improve response times during crises especially after office hours and on weekends. The additional staff will also enable the team to broaden the scope of their intervention to include provision of therapy in families’ homes and at faith-based organizations.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The Crisis Response Team will be managed by the Community Behavioral Health Services (CBHS) unit of the Department of Public Health (DPH). Implementation partners include the following agencies and roles:
- San Francisco Police Department – contacts the CRT when there is a violent incident
- Comprehensive Children’s Crisis team (also managed by CBHS) – coordinates services for children and their families, referral to appropriate agencies, education about the impact of violence on children at schools, child care centers, and community based organizations
- Medical Examiner’s Office – identification of victims and funeral arrangements
- Community Response Network – coordination of services within the neighborhoods impacted by the violence incident
- District Attorney’s Victim Services – access legal services for victims’ families
- Trauma Recovery Programs (proposed PEI project) – provide recovery and healing services to individuals and families exposed to trauma
- San Francisco General Hospital – notification to CRT when a victim of gun or stabbing violence passes away, emergency services immediately after the incident, intensive care and extended hospital stays for victims
- San Francisco Unified School District – provide venue for training and education of the impact of trauma and violence on children and families; brief interventions immediately after the incident
- Mayor’s Office of Criminal Justice – policy making and coordination of programs and services directed toward violence and trauma

The team will be temporarily housed in the same building as the Comprehensive Children’s Crisis Team but services will be provided at various sites.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.
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 large numbers of truancy among youths, and have active territorial gang rivalries. Over 40% of four SF neighborhoods’ population is low income (at or below 200% of the federal poverty level): Tenderloin, Bayview-Hunters Point/Visitation Valley, South of Market, and Chinatown; over 30% of the Mission and North Beach population is low income. As data also shows that in 2007, 90% of young homicide victims were either African-American (54%) or Latino (37%), it is not surprising that the vast majority of families served are African-American and Latino, followed by Asian/Pacific Islander.

e. Highlights of new or expanded programs.
PEI funding will expand the Crisis Response Team by adding two psychiatric social workers and a health program coordinator. This will increase the team’s ability to provide timely, caring and sustainable support to the families and friends of victims of violence. The additional staff will build capacity in communities by providing training to non-professional outreach workers on how to screen for indicators associated with healthy grieving process and complex post traumatic stress disorder.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
As this PEI project is already in operation with support from the General Fund, it will not require start-up activities. The project will include the following key ongoing activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respond to homicides</td>
<td>Episodic; average 100 incidents/year</td>
</tr>
<tr>
<td>Provide case management to families affected by violence, i.e. family support, assistance with victims services, burial services, liaise with homicide inspectors and medical examiner's office</td>
<td>Two weeks/episode; 30/60/90 day follow-up</td>
</tr>
<tr>
<td>Provide crisis and short-term therapy</td>
<td>Episodic; average 60/year</td>
</tr>
<tr>
<td>Clinical reviews of homicide incidents, outstanding cases (30/60/90 open cases)</td>
<td>Weekly; 2 hours each</td>
</tr>
<tr>
<td>Debriefing/crisis services in schools, child care centers, community based organizations</td>
<td>Every two weeks; 1 day/episode</td>
</tr>
<tr>
<td>Education about effects of violence delivered in schools, community meetings and non-profit organizations</td>
<td>Twice/month; two hours/ session</td>
</tr>
</tbody>
</table>
PEI PROJECT SUMMARY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency / Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff wellness – staff debriefings; therapy</td>
<td>Debriefing per incident; therapy up to 10 sessions</td>
</tr>
<tr>
<td>Trainings for non professionals on how to screen for indicators of complex PTSD and case management, strategies for outreach</td>
<td>Six/year; one day trainings</td>
</tr>
<tr>
<td>Support/socialization groups for the community</td>
<td>Weekly; one hours/group</td>
</tr>
</tbody>
</table>

**g. Key milestones and anticipated timeline for each milestone.**

- Apr '09 Contracting process
- May'09 Program fully implemented

### 4. Programs

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Crisis Response Team</td>
<td>Individuals: Families: 150</td>
<td>Individuals: Families: 60</td>
</tr>
<tr>
<td>TOTAL PEI PROJECT ESTIMATED UNDUPlicated COUNT OF INDIVIDUALs TO BE SERVED</td>
<td>Individuals: Families: 150</td>
<td>Individuals: Families: 60</td>
</tr>
</tbody>
</table>

### 5. Linkages to County Mental Health and Providers of Other Needed Services

- **Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.**

This project is designed specifically to create linkages to county and community mental health services for people affected by violence. The CRT is part of the County Mental Health system, and as such, will provide both immediate short-term counseling in the wake of a violent incident, and case management and follow up with surviving victims, families and friends. The CRT aims to establish a trusting relationship...
PEI PROJECT SUMMARY

with the community in order to facilitate access to needed services, be that mental health, behavioral health, primary care, etc. Individuals seeking mental health services will be linked to the Behavioral Health Access Center, which will identify the appropriate agency/program to match the individual’s needs.

b. **Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.**

A core principle that underlies the CRT approach is the involvement of community-based agencies or response organizations to provide needed services for those exposed to trauma. The CRT staff works closely with the Community Response Network to link victims’ families to appropriate services within their neighborhood. The CRN has a group of providers operating in Visitacion Valley, Bayview Hunters Point, Western Addition, and Mission - neighborhoods that have been highly affected by homicides and acts of violence. Available services cover the spectrum from mental health and substance abuse to funeral/burial assistance. The team’s partnership with the District Attorney’s Victim Services enables victims’ families to access legal protection for themselves and the victim.

c. **Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.**

This proposed PEI project expands the existing CRT specifically because of the need for increased staffing to achieve the desired outcomes. Increased staffing will not only improve capacity and response time, but will help prevent staff overload and burnout. Running a response team that is available 24 hours a day, seven days a week requires a well-organized and predictable method for the scheduling and deployment of sufficient staff. In addition to the CRT staff, this project leverages extensive resources from city and community sources, e.g. CRN, SFPD, Child Crisis, District Attorney’s Office victim services, that contribute to achieving positive outcomes.

6. **Collaboration and System Enhancements**

a. **Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this project and the roles and activities of other organizations that will be collaborating on the project.**

This project will be operated by CBHS. As described in previous sections, the CRT works in close collaboration with the Community Response Network, additional CBOs, the SFUSD, and General Hospital to provide needed services to individuals and families affected by violence and trauma.
b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.
This project is designed to build upon and expand the impact of the local community-based mental health system. Services are provided in community locations, including CBOs, hospitals, health centers, schools and faith-based organizations. The CRT acts as a connector between the services available to families, and provides short-term care, case management, and follow up after 30, 60 and 90 days.

c. Describe how resources will be leveraged.
The budget for this project includes six full-time CRT staff funded by the city’s General Fund - three Psychiatric Social Workers and three Health Workers. In addition to the revenue included in the budget, this project leverages considerable direct service and collaboration building resources from the many partners described above, including: SF Police Department; DCYF/CRNs; District Attorney’s Office; SF General Hospital; SFUSD; and the proposed Trauma Recovery Services PEI project.

d. Describe how the programs in this PEI project will be sustained.
We anticipate that this project will be an ongoing PEI project, pending assessment of the extent to which it meets the identified individual, program and system outcomes. The Mayor and Board of Supervisors have continually given their support to the CRT.

7. Intended Outcomes

During the start-up phase of this project, the PEI Evaluator will collaborate with program staff to develop a logic model that specifies the program’s theory of change. The PEI Evaluator and program staff will select one to two objectives to measure and work together to develop the procedures and supports needed to collect, track, and analyze the data.

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
• CRT staff provide effective crisis intervention services to trauma-exposed individuals, including crisis support; short term case management; and brief
• 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.

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.

8. Coordination with Other MHSA Components
a. Describe coordination with CSS, if applicable.
This project will coordinate with CSS in the following ways:
• Referral to CSS programs: when an individual or family is identified as needing more intensive and long-term intervention, the project staff will work with BHAC to refer them to appropriate services and/or placement.
• At the start of year one of PEI implementation, the PEI Coordinator will develop standard definitions of prevention, early intervention and treatment services, and a protocol for identifying when a consumer will benefit from each type of service. This will be folded into a referral protocol for each of the PEI projects, taking into consideration the other county and community mental health services that are available and appropriate for that particular project.
• The PEI Coordinator will be part of bi-weekly MHSA meetings, where s/he can discuss and troubleshoot coordination of this and other PEI projects.
• This, and all PEI projects will be discussed at the bi-monthly MHSA Advisory Board meetings.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable. Not applicable

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable. Not applicable

9. Additional Comments (optional)
**PEI PROJECT SUMMARY**

**County:** San Francisco  
**PEI Project Name:** Transitional Age Youth (TAY) Multi-Service  
**Date:** November 4, 2008

### 1. PEI Key Community Mental Health Needs
Select as many as apply to this PEI project:

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### 2. PEI Priority Population(s)
Note: All PEI projects must address underserved racial/ethnic and cultural populations.

**A.** Select as many as apply to this PEI project:

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</table>

**B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).**
Our process was designed to ensure that a broad representation of key PEI stakeholders contributed to the selection of the priorities and projects at every stage of the planning process, as discussed in Form 2. The process followed a widely used prevention planning approach,
PEI PROJECT SUMMARY

which included: (1) assessment of community mental health needs, priority populations and related risk and protective factors, (2) identifying capacity in the field, (3) development of PEI strategies to address the identified priorities, and (4) creation of a PEI plan. For stage three (the development of recommended PEI strategies) stakeholders selected one of seven facilitated workgroups organized around the key community mental health needs and priority populations17.

In the first stage of the community planning process, we used available data to estimate need, identified associated risk factors, and protective factors linked to positive outcomes. CBHS Research and Evaluation staff reviewed and presented three rounds of data, as additional data needs and sources were identified during the planning meetings. Our consultant reviewed the CSS Needs Assessment for information relevant to the PEI process. The data that contributed to the development of the Transitional Age Youth Multi-Service Center came from the following sources:

- Physicians for Human Rights, Health and Justice for Youth
- Youth Risk Behavior Survey
- MECA (Methods for the Epidemiology of Child and Adolescent) Mental Disorders survey conducted by the National Institute of Mental Health (NIMH)
- DPH Population Health and Prevention Management Information Systems
- Department of Children Youth and their Families
- SF MHSA Community Services and Supports Plan
- Focus groups and informal interviews with transitional age youth conducted by Planning Committee members and organizations

Building on these conversations, and due to the overlap of this age group across many of the key community mental health needs, most of the workgroups identified desired outcomes that pertained to transitional age youth (TAY). Planning Committee members and public participants that work with transitional age youth formed a “TAY Caucus” to ensure that the unique needs of this population were fully considered in each of the workgroups. As a result, not only are TAY are well represented in many of the proposed PEI projects, but a TAY Multi-Service Center was also chosen as a PEI project.

However, the project design is still being developed, and as such, the Planning Committee voted to include the TAY Multi-Service Center project for future funding, i.e. once the design is complete and can be issues in a competitive Request for Proposals.

17 Workgroups consisted of the five priority populations, plus the two additional key community mental health needs – stigma and discrimination reduction and suicide risk. The issue of disparities in access was integrated into all populations and proposed PEI Projects
This PEI project will address the following key community needs and priority populations within the transitional age youth population:

- At-Risk Children, Youth and Young Adult Populations
- Children and Youth at Risk for School Failure
- Children and Youth At-Risk For Juvenile Justice Involvement
- Children and Youth in Stressed Families
- Psycho-Social Impact of Trauma and Trauma Exposed Individuals
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Individuals At-Risk for Suicide
- Disparities in Access to Mental Health Services and Underserved Cultural Populations
- Stigma and Discrimination

3. PEI Project Description

a. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

In 2007, the Mayor’s Transitional Youth Task Force issued policy recommendations for serving TAY which included the development of comprehensive neighborhood-based multi-service centers focused on serving this population. In May of 2008, a workgroup comprised of representatives of City department and community-based organizations – most of whom were also part of the PEI TAY Caucus - came together to outline a service model.

The workgroup laid out a framework for TAY-SF Centers with core services and elements, and a governance and management structure. The management structure identified four possible models of TAY multi-service centers. As the needs of disconnected youth are complex and cross multiple systems and service providers, all of the models offer comprehensive support services and connections to education, employment and social support.

The proposed PEI project will support the creation of a TAY-SF Center. However, there is additional design work that needs to be done by TAY stakeholders before this project can be fully described and funded.

b. Description of proposed PEI Intervention

The following is excerpted from the TAY-SF Workgroup’s Multi-Service Center Report - Approach

---

San Francisco County MHSA PEI
Program and Expenditure Plan November 2008
for Disconnected Youth\textsuperscript{18} It describes core services, essential elements and service delivery model for a TAY Center, and offers four possible models of structure and management.

