File No. 150249 Committee Item No. 12
Board Item No. 11

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Sub-Committee **Date** March 25, 2015

Board of Supervisors Meeting **Date** March 31, 2015

Cmte	Board	
☐	☐	Motion
☒	☒	Resolution
☐	☐	Ordinance
☐	☐	Legislative Digest
☐	☐	Budget and Legislative Analyst Report
☐	☐	Youth Commission Report
☒	☒	Introduction Form
☒	☒	Department/Agency Cover Letter and/or Report
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☐	☐	Contract/Agreement
☒	☒	Form 126 – Ethics Commission
☒	☒	Award Letter
☐	☐	Application
☐	☐	Public Correspondence

OTHER **(Use back side if additional space is needed)**

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Completed by: Linda Wong **Date** March 20, 2015
Completed by: L.W. **Date** March 26, 2015

FILE NO. 150249 RESOLUTION NO.

[Accept and Expend Grant - Mentoring and Peer Support Project - $348,142]

Resolution retroactively authorizing the Department of Public Health to accept and expend a grant in the amount of $348,142 from Substance Abuse and Mental Health Services Administration to participate in a program entitled, "Mentoring and Peer Support Project," for the period of September 30, 2014, through September 29, 2015, waiving indirect costs.

WHEREAS, Substance Abuse and Mental Health Services Administration has agreed to fund Department of Public Health (DPH) in the amount of $348,142 for the period of September 30, 2014, through September 29, 2015; and

WHEREAS, The full project period of the grant starts on September 30, 2014, and ends on September 29, 2018, with years two, three, and four subject to availability of funds and satisfactory progress of the project; and

WHEREAS, As a condition of receiving the grant funds, Substance Abuse and Mental Health Services Administration requires the City to enter into an agreement (Agreement), a copy of which is on file with the Clerk of the Board of Supervisors in File No. 150249; which is hereby declared to be a part of this Resolution as if set forth fully herein; and

WHEREAS, The purpose of this project is to significantly enhance behavioral health and wellness outcomes while reducing criminal justice recidivism among recently released men and women under court jurisdiction who have diagnoses of both substance use and severe and persistent mental illness; and

WHEREAS, Through the proposed Mentoring and Peer Support Project, San Francisco Jail Health Services will explore the effectiveness of an ambitious peer support intervention

which has the potential to serve as a national model for enhancing the quality and impact of collaborative court services by supporting criminally-involved men and women with co-occurring disorders as they cope with behavioral health issues and strive to attain stability and self-sufficiency in their lives; and

WHEREAS, An Annual Salary Ordinance amendment is not required as the grant partially reimburses DPH for one existing position, one Epidemiologist II (Job Class No. 2803) at .38 FTE for the period of September 30, 2014, through September 29, 2015; and

WHEREAS, A request for retroactive approval is being sought because DPH did not receive notification of the revised award until February 2, 2015, for a project start date of September 30, 2014; and

WHEREAS, Mentoring and Peer Support Project Grant does not contain indirect costs because Substance Abuse and Mental Health Services Administration prohibits including indirect costs in the budget; and

WHEREAS, The grant terms prohibit including indirect costs in the grant budget; now, therefore, be it

RESOLVED, That DPH is hereby authorized to retroactively accept and expend a grant in the amount of $348,142 from Substance Abuse and Mental Health Services Administration; and

FURTHER RESOLVED, That the Board of Supervisors hereby waives inclusion of indirect costs in the grant budget; and, be it

FURTHER RESOLVED, That DPH is hereby authorized to retroactively accept and expend the grant funds pursuant to Administrative Code, Section 10.170-1; and, be it

FURTHER RESOLVED, That the Director of Health is authorized to enter into the Agreement on behalf of the City.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

APPROVED:

Office of the Mayor

for Office of the Controller

City and County of San F ncisco **D partment of Public Health**

Edwin M. Lee
Mayor

Barbara A. Garcia, MPA
Director of Health

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

FROM: **Barbara A. Garcia, MPA**
Director of Health

DATE: **February 4, 2015**

SUBJECT: **Grant Accept and Expend**

GRANT TITLE: **Mentoring and Peer Support (MAPS) Project - $348,142**

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

☒ Proposed grant resolution, original signed by Department

☒ Grant information form, including disability checklist -

☒ Budget and Budget Justification

☒ Grant application

☒ Agreement / Award Letter

☐ Other (Explain):

Special Timeline Requirements:

Departmental representative to receive a copy of the adopted resolution:

Name: Richelle-Lynn Mojica Phone: 255-3555

Interoffice Mail Address: Dept. of Public Health, Grants Administration for Community Programs, 1380 Howard St.

Certified copy required Yes ☐ No ☒

File Number: _____
(Provided by Clerk of Board of Supervisors)

Grant Resolution Information Form
(Effective July 2011)

Purpose: Accompanies proposed Board of Supervisors resolutions authorizing a Department to accept and expend grant funds.

The following describes the grant referred to in the accompanying resolution:

1. Grant Title: **Mentoring and Peer Support (MAPS) Project**

2. Department: **Department of Public Health, Behavioral Health Services**

3. Contact Person: **Jana Rickerson** Telephone: **(415) 255-3940**

4. Grant Approval Status (check one):

[X] Approved by funding agency [ ] Not yet approved

5. Amount of Grant Funding Approved or Applied for: **$1,392,568 in the 4-year project period (Year 1 = $348,142; Year 2 = $348,142; Year 3 = $348,142; Year 4 = $348,142)**

6a. Matching Funds Required: **No**
b. Source(s) of matching funds (if applicable): **N/A**

7a. Grant Source Agency: **Substance Abuse and Mental Health Services Administration (SAMHSA)**
b. Grant Pass-Through Agency (if applicable):

8. Proposed Grant Project Summary:
San Francisco Jail Health Services - a program of the San Francisco Department of Public Health Community Behavioral Health Section - in close collaboration with the San Francisco Collaborative Courts, San Francisco Peer Programs, HealthRIGHT 360, and the San Francisco Veterans Administration Medical Center - proposes to implement the Mentoring and Peer Support (MAPS) Project, an ambitious peer support program designed to significantly enhance behavioral health and wellness outcomes while reducing criminal justice recidivism among recently released men and women under court jurisdiction who have diagnoses of both substance use and severe and persistent mental illness. Through the proposed MAPS Project, San Francisco Jail Health Services will explore the effectiveness of an ambitious peer support intervention which has the potential to serve as a national model for enhancing the quality and impact of collaborative court services by supporting criminally-involved men and women with co-occurring disorders as they cope with behavioral health issues and strive to attain stability and self-sufficiency in their lives.

9. Grant Project Schedule, as allowed in approval documents, or as proposed:

Approved Year 1 Project	**Start-Date: 09/30/2014**	**End-Date: 09/29/2015**
Full Period Project	**Start-Date: 09/30/2014**	**End-Date: 09/29/2018**

10a. Amount budgeted for contractual services: **$289,649 in Year 1**
$1,163,996 in the 4-year project period

b. Will contractual services be put out to bid? **No.**

c. If so, will contract services help to further the goals of the Department's Local Business Enterprise (LBE) requirements?

d. Is this likely to be a one-time or ongoing request for contracting out? **Ongoing.**

11a. Does the budget include indirect costs? [ ] Yes [X] No

b1. If yes, how much? $
b2. How was the amount calculated?

c1. If no, why are indirect costs not included?
[X] Not allowed by granting agency [ ] To maximize use of grant funds on direct services
[ ] Other (please explain):

c2. If no indirect costs are included, what would have been the indirect costs? **10% ($34,814) per year.**

12. Any other significant grant requirements or comments:
We respectfully request for approval to accept and expend these funds retroactive to September 30, 2014. The Department received the revised award on February 2, 2015.

GRANT CODE (Please include Grant Code and Detail in FAMIS): HMAD-05

****Disability Access Checklist*****(Department must forward a copy of all completed Grant Information Forms to the Mayor's Office of Disability)**

13. This Grant is intended for activities at (check all that apply):

[X] Existing Site(s) [ ] Existing Structure(s) [ ] Existing Program(s) or Service(s)
[ ] Rehabilitated Site(s) [ ] Rehabilitated Structure(s) [ ] New Program(s) or Service(s)
[ ] New Site(s) [ ] New Structure(s)

14. The Departmental ADA Coordinator or the Mayor's Office on Disability have reviewed the proposal and concluded that the project as proposed will be in compliance with the Americans with Disabilities Act and all other Federal, State and local disability rights laws and regulations and will allow the full inclusion of persons with disabilities. These requirements include, but are not limited to:

1. Having staff trained in how to provide reasonable modifications in policies, practices and procedures;
2. Having auxiliary aids and services available in a timely manner in order to ensure communication access;
3. Ensuring that any service areas and related facilities open to the public are architecturally accessible and have been inspected and approved by the DPW Access Compliance Officer or the Mayor's Office on Disability Compliance Officers.

If such access would be technically infeasible, this is described in the comments section below:

Comments:

Departmental ADA Coordinator or Mayor's Office of Disability Reviewer:

Ron Weigelt
(Name)

Director of Human Resources and Interim Director, EEO, and Cultural Competency Programs
(Title)

Date Reviewed: 2-9-15 Darlene C. Daeun
(Signature Required)

Department Head or Designee Approval of Grant Information Form:

Barbara A. Garcia, MPA
(Name)

Director of Health
(Title)

Date Reviewed: 2/11/15
(Signature Required)

SAN FRANCISCO DEPARTMENT OF HEALTH SERVICES

SAMHSA GRANTS TO DEVELOP AND EXPAND BEHAVIORAL HEALTH TREATMENT COURT COLLABORATIVES
BUDGET JUSTIFICATION, EXISTING RESOURCES, AND OTHER SUPPORT

A1. PERSONNEL – Civil Service

Position	Name	Annual Salary/ Rate	Level of Effort	Number of Months	Cost
Epidemiologist II (2803)	Charles Simons	$102,440	38%	11	$ 35,386
Project Director	Jana Rickerson	In-Kind	5%	12	$ -
TOTAL					**$ 35,386**

1) The Evaluation and Data Collection allocation supports costs for essential program data collection, evaluation design, and data analysis and reporting functions through the San Francisco Community Behavioral Health Services Office of Quality Management, including collection of 6-months post-discharge GPRA data. A precise budget for this portion will be developed after the Project Workgroup determines the precise parameters, indicators, and data measures to be used to assess the MAPS program.

A2. PERSONNEL - Contract

Position	Name	Annual Salary/ Rate	Level of Effort	Number of Months	Cost
Project Manager	Angelica Almeida	$ 93,000	10%	12	$ 9,300
Project Coordinator	To be named	68,000	100%	11	$ 62,333
Lead Peer Mentor	To be named	45,000	100%	11	$ 41,250
Peer Mentors (5 @ 50%)	To be named	31,200	250%	9	$ 58,500
TOTAL					**$ 171,383**

Justification:

1) The Project Manager will have responsibility for overarching design, implementation, and monitoring of the program
2) The Project Coordinator will provide day-to-day oversight, management, planning, and reporting services for the program and will hire, train, and support Peer Mentors
3) The Lead Peer Mentor will provide support to assigned collaborative court clients while providing peer based support and assistance to the mentor team
4) Peer Mentors will provide support to assigned collaborative court clients using evidence-based and informal interventions

B. FRINGE BENEFITS

Component	Rate	Wage	Cost
Retirement	9.90%	$171,383.00	$ 16,966.92
Social Security	6.10%	$171,383.00	$ 10,454.36

Health & Dental	12.00%	$171,383.00	$ 20,565.96
Unemployment Ins	0.25%	$171,383.00	$ 428.46
Other Benefits	0.75%	$171,383.00	$ 1,285.37
	29%	Subtotal Contractor FB	$ 49,701
	47%	Subtotal Civil Service FB	$ 16,631
		TOTAL FRINGE BENEFITS:	**$ 66,332**

Justification:
Fringe levels above reflect current rates for the San Francisco Jail Health Services

B. TRAVEL

Civil Service Travel:

Purpose of Travel	Location	Item	Rate	Cost
One Grantee Conference	Albany, NY.	Airfare	$1,254/person x 2 persons	$ 2,508
		Hotel	$200/night x 3 nights x 2 persons	$ 1,200
		Per Diem	$71/day x 2 persons x 4 days	$ 568
		Local Transport	$200 x 2 persons	$ 400
			Subtotal Civil Service	**$ 4,676**

Contractor Travel:

Purpose of Travel	Location	Item	Rate	Cost
One Grantee Conference	Albany, NY.	Airfare	$1,254/person x 3 persons	$ 3,762
		Hotel	$200/night x 3 nights x 3 persons	$ 1,800
		Per Diem	$71/day x 3 persons x 4 days	$ 852
		Local Transport	$200 x 3 persons	$ 600
Local Travel	San Francisco, CA	Mileage	100 miles x $.565/mile x 12 months	$ 1,017
		Bus & Taxi Vouchers for Peer Mentors	Avg. $250/month x 8 months	$ 2,000
			Subtotal Contract	**$ 10,031**

Total Travel: $14,707

Justification:

Travel cost allocations are for required travel to the annual grantee conferences in Albany, NY. Travel expense estimates are based on actual average cost for Departmental travel in 2013.

D. EQUIPMENT - None

E. SUPPLIES

Item(s)	Rate	Cost
1 Laptop Computer with Printer	$1,800	$1,800
	TOTAL	**$1,800**

Justification:

1) The laptop and printer are for use by the new Project Coordinator and Lead Mentor - Yr. 1 Only

F. CONSULTANTS & CONTRACTS

Name	Service	Rate	Other	Cost
HealthRIGHT/360	Indirect Expenses	12%		$ 31,034
SF Collaborative Courts	Cross-Court Database Development			$ 22,500
			TOTAL	**$53,534**

Justification:

1. HealthRIGHT/360 12% Indirect
2. Collaborative Court costs are to support modifications of data tracking systems at all three participating courts to allow data sharing following HIPPA guidelines.

