File No. 100174 Committee Item No. 10
Board Item No. 2

# COMMITTEE/BOARD OF SUPERVISORS

## AGENDA PACKET CONTENTS LIST

Committee BUDGET AND FINANCE Date 3/17/10

Board of Supervisors Meeting Date 3/23/10

| Cmte | Board | |
|---|---|---|
| ☐ | ☐ | Motion |
| ☒ | ☒ | Resolution |
| ☐ | ☐ | Ordinance |
| ☐ | ☐ | Legislative Digest |
| ☐ | ☐ | Budget Analyst Report |
| ☐ | ☐ | Legislative Analyst Report |
| ☐ | ☐ | Introduction Form (for hearings) |
| ☒ | ☒ | Department/Agency Cover Letter and/or Report |
| ☐ | ☐ | MOU |
| ☐ | ☐ | Grant Information Form |
| ☐ | ☐ | Grant Budget |
| ☐ | ☐ | Subcontract Budget |
| ☐ | ☐ | Contract/Agreement |
| ☐ | ☐ | Award Letter |
| ☐ | ☐ | Application |
| ☐ | ☐ | Public Correspondence |

OTHER (Use back side if additional space is needed)

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Completed by: Gail Johnson Date 3/12/10
Completed by: AG Date 3/18/10

An asterisked item represents the cover sheet to a document that exceeds 25 pages. The complete document is in the file.

FILE NO. 100174 RESOLUTION NO.

[Approval of Mental Health Services Act Innovation Work Plan]

**Resolution authorizing adoption the Mental Health Services Act Innovation Work Plan and modification of Contract No. 07-77338-000 to include this Plan in the agreement.**

WHEREAS, Department of Mental Health released the guidelines for completion of the Innovation Component on January 30, 2009 under Department of Mental Health Information Notice No. 09-02 Guidelines for the Mental Health Services Act Innovation Component of the Three-Year Program and Expenditure Plan; and,

WHEREAS, San Francisco County received an Innovation allocations of $4,800,900 for FY 2008-2009 ($1.3 mil), FY 2009-2010 ($1.3 mil), and FY 2010-2011 ($2.2 mil), and this allocation has been submitted to be included in the FY 2010-2011 Annual Appropriations Ordinance; and,

WHEREAS, The approval of the Mental Health Services Act Contract No. 07-77338-000 and the designation of the Community Behavioral Health Director as the signatory of this agreement is on file with the Clerk of the Board of Supervisors in File No. 080122, which is hereby declared to be a part of this resolution as if set forth fully herein; and,

WHEREAS, Innovation unspent funds for each fiscal year are subject to reversion if left unspent after three years, and that the County could use these funds to supplement the Innovation budget within the period prior to reversion as outlined in Department of Mental Health Information Notice No. 08-07; now, therefore, be it

RESOLVED, That the Innovation Work Plan be adopted by the Board of Supervisors; and, be it

FURTHER RESOLVED, That the Board of Supervisors authorize the modification of the Mental Health Services Act Agreement to include the Innovation Work Plan.

Supervisor Mirkarimi

FILE NO. RESOLUTION NO.

1
2 RECOMMENDED:
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5 Mitchell Katz, M.D.
6 Director of Health
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Gavin Newsom
Mayor

Mitchell H. Katz, MD
Director of Health

**TO:** Angelo Calvillo, Clerk of the Board of Supervisors

**FROM:** Mitchell H. Katz, M.D.
Director of Health

**DATE:** February 10, 2010

**SUBJECT:** Resolution to approve the MHSA Innovation Plan and to authorize the amendment of the MHSA Agreement to include this plan in the agreement

**GRANT TITLE:** MHSA Innovation Plan

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Attached please find the original and 4 copies of each of the following:

☒ Proposed resolution, original signed by Department

☒ DMH Information Notice No. 09-02 Guidelines for the Mental Health Services Act Innovation Component of the Three-Year Program and Expenditure Plan

☒ DMH Information Notice 09-20 Mental Health Services Act Planning Estimates for Fiscal Year 2010/11, with Enclosure 3: FY 2010/11 Innovation Planning Estimates

☒ DMH Information Notice 08-36 Mental Health Services Act Planning Estimates for Fiscal Year 2009/10, with Enclosure 5: INN Community Program Planning

☒ Other (Explain): Section 5892 (h) of the MHSA Regulation and Resolution No. 90-08 (File No. 080122)

**Special Timeline Requirements:**

**Departmental representative to receive a copy of the adopted resolution:**

Name: Maria Iyog-O'Malley, MHSA Coordinator Phone: 255-3551

Interoffice Mail Address: CBHS, 1380 Howard Street, 4th Floor

Certified copy required Yes ☐ No ☒

(Note: certified copies have the seal of the City/County affixed and are occasionally required by funding agencies. In most cases ordinary copies without the seal are sufficient).



(415) 554-2600 101 Grove Street San Francisco, CA 94102-4593

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street,, Sacramento, CA 95814
(916) 654-2309

January 30, 2009

DMH INFORMATION NOTICE NO.: 09-02

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: PROPOSED GUIDELINES FOR THE MENTAL HEALTH SERVICES ACT INNOVATION COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN

REFERENCE: IMPLEMENTATION OF THE MENTAL HEALTH SERVICES ACT, WELFARE AND INSTITUTIONS CODE SECTIONS 5830, 5847, 5848 AND 5892

This Information Notice transmits to Counties[1] the Proposed Guidelines for Counties to submit their Innovation Component of the County's Three-Year Program and Expenditure Plan (Three-Year Plan).

Welfare and Institutions Code (WIC), Section 5830(a) specifies that an Innovation Project must include one or more of the following purposes: increase access to underserved groups; increase the quality of services, including better outcomes; promote interagency collaboration; and increase access to services. Counties must choose one or more of these purposes for each project. Pursuant to WIC Section 5830(b), the Mental Health Services Oversight and Accountability Commission (MHSOAC) shall have oversight/approval of the funding for Innovation projects.

These proposed guidelines (Enclosure 1) were developed through a comprehensive stakeholder process and are based on principles and priorities adopted by the MHSOAC. The principles and priorities were developed by the MHSOAC through conference calls, workgroups, general meetings, written comments and recommendations and are embodied in the MHSOAC's Innovation Resource Paper

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[1] "County " means the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per WIC Section 5701.5 (Title 9, California Code of Regulations, Section 3200.090.

(Enclosure 2). This component has its own Planning Estimate (see DMH Information Notice 08-36).

Sincerely,

Original signed by

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosures

# MENTAL HEALTH SERVICES ACT

## PROPOSED GUIDELINES

## for the

## INNOVATION COMPONENT

## of the

## COUNTY'S THREE-YEAR PROGRAM AND EXPENDITURE PLAN

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**PART I: Background**

Welfare and Institutions Code (WIC), section 5830 provides for the use of Mental Health Services Act (MHSA) funds for innovative programs. The Department of Mental Health (DMH) has given the name "Innovation (INN)" to this component of a county's Three-Year Program and Expenditure Plan (Three-Year Plan) for MHSA services. In order to receive INN funding, a county[1] must draft an INN work plan (work plan) and submit it as part of the INN component of its Three-Year Plan.

The MHSA is less specific in its directives for this component than for other components, forming an environment for the development of new and effective practices/approaches in the field of mental health. Further background is provided in the Mental Health Services Oversight and Accountability Commission's (MHSOAC) Innovation Resource Paper (Enclosure 2) and Guiding Principles for DMH Implementation of the Mental Health Services Act. These documents can be found on the DMH's website: http://www.dmh.ca.gov/Prop_63/MHSA/Innovation/.

INN projects are novel, creative and/or ingenious mental health practices/approaches that contribute to learning, and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals. The INN project must be aligned with the General Standards as set forth in Title 9 of the California Code of Regulations (CCR), section 3320. These guidelines provide direction with examples while maintaining the spirit of flexibility intended by the MHSA for this component.

**PART II: Community Program Planning**

**<u>Community Program Planning Funds</u>**

Counties may request up to 25 percent of the combined FY 2008/09 and 2009/10 INN Planning Estimate[2] for Community Program Planning Process (CPP Process) activities necessary for developing the INN component. Refer to DMH Information Notice No.: 08-36, Mental Health Services Act Planning Estimates for Fiscal Year 2009/10. To receive this funding, counties must submit a Request for Funding for Community Program Planning certified by the county's Mental Health Director (Exhibit G).

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[1] "County" means a county mental health department, two or more county mental health departments acting jointly, and/or city-operated programs receiving funds per WIC section 5701.5 (CCR, Title 9, § 3200.090).
[2] "Planning Estimate" means the estimate provided by DMH to a county of the maximum amount of MHSA funding that the county can request per WIC section 5898 (CCR, Title 9, § 3200.250).

## Community Program Planning Process

The process undertaken by counties in developing the various components of the Three-Year Plan provides an essential foundation for transformative Innovation planning, and accordingly, Innovations must be developed with the CPP Process set forth in CCR, Title 9, section 3300. If an Innovation was identified previously through the CPP Process, and stakeholders expressed support for making the Innovation the focus of a project, then no additional/separate CPP Process is required and the Local Review process can begin. See below for more detail. It is also conceivable that the planning process itself may be the focus of an INN project.

An example of a quality CPP Process for the INN component would include all of the following characteristics:

- Demonstrates engagement of the leadership and representatives of the community potentially affected by the proposed INN project
- Encourages culturally and linguistically competent outreach and accessibility that results in the inclusion of diverse stakeholders, including current and potential clients, their families and caregivers; people who are unserved and underserved by the mental health system; and service providers or other representatives of unserved communities
- Conducts planning sessions and meetings in convenient, community-based settings
- Conducts a fair, inclusive, respectful and effective process to facilitate community input, from unserved, underserved and inappropriately served individuals of diverse backgrounds (race, ethnicity, language, age, tribal affiliations, lesbian, gay, bisexual, transgendered, etc.)
- Incorporates community strengths in solutions to addressing challenges

## Local Review

The INN component of the county's Three-Year Plan shall be developed with local stakeholders and made available in draft form and then circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the documents, consistent with MHSA requirements in WIC section 5848, subdivisions (a) and (b) and CCR, Title 9, sections 3300 and 3315. The local Mental Health Board shall conduct a public hearing on the first INN component of the Three-Year Plan, as well as on subsequent Three-Year Plans, pursuant to WIC section 5848, subdivision (b) and CCR, Title 9, section 3315, subdivision (a)(2). The county shall submit a summary and analysis of any substantive revisions made to the INN component of its Three-Year Plan as a result of stakeholder input.

Once the county has an approved INN component, it may propose changes to existing approved work plans or add new work plans by submitting an update to

its Three-Year Plan. Counties must follow the local review requirements specified in Title 9, CCR section 3315, Local Review Process.

**Communicating Results**

Communicating the findings from any Innovation is important to transforming the mental health system. Counties should follow up with the stakeholders/community regarding the findings of the INN project. Counties and communities are encouraged to be creative in determining how best to communicate the results and lessons learned from the INN project. Examples of possibilities for maximizing learning opportunities from the Innovation include holding follow-up stakeholder/community meetings, participating in statewide or regional forums, developing a manual or other medium that describes the INN project in sufficient detail to allow others to replicate or adapt the practice/approach, reporting to other counties, DMH and the MHSOAC at statewide meetings, and/or contributing to national forums.

## PART III: General Requirements for Innovation

The following six sections describe general requirements of all INN projects.

**Voluntary Participation**

INN projects must be designed for voluntary participation per CCR, Title 9, section 3400, subdivision (b)(2). No person should be denied access based solely on his/her voluntary or involuntary status.

**Essential Purposes of Innovation**

The MHSA, Part 3.2 Innovative Programs, section 5830, subdivision (a)(1)-(4), specifies that funds for Innovation be used for the following purposes:

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

Counties must select one or more of these purposes for each INN project. The selected purpose(s) will be the key focus for learning and change.

**Definition of Innovation**

An Innovation project is defined, for purposes of these guidelines, as one that contributes to learning rather than a primary focus on providing a service. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an Innovation contributes to learning in one or more of the following three ways:

- Introduces new mental health practices/approaches including prevention and early intervention that have never been done before, or
- Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community, or
- Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings

To clarify, a practice/approach that has been successful in one community mental health setting cannot be funded as an INN project in a different community even if the practice/approach is new to that community, unless it is changed in a way that contributes to the learning process. Merely addressing an unmet need is not sufficient to receive funding under this component. By their very nature, not all INN projects will be successful.

Proposed INN projects that have previously demonstrated their effectiveness in a mental health setting and that do not add to the learning process or move the mental health system towards the development of new practices/approaches may be eligible for funding under other components, such as Community Services and Supports (CSS) or Prevention and Early Intervention (PEI), rather than with INN funds. To clarify, an INN project may include a prevention and early intervention strategy, but such a strategy would have to be distinctive from PEI requirements. If a county wanted to test a new approach that adds to current knowledge by enhancing a PEI strategy in a way that is not currently allowable under the PEI component, a county may do so. For instance, the distinctive characteristics may include:

- The duration of the prevention and early intervention strategies may exceed the time constraints permissible in the PEI Guidelines.
- The prevention and early intervention strategies may be targeted to a population group not listed as a "Priority Population" in the PEI Guidelines.
- The overall design of the INN project includes a full spectrum of integrated services from prevention and early intervention strategies combined with screening and treatment-oriented services.

In addition to the requirement to contribute to learning, the Innovation must be aligned with the General Standards identified in the MHSA when applicable, as set forth in CCR, Title 9, section 3320. The six General Standards are listed below with a brief description of how they might apply to Innovation taken from the MHSOAC Innovation Resource Paper.

Depending upon the Innovation, the application of these six General Standards will vary. A county is only required to apply the General Standards that are appropriate for the INN project:

- Community Collaboration
  Initiates, supports and expands collaboration and linkages, especially connections with systems, organizations, healers and practitioners not traditionally defined as a part of mental health care
- Cultural Competence, as defined in CCR, Title 9, section 3200.100
  Demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes
- Client Driven Mental Health System
  Includes the ongoing involvement of clients (and participants in prevention programs) in roles such as, but not limited to, implementation, staffing, evaluation and dissemination
- Family Driven Mental Health System
  Includes the ongoing involvement of family members in roles such as, but not limited to, implementation, staffing, evaluation and dissemination
- Wellness, Recovery and Resilience Focus
  Increases resilience and/or promotes recovery and wellness
- Integrated Service Experience
  Encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients and family members

**Scope of Innovation**

INN projects may address issues faced by children, transition age youth, adults, older adults, families (self-defined), neighborhoods, tribal and other communities, counties, multiple counties, or regions. The project may initiate, support and expand collaboration and linkages, especially connections between systems, organizations and other practitioners not traditionally defined as a part of mental health care. The project may influence individuals across all life stages and all age groups, including multigenerational practices/approaches.

An INN project may introduce a novel, creative, and/or ingenious approach to a variety of mental health practices, including those aimed at prevention and early intervention. As long as the INN project contributes to learning and maintains alignment with the MHSA General Standards set forth in CCR, Title 9, section 3320, it may affect virtually any aspect of mental health practices or assessment of a new application of a promising approach to solving persistent, seemingly intractable mental health challenges. To illustrate the breadth of possibilities outside of practices/approaches currently considered part of mental health, proposed INN projects may have an impact on (for example):

- Administrative/governance/organizational practices, processes or procedures
- Advocacy
- Education and training for service providers (including non- traditional mental health practitioners)

- Outreach, capacity building and community development
- Planning
- Policy and system development
- Prevention, early intervention
- Public education efforts
- Research
- Services and/or treatment interventions

A county may submit an INN work plan that adds a strategy to a currently approved CSS or PEI work plan, keeping in mind that the addition must meet all of the criteria for an INN project.

**Time Limit**

By their nature, INN projects are similar to pilot or demonstration projects and are subject to time limitations to assess and evaluate their efficacy. Since the project takes time to develop and implement, a work plan should be completed within a time frame that is sufficient to allow learning to occur and to demonstrate the feasibility of the project being assessed.

When developing a work plan, counties should consider the time needed to implement and assess the INN project and arrive at a timeframe that is logically needed for the particular project. This is not intended to fund longitudinal studies or ongoing services that would be more appropriately funded from CSS or PEI funds.

It is expected that Innovations will evolve and that some elements of a project might not work as originally envisioned. Such learning and adaptations are likely to be key contributions of the INN project. However, if the county and its stakeholders conclude that an INN project is not meeting design and outcome expectations to the extent that continuation is not useful and will not add to the learning, the county may terminate the project. The county must notify DMH in writing within 30 days of its decision to discontinue a project and provide the basis for the decision, including an explanation of how stakeholders provided input to the decision. The county must also describe the reasonable efforts made to ensure that all parties affected, including stakeholders, have been advised by public notice of the project's discontinuance. In the rare instance when a project needs to be terminated immediately due to unforeseen legal, ethical or other risk-related reasons, the county should immediately notify in writing, both the DMH and all parties affected of its decision and the basis for the decision. When a project is terminated early, any unspent distributed funds must be identified in the County's Revenue and Expenditure Report for the fiscal year.

**Reporting**

The following reports are expected to be included as a part of the county's annual update or integrated Three-Year Plan:

(a) Annual Reporting
Counties are required to provide a brief description on the progress of each of their projects in their annual update to DMH, consistent with the requirements contained in the proposed guidelines for annual updates.

(b) Final Innovation Report
Each county must provide to DMH and the MHSOAC a final report upon completion of the project. The final report may be included in the County's annual update or its integrated Three-Year Plan, whichever is due during the year the project is completed; the county does not have to provide a separate report. The Final Innovation Report will be posted on the DMH and MHSOAC websites from which others can learn about the project and its findings. The final report should include:

- A brief description of the issue addressed (up to one-half page)
- A description of the project including the purpose(s) and expected outcome (up to one page)
- An analysis of the effectiveness of the project using the data that was collected and including the perspective of the project participants. The analysis should include at least the following information: (up to three pages)
    - Any changes or modifications made during implementation
    - How it affected those who used it
    - What was learned
    - Whether the project would be recommended for others to replicate, including any lessons learned in implementation, with a comment about its cost effectiveness
    - Whether the project will be continued under a different funding source:
        - If not, why not?
        - If yes, what is the source for new, ongoing funding?
- A description or links to any reports, manuals, CDs or DVDs or videos, or other materials that have been developed and will be used to communicate lessons learned and project results

**PART IV: Innovation Funding**

WIC, section 5892, subdivision (a)(6) states:

> Five percent of the total funding for each county mental health program for Parts 3, 3.6 and 4 shall be utilized for Innovative Programs pursuant to an approved plan required by Section 5830 and such funds may be distributed by the department only after such programs have been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

This component has its own Planning Estimate (see DMH Info Notice 08-36). This funding source is independent of requirements and priorities adopted for CSS and/or PEI guidelines. Up to 100 percent of available funding may be

requested in the initial work plan submission for the INN component. Any remaining funds may be requested in subsequent updates expanding the initial INN work plan or beginning an entirely new work plan. INN Funding is subject to the three-year reversion requirement set forth in WIC section 5892, subdivision (h) (See DMH Information Notice 08-07).

**Regional Collaboration**

While regional collaboration among counties is allowed by the MHSA, it is encouraged under Innovation. Two or more counties can work together on a joint INN project. Each county will need to submit its own work plan as part of an INN component or update to access its Planning Estimate funds; however, the content of the work plans can be the same for all members of the regional collaborative and include the total budget that clearly displays each county's share of the budget.

**Sustaining the Innovation**

If an INN project has proven to be successful and a county chooses to continue it, the work plan must transition to a different funding source (as determined by the county), for example the CSS component, the PEI component, (i.e., a new work plan) or another source of stable funding. Counties should consider integrating a successful INN project into other components when planning for the future.

**Non-Supplant**

According to CCR, Title 9, Division 1, Chapter 14, section 3410, the MHSA non-supplant requirements related to county expenditures must be met.

**Community Partnering and Collaboration**

It is anticipated that the INN project will contribute to the development of collaborative partnerships, especially with organizations and systems not traditionally defined and funded as a part of mental health care.

Leveraging of resources is not required but is expected, when appropriate, to maximize the impact of a county's allocation for this component as a way of building capacity by extending the reach and impact of the project through collaboration with community partners. For the purposes of this component, the term "leveraging" is used broadly and may include, (for example):

- Cash match
- Federal reimbursements in the health system
- In-kind contributions
- Use of facilities and other resources

- Time commitment to develop, implement, assess and communicate the impact of the Innovation

Leveraging of resources is encouraged, for example, through forming partnerships outside the mental health system that broaden the scope of current mental health practice and enhance the work plan. Additionally, regional approaches, which are also encouraged, can leverage resources through collaboration.

**PART V: Innovation Work Plan**

Work plans should include Exhibits A through F. Exhibit G is optional.

**<u>County Certification</u> (Exhibit A)**

Provide a signed statement by the county's Mental Health Director that all requirements for the planning, implementation and funding of the work plan have been considered and will be followed, including non-supplant requirements, the CPP and Local Review processes. The certification should include a statement of assurance that an individual's participation in any INN project is voluntary and that all the information included in the documents submitted is true and correct.

The name and contact information of the Mental Health Director's designated project lead for all matters related to this work plan, along with a name for the project must also be provided.

**<u>Community Program Planning Process and Local Review</u> (Exhibit B)**

Counties must provide sufficient detail documenting that the requirements of CCR, Title 9, sections 3300 and 3315 were met. The documentation of the CPP and Local Review processes that were conducted shall include:

(a) A description of the Community Program Planning Process for development of the INN project, including the methods for obtaining stakeholder input;
(b) Identification of the stakeholder entities involved in the Community Program Planning Process, and
(c) The dates of the 30-day stakeholder review and public hearing including substantive comments received during the stakeholder review and public hearing and responses to those comments.

The county should indicate if no substantive comments were received. Counties should maintain copies or a log of all comments that were submitted during this process, including those submitted anonymously.

**Work Plan Narrative (Exhibit C)**

Counties shall respond to the following:

1. Indicate the purpose(s) and the reason for this selection.
2. Describe the INN project, the issue it addresses and the expected outcome, i.e. how the innovation may create positive change. Include a statement of how the project supports and is consistent with the General Standards as set forth in CCR, Title 9, section 3320.
3. Describe how this project is new to the field of mental health and contributes to learning, consistent with one or more of the three approaches to learning outlined in "Definition of Innovation."
4. Indicate the timeframe within which the project will operate: The county should provide a brief explanation why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the project.
5. Describe how the project will be reviewed and assessed and how the county included the perspectives of stakeholders in the review and assessment.
6. Provide a list of resources to be leveraged, if applicable.

**Work Plan Description (Exhibit D)**

Counties are to provide a concise overall description of each proposed project, including services to be provided, if applicable, along with the features of the project that further the goals of the MHSA. This information will be posted on the DMH website. In addition, if applicable, the county should provide a description of the population(s) to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity and language spoken as well as situational characteristic(s) of the population to be served for each proposed INN project.

**Innovation Funding Request (Exhibit E)**

Counties must complete an Innovation Funding Request worksheet to obtain funding for the component.

**Innovation Projected Revenues and Expenditures (Exhibit F)**

Counties must provide a completed Innovation Projected Revenues and Expenditures.

