Abstract

Recognizing the impact of trauma not just at the individual level, but the systems level, the Bay Area region of California seeks to create a shared and trauma informed regional infrastructure to implement, sustain, and improve services for children and youth affected by trauma.

The City and County of San Francisco Department of Public Health (SFDPH) proposes to convene and support the Bay Area Trauma Informed Systems of Care (BATISC) initiative as a regional collaborative of seven Bay Area counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara and Santa Cruz. The initiative will focus on creating a trauma informed region in order to reduce disparities in behavioral health access and improve the provision of trauma-informed services.

To coordinate and facilitate this regional effort, the Bay Area proposes to create a unique center purposed to promote the development of trauma informed systems and positioned to serve participating counties in Northern California. The BATISC Center will support the creation of a regional infrastructure that recognizes and responds to trauma in a culturally and linguistically competent, family-driven, youth-guided and evidence-based manner.

Within the BATISC structure, initiative activities will take place through partnership with children, youth, and families impacted by trauma and with a focus on reducing health and access disparities specifically for children ages 0-5, foster care and juvenile justice-involved children and youth, and transition aged youth. In order to enhance the quality of care, BATISC will also coordinate the creation of behavioral health and medical homes to serve children and youth placed “out-of-county.”

Given the large number of cities and counties working in close proximity, Bay Area counties are well positioned to share resources and knowledge. In the past, the lack of a coordinated regional system of care has led to duplication of efforts and disjointed services across county lines. The implementation of a Bay Area Trauma Informed Systems of Care initiative and the formation of the proposed BATISC Center will provide the needed coordination for county systems, resulting in more effective and seamless care in partnership with youth and families.

San Francisco Department of Public Health

Bay Area Trauma Informed Systems of Care (BATISC)

(RFA No. SM-14-002)

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Section A: Statement of Readiness/Evidence of Strategic Planning

Catchment area, demographic information, bringing systems of care to scale:

Childhood trauma can have long-term, intractable effects that are transmitted across generations (Dekel & Goldblatt, 2008; Felitti et al., 1998; Herman, 1992). These include increased risk for serious health and legal problems, suicide, truancy and dropout, unemployment, poor interpersonal relationships (Jennings, 2006). Up to 70% of children and youth involved in the foster care system have experienced recurrent trauma (Jennings et al., 2011). Many live in poverty and are exposed to violence, abuse, and neglect. Unknowingly, fragmented delivery systems and a workforce unprepared to understand and address trauma can add salt to these wounds with low-income minorities disproportionately bearing the brunt.

Programs, systems and the people within them can themselves be traumatized and as a result can help or hurt. As in individuals, trauma in organizations can result in reactivity, dysregualtion, numbing, and reflexive decisions and behaviors with significant consequences on our interactions, performance, quality of services and client outcomes. Many in the workforce live in the same communities as their clients and help them cope with the very traumas that they themselves have experienced.

While trauma-specific interventions, such as TF-CBT and CBITS , which are treatments for individual children have proven somewhat effective (Cohen, Mannarino & Deblineger, 2012: Jaycox et al., 2012) little has been done systematically to address the conditions within communities, organizations and systems that can exacerbate and reinforce the symptoms and experiences of chronic trauma exposure. Recently, much has been written about trauma-informed systems, however only a few systems of care (such as Thrive in Maine and the Sanctuary Model in Philadelphia: Bloom, 2005) have begun the work to develop, implement, and sustain trauma-informed systems and services.

As with treatment, opportunities for healing systems can be born of suffering. Combating the systemic impact of trauma provides opportunities for growth and resilience to turn lead into gold. The San Francisco Department of Public Health (SFDPH) proposes to convene the Bay Area Trauma Informed Systems of Care (BATISC) initiative to lead this work on the West Coast to reduce disparities in behavioral health access and improve the provision of trauma-informed services to children and youth in Bay Area counties. Together, the participating counties have a population of nearly 6.4 million people. There are more than 1.4 million children and youth under the age of 20 in the region.

The population of this region is characterized by race, language and ethnic diversity and by dramatic gaps in wealth and income. While the median income for the region is approximately $80,000, more than 10% of families live in poverty, including 12.6% of children under 18 and 13% of children under five. Disparities are growing in the region: a February 2014 study released by the Brookings Institution named San Francisco second in the country for income inequality and first for the rate at which it inequality has grown in the past five years.

Table 1: Demographic and Economic Characteristics of the Region[1]

Census Data: Ages	Total
Under 5	399,674
5-14	769,936
15-19	399,191
Total Population Under 20	1,568,801
Total Population	6,379,415
Census Data: Race	Total
White	3,266,343
Black or African American	413,099
American Indian and Alaska Native	39,987
Asian	1,587,459
Native Hawaiian /Pacific Islander	39,241
Some other race	693,936
Two or More Races	339,350
Census Data: Ethnicity	Total
Hispanic or Latino	1,502,096
Census Data: Language	Total
Speak a language other than English	42.8%*
Census Data: Families and Children in Poverty	Total
Children 18 and under	12.6%*
Children under 5	13.0%*

While the overall poverty rate is 12-13% for children, it is much higher for children of certain racial and ethnic groups. In the State of California nearly 29.9% of African-Americans, 27% of Latinos and 29.5% of Native Americans live below the poverty line. Socio-economic disadvantage is linked to higher rates of trauma and mental health issues, as is race and ethnicity. The statistics on children and youth with suicidal behaviors and risk factors, compared to their peers provide a striking example:

- Gay, Lesbian, Transgender, Bisexual and Questioning youth twice the risk
- American Indian and Alaska Native youth have 2.5 times greater risk
- Adolescent Latinas have 1.5 times greater risk. (Algeria, 2010)

Undertaking this work – to create systems change that implements and sustains trauma informed services – at the regional level is a strategic move in a state as large as California that builds upon existing strong relationships among Bay Area counties. Once fully established with a supported infrastructure, BATISC has the potential to expand to cover the entire Northern California region of 15.5 million people, and to partner with and share best practices with Southern California counties.

Need for enhanced infrastructure:

Each County in BATISC has a strong behavioral health system in place. Yet, each community

[1] Source: US Census Profile of General Population Characteristics 2010 * all averages in total column are weighted

also recognizes that children and youth who face trauma, and especially complex trauma, may not currently be identified early or may not receive the most appropriate trauma-informed services when needed to prevent the development of long-term consequences including mental illness. In particular, we have identified needs at three critical points: 1) among children 0-5 who have experienced trauma and are risk for or already involved in the foster care system, 2) foster youth placed out of county, or in need of care coordination and 3) Transitional Age Youth including cross over youth between juvenile justice and child welfare.

Early Childhood Trauma

When preschool and young children are exposed to trauma, they can experience feelings of helplessness, uncertainty about whether there is continued danger, and a general fear that extends beyond the traumatic event (National Child Traumatic Stress Network, 2013). These feelings can lead to loss of developmental skills, social isolation, sleep disturbances, and other negative outcomes from the traumatic event that can impact a child's ability to reach their greatest potential.

A literature review conducted in 2006 revealed that a variety of health and behavioral health challenges experienced by youth, including juvenile delinquency and school failure, can be linked to the emergence of early onset emotional/ behavioral problems in young children (Brauner & Stephens, 2006). In San Francisco, young children under age 5 with serious emotional disorders receiving publicly-funded mental health treatment represent only a fraction of the estimated 7,041 young children in need of these services. In Fiscal Year (FY) 2011-12, the San Francisco Department of Public Health (SFDPH) provided mental health treatment services to only 288 young children, birth to 4, representing roughly 4% of the estimated need (SFDPH, 2011-12).

The UCSF Child Trauma Research Program reported that among referrals of young children aged 5 and under, in FY 2011-12 (CTRP, 2013) the top five traumatic events experienced by children were domestic violence (71%), separation from their primary caregivers (14%), physical abuse (6%), sexual abuse (4%), and neglect (4%).

And these numbers appear to be growing. In 2013, the San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI), a behavioral health prevention initiative serving child care, domestic violence, and family resources centers citywide, conducted a survey of provider mental health referrals for infants and toddlers, birth through age 3. The survey found that there were over 200 referrals of infants and toddlers, and that 70% of these referrals, or 140 referrals, were infants and toddlers who had experienced trauma (SFDPH, 2013). Based on historical trend data for the ECMHCI provider that serves this population, the figure of 140 referrals represents a 28% increase over prior year referrals (SFDPH, 2013). Additionally, from 30% to 40% of infants and toddlers referred for child trauma annually were in-home dependents or in foster care; 100% met federal poverty guidelines; and 99% were Medi-Cal (Medicaid) eligible (SFDPH, 2013). A disproportionate percentage of these children were children of color (82%): 31% Hispanic, 25% Black/African American, 7% Asian, 5% Filipino, and 14% multi-racial or other (SFDPH, 2013).

Many older youth in foster care first entered the system as young children. A review of data for older youth, aged 16-17, currently in foster care found that nearly 2 out of 5 of these youth first entered care as young children, age 3 and under (SF HSA, 2013). Nearly 25% of young children, birth to 5, in foster care were in care for 24-35 months, while an additional 31.8% of young children, aged 3-5, were in care for 36 to 59 months (Needell, et al, 2013).

Disparities in Access for Out-of-County Foster Care

Foster children and youth are three to six times more likely than non-foster children to have emotional, behavioral and developmental challenges. Many have been exposed to severe violence or neglect in their homes. Removal from home adds another level of trauma. Placement changes that may occur while in foster care also impact a child's and young person's mental health. A review of literature revealed that youth in foster care exhibited problems that required a mental health assessment and/or intervention at a rate of five times greater than the rate for community-based youth who are not involved in the child welfare system (Greeson, et al., 2011). Experts estimate that up to 85% of children in foster care have mental health disorders (Martyna, 2013). These children and youth have experienced trauma, and many have experienced ongoing, complex trauma.

For geographic and economic reasons, Bay Area children and youth in the foster care system are often placed outside their community and in many cases outside their county of origin. This creates logistical and qualitative barriers to providing consistent culturally responsive care. The risk of falling between the cracks and not getting the right type or amount of services to address chronic trauma greatly increases. Currently, there is no regional Bay Area structure to plan, develop, implement and evaluate strategies to prevent and reduce disparities in behavioral health treatment access for children and youth placed out of county by the child welfare and juvenile justice systems. The BATISC will provide the infrastructure to reduce these disparities.

Katie A v. Bonta is a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. The settlement required that the Child Welfare System and Behavioral Health develop comprehensive and integrated practice standards that include universal screening, assessment and access to culturally responsive services. The BATISC initiative is consistent with State efforts to meet court mandates under *Katie A*.

As of July 1, 2013 there were nearly 4,860 children in care in the Bay Area.

