San Joaquin County
Behavioral Health Services

1212 N. California St.

Stockton, CA 95202

Mental Health Service Act
Innovation Component

Three-Year Program & Expenditure Plan

Fiscal Years 2006-07, 2007-08, 2008-09

Posting Date: March 21, 2011

Public Hearing: May 4, 2011

Board of Supervisors Review: May 10, 2011

ACKNOWLEDGEMENTS

San Joaquin County Behavioral Health Services wishes to thank the many consumers and their family members who gave their time and energy to this process. Their words of wisdom and stories of optimism, wellness, resiliency and recovery have shaped every component of this plan.

In addition, BHS wishes to recognize the contributions of the members of the MHSA Planning Stakeholder Steering Committee, the Mental Health Board, and representatives of partner agencies and community based organizations who helped guide the development of the planning process and the creation of this plan.

Prepared by Resource Development Associates

EXHIBIT A

INNOVATION WORKPLAN
COUNTY CERTIFICATION

County Name:	San Joaquin

County Mental Health Director	Project Lead
Name: Victor Singh Telephone Number: (209) 468-8750 Email: vsingh@sjcbhs.org	Name: Becky Gould Telephone Number: (209) 468-8750 Email: bgould@sjcbhs.org
Mailing address: 1212 N. California St. Stockton, CA 95202	Mailing address: 1212 N. California St. Stockton, CA 95202

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

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

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

_____ _____ _____

Signature (Local Mental Health Director/Designee) Date Title

Exhibit B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: San Joaquin
Work Plan Name: Residential Learning Communities

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

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

Oversight of the Planning Process

In January 2010, San Joaquin County Behavioral Health Services (SJCBHS) embarked on a planning process for the Innovation Component of the Mental Health Services Act (MHSA). The planning effort was facilitated by Vic Singh, Director of Behavioral Health Services, Frances Hutchins, Deputy Director of Administration, Becky Gould, Deputy Director of MHSA Programs, and Resource Development Associates, a consulting firm with Mental Health planning expertise.

The planning effort was advised by the MHSA Planning Stakeholder Steering Committee. Representation on the MHSA Planning Stakeholder Steering Committee was established during the original Community Services and Supports (CSS) planning process. Since that time the MHSA Planning Stakeholder Steering Committee has continued to meet regularly to discuss and make recommendations related to MHSA planning activities.

All recommendations by the MHSA Planning Stakeholder Steering Committee were reviewed by the San Joaquin County Mental Health Board, which provided additional insight and guidance on the Innovation planning process. All meetings of the MHSA Planning Stakeholder Steering Committee and the Mental Health Board are open to the public.

Outreach for the Planning Process

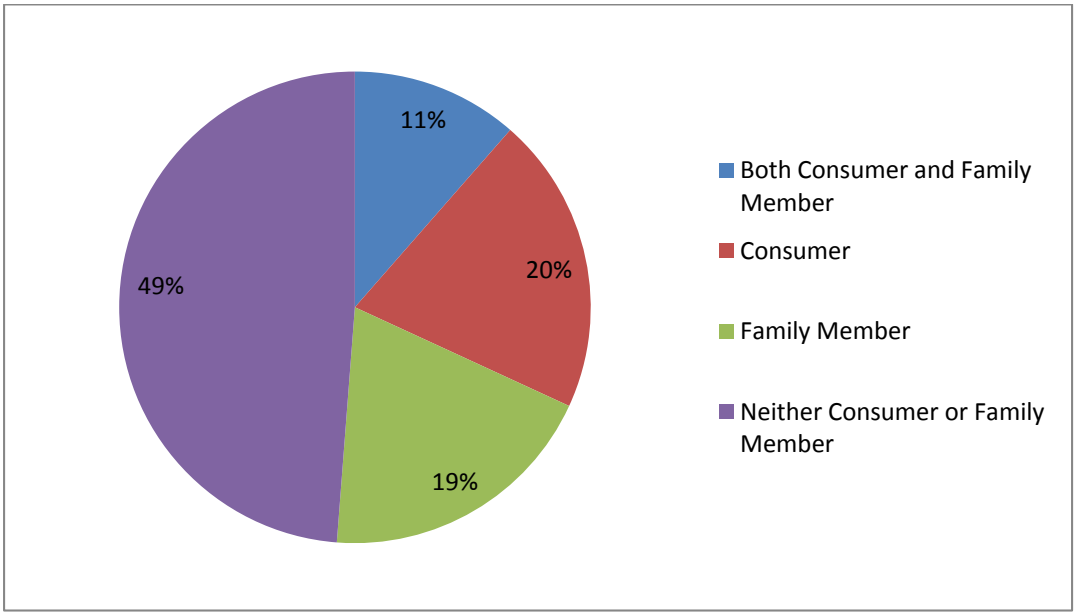
Meetings were noticed throughout the County via flyers posted in public spaces, including libraries, court houses, and public agencies. Flyers were also posted at all locations known to be frequented by consumers, including all Behavioral Health Services locations, the Martin Gipson Center, and the Wellness Center. Partner agencies, which provide community based services and supports such as the full service

partnership's case management services, were also sent meeting notifications with specific requests to post the flyers in prominent locations at their facilities. Flyers included messages in English, Spanish, and Cambodian. E-mail messages were also sent to all stakeholders who had ever provided their contact information for the purpose of receiving updates related to MHSA planning activities. Towards the end of the planning process, the newly hired cultural brokers also helped conduct outreach about the planning process. Cultural brokers received special training on the Innovation planning process and were tasked with conducting outreach and soliciting input for the proposed plan strategies from their respective communities.

These outreach efforts were shaped by the input of the MHSA Planning Stakeholder Steering Committee and the Mental Health Board, which helped ensure that we were reaching a broad spectrum of stakeholders and that the process was driven by community input.

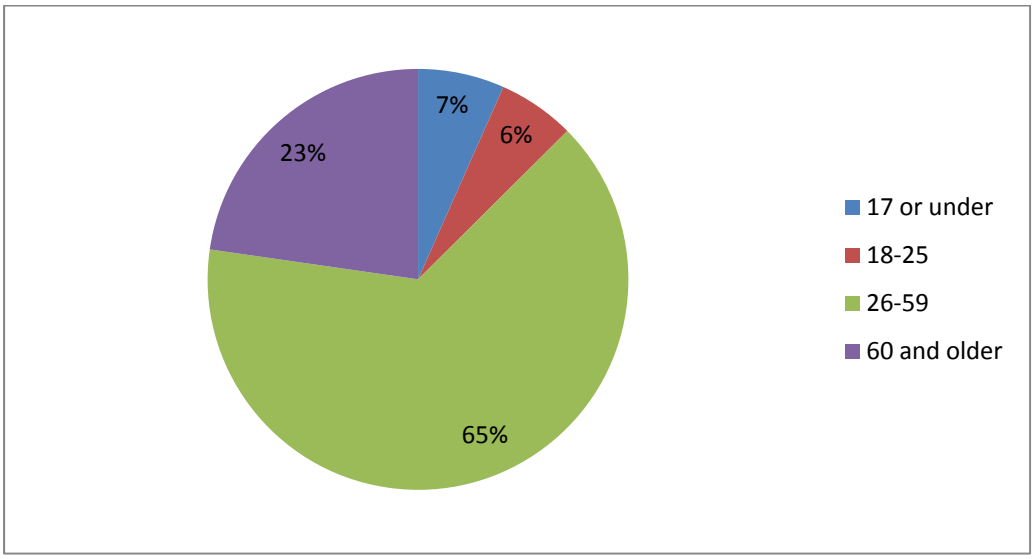
Nearly 600 people (N=577) participated in MHSA Innovation planning activities, representing a diverse spectrum of San Joaquin County. At the outset of all community meetings, discussion groups and interviews participants were given information about the Innovation Guidelines and the importance of 1) identifying a mental health challenge, 2) discovering something new about what works in mental health, and 3) creating strategies that are different from existing mental health services. At each public meeting or focus group an anonymous demographic form was given to participants. These forms asked participants to disclose their age, gender, race/ethnicity, and their mental health status. Responses from the demographic forms are described below.

