Crossroads To Hope

Sonoma County Mental Health Services Act
FY 2021 - 2027 Innovation Proposal

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

SONOMA COUNTY · 18 50 · CALIFORNIA REPUBLIC · AGRICULTURE INDUSTRY RECREATION

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

County Name: Sonoma County
Date submitted: September 17, 2021
Project Title: Crossroads to Hope
Total amount requested: $2,500,000 for FY 2021-27

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

SECTION 1: INNOVATION REGULATIONS REQUIREMENT CATEGORIES

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria.
The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☑ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☑ Increases access to mental health services to underserved groups
- ☑ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

SECTION 2: PROJECT OVERVIEW

PRIMARY PROBLEM

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. 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.

Sonoma County does not have any dedicated housing that provides supportive and recovery driven peer services for individuals with significant mental health and/or substance use disorders and criminal justice involvement. Instead, many individuals that have significant mental health and/or substance use disorders and criminal justice involvement that may be incompetent to stand trial are housed in the Sonoma County jails and do not receive supportive peer services and evidenced based treatment that will help them move towards recovery and away from criminal justice involvement.

At best, the jails can provide medications to stabilize acute mental health issues and keep the jail population safe. Recovery is difficult to achieve in such a setting. According to a report from the Bureau of Justice Statistics (BJS), more than half of those incarcerated in the United States have mental health issues. These individuals, says BJS, are more likely to have previous convictions and to serve a lengthier sentence than those who do not have mental health needs. Without treatment, mental health conditions can linger or worsen, increasing the likelihood of further involvement in the justice system.[1]

Sonoma County has seen a significant increase in the number of individuals with mental health and substance use issues entering the criminal justice system in recent years. County jail data for 2017 showed that 479 inmates (45.5% of the jail population) were receiving treatment for mental health concerns. In 2018 this number increased to 513, equal to 46.5% of the jail population. The most recent figure for April 17, 2019, indicates 520 inmates (47%) are involved with mental health services, with 246 (47.3%) of this group identified as having acute mental illness, and 117 (22.5%) determined to be seriously mentally ill.[2] In 2017, the Press Democrat published a series of investigative reports about the lack of psychiatric beds and the negative consequences for those individuals experiencing mild to severe mental illness in the local jails. Findings include:

- The number of inmates with severe mental illness diagnoses such as bipolar disorder and schizophrenia increased 60 percent to an average of 69 inmates a day in 2016, up from 43 in 2008.[3]
- Inmates found by the court to be "incompetent to stand trial" must be sent to a state psychiatric hospital to be treated until they are able to understand and face the charges

[1] "Addressing Mental Health in the Justice System", Richard Williams, National Conference of State Legislatures, Vol. 23, No. 31/August 2015.
[2] Data provided by the Sonoma County Sheriff's Department on 4/17/2019.
[3] "Jail is Largest Psychiatric Facility in Sonoma County", The Press Democrat, August 12, 2017.

against them. Because of the lack of bed space at the state's mental hospitals, inmates often wait up to three months or more for an opening.[4]

Recognizing that people with mental illness are over-represented in the local criminal justice system, Sonoma County held a two-day meeting (March 2018) of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services that can prevent deeper penetration into the criminal justice system. The County brought together over 40 stakeholders from multiple systems, including mental health consumers and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the county.[5]

The challenges in transitioning from the jails to community is widely documented and includes finding and securing housing, re-entry into the labor market, and accessing public assistance.[6] For those who are transitioning from the criminal justice system back into the community at large, there is an overwhelming need for safe and stable housing that can enable them to begin or continue their recovery and prevent recidivism back into the criminal justice system. A two-year study conducted by Resource Development Associates states that individuals released from the criminal justice system have the highest recidivism rate in the first 90 days. The findings of this study conclude that appropriate services and supports during that critical period can reduce recidivism.[7] Even when treatment services are available, if an individual cannot identify a safe and stable residence they are significantly less likely to be successful in a jail diversion program. Securing long-term housing and/or a treatment program for individuals takes time and requires the active participation of the client. Providing access to immediate and safe transitional housing, offers a way to bridge the gap so that the client can be diverted from jail with needed supports, begin a treatment program, and have the time and assistance to locate long-term housing.

Local data highlights the difficulty of maintaining stable housing for those who have been engaged with the justice system. The 2018 Point in Time Homeless Count for Sonoma County identified a total of 2,996 homeless individuals. Of this population, 32% had spent at least one night in jail or prison in the previous 12 months, and 28% reported they were on probation or parole at the time of the survey. In addition, 35% of the total number of homeless were identified as having psychiatric or emotional conditions and 33% reported drug or alcohol abuse.[8]

Of the 1,379 individuals on probation in 2018, 180 (13%) were homeless or transient. In terms of unmet needs, a total of 153 (11%) probationers were identified as having housing, but not receiving needed mental health services. On the other hand, 46 (3%) were receiving mental health services but had unmet housing needs. Finally, 122 (9%) were lacking both housing and needed mental health services. This means that nearly a quarter of the total probation population

[4] Ibid
[5] Sequential Intercept Model Mapping Report for Sonoma County, CA; Policy Research Associates, Inc, March 20-21, 2018.
[6] "From prisons to communities: Confronting re-entry challenges and social inequality", American Psycological Association, March 2018.
[7] Sonoma County AB 109 Recidivism Analysis Report, Resource Development Associates, 2019.
[8] Sonoma County Homeless Census And Survey, 2018, p. 52.

was lacking either or both mental health and housing services.[9] As a result of changes to California sentencing policies that reduce the incentives for misdemeanants to participate in services, motivating individuals with misdemeanors to participate in treatment can be difficult. Housing is a significant incentive for this population, and the ability to offer housing to potential participants could contribute greatly to their willingness and ability to participate in treatment.

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from incarceration.[10]

Assuming transitional housing is available to those with severe mental health diagnoses and involved in the criminal justice system, appropriate and effective clinical and other support services need to be available for a successful re-entry and to establish a foundation for recovery. Interventions, such as "jail diversion" programs, have mixed results. Many incorporate legal leveraging in the form of reporting back to the courts to promote adherence to treatment and services, but this is a coercive and avoidance driven model. Instead, Sonoma County would like to address the challenge of providing a comprehensive program model for individuals who are severely mentally ill and re-entering the community from the criminal justice system.

