San Joaquin County Behavioral Health Services
Progressive Housing Innovation Project

Date:	August 18, 2017
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Instructions:
The MHSA Innovation Component requires counties to design, pilot, assess, refine, and evaluate a "new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges" (Welfare and Institutions Code Section 5830, subdivision (c)). The eventual goal is for counties to implement successful practices without Innovation Funds and to disseminate successful practices to other counties. In this way, the Innovation Component provides the opportunity for all counties to contribute to strengthening and transforming the local and statewide mental health system and contributes to developing new effective mental health practices. (Mental Health Services Oversight and Accountability Commission, Innovative Projects Initial Statement of Reasons)

Submission: Progressive Housing: Adapting the Housing First Approach for Individuals with Serious Mental Illnesses

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Presented to the San Joaquin County Board of Supervisors: TBD

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Contents

Part I: Project Overview

The Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the reasons that this purpose is a priority for the County for which there is a need for the County to design, develop, pilot, and evaluate approaches not already determined as successful within the mental health system. *CCR Title 9, Division 1, Chapter 14, Sect. 3930(c)(2)*

1. Primary Problem

a) What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

1. What is the primary problem or challenge?

Individuals with serious mental illnesses require a safe and stable place to live in order to engage in treatment services and meet recovery goals. However existing housing solutions are scarce and expensive; rarely accommodate individuals with co-occurring disorders; are challenging to develop; and the most popular model (Housing First) appears to have mixed outcomes of improving housing stability but not necessarily improving recovery and wellbeing.

Individuals with serious mental illnesses require a safe and stable place to live in order to effectively engage in the treatment and recovery process. However too many individuals with mental illnesses have difficulty in securing and maintaining housing. Housing stability is even more problematic for individuals who are unserved or underserved by mental health services. This creates a vicious cycle whereby it is difficult to obtain housing while experiencing the acute symptoms of a mental illness but it is equally difficult to maintain participation in mental health treatment services without a stable place to live. For consumers that are unserved or underserved by public mental health services, a lack of stable housing is both a barrier to effective treatment services and a risk factor for worsening symptomology.

In San Joaquin County there is a severe shortage of affordable housing options for individuals with mental illnesses. Market rate rental costs have increased 12% in the last year, and 50% since 2007, and housing vouchers or SSI housing allocations are no longer sufficient to secure housing. Board and care facilities are closing throughout the County as property owners are seeing more lucrative returns in either renting or selling their properties (16 units have closed since 2015, reducing capacity by one-third). Further, the County's largest supported housing facility for individuals with serious mental illnesses was destroyed in May 2017 due to a catastrophic fire that displaced 42 residents. As a result of these housing challenges, too many individuals are experiencing "overstay days" in inpatient hospitals,

residential treatment programs, and other acute care facilities as case workers struggle to find a place to live for discharged consumers. Too often consumers are discharged to motels, shelters, or the streets; jeopardizing their recovery treatment plan.

- As safe and stable housing is necessary to maintain participation and progress in mental health treatment processes, more (affordable) housing options are needed for mentally ill consumers.

Finding safe and stable places to live is even more difficult for individuals with a co-occurring substance use disorder as many of the local housing programs (including all of the few remaining board and care facilities) have a zero-tolerance policy for drugs and alcohol and high barriers to entry. Consumers who are in the contemplation phase of the recovery process[1] find it nearly impossible to secure and maintain housing. Consumers who relapse while in the recovery process are at high risk for eviction.

- As both the contemplation and relapse phases are known stages[2] of the addiction treatment and recovery process, new housing strategies must be designed for individuals with co-occurring disorders that promote recovery across the spectrum of the treatment continuum.

Developing affordable housing solutions for individuals with serious mental illnesses is a complex and challenging process. Consumers, family members, clinicians, and housing providers all attest to the need for housing with supportive services and linkages to treatment. It is also recognized that effective housing programs have consumers living in close proximity to each other, rather than isolated in scattered sites throughout the region. Shared housing or group home environments offer the opportunity to create support networks of peers who are working together towards the recovery process. Group housing programs also account for economies of scale. It is more efficient to provide supportive services to clients who are in close proximity to each other.

Unfortunately, there is increasing opposition to the development of affordable housing units for individuals with mental illnesses. A proposed eight-bed facility in Kings County was rejected by the

[1] Recovery is a phrase that is used interchangeably through this document to reference both recovery from a substance use disorder and recovery in a mental health context. A *working definition* of recovery is provided by the U.S. Substance and Mental Health Services Administration (SAMHSA): *A process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential.* Further discourse on the working definition and its implications in research can be found at: https://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.WZHtWMFK148

[2] "Recovery stages", in this context, reference the phase of recovery experienced by someone with a substance use disorder who is moving from addiction into recovery. A national standard for the stages of recovery has been established by the American Society for Addiction Medicine (ASAM), and adopted into federal and state health care policy. This document references several of these recovery phases: pre-contemplation, contemplation, preparation, action, maintenance, and relapse. More information about the stages of recovery can be found at: http://www.csam-asam.org/sites/default/files/pdf/misc/StagesofChange.pdf

County Board of Supervisors over neighbor objections. The proposed Kings County facility was to be located on a rural stretch of road, outside city limits, surrounded by orchards and fields. Further, even for those projects that are eventually approved, the length of time required from conception to occupancy can take years. In 2008, Joaquin County Behavioral Health Services approved the allocation of MHSA funds for the purposes of constructing Zettie Miller's Haven, a large affordable housing facility with twenty units dedicated towards the mentally ill. But securing financing and approvals for large housing programs is time consuming, and it took a decade to complete the project and get tenants in.

- New approaches to housing for consumers with serious mental illnesses are needed that have fewer regulatory hurdles.
- New approaches to housing for consumers with serious mental illnesses are needed that can be rapidly deployed from conception to habitation.

San Joaquin County Behavioral Health Services has determined through its Community Program Planning Process that better, more affordable housing solutions are needed to quickly address the housing needs of individuals with mental illnesses -- particularly those that are homeless or at-risk of homelessness. However, in a literature review of effective practices conducted to inform the design of a mental health housing program it was discovered that there remain significant deficiencies in existing models of supportive housing programs.

Large scale supportive housing programs for mentally ill consumers can have good outcomes but are very costly to operate and difficult to develop due to neighbor opposition. Another barrier is that traditional supportive housing programs are designed for consumers that are committed to the recovery process and have low- or zero-tolerance policies for substance use that are designed to protect the recovery environment. As a result consumers with co-occurring disorders have difficulty entering or maintaining in these types of supportive housing options until they are well engaged in the recovery process.

Conversely, many housing advocates recommend a **Housing First** approach in which consumers are immediately housed, regardless of where they are in the recovery spectrum or their readiness for treatment interventions. The Housing First model provides assertive community treatment and case management supports that wrap-around the newly placed consumers and to help them obtain treatment services. Unfortunately, findings from the largest study of Housing First program consumers (At Home/Chez Soi, conducted by the Canadian Department of Health[3]) found only modest recovery gains through this program. Consumers placed using the Housing First models were less likely to be

[3] Aubrey, T., Nelson G., and Tsemberis, S. (2015) Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research Findings of the At Home Chez Soi Demonstration Project. Canadian Journal of Psychiatry. 2015 Nov. 60(11) 467-474.

homeless or to use emergency services, but they were also unlikely to meet recovery goals as measured by a reduction of symptomology or substance use[4] (see a discussion of the study findings in the literature review in Section 2, below).

- New models of affordable, easy to develop, and recovery-oriented housing are needed to help County Mental Health Departments connect consumers to housing and meet recovery goals.

San Joaquin County's challenges are similar to jurisdictions throughout California and nationally. Common sense, as well as a concerted body of evidence, indicates that housing stability is an integral factor in promoting wellness and recovery for individuals with a mental illness. Treatment compliance is severely hampered without a safe place to store medications. Case management and peer support services are compromised when there is neither an address nor a phone number with which to conduct follow-up activities. Wellness and recovery gains are also challenging for consumers to achieve without a stable home as housing uncertainty can foster anxiety and hopelessness.

Housing is a critical component of every consumer's recovery plan but finding and maintaining housing is a growing concern for consumers across California and the nation. As housing costs continue to rise, more consumers will continue to be squeezed out of housing programs, making it more difficult for clinicians, family members, and community partners assist consumers in meeting their recovery goals. New and improved housing strategies are required for individuals with serious mental illnesses and more research is needed to document the effectiveness of new types of supported housing programs and to demonstrate their cost effectiveness against existing models.

San Joaquin County Behavioral Health Services (BHS), in partnership with Stockton Self Help Housing, Inc. (SSHH) and UC Davis Behavioral Health Center of Excellence (UC Davis), will operate and investigate the Progressive Housing Innovation Project.

The Progressive Housing project will measure whether a modified Housing First approach to mental health treatment services improves engagement and retention amongst previously unserved or underserved individuals and leads to improved outcomes amongst consumers.

2. How does this challenge relate to your community?

San Joaquin County is a diverse community that is slowly making an economic recovery and experiencing a newly aggressive housing market. Addressing unmet housing needs, curbing

[4] Study outcomes show significant improvements pertaining to decreased number of arrests, hospital stays, and days homeless, but few changes pertaining to actual recovery, in terms of reduced substance use, improved wellness, reduce symptomology. The vision behind this INN project is a firm belief that curbing the negative effects of mental illness is not enough; more work is needed to develop truly recovery-oriented housing strategies.

homelessness, and developing more effective responses to engaging unserved and underserved individuals with mentally illnesses are top priorities for the County.

San Joaquin County, located in California's Central Valley, is a vibrant community of just over 700,000 individuals, with a diverse population. English is spoken by more than half of all residents, though 170,000 residents are estimated to speak Spanish as their first language. Tagalog, Cambodian, Chinese, Hmong, and Vietnamese are also spoken by large components of the population (approximately 6,000 – 9,000 residents for each language group). *Source: San Joaquin Council of Governments*

Race Ethnicity in San Joaquin County	Rate
White (not Hispanic or Latino)	33%
Hispanic or Latino	41%
Asian	16%
African American	8%
Two or More Races	2%
Total	100%

The median income of San Joaquin County is $53,700 with 18.6% of all residents living below the federal poverty level – the average income amongst residents living in poverty is $11,500 annually (defined as individuals whose incomes fall within the bottom 20% of all residents). Economic and employment gains following the Great Recession continue to lag in San Joaquin County compared to the rest of the State with unemployment at 7.3% in June 2017 compared to 4.7% for California and 4.5% for the nation during the same period. San Joaquin County has the highest unemployment rate of any large county (with a population over 700,000) in California. *Source: CA Employment Development Department*

While incomes and employment lag behind neighboring Sacramento, Alameda, and Contra Costa Counties, housing pressures and robust job markets in these counties are leading to increasing pressures on local housing markets. During the 2017 Community Program Planning Process consumers expressed fear and frustration with finding a safe and affordable place to live because the rental conditions are so tight. One consumer claimed to be living in sub-standard housing with vermin and only sporadic hot water but said she was too afraid to complain out of concern that doing so would lead to an eviction because, "so many other people would pay more for my place." Other tenants echoed these concerns, telling stories of how the stress and strain of their housing challenges impact recovery efforts. Consumers also reported that homelessness and housing insecurity have profound effects on their recovery efforts, with many stating that they were unable to actually engage in recovery efforts until after their housing situation stabilized.

Homelessness and housing insecurity is a major challenge for San Joaquin County. The San Joaquin County Board of Supervisors has adopted "addressing homelessness" as a strategic priority for all county departments. The January 2017 Homelessness Count identified 1,500 homeless individuals living within San Joaquin County – over 30% of whom self-reported having a mental health concern. Law

enforcement, community groups, and homeless advocates report that behaviors such lack of hygiene, public urination, and disorganized thinking lead them to think that there may be higher rates of mental illness amongst the chronically homeless, though this has not been verified. While some of these symptoms could be related to active substance use, the public perception is that there is a very high rate of mental illness amongst the homeless population.

b) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

In considering two interrelated challenges, lack of affordable housing for existing mental health consumers and lack of treatment services for homeless individuals, BHS has identified two target populations that require similar interventions:

1) Underserved Individuals: Identified consumers with serious mental illnesses who do not have a stable place to live, or cannot maintain successfully in available housing options due to recovery challenges (emotional regulation, substance use, etc.) and as a result are so poorly served they are at grave risk of becoming chronically homeless.
2) Unserved Individuals: Individuals with serious mental illnesses[5] who remain undiagnosed or are not successfully engaged by BHS. (An estimated 20-30% of the 1500 homeless individuals in San Joaquin County may meet this criterion based on self-reports of "having a mental health problem" amongst homeless individuals during the County's annual Point-in-Time Count[6].)

"Underserved" means clients of any age who have been diagnosed with a serious mental illness and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, or resilience…. These clients include, but are not limited to those who are so poorly served that they are at risk of homelessness…. *California Code of Regulations §3200.300*

[5] It is presumed that a significant majority of Progressive Housing clients will be individuals with a co-occurring substance use and mental health disorder, however the eligibility criteria is a diagnosis of a mental illness as there *may* be individuals with a mental illness but not a substance use disorder for whom the program is appropriate.

[6] San Joaquin County Continuum of Care, Point in Time Count. March 2017.
A survey of homeless individuals in San Joaquin County (N=567) found that 31% self-reported having mental health problems. Nationally, SAMHSA estimated that 20% of those experiencing homelessness have a serious mental illness and 30% of those who are chronically homeless have a serious mental illness. The National Coalition for the Homeless also found that mental illness is the third most prevalent reason for adults to become homeless.
http://blogs.esanjoaquin.com/stockton-city-hall-blog/files/2017/04/Point-in-Time-Report-overall-FINAL-4-4-17.pdf
https://www.samhsa.gov/homelessness-housing
http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

"Unserved" means those individuals who may have a serious mental illness and are not receiving mental health services….. *California Code of Regulations §3200.310*

As a result BHS has joined with consumers, family members, substance use providers, homeless advocates, housing providers, community based organizations and others to develop a new approach to working with individuals with serious mental illnesses who do not have a safe and stable place to live. In focused discussion groups, consumers and service providers expressed the importance of having peer-involvement in services, in creating consumer driven programming options, and in having on-site services and supports that are geared to gaining independence and promoting recovery goals.

Consumers further indicated that program flexibility is important as and that housing programs need to be designed with a no-fail approach. Meanwhile, local landlords and property management firms expressed hesitation at providing rental units for mentally ill consumers within their existing programs. Several voiced concerns about "tenant damages, beyond wear and tear." Two landlords expressed interest in creating supported housing units, but the properties suggested proved to be in too great a state of disrepair to be tenant ready without major property improvements, and further were located in neighborhood environments that are not conducive to recovery proximity to retail liquor outlets and other negative influences. Through these discussions about consumer needs and available resources it was determined that "new housing solutions" were required, beyond service as usual in San Joaquin County.

Simultaneously, the San Joaquin County Homelessness Taskforce created a series of recommendations which were subsequently adopted by the Board of Supervisors, these recommendations included:

- The creation of uniform discharge policies to prevent individuals being discharged into homelessness;
- Adoption of a "Housing First" strategy to reduce upfront barriers to housing; and
- Fostering new collaborative strategies to prevent homelessness before it occurs.

The findings of the Community Program Planning process, the recommendations of the Homelessness Taskforce, and the directive of the San Joaquin County Board of Supervisors led to the development of the proposed INN project to create a new model of Progressive Housing for individuals with mental illnesses and co-occurring disorders.