Consumer and Family Member Participation



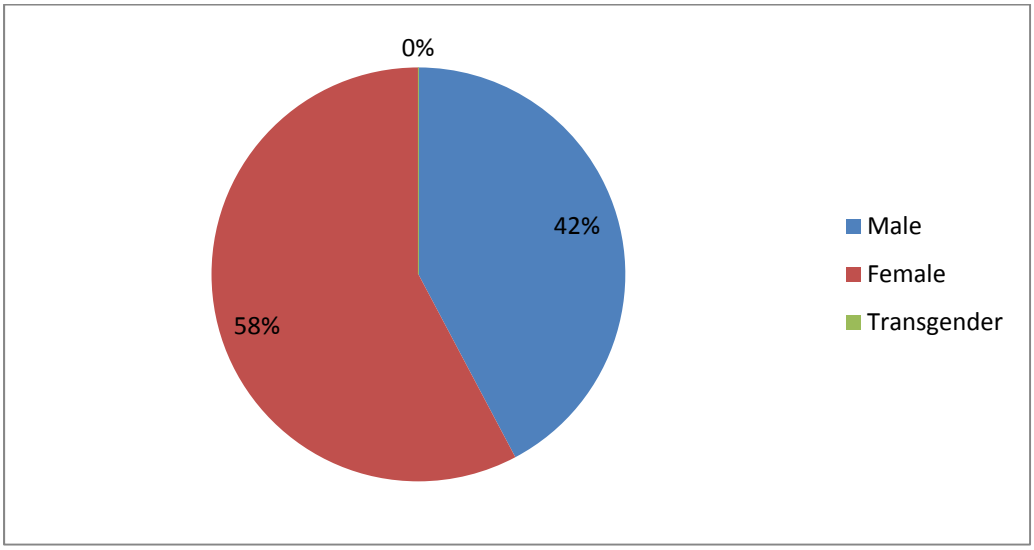
Over half of the Innovation Planning participants self-identified as consumers, family members, or both consumers and family members. The proportion of consumer participants during the planning process may be slightly undercounted. For example, of the 16 consumers who participated in a focus group at the Wellness Center, only 11 submitted the requested demographic forms. Only those who completed a demographic form are included in the analysis below.

Participant Age Ranges



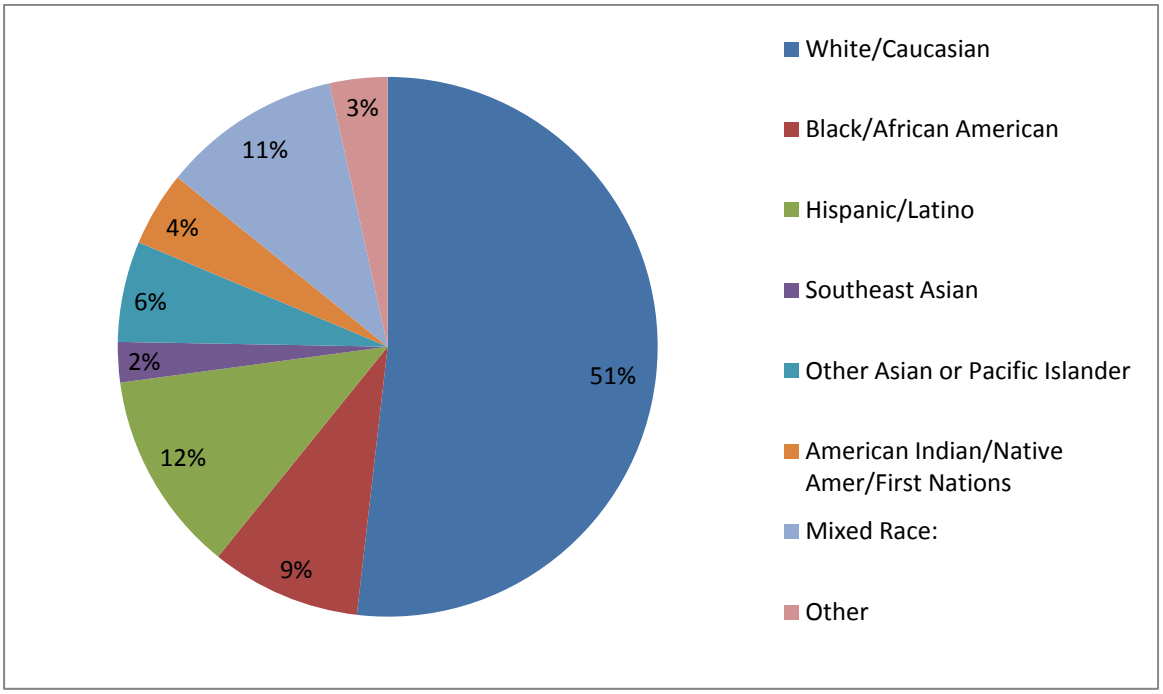
Participants were given the choice of selecting from four different age ranges corresponding to the MHSA categories of Children, Transitional Age Youth, Adults, and Older Adults. The overwhelming majority of participants were adults between 26 and 59 years (65%), with older adults, 60+ accounting for 23% of the participating stakeholder population and children and transition age youth jointly comprising 13%. Participation of youth ages 25 and younger was primarily through two focus groups, one targeting high school age youth and one of transitional age youth receiving mental health services.

Participant Gender



Meeting attendees were also given the opportunity to report their gender on the demographic form. Fifty-eight percent of participants were females, while 42% were males. One individual self-identified as transgender.

Participant Race / Ethnicity



Roughly half of the participants were white, while the other half represented the range of minority populations in the county. Hispanic/Latino participation was low compared to their proportion of the County population. Special efforts were made to increase Latino participation in the planning process. A presentation was conducted to the NAMI Spanish-language support group. Cultural brokers from El Concilio received training on the Innovation Plan concept and were asked to conduct outreach and solicit feedback for the planning process.

Planning Activities and Strategy Development

Key-informant Interviews and Focus Groups

On behalf of the planning team, RDA staff convened key-informant interviews with consumers, behavioral health staff and community partners. A list of those interviewed in the initial phase of the planning process is included in Section 2, below. In addition a focus group was convened at the Martin Gipson Center to solicit initial input from consumers on prevailing challenges associated with seeking mental health services. These conversations contributed essential background information on the status of services in San Joaquin County and an introductory glance at prevailing needs.

Community Meetings

The planning team held community meetings to ensure that all stakeholders, particularly consumers and their families, had the opportunity to hear about and provide input to the Innovation planning process. The initial public meetings were well attended with more than 120 consumers, family members, staff from partner agencies and mental health service providers opening up to share their perspectives. During the meetings, the planning team presented the overall vision of the planning process, quantitative data on services, and key challenges suggested by the initial interviews and focus groups.

The planning team made all public meetings interactive to ensure audience engagement and participation. After reviewing the findings, stakeholders were split into groups to discuss system strengths and challenges. Each group prioritized two of the challenges and developed potential strategies to respond to them. Based on the group input the following challenges emerged for further consideration:

- Responding to Co-occurring Disorders
- Improving Treatment Access and Wait Times
- Partnerships with Criminal Justice
- Improving Access to Services
- Expanding Children and Youth Services
- Revenue Gap for Inpatient Services
- Increasing Revenue and Ensuring Stability
- Improving Linkages Between Services

The Initial Community Meetings were held:

February 4, 2010 9:30am – 12:00pm
February 4, 2010 6:00pm – 8:30 pm

Strategy Roundtables

On behalf of the Planning Team, Resource Development Associates facilitated six strategy roundtables addressing the key challenges. The groups were deliberately kept small (between 10 and 20 participants) and targeted specific issues or population concerns. Roundtable discussions were announced in tandem with the initial community meetings and participants were invited to select one group to participate in. Each roundtable discussion included participants identified as consumers, family members of a consumer, BHS staff, and service providers. Every agency or person that expressed an interest in attending a strategy roundtable was accommodated.

