MACK CENTER ON NONPROFIT & PUBLIC SECTOR MANAGEMENT IN THE HUMAN SERVICES
University of California - School of Social Welfare - Center for Social Services Research - Berkeley, CA 90720 - www.mackcenter.org

September 2010

Building an Organizational Culture to Support Evidence-informed Practice: A Teaching Case

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Introduction

As the CEO of a strategic planning and evaluation firm (1984-2004) specializing in reform, evaluation, and funding of public and non-profit social service systems, we made important contributions in the fields of juvenile justice, homelessness, perinatal substance abuse, community policing, and mental health treatment. By 2004 I had become rather disheartened with the effort expended in persuading people to make change. So I decided to start looking for a job as executive director of a nonprofit human service organization where I could be responsible for actually making change, rather than just advocating for change. At about that time, the CEO of Family Service Agency of San Francisco—with whom we had been doing organizational consulting—left his position on very short notice. The Board President asked if I would be willing to act as interim CEO. It seemed to me like an ideal job to take it over on an interim basis to see if I liked it, as I could always help them find a permanent director and go back to consulting.

So that was how I got into FSA. While the services were pretty good it was an agency that was near death financially. It had lost money in 13 of the last 14 years. Successive CEO's had convinced the Board that losing money was inevitable given the nature of agency contracts. Each year, as the agency continued to lose money, the Board borrowed against assets to make up the deficit. Slowly, 120 years of accumulated assets had passed into the hands of lenders, often charging usurious interest rates since it was obvious that FSA was not long for this world. When I arrived—in September 2004— the Board had recently passed the annual budget with a $350,000 deficit. They were planning on selling the (heavily-mortgaged) agency headquarters to give the agency enough cash to survive one more year. So my first year was spent putting the fiscal house in order, reorganizing and pruning the top-heavy administration, and pulling FSA back from the brink. I loved the challenge, working with staff, and particularly valued working with programs serving the most needy individuals and families in San Francisco.

Beyond the Fiscal Challenges

One of the first things that I discovered was a rather weak set of middle-managers. They had mostly been promoted into management because they were skilled clinicians; being trained as therapists and not trained as managers, their management style was focused only on supporting their staff, whether they were effective or not. There were no metrics or standards for managing caseloads, measuring productivity, or even to tell if we were actually helping our clients. There was no way of separating effective from ineffective staff or to distinguish hard-working employees from those who were not putting in a full workday.

Although FSA has been around since 1889, the modern agency was assembled in the 1970's and 1980's by a dynamic Executive Director named Ira Okun. Ira had a burning passion to do everything that could be done for the poor. In pursuing that passion, he had built FSA into the largest outpatient service provider in San Francisco. The downside of this was that there was no underlying logic or focus to the services. While the agency provided a vast range of services to all ages, genders, and ethnicities, there was nothing like a continuum of care. Our service programs were located throughout the city/county of San Francisco and when staff came to the administrative offices, they acted like they were going to a foreign country rather than an agency that they actually worked for. Even though there were many different kinds of services across the age spectrum, no program ever referred a client to another program. In spite of these challenges, most of the programs were actually pretty good but the agency had no way of assessing or improving service quality.

Origins of Evidence-Based Practice

I came in to FSA as a reformer with the goal of putting our programs on the cutting edge of social service innovation. In the mid 80's, I got involved in the Children's System of Care (CSOC) movement. The goal of the CSOC movement was to unite on the local level the four major government agencies working with high-risk children: children's mental health services, child welfare services, juvenile probation , and the schools. CSOC's, once organized, would have common outcomes objectives, integrated services, and shared resources. The goals of CSOCs are to keep seriously emotionally disturbed kids "out of trouble, in school, and in the community". At the time I got involved, there was only one Children's System of Care in one California county and another six in the whole country. During the 20 years that I worked with most of the larger Children's Systems of Care in California, Washington and Oregon (as well as the federal level), CSOCs became the dominant service model throughout the United States, keeping children successfully in the community. For example, within 10 years of creating Children's System of Care, the children's wing at Napa State Hospital (which formerly had a long waiting list and year-long delays in admission) was closed for lack of clients. With the right incentives, localities had learned how to keep children with their families instead of locking them up in a big institution. The CSOC movement, starting with a great idea and a few model programs, brought changes in services for emotionally disturbed children that would have seemed impossible at the time the movement began. In the course of my career, I was involved with several other movements that transformed services for particular populations. I believe that the marriage of creative ideas with operational discipline can change the world. I wanted FSA to be a place where new ideas were emerging on a continuous basis.

In the five years before I came to FSA, I had been working with the National Institute of Mental Health in its efforts to bring evidence-based mental health practices (EBPs) to the community. EBPs are rigorous psychosocial methodologies for treating serious mental illness. Alone or in combination with medication, EBPs can address most cases of serious mental illness. However, attempts to migrate these treatments out of the university and into community-based settings had been a resounding failure. The vast majority of seriously mentally ill continued to receive unstructured psychotherapy and haphazard medication in community-based settings. This gap between what was possible and what was actually happening was very troubling to me. I kept thinking of the whole generation of people lost unnecessarily to severe mental illness and I wanted that situation to change.