Combining a healthy and solid transition from the criminal justice system to the community will not be solved by transitional housing alone, a supportive component staffed with peers, individuals with lived criminal justice, mental health and/or substance abuse experience can provide a trusting relationship for education, empowered recovery planning and successful connections with community resources. The Sonoma County MHSA FY 2016-19 Capacity Assessment articulates the finding that peer providers were exclusively located in discrete programs rather than integrated within DHS-BHD programs.[11] Consumers, as well as providers, participating in surveys and focus groups expressed having peer-led programs at all levels of care aligns with MHSA values and promotes a culture shift towards recovery with possible improved outcomes throughout the system of care. Research shows the effectiveness of peer support on many levels, including increasing engagement in treatment and recovery, promoting a sense of hope and self-empowerment, improving social functioning and overall quality of life, and decreasing hospitalizations.[12] Furthermore, having peer support embedded in programming is most effective if those peers have both lived experience with mental illness and criminal justice involvement. The experience with the criminal justice system impacts an individual's life in many ways and it is best understood by individuals who have experienced it.[13] Thus, the proposed Innovation Project, will establish a robust peer component in collaboration with the

[9] Data provided by the Sonoma County Department of Probation, 3/12/2019.
[10] Sonoma County Housing Needs Assessment, Harder + Company Community Research, April 2018.
[11] Sonoma County Mental Health Services Act FY 2016 – 19 Capacity Assessment, Resource Development Associates, January 2020.
[12] Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11(2), 123-8.*
[13] Substance Abuse and Mental Health Services Administration, GAINS Center for Behavioral Health and Justice Transformation. (Aug 2017). Peer Support Roles in Criminal Justice Settings, A Webinar-Supporting Document.

delivery of clinical mental health services within a transitional housing environment has promising impact for an underserved population.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

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

The County of Sonoma (County) Innovations Project proposal is Crossroads to Hope (Crossroads). Crossroads will expand access to community-based treatment for individuals who have a severe mental health illness, with a possible substance use disorders who are eligible criminal justice diversion clients. Crossroads seeks to enhance a multi-modality approach for adult diversion clients who are determined to be at-risk for IST (Incompetent to Stand Trial) by adding intensive peer support services for up to 6 individuals at one time within a transitional housing environment. Innovation funding will add a peer support component consisting of a team of peer providers who will lead a holistic client-centered program including: recovery and wellness strategies, independent living skills, building a support network, accessing community resources, and establishing long-term stable housing. Peer providers will collaborate with clinicians to support client-driven recovery plans, facilitate educational and support groups, provide navigation for needed community services, and help support the overall well-being of the residents. Capacity will be for up to 12 - 20 clients annually. In addition, Crossroads will establish a Peer Advisory Council for the project and conduct a formative and outcome evaluation. This model is consistent with the recommendations stated in the MHSOAC's report, *Together We Can, Reducing Criminal Justice Involvement for People with Mental Illness*. Recommendation #3 contained in this report, specifically states that to reduce the backlog of individuals who are found to be or at risk of IST, state and local programs must maximize diversions from the criminal justice system.

The County recently secured funds[14] and is in contract to purchase a three-bedroom house with a second unit that will provide for six beds (transitional housing). In addition to the peer provider staffing, the residents will be supported by a clinical Assertive Community Treatment (ACT) team that will be on-site daily. The ACT team will provide intensive case management, individual, group and family/couples therapy. Education, psychiatry and medication evaluation and monitoring will be provided by a registered nurse. The ACT team will be funded through an already secured California Department of State Hospitals Felony Incompetent to Stand Trial contract.

[14] California Health Facilities Financing Authority – Community Services Infrastructure Grant Program, 2020

Crossroads is designed to provide a robust peer provider program within a short-term residential setting for diversion clients for up to six months. The transitional housing beds, the first dedicated for diversion clients in Sonoma County, will be an invaluable resource providing a safe, stable and supportive environment for clients to begin their journey of recovery. Peer providers, people with similar lived experience in mental health recovery and criminal justice involvement, will staff the residence serving a maximum of 6 individuals at one time. The peer support component will complement ACT clinical services by providing educational and emotional support, advocacy for self-determination, and connection to community-based services and other peer services.

By establishing a supportive community of peers, clinicians, and community resources, this innovative project seeks to increase the quality of mental health services for an underserved group and increase the interagency coordination with community groups and support systems. The Crossroads peer-enhanced model is designed to engage members of the target population by encouraging a high level of contact with peers who share lived experiences resulting in the development of strong, trustworthy, therapeutic relationships. Second, the model encourages clients to share their journey with their fellow peers as a basis for self-actualization and development of a meaningful recovery plan. This recovery plan will be grounded in a philosophy of self-determination and supported by the peers providing personal encouragement, relevant education and connections to community resources. Third, the model is multi-disciplinary, enabling the treatment team to draw upon multiple perspectives to support recovery. Finally, the provision of transitional housing serves as a safe and stable environment; a solid foundation to begin the recovery journey.

Peer support promotes a sense of understanding among those in recovery because they've collectively "been there," shared similar experiences and can model for each other a willingness to learn and grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of "stuck" places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. Individuals may come to a peer support program because it feels safe and accepting. By sharing experiences and building trust, peers help each other move beyond their perceived limitations, old patterns and ways of thinking about mental health. This allows members of the peer community to try out new behaviors and move beyond the "illness culture" into a culture of health and ability.

Some models of therapy for mental illness focus on a series of problems or symptoms that lead the individual to feel different and alone, "othered", leaving them in relationships that are less than mutually empowering. These clients experience their illness as the driving factor to their lives and depend on professionals to interpret their everyday experiences. Peer support programs do not promote an "illness narrative" but rather look at how individuals have come to know what they know. This leads to a conversation and exploration on what else does the individual need to know and experience to move through the past and into the future. This transformative movement returns the power to the individual to open a new framework for problem solving and decision-making.