G. CONSTRUCTION - None

H. OTHER

Item	Rate	Cost
Evidence-Based Practice Licensing and Training Costs Pool		$ 5,000
	TOTAL	**$ 5,000**

Justification:

The Evidence-Based Cost Pool is a year 1 expense only to support the cost of licensing interventions and subsidizing EBR trainings for Peer Mentor staff.

I. INDIRECT CHARGES - $0

a. Start Date	10/1/2014	b. End Date:	9/30/2018

BUDGET SUMMARY

Category	Year 1	Year 2	Year 3	Year 4	Total Project Cost
Personnel	$35,386	$35,386	$35,386	$35,386	**$141,544**
Fringe	$16,631	$16,631	$16,631	$16,631	**$66,524**
Travel	$4,676	$4,676	$4,676	$4,676	**$18,704**
Supplies	$1,800	$0	$0	$0	**$1,800**
Contractual	$289,649	$291,449	$291,449	$291,449	**$1,163,996**
Total Direct Charges	**$348,142**	**$348,142**	**$348,142**	**$348,142**	**$1,392,568**
Indirect Charges	**$0**	**$0**	**$0**	**$0**	**$0**
Total Project Costs	**$348,142**	**$348,142**	**$348,142**	**$348,142**	**$1,392,568**

Notice of Award

Adult Treatment Court Collaborative **Issue Date:** 02/02/2015
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Grant Number: 1H79SM061694-01 REVISED
FAIN: SM061694

Program Director:
Jana Rickerson

Project Title: Mentoring and Peer Support (MAPS) Project

Grantee Address	Business Address
SAN FRANCISCO DEPT OF PUBLIC HEALTH Jana Rickerson 1380 Howard Street 4th Floor San Francisco, CA 941032651	Barbara Garcia Director of Health San Francisco Department of Public Health 101 Grove Street 3rd Floor San Francisco, CA 94102

Budget Period: 09/30/2014 – 09/29/2015
Project Period: 09/30/2014 – 09/29/2018

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby revises this award (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to SAN FRANCISCO DEPT OF PUBLIC HEALTH in support of the above referenced project. This award is pursuant to the authority of Section 509 and 520A of the PHS Act, as amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Darrell Russ
Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1H79SM061694-01 REVISED

Award Calculation (U.S. Dollars)	
Salaries and Wages	$35,386
Fringe Benefits	$16,631
Personnel Costs (Subtotal)	$52,017
Supplies	$1,800
Consortium/Contractual Cost	$289,649
Travel Costs	$4,676
Direct Cost	$348,142
Approved Budget	$348,142
Federal Share	$348,142
Cumulative Prior Awards for this Budget Period	$348,142
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$0

SUMMARY TOTALS FOR ALL YEARS	
YR	**AMOUNT**
1	$348,142
2	$348,142
3	$348,142
4	$348,142

*Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number:	93.243
EIN:	1946000417A8
Document Number:	14SM61694A
Fiscal Year:	2014

IC	CAN	Amount
SM	C96C524	$174,071
TI	C96T512	$174,071

IC	CAN	2014	2015	2016	2017
SM	C96C524	$174,071	$348,142	$348,142	$348,142
TI	C96T512	$174,071			

SM Administrative Data:
PCC: BHTCC / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1H79SM061694-01 REVISED

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-

800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1H79SM061694-01 REVISED

This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Award.
b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The HHS Grants Policy Statement.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – SM Special Terms and Conditions – 1H79SM061694-01 REVISED

Remarks:

This award is revised to correct the budget totals for the revised budget dated January 12, 2015. This is to correct and administrative error.

ALL PREVIOUS TERMS AND CONDITIONS REMAIN IN EFFECT UNTIL SPECIFICALLY APPROVED AND REMOVED BY THE GRANTS MANAGEMENT OFFICER.

CONTACTS:

Roxanne Castaneda, Program Official
Phone: (240) 276-1917 **Email:** Roxanne.Castaneda@samhsa.hhs.gov

Darrell Russ, Grants Specialist
Phone: (240) 276-1517 **Email:** darrell.russ@samhsa.hhs.gov

Notice of Award

Adult Treatment Court Collaborative **Issue Date:** 09/23/2014
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Grant Number: 1H79SM061694-01
FAIN: SM061694

Program Director:
Jana Rickerson

Project Title: Mentoring and Peer Support (MAPS) Project

Grantee Address	Business Address
SAN FRANCISCO DEPT OF PUBLIC HEALTH Jana Rickerson 1380 Howard Street 4th Floor San Francisco, CA 941032651	Barbara Garcia Director of Health San Francisco Department of Public Health 101 Grove Street 3rd Floor San Francisco, CA 94102

Budget Period: 09/30/2014 – 09/29/2015
Project Period: 09/30/2014 – 09/29/2018

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $348,142 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to SAN FRANCISCO DEPT OF PUBLIC HEALTH in support of the above referenced project. This award is pursuant to the authority of Section 509 and 520A of the PHS Act, as amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Gwendolyn Simpson
Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1H79SM061694-01

Award Calculation (U.S. Dollars)	
Salaries and Wages	$165,667
Fringe Benefits	$48,043
Personnel Costs (Subtotal)	$213,710
Supplies	$3,600
Consortium/Contractual Cost	$82,500
Travel Costs	$8,617
Other	$19,835
Direct Cost	$328,262
Indirect Cost	$19,880
Approved Budget	$348,142
Federal Share	$348,142
Cumulative Prior Awards for this Budget Period	$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$348,142

SUMMARY TOTALS FOR ALL YEARS	
YR	AMOUNT
1	$348,142
2	$348,142
3	$348,142
4	$348,142

*Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number:	93.243
EIN:	1946000417A8
Document Number:	14SM61694A
Fiscal Year:	2014

IC	CAN	Amount
SM	C96C524	$174,071
TI	C96T512	$174,071

IC	CAN	2014	2015	2016	2017
SM	C96C524	$174,071	$348,142	$348,142	$348,142
TI	C96T512	$174,071			

SM Administrative Data:
PCC: BHTCC / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1H79SM061694-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1H79SM061694-01

This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Award.
b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The HHS Grants Policy Statement.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – SM Special Terms and Conditions – 1H79SM061694-01

REMARKS:

This award reflects approval of the budget submitted on April 18, 2014 as part of the application.

SPECIAL TERM(S) OF AWARD:

NONE

SPECIAL CONDITION(S) OF AWARD:

1. Disparities Impact Statement (DIS)

By November 30, 2014, you must:

Submit an electronic copy of a disparity impact statement to the Government Project Officer (GPO) and Grants Management Specialist (GMS) as identified under Contacts on this notice of award. The disparity impact statement should be consistent with information in your application regarding access, *service use and outcomes for the program and include three components as described below. Questions about the disparity impact statement should be directed to your GPO. Examples of disparity impact statements can be found on the SAMHSA website at http://beta.samhsa.gov/grants/grants-management/disparity-impact-statement.

*Service use is inclusive of treatment services, prevention services as well as outreach, engagement, training and/or technical assistance activities.

The disparity impact statement, in response to the Special Condition of Award, consists of three components:

1. Proposed number of individuals to be served by subpopulations in the grant implementation area should be provided in a table that covers the entire grant period. The disparate population(s) should be identified in a narrative that includes a description of the population and rationale for how the determination was made.

2. A quality improvement plan for how you will use your program (GPRA) data on access, use and outcomes to monitor and manage program outcomes by race, ethnicity and LGBT status, when possible. The quality improvement plan should include strategies for how processes and/or programmatic adjustments will support efforts to reduce disparities for the identified sub-populations.

3. The quality improvement plan should include methods for the development and implementation of policies and procedures to ensure adherence to the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards and the provision of effective care and services that are responsive to:

a. Diverse cultural health beliefs and practices;

b. Preferred languages; and

c. Health literacy and other communication needs of all sub-populations within the proposed geographic region.

Failure to comply with the above stated Special Conditions by the identified submission date may result in your grant being placed on high risk, suspension and/or termination or denial of funding in the future.

STANDARD TERMS OF AWARD:

Refer to the following SAMHSA website for Standard Terms of Award:
http://beta.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions **(NEW)**

Key staff (or key staff positions, if staff has not been selected) are listed below:

Project Director, Janna Rickerson @ 5% (in-kind)

REPORTING REQUIREMENTS:

Submission of a Programmatic Annual Report is due no later than 90 days after the end of each budget year.

Failure to comply with the above stated terms and conditions may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

All responses to special terms and conditions of award and post award requests may be electronically mailed to the Grants Management Specialist and to the Government Program Official as identified on your Notice of Award.

It is essential that the Grant Number be included in the SUBJECT line of the email.

CONTACTS:

Roxanne Castaneda, Program Official
Phone: (240) 276-1917 **Email:** Roxanne.Castaneda@samhsa.hhs.gov

Darrell Russ, Grants Specialist
Phone: (240) 276-1517 **Email:** darrell.russ@samhsa.hhs.gov

San Francisco Department of Public Health Jail Health Services

The Mentoring and Peer Support (MAPS) Project:
An Application for SAMHSA 2014 Grants to Develop and Expand
Behavioral Health Treatment Court Collaboratives

Project Abstract

San Francisco Jail Health Services - a program of the San Francisco Department of Public Health Community Behavioral Health Section - in close collaboration with the San Francisco Collaborative Courts, San Francisco Peer Programs, HealthRIGHT 360, and the San Francisco Veterans Administration Medical Center - proposes to implement the Mentoring and Peer Support (MAPS) Project, an ambitious peer support program designed to significantly enhance behavioral health and wellness outcomes while reducing criminal justice recidivism among recently released men and women under Court jurisdiction who have diagnoses of both substance use and severe and persistent mental illness. The program will collaborate with and draw clients from three distinct courts that are part of the Collaborative Courts system - the Behavioral Health Court, the Drug Court, and the Veterans Justice Court. MAPS will employ, train, and support a diverse peer team consisting of 1 full-time Lead Peer Mentor and 5 half-time Peer Mentors who will utilize evidence-based practices to encourage, support, and foster treatment success and recidivism reduction among the members of its target population. The mentor team will be supervised and supported by a full-time MSW Level Project Coordinator who will provide ongoing mentor support and ensure that mentors are accessing and utilizing Supported Employment resources, including job training and ongoing mental health counseling. Each peer mentor will be teamed with an average of 6 collaborative court clients at a time, with an average length of support of 6 months per client, although the relationship could last as long as 12-18 months if the client is continuing to adhere to court-mandated treatment and substance use requirements. The project will serve a total of 252 individuals with co-occurring disorders who are leaving incarceration facilities over a 42-month implementation period from April 1, 2015 through September 30, 2018. The project population will be equally balanced between clients of the Drug Court and Behavioral Health Court (113 unduplicated clients per court) along with an additional 26 clients of the Veterans Justice Court. Beginning in year three, the project will also test a program in which a group of volunteer peer mentors are recruited and trained to provide support to the project's paid mentors, in part as an approach to helping to ensure long-term sustainability of the project. The project will measure a range of key outcomes related to both clients and Peer Mentors, including client mental health status and substance use and Peer Mentor employment advanced. Through the proposed MAPS Project, San Francisco Jail Health Services will explore the effectiveness of an ambitious peer support intervention which has the potential to serve as a national model for enhancing the quality and impact of collaborative court services by supporting criminally-involved men and women with co-occurring disorders as they cope with behavioral health issues and strive to attain stability and self-sufficiency in their lives.

SAN FRANCISCO DEPARTMENT OF HEALTH SERVICES

SAMHSA GRANTS TO DEVELOP AND EXPAND BEHAVIORAL HEALTH TREATMENT COURT COLLABORATIVES

BUDGET JUSTIFICATION, EXISTING RESOURCES, AND OTHER SUPPORT

A. PERSONNEL

Position	Name	Annual Salary/ Rate	Level of Effort	Number of Months	Cost
Project Director	Jana Rickerson	In-Kind	5%	12	$ -
Project Manager	Angelica Almeida	$ 90,000	10%	12	9,000
Project Coordinator	To be named	70,000	100%	12	70,000
Lead Peer Mentor	To be named	41,600	100%	10	34,667
Peer Mentors (5 @ 50%)	To be named	31,200	250%	8	52,000
TOTAL					**$ 165,667**

Justification:

1) The Project Manager will have responsibility for overarching design, implementation, and monitoring of the program
2) The Project Coordinator will provide day-to-day oversight, management, planning, and reporting services for the program and will hire, train, and support Peer Mentors
3) The Lead Peer Mentor will provide support to assigned collaborative court clients while providing peer based support and assistance to the mentor team
4) Peer Mentors will provide support to assigned collaborative court clients using evidence-based and informal interventions

B. FRINGE BENEFITS

Component	Rate	Wage	Cost
Retirement	9.9%	$ 165,667	$ 16,401
Social Security	6.1%	165,667	10,106
Health & Dental	12.0%	165,667	19,880
Unemployment Ins	0.25%	165,667	414
Other Benefits	0.75%	165,667	1,243
TOTAL	**29%**		**$ 48,043**

Justification:

Fringe levels above reflect current rates for the San Francisco Jail Health Services

B. TRAVEL

Purpose of Travel	Location	Item	Rate	Cost
One Grantee Conferences	Washington, D.C.	Airfare	$450/person x 4 persons	$ 1,800
		Hotel	$200/night x 3 nights x 4 persons	$ 2,400
		Per Diem	$71/day x 4 persons x 4 days	$ 1,136
		Local Transport	$66 x 4 persons	$ 264
Local Travel	San Francisco, CA	Mileage	100 miles x $.565/mile x 12 months	$ 1,017
		Bus & Taxi Vouchers for Peer Mentors	Avg. $250/month x 8 months	$ 2,000
			TOTAL	**$ 8,617**

Justification:
Travel cost allocations are for required travel to the annual grantee conferences in Washington, DC . Travel expense estimates are based on actual average cost for Departmental travel in 2013.