Table 2: Number of children in Care, July 1, 2013[2]

County	Child Population	Children in Care
Alameda	346,038	1,249
Contra Costa	253,746	1,029
Marin	51,412	76
San Francisco	119,793	861
San Mateo	163,248	302
Santa Clara	439,320	1,083
Santa Cruz	55,939	260
Total	**1,429,496**	**4,860**

[2] Source: http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx

An October 2011 Report issued by the California Child Welfare Council provided a statewide data analysis of the provision of mental health services to foster children and youth placed in and out-of-county. An estimated 18.4% of California's total foster care population is placed out-of-county (foster children and youth who entered care in their county of origin but were later placed in a different county). Member counties of the Collaborative have an out of placement average of 37%, ranging from 17.5% for Santa Cruz, to over 50% for San Francisco.[3]

This report found out-of-county placements both received less care and less intensive treatment, on average, than in-county placements.

- In-county foster children and youth received greater access to mental health services and a higher intensity of care on average than children and youth placed out-of-county.
- Out-of-county foster placements statewide were about 10% less likely to receive at least one mental health service than in-county placements.

In addition, out-of-county placements

- Had disparities in access to services that increased with age, from age 11 on.
- Were 34% percent more likely to be a group home, but 21% percent less likely to receive any care there; and for those placements receiving care, there were 38% percent fewer days of service per month.
- Were over 2.5 times as likely to be probation placements but half as likely to receive any mental health service; when served
- Received 10% to 30% fewer days of service in every category of mental health disorder reported.

Disparities in Access for Juvenile Justice Involved Youth

Youth in the region who are dually involved with child welfare and juvenile justice will also benefit greatly from this effort. As many as 70% of youth processed or detained in juvenile detention facilities across the nation have one or more diagnosable mental health disorders (Shufelt and Cocozza, 2006). The National Center for Mental Health and Juvenile Justice (NCMHJJ) reports that 27 percent of youth in detention, correctional, and community-based placements experience disorders so severe that their ability to function is highly impaired.

Meeting the behavioral health needs of juvenile justice involved youth placed out-of-county also requires a multi-jurisdictional response. According to the S.F. Juvenile Probation Department, in 2012, nearly one in four juvenile probation referrals were from non-San Francisco jurisdictions (Perla, 2013). Of the out-of-county referrals to San Francisco, 32% were from Alameda County, 9% from Contra Costa County, and 9% from San Mateo County. Of the 1,339 referrals to the S.F. Juvenile Probation Department, which were decided by the court in 2012, 120 youth, or 9%, were transferred out of San Francisco to another county. Each Bay Area County's decision regarding placement of juvenile justice involved youth impacts the others, making collaboration critical.

[3] Source: Child Welfare Council, Data Mining Project Final Report, October 2011

Strategic planning process:

Regional Directors of County Behavioral Health systems came together in July of 2013 to develop and share plans to take trauma-informed practices, knowledge, and approaches to a new level of regional coordination. The Directors have since met on a quarterly basis, or more frequently when particular agenda items require quick follow-up. Through these meetings, the group has drafted strategic planning documents, shared local approaches to systems change, and identified key goals and strategies for regional collaboration. Initial goals focus on resource sharing, policy coordination, coordination of care, and cross-systems coordination, as described in this proposal. Early planning efforts have also been vetted at the regional level with systems partners, parent partners, and consumer focus group participants.

Through the BATISC planning group, several of the counties have shared their modules and materials with the rest of the members of the Collaborative, and San Francisco, San Mateo and Santa Clara made space available in their local in-person trainings for participation by staff from other counties. With a funded and lasting infrastructure and dedicated staff for this regional effort, this type of sharing will be consistent and coordinated. All of the counties will be able to benefit from jointly conducted training and the integration of shared learning approaches across the counties. In addition, the effort to implement an organized response to trauma and complex trauma and to improve access to services for children placed out of county can only be coordinated through a regional body with support and infrastructure, as described in Section B. The strategies adopted here result from the incorporation of principles developed in other regions, recommended by experts in the field, and combined with the understanding of Bay Area populations and trends.

Section B: Proposed Approach and Implementation

Purpose of the proposed project, goals and objectives:

Trauma is a pervasive, long-lasting, public health issue that affects our workforce and our system in dynamic ways that prevent us from responding to each other and the people we serve in effective and optimally informed ways (Harris & Fallot, 2001). The Bay Area is undertaking the implementation of a regional Trauma Informed System of Care to help us realize, recognize and respond to trauma and its effects on ourselves, our colleagues, and those we assist (Jennings, in press; Jennings, 2008).

The Bay Area is fortunate to have national experts in trauma throughout the region. This expertise, however, remains in separate silos in university settings, challenged by needing to constantly seek soft funding, called upon to train other localities in the U.S or around the world, or simply challenged to reach beyond their program or facility. As a result, the opportunities to deliver and translate this local knowledge and expertise into practice for Bay Area community systems and programs have been few. In 2013, to combat this disconnection and fragmentation, the San Francisco Foundation convened a conference to engage local trauma experts in a conversation about barriers to developing and sustaining a workforce competently trained in the pervasive impacts of trauma on children, families, communities, and institutions. The expert summit concluded that that the Bay Area needed a centralized clearinghouse with a diverse advisory and oversight to help integrate practices, develop common principles and organize resources in a way that focus on knowledge transfer to the workforce, practice changes, and the

sustainability of changed practice

Building on the same conclusion, in 2013, county Children, Youth and Family Behavioral Health leadership from throughout the Bay Area began a planning process to launch a Regional Trauma Informed System of Care initiative to implement evidence based practices and programs in a regionally coordinated manner.

"Over the past decade, the science related to developing…'evidence-based practices and programs' has improved—however the science related to implementing these programs with fidelity and good outcomes for consumers lags far behind. As a field, we have discovered that all the paper in file cabinets plus all the manuals on the shelves do not equal real- world transformation of human service systems through innovative practice… Clearly, state and national policies aimed at improving human services require more effective and efficient methods to translate policy mandates for effective programs into the actions that will realize them." (Fixsen, 2005)

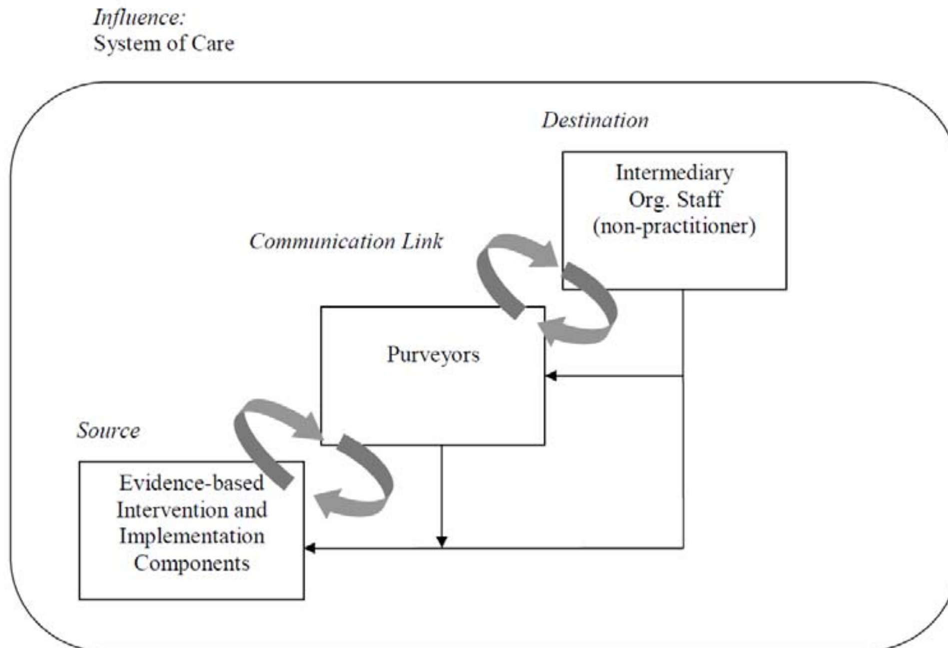
That is, implementation is synonymous with coordinated change at system, organization, program, and practice levels. In a fundamental sense, according to Fixsen, implementation appears most successful when:

- Carefully selected practitioners receive coordinated training, coaching, and frequent performance assessments;
- Organizations provide the infrastructure necessary for timely training, skillful supervision and coaching, and regular process and outcome evaluations;
- Communities and consumers are fully involved in the selection and evaluation of programs and practices; and
- State and federal funding avenues, policies, and regulations create a hospitable environment for implementation and program operations.

The BATISC initiative is poised to embrace these best practices in implementation. As a region, it is evident that thoughtful and effective implementation strategies, at multiple levels, are essential to any systematic attempt to successfully use the products of science to improve the lives of children, families, and adults. In response to this understanding, the Bay Area counties have joined together to develop the goals and strategies designed to bring about these changes on how we address trauma in our region:

<u>Overarching Goal</u>: Transform the regional, overlapping systems into a coordinated, trauma-informed, youth-guided and family driven, evidence-based system of care.

Fig. 1. Implementation Framework for Self-sustaining Sites within Organizations in Communities



Goal 1 - BATIS Center: Develop a regional center to support and sustain a system of care that is trauma-informed, youth-guided, family-driven, and culturally competent.

- Objective 1: Establish an oversight committee to engage consumers and stakeholders in planning the BATIS Center.
- Objective 2: Finalize strategic planning activities to formalize goals, objectives, action steps, and evaluation planning.
- Objective 3: Formalize regional communication and collaboration between different jurisdictions and systems of care.
- Objective 4: Solicit and engage an organization to implement the BATISC initiative.

Goal 2 · Training

- Develop training resources for dissemination to county staff, providers, and consumers.
- Objective 1: Gather resources from counties and experts, distilling promising curricula and delivering to county overlapping systems and provider agencies throughout the region.
- Objective 2: Create psycho-educational resources for youth and families, delivering presentations regionally.
- Objective 3: Coordinate effective resources and disseminate information to providers and consumers on availability of care.

Goal 3 · Coordination of Care

- Establish a regional model to provide coordinated services for youth and children placed out of county, and children, youth, and families served by multiple systems within counties.
- Objective 1: Establish coordinated trauma screening, improved information sharing, and

CANS assessment processes to engage and enroll youth and families into services in a similar and coordinated manner across systems and county lines.
- Objective 2: Establish culturally appropriate activities that build connection among youth and families.
- Objective 3: Establish evaluation activities to measure impact of care coordination.

Goal 4 · Policy and Practice Sustainability
- Develop and sustain promising practices from the project and incorporate them throughout the region.
- Objective 1: Establish mechanism to gather and review practices for screening, intake, assessment, and services plans.
- Objective 2: Make recommendations to counties and agencies for more similar policies and practices to increase the parity and seamlessness across systems.
- Objective 3: Establish a plan for financing the model as an ongoing collaborative structure.