Eligible individuals will be identified through Sonoma County's Pretrial program process. The Department of Probation administers a Pretrial Risk Assessment Tool, Public Safety Assessment (PSA) to identify individuals who are appropriate for Pretrial diversion into community

placement. Additionally, the County's Department of Health Services, Behavioral Health Division (BHD) has a clinician embedded within the Pretrial process to conduct needs assessments and determine appropriate level of care for those individuals in custody who have mental health and/or substance use disorders. The clinician consults with clients about available treatment in the community and with consent, the clinician provides a warm handoff to services.

Once a client is deemed eligible for diversion, the Peer provider support team will meet with the client before he/she is scheduled for placement in the transitional housing facility. Peer providers will conduct an orientation and intake to assure the client is fully informed of the program model and evaluation and consents to participation. The ACT team will facilitate the development of personal recovery plans for each client. These plans will be a hybrid of traditional clinical approaches and a philosophy and practice of encouraging client self-determination, a pillar of the peer model. The traditional aspects of the model include the administration of the ANSA (Adult Needs and Strengths Assessment) to establish history, behavior and functionality at entry into the program (baseline). The ANSA will be re- administered between 6 – 9 months after the baseline assessment to compare any changes (outcome). Utilizing the results of ANSA, the development of the personal recovery plan will primarily be led by the client to define their desired goals and definition of success. This approach to recovery planning will be supported by the Peer Providers encouraging a practice of empowerment and self-determination. It is this blended approach to recovery that is innovative for a diversion population and will be studied in the project's process and evaluation.

Crossroads will hire up to 4.5 FTE peers who will staff the transitional housing 24 hours per day, seven days per week. Peer Providers support their peers both individually and in groups. Their responsibilities may include the following:

- Help clients create individual service plans based on recovery goals and steps to achieve those goals
- Use recovery-oriented tools to help clients address challenges
- Assist clients to build their own self-directed wellness plans
- Support clients in their decision-making
- Set up and sustain peer self-help and educational groups
- Share community resources supportive of recovery
- Advocate with clients for what they need
- Work within integrated health settings
- Support clients in crisis
- Share their personal stories of recovery with clients

Qualifications for peer providers will include lived experience (mental health challenges and/or in recovery from a substance use disorder, and prior involvement with the criminal justice system), verified peer training or two years of local peer experience, and familiarity with local resources. Sonoma County has offered peer training utilizing the Intentional Peer Support curriculum through local community-based organizations and instructors may be engaged to provide further staff support and professional development.

One standard recovery goal for all Crossroads clients will be to identify and secure long-term housing as the transitional housing is meant for up to a 6-month stay. The ACT clinical team will interface with the Sonoma County Housing Authority (SCHA), a member of the Sonoma Accessing Coordinated Care and Empowering Self Sufficiency (ACCESS) interdepartmental multidisciplinary team and other housing providers to identify long term supportive housing where Crossroads clients can be placed.

Additional recovery goals may include:

- Community connections: familial, social and recovery support
- Healthy living, including nutrition, exercise, stress reduction, spiritual development, self-care
- Engagement in workforce and/or education

Clients will receive education and support in these areas, opportunities to practice skills and establish connections that promote achievement of personal recovery plan goals. The peer support program at Crossroads will include a nutritionist to help with menu planning, shopping, and cooking demonstrations once per week, a yoga/meditation practitioner once per week, guest speakers and instructors, and opportunities for visits to the Santa Rosa Junior College, Wellness and Advocacy Center, Job Link, and recreational centers.

Peer providers will work in tandem with clinicians of the ACT team, probation officers and other providers of wrap around services. The multi-disciplinary team coordinates around a client-directed approach and actions, decisions and progress will be documented in case notes and periodic reports from the peer providers. Not to be confused with a residential therapeutic treatment center, Crossroads is transitional housing with supportive and clinical services for the residents of the house. Peers will not have the role of supervising residents nor addressing compliance issues.

To ensure that Crossroads maintains a peer recovery focus and that the program structure, policies, and procedures are supportive of the Peer Provider Team, a Peer Advisory Council will be established. This Peer Advisory Council will be comprised of peer providers from the community, family members and other stakeholders who are aligned with the intent and philosophy of the project. The role of the Peer Advisory Council is to expand the diversity of experience and views of the peer community in accordance with Community Program Planning processes. This group will meet regularly to review program and evaluation design, progress on implementation and review evaluation findings at annual benchmarks. Peer Advisory Council members will be compensated for attending meetings if not already compensated by their employer.

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

The added benefit and positive outcomes resulting from the integration of peer providers into mental health services is not a new concept. In fact, self-help groups for substance abuse and addiction have been around since the first Alcoholic Anonymous meeting started in 1935. Peer

support is instrumental in developing strong trusting relationships among those in early recovery. Sonoma County has a strong history of peer provider engagement to successfully engage consumers in community-based recovery models. In 1996, a group of individuals with lived experience established Interlink Self-Help Center, a peer managed and operated service promoting self-directed mental health recovery and wellness. This was the first formal organization funded by the County of Sonoma. Since then, Sonoma County has supported a variety of peer-led services including the Wellness Center, Petaluma Peer Recovery Center, Russian River Empowerment Center, Peer Education and Training Program, and the MST Peer Supports Project with MHSA funding.

Realizing the benefits of having peers both as advisors and providers in the mental health continuum of care, Sonoma County has continued to look for opportunities to strengthen and expand the peer role in service delivery. In June of 2016, a group of community stakeholders including consumers, peers, mental health providers and County representatives met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In the Sonoma County Capacity Assessment Report released in January 2020, community stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery that could not be achieved by clinicians alone.[15] The FY 2016-19 MHSA Capacity Assessment report continues to state that consumers, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for consumers is aligned with MHSA values and could create a cultural shift in the way mental health services are delivered throughout the system of care.

C) Estimate the number of individuals expected to be served annually and how you arrived at this number.

The proposed project will serve six individuals residing in Crossroad's transitional housing beds. Assuming a maximum stay of six months, with some clients that will transition to long-term housing earlier or chose to leave the program, it is anticipated that the program will be able to serve 12 to 20 clients each year. The diversion transitional housing beds will be an invaluable resource for serving the diversion population in the county, by helping clients to focus on their recovery plan, connect to treatment services, and re-engage with the community and needed resources. All alumni who complete the transitional housing phase and are still actively in recovery will be invited back to the Crossroads transitional house to participate in support groups, meetings with ACT clinicians, weekly community dinners, and select educational groups and activities.