Core Services and Goals

**Academic Achievement.** All youth are engaged in their learning in the classroom.
- Adults promote high academic and technical success
- Workplace experiences support classroom learning
- Multiple educational approaches address individual needs
- Standards-based alternatives are available at all levels of education

**Career Development.** All youth are engaged in their learning in the workplace and community.
- Early employment exposure and experiences are provided
- Quality work-based learning opportunities are in place
- Community and workplace partners provide work and learning opportunities
- Classroom learning supports career development

**Community Services and Supports.** All youth receive individualized services and community support.
- All youth have safe and stable living arrangements
- All youth have strong and enduring adult and peer connections
- All youth receive life skills training and practice
- A full range of social services is available, with an emphasis on mental health, physical health and violence prevention.

**Youth Leadership.** Youth are visible and active in leadership roles.
- Youth actively participate in decisions about their lives
- Youth voice drives policy and decision making
- Youth are encouraged and supported in leadership roles
- Youth leadership opportunities are leveraged and connected

Essential Elements
In addition to the core services identified above, the following items comprise essential elements for TAY-SF Centers:

\textsuperscript{18} Full report available upon request from the TAY Initiative at taysf@taysf.org
Anchor provider. Each center will be anchored by an organization that provides education, employment or health services on-site and that embodies the values and principles articulated in this document. Anchor organizations will have capacity to serve at least 200 unduplicated youth in education or employment activities.

Timely access to services and supports. Participants are identified, referred and accepted into case management, and then linked to community-based services as quickly as possible.

Multiple pathways. No single program or approach will work for every youth and not every youth will be ready to take advantage of services when first presented. Multiple options for moving forward are essential for disconnected youth.

Responsive. Services will be responsive to individual and cultural differences. In many cases, youth may be more concerned about addressing immediate needs they have rather than working on key underlying issues. Service providers who wish to fully engage with this population must take this into in the design and delivery of services.

Programs and activities that appeal to youth. In order to draw youth in, Centers will offer services, programs and activities that are attractive and appealing to youth. This could include activities that support creative expression and that build skills.

Sustainability. Data are collected and analyzed and performance is assessed periodically to improve services and build support for the service model.

Service Delivery and Coordination
TAY-SF Centers will operate using a Daisy Wheel approach to service coordination and delivery which centralizes intake, assessment, case management and follow-up and delivers services via a network of provider organizations. This model creates an opportunity for seamless services and will reduce the number of youth who “fall through the cracks.” In creating an intermediary who brokers roles & responsibilities for city agencies and nonprofit programs, advocates for young people, supports training and system development and tracks outcomes, the City will be better equipped to support the holistic needs of disconnected young people. We imagine a “no wrong door” approach where young people have access to a wrap around system of care which they help create. In this approach, government and private funds are leveraged and real outcomes are possible to move young people to self-sufficiency.

Four models of Structure and Management
Each TAY-SF Center will be managed by a nonprofit, community-based organization that serves as the lead agency or by an educational entity. Each Center will have its own Director and staff. Lead agencies will partner with a number of local community and public agencies to offer the activities that occur at each Center. The design of each Center will be tailored to local community needs. At this stage in the planning process, the workgroup that created the model outlined in this document envisions the development of 3-4 centers, each of which would have a different focus population and anchor provider:
Full-Service Community School model. This TAY-SF Center will be anchored by a full-service school and serve younger disconnected youth at high risk of dropping out of high school. In this model, the school will be open past the regular school day, will offer comprehensive services on-site, and will deliver services to families as well as students.

Community College model. This TAY-SF Center will focus on at-risk youth, 16 to 20 years old, who have dropped out of school and would be anchored by a community college program that gives students the opportunity to earn a high school diploma while earning college credits and achieving college success.

Comprehensive Health and Wellness model. This TAY-SF Center would be anchored by a health clinic and provide access to a comprehensive set of health, wellness, educational and employment services. This Center would provide services to transition age youth in the entire age range and be located in neutral territory accessible to youth through San Francisco.

Feeder model. A smaller TAY-SF Center would be located in a neighborhood where services for disconnected youth are needed but where provider capacity and space issues currently constrain possible implementation of a full-scale multi-service center. This Center would offer some core services on site and have a strong linkage to the Center that provides comprehensive health and wellness services.

The workgroup recommends that oversight for the TAY-SF Neighborhood Multi-Service Centers Initiative be provided by a Steering Committee comprised of private funders, city agencies, the San Francisco Unified School District, City College of San Francisco, community partners, and youth representatives. The Steering Committee would promote the development of 3-4 TAY-SF Centers for disconnected youth in San Francisco. The Centers would serve 4,000 transitional age youth to self-sufficiency and wellness over the next five years.

The PEI Planning Team will continue to work with TAY-SF to develop a model that aligns with the MHSA prevention and early intervention principles and guidelines. Once that model is fully developed, the County will release the detailed RFP to solicit community-based organizations to implement it.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

To be determined
d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.
   To be determined

e. Highlights of new or expanded programs.
   To be determined

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.
   To be determined

g. Key milestones and anticipated timeline for each milestone.
   Apr-May ’09 Contracting process
   June-July ’09 Program start-up, including recruitment, hiring and training of staff

4. Programs
   To be determined

5. Linkages to County Mental Health and Providers of Other Needed Services
   To be determined

6. Collaboration and System Enhancements
   To be determined

7. Intended Outcomes
   To be determined

8. Coordination with Other MHSA Components
   To be determined

9. Additional Comments (optional)
## SF MHSA Prevention & Early Intervention Planning

### Top Priority Outcomes by Workgroup

#### Group 1: Trauma Exposed Individuals

<table>
<thead>
<tr>
<th>Desired outcomes for individuals and families</th>
<th>Desired outcomes for programs and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top Priorities</strong></td>
<td></td>
</tr>
<tr>
<td>❖ Increased opportunities for child and youth development and anti-oppression activities</td>
<td>❖ All circles of support are educated and understanding of scope, breadth and depth of trauma</td>
</tr>
<tr>
<td>❖ Increased opportunities for peer support</td>
<td>❖ Youth and community are involved in safety promotion</td>
</tr>
<tr>
<td>❖ Family of people exposed to trauma receive early care</td>
<td></td>
</tr>
</tbody>
</table>

#### Group 2: Reduction of Stigma and Discrimination

<table>
<thead>
<tr>
<th>Desired outcomes for individuals and families</th>
<th>Desired outcomes for programs and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top Priorities</strong></td>
<td></td>
</tr>
<tr>
<td>❖ Increasing a family’s ability to determine services in their community</td>
<td>❖ Increased cultural competency of providers for all subgroups (race, gender, LGBT, etc)</td>
</tr>
<tr>
<td>❖ Family stays together</td>
<td>❖ Reduction of existing programs (juvenile justice, hospitalization)</td>
</tr>
<tr>
<td></td>
<td>❖ Public is more knowledgeable about mental health services</td>
</tr>
</tbody>
</table>

#### Group 3: Children, Youth and Young Adults At-Risk for School Failure

<table>
<thead>
<tr>
<th>Desired outcomes for individuals and families</th>
<th>Desired outcomes for programs and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top Priorities</strong></td>
<td></td>
</tr>
<tr>
<td>❖ Children, youth and families have early and durable engagement with the school (pre to college) community</td>
<td>❖ Better collaboration between schools and the community they serve</td>
</tr>
<tr>
<td>❖ Prompt access to services when need is identified</td>
<td>Increased accessibility to services from one part of the system to other parts</td>
</tr>
<tr>
<td>❖ Successful transitions (pre to K; 5th-6th; 12th to higher education)</td>
<td>Increase awareness of and support for transitions within and between systems</td>
</tr>
<tr>
<td>❖ Children are physically and emotionally safe at school</td>
<td></td>
</tr>
</tbody>
</table>
Attachment: Summary of Desired Outcomes for Priority Populations

**Group 4: Children, Youth & Young Adults At-Risk for Juvenile Justice Involvement**

<table>
<thead>
<tr>
<th>Desired outcomes for individuals and families</th>
<th>Desired outcomes for programs and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top Priorities</strong></td>
<td></td>
</tr>
<tr>
<td>1. Joint outcomes among City Departments – shared funding and RFPs</td>
<td>2. Young people and families have tools to create healthy relationships</td>
</tr>
<tr>
<td>3. Reduce depth of involvement in juvenile justice system (including recidivism)</td>
<td>4. More youth participate in positive structured activities.</td>
</tr>
</tbody>
</table>

**Group 5: Children, Youth & Young Adults in Stressed Families (0-25)**

<table>
<thead>
<tr>
<th>Desired outcomes for individuals and families</th>
<th>Desired outcomes for programs and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top Priorities</strong></td>
<td></td>
</tr>
<tr>
<td>❖ #3 Two positive and meaningful relationships</td>
<td>❖ #1 Well utilized community center which provides resources to the community, also serves as a meeting hall or gathering place to support and build community</td>
</tr>
<tr>
<td>❖ #4 Increase family self-sufficiency</td>
<td>❖ #2 Consumer guided services i.e. consumers govern, are given leadership training, etc. (consumer driven priorities in developing programs)</td>
</tr>
<tr>
<td>❖ #5 Increased positive interactions between present and child(ren)</td>
<td></td>
</tr>
</tbody>
</table>

**Group 6: Individuals Experiencing Onset of Serious Psychiatric Illness**

<table>
<thead>
<tr>
<th>Desired outcomes for individuals and families</th>
<th>Desired outcomes for programs and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top Priorities</strong></td>
<td></td>
</tr>
<tr>
<td>❖ Reduced rate of onset of serious mental illness</td>
<td>❖ MH clinicians and Primary care clinicians are more knowledgeable about early signs of SMI</td>
</tr>
<tr>
<td>❖ Early connection to system of care (increase in level of trust)</td>
<td>❖ Fluid process of referral from school to MH services</td>
</tr>
<tr>
<td>❖ Greater rate of treatment adherence</td>
<td>❖ Increased availability of phase-specific treatment for early SMI</td>
</tr>
<tr>
<td></td>
<td>❖ Improved attitudes towards people with SMI o General public o MH and Primary care clinicians o School personnel</td>
</tr>
<tr>
<td>Desired outcomes for individuals and families</td>
<td>Desired outcomes for programs and systems</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Top Priorities</td>
<td></td>
</tr>
<tr>
<td>❖ Personal awareness and responsibility for health/wellness and connectedness to health services</td>
<td>❖ Increased awareness and reduction of stigma associated with suicide</td>
</tr>
<tr>
<td>❖ Cost effective services</td>
<td></td>
</tr>
<tr>
<td>❖ Increased Responsibility of community/public to recognize signs of risk and refer</td>
<td>❖ Increase access to referral, treatment, prescriptions, and psychotherapy</td>
</tr>
<tr>
<td>❖ Increased capacity (culturally appropriate) of treatment options</td>
<td></td>
</tr>
</tbody>
</table>
### PEI Revenue and Expenditure Budget Worksheet

**Form No. 4**

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **San Francisco**  
PEI Project Name: **School-Based Youth–Centered Wellness**  
Provider Name (if known):  
Intended Provider Category: **University/College/Community College & Community-Based Organizations**

<table>
<thead>
<tr>
<th>Proposed Total Number of Individuals to be served:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,650</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Number of Individuals currently being served:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>650</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Number of Individuals to be served through PEI Expansion:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Months of Operation:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A. Expenditure

1. **Personnel (list classifications and FTEs)**
   - a. Salaries, Wages  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - b. Benefits and Taxes @%  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - c. Total Personnel Expenditures  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |

2. **Operating Expenditures**
   - a. Facility Cost  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - b. Other Operating Expenses  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - c. Total Operating Expenses  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |

3. **Subcontracts/Professional Services (list/itemize all subcontracts)**
   - Institution of Higher Education #1 (with $97,500 match from MHSA WET funds)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $155,000 | $155,000 |
   - Institution of Higher Education #2 (with $97,500 match from MHSA WET funds)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $155,000 | $155,000 |
   - (K-12) Community Based Organization #1 (with 10% cash match from subcontractor)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $165,000 | $165,000 |
   - (K-12) Community Based Organization #2 (with 10% cash match from subcontractor)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $165,000 | $165,000 |
   - (K-12) Community Based Organization #3 (with 10% cash match from subcontractor)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $165,000 | $165,000 |
   - (K-12) Community Based Organization #4 (with 10% cash match from subcontractor)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $165,000 | $165,000 |
   - (K-12) Community Based Organization #5 (with 10% cash match from subcontractor)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $165,000 | $165,000 |
   - RAMS Wellness Center (at SOTA High School)  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $82,400  | $82,400 |
   - a. Total Subcontracts  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $1,217,400 | $1,217,400 |

4. **Total Proposed PEI Project Budget**  
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $1,217,400 | $1,217,400 |

#### B. Revenues (list/itemize by fund source)

- **MHSA Workforce Education and Training Plan**  
  | FY 08-09 | FY 09-10 | Total |
  | $0       | $195,000 | $195,000 |
- **Subcontractors 10% cash match (sources will vary by subcontractor)**  
  | FY 08-09 | FY 09-10 | Total |
  | $0       | $75,000  | $75,000  |

1. **Total Revenue**  
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $270,000 | $270,000 |

#### 5. Total Funding Requested for PEI Project
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $947,400 | $947,400 |

#### 6. Total In-Kind Contributions
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $0       | $0    |
BUDGET NARRATIVE
PEI Project: School-Based Youth-Centered Wellness

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. All staffing will be provided under contract with the community-based organizations and institutions of higher education that implement the project. (See subcontract line item.)