Roundtable Discussions were held:

February 5, 2010, in multiple sessions all day long

During each of the strategy roundtables, participants were asked to further refine the strategies developed in the prior community meetings. Each group developed two to three distinct strategies. Consistent themes that emerged from the strategies proposed included the need to develop new models for:

- peer-based supports to maintain and support consumers in the community
- stabilizing consumers who may experience mental health crisis to minimize use of the locked, psychiatric health facilities
- expanding or enhancing placement opportunities to ensure consumer stability

The results of the strategy roundtables were presented back to stakeholders in a second series of community meetings. During these meetings stakeholders discussed various refinements to create innovative and implementable programs.

The second round of Community Meetings was held on:

February 9, 2010 1:00pm - 2:30pm
February 9, 2010 6:00pm – 7:30pm
February 17, 2010 9:30am – 11:00am
March 17, 2010, 6:00pm – 8:00pm

Following the community meetings, participant input was shared with the MHSA Planning Stakeholder Steering Committee for further review and consideration. The principle criteria of the MHSA Planning Stakeholder Steering Committee in reviewing the proposed strategy concepts were project feasibility, cost, scope, and adherence to the Innovation guidelines.

Strategy Prioritizations

Over the course of several months, various strategies were presented to Stakeholders for prioritization and further consideration, including:

- Creating a new crisis residential program linked to the psychiatric health facility (PHF);
- Creating a new voluntary and consumer supported urgent care unit; and
- Creating new peer-based residential programs.

The planning team held a third round of community meetings in order to present the community with these innovation concepts and the results of a feasibility analysis. Over 75 stakeholders attended these day and evening sessions. After much discussion, community members, the MHSA Stakeholder Steering Committee and the Mental Health Board recommended *peer-based residential programs* for further consideration.

Meetings were held on[1]:

July 9, 2010 1:00pm – 2:30pm
September 15, 2010 6:00 – 8:00pm
January 31, 2011 1:00pm – 3:00pm
February 7, 2011, 6:00pm – 8:00pm

Final Community Input

The planning team held focused discussion groups with consumers, family members, and mental health service providers to get final recommendations on the key components of a peer-based residential learning program. From these discussions emerged the core concept of the proposed *Residential Learning Communities Program.*

September Discussion Groups

- Adult and Older Adult consumers of mental health services
- NAMI / Family members of mental health consumers
- NAMI / Spanish-speaking support group for family members of mental health consumers
- Community-based mental health service providers and advocates (2 groups)
- Direct service providers of mental health services (psychiatric technicians [psych techs], outreach workers, clinicians, etc).

[1] Innovation planning efforts were slowed in the latter half of 2010 in response to time required to research program concepts, a lengthy feasibility analysis, and concerns regarding the State budget impasse. Planning processes were re-initiated in January 2011following the release of the Governor's proposed budget. During this period ongoing feasibility analysis into proposed strategies was conducted by the planning team and the MHSA Planning Stakeholder Steering Committee. Community Stakeholders were kept informed of the status of the planning process in regular communications to the Mental Health Board, e-mails, one-on-one conversations, discussion groups, and a newly launched series of monthly question and answer sessions with the Behavioral Health Services Director.

February Discussion Groups

- Parents and Caregivers of youth with mental health issues
- Transitional Age Youth consumers of mental health services
- Adult and Older adult consumers of mental health services
- High school age youth

At the end of the planning process, formal presentations were made to the MHSA Planning Stakeholder Steering Committee and the Mental Health Board to solicit final suggestions. The meeting of the Mental Health Board on February 16, 2011 was noticed as a public hearing on the Innovation Plan concept.

Final support for the Innovation plan concept was given by the MHSA Planning Stakeholder Steering Committee on March 8, 2011.

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

Stakeholder entities who were involved in the planning process include:

- Anka Behavioral Health
- Central Valley Low Income Housing Corporation
- Community Partnership for Families
- El Concilio
- Family Resource and Referral Center
- First 5, San Joaquin
- FSP, La Familia
- FSP, BACOP
- FSP, SEARS
- Lao Family Community of Stockton
- Mary Magdalene Community Services
- NAMI of San Joaquin
- Native Directions, Inc (Three Rivers Lodge)
- San Joaquin AIDS Foundation
- San Joaquin County Office of Education
- San Joaquin County Sheriff
- San Joaquin County Probation
- San Joaquin County Conservator
- San Joaquin County Health Care Services Agency
- San Joaquin General Hospital
- San Joaquin Superior Court
- Students in Prevention
- University of the Pacific, Reentry Program
- Valley Community Counseling
- Victor Treatment Centers and Community Support Services
- Vietnamese Voluntary Foundation

Interviews were conducted with the following individuals:

- Wendy Moore, Deputy Director, San Joaquin Human Services Agency
- Mick Founts, Superintendent of Schools, San Joaquin County Office of Education
- Margaret Szczepaniak, Assistant Director, San Joaquin County Health Care Services Agency
- Vic Singh, Director, San Joaquin County Behavioral Health Services
- Richard Vlavianos, Judge, San Joaquin County Superior Court
- Cris Clay, Director, University of the Pacific Reentry Program
- Laura Rogers, Director, Victor Community Support Services
- Curt Willems, Chief Mental Health Clinician and Lead Manager, Substance Abuse Services
- Becky Gould, Deputy Director and MHSA Coordinator, San Joaquin County Behavioral Health Services
- Raul Sanchez, Mental Health Board and NAMI member
- Steven McCormick, Mental Health Board Member
- Jeffery Giampetro, Recovery Coach, University of the Pacific, Gipson Center

Additional input was provided by:

- Ad-Hoc Committee of the Mental Health Board on Penetration and Retention Rates
- Cultural Competency Committee
- Whatever it Takes Committee
- Full Service Partnership Managers
- Full Service Partnership Contracted Providers
- MHSA Consortium

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

San Joaquin County's Innovation Plan was posted for 30 day stakeholder review on March 21, 2011. Following a thirty day review period, a public hearing was convened by the Mental Health Board on May 4, 2011. The final approved plan was submitted to the County Board of Supervisors on May 10, 2011.

Public comments and responses are described below.

- No recommendations for edits were made during the 30 day review process or during the public hearing.

EXHIBIT C

Innovation Work Plan Narrative Date: February 2011

County: San Joaquin
Work Plan #: INN-01
Work Plan Name: Residential Learning Community

Purpose of Proposed Innovation Project (check all that apply)

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

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

This proposed Innovation will examine how residential learning communities for high-frequency users of unplanned mental health services increase consumer engagement in their own recovery. While incorporating education into residential programming has an established evidence-base, the method of implementation–one which encourages consumers to find and explore their own intellectural passions while at the same time encouraging social interaction--represents an innovation in service delivery.

Problem Statement

San Joaquin County has identified a specific group of individuals who are frequent users of unplanned mental health services. Unplanned services are defined as any use of mental health crisis service, including an admission to the psychiatric health facility or an emergency response by the crisis community response team (CCRT) or law enforcement officers. In San Joaquin County, approximately one third of mental health services to high frequency users in 2009 were provided in an inpatient psychiatric setting. Further, these high frequency users were 50% *less likely* to receive care in outpatient mental health settings compared to other consumers. High frequency users are also disproportionately Native American and African American[2].