Describe how achievement of goals will increase system capacity to support effective systems of care development for children, youth, and families.

Given the large number of cities and counties working in close proximity, Bay Area counties are well positioned to share resources and knowledge. In the past, the lack of a coordinated regional system of care has led to duplication of efforts and disjointed services across county lines. The implementation of a Bay Area Trauma Informed Systems of Care initiative and the formation of the proposed BATIS Center will provide the needed coordination for county systems, resulting in more effective and seamless care for youth and families.

Our vision is to develop a mechanism with which to work across local "borders," that reflects an understanding of how our colleagues and the people we serve experience trauma in both shared and unique ways. Within the BATISC structure, these initiatives will take place through assisting children and youth impacted by trauma by reducing health disparities for foster care and juvenile justice-involved children and transition aged youth. BATISC will also coordinate the creation of behavioral health and medical homes to serve young children and children and youth placed "out-of-county."

Describe the proposed project activities, how they meet your infrastructure expansion and sustainability needs, how they relate to required services, and your goals and objectives.

To eliminate fragmentation across county lines and create an entire regional system of care that is aligned and integrated, the Bay Area proposes to create a Center for Trauma Informed Systems of Care to serve the entire Bay Area, ensuring high quality, trauma-informed services to youth and families throughout the local systems of care. The Bay Area Trauma Informed Systems of Care (BATISC) initiative will achieve these goals through the creation of a regional clearinghouse and coordinating center designed to integrate existing knowledge, incorporate new ideas, address challenges to training and sustaining an effective and diverse trauma informed work force and develop mechanisms to support implementation and sustainability of best practices.

The implementation of this important initiative will break down existing silos and challenge historical problems in implementing and sustaining best practices to our most at risk and

traumatized populations. The Bay Area systems hold many strong practices. Our challenge is to create a centralized, sustainable structure dedicated to helping build implementation strategies focused on fidelity, responsive to substantial cultural and linguistic differences.

This Center will bring together our service providers, our education, workforce, and juvenile justice systems, regional trauma experts, and consumers with lived experience. We seek to create a model development process that is fully influenced by consumers.

The BATIS Center will be founded and governed using the following six core principles and competencies with a focus on developing and disseminating specific and concrete strategies and tools to increase these competencies in our regional systems and workforce:

Understanding Trauma & Stress
Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative and unhealthy. However, when we understand trauma and stress we can act compassionately and take well-informed steps toward wellness.
1. Trauma – We understand that trauma is common, but experienced uniquely due to its many variations in form and impact.
2. Stress – We understand that optimal levels of positive stress can be healthy, but that chronic or extreme stress has damaging effects.
3. Reactions – We understand that many trauma reactions are adaptive, but that some resulting behaviors and beliefs may impede recovery and wellness.
4. Recovery – We understand that trauma can be overcome effectively through accessible treatments, skills, relationships, and personal practices.

Compassion & Dependability
Trauma is overwhelming and can leave us feeling isolated or betrayed, which may make it difficult to trust others and receive support. However, when we experience compassionate and dependable relationships, we reestablish trusting connections with others that foster mutual wellness.
1. Compassion – We strive to act compassionately across our interactions with others through the genuine expression of concern and support.
2. Relationships – We value and seek to develop secure and dependable relationships characterized by mutual respect and attunement.
3. Communication – We promote dependability and create trust by communicating in ways that are clear, inclusive, and useful to others.

Safety & Stability
Trauma unpredictably violates our physical, social, and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our daily lives and having these core safety needs met can minimize our stress reactions and allow us to focus our resources on wellness.
1. Stability – We minimize unnecessary changes and, when changes are necessary, provide sufficient notice and preparation.
2. Physical – We create environments that are physically safe, accessible, clean, and comfortable.
3. Social-Emotional – We maintain healthy interpersonal boundaries and manage conflict appropriately in our relationships with others.

Collaboration & Empowerment
Trauma involves a loss of power and control that makes us feel helpless. However, when we are prepared for and given real opportunities to make choices for ourselves and our care, we feel empowered and can promote our own wellness.
1. Empowerment – We recognize the value of personal agency and understand how it supports

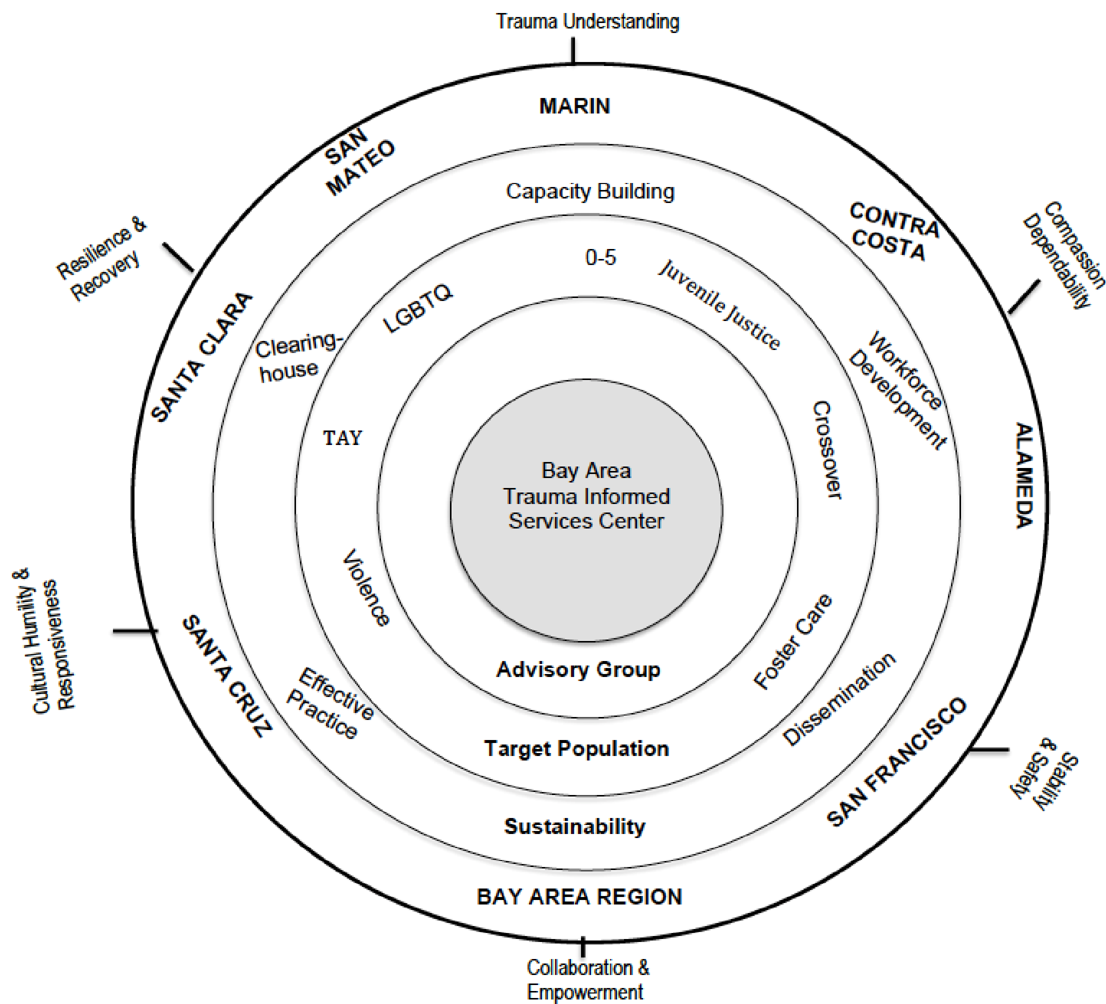
recovery and overall wellness.
2. Preparation – We proactively provide information and support the development of skills that are necessary for the effective empowerment of others.
3. Opportunities – We regularly offer others opportunities to make decisions and choices that have a meaningful impact on their lives.

Cultural Humility & Responsiveness
We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced.
1. Differences – We demonstrate knowledge of how specific social and cultural groups may experience, react to, and recover from trauma differently.
2. Humility – We are proactive in respectfully seeking information and learning about differences between social and cultural groups.
3. Responsiveness – We have and can easily access support and resources for sensitively meeting the unique social and cultural needs of others.

Resilience & Recovery
Trauma can have a long-lasting and broad impact on our lives that may create a feeling of hopelessness. Yet, when we focus on our strengths and clear steps we can take toward wellness we are more likely to be resilient and recover.
1. Path – We recognize the value of instilling hope by seeking to develop a clear path towards wellness that addresses stress and trauma.
2. Strengths – We proactively identify and apply strengths to promote wellness and growth, rather than focusing singularly on symptom reduction.
3. Practices – We are aware of and have access to effective treatments, skills, and personal practices that support recovery and resiliency.

The regional structure will be focused on systems improvements that are consistent with Fixsen's model of effective and coordinated implementation. The following chart illustrates the interaction of the BATIS Center activities, consumers, the Core Principles, and the partners.

Fig. 2. The BATISC System Change Ecology



Timeline, Milestones:

TASK	RESPONSIBLE ENTITY	Q1	Q2	Q3	Q4
YEAR 1					
Determine planning team schedule, location, agenda, and related logistics, preparation, and follow-up	Project Director	X	X	X	X
Consult with key stakeholders, including but not limited to, child welfare, juvenile justice, consumers, evaluator, and clinical consultants to plan solicitation for BATIS Center	Project Director	X			
Solicit, interview and select Center provider candidates	Project Director Oversight Committee		X	X	
Evaluator and Oversight Committee	Project Director	X	X		

develop systems for GPRA data collection	Oversight Committee Evaluator				
Center identifies staff, hosts planning meetings with Directors, Stakeholders, Consumers	BATIS Center			X	X
Center creates initial cross-systems tools and training curriculum plans	BATIS Center			X	X
Counties begin pilot implementation of regional tools, identify staff from multiple systems for training participation	Oversight Committee Directors				X
YEAR 2-4					
Provide training to all impacted systems	BATIS Center	X	X	X	X
Deliver follow-up, tailored trainings to smaller groups (e.g., child welfare workers, judges, substance abuse programs)	BATIS Center		X	X	X
Evaluator administers GPRA and coordinates with Project Director	Project Director Evaluator	X	X	X	X
Coordination of cross-county and cross-systems tracking and support is implemented	BATIS Center	X	X	X	X

Oversight Committee:

The BATISC Directors' Committee will serve as the initial membership of the governing body for the BATISC. Through this group, invitations have been proffered to the representatives outlined in the chart above. The full membership will form an Oversight Committee.

The BATISC Oversight committee will represent a collaborative of all major child serving public agencies (behavioral health, child welfare, juvenile justice, and public schools), community partners, and family and youth change agents working together to coordinate the development and expansion of the regional trauma informed systems of care.