   Total Personnel Expenditures - $0

2. Operating Expenditures
   There are no expenses in this category. All operations will be covered under subcontracts.

   Total Operating Expenses - $0

3. Subcontracts/Professional Services
   There will be two subcontracts for Supported Higher Education, four-six for School-Based Services, and one for the Wellness Center.

   $57,500 - Institution of Higher Education #1. The subcontractor will be chosen through a competitive RFP process as part of the MHSA WET Plan. This augments the WET award of $97,500 to increase staffing, capacity and quality. It will fund:

   • 1 Center Coordinator @ $80,000, including benefits.  
     0.25FTE is covered by PEI funds = $20,000  
     0.75FTE is covered by WET funds = $60,000
   
   • 1 Peer Counselor/Advocate @ $35,000, including benefits.  
     0.5FTE is covered by PEI funds = $17,500  
     0.5FTE is covered by WET funds = $17,500
   
   • 1 Administrative Assistant @ $40,000, including benefits.  
     0.5FTE is covered by PEI funds = $20,000  
     0.5FTE is covered by WET funds = $20,000

   $57,500 - Institution of Higher Education #2. The subcontractor will be chosen through a competitive RFP process as part of the MHSA WET Plan. This augments the WET award of $97,500 to increase staffing, capacity and quality. It will fund:

   • 1 Center Coordinator @ $80,000, including benefits.  
     0.25FTE is covered by PEI funds = $20,000  
     0.75FTE is covered by WET funds = $60,000
   
   • 1 Peer Counselor/Advocate @ $35,000, including benefits.  
     0.5FTE is covered by PEI funds = $17,500  
     0.5FTE is covered by WET funds = $17,500
   
   • 1 Administrative Assistant @ $40,000, including benefits.  
     0.5FTE is covered by PEI funds = $20,000  
     0.5FTE is covered by WET funds = $20,000

   $150,000 - Community-based organization #1. The subcontractor will be chosen through a competitive RFP process. The average contract amount will be $150,000. Subcontractors will be required to provide a 10% cash match. Contract will cover cost of staffing and
operations to provide school-based services in the areas of Promoting Healthy Development and Preventing Problems and Early Intervention.

Value of subcontract with match = $165,000

$150,000 - Community-based organization #2. The subcontractor will be chosen through a competitive RFP process. The average contract amount will be $150,000. Subcontractors will be required to provide a 10% cash match. Contract will cover cost of staffing and operations to provide school-based services in the areas of Promoting Healthy Development and Preventing Problems and Early Intervention.

Value of subcontract with match = $165,000

$150,000 - Community-based organization #3. The subcontractor will be chosen through a competitive RFP process. The average contract amount will be $150,000. Subcontractors will be required to provide a 10% cash match. Contract will cover cost of staffing and operations to provide school-based services in the areas of Promoting Healthy Development and Preventing Problems and Early Intervention.

Value of subcontract with match = $165,000

$150,000 - Community-based organization #4. The subcontractor will be chosen through a competitive RFP process. The average contract amount will be $150,000. Subcontractors will be required to provide a 10% cash match. Contract will cover cost of staffing and operations to provide school-based services in the areas of Promoting Healthy Development and Preventing Problems and Early Intervention.

Value of subcontract with match = $165,000

$150,000 - Community-based organization #5. The subcontractor will be chosen through a competitive RFP process. The average contract amount will be $150,000. Subcontractors will be required to provide a 10% cash match. Contract will cover cost of staffing and operations to provide school-based services in the areas of Promoting Healthy Development and Preventing Problems and Early Intervention.

Value of subcontract with match = $165,000

$82,400 – Richmond Area Multi-Services, Inc. This subcontract is to run the Wellness Center at the School of the Arts. This was previously funded under the CSS Plan. The contract will cover cost of staffing and operations to provide culturally competent, consumer-guided, coordinated and integrated behavioral health services - including coordinated health education, assessment, intervention, counseling, and other support services - to students at School of the Arts, consultation to the school personnel, psychiatric consultation to students/families as needed. $55,581 of the contract pays salary and benefits for a full-time Behavioral Health Counselor, and $15,044 pays for between 1-7% of other staff time, i.e. behavioral health director, child psychiatrist, clinical supervisor, and office manager. The contract includes $2,946 in operations costs, e.g. rent, utilities, travel and insurance, and $8,829 in indirect costs.

Total Subcontracts – $1,142,400
Total Value of Subcontracts with match and WET funds = $1,217,400

4. Proposed PEI Project Budget - $1,217,400
The total budget for the three programs included under the School Based Youth-Centered Project is $1,217,400.
B. REVENUES

1. **Total Revenue - $270,000**
   Revenue comes from the MHSA WET Plan and from Subcontractors, as follows:

   - **MHSA WET Plan – $195,000**
     Funds from the WET Plan will pay for partial staffing at each of the two Supported Education Centers. A total of $97,500 will go to each of the two Centers funded to pay for personnel listed above.

   - **Subcontractor Match - $75,000**
     Each subcontractor will provide a 10% cash (not in-kind) match to their contract that directly supports implementation of the School Based Services Project = $75,000

5. **Total Funding Requested for PEI Project: $947,400**

6. **Total In-Kind Contributions**
   In-kind contributions have not been calculated for this project and will vary by subcontractor.
**PEI Revenue and Expenditure Budget Worksheet**

**Form No. 4**

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

<table>
<thead>
<tr>
<th>County Name:</th>
<th>San Francisco</th>
<th>Date:</th>
<th>November 4, 2008</th>
</tr>
</thead>
</table>

**PEI Project Name:** Screening, Planning and Supportive Services for Incarcerated Youth

**Provider Name (if known):** Community Behavioral Health Services & Community-Based Organizations TBD

**Intended Provider Category:** County Agency and Other Community-Based Organizations

<table>
<thead>
<tr>
<th>Proposed Total Number of Individuals to be served:</th>
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<th>FY 09-10</th>
<th>700</th>
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<td>FY 09-10</td>
<td>0</td>
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<tr>
<td>Total Number of Individuals to be served through PEI Expansion:</td>
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<td>FY 09-10</td>
<td>700</td>
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<tr>
<td>Months of Operation:</td>
<td>FY 08-09</td>
<td>0</td>
<td>FY 09-10</td>
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</table>

**Total Program/PEI Project Budget**

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
</table>

**A. Expenditure**

1. **Personnel (list classifications and FTEs)**
   - **a. Salaries, Wages**
     - 2.0 FTE Psychiatric Social Worker (2930/31) $159,524 $159,524
     - 2.0 FTE Health Worker I (2585) $80,028 $80,028
     - 0.2 FTE Health Program Coordinator II (2591) $15,439 $15,439
   - b. Benefits and Taxes @ 35% $89,247 $89,247
   - c. **Total Personnel Expenditures** $0 $344,238 $344,238

2. **Operating Expenditures**
   - a. Facility Cost $0 $0 $0
   - b. Other Operating Expenses (e.g., equipment, supplies, stipends) $0 $18,137 $18,137
   - c. **Total Operating Expenses** $0 $18,137 $18,137

3. **Subcontracts/Professional Services (list/itemize all subcontracts)**
   - CANS Training/John Lyons $0 $6,000 $6,000
   - Early Intervention Services $0 $100,000 $100,000
   - External Evaluation $0 $8,750 $8,750
   - a. **Total Subcontracts** $0 $114,750 $114,750

4. **Total Proposed PEI Project Budget**
   - **$0 $477,125 $477,125**

**B. Revenues (list/itemize by fund source)**

- CBHS DOJ Grant: 0.7 FTE Social Worker with benefits $0 $75,375 $75,375
- CBHS DOJ Grant: CANS Training $0 $3,000 $3,000
- CBHS DOJ Grant: Evaluation $0 $8,750 $8,750
   - a. **Total Revenue** $0 $87,125 $87,125

5. **Total Funding Requested for PEI Project**
   - **$0 $390,000 $390,000**

6. **Total In-Kind Contributions**
   - **$0 $45,000 $45,000**
BUDGET NARRATIVE
PEI Project: Screening, Planning and Supportive Services for Incarcerated Youth

A. EXPENDITURES

1. Personnel - $344,238
   Total personnel costs amount to $344,238. This amount is a sum of the salaries, benefits and taxes shown below.

   a. **Salaries and Wages.** Costs for salaries and wages amount to **$254,991.**

   - **Clinical and Community Liaisons @ 2.0FTE** $159,524
     Clinical and Community Liaisons are responsible for completing CANS assessments, coordination of a systematic decision-making process for case planning, and development of intervention plans in collaboration with SPY and JPD staff. In addition, the Liaisons advocate for youth in the Multi-Disciplinary Team Meetings, coordinate peer support and facilitate linkages with a network of community-based providers.
     
     In order to perform the clinical responsibilities associated with this role, the Liaisons must have a Master’s degree in a clinical field (e.g., social work). The base salary for this Psychiatric Social Worker (2930/31) position is $79,762 x 2 = $159,524.

   - **Youth Advocate and Linkage Coordinators @ 2.0FTE** $80,028
     The Youth Advocate and Linkage Coordinators work closely with JPD and Community Behavioral Health Services staff to advocate for youths' needs and implement the intervention plan including: pre-referral or placement dispositional advocacy, outreach with youth and their families to connect and engage them in available interventions, and follow-up to determine whether interventions are helpful and address ongoing needs related to system navigation. The base salary for this Health Worker I (2585) position is $40,014 x 2 = $80,128.

   - **Health Program Coordinator @ 0.2FTE** $15,439
     The Health Program Coordinator II provides administrative oversight for the effective integration of this project into existing services at the Juvenile Justice Center. The base salary for this position (2591) is $77,194 x .20 = $15,439.

   b. **Benefits and Taxes.** Benefits are calculated at 35% of total salaries ($254,991 x .35) for a total cost of **$89,247.**

2. Operating Expenditures - $18,137
   Total operating expenses amount to $18,137.

   a. **Facility Cost.** None.

   b. **Other Operating Expenses.** Other operating expenses are estimated at **$18,137.** These expenses include the cost for project computers that will be used for tasks such as plan development and tracking and stipends for peer advocates who will work as part of the advocacy and linkage team.
3. **Subcontracts/Professional Services - $114,750**  
Total subcontract and professional expenses amount to $114,750.

**CANS Training @ $6,000**  
CANS Training (Child and Adolescent Needs and Strengths Comprehensive Assessment) will be provided to the Community and Clinical Liaisons, SFJPD and SPY staff two times per year by John Lyons, Ph.D., the developer of the instrument. The initial one-day training is a basic training on all CANS Modules (including establishing reliability). At the second training, new staff will be trained as needed and previously trained staff are re-tested to prevent rater drift and maintain adequate reliability. The cost of a one-day training is $3,000 and includes Dr. Lyons’ daily rate of $1,200, an additional $800 for costs associated with reliability testing and certifying, and $1,000 in travel and hotel expenses. Total CANS training costs are estimated at $6,000 ($3,000/training x 2).

**Early Intervention Services @ $100,000**  
This includes the cost for ten additional Multisystemic Therapy slots estimated at $60,000 per year and trauma-based services at Log Cabin Ranch for youth who have screened positive for PTSD symptoms on the CANS, estimated at $40,000 per year.

**Evaluation @ $8,750**  
Subcontractor will partner with Dr. Joe Turner of CBHS’ Research, Evaluation and Quality Management (REQM) Department to plan, develop and implement the program evaluation. Evaluator will conduct data analysis, while REQM will compile data from their integrated data sources as well as extract tracking, referral, and process information from administrative and case management sources. Evaluator and REQM will be responsible for on-going feedback to MDT and semi-annual reports. The hourly rate for is calculated $100 with an expected level of effort at .25 for approximately 2 months per year ($100 x 10 hours x 8.75 weeks = $8,750).