**Request for Community Program Planning Funds (Exhibit G)** ***[Optional]***

Counties may submit a Request for Community Program Planning Funds at any time before submission of its initial INN component. The intent of funding for the Innovation CPP Process is to provide the resources (if needed) to engage in activities necessary to develop the county's INN component of its Three-Year

Plan. Counties should submit a hard copy of the Request for Funding with the original signature of the county Mental Health Director and transmit an electronic copy to:

Mailing address: Local Program Support
Department of Mental Health
1600 9th Street, Room 100
Sacramento, CA 95814
Email: ccta@dmh.ca.gov

**PART VI: Submission Guidelines and Work Plan Approval Process**

Counties may request MHSA INN component funding through a work plan, which is to be submitted to DMH and the MHSOAC. Counties can submit more than one work plan, up to the total of the county's Innovation Planning Estimate.

One original copy should be submitted to Local Program Support liaison. In addition, one electronic copy should be submitted to both the Local Program liaison and to the MHSOAC:

Mailing address: Local Program Support
Department of Mental Health
1600 9th Street, Room 100
Sacramento, CA 95814
Email: ccta@dmh.ca.gov

MHSOAC copies should be sent to:

Mailing Address: MHSOAC
1300 17th St., Suite 1000
Sacramento, CA 95811
Attn: Sheri Whitt
E-mail: MHSOAC@dmh.ca.gov

All work plans must include:

- County Certification (Exhibit A)
- Community Program Planning Process and Local Review (Exhibit B)
- Work Plan Narrative (Exhibit C)
- Work Plan Description (Exhibit D)
- Innovation Funding Request (Exhibit E)
- Innovation Projected Revenues and Expenditures (Exhibit F)

Request for Community Program Planning Funds (Exhibit G) is optional.

Final electronic versions of the exhibits will be posted on the DMH website.

## Review and Approval

Upon receipt of a Three-Year Plan or an update containing a completed work plan, DMH and the MHSOAC will have sixty days to review and comment on the plan, including the approval of funds by the MHSOAC. Staff from the MHSOAC will work closely with county staff to assist with submission, identifying any needed information and obtaining approval of the Three-Year Plan or update from the MHSOAC.

## COUNTY CERTIFICATION

**County Name:** San Francisco

| County Mental Health Director | Project Lead |
|---|---|
| Name: **Robert P. Cabaj, MD**<br>Telephone Number: **415-255-3401**<br>E-mail: **bob.cabaj@sfdph.org** | Name: **Alice Gleghorn**<br>Telephone Number: **(415) 255-3722**<br>E-mail: **alice.gleghorn@sfdph.org** |
| Mailing Address:<br>**1380 Howard Street, 5th Floor**<br>**San Francisco, CA 94103** | Mailing Address:<br>**1380 Howard Street, 4th Floor**<br>**San Francisco, CA 94103** |

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

| Signature (Local Mental Health Director/Designee) | Date | Title |
|---|---|---|

## DESCRIPTION OF COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

| County Name: | San Francisco |
|---|---|
| Work Plan Name: | Innovation Work Plan |

*Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.*

1. *Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)*

Innovation planning for the County of San Francisco began with a series of four public meetings in April 2009. At each meeting, participants were separated into project and priority brainstorming groups where each idea was recorded. Staff and interested participants from the community meetings met and sorted the project ideas generated from the community planning process into broad categories for review by the MHSA Innovations Advisory Committee. These categories included six of the non-direct service categories provided by the state, and 17 direct service categories identified by the group. A project template was also developed for people to submit additional innovation project ideas by July 22, 2009. The template was shared with all participants at the community planning meetings, sent out via email to all those who sent requests, and posted on the MHSA website. The project submissions were then added to the identified categories. This initial Innovation planning resulted in hundreds of project ideas.

Over a series of four meetings in July and August 2009, the Innovation Advisory Committee reviewed the list of project ideas from the initial community planning meetings and submissions. The Advisory Committee reviewed each project idea, asked clarifying questions, provided additional information (e.g. project is already being implemented or falls into other MHSA funding stream), and reclassified projects when necessary. The Advisory Committee removed from consideration or modified project ideas that did not meet the State's guidelines for Innovation. The Advisory Committee and participating community members held an email vote on the remaining ideas. At the final Advisory Committee the highest ranked project ideas were reviewed and approved for submission to the State.

2. *Identify the stakeholder entities involved in the Community Program Planning Process.*

The Advisory Committee was co-chaired by Alice Gleghorn, Deputy Director of Community Behavioral Healthcare and Steve Tierney, CIIS Community MH Program Director and member of the S.F. Health Commission. The committee was staffed by Marlo Simmons, PEI Coordinator, and Maria Iyog O'Malley, MHSA Coordinator. Tim Tabernik, Jamie Harris and Chandreve Clay of Hatchuel Tabernik and Associates (HTA) provided facilitation support to the Advisory Committee and wrote the Innovations plan. When the proponent of the project idea was known, these individuals were involved in developing the work plan narratives and budgets.

Innovation Advisory Committee members (in bold) and additional members of the community actively involved in Innovation planning process included:

- **Gifford Boyce-Smith***, National Alliance for the Mentally Ill-SF
- **Bridget Brown**, Independent Living Resource Center .
- **Eric Brown**, UCSF-Citywide
- **Linda Chafetz**, UCSF-Nursing
- **Roy Crew***, CA Network of Mental Health Clients
- **Arthur Curry***, Office of Self Help
- **Toby Eastman**, Larkin Street Youth
- Edward Fong*, Office of Self-Help
- **Estela Garcia**, Instituto Familiar de la Raza
- **Vera Haile***, Long-term Care Coordinating Committee
- Frank Isidro*, MHSA IT
- Greg Jarasitis, UCSF Citywide Forensics
- **Lisa Lee**, Community Youth Center
- **Michelle Maas**, Native American Health Center
- **Emilio Orozco**, Citizen-Student
- **Sylvia Pizzini**, Seneca Center
- **Dina Redman**, SFSU School of Social Work
- **Christina Shea**, RAMS, Inc
- **Mickey Shipley***, CBHS-Client Council
- Ursala Steck, Community Member
- **Mellissa Syropiatke**, Mental Health Association – San Francisco
- **Steve Tierney**, California Institute of Integral Studies
- Kathleen Wallace*, CBHS, MHSA Implementation Specialist
- Michael Wise*, CBHS, MHSA Implementation Specialist
- **David Yonomoto**, Asian American Recovery Services

* Self-identified as Consumer/Family Member

3. *List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.*

The Innovation Plan was made available for review on Tuesday, February 9th, 2010 -on the SFDPH website (www.sfdph.org). Notice was given to all members of the MHSA listserv which includes over 800 email addresses of mental health providers, community members, other government partners and individuals involved in the planning process.

The public hearing, which represents the closing of the stakeholder review process, was hosted by the San Francisco Mental Health Board on:

**Wednesday, March 10th, 2010 at S.F. City Hall**
One Carlton B. Goodlett Place
2nd Floor, Room 278
San Francisco, CA 94102
**6:30 PM - 8:30 PM**

The substantive comments received during the stakeholder review and public hearing and responses to those comments are listed below. The County defined "substantive" as those comments which request a change that would result in significant alteration in the programmatic elements, proposed budget or timeline of the draft plan.

TBD...

# EXHIBIT E

**Mental Health Services Act**

**Innovation Funding Request**

County: San Francisco

Date: 2/5/2010

| | Innovation Work Plans | | FY 09/10 Required MHSA Funding | Estimated Funds by Age Group (if applicable) | | | |
|---|---|---|---|---|---|---|---|
| | No. | Name | | Children, Youth | Transition Age Youth | Adult | Older Adult |
| 1 | INN-1 | Adapt the WRAP | $ 323,069 | | $ 323,069 | | |
| 2 | INN-2 | Mindfulness -Based Intervention for Youth and Their Providers | $ 100,500 | $ 50,250 | $ 25,125 | $ 25,125 | |
| 3 | INN-3 | Supported Employment & Cognitive Training (SECT) Project | $ 331,775 | | | $ 248,831 | $ 82,944 |
| 4 | INN-4 | Digital Story Telling for Adults | $ 224,586 | | | $ 168,440 | $ 56,147 |
| 5 | INN-5 | Youth-Led Evaluation of Health Assessment Tools | $ 207,763 | $ 155,822 | $ 51,941 | | |
| 6 | INN-6 | Peer Education / Advocacy on Self-Help Movement and Consumer Rights | $ 246,087 | | | $ 246,087 | |
| 7 | INN-7 | Peer-led Hoarding and Cluttering Support Team | $294,688 | | | $ 147,344 | $ 147,344 |
| 8 | INN-8 | Collaboration with the Faith Community | $ 338,756 | $ 84,689 | $ 84,689 | $ 84,689 | $ 84,689 |
| 9 | INN-9 | Mini-Grants. | $1,253,875 | $ 313,469 | $ 313,469 | $ 313,469 | $ 313,469 |
| 10 | | | | | | | |
| 11 | Subtotal: Work Plans | | $ 3,321,098 | $ 604,230 | $ 798,292 | $ 1,233,984 | $ 684,592 |
| 12 | Plus County Administration | | $ 504,612 | 18% | 24% | 37% | 21% |
| 13 | Plus Optional 10% Operating Reserve | | $ 375,190 | | | | |
| 14 | **Total MHSA Funds Required for Innovation** | | **$ 4,200,900** | | | | |

## Innovation Work Plan Narrative

**Date:** 02/05/2010

**County:** San Francisco

**Work Plan #:** INN-1

**Work Plan Name:** Adapt the WRAP (Wellness Recovery Action Plan)

**Purpose of Proposed Innovation Project (check all that apply)**

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The Wellness Recovery Action Plan (WRAP) developed by the Copeland Center for Wellness and Recovery teaches individuals with mental health challenges to use tools to self-manage their recovery by identifying a plan of action to be employed during stressful or crisis situations. It identifies triggers and early warning signs and associated action plans, crisis planning, and post-crisis planning. The WRAP is an instrument that has been used mostly by adults and older adults and has not been tailored specifically for Transitional Age Youth (TAY).

Adapting this self-management tool to be more age and culturally appropriate for use by TAY and enlisting youths to create a WRAP in a medium that they identify with would be an innovative approach in engaging youth in mental health discussions; in increasing their wellness and resiliency and improving self-management. It is hoped that, ultimately, TAY-developed WRAP media[1] would **improve outcomes** for this population. This project will engage young adults through a competition to infuse the WRAP "tool" with youth culture by using highly creative approaches to make WRAP more accessible to youth – through performing, digital, or visual arts that adapt the tool to different learning and cultural styles among TAY. Prizes will be given to the authors of the most creative and useful WRAP adaptations.

By having "youth culturally competent" approaches in place we hypothesize that TAY will be able to employ the "teachings" from the winning WRAP media (e.g., verse, video, dance, or music) and learn to face challenging and stressful situations in a positive and healthy manner. This approach can also help to destigmatize mental illness among TAY – showing other youth that mental illness can be managed in ways that are creative and even appealing. We also expect that this approach will help TAY to self-manage their mental illness and make more effective use of community resources leading to **better outcomes** for TAY consumers. Our learning will be whether modifying a proven strategy to be better suited to youth culture will encourage TAY consumers to use and benefit from a self-management approach.

[1] At this point it is not clear whether, given different cultural and learning styles of TAY, the ultimate product will be a single tool or more than one tool, addressing the diversity of the TAY population.

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description:** Transitional Age Youth have their own specific culture, and, in order to reach them, mental health campaigns/strategies should use media to which they can relate. The Adapt the WRAP Project will take an existing self-management tool, WRAP, and engage youth to adapt this tool using media that that are specific to TAY culture. The project will involve three phases: (1) training on WRAP; (2) a contest to modify the existing WRAP using media specific to youth culture: (3) dissemination of the winning WRAP media to youth and youth providers as an educational, outreach and engagement vehicle.

This project expects to teach the benefits of WRAP to youth and attract youth participation in creating a WRAP media with which youth could readily identify. As the winning WRAP media are circulated, these WRAP media would help educate youth about the use of positive self-management tools to help support their wellness and resiliency. It is also anticipated that TAY providers would be able to use these WRAP media as effective outreach and engagement vehicles for TAY services, ultimately leading to better outcomes for TAY.

**Expected Outcome/Positive Change:** *If this project is successful, the primary outcome would be:*

- A significant number of TAY consumers who report using the winning WRAP media as tools to manage difficult situations in a healthy and positive manner,
- Outreach workers will report improved access to TAY consumers using the winning WRAP media as an entrée, and
- Participating TAY consumers will report improved self-management skills as a result of using the winning WRAP media strategies.

**Title 9 General Standards:** *The Adapt the WRAP project will apply the following general standards.*

- ***Cultural Competence.*** The tool(s) will enhance the cultural competence of the WRAP tool – specifically by addressing youth culture as well as ethnic culture among the TAY population. The development of the new TAY WRAP tool(s) will integrally involve the TAY consumer population through a competition that will include a diverse population of TAY that is reflective of the ethnic, gender and sexual orientation of young people in San Francisco.
- ***Client Driven Mental Health System.*** Adapt the WRAP will involve a client-driven approach by its very nature. The tool was developed originally by a mental health consumer as a self-help approach whereby consumers are able to identify stressful situations and triggers that they can mitigate through their chosen strategies – anchored by practices that help relieve stress and minimize the potential for behavioral problems. The TAY-focused WRAP will be developed by youth themselves, using a competitive process with prizes to engage and draw wider participation among them.
- ***Wellness, Recovery and Resilience Focus.*** This approach is wellness, recovery and resiliency focused because it provides TAY consumers with culturally relevant tools to self-stabilize and a community of TAY who are using similar methods for ensuring optimum functioning and independence in the community.

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

This project is innovative because it 1) adopts a strategy proven successful with older adults (WRAP) and adapts it to youth through use of popular media that they can relate to; 2) educates a group of TAY about the effectiveness of the WRAP wellness and resiliency tool and engages them in developing the new youth-specific tool(s); and 3) supports TAY consumers to self-manage their mental illness. Our plan is that youth (both consumers and non-consumers) will be engaged in a contest to design tools that take into consideration the principles of adult learning and multiple learning styles (e.g., auditory, visual, kinesthetic, etc.). Our Theory of Change is that transition age youth (TAY) consumers will find these tools attractive and useful and will use them to self-manage their mental illness, reduce crises, and improve their quality of life - resulting in better outcomes.

We anticipate that our evaluation will determine the following:

- The degree to which a diverse mix of TAY participate in creating the Adapt the WRAP media,
- The degree to which TAY consumers actually use these tools in their self-management,
- The degree to which TAY consumers credit these tools with helping them avert crises and manage their mental illness – resulting in better outcomes, and
- Whether Adapt the WRAP provides meaningful community education and outreach and engagement strategy to connect youth to services

Our learning methodology will include: 1) monitoring the competition process to determine the diversity and scale of participation; 2) surveying TAY consumers before and after implementation of Adapt the WRAP to determine whether they find the tools useful in self-management and whether they have helped them improve their quality of life; and 3) surveying TAY providers to determine whether they have used the winning WRAP media as wellness and resiliency education tools and/or an effective outreach and engagement strategy to connect youth to services. We anticipate that the "process" of creating the winning WRAP media is an important ingredient in the ultimate success of the model. We will test this hypothesis by surveying or interviewing TAY who are familiar with the competition and those who are using the winning WRAP but who did not know about the competition. Our objective will be to determine whether they think the "youth culture" aspects of the winning WRAP contribute positively to their support for and/or use of the tools.

If Adapt the WRAP is successful in San Francisco, we anticipate writing an article on our findings and disseminating them to other communities through local agencies/ organizations, the Department of Mental Health, NAMI, and a variety of other venues.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 06/12

**Phase I - Start Up (07/10 – 12/10)**
This six month period will include, hiring a Coordinator who will be charged with project implementation. Once a Coordinator is hired, WRAP trainings will be conducted at different sites where TAY services are provided. The next step will be to organize the multi-media competition that underpins Adapt the WRAP. Participants will receive education about WRAP. Program staff will organize a contest for the best "youth culturally competent" media on the WRAP. A panel of TAY and a few practitioners who serve TAY will review the presentations/performances, and prizes will be awarded to the three best tools – preferably drawing from multiple media and learning modalities. The evaluation plan will be devised during this period, and baseline data on TAY consumers' knowledge and use of self-management tools will be collected.

**Phase II - Implementation (1/11 – 9/11)**
This nine month period will focus on dissemination and implementation of the winning WRAP media among TAY consumers. The objective is to have a significant number of youth adopt one or more WRAP strategies, anchored by multi-sensory, multi-media approach to managing stressful situations and avoiding crises. In addition to implementation, we expect to launch a thoughtful evaluation strategy that will gather survey, focus group and key informant interview data to determine whether the Adapt the WRAP approach is actually utilized and useful to TAY consumers as a crisis averting approach and as a self-management tool for wellness and resiliency. We expect that qualitative data will be most important to determining the usefulness of the tools – since this approach will provide nuanced information about the ways in which TAY consumers use the tools, the perceived usefulness of the tools and if there is any impact on stigma. During this phase the evaluation will be used formatively to suggest changes in the tools themselves, training for staff and consumers, and any other barriers or challenges we discover to effective use of the tools.

**Phase III - Reflection, evaluation, dissemination (08/11 – 06/12)**
This eleven month period (overlapping with Phase II) will be used to conduct focus groups and reflection groups to assess the effectiveness of the winning WRAP media to increase participation in services, enhance wellness and result in better outcomes among TAY consumers. During this period surveys will also be conducted with a broader group of TAY consumers to gather retrospective data on benefits or liabilities of the approach. Other youth who are not consumers will also be surveyed to determine whether there has been any reduction in stigma and victimization as a result of the project and understanding of the lessons embedded in the winning WRAP media. These quantitative and qualitative data will be analyzed, and a report will be written on the model. This report will be disseminated to other counties and to professional groups in the mental health and juvenile justice fields. If the pilot is successful, we anticipate that it may be folded into our CSS and PEI work plans and would be subject to ongoing evaluation. If the approach shows longitudinal benefits, we would anticipate conducting a more thorough evaluation of impact and publishing the results of the study.

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

As mentioned above, the CBHS evaluators will be working with the implementation team to assess the efficacy of *Adapt the WRAP*. There are a number of process and outcome measures that will be included in this evaluation. However, because this is a pilot project and will only be

operational for about ten months prior to the evaluation period, we can only expect that process and intermediate outcomes will be measured. The objectives that will be measured are:

- The competition for Adapt the WRAP media will include at least 20 TAY consumers who are reflective of the diversity of the San Francisco TAY community. (process – project records)
- The media "products" of the competition will include a variety of art forms including music, poetry/prose, visual, dance, and multimedia to engage all learning styles to the extent possible. (process – project records)
- The winners of the competition will be chosen by a diverse panel of reviewers who will include TAY and TAY consumers, behavioral health professionals, and individuals knowledgeable in multi-media. (process – project records)
- At least 100 TAY consumers will elect to utilize one or more of the Adapt the WRAP tools to create a personal self-management plan. (outcome – project records)
- At least 75% of the TAY consumers using Adapt the WRAP tools will indicate that the tools were useful for them in managing symptoms and staying focused on their personal development (e.g., school, employment, etc.). (outcome – participant surveys)
- At least 75% of the TAY consumers using Adapt the WRAP tools will indicate that this approach to self-management helped to educate other TAY and reduced the stigma of mental illness among their non-consumer peers. (outcome – participant surveys)
- Once the evaluation is completed, the successful bidder and the CBHS evaluators will collaborate to complete a report that will be disseminated to other Mental Health Departments and agencies throughout California (process – project records). If successful, the project will be sustained by being built into CSS or PEI funding streams.

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

WRAP training will be provided by either an Implementation Specialist and/or Pathways to Discovery Wellness Center Health Worker who are certified WRAP trainers. These consumer positions are funded through the Community Services and Support (CSS) component.

## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

INN-1, Adapt the WRAP (Wellness Recovery Action Plan)

Annual Number of Clients to Be Served (If Applicable)
120 Total

Population to Be Served (if applicable):

This plan will serve a minimum of 120 transitional age youth (TAY) and specific attention will be given to recruiting youth from underserved and overserved ethnic and cultural populations.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The goal of this project is to utilize youth culture (e.g. rap, spoken word, multi-media) to educate transition age youth (TAY) about self-management tools they can use to manage mental illness and promote their wellness.

The project will conduct a competition for at least 20 TAY to adapt the WRAP (Wellness Recovery Action Plan) tool for TAY to improve their capacity to deal with common emotional triggers in positive ways. This competition will encourage TAY to develop a "youth friendly" product promoting mental health and the use of a modified WRAP tool. A diverse team of judges will select the three best tools and prizes will be awarded accordingly.

Once the tools are developed and selected, the TAY developers and the project lead will help to disseminate the final products to TAY audiences and services providers. The next step is to determine the degree to which the WRAP tools and strategies are actually in use and proving to be useful to the target population for which they were intended. We anticipate that at least 100 TAY consumers will be engaged in using Adapt the WRAP tools. The evaluator for this project will conduct surveys with these consumers to determine their satisfaction with the tools, what has been most useful to them in averting crises, etc. These findings will be incorporated in a final report that will be disseminated locally and on a statewide basis.

**EXHIBIT F**

## Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-1

Work Plan Name: Adapt the WRAP

New Work Plan ☑

Expansion ☐

Months of Operation: 07/10 - 06/12
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | 276,069 | | | $276,069 |
| 2. Operating Expenditures | 23,500 | | | $23,500 |
| 3. Non-recurring expenditures | 8,500 | | | $8,500 |
| 4. Training Consultant Contracts | | | 15,000 | $15,000 |
| 5. Work Plan Management | | | | $0 |
| **Expenditures** | **$308,069** | **$0** | **$15,000** | **$323,069** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$308,069** | **$0** | **$15,000** | **$323,069** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-255-3915

## Innovation Work Plan Narrative

**Date:** 02/05/2010

**County:** San Francisco County

**Work Plan #:** INN-2

**Work Plan Name:** Mindfulness-based Intervention for Youth and their Providers

**Purpose of Proposed Innovation Project (check all that apply)**

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

Young people are exposed to or are at risk of exposure to many different types of violence including child abuse and neglect, domestic, intimate partner, and community violence, in conjunction with multiple forms of oppression associated with race, gender, and poverty. The short term impacts of violence-related trauma and oppressive circumstances experienced in adolescence include anxiety, depression, and behavioral health challenges. Young people exposed to violence may have lower cognitive functioning, may develop attitudes that justify the use of violence, and may perform poorly in school. Exposure to violence can also leave children and youth behind their peers developmentally, socially, and academically. Without appropriate interventions, youth exposed to violence can experience long-term effects lasting into adulthood.[2]

Providers working with at-risk and violence-exposed youth also face a variety of challenges arising from the acuity of the needs of this population. As young people face increasing levels of stress and trauma, the providers working with them in turn experience increased stress levels. Chronic stress has a cascade of negative health repercussions, including immune deregulation, effects on emotional equilibrium, and effects on short-term memory. Additionally, trauma in young clients can activate unresolved emotional issues in adult providers, or simply become overwhelming. This can result in providers being less willing to or capable of attending to the physical, emotional, and psychological needs of their clients.