The initiative includes county agency partners from Alameda, Contra Costa, San Mateo, Santa Clara, Santa Cruz, and San Francisco Counties that have provided written commitments to collaborate on achieving our regional goals to address disparities in access to behavioral health services for trauma impacted children and youth.

Collaborative partner commitments include participating in planning meetings and assessment activities, assisting with the identification of additional collaborative partners, and recruiting families and youth to engage in planning and implementation efforts. Partners will also be the primary implementers, bringing policies and practices back to each county, overseeing their execution, and working with evaluators to document changes.

Upon implementation of the full BATISC initiative, the BATISC Oversight Committee will meet monthly, and will invite representation from the following additional groups:

Participant	Letter of Support /Oversight Member
Lead Agency SFDPH	Barbara Garcia, Executive Director
Alameda County	Carolyn Novosel

Contra Costa County	Vern Wallace
Marin County	Brian Robinson
San Francisco County	Barbara Garcia, Executive Director
San Mateo County	Toni DeMarco
Santa Clara County	Sherri Terao
Santa Cruz County	Dane Cervine
Education	County Combined SOC, State Special Education
Foundations	San Francisco Foundation, Zellerbach, Enterprise Community Partners
Juvenile Justice	County Combined SOC Letters
Trauma Experts	Alicia Lieberman
Disparate Access	Native American Health, Family Acceptance, Center for Youth Wellness
Youth and Family	Parent Partner positions plus TAY recruitment by Community Liaison

Describe how the proposed project will address the required activities as follows:

Culturally and Linguistically Appropriate Services

In a region as diverse as the Bay Area, cultural and linguistically appropriate services are critical to successful service delivery and strong outcomes, especially among underserved populations. Partners in the BATISC initiative are well on the way to meeting the national Culturally and Linguistically Appropriate Services (CLAS) Standards issued by the United States Department of Health & Human Services. With the implementation of BATISC, the strongest practices from each county will be shared with the others through coordination, development of best practices, and technical assistance.

Many of the counties have a cultural and linguistic competency committee or task force at the Behavioral Health level, at the Public Health level, or both. In Alameda County, Behavioral Health Care Services established a Cultural Competency Committee. The committee informed the County's Cultural Competency Plan and had subgroups that focused on specific population needs, such as the mental health needs of African Americans. The Public Health Department has also provided system-wide trainings on Cultural Competency and Cultural Humility. San Francisco County established the Cultural and Linguistic Competency Task Force (CLCTF) to assist in the implementation of its policy directives and recommendation in advancing cultural competence. The Task Force has been critical in the implementation of the CLAS Standards and includes representation from all facets of County-supported health care including Ambulatory Programs, Behavioral Health Services, Housing Urban Health, HIV Health Services, Community-oriented Primary Care and Maternal Child and Adolescent Health, as well as contracted programs and client representatives. Santa Clara County had both a Minority Advisory Committee and a number of Ethnic and Cultural Community Advisory Committees in the preparation of its Cultural Competence Plan. San Mateo County has adopted county-level Culturally and Linguistically Appropriate Services (CLAS) standards that align with the national standards.

The involvement of consumers and family members in the design and delivery of services is a fundamental step recognized by the county-level plans, various task forces and training efforts of the BATISC counties. In San Francisco the CLC Task Force's primary recommendation was aligned with national CLAS Standard #12, which is designed to *facilitate community and patient/consumer involvement in designing and implementing CLAS related activities*. As the BATISC counties work together to implement a regional, trauma-informed system of care, the incorporation of the learning from County plans and best practices, and the inclusion of

consumers with disparate access experiences in the Center will support reaching CLAS standards in this effort across the entire region.

Family-driven, youth-guided framework and Governance:

Family and Youth Guidance in BATISC Activities and Oversight: Training for providers will be vetted by youth and family participants on the oversight committee, and will be co-presented by trainers with lived experience and cultural understanding. Training will also be offered to consumers to educate youth and families on the effects of trauma on trauma informed care.

Family Partners play a critical role in the approach to the delivery of children's and family services in all the counties. In Alameda County, Family Partners are active throughout the System of Care and required for all new programs. Alameda County has a Family Empowerment Manager who is part of the Executive Management Team. In Contra Costa, Family Partners provide support by encouraging families to remain engaged and informed and help prepare families for effective self-advocacy. In Marin, Family Partners are co-located in county offices and work side by side with clinicians. Family Partners participate in policy and staff meetings to provide consumer input. In Santa Cruz County the county contracts with the Volunteer Center's Family Partnership Program, to recruit, hire and train peer-parents to provide education, outreach, and direct services to families. In particular, parent-partners provide integral services to Probation youth via the Santa Cruz Wraparound Program for Court Wards. Santa Clara County's Mental Health Peer Support Worker positions also include family members.

Youth Peers: County SOC's have identified specific youth peer roles, including peers from targeted communities such as LGBT youth and juvenile justice involved young people. In Marin, consumers led cultural competence training in May to train mental health and substance use staff on consumer perspectives about access to services and cultural sensitivity. In San Francisco, the input of youth is incorporated in leadership/planning, social marketing, and cultural competency. Their paid internship program provides mentoring, support, and education to ensure that youth are successful and have their personal goals met. In Santa Clara, two peer positions are for Transition Age Youth Mental Health Peer Support Workers who are former foster youth and/or have been involved with the juvenile justice system. In Santa Cruz MHSA funds are used to support a foster youth advisory group, which is connected to the California Youth Connection at the state level. Santa Cruz also supports Youth Partnerships via the STRANGE program, and the Diversity Center, both of which provide a range of support and educational services regarding Lesbian, Gay, Bisexual, Transgendered, & Questioning (LGBTQ) youth.

Regional Coordination:

The BATISC initiative will create (through a solicitation process for a qualified contractor) a Bay Area Trauma Informed Systems Center for the coordination and dissemination of best practices and resources. Within the Center structure will be:

1. A Regional Training Team: The counties will pool training resources and curricula already developed. The BATISC Center will coordinate the dissemination of these and other best practices curricula to government and provider agencies throughout the region.

2. Regional Policy Committee: The counties will collaborate to identify key policy initiatives where the consumers throughout the region will benefit from coordinated policy statements and procedural initiatives.

3. Systems Administration: As the lead agency, San Francisco's Department of Public

Health will oversee the administrative infrastructure for the grant, including contracting with the BATISC Center, staffing the BATISC oversight committee, oversight of data gathering and evaluation activities, matching funds coordination, and reporting to SAMHSA.

The BATISC will work with the oversight committee, the Project Director, and the counties to directly apply the Six Core Principles to proposed regional policies and practices.

Policy, administrative and/or regulatory structures that support SOC implementation:

The establishment of the BATISC Center will provide a hub for collaboration and dissemination of policies and administrative approaches that support regional implementation efforts, including legislative efforts and development of regional policy recommendations. Already, key policies and practices on out of county placement, procedures for crossover with Juvenile Justice, potential regionally standardized use of the CANS (Child and Adolescent Needs and Strengths) tool, and others have been identified for study, potential standardization, and dissemination.

Family and youth involvement in implementation activities:

In order to ensure our activities are informed by consumer oversight, youth advocacy organizations along with consumers, parent partners, and service providers will maintain involvement at the local and regional level through focus groups, oversight committee participation, regional forums and training opportunities, and direct involvement in evaluation planning and data compilation, as described in the data collection and evaluation plan.

Collaborate across child and youth serving agencies and among critical providers:

One of the primary motivating factors in establishing BATISC has been the need to collaborate across systems within counties, in addition to collaborating throughout the region. County CYF Directors have already begun sharing strategies for reaching across systems, including community and residential treatment, with training and procedural strategies on health care, education, substance abuse, and juvenile justice. Representatives from each of these connected systems will be invited to participate in the ongoing collaboration under the BATISC Initiative.

Community and residential treatment services are most commonly contracted to provider agencies in the Bay Area. Each contracted agency will be included in the training initiatives and in the policy and practice development. Further, the regional cross-systems work will include provider agencies as part of the treatment systems and policy development. In many cases, clients are referred to a provider in another county. The BATISC initiative will provide the care coordination necessary to ensure the clients accessing treatment receive appropriate follow-up and aid in transitioning back to their home county, if the treatment was residential.

Collaborate between child and adult serving agencies as well as consumer groups, which are critical when serving older youth who are transitioning to adulthood:

Transition aged youth risk losing critical services when they turn 18 or 21. For youth in foster care, California has recently implemented AB12, which extended care until the age of 21, allowing youth to maintain services and housing assistance as long as they are pursuing educational or employment-related goals. Bringing the foster care system into alignment with behavioral health in responding to trauma will allow these youth, before and after age 18, to access needed assistance.

At the regional level, the BATISC Center will be instrumental in connecting the adult and youth-serving agencies as part of their Care Coordination role, and adult systems will be included in policy analysis and training initiatives.

The Bay Area has a very active community of youth-serving agencies who have been and will continue to be involved in planning and steering the BATISC initiative through local discussions, steering committee involvement, and BATIS Center services.

Integrate between mental health and substance abuse services and systems:

A collaborative planning process coordinated by the Center will engage already identified behavioral health providers and probation officers, judges and other legal stakeholders in developing a blueprint for cross-system collaboration and treatment that will address the need for a common practices and trauma informed care. By better anticipating and planning for points where natural cross-system tensions around perspectives and practices are likely to emerge (e.g., court-ordered vs. voluntary consent to treatment, consequences for dirty UAs, and decision-making about services), BATISC can improve the likelihood of success in treatment.

During the project-planning period, the Center will work regional substance abuse treatment providers to develop a uniform evidence-based standard of care that incorporates trauma screening and treatment. The Center will provide implementation support for improved practice (e.g., coaching on family-focused approaches, co-leading relapse prevention groups, and development of peer-led recovery support) to supervisors, clinicians, youth and families.

Continuous information feedback and communication about plan goals and progress are critical to ensure that youth, families, probation officers, courts, and providers stay on the same page. The Project Director will track processes like plan development, communication, engagement in services, client functioning and recidivism data to guide cross-system planning and actions at the individual, program and systems level. The project's evaluation team will be responsible for analyzing engagement and outcome data at an aggregate level to determine whether BATISC contributes to improvements in community safety, integrated treatment delivery and child and youth health and well-being.

Outcome measurement strategy alignment:

- BATISC will enable the regional partners to better inform the development of behavioral health contractor performance objectives, basing them on desired outcomes for young children. They will also be able to expand the Shared Youth Database to include data for young children.
- For the first time, counties will be able to seamlessly collect county level data on the need and supply for services for out-of-county children and youth.
- Regional coordination through the Center will allow the counties to identify federal, state and local policy, administrative and regulatory barriers to providing mental health services to out-of-county youth.
- The strong practices in juvenile justice in the region will to add representation from the juvenile justice system from Alameda, Contra Costa, and San Mateo Counties to complete regional participation in a juvenile justice collaborative.