So I came to FSA thinking here was a chance to implement evidence-based treatment at the community level. I assumed that this would be enthusiastically embraced by staff and clients. I discovered first that no one had heard of EBP and—when it was explained to them—they wanted nothing to do with it. They did not want the structure that EBP required. They did not want to do disease-specific treatment. They were offended that I seemed to be saying that the approach they had been practicing for decades was somehow inadequate. I quickly discovered that therapists whom I liked and deeply respected detested me. Many people quit. In Thomas Kuhn's *Structure of Scientific Revolutions,* he says that most paradigm shifts happen not because practitioners of the old paradigm are converted to the new paradigm, but because practitioners of the old paradigm retire or die, and are replaced by practitioners of the new paradigm. I had walked unwittingly into the maelstrom of paradigm shift. It was deeply troubling to me to be so disliked, but I was determined to push this change through: indeed, I thought that I had a moral obligation to push it through. I suppose that it is a character flaw to be able to hold to your opinion even when no one shares it, and when many people are violently opposed to it. But I did see it through and most of those people who originally opposed EBT and who are still at FSA now believe that they thought it was a good idea all along.

Over the next three years, there were a several failed attempts to implement EBPs. However, over time, a expanding group of staff learned how to establish the infra-structure, develop the trainings, and provide the clinical supervision necessary to implement EBPs. FSA is a happier place now (supported by annual staff survey results) and staff are proud of their effective work. What follows is a brief summary of that process.

In the beginning, staff viewed nearly every new initiative as hopeless and the agency as doomed. Therefore, continuing to soldier on in one's job was their only responsibility while they waited for the inevitable pink slip. In contrast, I was saying that we can be the best in the country by demonstrating evidence-based practice. Most of the staff seemed to be thinking that "the agency director is nuts for introducing evidence-based practice in an under-funded and overloaded staff dealing with increasingly crazy and non-compliant clients as well as implying that what we have been doing for the past twenty years is no longer good enough and he is not even a mental health clinician".

In the light of all this resistance, my first failed strategy was to try to build a consensus about EBPs. I established a joint management and staff team to plan out what evidence-based practices we wanted to do and what path we would take to train people in evidence-based practices. I soon realized that the implicit goal of the committee was to prevent me from implementing any evidence-based practices, although one or two program directors were actually excited by the idea. Finally, I hit on the idea of creating

the "Felton Institute". Kitty Felton was FSA's founding director and a real pioneer in the heroic age of social service at the turn of the 1900's. I appointed as Director of the Institute one of the program managers who was most enthusiastic about EBP. She got a new title, but still had to keep doing her program director job, since we didn't have any money to fund her position. However, the process of naming things—I discovered—gives them a reality and permanence. It seemed silly and grandiose to name an entity that didn't exist. However, once we had an "Institute" in FSA, people began to accept that we were going to do EBPs one way or the other. The terms of the conversation began to change.

The second thing I did turned out to have much greater ramifications than I ever thought. This was to develop an electronic health record system to replace our paper records. When I came to FSA, everything was documented on paper only: vast amounts of paper securely locked in file cabinets. One of the mantras that my consulting firm would always say to clients was "you can't change what you can't measure." By that standard, FSA couldn't change anything since it couldn't measure anything. I wanted to change everything, so we began to plan to automate all our client charts. Since we have 24 programs, we needed 24 versions of our client chart. With the help of a software developer, we built an agency-wide electronic health record system using Salesforce.com as a data platform. Salesforce wound up donating 285 licenses and some cash for development in exchange for using FSA in their marketing.

Initially there was a lot of fear. We had staff members in their 50s and 60 who had never turned on a computer. We had an 80 year old psychiatrist who would hand-write his progress notes and give them to a 70 year old woman who would type them on an IBM Selectric typewriter; that was her full-time job. Ironically, none of the other big agencies were automated either; it was a sad commentary on the state of nonprofits in the heart of the silicon economy. People ask how we got user adoption. It was a combination of things. First, we made the system look exactly like the paper charts. People didn't have to learn new business rules at the same time they were learning to use a computer. Secondly, we gave people a lot of support. If we had to teach them to type, we did that. If they needed forty hours of one-to-one training (one person did), we gave them that. In exchange, we ruled out "I am too old; I can't do it; you never trained me; it doesn't do what I need" as possible excuses for not using it.

The way in which we rolled it out also stimulated user acceptance. We started with our best managed program and then rolled it out to successive programs, one or two programs per month. Our general rule was "we'll give you all the support you need, all the training you need, we'll set up your charts for you on the computer so all you have to do is start using it on the first day. Then, after thirty days, nothing you do on paper will count any more". Actually, we had to give some people 60 or 90 days, but in general terms everybody in a program got automated simultaneously. No excuses, no keeping your case notes on post-its for a month. Once a couple of programs were automated, we realized that staff were spending about 50% less time on paperwork, giving them 25% more face-to-face time with clients. Once rumor started getting around about how much easier paperwork was with the automated system, there was a clamor from the other programs to get automated as soon as possible. Finally, although it seems silly, it was important that we gave it a name: CIRCE (Client Integrated Record of Care). Calling it CIRCE gave it a unified existence. People think of it—like the Felton Institute—as an inevitable and unchangeable part of FSA.