The benefits of mindfulness-based interventions are well documented among adult populations and incarcerated youth populations. This project proposes to determine whether youth who are exposed to violence or who live in violent communities will benefit from interventions grounded in mindfulness to facilitate the learning of necessary skills to build greater focus and attention on self-regulation, emotional competence, and to begin working with the complex trauma that they are carrying. In addition, we propose to test the efficacy of mindfulness interventions to help the adult providers working with trauma-exposed youth access tools for self-care, stress reduction, and manage/work with their own trauma and negative emotionality. We expect this strategy to **improve the quality of services** for trauma-exposed youth who display social/emotional risk

[2] Fox, A. and Mayer, A. (2005) San Francisco's Response to Children Exposed to Violence. City and County of San Francisco. San Francisco, CA.

factors but who have not yet been incarcerated. Furthermore, we expect that this use of mindfulness interventions will **improve outcomes** among the youth receiving this service – including school attendance, grades, matriculation/graduation rates and avoidance of involvement in the juvenile justice system.

San Francisco CBHS therefore proposes to extend the benefits of mindfulness-based interventions to reach youth. We also propose this intervention for the adult providers who serve youth in and out of school, including school-based Wellness Center staff, Department of Public Health youth clinic staff, and youth-serving community based organizations. This recommendation is proposed in response to community needs as identified through community planning processes. This is a new intervention to the San Francisco behavioral health care field and will contribute to learning by allowing a brief study of the impact of mindfulness-based training on both youth and their professional caregivers.

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

The mindfulness-based intervention includes planning, facilitation, and evaluation of two interventions for youth, one intervention for providers, and one train-the-trainer for providers. The experiential mindfulness-based pilot intervention for youth will be taught by trained facilitators and delivered in youth vernacular with concepts relevant to youth's lives. The curriculum is a mental and emotional training program designed specifically to meet the social and emotional needs of high-risk youth coping with complex trauma. The class structure will include periods of check-in, mindfulness practice, and group discussion. Classes teach youth tools to reduce stress, regulate emotional states, identify the legitimate needs underlying negative behaviors, and take responsibility for their actions. Our objectives are to test whether the intervention: 1) reduces the psychological distress experienced by young people who have experienced multiple adverse childhood experiences, 2) increases capacity for emotion regulation, self-control, and acceptance of experience, and 3) increases the number of our youths' internal assets.

The intervention for providers will empower through self-care, mindfulness, and emotional self-awareness tools and competencies. Our objectives are to test whether the intervention: 1) supports the wellness and effectiveness of providers serving at-risk youth, 2) supports organizations and agencies to build and sustain self-care and self-awareness practices as part of their organizational culture.

The train-the-trainer component is designed to build providers' ability to master mindfulness-based techniques and the confidence to facilitate interventions for youth and other providers. Our objectives are to test whether the intervention: 1) builds the skills and confidence to lead mindfulness-based interventions with youth and other providers, and 2) sustains and increases mindfulness-based intervention efforts in SF organizations.

Project activities include: 1) contracting with training consultants, 2) identifying priority youth populations and school/community sites, 3) coordinating interventions for youth, 4) recruiting participants with appropriate permissions, 5) delivering two, ten-session interventions for youth,

6) delivering a six-hour provider training for 60-80 providers, 7) providing ten two-hour train-the-trainer sessions, and 8) evaluating mindfulness-based interventions through pre and post surveys and other social adjustment measures.

**Expected Outcome/Positive Change:** If the mindfulness-based interventions for youth and their providers are successful, participants will experience:

- Reduced stress,
- Greater personal wellbeing, and
- Stronger emotional capacity.

**Title 9 General Standards:** The Mindfulness-based Intervention for Youth and Their Providers project will apply the following general standards.

- **Community Collaboration.** The mindfulness-based intervention pilot project will work collaboratively with school-based Wellness Centers, DPH clinics, and CBOs on all project-related activities.
- **Cultural Competence.** The target schools/communities will be in low-income, high crime areas of San Francisco which are disproportionately communities of color. Therefore, the intervention team recruited will have capacity for working with diverse groups of youth - taking into account language, culture, class and historical trauma.
- **Wellness, Recovery and Resilience Focus.** The core principle of this project is to build internal skills that support wellness, recovery and resilience in individuals who have been repeatedly or chronically exposed to trauma. The practice of mindfulness provides tools that provide the ability to manage stress and diminish symptoms of trauma exposure – direct or secondary.
- **Integrated Service Experience.** The Mindfulness training intervention will take place in one or more of the following community settings: school-based Wellness Centers, DPH clinics, and/or CBOs. The client interventions will be integrated into existing clinical programs as a service option for youth.

## Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

The proposed intervention contributes to new learning, new approaches, and new applications of an intervention which has been proven effective in another setting. Mindfulness-based interventions are not currently utilized within the CBHS service delivery system, the school-based Wellness Centers or DPH clinics – the primary access points for mental health services among youth in San Francisco. Nor have the effects of mindfulness been fully explored as interventions for youth experiencing trauma, or among providers experiencing secondary trauma. The success of mindfulness-based interventions is, however, well documented among incarcerated youth and adults.[3] We, therefore, propose to test a proven approach with a new population and in a new setting.

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[3] Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Sprague, C., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van de Kolk, B. (2007). Complex Trauma

The proposed pilot will have an evaluation component to determine whether the intervention demonstrates an impact on client/caregiver stress and trauma related symptoms. Standardized clinical instruments will be used on a pre- and post-intervention basis to determine effect. The evaluator will also identify any barriers to implementation and provide formative feedback to the project team to overcome these barriers.

A final report will be written to document the results based on our project objectives and any lesson learned from the process. This information will be disseminated within to the State Department of Mental Health, and other county Departments. If successful, we plan to continue the trainer-of-trainers approach to spread the model to other parts of the San Francisco system and to other communities.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10-06/11
MM/YY – MM/YY

**Phase I (07/10 – 08/10)**
Phase I will focus on identifying and contracting with mindfulness-based intervention training consultants, and working in collaboration with SF Wellness Centers, Dept. of Public Health (DPH), and community based organizations (CBOs) to identify priority youth populations and school/clinic/community based training sites,

**Phase II (09/10 – 01/11)**
Phase II will include identification of two groups of 10-12 youth participants and a group of provider participants and securing proper permissions to participate (09/10). Once the required number of youth has been reached, the 10-week program will be implemented by 10/10. The provider intervention program will run concurrently with the youth interventions. Pre- and post-intervention data will be collected from all participants.

**Phase III (02/11 – 04/11)**

in Children and Adolescents. *Focal Point: Research, Policy, and Practice in Children's Mental Health: Traumatic Stress/Child Welfare, 21*(1), 4-8.

Roth, B. & Robbins, D. (2004). Mindfulness-Based Stress Reduction and Health-Related Quality of Life: Findings From a Bilingual Inner-City Patient Population. *Psychosomatic Medicine* 66, 113-123.

Jenkins, S.R. & Baird, S. (2002). Secondary Traumatic Stress and Vicarious Trauma: A Validational Study. *Journal of Traumatic Stress, 15*(5), 423–432.

Samuelson, M., Carmody, J., Kabat-Zinn, J., Bratt, M.A., (2007). Mindfulness-Based Stress Reduction in Massachusetts Correctional Facilities. The Prison Journal, Volume 87 Number 2 June 2007, 254-268.

http://www.nctsnet.org The National Child Traumatic Stress Network.

http://www.mbaproject.org The Mind Body Awareness Project.

www.umassmed.edu/cfm Website of the Center for Mindfulness, UMASS Medical School.

Phase III will include recruitment of mindfulness-based intervention provider participants from Wellness Centers, DPH clinics and CBOs for the train-the-trainer component.

**Phase IV (05/11-06/11)**
The final phase will be focused on evaluation analysis and reporting. It will include fidelity of implementation, outputs (e.g., numbers served and dosage), participant satisfaction and symptom reduction outcomes. Dissemination of findings will occur after the project period on an in-kind basis.

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

- If the mindfulness-based interventions for youth and their providers are successful, participants will experience reduced stress, greater personal well-being, and stronger emotional capacity. These outcomes will be measured using one or more of the following validated self-report instruments selected for this purpose: Perceived Stress Scale (PSS-10), Mindful Attention Awareness Scale (MAAS), Barratt Impulsiveness Scale, (NAS-PI) Novaco Anger Scale and Provocation Inventory, and/or the Self-Compassion Scale. The selected instrument(s) will be administered on a pre/post intervention basis to determine the effect of the program – both for youth and for their service providers.
- If the mindfulness-based train-the-trainer is successful, provider participants will self-report significant increases in knowledge, skill, and confidence in their ability to lead mindfulness-based interventions for youth and other providers. Train-the-trainer participants will also contribute their review and assessment of the applicability of the mindfulness-based intervention to their overall programs.
- Participants will also complete satisfaction surveys regarding their experience with the intervention.

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

Existing community groups that are currently providing adolescent behavioral health care services and youth development will assist with identifying, assessing, identifying, and recruiting participants for the project – both youth and adult providers. A collaborative youth service group will help to identify and select the trainers and evaluator. Training sites will be leveraged through already existing partnerships with Wellness Centers, DPH clinics, and CBOs.

## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Annual Number of Clients to Be Served (If Applicable)
100 Total

Work Plan Name

INN-2, Mindfulness-based Intervention for Youth and Their Providers

Population to Be Served (if applicable):

This project serves both youth and their adult providers. The priority youth population will consist of 12-18 year old youth from communities and schools with the highest rates of violence and crime. Similarly, providers will be recruited from school-based Wellness Centers, CBHS clinics, and CBOs that serve violence afflicted communities and schools. The range of providers will include social workers, therapists, nurses, case managers, and health educators. Participants for the train-the-trainer will be drawn from participants in the initial intervention. Efforts will be made to ensure that the trainees come from different professions, agencies and geographic areas to maximize the dissemination of this methodology.

Project Description (suggested length - one-half page): *Provide a concise overall description of the proposed Innovation.*

The *Mindfulness-based Intervention for Youth and Their Providers* trains youth and service providers in mindfulness techniques. These techniques help to reduce stress and trauma affecting youth living in violent communities and to reduce the stress experienced by providers serving traumatized youth in community based programs.

Our initial focus for services will be 20-24 students who are involved in school-based Wellness Centers, DPH clinics, and CBOs in high violence communities. Two groups of these youth (10-12/group) will be provided a 10-week, practice-based group intervention that teaches them pragmatic strategies they can use to reduce stress and reactive behaviors while gaining greater self-control. Approximately 20-40 youth workers (therapists, social workers, nurses, outreach workers, etc.) will also be provided a similar group intervention. Approximately 10-12 of the adult participants will receive additional train-the-trainer instruction, thereby allowing them to carry the intervention to staff members at their agencies/collaboratives and to other youth groups in the City.

The program will be evaluated by the CBHS evaluation department that will select appropriate instruments to be used as a pre/post measure of the impact of the intervention on behavior and well-being of the different groups of participants. Participant satisfaction and qualitative assessments of what could be done to improve the interventions will also be collected post intervention. After the term of this pilot, the MHSA overall evaluator will also collect longitudinal data on the degree to which the train-the-trainers strategy results in a sustained use of these strategies in various agencies throughout the City. The outcomes will be written up for dissemination to other communities throughout the State.

## EXHIBIT F

### Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN_2

Work Plan Name: Minfulness-Based

New Work Plan ☑

Expansion ☐

Months of Operation: 0710 - 06/11
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | | | 57,000 | $57,000 |
| 2. Operating Expenditures | | | 8,805 | $8,805 |
| 3. Non-recurring expenditures | | | | $0 |
| 4. Training Consultant Contracts | | | 21,586 | $21,586 |
| 5. Work Plan Management | | | 13,109 | $13,109 |
| **6. Total Proposed Work Plan Expenditures** | **$0** | **$0** | **$100,500** | **$100,500** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$0** | **$0** | **$100,500** | **$100,500** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-255-3915

## Innovation Work Plan Narrative

**Date:** 02/05/2010

**County:** San Francisco County

**Work Plan #:** INN-3

**Work Plan Name:** Supported Employment & Cognitive Training (SECT) Project

## Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

*SECT* is designed to assist individuals with serious mental illness to become more independent and successful in employment by combining two interventions – Supported Employment (SE) and a newly developed, computerized Cognitive Training (CT) program. Although each intervention has independently proven to be effective, no one has tested whether they would be **more effective** in combination. In addition, our research suggests that the Cognitive Training program has only been tested in the university setting and has yet to be studied in the field. It is hypothesized that the combination of SE and CT will be more effective than separately administered and that they will be effective in field conditions.

*SECT* specifically focuses on a population of consumers that face the greatest barriers to successful community integration and to employment – that is, chronically mentally ill individuals with co-occurring substance abuse and a history of homelessness and involvement in the criminal justice system. It is expected that SECT would **improve outcomes** by helping this underserved group successfully obtain subsidized and competitive employment.

## Project Description

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description.** The *Supported Employment & Cognitive Training Project (SECT)* harnesses together two evidence-based interventions in order to empower individuals with serious mental illness to obtain competitive jobs in the community. In this project, we combine state-of-the-art Supported Employment (SE) practices with cutting-edge computerized cognitive training that sharpens clients' thinking, memory, and problem-solving skills. Clients participate in 12 weeks of daily computerized cognitive training exercises to improve their brain information processing abilities. They then enter individualized job placement and support. The goal is for participants to achieve and maintain successful and enduring competitive employment in the community within a one year timeframe.

The *SECT Project* will leverage the successful applicant's SE program with a selected provider of Cognitive Training. The proponents of this project sited the work of Dr. Sophia Vinogradov (UCSF-SFGH Psychiatry) as a model for the CT component of the project. Her previous work has shown that her cutting edge cognitive training approach (based on software developed at Positscience Inc.) significantly improves attention, verbal learning and memory, and problem solving in people with schizophrenia, when compared to other computer-based cognitive remediation methods. However, so far this approach has only been studied in an academic setting. It is critically important to see if clients who receive this computer-based cognitive training in a community setting can obtain the same kinds of improvement in their cognitive skills. Even more importantly, we must discover whether an improvement in cognitive functioning allows clients to make better use of other recovery-based programs such as job placement and support so they can re-integrate into their communities.

In this Innovations project, we will: 1) Learn how to translate the highly successful and novel cognitive training into a community mental health center; 2) Further increase its power by combining it with evidence-based SE for seriously mentally ill individuals, using the Individual Placement and Support (IPS) model.

The IPS model of SE is one of the most robust psychosocial interventions available for persons with severe mental illness, resulting in significant and meaningful gains in community functioning. Average competitive employment rates are 62% in patients receiving SE vs. 25% receiving other interventions.[4] Through employment, people increase their independence, their sense of self-worth and dignity, and their inclusion in community life, while reducing their sense of disability, isolation and stigma.

However, even though the IPS model is a highly successful SE intervention, it still fails to help all clients fully. In most studies, less than half of participants achieve significant employment status, and the length of the employment is often brief; 50-75% terminate within six months. Previous research has shown that most of these terminations are due to difficulty in performing the task and poor quality of work, and that cognitive impairments are associated with poor work outcomes. It is becoming increasingly clear that the success of SE is limited when participants have cognitive impairment. Indeed, some initial research shows that, if one combines SE with cognitive remediation, participants experience much better work outcomes. No one so far, though, has attempted to combine SE with cognitive training methods for serious mental illness. This is the purpose of the *SECT Project*.

**Expected Outcome/Positive Change:**

- Increase employment retention for seriously mentally ill consumers
- Improve self-confidence and cognitive functioning among target consumers

**Title 9 General Standards:** The Supported Employment & Cognitive Training (SECT) Project will apply the following general standards.

***Community Collaboration.*** SECT at its core involves collaboration between the selected providers of SE and Cognitive Training. We also expect that SECT will

[4] Bond, G.R., Drake, R.E., and Becker, D.R. (2008) *An Update on Randomized Controlled Trials of Evidence-Based Supported Employment.* Psychiatric Rehabilitation Journal. 31, no. 4, 280-290.

collaborate with employers, case managers, and other providers who are involved in supporting the consumer participants.

***Cultural Competence.*** The successful applicant for the SE and CT components will be selected, at least partially, because it has a proven track record of cultural competence. The selected providers will be expected to recruit, hire and retain clinical staff who are bicultural and fluently bilingual in the cultures and languages of the consumers served. The SE and CT teams will have the capacity to work with monolingual consumers in a wide array of languages. The SE provider will provide support groups that address culture, gender and sexual orientation.

***Client Driven Mental Health System.*** The SECT participants will be individuals who choose to enroll in the program and who are motivated to seek employment through this model. SECT provides a specific array of supports for cognitive functioning and for employment, but the client is inherently in charge of utilizing these resources.

***Wellness, Recovery and Resilience Focus*** SECT is fundamentally aligned with the Wellness, Recovery and Resilience Focus because it is about improving cognitive functioning in order to increase independence and empowerment through successful, long term employment.

***Integrated Service Experience.*** Once again SECT is a service integration model by its very nature. The SECT clients will be provided cognitive training that directly impacts their ability to obtain and retain competitive employment through a supported employment service. The SECT team will work closely together to assure an integrated service experience for all participating consumers.

## Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

The *SECT Project* takes two state-of-the-art and highly effective interventions and *combines* them in a novel approach to recovery for individuals with severe mental illness. The SE model, when implemented according to high-fidelity evidence-based practices, is very successful in helping individuals obtain competitive jobs in the community. However, it is somewhat less successful in helping clients maintain *long-term* employment. It appears that the rate-limiting factor for long-term job success is the cognitive impairment of serious mental illness: the poor memory, thinking, and problem-solving skills that are a result of the brain dysfunction. We propose to directly target those cognitive impairments by having clients first participate in 12 weeks of intensive, computerized cognitive training exercises that are designed to improve this brain dysfunction. We already know from Dr. Vinogradov's prior research that these types of training exercises induce lasting cognitive improvements; people with schizophrenia show significantly better memory and problem-solving abilities after the training.[5] [6] We predict that vigorous cognitive training will allow clients to make better use of SE, and that this will translate into better ability to maintain and function in employment settings.

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[5] Fisher M, Holland C, Merzenich M, Vinogradov S. (2009 Mar 5) *Neuroplasticity- based cognitive training in schizophrenia: An interim report on the effects 6 months later.* Schizophrenia Bulletin Advance Access. [Epub ahead of print].

[6] Fisher M, Holland C, Merzenich M, Vinogradov S. (2009 June 10) *Using Neuroplasticity-based auditory training to improve verbal memory in schizophrenia.* Am J Psychiatry. [Epub ahead of print].

The *SECT Project* will be a landmark study. It will add to the literature of knowledge on successful interventions for individuals with serious mental illness, on the neuroscience of cognitive remediation, and on optimal vocational rehabilitation practices. SECT will be able to generate extensive evaluation and outcomes data that will likely result in several publications.

## Timeline

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 12/12
MM/YY – MM/YY

We anticipate that the selected providers will require three months to adapt their programs to interface with each other, since this will require staff training and computer modifications so that cognitive training can be provided at the SE provider sites, and establishing protocols between the treatment site and the CT provider will assess client outcomes at 12 months, 18 months, and 24 months follow-up. Based on prior research, we anticipate that we will see the maximal gains in clients' functioning at the 1-2 year follow-up timepoint.

**Phase I (07/10 – 10/10)**
Phase I provides the time to ramp up the SE program, including training staff, setting up equipment for the cognitive training, and establishing research protocols.

**Phase II (10/10 – 06/12)**
Phase II provides 21 months of intervention, including three months per cohort of cognitive training and an extended period of SE as needed by the consumers.
Data on the project will be collected throughout the project period and analyzed at 12, 18 and 24 months post intake. An interim report will be provided at 12 months.

**Phase III (07/12 – 12/12)**
Phase III provides six months for data analysis, report writing, and initial dissemination of findings. A final report will be provided at 30 months from project launch.

## Project Measurement

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

- If *SECT* is successful, consumers with serious mental illness will be fully engaged in a recovery process where they are successfully learning employable skills and are working in competitive jobs in the community. In addition, they will have participated in 12 weeks of daily computerized cognitive training exercises, and will have significantly improved their attention, learning and memory functions, and problem-solving skills. These cognitive gains, in combination with the skills and supports provided by SE, will improve their overall employment outcomes during the one to two year follow-up period.
- *SECT's* overall goal is to reintegrate clients in a self-sustaining manner into their larger community. We will therefore measure both the cognitive gains made during the cognitive training program – using standardized instruments – and the degree to which participants are able to gain and sustain employment in the community. SECT participants will be asked for their perceptions of and satisfaction with the program as a way to gather formative

feedback for program improvement. The evaluation will consider barriers to participation and will interview any consumers that drop out of the program as well as those that persist as feasible.

- Furthermore, we will gather key informant data from employment and training programs and public and private sector employers to determine whether their experience with this project has had any impact on their attitudes and beliefs about the benefits of hiring consumers.

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

*SECT* will result in the leveraging of an effective Supported Employment and Cognitive Training to the SE participants. Additional supporters of the project may include:

- Employment Partners: San Francisco Job Developers Association, Mayor's Office of Economic and Workforce Development, Central Benefits District, CBHS Vocational Task Force, Urban Solutions, San Francisco Reentry Council;
- Education Providers: San Francisco Public Library's Project Read, City College, Tenderloin Technology Lab, and Rose St. GED Program;
- One-Stop Centers: Goodwill, Mission, and Western Addition Locations
- Job Resources: Clean Slate Program, Department of Rehabilitation, CVE, JVS, RAMS Hire-Ability, Rubicon Landscape Services, and Dress for Success

**Innovation Work Plan Description**
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

INN-3, Supported Employment & Cognitive Training Project (SECT)

Annual Number of Clients to Be Served (If Applicable)
30/yr Total

Population to Be Served (if applicable):

*SECT* will serve participants in an intensive SE program(s) that provide wrap-around support services to seriously mentally ill individuals with a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. The selected provider of SE will have a track record providing SE or other employment services to San Francisco residents who suffer from severe mental illness. These individuals are generally high utilizers of the mental health and jail systems.

The program will serve approximately 30 unduplicated clients annually over a 24 month period. Clients will receive both cognitive training and supported employment.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

*SECT* is a collaboration between selected SE and CT providers, who will conduct an extensive evaluation of the effectiveness of the intervention. *SECT* harnesses together two evidence-based interventions in order to empower individuals with serious mental illness to obtain competitive jobs in the community. *SECT* combines state-of-the-art Supported Employment (SE) practices with cutting-edge computerized cognitive training that sharpens clients' thinking, memory, and problem-solving skills. Clients will participate in 12 weeks of daily computerized cognitive training exercises to improve their brain information processing abilities cumulating in individualized job placement and support. The goal is for participants to achieve and maintain successful and enduring competitive employment in the community within a one year timeframe.

In this Innovations project, we will: 1) Learn how to translate the highly successful and novel cognitive training methods into a community mental health center; 2) Further increase the power of the cognitive training by combining it with evidence-based SE for seriously mentally ill individuals, using the Individual Placement and Support (IPS) model; 3) Demonstrate that clients that receive the combined *SECT* intervention will achieve better employment outcomes than those who receive only one of the two interventions. We also expect to measure the degree to which employment helps study clients to increase their independence, their sense of self-worth and dignity, and their inclusion in community life, while reducing their sense of disability, isolation and stigma.

The study will result in publications and will be disseminated on a local, national and international scale.