Stockton Self Help Housing Inc. was selected as the project partner following the discussions with local landlords, the Housing Authority of San Joaquin County, and the federally designated Continuum of Care provider, Central Valley Low-Income Housing Corporation. The SSHH program model offers a unique approach to overcoming some of the challenges associated with housing consumers with serious mental illness. In their model, SSHH:

- Rents single-family homes directly from the owners and serves as the master tenant. As the master tenant, SSHH is responsible for the timely payment of rent and general upkeep and maintenance of the property.
- Under a negotiated master-lease agreement, SSHH and the landlord agree on the number of sub-tenants that will be allowed and the terms and conditions for sub-tenancy.
- In some houses (the trial houses for individuals just thinking about the program, defined later as "level 1" houses) individuals are in the pre-contemplation phase of recovery and are offered a room as a "guest" until there is a mutual determination of whether the program is a good fit. Once eligibility and commitment to program services are confirmed program clients become sub-tenants and can move "progressively" through the different levels of houses in accordance to their recovery gains.
- Mental health, medical, or other treatment providers are allowed to make "home visits" as they would for any client, but clinical or therapeutic services do not operate on site.
- Houses are staffed by a "Resident House Manager" who facilitates house meetings, mediates tenant conflicts, and maintains dialogue with neighbors to ensure that any concerns or complaints regarding the house or the tenants can be resolved in a speedy fashion.
- Clients work with a "Housing Case Manager" to develop their own personal case plan to achieve permanent housing. Case plans include a range of different component including developing a positive tenant history, procuring identification and benefits, and meeting financial goals such as opening a bank account, living to a budget, and saving for a deposit.
- Clients graduate, or complete the program, when housing is stabilized in a permanent supportive housing or independent living situation.

This model addresses some of the barriers commonly found in opening new board and care facilities, group homes, or affordable housing programs as it eliminates or alleviates the following challenges:

- Renting existing single-family homes eliminates the need for tax credit or other complex financing as is required to construct or renovate an affordable housing development.
- Operating within the designated use of a single-family home eliminates the need for a city occupancy or use permit.
- Creating a shared housing situation, without embedded medical staff or clinical staff eliminates the need for Community Care Licensing or Medi-Cal Certification.
- Including a staff position of a resident house manager alleviates neighbor concerns and has led to stability in SSHH's portfolio of rental units.

San Joaquin County's INN project modifies the ***Housing First*** approach and studies a local promising practice developed by SSHH. This model, developed to house homeless individuals in neighboring Sacramento County, will be enhanced by a closer collaboration with the County Mental Health Department and coordination between housing and treatment services. The proposed project provides

a low barrier approach to housing that is respectful of the recovery process, accommodates the contemplation and recovery phase, and provides a new approach to integrated treatment support services. A comprehensive evaluation will be undertaken by research partners at the UC Davis Behavioral Health Center of Excellence.

2. What Has Been Done Elsewhere to Address Your Primary Problem?

a)	Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

For the development of this project, BHS formulated the following research questions for a literature review:

1. What housing approaches are currently being used to house the chronically homeless mentally ill population and what are the principles within which they operate?
2. What outcomes do these approaches generate?
3. What are the research gaps with regards to these approaches? How might the models be modified to improve outcomes?

Our research focused on an exploratory study of Housing First programs throughout the United States published by HUD in 2007[7]. We then reviewed two meta-analyses on Housing First, one conducted in Canada[8] and the other in the United States[9], both published in 2015.

1. What housing approaches are currently being used to house the chronically homeless mentally ill population and what are the principles within which they operate?

The literature revealed that since deinstitutionalization in the 1970s, three types of housing emerged for chronically homeless mentally ill individuals: 1) custodial board and care, which was shown to provide inadequate care at an insufficient supply to meet the growing demand; 2) single site supportive housing,

[7] CI Pearson, C.L., Locke, G., Montgomery, A.E., & Buron, L. (2007). The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness: Final Report. Washington, DC: U.S. Department of Housing and Urban Development.

[8] Aubry, T., Nelson, G. and Tsemberis, S. (2015)

[9] Polcin, D.L. (2015). Co-occurring substance abuse and mental health problems among homeless persons: suggestions for research and practice. Journal of Social Distress and the Homeless.

which was criticized for segregating people with mental illness from others in the community and failing to prepare people for independent living; and 3) scattered-site, independent housing of which there are two principle philosophical approaches.

The ***Housing First*** approach offers direct placement of homeless people in housing and voluntary services that do not require participation to remain in housing.[10] In addition, the Housing First model does not require sobriety, and clinical and housing services are separated geographically, philosophically, and conceptually[11]. The ***Linear Residential Treatment*** approach on the other hand, maintains the goal of alcohol and drug abstinence and compliance with mental health treatment. Sobriety is expected and/or required as a condition of housing. Linear[12] approaches require individuals to move in a stepwise manner through treatment, rehabilitation, and transitional housing before they can access permanent housing. Within this model, treatment providers do not usually manage housing or housing subsidies, and as a result, treatment does not always lead to permanent housing.[13]

2. What outcomes do these approaches generate?

The 2007 HUD study looked at three Housing First sites, serving 80 homeless individuals with mental illness and co-occurring substance-related disorders. The primary indicator of program success was the clients' ability to stay in housing. After one year, 43% stayed in housing and 41% left and then returned to the housing and 16% died or left the housing. The study found that the highest percent to leave the program were those with higher levels of psychiatric impairment and dually diagnosed substance-related and mental health disorders. No substance use or psychiatric symptom trends were observed over the course of the one-year study.[14]

More recently, a 2015 report from Canada summarized current research and found better housing outcomes from Housing First than from what they called "Standard Care," which transitions clients from supportive housing that requires sobriety and treatment to eventual independent living in scattered site apartments. The research review found mixed findings for Housing First's non-housing outcomes, including use of emergency departments, justice system involvement and quality of life. The Canadian

[10] CI Pearson, C.L., Locke, G., Montgomery, A.E., & Buron, L., (2007)

[11] Aubry, T., Nelson, G. and Tsemberis, S. (2015)

[12] The phrase *linear residential treatment*, was first introduced by Sam Tsemberis, founder of the Pathways Housing First program in New York City, and popularly credited with starting the Housing First movement as a means to address the housing needs of people living on the streets without preconditions or barriers to entry. The phrase linear is intended to imply the opposite of the Housing First approach which offers immediate access to permanent housing with no readiness conditions. See more about the original principals and approach to Housing First at: https://www.pathwayshousingfirst.org/

[13] Polcin, D.L. (2015)

14 CI Pearson, C.L., Locke, G., Montgomery, A.E., & Buron, L., (2007)

report also presented findings on a demonstration project that compared 1158 clients enrolled in Housing First programs with 990 people receiving Standard Care. The demonstration project, called *At Home-Chez Soi,* also found greater housing stability within Housing First programs. After 2 years, Housing First participants achieved 73% of their time in stable housing compared to 32% for Standard Care housing recipients. Additionally, Housing First participants showed greater improvements in community functioning and quality of life after the first year. This study, while citing housing stability and quality of life outcomes, recognized that Housing First programs are challenged to demonstrate long-term outcomes in the areas of mental and physical health, substance use, community integration, work, education, and "ultimately, recovery."[15]

3. What are the research gaps with regards to these approaches? How might the models be modified to improve outcomes?

The 2015 review of Housing First, Linear, and Supportive Housing approaches found inconsistent findings and flaws in research design. While several studies of Housing First showed excellent retention (compared to the Linear model), as stated earlier, they showed mixed outcomes related to substance use and mental health. Additionally, the review stated that Housing First research suffers from inadequate outcome measures, poorly defined criteria for study participant inclusion, particularly with regards to mental health diagnosis, and a lack of adherence to service model fidelity.[16]

Linear approaches to housing have shown comparatively poor housing stability outcomes, especially among those with mental health disorders, but more favorable substance abuse outcomes. Longitudinal studies of Linear housing, furthermore, are hindered by the fact that many lack stable, permanent options for those who complete treatment: "Even when individuals in linear service models achieve abstinence, they are vulnerable to relapse and reoccurrence of homelessness if they are not able to find permanent housing."

The research on permanent supportive housing has shown that while associated with reduced homelessness and hospitalizations, there are inconsistent findings related to mental, physical health and substance abuse.

According to the author, general research design flaws for housing models include a lack of standardized assessment tools to measure substance use and mental health status, and a reliance on randomized controlled studies, which eliminate self-determination and housing choice. Notably, the author states

[15] Aubry, T., Nelson, G. and Tsemberis, S. (2015)

[16] Polcin, D.L. (2015)

that the studies would benefit from a naturalistic pre-post longitudinal study with validated behavioral health measurement instruments.[17]

The research design gaps and the lack of valid, reliable longitudinal data on a full range of social and health outcomes afford a unique opportunity to develop and then study innovative housing strategies. The author of the above study, Douglas Polcin, of Public Health Institute, postulates that the most effective housing model may draw from aspects of all three models: Housing First; Linear; and Supportive Housing. Specifically, because homeless persons' needs vary dramatically, housing options should be flexible and multidimensional. For those who have no desire to quit using substances, the Housing First model may be more effective. On the other hand, mentally ill homeless individuals who are trying to abstain from alcohol and/or drugs may benefit from sober living environments. For these individuals, the linear model with guaranteed permanent housing support may be most effective. However, if these individuals relapse, they will continue to need housing. Therefore, a variety of housing choices may provide the best results. [18]

b) Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

The proposed innovation project adopts several of Polcin's recommendations and answers the call for "broader based, flexible, and integrated service delivery to homeless persons" proposed by Corporation for Supportive Housing & National Council for Behavioral Health.[19] To develop this proposal, a variety of local housing programs were reviewed to determine which, if any, offer a combination of Housing First, Linear and Supportive Housing options targeting homeless people with comorbid mental illness and substance use and/or chronic health conditions. One program found, managed by Sacramento Self-Help Housing, is a choice-oriented and needs-based housing model used in Sacramento that rapidly houses homeless individuals, and provides graduated housing opportunities based on degree of sobriety and willingness to participate in treatment.

[17] Polcin, D.L. (2015)

[18] Polcin, D.L. (2015)

[19] Corporation for Supportive Housing & National Council for Behavioral Health (2014). National substance use treatment and housing leadership forum: Framing paper. Washington, DC, October 6–7.

The modified model will:

1) be targeted exclusively to individuals with severe and persistent mental illness who are homeless or at risk of homelessness, regardless of substance use dependence;

2) include a peer-managed sober-living housing component to support individuals who have graduated to more independent and treatment-compliant housing; and

3) involve research designed to overcome previous flaws in research design and gaps in knowledge.

Most notably, research will focus on:

1) use of standardized assessments to determine eligibility and measure mental health wellness and substance use outcomes longitudinally;

2) naturalistic pre-post longitudinal studies demonstrating consumer housing and behavioral health outcomes over time;

3) a study of neighborhood and community experience with the model; and

4) a cost-benefit analysis to determine if the program can be offered at a reasonable cost to behavioral health departments and at reduced cost to law enforcement and hospital emergency departments.

3. The Proposed Project

Provide a description of the new or changed mental health approach that the County will develop, pilot, and evaluate. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.

Support Innovation approaches by doing one of the following:

a. Introducing new mental health practices or approaches, including but not limited to, prevention and early intervention.

b. Making a change to an existing mental health practice or approach, including but not limited to adaptation for a new setting or community.

c. Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

d. Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.

Mental Health Services Act, as Amended April 2017

a) Provide a brief narrative overview description of the proposed project.

The Progressive Housing Innovation Project is an adaptation of the ***Housing First*** model. Housing First is recommended by a number of federal and state agencies[20], but after years of study there is still inconclusive evidence pertaining to recovery outcomes. This INN project seeks to modify the Housing First program model to determine if the adaptation will improve access to treatment services and recovery outcomes as compared to what is evidenced by the existing model.

Introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

The Progressive Housing Innovation Project is anticipated to have two major outcomes:

1) Increase *access* to mental health services amongst unserved and underserved populations.
2) Improve *recovery outcomes* for program participants.

[20] Housing First is recommended by the US Department of Housing and Urban Development, SAMHSA, and the California Mental Health Planning Council.
https://www.huduser.gov/portal/publications/hsgfirst.pdf
https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/housing-first-supports-recovery
http://www.dhcs.ca.gov/services/MH/Documents/2015_HopeForTheHomeless.pdf

Proposed Program Services:

INN funds will be used to create rehabilitative housing environments for adults with co-occurring disorders. The project will provide different levels of supportive housing services *and* mental health services that align with recovery phases. The program is designed to stabilize a person's living situation while also providing supportive services on site.

Clients enrolled in program services are placed in houses. Each house is staffed by a resident house manager with lived experience in recovery. Each house has a different "level" designation. For example, Level 1 houses are designed for clients in the pre-contemplation stage of recovery. This is a very low-barrier to entry house for participants to contemplate readiness for program participation.

The chart below describes client and service expectations for the different housing levels[21].

Table 1: Chart of Progressive Housing Program Services			
	Client Characteristics	**Housing Services**	**Treatment Services**
Level 1: ***Pre-contemplation*** Pre/Post Assessment Process	Client is suspected of having a mental health concern as a result of a valid screening and has been referred by a health navigator, outreach worker, or service provider for assessment.	Clients are provided with a place to stay as a guest (not a tenant) while they complete the assessment process and decide if they are ready to participate in treatment interventions.	Regular engagement by outreach worker to encourage program participation. A clinical psycho-social assessment is made to determine diagnosis, initial case plan and referrals to treatment.
Level 2: ***Contemplation and Treatment*** ***Sober Living and Treatment*** Engagement and linkage to routine mental health services.	Clients have been assessed as having a co-occurring disorder and have been referred to housing program for treatment interventions. Clients will be referred to a contemplation house or a sober living house. Clients may be moved from one type of	Clients are placed in a shared housing environment, staffed by a resident house manager. Clients are expected to take their own medications, perform household chores, attend house meetings, and create/abide by house rules.	BHS will provide 1x week home visits by a psych tech to conduct a medication support services for all clients. BHS will provide 2-3x week home visits by outreach workers to meet individually with clients and discuss wellbeing.

[21] This chart represents a joint vision between BHS and SSHH. Further refinements will be made during the implementation phase, as the project gathers more input from a wider coalition of community partners in order to ensure the best success for consumer's participating in the program.

Table 1: Chart of Progressive Housing Program Services			
	Client Characteristics	**Housing Services**	**Treatment Services**
	house to another depending on progress, and client needs. Clients enroll in Medi-Cal, obtain SSI, and may have a representative payee appointed. Clients will have a goal of exiting the treatment house within 12-18 months.	BHS Clinician will attend a house meeting 1x a month to listen to any emerging issues and help house manager brainstorm responses strategies, as needed. Clients are assigned a housing case manager to help them create a pathway to permanent housing plan.	BHS will provide transportation services for household members to Wellness Center, BHS, and Gibson Center on regular days/times at least 2x a week. BHS staff will conduct regular home visits to meet individually with clients and/or conduct treatment groups.
<u>Level 3:</u> ***Recovery and Treatment*** Stabilization and Recovery Support services	Client is stabilized and participating successfully in routine mental health treatment services. Clients are utilizing extant community resources and have more independent living skills.	Clients elect to participate in a shared housing environment, with a portion of income contributing to monthly household expenses. Clients have a plan to obtain permanent housing and are working to establish tenant history, income, and documentation for housing vouchers / rental applications.	BHS will provide 1X week home visits by recovery coaches to meet individually with clients and discuss wellbeing. BHS will provide transportation services for household members to Wellness Center, BHS, and Gibson Center on regular days/times at least 2x week. BHS will refer clients to Independent Living Skills classes in preparation for graduation to independent living

Table 1: Chart of Progressive Housing Program Services			
	Client Characteristics	**Housing Services**	**Treatment Services**
Level 4: ***Graduation*** Independent, permanent housing	Client is stable in routine treatment services. Client assumes responsibilities for paying a portion of the rent through SSI. Goal – client obtains tenant rights and responsibilities.	Client obtains independent housing. Goals: • Housing is not supported by a house manager. • Client pays rent from SSI or other income. • Client maintains residence for 1+ yr.	Client is stable in treatment. Goals: • Client attends 90% of routine scheduled appointments, is medication compliant. • Client has 0-1 Crisis visits in a year.