We provide really good support to the clinicians, so that they have come to see CIRCE as a tool that makes their work life better. Each program selects a representative to the CIRCE Advisory Board, which meets monthly. The Advisory Board brings in suggestions for enhancements, with one or two enhancements being selected for implementation each month. The Salesforce.com platform is such a rapid development environment that the selected enhancements are usually rolled out to the staff within two weeks, giving CIRCE a lot of credibility.With our records automated and our staff on-line, we went from having no information to having a vast amount of information. that took us a while to figure out how to use for operational management.

One of our consultants pointed out that FSA, like every organization whose product is words (law firms, schools, social service agencies, consulting firms), had difficulties communicating between the programs. Each program thought it was doing a great job, that its staff was overworked, and that other programs were not doing so well and were dragging down the agency. So we set up CIRCE so that every program could see every other program's performance metrics. Then we set up a monthly operations committee meeting where each program reported on its metrics; if they did not meet their goals, they shared their analysis to explain why they had not met them and what they were going to go to do to meet them next month. This change led to a number of changes: 1) trained our middle managers how to manage with a focus on outcomes, 2) made it very clear which programs were strong (most of them) and which were weak (two of them), and 3) program staff began to see that most of the other programs were working as hard as they were and program managers began to help each other to address ongoing problems.

Although each program has its own performance metrics, the focus in this teaching case is on the metrics for the mental health programs, since those targeted the area where our agency was most vulnerable. The metrics in mental health are based on county-developed standards for contracted services. For example, our staffs needs to document 1055 hours of billable client service per year; about 89 hours per month. A small number of staff members were simply not working hard and many left the agency within six months. Many more staff members were working really hard to serve the clients, but were not documenting their hours. As a result, we were not getting paid for the work they were doing and we were essentially paying them to work for free for the County. Over about a six month period, by focusing on this metric, our revenue per FTE went up by about 20%. This meant that we could earn our contracts with fewer staff, give staff raises, and still have funding left over for our new initiatives.

The second metric that we came up was called Chart Health. We got really burned—almost destroyed—in an audit during my first two years. We fired a staff member for fraud. That ex-staff member then went to the County and claimed that everyone in her program was committing fraud. The resulting audit found that there was no fraud except by the person who reported us, but the inadequate charting that was discovered in the audit resulted in a loss of about $400,000. That almost sent us over the edge one more time. So we set up CIRCE to track what we call the "five pillars of chart health". The five pillars include: 1) timely assessments with annual updates, 2) timely care planning within two months of assessment, 3) documentation of client consent, 4) documentation of HIPPA consent, and 5) treatment authorization for extended hours of service. If a chart had all five pillars correct, it was invulnerable to an audit. We set the standard so that no more than 5% of the charts could be out of compliance in even one of those five pillars and no chart could be out of compliance for more than 30 days (when we started, about

40% of the charts in the agency were out of compliance). Rather than come down hard on the managers for chart health (especially since we were doing so many other things at once) we started giving gold stars at the Operations Committee meeting for programs meeting their chart health target. Soon getting the gold star became a matter of urgency for the programs. They all wanted gold stars.

Finally, our final operational metric was that there could elapse no more than three working days between the time a client is seen and the time the progress note is recorded. This change, after almost two years, brought us back to what I wanted to do the day we started: bring in evidence-based practices for all our programs.

Here is where the university-developed EBPs clashed with the realities of non-profit work. Staff members had caseloads of 40-50 severely mentally ill clients. These clients usually had more than one severe mental illness; half were substance abusers; more than a quarter had chronic physical or cognitive conditions. Staff members were constantly trying to prevent clients from being evicted from their housing, from being arrested, from being denied food stamps, and/or from going hungry. The first thing I wanted to do was to reduce the caseloads from 50 to 30 severely mentally ill clients. This was a challenge because the county said we have to take anybody that came in the door or anybody who is referred to us. And our staff would make great efforts to reach out by going to their houses and often shout at them through the door until they could get the door open. Staff members were working really hard to maintain client contact with very little time for therapeutic work with their clients. I wanted to reduce the caseloads and increase their salaries while also increasingly hold staff accountable for their service contract obligations.

I realized that we needed to do two things before we could successfully implement evidence-based treatments. First, the case management model of service needed to become more systematized, rather than just continuously responding to client's self-generated crises. In essence, we needed to move from a kind of deficit focus to a strengths focused case management model. Because of the lack of research evidence nationally on validated case management regimens, we developed our own, based on the principles of motivational interviewing and strengths-based case management. We had, by this time, begun to make significant academic connections with UCSF, UCB, and other Bay Area universities. Working with many nationally-known experts, we were able to design a comprehensive approach to case management—called "Motivational Care Management". All of our staff are now required to be certified in MCM within their first two years. All our program directors and clinical supervisors are required to be certified as MCM clinical supervisors. Once a staff person is certified in MCM, they get a significant raise. MCM helped our staff to learn how to set boundaries so that they did not devote their whole work day to addressing the crises in their client's lives. This new approach to case management helped staff clear space to actually have time to do therapy with their clients.