## EXHIBIT F

## Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-3

Work Plan Name: Supported Employ

New Work Plan ☑

Expansion ☐

Months of Operation: 07/10 - 6/12

MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | | | 220,000 | $220,000 |
| 2. Operating Expenditures | | | 48,000 | $48,000 |
| 3. Non-recurring expenditures | | | 3,500 | $3,500 |
| 4. Training Consultant Contracts | | | 17,000 | $17,000 |
| 5. Work Plan Management | | | 43,275 | $43,275 |
| **6. Total Proposed Work Plan Expenditures** | **$0** | **$0** | **$331,775** | **$331,775** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$0** | **$0** | **$331,775** | **$331,775** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-255-3915

## Innovation Work Plan Narrative

**Date:** 02/05/2010

**County:** San Francisco County

**Work Plan #:** INN-4

**Work Plan Name:** Digital Story Telling (DST) for Adults

**Purpose of Proposed Innovation Project (check all that apply)**

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The *DST for Adults* project will use the universal cultural medium of storytelling to allow adults and older adults of all cultures and language groups to tell their story of trauma. This approach will be augmented by the modern digital recording and editing process to allow consumers to have a brief DVD of their story in their own words. We are proposing that these individuals would receive a combination of Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) and *DST* healing circle process. We hypothesize that the combination of TF-CBT and *DST* will be more effective than TF-CBT alone. This will **increase the quality of services and achieve better outcomes.**

While we anticipate that most of the participants will be consumers or family members of consumers, we also anticipate that some individuals who are no longer in treatment, or who never accessed treatment for their trauma, may choose to participate. In those instances we expect that *DST* may lead them to opt for treatment as stigma or cultural/linguistic barriers are broken down.

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description.** The *Digital Storytelling (DST) For Adults* Project is a collaborative partnership between Community Behavioral Health Services (CBHS), the Center for Digital Storytelling, and a group of human services providers throughout San Francisco that serve adults and older adults living with mental illness.

The *DST* goals are: 1) helping consumers and family members heal from their individual trauma; 2) engaging consumers more effectively with behavioral health services to reduce the impact of mental health challenges such as post traumatic stress disorder; and 3) training mental health providers to use *DST* in combination with evidence-based treatment for trauma.

The *DST* will use the culturally and linguistically competent age old tradition of "telling stories" that is honored by generations across all cultures, and we will modernize it through the use of today's media. Through story telling, consumers will be provided an opportunity to tell their life

stories to a supportive and appreciative audience of peers while being digitally recorded. A variety of service providers, across the geographic and ethnic diversity of the City, will identify adult and older adult consumers who have experienced trauma and who are willing to participate in this therapeutic process.

Although digital media may seem to be a "youth" strategy, it is the use of *DST* with the adult population that is particularly unique and innovative. We expect, however, that there will be things to learn as we implement this strategy with individuals who are neither computer literate nor fluent in English.

Participants will engage in three activities: 1) a three day *DST* workshop where participants share their stories in a healing circle, learn how to create a digital story by working with creative software on computers, and produce a 4-5 minute DVD of their story; 2) a debriefing session held two weeks after the workshop to bring participants together to share how they are feeling and to link participants to behavioral health services as needed; and 3) a film festival where all participants will come together with public agency partners, community providers, family members and others to celebrate and view the final cuts of their stories that have been produced by the Center for Digital Storytelling. Participants will be asked to fill out assessments that measure individual hope and change in behavior and attitude as a result of going through the *DST* process. Stipends for food, transportation, and childcare will be provided to participants. *DST* workshops will be done in a comfortable community setting.

The *DST* will recruit six consumers, who are reflective of the linguistic and ethnic diversity of the target population, to become *DST* paid interns to facilitate workshops, debriefings, and film festivals. The *DST* will also develop a resource guide/curriculum to teach clinicians to use Trauma-Focused Cognitive Behavioral Health Therapy (TF-CBT) in combination with *DST* for adults exposed to ongoing community violence. Some consumers who have participated in the *DST* training will co-present their digitized stories to clinicians in collaboration with the lead trainer, who will provide ongoing biweekly consultation to clinicians who are being trained to use TF-CBT and the DST.

In addition, with prior permission from consumers, the *DST* documentary films will be used by CBHS, institutions of higher education, and public media to educate the public about the impact of trauma on adults and older adults and the effectiveness of *DST* in combination with TF-CBT to mitigate these effects.

Since we anticipate that *DST* will create a culturally appropriate and accessible strategy for engaging linguistically isolated groups, we will have documented stories in multiple languages with subtitles. This will be a particularly powerful way of illustrating the universality of the story telling process across cultures.

**Expected Outcome/Positive Change:**

- Improved healing and access to services for a diverse cross section of adults exposed to trauma.

**Title 9 General Standards:** *The Digital Story Telling for Adults project will apply the following general standards.*

- ***Community Collaboration.*** This strategy is inherently collaborative, involving CBHS, DST, trainers, and a variety of behavioral health care and social service agencies that serve a diverse and geographically disparate cross section of San Francisco. These organizations will recruit and screen participants, and their clinical staff will participate in the DST/TF-CBT

- ***Cultural Competence.*** As mentioned, we expect to engage a cross section of social services agencies that serve the entire range of cultural and linguistic groups. We believe that our approach, using the individual stories of selected consumers as a part of the healing process, can help to break down cultural and linguistic barriers and remove stigma. Through our broad collaboration of agencies, we expect that we will be able to engage adult consumers of all ages, ethnicities, languages, disabilities and socioeconomic status in a meaningful way. We plan to engage a diverse group of consumer interns to assist with the program, and we will hire translators, as needed, to support consumers during the *DST* workshops.
- ***Client Driven Mental Health System.*** We are proposing to use consumer story telling as a mechanism for empowerment and self-help. This allows consumers to deal with traumatic events in their lives in a safe setting while at the same time using their story to help others. While this is certainly not an approach for everyone, it connects with ancient traditions of storytelling across cultures and ages. It puts the consumer in charge of his/her own situation and allows him/her to objectify their trauma and make an external rendering of it and their dealings with it for all to see.
- ***Wellness, Recovery and Resilience Focus.*** This strategy is focused on wellness, recovery and resilience because it augments evidence-based TF-CBT with a story telling process in a healing community. It documents this approach and empowers consumers to help to train clinicians in this methodology so that it can be replicated elsewhere.

## Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

Community violence is severely impacting San Francisco neighborhoods and residents of all ages. Consumers of behavioral health services and other vulnerable populations are at high risk for trauma and, as a result, need a therapeutic approach that is effective and that engages them in culturally appropriate ways. We hypothesize that Digital Storytelling in combination with TF-CBT will provide a healing circle and supportive community in combination with an evidence based therapeutic strategy. Because males tend to be underrepresented in treatment for trauma, we will prioritize recruitment for males to participate in this project. We will introduce *DST* into behavioral health care agency settings throughout the City. To date in San Francisco, *DST* has been exclusively focused on youth. Therefore, we believe focusing *DST* on adults and older adults is an innovation that is worthy of testing.

The Center for Digital Storytelling has assisted youth and adults around the world in using media tools to share, record, and value stories from their lives, in ways that promote artistic expression, health and well being, and justice. Although the term "digital storytelling" has been used to describe a wide variety of new media practices, what best describes this approach is its emphasis on first-person narrative, meaningful workshop processes, and participatory production methods.

Given these promising results with youth, we would like to test the *DST* project in several community-based clinics with adult populations that have been traditionally underserved by the behavioral health system. The proposed project would test *DST's* efficacy in a clinical setting

when used in combination with TF-CBT. It is likely that we would change the instruments used to measure program impact. We will work with external CBHS evaluator to develop a formal evaluation design, to select instruments, to choose a comparison group, and to conduct the evaluation and provide reports to CBHS.

Another aspect of this effort will be to train clinicians to use TF-CBT and *DST* in their work with consumers. Some *DST* participants will be selected as interns to co-teach the clinical training program for practitioners. This process will help to spread this approach more broadly in the community. We will also gather satisfaction surveys from clinicians who receive this training to determine whether the *DST* component was useful and whether the consumer interns added value to the training.

Therefore, we believe that the proposed project will contribute to learning by testing the TF-CBT and *DST* convergence for adults and older adults – looking at fidelity of implementation and participant outcomes. We will also ascertain whether clinicians who receive training in these two disciplines found the training valuable. The results of this evaluation will hopefully provide validation of our theory of change and lead to replication of the model in other locations both in San Francisco and statewide.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 06/12
MM/YY – MM/YY

**Phase I (07/10 – 08/10)**
During Phase I we will assign a CBHS evaluator and develop the evaluation plan for the pilot. This will include selecting appropriate instruments and ensuring that they are translated into applicable languages as needed. We will also select four to six community behavioral health clinics in high violence communities to implement the *DST* program in combination with TF-CBT which is already being utilized. A treatment group and comparison group selection process will be devised as a part of the evaluation plan.

**Phase II (09/10 – 12/11)**
During Phase II we will implement the pilot at multiple sites. We anticipate that the implementation will take about one month per site. This will involve conducting multiple healing circles, ensuring that the participants are also receiving TF-CBT from their individual therapist, and recording individual stories. Once the stories have been recorded *DST* will work with consumers to edit the stories and combine them into a documentary format. Once this process is complete at all four to six sites, *DST* will convene a film festival. This will allow the documentaries from all of the sites to be shown to the participants, their treatment staff, and any interested members of the therapeutic community and the general public.

In addition, any participants who find that the *DST* process brings up feelings and thoughts that they find hard to cope with will be provided additional support and therapy from the host site agency.

During this period, the project trainer and trained consumer interns will be training groups of clinicians in the combined TF-CBT and *DST* strategies.

**Phase III (12/11 – 06/11)**
This phase will be devoted to wrapping up the evaluation process, writing a final report, and determining whether there are opportunities for dissemination of results and replication of the model in other clinics and communities.

## Project Measurement

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

Measuring **individual** outcomes:

- Reducing the negative impact of trauma and violence on participants. We anticipate that the use of both TF-CBT and *DST* will be more effective than TF-CBT alone. This will be determined through the use of clinical instruments measuring PTSD and depression symptoms among an intervention and comparison group of adults at the same programs. The evaluator will need to devise a way to avoid or at least control for selection bias in the two groups of consumers.
- Promoting hope, wellness and resiliency. The applicant and the evaluator will select age appropriate measures of hope, wellness and resiliency to be administered to the intervention and comparison group of consumers.
- Increasing consumer awareness of the impacts of trauma and violence on mental and physical health. Participants will complete pre and post intervention surveys that will measure satisfaction, gather suggestions for program improvement, and assess knowledge of the impact of trauma on mental and physical health.
- Consumers who become interns will indicate that their training was valuable, the experience of training clinicians was meaningful and that they learned more about themselves and gained valuable skills through the process.
- Individuals that attend the "film festival" will report that they learned more about the effects of trauma and about the benefits of the *DST* methodology.

Measuring **system** outcomes:

- Piloting and testing an innovative strategy that allows victims of trauma to engage in a healing community experience that enhances a best practice therapeutic intervention.
- Demonstrating that this interagency, cross-disciplinary process has greater beneficial effects on consumers than TF-CBT by itself. This outcome will be dependent on the project actually showing more positive results than business as usual. In either case, a report will be produced that explains the findings to the field.
- Our hypothesis is that using a digital storytelling approach will allow for linguistically and culturally diverse populations to benefit equally from the experience, both as participants and as viewers at the "film festival". We expect that this approach will tap successfully into the tradition of oral storytelling that is rooted in many cultures. If this is the case, use of digital storytelling may become a more standard practice in the field in the long term. Measures of success will be largely based on satisfaction surveys gathered from participants in the intervention.
- The new TF-CBT training for providers will be developed using the *DST* documentaries and consumer interns as co-trainers. Once again we hypothesize that the combination of TF-CBT and *DST* will be powerful and successful as a training technique. Having the opportunity to actually see victims of trauma tell their stories and then to have some of them available to provide portions of the training should be very useful to practitioners. We intend

to measure this through satisfaction surveys and measures of knowledge gained during the training.

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

The *DST for Adults* program will leverage the following in-kind resources:

- Space at the 4-6 behavioral health care centers where the intervention and trainings will occur.
- Computer labs at the Center for Digital Storytelling where the editing will be done.
- The existing TF-CBT interventions that are being delivered by clinicians at the pilot behavioral health care centers.
- Clinician time to complete any required surveys or clinical rating scales that are required for the evaluation.

**Innovation Work Plan Description**
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

INN-4, Digital Storytelling for Adults

Annual Number of Clients to Be Served (If Applicable)
40-80/yr Total

Population to Be Served (if applicable):

The *DST* for Adults project will serve 10-20 individuals that have experienced trauma per site at a minimum of four sites across the City. These 40-80 consumers will be representative of the diversity of San Francisco demographics, with a deliberate over representation of communities that are most affected by violence. In addition, the proposed TF-CBT *DST* curriculum workshops will reach 60 clinicians/staff at partner clinics.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Digital Storytelling (DST) for Adults project is a collaborative partnership between Community Behavioral Health Services (CBHS), the Center for Digital Storytelling, and a group of human services providers throughout San Francisco that serve adults and older adults living with mental illness.

The *DST* goals are: 1) demonstrating that *DST* and Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) in combination is more effective in helping consumers heal from their individual trauma than business as usual; 2) the *DST* will be effective in overcoming barriers and linking consumers to behavioral health services to reduce the impact of mental health challenges such as post traumatic stress disorder, and 3) training mental health providers to use *DST* in combination with evidence-based treatment for trauma will be effective for clinicians and their clients. The *DST* will use the culturally and linguistically competent age old tradition of telling stories that is honored by generations across all cultures and modernize it through the use of today's media.

Participants will engage in three activities: 1) a three day *DST* workshop where participants share their stories in a healing circle, learn how to create a digital story by working with creative software on computers, and produce a 4-5 minute DVD of their story; 2) a debriefing session held two weeks after the workshop to bring participants together to share how they are feeling and to link participants to behavioral health services as needed; and 3) a film festival where all participants will come together with public agency partners, community providers, family members and others to celebrate and view the final cuts of their stories that have been produced by the Center for Digital Storytelling.

Project process and outcomes will be measured and fidelity of implementation and client outcomes will be analyzed and reported. These results will be widely disseminated in San Francisco and throughout the State. If the method proves to be valuable, CBHS will seek to fund wider implementation of the model using other MHSA funding in the future.

# EXHIBIT F

## Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-5

Work Plan Name: Youth-Led Evaluat

New Work Plan ☑

Expansion ☐

Months of Operation: 7/10 - 6/11
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | 143,763 | | | $143,763 |
| 2. Operating Expenditures | 52,000 | | | $52,000 |
| 3. Non-recurring expenditures | | | | $0 |
| 4. Training Consultant Contracts | | | 12,000 | $12,000 |
| 5. Work Plan Management | | | | $0 |
| **6. Total Proposed Work Plan Expenditures** | **$195,763** | **$0** | **$12,000** | **$207,763** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$195,763** | **$0** | **$12,000** | **$207,763** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-309-4794

## Innovation Work Plan Narrative

**Date:** 02/05/2010

**County:** San Francisco County

**Work Plan #:** INN-5

**Work Plan Name:** Youth-Led Evaluation of Behavioral Health Assessment Tools

**Purpose of Proposed Innovation Project (check all that apply)**

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☒ NCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

Based on feedback from youth, we believe that youth sometimes fail to be accurately assessed simply through lack of cooperation with psychological assessments that are perceived as demeaning, invasive, and out of touch with youth culture. Many youth "blow off" these assessments by providing rote answers or otherwise withholding information.

Therefore we believe that this project can help clinicians to select instruments and/or use assessment methods that are more youth friendly and that increase the likelihood that underserved populations of youth will receive valid psychological assessments. By ensuring that more youth are successfully assessed, we surmise that better diagnoses and earlier intervention may be possible, thereby ***improving the quality of services and achieving better outcomes.***

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description:** CBHS proposes to implement a youth-led evaluation of the "youth friendliness" of existing behavioral health assessment tools (CANS, Assess Your Self, AHWG Behavioral Health Toolkit, and Do You Feel Me?), the methods of administration of these tools, and to identify other potential instruments that might be more youth friendly.

We expect that a team of 15 stipended youth will be recruited from local high schools – reflecting the demographics of the City both from a racial/ethnic and socioeconomic perspective. We would also expect that a significant number of the participants on the team would be consumers of mental health services.

The team will be given an extensive orientation to behavioral health assessment instruments – both those in use in the City and others that have been used extensively in the United States but are not currently used by San Francisco CBHS.

The team will also be asked to develop a rating scale that provides a structured way of rating the youth friendliness of the various instruments being reviewed. This scale will look at a variety of factors (e.g., cultural issues – including both ethnic culture and youth culture; invasiveness; engagement vs. aloofness; etc.). The elements of this scale may also be weighted, giving greater importance to elements that the youth believe have greater impact on the youth friendliness of the questions, etc.

Given that some instruments are "home grown" in San Francisco (e.g., the AHWG Behavioral Health Toolkit), we anticipate that the authors would be provided feedback that could be immediately incorporated into current practice. For standardized instruments that have been nationally normed and validated, this is a much more complex process. Nonetheless, we expect to provide feedback to the purveyors of these instruments which may eventually be incorporated in future updates. In addition, the feedback will also be provided to a broad array of practitioners in San Francisco – thereby informing behavioral health care programs and staff about the perceived youth friendliness of the instruments they are using.

It is also important to note that some instruments are designed for youth to complete themselves and others are completed by a clinician through a structured interview process. For the clinician completed instruments, it is conceivable that the youth will also have suggestions about the method of administration, that is, how the clinician conducts the interview. This is especially pertinent for the CANS, a tool all CBHS contractors are required to use.

The team and their adult mentors are likely to need feedback on instruments from a wider cross section of youth in the City. If that is the case, the team will create testing focus groups that are provided incentives to review the various instruments.

Finally, the team will analyze their findings and write up a brief report that will be disseminated to the provider community in San Francisco and more widely if appropriate.

**Expected Outcome/Positive Change:**

- Improved (youth) cultural competence of assessment process among agencies and practitioners in San Francisco

**Title 9 General Standards:** The Youth-Led Evaluation of Health Assessment Tools project will apply the following general standards.

***Community Collaboration.*** We expect that the behavioral health care community will collaborate with CBHS on this project by helping to secure a diverse team of youth from across the City to lead the evaluation. We also anticipate that the results will be disseminated to youth serving organizations across the City.

***Cultural Competence.*** This project has been designed specifically to address (youth) cultural competence in the behavioral health assessment process. In addition to this primary objective, we expect to create a culturally diverse youth team that is broadly representative of the City to implement the project. The CBHS lead team will be expected to demonstrate the cultural and linguistic competence required to lead a project of this significance.

## Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts.*

*(suggested length - one page)*

The proposed project is almost exclusively focused on increasing learning among behavioral health providers. We expect that youth will evaluate the youth friendliness and effectiveness of an array of assessment instruments and practices among practitioners. In order to increase the reliability of the study, the youth leadership group will reach out to another 45 youth through focus groups comprised of a broad cross section of the youth community. The findings of this study will be disseminated widely to practitioners throughout the City. Dissemination methods will include emailing the report or a link to the report to all City Behavioral Health contractors, Departments of Psychology and Social Work at local universities, and to the organizations that distribute various standardized assessments. We anticipate that the report will use multi-media to ensure that the findings are widely accessible and disseminated to professionals as well as to other youth.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 06/11
MM/YY – MM/YY

This project is a time limited study that will result in a report and recommendations regarding the youth friendliness of various instruments and assessment practices.

Phase I (07/10 – 09/10) Recruitment

During Phase I, the CBHS project coordinator will reach out to a variety of organizations throughout the City to secure a diverse group of youth participants who have the interest and capacity to lead this effort. These youth will be provided a competitive hourly wage for their regular participation on the study team.

Phase II (10/10 – 04/11) Testing

During Phase II, the team will review a wide variety of instruments and assessment approaches to determine whether these tools and practices are user-friendly for teens and young adults. They will gather data from other youth, and they will analyze the data with the help of the CBHS coordinator and the project evaluator.

Phase III (05/11 – 06/11) Reporting

During Phase III, the team will discuss, review, and write a report that provides feedback to the field regarding the efficacy of assessment tools and practices. This report will be disseminated to the field of youth serving agencies in San Francisco and beyond. This report may include mixed media approaches to ensure it is widely accessed by professionals, policy makers, and other youth.

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

- This effort is specifically focused on youth with youth stakeholders as the leaders of the project. The youth team will write/record the report with adult support. Before the report is disseminated to the field, CBHS staff will review the content to ensure that there are no breaches of confidentiality or copyright protection. Otherwise this report will be developed by youth with adult mentors.
- CBHS evaluators will assess whether the project was implemented with fidelity and whether the findings were gathered, stored, analyzed and reported in a high quality manner.

**Leveraging Resources (if applicable)**

Provide a list of resources expected to be leveraged, if applicable.

N/A

## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

INN-5, Youth-Led Evaluation of Health Assessment Tools

Annual Number of Clients to Be Served (If Applicable)
60 Total

*Population to Be Served (if applicable):*

This project is a youth-led effort to assess the user-friendliness of assessment instruments and processes from the perspective of a diverse cadre of consumer and non-consumer youth that are representative of the diversity of the youth population in San Francisco. There will be 15 youth who will be integrally involved in leading this study. There will also be another 45 youth who will participate in focus groups. Ultimately, however, this study will lead to a youth-developed report that may help to inform clinical practice in the City for many hundreds of youth.

*Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.*

This youth-led project will assess the youth-friendliness of a wide array of standard instruments and assessment practices in the City. CBHS' project coordinator will recruit a cross-section of stipended youth who are broadly representative of the youth population. The leadership team will be comprised of 15 youth who will be responsible for researching instruments and practices, reviewing these tools, ascertaining their youth-friendliness based on structured measures, and writing a final report with recommendations to the field. The youth team may recruit approximately 45 additional youth who would participate in focus groups to provide further input to the team.

The final report will include an explanation of methodology, findings and recommendations that emerge from a youth perspective. Adult mentors will help the youth with technical issues and with organizational support as needed. Since many of the youth participants will be in high school or college, we anticipate that the study will take about nine months to ensure that the work does not interfere with their studies.

The final report will be reviewed by CBHS staff to ensure that copyright and confidentiality laws are observed, but otherwise the youth perspective will be reported without modification. The final product may include multi-media strategies to make sure the report is accessible to youth as well as practitioners.

## EXHIBIT F

## Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-5

Work Plan Name: Youth-Led Evaluat

New Work Plan ☑

Expansion ☐

Months of Operation: 7/10 - 6/11
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | 143,763 | | | $143,763 |
| 2. Operating Expenditures | 52,000 | | | $52,000 |
| 3. Non-recurring expenditures | | | | $0 |
| 4. Training Consultant Contracts | | | 12,000 | $12,000 |
| 5. Work Plan Management | | | | $0 |
| **6. Total Proposed Work Plan Expenditures** | **$195,763** | **$0** | **$12,000** | **$207,763** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$195,763** | **$0** | **$12,000** | **$207,763** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-309-4794

## Innovation Work Plan Narrative

**Date:** 02/05/2010

**County:** San Francisco County

**Work Plan #:** INN-6

**Work Plan Name:** Peer Education / Advocacy on Self-Help Movement and Consumer Rights

### Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The *PeerEd Project* will primarily focus on increasing the quality of services. Because *PeerEd* will provide important knowledge about self-help, recovery and consumer rights to students who are entering the behavioral health care and social work fields, we anticipate that it will change attitudes, beliefs and knowledge among the students served during the pilot project. Insofar as these students are better trained in the recovery model, they will help to ***improve the quality of services*** to consumers. The successful applicant will work closely with local Colleges and/or Universities to ensure that consumer voice is heard within the syllabus and that the history of the consumer recovery and consumer rights movement is articulated by consumers.