Services are offered in coordination with a range of outreach, engagement, and therapeutic services that are provided outside of this INN project. Program partners include:

- **Outreach and Engagement:** Homeless Outreach Teams, The Stockton Shelter of the Homeless, St. Mary's Dining Hall, community based organizations, inpatient and crisis residential programs, local law enforcement, and others which will identify potential program participants and link them to a service navigator.
- **Screening and Assessment:** Community Medical Centers (CMC) Assessment and Respite Center, BHS Crisis Unit, and local mental health clinic providers which will conduct mental health assessments to determine eligibility for the program and to establish a baseline assessment of health status that will be measured against recovery outcomes following receipt of program interventions.
- **Treatment and Recovery Services:** Mental Health Services, Wellness Center, Martin Gipson Socialization Center, outpatient recovery groups, 12-Step programs and recovery support groups, and various community based organizations which provide ongoing mental health treatment services, recovery services, therapeutic groups, social and emotional support services, case management, and advocacy.

Additional Program Details

1. Target Population: Homeless individuals and individuals at-risk of homelessness, with co-occurring serious mental illnesses and substance use disorders.

2. Housing Type: Scattered-site, single-family homes. Houses are master-leased through SSHH; clients are placed in the house with the level of services the best aligns with the treatment

needs of the individual. Houses are offered at different levels, allowing clients to move "up" and "down" the recovery spectrum and between houses, without losing their connection to the housing program.

3. Recruitment: Homeless outreach teams, homeless service providers, and others will conduct outreach and engagement with homeless individuals that are deemed likely of having a mental illness. Individuals screened as likely for having a mental illness will be referred to the CMC Assessment and Respite Center for an introduction to services, a full psycho-social assessment, and engagement by a service navigators, and potential placement into a Level 1 contemplation house.

   Recruitment: Residential treatment program and hospital discharge teams that identify an individual with a serious mental illness who is at risk of homelessness upon discharge will contact the Housing Liaison to evaluate potential placement in a house, at the appropriate treatment level.

4. Referral to Services: Referrals to Progressive Housing may be made by approved housing navigators, discharge coordinators, etc. Referrals to low barrier housing may occur prior to the completion of the full psycho social assessment as a strategy to stabilize the individual.

5. Housing Programming: Provides a Housing First approach to housing for the mentally ill, with low barriers to entry (sobriety is not a pre-condition). Includes an adaptation of the model, offering different levels of housing to align with clients' recovery processes. All housing includes a peer partner that serves as a Resident House Manager and a Housing Case Manager to help clients create and move towards their permanent housing plans.

6. Treatment Programs: Provided through existing mental health programs and services (not Innovation funded). Includes intensive case management and clinical services. Some clients may be enrolled in FSP programs. Includes a clinical case manager assigned to each house. Most clinical treatment services are provided off site, with transportation support.

7. Visiting Services: May include home wellness checks by outreach workers, home visits by medical personnel, case manager home visits, on-site educational classes and activities, transportation to appointments, etc. Visiting services are not reimbursable through Medi-Cal.

8. Consumer Choice Programming: Level 2 and above houses will be offered Consumer Choice Programming to foster cohesion amongst residents and the support shared recovery goals. Consumer Choice Programming was introduced by BHS in select Board and Care houses and has proven to be an effective strategy for enhancing program engagement. Examples of Consumer

Choice Programming include: health, nutrition, and exercise; art and creative discovery; community gardening or beautification projects, etc. Consumer Choice Programs are discussed and designed by clients and implemented with sponsorship from BHS through peer supports, classes, and group activities.

9. Vocational Opportunities: Peer partners are an important component of the program model and offer an opportunity for clients to consider a career pathway. Entry level positions include resident house managers (SSHH) and outreach workers (BHS). A range of volunteer opportunities are also available through a range of community based program partners that provide work experience and rob readiness skills.

10. Permanency and Relapse: This is a transitional housing program with an aggressive pathway to permanent housing. Most program participants will remain in the program for one-two years, before being ready to enter into a lease agreement within an independent apartment or supported housing program. While in Progressive Housing program it is anticipated that clients will move up and down the recovery stages. Clients who relapse, and begin to pose a threat to their house-mates recovery process, will be moved to a different (lower level) house – one that better aligns with their recover needs and commitments. Hence the exact place in which an individual is housed will change based on their stage of recovery[22].

Program Completion or Graduation

The Progressive Housing Program will operate over five years with total funding time of 60 months, with a six month period of start-up at the beginning of the project and the completion of research and client transition in the final six month period.

During the first three years of the program the housing provider will lease and open for services approximately one new house every two-three months. At the end of the three year period there will be an estimated 12 – 18 program houses. New clients will be enrolled only during the first three years of the project, providing researchers with at least 12 months of programming by which to measure interventions.

[22] The term r*ecovery* in this context is principally intended to apply to recovery from substance use disorders, as relapse can have a grave impact on others. In so far as clients may experience an increased acuity in their mental health symptomology that is not related to substance use, clients may be temporarily removed from their homes and placed in a crisis residential treatment program for a short duration, until they are ready to return. A program absence related to seeking more intensive treatment will not, in and of itself, result in program termination. In most instances a client will be able to return to their home following a 30 – 90 period of more intensive treatment.

It is anticipated that it will take one to two years for most clients to reach the "graduation" stage. Graduation status is achieved when any *one* of the following conditions is met:

- Rental payments are partially paid by all the program participants in a house
- House is leased in tenants' (not program's) name
- House becomes consumer managed not program managed
- Client moves into a permanent housing situation of their choice
- Client meets their stated recovery goals and elects to exit the program

b) Identify which of the INN approaches the project will implement

Introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

This project also creates a new type of housing program designed to stabilize a person's living situation while also providing supportive services on site, addressing key concerns and interests expressed by the California Legislature in the updated Mental Health Services Act of 2017.

c) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.

The Progressive Housing Project is an appropriate use of San Joaquin County's INN funding for the following reasons:

1. It is responsive to a major concern identified by consumers and family members and aligns with the strategic priorities identified by the San Joaquin County Board of Supervisors.

2. It is reflective to statewide efforts to address the nexus between housing and mental health treatment services and proposes a project design and research study that will help advance learning within the field of mental health.

3. It enhances and investigates a local promising practice that has not yet been rigorously studied or proven effective.

4. It is a time-limited project. New program participants will be enrolled through the fourth year, with program services concluding within five years.

5. No other MHSA related funds are available or appropriate for this use.
    a. PEI funding is not appropriate; services are neither preventive nor early interventions.

   b. CSS Full Service Partnership funding is not appropriate because it would limit enrollment to FSP program partners and it is unknown if all individuals in the target population would be eligible for program services.
   c. CSS Housing funds are 100% allocated in the construction of new housing units.
   d. CSS General System Development funds may not be used to pay for housing.

6. INN funds may be applied to the provision of housing if the goal is to increase access to services, stabilize a persons living situation, or to provide on-site services. This project meets all three criteria (See Welfare and institutions Code Part 3.2 Innovative Programs §5830(b)(2)(D).)

7. It will operate under the umbrella of a large county-wide collaborative initiative to respond to the needs of individuals that are homeless or at-risk of homelessness and have a mental illnesses or co-occurring substance use disorders. Aligned projects include:
   a. Outreach and Engagement – Homeless Outreach Teams (Whole Person Care Grant)
   b. Screening and Assessment – Assessment and Respite Center (INN Funding Proposal)
   c. Sobering and Detox – Withdrawal Management Center (Prop 47 Grant Award)
   d. Low-Barrier / Recovery Housing – Progressive Housing (this INN Project)
   e. Re-Entry Employment Training – Ready to Work (Private Philanthropy and Grants)
   f. Mobile Crisis Support Teams and Crisis Stabilization Unit (CHFFA grant awards)

8. It is consistent with the primary purpose of Innovation projects.

4. Innovative Component

"A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach. *CCR, Title 9, Division 1, Chapter 14, Sect. 3910(b)*).

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

San Joaquin County's Progressive Housing project adapts the ***Housing First*** model of housing for consumers with co-occurring mental health disorders by building in some of the practices from ***Linear Residential Treatment*** models and incorporating more consumer choice and empowerment.

A Linear Approach to Housing First

Housing First models typically places consumers in housing and wraps individualized treatment services around the *consumer*. The adapted approach to Housing First continues this approach, and additionally wraps recovery services around the *household of consumers*. Individualized treatment services will continue through routine behavioral health services (clinical mental health services with integrated substance use disorder treatment). INN funding will be used to create households of consumers that move forward collectively in their recovery process.

- Proposed Model:
  - Level 1: Pre-Contemplation House with low barriers to entry
  - Level 2a: Contemplation House with supportive services
  - Level 2b: Treatment House with more intensive supportive services
  - Level 3: Recovery House with less intensive support services
  - Level 4: Graduation Houses: Not supported by a house manager, no on-site services

- Program participants move from house to house as appropriate to their treatment stage – this ensures that individuals who relapse are not ejected from housing but rather are placed in a (lower) level of housing which is more responsive to their treatment needs.

- Houses will change level designations when all householders achieve approximately the same level of recovery services will be adjusted to meet the shared treatment needs.

- The ultimate goal of the project is "household graduation," where all members of a house have reached a recovery milestone of being able to take collective responsibility for becoming leaseholders and achieving a permanent housing solution.

Consumer Choice Programming

Through an earlier INN program, Residential Learning Communities, BHS learned that one of the most important motivators for program participation amongst consumers was the extent to which consumers were involved in determining the meals and activities that occur in their own living environments. Consumers were intrigued by the concept of living in a learning program and were more willing to engage in program services in such an environment, compared to supportive housing services as usual where meals and activities are planned by staff with only modest consumer input.

BHS seeks to continue to study this approach to housing consumers with serious mental illness as their remains little in the literature that testifies to the importance of having group decision making experiences and activities outside of the therapeutic milieu.

Consumer Choice Programming is a process whereby households of consumers collectively agree on the social, recreation, and learning themes for their household. The process of developing the "house theme" helps consumers get to know each other and discover shared and collective interests. Households design their own programs and submit funding requests for the minor costs associated with Consumer Choice Programming such as gardening tools, art supplies, pet care and training, sports equipment, etc.

Low Levels of Independent Living Skills

Shared housing arrangements are common amongst mental health consumers. BHS housing navigators encourage clients to consider shared housing arrangements and will help place consumers in several existing shared housing homes operated by a local non-profit organization.

The major difference between the Progressive Housing model and other shared housing situations is the recovery stage that most clients will have on entry into the program. Existing shared housing in San Joaquin County requires a moderate-high level of independent living skills. Progressive Housing clients will be higher acuity clients who may not be able to live independently on entry. The program model is designed to teach independent living skills concurrent to program participation, rather than requiring a high level of independent living skills prior to program entry.

Defining characteristics of Housing First program models and the proposed adaptations that distinguish the project from tested models:

The adapted model of Housing First retains some of the defining characteristics[23] of the established program model and modifies others to be more typical of linear, or treatment first, oriented housing. It also builds in lessons learned from a prior INN project pertaining to consumer driven services.

- **Low Barriers to Entry:** *adaptation* program entry is contingent upon a screening and assessment process to determine if clients have a serious mental illness. Individuals who do not have a serious mental illness, or who choose not to be in the program, will be diverted to other programs such as a residential or outpatient substance use disorder treatment program or a local Ready to Work program based on client needs and input.
- **Harm Reduction:** no adaptation
- **Eviction Prevention:** *adaptation:* clients may be removed from a household environment into a different house where the interventions are more aligned with their own recovery stage. Clients may be "evicted" from a specific house, but are encouraged to remain in the program within a "lower level" house until they are ready to advance into a higher level house.
- **Re-entry following incarceration/hospitalization:** no adaption
- **Reduced Service Requirements:** *adaptation:* service requirements align with the recovery stage with more expectations to participate in services depending on their self-determined recovery phase. Clients may elect to join households with higher service requirements, reaffirming the client choice component of Housing First programs. In higher level houses the client is also reframed as the "household" not the "individual" with the service interventions designed to support household recovery and wellbeing.
- **Separation of Housing and Case Management Services:** *no adaptation*
- **Separation of Housing and Treatment Services:** *adaptation:* Therapeutic services remain separated from household services. Clients participate in clinical services through an assertive community treatment or wraparound model. Therapeutic groups are not convened within the home. But the housing milieu is itself identified as a treatment intervention that supports wellness and recovery. To support housing as a treatment intervention BHS clinicians will work with the housing managers to help them develop strategies for responding to interpersonal conflicts or behavioral concerns that are related to living in a shared housing environment. Interventions within the home environment are primarily focused on addressing *behaviors that impact co-habitants* (loud voices late at night) not on illness symptoms (such as substance use).

[23] D. Watson, D. Wagner, and M. Rivers (2013). Understanding the Critical Ingredients Facilitating Consumer Change in Housing First Programs: A Case Study Approach. *Journal of Behavioral Health Services and Research.* Apr. 40(2): 169-179.

The role of the clinician is to help the housing manager develop suitable resolution strategies based on shared knowledge of resident dynamics, not to facilitate the process itself.

- **Consumer Education:** *adaptation:* Consumer education within the Housing First model primary supports the importance of consumer individualized rights and the rights of self-determination regarding participation. In the adapted version, consumers are also empowered to determine their own learning and person growth goals and to have Consumer Choice Programming as a component of every household.

Justification for Adaptation

This adaptation was selected for the following reasons:

- Promising results were emerging from the SSHH program model, but prior evaluation efforts were not rigorous enough to make definitive claims or be published in a peer reviewed journal.
- San Joaquin County consumers and family members provided extensive input on what they felt was needed within a housing program to meet recovery goals – and many expressed skepticism with a pure *Housing First* approach stating a need for a more holistic approach to recovery that integrates behavioral health, primary health, housing, and whole person wellbeing.
- A literature review of the Housing First approach revealed only modest behavioral health recovery outcomes. As one consumer stated, "*it gets us off the street, but doesn't help us get better.*" The literature review suggested opportunities for further study and the program model and research plan attempts to incorporate the recommendations from the prior studies into the proposed program design.

5. Learning Goals / Project Aims

Describe the learning goals identified for the Innovation Project. There is no maximum number of learning goals required, but at least two are suggested. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system.

INN projects are novel, creative and/or ingenious mental health practices/approaches that contribute to learning, and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals.

Mental Health Services Act, 2004, 2012, and 2017

a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

BHS seeks to determine if a new application of a promising community-driven practice is more successful than the evidence-based practice on which it is based. To this aim BHS has four learning questions:

Learning Question 1: Client Outcomes compared to Other Models

- Whether an *Adapted Approach to Housing First* leads to comparable or better treatment outcomes. (As measured against the gains described in the At Home/Chez Soi study, and other meta- studies.)

Learning Question 2: Cost Effectiveness of Model compared to Other Approaches

- Whether this model presents significant costs savings to Counties over more commonly used (alternative) housing placements used by county mental health department facing a lack of permanent and affordable housing options (As measured against the costs incurred for motels, board and care facilities, or crisis residential treatment programs.)

Learning Question 3: Timeliness to Implement Model Compared to Other Approaches

- Whether the adapted approach can be deployed rapidly, and avoid some of the barriers that have prevented other supportive housing models from launching; such as burdensome financing processes or neighborhood opposition to a facility use permit or license. (As measured against the start-up time for the MHSA funded housing programs.)

Learning Question 4: What Factors are Associated with Implementation

- Document whether and how the Progressive Housing Model works in practice, including a full descriptive summary of the operations, including timely transitions between services, as well as a narrative description of client and staff experience with the program.

The Progressive Housing Innovation Project is intended to address critical challenges and determine:

- If a collaborative approach to mental health treatment and housing services prevent homelessness and facilitate the recovery process;
- If an integrated approach to screening, assessment, treatment, housing, and consumer driven services increases access to mental health services amongst underserved groups; and,
- If there is an effective and affordable strategy for housing individuals with mental illnesses that can be replicated and implemented rapidly.

b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

Learning Question # 1: Determines if the proposed new model is successful at both keeping individuals with serious mental illnesses housed as well as impacting wellness, recovery and client outcomes.

Learning Question # 2: Determines if the proposed new model is more cost effective than alternative housing strategies (such as motels, etc.) that are being used to address a lack of affordable housings.

Learning Question # 3: Determine if the proposed new model can be implemented quicker than other housing strategies such as licensed facilities or other affordable housing programs within our County.

Learning Question # 4: Are there pertinent design recommendations for other jurisdictions seeking to replicate the proposed new model.