Frequent use of unplanned services places an enormous burden on county systems. More importantly, use of these services implies an escalated mental health crisis requiring intensive treatment interventions, including involuntary commitment in locked facilities, seclusion, or physical or chemical restraints. While these are a part of existing medical practices, they are incompatible with an ideal of community-based recovery. The use of unplanned mental health services results in an enormous cost burden and results in more restrictive treatments which can be traumatizing to consumers. These findings suggest that there

[2] Native Americans are 5% of high frequency users vs. a 1% target penetration rate for mental health services. African Americans account for 17% of high frequency users vs. a 9% target penetration rate.

should be effective programs that engage and retain consumers in outpatient treatment settings and reduce the demand for crisis services, and that these services should be culturally relevant to the African American and Native American consumers who disproportionately use unplanned mental health services.

High frequency users are not unique to San Joaquin County. Studies across the nation have proposed strategies for addressing the needs of high frequency mental health users who are typically characterized as chronically mentally ill, with severe and persistent mental illness (SPMI). Many meet U.S. Housing and Urban Development (HUD) definitions of chronically homeless and suffer from co-occurring substance use disorders.

SAMHSA-recommended best practices for this target population include residential programs with wraparound services, substance abuse treatment services, peer recovery coaches and intensive case management, such as Assertive Community Treatment (ACT)[3]. In San Joaquin County, a number of best practices have been attempted, including enrolling high frequency users in Full Service Partnerships, pairing individuals with peer recovery coaches, and providing crisis residential housing. In spite of these efforts, high frequency use of emergency mental health and other safety net services still persists, and improved outcomes dissipate once program involvement terminates. Further, a literature review of SAMHSA-based research studies examining these practices finds, *at best,* improved stability and mental health treatment compliance in approximately 50% of participants after six months of follow-up (Talpade M, 2010). In another study of homeless individuals with severe and persistent mental illness, researchers concluded that:

> *Of those that had received inpatient or residential programs within the past year, only a minority of participants achieved favorable employment or housing outcomes at one year. The authors acknowledge that this treatment, although resource intensive, was insufficient to help many participants with both homelessness and high levels of psychological distress (Kertesz & al., 2007).*

Due to the shortage of effective strategies, San Joaquin County Behavioral Health Services is seeking to develop an innovative approach to reduce the use of unplanned services by an identified group of high frequency users and improve their recovery outcomes.

[3] www.nrepp.samhsa.gov

Project Description

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

Proposed Practice Adaptation: Residential Learning Communities

Residential learning communities have been successfully developed by institutions of higher education as a strategy to increase learning, personal development, and positive educational outcomes. SJCBHS seeks to determine if residential learning communities, adapted to the mental health environment, can serve similar functions in:

- Increasing consumer knowledge, motivation, and engagement in their own treatment and recovery plans;
- Improving personal relationships and communication with peers, family members, and others; and
- Improving mental health outcomes and enhanced recovery, wellness and resiliency.

Residential learning communities have emerged as a strategy to promote academic success and facilitate student engagement. They first emerged on college campuses in the mid-1920s in the form of "experimental colleges." Variations in this idea emerged in the 1960s with efforts to "humanize the learning environment" through the formation of various theme houses targeting special student populations such as athletes, historically underrepresented students, students with disabilities, etc (Zhao & Kuh, in press).

In academic settings, residential learning communities are intentionally structured environments that house students taking two or more classes together. The close proximity of the living situation is intended to stimulate opportunities for out-of-class discussions and provide supplemental learning opportunities. Residential learning communities also provide increased opportunities for group learning, shared commitment to a topic, and peer support. Most learning communities also incorporate complimentary social activities, which are linked to improved engagement with peers and the potential to integrate academic instruction with real world experiences (Cross, 1998).

San Joaquin County seeks to develop residential learning communities for individuals with serious and persistent mental illnesses who have failed to achieve sustained recovery using usual and customary mental health interventions. Particularly, this project will target frequent users of unplanned services.

Proposed Innovation to Mental Health Services

There are two core components of residential learning communities that once adapted may lead to significant improvements in the quality of mental health services and consumer outcomes:

- ❖ An emphasis on self-directed, passionate learning, and
- ❖ A peer cohort group that contributes joint direction and motivation.

Based on the recent promising experiences of the European Union's EMILIA Project (Empowerment of Mental Illness Service Users : Lifelong Learning, Integration and Action), this initiative is built on a belief that all individuals have "a continuous capacity to learn, adapt, and change" and that opportunities to participate in collective learning facilitate the social inclusion of individuals with mental illnesses because they promote meaningful community engagement (Ryan, February 10, 2010).

The San Joaquin County Residential Learning Communities will expand on research conducted in Europe by adding a residential component and focusing on their impact on high frequency users. Additionally, San Joaquin's Residential Learning Communities will include both self-directed and cohort-driven learning opportunities. By including self-directed as well as peer-driven learning, our hypothesis is that participants will feel more engaged and program retention rates will improve.

> *"Lifelong learning is 'at the heart' of policy debate and discourse on community cohesion, citizenship and social inclusion."*
>
> *EMILIA Project*

Project Overview

SJCBHS's Residential Learning Communities Program will develop four unique centers for consumer recovery and wellbeing. Each center will involve a 10-person cohort group whose members will jointly create the learning direction based on their shared interests. The basic program framework will include:

- Targeted education and classes designed to stimulate cognitive awareness of mental health issues and control over the factors that influence personal wellbeing.
- Opportunities for consumers to serve as teachers, encouraging further subject mastery and providing peer-to-peer instruction.
- Recreational programs designed to reinforce learning through experience.
- Therapeutic interventions aligned with the identified learning approach that include individual and group therapy, peer support and collaboration with community-based educators and healers.

Residential Learning Communities will be voluntary, and will target adults meeting the following criteria:

- Primary diagnosis of a serious and persistent mental illness;
- Multiple unplanned service encounters within the previous year;
- Eligible for or receiving SSI;
- Recognized by a BHS clinician as a "frequent user of unplanned services";
- History of successive housing placements;
- Commitment to a lifelong learning approach.

The residential learning community approach will provide a new method for engaging consumers for whom existing mental health services are failing to prevent frequent use of unplanned services. The program will provide structured opportunities to engage in self-directed as well as cohort-driven learning, which we

hypothesize, will lead to enhanced commitment to maintaining a recovery and wellness plan and, ultimately, fewer unplanned uses of behavioral health services.

A core objective of the Residential Learning Communities will be to increase participant sense of empowerment, which has been positively correlated with improved recovery, wellness, and resilience. Empowerment is positively correlated with quality of life, income and community activity and inversely related to use of traditional mental health services (Rogers S, 1997).

Each of the four learning communities will be linked around an orienting theme that will guide the program activities. The theme will be chosen by the cohort groups, and participants and staff will work together to identify community resources and supports outside of traditional mental health services who can provide recreationional and educational services and non-traditional/alternative healing opportunities. A sample list of potential learning community themes is included below for illustrative purposes. This list was generated during the initial planning process by consumers, family members, and BHS direct service staff (psych techs, mental health specialists, and outreach workers). The actual learning community topics will be developed through a participatory process with the identified participants.