In addition to participation in the classroom, the *PeerEd Project* will also provide peer-led consultation and support for faculty, the campus counseling offices, dorm advisors, and other support personnel to ensure that the recovery, wellness and resilience philosophy is imbued into the culture of the universities to be served.

To support *PeerEd* implementation, the successful applicant will convene an advisory group consisting of the key stakeholders from local Colleges and/or Universities and the applicant's leadership. It is expected that, once the *PeerEd Project* has been proven successful, it will become an institutionalized part of the curriculum and student support services at the five IHE partners.

### Project Description

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description:** The recovery, wellness, and resilience focus of the MHSA has been developing for many years, largely through the consumer civil rights, self-help and advocacy movement. Unfortunately until recently, this perspective has been considered outside the mainstream of the mental health field which has been dominated by the medical model. Admirable advancements in psychopharmacology have ironically helped to make recovery more possible while at the same time being used as a tool to reinforce the medical model and to militate against consumer rights. As a result, the recovery model is often not taught in two-year

and four-year colleges and universities or graduate schools of psychology, social work and psychiatry.[7]

*PeerEd* is a concerted effort to bring the self-help, recovery model to College and University classrooms and campuses in a compelling manner so that professional mental health workers in training and their professors are made aware of:

- The history of the consumer movement within the context of the civil rights movement and struggles for justice
- Culturally competent, self-help methods used in working with individuals and groups
- Effective advocacy on behalf of self and others
- The organizational structure of self-help agencies and the ways that they maintain fiscal sustainability

In order to accomplish this objective, we propose that a qualified organization develop a team that provides education and training at San Francisco City College, San Francisco State University, University of San Francisco, Alliant International University, and University of California San Francisco or other comparable institutions in San Francisco. Classes, groups, and individual consultation for faculty and students would be offered.

While we expect that a consumer lead educator and an administrative staff person will be hired to staff the *PeerEd*, we also expect to provide stipends to a diverse team of consumers who will be trained to provide the aforementioned instruction/intervention. The *PeerEd* team will be marketed to a variety of psychology, medical, and social work programs – to be incorporated in the curriculum. Our expectation is that, over time, this curriculum will be institutionalized as a regular part of the course work in these subject areas.

In addition to the curricular component, the *PeerEd* team will be available to consult with faculty, counselors, dorm advisors, and other student support services to provide the consumer perspective and a recovery lens to the work being done by these university personnel.

**Expected Outcome/Positive Change:**

- Social Work and Mental Health higher education faculty and their students will increasingly understand and support the recovery model and seek out ways to empower and support the civil rights of consumers.
- Student support programs of all kinds will be imbued with the self-help, recovery philosophy which will be sustained after the pilot project.

**Title 9 General Standards:** The *PeerEd* project will apply the following general standards.

**Community Collaboration.** This *PeerEd* project is fundamentally a collaboration among institutions of higher education (IHEs) and a consumer-led organization to provide the proposed support and knowledge base to students, faculty and administrators.

[7] The California Association of Social Rehabilitation Agencies (CASRA) has developed a certificate program at the Community College level in Psychosocial Rehabilitation. However, *PeerEd* represents a departure from the college faculty providing students with information about Social Rehabilitation and consumer rights. *PeerEd* models consumer empowerment by training consumers to provide this instructional component by co-teaching with the professor and providing supplemental groups and individual support for students.

**Cultural Competence.** Diversity (in ethnicity, gender, and sexual orientation) will be affirmatively sought in developing the team of peer educators to ensure that the "message" is accessible to all demographic groups.

**Client Driven Mental Health System.** The training/teaching being proposed models the benefits of consumer self-help strategies. The successes of this approach in the college classroom and campus will be carefully documented and disseminated.

**Wellness, Recovery and Resilience Focus.** As has been mentioned elsewhere, the entire focus of this project is to imbue postsecondary education for behavioral health professionals with a deep understanding of the wellness, recovery and resilience philosophy.

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

Creating the practice and systems change represented by the MHSA requires that providers and policy-makers fully understand the theory and practice of self-help and recovery. The concepts of mutuality, empowerment, and self-determination have sometimes conflicted with the medical model approach that has characterized mental health service provision. This proposal would support those with the greatest expertise in self-help in disseminating the knowledge gained through years of experience.

Despite the gains made through the MHSA, the concept and practice of self-help has yet to be fully understood and embraced. It is uncommon in the postsecondary educational system to find these principles either utilized or taught. Therefore, this project would represent an innovative approach.

We plan to evaluate this project over the course of 24 months to determine whether the following interventions have a sustainable effect on IHE instructional practices in psychology, medical, and social welfare coursework:

- Having experienced consumers as peer educators provide training and technical assistance to faculty regarding incorporation of recovery, self-help and resilience in the behavioral health curriculum
- Having experienced peer educators providing in-classroom instruction to a wide range of students who are interested in pursuing careers in behavioral health and health care fields
- Having experienced peer educators providing one-on-one consultation to faculty who need additional TA and support to successfully integrate the recovery model into their practice and coursework

We also would expect that the peer educators would provide support and consultation to other student support services providers, such as counselors, dorm advisors, and mentors.

- Having experienced consumers providing one-on-one and group support for students who are consumers or who need to consult with a consumer to better understand the recovery process
- Providing TA to support service providers to ensure that they understand how to utilize the principles of recovery in their work with students.

In other words, we plan to determine whether having experienced consumers offering technical assistance and instruction can help IHEs to incorporate the recovery model into their curricula and their campus services in a sustainable manner. This will be determined through key informant interviews and surveys of faculty and other staff to determine whether the effort has changed their thinking about recovery and whether they intend to continue teaching and utilizing the recovery model in the future. We will also assess whether the IHEs will continue the practice of having consumers co-instruct with university faculty in the identified topical areas related to recovery and civil rights and whether they will continue to train support service staff in the recovery model.

These findings will be incorporated in a final report regarding the success of the interventions and the degree to which the approaches are sustainable without continued infusions of MHSA funding. The report will be widely disseminated among the participating IHEs and to counties and universities throughout the state

## Timeline

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 06/12
MM/YY – MM/YY

Phase I (07/10 – 08/10)

During this two month period, the successful applicant will reach out to a minimum of five IHEs and secure commitments to include a peer-led instructional component in at least one course of study (e.g., psychology, social work, medicine). The IHEs will commit specific amounts of time and schedule presentations. The IHEs will also be asked to include peer educators in the training of various student support service workers, including counselors, dorm advisors and mentors.

Phase II (09/10 – 04/12)

This period of time will span two school years. It is expected that the applicant will provide faculty technical assistance and in-classroom instruction at five San Francisco IHEs. It is further expected that peer-led instruction will occur in several different disciplines and over an extended period of time. This period of time will allow the applicant to test the level of implementation of peer-led instruction, the quality of that instruction, and the degree to which the participating IHEs will continue to implement the program after funding ceases. Pre/post data will be gathered to determine if students have learned anything new about the self-help process and the recovery model. The applicant will also gather satisfaction data – both from faculty and students regarding the value of the peer-led instruction. In addition, the applicant will gather process data about the number of students and faculty affected by the program.

Similarly during this period the peer educators will provide training and technical assistance to student support service providers on campus. Data will be collected from these providers to determine whether the training they received from experienced consumers has positively affected their practice and whether they intend to sustain these changes in the future.

Phase III (05/12 – 06/12)

The final two months will be used to analyze findings, provide formative feedback to the applicant, and write up an evaluation report that specifies the efficacy of the intervention. The degree to which the pilot will be sustained after MHSA funding ceases will be a major consideration, but not the only one. The quality of the program and the effect on faculty, support staff and student attitudes and beliefs will be the primary outcome metric. If successful, sustainability of this model may be enhanced by building it into the WDET funding stream in future years.

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

The *PeerEd* Project is dedicated to building and implementing a successful and sustainable peer-led curriculum and support system at the postsecondary level. The *PeerEd* Project will provide technical assistance for faculty and in-classroom instruction to postsecondary students who are pursuing certificates and/or degrees in behavioral health, medicine and social work. It will also provide training and technical assistance to a wide variety of student support service workers on the selected campuses.

Measures of success will include:

Process Measures:
- Numbers of IHEs contacted and enrolled in the program (measure: activity logs)
- Numbers of postsecondary courses of study that incorporate *PeerEd* (measure: activity logs)
- Numbers of postsecondary classes taught during the project implementation period (measure: activity logs)
- Numbers of trainings provided to what number of student support services staff (measure: activity logs)
- Hours of technical assistance provided to what number of faculty and student support services staff (measure: activity logs)

Outcome Measures:
- Increase in awareness of and clinical knowledge about self-help and recovery model approaches among postsecondary student participants (measure: pre/post surveys)
- Increase in commitment of faculty to incorporate self-help, recovery model focus in the classroom on an ongoing basis (measure: pre/post surveys)
- Increase in commitment of student support services staff to incorporate self-help, recovery model in their work (measure: pre/post surveys)
- Continuation rate for peer-led instruction during the 2011/12 school year (measure: pre/post surveys)

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

The *PeerEd Project* will leverage the considerable resources of at least five IHEs that will host the project by incorporating it into at least one course of study per college or university. This will leverage classroom space and faculty time required to implement the project. It will also leverage the time and expertise of student support services staff who will be trained by experienced consumers to use peer-led and recovery oriented strategies in their ongoing work.

It will also leverage a group of trained consumers who will provide some of the in-classroom instruction in collaboration with applicant staff. Although these experienced consumers will receive small stipends, they will be essentially volunteers who will augment the work of the paid peer instructor.

## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

INN-6, Education and Advocacy on Self-Help Movement and Consumer Rights

Annual Number of Clients/Students to Be Served (If Applicable)
750 Total

*Population to Be Served (if applicable):*

The *PeerEd* Project will primarily serve students and faculty in five postsecondary educational institutions that offer certificates or degrees in behavioral health, medicine or social work. We anticipate that at least 750 students and their faculty will be served during the 24-month project period.

*Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.*

The *PeerEd* Project is dedicated to building and implementing successful and sustainable peer-led instruction and student support services at the postsecondary level. The *PeerEd* Project will provide technical assistance for faculty and in-classroom instruction to postsecondary students who are pursuing certificates and/or degrees in behavioral health, medicine or social work

The successful applicant will be an agency that has the capacity to build effective alliances with at least five qualifying postsecondary institutions (see above). The applicant will negotiate agreements with the IHEs, deliver technical assistance to faculty and students and provide a sequence of classes that provide community college, undergraduate and graduate students with academically appropriate instruction on the self-help movement and the recovery model, for example:

- The history of the consumer movement and within the context of the civil rights movement and struggles for justice
- Culturally competent, self-help methods used in working with individuals and groups
- Effective advocacy on behalf of self and others
- The organizational structure of self-help agencies and the ways that they maintain fiscal sustainability

The successful applicant will also provide training and technical assistance to student support services staff on these same campuses – leading to use of peer-based and recovery model principles and practices in those departments.

The efficacy of this approach will be carefully evaluated. We anticipate that a CBHS evaluator will be assigned to measure both process and outcome variables. The process evaluation will measure fidelity of implementation and the degree to which the *PeerEd* Project has met its deliverables such as students served, faculty served, classes delivered, etc. The outcome measures will consider the attitudes and knowledge of students, support staff and faculty about the recovery model and self-help.

These findings will be incorporated in a final report that will be widely disseminated among the participating IHEs and to counties and universities throughout the state.

**EXHIBIT F**

## Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-6

Work Plan Name: Peer Education / A

New Work Plan ☑

Expansion ☐

Months of Operation: 07/10 - 06/12
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | | | 156,000 | $156,000 |
| 2. Operating Expenditures | | | 64,000 | $64,000 |
| 3. Non-recurring expenditures | | | | $0 |
| 4. Training Consultant Contracts | | | | $0 |
| 5. Work Plan Management | | | 26,087 | $26,087 |
| **6. Total Proposed Work Plan Expenditures** | **$0** | **$0** | **$246,087** | **$246,087** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$0** | **$0** | **$246,087** | **$246,087** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-309-4794

## Innovation Work Plan Narrative

**Date:** 2/5/2010

**County:** San Francisco County

**Work Plan #:** INN-7

**Work Plan Name:** Peer-led Hoarding and Cluttering Support Team

### Purpose of Proposed Innovation Project (check all that apply)

- [x] INCREASE ACCESS TO UNDERSERVED GROUPS
- [ ] INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- [ ] PROMOTE INTERAGENCY COLLABORATION
- [ ] INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

Only a small proportion of the 12,000-15,000 San Franciscans with serious hoarding and cluttering issues receive any form of treatment. Unfortunately, most interventions occur after eviction proceedings are underway or after the individual is homeless. The proposed project would **increase access to services** for this underserved target group by using a peer-based strategy that has not heretofore been used with this population. We believe the peer-based approach will improve access to services because of supportive connections with others who have faced the same challenges and have overcome those issues. This reduces stigma and enhances self-worth and willingness to seek and persist with treatment. This strategy will provide a sustainable model of support from a community of peers.

We hypothesize that adding a peer-based approach to this population will help to reduce isolation and stigma that is a serious barrier to engagement in treatment. We expect that Peer Responders will have tremendous advantages in securing buy-in and cooperation with the treatment process.

This project will enhance the collaboration between Adult Protective Services, Community Behavioral Health Services, Public Health and a number of housing programs across the City to provide interventions and access to therapeutic services while maintaining the consumers in their housing.

### Project Description

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description.** The purpose of this project is to provide peer support, community and system navigation by and for individuals who suffer from hoarding and cluttering behaviors. This project would create a peer-led hoarding and cluttering support team that would initially make contact with a client when they are in time of crisis/assessment and continue this support through a period of intensive case management, until the client has completed treatment and ideally becomes a peer supporter as well.

Hoarding and cluttering is a serious, treatable set of behaviors that we hypothesize will respond favorably to a team intervention approach whereby peer supporters and other case workers provide knowledgeable and compassionate intervention. Peer supporters will be selected from the graduates of hoarding and cluttering treatment groups. Peer supporters will receive initial intensive orientation and ongoing training while maintaining peer status. This person will have taken the steps necessary to address his/her own behaviors and will be in a position to assist others who are dealing with these issues. The peer supporters will serve as a resource, building trust and reducing client anxiety. They will provide long term care connections for the consumer by remaining in contact and providing systematic, peer and communal support through the recovery process. The peer supporter will bring personal experience with these behaviors and emotions which we expect will instill trust and acceptance of treatment. They will have familiarity with the system of care so that they can help the client navigate through the system – thereby helping to promote participation and increase client functioning. The peer supporter's own experience with the ups and downs of treatment will help provide stability and put the treatment process in context if/when the client encounters any problems. This peer responder network will work in conjunction with an Adult Protective Services staff member and a designated Social Worker who will provide intensive case management and training/supervision for the peer team.

The Social Worker, in collaboration with the peer intervention team, will help provide the therapeutic case management and supportive services to clients in their homes. S/he will also provide supervision and manage the peer support team. Our goal is to grow the peer support network over time with trainings and supervision to create a robust community of peer support. Ideally we will develop the peer responders over time so that they can take over some of the case management responsibilities and the Social Worker will primarily supervise the peer network.

Our learning objective is to determine whether a peer intervention team, in combination with professional case management, is more effective than case management alone. We are also interested in knowing whether the peer network is a sustainable model if proven effective.

**Expected Outcome/Positive Change:**

- Increased support and crisis response for individuals dealing with hoarding and cluttering issues through a peer-based network will result in improved consumer outcomes – such as, lower eviction rates, reduction or elimination of target behaviors, and improved consumer satisfaction and wellbeing.

**Title 9 General Standards:** The Peer-led Hoarding and Cluttering Support Team project will apply the following general standards.

***Community Collaboration.*** At its core this pilot will deploy a part time Social Worker who provides case management and peer advisors who will work with Adult Protective Services and CBHS to assist individual with serious hoarding and cluttering issues. The peer network will also interact with housing programs, tenants' rights organizations, and a wide variety of social service and behavioral health care agencies that will be involved with the consumers being served. We also expect that the project team will work with higher education – especially programs funded through MHSA WDET to help the peer advisors to pursue certification and degrees in behavioral health.

***Cultural Competence.*** The peer network will be selected to ensure that it reflects the diversity of the population being served. We will ensure that the network has both cultural and linguistic diversity sufficient to meet the needs of our client population. We will also ensure that the gender balance is appropriate to identified needs.

***Client Driven Mental Health System***. The use of a peer network is designed to create real empowerment for consumers who have problems with hoarding and cluttering. This peer group can provide help with navigating the system of services and providing an empathetic understanding of the emotions and behaviors of individuals with this problem as they move to recovery. We hope to sustain the peer network by recruiting consumers from the treatment group to join it over time.

***Wellness, Recovery and Resilience Focus.*** This strategy is designed to support recovery and wellness by providing role models who have overcome the problem and who understand the feasibility of recovery. These peers can also provide practical suggestions that help in moments of doubt or crisis. They can also help consumers understand their rights and help them with self-advocacy.

***Integrated Service Experience***. This pilot brings Adult Protective Services and Behavioral Health Care Services together with other service providers to help individuals with hoarding and cluttering behaviors. This team approach – augmented with peer navigation – helps the consumer to have an integrated experience and a clear plan of action toward recovery.

## Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

This project addresses the 12,000 – 25, 000[8] San Franciscans who suffer from hoarding and cluttering behaviors, many of whom are too ashamed and afraid to seek help. Many of these individuals are extremely isolated, at risk of eviction and physical harm. San Francisco is currently only responding when issues associated with hoarding reach a crises level. Only when an individual with hoarding behaviors has posed as a fire risk or has triggered eviction proceedings do the appropriate agencies intervene. This crisis response approach costs approximately $6.4million per year in eviction and service provider expenses[9]. The proposed peer support system will allow for more proactive intervention by creating a familiar community of peers where individuals receive useful information and feel more comfortable accessing treatment.

This project is innovative because there is no current hoarding and cluttering support network, and peer-based services have not been applied to this particular mental health issue. Outside of

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[8] It's estimated that compulsive hoarding and cluttering effects 2-4% of the population or 12-25,000 of San Franciscans. Mental Health Association of San Francisco, *Beyond Overwhelmed: The Impact of Compulsive Hoarding and Cluttering in San Francisco and Recommendations to Reduce Negative Impacts and Improve Care, A Report to the San Francisco Task Force on Compulsive Hoarding, 2009.*

[9] Mental Health Association of San Francisco, *Beyond Overwhelmed: The Impact of Compulsive Hoarding and Cluttering in San Francisco and Recommendations to Reduce Negative Impacts and Improve Care, A Report to the San Francisco Task Force on Compulsive Hoarding, 2009.*

crisis response through Adult Protective Services, there are almost no services or programs in the city and even the country on this issue. The proposed peer positions in combination with an intensive case management approach would be a totally new and innovative approach to this problem which is not currently being addressed, and *ongoing* peer involvement and support has not been utilized before for this population.

Like many mental health challenges, hoarding and cluttering behaviors are often accompanied by shame and denial which act as barriers to treatment. In other areas of the behavioral health continuum, peer outreach and engagement has been proven effective because having someone who has experienced these conditions pave the way reduces shame and stigma, offers hope for recovery, and helps the individual open themselves to treatment. The proposed pilot will test whether a peer approach will successfully access this very isolated population and keep them engaged in community and treatment.

We expect to learn whether this peer-based approach is effective in helping consumers struggling with this issue to successfully enter treatment and achieve their objectives. We expect to see reductions in evictions and homelessness among the individuals served by the peer network as compared to those who do not receive these services.[10]

Development of effective intervention tools and techniques that can be utilized by the peer population will contribute to learning. These tools and techniques will be documented by the project leadership and made available for dissemination to other communities. It also seems that a peer approach to this debilitating problem will be more effective and cost-beneficial than current reactive strategies. We propose to test the efficacy of the model using a CBHS evaluator who will measure the outcomes of the pilot and provide a formative and summative report that addresses the impact of the pilot and its replicability. Since this is a generally underserved population, we expect to disseminate our findings to other communities whether our hypotheses are corroborated or not.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 06/12
MM/YY – MM/YY

**Phase I (07/10 – 09/10)**
The first three months of the pilot will be spent hiring and training the Social Worker and the peer responders. The CBHS evaluator will develop the evaluation design during this period.

**Phase II (10/10 – 04/12)**
This period will allow for the team to test the intervention, develop tools and protocols, and document results to determine whether a peer model will be effective with this population. The evaluation will be implemented and data will be collected and preliminary analyses completed.

[10] The CBHS evaluator will assist the project to identify a suitable comparison group and minimize the effect of selection bias on the study.

**Phase III (04/12 – 06/12)**
This two month period will allow for a focus on sustainability. The evaluator will conduct an exit interview with CBHS lead staff, the peer advisors, and a selected group of consumers. The evaluator will triangulate these qualitative data with quantitative data collected during the intervention (e.g., eviction documentation, treatment follow through, etc.) and will then finalize the report. One of the key considerations will be to assess the social return on investment possible through this peer-based approach. If the approach is effective and cost beneficial, CBHS will seek to sustain the intervention through other funding.

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

There are a number of objectives that emerge from this pilot, and their measurement will be done as follows:

Consumer Outcomes:

- Individuals with hoarding and cluttering behaviors will report reduced risk of homelessness, isolation and physical harm (measure: pre/post survey of participants)
- Individuals will know that a peer community is available to provide them with support (measure: pre/post survey)
- Individuals will be more inclined to ask for help because they have a peer to help guide them through all avenues of treatment and support (measure: pre/post survey)
- This guidance will increase the number of individuals accessing treatment and persisting in treatment as compared to business as usual (measurement: program participation and attrition rates)

Peer Responder Outcomes:

- Peer responders will increase their commitment to recovery and their self-confidence in the wellness/recovery process (measure: pre/post survey, evaluator interview)
- At least half of the peer responders will enroll in educational programs that result in certification or a degree in the behavioral health care field (measure: pre/post survey, evaluator interview)
- Peer responders demonstrate an increase in knowledge and competence in supporting others with hoarding and cluttering behaviors (measure: pre/post survey, evaluator interview)

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

The initial crisis/assessment contact will need to be accompanied by an Adult Protective Services Worker which leverages the funding that supports these positions.

## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

Peer-led Hoarding and Cluttering Support Team

Annual Number of Clients to Be Served (If Applicable)
25 – 40/yr

*Population to Be Served (if applicable):*

This project will serve a pilot group of 25-40 adults and older adults annually suffering from hoarding and cluttering behaviors in San Francisco. These individuals will be served from the crisis/ assessment phase through intensive case management/treatment, to recovery by a social worker and peer responders.

*Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.*

The purpose of this project is to provide peer support, community and system navigation by and for individuals who suffer from hoarding and cluttering behaviors. This project entails creating a peer led hoarding and cluttering support team that would initially interact with a client when they are in time of crisis/assessment and continue this interaction through intensive case management, until the client has completed treatment and potentially becomes a peer supporter as well.

A peer responder will be a graduate from a hoarding and cluttering treatment group. Peer responders will receive initial intensive orientation and ongoing training while maintaining peer supporter status. They will have familiarity with the "systems" so that they can help the client navigate through the complex system of care, thereby helping to promote participation and increase client functioning. The peer responder's own experience with the ups and downs of recovery will help provide stability and put the treatment process in context if the client encounters any problems.

This peer responder network will work in conjunction with an Adult Protective Services staff member and a social worker acting as an intensive case manager/trainer. It is our hypothesis that hoarding and cluttering is a serious, treatable set of behaviors that will respond favorably to a team intervention approach whereby peer responders and other case workers receive overarching supervision and training. The social worker will work in collaboration with the peer intervention and will help provide the therapeutic case management and supportive services to clients in their homes as well as supervision and maintenance of the peer support team.

Over the course of this pilot, we will be seeking to learn 1) whether a peer-based support system will be adaptable to and effective for this underserved population; 2) whether this model can achieve better client outcomes than business as usual; and 3) whether the SROI demonstrates that this model is cost-effective and should be expanded in San Francisco and replicated elsewhere. If this pilot proves effective, CBHS will seek to sustain and expand the program using other MHSA funding as feasible.

## EXHIBIT F

## Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-7

Work Plan Name: Peer-Led Hoardin(

New Work Plan ☑

Expansion ☐

Months of Operation: 07/10 - 06/12

MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | | | 182,250 | $182,250 |
| 2. Operating Expenditures | | | 53,000 | $53,000 |
| 3. Non-recurring expenditures | | | | $0 |
| 4. Training Consultant Contracts | | | 21,000 | $21,000 |
| 5. Work Plan Management | | | 38,438 | $38,438 |
| **6. Total Proposed Work Plan Expenditures** | **$0** | **$0** | **$294,688** | **$294,688** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$0** | **$0** | **$294,688** | **$294,688** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-309-4794

## Innovation Work Plan Narrative

**Date:** 2/5/2010

**County:** San Francisco County

**Work Plan #:** INN-8

**Work Plan Name:** Collaboration with the Faith Community

**Purpose of Proposed Innovation Project (check all that apply)**

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☒ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

Despite having a robust faith community in San Francisco, CBHS, in general, does not have a strong collaborative relationship with this sector of society, and engagement of mental health consumers and family members with this crucial source of support for recovery and well-being could be increased.

At this point CBHS does not have a clear idea why there is a disconnect between the department and the faith community, but we are clear that it exists. The proposed *Collaboration with the Faith Community* project seeks to better understand the existing situation and to pilot a yet-to-be-developed collaborative project, in partnership with the faith community, to support individuals in our community who are suffering from mental illness to recover and become better integrated and functioning members of the community. The primary purpose is to learn how to **promote interagency collaboration** between the faith and behavioral health systems.

The proposed project will have a planning year to explore strengths and barriers to collaboration and a pilot year to put collaboration to the test. This will allow the faith and mental health communities to better understand the opportunities and practical challenges of collaboration.

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description.** Understanding the current situation will be accomplished in Year One by: 1) convening leaders of the faith community and leaders of the behavioral health care community through a facilitated process to explore the strengths and opportunities afforded through collaboration and identifying the barriers to collaboration; 2) key informant interviews of CBHS leadership, CBO leadership, and faith community leadership will also add to this knowledge base; 3) consumer focus groups will explore the benefits and challenges associated with being a consumer and interacting with the faith community; and 4) beginning to plan one or more pilot projects that inherently require collaboration between the two sectors.

In Year Two, one or more pilot projects will be launched, primarily to explore the working relationships and to better understand the factors that facilitate collaboration and those that impede it. We anticipate that these pilots will be designed to ensure that they are fully collaborative and involve mutual assistance and day-to-day interaction – with the end goal of helping mental health consumers with recovery and wellness. This type of close working relationship will allow issues to emerge and be resolved in the course of project implementation. Our goal will be to take our learning beyond personalities and historical issues and to candidly look at systemic barriers, differences in perception and world view, and issues related to expectations and social return on investment (SROI).

An evaluator will work with CBHS and the lead representatives of the faith community to develop a logic model, theory of change, and an evaluation plan during Year One. The evaluator will conduct surveys, focus groups and key informant interviews with representatives of the faith and mental health communities in Year Two to determine whether the pilot was implemented as planned in Year One and to determine what strengths, resources and barriers affected the pilot projects and the systemic relationships as a whole.

**Expected Outcome/Positive Change:**

- The faith community, in all its diversity, and the public mental health system will adopt a common mission to support consumers and family members toward recovery and wellness; and the collaboration will develop actionable ways to express that common mission in pragmatic terms.

**Title 9 General Standards:** The Collaboration with the Faith Community project will apply the following general standards.

**Community Collaboration.** This project is expressly focused on developing collaboration with the faith community which has traditionally not been closely linked with the CBHS system of services. We intend to discover the opportunities for greater collaboration and the barriers to collaboration so that we can strengthen this relationship to better serve the mental health consumers and families of San Francisco.

**Cultural Competence.** The faith community of San Francisco is extremely diverse – representing all of the cultures and language groups in our community. This project will attempt to reach as broadly as possible into that diverse array of churches, temples, synagogues, mosques, and non-institutional faith groups. This is the power of this potential alliance – to reach virtually every segment of the community to support mental health in the entire community.

**Wellness, Recovery and Resilience Focus.** A key reason for engaging the faith community is to help to spread the philosophy of recovery more broadly in the community and to combat stigma associated with mental illness. This topic will be a critical part of the collaboration building that is being done in Year One – especially addressing the evolving science of recovery and discussing it in the context of traditional healing and beliefs about mental illness.

**Integrated Service Experience.** The faith community is a critical player in the system of care for individuals dealing with mental health challenges and their families. Faith leaders and communities are often the first place that a family or individual will go to discuss emerging problems in their lives. The faith community is in a position to be extremely helpful by triaging the situation and making appropriate referrals as needed. The faith community can also be an

enormous support to consumers and their families as they deal with the treatment process and to support successful community integration. Insofar as the faith community and the mental health system are working effectively together, the consumers and family members will experience the process as integrated and clear.

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

The Collaboration with the Faith Community Project has been designed specifically to learn why the San Francisco faith community is not better connected to the mental health system, to discover ways to change that situation, and to test the efficacy of collaboration between the sectors to improve outcomes for mental health consumers and their families. Although there are other counties with a strong connection between the faith and mental health communities, those connections are not particularly relevant to the San Francisco condition which is imbued with its own history, culture, and institutional relationships. It seems that there is a unique circumstance in every county and the systems need to learn how to build on their strengths and overcome their barriers in an idiosyncratic manner associated with that community.

That said and as mentioned above, we intend to use the first year of this project to uncover the nature of the opportunities and challenges inherent in the relationship between the faith and mental health community in San Francisco. This discovery process will be facilitated by a CBHS staff person with sufficient political and organizational skill to ensure that the discovery process is candid and effective. It will be extensive in nature because of the enormous diversity of the San Francisco cultural and faith communities. The goal for Year One is to learn about the community and to develop a pilot project that would engage the faith community in a collaborative pilot project that would be implemented in Year Two.

Year Two will move beyond planning to a collaborative program that will test the efficacy of the collaboration developed in Year One. This approach will ensure that the learning moves beyond theory and explores the issues involved in practice.

The evaluator will gather information from faith and mental health system participants during both program years to ascertain the effectiveness of the planning and practice elements of this collaboration. Measures will include surveys, focus groups, key informant interviews, and ultimately programmatic success in working together to accomplish a specific program goal.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 07/10 – 06/13
MM/YY – MM/YY

**Phase I (07/10 – 08/10)**
Phase I Start up. The first two months of Year One will be dedicated to staffing the project by reassigning a qualified CBHS staff person who is able to lead the planning process with the faith

community and the mental health community. The evaluator will also develop the logic model, theory of change and evaluation plan for the project during this period.

**Phase II (09/10 – 09/11)**
Phase II Planning Period. Phase II will focus on convening a planning group that reflects the diverse faith community of San Francisco and facilitating a candid dialogue that identifies opportunities and challenges inherent in a truly collaborative relationship in support of mental health consumers and families. The evaluation during this period will consider: 1) the quality of the planning process; 2) whether it is sufficiently inclusive; 3) what is discovered about strengths, opportunities and barriers to collaborative action on behalf of the mentally ill in San Francisco; and 4) whether a meaningful pilot has been developed for Phase III. A formative report will be provided to help policy makers to decide whether the project is ready to move to implementation in Phase III.

**Phase III (9/11 – 9/12)**
Phase III is focused on implementing one or more pilot programs that are inherently collaborative and that focus on the ways in which the faith community can become an integral part of the recovery and wellness effort underway in San Francisco.

**Phase IV (9/12 – 6/13)**
During this period the evaluator will consider: 1) the effectiveness of the collaboration, including success and challenges; 2) program efficacy in achieving shared objectives; and 3) replicability and sustainability of the models developed. A summative report will be provided to help inform the mental health system and the faith community regarding the effectiveness of this two year effort, the benefits of sustaining the effort, and any remaining barriers to be overcome to optimize the collaboration.

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

The *Collaboration with the Faith Community Project* will be assessed on two levels: 1) how effective the Year One planning process was in bringing the key players together in a meaningful way to consider the benefits and challenges of collaboration to serve mental health consumers and their families; and 2) whether one or more pilot projects that emerged from the Year One planning process have been effectively implemented in a collaborative manner during Year Two.

Year One will largely be evaluated by survey, focus groups key informant interviews, and direct observation of collaborative convenings by the evaluator. This largely qualitative assessment will measure satisfaction with the process and whether the planning process results in meaningful actions steps and one or more pilots to be undertaken in Year Two.

Year Two will involve many of the same qualitative data gathering techniques, but it will also assess the effectiveness of the pilot projects – with an eye to both the quality of collaboration between the involved faith and mental health system participants AND the outcomes for consumers and their families to determine whether the participation of the faith community had meaningful impact on reducing stigma, improving access to services, providing a more integrated experience, increasing cultural competence in service provision, etc. These latter data will be gathered by survey from consumers and/or family members as appropriate.

After Year One the evaluator will produce a narrative report that will help the participants make midcourse corrections. After Year Two a summative report will be produced that will inform the leaders whether the effort should be sustained and/or replicated in other communities. In any event, the results will be disseminated within the San Francisco mental health and faith communities and to other counties across the state.

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

The *Collaboration with the Faith Community Project* will leverage the social capital, time, and dedication of the faith community in San Francisco. It is anticipated that many faith leaders will step forward to participate in the planning and implementation process of this initiative. All of their time will be provided on a pro bono basis as they participate in both planning and implementation phases.

## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

Collaboration with the Faith Community

Annual Number of Clients to Be Served (If Applicable)
N/A Total

Population to Be Served (if applicable):

This project is designed to build the system of services that support individuals with mental illness and their families in San Francisco. Our primary objective is to bring the extensive faith community together with the mental health system to plan a more collaborative and effective relationship on behalf of consumers and family members. In Year Two one or more pilot projects will be implemented that will have direct impact on (yet to be determined) consumer populations. Presumably these populations will be individuals who can be optimally served with the partnership of the faith community. However, the specific nature of these pilots will be determined at the end of the Year One planning process.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Understanding the current situation will be accomplished in Year One by: 1) convening leaders of the faith community and leaders of the behavioral health care community through a facilitated process to explore the strengths and opportunities afforded through collaboration and identifying the barriers to collaboration; 2) key informant interviews of CBHS leadership, CBO leadership, and faith community leadership will also add to this knowledge base; 3) consumer focus groups will explore the benefits and challenges associated with being a consumer and interacting with the faith community; and 4) beginning to plan one or more pilot projects that inherently require collaboration between the two sectors.

In Year Two one or more pilot projects will be launched, primarily to explore the working relationships and to better understand the factors that facilitate collaboration and those that impede it. We anticipate that these pilots will be designed to ensure that they are fully collaborative and involve mutual assistance and day-to-day interaction – with the end goal of helping mental health consumers with recovery and wellness. This type of close working relationship will "force" issues to emerge and be resolved in the course of project implementation. Our goal will be to take our learning beyond personalities and historical issues and to candidly look at systemic barriers, differences in perception and world view, and issues related to expectations and social return on investment (SROI).

An evaluator will work with CBHS and the lead representatives of the faith community to develop a logic model, theory of change, and an evaluation plan during Year One. The evaluator will conduct surveys, focus groups and key informant interviews with representatives of the faith and mental health communities in Year Two to determine whether the pilot was implemented as planned in Year One and to determine what strengths, resources and barriers affected the pilot projects and the systemic relationships as a whole.

## EXHIBIT F

### Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-8

Work Plan Name: Collaboration with

New Work Plan ☑

Expansion ☐

Months of Operation: 7/10 - 6/13
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | $ 264,756 | | | $ 264,756 |
| 2. Operating Expenditures | $ 53,000 | | | $ 53,000 |
| 3. Non-recurring expenditures | | | | $ - |
| 4. Training Consultant Contracts | | | $ 21,000 | $ 21,000 |
| 5. Work Plan Management | | | | $ - |
| **6. Total Proposed Work Plan Expenditures** | **$317,756** | **$0** | **$21,000** | **$ 338,756** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | **$0** |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | **$0** |
| b. (insert source of revenue) | | | | **$0** |
| c. (insert source of revenue) | | | | **$0** |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$317,756** | **$0** | **$21,000** | **$338,756** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-309-4794

## Innovation Work Plan Narrative

**Date:** 2/5/2010

**County:** San Francisco County

**Work Plan #:** INN-9

**Work Plan Name:** Community Mini-Grants for Innovation**

**Purpose of Proposed Innovation Project (check all that apply)**

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The primary purpose of the *Community Mini-Grants for Innovation* project is to **increase the quality of services, including better outcomes** for individuals living with mental health challenges in San Francisco. CBHS will develop and test a community-run grant making program modeled on the funding methodology commonly employed by venture capitalists in the for-profit sector and donor advised funds in a community foundation.

The primary learning objectives are to determine if adopting a funding model that 1) increases community members' influence over funding decisions and 2) engages community members who have not traditionally been engaged in funding mental health projects will **improve the quality of programs and their outcomes**.

The project's secondary goals include expanding the community's understanding of the mental health system and increasing community members' meaningful involvement in program development. We hypothesize that increasing community involvement in the funding process will empower community members, improve feelings of self efficacy in decision making and increase the level of trust community members have towards CBHS. In addition, CBHS administration will learn from the innovative funding process, while the age-based Systems of Care will learn from outcomes of specific projects.

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**Project Description.**
The proposed Community Mini-Grants for Innovation project builds upon the County's work developing and implementing the various components of MHSA. During the CSS planning process, CBHS conducted outreach to providers, consumers and family members with

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experience and expertise implementing or accessing CSS specific services. Subsequently, PEI presented CBHS with an opportunity to engage a broader community of providers and individuals. These expanded outreach and information sharing efforts were greeted with excitement from the community. The *Community Mini-Grants for Innovation* project builds upon these efforts and will allow CBHS to tap even further into the community's internal capacity, wisdom and knowledge.

It is standard practice, including with MHSA funding, for CBHS to engage the community in the identification of broad strategies and priorities that are subsequently formed into operational programs by CBHS staff. Once projects are formed by staff, CBHS releases Request for Proposals (RFP) to implement the projects. The standards by which CBHS awards contracts are stringent, often sifting out many capable small or non-traditional providers. Moreover, the current RFP process is lengthy, often spanning five or more months from RFP release to funding allocation.

The *Community Mini-Grants for Innovation* funding process will differ in that it will allow individuals or organizations to develop and actually test Innovative projects. These projects may consist of significantly different types of programmatic/service models than currently exist in San Francisco's behavioral health care or public health prevention systems. CBHS, in partnership with the INN Funding Board, will conduct ongoing evaluation efforts to understand whether this funding model and the engagement and empowerment of diverse and non-traditional mental health decision makers improve the funding process, programs or outcomes. The process will also differ from the existing contracting process, in that funding will be administered through a partnership with a local fiscal intermediary selected through a competitive process. This partnership will ensure that funding to support Innovation projects is distributed in a timely manner.

The *Community Mini-Grants for Innovation* project involves a number of strategies that will roll out in the following phases, which will be managed and coordinated by the CBHS Innovation Coordinator. The work of the Coordinator will also focus on managing the work of T.A. providers and any consultants contracted to assist with facilitation of the various planning processes outlined below.

**Phase I: Developing the Innovation Funding Board**

Phase I will involve the development of an Innovation (INN) Funding Board which will be comprised of at least 15 members. The Board will include a diverse membership reflecting the racial/ethnic diversity of San Francisco. The Innovation Board will consist of individuals that identify as at least one of the following groups: consumers, family members; non-traditional partners; community experts; and service providers. Innovation Funding Board members will be recruited and selected by a sub-committee of the Mental Health Services Act Advisory Committee. This selection committee will evaluate the fit of interested applicants using criteria including:

- A personal or professional commitment to behavioral health and community wellness,
- The ability to represent the needs of diverse communities as well as contributing to the

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- Ability to engage in difficult decision making and prioritization, and
- Ability to make a sufficient commitment of time.

CBHS will conduct special outreach and recruitment to ensure that members of communities that have not traditionally been engaged in the design, funding or implementation of behavioral health programs. CBHS will also work to ensure that Board members represent a diverse range of ages, genders, and sexual orientation.

**Phase II: Fine-tuning the Innovation Funding Model**

The newly created INN Funding Board will review, help develop and endorse INN projects for funding. They will also inform the development of evaluation strategies for the Innovation projects. With the support of CBHS Innovation staff and consultants, the INN Funding Board's first task will be to develop a simple (up to three-pages) Innovation Project Proposal Template as well as the detailed process and criteria for evaluating INN proposals. Strategies for avoiding conflicts of interest among the members and potential applicants will also be adopted. While the goal of this phase is to empower the Board to develop a process of their own design, the Board will need to ensure compliance with the following:

- All State guidelines on Innovation must be followed.
- INN Projects must contribute to learning (rather than focusing on providing a service). Examples of this include:
  - Introducing a new mental health practice that has never been done, or making a change to an existing practice, including adaptation for a new setting or community; and/or
  - Adapting a promising community-driven practice, or one that has been successful in a non-mental health context, for use in the mental health system.
- Innovative Projects must target at least one of the State's four innovation goals:
  - Increase access to underserved groups
  - Increase the quality of services, including better outcomes
  - Promote interagency collaboration
  - Increase access to services
- The Project Proposal Template must include the estimated grant amount; the issue or community need being addressed; a project description and the target population.
- Applicants must also be required to demonstrate how their ideas will 1) contribute to the County's learning (e.g. how to serve our clients more effectively) and 2) improve the quality of mental health programs and/or services.
- Innovative Projects must serve low-income individuals and families experiencing or at risk of experiencing mental health challenges.
- Accepting rare instances, projects should be completed within 24 months of receiving funding.
- Grantees must submit regular updates and a final report upon completion.

**Sub-Committees:** Throughout the planning for the different MHSA components, participants have demonstrated a strong desire to address and mental health challenges in particular high-risk communities (e.g. African-American, transgender and older adult communities). The MHSA

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and countless data sources support the use of targeted funding and strategies. Given this priority, some members of the community have argued that having one citywide planning committee designed to include representatives of a broad range of stakeholders and communities dilutes an opportunity for real cultural competence or true representation of underserved communities. In response to these concerns, this phase will likely include the development and recruitment of ad-hoc Advisory Committees charged with advising the Innovation Funding Board about the needs of specific populations. These Committees will also help ensure that the following INN education and engagement efforts reach as deeply as possible into the MHSA priority populations.

**Phase III: Educating and Engaging the Community**

In partnership with the newly created INN Funding Board, CBHS will host a series of Community Information meetings designed to educate community members about the *Community Mini-Grants for Innovation* project. The goal of these meetings will be to educate the public on the State's Innovation guidelines, the new funding process, priorities and eligibility criteria. Partner agencies, individuals, groups, nontraditional mental health providers and community agencies will be invited to learn and participate in these meetings. Special outreach will be made to the under- and inappropriately-served groups identified in San Francisco's previous MHSA planning processes, such as those defined by race/ethnicity, gender, physical ability, veterans status, language capacity, geographic location, age and criminal justice involvement.

**Phase IV: Reviewing and Endorsing (or further developing) Innovation Project Proposals**

Community members and organizations from around San Francisco will be able to submit an Innovative Project Idea to the Innovation Funding Board (or to the Board via one of the sub-committees). In addition to the Information Meetings, CBHS staff and the INN Funding Board members will hold Bidder's Conferences for interested parties and respond to questions and feedback about the process. CBHS, with guidance from the INN Funding Board, will also develop an Innovation web page outlining the INN project, so interested parties may view the funding requirements and assess their interest in and eligibility for applying for this funding stream. This phase will promote "outside the box" thinking and meaningful learning about service and outcome improvements.

While the INN Funding Board will develop the specific details of the funding process and criteria for evaluating project proposals, CBHS will suggest using the following framework, developed by Alameda County, as a starting point. Once the Project Proposals are submitted, they would be reviewed and receive one of four ratings:

*1 - Strongly Endorse*: Proposal meets State and local criteria and principles, received unanimous support from the Board as submitted, and has a strong chance of success;
*2 - Endorse:* Proposal meets State and local criteria and has a reasonable chance of success;
*3 - Needs Development:* Proposal has a promising concept, but needs further development/refinement to have a reasonable chance of success; or
*4 - Not Recommended:* Proposal does not meet the Innovation Guidelines or principles and/or does not have a reasonable chance of success;

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Projects receiving scores of 1 or 2, *Strongly Endorse* and *Endorse*, will be compiled into a proposed INN Funding Plan. This Plan will be reviewed by select CBHS units (contracts, finance, etc.) to ensure compliance with City, County and DPH policies, laws and regulations. Any substantive feedback will be returned to the Planning Committee to be resolved. After a final round of review and prioritization, the final INN Funding Plan will be forwarded to the fiscal Intermediary for implementation (in close partnership with CBHS staff).

The authors of the project proposals receiving a score of 3, *Needs Development,* will be offered an opportunity to receive technical assistance (T.A.) to further develop their proposal or to address other concerns raised by the Board (e.g. developing budgets, outcomes, etc.). Ideally, the T.A. will be conducted in small groups with Board member participation and multiple applicants to foster cross learning.

The authors of the project proposals receiving a score of 4, *Not Recommended*, should receive feedback in a timely manner that explains why their proposal will not be considered for funding.

**Phase V: Implementation of Innovation Projects**

It is expected that at least ten INN projects will be implemented in the initial Phase V. Most projects will likely be funded for up to 24 months, depending on the project type. The selected Innovative projects will be guided by learning questions, which grantees will work to answer over the course of their project's implementation. Technical assistance for organizations that do not have experience with data collection or investigating learning questions will be offered to project grantees. Technical assistance providers will be sub-contracted.