- BATISC will create the opportunity to work as a region with the State of California on *Katie A.* implementation and data collection systems.

Coordinate SOC strategies with block grants and other health care reform efforts:

This initiative sits with county behavioral health care providers, who are directly involved in the integration of primary and behavioral health care in conjunction with the Affordable Care Act. We have already noted the important role of pediatricians in screening for trauma, especially in very young children. For all youth and families, team based care will strengthen our trauma screening and response.

This initiative will also build on the significant efforts underway with the Mental Health Services Act. Each county submits an integrated plan to the state, detailing its efforts in trauma informed care and other services for people with serious mental illnesses. With this initiative, the counties will be able to demonstrate a unique and effective method of integrating MHSA practices regionally and bringing the full participation of youth and families into their dissemination.

Incorporate trauma-related activities into the service system:

Through the sharing and dissemination of resources from the participating counties, the following services and practices will be implemented regionally:

- Integrated medical-behavioral health homes for young children through primary care and behavioral health clinics.
- Utilization of evidence-based assessments including the Diagnostic Classification of Mental Health and Developmental Disorders (DC:03R) and the Child and Adolescent Needs and Strengths.
- Evidence-based treatment such as Trauma Focused Cognitive Behavioral Therapy and Child-Parent Psychotherapy.
- Expanded peer support services for caregivers with young children.
- Social marketing and strategic communications activities to promote social inclusion, develop partnerships, and promote SOC values and principles.
- Family friendly social marketing campaign to educate the community about the impact of trauma on young children and available resources.
- Annual trauma summit in conjunction with National Mental Health Awareness Day to raise community awareness about the impacts of trauma and available community resources, created for providers and consumers.
- Comprehensive social marketing to educate and encourage caregivers for children and youth placed out-of-county to access mental health services for children and youth in their care and reduce the stigma associates with seeking services.
- Youth-driven social marketing strategies to encourage older youth to seek mental health treatment.

Recently, San Francisco launched a campaign to reach consumers through public transportation. Children and youth collaborated with staff to design, produce, and implement it through public transportation. The goal was to raise awareness of culturally appropriate services available to Native American children, youth and families, and to decrease stigma. The ads were displayed on buses and in subway stations during a month long campaign. The campaign was successful in raising awareness, the youth reported experiencing pride and a sense of community involvement,

and the program has been invited to present on it at regional and national forums.

Through efforts like this, the Center will reach out on a regional basis, involving the specific target populations assessed as underutilizing services.

Create sustainable training and technical assistance strategies:

One of the important topics that brought the Counties together to begin the strategic planning process was the desire to collaborate on training for trauma informed systems. In the first nine months of the collaboration, Directors have begun inviting staff from other counties to participate in their training initiatives, or to pool resources to pursue other needed training. San Mateo County and San Francisco County have shared their curricula for behavioral health staff. Santa Clara County and Alameda County have collaborated to bring Juvenile Justice training resources to their counties.

In addition to improving services in their own departments, the Directors will use BATISC to develop and provide trauma-informed care training for contracted behavioral health, substance abuse programs, primary care clinics, the courts, social workers, early education and child care workers, LGBTQ services, TAY case management and housing services, and other community providers.

- BATISC will provide training to professional staff in the Bay Area that work with young children to use the Diagnostic Classification of Mental Health and Developmental Disorders (DC:03R) assessment tool and other trauma-focused evidence-based practices. Use of the DC:03R should improve providers' ability to screen for trauma and its effects in infants and toddlers.[4]
- County partners will be cross-trained to understand the system of care in each county, its organizational framework, and its philosophy and approach.
- BATISC will provide training and technical assistance to integrate culturally and linguistically competent, family-driven, youth-guided practices within the behavioral health, child welfare, juvenile justice, and school systems across counties.

Participating Organizations:

Agency	BATISC Representative	Experience/Bio
Alameda County	Jeff Rackmil, LCSW	As the Alameda County Juvenile Justice Health Services Director, Jeff Rackmil plans, organizes, directs, and evaluates the operations of all health services programs for minors in the Alameda County juvenile justice system including the Guidance Clinic, Public Health Nursing Transitional Services Program, and other programs. He is liaison to the Juvenile Court and Probation Department for juvenile health services operations, collaborations and re-entry planning, coordinates service systems to ensure compliance with legislative mandates, minimum standards as well as State and Federal rules and regulations, including Title 15 – Minimum Standards for Juvenile Facilities.

[4] Zero To Three (2005). Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (dc:0-3r). Washington, DC, ZERO TO THREE Press.

Contra Costa County	Vern Wallace, MFT	Currently the Mental Health Program Chief, Children's System of Care, Vern Wallace has been with the Contra Costa Department of Mental Health since 1986. He manages a County wide mental health service serving children and their families. He is responsible for the development of policy, programming, and procedures for a County System of Care. He participates in Mental Health Division Executive Staff planning and development consistent with the System of Care Principles. He has overseen the implementation of the Mental Health Services Act, and partners with Education, Social Services, Juvenile Probation and Public Health.
Marin County	Brian Robinson, Psy.D	Brian Robinson has been a Mental Health Services manager for the Children's System of Care in Marin since 2004. He manages Children's System of Care program at Marin County juvenile probation. He supervises Katie A implementation. He established the full service partnership program (CSOC) with MHSA funds, and helped to establish new TAY program as part of MHSA planning. He helped to establish SB163 Wraparound program for youth at risk of placement, participates in committees to increase collaboration among county agencies, and helped to create an MOU with schools and probation to establish clear protocols for successful partnership.
San Mateo County	Toni DeMarco	Toni DeMarco has been with San Mateo County Health System, Behavioral Health and Recovery Services since 1998 and is currently the Clinical Services Manager, over the Juvenile Probation, Child Welfare and Prenatal to Three Behavioral Health and Recovery Services Teams. She supervises Unit Supervisors of the Juvenile Probation, Child Welfare and Prenatal to Three Behavioral Health and Recovery Services Teams. She oversees, manages, and provides interagency collaboration regarding the units involved in court related services.
Santa Clara County	Sherri Terao, Ed.D	Sherri Terao is a licensed psychologist and the Family & Children's Division Director with the Santa Clara County Mental Health Department. Prior to this, Sherri held the position as Chief Program Officer at FIRST 5 Santa Clara County. Sherri has worked in the area of child welfare and completed her pre and post-doctoral training at the UC Davis Medical Center's Child Protection Center. She also worked at the University of Chicago's Chapin Hall Center for Children and directed the first national longitudinal study of youth aging out of foster care in three states
Santa Cruz County	Dane Cervine, MA, LMFT	Dane Cervine serves as Chief of Children's Mental Health for the Santa Cruz County Mental Health/Substance Abuse Department, where he has worked for 27 years. Dane presents frequently on Children's Interagency Systems of Care, and facilitates dissemination of trauma-informed treatment and systems training among Child Welfare, Probation, First Five Commission, etc. Dane is the current chair of the Bay Area Children's System of Care Coordinators/Partners

		meeting for the California Mental Health Directors Association (CMHDA).

Describe how the proposed project will address demographics, language and literacy, sexual identity, and disability:

The BATISC approach to trauma and complex trauma will allow our region to focus on the traditionally poorly served and underserved while developing a common understanding and knowledge transfer that will impact all of our children youth and families. By helping the workforce and consumers throughout the region understand the nature and effect of trauma on themselves and others, we expect to provide the most significant improvement to populations most susceptible to disparities.

BATISC will develop a regional workforce that better represents the children, youth and families served. As a region, the Bay Area has many national innovators in integrating Youth and Families into the workforce, leadership and decision-making. This systems change grant is the logical next step. The counties are proposing to integrate knowledge about Trauma across the region and across systems of care, combating the fragmented and separate silos of knowledge and practice in favor of a collaborative effort that builds regional infrastructure that supports local implementation and allows for shared resources and practices.

In addition, the involvement of youth and family peers will directly inform the work of our center. Their first-hand knowledge and lived experience of traumas directly related to age, ethnicity, race, culture, language, literacy, gender and sexual identity, and disability will insure understanding is translated into policies and practices.

Financing Plan:

There are multiple approaches the Bay Area intends to use to ensure sustainability. Here are some of the ways we expect BATISC to lead to new revenue to sustain our efforts and an expansion of trauma-informed services.

Generating savings for community-based services: As our systems and services become infused with trauma-informed principles and practices we expect improvement in our permanency rates will allow us to invest more dollars in reinvestment in community-based services. Obtaining agreements to reinvest these savings in services will be a critical component to this work.

Improving regional coordination: Policy and regulatory changes will allow for financing mechanisms that expedite payments by counties of origin for mental health services provided to out-of-county youth.

Expanding services: The children, youth and families served by Bay Area Systems of Care stand to benefit greatly from the Affordable Care Act (ACA). It's estimated that the ACA will provide health insurance for over 3 million people in California. Enrollment in Medi-Cal is expected to increase by nearly 2 million people (Long & Gruber, 2011). Increased coverage represents a great opportunity for BASTISC to expand the impact of TIS training and services. Recent expansion of Drug Medi-Cal to support more adolescent treatment is also a critical lever in our work with regional substance abuse treatment providers to develop a uniform evidence-based standard of care that incorporates trauma screening and treatment

Providing integrated, team-based care: The Affordable Care Act provides incentives for the creation of health homes. Having a one-stop shop for seamless care that addresses both the

impact that trauma has on mind and body will provide a foundation for services that are accessible, continuous, dependable and more cost effective.

Sustainability and Continuity:

Sustainability: Our plan is designed to support and sustain systems changes, and increase access to and enhance trauma-informed services. Regional efforts will include support for BASTIC operations and the sustainability of its work and increased access to and capacity for trauma-informed services. However, ultimately BATISC's success will be measured by the fundamental shift in how we work together and provide services.

Approach to Implementation: This training and skills development model has multiple levels (from basic to train-the-trainer) to maintain enduring local expertise. BASTISC has sought to incorporate the research of the National Implementation Research Network (http://nirn.fpg.unc.edu/), in order to ensure that practice changes are implemented during and sustained after the grant period.

Developing Tools and Curriculum for Dissemination: The Center will develop TIS assessments, training curriculum, supervision and practice skills and strategies with related technology and social media platforms to encourage replication and the scaling up of TIS system and practice change. These products will be available to be downloaded or distributed free of charge.

Sustaining Center Operations: Resources to support center operations can come form MHSA funding, for which trauma is a priority area. Each county will be asked to MHSA funds to the initiative. Based on the success of the collaboration, the counties will have the ability to advocate for MHSA or other State Dollars to support this regional work. Title IVE Training Dollars are also available for those activities that match the criteria. In addition several Regional Foundations have already expressed support for this initiative, which could result in funding.