4. **Total Proposed PEI Budget - $477,125**  
The total expenditure level for the Screening, Planning and Supportive Services for Incarcerated Youth Project is $477,125.

B. **REVENUES**

**Total Revenue - $87,125**  
Revenues for this program are estimated at $87,125. Revenue comes from Federal Office of Justice Programs, Department of Justice funding awarded to CBHS through the Criminal Justice and Mental Health Collaboration Program. This includes $75,375 for a 0.7FTE Social Worker position, $3,000 for CANS Training, and the $8,750 for program evaluation.

5. **Total Funding Requested for PEI Project - $390,000**

6. **Total In-Kind Contributions - $45,000**  
Total in-kind contributions are estimated at $45,000. These contributions include $5,000 in facility expenses and $40,000 for supervising staff salaries and related expenses.
**PEI Revenue and Expenditure Budget Worksheet**

**County Name:** San Francisco  
**PEI Project Name:** Re-Engagement of Truant and Out-of-School Youth  
**Provider Name (if known):** San Francisco Unified School District  
**Intended Provider Category:** PreK-12 school district

<table>
<thead>
<tr>
<th>Proposed Total Number of Individuals to be served:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>50</th>
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</thead>
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<tr>
<td>Total Number of Individuals currently being served:</td>
<td>FY 08-09</td>
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<tr>
<td>Total Number of Individuals to be served through PEI Expansion:</td>
<td>FY 08-09</td>
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<tr>
<td>Months of Operation:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>11</td>
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</table>

**Total Program/PEI Project Budget**

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
<td></td>
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<tr>
<td>a. Salaries, Wages</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Benefits and Taxes @ 30%</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>c. Total Personnel Expenditures</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Operating Expenditures</td>
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<td></td>
</tr>
<tr>
<td>a. Facility Cost</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Other Operating Expenses</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>c. Total Operating Expenses</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Subcontracts/Professional Services (list/itemize all subcontracts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Francisco Unified School District for staffing and supplies</td>
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<td>$268,000</td>
<td>$268,000</td>
</tr>
<tr>
<td>Revenue from SFUSD</td>
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<td>$64,150</td>
<td>$64,150</td>
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<tr>
<td><strong>a. Total Subcontracts</strong></td>
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<td>$0</td>
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<tr>
<td>4. Total Proposed PEI Project Budget</td>
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<td>$332,150</td>
<td>$332,150</td>
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<td><strong>B. Revenues (list/itemize by fund source)</strong></td>
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<tr>
<td>SFUSD: personnel, curriculum</td>
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<td>$64,150</td>
<td>$64,150</td>
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<td><strong>1. Total Revenue</strong></td>
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<td>$64,150</td>
<td>$64,150</td>
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<td><strong>5. Total Funding Requested for PEI Project</strong></td>
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<td>$268,000</td>
<td>$268,000</td>
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<tr>
<td><strong>6. Total In-Kind Contributions</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
BUDGET NARRATIVE
PEI Project: Re-Engagement of Truant and Out-of-School Youth

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. All personnel will be provided under contract with the school district.
   
   Total Personnel Expenditures - $0

2. Operating Expenditures
   There are no expenses in this category. All operations will be covered under contract with the school district.
   
   Total Operating Expenses - $0

3. Subcontracts/Professional Services
   There will be one subcontract with the San Francisco Unified School District.
   
   $268,000 - San Francisco Unified School District
   This subcontract is with the San Francisco Unified School District to open a re-engagement program in an unserved school and community. The contract covers the cost of staffing and operations to serve one cohort of 20-30 students per semester with academics, enrichment and life skills, and PEI mental health services and linkages, as follows:
   - 1 FTE Teacher @ $80,000
   - 1 FTE Counselor @ $80,000
   - 0.5FTE Case Manager @ $38,000 = $19,000
   - 0.2FTE Learning Support Professional @ $80,000 = $16,000
   - Benefits for all four positions, calculated at 30% of salary = $58,500
   - Youth Incentives, calculated at $200 per student x 50 students = $10,000
   - Materials, including start up supplies @ $1,800 and food for bi-weekly nutrition and/or life skills classes @ $150/class for 18 classes = $2,700, for a materials total of $4,500

   SFUSD is providing direct cash match to this subcontract in the amount of $64,150.
   
   Total Subcontracts – $268,000
   Total Value of Subcontracts with SFUSD match = $332,150

4. Proposed PEI Project Budget - $332,150
   The total budget for the Reengagement of Truant and Out-of-School Youth Project is $332,150.
B. REVENUES

1. Total Revenue - $64,150
San Francisco Unified School District is providing revenue of $64,150 for personnel and materials directly involved in this project, specifically:
   - 0.5FTE Attendance Liaison @ $52,000 = $27,000
   - 0.1FTE Wellness Coordinator @ $70,000 = $7,000
   - 0.2FTE SAP/CARE team staff (4 additional members) @ $125/hr for 2 hrs/week for 36 weeks = $9,000
   - Benefits for all positions, calculated at 30% of salary = $12,900
   - Curricula, at $165 x 50 students total = $68,250

5. Total Funding Requested for PEI Project: $268,000

6. Total In-Kind Contributions:
   In-kind contributions have not been calculated for this project.
PEI Revenue and Expenditure Budget Worksheet

**Instructions:** Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

<table>
<thead>
<tr>
<th>County Name: San Francisco</th>
<th>Date: November 4, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Project Name: Holistic Wellness Promotion in a Community Setting</td>
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<tr>
<td>Provider Name (if known):</td>
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<tr>
<td>Intended Provider Category: Ethnic or cultural organization</td>
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<tr>
<td>Proposed Total Number of Individuals to be served:</td>
<td>FY 08-09</td>
</tr>
<tr>
<td>Total Number of Individuals currently being served:</td>
<td>FY 08-09</td>
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<tr>
<td>Total Number of Individuals to be served through PEI Expansion:</td>
<td>FY 08-09</td>
</tr>
<tr>
<td>Months of Operation:</td>
<td>FY 08-09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Salaries, Wages</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Benefits and Taxes @ %</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>c. Total Personnel Expenditures</td>
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<td>$0</td>
</tr>
<tr>
<td>2. Operating Expenditures</td>
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</tr>
<tr>
<td>a. Facility Cost</td>
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<tr>
<td>b. Other Operating Expenses</td>
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<td>$0</td>
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<tr>
<td>c. Total Operating Expenses</td>
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<td></td>
<td>$0</td>
</tr>
<tr>
<td>3. Subcontracts/Professional Services (list/itemize all subcontracts)</td>
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<td>Community Based Organization #1 (with 10% cash match from subcontractor)</td>
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<tr>
<td>Community Based Organization #2 (with 10% cash match from subcontractor)</td>
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<td>$275,000</td>
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<tr>
<td>Community Based Organization #3 (with 10% cash match from subcontractor)</td>
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<td>$275,000</td>
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<tr>
<td>a. Total Subcontracts</td>
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<td>4. Total Proposed PEI Project Budget</td>
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<tr>
<td></td>
<td>$0</td>
<td>$825,000</td>
<td>$825,000</td>
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<td><strong>B. Revenues (list/itemize by fund source)</strong></td>
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<tr>
<td>Subcontractors 10% cash match (sources will vary by subcontractor)</td>
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<td><strong>5. Total Funding Requested for PEI Project</strong></td>
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<tr>
<td></td>
<td>$0</td>
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<tr>
<td><strong>6. Total In-Kind Contributions</strong></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>
BUDGET NARRATIVE
PEI Project: Holistic Wellness Promotion in a Community Setting

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. All staffing will be provided by subcontractors.
   
   \textit{Total Personnel Expenditures} - $0

2. Operating Expenditures
   There are no expenses in this category. All operations will be covered under subcontracts.
   
   \textit{Total Operating Expenses} - $0

3. Subcontracts/Professional Services
   There will be three subcontracts for Holistic Wellness Promotion in a Community Setting. Each contract will range from $150,000 - $250,000. Subcontracts will provide community outreach and education, pro-social community building events, community wellness promotion activities, cultural activities and traditional healing, and service linkages to individuals, families and community members. The subcontractor will have a history of serving and existing relationships with their target community. The majority (at least 75%) of project funding will go to prevention activities, with up to 25% allocated for early intervention.

   Subcontractor #1 $275,000
   Subcontractor #2 $275,000
   Subcontractor #3 $275,000

   Each subcontractor will provide a 10% cash (not in-kind) match to their subcontract = $75,000

   \textit{Total Subcontracts} – $825,000

4. Proposed PEI Project Budget - $825,000
   The total budget for the Holistic Wellness Promotion in a Community Setting Project is $825,000.

B. REVENUES

1. Total Revenue - $75,000
   Each subcontractor will provide a 10% cash (not in-kind) match to their subcontract = $75,000

5. Total Funding Requested for PEI Project: $750,000

6. Total In-Kind Contributions
   In-kind contributions have not been calculated for this project and will vary by subcontractor.
### PEI Revenue and Expenditure Budget Worksheet

**Form No. 4**

**County Name:** San Francisco  
**Date:** November 4, 2008  
**PEI Project Name:** Early Childhood Mental Health Consultation

#### Provider Name (if known):

**Provider Name:**  
**Intended Provider Category:** Community based organizations

#### Proposed Total Number of Individuals to be served:

<table>
<thead>
<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>625</td>
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#### Total Number of Individuals currently being served:

<table>
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<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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#### Total Number of Individuals to be served through PEI Expansion:

<table>
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<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>625</td>
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#### Months of Operation:

<table>
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<th>FY 08-09</th>
<th>FY 09-10</th>
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<tbody>
<tr>
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#### Total Program/PEI Project Budget

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Salaries, Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0 FTE Health Program Coordinator III (2593)</td>
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<td>$92,315</td>
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<td>1.0 FTE Junior Administrative Analyst</td>
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<td>0.5 FTE Evaluator (2119)</td>
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<td>b. Benefits and Taxes @ 32%</td>
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<td>c. Total Personnel Expenditures</td>
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<tr>
<td><strong>2. Operating Expenditures</strong></td>
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<td></td>
</tr>
<tr>
<td>a. Facility Cost for Training Institute</td>
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<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>b. Other Operating Expenses: Training Institute food, materials</td>
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<td>$10,000</td>
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<tr>
<td>c. Total Operating Expenses</td>
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<td>$15,000</td>
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<td><strong>3. Subcontracts/Professional Services (list/itemize all subcontracts)</strong></td>
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<tr>
<td>New Subcontracts with Mental Health Consultants</td>
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<tr>
<td>New Subcontracts with Training Organizations</td>
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<td><strong>4. Total Proposed PEI Project Budget</strong></td>
<td>$0</td>
<td>$5,363,835</td>
<td>$5,363,835</td>
</tr>
<tr>
<td><strong>B. Revenues (list/itemize by fund source)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Services Agency</td>
<td>$0</td>
<td>$1,539,110</td>
<td>$1,539,110</td>
</tr>
<tr>
<td>Department of Children, Youth and their Families</td>
<td>$0</td>
<td>$1,494,700</td>
<td>$1,494,700</td>
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<tr>
<td>First 5 San Francisco</td>
<td>$0</td>
<td>$1,480,025</td>
<td>$1,480,025</td>
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<tr>
<td>EPSDT (billed by SF DPH)</td>
<td>$0</td>
<td>$200,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>1. Total Revenue</td>
<td>$0</td>
<td>$4,713,835</td>
<td>$4,713,835</td>
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<tr>
<td><strong>5. Total Funding Requested for PEI Project</strong></td>
<td>$0</td>
<td>$650,000</td>
<td>$650,000</td>
</tr>
<tr>
<td><strong>6. Total In-Kind Contributions</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
BUDGET NARRATIVE
PEI Project: Early Childhood Mental Health Consultation

A. EXPENDITURES

1. Personnel Expenditures
   Total personnel costs amount to $245,331. This amount is a sum of the salaries, benefits and taxes shown below.

   a. Salary and wages. Costs for salaries and wages amount to $185,857.

   Health Program Coordinator III @ 1.0FTE $92,315
   The HPC provides programmatic and fiscal oversight for the Early Childhood Mental Health Consultation Initiative. This includes contract negotiations, managing the RFP process, identifying, selecting and matching childcare sites to consultants, conducting readiness assessment with potential childcare sites, facilitating monthly convenings of contractor network, promoting advocacy, public awareness, joint training and systems enhancements, and represent the initiative on citywide councils and collaboratives. 0.2 FTE of this position will be covered by PEI funds ($18,463); the remainder is covered in revenue from DCYF.