D. EQUIPMENT - None

E. SUPPLIES

Item(s)	Rate	Cost
2 Laptop Computers with Printer	$100/mo x 12 mos x $1,800	$ 3,600
	TOTAL	**$ 3,600**

Justification:
1) The laptop and printer are for use by the new Project Coordinator and Lead Mentor - Yr. 1 Only

F. CONSULTANTS & CONTRACTS

Name	Service	Rate	Other	Cost
SF Office of Quality Management	Project Evaluation & GPRA Follow-Up			$ 50,000
To be selected	Peer Training Curriculum Development Consultant	$100/hour x 76 hours =		$ 7,500
SF Collaborative Courts	Cross-Court Database Development			$ 25,000
			TOTAL	**$ 82,500**

Justification:

1) The Evaluation and Data Collection allocation supports costs for essential program data collection, evaluation design, and data analysis and reporting functions through the San Francisco Community Behavioral Health Services Office of Quality Management, including collection of 6-months post-discharge GPRA data. A precise budget for this portion will be developed after the Project Workgroup determines the precise parameters, indicators, and data measures to be used to assess the MAPS program.
2) The Peer Training Curriculum allocation is for one or more professionals with extensive peer training experience to assist the program in designing and presenting basic peer mentor trainings This is a year 1 expense only.
3) Collaborative Court costs are to support modifications of data tracking systems at all three participating courts to allow data sharing following HIPPA guidelines. This is a year 1 expense - the cost for this activity decreases to $5,000 in year 2 - 4.

G. CONSTRUCTION - None

H. OTHER

Item	Rate	Cost
Residential Drug Treatment Support Pool		$ 9,835
Evidence-Based Practice Licensing and Training Costs Pool		$ 10,000
	TOTAL	**$ 19,835**

Justification:

1) The residential treatment pool provides a small amount of funding each year to help clients access unreimbursed residential drug treatment services on an emergency basis. The allocation increases tc to $21,037 per year beginning in program year 2.
2) The Evidence-Based Cost Pool is a year 1 expense only to support the cost of licensing interventions and subsidizing EBR trainings for Peer Mentor staff.

I. INDIRECT CHARGES

12% of Salaries Only ($165,667 * .12) $19,880

DATA COLLECTION & PERFORMANCE MEASUREMENT COSTS (20% Max Per Year)

Category	Year 1	Year 1	Year 2	Year 3	Total Data Collection & Performance Measurement Costs
Personnel					
Project Coordinator	$ 14,000	$ 14,000	$ 14,000	$ 14,000	$ 56,000
Fringe	4,060	4,060	4,060	4,060	16,240
Travel	-	-	-	-	-
Equipment	-	-	-	-	-
Supplies	-	-	-	-	-
Contractual	-	-	-	-	-
Quality Mgmt. Office	50,000	35,000	35,000	35,000	155,000
Other	-	-	-	-	-
Total Direct Cost	**$ 68,060**	**$ 53,060**	**$ 53,060**	**$ 53,060**	**$ 227,240**
Indirect Costs	-	-	-	-	-
Total Costs	**$ 68,060**	**$ 53,060**	**$ 53,060**	**$ 53,060**	**$ 227,240**
% of Budget	**19.5%**	**15.2%**	**15.2%**	**15.2%**	**16.3%**

INFRASTRUCTURE DEVELOMENT (30% Max in Year 1 /15% Max in Years 2 - 4)

Category	Year 1	Year 2	Year 3	Year 4	Total Data Collection & Performance Measurement Costs
Personnel	-	-	-	-	
Fringe	-	-	-	-	-
Travel	-	-	-	-	-
Equipment	-	-	-	-	-
Supplies	-	-	-	-	-
Contractual					
Database Development	25,000	5,000	5,000	5,000	40,000

Other	-	-	-	-	-
Total Direct Cost	**25,000**	**$ 5,000**	**$ 5,000**	**$ 5,000**	**$ 40,000**
Indirect Costs	-	-	-	-	-
Total Costs	**$ 25,000**	**$ 5,000**	**$ 5,000**	**$ 5,000**	**$ 40,000**
% of Budget	**7.2%**	**1.4%**	**1.4%**	**1.4%**	**2.9%**

BUDGET SUMMARY

Category	Year 1	Year 2	Year 3	Year 4	Total Project Cost
Personnel	$ 165,667	$ 196,800	$ 196,800	$ 196,800	**$ 756,067**
Fringe	48,043	57,072	57,072	57,072	**$ 219,259**
Travel	8,617	9,617	9,617	9,617	**$ 37,468**
Equipment	-	-	-	-	**$ -**
Supplies	3,600	-	-	-	**$ 3,600**
Contractual	82,500	40,000	40,000	40,000	**$ 202,500**
Construction	-	-	-	-	**$ -**
Other	19,835	21,037	21,037	21,037	**$ 82,946**
Total Direct Charges	$ 328,262	$ 324,526	$ 324,526	$ 324,526	**$ 1,301,840**
Indirect Charges	$ 19,880	$ 23,616	$ 23,616	$ 23,616	**$ 90,728**
Total Project Costs	**$ 348,142**	**$ 348,142**	**$ 348,142**	**$ 348,142**	**$ 1,392,568**

Section A. Population of Focus and Statement of Need

Population of Focus: The **Jail Health Services** program of the San Francisco Department of Public Health - in close collaboration with the San Francisco Collaborative Courts, San Francisco Peer Programs, HealthRIGHT 360, and the San Francisco Veterans Administration Medical Center - proposes to implement the **Mentoring and Peer Support (MAPS) Project,** an ambitious peer support program designed to significantly enhance behavioral health and wellness outcomes while reducing criminal justice recidivism among **substance using** men and women under Court jurisdiction who have diagnoses of **severe and persistent mental illness**. The program will partner with and draw clients from **three** distinct courts that are part of the Collaborative Courts system - the **Behavioral Health Court**, the **Drug Court,** and the newly created **Veterans Justice Court.** MAPS will employ, train, and support a diverse peer team consisting of **1 full-time Lead Peer Mentor** and **5 half-time Peer Mentors** who will utilize evidence-based practices to encourage, support, and foster treatment success and recidivism reduction among the members of its target population. Beginning in year three, the project will also test a program in which a group of **volunteer peer mentors** are recruited and trained to provide support to the project's paid mentors, in part as an approach to helping ensure the long-term sustainability of the project.

The MAPS Project will provide comprehensive peer mentoring and support services to a total of **252** individuals with co-occurring disorders who are leaving incarceration facilities over a **42-month implementation period** from April 1, 2015 through September 30, 2018. **In order to reach clients under the Court's jurisdiction who are most in need of peer support and encouragement, all project clients will have an identified substance use issue and will have a confirmed diagnosis of severe and persistent**

Figure 1. Estimated Demographic Characteristics of MAPS Client Populations

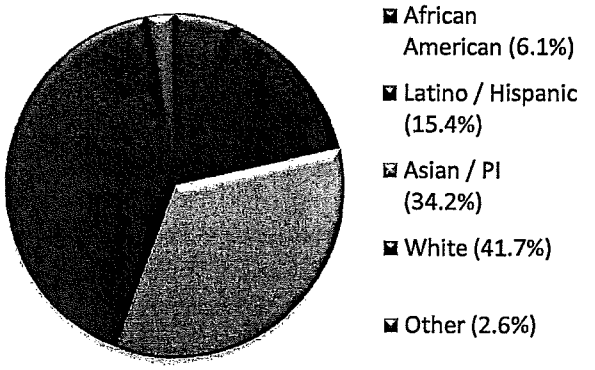
Demographic Category	Number	Percent
Gender		
Female	58	23%
Male	192	76%
Transgender	3	1%
Ethnicity		
African American	131	52%
Latino	30	12%
Asian / Pacific Islander	15	6%
White	58	23%
Other / Multiethnic	18	7%
Age		
19 - 39	131	52%
40 - 65	121	48%
Living Situation		
Apartment / House	81	32%
Streets / Shelters	55	22%
Relatives	71	28%
Hotel / SRO	45	18%
Sexual Orientation		
Straight / Heterosexual	234	93%
Gay / Bisexual	18	7%
Income		
None	144	57%
Disability	48	19%
Assistance	28	11%
Other / Informal	15	6%
Employed	18	7%
Drug Court Clients	**113**	**45%**
Behavioral Health Court Clients	**113**	**45%**
Veterans Court Clients	**26**	**10%**
Total	**252**	**100%**

mental illness. As noted in **Figure 1** at right, the project population will be comprised of **76%** men, **23%** women, and **1%** transgender individuals. The population will be extremely diverse ethnically, with **77%** of project clients are expected to be persons of color, including a population that is **52%** African American, **12%** Latino, and **6%** Asian and Pacific Islander. The average age of project participants will be **39**, with an expected age range of project participants stretching from **19 to 65**. Reflecting the diversity of San Francisco, **7%** of project clients are expected to be gay and lesbian individuals. Only **13%** of project clients are expected to report having a partner or 'significant other'.

The socioeconomic profile of the target population reflects the degree to which untreated substance use and mental illness disproportionately impact low-income and disenfranchised communities. Fully **57%** of participants - a strong majority - are expected to have **no income of any kind**, based on combined population data for the city's Drug and Behavioral Health Courts. Another **19%** of project clients will be on disability; **11%** will be receiving some other form of assistance; and only **7%** will have any form of employment. Additionally, **less than a third** of project clients (**32%**) will be living in a viable apartment or house situation following their release from jail. **Nearly one-quarter** of project clients (**22%**) will be living on the streets or in temporary shelters; **28%** will be living with relatives or friends, generally on couches or on the floor; and **18%** will be living in SRO hotels, generally using Section 8 certificates. Only **27%** of project participants are expected to have a high school diploma, and another **20%** will possess a GED degree. An anticipated **5%** of project clients will not have completed middle school.

Profile of the Service Region and Relationship to Population of Focus: The proposed project will be implemented in the **City and County of San Francisco**, a uniquely concentrated region with high proportions of substance use and homelessness. With a land area of only **46.7** square miles, San Francisco County is by far the **smallest county in California** geographically, and the **sixth smallest county in the US** in terms of land area. San Francisco is also one of only three major US cities in which the city's and county's borders are identical. According to the US Census, San Francisco had an estimated 2013 population of **837,442** persons, resulting in a density of **17,932 persons per square mile** - the highest population density of any county in the nation outside of New York City. The region is also **diverse**, with persons of color making up **45.7%** of the city's total population. This includes a population that is **35.7%** Asian/Pacific Islander, **15.4%** Latino, **6.1%** African American, and **0.9%** Native American. (see Figure 2). The nation's largest population of Chinese Americans lives in the City of San Francisco, joined by a diverse range of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents. A large number of Latino immigrants also reside in the EMA, including native residents of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **41.7%** of residents speak a language other than English at home, with over **100** separate Asian dialects alone spoken in SF. Only **half** of the high school students in the City of San Francisco were born in the United States, and almost **one-quarter**

Figure 2. Ethnic Distibution of San Francisco Residents, 2013 Estimate



have been in the country six years or less. A total of over **20,000** new immigrants join the EMA's population each year, in addition to at least **75,000** permanent and semi-permanent undocumented residents.

Because of the prohibitively high cost of housing in San Francisco and the shortage of affordable rental units, the problem of **homelessness** has reached crisis proportions in the city, creating formidable challenges for organizations seeking to serve disadvantaged populations. According to the National Low Income Housing Coalition's *Out of Reach 2012* report, San Francisco County is tied with adjoining Marin and San Mateo Counties as the **three least affordable counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **$36.63 per hour** (see Figure 3).[1] Meanwhile, as of 2012, the City of San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at $1,795 per month for a 2-bedroom apartment, defined as the amount needed to "pay the gross rent of privately owned, decent, and safe rental housing of a modest nature".[2] The 2013 San Francisco Homeless Count found **6,436** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities[3], while the city serves an additional **3,000 - 7,000** temporarily homeless persons per year, giving the city the **second highest per capita homelessness rate of any city in the U.S.**[4]

Figure 3.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2012

County	Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rents
San Francisco County, CA	$ 36.63
Marin County, CA	$ 36.63
San Mateo County, CA	$ 36.63
Nantucket County, MA	$ 34.60
Honolulu County, HI	$ 33.98
Nassau County, NY	$ 32.35
Suffolk County, NY	$ 32.35
Orange County, CA	$ 31.77
Santa Clara County, CA	$ 31.21
Westchester County, NY	$ 30.38

The high prevalence of **mental illness** and **mental health issues** in San Francisco further complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health reported in its most recent report that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[5] In part because of the Golden Gate Bridge, San Francisco has one of the nation's highest rates of both adult and teen suicide completion, and the

rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[6]

Nature of the Problem: The crisis of **substance use** is an ongoing challenge for the City and County of San Francisco. The city is embroiled in a major substance use epidemic which is fueling the spread of a wide range of co-morbidities including HIV, sexually transmitted infections, hepatitis C, mental illness, and homelessness - conditions that complicate access to and provision of care to low-income populations. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco, well above the average statewide rate of **6.6** per 10,000.[7] At the same time, the rate for drug-induced deaths in San Francisco stood at **24.8** per 100,000, more than double the statewide rate of **10.8** per 100,000.[8] Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with nearly three San Franciscans dying each week of a drug-related overdose or poisoning.**[9] Recreational use of **methamphetamine (speed)** has been linked to **30%** of San Francisco's new HIV infections in recent years.[10] The costs associated with the substance addiction epidemic in San Francisco also add significantly to the local burden of health and human service care. According to the National Institute on Drug Abuse (NIDA), the total national costs of drug abuse and addiction due to use of tobacco, alcohol, and illegal drugs are estimated at **$524 billion** a year and illicit drug use alone accounts for **$181 billion** in health care costs, lost productivity, crime, incarceration, and drug enforcement.[11]

As with many other disorders, substance addiction tends to disproportionately impact **ethnic minority populations** who face greater stresses related to poverty, reduced access to services, and institutionalized discrimination. African Americans, for example, have significantly higher risks for developing alcohol-related disorders, including liver cirrhosis, and a greater propensity to experience toxic effects of cocaine that may lead to earlier onset or greater risk for health problems, particularly cardiovascular disease.[12] Substance users from ethnically diverse backgrounds face greater risks for developing chronic conditions such as hypertension, high blood pressure, and HIV/AIDS.[13]