Continuity: If there is staff turnover, the project will maintain services. Because matching staff will sit in each county, clients will always have contacts within their counties in addition to the BATISC.

Section C: Staff, Management and Relevant Experience

Lead Agency Relevant Experience: The San Francisco Department of Public Health successfully administers over $1 billion federal, state and local behavioral health, health (Medi-Cal), HIV prevention and treatment, long-term care, and public health dollars in addition to having oversight responsibility for implementation of federal healthcare reform.

Beginning in fall of 2012, SFDPH began a planning process to shift our local system toward becoming trauma informed. These efforts have resulted in a unique workforce development model in which all SFDPH staff at all levels and all types of positions – over 7,000 total – will be trained in understanding the impact of trauma and the approach of a trauma informed system. The result being a system-wide workforce that has a common understanding of trauma and a shared language with which meaningful conversations can be held. Recognizing the need for not just training, but for supported and sustainable implementation that blends system of care values with trauma informed system principles, a complementary coaching and train-the-trainer model is being administered concurrently. The development process and implementation plan have been and will continue to be participatory – all levels of staff and diverse community members

have participated in the development and review process from inception to enactment. SFDPH's efforts to become a trauma informed system are reflective of the region's growing awareness of trauma and motivation to be responsive to it beyond individual efforts. For instance, the San Francisco Unified School District has also implemented a trauma informed system training for their teachers. Many other child serving agencies and departments are also developing plans to implement similar programs. SFDPH, as a large system that interfaces with many partners both locally and regionally, is well-positioned to positively influence and support these growing efforts.

San Francisco's commitment to embracing models that provide the highest level of care to our children, youth, and families is evident in the early adoption of system of care values. San Francisco was one of the first California counties to receive a Children's System of Care (CSOC) Grant from the California Department of Mental Health Services. State grant funds were used to plan, develop, implement, and evaluate the local system of care, all components of which continue today, including:

- The CSOC Steering Committee, comprised of senior managers from the behavioral health, child welfare, juvenile justice, public school, and other child serving systems, as well as families, youth, and community providers;
- The CSOC Family Involvement Team, a peer support services team comprised of caregivers with experience in the behavioral health, child welfare, juvenile justice and special education systems;
- The Shared Youth Database, a multi-agency database that supports care planning across the behavioral health, child welfare, and juvenile justice systems.
- The San Francisco Children's System of Care Clinic, an agency with responsibility for promoting the local children's system of care and facilitating family-driven, youth-guided care management services to children and youth with serious emotional challenges and their families.

From 2002-2007, SFDPH received a SAMHSA SOC Implementation Grant to expand the work begun with state funding. The SFDPH *exceeded* grant goals and successfully sustained initiatives implemented through the SAMHSA SOC Grant:

- Increased access to family-driven, youth-guided behavioral health services for 680 San Francisco children, youth and their families (53% higher than goal);
- Implemented evidence-based practices in partnership with the child welfare, juvenile justice and school systems, including, Multi-Systemic Therapy, The Incredible Years, Triple P Parenting, SB 163 Wraparound Services, SF AIIM Higher, Dialectical Behavior Therapy, Aggression Replacement Therapy, and Therapeutic Foster Care Visitation;
- Created the CSOC Youth Involvement Team and Youth Task Force to bring youth voices into the child serving system through the adoption of a departmental youth-driven care policy, youth therapy rating, and healing circles for youth and families impacted by trauma;
- Expanded the CSOC Family Involvement Team to support the integration of family-driven care within behavioral health clinics;
- Established at all public high schools, the Wellness Program, a nationally recognized behavioral health prevention and early intervention initiative that assesses and treats youth with behavioral health challenges;
- Implemented the Early Childhood Mental Health Consultation Initiative to provide assessments and services to young children and their families receiving services through

child care, domestic violence, and family resource centers across San Francisco;

- Developed new cultural competency trainings on family-driven, youth-guided care, which led to the creation of family and youth councils at multiple provider sites and changes in practice in the child welfare system.

Based on the success of the first SAMHSA SOC Grant, SFDPH received a multi-year SAMHSA Tribal Community SOC Grant in 2009 to expand the local system of care organizational framework and philosophy to Native American and other Indigenous families in San Francisco in partnership with the Native American Health Center, which provides services under the grant.

Regional Experience: Trauma Informed Systems: Significant efforts to develop and implement trauma-informed systems have already begun at the County level in all of the participating communities. Each county has provided or brought in some internal training for mental health providers and administrators, and many are considering or initiating cross- system initiatives with other systems of care such as child welfare, school districts and early childhood providers. Alameda County has launched a countywide initiative for all of its providers to use the CANS when assessing youth for services, including a trauma module. As part of a grant to work with Cross Over Youth, Alameda County will have Trauma Informed Care training delivered to public and community partners including the Public Defender, District Attorney, Probation, Child Welfare, Juvenile Court and community providers.

Contra Costa is training clinicians in regional clinics in provide Trauma Informed Services, using a range of Evidence Based Practices (EBP) to target clients with acute/serious difficulties related to trauma. EBP team leaders are assigned to each clinic to help supervise and provide ongoing support for the dissemination of EBP's throughout the county clinic system. They are also looking at a broader initiative to bring trauma informed practice across multiple Systems of Care, partnering with First Five, Head Start, Children and Family Services, and Public Health.

In Marin the MHSA Workforce, Education and Training group recently provided trainings on Trauma Informed Care to introduce this topic to the entire system of care and community providers. In the children's system of care, six clinicians in trauma-focused CBT have been hired and will continue training in child/parent psychotherapy in April. The county also provided all staff the Trauma and Resilience toolkit to enhance skills in working with trauma.

As noted previously, San Francisco is moving toward becoming a fully trauma informed system. Through a participatory development process a full, interactive, curriculum has been designed to support the entire workforce in understanding and applying essential aspects of trauma. San Francisco is currently carrying out key activities to: 1) develop a foundational understanding and shared language around trauma and its effects, 2) embed leaders/champions of change within the system, 3) support and maintain change through harnessing experts and consumer voices. .

In 2009 and 2010 San Mateo County hosted and organized two conferences on developing trauma-informed systems of care, and increasing capacity for care through provider training. These conferences were very popular and reached over 1,000 attendees. Following the conferences, the County had a TIC policy expert train program supervisors on Trauma Informed Care programming and created *Trauma 101* to help educate other systems of care regarding trauma including the Medical Center and special education teachers and para-professionals through local school district. The County also has supported *Seeking Safety* training for teams

working with transitional age youth as well as adults in outpatient and inpatient settings.

Santa Clara County has recently begun using TARGET, an educational and therapeutic approach for the prevention and treatment of complex Post Traumatic Stress Disorder (PTSD). They also have created a joint DFCS and JPD co-located unit with Probation Officers, Social Workers, Dually Involved Youth Advocate, and a community voice.

Santa Cruz County has supported a range of training opportunities in the community including training by Dr. Bruce Perry, Dr. Chandra Goshen, Gabrielle Grant and Dr. Sharon Melnick. The trainings are the beginning of what the County plans to be a more strategic, integrated approach to truly developing a "trauma informed system" among all child/youth-serving agencies.

Key staff experience, competencies, and resources:

Principal Investigator: Kenneth Epstein, LCSW, PH.D. is the Director of the SFDPH Child, Youth & Family System of Care (CYF SOC). Dr. Epstein has over 25 years of extensive experience at Bay Area non-profits in developing effective programs and providing public behavioral health services to diverse children, youth and families. As a UCSF researcher and professor, Dr. Epstein has been instrumental in developing ways to train and coach the clinical workforce in effective family-focused interventions. Dr. Epstein is responsible for the fiscal and administrative oversight of the cooperative agreement, accountable to the funder for performance and financial aspects of activities conducted. He will actively participate in the development and implementation of the strategic plan for BATISC, ensure its technical success, and maintain communication with partners. He will serve as the supervisor for the Project Director.

Grants Administrator: Jana Rickerson, LCSW is the business official and authorized representative for the grant. Ms. Rickerson has over 20 years of experience with the Annie E. Casey Foundation and the SF Human Services Agency in improving services for Foster Care Youth and their families. In her role, she will receive and insure that all official communications from SAMHSA are addressed in a timely manner. She will be responsible for signing and oversight of official grants reports and documentation to SAMHSA.

Project Director: SFDPH will hire a BATISC Project Director (PD). This individual will be responsible for coordinating the development and implementation of an ongoing and comprehensive strategic plan for the system of care. She or he will manage communications between the child serving county agencies and partners and will foster interagency collaborations. The PD will be responsible for establishing an organizational structure and overseeing timely progress toward grant goals. The PD will be responsible for monitoring, identifying and responding to technical assistance needs related to the grant. She will serve as the primary supervisor for grant staff. A sample job description is attached.

Evaluator Psychologist: Psychologist: Briana Loomis, PhD, is a psychologist and evaluator for the SFDPH Child, Youth & Family System of Care (CYF SOC). She has over a decade of experience in the field of trauma psychology including research,teaching, training, and the provision of clinical services. Dr. Loomis has worked with multiple systems and local governments to improve care for those who have experienced trauma. She is trained in the design and implementation of research programs, from theory to final analysis. As researcher and clinician, Dr. Loomis will serve to support trauma informed content development and implementation, as well as conduct analyses on both local and regional data, and support dissemination of findings.

Regional TIS Center Staffing: Designation and selection of key personnel within the Regional TIS Center will occur through a planning and RFP process during the first year of the initiative, per San Francisco City Ordinance. Given the role of the Center, it is expected that key personnel will include positions that oversee (1) policy development, (2) training and technical assistance, (3) care/placement coordination, and (4) community engagement (social marketing and youth/family engagement). Qualifications would include experience and education in trauma, as well as specific knowledge, skills, and abilities relevant to the individual positions.

Cultural and Linguistic Competency Coordination: Cultural and linguistic competency coordination will not be held by a single key personnel position, given the regional nature of the initiative. As each county has staff supporting county level efforts to provide services that reflect cultural humility, awareness, and responsiveness, these staff will work collaboratively to support the implementation of BATISC activities in a manner that is sensitive to the diverse social and cultural needs across the region. In San Francisco, this role will be held by Nelson Jim, whose qualifications are included.

Consultants: Although not identified as key personnel, the BATISC initiative is pleased to note the support and expertise of several consultants who will support development and implementation in the areas of evaluation, foster care, cultural and linguistic competency. A biosketch highlighting the experience and qualifications of each consultant is attached.

Youth and Family participation in application:

BATISC Application and Strategic Planning: In order to include the perspectives of youth and families in the strategic planning process, county agency directors included parent partners and youth serving organizations through existing advisory bodies. Each CYF Director presented strategic planning efforts in monthly forums of other appropriate membership groups that include consumer groups. The Directors Committee hosted focus groups with parent partners and current and former foster youth and their advocates from five counties (Alameda, Contra Costa, San Mateo, San Francisco, and Marin) to present the proposed implementation activities and garner responses on current access to trauma informed services.