If client outcomes are the same or better than is found amongst clients licensed group homes or other supportive housing units – but cost is lower and timeliness is faster – this model may have significant implications for jurisdictions attempting to create more housing opportunities for individuals with serious mental illnesses.

6. Evaluation or Learning Plan

The County shall design a method for evaluating the effectiveness and feasibility of the Innovative Project and shall conduct the evaluation according to the method designed.

a) Describe the approach you will take to determine whether the goal or objective was met.

Due to the complexity of a multi-stage housing model and the typically complex health needs of the target population, it is important to understand how the model works in practice, and to identify and resolve any issues around implementation. Thus evaluation of the Progressive Housing project will include three different approaches:

- Feasibility analysis
- Client outcome analysis
- Implementation cost and time analysis

UC Davis Behavioral Health Center for Excellence (BHCE) will lead evaluation activities for San Joaquin County. Preliminary discussions with Cameron Carter, the Center Director and other researchers from BHCE have occurred to help develop the learning questions and establish the general evaluation needs. Final determination of the evaluation scope and design will be determined through comprehensive discussion between BHCE and BHS. A contract and scope of work will executed upon approval of the project by the MHSOAC.

UC Davis BHCE brings a talented and dedicated research team to the project. Over the past two years of operations BHCE has published numerous articles innovative clinical care best practices and presented at multiple national conferences. They also publish *Innovate,* a brief bulletin highlighting evidence-based mental health research.

Amongst the first tasks of the design phase will be selecting the most appropriate research approaches. Some options include:

1) A full descriptive summary of the program, detailing enrollment rates, rate of progression through the stepped-care model, dropout, relapses, and length of time for each transition between care levels. This data will be used to identify any potential bottle-necks in the system, and to determine the proportion of housing places needed at each level of the stepped-care model.
2) A semi-structured qualitative interview study with clients and housing staff to determine the acceptability of the Scattered-site Housing Innovation Program model, and to identify and barriers and facilitators to successful implementation. Specific areas of interest will be client and

staff experiences of the different stages of the program (pre-contemplation, contemplations and treatment, recovery, graduation); the assessment procedure; the transition between stages; and their experiences in periods of relapse. All interviews will be transcribed, and analyzed using a grounded theory approach to thematic analysis. These findings will be used to refine the delivery of the model in the second part of the project.

3) A pre- and post-assessment of client wellbeing and recovery. BHS has worked with the Praed Foundation to create a modified version of the Adult Needs and Strengths Assessment (ANSA 2.0) that is suitable for our County. The modified assessment tool blends questions from the child and adult versions to create an instrument that is suitable for all ages and better transitions youth between the ages of 16-24 into the adult system of care. The modified tool (CANSA) will be administered for all Progressive Housing program clients and will be used to track progress in a variety of domains pertaining to health, wellness, and recovery.

b) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?

- Target participants for the evaluation: All program clients
- Recruitment: All clients will be asked to participate at entry into the program. Participation will not be a condition of services.
- Comparison Group: To be determined in consultation with UC Davis BHCE during the evaluation design phase. One consideration is to conduct a historic comparison of similar clients to determine whether participation in Progressive Housing leads to greater recovery gains than has been seen by a similar population of clients.

c) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.

A specific purpose of the evaluation study will be to address the research limitations found in previous studies of Housing First programs for individuals with mental illnesses, including:

- The use of standardized assessment tools to measure substance use and mental health status
- a study design that supports self-determination and housing choice
- a study design that measures (1) recovery outcomes compared to baseline; (2) client satisfaction and perceived improvements in quality of life; (3) treatment retention and participation in clinical services; and (4) housing stability as measured by program retention or graduation.

Data to be collected will likely include:

- Client history / demographics
- Baseline and ongoing housing status
- Baseline and ongoing assessment of the level of care needed (through the CANSA)
- Baseline and ongoing utilization of treatment services and service costs (BHS clinical database)
- Timeliness of services – length of time to enroll in routine treatment services from assessment
- Client and Stakeholder program satisfaction, perceptions of effectiveness

d) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?

The evaluation design will determine the method for collecting the data. *Potential* data collection strategies include, but are not limited to:

- Pre and post psycho social assessments
- Treatment utilization and cost data – units of service by service type, treatment cost per client
- Program participation data – Days in housing program by type, drop-out/graduation rates, etc.
- Key event tracking – hospitalizations, jail days, etc.
- Confidential client impact surveys
- Client focus groups
- Program Staff focus group
- Key Partner interviews

e) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?

BHS currently collects the following information for all program clients and will make this data available to the UC Davis evaluation team for analysis.

- Routine client encounter data is entered into electronic health records
- Key event tracking forms are completed for all major events that occur in clients lives that are reported to their case manager or clinician
- Housing duration and status will be managed within a program specific database
- Aggregate service utilization and cost data runs, provided annually for a comparison group, of similar clients not enrolled in the scattered site housing services.

Additionally, BHS has the capacity to support client and/or partner recruitment for the following qualitative evaluation activities:

- Client surveys, administered annually.
- Focus groups, conducted annually.
- Key partner interviews, collected at baseline, mid-way through the program, and toward project completion to determine perceived goals, perceived progress in meeting goals, and perceived effectiveness of the program in meeting project goals.

f)	What is the *preliminary* plan for how the data will be entered and analyzed?

BHS and SSHH will enter and store the following client information in existing databases:

- Clinical data will be kept in electronic health records, managed by BHS.
- Housing data will be kept in a project data base (likely Excel) managed by SSHH.

Qualitative data, from surveys and focus groups, will be managed by the project evaluator.

Data analysis will be conducted by the project evaluator through a Business Services Agreement.

- Aggregate and de-identified client data will be provided to the project evaluator using secure protocols for the transfer of information. The pre and post analysis of changes experienced by clients will be conducted through a unique identifier (which is not the medical record number, social security number, or other common identifier) that will be attached to each client.

All evaluation efforts will be reviewed by the San Joaquin County Health Care Services Institutional Review Board (IRB) and/or the UC Davis IRB through the evaluation contract.

7. Contracting

a) What project resources will be applied to managing the County's relationship to the contractor(s)?

Administration and Oversight

The BHS Deputy Directors over Community and Adult Treatment Services (CATS) and MHSA Projects will be jointly responsible for managing the County's relationship with the program and evaluation contractors. The CATS Deputy Director (BHS Program Administrator for the project) will oversee program implementation and performance. The MHSA Deputy Director will oversee the program evaluation contract and help coordinate evaluation efforts between related projects.

Routine Activities in Support of the Collaboration

Additional BHS program staff assigned to this project for the purpose of managing the County's relationship with the contractor(s) include the Progressive Housing Program Manager and a Housing Liaison. The Program Manager is responsible for the daily coordination of clinical services and supports with the houses. This includes ensuring that there are regular check-ins with both Resident House Managers and the SSHH Project Lead. The Program Manager will also oversee the referral, screening, and assessment processes to ensure that all partners align with BHS expectations for using validated and approved instruments and protocols. The Housing Liaison is responsible for monitoring clients functional level within each home and working with the SSHH Resident Manager on a daily basis to problem solve and situations. The Housing Liaison is responsible for communicating situations to the clinical team or other service providers to ensure a rapid response to address recovery concerns.

Contract Monitoring

Ongoing contract monitoring and quality control is undertaken through the contract monitoring team at BHS, per the protocols outlined by the organization. Protocols include comprehensive contract review and auditing protocols, including annual site visits to program service locations.

FTE allocations for all project staff are described in the budget narrative.

Consumer and Community Stakeholders

For the Progressive Housing Project, oversight will also be conducted through the ***Community Collaborative***. The Community Collaborative will meet quarterly for the duration of the project to review program implementation, evaluation findings, and to make recommendations for program improvements and sustainability. Meetings will be convened by the BHS Program Administrator. The Community Collaborative will be comprised of key stakeholder partners, including (at a minimum):

- Behavioral Health Services
- Stockton Self Help Housing
- Community Medical Centers
- Health Care Services Agency
- A representative of a local (city) government agency
- A community based Homeless Service Provider
- At least one consumer
- At least one family member

b) How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BHS contract monitoring is a year-long process of evaluating a contractor's performance based on measurable deliverables and verifying contractor compliance with the terms and conditions of the contract with the County. The purposes of the monitoring are to 1) improve program performance, thereby mitigating program inefficiencies; 2) evaluate contractor performance controls to ensure there is a reliable basis for validating service deliverables; 3) to assure that the financial documentation is adequate and accurate; 4) and review compliance with applicable regulatory requirements.

The contract monitoring process consists of five major elements:

1. Analysis of each contract, scope of work and budget proposed by the manager and the contractor prior to finalization of the contract.
2. Review and analysis of monthly or quarterly fiscal invoices submitted by contractors.
3. Review and analysis of program data submitted via contractor's quarterly progress reports.
4. In-person review of program and fiscal data conducted during annual site visits.
5. Review of contractor's annual financial audit, IRS Form 990, quarterly payroll tax returns and insurance certificate.

Part II Additional Information for Regulatory Purposes

1. Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications.

Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services within 30 days after adoption.

☒ Adoption by the County Board of Supervisors See Appendix.
Resolution Date: _____

Include a Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

☒ Certification Date: _____ See Appendix.

Include a Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

☒ Certification Date: _____ See Appendix.

Provide assurance that five percent of the total funding for each county mental health program shall be utilized for innovative programs.

☒ Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation. See Budget.

Provide assurance that the County submitted, to the Department of Health Care Services, an Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report, no later than December 31 following the end of the fiscal year.

❒ Annual Mental Health Services Act Revenue and Expenditure Report See Budget.

The County shall expend Innovation Funds for a specific Innovative Project only after the Mental Health Services Oversight and Accountability Commission approves the funds for the Innovative Project.

2. Community Program Planning

The Community Program Planning Process shall, at a minimum, include:

1) Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.
2) Participation of stakeholders, as stakeholders is defined in Section 3200.270.
3) Training.

Mental Health Services Act, 2012 and 2017

a) Describe the Stakeholders that participated in the Community Program Planning Process.

The Community Program Planning (CPP) process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges for consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served.

Per recommendations of the San Joaquin County Planning Stakeholder Steering Committee, 2017 INN project planning outreach and engagement process was specifically focused towards a target population of unserved and underserved adults. This planning focus was determined based on several factors:

1) A current INN project is focusing on children and youth
2) Feedback from 2015 and 2016 community planning processes identified growing concern for unserved and underserved adults
3) Feedback from Children and Youth Services providers and partners resulted in a finding that the that necessary service enhancements would be best funded through CSS or PEI funds; that service needs were not innovative, nor time limited.

A summary of the stakeholders that participated in the CPP process is described below:

Clients with serious mental illnesses and or serious emotional disturbances and their family members comprise the majority of stakeholders that participated in the 2017 INN planning process - accounting for 53% of community meeting participants and 51% of survey respondents.

In 2017, stakeholders were able to participate in the planning process and provide feedback through many different input strategies, including:

- Community meetings
- Focused discussion groups
- Client and Stakeholder Surveys

Stakeholders that participated in the general community meetings included a range of community based service providers, consumers, and family members. Outreach was also conducted to other public agencies including law enforcement and education to encourage their participation.

Three consumer serving programs hosted client discussion groups. Participants included a diverse array of clients with the majority of discussion group participants inclusive of underserved consumers. Of the nearly 30 consumers who participated in the discussion groups, three spoke Spanish as a first language and were included in the group discussion through translation assistance. Nearly all consumers participating in the discussion groups reported having co-occurring mental health and substance use disorders.

Focused discussion groups were also held with dozens of stakeholders and community partners to determine new opportunities to expand and enhance services for individuals with mental illnesses, per San Joaquin County Board of Supervisors' directives to expand and enhance collaborative efforts across government and community based partners (Three Year Strategic Priorities) and per the stipulations of the Mental Health Services Act which stipulates that one of the essential purposes of INN funds is to promote interagency and community collaboration. The BHS planning team met with housing providers, substance use disorder treatment providers, primary health care providers, and law enforcement and justice partners in order to brainstorm innovative strategies to address local needs and challenges.

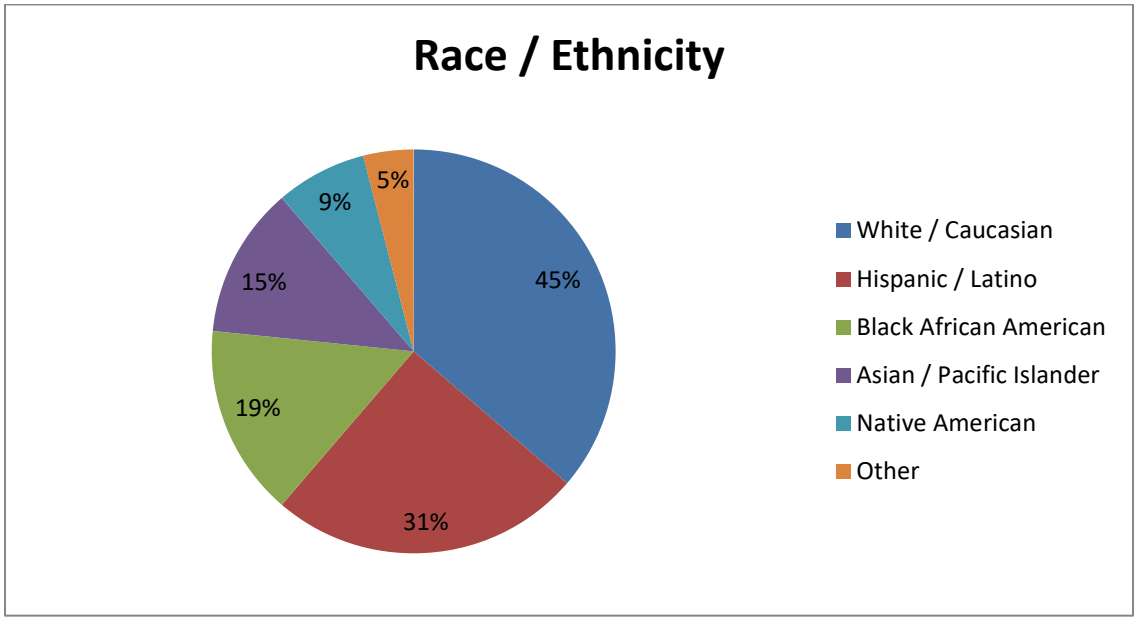
They greatest challenge in the community program planning process is reaching out to clients that speak Spanish or other languages. This is somewhat addressed by conducting targeted discussion groups with translation assistance, though overall participation of individuals for whom English is a second language suggests that this strategy could be improved. Recommended improvements to future community program planning processes is the inclusion of a Spanish Language survey.

b) Demonstrate that Stakeholders included representatives of unserved or underserved populations, and individuals that reflect the cultural, ethnic, and racial diversity of the County's community.

During the 2017 Community Program Planning process the largest proportion of feedback was received through the Client and Stakeholder Surveys. The surveys were distributed through local community based organizations and mental health clinics, helping to ensure that a broad cross section of individuals were able to complete the survey. In general the racial and ethnic diversity of survey respondents was representative of the population of clients served by BHS.

Surveys were distributed to individuals seeking mental health and substance abuse treatment services at clinic and treatment programs throughout San Joaquin County. Over 600 surveys were returned (N=665) allowing for a statistically significant sample. Slightly more females than males completed surveys (53% compared to 46%) and nine individuals identified as transgender.

Half of all surveys were completed by individuals self-identifying as a mental health consumer and nearly 20% of survey respondents identified as a family member of a consumer; corresponding to a high rate of returns received from clients of the Children and Youth Services clinics. Forty percent of respondents also reported working for an agency that provides metal health or substance use treatment services, suggesting that some of those who report as professionals also are parents, family members, or consumers themselves.



c)	Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

Prior to every MHSA community planning meeting, the meeting facilitator will conduct a brief training on the goals and objectives of the Mental Health Services Act; how funding is allocated to Counties and within San Joaquin County; and the types of program and activities that are funded by MHSA. Additionally the meeting facilitator will also review the regulations and guidelines that direct the planning process and the use of funds. For the INN Community Program Planning Process it is important that stakeholders understand the intention and purpose of the legislature in developing Innovative

programs. All meetings to discuss the potential use of the INN funds include an overview of the following key concepts:

- Purpose and Intent of INN funding
- Overview of key terms, including "Unserved," "Underserved" "Timely" "Access to Services" "Outcomes" "Interagency Collaboration"
- All Innovation projects are described as time limited learning endeavors, that will help answer key research questions, and (if successful) lead to improvements in service delivery.