Substance abuse is closely linked to **mental illness and mental health issues** that necessitate the need for both psychological and psychiatric approaches to addressing substance use conditions. The published literature has consistently demonstrated that alcohol or drugs are often used to **self-medicate** symptoms of depression or anxiety.[14] Alcohol and drug abuse can also increase underlying risk for mental disorders while making symptoms of existing mental health issues worse, at times by interacting with medications such as antidepressants and mood stabilizers to make them less effective. According to a report in the Journal of the American Medical Association, an estimated **50%** of individuals with severe mental disorders are affected by substance abuse; **37%** of alcohol abusers and **53%** of drug abusers have at least one serious mental illness; and of all people diagnosed as mentally ill, **29%** abuse either alcohol or drugs.[15]

There is also a growing recognition of the interconnections that link exposure to **violence and trauma** with substance use. Emerging findings suggest that children and youth who are exposed to violence or who are victims of abuse at an early age are at higher risk for criminal justice involvement and substance abuse at a later age. Reed, Anthony, and Breslau, in a study of 988 young people aged 19-24 years, found that prior exposure to trauma was associated with **significantly increased risk for drug abuse or dependence** and emerging dependence problems compared to young people with no prior trauma.[16] Kaslow and Thompson, in a study of African American urban youth, found that children who experienced maltreatment and

children whose mothers experienced physical intimate partner violence (IPV) had substantially higher levels of **psychological distress** than their respective counterparts, and were in need of targeted prevention and intervention programs to prevent later behavioral problems.[17] Evidence also suggests a strong link between the experience of violence, domestic abuse, and trauma with substance abuse, particularly in regard to coping with post-traumatic stress disorder (PTSD). Kessler, et al. found that among individuals with a history of PTSD, **34.5%** reported drug abuse or dependence at some point in their lives versus **15.1%** without PTSD.[18] In a study of 1,007 young adults, researchers found that PTSD was associated with a more than **fourfold** increased risk of drug abuse and dependence as compared to youth who did not exhibit PTSD symptoms.[19]

These risks are also widespread among **veterans**, including returning veterans of the Iraq and Afghanistan conflicts. Studies have demonstrated that between **36.9%** and **50.2%** of Iraq and Afghanistan veterans served by the Veterans Administration (VA) health system have received a diagnosis of a mental disorder such as depression or post-traumatic stress disorder (PTSD).[20] At least **22%** of Iraq and Afghanistan veterans with PTSD in the VA system have also been diagnosed with a substance use disorder, with veterans diagnosed with mental disorders significantly more likely to receive prescription opioid medication for conditions related to pain than those with no health conditions.[21] Based on a separate survey of nearly **2,000** returning Iraq and Afghanistan War combat veterans utilizing VA services, an estimated **25%** to **56%** of combat veterans reported "some" to "extreme" difficulty in key social reintegration issues including social functioning, productivity, community involvement, and self-care domains.[22] At least **41%** of these study participants also screened positive for PTSD, and probable PTSD was associated with reporting more readjustment difficulties and expressing interest in more types of services, including traditional mental health services.[23] Most shockingly, at least **3,500** returning Iraq and Afghanistan war veterans have already lost their lives to **suicide**, including **283** Army suicides in 2011 alone - a rate of more than one every two days.[24]

Although the literature is still emerging, **peer mentoring or coaching** is increasingly being acknowledged and utilized as an effective approach to augment or support recovery services for persons with co-occurring disorders. A May 2011 controlled study by Sledge, et al. of **36** patients 18 and older who had been hospitalized three of more times in the previous 18 months found that participants who were assigned a peer mentor had significantly fewer re-hospitalizations and fewer overall hospital days than patients who did not have an assigned peer mentor.[25] A 2009 analysis of the Peer-to-Peer program, a structured, experiential relapse prevention and wellness program led by trained peer mentors for people with mental illness, found that **550** individuals enrolled in the program gained significant benefits in regard to the central curriculum areas of knowledge and management of their illness; feelings of being less powerless and more confident; and connection with others.[26]

According to SAMHSA, the terms peer mentoring or coaching "refer to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery."[27] The nature and functions of this relationship can vary greatly from program to program. Generally, however, mentor or coaches support peers in tasks such as setting recovery goals, developing recovery action plans, dealing with physical or mental challenges, and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving job skills. SAMHSA notes that the relationship of the peer leader to the peer receiving help is highly **supportive**, rather than **directive**. William White (2006) notes that a peer mentor or coach implicitly holds himself or herself out as a

recovery role model, using honesty and disclosure around **one's own story** as means of enhancing the value of the service.[28] White notes that this core competency entails "modeling of core recovery values (e.g., tolerance, acceptance, gratitude); the capacity for self-observation, self-expression, sober problem-solving; recovery-based reconstruction of personal identity and interpersonal relationships; freedom from coercive institutions; economic self-sufficiency; positive citizenship and public service."

Relationship of Population of Focus to General Population: Because of higher rates of substance abuse and untreated mental illness and lower utilization of health and social services among members of its target population, the MAPS Project will serve some of the most highly disadvantaged and impoverished men and women living in San Francisco. The most obvious markers for this overrepresentation of socioeconomically disadvantaged individuals lie in the extremely high prevalence of low-income and inadequately housed project clients. While the 2010 US Census reports the average household income in San Francisco at **$73,802**, fully **57%** of our project's clients are expected to have **no source of income of any kind**, and at least **90%** of project clients will be living below the 2014 Federal Poverty line. Additionally, while the Census reports that **84%** of San Franciscans have lived in the same housing unit for 1 year and over, only **32%** of our project population will be living in a comparable house or apartment, with nearly **one-quarter** living on the streets or in shelters at the time of admission to our program.

The MAPS Project will also reflect the degree to which substance use and undiagnosed mental illness disproportionately impact **communities of color**, particularly in regard to **African American** populations. While only **6%** of all San Francisco residents are African American, at least **52%** of our project population is expected to be African American - a percentage that may be even higher when the program is implemented. The high proportion of African Americans in the program means that all other ethnic groups will be underrepresented in our program. The high proportion of African American clients also reflects ingrained patterns of unequal criminal justice enforcement, in which African Americans are targeted at significantly higher rather than other ethnic groups. This inequity is reflected to a different degree in the high proportion of **men** to be served by the program, the majority of whom will also be African American. While men make up **51%** of San Francisco's 2010 Census population, they make up **76%** of our projected service population.

Breakdown of Requested CSAT and CHMS Funds: The proposed MAPS Project explicitly recognizes and addresses the interconnected and inextricable nature of substance use and severe and persistent mental illness as key linked issues that frequently underlie criminal justice involvement and recidivism among low-income and disenfranchised populations. It is vital that any proposed behavioral court enhancement effort address **both conditions simultaneously**, particularly in terms of severely mentally ill populations, who often use substances as a way to self-medicate against untreated or undertreated conditions and are often misdiagnosed as having a primary substance use condition as a result. For this reason, our project strikes an **appropriate balance** between the two conditions. Not only will **all** project clients have both diagnosed substance use and mental illness, but as noted in Figure 1, the project will draw **113 participants each** from both the San Francisco Behavioral Health Court and the San Francisco Drug Court, representing a combined **90%** of the total client population. At the same time, the project will draw the remaining **10%** of its clients (n=**26**) from the recently

instituted Veterans Justice Court, which serves a high percentage of individuals with co-occurring substance use and mental health disorders, particularly in terms of trauma and PTSD. The project's populations and dual condition approach acknowledge that no successful court enhancement proposal can logically **separate** these two conditions, but must deal with both in an integrated and coordinated manner, ideally with enhanced supportive services provided by peers who have personal experience of co-occurring disorders and have experienced and successfully lived through the trauma and pain of living with both conditions.

Section B. Proposed Evidence Based Service Practice

Project Purpose, Goals, and Objectives: The proposed Mentoring and Peer Support (MAPS) Project will implement an innovative collaborative enhancement project designed to **significantly expand the availability of peer mentoring and support services** for clients with co-occurring disorders within **three** separate courts within the San Francisco Collaborative Courts system: the Behavioral Health Court; the Drug Court; and the Veterans Justice Court. The program will exclusively focus on substance using clients with severe and persistent mental illness who are exiting the jail system, and will offer critical and much-needed peer support as clients undergo treatment, work to stabilize their lives, and strive to reintegrate themselves into the community. The **program purpose** corresponds to SAMHSA's project purpose of fostering greater collaboration between the courts, the criminal justice system, and public and private treatment and recovery providers while incorporating a greater understanding of the complex behavioral health needs and issues that frequently underlie involvement in the criminal justice system. The **overarching goal** of the program is to significantly enhance client outcomes in regard to substance use, mental health issues, employment, housing, and criminal justice recidivism while offering opportunities for participating peer mentors to receive job experience and training and to move on to successful careers following the conclusion of the program.

MAPS will accomplish its goals through **a linked series of process and outcome objectives** that allow the program to systematically track impacts and project effectiveness throughout the four-year project period. These objectives – based on a projected grant period of October 1, 2014 through September 30, 2018 - are as follows:

Process Objectives:

- **Objective # 1:** Between October 1, 2014 and March 31, 2015, to utilize a **six-month project start-up period** to establish project parameters, negotiate and finalize project subcontracts, convene a Behavioral Health Treatment Court Collaborative (BHTCC) Workgroup, hire and train program staff, develop project interventions and curricula, develop data collection and evaluation systems, and establish project timelines and schedules.
- **Objective # 2:** Between April 1, 2015 and September 30, 2018, to support, supervise, and build the skills of a diverse team of **7 new peer mentors** who reflect the experiences and demographic characteristics of the clients they serve, including **1** full-time Lead Peer Mentor and **6** half-time Peer Mentors.
- **Objective # 3:** Between April 1, 2015 and September 30, 2018, through the project's peer mentor staff, to provide an average of **6 months** of high-quality peer mentoring and support services incorporating evidence-based practices for a minimum of **252 individuals with co-occurring disorders** who are clients of the three participating collaborative courts

- **Objective # 4:** Between April 1, 2015 and September 30, 2018, to continually build the **vocational and job skills** of the project's peer mentor team to ensure a successful career transition at the conclusion of the project.
- **Objective # 5:** Between October 1, 2016 and September 30, 2018, to begin to pilot a program of **volunteer peer support** through which the MAPS Project recruits and trains a minimum of **10** volunteer peers to provide additional peer support services which augment those of the project's peer mentor staff and help the project work toward long-term sustainability.
- **Objective # 6:** Between October 1, 2014 and September 30, 2018, to continually work with the three participating courts to **improve the quality and functionality of their existing electronic health record (EHR) systems** while increasing data-sharing and reporting capabilities between the three courts that adhere to HIPAA regulations.
- **Objective # 7:** Between October 1, 2014 and September 30, 2018, to continually assess and evaluate the quality and impact of the proposed intervention by conducting an ongoing **performance assessment** and by administering the GPRA tool at baseline, discharge, and 6 months post-baseline, achieving at least an **80% GPRA follow-up rate** across the project treatment population.

Outcome Objectives:

- **Objective # 8:** Between April 1, 2015 and September 30, 2018, to ensure that at least **70%** of project clients with co-occurring disorders (n=**206**) complete at least **3 months** of peer support services to enhance treatment outcomes, including GPRA completion at admission, discharge, and 6 months post-baseline.
- **Objective # 9:** Between April 1, 2015 and September 30, 2018, to ensure that at least **45%** of project clients with co-occurring disorders (n=**132**) complete at least **6 months** of peer support services to enhance treatment outcomes, including GPRA completion at admission, discharge, and 6 months post-baseline.
- **Objective # 10:** Between April 1, 2015 and September 30, 2018, to document reductions in substance use **6 months** post-baseline for at least **50%** of clients who complete at least 3 months of peer support services and at least **70%** of clients who complete at least 6 months of peer support services.
- **Objective # 11:** Between April 1, 2015 and September 30, 2018, to document significantly enhanced mental health status and improved outlook **6 months** post-baseline for at least **60%** of clients who complete at least 3 months of peer support services and at least **75%** of clients who complete at least 6 months of peer support services.
- **Objective # 12:** Between April 1, 2015 and September 30, 2018, to document high rates of **staff satisfaction** among at least **86%** of peer support staff participating in the program, including satisfaction with staff support and with job skills assessment and vocational and job skills training opportunities.
- **Objective # 13:** By September 30, 2018, to ensure that at least **57%** of peer support staff participating in the program are **successfully placed in new positions** prior to or at the conclusion of the project period.
- **Objective # 14:** Between April 1, 2015 and September 30, 2018, to document high rates of satisfaction with the program among **participating collaborative court staff and judges,** including satisfaction with project management, peer skills, computer systems enhancement

activities, and impact on clients' ability to successfully complete assigned courses of treatment.

Proposed Evidence-Based Practices (EBPs) to be Used: The MAPS Project will directly utilize a range of evidence-based practices (EBPs) that will be applied from **two** distinct program perspectives. The first perspective is that of **project clients** who will be supported and nurtured by our new Peer Mentor staff. To assist these populations, Peer Mentors will be trained in and apply **three** specific EBPs in order to give structure to the mentor / client relationship and to appropriately address specific client needs, conditions, and situations based on initial, in-depth assessments. The second project perspective involves training and support for **paid and volunteer Peer Mentor staff.** EBPs will be utilized to help guide the process of peer support from an evidence-based perspective.