In response to questions on Bay Area SOC, participants spoke about several proposal areas.

Cross Systems Notes

- One respondent asked that we include police and Child Protective Services in our training sessions as they are nonresponsive to concerns about the effects on children.
- Participants voiced strong support for the work of parent partners in assisting families in navigating the systems they encounter.
- Substance abuse providers and juvenile justice do not reflect understanding of trauma.

Regional Notes

- Some families said the resources in their counties and, even more so, in other counties, were hard to get information about.
- If you switch public health systems, you have to start all over.
- It would help youth a lot if intake and assessments could be shared.

TAY Notes

- Improve coordination between TAY services and substance and mental health providers.

- There is little coordination between TAY in one county and family in another county.
- They should have a way of assessing trauma within Juvenile Justice system.
- Need to develop and provide training and other means of educating or promoting trauma-informed transitions.

These results were presented to the Directors in a regional meeting and the proposal was modified to better address LGBT concerns and to build in training and resource sharing activities involving consumers. The Directors agreed that they would make a general regional policy to include presenters with lived experience in these regional trainings to be developed.

BATISC Implementation and Assessment

As described, consumers will be involved in all aspects of the implementation process. They will have representation on the oversight committee, will have input on policies and practices to be developed, and will be recruited to assist in training development and presentation.

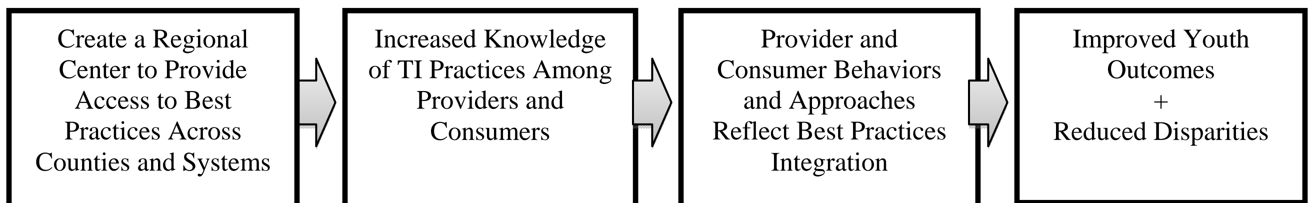
Consumers will participate in the development of assessment activities and tools through focus groups and through the oversight committee, who will vet the evaluation design. Evaluation activities will utilize individual and group interviews, surveys, and other collection methods.

Section D: Performance Assessment and Data

The Directors have engaged Learning for Action (LFA) to provide professional third-party evaluation services for BATISC. The evaluation design ensures all required process and outcomes data for the grant, including all NOMS measures, will be collected. LFA will create a quality improvement performance management system through the evaluation design and implementation process. LFA has conducted several multi-County and cross-departmental projects to strengthen systems of care, including the development of a Health Department Cultural Competence self-assessment tool for the Bay Are Health Inequities Initiative (BARHII), an evaluation of a multi-County Bay Area regional Children and Families Commission Children's Health Initiative, and an evaluation of the development of a regional Center of Excellence in treating triple diagnosed (HIV, substance use, mental health) patients.

Working in partnership with local County evaluation teams, LFA will develop a well-articulated theory of change that delineates the strategies and time-sequenced outcomes at the systems and individual client levels. The basic theory of change is summarized in the graphic below:

Fig. 3. BATISC Theory of Change



Using the theory of change as the roadmap, and grounding in required demographic, process, and outcomes data specified in the RFA, LFA will develop data collection protocols and processes:

TIS Assessment / Provider Survey and Interviews: Based training resources developed, a survey

of all staff providers will be administered at baseline and at two follow-up time points (Years 2 and 4). The Provider Survey will be supplemented with an annual set of in-depth interviews with partners and providers to assess systems change outcomes including (but not limited to):

Number of policy changes completed; number of agencies, organizations, and communities that demonstrate improved readiness to change their systems to implement TIS mental health- related practices; number of organizations sharing resources; changes made to policies in order to incorporate expertise needed to improve mental health-related practices/activities; amount of additional funding obtained for specific mental health-related practices/activities as a result of the grant; and number of financing policy changes completed.

Infrastructure and Systems Change Tracking Tool: To capture additional infrastructure and systems changes, LFA will develop a tracking tool that will include measures required by the grant such as:

Number of agencies entering into formal written inter/intra- organizational agreements (e.g., MOUs/ MOAs) to improve mental health-related practices/activities; number and percentage of work group/advisory group/council members who are youth/family members; number of youth/family members representing youth/family organizations who are involved in on-going mental health-related planning and advocacy activities; number of youth/family members who are involved in mental health-related evaluation oversight, data collection, and/or analysis activities; and number of individuals exposed to mental health awareness messages.

The Infrastructure and Systems Change tracking tool also will capture additional measures integral to a comprehensive performance management system for continuous quality improvement purposes such as staff days on the job (reduced absenteeism), increased client engagement (reduced no-shows/dropouts), reduced personnel actions, and client satisfaction.

Youth Outcomes Survey: To assess youth outcomes, LFA will administer the CMHS Child Outcome Measures for Discretionary Programs, which collects data on the following performance measures:

Mental illness symptomatology; employment/education; crime and criminal justice; stability in housing; access, i.e., number of persons served by age, gender, race and ethnicity; rate of readmission to psychiatric hospitals; social support/social connectedness; and perception of care.

The survey will be administered to cohorts of youth in each participating County at baseline, 6-month follow-up, and discharge for cohorts in Years 1, 3, and 4. Demographic and risk factors will be included to enable data analysis that will reveal overall achievement of outcomes and whether or not there are changes over time in health disparities among youth reached by providers trained through Center.

Case Review and Assessment for Youth Placed Out of County: To assess the effectiveness of the Client Care Coordinator for the Center, who will provide temporary case management and services coordination for youth placed out of county, the evaluation team will (annually) review case files and make determinations regarding outcomes for each, considering the youth outcomes described above as well as outcomes that are specific to the Client Care Coordinator role (such as client placement and post-placement stability outcomes).

Post-Group Participation Survey: To assess outcomes of the psycho-educational groups on topics related to trauma and recovery from trauma that will be provided to children, youth, and families, the evaluation team will develop a post-group participation survey. The survey will be

administered to participants immediately following a single group session or series of groups, as appropriate given the topic(s) and intended length of participation in the group(s). The survey will assess increases in knowledge of trauma-related topics and trauma-recovery skills among participants; increased access to resources; and increased perceptions of social support in managing experiences of trauma and the recovery process.

<u>Reporting:</u> The third-party evaluation team will work with Project Leads to prepare six- and 12-month progress reports according to the grant requirements. As process and outcomes evaluation data become available, key results will be highlighted in progress reports.

The LFA evaluation team also will prepare an annual evaluation report summarizing all key findings to date, including recommendations for program improvement and implications for infrastructure and policy development to support service quality and effectiveness.

A. Personnel:

FEDERAL REQUEST

Position	Name	Annual Salary Rate	Level of Effort	Cost
Project Director (2593)	To be hired	$ 108,576	100%	$ 108,576
Evaluator Psychologist (2574)	Briana Loomis	$ 107,328	25%	$ 26,832
TOTAL				**$ 135,408**

JUSTIFICATION:
The Project Director will manage and organize the Bay Area Trauma Informed System of Care (BATISC) including activities related to the coordination of BATISC regional collaboration among member California counties, cross-training, disparity reduction, communication, and sustainability.

The Evaluator Psychologist will help coordinate the efforts of Learning for Action (LFA), the evaluation contractor, conduct analyses on collected data, and support the dissemination of findings.

NON-FEDERAL MATCH

Position	Name	Annual Salary Rate	Level of Effort	Cost
Principal Investigator	Kenneth Epstein	$ 154,544	15%	$ 23,182
Grants Administrator	Jana Rickerson	$ 94,078	10%	$ 9,408
Accountant IV	Miguel Quinonez	$ 109,678	10%	$ 10,968
Accountant III	Christina Zhou	$ 90,230	20%	$ 18,046
Principal Admin Analyst II	Shirley Giang	$ 124,779	10%	$ 12,478
Senior Admin Analyst	Judy Perillo	$ 98,488	10%	$ 9,849
Manager II	Nelson Jim	$ 121,514	10%	$ 12,151
Health Care Analyst	To be designated	$ 85,905	10%	$ 8,590
Evaluation Consultant	Deborah Sherwood	$ 126,630	5%	$ 6,332
Foster Care Consultant	Lynn Dolce	$ 102,877	10%	$ 10,288
County Partners				
Children MH Director	identified at County partner	$ 154,544	3% x 6 positions	$ 27,818
Health Care Analyst	identified at County partner	$ 85,905	4% x 6 positions	$ 20,617
Placement Coordinator	identified at County partner	$ 90,230	4% x 6 positions	$ 21,655
CLC Coordinator	identified at County partner	$ 121,514	4% x 6 positions	$ 29,163
TOTAL				**$ 220,545**

JUSTIFICATION: The Principal Investigator will provide leadership and administrative oversight to the initiative. The Principal Investigator will oversee fiscal accountability, progress toward grant goals, and facilitate collaboration between regional county partners. The Grants Administrator will receive and ensure that all official communications from SAMHSA are addressed in a timely manner, as well as sign and provide oversight of official grants reports and documentation to SAMHSA. The team of Fiscal and Budget department staff, including senior

and junior accountants, a budget manager, and budget analyst are required to ensure the effective use of fiscal resources and achievement of fiscal sustainability in collaboration with grant leadership, staff, and contractors to meet fiscal goals and support planning. The Manager II/CLC Coordinator will ensure that the initiative's efforts are inclusive, responsive, and characterized by cultural humility and will work collaboratively with the CLC Coordinators identified by each county (see below). The Health Care Analyst will work collaboratively with LFA, Evaluation Contractor, to provide needed data and support. The Evaluation Consultant will participate in and help to guide the progress of evaluation efforts. The Foster Care Consultant will participate in and help guide BATISC activities involving foster youth. Each of the six BATISC partnering counties will identify staff who hold the following roles and responsibilities: The Children's Mental Health Director will participate in regular planning and implementation activities and will hold responsibility for ensuring progress toward initiative goals within their own counties. The Health Care Analyst will assist with data collection and management at the county level. The Placement Coordinator will hold responsibility for overseeing out-of-county placement of foster care children and work collaboratively with BATISC staff and regional county Placement Coordinators to improve placement stability and the quality of care provided to out-of-county foster care children. The CLC Coordinator will ensure that the BATISC efforts are inclusive, responsive, and characterized by cultural humility and will work collaboratively with the regional county CLC Coordinators.