Learning Community	Therapeutic Approach	Recreation / Activities	Targeted Learning
Example 1: Traditional Healing	*Clinician collaboration with clan leader, shaman, medicine woman/man, or other community healers to develop an integrated approach to medication management and treatment plan.* *Also with a focus on co-occurring disorders.*	*Traditional arts and crafts; guided nature walks , journal writing.*	*Yoga, meditation, and the use (and misuse) of herbal or non-traditional medication supplements. Alcohol and drug abuse in traditional cultures and historic promotion of alcohol and drugs in various populations.*
Example 2: Health and Nutrition	*Clinician collaboration with nutritionist or dietician to develop an integrated treatment plan that is mindful of the potential side effects of medications and incorporates regular diet and exercise.*	*Gardening and healthy cooking classes; low impact aerobics, basketball*	*Basic physiology; nutrition and weight management; impacts of food and exercise on mental health; and impact of drug and alcohol use on physical and mental health*

Example 3: Creative Expression	*Art psychotherapy will be used within the clinical setting to discuss, issues, emotions, and conflicts with patients. Therapy techniques may include discussion or interpretation of drawing, sculpturing, or other creative outlet.*	*Session times for drawing, painting, and writing. Creative pieces will be framed and hung in the living environment and be displayed in other appropriate venues with the permission of the artist.*	*How to use creative expression to cope with stress.*
Example 4: Kinship and Relationship Building	*Clinician collaboration with social services or other mental health professionals to provide safe opportunities for joint family/kinship sessions targeting the strengthening of relationships with older children not in custody.* *Also with a focus on co-occurring disorders.*	*Combines some of the traditional healing activities with family connection activities such as "family meal times," with family pairs jointly responsible for cooking and presenting a dinner for others.* *Partnership with NAMI to help family members understand mental health illnesses.*	*Parenting classes focusing on relationship building outside of the traditional parenting dynamic. Trauma, grief and survivor work, such as Seeking Safety to help address past traumas.* *Inter-generational impacts of mental illness and alcohol and drugs.*

Additional themes that were highly rated by consumers in our initial planning discussions include:

- Spirituality
- Co-Occurring Disorders

Anticipated activities for each phase of the project are described below and are included in the project timeline on page 25.

1: Finalize Project Design

- Convene a Program Planning Committee composed of diverse stakeholders, including consumers and family members, to serve as an ongoing advisory body for planning, implementation and evaluation.
- Hire and train staff, including a Program Coordinator and *Learning Community Guides,* who will facilitate cohort group activities. Engage Recovery Coaches and/or Psych Techs to serve as a special response team for participants in the event of a crisis.
- Identify and Recruit Program Participants. Review data on high frequency users. Meet with crisis, psychiatric inpatient, and law enforcement staff to help identify high frequency users who might qualify for the program. Outreach to and recruit qualified consumers.

- Identify and Recruit Community Resources. Conduct an environmental scan of potential individuals and community organizations who can serve as resources for learning community topics. Conduct community presentations to build awareness of and engagement in the Residential Learning Communities Program.

2: Implement Program

- Participants achieve stability. Ensure all identified participants are stabilized and ready to participate in the Residential Learning Community Program.
- Form cohort groups and plan learning community topics. Bring program participants together in small groups according to self-identified learning interests. Each cohort group will be facilitated and supported by a dedicated Learning Community Guide. Cohort groups will begin planning their learning community topics and enrichment activities prior to the residential phase. Learning Community Guides will then coordinate instructors, classes and enrichment activities.
- Initiate Residential Learning Communities. Place cohort groups within residential facilities. Initiate classes and enrichment activities. Facilitate weekly or bi-weekly cohort group discussions to assess and plan learning community topics, reflect upon peer relations and living situation, and provide feedback for program improvement.
- Graduate participants to long-term housing placements 18 – 24 months following program initiation. Throughout the program, participants will develop strategies and placement options for more independent living, including independent housing or board and care.
- Transition to a dispersed community-based learning community. Develop strategies and approaches for continuing the learning community program without living under a shared roof. Leverage findings from the program evaluation to determine which program characteristics need to be modified to promote program success and to identify any anticipated challenges to the transition.
- Transition to a peer-managed learning community. Develop strategies for each cohort group to facilitate and plan their own learning community topics. Identify recovery coaches or other peer leaders that can serve as cohort guides.

3: Measuring and Assessing Impact

- Select evaluator/evaluation team. Evaluator selection will be made by the Behavioral Health Services Director with input from the Program Planning Committee.
- Develop evaluation design. Review program objectives with the Program Planning Committee and develop an evaluation logic model describing the measurable objectives, indicators, and data sources for each program goal. Develop evaluation plan, methods and tools.
- Collect and analyze relevant data. Data collection will be guided by the evaluation plan and the research questions (see evaluation section below).

4: Distributing Findings

- Incorporate interim findings into program improvement. Evaluation findings will be shared with the Program Planning Committee, participants, and other stakeholders on an ongoing basis to promote

continuous program improvement. Annual half-day workshops will allow stakeholders to reflect on the findings and to make recommendations for program improvement.

- Distribute written program updates. Provide monthly updates to the MHSA Planning Stakeholder Steering Committee and San Joaquin's Mental Health Board. Present an annual update to community stakeholders during regularly convened public meetings.
- Prepare final report. Prepare a final technical report and public presentation 48 months after program launch and share with all project partners, including DMH and the OAC, consumer and mental health advocacy groups, and county mental health directors and MHSA coordinators.
- Assess potential for publication. Review findings with key personnel or subcommittees within or affiliated with DMH and the OAC. Determine strengths of findings and importance of broader distribution. Solicit support and input in preparing findings for publication.

Additional Considerations

This initiative considers the cyclical nature of severe and persistent mental illness and therefore places more emphasis on the continuity of the relationships built between cohort members than it does on the issue of housing stability. Therefore if a participant requires a temporary change of housing venue or admittance into a higher level of care they will not lose their placement in this program or jeopardize the relationships they have worked hard to develop.

The program model includes a residential component only to the extent that it provides a mechanism to stabilize an individual in their recovery and treatment enough to engage with their cohort group in the learning experience. BHS fully expects that not all participants will be able to live together under one "residential roof" for the entire duration of the project. It is anticipated that program participants will move up and down a continuum of housing placements at different times during the course of their involvement in the program.

Too frequently consumers are forced to drop out of programs because they are unable to maintain a specific housing placement. In this model, individuals may transition to different housing options at different paces. Within the program budget (see budget narrative pg. 33) funding is allocated to a range of placement options. A special crisis placement response team will help participants stabilize in-place or transition to a higher level of care if and when they experience a mental health related crisis. Program engagement in learning community activities and linkages to the cohort group will be facilitated, encouraged, and respected regardless of current residential placement. While the program overall will be measured on a number of different outcomes including housing stability and fewer admissions to unplanned services, *participation* will be measured by engagement with the cohort group and participation in learning community activities, not by housing placement.

This work plan is consistent with the General Standards identified in the MHSA, and emphasizes the following principles:

Community Collaboration: A Program Planning Committee, comprosed of community-based service partners, housing providers, educators, consumers and family members, and other mental health advocates will be convened during the initial planning phase and will continue to advise the program staff through implementation and evaluation. Committee members will be encouraged to provide resources to the Learning Community Guides to help them develop targeted curricula and plan related activities. In addition to program planning and implementation, the Committee will provide input and guidance on the evaluation framework and will be instrumental inreviewing evaluation findings and making recommendations for program improvements on an ongoing basis.

Cultural Competence: One of the primary motivations for developing this Innovation strategy was to reduce the over-reliance on inpatient psychiatric health facilities and other crisis/emergency services by a relatively small number of consumers, a disproportionate number of whom are African American and Native American. The model we've chosen to use is based on a strategy to retain minority students in academic environments. The theory is that by helping to establish a tightknit cohort of like-minded individuals, and by providing them with opportunities to support each other in their learning pursuits, they would feel more connected to their environment, and therefore be less likely to drop-out of programming.

This project was developed with input from culturally-specific community-based organizations, such as Native Directions (serving Native Americans) and Mary Magdalene Community Services (serving African Americans). Additionally, in designing this proposal, the Cultural Competency Committee was asked to provide input on best practices associated with serving these historically disproprtionately served populations.

Consumer and Family Driven: This program is intended to motivate, engage, and empower consumers and their families in their recovery process. Consumers and family members involvement occures at all stages.

1. *Program Selection:* Consumer input was the primary mechanism for the selection of this Innovation. During successive focus groups with consumers, participants repeatedly identified and prioritized strategies that includes the following components:
    - Peer-based and recovery-oriented
    - Flexible and accomodating to the cyclical nature of mental illness
    - Providing opportunities for growth and enrichment
    - Preventing mental health crisis and reducing the use of unplanned services

2. *Initial Planning Phase:* The Program Planning Committee will include consumer and family member representation, and will be open to participation by Residential Learning Community participants and their family members. Input into the planning process will be solicited from the target population (i.e., high frequency users) through small group discussions. Specifically, they will be asked to contribute ideas of educational themes and activities.