   Junior Administrative Analyst @ 1.0FTE $51,678
   The Jr. Administrative Analyst provides support to the Program Coordinator in overseeing the ECMHC Initiative. They assist with contracts, reporting, logistics, and outreach for the mental health consultation and the Trainer Institute. Just over half of this position is covered by leverage funds, the remainder by PEI ($24,001).

   Evaluator @ 0.5FTE $41,864
   The Evaluator has primary responsibility for evaluating the implementation and effectiveness of the mental health consultation. They will also evaluate the Trainer Institute and share recommendations for improvement with the staff. The Evaluator will work closely with the Program Coordinator and with the PEI Evaluator in their duties. Just over half of this position is covered by leverage funds, the remainder by PEI ($17,131).

   b. Employee Benefits – Benefits are calculated 35% of total salaries($185,857 x .35) for a total cost of $59,474.

   Total Personnel Expenditures - $245,331

2. Operating Expenditures
   a. Facility Cost – The budget includes $5,000 for facility rental for a year-long Training Institute to build the capacity of the mental health consultants and improve the quality of service across the County. The Training Institute will consist of biweekly didactic trainings and biweekly small group discussion sessions.

   b. Other Operating – The budget includes $10,000 for operation costs of the Training Institute. This covers food and materials for two meetings per month for the year.

   Total Operating Expenses - $15,000
3. **Subcontracts/Professional Services**
   This project includes multiple subcontracts, as follows

   **$490,000** – New subcontracts with community-based organizations with qualified and supervised mental health professionals who can provide on-site mental consultation to 27 new childcare programs, homes and centers. This cost is estimated at $14,000/site for childcare sites and Family Resource Centers, $11,000/site for substance abuse day treatment drop-in child care sites, and $50,000/each for Family Child Care Networks.

   **$24,000** – Subcontracts with professional trainers to present at the Training Institute. Trainers will be chosen for expertise in specific content areas relevant to providing mental health consultation to early care and education providers caring for SF’s youngest children, e.g. the Infant Parent Program and Child Trauma Research Institute.

   **$4,589,402** – Existing subcontracts with community-based organizations to provide mental health consultation to 169 childcare programs, homes and centers. Activities include providing professional development, child observation and individual/group consultation to staff; service linkage; and direct services to children and families. Approximately $350,000 of these subcontracts are for operations-related contracts, e.g. fiscal analyst.

   **Total Subcontracts – $5,103,402**

4. **Proposed PEI Project Budget - $5,363,835**
   The total budget for the Early Childhood Mental Health expansion project is $5,363,835

**B. REVENUES**

1. **Total Revenue - $4,713,835**
   Revenue comes from four major sources:
   - Human Service Agency = $1,539,110
   - Department of Children Youth and Families (DCYF) = $1,494,700
   - First 5 San Francisco = $1,480,025
   - EPSDT Billing via SF Department of Public Health = $200,000

5. **Total Funding Requested for PEI Project: $650,000**

6. **Total In-Kind Contributions:**
   In-kind contributions have not been calculated for this project and will vary by subcontractor.
### San Francisco County MHSA PEI

**Program and Expenditure Plan November 2008**

---

**Form No. 4**

**Instructions:** Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

<table>
<thead>
<tr>
<th>County Name:</th>
<th>San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Project Name:</td>
<td>Mental Health Consultation for Providers Working with At-Risk Youth</td>
</tr>
<tr>
<td>Provider Name (if known):</td>
<td></td>
</tr>
<tr>
<td>Intended Provider Category:</td>
<td>Community based organizations</td>
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</table>

#### Proposed Total Number of Individuals to be served:

<table>
<thead>
<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,100</td>
<td>1,100</td>
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</table>

#### Total Number of Individuals currently being served:

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<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
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#### Total Number of Individuals to be served through PEI Expansion:

<table>
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<tr>
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<th>FY 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,100</td>
<td>1,100</td>
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#### Months of Operation:

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<th>FY 09-10</th>
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</thead>
<tbody>
<tr>
<td>11</td>
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### Total Program/PEI Project Budget

#### A. Expenditure

<table>
<thead>
<tr>
<th>Item Description</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Salaries, Wages</td>
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<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Benefits and Taxes @ %</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>c. Total Personnel Expenditures</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Operating Expenditures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Facility Cost</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Other Operating Expenses</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>c. Total Operating Expenses</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Subcontracts/Professional Services (list/itemize all subcontracts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcontracts for Mental Health Consultation Services to 20 sites – up to 5 subcontracts</td>
<td>$0</td>
<td>$400,000</td>
<td>$400,000</td>
</tr>
<tr>
<td>Subcontract for Coordination of Mental Health Consultation Providers</td>
<td>$0</td>
<td>$25,000</td>
<td>$25,000</td>
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<tr>
<td>a. Total Subcontracts</td>
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<td>$425,000</td>
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<tr>
<td>4. Total Proposed PEI Project Budget</td>
<td>$0</td>
<td>$425,000</td>
<td>$425,000</td>
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#### B. Revenues (list/itemize by fund source)

<table>
<thead>
<tr>
<th>Item Description</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Revenue</td>
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<td>$0</td>
<td>$0</td>
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</table>

#### 5. Total Funding Requested for PEI Project

<table>
<thead>
<tr>
<th></th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$425,000</td>
<td>$425,000</td>
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</tbody>
</table>

#### 6. Total In-Kind Contributions

<table>
<thead>
<tr>
<th></th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
BUDGET NARRATIVE
PEI Project: Mental Health Consultation for Providers Working with Youth At-Risk for Juvenile Justice Involvement

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. All staffing will be provided under contract with the community-based organizations that implement the project. (See subcontract line item.)

   **Total Personnel Expenditures - $0**

2. Operating Expenditures
   There are no expenses in this category. Operations will be covered under subcontracts.

   **Total Operating Expenses - $0**

3. Subcontracts/Professional Services
   There will be up to five subcontracts for the Mental Health Consultation Project. Subcontractors will provide mental health consultation services to 20 community-based organizations that work with youth who are at-risk for involvement (or already involved) with the juvenile justice system, as well as to the youth themselves. The consultants build the capacity of staff via group trainings and consultation, individual coaching, observation and case consultation and service linkages. The consultants also provide limited, short-term interventions with youth and families.

   There will be an additional allocation of $25,000 for Coordination of Mental Health Consultation Providers. This may be included in a subcontract for mental health consultation services or executed as a separate contract. The subcontractor will help ensure that all of the mental health consultants - those involved in the DCYF initiative and those funded through PEI – will convene monthly to coordinate and improve their approaches, build linkages and document the consultation model and methods so that it can be expanded in the future.

   - $400,000 - Subcontracts for Mental Health Consultation Services
   - $25,000 – Subcontract for Coordination of Mental Health Consultation Providers

   **Total Subcontracts – $425,000**

4. Proposed PEI Project Budget - $425,000
   The total budget for the Mental Health Consultation Project is $425,000.

B. REVENUES

1. Total Revenue - $0
   There is no revenue included in the project budget

5. Total Funding Requested for PEI Project: $425,000

6. Total In-Kind Contributions:
   In-kind contributions have not been calculated for this project and will vary by subcontractor and participating youth service provider.
### PEI Revenue and Expenditure Budget Worksheet

**Form No. 4**

**Instructions:** Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

**County Name:** San Francisco  
**Date:** November 4, 2008

**PEI Project Name:** Depression Screening and Response  
**Intended Provider Category:** health care

<table>
<thead>
<tr>
<th>Proposed Total Number of Individuals to be served:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Individuals currently being served:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>0</td>
</tr>
<tr>
<td>Total Number of Individuals to be served through PEI Expansion:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>2,500</td>
</tr>
<tr>
<td>Months of Operation:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
</table>

#### A. Expenditure

1. **Personnel (list classifications and FTEs)**
   - a. Salaries, Wages  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - b. Benefits and Taxes @ 35%  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - c. **Total Personnel Expenditures**  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |

2. **Operating Expenditures**
   - a. Facility Cost  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - b. Other Operating Expenses: training materials, hospitality  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |
   - c. **Total Operating Expenses**  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $0       | $0    |

3. **Subcontracts/Professional Services (list/itemize all subcontracts)**
   - Training Contract  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $13,000  | $13,000|
   - Subcontracts with 3 Health Care Centers  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $287,145 | $287,145|
   - Revenue from subcontractors  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $40,500  | $40,500|
   - a. **Total Subcontracts**  
     | FY 08-09 | FY 09-10 | Total |
     | $0       | $340,645 | $340,645|

4. **Total Proposed PEI Project Budget**  
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $340,645 | $340,645|

#### B. Revenues (list/itemize by fund source)

- Subcontractors: staff to administer screening tool  
  | FY 08-09 | FY 09-10 | Total |
  | $0       | $8,100   | $8,100|
- Medi-cal billing by psychiatrist  
  | FY 08-09 | FY 09-10 | Total |
  | $0       | $32,400  | $32,400|

1. **Total Revenue**  
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $40,500  | $40,500|

5. **Total Funding Requested for PEI Project**  
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $300,145 | $300,145|

6. **Total In-Kind Contributions**  
   | FY 08-09 | FY 09-10 | Total |
   | $0       | $0       | $0    |
BUDGET NARRATIVE
PEI Project: Depression Screening and Response Pilot

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. All staffing will be provided under contract with the organizations that implement the project. (See subcontract line item.)
   
   Total Personnel Expenses - $0

2. Operating Expenditures
   There are no expenses in this category. Operations will be covered under subcontracts.
   
   Total Operating Expenses - $0

3. Subcontracts/Professional Services
   There will be four subcontracts for the Depression Screening and Response Project.

   $13,000 – Subcontract with qualified Training organization
   Subcontract is to training and consultation on the model chosen by the subcontractors. Contract will include multiple trainings for different types of staff (physicians, Care Managers, administrative staff), and different topics (overview, processes, in-depth training on evidence-based brief treatment options). The contract cost covers time, expenses and materials and is budgeted based on training costs for one of the four possible models.

   $287,145 – Subcontracts with three Health Care Centers
   Each subcontract will cover the same staff positions:
   
   Care Manager @ 0.6 FTE $41,400
   The Care Manager is a master’s level social worker who provides direct service at the to older adults identified via the screening process. The Care Manager provides outreach, care planning, short-term interventions with follow-up, and linkages to additional services as needed. S/he works with the physician and consulting psychiatrist to ensure timely and appropriate services for consumers. The Care Manager is 0.6 FTE each, at a base salary of $69,000.

   Administrative Support @ .25 FTE $13,500
   This title of this position will vary by subcontractor. This is an operations or administrative position who is responsible for logistics and paperwork for the center. They will be responsible for ensuring that the project is integrated into the processes and policies of the center. The position is .25 FTE at a base salary of $54,000.

   Psychiatrist @ 0.15 FTE $24,000
   The Psychiatrist provides consultation to the Care Manager and physician/nurses on prescriptions, medication management, and more intensive evaluation of high-risk cases. In instances when patients are sent to the psychiatrist for evaluation, Medi-cal will be billed. The PEI project will fund 0.1 FTE at a base salary of $160,000. The other 0.05 FTE will be leveraged from Medi-cal.

   Screener @ 0.05 FTE $2,000
   This position will also vary by subcontractor. This person will administer the screening tools when a patient first comes to the clinic. If the patient screens as at-risk for depression, they will immediately contact the Care Manager. This position is leveraged from the Health Center and is calculated at 0.05 FTE of a base salary of $40,000.
PEI Revenue and Expenditure Budget Worksheet

Benefits @ 35% $28,315
Benefits for the positions listed above are calculated at 35% for a total of $28,315

Total Subcontracts – $340,645

4. Proposed PEI Project Budget - $340,645
   The total budget for the Depression Screening and Response Pilot Project is $340,645

B. REVENUES

1. Total Revenue
   Revenue comes from two sources:
   • Health Care Center. Each center will provide a staff person to administer the screening tool. This is calculated at 0.05 FTE of a base salary of $40,000, plus benefits. The total amount of revenue for all three centers is $8,100.
   • Medi-Cal will be billed for psychiatric evaluation of patients of this project. This is estimated to be equivalent of 5% of a psychiatrist’s base salary of $160,000, plus benefits. The total revenue across the three centers is $32,400.