B. Fringe Benefits:

FEDERAL REQUEST

Component	**Rate**	**Wage**	**Cost**
Retirement	22.9%	$ 135,408	$ 31,008
Social Security	6.1%	$ 135,408	$ 8,260
Health & Dental	12.0%	$ 135,408	$ 16,249
Unemployment Insurance	0.25%	$ 135,408	$ 339
Other Benefits	0.75%	$ 135,408	$ 1,016
TOTAL	**42.0%**		**$ 56,872**

NON-FEDERAL MATCH

Component	Rate	Wage	Cost
Retirement	22.9%	$ 220,545	$ 50,505
Social Security	6.1%	$ 220,545	$ 13,453
Health & Dental	12.0%	$ 220,545	$ 26,465
Unemployment Insurance	0.25%	$ 220,545	$ 551
Other Benefits	0.75%	$ 220,545	$ 1,654
TOTAL	**42.0%**		**$ 92,628**

JUSTIFICATION: The total fringe benefit rate is 42% which is the standard rate for the City and County of San Francisco.

C. Travel:
FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
SOC Training	Washington, D.C.	Airfare	$520/flight x 3 persons	$ 1,560
		Hotel	$258/night x 5 nights x 3 persons	$ 3,870
		Per Diem	$71/day x 3 persons x 4 days; $53.25 x 3 persons x 2 (first and last day)	$ 1,172
		Registration	$895/person x 3	$ 2,685
		Local Transport	$50 x 3 persons	$ 150
Local Travel		Mileage	250 miles/ month x 12 months @ .56/mile x 3 persons	$ 5,040
			TOTAL	**$ 14,477**

JUSTIFICATION: Cost of three BATISC grant members to attend a grantee meeting in Washington, D.C. Local travel is needed to support monthly travel of three staff to work with BATISC partners on planning, development and implementation activities. Local travel between the participating counties is expected to average 250 miles per month, and staff will be reimbursed through grant funds at the CCSF rate of 0.56 per mile which is commensurate with the IRS approved mileage reimbursement rate. Public transportation fees will be reimbursed where applicable and appropriate in lieu of mileage.

NON-FEDERAL MATCH

Purpose of Travel	Location	Item	Rate	Cost
Local Travel (county partners)		Mileage	250 miles/ month x 12 months @ .56/mile x 12 persons	$ 20,160
			TOTAL	**$ 20,160**

JUSTIFICATION: Local travel is needed to support monthly travel of three staff to work with BATISC partners on planning, development and implementation activities. Local travel between the participating counties is expected to average 250 miles per month, and staff will be reimbursed at the CCSF rate of 0.56 per mile which is commensurate with the IRS approved mileage reimbursement rate. Public transportation fees will be reimbursed where applicable and appropriate in lieu of mileage.

D. Equipment: None requested
FEDERAL REQUEST: $0
NON-FEDERAL MATCH: $0

E. Supplies:
FEDERAL REQUEST

Item(s)	Rate	Cost
Collaboration Technology	$ 828.00	$ 828
Printing	($3/brochure x 700) + ($6/poster x 350) ($.10/copy x 700)	$ 4,270
Laptops	$900/laptop x 2	$ 1,800
Mobile Projector	$900/ project	$ 900
	TOTAL	**$ 7,798**

JUSTIFICATION: Collaboration technology will improve the ability of regional county partners and programs across the broad geographic area of the Bay Area, to provide training webinars at the broader community and provider level and to allow for coordination with the regional and national sources of support. Printing of educational and social marketing materials, as well as resource and training materials, will support BATISC collaborative efforts, training, youth and family engagement, and the dissemination of information and results throughout the BATISC region. The laptops are needed to for both project work and presentations in support of the need for staff to work remotely across BATISC counties. The projector is needed for presentations, trainings, and outreach activities.

F. Contract:
FEDERAL REQUEST

Name	Service	Rate	Other	Cost
BATISC Center	Development and management of regional TIS Center	Detailed contract budget to be provided in six months		$ 425,568
	County level data and collection management staffing	Detailed contract budget to be provided in six months		$ 25,632
	Center Staff and County representatives travel so SOC Conference	Detailed contract budget to be provided in six months		$ 43,408

Learning for Action	Development and implementation of evaluation plan including project start up, GPRA baseline data collection, baseline providers and systems change interviews, data analysis, reporting, and evaluation project management.	Evaluation Director 219 hours @ $160/hour, Evaluation Manager 373 hours @ $135/hour, Research Associate 422 hours @ $90/hour, Project Assistant 293 hours @$75/hour	Mileage $1,250, Telephone $500, Printing $150, Report Production $750, GPRA Survey Incentives (400 respondents@$5) $2,000	$ 150,000
SF Public Health Foundation	Development of a strategic financing plan to bring the SOC framework to scale and sustainability in region; development of a social marketing plan; recruitment and engagement of SOC partners outside behavioral health leaders in BATISC; development of a regional training and technical assistance plan; development of a compliance plan across region for meeting CLAS standards; development of a form to capture regional partner match for federal funding requirement; and development of inventory of current practices and initiatives in the seven BATISC counties; and development of an interim work plan for grant planning and implementation activities.	Interim Project Coordinator: $100,906 *.5 (6 mos) + 28.2% fringes Incentives: 25 participants x 4 meetings @ $50/participant Travel: 2 meeting x 10 persons @ $2,000/person Meetings: 10 meetings x $500	11% Indirect Cost	$ 127,296
			TOTAL	**$ 771,904**

JUSTIFICATION: BATISC Center will support the creation of a regional infrastructure that recognizes and responds to trauma in a culturally and linguistically competent, family-driven, youth-guided and evidence-based manner. The BATISC Center contractor will be procured via a competitive bid process before a final selection is made. Once procured, the BAITSC Center will identify staff and host meetings with BATISC regional collaborative members, consumers and other key stakeholders and create initial cross-systems tools and training curriculum plans.

Learning for Action will develop and conduct the BATISC grant evaluation.

SF Public Health Foundation will be contracted to support an interim project director to assist in grant start-up and planning activities while a BATISC Project Director is hired into an SFDPH civil service position.

NON FEDERAL MATCH (Years 1, 2, and 3): $0 (matching requirement met through other categories).

NON FEDERAL MATCH (Year 4):

Name	Service	Rate	Other	Cost
HR360 - FI	Kaytie Speciale - CYF Care Management	Salary and Fringe Benefits $113,743 x 74%		$ 84,170
HR360 - FI	MH Triage - New Mobile Crisis Teams	35% of $1,011,460		$ 354,102
IFR	MH Triage - Mission Connect	30% $432,000		$ 129,600
Seneca	Stephanie Romney - Parenting Training Institute	Salary and Fringe Benefits $115,591 x 5%		$ 5,780
UC Child Trauma	Strategic counsel to the BATISC initiative	Salary and Fringe Benefits $13,628	Supplies & Other Operating Expenses $380. Indirect Cost $1,681	$ 15,689
UC Child Adolescent Services	Consultation services to the BATISC initiative	Salary and Fringe Benefits $26,138	Supplies & Other Operating Expenses $648 Indirect Cost $3,214	$ 30,000
			TOTAL	**$ 619,341**

JUSTIFICATION: In Year 4, HealthRight360, the SFPDH Fiscal Intermediary, will donate staff time to provide care management support for the BATISC initiative. New Mobile Crisis Teams will designate a portion of their time for mental health triage services in support of BATISC consumers. The Parent Training Institute Director will designate a portion of time to support evidence-based parent skill building classes for families impacted by trauma. The UCSF Child Trauma Research Program will donate a portion of the Director's time to provide strategic counsel to the BATISC initiative. The UCSF Child & Adolescent Psychiatry Services will donate consultation services to the BATISC initiative.

G. Construction: Not allowed

H. Other: None requested

FEDERAL REQUEST $0
NON-FEDERAL MATCH $0

Indirect Cost Rate:
FEDERAL REQUEST

10% of salaries: $ **13,541**

JUSTIFICATION: The indirect cost rate is 10% of salaries. CCSF Department of Public Health will begin the process of negotiating a federal indirect cost rate for all grants.

BUDGET SUMMARY

FEDERAL REQUEST

Category	Year 1	Year 2	Year 3	Year 4
Personnel	$ 135,408	$ 135,408	$ 135,408	$ 135,408
Fringe Benefits	$ 56,872	$ 56,872	$ 56,872	$ 56,872
Travel	$ 14,477	$ 14,477	$ 14,477	$ 14,477
Equipment	$ -	$ -	$ -	$ -
Supplies	$ 7,798	$ 7,798	$ 7,798	$ 7,798
Contract	$ 771,904	$ 771,904	$ 771,904	$ 771,904
Construction (Not Allowed)	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -
Total Direct Charges	**$ 986,459**	**$ 986,459**	**$ 986,459**	**$ 986,459**
Indirect Charges	$ 13,541	$ 13,541	$ 13,541	$ 13,541
Total Project Costs	**$ 1,000,000**	**$ 1,000,000**	**$ 1,000,000**	**$ 1,000,000**

NON FEDERAL MATCH

Category	Year 1	Year 2	Year 3	Year 4
Personnel	$ 220,545	$ 220,545	$ 220,545	$ 253,872
Fringe Benefits	$ 92,628	$ 92,628	$ 92,628	$ 106,627
Travel	$ 20,160	$ 20,160	$ 20,160	$ 20,160
Equipment	$ -	$ -	$ -	$ -
Supplies	$ -	$ -	$ -	$ -
Contract	$ -	$ -	$ -	$ 619,341
Construction (Not Allowed)	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -
Total Direct Charges	**$ 333,333**	**$ 333,333**	**$ 333,333**	**$ 1,000,000**
Indirect Charges	$ -	$ -	$ -	$ -
Total Project Costs	**$ 333,333**	**$ 333,333**	**$ 333,333**	**$ 1,000,000**

DATA COLLECTION & PERFORMANCE MEASUREMENT				
Category	Year 1	Year 2	Year 3	Year 4
Personnel	$ 13,416	$ 13,416	$ 13,416	$ 13,416
Fringe Benefits	$ 5,635	$ 5,635	$ 5,635	$ 5,635
Travel	$ -	$ -	$ -	$ -
Equipment	$ -	$ -	$ -	$ -
Supplies	$ -	$ -	$ -	$ -
Contract	$ 175,632	$ 175,632	$ 175,632	$ 175,632
Construction (Not Allowed)	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -
Total Direct Charges	**$ 194,683**	**$ 194,683**	**$ 194,683**	**$ 194,683**
Indirect Charges	$ 1,342	$ 1,342	$ 1,342	$ 1,342
Total Project Costs	$ 196,024	$ 196,024	$ 196,024	$ 196,024
	20%	20%	20%	20%