[15] Sonoma County MHSA FY 2016-2019 Capacity Assessment, Research Associates Development, January 2020.

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

The population to be served aligns with AB1810 and the criteria for Specialty Mental Health Services for the Department of Health Services, Behavioral Health. Individuals who are eligible for local Diversion services, include the following:

- Felons or Misdemeanants
- Individuals with a serious mental illness (SMI) as identified under AB1810
- Preference will be given to clients participating in the Mental Health Diversion Court who also have a diagnosis of:
    - Schizophrenia
    - Schizo-Affective Disorder
    - Bi-Polar Disorder
- At low or no-risk to public safety and the community
- Voluntarily seeks to participate in treatment, agreement to comply/consent
- Found to be ICST (Incompetent to Stand Trial) or At risk for ICST
- Significant relationship between Mental Health condition and charged offense
- Medi-Cal eligible

Crossroads will provide services to Spanish-speakers and has contracted ASL interpreters for the hearing impaired. The transitional housing will be welcoming to all gender identities.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Sonoma County does not have any dedicated housing that provides supportive and recovery driven peer services for individuals with significant mental health and/or substance use disorders and criminal justice involvement. Instead, many individuals that have significant mental health and/or substance use disorders and criminal justice involvement that may be incompetent to stand trial are housed in the Sonoma County jails and do not receive supportive peer services and evidenced based treatment that will help them move towards recovery and away from criminal justice involvement.

The proposed project, Crossroads, is based upon a combination of evidenced-based approaches, including Housing First, Assertive Community Treatment (ACT) and peer support integration into mental health treatment and recovery processes. The innovation is combining those approaches into one program model to fully engage and support individuals in their early recovery with that is client driven and addresses the barriers to successful achievement of recovery goals.

The initial research question was whether there was a successful model serving individuals with mental illness having a criminal justice background with a robust peer provider program combined with a clinical team within a supportive housing model. Research for this project discovered existing models that combined housing with ACT and/or peer-led services for the homeless, but not for adult diversion clients. The New York based homeless project, Pathways' Housing First is focused on obtaining market rate housing with minimum rules. It is almost expected that there will be challenges in maintaining housing and that the policies and procedures need to be flexible and client-driven. Pathways incorporates five principals: 1). Housing First, 2) Consumer Choice and Self-Determination, 3) Recovery Orientation, 4) Individualized and Person Driven and 5) Social and Community Integration. These five principles have transformed many staff to think differently about their approaches and understanding of recovery, and simultaneously empowered clients to be open to new ways of thinking, acting and increase ownership of their actions in the context of recovery.

The Peer Wellness Program, a service component of Pathways to Housing is exclusively run and managed by peers with lived experience. The peer run model emphasizes empowerment, social inclusion and true collaboration. Furthermore, the service delivery model focuses on the whole person, offering an array of supportive services, including housing retention, employment, pursuing their education, securing entitlements, making social connections, criminal justice issues, reuniting with children and families, living healthier lifestyles, becoming financially informed, and dealing with trauma. Pathways to Housing does use similar evidence-based and promising practices including: Housing First, Supported Employment—IPS (Intentional Peer Support) model, Integrated Dual Disorder Treatment (IDDT), the Wellness Self-Management tool, and Assertive Community Treatment Model (ACT). However, this project is not a criminal justice diversion project focusing on the severely mentally ill who are at risk of being found incompetent to stand trial.[16]

Crossroads to Hope is different from Pathways to Housing in that Crossroads will have transitional beds open and dedicated to eligible individuals leaving the criminal justice system. Pathways relies on market housing available to the broader public. In Sonoma County, housing is sparse and competition for rentals is fierce. Clients could be waiting many months for housing and thus delay access to treatment and possibly impact motivation.

Another model closer to home in California is the Amity Foundation, located in Los Angeles County. The Amity Foundation has implemented a model of short-term supportive housing coupled with case management for diversion clients but does not integrate peers into the clinical service delivery model. Furthermore, the Department of Health Services' Office of Diversion and Reentry's program offers long-term (not transitional) supportive housing with intensive case management to Probationers. Additional diversion programs have been developed by LA's Office of Diversion and Reentry for individuals found to be incompetent to stand trial, but again does not incorporate peers into the recovery model. [17]

[16] "Peer Wellness Program and Pathways to Housing", Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/peer-wellness-pathways-housing

[17] Health Services, Los Angeles County, Office of Diversion and Reentry, http://dhs.lacounty.gov/wps/portal/dhs/diversionandreentry/jcbd

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

With the support of MHSOAC staff, Sonoma County reviewed three additional Innovation Projects from Marin, Sacramento, and San Joaquin counties. Although Marin and Sacramento counties address the challenges in providing effective services for those involved with the criminal justice system, Marin takes a housing and holistic therapeutic approach and Sacramento is modifying their Child and Family team model to a forensic behavioral health multi-system team approach. Marin does incorporate one staff member with lived experience (peer), but does not build a strong peer provider program component as their centerpiece. Rather, Marin focuses on holistic health to address trauma within an exclusively female population.

San Joaquin is housing first focused for individuals experiencing mental illness and homelessness. San Joaquin's project does not incorporate a peer provider component at all.

Casting a wider net of research, a review of consumer-provided services (peer provider services) combined with Assertive Community Treatment (without housing) was conducted and identified 16 published studies. Findings were mixed, with evidence supporting consumer-provided services for improving (client) engagement. However, evidence was lacking for other outcomes, such as symptom reduction or improved quality of life.[18] The gaps in research indicate a lack of documentation and evaluation on a model that combines Housing First, Assertive Community Treatment with peer-led provider support for diversion clients from the criminal justice system. This innovation proposal for Crossroads to Hope would be an excellent model to measure impact and has promising benefits for those in the criminal justice system in Sonoma County and throughout California.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

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?

The first overarching goal for the program is to learn if a combined peer-provider model that is client centered and self-directed can be blended with a clinical approach that is often compliance focused and driven by the clinician. Furthermore, the County would like to understand the challenges and successes in that development process. The second and third goal is to

[18] A review of consumer-provided services on Assertive Community Treatment and intensive case management teams: Implication for future research and practice. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117264/

understand if the peer provider programming is a significant factor on client engagement and achievement of treatment plan goals. The lessons learned from developing this blended model and outcomes can be used for future programming that integrates **peer providers** and self-empowered, self-directed recovery philosophies.