The second thing we developed involved the developing outcome measurement tools that reflected the realities of our clients rather than the controlled treatment environments in which most evidence-based treatments have been validated. Our clients arrive with multiple conditions and we did not have the luxury of using hour-long diagnostic tools for each condition. However, we needed accurate and comprehensive diagnoses, since EBPs are diagnosis-specific. So we needed diagnostic tools that quickly provided rigorous diagnoses and could be completed in less than two hours but there was no such tool. The diagnostic tool needed to measure the functional severity of the mental

illness as well as the client's feelings about their lives within the context of the recovery model where staff members move beyond treating the disease to really help clients recover their whole life. At this point, we began working with Dr. Patricia Arean, a Professor in the UCSF Psychiatry Department and a national figure in mental health treatment for the elderly. We developed a proposal for a five year grant from the National Institute of Mental Health to underwrite the Felton Institute and fund our EBP implementation. This grant was funded; a central initiative of the NIMH project was to create these diagnostic and measurement tools. After almost two years of work, we developed and piloted a suite of assessment tools that now allow us to provide truly outcome-guided treatment.

The set of tools—named the ADEPT—includes two components:

- The "Diagnostic Tree". The tree is administered by the therapist. It begins with a series of trigger questions that probe for the possibility of a particular mental illness. If clients answer the trigger questions in a positive way, then there are probing questions that dig deeper with respect to a particular illness. So if the answers the two depression questions are "yes", then the probes include a depression inventory. If they answer the depression questions is "no", then the clinician moves on to the next series of question. We assess in this way the ten most common mental illnesses and substance abuse.
- The "Outcome Toolkit": The toolkit consists of a series of questions that are answered by the clients every month. In our pilot trials, it takes clients about a half hour to answer these questions. Elements of the toolkit are:
    a. Disease Severity Scale: With EBPs, we are committed to remitting each mental illness, reducing symptom severity to a normal level. The Severity Scale tracks progress toward this goal.
    b. WHOQOL: For assessing the quality of life, we use the *World Health Organization Quality of Life Scale*
    c. Community Living Skills scale: This scale assesses clients' acquisition of key skills for independent living.

Each of these assessment tools was vetted and modified by a committee of clients to ensure that they captured those things that clients felt it was essential for us to know.

Using Federal stimulus funding, we put these scales on a computer kiosk for clients to self-administer using a touch screen with availability in Spanish, Chinese, and English. They are also available in audio versions for who are not sufficiently literate. The clients also get to see how they are doing and the kiosk encourages them to enter any issues they want to talk about with the therapist because a lot of clients are too reluctant to raise issues face to face with therapist; this gives them a chance to do it more indirectly. The therapist and the client get the same sets of results. It took about four years to get to the point of training staff on the assessment tools and implementing a range of evidence-based treatments.

Finally, after all this work, we designed a comprehensive curriculum for our staff, that each staff person is required to complete within three years of coming to FSA. *The Path of Learning* is tailored to the type of program and the age range of the target population. Classes are organized by the Felton Institute. To pass each class, staff are required to master the elements of the EBP (which usually takes 2-3 months) and then to practice the EBP for at least six months under a trained clinical supervisor. The clinical supervisor will listen to sessions taped with the permission of the client, monitoring the extent to which the staff person has mastered the techniques of the treatment or social

service. Once certified in an EBP, staff receive a salary increase. Once they complete the entire Path of Learning, they are moved up to the highest pay grade in their field. As part of our commitment to recovery, we have a Path of Learning for all our staff: clerical staff, peer case aides and outreach workers, childcare providers, and receptionists in addition to case managers and therapists.

The Felton Institute now has a fund of intellectual property that is starting to find a market. We are selling our Motivational Care Management training very broadly. A number of organizations are looking to adopt our Outcome Kiosks. Many grants and donations are being received specifically for the Institute, which now has a training and research budget over $1 million annually.

Not all staff appreciated this new approach to professional development and approximately 20-30% left the agency. Obviously I needed and received the support of the Board of Directors as I expected some staff to complain to Board members. Actually the Board members were far more supportive than I expected. In the beginning, it was just me pushing for training and research along with the support of one other person and now the whole agency buys in. It helped to have several senior staff members either retire or resign because the younger staff members who were far more receptive to the changes related to evidence-informed practice. As we now hire new staff, we describe our evidence-based treatment programs and promise to train them on the different models and it does work well.

Lessons Learned

I was a lousy manager when I became the Executive Director. I came in and I thought I was going to inspire everybody and they were going to work effectively. Most were not inspired. Those who were inspired did not know how to translate inspiration into achievement. I slowly came to realize that much training and coaching was necessary to develop an effective management team.