3. Primary Purpose

All projects included in the innovative program portion of the county plan shall address one of the following purposes as its primary purpose:

(A) Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.

(B) Increase the quality of services, including measurable outcomes.

(C) Promote interagency and community collaboration.

(D) Increase access to services, which may include providing access through the provision of permanent supportive housing.

Mental Health Services Act, as Amended April 2017

☒ Insert Primary Purpose

Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.

The primary purpose of the project is to (1) increase the access to services amongst previously unserved individuals into mental health services (e.g. those that are homeless and not receiving services); (2) increase the consistent participation in services amongst underserved mental health consumers that experience frequent incidences of housing insecurity or homelessness such as those living in motels, shelters, on the streets, or other non-permanent housing situations and have been lost to services as a result; and (3) as a result of this increase access see better recovery outcomes.

The secondary purpose is to demonstrate that the public/private partnership demonstrated in the modified Housing First approach (1) leads to better program participation, retention, and satisfaction amongst clients; (2) enables a faster start-up time and is easily replicable; and (3) is more cost effective.

4. MHSA Innovation Project Category

All projects included in the innovative program portion of the county plan shall support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention

(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

(D) Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.

Mental Health Services Act, Amended April 2017

☒ Insert MHSA Innovation Project Category

Introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

A Housing First approach to mental health outreach and engagement has long been advocated by homeless service advocates, particularly for the engagement and treatment of individuals with co-occurring disorders. However several large studies show mediocre recovery outcomes amongst mental health clients served using a Housing First approach, in part because of the very nature of the model which requires neither a commitment to recovery nor participation in treatment activities. (See the literature review above for a further summary of the outcomes and challenges documented in the Housing First studies.)

Stockton Self Help Housing has developed a promising community-driven practice that blends a ***Linear*** Residential Treatment approach, with a ***Housing First*** approach. This model has been pilot tested in a neighboring county, but the program was targeted generally to those that were homeless, and not necessarily to those with serious mental illnesses.

This Innovation seeks to determine whether this promising community driven approach can be successfully adapted to the mental health system. It introduces a modified Housing First approach that can move clients through different levels of housing, depending on their recovery stage. It also builds in best practices learned through prior Innovation efforts in San Joaquin County, such as the importance of

building Consumer Choice Programming into each group living situation as a way to foster cohesion and mutual support amongst residents.

5. Population (if applicable)

Include the following section if the INN project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance.

If applicable, describe the population to be served, including demographic information such as age, gender identity, race, ethnicity, sexual orientation, and language used if relevant to the specific Project. If applicable, describe the estimated number of clients expected to be served annually.

CCR, Title 9, Division 1, Chapter 14, Sect. 3930(c)(4)(B)

a) Estimate number of individuals expected to be served annually. How are you estimating this number?

The Project estimates that it will enroll 30 new individuals annually, for three years with a maximum number to be served through the project being 90-100 individuals. This estimate is based on the number of houses that will be opened and the anticipated number of residents in each house.

The Progressive Housing Project estimates opening of six houses annually, for the first three years of the project with each house supporting five clients and one resident manager.

6 x 5 = 30 clients x 3 years = a target population of 90 enrolled clients by the project termination[24].

b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate.

The population to be served will include ADULTS:

- Individuals who are homeless and are suspected of having a serious mental illness as a result of a screening by homeless outreach workers. Individuals with suspected mental illnesses may participate in a level 1 pre-contemplation house for up to 30-45 days or as needed to conduct

[24] While every effort will be made to retain clients in the program, this project will likely have a high drop-out rate during the pre-contemplation phase. "Enrolled clients" refers to those clients that meet the eligibility requirements and choose to join the program, moving beyond the pre-contemplation phase.

concerted engagement and complete a full psycho social assessment. The maximum amount of time an individual will spend in a pre-contemplation house without a full psycho-social assessment will be 90-days.

- Individuals who have a serious mental illness and require an intensively supported living environment in order to achieve recovery goals and gain the necessary skills that will enable them to succeed a permanent housing program. This may include individuals that are being discharged from a crisis residential program or inpatient facility and who are at risk of homelessness upon discharge.

Program participation will prioritize individuals that are homeless or at risk of homelessness upon discharge.

Program eligibility will not be restricted by race, ethnicity, gender identity, language, sexual orientation, or disability status. Program participation is limited to adults 18 and older.

c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

See above.

Further, all program participants must meet the following eligibility guidelines:

1) Must have been referred to the program by an approved outreach coordinator or navigator.
2) Must meet criteria for having a serious mental illness, except as described above.
3) Must be determined as "ready" to live with others in a group housing situation[25].

The focal population includes individuals with serious mental illness that are homeless or at risk of homelessness. Individuals engaged by this program may also have co-occurring disorders, poor tenant histories, or previous justice encounters. Within the broad inclusionary guidelines of the program there are some eligibility restrictions that will be created to ensure the health, safety, and wellbeing of other program clients and staff.

6. MHSA General Standards

Describe briefly, with specific examples, how the Innovative Project will reflect and be consistent with all relevant Mental Health Services Act General Standards.

[25] The phase "ready" to live with others refers to mental health status not sobriety. Clients must be able to live safely with others, and not pose a danger. Consumers that may be barred from entry may include those who are registered sex offenders, have a history of fire-starting behavior, or are a danger to themselves or others.

The County shall adopt the following standards in planning, implementing, and evaluating the programs and/or services provided with Mental Health Services Act (MHSA) funds. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the Three-Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery.

(1) Community Collaboration, as defined in Section 3200.060.

(2) Cultural Competence, as defined in Section 3200.100.

(3) Client Driven, as defined in Section 3200.050.

(4) Family Driven, as defined in Section 3200.120.

(5) Wellness, Recovery, and Resilience Focused.

(6) Integrated Service Experiences for clients and their families, as defined in Section 3200.190.

MHSA General Standards CCR, Title 9, Division 1, Chapter 14, Sect. 3320.

a) Community Collaboration

The Progressive Housing Project was developed with significant community input and is designed as a component of a larger initiative to reduce the incidence of untreated mental illnesses and the risk of homelessness amongst individuals with serious mental illnesses. The majority of clients will receive ongoing mental health services through BHS, and many will be enrolled in Full Service Partnership programs. The Progressive Housing project will measure whether a modified Housing First approach to mental health treatment services improves engagement and retention amongst previously unserved or underserved individuals and leads to improved outcomes amongst consumers.

Program Partners will include:

Lead Agency: Stockton Self Help Housing

Service Partners:

- Community Medical Centers
  - Assessment and Respite Center
  - Withdrawal Management Center
  - Primary Health Care Services
- St Mary's Dining Hall
  - Food and Clothes Pantry
- Various Community Based Organizations

- Case Management
- Advocacy, legal/document procurement services, and cultural/linguistic supports
- Other Support Services and Wellness Groups

Referral Partners:

- Stockton Shelter for the Homeless
- Homeless Outreach Teams (operated by various partners, including BHS and local law enforcement agencies) that have been trained to conduct a brief mental health screening.
- Various Community Based Organizations

Collaboration Team Meetings

Behavioral Health Services will convene monthly collaborative team meetings between BHS management and SSHH in order to ensure program services are meeting project goals and objectives. Program staff will also meet on a regular (and at least weekly) to discuss individuals and house specific program services.

Community Collaborative meetings will be held quarterly through the Homeward Bound Initiative. The Homeward Bound Initiative is the umbrella initiative over several interconnected projects that are serving this target population:

- Homeless Outreach Teams (Whole Person Care Funds granted)
- Withdrawal Management Center (Proposition 47 Funds granted)
- Assessment and Respite Center (INN Funding proposed)
- Allies and Allies/SOAR Clinical Mental Health Services (CSS Funding allocated)
- **Progressive Housing** (INN Funding proposed)

Community Collaborative meetings will ensure that the separate projects continue to serve distinct needs along the recovery continuum while coordinating referrals and treatment plans across the continuum.

Cultural Competence

Ensuring Cultural Competence of Service Delivery:

Community Collaborative meetings are inclusive of all program partners, including a range of community based programs that have expertise and experience in serving diverse populations. BHS works with a number of community program partners to provide “cultural brokerage” or “promotores” services through our *Peer Partners in Recovery* program that helps consumers, who are traditionally underserved by public mental health systems, navigate the services, supports, and benefits to which they are

entitled. Partnership with these programs remains a critical part of the program design. Community program partners will continue to serve as cultural brokers for consumers in full services partnership programs, or identified as likely to benefit from full service partnership programs. In addition to helping consumers navigate the mental health system, these program partners also help BHS create programs that are respectful and responsive to diverse cultural needs and experiences. Their participation in Community Collaborative meetings will help BHS and the lead program partner ensure that program services are designed and delivered in a way that fosters and celebrates the diversity of all program participants.

Ensuring Cultural Respect and Recognition within Houses:

The Progressive Housing program is open to all adults that meet the target population criteria, regardless of race, ethnicity, language, gender identity, or sexual orientation. Houses will be located throughout the metropolitan region, ensuring that program participants have choices regarding which neighborhoods they live in and opportunities to live in diverse communities. It is expected that each house will include a diverse population, who will vary from each other in many ways and clients will be provided with life skills classes and programming that will help them value the differences amongst each other. Consumer Choice programming helps promote cultural competency by allowing house-mates to explore shared interests and experiences (such as gardening or cooking) in a manner that promotes the recognition and value of racial and ethnic diversity of all residents.

Ensuring a Culturally Relevant and Responsive Evaluation

One of the challenges of conducting an evaluation with a small sample size is developing statistically significant findings of how the program serves diverse populations. The small study design of this project shall be addressed through the use of qualitative interviews and focus discussion groups that will allow the researchers to more fully draw out the nuances of cultural competent services delivery from a smaller sample size in order to confidently demonstrate that the program is equally effective across different race/ethnicities, genders, ages, sexual orientations, etc.

See also Section 8, below for additional details pertaining to the County's plan to ensure cultural competency of the evaluation.

b) Client Driven

Client has primary decision making role is identifying level of housing / recovery stage. The Progressive Housing program model respects that each client comes to the recovery process along their own path. Level houses enable clients to realistically set their own recovery goals, without fear of a loss of housing as a result. Case managers, clinicians, and recovery partners can support a harm reduction approach to treatment without concern that this will jeopardize housing tenure.

Clients in each household collectively select the Consumer Choice Programming theme for the house. Consumer Choice Programming is a meaningful way for clients to determining the program activities and services that will be most supportive of their recovery, resilience, and wellbeing. Too often treatment programs focus on the objective markers of program success – reductions in emergency room utilization, medication treatment compliance etc. However on a day to day basis clients are more likely to judge their recovery on the more nebulous, and subjective, state of well-being as measured by program satisfaction or general happiness. Consumer Choice Programs allow clients to build in the person-centered programs that help them feel better about themselves and optimistic for the future and to define their own treatment needs.

Peer support in Recovery. The Progressive Housing program believes that peer support in treatment is a critical component of the program. Peer support is fostered through formal and informal means. Informally, the Resident House Manager is tasked with creating a convivial atmosphere between the residents and a home in which housemates support each other in the recovery process. More formally, BHS has a robust program of *Peer Partners in Recovery* program. This program uses the ***Promotores*** model to engage consumers entering into the recovery process. Peers with lived experience work with clients to:

1. Understand the diagnosis of mental illness and address the stigma of living with a mental illness;
2. Navigate the mental health system of care and provide advocacy and support in seeking services; and
3. Complete a *Wellness Recovery Action Plan (WRAP)* to self-identify triggers, recovery strategies, and support networks in the event of a stressful or crisis situation.

c) Family Driven

Input received from family members was one of the main factors driving the planning of the proposed project. For the past three years family members of adult consumers have strongly advocated for new housing solutions to support their loved ones. Family members repeatedly advocated for BHS to address two concerns:

1) Family members sited instances in which consumers are discharged from treatment facilities to motels, shelters, or to the streets and who then subsequently are lost to treatment services. Discharges to motels or shelters occur when the client does not have a permanent home in which to be released too. While parents and family members often care for their adult children consumers do not always want to be placed with their families and at times it is not appropriate (or successful) for parents to accept their adult children back into their homes. Family members advocated for more housing options for adults with serious mental illness, and more long term programs to support consumers in gaining the skills necessary for independence.

2) Family members also expressed extreme anxiety over the long-term care and well-being of their adult children as they themselves age and have more difficulty acting as care givers. Parents and family members strongly advocate for better housing solutions that can help consumers gain independent living skills, achieve recovery goals, and develop pathways towards permanent housing solutions.

d) Wellness, Recovery, and Resilience Focused

Progressive Housing encompasses a whole-person approach to wellness. San Joaquin County recognizes that "wellness" means addressing the health and care needs of the whole person in a comprehensive and integrated fashion. Critically, this means going beyond health and behavioral health care to addressing the emotional well-being of clients through the deliberate creation of social support networks, recreation, and emotional growth and learning. The shared housing environment is intended to build social support networks. These networks are real, and have a tangible effect on housing stability and treatment participation, as is evidenced by San Joaquin County's *Residential Learning Communities* pilot project. *Consumer Choice Programming* is also a respectful way to allow consumers to provide input and plan programming to foster wellness. Clients in the *Residential Learning Communities* pilot expressed strong satisfaction with the consumer choice programming and stated that an ability to design and implement their own wellness program was a leading factor in their ongoing participation.

Securing safe and stable housing is an essential component of the recovery process. An increasing body of literature recognizes that safe and stable housing is an essential component of mental health treatment services. This recognition is addressed through local and state public policies designed to compel local mental health departments to more decisively address housing for mental health consumers. Progressive Housing is responsive to the updated Mental Health Services Act of 2017, the No Place Like Home Initiative of 2016, the strategic priorities of the San Joaquin County Board of Supervisors, and the input of consumers, family members and other stakeholders, all of whom declare an urgent and critical need for additional housing to promote mental health recovery amongst those with serious mental illnesses.

Progressive Housing builds in peer support, consumer choice, and a no-fail approach to support the resilience of consumers, even during relapse or crisis episodes. Hardships occur in life and consumers with serious mental illnesses and co-occurring substance use disorders that experience hardships are at risk for major set-backs in treatment progress. This program is designed to support consumers wherever they are at within the treatment continuum and foster resiliency against hard times. Two critical design elements are included in the program in order to foster resiliency:

1. Level housing: The capacity to move up and down the housing levels supports resiliency by encouraging consumers to find a pathway back to recovery, even during relapse.

2. Peer Partners in Recovery: Peer partners support resiliency by encouraging consumers to develop a WRAP plan, identifying the social networks and strategies that will help maintain resilience in the face of difficult times.

e) Integrated Service Experiences for clients and their families

The Progressive Housing Model offers an integrated service experience for clients. The entire program model is in itself an integration of mental health services, substance abuse treatment, and supportive housing services. Program participation will begin with a comprehensive psycho-social and medical evaluation conducted by a local community clinic within the newly formed Assessment and Respite Center. Through the Center, program participants will be linked to appropriate mental health services, withdrawal management or substance use disorder recovery services, supportive housing, and primary health care. Programming is also integrated and connected to a range of consumers support services, including the proposed regular transport of consumers to the Wellness Center, Martin Gipson Socialization Center, and other peer/consumer support programs.

7. Continuity of Care for Individuals with Serious Mental Illnesses

If applicable, provide a description of how the County plans to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation Funds.

Progressive Housing is designed as a five year pilot project to test the success of an adaptation to the Housing First model. As such the following design considerations will help ensure continuity of care for individuals with serious mental illness who receive program services.