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

A literature review finds evidence that peer-led programs have value and positive impact on mental health recovery for individuals. But there is lacking evidence on **how** peer support specifically contributes to positive outcomes. In Sonoma County, peer-led programs are usually stand-alone programs and not integrated with a clinical model. Thus, the first learning goal will contribute to an understanding of best practices for the development of future peer integrated programs. The second and third learning goals provide additional information on the impact and specifically the cause and effect of the peer support team.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Crossroads to Hope enhances a model of transitional housing and clinical support with peer provider staffing and a robust peer-recovery program for improved outcomes for diversion clients. The County of Sonoma is planning to contract with RDA Consulting, a firm that has extensive knowledge of MHSA and experience in research and evaluation, including Innovation projects. The following learning goals are proposed for the Crossroads Innovation Project:

Learning Goal 1: How do peer providers and clinicians work together to create a treatment milieu that incorporates the principles of self-determination and choice for clients?

- What were the significant barriers to overcome in developing this model?
- What were the factors that helped overcome challenges and led to success?
- Are there professional development standards for peer providers that factor into the success of a blended treatment and support team? Contributing factors may include required qualifications for the position, certification, training, team support, mentorship, and supervision.

Learning Goal 2: How do the peer providers impact the diversion clients in their early engagement in recovery?

- What is the diversion clients' perception of value/benefit in receiving peer provider support and services?
- What is the peer providers' perception of value/benefit of their support and services?
- What is the ACT teams' perception of value/benefit of having peer provider support and services?

Learning Goal 3: How do peer providers impact the accomplishment of treatment goals among the diversion clients that complete the first 6 months at Crossroads?

- Are there specific activities that peers provide that are most beneficial to diversion clients' achievement of treatment goals and what are they?
- Are there other factors that influence the success of diversion clients' to achieve treatment goals? (i.e. amount of time spent with peer providers, qualities of peer providers)

METHODOLOGY

The evaluation team will commence their planning work in tandem with the peer provider organization and the Peer Advisory Council at a session(s) designed to define the theory of change (TOC) and identify the specific ways that peers may engage clients and support the achievement of recovery goals within the six-month intervention. This TOC will be the basis for the development of the evaluation plan. It is anticipated that the evaluation will consist of a mixed-methods data collection approach including both qualitative and quantitative data. In addition, the evaluation process will employ a community-based participatory research model, engaging the Peer Advisory Council in the design and implementation of the evaluation process; collection and analysis of the data; and development/dissemination of the final report to stakeholders in the community.

Learning Goal 1 is a formative evaluation. Documentation of team meetings with peer providers and ACT team members will be maintained with a focus on discussions related to the integration of peer-model principles of self-determination and client choice. The findings in the process documentation will be validated with an annual mixed-methods (qualitative and quantitative) questionnaire to be completed by the clinical/case management team and peer providers, key informant interviews and review of program documentation.

Learning Goal 2 is an outcome evaluation question measuring the impact of peer providers on the engagement from the perspective of the clients and peer providers. The specific measures are yet to be determined, but will consist of a pre-post measure(s). For example, a tool such as the Self-Sufficiency Matrix can be completed by a peer provider as an assessment based on interactions with the client. The Self-Sufficiency Matrix consists of 20 domains examining the status/outcomes of the individual's activities of daily living. This non-clinical assessment can be completed at entry and again at the 6-month exit from transitional housing. In addition to a standardized assessment tool, interviews will be conducted with a randomized convenience sample of clients, peer providers and clinical staff to collect qualitative data to triangulate and validate findings.

Learning Goal 3 is also an outcome evaluation question focusing on the effect that peer providers have on the achievement of client treatment goals. The theory of change developed by the evaluation team and peer providers will inform the specifics of how the peer provider support may influence and ultimately impact client recovery outcomes. Appropriate tools will be identified and may include the Adult Needs and Strengths Assessment (ANSA) to benchmark client changes in clinical status and achievement of recovery goals. The ANSA is a multi-use assessment tool that can be used for treatment planning, determining levels of care, measuring outcomes and serves as a communication tool. This assessment will be administered every six months. The ANSA will be administered upon entry into the program (baseline) to help inform and support the development of treatment goals. The ANSA will be re-administered a second time at 6-months, when the client is expected to exit transitional housing. Additional administration of the ANSA at 12, 18 and 24-months will be administered by the ACT team. The local evaluation team and Peer Advisory Council will continue to review ANSA data with the participant's consent at 12, 18 and 24 months. The evaluator will conduct statistical analysis of the ANSA data to determine if there is a correlation between the Crossroads interventions and longer-term client outcomes/status. These findings will be included in the annual and final Innovation Reports.

A qualitative database will be added to examine the peer provider support intervention and whether those activities contributed to the client outcomes. An example method of data collection might be interviews conducted with all clients at 6-months to determine what factors influenced client success. Interviews could consist of open-ended questions and allow the client to respond without prompts or direction. If needed, clients may be offered suggestions such as educational groups, housing, relationships with staff/peers/peer providers/probation officers, wrap around services, community connections, etc. This will be determined by the evaluation team, peer providers and Peer Advisory Council.

SECTION 3: ADDITIONAL INFORMATION FOR REGULATORY REQUIREMENTS

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

Sonoma County Department of Health Services (DHS) will solicit up to a five-year contract with a community-based organization to provide the peer-led services for the proposed term of the Innovation funding award. DHS will need to develop a request for proposals (RFP) to select an appropriate community-based provider for the peer provider component.

In addition, the County will seek an independent evaluator from the County's qualified contractor list to oversee the evaluation. Early discussions have been held with Resource Development Associates (RDA) based in Oakland, CA as to their interest and role as the local project evaluation team. RDA has indicated that they are very interested in evaluating this project, and they have provided the County with a cost estimate. RDA has decades of experience with MHSA funded programs, including Innovation Projects, Capacity Assessments, and Community Program Planning models.