In the early years, there was a whole lot of drama displayed by our management staff among those who supported/liked me and those who did not. I tolerated much of this drama because I felt that I should not censor honest expressions of opinion. After many painful lessons in this regard, we now set standards of discourse that does not tolerate acting out in meetings or complaining behind people's backs. All staff can disagree with one another but it needs to be done in a respectful and constructive way.

In a lot of ways I am not as nice of person as I used to be. In the beginning I held onto too many poorly performing managers because they were dedicated or because I worried that they would not be able to find another job. These decisions caused much turmoil among the staff as well as failed audits and loss of funding. In hindsight, all the bad managers wound up leaving anyway. All I had done by my worrying about them was to inflict much longer periods of suffering among their staff and clients.

I slowly began to recognize some of my limitations. I am not the kind of manager who is going to sit down with each program director and help them identify the 17 things that they need to do next month. I am good with the big picture but bad with checklists and GANNT charts. I finally hired a Chief Operating Officer (COO) who does a great job of supervising program managers, while I get to concentrate on things I actually do well.

My job now is more external as we have grown a lot in recent years (even in the recession of 2008-2010) and are on the verge of much more growth. We have moved into a new county across the Bay with a $1 million contract for mental health services and

have been encouraged by a statewide organization to establish mental health programs like ours in smaller, more rural counties. After six years as Executive Director, we are in the midst of figuring out our future directions as they relate to service expansion, marketing intellectual property, and identifying a group of staff internally that is capable of starting up new programs in other communities. We've also adapted the military's model of "after action reviews" to learn from each other as to how we can do a better job of implementing and monitoring new programs.

In consultation with our Board, we began to realize that the future of our 120 year old agency needed to be located in more communities outside the San Francisco, so that we would not be so dependent for our survival on a single city or county. In addition, we believe that our evidence-based service model is better for clients. We want to see our service model offered in other localities, either by FSA providing the services directly or by us training other non-profits to use our service model. Our major question is: "How do we share this model with other communities in a way that is best for people in need?"

Figure 1: History and Programs of Family Service Agency of San Francisco

Founded in 1889, Family Service Agency of San Francisco (FSA) is one of the oldest nonsectarian, nonprofit charitable social-services provider in the City and County of San Francisco. The mission is to strengthen families by providing caring, effective, and innovative social services, with special emphasis on the needs of low-income families, children, the elderly, and disabled people, thus improving the quality of life for all San Franciscans. The values that inform the services include the belief that individuals and families in crisis must have access to services and resources to help them build on their inherent strengths and develop self-sufficiency.

FSA addresses a large and varied population with 34 programs in 11 languages at sites with services that reach across all racial, ethnic, cultural, and linguistic lines. More than 70% of our clients have annual incomes below the poverty level, about 65% of the clients are of ethnic or racial minorities, and over half are female. The array of services include:

I. Children, Youth & Family Services

1. Developmental Education for Parents Program (DEPP)

Our Developmental Education Program for Parents (DEPP) operates on-site within the Family Developmental Center, annually providing 70 low-income, at-risk parents with stipended, educational workshops that address basic childhood development issues, including the relationship between early parenting practice and children's cognitive, social, and behavioral capacities to learn.Working with children's earliest educators – their parents – in a familiar and culturally-sensitive environment, DEPP helps low-income, at-risk parents to begin to perceive themselves as their children's valuable and successful "first teachers," aware of the long-lasting effects of early social interaction and environment on children's overall development.

2. Early Childhood Mental Health

Services to preschoolers are located in eight childcare facilities in San Francisco where mental health coordinators observe children, provide counseling to children and parents, and provide consultation and training to childcare staff.

3. Family Developmental Center (FDC)

Family Developmental Center offers a developmental childcare and school-readiness program for infants and toddlers (2 weeks to 3 years, 8 months) and their families. FDC provides a nurturing, developmentally challenging, and inclusive environment for very young children of low income, at-risk families, including those involving violence, abuse, teen parents, the involvement of Child Protective Services, or the criminal justice system. FDC also offers a mainstreaming model for medically fragile and developmentally delayed infants and toddlers. Blending clinical and educational components, the program provides assessment, Individual Education Plans, and a play-based curriculum. FDC services include family support, parent education, speech therapy, occupational and

physical therapy, psychological therapy for children and families, and an on-site Nurse. All of FDC's teaching staff hold early Childhood Education credentials.

FDC also maintains the Child Care Food Program, the Golden Gate Regional Primary Therapeutic Day Program, the Molera Medically Fragile Infant/Toddler Program, the Sanguinetti Special-Needs Therapy Program, and the State Department of Education General Child Development Program.

4. Hilltop Developmental Center

A model public-private partnership, the Hilltop Developmental Center (HDC) combines child-development education with center-based developmental childcare services. Participants are the pregnant and parenting teens who are case-managed by FSA's Teenage Pregnancy and Parenting Project (TAPP) and who are attending the SFUSD Hilltop School. HDC also includes an on-site breast-feeding clinic, along with nutrition and school-nursing services provided through both FSA and the San Francisco Unified School District.