In terms of **client service and support**, the project will rely on the following three evidence-based practices:

- **Wellness Action Recovery Plan (WRAP):** First established in 1997, WRAP is a well-established, manualized, self-help oriented group intervention for adults with mental illness which is included in the SAMHSA National Registry of Evidence-Based Programs and Practices.[29] A 2009 study by Cook, et al. examined changes in psychosocial outcomes among **80** participants in an eight-week, peer-led WRAP group at 5 sites in Ohio and demonstrated significant improvements in self-reported symptoms, recovery, hopefulness, self-advocacy, and physical health, with those attending six or more sessions showing greater improvement than those attending fewer sessions.[30] WRAP guides participants through the process of identifying and understanding their **personal wellness resources** (called **"wellness tools"** in the context of the intervention) and helps them develop an **individualized plan** to use these resources on a daily basis to manage their mental illness. WRAP has the following goals:

  - To teach participants how to implement key concepts of recovery such as hope, personal responsibility, education, self-advocacy, and support in their day-to-day lives;
  - To allow participants to organize a list of their **wellness tools** - activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising;
  - To assist each participant in creating an **advance directive** that guides the involvement of family members or supporters when the individual can no longer take appropriate actions on her or his own behalf; and
  - To help each participant develop an **individualized post-crisis plan** for use as the mental health difficulty subsides, to promote a return to wellness

  WRAP groups typically range in size from **8 to 12 participants** and are led by two trained co-facilitators. **In the context of the MAPS Project, each WRAP group will be co-facilitated by two of our project's trained Peer Mentors under the supervision of the Project Coordinator.** WRAP information is imparted through lectures, discussions, and individual and group exercises, and key WRAP concepts are illustrated through examples from the lives of the co-facilitators and participants. The intervention is typically delivered over **eight weekly 2-hour sessions**, but it can be adapted for shorter or longer times to more effectively meet the needs of participants. Participants often choose to continue meeting after the formal 8-week period to support each other in using and continually revising their WRAP

plans. As of February 2010, more than **2,000** people had been trained as WRAP facilitators, and **120** of these individuals had been trained as advanced-level facilitators. **A full-time Peer Worker employed through San Francisco Peer Programs has been certified as an advanced-level facilitator and is now able to provide WRAP trainings directly within the San Francisco system.** This individual is currently presenting WRAP trainings to both peers and professionals in San Francisco on a **bi-annual** basis. **All** peer staff employed by MAPS will be trained and certified in the WRAP intervention and will receive ongoing support in WRAP implementation from both the Project Coordinator and the advanced-level facilitator employed through San Francisco Peer Programs.

- **Illness Management and Recovery (IMR):** Illness Management and Recovery is a SAMHSA-approved curriculum in which a specially trained mental health practitioner **or trained consumer specialist** supports individuals in coping with serious mental illness and in moving forward with their lives. IMR is based on research that shows that by learning more about managing mental illnesses, persons who have experienced psychiatric symptoms can take important steps toward recovery. IMR practitioners use a combination of motivational, educational, and cognitive-behavioral techniques. A review of IMR-based research by Mueser, et al. (2002) demonstrated that Illness Management and Recovery is highly effective in helping clients: a) learn more about mental illnesses; b) reduce relapses and re-hospitalizations; c) reduce distress from mental health symptoms; and d) use medications more consistently.[31] The IMR model has been shown to have particularly strong benefits for persons with **schizophrenia spectrum disorders**, with no appreciable outcome differences attributable to ethnicity, gender, age, geographic setting, or inpatient / outpatient status. **The IMR model especially well-suited to the MAPS intervention because it was developed with extensive consumer input; can be conducted by trained peers; and is fully compatible with consumer-led recovery programs.**

  IMR includes education about mental illness but emphasizes putting information into action through the development of **personal goals** and the setting of practical strategies for putting those goals in place. The core components of IMR include: a) **Psychoeducation**, offering basic information about mental illnesses and treatment options; b) **Behavioral Training**, helping consumers manage daily medication regimes by teaching them strategies that make taking medications part of their daily routine; c) **Relapse Prevention**, designed to teach consumers to identify triggers of past relapses and early warning signs of an impending relapse and to develop plans for preventing relapse; and d) **Coping Skills Training** through which consumers identify current coping strategies for dealing with psychiatric symptoms and either increasing their use of these strategies or teaching new strategies. Throughout the program, consumers are encouraged to define what recovery means to them and to identify what goals and dreams are important to them. As participants gain more mastery over their symptoms, they gain more control over their lives and become better able to realize their vision of recovery.

  IMR practitioners meet **weekly** with clients on an **individual or group basis** for a period lasting from **3 to 10 months**. IMR students are asked to do home practice and homework and families and other supportive people are included if desired. Project-related education handouts cover issues such as recovery strategies; practical facts about mental illness; the

stress vulnerability model and treatment strategies; building social support; reducing relapses; using medication effectively; and getting your needs met in the mental health system. **IMR can also be offered in conjunction with other structured and time-limited EBRs such as the WRAP intervention described above, and produces strong results when administered by consumers.** All MAPS Peer Mentor staff will be trained in IMR and will offer the intervention in a wide range of formats to best meet client needs, including in one-on-one formats and in group settings co-facilitated by two or more Peer Mentors.

- **Thinking for a Change:** Thinking for a Change (T4C) is a critical EBP for the MAPS Project because it specifically addresses **criminal thinking** in the context of the cognitive behavioral treatment model. [32] Based on our own experience working with incarcerated populations, Jail Health Services has learned that it is crucial not to treat co-occurring disorders in isolation but to place treatment in the context of **criminal attitudes and beliefs** that may have led to criminal justice involvement and have facilitated criminal justice recidivism. T4C incorporates cognitive restructuring, social skills development, and development of problem solving skills and is designed for delivery to **small groups** in **25 lessons** which can be expanded on to meet the needs of specific participant sub-groups or populations. Participants learn to examine their own thinking patterns and responses; learn to take a more active role in both listening and responding to others; and learn strategies for changing thinking patters in order to move away from reflexive, defensive, and/or anger-based responses. The curriculum was developed by Barry Glick, Ph.D., Jack Bush, Ph.D., and Juliana Taymans, Ph.D., in cooperation with the National Institute of Corrections.

  The T4C program is used in prisons, jails, community corrections, probation, and parole supervision settings, and is particularly well-suited to post-incarceration populations. Since its development in 2002, more than **8,000** staff have been trained as T4C group facilitators. **As with the IMR model above, T4C is ideally suited to our program because it can serve as one intervention elements within a continuum of interventions to address the cognitive, social, and emotional needs of offender populations.** As with T4C, **all** Peer Mentor staff will be trained in the T4C intervention, and group sessions will be structured to meet the needs of specific client backgrounds and needs. Since it addresses issues related to criminal thinking, not all MAPS clients will be appropriate participants in the EBP, since many instances of criminal justice involvement among individuals with co-occurring disorders do not involve criminal intent. However, for those clients who do have an orientation toward criminal justice behaviors, the EBP provides an ideal component of the MAPS support continuum.

In addition to the EBPs, Peer Mentors will also provide more informal support in formats such as in-person conversations over coffee, short phone-based check-ins, responses to calls for emergency support, or driving or accompanying clients to mental health, drug treatment, or other appointments. Additionally, the EBPs above are **in addition to** evidence-based practices that will be applied in the context of external behavioral health treatment programs in which the vast majority of clients will also be involved. In terms of our lead proposed treatment partner, HealthRIGHT 360, for example, standard substance use treatment will incorporate the **Seeking Safety** model, a present-focused, cognitive-behavioral treatment for clients with a history of **trauma and substance use** originally developed by Dr. Lisa Najavits in 1992.[33] Seeking Safety

theorizes that when a person is suffering both active substance abuse and PTSD, their most urgent clinical need is to establish **safety and trust**. The EBP is a particularly appropriate choice for our target population - including our project's veteran population - because of its focus on **trauma** and its understanding of the complex interconnections between traumatic experiences and substance use and mental health issues. Seeking Safety is delivered over the course of a **16-week period**, with session lasting **55** minutes. In each session, participants learn about issues such as safety; detaching from emotional pain; seeking help; taking control and care of one's self; recovery issues; boundary limitations; nurturing; self and community resources; managing anger; and making better life choices.

In terms of the **Peer Mentors** employed through our program, MAPS will rely on the **Supported Employment model** which views productive employment coupled with a tailored array of supportive services as the most effective way to ensure long-term success in the workplace while leveraging workplace involvement as a tool for supporting long-term substance use reduction and mental health stabilization. While supported employment takes many forms, the overarching intervention was developed by Cook, et al. (2005) who in a randomized controlled trial involving **1,273** outpatients with severe mental illness from **7** states in the United States employed for more than 40 hours per month using the model found that participants were more likely to obtain and retain competitive employment; more likely to work more than 40 hours per month; and more likely to have higher earnings than control group members. Supported employment combines practical and realizable job tasks with an array of supportive services including psychiatric medication management, mental health counseling services, and supportive programs to monitor employee progress and allow for mutually supportive information with other similar employees. Supported employment also incorporates **ongoing job development and job training services** which give employees the opportunity to build skills to help them advance to higher paying and even more responsible positions. **All of these elements will be incorporated into the services provided by the MAPS Project to our new proposed Peer Mentor staff.**

How Proposed EBPs Will Help Address Subpopulation Disparities: The proposed evidence based practices to be used by our program have been selected for their specific ability to effectively address the needs, conditions, backgrounds, and situations of substance using individuals involved in the collaborative courts who have pre-existing diagnoses of severe and persistent mental illness **from a peer support perspective**. All of the selected client interventions can be effectively administered by trained peers and consumers, and have undergone evaluation specifically in relation to these populations. Additionally, because MAPS is proposed as an **enhancement** to an existing collaborative court structure, our program will neither provide nor supplant direct substance abuse and mental health treatment services. Instead, our program will add a vital supportive layer which we hope will significantly increase both client satisfaction and client outcomes in relation to a range of behavioral health and life indicators. For this reason, all of the evidence-based practices chosen will serve to **complement and supplement** standard behavioral health treatment for behavioral health conditions without interfering with the practice or outcomes of those standardized treatment approaches.

The selected EBPs will also impact subpopulation disparities by being delivered by consumers who **directly mirror the experiential and sociodemographic characteristics of the populations they will serve**. For example, the majority of Peer Mentors will be **African**

American and will be intimately familiar with the issues and barriers faced by these populations in San Francisco. All Peer Mentors will also have personal experience in living with both substance use and mental illness, and will have had success in stabilizing their lives which they utilize as a tool to inspire and support others in making the same successful transition. The majority of Peer Mentors will also have experience with involvement in the criminal justice system, and will be aware of the psychological issues faced by clients both in terms of coping with incarceration and in addressing behavioral and attitudinal factors that can influence the probability of recidivism.

Potential Modifications to EBPs: No specific modifications to the proposed EBPS are projected or anticipated.

Project Logic Model: Please see chart on following page.

Section C. Proposed Implementation Approach

Overview of the Intervention: As noted above, the **Jail Health Services** program of the San Francisco Department of Public Health Community Behavioral Health Services program - in close collaboration with the San Francisco Collaborative Courts, San Francisco Peer Programs, HealthRIGHT 360, and the San Francisco Veterans Administration Medical Center - proposes to implement the Mentoring and Peer Support (MAPS) Project, an ambitious peer support program designed to significantly enhance behavioral health and wellness outcomes while reducing criminal justice recidivism among recently released men and women under Court jurisdiction who have diagnoses of both **substance use and severe and persistent mental illness**. The program will collaborate with and draw clients from **three** distinct courts that are part of the Collaborative Courts system - the **Behavioral Health Court**, the **Drug Court,** and the **Veterans Justice Court.**

MAPS will employ, train, and support a diverse peer team consisting of **1 full-time Lead Peer Mentor** and **5 half-time Peer Mentors** who will utilize evidence-based practices to encourage, support, and foster treatment success and recidivism reduction among the members of its target population. The mentor team will be supervised and supported by a **full-time MSW Level Project Coordinator** who will provide ongoing mentor support and ensure that mentors are accessing and utilizing Supported Employment resources, including job training and ongoing mental health counseling. Each peer mentor will be teamed with an average of **6** collaborative court clients at a time, with an average length of support of **6 months per client,** although the relationship could last as long as **12-18 months** if the client is continuing to adhere to court-mandated treatment and substance use requirements. The project will serve a total of **252** individuals with co-occurring disorders who are leaving incarceration facilities over a **42-month implementation period** from April 1, 2015 through September 30, 2018. The project population will be equally balanced between clients of the Drug Court and Behavioral Health Court (**113** unduplicated clients per court) along with an additional **26 clients of the Veterans Justice Court.** Beginning in year three, the project will also test a program in which a group of **volunteer peer mentors** are recruited and trained to provide support to the project's paid mentors, in part as an approach to helping to ensure long-term sustainability of the project.

SAN FRANCISCO JAIL HEALTH SERVICES MAPS PROJECT
MAPS PROJECT LOGIC MODEL

Resources

- The financial support of the SAMHSA BHTCC Program
- The expertise and staff resources of San Francisco Jail Health Services
- The client base, experience, and commitment to excellence of the San Francisco Collaborative Courts
- The commitment, compassion, diversity, and life experience of project peer staff in recovery
- The peer expertise of San Francisco Peer Programs and the VA Medical Center
- The evaluation and data expertise of the San Francisco Quality Management Office

Components

- A 8% - 10% PhD Project Manager with strong experience in client treatment and peer support
- A full-time MSW Project Coordinator with experience in peer support and management and project administration
- A diverse team of 1 full-time Lead Peer Mentor and 5 half-time Peer Mentors who are living with co-occurring disorders
- Active participation by a collaborative BHTCC Workgroup that includes three collaborative courts, qualified treatment agencies, and programs with expertise in peer support and evaluation

Outputs

- Intensive Peer Mentor support using EBPs for an average of 6 months and up to 18 months for a total of **252** substance using individuals with severe and persistent mental illness who are leaving incarceration facilities and are under the jurisdiction of the collaborative courts
- Enhanced EHR and data sharing capacities following HIPPAA guidelines among the three participating courts
- Recruitment, training, and support of at least 10 volunteer mentors in order to move the program toward self-sufficiency following grant completion

Sample Outcomes

- Reductions in substance use for at least **50%** of clients who complete 3 months of peer support services and at least **70%** of clients who complete 6 months of peer support services
- Enhanced mental health status and improved outlook for at least **60%** of clients who complete 3 months of peer support services and at least **75%** of clients who complete 6 months of peer support services
- At least **57%** of peer support staff placed in new positions by conclusion of grant

San Francisco Peer Programs - a program of San Francisco Community Behavioral Health Services - will play a key role in our project by providing ongoing advice and technical assistance related to the recruitment, hiring, training, supervision, and support of Peer Mentors for our project. This expertise is based on Peer Programs' longstanding experience as an employer of more than 50 peers working in a variety of County departments and programs. The project will utilize the highly respected, multi-service community-based provider known as **HealthRIGHT 360** (formerly Walden House and Haight Ashbury Free Clinics, among other entities) to provide both residential and outpatient drug treatment services and psychiatric and mental health services to program clients, including professional case management services that will be coordinated with the work of our project's Peer Mentors. Further key support will come through the **San Francisco Veterans Administration (VA) Medical Center**, which provides comprehensive case management and mental health treatment services for clients of the city's Veterans Justice Court, and which itself has extensive experience in operating high-quality, large-scale peer programs utilizing veteran personnel in California. The **San Francisco Department of Rehabilitation** will provide employment and job training support services planned and operated in collaboration with the Project Coordinator and Peer Mentors.