1. Eligibility Criteria: All clients will have a diagnosis of serious mental illness and all will be receiving treatment services outside of INN funds. *Upon project termination, mental health services shall continue to be offered regardless of their housing status.*
2. Limited Period for Enrollment: No new houses will be opened in years four or five and new clients will only be enrolled through December 2022[26]. A planned halt on most new client enrollments means that clients will have a significant period of time to receive services, make steps towards stabilizing in their recovery, and to develop a Continuity of Care Plan prior to project termination.

[26] Clients enrolled following December 2022 may not have sufficient programming time to receive the full benefit of the services and may not be included in the evaluation study. Final determination on the end date for enrollment period and protocols for entry following the enrollment period will be determined following program implantation, upon determination of sustainability, and in collaboration with the evaluation team at UC Davis.

3. Continuity of Care Planning: BHS case managers will work with clients to develop a plan to successfully maintain recovery even as housing changes. SSHH will help clients develop a housing case plan and provide support and encouragement in achieving their housing goals. Both case management teams will work jointly to secure housing for individuals that are unable to meet their housing case plan goals prior to project termination[27].
4. Services Vulnerable to Discontinuation: If the program is not elected for ongoing continuation, core services (housing and treatment) will continue at some level. Special services provided through this project that may be eliminated upon discontinuation are:
   - Consumer Choice Programming
   - Client Transportation
   - Peer Partners
   - Home visiting
   - Client incentives, special funding for activities
   - Housing Liaison and
   - Housing Case Management Services

8. Compliance Standards for INN Project Evaluation

The evaluation shall be culturally competent and must include meaningful involvement by diverse community stakeholders.

a) Describe the County's plan to ensure the *Cultural Competency* of the evaluation.

Targeted actions will be made to ensure that consumers are represented in all phases of the evaluation design and implementation phase. The evaluation team will work with program partners (BHS, SSHH, CMC, and other community based organizations) to identify consumers who have lived experience with homelessness and/or housing insecurity to provide guidance on the development of the evaluation plan and the proposed strategies for collecting information directly from project participants.

Evaluation tools will also be vetted with Community Collaborative stakeholder group. Furthermore, all evaluation activities will be linked to a participant demographic form, which will gather information about participants' age, sexual orientation, gender identity, race/ethnicity, etc. in order to better understand whether there are disparities that are revealed through the evaluation. Any disparities

[27] Market factors will play a large part in determining whether a client can secure permanent housing both during and upon termination of this project. A shortage of affordable housing units remains a critical challenge in San Joaquin County and will not be entirely addressed by the Progressive Housing Project. However, if clients can stabilize their income through SSI benefits and/or obtain a Housing Choice Voucher than it may be possible to sustain some houses, even without INN funding. See Section 9, Continuity of Project without INN Funds, below.

uncovered will be shared with BHS, SSHH, and the Community Collaborative in order to develop program course corrections to increase participation and service delivery across diverse populations.

b) Describe the County's plan to include *Meaningful Stakeholder Involvement* in the evaluation.

In order to ensure meaningful stakeholder participation in the evaluation activities, the UC Davis BHCE will rely on a workgroup formed from the Community Collaborative to support evaluation design and implementation activities. Stakeholders engaged in the Community Collaborative may include County staff, providers, consumers, and consumers' families. The *Evaluation Workgroup* will play a critical role for informing overall evaluation design, tool development, and implementation.

Evaluation findings will be communicated to stakeholders, and stakeholders will have the opportunity to contribute to their interpretation and provide input on reports. UC Davis BHCE will also provide training and technical assistance to the *Evaluation Workgroup* throughout the project to support meaningful stakeholder participation.

9. Continuity of Project Without INN Funds

The County shall have preliminary plan, from the outset, about how it will decide to continue an Innovation Project.

a) Provide a description of how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds.

Determination of whether and how to continue the Progressive Housing project will be made by BHS, with input from the Community Collaborative. All decisions are subject to the approval of the San Joaquin County Board of Supervisors.

In order for the project to continue beyond the scope of the INN funds a budget recommendation for continued program funding must be received by BHS from the Community Collaborative no later than January 31, 2022 in order to include financing for the transition plan and ongoing sustainability into County-wide budget for any services beyond the project termination in December 31, 2022.

Determination of continuation will be based on a number of factors:

1. Success: At a minimum the project must show some success. Program participants must have increased their access to and utilization of mental health services. Participants must demonstrate positive outcomes, at least comparable with other programs and indicate a strong level of satisfaction with the program. The program must be cost effective, easily replicated, and implemented in accordance with the program design and intention.

2. Cost and available financing: There is a possibility that some of the costs associated with housing may be absorbed through existing CSS program funding, pending changes to the regulations. Currently MHSA regulations only allows for the use of CSS funding to pay for consumer housing if the consumer is enrolled in a full service partnership. There may at a future time be interest in expanding this to include all consumers, not just FSP consumers.
3. Leveraged Financing: BHS is currently working with the Housing Authority of San Joaquin County to determine whether mental health consumers who are discharged from transitional living environments may be given priority status for Housing Choice Vouchers. If this practice is adopted within San Joaquin County it will greatly enhance the capacity of the County to consider ongoing sustainability of the program beyond the time period for the expenditure of INN funds.
4. Partnership commitment: Ultimately this project is also a test of a multi-agency community collaboration. The end of five years will determine if the project has been a success, and if community partners are committed to continuing the project or if a new model has emerged from the process.

10. Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

a) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

BHS will work with the MHSOAC and its program partners to disseminate information regarding the Progressive Housing Innovation Program to local stakeholders and other counties. In general, communication pertaining to the availability of evaluation findings or the publication of research studies will occur through the following steps:

1) BHS, SSHH, and the UC Davis Behavioral Health Center of Excellence will issue a joint press release and post the report on their respective web sites.
2) BHS will simultaneously send the evaluation report to the MHSOAC for posting to statewide bulletins.
3) BHS, SSHH, UC Davis, and MHSOAC will further use a range of social media outlets to announce findings and direct subscribers to the report.

b) How will program participants or other stakeholders be involved in communication efforts?

The Community Collaborative group, with input from BHS, SSHH, UC Davis, and the MHSOAC, will ultimately be responsible for finalizing the plan to communicate results and lessons learned from the Progressive Housing Innovation Project. In addition to the strategies discussed above, the Community Collaborative may also consider whether they want to host a *Learning Community* or prepare a *Conference Presentation*.

Learning Communities

San Joaquin County hosts periodic Learning Communities to address topics of interest to a wide variety of local stakeholders. Learning Communities are typically half-day sessions to discuss project activities and lessons learned. During the Start-up phase a Learning Community is used to announce the program intention and to solicit the support and engagement of potential program partners and community allies. During Implementation, Learning Communities are valuable opportunities for program participants and stakeholders to review best practices, discuss program activities, and make recommendations for program improvements. Towards the end of a project Learning Communities are an opportunity to convey findings, determine the level of stakeholder support for on-going sustainability, and to plan for program termination and the transition of clients into other services and supports (as needed if the program is not recommended for continuation in some fashion).

Conference Presentations

Conference presentations, poster boards, and exhibits may also be used to communicate project results to a statewide audience of Behavioral Health Directors, Housing Departments, Homeless Service Providers, and other interested stakeholders. As feasible, program participants should be part of the conference proceedings in order to offer a "lived experience" perspective on what aspects of the program worked and what challenges still need to be addressed.

c) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

1. Housing First
2. Linear Residential Treatment
3. Housing for Individuals with Co-occurring Disorders
4. Housing for Homeless Individuals with Mental Illness
5. At Home / Chez Soi

11. Timeline

An Innovative Project shall have an end date that is not more than five years from the start date of the Innovative Project. The County designates the timeframe to complete the Innovative Project based on the complexity of the evaluation and the approach to be evaluated.

☒ Specify Total Timeframe 5 **Yrs**. 0 **Mo.**

☒ Anticipated Start and End Date Jan 2018 **Start** Dec 2022 **End**

Include a timeline that specifies key milestones for development and refinement of the approach; ongoing assessment and final evaluation of the Innovative Project; decision- making, including meaningful involvement of stakeholders, about whether and how to continue a successful Innovative Project or parts of the project; and communication of the results and lessons learned with a focus of dissemination of successful Innovative Projects.

a) Provide a project timeline that specifies key activities and milestones.

See Timeline below.

INN Project Timeline					
Launch & Startup	**INN Project Period**				**Evaluation & Dissemination**
• MHSOAC Approval • Contract Negotiations • Board of Supervisors Approval • Hire staff • Establish Quarterly Collaborative Meetings • Establish subcommittees to develop joint protocols regarding: o Program referrals and screening processes o House levels and transfers between levels o Integrated and coordinated service expectations o On-site partner activities • Open 1- 2 new houses • Develop Evaluation Plan o Develop research protocols o Consumer input/review of evaluation plan o IRB approval of the evaluation plan	• Open 3-5 new houses • Begin placing consumers in Level 1 and Level 2 houses according to stage of recovery • Begin Client Choice Program • Establish no-fail protocols for moving clients up and down the housing continuum • Establish evaluation sub-committee • Begin baseline data collection **Year End Goal:** 6 houses in operation, 30 clients have housing and are receiving routine mental health services.	• Open additional 4-6 houses • Open at least one level 3 house • Expand consumer choice programming to include classes, activities, and programming from a range of CBO partners • Begin negotiations with Housing Authority for expedited Housing Choice Vouchers for program graduates • Establish data sharing protocols with UC Davis between health and justice partners • Complete secure project database **Year End Goal:** 10-12 houses are in operation, at least 50 clients are receiving routine mental health services.	• Open additional 4-6 houses • Operate at least three Level 3 Recovery Houses. • Begin graduating clients from the initial cohort. • Complete evaluation report of Lessons Learned / Recommendations from the Start-up period by 11/15/2020. • Review housing levels and revise program design based on lessons learned. • Modify polies and procedures as appropriate. • Revise evaluation tools and protocols as appropriate **Year End Goal:** 12-18 houses in operation, 90-100 clients have received program services and are engaged in routine mental health services.	• Complete evaluation report of Preliminary Outcomes • Develop Client and Program Sustainability Plan o Document actual financial model o Convene key partners to review costs and program needs o Identify partner or other funding for program continuity • "Graduate" at least two households into Level 4 homes • Conclude consumer data collection. • Budget recommendation is made for continued program funding in FY 22/23 **Year End Goal:** At least two houses are occupied by clients that pay a portion of the rent through their own income.	• Continuity of Care Plans developed for clients remaining in the program. • Final evaluation reports are completed o Final Outcomes Report o Cost / Benefit Analysis • Findings are presented to community partners and stakeholders • Reports are submitted to the MHSOAC and posted for Public Review. Press Release is sent to local news outlets of project completion. • UC Davis and BHS staff present findings in at least one conference convened by MHSOAC, DHCS, or CIBH. **Year End Goal:** Disseminate evaluation and research findings to stakeholders and throughout California.
1/1/18 – 6/30/18	7/1/18 – 6/30/19	7/1/19 – 6/30/20	7/1/20 – 6/30/21	7/1/21 – 6/30/22	7/1/22 – 12/31/22

b) Provide a brief explanation of how the project's timeframe will allow sufficient time for project implementation, operations, evaluation, determination of continuation, and communication of results and lessons learned.

The project time frame is five years, terminating in December 2022. As discussed in the table above the following benchmarks must occur within the stated time periods:

Start-up and Implementation: January 2018 – June 2018

- MHSOAC approval is received
- Contracts are executed
- New staff are hired
- Initial leases are procured
- Evaluation Plan is due June 1, 2018 (Major Deliverable # 1)
- Operating policies and referral protocols are developed

Operations and Evaluation: July 2018 – June 2022

- Client enrollment begins
- Evaluation data collection begins
- Lessons Learned Evaluation Report is due November 15, 2020 (Major Deliverable # 2)
- Community Collaborative reviews program Design and makes revisions for implementation in FY 21/22

Determination of Continuation: July 2021 – June 2022

- Preliminary Outcomes Report is due July 15, 2021 (Major Deliverable # 3)
- Community Collaborative develops sustainability plan, due November 15, 2021
- Recommendation of Program Continuation is given to BHS Director by January 31, 2022
- BHS makes determination of ongoing funding and presents plan by June 30, 2022
- Notice of continuation or termination of the project is issued by July 15, 2022.

Communication of Results and Lessons Learned: July 2018 – December 2022

- Determination of Communication Strategy is made by the Community Collaborative, with a written plan due by September 2018, discussing recommendations for:
  - Learning Communities
  - Conference Presentations
  - Other methods of stakeholder communication throughout the duration of the Progressive Housing Innovation Project
- Final Outcome report is due November 15, 2022 (Major Deliverable # 4)
- Press Release and Project Brief are distributed by December 31, 2022.

Part III. Budget

1. Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project.

Expenditures:

1) Personnel Costs (BHS)

Several BHS personnel will work on this project. These will include:

- Project Director: *Classification* Chief Mental Health Clinician
- Housing Liaison: *Classification* Mental Health Specialist II
- Two Peer Partners: *Classification* Mental Health Outreach Worker Trainee

The Salary and Benefit Cost chart below is illustrative of salaries and benefits for the 12-month operating period of BY 2018-19, reflective of the first year of full staff operations. Salaries and benefit costs will increase annually, per San Joaquin County's collective bargaining agreements.

Position	FTE	Base Salary	Salary	Benefits	Total Annual Personnel
Project Director	.15	$106,000	$52,790	$17,959	$56,908
Housing Liaison	.25	$49,824	$12,456	$7,574	$20,030
Peer Partners (2 total)	1.5	$35,193	$15,900	$10,471	$26,371
Total Salary and Benefit Costs for FY 2018/19			$81,146	$22,163	$103,309

Benefit costs vary by employee and include the following

- Cafeteria
- Retirement (38%)
- Life
- Health
- Dental
- Vision
- Unemployment (15%)
- Social Security (6.2%)
- Medicare (1.45%)

Total Personnel Costs for the duration of the project are:

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$ 48,280	$103,309	$104,445	$106,434	$107,618	$470,086

2) Operating Costs

Other Direct Costs are inclusive of:

	2018, 6 mo.	2018-19	2019-20	2020-21	2021-22	5 Year Total
Motor Pool (2 cars @ $10,700 per car per year)	$10,700	$21,400	$21,400	$21,400	$21,400	$96,300
Incentives $50 per house per month	600	3,900	7,500	10,500	10,000	32,500
Activity Supplies & Equipment $2,000 annual	1,000	2,000	2,000	2,000	2,000	9,000
Clothing, linen, personal items $1,800 per house	5,400	10,800	10,800	5,400		32,400
Staff Training & Education $1,000 a year	500	1,000	1,000	1,000	1,000	4,500
Client Trainings $500 per house per year	4,500	4,500	7,500	9,000	9,000	31,500
Total Other Direct	$19,700	$43,600	$50,200	$49,300	$43,400	$**206,200**

BHS indirect cost rate is 15%. Indirect costs are a sum of all county expenditures pertaining to county personnel, county programming costs, and evaluation.

Indirect costs account for the costs associated with BHS program operations, including overhead costs, contract management, financial analysis and reporting, information systems, and the MHSA Coordinator.

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$ 17,622	$ 36,886	$ 38,047	$ 38,210	$ 37,503	**$168,268**

3) Non Recurring Costs

Non-recurring costs include security deposits and furnishings for each house. These costs will be incurred by the contracted program partner and are described below.

4) Consultant Contracts

BHS will contract with UC Davis Behavioral Health Center for Excellence to conduct the comprehensive program evaluation. Budget amounts allocated for program evaluation will include:

- $49,500, for the period of Jan 2018- June 2018, for Evaluation Design
- $99,000, annually for FY 2018/19, 2019/20, 2020/21 and 2021/22, for ongoing research, evaluation and technical assistance.

See evaluation line item.

Project Deliverables and Scope of Work to be determined.

5) Contracted Service Provider

BHS will contract with Self Help Housing to operate and manage the housing component of the project. Costs associated with program operations include program staff, housing costs, direct and indirect program costs. Budget considerations are described below. The budget will change annually given the following factors: (1) personal costs will increase 3% annually, (2) rental costs will vary by the number of houses that are open, and (3) direct and indirect costs will also increase according to the number of houses and clients served. The narrative below explains the cost model that has been used to derive the project budget. Actual allocations may be adjusted according to the number or houses and clients served annually.