5. Japanese Family Service Program

This program provides counseling and crisis intervention to all members of the Asian community, including individuals, couples, families, and groups, while primarily focusing on Japanese families. Bilingual and bicultural Japanese professionals assist with marital problems, parent-child communication, school difficulties, personal growth, aging, loss, depression, anxiety, problems of daily living, and mental illness. The program also provides consultations and information to groups, agencies, and individuals concerned with aspects of mental health issues and Asian cultures.

6. Teen Resources to Achieve Positive Practices (T-RAPP)

T-RAPP provides teen-parent peer support and youth development/leadership in conjunction with pregnancy prevention and other at-risk education services. The program includes four components: peer counseling, peer education, community education and teen peer groups. Services include classroom education; school and community presentations at youth and family fairs/forums; one-to-one education; peer educator support groups; and counseling.

T-RAPP coordinates with the San Francisco Unified School District to provide teen-parent peer education in classrooms throughout the city, and with New Generations Health Center, which includes T-RAPP teen peer-educator as staff members at the teen health center.

7. Teenage Pregnancy and Parenting Project (TAPP)

As the local provider of the California state program known as the Adolescent Family Life Program, San Francisco's Teenage Pregnancy and Parenting Project (TAPP) is a comprehensive case management program for pregnant and parenting teens city-wide. TAPP case managers help ensure that these teens have access to all available health,

education, and social services for which they are eligible, regardless of whether they are in school.

Focusing on the reduction in second births to teenage parents, academic enrollment and retention of pregnant and parenting teenagers, reduction of low birth-weight babies, and reduction in risk behaviors, TAPP also provides a myriad of support services, including child development and parenting education, childcare support services, nutrition and health education, job readiness, mental health programs, relationship violence prevention, and academic counseling. These support services are provided at TAPP as "one-stop" shopping or are facilitated through longstanding partnerships with other youth-serving agencies.

8. Full Circle Family Program

Full Circle Family Program offers outpatient mental-health services for multicultural, low-income, uninsured children ages 5 to 18 and to their families. The Full Circle Family Program has taken over for the former Tenderloin program. FCFP takes a family systems approach, working with children in the constellation of their caregivers, family and broader support systems. FCFP applies a rigorous strength-based culturally competent approach to address the issues within the family. Referral sources include the San Francisco County Mental Health Department, San Francisco Unified School District, and foster care and social service programs, as well as parents themselves. Services are also provided for teen parents at FSA's TAPP program.

9. Workforce Investment Act (WIA)

A component of our TAPP programming, the Workforce Investment Act program invests in youth who are already heads of households, providing a pathway to family economic success by encouraging them to stay in school and make plans to continue on to higher levels of education or permanent employment. Addressing such barriers as childcare, transportation, and other needs, WIA provides job readiness and occupational skills training, along with job placement, job retention, and job advancement skills both in-house and in collaboration with other organizations. A G.E.D. component is included in program services.

10. Young Family Resource Center (YFRC)

The Young Family Resource Center is one of California's first peer-directed, peer-focused Family Resource Centers for teen parents, their children, and their families. Integrating a youth development model, peer-to-peer service delivery, and wraparound resources, the YFRC acts as the hub of a network of support, education, and child-development information for adolescent and young adult parents throughout San Francisco. Building on our Teenage Pregnancy and Parenting Project (TAPP) case-management program for teenage parents, it offers comprehensive resources for young parents and their children, including financial education, nutritional education, grief & trauma support, mental health services, and vocational training.

11. Young Teen Parent Program

The Young Teen-Parent program provides targeted developmental parenting education and related activities for pregnant or parenting teens under age 15. This school-based program provides intensive daily support. The Teen Parent Child Development Services Program provides developmental education, assessment, counseling, and practicum activities to promote positive developmental parenting for pregnant girls, young fathers-to-be, and parenting teens of both sexes.

II. Adult Services

1. Administrative Services for Community Mental Health

The primary goal of this program is to provide on-site cost-efficient, high quality mental health administrative services to the San Francisco Mental Health Plan staff, who serve low income, culturally diverse, Medi-Cal or uninsured populations with mental health needs in San Francisco. By providing administrative services to SFMHP staff, this program promotes clients' higher satisfaction with treatment.

2. Adult Care Management Services Program

Adult Care Management provides intensive case-management for severely mentally ill individuals, enabling them to live in the community and to maintain the greatest possible independence, stability, and level of functioning. Every attempt is made to ensure continuity of care and to develop a community support system. Individuals are connected to appropriate resources and community health and mental health services, facilitating the development and implementation of their plans to achieve their desired outcomes.

3. Back on Track

A Deferred Entry of Judgment program, Back on Track provides strict accountability and close supervision for eligible first-time, low-level felony drug offenders, ages 18-24, who have no history of violence, gun possession, or gang involvement. Through Back on Track, first-time offenders may avoid incarceration while engaging in an individualized program of educational support, employment training, life-skills development, restorative community service, and behavioral health treatment.