Through the proposed MAPS Project, San Francisco Jail Health Services will explore the effectiveness of an ambitious peer support intervention which has the potential to serve as a national model for enhancing the quality and impact of collaborative court services by supporting criminally-involved men and women with co-occurring disorders as they cope with behavioral health issues and strive to attain stability and self-sufficiency in their lives.

<u>Implementation of Project Phase 1:</u> The MAPS Project will utilize the project's six-month planning phase to organize, develop, and effectively implement the proposed collaborative peer enhancement initiative. Jail Health Services - which already enjoys close working relationships with all of the proposed collaborative court entities - will employ a **comprehensive, multi-agency, systems transformation approach** to enhance behavioral health treatment and recovery support services to adult clients and their families through the proposed peer model. Through the proposed **Project Manager - Angelica Almeida, PhD** of Jail Health Services - the project will convene a **Behavioral Health Treatment Court Collaborative (BHTCC) Workgroup** which will oversee and collaborative directly the MAPS Project throughout the four-year grant period. The BHTCC Workgroup will consist of the Project Manager and Project Coordinator; the Executive Director of Jail Health Services, Tanya Mera; presiding judges of **each** of the three participating collaborative courts, along with additional relevant court staff; representatives of key partner entities including HealthRIGHT 360, the Veterans Administration Medical Center, and San Francisco Peer Programs; and at least **two** consumer representatives, including the full-time Lead Mentor and at least one of the project's half-time Peer Mentors, who may serve on a rotating basis during the project period. The BHTCC Workgroup will ensure relevant interagency collaboration; will oversee the project's evaluation; and will develop and implement plans for the long-term sustaining of the project's integrated and collaborative processes. More importantly, the workgroup will create a new context for **creative interaction** and **mutual planning** between the San Francisco Behavioral Health, Drug, and Veterans Justice Courts, while laying the groundwork for expanded peer and consumer involvement in court programs. The workgroup will be convened and hold its first meeting **within the first month of the grant** and will hold at least **monthly** meetings throughout the six-month implementation period, and at least **quarterly** meetings thereafter.

Key tasks for the BHTCC Workgroup during the first six months of the project include the following:

- Finalizing project parameters and expectations in collaboration with SAMHSA;
- Negotiating and finalizing project-related subcontracts and agreements;
- Finalizing evidence-based practices and developing a master EBP training schedule for project staff in collaboration with San Francisco Peer Programs;
- Conducting consumer surveys and/or focus groups as needed to obtain input into project design and interventions;
- Finalizing process to ensure fully Supported Employment to Peer Mentor staff, including providing ongoing vocational counseling and training and developing systems to monitor peer staff activities and status and to track peer staff satisfaction;
- Finalizing client admission criteria and standards for client support and success;
- Developing procedures to address both client and peer staff crises, emergencies, and attrition;
- Developing data collection, reporting, and evaluation indicators and procedures, including indicators to be used in the local performance assessment;
- Developing systems to ensure participant protection and confidentiality, including client consent forms, client education procedures, and client privacy protection systems;
- Implementing data procedures, including assessing needed modifications of electronic records systems in use at the three collaborative courts and beginning records system adaptations as needed to facilitate mutual reporting;
- Finalizing Peer Mentor training curricula in collaboration with San Francisco Peer Services and the VA Medical Center;
- Developing systems to ensure ongoing coordination of services among the collaborative courts, public and private treatment programs, and the new proposed peer team; and
- Developing and conducting training and orientation sessions for providers and staff at key partner agencies to ensure their familiarity with the MAPS Project and its procedures.

In addition to the above activities, another crucial activity of the six-month planning phase involves the **identification, hiring, and training of project staff.** The process will begin with the hiring of a **full-time Project Coordinator** who will be a masters-level counseling or social work professional with extensive experience in peer staff supervision and support to disadvantaged populations with co-occurring disorders. The Coordinator will be appointed as close to the project start date as possible, and will have responsibility for working with San Francisco Peer Programs to hire the **full-time Lead Peer Mentor by the start of the third project month.** The Lead Mentor will have served successfully in a peer role for at least **two years** and will show superior communication, organization, and team-building skills. The Lead Mentor will immediately become a member of the BHTCC Workgroup. The final phase in the staff process will involve hiring **5 new part-time Peer Mentors** who reflect the diversity of the proposed service population **by the start of the fifth project month.** These individuals will be extensively trained in project procedures and evidence-based practices by the conclusion of the six-month planning period.

How Achievement of Goals Will Produce Meaningful Results: As noted above, the purpose of the MAPS Project corresponds to the project purpose of fostering greater collaboration between the courts, the criminal justice system, and public and private treatment

and recovery providers while incorporating a greater understanding of the complex behavioral health needs and issues that frequently underlie involvement in the criminal justice system. While the MAPS Project does not produce a new collaborative court structure, it offers the potential for a **significant enhancement of the collaborative court model** by bringing trained peers with co-occurring disorders **directly into the court system** to serve as supporters, mentors, and trusted friends of court-involved individuals who are struggling to bring stability, hope, and productivity to their lives. Through this interaction, the project has can enhance the quality of the client experience in collaborative courts while producing enhanced outcomes in relation to mental health issues, substance use, health and wellness, and life circumstances. The project also has the potential to provide a **national model** for the enhancement of collaborative court services and outcomes through peer involvement. San Francisco offers an ideal laboratory to explore this model through its nationally regarded network of **10 collaborative courts** which strive to create alternatives for defendants that work to create better health outcomes for clients while reducing the potential for criminal justice recidivism.

Project Timeline: As noted above, the MAPS Project will be implemented in **two key phases.** The first phase consists of a **six-month start-up phase** in which staff are hired and trained, collaborative relationships are developed, project systems and interventions are finalized, and project data collection and systems are put in place. The second phase consists of the **implementation phase** beginning at the start of month 7, or on April 1, 2015, when court clients begin to be screened and paired with trained Peer Mentors. Because of the differences between the two project phases, **two** project timelines are provided below, one a concentrated timeline for the 6-month start-up phase and the other a broader timeline for the 42-month implementation phase.

MAPS Project Timeline # 1: 6-Month Start-Up Phase

Key Project Activities	Project Weeks – 10/1/14 - 3/31/15											
	1/2	3/4	5/6	7/8	9/10	11/12	13/14	15/16	17/18	19/20	21/22	23/24
Finalize agreements with SAMHSA and finalize project subcontracts and agreements	■	■										
Hire and train Project Coordinator	■	■	■									
Convene and hold monthly meetings of the BHTCC Workgroup		■		■		■		■		■		■
Finalize evidence-based practices and develop master EBP training schedule			■	■	■	■						
Conduct consumer surveys and/or focus groups as needed to obtain input into project design			■	■	■	■	■					
Assess computer systems and data sharing enhancements among the three courts			■	■	■	■	■					
Hire and train Lead Peer Mentor				■	■	■						
Finalize Peer Mentor staff procedures to ensure fully Supported Employment				■	■	■	■	■				

Key Project Activities	Project Weeks – 10/1/14 - 3/31/15
Finalize client admission criteria and standards for client support and success	
Develop data collection, reporting and evaluation parameters and begin to implement data procedures	
Finalize Peer Mentor training curricula in collaboration with SF Peer Services and the VA	
Enhance computerized databases at the three courts to maximize information and data-sharing	
Hire and train half-time Peer Mentors	
Conduct initial staff orientations at each site and begin the process of training all treatment agency staff	

MAPS Project Timeline # 2: 42-Month Implementation Phase

Key Project Activities	Project Quarters – 4/1/15 - 9/30/18													
	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Screen and enroll clients in the MAPS Project and match with Peer Mentors														
Provide client support through Peer Mentors, including through EBPs														
Continually track client services and Peer Mentor activities through data procedures														
Continually monitor and support the quality of the mentor / client relationship														
Convene quarterly meetings of the BHTCC Workgroup														
Provide supportive services to Peer Mentors, including mental health support														
Provide continual employment assistance and job training to Peer Mentors														
Administer GPRA to clients at admission, discharge, and six months post-baseline														
Continually collect project outcomes data from clients and Peer Mentors														
Continually review project data and share with Workgroup to enhance program														
Attend annual grantee meetings as required by SAMHSA														
Prepare and submit regular reports to SAMHSA by established deadlines														

Funding for Planned But Not Yet Operational Courts: This item is not applicable to the narrative since the MAPS Project will involve collaborations with three fully operational behavioral health courts.

Achieving Equitable Balance in Serving Co-Occurring Disorders: As described in the Statement of Need section above, the MAPS Project attempts to strike a true balance between mental health and substance use services by acknowledging and addressing the **interconnectedness** of these two issues, particularly in forensic populations with severe and persistent mental illness. The project draws an equal number of clients both from the Behavioral Health and Drug Courts, and **all** clients will have **both** a substance use and severe mental illness diagnosis. Peer Mentors will work **across all three court systems,** gaining information on client needs within the three courts and **cross-pollinating** the system with enhanced client treatment and support knowledge by sharing their experiences with the BHTCC Workgroup on at least a **semi-annual basis.** Peer Mentors supported through the program will also be persons in recovery with co-occurring disorders themselves, many of them with severe and persistent mental illness and many with histories of criminal justice involvement. In contradistinction to typical social attitudes regarding the hiring of persons with incarceration, substance abuse, and mental health histories, our project will **honor these experiences as virtues and see them as professional qualifications to be respected and valued.** In turn, it is hoped that this respect will offer a new level of validation and sustenance to Peer Mentors which will support the recovery and professional growth of these individuals throughout the project period.

How Achievement of Goals Will Produce Meaningful Trauma-Related Results: San Francisco Community Behavioral Health Services (CBHS) - the overarching program unit in which Jail Health Services is situated - operates through a **trauma-informed system** in which all behavioral health work is influenced by a foundational understanding of trauma from birth to death, with all staff and providers having a shared knowledge and terminology in regard to trauma and its impacts. The MAPS Project reflects this perspective, incorporating trauma-informed care at all levels of client service, care, and behavioral health treatment, such as through utilization of the Seeking Safety model in the context of drug and mental health treatment. All Peer Mentor staff employed through MAPS will undergo extensive training on trauma and PTSD and the impact these conditions can have on substance use and mental health issues. The project will place a particular focus on the manner in which trauma and PTSD impact **African Americans, women, and veterans** - all of whom are disproportionately impacted by trauma and require trauma-focused care to ensure recovery. MAPS holds the promise of developing highly effective court-based peer support models that operate on a fully trauma-informed basis.

Tracking and Addressing Overrepresented Populations: As described in the Population of Focus section at the start of this document, the MAPS Project will impact those individuals with co-occurring disorders in San Francisco who are in greatest need of peer support services to ensure the effectiveness of their court-mandated recovery programs. For example, while **6%** of San Francisco residents are African American, **52%** of our project population is expected to be African American. Additionally, **57%** of participants are expected to have **no income of any kind** while another **19%** will be on disability; **11%** will be receiving some other form of assistance; and only **7%** will have any form of employment. **Less than a third** of project clients

will be living in a viable apartment or housing situation following their release from jail and **nearly one-quarter** will be living on the streets or in temporary shelters. Only **27%** of project participants are expected to have a high school diploma; **20%** will possess a GED degree; and **5%** will not have completed middle school. MAPS will carefully track the demographic characteristics of all clients enrolled in and receiving Peer Mentor services through the program, and will analyze data findings and outcomes in relation to specific overrepresented populations including persons of color, low-income persons, homeless and inadequately housed persons, transgender persons, and gay and lesbian populations. The project will also analyze mental health and substance abuse impacts both independently and together in relation to these key subgroups and will seek to minimize **outcomes disparities** across the client group as a whole.

Identification, Recruitment, and Retention of Population of Focus: The MAPS Project will benefit from the presence of three robust collaborative court partners which have a steady influx of substance using clients who are living with severe and persistent mental illness. At the present time, the Drug Court serves an average of **150** clients per year; the Behavioral Health Court involves **140** clients per year; and the Veterans Justice Court has a current caseload of just over **30.** The combined annual client population of **320** is fully capable of providing the study's annual project population of **72** clients per year. Additionally, all three courts will participate in the BHTCC Workgroup which will ensure awareness of the MAPS Project while instituting systems to evaluate and screen prospective project clients on an ongoing basis.

Ensuring Consumer Input: San Francisco Jail Health Services is committed to the strong and continual involvement of consumers in all facets of MAPS Project design and implementation. The project as a whole is in fact **based on the principle of peer involvement and management**, and incorporates a strong respect for the ability of peers and consumers to play a critical and indispensable role in supporting the recovery of persons with co-occurring disorders. The project will extensively consult with consumers during the project's initial design phase through both questionnaires and focus groups involving current and past collaborative court participants. The project's Lead Peer Mentor will be a highly experienced consumer who will partner with the Project Coordinator in supporting the work of Peer Members while serving as a permanent member of the BHTCC Workgroup. At least one of the project's half-time Peer Mentors will also serve on the Workgroup, possibly on a rotating basis. The Peer Mentors will also attend Workgroup meetings at least **semi-annually** to provide personal input on the progress of the program and on ways in which it could be improved. **Bi-weekly staff meetings** will provide another key source of input for peer staff. **Project clients** will also play a key role in shaping and refining by the program through their completion of project forms and questionnaires - including client satisfaction surveys - and through the specific outcomes they achieve with the support of peer staff. In a more direct sense, clients will also provide ongoing, de facto input on the program through their day-to-day formal and informal interaction with peer mentor staff, who will absorb the messages and responses provided by clients and relay these on to project management and staff to continually enhance the intervention.