In order to expedite the funding process, CBHS intends to use a fiscal intermediary, selected through a competitive process, to develop contracts and dispense the INN funds. The CBHS Innovation Coordinator, in partnership with Fiscal Intermediary staff, will oversee the contracting process for mini-grants that are awarded and monitor progress. Grantees will be asked to send quarterly reports and updates to the Innovation Coordinator, who will share the information with the Innovation Funding Board and CBHS Administration.

**Phase VI: Evaluating and Sharing INN Project Outcomes and Lessons**

An annual Innovation Findings Report will be developed. This report will highlight the outcomes and lessons learned from the implementation of the time limited Innovative projects and distributed in San Francisco and across the State. Identified best practices, challenges and positive outcomes will be used to inform CBHS system and development of future projects.

**Expected Outcome/Positive Change:**

- Improved quality of programs and their outcomes,
- Community empowerment, improved feelings of self efficacy in decision making and increased trust in CBHS.
- Expanded community understanding of the mental health system,
- Increased meaningful involvement of community members in funding decisions, and

**Title 9 General Standards:**

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**Community Collaboration.** This project is expressly focused on strengthening our collaboration with the community so that we can better serve the mental health consumers and families of San Francisco. This project also includes efforts to engage communities that have not been previously engaged in the development or implementation of behavioral health programs.

**Cultural Competence.** Engaging the communities we hope to serve should increase the level of cultural competence of the INN programs and funding decisions. Diversity (in ethnicity, gender, and sexual orientation) will be actively sought in developing the INN Funding Board The sub-committees of the Funding Board will also lead to increase cultural competence by engaging participants that are reflective of the ethnic, gender and sexual orientation of certain target populations.

**Wellness, Recovery and Resilience Focus.** This project is fundamentally aligned with the Wellness, Recovery and Resilience because it is focused on empowering and engaging consumers, families and community members in decision making about INN strategies to support their own wellness and recovery.

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

This project will contribute to learning by **introducing new applications or practices/ approaches that have been successful in non-mental health contexts.** CBHS will develop and test a community-run grant making program modeled on the funding methodology commonly employed by venture capitalists in the for-profit sector and donor advised funds in a community foundation. The primary learning objectives are to determine if adopting a funding model that 1) increases community members' influence over funding decisions and 2) engages community members who have not traditionally been engaged in developing or funding mental health projects will **improve the quality of programs and their outcomes.**

In addition, CBHS administration will learn from the innovative funding process, while the age-based Systems of Care will learn from outcomes of specific projects.

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: January 2010-July 2013

The following timeline is the estimated timeline for the **first round** of development and implementation of Innovation projects.

** Many components of this project, the proposed funding model and segments of text in this narrative were borrowed liberally from the recently approved Alameda County Innovation Plan.

**Phase I:** Developing the Innovation Funding Board (07/10 – 9/10)

**Phase II:** Fine-tuning the Innovation Funding Model (10/10 – 12/11)

**Phase III:** Educating and Engaging the Community (1/11 – 2/11)

**Phase IV:** Reviewing and Endorsing (or further developing) Innovation Project Proposals (3/11 – 4/11)

**Phase V:** Implementation of Innovation Projects (5/11 – TBD*)

**Phase VI:** Evaluating and Sharing INN Project Outcomes and Lessons (TBD*)

It is expected that these phases will evolve into a circular process. For example, Phase V for some projects will likely continue as the Funding Board begins a second round of Phase IV to fund a second round of projects.

* Pending decisions from the INN Funding Board

**Project Measurement**
*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

The Proposed project will be reviewed at the end of each phase for the following domains using the indicated mechanisms. (These measurements will be developed further with the help of CBHS staff and community based sub-contracted technical assistance providers.)

**Impact on Program Quality and Outcomes:** In order to determine whether each project improved quality of services or outcomes, the evaluation of each project will be designed in collaboration with the project grantee.

**Impact on Funding Process:** CBHS will assess if this particular funding model has a positive impact (more efficient, expeditious, and/or programmatic diversity). Example learning questions will include:

- How fast did the funding cycle take as compared to the current timeline?
- How fast was money distributed?
- What types of projects were funded versus current projects?
- How many projects were proposed?
- How many new providers were selected to implement projects?
- Number of projects funded?
- Types of funded projects versus current projects will be compared by examining CBHS traditionally funded projects and the newly selected projects. An analysis of similarities and differences will be made.
- Demographic information about the participant parties in each phase will be gathered.
- Number of new providers selected to implement projects will be measured by counting the number of new providers (those are do not already exist as CBHS contractors)

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**Impact on Individuals:** CBHS will learn how those involved in the process were impacted. Individuals that participate will be asked to provide feedback on how the process impacted participants who had not been traditionally involved in the mental health decision making process. The learning questions will pay particular attention to diverse individuals from under or inappropriately-served populations. Example learning questions will include:

- In which ways, if any, were you engaged in mental health decision making before engaging in this process?
- What impact has this process had on you?
- In which ways have you shared your experience with others in your community?
- How did you feel about participating in decision making before this process?
- How do you feel things are different now?
- How do you feel you have impacted the system?
- How did you feel about mental health systems before this process?
- What will you do differently in the future?
- What have you learned about mental health and the mental health system?
- Participant rating on the usefulness of information that was disseminated
- How participants (those who were part of the Innovation Board as well as applicants) heard about the process

The feedback received from those that participated will provide insight into how the process impacted and changed their roles. Each phase will also involve a satisfaction survey, which will be distributed to the participants in that phase, including members of the Innovation Funding Board, applicants and CBHS staff.

The results of these measurements will be tabulated, analyzed, disseminated by the Innovative Coordinator to the Innovation Funding Board, CBHS Administration, and grantees as well as made available for public review and used to improve services, implement both system and project specific improvements for the future.

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

The Funding Board will act as a voluntary body, which will devote time and energy to the project. Moreover, the Board's insights and talents will also be leveraged to determine the best projects to be funded. In sum, the leveraged resources of the Board and foundations will be based on collaborative community resources, such as time, talent, experience, relationships and possible funding.

CBHS will work with community foundations, CBHS programs and the fiscal intermediary to establish partnerships that will leverage these funds in a mutually beneficial matter. The fiscal intermediary will help the County attract groups and organizations that have not traditionally provided mental health services yet have established programs that effectively serve individuals and families experiencing or are at risk of experiencing mental health challenges. This would include social service organizations, mentoring groups, educational organizations and others.

Foundations may also see this partnership as an opportunity to leverage their investments with

** Many components of this project, the proposed funding model and segments of text in this narrative were borrowed liberally from the recently approved Alameda County Innovation Plan.

these organizations and help establish alternative long-term funding streams for programs that can qualify for Medi-Cal, EPSDT or other related funding in the future.

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## Innovation Work Plan Description
**(For Posting on DMH Website)**

County Name

San Francisco

Work Plan Name

INN 9 - Community Mini-Grants for Innovation

Annual Number of Clients to Be Served (If Applicable)
N/A Total

Population to Be Served (if applicable):

Innovative Projects will serve low-income individuals and families experiencing mental health challenges or are at-risk.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The primary purpose of the *Community Mini-Grants for Innovation* project is to increase the quality of services, including better outcomes for individuals living with mental health challenges in San Francisco. CBHS will develop and test a community-run grant making program modeled on the funding methodology commonly employed by venture capitalists in the for-profit sector and donor advised funds in a community foundation. The primary learning objectives are to determine if adopting a funding model that 1) increases community members' influence over funding decisions and 2) engages community members who have not traditionally been engaged in developing or funding mental health projects will **improve the quality of programs and their outcomes.**

The project's secondary goals include expanding our community's understanding of the mental health system and increasing community members' meaningful involvement in program development. We hypothesize that increasing community involvement in the funding process will empower community members, improve feelings of self efficacy in decision making and increase the level of trust community members have towards CBHS. In addition, CBHS administration will learn from the innovative funding process, while the age-based Systems of Care will learn from outcomes of specific projects.

The *Community Mini-Grants for Innovation* funding process will differ from the current DPH RFP and contracting system in that it will allow a broader group of individuals and organizations from the community to develop and test Innovative projects. These projects may consist of significantly different types of programmatic/service models than currently exist in San Francisco's behavioral health care or public health prevention systems. CBHS will conduct ongoing evaluation efforts to understand whether this funding model and the engagement and empowerment of diverse and non-traditional mental health decision makers improve the funding process, programs or outcomes.

## EXHIBIT F

### Innovation Projected Revenues and Expenditures

County: San Francisco

Fiscal Year: 2009/10

Work Plan #: INN-9

Work Plan Name: Community Mini-G

New Work Plan ☑

Expansion ☐

Months of Operation: 7/10 - 6/13
MM/YY - MM/YY

| | County Mental Health Department | Other Governmental Agencies | Community Mental Health Contract Providers | Total |
|---|---|---|---|---|
| **A. Expenditures** | | | | |
| 1. Personnel Expenditures | $ 96,625 | | | $ 96,625 |
| 2. Operating Expenditures | $ 36,000 | | $ 850,000 | $ 886,000 |
| 3. Non-recurring expenditures | | | | $ - |
| 4. Training Consultant Contracts | | | $ 125,000 | $ 125,000 |
| 5. Work Plan Management | | | $ 146,250 | $ 146,250 |
| **6. Total Proposed Work Plan Expenditures** | **$132,625** | **$0** | **$1,121,250** | **$1,253,875** |
| **B. Revenues** | | | | |
| **1. Existing Revenues** | | | | $0 |
| **2. Additional Revenues** | | | | |
| a. (insert source of revenue) | | | | $0 |
| b. (insert source of revenue) | | | | $0 |
| c. (insert source of revenue) | | | | $0 |
| **3. Total New Revenue** | **$0** | **$0** | **$0** | **$0** |
| **4. Total Revenues** | **$0** | **$0** | **$0** | **$0** |
| **C. Total Funding Requirements** | **$132,625** | **$0** | **$1,121,250** | **$1,253,875** |

Prepared by: Marlo Simmons

Date: 2/5/2010

Telephone Number: 415-309-4794

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

December 10, 2009

DMH INFORMATION NOTICE NO.: 09-20

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: MENTAL HEALTH SERVICES ACT PLANNING ESTIMATES FOR FISCAL YEAR 2010/11

REFERENCE IMPLEMENTATION OF THE MHSA, WELFARE AND INSTITUTIONS CODE SECTIONS 5847, 5848, AND 5892

This Department of Mental Health (DMH) Information Notice transmits the Mental Health Services Act (MHSA) Planning Estimates[1] for Counties[2] for the Fiscal Year (FY) 2010/11 for the three components of the Three-Year Program and Expenditure Plan funded in FY 2010/11 (Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Innovation (INN). Enclosure 1 provides the FY 2010/11 Planning Estimates for the CSS component and Enclosures 2 and 3 provide the FY 2010/11 Planning Estimates for PEI and INN components. Enclosure 4 provides a summary of the FY 2010/11 Planning Estimates for CSS, PEI and INN. Enclosure 5 provides the maximum amount of CSS funds that can be transferred to other components pursuant to Welfare and Institutions Code (WIC) section 5892, subdivision (b).

Total statewide funding for each component is determined each year based on actual deposits into the Mental Health Services Fund (MHS Fund) compared to existing commitments and obligations against the MHS Fund. The Department, in consultation with the California Mental Health Directors' Association (CMHDA), the Mental Health Services Oversight and Accountability Commission (MHSOAC), and the Mental Health Planning Council, then establishes the total fiscal year statewide funding for each component, using the percentages set forth in the Act. (See Welf. & Inst. Code § 5892)

The MHSA services and programs are funded by revenues from the voter approved one percent (1%) tax levy on individuals earning a gross adjusted income above one million dollars. Due to the current economic recession, the numbers of individuals in this tax bracket

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[1]Planning Estimates are the estimates provided by the Department of each County of the maximum amount of MHSA funding by component that the County can request through its Three-Year Program and Expenditure Plan or update(s) for a given year.

[2] "County" means the County Mental Health Department, two or more County Mental Health Departments.

have decreased. As a result, future MHSA revenues are expected to decline, resulting in reductions to MHSA Planning Estimates. If deposits into the MHS Fund decline in future years, the total statewide funding for a component may be less than prior years. Also, if deposits into the MHS Fund from prior years have not been fully obligated or committed for a component, total statewide funding for that component may be greater in one year than the next.

DMH will provide further guidance on how a County can access MHSA funds for FY 2010/11 in a separate Information Notice. Distribution of funds is subject to approval of a County's request by DMH and, for PEI and INN, the MHSOAC.

Pursuant to the MHSA Section 5847 (f), the Act requires DMH, in consultation with CMHDA, to annually inform Counties of the amounts of funds available for services. Based on this consultation and the Principles for MHSA Distribution Methodology developed by CMHDA, during the years in which funding available for a MHSA component is in decline, the distribution formula applied to that component should support maintaining service obligations by applying a proportional reduction across all Counties. The reduction in individual County Planning Estimates for CSS and PEI are based on the previously used methodology updated with the most current information from state and national databases as provided in detail in DMH Information Notice No.:08-36. The Planning Estimates include the following factors that have been weighted:

1. The need for mental health services in each County
2. Adjustments to the need for mental health services in each County

Planning Estimates for INN are based on the relative share of total CSS and PEI Planning Estimates provided to each County in FY 2009/10 and 2010/11 in order to be consistent with Welfare and Institutions Code § 5892(a)(6), in which funding utilized for innovative work plans is a proportion of CSS and PEI funding (Enclosure 3).

If you have questions about this Information Notice, please contact your County Technical Assistance representative identified on the following DMH website:
http://www.dmh.ca.gov/Services_and_Programs/Local_Program_Support/County_Technical_Assistance.asp

Sincerely,

Original signed by

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosures (5)

cc: California Mental Health Planning Council
California Mental Health Directors Association
Mental Health Services Oversight and Accountability Commission
Deputy Director, Community Services Division

## Enclosure 3
## FY 2010/11 Innovation Planning Estimates

| County | Total FY 09/10 CSS and PEI Planning Estimates | Percent of Statewide Total CSS and PEI Planing Estimates | FY 10/11 Planning Estimate |
|---|---|---|---|
| Alameda | $35,795,700 | 3.5803% | $4,282,100 |
| Alpine | $907,100 | 0.0907% | $108,600 |
| Amador | $1,626,000 | 0.1626% | $194,600 |
| Butte | $5,843,900 | 0.5845% | $699,100 |
| Calaveras | $1,760,600 | 0.1761% | $210,700 |
| Colusa | $1,461,700 | 0.1462% | $174,900 |
| Contra Costa | $22,731,800 | 2.2736% | $2,719,300 |
| Del Norte | $1,539,900 | 0.1540% | $184,300 |
| El Dorado | $4,058,500 | 0.4059% | $485,500 |
| Fresno | $24,597,000 | 2.4602% | $2,942,400 |
| Glenn | $1,548,200 | 0.1549% | $185,300 |
| Humboldt | $3,600,000 | 0.3601% | $430,700 |
| Imperial | $4,961,700 | 0.4963% | $593,600 |
| Inyo | $1,047,300 | 0.1048% | $125,300 |
| Kern | $21,225,000 | 2.1229% | $2,539,100 |
| Kings | $4,167,200 | 0.4168% | $498,500 |
| Lake | $2,058,400 | 0.2059% | $246,300 |
| Lassen | $1,542,300 | 0.1543% | $184,500 |
| Los Angeles | $285,792,300 | 28.5849% | $34,184,400 |
| Madera | $4,365,900 | 0.4367% | $522,300 |
| Marin | $5,666,000 | 0.5667% | $677,800 |
| Mariposa | $1,055,200 | 0.1055% | $126,300 |
| Mendocino | $2,509,200 | 0.2510% | $300,200 |
| Merced | $7,351,300 | 0.7353% | $879,400 |
| Modoc | $985,000 | 0.0985% | $117,900 |
| Mono | $1,026,700 | 0.1027% | $122,900 |
| Monterey | $11,722,900 | 1.1725% | $1,402,400 |
| Napa | $3,361,600 | 0.3362% | $402,200 |
| Nevada | $2,746,400 | 0.2747% | $328,600 |
| Orange | $81,328,300 | 8.1345% | $9,728,900 |
| Placer | $6,817,200 | 0.6819% | $815,600 |
| Plumas | $1,416,800 | 0.1417% | $169,500 |
| Riverside | $52,113,200 | 5.2124% | $6,234,000 |
| Sacramento | $32,137,800 | 3.2144% | $3,844,500 |
| San Benito | $1,986,900 | 0.1987% | $237,700 |
| San Bernardino | $52,759,600 | 5.2770% | $6,311,400 |
| San Diego | $81,995,500 | 8.2012% | $9,808,700 |
| San Francisco | $18,585,200 | 1.8589% | $2,223,300 |
| San Joaquin | $16,881,400 | 1.6885% | $2,019,500 |
| San Luis Obispo | $6,806,700 | 0.6808% | $814,300 |
| San Mateo | $16,326,600 | 1.6330% | $1,953,100 |
| Santa Barbara | $11,610,600 | 1.1613% | $1,389,000 |
| Santa Clara | $46,014,800 | 4.6024% | $5,504,500 |
| Santa Cruz | $7,378,700 | 0.7380% | $882,700 |
| Shasta | $4,844,900 | 0.4846% | $579,600 |
| Sierra | $926,500 | 0.0927% | $110,900 |
| Siskiyou | $1,716,500 | 0.1717% | $205,400 |
| Solano | $10,117,000 | 1.0119% | $1,210,300 |
| Sonoma | $11,371,000 | 1.1373% | $1,360,300 |
| Stanislaus | $12,880,600 | 1.2883% | $1,540,900 |
| Sutter | $2,515,700 | 0.2516% | $301,000 |
| Tehama | $1,994,800 | 0.1995% | $238,700 |
| Trinity | $1,022,900 | 0.1023% | $122,400 |
| Tulare | $12,193,700 | 1.2196% | $1,458,700 |
| Tuolumne | $1,903,800 | 0.1904% | $227,800 |
| Ventura | $20,818,000 | 2.0822% | $2,490,400 |
| Yolo | $5,424,900 | 0.5426% | $649,000 |
| Yuba | $2,244,900 | 0.2245% | $268,600 |
| Berkeley City | $3,034,400 | 0.3035% | $363,000 |
| Tri-City | $5,576,300 | 0.5577% | $667,100 |
| Total | $999,800,000 | 100.0000% | $119,600,000 |

## Enclosure 4
## Summary FY 2010/11 MHSA Planning Estimates

| County | CSS (Enclosure 3) | PEI (Enclosure 5) | INN (Enclosure 6) |
|---|---|---|---|
| Alameda | $27,786,800 | $8,008,900 | $4,282,100 |
| Alpine | $759,700 | $147,400 | $108,600 |
| Amador | $1,435,100 | $190,900 | $194,600 |
| Butte | $4,649,400 | $1,194,500 | $699,100 |
| Calaveras | $1,527,400 | $233,200 | $210,700 |
| Colusa | $1,314,300 | $147,400 | $174,900 |
| Contra Costa | $17,715,700 | $5,016,100 | $2,719,300 |
| Del Norte | $1,370,900 | $169,000 | $184,300 |
| El Dorado | $3,260,500 | $798,000 | $485,500 |
| Fresno | $19,343,600 | $5,253,400 | $2,942,400 |
| Glenn | $1,379,600 | $168,600 | $185,300 |
| Humboldt | $2,908,500 | $691,500 | $430,700 |
| Imperial | $3,985,000 | $976,700 | $593,600 |
| Inyo | $899,900 | $147,400 | $125,300 |
| Kern | $16,726,300 | $4,498,700 | $2,539,100 |
| Kings | $3,370,100 | $797,100 | $498,500 |
| Lake | $1,728,300 | $330,100 | $246,300 |
| Lassen | $1,374,000 | $168,300 | $184,500 |
| Los Angeles | $222,154,900 | $63,637,400 | $34,184,400 |
| Madera | $3,515,500 | $850,400 | $522,300 |
| Marin | $4,461,700 | $1,204,300 | $677,800 |
| Mariposa | $907,800 | $147,400 | $126,300 |
| Mendocino | $2,055,600 | $453,600 | $300,200 |
| Merced | $5,866,200 | $1,485,100 | $879,400 |
| Modoc | $837,600 | $147,400 | $117,900 |
| Mono | $879,300 | $147,400 | $122,900 |
| Monterey | $9,208,800 | $2,514,100 | $1,402,400 |
| Napa | $2,705,600 | $656,000 | $402,200 |
| Nevada | $2,262,300 | $484,100 | $328,600 |
| Orange | $63,187,200 | $18,141,100 | $9,728,900 |
| Placer | $5,441,100 | $1,376,100 | $815,600 |
| Plumas | $1,269,400 | $147,400 | $169,500 |
| Riverside | $41,023,400 | $11,089,800 | $6,234,000 |
| Sacramento | $25,119,700 | $7,018,100 | $3,844,500 |
| San Benito | $1,680,400 | $306,500 | $237,700 |
| San Bernardino | $41,393,300 | $11,366,300 | $6,311,400 |
| San Diego | $63,703,900 | $18,291,600 | $9,808,700 |
| San Francisco | $14,337,300 | $4,247,900 | $2,223,300 |
| San Joaquin | $13,314,800 | $3,566,600 | $2,019,500 |
| San Luis Obispo | $5,395,100 | $1,411,600 | $814,300 |
| San Mateo | $12,665,000 | $3,661,600 | $1,953,100 |
| Santa Barbara | $9,120,000 | $2,490,600 | $1,389,000 |
| Santa Clara | $35,464,100 | $10,550,700 | $5,504,500 |
| Santa Cruz | $5,799,200 | $1,579,500 | $882,700 |
| Shasta | $3,887,300 | $957,600 | $579,600 |
| Sierra | $779,100 | $147,400 | $110,900 |
| Siskiyou | $1,501,300 | $215,200 | $205,400 |
| Solano | $7,969,500 | $2,156,500 | $1,210,300 |
| Sonoma | $8,911,400 | $2,459,600 | $1,360,300 |
| Stanislaus | $10,173,700 | $2,706,900 | $1,540,900 |
| Sutter | $2,071,800 | $443,900 | $301,000 |
| Tehama | $1,679,800 | $315,000 | $238,700 |
| Trinity | $875,500 | $147,400 | $122,400 |
| Tulare | $9,651,600 | $2,542,100 | $1,458,700 |
| Tuolumne | $1,628,800 | $275,000 | $227,800 |
| Ventura | $16,304,200 | $4,513,800 | $2,490,400 |
| Yolo | $4,331,600 | $1,093,300 | $649,000 |
| Yuba | $1,855,700 | $389,200 | $268,600 |
| Berkeley City | $2,339,600 | $694,800 | $363,000 |
| Tri-City | $4,343,800 | $1,232,500 | $667,100 |
| Total | $783,600,000 | $216,200,000 | $119,600,000 |

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

December 11, 2008

DMH INFORMATION NOTICE NO.: 08-36

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: MENTAL HEALTH SERVICES ACT PLANNING ESTIMATES FOR FISCAL YEAR 2009/10

REFERENCE IMPLEMENTATION OF THE MHSA, WELFARE AND INSTITUTIONS CODE SECTION 5847, 5848, AND 5892

This Department of Mental Health (DMH) Information Notice transmits the Mental Health Services Act (MHSA) Planning Estimates[1] for fiscal year (FY) 2009/10 for the three components of the integrated Three-Year Program and Expenditure Plan funded in FY 2009/10 (Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Innovation (INN)). Enclosure 1 provides the FY 2009/10 Planning Estimates for each component.