A collaboration of Family Service Agency of San Francisco, Goodwill Industries, the District Attorney's Office, the Public Defender's Office, and the Probation Department, Back on Track requires participants to successfully complete a 12-month course of educational and vocational progress, judicial accountability, and community service. At the end of the year, and if the client has fulfilled the established goals, the District Attorney will dismiss the original criminal case.

4. Comprehensive Adult Recovery and Engagement Program (CARE)

Serving adults with serious mental illnesses, CARE provides an intensive array of recovery-oriented services and supports, including housing and basic needs assistance, physical health care, benefits assistance, employment services, and integrated mental health and substance abuse treatment services. CARE is a collaborative, integrated

partnership including Goodwill Industries, Community Awareness and Treatment Services, and the Tom Waddell Health Center.

5. Community Aftercare Program

The goal of the Community Aftercare Program (CAP) is to provide case management and mental health services to severely and persistently mentally ill individuals and dual-diagnosed clients who are living in residential care facilities. We work with clients to help them remain in the community and to maintain the greatest possible independence, stability, and level of functioning.

6. Early Crisis Intervention and Eviction Assistance Program

FSA's Eviction Assistance Program is a component of the San Francisco Sheriff's Eviction Assistance Program, providing resources and early crisis intervention and homelessness prevention services to individuals at particular risk of eviction. Additionally, the program allows for immediate access to existing funding and the supportive services needed to ensure that high-risk families retain their housing.

7. Moving Ahead Program for Youth (MAP for Youth)

The Moving Ahead Program for Youth (MAP for Youth) assists seriously mentally ill young (16-25) people in becoming independent and productive members of the community. MAP for Youth provides mental health and substance abuse treatment, physical health care, housing assistance, and vocational and educational support to San Francisco's most seriously disturbed young people. MAP for Youth is a collaborative, integrated partnership including Goodwill Industries, the Public Defender's office, the District Attorney, Community Awareness and Treatment Services, and the Tom Waddell Health Center.

III. Senior Services

1. Foster Grandparent Program

In this program, low-income, mobile seniors receive small stipends as they provide support services to children with special needs in health, educational, welfare, or other community settings.

2. Geriatric Outpatient Mental-Health Services

This outpatient program offers comprehensive services for seniors with mental health concerns, helping them to maintain independence and dignity to age in place. Fees are provided at no cost for people with Medi-Cal benefits. Sliding scale for private pay and MediCare recipients. Some private insurance coverage is accepted.

3. Long-term Care Ombudsman Services

The Long Term Care Ombudsman has professional staff, who are supported by visiting Ombudsman volunteers. All visit all the nursing homes and assisted living facilities in San Francisco, to advocate for good care, rights, and well ness. Every Ombudsman visits these consumers who are institutionalized, have conversations with them, and simultaneously reduce the very real social isolation, and provide community contact with those in placement. The Ombudsman Program in California is also mandated to investigate allegations of abuse and neglect, if the victim of abuse is in long term care. Many consumers call the Ombudsman Program for problems with their discharge plan from rehabilitative centers.

Finally, many consumers and family call the Program staff for tips on how to navigate the system of long term care, and obtain choices on the best option for receiving long term care. The Ombudsman Program functions in a web of collaborative relationships with agencies, both case-management, and enforcement throughout San Francisco.

4. Older Adult Day Support Center

The Older Adult Day Support Center is a daily, peer-supported, activity and socialization program set in a therapeutic milieu, serving people age 55+ who have mental health concerns, including substance abuse. Using a mutual aid model, the Center enables participants to be part of a supportive community and encourages the sharing of ideas, creative arts, and interpersonal growth. Fees are charged on sliding scale, no fees are charged to participants on SSI.

5. Older Adult Reintegration Services (OARS)

A socialization program to assist with transitions, OARS helps socially isolated and disenfranchised older adults living with mental health concerns make successful transitions to the most appropriate community-based programs, reducing fragmentation of services, increasing personal empowerment, and preventing relapses of physical, mental, or co-occurring disorders. Fees are charged on sliding scale, no fees are charged to participants on SSI.

6. Senior Companion Program

Low-income, mobile seniors provide companionship services to their homebound or frail counterparts at public health clinics, hospitals, and other sites.

7. Senior Full Service Wellness Program

The Senior Full Service Wellness program serves some of San Francisco’s most seriously disturbed older adults, providing comprehensive and integrated treatment services, including mental health and substance abuse treatment, physical health care, housing assistance, and vocational and educational support. The program is a collaborative partnership with Curry Senior Center, Community Awareness and Treatment Services, Goodwill Industries, the Over 60 Project at UCSF, and the Tom Waddell Health Center.

8. Senior Peer Counseling Program

Trained peer counselors aged 55 and older provide supportive counseling to other seniors, helping them continue independent living as long as possible, relieving depression and enhancing their quality of life.