Other Participating Organizations: As noted above, the project's key partners are the **three** San Francisco Collaborative Court units that will participate in the MAPS Project: **the Behavioral Health Court, Drug Court,** and **Veterans Justice Court.** Additional key partners include **San Francisco Peer Programs** and the **San Francisco Veterans Administration**

Medical Center, which will provide input and support on the peer hiring, training, and supported employment component, and **HealthRIGHT 360**, which will be a major provider of integrated mental health and substance abuse treatment in collaboration with the participating courts. The **San Francisco Department of Public Health Office of Quality Management** will provide support in designing and implementing data collection systems related to the performance assessment, and will be responsible for collecting GPRA data 6 months post-baseline for clients who are no longer in the program at that juncture. **Jennifer Pasinosky,** database and IT systems specialist for the San Francisco Collaborative Courts, will head the effort to enhance client tracking and data sharing systems between the three participating court entities.

Expansion or Enhancement of Services: The MAPS Project represents a **services enhancement** that adds a layer of strong peer support services to an existing collaborative court structure.

Section D. Staff and Organizational Experience

Capacity and Experience of Participating Organizations: The project's grantee agency, the San Francisco Department of Public Health, is the overseeing public health agency for the city and county of San Francisco, administering both prevention and direct health service programs on behalf of the diverse citizens of the region. The proposed MAPS Project will be housed under **Community Behavioral Health Services (CBHS),** a unit established in 2003 with the integration of Community Substance Abuse Services (CSAS) and Community Mental Health Services (CMHS). CBHS funds and operates a system of care that strives to provide integrated substance abuse and mental health services to all eligible San Francisco residents with substance abuse challenges and mental health needs. The mission of CBHS is to (1) assess the nature and magnitude of mental illness, alcohol, and other drug related problems in San Francisco, (2) ensure provision of quality, culturally competent, cost effective mental illness, alcohol and other drug prevention, treatment, and recovery services to individuals, families and communities, and (3) promote cooperation and collaboration among a broad spectrum of public and private service systems to reduce the level of mental illness, alcohol and other drug problems in San Francisco.

The array of behavioral health programs and services provided by CBHS includes outreach and prevention; assessment and placement; outpatient care; day treatment services; case management; residential services; support services; peer and wellness centers; detoxification services; medication management programs; and full-service partnerships with programs such as Proposition 36 drug funding, the San Francisco Drug Court, Behavioral Health Access, the San Francisco Mental Health Plan, Healthy Workers, Healthy Families / Healthy Kids, Medi-Cal (Short-Doyle, Mental Health, and Drug Medi-Cal), and the Mental Health Services Act. CBHS serves uninsured and indigent San Francisco residents and has a long history of developing and administering innovative linked mental health and substance abuse services.

CBHS administers at least **146** separate substance abuse treatment programs housed in more than **50** agencies throughout San Francisco. CBHS has received and successfully overseen several SAMHSA grants including grants funding Targeted Capacity Expansion for pregnant and postpartum women; community-based, medically supported detoxification services; mobile methadone treatment services; an Office-Based Opiate Addiction Treatment Program; the San Francisco Practice Improvement Collaborative; the Post Release Education Program; and the

Homeless and Addiction Vocation, Education, and Network project. These SAMHSA initiatives were either targeted specifically for women or were gender responsive in design and implementation, thus addressing the needs of women from diverse racial/ethnic and class backgrounds as well as the behavioral health and familial issues of women with children. CBHS has also received and administered several Department of Justice grants that are gender responsive and family focused, including the Women's Integrated Services and Health Project and the Second Chance With Open Arms Initiative for San Francisco Women.

Originally founded as part of Haight Ashbury Free Clinic, CBHS's **Jail Health Services** program has provided behavioral health and case management services in the San Francisco Jail system since **1973**. JHS provides a variety of in-jail treatment modalities including evaluation; crisis intervention; brief supportive therapy; individual and group therapy; medication consultation and planning; substance abuse screening, assessment, and referrals; and evaluation and monitoring of prisoners in psychiatric segregation. JHS Reentry Services employs **6** therapists providing case management services while the Discharge Planning Program provides discharge assistance and planning to prisoners with special needs such as homelessness, substance abuse, and/or mental illness. Two years ago, the agency also launched a pilot program through which it appointed **2 peer mentors** to work in collaboration with the San Francisco Behavioral Health Court which is a key partner in the MAPS initiative. The success of this program led to the current peer expansion proposal to SAMHSA.

The **San Francisco Collaborative Court (SFCC)** is a nationally recognized program of the Superior Court of California, County of San Francisco. SFCC operates through a network of "problem-solving" courts which work with individuals and families who are involved in the criminal justice, juvenile delinquency, and child welfare systems and are challenged by substance abuse, mental illness and other social welfare concerns. Judicial Officers supervise treatment progress through interaction with defendants during court hearings, while the use of sanctions and incentives promotes defendants' accountability with a focus on recovery. The Court works with many partner agencies and programs to address the complex social and behavioral health problems that have led defendants to cycle through the courts and jails. Policies and programs of the Court are evidence-based and data-driven, and the Court strives to be accountable and transparent to the Court, the City, and the community. The overarching goal SFCC is to improve individual and family outcomes, minimize incarceration, reduce criminal recidivism and improve public safety. The MAPS Project will collaborate closely with **three** distinct Court entities, each of which has a specific relationship to the proposed SAMHSA target populations, as follows:

- **Behavioral Health Court** (BHC) addresses the complex needs of mentally ill defendants, including those with co-occurring substance use disorders. An individualized treatment plan is developed which includes psychiatric rehabilitation services, medication management, supportive living arrangements, substance abuse treatment, supported employment, and intensive case management services. BHC received the 2008 Council on Mentally Ill Offenders Best Practices Award and currently has **140** clients.
- **Drug Court** (DC) is a felony court that provides an intensive supervision case management program for non-violent offenders with substantial substance abuse problems. When a participant successfully completes Drug Court, generally after 10-24 months, probation is terminated or charges may be dismissed. Drug Court has its own treatment clinic located one

block from the Hall of Justice and is supported by state funding through the San Francisco Department of Public Health. The Drug Court serves an average of **150** clients per year.

- **Veterans Justice Court** (VJC) was initiated in April 2013. The program serves veterans who are returning from current or recent conflicts, are separating from the military, and are appearing in either San Francisco jails or in federal and state correctional institutions. The goal of the VJC is to provide participants who have substance abuse and mental health disabilities with wide-ranging social service support along with academic and vocational skills that lead to job placement and retention. Treatment services through the program are provided though the San Francisco Veterans Administration Medical Center. Still in its pilot phase, the VJC currently has **30** clients.

San Francisco Peer Programs - also a part of CBHS - provides a wide range of peer employment opportunities that enhance the quality of client support services throughout San Francisco. From the point of view of employed peers, the program's goal is to help consumers and family members become engaged and stay engaged in the recovery process; to learn and develop new skills for entry-level peer support services; and to develop positive support system that maintains wellness and recovery. Peer recovery support services are designed and delivered by individuals who have lived experienced as mental health consumers, or by family members or significant others of a consumer. CBHS Peer Programs provides recruitment, screening, hiring, training, and supervision for nearly **50** peers employed through the program, and has a wealth of experience in supporting and supervising peers, and in addressing issues and barriers as they arise. Current programs of the office include the Peer Support Internship Program (PSIP), the Consumer Employment Program (CEP), and the Pathways to Discovery Program (PDP).

Established in 1934, **the San Francisco VA Medical Center (SFVAMC)** has a long history of conducting cutting edge research, establishing innovative medical programs, and providing compassionate care to veterans. The Medical Center has 104 operating beds and a 120-bed Community Living Center while primary and mental health care are provided through outpatient clinics in San Francisco, Clearlake, Santa Rosa, Eureka, Ukiah, and San Bruno. SFVAMC has several National Centers of Excellence and has recently been designated as one of only five VA Centers of Excellence in Primary Care Education. SFVAMC's Community Resource and Referral Center has also been selected as one of only 12 locations designed to serve homeless and at-risk for homeless Veterans and their families. Through its San Francisco VA Downtown Clinic, the SFVAMC serves as a key partner with the recently established Veterans Justice Court (VJC), providing comprehensive case management and mental health treatment services for court clients.

Finally, our project's main treatment partner, **HealthRIGHT 360 (HR360)** is a statewide healthcare organization headquartered in San Francisco whose mission is to give hope, build health, and change lives for people in need, often during chaotic, desperate, and isolated periods. This organization represents a unique **family of programs** that includes such nationally known providers as Walden House, Haight Ashbury Free Clinics, Asian American Recovery Services, and Rock Medicine. HR360 provides primary medical care, mental health services, substance use disorder treatment, and extensive reentry and support resources, delivered by a nonjudgmental and supportive professional staff. HR360 represents the combined vision of **Haight Ashbury Free Clinics** and **Walden House**, which were established in 1967 and 1969 respectively, and which have been strengthening their treatment services for over **40 years**. The

organizations merged into HealthRIGHT 360 in 2011 to create a comprehensive and integrative service delivery model of the highest caliber.

HealthRIGHT 360 provides a full continuum of substance use disorder treatment services to adults, youths, and families, including outpatient, residential, jail-based, sober living environments, and case management programs. All agency services are based upon evidence-based practices, so that the therapeutic environment and the clinical interventions are appropriate and effective for the needs of the individuals served by each program. Most programs are specialized to serve men and women separately, although participants are encouraged to invite their family members to join them for therapeutic and recreational activities whenever possible. Services are tailored to help men and women reunite with their families and learn essential skills that will help them recover from substance use disorders, build stable lives, and avoid future incarceration.

Proposed Project Staff: The 5% time in-kind **Project Director, Jana Rickerson, LCSW** will have overarching responsibility for the program within the Department and will serve as the ongoing project liaison to SAMHSA. In this role, Ms. Rickerson will be responsible for ensuring the submission of timely and thorough project reports and for disseminating findings and outcomes regarding the program throughout the Department. Ms. Rickerson currently serves as Grants Administrator for the San Francisco Department of Public Health. **Angelica Almeida, PhD** of Jail Health Services will serve as **Project Manager** on a **10%** basis in year 1 and an **8%** basis in years 2 through 4, guiding and monitoring the program on behalf of Jail Health Services while supervising and providing clinical monitoring to the Project Coordinator. The Project Manager will also coordinate project-related agreements and subcontracts with other departments, agencies, and consultants and will publicize and integrate the program throughout the Department of Public Health

The MAPS Project will also hire a **full-time Project Coordinator** who will be responsible for the day-to-day coordination, management, and operation of the MAPS Project while providing supervision and direct counseling and support services for Peer Mentor staff. The Coordinator will convenes and facilitate BHTCC Workgroup and staff meetings and coordinate ongoing consumer input to the Workgroup; train, supervise, and support the project's Peer Mentor team; ensure access to Supported Employment for Peer Mentors including access to emotional support, treatment and recovery services, and ongoing job skills training, skills building, and career planning services; coordinate training and certification in selected evidence-based interventions for Peer Mentor staff; and develop the project's overarching peer mentor training curriculum in collaboration with project consultants and with partners agencies and establishes the peer training schedules. The Coordinator will also oversee recruitment, training, and supervision of a pilot group of peer volunteers beginning in approximately year three, including working toward a volunteer peer model to ensure continuation of the program following conclusion of the grant period and will work in close collaborators with the project evaluators to design effective data collection and reporting methods and tracks the quality and thoroughness of ongoing data collection activities. The Coordinator will also be responsible for project dissemination and replication activities, including preparing journal and newsletter articles; presenting project findings at relevant conferences and gatherings; and preparing a dissemination plan which may include production of a comprehensive replication kit and a series of activities to inform agencies of the availability of the intervention model.

Meanwhile, the project's **full-time Lead Peer Mentor** will serve as an indispensable project staff member, providing direct peer mentor services to eligible clients of the three participating collaborative courts while serving as a role model and ongoing peer support resource for the team of 5 half-time Peer Mentors employed through the program. The Lead Peer Mentor will work in close collaboration with the Project Coordinator to design and implement MAPS Project peer services and programs and serves as a key member of the BHTCC Workgroup and will provide culturally congruent peer counseling and support, resource linkage, and skill building support to clients of participating collaborative courts with co-occurring mental illness and substance use conditions, including informal one-on-one in-person and phone based peer counseling to clients regarding behavioral health issues and will lead and organize client advocacy activities that engage clients in the development, implementation, and evaluation of the services that they receive. Of equal importance, the Lead Peer Mentor will provide continual support and advice to half-time Peer Mentors in carrying out their tasks and responsibilities, maintaining an "open door policy" in regard to Peer Mentor support inquiries and informal support meetings. The Lead Peer Mentor will also assist in the review and analysis of project data and channel recommendations from Peer Mentors to the BHTCC Workgroup.

Both the Lead Peer Mentor and the project's **five half-time Peer Mentors** will also maintain an active client caseload averaging **8** collaborative court clients at any one time, with caseloads varying based on demand and the length of the peer / client relationships. All Peer Mentors will receive training and certification in evidence-based practices utilized by the programs and will lead and facilitate one-on-one and group EBPs as needed. Peer Mentors will also assist clients in accessing, navigating, and following up on resources in the community, including medical and social service appointments, transportation, mobility, housing, decision-making, assistive technology, language, government programs, cultural adjustment, food assistance, legal assistance, women's services, medical assistance, mental health services, vocational services, volunteerism, education programs, and any other services that may support the client on overcoming external barriers to well-being and self-sufficiency. Mentors will also attend project staff meetings and participate as members of the BHTCC Workgroup on a rotating basis while participating in ongoing professional skills building and vocational assessment and job training programs sponsored by the program. Mentors will continually maintain a detailed staff activity log and record and enter project data following procedures developed during the project planning phase.