5. Total Funding Requested for PEI Project: $300,145

6. Total In-Kind Contributions: In-kind contributions have not been calculated for this project.
## PEI Revenue and Expenditure Budget Worksheet

### Form No. 4

#### Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

<table>
<thead>
<tr>
<th>County Name:</th>
<th>San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Project Name:</td>
<td>Early Intervention and Recovery for Young People with Early Psychosis</td>
</tr>
<tr>
<td>Provider Name (if known):</td>
<td>Community Behavioral Health Services</td>
</tr>
<tr>
<td>Intended Provider Category:</td>
<td>County Mental Health Agency and CBOs/Mental health service providers</td>
</tr>
</tbody>
</table>

### Proposed Total Number of Individuals to be served:

<table>
<thead>
<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>1200</th>
</tr>
</thead>
</table>

### Total Number of Individuals currently being served:

<table>
<thead>
<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>0</th>
</tr>
</thead>
</table>

### Total Number of Individuals to be served through PEI Expansion:

<table>
<thead>
<tr>
<th>FY 08-09</th>
<th>FY 09-10</th>
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### Months of Operation:

<table>
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<th>FY 09-10</th>
<th>10</th>
</tr>
</thead>
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### Total Program/PEI Project Budget

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Salaries, Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.0 FTE Clinical Psychologist (2576)</td>
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<td>$169,674</td>
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<tr>
<td>2.0 FTE Clinician (2930/31)</td>
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<td>$135,564</td>
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<tr>
<td>2.0 FTE Case Manager (2585)</td>
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<tr>
<td>0.75 FTE Child Psychiatrist (2230)</td>
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<td>Total Salaries, Wages</td>
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<tr>
<td>b. Benefits and Taxes @ 35%</td>
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</tr>
<tr>
<td>$181,417</td>
<td>$181,417</td>
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<tr>
<td><strong>c. Total Personnel Expenditures</strong></td>
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<tr>
<td>2. Operating Expenditures</td>
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<tr>
<td>a. Facility Cost</td>
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<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Other Operating Expenses (peer advocate stipends, equipment, phone line, &amp; supplies)</td>
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<tr>
<td><strong>c. Total Operating Expenses</strong></td>
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<tr>
<td>3. Subcontracts/Professional Services (list/itemize all subcontracts)</td>
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<tr>
<td>Outreach and Education</td>
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<td>Training on EBAs and EBPs</td>
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<td>Neuropsych Assessment Services</td>
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<td>Wraparound Services</td>
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<td>$0</td>
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<td>$1,336,614</td>
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<td><strong>B. Revenues (list/itemize by fund source)</strong></td>
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<td></td>
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<tr>
<td>EPSDT 0.4 FTE Clinical Psychologist (2576)</td>
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<td>$45,812*</td>
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<td>EPSDT 0.4 FTE Clinician (2930/31)</td>
<td>$0</td>
<td>$36,602*</td>
<td>$36,602*</td>
</tr>
<tr>
<td>EPSDT 0.4 FTE Case Manager (2585)</td>
<td>$0</td>
<td>$21,608*</td>
<td>$21,608*</td>
</tr>
<tr>
<td>EPSDT 0.3 FTE Child Psychiatrist (2230)</td>
<td>$0</td>
<td>$32,592*</td>
<td>$32,592*</td>
</tr>
<tr>
<td><strong>1. Total Revenue</strong></td>
<td>$136,614*</td>
<td>$136,614*</td>
<td></td>
</tr>
<tr>
<td><strong>5. Total Funding Requested for PEI Project</strong></td>
<td>$0</td>
<td>$1,200,000</td>
<td>$1,200,000</td>
</tr>
<tr>
<td><strong>6. Total In-Kind Contributions</strong> (Intake Worker)</td>
<td>$0</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

*Note: Includes 35% in benefits and taxes
BUDGET NARRATIVE
PEI Project: Early Intervention and Recovery for Young People with Early Psychosis

A. EXPENDITURES

1. Personnel
Total personnel costs amount to $699,753. This amount is a sum of the salaries, benefits and taxes shown below.

a. Salaries and Wages. Costs for salaries and wages amount to $518,336. This funds two clinical teams.

Clinical Psychologist 2.0FTE $169,674
Under general direction, the clinical psychologist on each team plans, organizes, directs, and assumes responsibility for the Early Intervention and Recovery for Young People with Early Psychosis Program. S/he oversees the outreach and education component of the program. Assigns, maintains standards for, and supervises the work of intake and clinical staff in the psychological assessment, planning and treatment of consumers. Monitors and maintains the fidelity of the treatment model, associated evidence based practices and tracks treatment outcomes. Budget planning and monitoring of expenditures. The Program Director will have a Doctoral degree in a clinical field, e.g., psychology.

Clinician 2.0FTE $135,564
As part of each intervention team, a master’s level clinician will be responsible for assessment, planning as well as implementing the intervention plan. This package of services may include individual CBT, family psychoeducation and therapy, and other services and duties as needed (e.g., billing and documentation).

Case Manager 2.0FTE $80,028
The Case Manager on each team will be responsible for coordinating and linking youth and their families to additional services that may include neuropsychological assessment, vocational or educational services, and family support, wraparound services and other services and duties as needed (e.g., billing and documentation).

Child Psychiatrist 0.75FTE $133,070
In collaboration with the treatment teams, the child psychiatrist will evaluate, plan and implement pharmacological treatment for youth and their families and other services and duties as needed (e.g., billing and documentation).

b. Benefits and Taxes. Benefits are calculated at 35% of total salaries ($518,336 x .35) for a cost of $181,417.

2. Operating Expenditures
Total operating expenses amount to $26,861.

a. Facility Cost. None.

b. Other Operating Expenses - $26,861. These expenses include stipends for four peer advocates ($6,000 x 4 = $24,000) who have experienced and received intervention for psychosis to be part of the outreach and education team. An
additional $2,861 covers supplies for the outreach and advocacy team, internet and phone service.

3. Subcontracts/Professional Services
Total subcontract and professional expenses amount to $610,000.

- **$300,000 - Community Outreach and Education.**
  An RFP will be issued to contract for outreach and education services in schools, community centers, religious and spiritual institutions and other settings where children, youth and families naturally spend time throughout San Francisco. Four full-time outreach workers ($50,000 per year x 4) will work as part of the program team to educate and identify youth and families eligible for this program.

- **$110,000 - Training and Materials for Evidence-Based Assessment and Practices.**
  Research has shown that a number of assessment tools (e.g., SIPPS) are highly effective at identifying children and youth at risk for or in the early stages of psychosis. In addition, there are several evidence-based practices (CBT for psychosis, solution-focused family therapy) that have been shown to effectively treat the prodromal symptoms and early stages of psychosis. The clinical team will require training, certification and ongoing supervision in these practices.

- **$100,000 - Neuropsychological Assessment Services.**
  In more complex cases, neuropsychological evaluation may be necessary to understand the contributions of co-morbid conditions (e.g., learning disabilities or executive functioning) or to rule out other etiological factors. An RFP will be issued to contract for these services.

- **$100,000 - Family Support and Wraparound Services.**
  An RFP will be issued to contract for respite care and wraparound services. Respite care may be provided to families on a short-term basis at home or in other settings to reduce family stress, which is a contributing factor to early psychosis. In addition, wraparound services will be needed by some families to assure that services are accessible (transportation), that other key needs are being met (vocational and or educational services) to support children and youth to return to their usual lives as soon as possible.

4. Total Proposed PEI Budget - $1,336,614
The overall expenditure level for this program is $1,336,614.

B. Revenues
Revenues for this program are estimated at $136,614 in services that will be billed by the clinical team to EPSDT Medi-Cal.

5. Total Funding Requested for PEI Project - $1,200,000

6. Total In-Kind Contributions
Total in-kind contributions total $12,000. Given that this program will be located in existing civil service clinic, this contribution reflects approximately .20 FTE for the onsite intake coordinator who will screen and schedule consumers for the program.
## PEI Revenue and Expenditure Budget Worksheet

### Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

| County Name: | San Francisco |
| PEI Project Name: | Trauma Recovery Services |
| Provider Name (if known): | Instituto Familiar de la Raza & Urban Service YMCA |
| Intended Provider Category: | Community-Based Organizations |

| Proposed Total Number of Individuals to be served: | FY 08-09 | FY 09-10 | 1,470 |
| Total Number of Individuals currently being served: | FY 08-09 | FY 09-10 | 1,470 |
| Total Number of Individuals to be served through PEI Expansion: | FY 08-09 | FY 09-10 | n/a |
| Months of Operation: | FY 08-09 | FY 09-10 | 12 |

### A. Expenditure

1. **Personnel (list classifications and FTEs)**

   a. Salaries, Wages  $0 $0 $0
   b. Benefits and Taxes @ %  $0 $0 $0
   c. Total Personnel Expenditures  $0 $0 $0

2. **Operating Expenditures**

   a. Facility Cost  $0 $0 $0
   b. Other Operating Expenses  $0 $0 $0
   c. Total Operating Expenses  $0 $0 $0

3. **Subcontracts/Professional Services (list/itemize all subcontracts)**

   Instituto Familiar de la Raza  $0 $123,600 $123,600
   Urban Services YMCA  $0 $123,600 $123,600
   a. Total Subcontracts  $0 $247,200 $247,200

4. **Total Proposed PEI Project Budget**

   $0 $247,200 $247,200

### B. Revenues (list/itemize by fund source)

1. Total Revenue  $0 $0 $0

5. **Total Funding Requested for PEI Project**

   $0 $247,200 $247,200

6. **Total In-Kind Contributions**

   $0 $0 $0
BUDGET NARRATIVE
PEI Project: Trauma and Recovery

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. Staffing will be provided under contract with the community-based organizations that implement the project.

   \[ \text{Total Personnel Expenditures} = 0 \]

2. Operating Expenditures
   There are no expenses in this category. All operations will be covered under subcontracts.

   \[ \text{Total Operating Expenses} = 0 \]

3. Subcontracts/Professional Services
   There will be two subcontracts

   \$123,600 – Instituto Familiar de la Raza
   The contract will cover cost of staffing and operations to provide trauma recovery and healing services to youth under 18 years old and their families with an emphasis upon Latinos and multicultural youth and families living in the Mission district. \$67,638 of the contract pays salary and benefits for 1.2% FTE Licensed Clinical CM/LCSW, and \$23,540 pays for between 7-30% of other staff time, i.e. the program director, youth worker/peer counselor, and program support clerk. The contract includes \$19,180 in operations costs, e.g. rent, utilities, travel, insurance, and supplies and \$13,242 in indirect costs.

   \$123,600 – Urban Services YMCA
   The contract will cover cost of staffing and operations to provide comprehensive mental health, clinical case management, and outreach services to youth and their families affected by violent events in order to reduce the levels of untreated trauma to San Francisco residents. \$68,649 of the contract pays salary and benefits for 1.38% FTE Therapist, \$3,612 pays salary and benefits for a 23% FTE Executive Director of Mental Health, \$18,907 pays salary and benefits for a 23% FTE Coordinator of Mental Health Services, \$15,787 pays salary and benefits for a 23% FTE Eligibility Coordinator, and \$3,402 pays salary and benefits for a 23% FTE Clinical Supervisor. The contract includes \$13,243 in indirect costs.

   \[ \text{Total Subcontracts} = \$247,200 \]

4. Proposed PEI Project Budget - \$247,200
   The total budget for the Trauma and Recovery Project is \$247,200.

B. REVENUES

1. Total Revenue
   There is no revenue for this project = \$0

5. Total Funding Requested for PEI Project: \$247,200

6. Total In-Kind Contributions:
   In-kind contributions have not been calculated for this project and will vary by subcontractor.
## PEI Revenue and Expenditure Budget Worksheet

**Form No. 4**

**Instructions:** Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

<table>
<thead>
<tr>
<th>County Name:</th>
<th>San Francisco</th>
<th>Date:</th>
<th>November 4, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Project Name:</td>
<td>Crisis Response Team</td>
<td>Provider Name (if known):</td>
<td>Community Behavioral Health Services</td>
</tr>
<tr>
<td>Intended Provider Category:</td>
<td>County Mental Health Agency</td>
<td>Proposed Total Number of Individuals to be served:</td>
<td>FY 08-09</td>
</tr>
<tr>
<td>Total Number of Individuals currently being served:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>300</td>
</tr>
<tr>
<td>Total Number of Individuals to be served through PEI Expansion:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>150</td>
</tr>
<tr>
<td>Months of Operation:</td>
<td>FY 08-09</td>
<td>FY 09-10</td>
<td>12</td>
</tr>
</tbody>
</table>

### Proposed Expenses and Revenues

<table>
<thead>
<tr>
<th>A. Expenditure</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Salaries, Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.0 FTE Psychiatric Social Worker (2930/31)</td>
<td>$397,280</td>
<td>$397,280</td>
<td></td>
</tr>
<tr>
<td>3.0 FTE Health Worker III (2587)</td>
<td>$172,572</td>
<td>$172,572</td>
<td></td>
</tr>
<tr>
<td>1.0 FTE Health Program Coordinator III (2593)</td>
<td>$98,982</td>
<td>$98,982</td>
<td></td>
</tr>
<tr>
<td>b. Benefits and Taxes @ 35%</td>
<td></td>
<td></td>
<td>$234,092</td>
</tr>
<tr>
<td>c. Total Personnel Expenditures</td>
<td>$0</td>
<td>$902,926</td>
<td>$902,926</td>
</tr>
<tr>
<td>2. Operating Expenditures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Facility Cost</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Other Operating Expenses (e.g., equipment, supplies, stipends)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>c. Total Operating Expenses</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Subcontracts/Professional Services (list/itemize all subcontracts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Total Subcontracts</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Total Proposed PEI Project Budget</td>
<td>$0</td>
<td>$902,926</td>
<td>$902,926</td>
</tr>
<tr>
<td>B. Revenues (list/itemize by fund source)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SF General Fund: Six staff positions</td>
<td>$0</td>
<td>$554,769</td>
<td>$554,769</td>
</tr>
<tr>
<td>a. Total Revenue</td>
<td>$0</td>
<td>$554,769</td>
<td>$554,769</td>
</tr>
<tr>
<td>5. Total Funding Requested for PEI Project</td>
<td>$0</td>
<td>$348,157</td>
<td>$348,157</td>
</tr>
<tr>
<td>6. Total In-Kind Contributions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
BUDGET NARRATIVE
PEI Project: Crisis Response Team

A. EXPENDITURES

1. Personnel - $902,926
   Total personnel costs amount to $902,926. This amount is a sum of the salaries, benefits and taxes shown below.

   a. Salaries and Wages. Costs for salaries and wages amount to $668,834.