5.1 Personnel

SALARY Project Staff:

- Project Manager – oversees program operations, supervises staff, interfaces directly with BHS Project Supervisor, and is responsible for the budget and fulfillment of all contractual obligations The Project Manager also attends the quarterly Community Collaborative meetings and works directly with the BHS Project Manager to ensure coordination and collaboration of efforts.
- Housing Locator Specialist – is responsible for finding the houses used for the program, this requires a comprehensive knowledge of the local housing market.
- Housing Case Plan Manager – meets with all enrolled clients on a regular basis to develop a housing case plan that establishes a pathway to permanent housing. Meets regularly to check progress on achieving case plan milestones and to encourage follow-up on necessary tasks to become “rent ready.” 1 FTE per 9 houses.

PART-TIME or HOURLY Project Staff include:

- Resident House Managers – responsible for monitoring the house and reporting safety concerns to the Housing Operations Specialist, submitting written reports of participant house rule violations and maintenance requests to the Housing Operations Specialist

and will report directly to The Housing Operations Specialist. 1 per house / 70 hrs. work-time per month

- House Operations Specialist – is responsible for the operation of houses. The Housing Operations Specialist makes weekly visits to each house to inspect for safety and habitability, will be responsible for the training of House Leaders, will keep written records of House Rule violations and will implement behavior modification contracts with participants who are in violation of program/house rules. Will report directly to the Project Manager. (estimated 10 hours of associated work per month)
- Property Manager is responsible for the upkeep and maintenance of each house and will keep records of maintenance preformed. Will be responsible for signing leases, and setting houses prior to occupancy, will be the primary contact for the owners of the properties we will be leasing. This is a supervisory position and will report directly to SSHH Executive Director. (estimated 11 hours of associated work per month)

	2017/18	2018/19	2019/20	2020/21	2021/22	5 Year
Project Manager	$31,000	$62,930	$64,818	$66,763	$68,766	$294,276
House Case Plan Manager	18,750	38,063	39,205	40,381	41,592	177,990
Housing Locator Specialist (.5 FTE)	9,375	19,032	19,603	9,946	-	57,955
Benefits 25%	12,438	25,248	26,006	26,786	27,589	118,066
Resident House Managers	14,868	98,426	194,635	280,303	274,522	862,754
Housing Operations	2,263	14,975	29,617	42,651	41,769	131,274
Property Management	4,291	28,400	56,167	80,883	79,206	248,947
Total Salary Costs by Year	**$92,983**	**$287,073**	**$430,050**	**$547,712**	**$533,443**	**$1,891,262**

5.2 Other Direct Costs

Direct Costs are inclusive of

- Rent
- Security deposits
- Utilities
- Client Food
- Household maintenance supplies
- Telephone
- Staff mileage
- Client Transportation
- Maintenance Costs
- Furnishings

The Chart below describes the one-month operations cost of each house. Operating costs vary annually depending on the number of houses that are presumed to be in operation.

Estimated: One-Month Cost to Operate a House	
Rent	$ 1,800
Utilities	375
Client Food	350
Household Supplies	240
Telephone	55
Staff Mileage	250
Client Transportation	145
Maintenance Costs	350
Total	$3,565

Additional estimated costs that are included in the budget, actual costs to be determined.

- Each house will receive a $5,000 allocation for the purchase of basic furnishings at the onset of operations within that house.
- Anticipated maintenance tasks (such as pest control) are budgeted at $3,000 annually.
- Security deposits $36,000 (for life of the project)
- Office Rent: $2,000 / month
- Office set-up, minor furnishings, and other equipment $25,000 (one time cost)

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$ 104,280	$ 349,930	$ 607,341	$ 798,993	$ 745,119	**$2,605,663**

5.3 Indirect Costs

Indirect costs are calculated at 15% of Self Help Housing's Direct Costs (Personnel + Other Direct Costs)

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$ 29,590	$ 95,550	$ 155,609	$ 202,006	$ 191,784	**$ 674,539**

5.4 Total Operating Costs for Self-Help Housing

This is a sum of all costs incurred by the Contracted Service Provider.

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$ 226,853	**$ 732,553**	**$ 1,193,000**	**$ 1,548,711**	**$ 1,470,346**	**$ 5,171,463**

6) Other Expenditures

None.

7) Administration

The total amount incurred for the administration of this program, exclusive of the evaluation, is indicated below.

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$312,455	$916,348	$1,385,692	$1,742,655	$1,658,867	$ 6,016,017

8) Evaluation

See above. Evaluation funds are allocated to the Evaluation Contractor.
BHS will negotiate the scope of work and actual annual allocation upon project approval.

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$49,500	$ 99,000	$ 99,000	$ 99,000	$ 99,000	**$ 445,500**

9) Total Budget

The total project budget, inclusive of the evaluation, is indicated below.

2017/18	2018/19	2019/20	2020/21	2021/22	Total 5 Year
$361,955	$1,015,348	$1,484,692	$1,841,655	$1,757,867	**$6,461,517**

2. Budget by Fiscal Year and Specific Budget Category

See Budget Tables.

3. Budget Context, if applicable

Explain the broader context of the Innovation Project, for example if the innovation project is a component of a larger initiative. If MHSA funds are being leveraged with other funding sources, describe the other funds leveraged.

a) Provide a brief description of the broader project or initiative to which the Innovation is a component of.

This INN program operates within a broader Homeward Bound Initiative. The Homeward Bound initiative targets individuals with serious mental illnesses that are homeless or at risk of homelessness. It is also presumed that the majority of individuals within this target population will also have co-occurring substance use disorders. The Homeward Bound Initiative consists of five interrelated program components that, collectively, are designed to increase access to treatment services for this chronically unserved and underserved population. The five components include:

Outreach & Engagement *Identify potential clients, and conduct a brief screening to determine the likeliness of mental illness*	Homeless Outreach Teams Mobile Crisis Response Team Community Outreach Partners
Stabilization *Address urgent stabilization needs (housing and substance withdrawal) prior to completing the assessment*	Withdrawal Management Center Pre-Contemplation Home
Assessment & Access to Care *Conduct a multi-phase assessment process with brief treatment interventions to address high-risk behavior and options for care.*	**Assessment and Respite Center**[28]
Whole Person Treatment Model *Provide integrated housing and clinical services in a program designed to increase housing stability and recovery.*	**Progressive Housing** Clinical Treatment Services
Linkage Additional Community Supports *Create a seamless referral process to wrap existing services and supports around consumers as best fits their needs and interests including substance use recovery and peer supports.*	Substance Use Treatment Programs Wellness Centers

b) Provide the total amount of funding that will be used and the extent to which non-MHSA funds are being leveraged. List additional funding sources, the amounts anticipated to be leveraged, and provide a brief description of the funding source.

N/A

[28] Bold project are those projects for which INN funding will be applied upon approval by the MHSOAC. All other programs are currently funded.

All projects within the Homeward Bound Initiative have their own program budgets and will be managed and operated independently from the Progressive Housing Project.

A. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
1.	Salaries	**$ 48,280**	**$ 103,309**	**$ 104,445**	**$ 106,434**	**$ 107,618**	**$ 470,086**
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	**$ 48,280**	**$ 103,309**	**$ 104,445**	**$ 106,434**	**$ 107,618**	**$ 470,086**
OPERATING COSTs		**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
5.	Direct Costs	**$ 19,700**	**$ 43,600**	**$ 50,200**	**$ 49,300**	**$ 43,400**	**$ 206,200**
6.	Indirect Costs	**17,622**	**36,886**	**38,047**	**38,210**	**37,503**	**168,268**
7.	Total Operating Costs	**$ 37,322**	**$ 80,486**	**$ 88,247**	**$ 87,510**	**$ 80,903**	**$ 374,468**
NON RECURRING COSTS (equipment, technology)		**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
8.	**N/A**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
11.	Direct Costs	**$ 49,500**	**$ 99,000**	**$ 99,000**	**$ 99,000**	**$ 99,000**	**$ 445,500**
12.	Indirect Costs						
13.	Total Consultant Costs	**$ 49,500**	**$ 99,000**	**$ 99,000**	**$ 99,000**	**$ 99,000**	**$ 445,500**
Contracted Service Provider (Name: Stockton Self Help Housing)		**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
11a.	Personnel (Salary + Benefits)	**$ 92,983**	**$ 287,073**	**$ 430,050**	**$ 547,712**	**$ 533,443**	**$1,891,261**
11a.	Other Direct costs	**104,280**	**349,930**	**607,341**	**798,993**	**745,119**	**2,605,663**
12a	Indirect Costs	**29,590**	**95,550**	**155,609**	**202,006**	**191,784**	**674,539**
13a	Total Operating Costs	**$ 226,853**	**$ 732,553**	**$1,193,000**	**$1,548,711**	**$1,470,346**	**$5,171,463**

New Innovative Project Budget By FISCAL YEAR (continued)						
EXPENDITURES						
OTHER EXPENDITURES (please explain in budget narrative)	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
14.						
15.						
16. Total Other expenditures						
BUDGET TOTALS						
Personnel (line 1)	**$141,263**	**$ 390,382**	**$ 534,495**	**$ 654,146**	**$ 641,061**	**$2,361,347**
Direct Costs (add lines 2, 5 and 11 from above)	**173,480**	**492,530**	**756,541**	**947,293**	**887,519**	**3,257,363**
Indirect Costs (add lines 3, 6 and 12 from above)	**47,212**	**132,436**	**193,656**	**240,216**	**229,287**	**842,807**
Non-recurring costs (line 10)						
Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET	**$361,955**	**$1,015,348**	**$1,484,692**	**$1,841,655**	**$1,757,867**	**$6,461,517**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

A. *Expenditures By Funding Source and FISCAL YEAR (FY)*

Administration:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Total
1.	Innovative MHSA Funds	$ 312,455	$ 916,348	$1,385,692	$1,742,655	$1,658,867	$6,016,017
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	$ 312,455	$ 916,348	$1,385,692	$1,742,655	$1,658,867	$6,016,017

Evaluation:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Total
1.	Innovative MHSA Funds	$ 49,500	$ 99,000	$ 99,000	$ 99,000	$ 99,000	$ 445,500
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation	$ 49,500	$ 99,000	$ 99,000	$ 99,000	$ 99,000	$ 445,500

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Total
1.	Innovative MHSA Funds	$ 361,955	$1,015,348	$1,484,692	$1,841,655	$1,757,867	$6,461,517
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	$ 361,955	$1,015,348	$1,484,692	$1,841,655	$1,757,867	$6,461,517

*If "Other funding" is included, please explain.

4. Budget Assurances

a) Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation.

San Joaquin County is providing assurance that our INN funds are within the 5% of our total MHSA allocation.

b) Documentation that the Annual Mental Health Services Act Revenue and Expenditure Report was submitted by December 31, following the end of the fiscal year.

San Joaquin County has not submitted our 2015-16 Mental Health Services Act Revenue and Expenditure Report. It will be completed and submitted on or before September 30, 2017.

Appendix

Certifications

1. Board of Supervisors Resolution
2. Certification of Regulatory Compliance
3. Certification of Fiscal Compliance

NOTE: All certifications will be inserted following the public hearing on September 20, 2017.

Community Program Planning Process

4. Survey Instrument
5. Paper Survey Distribution and Return Count
6. Email Invitation to Targeted Roundtable Discussions
7. Sample Meeting Flyer
8. Demographic Form
9. Homeward Bound Project Presentation
10. Progressive Housing Project Presentation

1. Board of Supervisors Resolution

This Page deliberately left blank on August 18, 2017

Insert Resolution Here before final submission to MHSOAC

2. San Joaquin County Compliance Certification

County/City:

X Innovation Plan
☐ Annual Update

Local Mental Health Director	**Program Lead**
Name:	Name:
Telephone Number:	Telephone Number:
E-mail:	E-mail:

Local Mental Health Mailing Address:

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan, including stakeholder participation and non-supplantation requirements.

This Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached Three Year Program and Expenditure Plan are true and correct.

NAME , _____ _____
Mental Health Director Signature Date

3. San Joaquin County Fiscal Accountability Certification

County/City:

X Innovation Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	**County Auditor-Controller / City Financial Officer**
Name:	Name:
Telephone Number:	Telephone Number:
E-mail:	E-mail:

Local Mental Health Mailing Address:

I hereby certify that the Three-Year Program and Expenditure Plan is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Name, _____ _____
Mental Health Director Signature Date

I hereby certify that for the fiscal year ended June 30, 2016, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2016 . I further certify that for the fiscal year ended June 30, 2016, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Name, _____ _____
County Auditor Controller Signature Date

San Joaquin County Behavioral Health Services (BHS)

2017 MHSA 3-Year Program Plan: Stakeholder Input Survey

Please answer the following questions to provide feedback on mental health services in San Joaquin County. Your responses will help us understand what works well and how we can improve services. Thank you!

Q1 Are you a consumer or family member of someone receiving mental health services at BHS?

- ☐ Yes, I am a consumer
- ☐ Yes, I am a family member
- ☐ Yes, I am both a consumer and a family member
- ☐ No, I am neither a consumer or a family member — Go to Question 3 if you are neither a consumer or family member

Q2 If you are a consumer or a family member, what mental health clinic do you or your family member mostly receive services at?

- ☐ Children and Youth Services
- ☐ BACOP
- ☐ La Famila
- ☐ TCC/SEARS
- ☐ CATS, Team A, B, C or D
- ☐ GOALS
- ☐ Other
- ☐ Tracy
- ☐ Lodi
- ☐ Forensic

Please enter the name of the other clinic location: _____

Q3 Please rate your satisfaction with the following aspects of our services:

	Poor	Fair	Very Good	Excellent	Don't Know
The location of our services.	☐	☐	☐	☐	☐
Informational flyers and pamphlets	☐	☐	☐	☐	☐
Access to information on our website	☐	☐	☐	☐	☐
The length of time it takes to get an appointment	☐	☐	☐	☐	☐
The professionalism of our staff	☐	☐	☐	☐	☐
The cultural sensitivity of our services	☐	☐	☐	☐	☐
The thoroughness of our services	☐	☐	☐	☐	☐

Q4 Would you recommend our services to someone who needs help for a mental health concern?

- ☐ Yes
- ☐ No
- ☐ Maybe
- ☐ Don't Know

BHS is also interested in ensuring that program activities fill unmet needs and work with those who need help the most.

Q5 Which of the following services do we need more of?

	Right Amount	Need a little more	Need alot more	Don't Know
Mental health clinic services	☐	☐	☐	☐
Crisis services	☐	☐	☐	☐
Respite services	☐	☐	☐	☐
Peer drop-in, wellness, or socialization services	☐	☐	☐	☐
Services to get basic needs met (food, clothing, hygiene products)	☐	☐	☐	☐
Transportation to appointments	☐	☐	☐	☐
Help finding the right health care provider	☐	☐	☐	☐

Q6 Do we need more services for the following populations?

	Right Amount	Need a little more	Need alot more	Don't Know
Homeless individuals	☐	☐	☐	☐
Individuals with frequent mental health crises	☐	☐	☐	☐
Individuals with frequent visits to the emergency room	☐	☐	☐	☐
Individuals with frequent arrests for mental health related behaviors	☐	☐	☐	☐
Individuals with both mental health and substance use disorders	☐	☐	☐	☐
Individuals at-risk of institutional care for a mental health illness	☐	☐	☐	☐

Q7 Are there any other services or populations that we should be prioritizing?

We would like to know a little bit more about you so we can understand the needs and experiences of different types of people.

Q8 Please indicate your age range:

- Under 18 ☐
- 18-25 ☐
- 26-59 ☐
- 60 and older ☐

Q9 What is your gender:

- Female ☐
- Male ☐
- Other, Both, Transgender ☐

Q10 Please indicate the primary language spoken in your home:

- English ☐
- Spanish ☐
- Other ☐

If other please specify: _____

Q11 What is your race / ethnicity (check all that apply)

- White/Caucasian ☐
- Black/African American ☐
- Hispanic/Latino ☐
- Asian or Pacific Islander ☐
- American Indian, Native American, First Nations ☐
- Other ☐

If other please specify: _____

Q12 Do you work with an agency that currently provides mental health or substance use treatment services in San Joaquin County

Yes ☐ No ☐ Don't Know ☐

Q13 Do you have any other recommendations on how we can improve program services?