9. Senior Peer Recovery Center

Based at the Curry Senior Center on Turk Street, FSA's Senior Peer Recovery Center is a comprehensive drop-in resource and recovery center for severely mentally ill seniors. Offering gentle, multilingual, culturally competent, peer-based services and support, the Center operates from 8:30 a.m. to 3 p.m. in conjunction with the Curry Center's daily meal program. The Center provides low-pressure connection with an array of available services, including mental health and substance abuse treatment, medical care, social activities, and peer-to-peer recovery support.

IV. The Felton Institute

Named for Kitty Felton, FSA's pioneering founding director, the Felton Institute for Excellence in Clinical Training provides intensive clinical training in evidence-based treatments to address the most complex mental-health issues facing America today.

Untreated and under-treated mental illness is strongly correlated with myriad other social problems, including homelessness, high medical-care costs, drug abuse and addiction, and poverty. But research demonstrates that – if met with the best and most appropriate treatments – even severe mental illness can become a manageable condition for most people, opening the way to recovery.

The Felton Institute serves as FSA's central resource in the implementation of evidence-based practices in every element of our service delivery, to maximize client recovery. Drawing on the nation's best teachers and clinicians, in many cases FSA classes are taught by the very professors and clinicians who developed the original treatment methods.

Figure 2: Path of Learning

Motivational Care Management
Level 1: Core Courses

MCM 101 Strength-based Practice for Real Situations: 3 hours

Principles of Strength-based Assessment

- Consumers strengths are highlighted in progress notes and on the plan of care in the interventions utilized
- Care managers are able identify a consumer's strengths in the contexts of their history

MCM 102 Culturally Relevant Assessments: 3 hours

Ability to bring cultural reflection into the assessment process

- The provider is able to identify cultural significance in a case presentation
- The provider asks all consumers they work with if they are identified with a particular culture and what makes that culture unique. This information is then reflected in the original assessment plan.

MCM 103 Identifying Unmet Needs: **3 hours**

Ability to assess for unmet need

- Ability to identify unmet needs in applied settings
- Ability to craft needs statements that support engagement

MCM 104 Client Centered Care Planning: **3 hours**

Ability to solicit consumer voice in the care planning process

- Progress note, assessments and/or plans of care clearly articulate the voice of the consumer, either literally or through interpreted behavior.
- There is voiced respect in communication on the part of the provider toward the consumer when the client is being presented at care conferences.

MCM 105 Embodying Culture authentically in serving a Diverse Population: 3 hours

Ability to understand and incorporate cultural understanding and preferences in the care planning process

- Progress note, assessments and/or plans of care clearly articulate culturally specific approaches to service.
- There is voiced respect in communication on the part of the provider toward the consumer when the client is being presented at care conferences.

MCM 106 Promoting Healthy Transitions: 3 hours

An overview of crisis plan and safety plan

- Ability to assess the difference between crisis and safety and modifying crisis and safety plans for better outcomes
- Ability to craft crisis/back up plan with consumers

MCM 107 Ending with Engagement in Mind: 3 hours

Exploring transition as it impacts people receiving services.

- There is a transition plan written out in the progress notes that notes the consumer has participated in the planning and has a copy of the plan.

MCM 201 Strength based Supervision and Evaluations: 12 hours (Supervisors Only)

- Best practices in supervision & evaluation and sustaining strength-based motivational care management practice habits

Level 2: Foundations of Evidence Based Practice

EBP 101 Motivational Interviewing I: **12 hours**

Ability to demonstrate four basic strategies of Motivational Interviewing:

1. **Open-ended questions:**
   - Care provider starts their meetings with consumers by asking about the client's main concerns, perceptions, and ideas.
   - Care providers refrain from asking too many narrowly-focused questions whenever possible.
2. **Affirmations:**
   - Care providers are able to be genuine in affirming effort over success and reframing "negative attributes" as assets observable strengths and affirming potentially negative aspects of a client's behavior in a positive reframe. Providers verbally praise efforts made by the client or intentions.
   - Providers verbally reframe qualities that may be challenging about the client into assets.
3. **Reflective listening:**
   - Care providers strive for a ratio of 2 reflective statements for every question asked
   - Care providers strive to craft reflective statements that move beyond restating simple meaning to more complex statements
4. **Summaries:**
   - Care providers end each session with a summary statement
   - Care providers use summary statements during the session when a content area has been fully explored and it is time to transition to a new area

***Please Note**: Motivational Interviewing can be population specific application of techniques. **EBP 101-OA** is suitable for providers working with older adults and **EBP101-CYF** is suitable for providers working with children, youth and families.*

EBP 201 Motivational Interviewing II: **12 hours**

Deepening the engagement practice habits learned in MI I

EBP 301 Core Components of Cognitive Behavioral Therapy: 12 hours

Ability to demonstrate core principles in CBT as it is the foundation of many EBP's to follow on FSA's Path of Learning.

Objectives:

- Provide a comprehensive introduction to cognitive behavioral therapy techniques.
- Become familiar with the scientific evidence for CBT
- Work actively with case material to learn CBT case formulation and treatment planning applied to a variety of mental health problems.
- Discuss how CBT can be integrated into clinical care and case management in community mental health settings
- Cover modifications to CBT for special populations (e.g., ethnic minority and geriatric)