      Psychiatric Social Worker @ 5.0FTE $397,280
      The Social Workers work in tandem with the Health Workers to respond to violent incidents in the community. They provide 24/7 immediate crisis care and follow-up case management services to family members and loved ones of victims of violence. The Social Worker provides direct therapeutic interventions and addresses the mental health needs of the consumers. The base salary for the Psychiatric Social Worker (2930/31) position is $79,456 x 5 = $397,280.

      Health Worker III @ 3.0FTE $172,572
      The Health Workers work in a team with the Social Workers to respond to violent incidents in the community. The Health Worker acts as the primary case manager for all supportive and basic needs of an impacted family. The base salary for this Health Worker III (2587) position is $57,524 x 3 = $172,572.

      Health Program Coordinator @ 1.0FTE $98,982
      The Health Program Coordinator provides administrative oversight for this project as well as providing direct service as part of a Crisis Response Team when they are scheduled as a responder. The base salary for this position (2593) is $98,982.

   b. Benefits and Taxes. Benefits are calculated at 35% of total salaries ($668,834 x .35) for a total cost of $234,092.

2. Operating Expenditures
   There are no operating expenditures associated with this project.

   Total Operating Expenses - $0

3. Subcontracts/Professional Services
   There are no subcontracts associated with this project.

   Total Subcontracts - $0

4. Total Proposed PEI Budget - $902,926
   The total project budget for the Crisis Response Team is $904,179

B. REVENUES

1. Total Revenue - $554,769
   The City General Fund provides revenue of $554,769 for personnel involved in this project, specifically:
   - 3 Psychiatric Social Workers @ $79,456 x 3 = $238,368
   - 3 Health Workers @ $57,524 x 3 = $172,572
   - Benefits @ 35% = $143,829

5. Total Funding Requested for PEI Project - $348,157

6. Total In-Kind Contributions. In-kind contributions have not been calculated for this project.
PEI Revenue and Expenditure Budget Worksheet

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

<table>
<thead>
<tr>
<th>County Name:</th>
<th>San Francisco</th>
<th>Date: November 4, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Project Name:</td>
<td>Transitional Aged Youth Multi-Service Center</td>
<td></td>
</tr>
<tr>
<td>Provider Name (if known):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intended Provider Category:</td>
<td>Community Based Organization</td>
<td></td>
</tr>
</tbody>
</table>

Proposed Total Number of Individuals to be served: FY 08-09 _______ FY 09-10 TBD
Total Number of Individuals currently being served: FY 08-09 _______ FY 09-10 TBD
Total Number of Individuals to be served through PEI Expansion: FY 08-09 _______ FY 09-10 TBD

<table>
<thead>
<tr>
<th>Months of Operation:</th>
<th>FY 08-09</th>
<th>FY 09-10</th>
<th>TBD</th>
</tr>
</thead>
</table>

### Proposed Expenses and Revenues

#### A. Expenditure

1. Personnel (list classifications and FTEs)
   - **a. Salaries, Wages**
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0
   - **b. Benefits and Taxes @ %**
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0
   - **c. Total Personnel Expenditures**
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0

2. Operating Expenditures
   - **a. Facility Cost**
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0
   - **b. Other Operating Expenses**
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0
   - **c. Total Operating Expenses**
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0

3. Subcontracts/Professional Services (list/itemize all subcontracts)
   - Community Based Organization
     - FY 08-09: $0
     - FY 09-10: $200,000
     - **Total**: $200,000
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0
     - FY 08-09: $0
     - FY 09-10: $0
     - **Total**: $0
   - **a. Total Subcontracts**
     - FY 08-09: $0
     - FY 09-10: $200,000
     - **Total**: $200,000

4. Total Proposed PEI Project Budget
   - FY 08-09: $0
   - FY 09-10: $200,000
   - **Total**: $200,000

#### B. Revenues (list/itemize by fund source)

1. **Total Revenue**
   - FY 08-09: $0
   - FY 09-10: $0
   - **Total**: $0

5. **Total Funding Requested for PEI Project**
   - FY 08-09: $0
   - FY 09-10: $200,000
   - **Total**: $200,000

6. **Total In-Kind Contributions**
   - FY 08-09: $0
   - FY 09-10: $0
   - **Total**: $0
BUDGET NARRATIVE
PEI Project: Transitional Aged Youth Multi-Service Center

A. EXPENDITURES

1. Personnel Expenditures
   There are no expenses in this category. All staffing will be provided by the subcontractor.
   
   Total Personnel Expenditures - $0

2. Operating Expenditures
   There are no expenses in this category. All operations will be covered under the subcontract.

   Total Operating Expenses - $0

3. Subcontracts/Professional Services
   There will be a single subcontract for $200,000 for the Transitional Aged Youth Multi-Service Center. The model and menu of services for this project still being developed.

   Total Subcontracts – $200,000

4. Proposed PEI Project Budget - $200,000
   The total budget for the Transitional Aged Youth Multi-Service Center is $200,000.

B. REVENUES

1. Total Revenue
   Revenue for this project has not yet been determined.

5. Total Funding Requested for PEI Project: $200,000

6. Total In-Kind Contributions
   In-kind contributions have not been calculated for this project.
### PEI Administration Budget Worksheet

**County:** San Francisco  
**Date:** November 4, 2008

<table>
<thead>
<tr>
<th>A. Expenditures</th>
<th>Client and Family Member, FTEs</th>
<th>Total FTEs</th>
<th>Budgeted Expenditure FY 2008-09</th>
<th>Budgeted Expenditure FY 2009-10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personnel Expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. PEI Coordinator</td>
<td>1</td>
<td></td>
<td>$98,982</td>
<td>$98,982</td>
<td></td>
</tr>
<tr>
<td>b. PEI Support Staff</td>
<td>1</td>
<td></td>
<td>$33,774</td>
<td>$33,774</td>
<td></td>
</tr>
<tr>
<td>c. Other Personnel (list classifications)</td>
<td>1</td>
<td></td>
<td>$93,314</td>
<td>$93,314</td>
<td></td>
</tr>
<tr>
<td>PEI Evaluator</td>
<td>1</td>
<td></td>
<td>$73,502</td>
<td>$73,502</td>
<td></td>
</tr>
<tr>
<td>Assistant Health Educator</td>
<td>1</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>d. Employee Benefits @ 35%</td>
<td>1</td>
<td></td>
<td>$104,850</td>
<td>$104,850</td>
<td></td>
</tr>
<tr>
<td>e. Total Personnel Expenditures</td>
<td>1</td>
<td></td>
<td>$0</td>
<td>$404,422</td>
<td>$404,422</td>
</tr>
</tbody>
</table>

| 2. Operating Expenditures |  |  |  |  |  |
| a. Facility Costs |  |  | $0 | $0 | $0 |
| b. Other Operating Expenditures |  |  | $10,000 | $10,000 |  |
| c. Total Operating Expenditures |  |  | $0 | $10,000 | $10,000 |

| 3. County Allocated Administration |  |  |  |  |  |
| a. Total County Administration Cost |  |  | $0 | $31,755 | $31,755 |

| 4. Total PEI Funding Request for County Administration Budget |  |  |  |  |  |
|  |  |  | $0 | $446,177 | $446,177 |

### B. Revenue

| 1. Total Revenue |  |  |  |  |  |
|  |  |  | $0 | $0 | $0 |

| C. Total Funding Requirements |  |  |  |  |  |
|  |  |  | $0 | $446,177 | $446,177 |

| D. Total In-Kind Contributions |  |  |  |  |  |
|  |  |  | $0 | $0 | $0 |
BUDGET NARRATIVE: PEI Administration

A. EXPENDITURES

1. Personnel
   a. Salaries and Wages. Costs for salaries and wages amount to $299,572

   **PEI Coordinator @ 1.0 FTE - $98,982**
   The PEI Coordinator will provide oversight for all PEI projects. S/he will meet regularly with subcontractors and partners to ensure full implementation of the projects, build linkages and collaboration, and troubleshoot challenges. S/he will also keep the stakeholders and public informed on the progress and impact of the PEI programs, work closely with the consultant hired to implement the community-wide assessment, and reconvene key stakeholders as necessary to assess the success of the PEI projects and to revisit the PEI Plan and priorities. S/he will represent the PEI effort at city, state and federal levels, participate in DMH activities and work with the PEI Evaluator to produce state required reports. The PEI Coordinator will work with the MHSA Coordinator in developing and updating the annual integrated plan. S/he will develop policies and procedures and interpret and disseminate legislations relating to MHSA. The base salary for this position is $98,982. This position will be contracted at the same salary range offered by the City.

   **PEI Peer Implementation Specialist @1.0 FTE - $33,774**
   The PEI Peer Implementation Specialist will assist the PEI administrative staff in all facets of implementation; liaise with consumer organizations regarding consumer involvement in the planning and implementation of PEI initiatives; facilitate all logistical needs for stakeholders and public information processes; and coordinate with the MHSA Administrative Assistant in updating the local PEI website.

   **PEI Evaluator @ 1.0 FTE - $93,314**
   The PEI Evaluator will take the lead on evaluating the PEI projects. S/he will work with each PEI project staff and funded agencies to develop a program logic model and evaluation procedures and outcome measures. The PEI Evaluator will work in tandem with the CBHS Research Evaluation and Quality Management (REQM) Department, and will utilize REQM evaluation infrastructure, procedures and processes. The PEI Evaluator will represent the county in statewide evaluation and outcome workgroup efforts and complete state required reports. The base salary for this position is $93,315.

   **Assistant Health Educator @ 1.0 FTE - $73,508**
   The Assistant Health Educator will serve as the County’s point person for the statewide suicide prevention initiative. S/he will provide significant support to the PEI Coordinator and Evaluator by conducting field work, e.g. consumer interviews, disseminating information and reports resulting from statewide and local implementation efforts, designing informational and educational materials, and providing assistance in developing and implementing pre and post implementation surveys. S/he will also support the PEI Coordinator in keeping the community informed and engaged in the PEI effort. The base salary for this position is $73,508.

   b. Benefits and Taxes. Benefits are calculated at 35% of total salaries ($299,572 x .35) for a total cost of $104,850.

   **Total Personnel Expenditures - $404,422**
2. Operating Expenditures
   c. Facility Cost – None
   d. Other Operating Expenses - $$
      Other Operating Expenses include project related costs such as computers for the Coordinator and Evaluator ($2 x $2,500), project supplies ($1,000), office supplies ($1,000), reproduction costs ($2,000), and other miscellaneous expenses ($1,000) associated with the planning and implementation of all PEI initiatives.

      Total Operating Expenditures - $10,000

3. County Allocated Overhead - $31,755
   This includes costs attributable to the proposed PEI programs and county allocated administrative overhead, at 10.6% of salaries, including centralized accounting and human resources costs.