An additional $250 million is being made available to Counties[2] participating in the MHSA for the CSS component during FY 2009/10. Thus, the aggregate statewide FY 2009/10 funding level for CSS is being increased from $650.0 million to a total of $900.0 million (Enclosure 2).

An additional $97.4 million is being made available to Counties participating in the MHSA for the PEI component during FY 2009/10. Thus, the aggregate statewide FY 2009/10 funding level for PEI is being increased from $232.6 million to $330.0 million (Enclosure 3).

[1] Planning Estimates are the estimates provided by the Department to each County of the maximum amount of MHSA funding by component that the County can request through its Three-Year Program and Expenditure Plan or update(s) for a given year.

[2] "County" means the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per WIC Section 5701.5 (California Code of Regulations, Section 3200.090).

An initial $71.0 million per year is being made available in both FY 2008/09 and 2009/10 for implementation of the INN component. Thus, a total of $142.0 million is available for INN over the two year period.

Total statewide funding for each component is determined each year based on actual deposits into the Mental Health Services Fund (MHS Fund) compared to existing commitments and obligations against the MHS Fund. The Department, in consultation with the California Mental Health Directors' Association (CMHDA), the Mental Health Services Oversight and Accountability Commission (OAC), and the Mental Health Planning Council, then establishes the total fiscal year statewide funding for each component, using the percentages set forth in the Act. (See Welfare and Institutions Code § 5892.) If deposits into the MHS Fund decline in future years, the total statewide funding for a component may be less than prior years. Also, if deposits into the MHS Fund from prior years have not been fully obligated or committed for a component, total statewide funding for that component may be greater in one year than the next. For FY 2009/10, $60.0 million of the $97.4 million increase in PEI funding is due to prior years' revenues exceeding obligations and commitments. Thus, DMH has identified the Planning Estimates associated with these funds separately as a supplemental increase to the FY 2009/10 PEI Planning Estimates so that Counties take this into account when developing the PEI component of their FY 2009/10 Three-Year Program and Expenditure Plans.

To receive MHSA funding in FY 2009/10, Counties should follow the process outlined in DMH Information Notice 08-28. Distribution of funds is subject to approval of a County's request by DMH and, for PEI and INN, the OAC.

The increases in individual County Planning Estimates for CSS and PEI are based on the previously used methodology updated with the most current information from state and national databases. The Planning Estimates include the following factors that have been weighted:

1. The need for mental health services in each County, which is based on:
   a. Total population of each County on January 1, 2008, as reported by the State of California, Department of Finance, *E-1 City / County Population Estimates, with Annual percent Change, January 1, 2007 and 2008*. Sacramento, California, May 2008.
   b. Population most likely to apply for services, which represents the sum of:
      1) The poverty population, defined as households with incomes below 200% of the federal poverty level as reported in the 2000 U.S. Census Bureau survey and updated to reflect the 2008 population, and
      2) The uninsured population (persons who did not have insurance at any time in the past year and persons who had insurance only part of the past year) with incomes above 200% of the federal poverty level as reported through the 2005 California

Health Interview Survey (CHIS) based at UCLA Center for Health Policy Research in Los Angeles, California.

c. Population most likely to access services, which represents the prevalence of mental illness among different age groups and ethnic populations of poverty households in each County as estimated through a study conducted by Dr. Charles Holzer, Ph.D., in 2000. The 2000 results were updated to reflect the 2008 population.

2. Adjustments to the need for mental health services in each County, which is based on:

   a. The cost of being self-sufficient in each County relevant to the statewide average as reported through *The Self-Sufficiency Standard for California 2003*, December 2003, a project of the National Economic Development and Law Center. A weighted average of households with one single childless adult (67%) and a single adult with two children (33%) was used to develop the adjustment.

   b. The available resources to be provided either by or through the Department of Mental Health to each County in FY 2008/09, including realignment funding, State General Fund managed care allocations, other State General Fund community services allocations such as AB 3632 funding, federal SAMHSA block grants, federal PATH grants, FY 2005/06 Early and Periodic Screening Diagnosis and Treatment (EPSDT) State General Funds, and the FY 2008/09 CSS and PEI Planning Estimates. (Medi-Cal federal financial participation is excluded.)

To provide a base level of funding for less populous counties, a minimum Planning Estimate is established for each component based on recommendations from CMHDA. The minimum Planning Estimate represents the minimum level of funding made available to each County should the formula described above result in a lower amount. Thus, the State makes available to each County a Planning Estimate equal to the amount determined through the formula or the minimum amount, whichever is greater.

From the $250.0 million additional CSS funding in FY 2009/10, a minimum CSS Planning Estimate of $250,000 is available to each County with a population of less than 20,000 and a minimum CSS Planning Estimate of $350,000 is available to all other counties. From the additional PEI funding in FY 2009/10, a minimum PEI Planning Estimate of $50,000 is available to each County from the $37.4 million increase and a minimum PEI Planning Estimate of $50,000 is available to each County from the $60.0 million supplemental increase.

The Planning Estimates for the two city-operated programs (Tri-City and the City of Berkeley) are based solely on the percent of statewide population in the area served by each city in 2007.[3]

[3] The City of Berkeley serves the cities of Berkeley and Albany and Tri-City serves the cities of Claremont, La Verne and Pomona.

Planning Estimates for INN are based on the relative share of total CSS and PEI Planning Estimates provided to each County in FY 2008/09 and 2009/10 in order to be consistent with Welfare and Institutions Code § 5892(a)(6), in which funding utilized for innovative work plans is a proportion of CSS and PEI funding (Enclosure 4). Counties may request up to 25 percent (Enclosure 5) of the combined FY 2008/09 and 2009/10 INN Planning Estimates for Community Program Planning activities related to INN pursuant to Title 9 California Code of Regulations Section 3300. Counties should refer to the forthcoming INN proposed guidelines as to how to request INN funds, including INN Community Program Planning funds.

If you have any further questions, please contact your County Operations liaison identified on the following Internet site: http://www.dmh.ca.gov/Provider_Info/default.asp.

Sincerely,

Original signed by

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosures

Enclosure 5

Mental Health Services Act
Fiscal Year 2010-11 Limit on Use of CSS Funds[a]
Pursuant to Welfare and Institutions Code, Section 5892(b), Updated as of 09/17/09

| | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 | Total | Average | Maximum |
|---|---|---|---|---|---|---|---|---|
| | CSS, WET | CSS, CSS Housing, PEI, CFTN, WET | CSS, PEI, CFTN, INN | CSS, PEI, INN | CSS, PEI, INN | Five Fiscal Years | Five Fiscal Years | 20% Limit |
| Alameda | $14,790,798 | $53,607,250 | $39,647,000 | $48,361,000 | $40,077,800 | $196,483,848 | $39,297,000 | $7,859,000 |
| Alpine | $479,927 | $1,283,300 | $1,023,300 | $1,184,800 | $1,015,700 | $4,987,027 | $997,000 | $199,000 |
| Amador | $756,570 | $2,280,900 | $1,829,600 | $2,091,100 | $1,820,600 | $8,778,770 | $1,756,000 | $351,000 |
| Butte | $2,541,424 | $8,894,760 | $6,528,600 | $7,832,900 | $6,543,000 | $32,340,684 | $6,468,000 | $1,294,000 |
| Calaveras | $834,442 | $2,560,900 | $2,011,500 | $2,284,000 | $1,971,300 | $9,662,142 | $1,932,000 | $386,000 |
| Colusa | $655,973 | $1,931,200 | $1,602,600 | $1,864,100 | $1,636,600 | $7,690,473 | $1,538,000 | $308,000 |
| Contra Costa | $9,469,309 | $33,915,830 | $25,207,000 | $30,676,000 | $25,451,100 | $124,719,239 | $24,944,000 | $4,989,000 |
| Del Norte | $700,514 | $2,112,400 | $1,708,100 | $1,969,600 | $1,724,200 | $8,214,814 | $1,643,000 | $329,000 |
| El Dorado | $1,802,852 | $7,236,820 | $4,570,700 | $5,421,800 | $4,544,000 | $23,576,172 | $4,715,000 | $943,000 |
| Fresno | $10,348,129 | $36,169,430 | $27,062,000 | $33,125,200 | $27,539,400 | $134,244,159 | $26,849,000 | $5,370,000 |
| Glenn | $711,119 | $2,114,200 | $1,720,200 | $1,981,700 | $1,733,500 | $8,260,719 | $1,652,000 | $330,000 |
| Humboldt | $1,607,931 | $6,180,910 | $4,040,400 | $4,799,500 | $4,030,700 | $20,659,441 | $4,132,000 | $826,000 |
| Imperial | $2,142,812 | $8,051,010 | $5,504,200 | $6,636,700 | $5,555,300 | $27,890,022 | $5,578,000 | $1,116,000 |
| Inyo | $598,705 | $1,655,600 | $1,197,000 | $1,358,500 | $1,172,600 | $5,982,405 | $1,196,000 | $239,000 |
| Kern | $9,026,279 | $30,836,350 | $23,387,300 | $28,565,800 | $23,764,100 | $115,579,829 | $23,116,000 | $4,623,000 |
| Kings | $1,865,085 | $6,748,610 | $4,652,700 | $5,558,300 | $4,665,700 | $23,490,395 | $4,698,000 | $940,000 |
| Lake | $985,035 | $3,165,800 | $2,381,100 | $2,706,900 | $2,304,700 | $11,543,535 | $2,309,000 | $462,000 |
| Lassen | $704,453 | $2,112,500 | $1,710,800 | $1,972,300 | $1,726,800 | $8,226,853 | $1,645,000 | $329,000 |
| Los Angeles | $119,540,711 | $425,277,710 | $316,635,500 | $386,017,900 | $319,976,700 | $1,567,448,521 | $313,490,000 | $62,698,000 |
| Madera | $1,886,415 | $7,415,020 | $4,848,000 | $5,833,800 | $4,888,200 | $24,871,435 | $4,974,000 | $995,000 |
| Marin | $2,263,827 | $9,313,480 | $6,251,900 | $7,621,700 | $6,343,800 | $31,794,707 | $6,359,000 | $1,272,000 |
| Mariposa | $605,977 | $1,673,200 | $1,206,700 | $1,368,200 | $1,181,500 | $6,035,577 | $1,207,000 | $241,000 |
| Mendocino | $1,151,687 | $4,311,400 | $2,841,800 | $3,329,100 | $2,809,400 | $14,443,387 | $2,889,000 | $578,000 |
| Merced | $3,186,123 | $10,607,320 | $8,146,500 | $9,853,000 | $8,230,700 | $40,023,643 | $8,005,000 | $1,601,000 |
| Modoc | $546,891 | $1,481,400 | $1,119,700 | $1,281,200 | $1,102,900 | $5,532,091 | $1,106,000 | $221,000 |
| Mono | $581,737 | $1,594,800 | $1,171,300 | $1,332,800 | $1,149,600 | $5,830,237 | $1,166,000 | $233,000 |
| Monterey | $5,035,818 | $16,980,600 | $13,087,200 | $15,776,500 | $13,125,300 | $64,005,418 | $12,801,000 | $2,560,000 |
| Napa | $1,430,272 | $5,542,160 | $3,750,900 | $4,489,000 | $3,763,800 | $18,976,132 | $3,795,000 | $759,000 |
| Nevada | $1,237,437 | $4,338,980 | $3,119,200 | $3,636,000 | $3,075,000 | $15,406,617 | $3,081,000 | $616,000 |
| Orange | $34,024,758 | $117,811,210 | $90,456,500 | $109,878,400 | $91,057,200 | $443,228,068 | $88,646,000 | $17,729,000 |
| Placer | $2,878,545 | $10,193,450 | $7,561,500 | $9,149,700 | $7,632,800 | $37,415,995 | $7,483,000 | $1,497,000 |
| Plumas | $617,188 | $1,811,900 | $1,546,600 | $1,808,100 | $1,586,300 | $7,370,088 | $1,474,000 | $295,000 |
| Riverside | $21,634,427 | $73,903,170 | $57,242,800 | $70,258,900 | $58,347,200 | $281,386,497 | $56,277,000 | $11,255,000 |
| Sacramento | $13,098,051 | $49,719,500 | $35,234,200 | $43,365,100 | $35,982,300 | $177,399,151 | $35,480,000 | $7,096,000 |
| San Benito | $962,007 | $3,047,400 | $2,312,200 | $2,606,600 | $2,224,600 | $11,152,807 | $2,231,000 | $446,000 |
| San Bernardino | $22,371,008 | $75,186,660 | $58,249,700 | $71,105,800 | $59,071,000 | $285,984,168 | $57,197,000 | $11,439,000 |
| San Diego | $33,920,508 | $120,164,560 | $90,603,200 | $110,788,200 | $91,804,200 | $447,280,668 | $89,456,000 | $17,891,000 |
| San Francisco | $7,309,699 | $28,482,590 | $20,313,600 | $25,139,300 | $20,808,500 | $102,053,689 | $20,411,000 | $4,082,000 |
| San Joaquin | $7,226,271 | $24,543,200 | $18,654,100 | $22,705,300 | $18,900,900 | $92,029,771 | $18,406,000 | $3,681,000 |
| San Luis Obispo | $2,961,878 | $10,527,110 | $7,613,500 | $9,134,800 | $7,621,000 | $37,858,288 | $7,572,000 | $1,514,000 |
| San Mateo | $6,708,292 | $24,363,400 | $18,125,500 | $22,050,900 | $18,279,700 | $89,527,792 | $17,906,000 | $3,581,000 |
| Santa Barbara | $4,994,802 | $17,918,620 | $12,967,000 | $15,626,000 | $12,999,600 | $64,506,022 | $12,901,000 | $2,580,000 |
| Santa Clara | $18,321,052 | $66,530,460 | $50,833,500 | $62,316,300 | $51,519,300 | $249,520,612 | $49,904,000 | $9,981,000 |
| Santa Cruz | $3,119,826 | $10,885,740 | $8,231,700 | $9,924,500 | $8,261,400 | $40,423,166 | $8,085,000 | $1,617,000 |
| Shasta | $2,143,376 | $8,480,260 | $5,414,900 | $6,475,900 | $5,424,500 | $27,938,936 | $5,588,000 | $1,118,000 |
| Sierra | $496,896 | $1,330,200 | $1,047,200 | $1,208,700 | $1,037,400 | $5,120,396 | $1,024,000 | $205,000 |
| Siskiyou | $813,535 | $2,470,800 | $1,951,500 | $2,216,700 | $1,921,900 | $9,374,435 | $1,875,000 | $375,000 |
| Solano | $4,223,106 | $15,014,700 | $11,211,500 | $13,615,800 | $11,327,300 | $55,392,406 | $11,078,000 | $2,216,000 |
| Sonoma | $4,877,394 | $17,414,070 | $12,706,000 | $15,308,500 | $12,731,300 | $63,037,264 | $12,607,000 | $2,521,000 |
| Stanislaus | $5,492,770 | $21,445,960 | $14,252,700 | $17,318,600 | $14,421,500 | $72,931,530 | $14,586,000 | $2,917,000 |
| Sutter/Yuba | $2,211,564 | $7,437,500 | $5,411,100 | $6,299,900 | $5,330,200 | $26,690,264 | $5,338,000 | $1,068,000 |
| Tehama | $941,402 | $3,640,600 | $2,292,500 | $2,624,400 | $2,233,500 | $11,732,402 | $2,346,000 | $469,000 |
| Trinity | $580,222 | $1,573,900 | $1,166,600 | $1,328,100 | $1,145,300 | $5,794,122 | $1,159,000 | $232,000 |
| Tulare | $5,225,799 | $17,732,720 | $13,478,500 | $16,385,600 | $13,652,400 | $66,475,019 | $13,295,000 | $2,659,000 |
| Tuolumne | $918,980 | $2,935,500 | $2,205,200 | $2,484,200 | $2,131,600 | $10,675,480 | $2,135,000 | $427,000 |
| Ventura | $8,856,115 | $30,561,770 | $23,182,800 | $28,058,900 | $23,308,400 | $113,967,985 | $22,794,000 | $4,559,000 |
| Yolo | $2,321,823 | $9,086,120 | $6,030,500 | $7,269,800 | $6,073,900 | $30,782,143 | $6,156,000 | $1,231,000 |
| Berkeley City | $1,209,884 | $5,269,160 | $3,348,300 | $4,109,600 | $3,397,400 | $17,334,344 | $3,467,000 | $693,000 |
| Tri-City | $2,503,690 | $9,286,930 | $6,392,300 | $7,508,000 | $6,243,400 | $31,934,320 | $6,387,000 | $1,277,000 |
| **Total** | **$420,453,120** | **$1,488,163,000** | **$1,108,000,000** | **$1,347,000,000** | **$1,119,400,000** | **$5,483,016,120** | **$1,096,602,000** | **$219,318,000** |

a/ Up to 20% of the most recent five year allocations to each county may be used for Capital Facilities and Technological Needs, Workforce Education and Training, and the local prudent reserve.

# WELFARE AND INSTITUTIONS CODE SECTION 5890-5898

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the State Department of Mental Health. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are continuously appropriated to the department, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(3) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing such obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Mental Health.

(d) The State Department of Health Services, in consultation with the State Department of Mental Health, shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless such Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental

health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

5892. (a) In order to promote efficient implementation of this act allocate the following portions of funds available in the Mental Health Services Fund in 2005-06 and each year thereafter:

(1) In 2005-06, 2006-07, and in 2007-08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) Twenty percent for prevention and early intervention programs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association pursuant to Part 3.6 (commencing with Section 5840) of this division. Each county's allocation of funds shall be distributed only after its annual program for expenditure of such funds has been approved by the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(4) The allocation for prevention and early intervention may be increased in any county which the department determines that such increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The statewide allocation for prevention and early intervention may be increased whenever the Mental Health Services Oversight and Accountability Commission determines that all counties are receiving all necessary funds for services to severely mentally ill persons and have established prudent reserves and there are additional revenues available in the fund.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs

pursuant to an approved plan required by Section 5830 and such funds may be distributed by the department only after such programs have been approved by the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of such costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), the department shall also provide funds for the costs for itself, the California Mental Health Planning Council and the Mental Health Services Oversight and Accountability Commission to implement all duties pursuant to the programs set forth in this section. Such costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division.

(e) In 2004-05 funds shall be allocated as follows:

(1) 45 percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.

(2) 45 percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) 5 percent for local planning in the manner specified in subdivision (c) and

(4) 5 percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on such investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an

approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of such revenues to further the purposes of this act and the Legislature may appropriate such funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The fund shall be increased by its share of the amount earned on investments.

5894. In the event that Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) of this division, are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however, that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 (commencing with Section 5800), or Part 4 (commencing with Section 5850) of this division, are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the State Department of Mental Health shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services

provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements.

(e) Contracts awarded by the State Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the department of the anticipated county matching funds needed for community mental health programs.

5898. The department shall develop regulations, as necessary, for the department or designated local agencies to implement this act. In 2005, the director may adopt all regulations pursuant to this act as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purpose of the Administrative Procedure Act, the adoption of regulations, in 2005, shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall not be subject to the review and approval of the Office of Administrative Law and shall not be subject to automatic repeal until final regulations take effect. Emergency regulations adopted in accordance with this provision shall not remain in effect for more than a year. The final regulations shall become effective upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

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1 [Approval of Mental Health Services Act (MHSA) Agreement and authorization to designate
2 the Director of Community Behavioral Health Services (CBHS) to sign said agreement.]

3

4 **Resolution retroactively approving the Mental Health Services Act Contract No. 07-77338-000,**
5 **incorporating Community Program Planning Funds in FY04-05 and Community**
6 **Services and Supports Funds for Fiscal Years 05-08, with the Department of Mental**
7 **Health for $18,922,386 and authorizing the San Francisco Department of Public Health**
8 **(SFDPH) - CBHS Director to sign said agreement and any and all amendments in the**
9 **future, including increases to add other components of MHSA.**

10

11 WHEREAS, the Mental Health Services Act Expenditure Plan outlined the programs,
12 services, and activities for three years from Fiscal Year 2005-2008; and,

13 WHEREAS, the Mental Health Services Act Community Services and Supports
14 Expenditure Plan was supported by the Board of Supervisors under Resolution No. 744-05 on
15 October 11, 2005; and,

16 WHEREAS, As a condition of receiving the balance of these funds, DMH requires
17 CBHS to enter into an agreement (the "Agreement"), a copy of which is on file with the Clerk
18 of the Board of Supervisors in File No. 080122, which is hereby declared to be a part of this
19 resolution as if set forth fully herein; and,

20 WHEREAS, the Director of Community Behavioral Health Services is designated to
21 sign this Agreement and any and all amendments in the future including increases to add
22 other components of MHSA on behalf of the SFDPH; and

23 WHEREAS, the Department of Mental Health agrees to pay 75 percent of the approved
24 plan amount upon approval of this agreement, with the remaining 25 percent to be released
25 upon submission of required reports detailed in the contract; and,

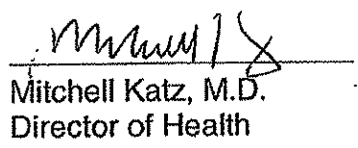
NOW, therefore, be it

RESOLVED, That SFDPH is hereby retroactively authorized to enter into a contract agreement in the amount of up to $18,922,386 with DMH; and, be it

FURTHER RESOLVED, That the Board of Supervisors hereby designates the Director of CBHS to sign said agreement on behalf of SFPH; and, be it

FURTHER RESOLVED, That the Director of CBHS is designated to sign any and all amendments to this agreement including increases to add other components of MHSA

RECOMMENDED:



Mitchell Katz, M.D.
Director of Health

# City and County of San Francisco

## Tails

## Resolution

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

**File Number:** 080122 **Date Passed:**

Resolution retroactively approving the Mental Health Services Act Contract No. 07-77338-000, incorporating Community Program Planning Funds in FY04-05 and Community Services and Supports Funds for Fiscal Years 05-08, with the Department of Mental Health for $18,922,386 and authorizing the San Francisco Department of Public Health (SFDPH) - CBHS Director to sign said agreement and any and all amendments in the future, including increases to add other components of MHSA.

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February 26, 2008 Board of Supervisors — ADOPTED

Ayes: 10 - Alioto-Pier, Ammiano, Chu, Daly, Elsbernd, Maxwell, McGoldrick, Mirkarimi, Peskin, Sandoval
Excused: 1 - Dufty

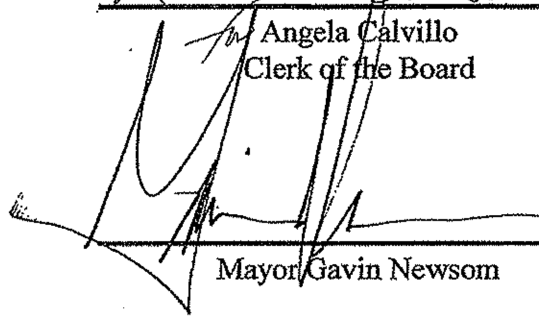
File No. 080122

**I hereby certify that the foregoing Resolution was ADOPTED on February 26, 2008 by the Board of Supervisors of the City and County of San Francisco.**

for Angela Calvillo
Clerk of the Board

2-29-08

**Date Approved**



Mayor Gavin Newsom