3. *Designing Individual Learning Communities:* Each cohort will begin meeting to plan their learning community prior to starting the residential component. Discussions, facilitated by the assigned Learning Community Guide, will ask consumers to design their own learning module that will include a learning topic, classes, enrichment or recreation activities associated with the topic and ideas on how the learning topic can be incorporated into treatment practices. A core challenge of the program will be to ensure that learning content is engaging to consumers as individuals and leads to passionate engagement within the learning community. This means that consumers must have an active role in planning how to deliver content in a manner which takes into account varying literacy levels, learning abilities, and fears of traditional pedagogical approaches.

4. *Cohort Governance:* Each cohort group will convene in weekly or bi-weekly house meetings to plan and discuss upcoming learning community topics and enrichment activities, discuss house/peer incidences, and develop better strategies for learning, living, and working with each other.

5. *Assessment and Program Improvement*: Interim findings will be presented to each learning community cohort and to the Program Planning committee on a semi-annual basis. Presentations will be followed by a facilitated discussion session about the relevance of the findings and suggested strategies for program improvement.

6. *Program Transition*: At the conclusion of the residential component, each cohort group will develop strategies for continuing to learn together without the benefit of shared housing. At the conclusion of the program, the support and assistance of the dedicated Learning Community Guide will end. At this time, the cohort group will be asked to develop strategies to continue the learning community within the Wellness Center or other community-based setting. Learning communities will transform into consumer-run endeavors.

7. *Family Involvement:* Families are an important component of wellness and recovery. Families provide a deep motivation and sense of security for most individuals. Consumers interviewed for this project frequently referenced the importance of families and loved ones in helping them sustain their recovery. Unfortunately, many consumers have strained or difficult relationships with their families. Program participants will be encouraged to invite their family members to visit their new homes, meet their friends, and to join them in various learning community activities. Learning Community Guides will work with the cohort groups to help them develop various ways to involve their families in the learning community activities. Family members will also be asked to provide input and give recommendations to the cohort group on learning community activities, especially those which will help strengthen family ties.

Wellness, Recovery, and Resilience Focused: This program increases resilience and promotes recovery and overall wellness for those living with severe and persistent mental illnesses and related chronic homelessness through a peer-motivated learning experience. The program is designed to strengthen

consumers' ability to drive their recovery and control their own living situation. The program design is also intended to transition to consumer-run learning communities that, over time, can be expanded and adapted for all mental health consumers. It is also intended as a model for professional mental health service providers on how changing the nature of participant engagement can lead to positive recovery outcomes.

Contribution to Learning

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

This project will contribute to learning by exploring how residential learning communities can increase engagement in recovery by high frequency mental health users. The project will assess whether and how the unique factors of a *self- and group-directed learning experiences* and *cohort-based peer support* can result in enhanced engagement and commitment by high frequency users to their own mental health recovery. The model may be seen as an adaptation of the substance abuse Recovery House model, which also provides on-site classes and education. However this proposed initiative is unique in the following ways: 1) the development of a consistent cohort group to provide motivation and support in maintaining recovery efforts; 2) the creation of cohort groups that share similar values, hobbies, vocational interests, or intellectual pursuits; 3) the opportunity for participants to select the cohort group they are interested in joining, and 4) once part of the group, to jointly develop classes, enrichment, and recreational activities in pursuit of those common hobbies, vocational interests, or intellectual pursuits.

This delivery model is significant for San Joaquin County as we continue to struggle with overutilization of restrictive services by African American and Native American populations. These trends suggest that we need to continue to explore strategies of how to deliver mental health services in unique and compelling ways for different population groups. Further, the current funding realities have severely limited the capacity of programs to provide the same frequency and intensity of services for consumers as was practiced in previous years. Mental health service providers need to work harder to empower consumers to 1) manage their own recovery and 2) determine how services are delivered to meet their needs and expectations. This project will provide a model for how a brief investment in intensive supports will provide long term dividends in consumer self-determination, stability, and engagement in recovery.

Key questions that the project will attempt to assess for a population of high frequency users with severe and persistent mental health illnesses will be to determine the extent to which the model was able to:

1) Recruit and retain a diverse group of high frequency users;
2) Empower consumers to pursue their own interests and passions;

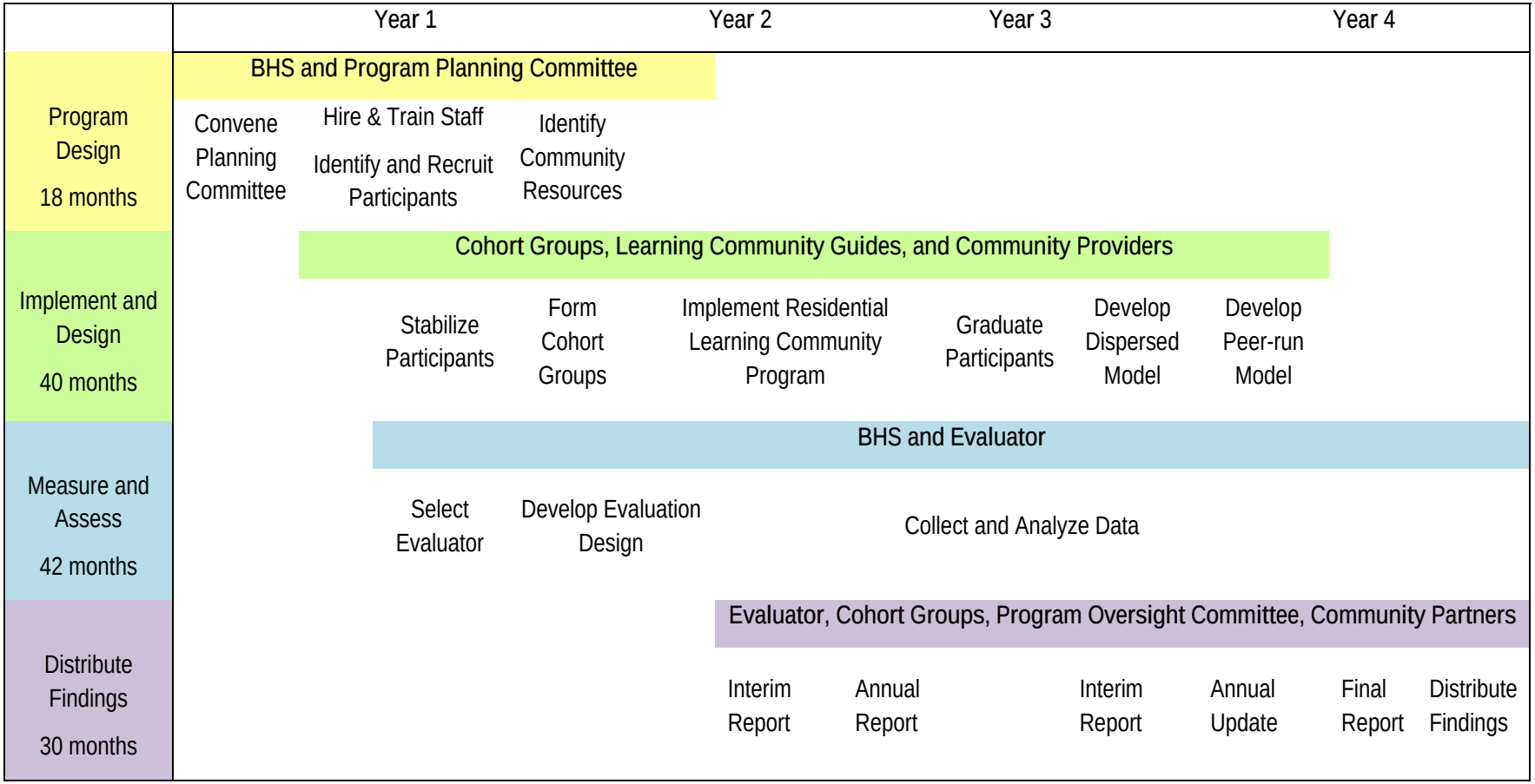
3) Engage high frequency users with severe and persistent mental health illnesses in pursuing self-selected learning topics;
4) Leverage existing community resources;
5) Provide services in a culturally competent manner; and
6) Support positive consumer outcomes, including long term stability and reduced usage of unplanned services.