The MHSA Coordinator and the Forensic Health Program Manager of the Sonoma County DHS BHD will share responsibility to monitor the progress of **Crossroads to Hope** and assure contract compliance per County and State regulations for both the program and the evaluation contractors. The County may provide technical support in program delivery and evaluation, fiscal reporting and program reporting to these contractors. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and regulations. In addition, the selected contractor will be expected to submit quarterly reports that include client demographics (as per MHSA INN regulations), program data, program progress and challenges, and invoices for services rendered.

The selected evaluation contractor will engage with the DHS Health Prevention, Planning and Evaluation Unit to ensure alignment with the overall evaluation of the Diversion project. The evaluation contractor will also meet with the MHSA Coordinator and the Forensic Health Program Manager with regular frequency (minimum quarterly) to facilitate and assure the evaluation is on track.

COMMUNITY PROGRAM PLANNING

In June of 2016, a group of community stakeholders including consumers, peers, mental health providers and County representatives met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and

recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In March of 2018, Sonoma County held a two-day meeting of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services that can prevent deeper penetration into the criminal justice system. The County brought together over 40 stakeholders from multiple systems, including mental health consumers and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the county.[19]

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration and/or inpatient psychiatric services. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from inpatient psychiatric facilities or incarceration.[20]

In the Sonoma County Capacity Assessment Report released in January 2020, community stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery that could not be achieved by clinicians alone.[21] The 2019 MHSA Capacity Assessment report continues to state that consumers, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for consumers is not only aligned with MHSA values, but could create a cultural shift in the way mental health services are delivered throughout the system.

Specific to this innovation project, a few members and consultants from the Sonoma County Peer Council have been participating in the development and planning of Crossroads to Hope. Interviews with three peer providers who have lived mental health and criminal justice experience and two mental health providers at local mental health agencies were conducted in April and May 2020.

The chart below lists those individuals and their affiliations.

Name	Affiliation	Organization
Sean Bolan	Peer provider	Manager, Wellness and Advocacy Center
Sean Kelson	Peer provider	Manager, Interlink and Petaluma Peer Recovery Center

[19] Sequential Intercept Model Mapping Report for Sonoma County, CA; Policy Research Associates, Inc, March 20-21, 2018.
[20] Sonoma County Housing Needs Assessment, Harder + Company Community Research, April 2018.
[21] Sonoma County MHSA FY 2016-2019 Capacity Assessment, Research Associates Development, January 2020.

Kate Roberge	Peer provider	Consumer Affairs Coordinator, Wellness and Advocacy Center
Steven Boyd, LCSW	Clinician	Clinical Director to Napa and Sonoma Programs, Progress Foundation
Sid McColley, RN, CNS	County	Section Manager, Acute and Forensic Services Sonoma County Behavioral Health Services

In addition, the Crossroad to Hope Innovation proposal and program highlights have been presented to groups of MHSA Stakeholders at the meetings listed on the table below.

Date	Stakeholder Group
May 7, 2021	MHSA Community Program Planning Workgroup
May 11, 2021	MHSA Steering Committee
May 27, 2021	MHSA Stakeholder Meeting (comprised of a broad group of stakeholders)
September 13, 2021	Innovation Contractors
September 16, 2021	Prevention and Early Intervention Contractors
October 6, 2021	Community Services and Supports Contractors
October 14, 2021	DHS-BHD Staff
November 4, 2021	Mental Health Board

Thus far all of the comments received about the proposal from the various stakeholder groups have been positive and include the following themes.

- Creates transitional housing
- Helps individuals to develop skills that will promote their ability to get and keep permeant housing
- Diverts people with mental health concerns from jail
- Integrates supportive peer services to help individuals to move towards recovery

The 30-day public review period commenced on December 1, 2021 with the publication of the Crossroads to Hope application posted on the Department of Health Services Behavioral Health website and publicized in the MHSA newsletter, emailed to list of over 2000 on the MHSA listserv, stakeholders and contractors. The Mental Health Board will host the public hearing on Crossroads on January 18, 2022, and the Board of Supervisors will review the proposal for approval on February 8, 2022.

Finally, a Peer Advisory Council specific to Crossroads will be re-convened to receive updates to the project's progress and provide input to the final design and implementation of the project's evaluation and program modifications.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The discussion of increasing peer providers in the continuum of mental health services for Sonoma County has been evolving over the past 8 years or more with a stakeholder group comprised of peers, family members, clients, criminal justice personnel, behavioral health clinicians and management in that has resulted the establishment of a variety of peer-led programs in the community and an application for funding for a Peer Respite program in 2018. The dialogue between peer providers (trained and certified) and behavioral health clinicians/management has been ongoing to improve and expand peer provider services in the system of care.

Crossroads to Hope is a model that incorporates a multi-disciplinary team comprised of consumers, mental health providers, law enforcement, housing and community-based organizations. Case conferences and meetings on program operations will held with frequent regularity, especially in the first year of the project. Furthermore, a Peer Advisory Council will be established for ongoing consultation and monitoring of this project which will assure a peer perspective and support for the peer providers.

B) Cultural Competency

The diversion clients coming from the local county jails will most likely represent the diversity of ethnic and racial demographics of the jail population. The model of client-driven and self-determination will address and hopefully prevent inherent biases of a western medical model. In addition, the Behavioral Health Division has a Cultural Responsiveness Committee that will receive updates on this project and make recommendations on policy and procedures to assure the services are free from racial, economic and gender biases.

C) Client-Driven

By adopting a philosophy and practice of self-directed recovery planning supported by a peer-led support model, Crossroads will identify and provide opportunities to assure that diversion clients are empowered to define their recovery goals, actions for achievement and definitions of success.

D) Family-Driven

As noted in the earlier value of "client-driven", if diversion clients have family members (defined by the client) whom they would like to involve in their recovery, those family members will be engaged in recovery planning and actions. In addition, family member representatives will be sought to participate in the Peers Advisory Council which will guide the development, engagement and evaluation of Crossroads.