Experience and Qualifications of Key Project Staff: The MAPS Project will utilize a diverse range of highly qualified and culturally competent staff to develop, implement, and continually evaluate and refine the proposed intervention. **Angelica Almeida, PhD,** who will serve as Project Manager, is the staff psychologist with Jail Health Services and the Deputy Director of Reentry Services within the San Francisco County Jail. She completed her BA in Psychology at the University of California, Berkeley and her PhD in Clinical Psychology at the California School of Professional Psychology, San Francisco. She is experienced in working with individuals who have histories of complex trauma and the chronically mentally ill in forensic settings. Dr. Almeida has worked with the Behavioral Health Court program for the last four years and has worked closely with the collaborative courts in the San Francisco system of care. She has served as a primary developer and instructor of the Enhanced Practical Interventions for Collaboration (EPIC) Training, which is a CIT based curriculum for deputies working within the jail. Outside of her work at the jail, she is a professor at a local university

where she teaches courses on psychological assessment and has been published in the same area. Dr. Almeida has also presented at a wide range of national conferences and trainings.

Meanwhile, the Project Coordinator will be a Masters-level counseling or social work professional with at least **5 years** experience in behavioral health treatment and at least **3 years** experience training and supervising human service peer workers. The Coordinator will also have experience in health projects management, coordination, and/or capacity-building, including experience with training and data management and reporting. The Lead Peer Mentor will have personal experience and history in dealing with co-occurring disorders and at least **3-5 years** of lived experience with the community behavioral health system required, preferably in San Francisco. The Lead Mentor will also have at least **1 year** of peer counseling or related experience required, particularly in working with diverse communities.

The 6-member Peer Mentor team as a whole will be a highly diverse group that will embody the full range of diversity of the clients they serve. In addition to having strong interpersonal and active listening skills and the ability to work effectively and to interact professionally with a diverse, multi-cultural, and interdisciplinary team, Mentors must themselves also be individuals with co-occurring disorders who are successfully managing their recovery, preferably also with personal experience of the criminal justice system. While a high school diploma or GED is **not** required for half-time Peer Mentors, mentors will undergo significant training and education in peer support and EBP skills, and will need to fulfill extensive ongoing reporting requirements related to project services.

Preserving Program Continuity: Jail Health Services is committed to ensuring continuation of project services following the conclusion of the SAMHSA grant period in the event they prove successful. Our program will employ **two** key strategies for ensuring this occurs. First, the program will continually work with the collaborative court system to assess the impact of the program in relation not only to client success and outcomes but to the degree to which these impacts affect **potential costs to the system** in terms of factors such as reduced recidivism, reduced court costs, and reduced use of emergency medical and housing resources. These methods have proven successful in the past in regard to obtaining local general funds to continue all or part of successful grant demonstration programs. MAPS will also pilot a small scale program beginning in year 3 in which it will recruit, train, and supervise approximately **10 volunteer mentors** to see to what degree the work of volunteers might be a partial alternative to the work of paid mentors. In time, volunteers could potentially take over some of the responsibilities of grant-funded staff, although it is assumed there would still be a need for paid Lead Mentor and Coordinator roles. The volunteer mentor component will be incorporated into the local assessment process and will be continually reviewed by the Workgroup to explore its potential effectiveness.

Section E. Performance Assessment and Data

Ability to Collect and Report Required Performance Measures: Evaluation, data collection, and performance assessment activities of MAPS will be carried out by the San Francisco Community Behavioral Health Services **Office of Quality Management (OQM)**. The Office maintains responsibility for execution and oversight of research and evaluation of service programs operated through the Department. The Office has a keen interest in determining precisely how effective behavioral interventions are in helping clients meet their needs and

successfully move toward recovery and integration into the community. The Office has a particular interest in the proposed MAPS program as the program's goals and objectives directly align with the program's ongoing efforts to provide excellent integrated care for our most vulnerable populations.

The Office of Quality Management's **Research and Evaluation Section** employs Doctorate and Masters level data analysts, epidemiologists, and psychologists with many years of experience in designing and conducting evaluation projects and in managing and analyzing complex health services data. The Section has significant expertise in SQL Server, MS Access, Crystal Reports, SPSS, and other data management and analytic tools. The Section also has access to a secure data warehouse which contains service utilization and clinical data for **all** CBHS clients. The primary data sources available for evaluation projects include behavioral health and primary care data. In addition, through our **Coordinated Care Management System (CCMS),** additional data are available from emergency room encounters, ambulance transports, homeless shelters and other sources throughout the city.

The Office of Quality Management has many years of experience evaluating SAMHSA-funded projects as well as projects funded by other federal, state, and city agencies. SAMHSA-funded programs currently evaluating by the Office include the Primary Behavioral Healthcare Integration project and the Minority AIDS Initiative Targeted Capacity Expansion project.

Data-Driven Quality Improvement Process: In collaboration with SAMHSA staff, MAPS will implement a comprehensive data collection, evaluation, and quality improvement approach designed to collect required GPRA data while tracking and reporting on a broad range of quantitative and qualitative program indicators. For the GPRA reporting component, MAPS will closely collaborate with the Office of Quality Management to train peer staff in administering GPRA surveys at intake, discharge, and - where possible - at 6 months post-discharge for clients still in the program. The Office itself will oversee and conduct the 6-month follow-up GPRA interviews for clients who are no longer in the program, using trained staff who are skilled at locating project clients and administering the GPRA tools in a variety of settings. The Office will work to ensure a minimum **80% success rate** in obtaining 6-month GPRA data post-baseline. MAPS staff and OQM will enter newly collected GPRA data directly onto the SAMHSA GPRA website. Both Jail Health Services and OQM will retain hard copies of the GPRA instruments at their respective sites. Treatment sites will file the GPRA instruments in each client's treatment file while OQM will retain GPRA instruments in a locked file cabinet that is located in a secured data storage room.

The MAPS Project will also collect and report data related to a broad range of additional project activities and outcomes and will work in collaboration with SAMHSA, the project Workgroup, and OQM to design effective tracking and reporting systems for these components. Examples of additional outcomes to be tracked in regard to MAPS include:

- Tracking the characteristics and key demographics of project clients, including summaries of previous drug use, mental health, and criminal justice histories;
- Tracking the scope and content of services provided by Peer Mentors to clients, including participation in evidence-based practices and hours and type of additional formal and informal support contacts made;

- Conducting baseline and follow-up surveys to ascertain client progress in key domains such as substance use and mental health status, housing and employment status, and overall satisfaction;
- Reviewing evidence of utilization and outcome disparities involving project sub-populations, along with responses to address and overcome these disparities;
- Assessing the impact of the program on the Peer Mentors themselves, including the program's success in retaining peer staff and in ensuring transition to alternate or enhanced employment during or following the conclusion of the project;
- Documenting proceedings and outcomes of project-related planning meetings and focus groups, including producing regular minutes of project Workgroup meetings;
- Documenting replication and dissemination activities and products growing out of the proposed intervention; and
- Documenting the extent to which the project is successful in continuing some or all of its key elements following completion of the grant period, including the extent to which project replication models incorporate cost-effective approaches to adoption by other agencies.

Local Performance Assessment: Project directors, administrators, and key staff - in collaboration with the Office of Quality Management - will conduct an **ongoing performance assessment** designed to evaluate the overall success of the MAPS intervention. The Workgroup will use data produced through this assessment to continually improve the implementation and effectiveness of the proposed program. The performance assessment will be designed to determine whether Jail Health Services and its partners are achieving stated project goals, objectives, and outcomes and whether adjustments need to be made to the project. The performance assessment will also be used to determine whether the project is having its intended impact on client recovery and stabilization, and whether these outcomes can be traced in whole or part to the new client support component. MAPS will regularly report to SAMHSA on progress achieved, barriers encountered, and efforts to overcome these barriers through a performance assessment report to be submitted on at least a **quarterly basis**. The performance assessment will include all required performance measures identified for the program as well as outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/ sexual identity (sexual orientation/gender identity)?
- How durable were the effects?
- Was the intervention effective in maintaining the project outcomes at 6-month follow-up?
- What is the prevalence of trauma among individuals who participate in the BHTCC?

- What is the breakout of project data by ethnic group or other demographic factors and how can services be improved to ensure that disparities in services and outcomes are minimized?

Process Questions:

- Is the program being delivered as intended?
- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the CLAS standards?
- How did the collaboration across courts improve client's access to services?
- What evidence based practices were implemented and what adaptations were made to accommodate the target population?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community) and at what costs (facilities)?
- What was the effect of the intervention on key outcome goals for the women, children, and other family members within the population of focus?

Quarterly performance assessment reports will summarize the answers to these and other questions, and will provide specific recommendations related to program enhancement and potential replication. Project staff will review draft assessment findings to ensure accuracy and relevance and to contribute additional recommendations. Regular SAMHSA reports will include both results of performance assessments and the specific steps taken by the program to address key issues, barriers, and enhancement recommendations.

How Local Performance Measurement Will Improve Quality of Services: The MAPS Project will aggregate project data on a **quarterly basis** and will provide comprehensive, ongoing data reports to the Project Management Team. The Team will review data findings in conjunction with project staff and will identify specific potential project enhancements or improvements. Evaluation findings will also be discussed directly with SAMHSA project staff to identify key areas in which project approaches and systems could be modified to produce better implementation and outcome results. Staff will also continually be engaged in helping interpret project data and in relaying these interpretations to the Management Team, At least **4** key project staff will also activity participate in SAMHSA national meetings and in any designated activities designed to share project findings and to promote the dissemination and replication of successful project approaches.

Section F. Electronic Health Record (EHR) Technology

Existing EHR Systems and Systems Issues: Although the proposed project will **not** provide direct clinical services and therefore is technically exempt from the requirement to verify the existence of EHR systems, it is important to note that the project will devote a share of its resources to enhancing the existing data systems in use at the three participating collaborative

courts. At the present time, each court uses a different client tracking system, and some systems are more user-friendly than others in regard to both entering and extracting client data. The use of different systems precludes the three courts from sharing data following HIPAA guidelines - a capacity which would greatly assist the MAPS Project's local assessment. Through the court system's IT specialist, MAPS will conduct an assessment of the three court's client data systems during the first 3 project months and design an IT enhancement plan that will build the capacity for effective data sharing with strong privacy protection among the court sites. Support for this process will continue on a smaller level in years 2 through 5.

Additionally, the project's lead treatment provider, HealthRIGHT 360, employs the **Welligent** electronic health record to track client-level data and maintain client records across the agency's entire range of medical and service programs. Welligent is a **fully web-based** EHR that incorporates comprehensive scheduling tools, links to a patient call center, client check-in and payment collection, individual and group progress notes with supervisor co-signature, clinical features including medication management and John Wiley treatment libraries, e-forms, classroom management/attendance tracking, special education/IEPs, a health management module, billing, and reporting. The system can easily incorporate custom data fields, including new fields required to effective track services and outcomes of the MAPS Project.

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

☒ 1. For reference to Committee. (An Ordinance, Resolution, Motion, or Charter Amendment)

☐ 2. Request for next printed agenda Without Reference to Committee.

☐ 3. Request for hearing on a subject matter at Committee.

☐ 4. Request for letter beginning "Supervisor _____ inquires"

☐ 5. City Attorney request.

☐ 6. Call File No. _____ from Committee.

☐ 7. Budget Analyst request (attach written motion).

☐ 8. Substitute Legislation File No. _____

☐ 9. Reactivate File No. _____

☐ 10. Question(s) submitted for Mayoral Appearance before the BOS on _____

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use a Imperative Form.

Sponsor(s):

Breed

Subject:

Accept and Expend Grant- Mentoring and Peer Support Project - $348,142

The text is listed below or attached:

Resolution authorizing the San Francisco Department of Public Health to retroactively accept and expend a grant in the amount of $348,142 from Substance Abuse and Mental Health Services Administration to participate in a program entitled Mentoring and Peer Support Project for the period of September 30, 2014, through September 29, 2015, waiving indirect costs.

Signature of Sponsoring Supervisor: London Breed

For Clerk's Use Only:

150249

File No. 150249

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): Members, SF Board of Supervisors	City elective office(s) held: Members, SF Board of Supervisors

Contractor Information *(Please print clearly.)*	
Name of contractor: **HealthRIGHT/360**	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. 1) Board – See Attachment 1 2) Dr. Vitka Eisen – CEO 3) N/A 4) N/A 5) N/A	
Contractor address: 1735 Mission St., San Francisco, CA 94103	
Date that contract was approved:	Amount of contract: $
Describe the nature of the contract that was approved: HR360 will be providing staff with the expertise in jail treatment services and peer development. They will provide training and curriculum development for peer based learning, database development for evaluation and maintain and service all computer equipment.	
Comments:	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form (Mayor, Edwin M. Lee)

X a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Clerk of the SF Board of Supervisors	Contact telephone number: (415)554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place	E-mail: Bos.Legislation@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) — Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) — Date Signed

HealthRIGHT/360	
Board of Directors:	**Management Team:**
• The Hon. Harlan Grossman - Chair • Elaine Howard - Vice Chair • Emalyn Lapus - Secretary • John Baer - Board Member • The Hon. Ellen Chaitin - Board Member • Dr. Tom R. Hofstedt - Board Member • Kathryn Holmes - Board Member • Jack Kahler - Board Member • Jamie Kasvikis - Board Member • Deborah Koski - Board Member • Ann Ma - Board Member • Melyssa Mendoza - Board Member • Victor R. Ortiz - Board Member • Cindy Perry - Board Member • Peter Sullivan - Board Member • Trisha Walsh - Board Member • Kan Wong - Board Member • Jeanne Woodford - Board Member	• Dr. Vitka Eisen - CEO • David Crawford - CFO • Jegan Anandasakaran - CIO • Wayne Garcia - Vice President of Programs • Dr. Mardell Gavriel - Vice President, Mental Health Services • Demetrius Andreas - Vice President, Community Reentry Services • Michelle Hudson - Vice President of Development • Denise Williams - Vice President of Contracts & Compliance • Jack Cheng - Vice President of Healthcare Services • Tony Duong - Vice President, Business Development • Sarah Schoenberger - Managing Director of Clinical Services • Leo D'Agostino - Director of Human Resources • Lauren Cimino - Grants Director • Dr. Scott Collier - Director of Research and Evaluation • Dr. Ako Jacintho - Medical Director • Jeff Schindler - Director of Advancement