      Total Overhead - $31,755

4. Total PEI Funding Request for County Administration Budget = $446,177

B. Revenue: There is no revenue included in the budget.

C. Total Funding Requirements - $446,177

D. Total In-Kind Contributions: There are no in-kind contributions included in the budget.
Instruction: Please provide a listing of all PEI projects submitted for which PEI funding is being requested. This form provides a PEI project number and name that will be used consistently on all related PEI project documents. It identifies the funding being requested for each PEI project from Form No. 4 for each PEI project by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5 (line C).

| County: | San Francisco |
| Date: | November 4, 2008 |

<table>
<thead>
<tr>
<th>#</th>
<th>List each PEI Project</th>
<th>FY 08/09</th>
<th>FY 09/10</th>
<th>Total</th>
<th>*Children, Youth, and their Families</th>
<th>*Transition Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>School-Based Youth-Centered Wellness</td>
<td>$0</td>
<td>$947,400</td>
<td>$947,400</td>
<td>$641,200</td>
<td>$260,200</td>
<td>$46,000</td>
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<tr>
<td>2</td>
<td>Screening, Planning and Supportive Services for Incarcerated Youth</td>
<td>$0</td>
<td>$390,000</td>
<td>$390,000</td>
<td>$234,000</td>
<td>$156,000</td>
<td></td>
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<tr>
<td>3</td>
<td>Reengagement of Truant and Out of School Youth</td>
<td>$0</td>
<td>$268,000</td>
<td>$268,000</td>
<td>$214,400</td>
<td>$53,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Holistic Wellness Promotion in a Community Setting</td>
<td>$0</td>
<td>$750,000</td>
<td>$750,000</td>
<td>$450,000</td>
<td></td>
<td></td>
<td>$300,000</td>
</tr>
<tr>
<td>5</td>
<td>Early Childhood Mental Health Consultation</td>
<td>$0</td>
<td>$650,000</td>
<td>$650,000</td>
<td>$650,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mental Health Consultation with Providers working with At-Risk Youth</td>
<td>$0</td>
<td>$425,000</td>
<td>$425,000</td>
<td>$318,750</td>
<td>$106,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Depression Screening and Response</td>
<td>$0</td>
<td>$300,145</td>
<td>$300,145</td>
<td>$300,145</td>
<td></td>
<td></td>
<td>$300,145</td>
</tr>
<tr>
<td>8</td>
<td>Early Intervention and Recovery for Young People with Early Onset</td>
<td>$0</td>
<td>$1,200,000</td>
<td>$1,200,000</td>
<td>$600,000</td>
<td>$600,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Trauma Recovery</td>
<td>$0</td>
<td>$247,200</td>
<td>$247,200</td>
<td>$123,600</td>
<td>$49,440</td>
<td>$74,160</td>
<td></td>
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<tr>
<td>10</td>
<td>Crisis Response Team</td>
<td>$0</td>
<td>$348,157</td>
<td>$348,157</td>
<td>$348,157</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11</td>
<td>Transitional Age Youth Multi-Service Center</td>
<td>$0</td>
<td>$200,000</td>
<td>$200,000</td>
<td>$200,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Administration**

| $0       | $446,177 | $446,177 | $251,842 | $111,078 | $59,869 | $23,388 |

**Total PEI Funds Requested:**

| $0       | $6,172,079 | $6,172,079 | $3,483,792 | $1,536,568 | $828,186 | $323,533 |

*A minimum of 51% of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 (“small counties” are excluded from this requirement).*
County: San Francisco  Date: November 4, 2008

☐ Check this box if this is a “very small county” (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name: Holistic Wellness Promotion in a Community Setting

1. a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.

San Francisco’s local MHSA PEI evaluation will focus on the Holistic Wellness Promotion in a Community Setting (HWPCS) project. This project consists of three wellness centers that will provide services within communities that have been disproportionately exposed to and affected by trauma. The menu of services provided by each center will vary depending on the needs and cultural practices of the target community, but all services will incorporate Community Wellness Promotion and/or Cultural Activities and Traditional Healing.

1. b. Explain how this PEI project and its programs were selected for local evaluation.

The Holistic Wellness Promotion in a Community Setting (HWPCS) project is based on a best practice model that was developed locally for San Francisco’s Native American population: the Holistic System of Care for Native American in an Urban Environment. The proposed PEI project will adapt that model to three other underserved populations in San Francisco that are disproportionately affected by trauma exposure. The HWPCS project was selected as the focus of the local evaluation for the following reasons:

1) Although the project is based on a best practice model for the Native American population, it has not yet been evaluated for use with other populations. The evaluation will examine the effectiveness of the three adapted models and identify cultural modifications that lead to better wellness outcomes for the three target populations.

2) In addition, the substantial funding allocated to the project ($750,000) and the community effort required to successfully develop three wellness centers represent a considerable investment of resources. Stakeholders involved in the PEI planning process believe that such a significant investment warrants an equally significant level of attention paid to evaluating the impact of the project.

2. What are the expected person/family-level and program/system-level outcomes for each program?

The specific outcomes and objectives for each center are expected to vary based on the needs and cultural practices of the community it serves. The communities in San Francisco that will receive HWPCS services are currently being identified through a needs assessment process that is intended to supplement the initial PEI planning process. Nonetheless, the following objectives are expected to be common across the three centers.
PERSON/FAMILY LEVEL
- Increased caregiver ability to provide consistent nurturing environments for their children, have positive interactions with them, and to address problematic child behaviors effectively.
- Increased ability of children and youth to participate in safe, culturally-appropriate afterschool activities that develop positive self-esteem and self-efficacy, including youth development and anti-oppression activities.
- Increased exposure of community members to cultural activities and traditional healing experiences.
- Increased community member knowledge of safety planning and risk reduction strategies related to family and community violence.
- Increased access to counseling and/or case management services for community members experiencing emotional distress related to trauma exposure.

PROGRAM/SYSTEM LEVEL
- Increased community capacity to ameliorate the negative impact of trauma exposure on community members through:
  - Provision of counseling and case management services.
  - Provision of peer counseling / mentoring.
  - Home visits to individuals and families.
  - Provision of safety planning and risk reduction counseling.
- Increased community capacity to support the healthy development of children and youth by:
  - Increasing their participation in safe, culturally-appropriate afterschool activities.
  - Increasing caregiver knowledge and use of effective parenting practices.
- Increased community capacity to provide cultural activities and traditional healing experiences to community members who wish to participate in them.

3. **Describe the numbers and demographics of individuals participating in this intervention.** Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For “other”, provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total unduplicated count of individuals to be served. If the focus of the intervention is families, count each person in the family.

The specific cultural focus of each wellness center has not yet been determined and therefore, the ethnicity of the proposed participants is currently unknown. The gender of participants is similarly unknown at this time. However, the three centers are intended to serve communities in San Francisco that are disproportionately exposed to trauma. Candidate communities will likely reflect the communities experiencing poverty, since poverty levels are highly correlated with violence exposure. As noted earlier, 15% of all San Francisco children live in poverty, and that percentage varies by ethnicity: 29% of African-American children and youth live in poverty, followed by 27% of Latinos, 10% of Asian/Pacific Islanders, and 1% of Whites. The ethnicity numbers provided in the table below are based on these estimates and on 2000 census data showing the representation of each ethnicity within San Francisco. However, the actual ethnicity of participants will depend on the outcome of the needs assessment and the responses to the RFP.
## Local Evaluation of a PEI Project

### Person to Receive Intervention

<table>
<thead>
<tr>
<th>Population Demographics</th>
<th>Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trauma</td>
</tr>
<tr>
<td><strong>Ethnicity/Culture</strong></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>260</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>360</td>
</tr>
<tr>
<td>Latino</td>
<td>460</td>
</tr>
<tr>
<td>Native American</td>
<td>30</td>
</tr>
<tr>
<td>Caucasian</td>
<td>60</td>
</tr>
<tr>
<td>Other (Indicate if possible)</td>
<td>30</td>
</tr>
<tr>
<td><strong>Age Groups</strong></td>
<td></td>
</tr>
<tr>
<td>Children &amp; Youth (0-17)</td>
<td>400</td>
</tr>
<tr>
<td>Transition Age Youth (16-25)</td>
<td>400</td>
</tr>
<tr>
<td>Adult (18-59)</td>
<td>300</td>
</tr>
<tr>
<td>Older Adult (&gt;60)</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1200</td>
</tr>
</tbody>
</table>

Total PEI project estimated **unduplicated** count of individuals to be served: **1,200** individuals per year

### 4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

As noted above, the specific outcomes and objectives for each center are expected to vary based on the needs and cultural practices of the community. The PEI Evaluator will assist each center in developing a logic model, and evaluation procedures and measures for each center will be selected, in collaboration with the center, based on this model. Some of the measurement, tracking, and evaluation strategies expected to be common across the three centers are:

1. The RFP will specify that the lead agency for each of the three wellness centers will be required to collect and report participant demographic data (e.g., age, ethnicity, primary language) and participant counts for each of the center’s main activities (e.g., afterschool...
programs, parenting classes, support groups, etc). These reports will be provided on a quarterly basis.

2) During the start-up phase, focus groups will be held in each of the three communities to assess community member and wellness center staff perspectives on access, engagement, and appropriateness of the services (including cultural adaptations made to the original model) provided at the centers. The results of the focus groups will be disseminated to the centers as part of a formative evaluation designed to improve services.

3) Following the start-up phase, each center will summarize any implementation challenges and/or changes the center has made to its service array, staffing, clientele, or program model (including cultural adaptations) in an annual Implementation Status survey.

4) The PEI Evaluator, in collaboration with other staff from the CBHS Research, Evaluation, and Quality Management (REQM) Unit, will develop a database to store and track the data received from the three centers and provide feedback to each center and to MHSA implementation staff regarding data quality and each center’s performance on its specific objectives.

5) Centers that provide positive parenting programs are expected to utilize an evidence-based curriculum that has been shown to be effective for the population they serve, if one is available. They are further expected to administer the accompanying outcome, satisfaction, and fidelity measures associated with the curriculum. These measures will be collected by the PEI Evaluator and findings will be reported back to each center to aid in program improvement.

5. How will data be collected and analyzed?

The framework for collecting, tracking, and analyzing data from the three wellness centers will be developed by the PEI Evaluator in consultation with the Director of REQM, other REQM staff, and the lead agencies for the three funded wellness centers. Summary reports of service and outcome data will be generated quarterly and provided to the three centers and to the MHSA Coordinator. Data analysis strategies designed to measure the impact of the wellness centers on the local community and on the larger behavioral health system in San Francisco will be developed by the PEI Evaluator, and these findings will be reported annually.

6. How will cultural competency be incorporated into the programs and the evaluation?

The HWCS project is based on a culture-specific best practice model for the Native American population. This model will be adapted, as needed, by each of the three centers, in order to be culturally appropriate for the population served by each center. To ensure cultural competency within the programs, the RFP for this project will require candidate lead agencies to demonstrate such competence, as indicated by 1) knowledge of and experience delivering services that incorporate best practices for the population of interest, 2) language capacity to provide services in the primary language of the population of interest, 3) ethnic, cultural, and linguistic similarity of agency staff to the population of interest, and 4) recognition of the candidate lead agency as a trusted organization within the community that the center is intended to serve. As noted earlier, the evaluation unit will collaborate with each center to develop a logic model specifying the theory of change underlying the center’s service provision. Following this process, the evaluation unit will collaborate with each center to develop evaluation procedures and measures that are culturally-appropriate, minimally intrusive, and relevant to addressing the processes and outcomes specified in the logic models. Cultural adaptations from the original model will be tracked for
each funded wellness center through the focus groups during the start-up phase, and then subsequently, through an annual implementation status survey.

7. **What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?**

The PEI Evaluator and MHSA Coordinator will consult with local experts who have successfully implemented the Holistic Wellness Promotion model at San Francisco’s Native American Health Center in order to benefit from their expertise in implementing with model with fidelity. Since the HWPCS project is intended to expand this model outside of San Francisco’s Native American community (the specific communities are currently being determined through a supplemental needs assessment process), it will be essential to balance the need for model fidelity with the need for appropriate cultural adaptation. The RFP will require candidate lead agencies to specify their understanding of the Holistic Wellness Promotion model, describe any adaptations they expect to make in order to be culturally responsive to the populations they serve, and describe how to document and track these modifications. As described earlier, cultural adaptations will also be an area of inquiry for the focus groups (conducted during the start-up phase implementation) and also the implementation status surveys (administered annually).

8. **How will the report on the evaluation be disseminated to interested local constituencies?**

A summary of the PEI evaluation findings will be posted on the CBHS website. In addition, these findings will be distributed at the MHSA Advisory Committee meetings. The PEI Evaluator will create individualized evaluation reports summarizing key findings for each of the three wellness centers will meet at least annually with wellness center staff and other interested community stakeholders to present the findings and answer any questions about the evaluation.