Additionally the evaluation will assess the impact and importance of a cohort designed and supported learning experience on consumer well-being and engagement in their recovery.

Timeline

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

Implementation & Completion Dates: June 2011 – June 2015 (4 yrs.)



Project Measurement

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

San Joaquin County proposes to design and implement a Residential Learning Community Program with a specific aim of improving outcomes for high-frequency users of unplanned mental health services. The project will document and assess processes throughout the implementation phase and measure outcomes at various intervals and at the conclusion of the initiative

Process Evaluation

1. To assess whether and how the model was successful in recruiting and retaining a diverse group of high frequency users, the project proposes to document the outreach and recruitment strategies used to identify and engage participants. It will also track participation and retention in the program by demographic characteristics such as age, race/ethnicity, and gender.
2. To assess if and how the model successfully empowered participants and the cohort group to select their learning community topic and identify learning classes, enrichment, or recreation activities related to the learning topic information will be gathered through program observation, activity reports, and interviews or focus groups with program participants before, during and following program participation.
3. To assess if and how the model was successful in engaging participants in the learning community topics information will be gathered through program observation, class and enrichment provider interviews, and interviews or focus groups with program participants, before, during and following program participation.
4. To assess if and how the model was able to leverage existing community resources, the project will collect information on the various organizations and individuals that were engaged to help deliver learning community content or facilitate enrichment or recreation activities.
5. To assess if and how the model was successful at providing culturally competent services demographic information will be collected on the staff and individuals engaged to help deliver learning community content. In addition to traditional demographic information the anonymous demographic forms given to each class or enrichment provider will also ask each individual to self-rate their own comfort and understanding of various cultural communities including the consumer community, gay, lesbian, bisexual, transgender, questioning (GLBTQ) community, homeless community, various racial/ethnic communities, etc.

Outcome Evaluation

6. To assess whether the model was able to positively impact consumer outcomes, the project

proposes to follow and assess consumers over the project duration. Participants will be asked to engage in either structured interviews or focus groups to discuss program impacts. Additionally the program will track specific consumer outcomes related to service utilization, including:

- *Engagement in mental health treatment*, did participants improve their attendance in regularly scheduled outpatient visits to community mental health services?
- *Use of Crisis and PHF Services*, did participants decrease their use of inpatient and crisis services?
- *Stable living situation*, did housing stability improve during and following program participation?
- *Consumer well-being,* did participants report improvements in their well being as a result of program participation?

Comparison Evaluation

7. To assess whether a cohort supported learning community provides a significant advantage over traditional residential programs for individuals with severe and persistent mental illnesses, a random comparison group will be selected from individuals treated in the PHF and discharged to a residential placement. The comparison group will be identified to the evaluation team by a randomly assigned client identification number that is not linked to the consumer's actual client identification number. Statistics pertaining to missed and cancelled appointments, admissions to PHF and Crisis Units, and length of stay in supported housing placements will be compared to those of the program participants.

8. To assess the importance of the program a cost benefit analysis will compare program costs and emergency service utilization costs of program participants to the comparison group. The essential cost analysis will be compiled from the following similar expenses:
    - Residential program costs
    - Crisis visit costs
    - CCRT response costs
    - PHF admission costs
    - Law enforcement transport service costs

The proposed Residential Learning Communities will be measured through the joint efforts of Dr. Paul Mascovich, Medical Director for San Joaquin County Behavioral Health Services, and the evaluator. Dr. Mascovich will oversee the clinical assessments of client recovery and the evaluation team will assess other indicators of participant success, including participant retention, use of services, satisfaction, and long term housing stability. In addition the evaluation team will conduct interviews with program participants, learning community guides, housing providers, and other enrichment providers to hear their input on program strengths and challenges. At no time will the evaluator have access to confidential treatment information including participant names, except as self-disclosed by participants in interviews.

Leveraging Resources

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

Expertise and Knowledge

- Consumer advocates and mental health outreach recovery coaches will provide insight and guidance on engaging individuals with severe and persistent mental health illnesses.
- Community housing providers will provide insight and guidance on developing the residential component and how to create a dispersed learning community tract.
- Community based service providers, especially existing full service partnership partners, will provide recommendations and support in delivering culturally competent services.
- Local non-profit and educational organizations will provide guidance on how to bring appropriate learning community content to program participants.
- Local law enforcement will provide input and recommendations for identifying and finding known high frequency users.

Financial and Programmatic Resources Leveraged

- SSI/SSDI housing allocations will be leveraged to fund a portion of the anticipated residential housing costs.
- The Crisis Community Response Team will be leveraged to fund a portion of the 24/7 in-home response available for participants.
- The Wellness Center and other BHS sites for cohort group meeting space and peer supports.

Exhibit D
Innovation Work Plan Description
(For Posting on DMH Website)

County Name:
San Joaquin County

Work Plan Name:

Residential Learning Community

Annual Number of Clients to be Served: 40

Population to Be Served (if applicable):

The Residential Learning Community Project will target adults (individuals 18 and over) with severe and persistent mental illnesses who are frequent users of emergency psychiatric services. Services will be voluntary, but will specifically target those individuals currently accessing mental health services on a crisis basis. In addition to chronic mental health concerns, most program participants are likely to have co-morbid substance abuse issues and meet the HUD criteria for a chronically homeless individual.

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

The Residential Learning Community Program will engage 40 high frequency mental health users in cohort groups formed around common hobbies, vocational interests, or intellectual or spiritual pursuits. Cohorts will be placed in a shared living environment and be assigned dedicated learning community guides to help program participants identify and engage in desired learning topics and align their learning community goals with mental health service experiences.

This proposed Innovation will examine how a cohort based residential learning community increases engagement in recovery amongst high frequency mental health users. While incorporating education into residential programming has an established evidence-base, the method of implementation represents an innovation in service delivery that encourages consumers to find and explore their own intellectural passions and interest and leverages an inherent, human, motivation for knowledge to empower recovery efforts.

The project will assess whether the model was: 1) able in engage and retain a diverse group of high frequency users; 2) able to empower consumers to pursue their own interests and passions; 3) able to engage high frequency users with severe and persistent mental health illnesses in pursuing a self-selected learning topics; 4) able to leverage existing community resources; 5) able to provide services in a culturally competent manner; and 6) support positive consumer outcomes, including long term stability and reduced usage of crisis and PHF services. Additionally the evaluation will assess the impact and importance of a cohort designed and supported learning experiences on consumer well-being and engagement in their own recovery.