_____

Thank you so much for taking the time to let us know what you think!

2017 MHSA 3-Year Program Plan: Stakeholder Input Survey

2017 Substance Use Disorder Treatment Services: Client Input Survey

Distribution List

Clinic or Program Name	Date Received	Date Returned	Number Returned
CATS Team A		3/27	18
CATS Team B		3/27	5
CATS Team C		3/20	18
CATS Team D		3/27	2
CYS Clinic		3/20	45
Forensic Clinic		3/20	31
Crisis Clinic		3/20	28
BACOP Clinic		3/20	13
La Familia Clinic		3/20	30
GOALS Clinic		3/28	56
TCC / SEARS Clinic		3/21	27
Manteca Clinic		3/28	11
Lodi Clinic		3/27	13
Tracy Clinic		3/27	10
The Wellness Center		3/27	46
Martin Gipson Socialization Center		3/20	37

CDCC		3/17	71
Recovery House		3/6	30
Family Ties		3/9	24
ADAP		3/7	4
Central Intake		3/7	2
New Directions		3/28	66
CYS Tracy		3/28	11
CYS Manteca		3/28	11

Email invitation for: MHSA - Homelessness—Strategy Roundtable # 1

Subject line: IMPORTANT—MHSA Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion on the issue of providing mental services to homeless individuals in San Joaquin County.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday January 11, from 10am – noon at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:
Frances Hutchins / Cara Dunn
Billy Olpin
Members of the San Joaquin County Homelessness Task Force
All LAC

Email invitation for: MHSA Housing Services—Strategy Roundtable # 2

Subject line: IMPORTANT—MHSA Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion on the issue of providing housing services for individuals with mental health illnesses, a substance use disorder, and/or are re-entering the community from jail or prison.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday January 11, from 3:00 – 5:00pm at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:
Frances Hutchins / Cara Dunn
Billy Olpin
Cindy Morishigue
MHSA Housing Providers, AOD continuum partners, and sober living partners
All LAC

Email invitation for: Prop 47 Diversion and Reentry —Strategy Roundtable # 1

Subject line: IMPORTANT—Prop 47 Diversion and Reentry Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion on the issue **diversion and re-entry services and supports** for individuals arrested, convicted or incarcerated for non-violent and non-serious offenses in order to prevent recidivism and support successful reentry into the community.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday January 18, from 10am – noon at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:
Frances Hutchins / Cara Dunn
Billy Olpin
Friends Outside
Partners in the San Joaquin County Assessment Center
San Joaquin County Court Partners
All LAC

Email invitation for: Prop 47 Behavioral Health Treatment Services —Strategy Roundtable # 2

Subject line: IMPORTANT—Prop 47 Mental Health and Substance Use Disorder Treatment Services Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion to identify the needs and opportunities to provide **mental health and substance use disorder treatment services** for individuals arrested, convicted or incarcerated for non-violent and non-serious offenses in order to prevent recidivism and support successful reentry into the community.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Thursday, January 19 from 10am – noon at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:
Frances Hutchins / Cara Dunn
Billy Olpin
Cindy Morishige
Donna Bickham
FSP partner programs
Mental health treatment organizational providers (St. Joseph? Community Medical Centers?)
All LAC

Email invitation for: Behavioral Health Treatment Continuum of Care —Strategy Roundtable # 1

Subject line: IMPORTANT—MHSA Mental Health Treatment Services Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion to identify the needs and opportunities to develop a broad spectrum of public and private mental health treatment services in San Joaquin that are designed to serve individuals and families within the full spectrum of mental health treatment needs.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Thursday, January 19 from 3:00 – 5:00pm at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:
Frances Hutchins / Cara Dunn
Cindy Morishige
Donna Bickham
Jacqui Coulter
FSP partner programs
CYS contracted mental health partners
Residential program partners
Mental health treatment organizational providers (St. Joseph? Community Medical Centers?)
Health Plan of San Joaquin

Email invitation for: Behavioral Health Treatment Continuum of Care —Strategy Roundtable #2

Subject line: IMPORTANT— Provider Partners Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion to identify the needs and opportunities to strengthen the capacity of community partners to provide mental health and substance use treatment services by becoming a licensed and certified organizational provider.

At this meeting we will:

- Current Regulations
- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday, January 25 from 3:00 – 5:00pm at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:
Frances Hutchins / Cara Dunn
Billy Olpin
Donna Bickham
FSP partner programs
SAS partner programs
Health Plan of San Joaquin

San Joaquin County Behavioral Health Services

Transforming Mental Health Services

Mental Health Services Act
3-Year Program and Expenditure Plan
MHSA Program Partners for Contracted Services

A new MHSA Three Year Program and Expenditure Plan for FY 2017-18, 2018-19, and 2019-20 is due to the Mental Health Services Oversight and Accountability Commission in June, 2017.

BHS is currently conducting a community program planning process to solicit input from consumers, family members and other stakeholders on existing programs and services; opportunities for improvements; and recommended changes or additions to the plan. Please join us for a special discussion of our partner organization to talk about strategies to strengthen the broad continuum of care of community mental health services. The discussion will be inclusive of prevention, early intervention, clinical treatments services, and other support services for consumers with serious mental illnesses.

While not within the scope of the MHSA, we will also be soliciting feedback on the broad continuum of care for individuals that do not meet the clinical criteria for a serious mental illness and will be asking for feedback and suggestions on how we can collectively strengthen the system of care for all individuals and families in San Joaquin County.

Wednesday February 8, 2017

10:00 – 12:00

Conference Room A

1212 N. California Street

Stockton, CA 95202

We are also hosting Community Meetings to generate feedback about existing program services. Please ask your clients to join us at our next Community Meeting:

Thursday, February 9, 2017, from 3:30 – 5:30pm
San Joaquin County Public Health Department – Conference Room
1601 East Hazelton Avenue, Stockton CA 95205

Thank you for your assistance in spreading the word about our upcoming community meeting!

San Joaquin County Behavioral Health Services
Community Program Planning Process

Per State of California guidelines, we must report demographic information on planning participants. This information will be kept confidential and used for reporting purposes only. You may decline to answer these questions.

- ☐ I decline to answer the demographic questions

Please indicate your age range:
- ☐ Under 18
- ☐ 18-25
- ☐ 26-59
- ☐ 60 and older

Please indicate your gender:
- ☐ Male
- ☐ Female
- ☐ Transgender

Please indicate the primary language spoken in your home:
- ☐ English
- ☐ Other: _____

Consumer Affiliation (check all that apply)
- ☐ Mental health client/consumer
- ☐ Family member of a mental health consumer

Stakeholder Affiliation (check all that apply)
- ☐ County mental health department staff
- ☐ Substance abuse service provider
- ☐ Community-based/non-profit mental health service provider
- ☐ Community based organization (not mental health service provider)
- ☐ Children and families services
- ☐ K-12 education provider
- ☐ Law enforcement
- ☐ Veteran services
- ☐ Senior services
- ☐ Hospital/ Health care provider
- ☐ Housing or housing services provider
- ☐ Advocate
- ☐ Other: _____

What is your race ethnicity?
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Southeast Asian
- ☐ Other Asian or Pacific Islander
- ☐ American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)
- ☐ Mixed Race: _____
- ☐ Other: _____

Please return to facilitator upon concluding the meeting. The demographic information is confidential. Your name WILL NOT be connected to your response.

2017 - 2020
Mental Health Services Act Plan

SAN JOAQUIN COUNTY
BEHAVIORAL HEALTH SERVICES

HOMEWARD BOUND
&
OUR PROPOSED APPROACH TO SYSTEM STRENGTHENING

BHS Major Initiatives

Planning Directives

- Re-examine what is working, incorporate emerging best practices, and strengthen outcomes for consumers.
- Develop collaborative programs that leverage multiple funding sources.
- Broaden the behavioral health system of care and add more partners to the mental health and substance use disorder treatment system.

Meeting Objectives

- Discuss the merits of potential project initiatives under consideration.
- Provide feedback on FSP and PEI program strengths and challenges.
- Rank order priority funding areas for consideration.
- Provide input on other areas of interest or concern.

MHSA Overview

- MHSA Program Feedback
  - FSP – 5 Full Service Partnership Programs
    - Children and Youth, Transitional Age Youth
    - Adults, Older Adults, Justice Consumers
    - Includes outreach, engagement, and wrap-around support services
  - PEI – Prevention and Early Intervention
    - Suicide prevention in schools, mentoring for high risk youth, parenting classes, assessment and linkages at JJC
    - Trauma informed treatment for children in schools and with CWS, and treatment of youth with emerging psychosis,

Discussion # 1

- PEI and FSP Project Review
  - PEI – prevention and early intervention. Most programs target high-risk children, youth, and families.
  - FSP – Full Service Partnership Program. Program services are reserved for those with serious mental illnesses and the highest level of functional impairment.
- Activity Instructions
  - Complete the program feedback survey for PEI or FSP program services.
  - In groups discuss the strengths and challenges identified.
  - Develop a recommendation to improve programming.
- Handout MHSA Program Survey

Organized Delivery System Overview

- 1115 Waiver
  - A pilot-project of the State of California
  - Designed to test a process to increase the effectiveness of substance use disorder treatment.
  - Counties must submit an application to "opt-in"
  - Adopts the American Society of Addiction Medicine (ASAM) criteria for referring clients to treatment
  - Requires providers to become licensed and certified by DHCS
- Opportunity for San Joaquin
  - Leverage new funding to pay for substance use treatments
  - Potentially expanding the amount of services available

Prop 47 Overview

- Safe Neighborhoods and Schools Act
  - Maximize alternatives for non-serious, non-violent crimes.
  - Funding must be used to provide mental health, substance use disorder treatment, and / or diversion programs.
  - Reduce recidivism of people convicted of non-serious, non-violent offenses and have substance use or mental health problems.
- Target Population
  - Serve people who have been arrested, charged with, or convicted of a criminal offense AND have a history of mental health issues or substance use disorders.
- Other Requirements
  - 50% of funding must be allocated to non-governmental partners.

Innovation Overview (INN)

- Intended to create new, effective practices and approaches in the field of mental health.
  - Novel, creative, and contribute to learning
- Essential Purposes of Innovation Funding
  - Increase access to underserved groups
  - Increase quality of life, including better outcomes
  - Promote interagency collaboration
  - Increase access to services

Consumer & Stakeholder Input

- Housing!!!
  - Consumers are unstably housed, impacting health, well-being and recovery.
- Co-occurring Disorders
  - Appropriate treatment services are difficult to access
    - There are no residential treatment services designated for individuals with co-occurring mental health disorders.
    - Only a small portion of substance use disorder treatment staff have been trained in mental health approaches.
- Case Management
  - Having an ally and a navigator is essential to access services and to stay accountable and engaged in treatment plan
- Stigma and Disparities in Access
  - Many consumers are still not receiving needed services
  - Populations remain reluctant to access services through BHS

INN Concept Ideas

- Review and Assess Initial Concept Ideas
  - Supportive Housing for high-acuity consumers with co-occurring disorders with on-site programming and case management
    - Increase quality of life, including better outcomes
  - Residential Substance Use Treatment Facility for individuals with co-occurring Disorders
    - Increase access to underserved groups
    - Increase quality of life, including better outcomes
  - Community Assessment and/or Respite Center – integrated with primary health care services and linkages to case management
    - Increase access to underserved groups
    - Increase quality of life, including better outcomes
    - Promote interagency collaboration
    - Increase access to services

Activity # 2

- Activity Instructions:
  - In groups, review the project summaries.
  - Discuss the pros and cons
- Determine validity of concept
  - Is it needed?
  - Will it serve an essential purpose in Mental Health Services?
- Brainstorm Additional Concepts

- Handout, Discussion Recording Form

Closing Discussion

- Activity Review
  - Summary of Feedback
  - Key Findings
- Next Steps
  - Provide written comments or meeting feedback
  - Opportunities for Further Participation
- PLEASE, spread the word…..

THANK YOU!

CONTACT INFO:

KAYCE RANE
RANE COMMUNITY DEVELOPMENT
KAYCERANE@RANECD.COM

Progressive Housing Innovation Project

Presentation to:
San Joaquin County Behavioral Health Board
August 16, 2017

Mental Health Services Act

Innovation

- Increase access
- Increase quality
- Promote collaboration

Overview & Primary Purpose

2

Individual with co-occurring serious mental illnesses and substance use disorders need a safe and stable place to live in order to engage in treatment services and meet their recovery goals.

Our Vision

3

Existing housing options are scare, expensive, rarely accommodate individuals with co-occurring disorders, and are challenging to develop.

Our Challenge

4

Our Need

Develop a new model of affordable, easy to develop, and recovery oriented housing that can be quickly started by a county mental health departments with limited resources.

5

Project Objective

Progressive Housing

Introduce a new application to the mental health system of a promising community-driven practice.

6

Progressive Housing:

An Adapted Approach to *Housing First*

Proposed Project

7

A model that places homeless individuals in a permanent home*, without preconditions.

* typically scattered site apartments

Housing First

8

Designed in New York City with the following design considerations:

- High Density
- Access to Public Transportation
- Rich, Decentralized Service Environment

Implementing Housing First

9

- **Level Housing** to create safe home spaces that align to recovery stages, and cluster individuals at similar stages in their recovery.
- **Wellness Environment** with the inclusion of *Consumer Choice Programming* and a *Resident House Manager* with lived experience.

Adaptation

10

Target Population

Unserved* or *Underserved

individuals with severe and persistent mental illness who are homeless or at risk of homelessness

11

The Innovation

A Linear Approach to Housing First

House Levels align with ASAM stages of recovery:

- Pre-contemplation house (Assessment phase)
- Contemplation, Treatment and (Sober) Recovery Houses
- Graduation House (Post-programming)

12

Provide shared housing in three- to five-bedroom houses, with each client having a private bedroom but sharing common areas, chores, and living conditions.

Housing Component

13

All clients will receive treatment services by BHS according to their individualized treatment needs, including FSP enrollment, access to substance use services, etc.

Clinical Component

14

A *Resident House Manager* with lived experience

Consumer Choice Programming

Volunteer &/or Vocational opportunities

Consumer Driven

15

Very-low barriers to entry

Design model anticipates relapse within the recovery process

Housing Case Manager helps guide consumers towards permanency

Family Driven

16

Treatment Component

17

Non – Clinical

Shared Recovery-oriented Home

Consumer Choice Programming and Classes

Housing Permanency Case Plans

Peer-partners in Recovery

- WRAP
- Home Visits / Peer Support
- Transportation to Wellness Center, Martin Gipson, and other Support Groups

Treatment Component

18

Other Clinical Services

- Outreach Worker assigned to houses
- Home Visits by medical and mental health practitioners
- Coordination and collaboration between clinical and housing services

Learning Questions

Is it Feasible?

Is it Effective?

Are Costs Reasonable?

Is Implementation Timely?

19

Implementation Model

Lead Partner:
Sacramento Self Help Housing

Collaborative Partners:

- Homeless Outreach Teams
- Withdrawal Management Center
- Assessment and Respite Center
- Allies and Allies / SOAR Clinical Services
- Other Community Based Agencies

20

Research Partner: UC Davis – Behavioral Health Center for Excellence

- Feasibility Study
- Outcomes Study
- Cost Benefit Study

Evaluation

21

Projections show INN funds decreasing annually.

Over the four year period of FY 19/20 – 22/23, total INN funds decrease from $4.4 million to $3.9 million

BHS anticipates spending approximately $1 – 1.75 million on the Progressive Housing project annually, depending on the number of houses operating.

This accounts for 30% - 40% of total available INN funds in any given year.

Additional INN projects are in development, including the Assessment and Respite Center

Budget

22

Questions?

23

Plan Posting Date: August 18, 2017

30-day public comment period 8/18 – 9/20

Submit comments to:
mhsacomments@sjcbhs.org

Public Hearing: September 20, 2017

Next Steps

24