E) Wellness, Recovery, and Resilience-Focused

The premise of peer-led services integrated into a more compliance oriented, illness-focused, clinical model will necessitate a transformation of how the team looks at recovery. The journey of people in recovery does not start with a recovery plan, but of telling and understanding how they got to where they are today and where they want to go and what they want to do. Practicing self-care leading to wellness and resilience is an ongoing process. The structures that will be in place to maintain the focus on wellness, recovery and resilience include: 1). Trained and supported Peer providers; 2). Informed and engaged Peer Advisory Council; and 3) Realized opportunities for staff-development and training.

F) Integrated Service Experience for Clients and Families

The Crossroads model is inter- and multi-disciplinary. In supporting diversion clients with transitional housing, a home-base is established whereby services can come to the clients rather than asking clients to work with traditionally siloed providers. Case conferences will provide the mechanism to further identify areas of integration and coordination to support a solid start to recovery.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned throughout this application, a Peer Advisory Council will be established to provide counsel and accountability to both the program and evaluation design and implementation. This Peer Advisory Council is reflected in the budget to offer stipends and cover expenses. The PAC will meet regularly with the MHSA Coordinator or designee to assure communication and continuity of policy and procedural practices. Documentation of these meetings will be maintained contributing to the formative evaluation and continuous improvement.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

A) **Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.**

Determination of whether the program will continue after the end of the Innovation Period using other funding will be made through the Community Program Planning Process by analyzing data gathered that address the learning questions and additional outcome data including occupancy, cost-effectiveness and cost-savings to the larger community, client-feedback, and availability/prioritization of funding. Funding with MHSA Community Services and Supports (CSS) component will be considered. Also, the implementation of the California Advancing and Innovating Medi-Cal (CalAim) reforms will be continually monitored over the next five years and this is a potential be a source of funding this type of innovative whole person approach that addresses key social determinants of health. In addition, if successful outcomes are achieved through this innovative approach, the Probation department may be another potential funding source to continue this work.

B) Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

Crossroads will be serving individuals with serious mental illness and if the project is to terminate at the end of the five-year Innovation funding, the ACT clinical team will continue to support diversion clients while they are in the transitional housing as well as afterwards when they are in long-term housing. There will be no break in those clinical services.

COMMUNICATION AND DISSEMINATION PLAN

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

The MHSA Coordinator will be primarily responsible for communicating the progress, results, and lessons learned to community stakeholders, including the County Mental Health Board, Board of Supervisors, MHSA Steering Committee, key Department Heads and other community leaders/stakeholders. The Peer Advisory Council and Crossroads clients will be invited to engage in the development of public materials, reports and presentations. In addition, clients may participate in testimonials at public hearings, conferences, or other key policy meetings.

In light of the MHSOAC Commission and State of California's interest in reducing the population of those with severe mental health conditions in the criminal justice system, Crossroads hold promise of an innovative, comprehensive and effective model that can be replicated in other counties throughout the state. Crossroads evaluation will document the formation and outcomes of the project for ease of replication.

B) 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.

- Mental Health Peer Providers
- Criminal Justice Diversion
- Innovative Mental Health Models

TIMELINE

A) Specify the expected start date and end date of your INN Project

B) Specify the total timeframe (duration) of the INN Project

C) Include a project timeline that specifies key activities, milestones, and deliverables by quarter.

Year 1			
April 2022	**July 2022**	**October 2022**	**January 2023**
• Contractor recruits Peer Providers, Peer Advisory Council • Convene kick-off meeting with ACT team, Peer Providers, law enforcement, evaluator • Establish policy and procedures for Crossroads • Refine roles and responsibilities of Peer Providers • Establish draft of evaluation protocols and instruments	• Enroll eligible clients for Crossroads, administer ANSA • Clients develop recovery plans • Peer providers implement educational curriculum, supportive services • Quarterly meeting with Peer Advisory Council • Establish evaluation protocols • Quarterly meetings with contractors, evaluator • Evaluator reviews evaluation protocols and data collection methods with peer providers	• Program operations refined • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator • Evaluator reviews data collection methods • Evaluator reviews evaluation protocols and data collection methods with Peer Advisory Council and providers	• Clients moving from transitional to long-term housing, administer ANSA • Survey administration for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA

Year 2 - 4			
April 2023 - 2025	July 2023-2025	October 2024 - 2026	January 2024 - 2026
• Clients develop recovery plans • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator	• Clients moving from transitional to long-term housing, administer ANSA • Survey administration for exiting clients and ACT team • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for vacancies in Crossroads, administer ANSA • Clients develop recovery plans	• Peer providers implement educational curriculum, supportive services • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator	• Clients moving from transitional to long-term housing, administer ANSA • Survey for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA • Clients develop recovery plans

Year 5			
April 2026	July 2026	October 2027	January 2027
• Peer providers implement educational curriculum, supportive services • Meetings with contractors, evaluator • Analyze first 2 years of evaluation, share findings with Peer Advisory Council	• Clients moving from transitional to long-term housing • Survey administration for exiting clients and ACT team • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for Crossroads • Begin disseminating preliminary findings from evaluation on impact, lessons learned to stakeholders, policy makers and funders	• Continued dissemination of preliminary findings from evaluation on impact, lessons learned to stakeholders, policy makers and funders • Determination of continued funding or termination of peer provider component of Crossroads • Peer Advisory Council meeting • Meetings with contractors, evaluator • On-going program implementation	• Clients moving from transitional to long-term housing, administer ANSA • Survey for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Peer Advisory Council meeting • Meeting with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA • Clients develop recovery plans • Final evaluation report • Dissemination of final evaluation report to stakeholders, policy makers and interested members of the public

SECTION 4: INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

1. A) **BUDGET NARRATIVE** (Specifics about how money is being spent for the development of this project)
2. B) **BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY** (Identification of expenses of the project by funding category and fiscal year)
3. C) **BUDGET CONTEXT** (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

Personnel Costs:

Year 1

- **1 FTE Senior Peer Provider** (2080 hours) x $25 per hour = $52,000 prorated for 3 months (.25 of year).
- **2 FTE Peer Provider** (4160 hours) x $20 per hour = $83,200 prorated for 3 months (.25 of year).
- **1 FTE Relief Peer Provider**, 2080 hours x $20 = $41,600 prorated for 3 months (.25 of year).
- **Direct Costs:** Wages of 4 FTE Peer Providers x .33 (benefits, payroll taxes, insurance) = $58,344, prorated for 3 months (.25 of year).
- **Indirect Costs** are administrative expenses related to recruitment, administrative management of Peer Providers at 10% of contract with non-profit contractor. Year 1 is prorated for 3 months (.25 of year).