EXHIBIT E

Innovation Funding Request

Mental Health Services Act
Innovation Funding Request

County: San Joaquin County

Date: April 2011

	Innovation Work Plans		FY10/11 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	1	Residential Learning Community	$4,242,924				
2							
3							
4							
5							
6							
7							
8							
9							
10	Subtotal: Work Plans		$4,242,924	$	$	$	$
11	Plus County Administration		$587,504				
12	Plus Optional 10% Operating Reserve						
13	Total MHSA Funds Required for Innovation		$4,830,428				

Exhibit F

Innovation Projected Revenues and Expenditures

County: San Joaquin
Fiscal Year: 2011/12 to 2013/14
Work Plan #: Inn 01
Work Plan Name: Residential Learning Communities

Months of Operation: 07/11-06/14

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	2,384,786	143,791		$2,528,577
2. Operating Expenditures	106,787		1,440,560	$1,547,347
3. Non-recurring expenditures			30,000	$ 30,000
4. Training Consultant Contracts	137,000			$ 137,000
5. Work Plan Management	587,504			$ 587,504
6. Total Proposed Work Plan Expenditures	$2,511,573	$143,791	$1,470,560	$4,830,428
B. Revenues				
1. Existing Revenues	0			$0
2. Additional Revenues				
a. (Medi-Cal)	191,528			$191,528
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	$191,528	$0	$0	$191,528
4. Total Revenues	$191,528	$0	$0	$191,528
C. Total Funding Requirements	$2,320,045	$143,791	$1,470,560	$4,638,900

INNOVATION WORK PLAN – EXPENDITURE DETAIL

	Expense	Year 1	Year 2	Year 3	Total Request
BHS Personnel					
1 F/T	Project Manager	140,606	144,824	149.169	434,599
1 F/T	Administrative Support	64,767	66,710	68,711	200,188
4 F/T	Learning Community Guides II	312,340	321,711	331,360	965,412
2 P/T	Learning Community Guides I	52,349	53,919	55,537	161,805
1 F/T	Learning Community Outreach	58,043	59,784	61,578	179,405
2 P/T	Recovery Coach	52,349	53,919	37,210	143,477
2 P/T	Psych Tech	117,128	120,642	62,131	299,900
1 F/T	Representative Payee	70,833	72,958		143,791
Operating Expenditures					
	Consumer Stabilization	551,194	589,360		1,140,554
	Consumer Respite	6,120	6,120		12,240
	Learning Community Supplies	138,848	148,918		287,766
	Expanded Security Hours	51,567	55,220		106,787
Non-Recurring Expenditures					
	Minor Household Furnishings	15,000	15,000		30,000
Training / Consultant Contracts					
	Training	10,000	10,000		20,000
	Evaluation	70,000	37,000	10,000	117,000
Administration					
	Administration	256,671	263,413	67,420	587,504
Total Expenditures		$1,967,814	$2,019,500	$843,114	$4,830,428

INNOVATION WORK PLAN BUDGET NARRATIVE

Summary of Expenses for the Residential Learning Community Project

Personnel Expenditures

- *Project manager*: A full time project manager will be actively engaged in all phases of the project and will supervise the implementation of the learning community and coordination of the program planning committee /program oversight committee. The project manager is responsible for ensuring fidelity to proposed model including the formation of cohort groups, staff training and supervision, and ensuring that the learning community promotes self-directed learning that in engaging and meaningful to program participants.

	3-year funding request
Project Manager (Chief MHC 1.0 FTE)	$ 434,599

- *Administrative support*: A full time administrative support person will help manage all aspects of project including tracking of expenditures; receiving, entering, and collating monthly project reports; and providing general administrative support to the project manager.

	3-year funding request
Admin Support (Sr Office Assistant 1.0 FTE)	$ 200,188

- *Learning Community Guides*: Specialized learning community guides will work with the cohort group to implement learning community goals. Part case manager, part group facilitator and part learning community coach the learning community guides will work with participants in each cohort group to develop learning community modalities and to ensure group cohesion. Learning community guides will also be available for individualized support services as necessary although it is assumed that each program participant will receive counseling and case management through existing program services.

	3-year funding request
Learning Community Guides II (MHS II 4 FTE)	$ 965,412
Learning Community Guides I (MH Outreach Wkr. 2 PT/1.5 FTE)	$ 161,805
Learning Community Outreach (MH Outreach Wkr. 1 FTE)	$ 179,405

- *Crisis Placement Response Team*: Funding will be provided to expand the crisis community response team with psych techs and recovery coach. The additional staff members will provide first

priority response to the residential learning community participants and will provide 24-48 hour one-on-one monitoring to help an individual stabilize in a mental health crisis.

	3-year funding request
Recovery Coaches (MH Outreach Wkr 1.5 FTE/24 months, decreasing to 1.0 FTE)	$ 143,477
Psych Techs (1.5 FTE/24 months, decreasing to .75 FTE)	$ 299,900

- *Representative Payee*: The designated representative payee will work with program participants to maintain and ensure the security of their financial, medical, and housing benefits. The representative payee will be an integral part of the learning community program and will be tasked with not simply managing consumer affairs but with working with consumers to help them manage their own affairs.

	3-year funding request
Representative Payee (OA Specialist 1.0 FTE)	$ 143,791

Operating Expenditures

- *Consumer stabilization costs:* Housing will be subsidized for learning community participants for the first two years with anticipated transition to a standardized board and care or other long term housing arrangement. Various intensities of housing will be available and assigned to the different cohort groups depending on their recovery needs. Board and care providers that agree to house a residential learning community within their facility will be offered a per-person stipend, or "patch," for the responsibility of supporting the living arrangements of the learning community. Additional funding will be available to support consumers in the event that they require more intensive stabilization supports during their participation in the program. Funding is reserved for fees associated with placements in residential recovery programs and crisis and transitional residential programs that would offer enhanced supervision and clinical support to participants.

	3-year funding request
Crisis, transitional, and recovery residential program fees as required for initial and periodic stabilization	$ 700,000
Board and Care patches (the average patch over the 24 month period is $459 per month for forty patients)	$ 440,554

- *Consumer respite*: Consumers who experience a decompensation in their mental health status that requires a brief, temporary removal from the residential facility will have the option of staying in respite housing. Respite housing apartments are available on a daily and weekly basis. Respite and stabilization will be supervised by the Crisis Placement Response Team with a goal of

returning the participant to the shared residence of the learning community participants as soon as possible.

	3-year funding request
Respite apartment units	$ 12,240

- *Materials and supplies*: Funding will be allocated to all cohort groups for the purchase of materials and supplies related to learning community activities. Funding will also be used to contract with community vendors to provide various learning community activities.

	3-year funding request
Activities/contracts for educational classes	$ 237,766
Curriculum & related materials and supplies (Approximately $12,000 for each learning community cohort group)	$ 50,000

- *Security*: Some learning community activities will use existing facility space at the Wellness Center and occur after the Center's normal operating hours. Additional funding is allocated for the required security personnel to use the facility for extended hours.

	3-year funding request
Contract security provider	$ 106,787

Non-Recurring Expenditures

- *Housing Supplies and Furnishings*: Funding will be available for Learning Communities to purchase minor furnishing and decorations for their houses. Minor furnishings may include beds, tables chairs, and decorative items associated with the learning community objectives.

	3-year funding request
Minor Household Furnishings	$ 30,000

Training / Consultant Expenditures

- *Training:* Comprehensive staff training will be undertaken in the first phase of the project. Ongoing and continuous training will also be developed for the project. In some instances travel may be required for the training, e.g. participation in statewide training activities.

	3-year funding request
Trainings	$ 20,000

- *Evaluator / Analyst*: The evaluator will be an integral component to the project team, responsible for working with the project manager during the start up and design phase to identify validated tools for assessing program impact, for collecting and analyzing data on program participants, and reporting out on findings.

	3-year funding request
Subcontract or MA II for Data Analysis .6/.2/.1 FTE	$ 117,000

- *Administration*: Administrative expenses range from 5% to 15% of the total project budget. Administrative costs include expenses related to human resources, financing, purchasing, etc.

	3-year funding request
Administration	$ 587,504

Summary of Revenue for the Residential Learning Community Project

Revenue

Medi-Cal Revenues: Medi-Cal revenues are calculated based on the current SMA rate for outpatient services. Calculations were based upon 20% of program participants with Medi-Cal and a 50% productivity rate by the clinical staff providing services.

	3-year revenue projections
Medi-Cal	$ 191,528

Total Three-year Project Cost	$ 4,830,428.00
Net Project Cost / Funding Request	$ 4,638,900.00

- Note: the total anticipated project duration is four years. Additional resources will be requested to complete the project per DMH guidelines and the County's Innovation allocation.

Footnotes

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