Year 2 – 5

- Each year, a proposed .03 Cost of Living increase is added to salaries if personnel is stable. Direct Cost of benefits, payroll taxes and insurance of .33 is consistent, as is Indirect Cost of .10 for non-profit contractor.

Direct Operating Costs (Years 1 and 5 are prorated)

- **Peer program costs include:** Supplies (workbooks, journals, art supplies) - $4000. Educational materials - $4000. Guest speakers - $3000. Field trips - $3000. Subscriptions - $2000.
- **Food** – Year 1 = $40,000 Estimated $300 - 334/person per month @ 10 – 12 people Year 3 - 5 and 3 included $5,000 increase per year.
- **Peer Advisory Council stipends** $2400 per year for (6 meetings per year, 8 participants, $50 per meeting). $600 for snacks/meals for meetings;
- **Peer training and professional development:** 4 x $500 = $2000
- **Transportation:** County pool car fees: $1500 per year. Bus passes for clients: $62.50 per month x 6 clients x 12 months = $4,500.
- **Housewares:** dishes, silverware, glasses, mugs, serving platters at $10,000 year 1 with replacement allowance at Year 3 - $2000 and Year 5 - $1000.
- **Household Expenses:** Consumable products, including cleaning supplies, toilet paper, paper towels, and maintenance supplies = $10,000
- **Utilities:** $5,500 per month including communications for the house and cellular for peer providers, IT, PGE, water, garbage
- **Building improvements:** $5,000 for repairs, maintenance on building and grounds
- **Client Educational Funds:** $24,000 - $2,000 per client x 12 annually for GED, computer classes, books, professional development
- **Office Expense:** $2000 per year for printer paper, ink, postage, stationary, supplies
- **Peer provider education and training:** $5,500 = $1,375 annually per peer provider x 4
- **Recreation:** $7,200 per year to promote wellness and self-care - Bicycles for house (4 x $500 = $2000), yoga ($100 per week x 52 weeks = $5,200)
- **Professional & Special Services:** $23,400 for nutritionist/chef at $75 per hour x 6 hours x 52 weeks. For nutritional guidance, menu planning and meal prep education.
- **Transportation:** $4,200 lease car with insurance and registration at $350 per month for peer providers to transport clients to court, medical appointments, and other important appointments.
- **Client travel:** $4,500 for bus vouchers. $62.50 per month x 6 clients x 12 months.
- **Gas, oil, maintenance on lease vehicle:** $3,000 per year
- **Rents & Leases:** $32,000 for first, last and deposit to support clients leaving transitional housing when needed.

Indirect Operating Costs:

- 10% to non-profit contract for administration of payments, managing house inventory and utilities, lease of vehicle.

Non-Re-occurring Costs

- Computers - $4,500: Five computers for clients and peer providers at $750 each and 2 printers at $325 each.

Consultant Costs:

- Evaluation Contractor (propose RDA to evaluate the program): Year 1: $47,000; Years 2-4: $11,750; and Year 3: $25,000

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*

EXPENDITURES								
PERSONNEL COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1	Salaries	$44,200.00	$176,800.00	$182,104.00	$187,567.00	$193,194.00	$113,020.00	$896,885.00
2	Direct Costs	$14,586.00	$58,344.00	$60,094.00	$61,897.00	$63,754.00	$37,296.00	$295,971.00
3	Indirect Costs	$5,879.00	$23,514.00	$24,220.00	$24,946.00	$25,695.00	$15,031.00	$119,285.00
4	Total Personnel Costs	$64,665.00	$258,658.00	$266,418.00	$274,410.00	$282,643.00	$165,347.00	$1,312,141.00
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
5	Direct Costs	$30,759.00	$181,841.00	$191,300.00	$193,900.00	$194,900.00	$174,899.00	$967,599.00
6	Indirect Costs	$3,076.00	$18,184.00	$19,130.00	$19,390.00	$19,490.00	$17,490.00	$96,760.00
7	Total Operating Costs	$33,835.00	$200,025.00	$210,430.00	$213,290.00	$214,390.00	$192,389.00	$1,064,359.00
NON RECURRING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
8	Computers for clients and peers	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
9	Total Non-recurring costs	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
CONSULTANT COSTS / CONTRACTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
10	Direct Costs	$47,000.00	$11,750.00	$11,750.00	$11,750.00	$11,750.00	$25,000.00	$119,000.00
11	Indirect Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12	Total Consultant Costs	$47,000.00	$11,750.00	$11,750.00	$11,750.00	$11,750.00	$25,000.00	$119,000.00
OTHER EXPENDITURES		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
13	Total Other Expenditures	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
BUDGET TOTALS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Personnel (line 1)		$44,200.00	$176,800.00	$182,104.00	$187,567.00	$193,194.00	$113,020.00	$896,885.00
Direct Costs (add lines 2, 5 and 10 from above)		$92,345.00	$251,935.00	$263,144.00	$267,547.00	$270,404.00	$237,195.00	$1,382,570.00
Indirect Costs (add lines 3, 6 and 11 from above)		$8,955.00	$41,698.00	$43,350.00	$44,336.00	$45,185.00	$32,521.00	$216,045.00
Non-recurring costs (line 9)		$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
Other Expenditures (line 13)		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL INNOVATION BUDGET		$150,000.00	$470,433.00	$488,598.00	$499,450.00	$508,783.00	$382,736.00	$2,500,000.00

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
ADMINISTRATION								
	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$103,000	$458,683	$476,848	$487,700	$497,033	$357,736	$2,381,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Administration**	$103,000	$458,683	$476,848	$487,700	$497,033	$357,736	$2,381,000
EVALUATION								
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$47,000	$11,750	$11,750	$11,750	$11,750	$25,000	$119,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Evaluation**	$47,000	$11,750	$11,750	$11,750	$11,750	$25,000	$119,000
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$150,000	$470,433	$488,598	$499,450	$508,783	$382,736	$2,500,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Expenditures**	$150,000	$470,433	$488,598	$499,450	$508,783	$382,736	$2,500,000