COUNTY OF MARIN
MENTAL HEALTH SERVICES ACT (MHSA)
INNOVATION PLANNING

MHSOAC Mental Health Services Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☒ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☐ Local Mental Health Board approval Public Hearing Date: **4/13/2021**
☐ Completed 30-day public comment period Comment Period: **3/13-4/13/2021**
☐ BOS approval date Approval Date: If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: **5/2021** *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: **May or June 2021** *Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.*

County Name: **Marin**

Date submitted: **March 13, 2021**

Project Title: **From Housing to Healing, Re-Entry Community for Women**

Total amount requested: **$1,795,000**

Duration of project: **5 years**

Section 1: Innovations Regulations Requirement Categories

CHOOSE A 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

CHOOSE A 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

"Trauma is the elephant in the room: We talk about the diagnosis, the lack of ability to engage, but the bottom line is the trauma."

Women in the county jail have experienced significantly more trauma than the general population. As the Jail Mental Health Unit Supervisor describes "I see our team, usually our psychiatrist, being repeatedly called on to "treat" clients with medications, hoping the medication will target impulsivity, self-harm ideation, intense interpersonal relational patterns, rapid mood cycling and other symptoms that can be better explained by a history of untreated childhood trauma. The medications usually aren't effective in these cases, but the narrative of untreated Mental Health (and/or untreated Substance Use Disorder) continues to be the explanation for treatment failure." While taking medications may help to temporarily shut down learned alarm reactions, medication treatment alone is insufficient to heal the underlying trauma that often contributes to maladaptive behaviors. Similarly, psychotherapeutic approaches to healing trauma that rely on utilizing the pre-frontal cortex or "thinking brain" may have limited effectiveness for trauma survivors. For many individuals who have experienced trauma, the "thinking" part of the brain is shut down or under-activated. Therefore, these approaches—often referred to as "top down" interventions—that rely on an individual's ability to access this part of the brain by "talking through" the trauma and its associated behaviors may serve to perpetuate anxious feelings or feelings of "stuckness."[1] Recent studies have demonstrated that somatic practices such as yoga—or "bottom-up" approaches—may be more effective than psychotherapy and medication treatment alone for treating the effects of trauma. By helping individuals develop an awareness of the mind-body connection and helping them become more tolerant of physical and sensory experiences, somatic interventions can help individuals develop their emotional awareness and acceptance of uncomfortable feelings. Yoga, for example "with its cultivation of an observing mind, its release of chronic tension stored in the body, and its many techniques using breathing and sound that help clients access the wellspring of wellbeing that exists beneath the effects of trauma, can provide trauma survivors a way to feel safe in their bodies and safe in the world".[2]

Mental Health and Substance Use diagnoses often stem from or are greatly exacerbated by untreated trauma. Starting in 2020, the Marin County Jail Mental Health team in partnership with nursing students have started preforming ACEs (Adverse Childhood Experiences) assessments within the county jail. These scores revealed that (similar to other literature) the scores were significantly higher than the community at large, and women in particular to a significantly greater proportion. In a study including over 214,000 people from the general population, 17.8% of the women scored 4 or higher.[3] In our

[1] Van der Kolk, Bessel A. (2014). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*.
[2] Weintraub, A. (2012). *Yoga Skills for Therapists: Effective Practices for Mood Management*. United States: W. W. Norton. Page 13.
[3] Merrick, M.T., Ford, D.C., Ports, K. A., Guinn, A. S. (2018). Prevalence of Adverse Childhood Experiences From the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. JAMA Pediatrics, 172(11), 1038-1044

Marin County Jail Mental Health population, it was three times higher with 53.3% of the women in the jail having experienced 4 or more adverse childhood experiences. And even more worryingly, over 1 in 4 (26.67%) of the women in the jail had a score of 7 or higher. As found in a study from 2001 of over of 17,000 HMO members, an ACE score of at least 7 increased the likelihood of childhood/adolescent suicide attempts 51-fold and adult suicide attempts 30-fold (P<.001).[4] It has also been shown that people with six or more ACEs died nearly 20 years earlier on average than those without histories of these adverse childhood experiences.[5]

PROPOSED PROJECT

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

This project is centered around addressing trauma as the focal point of treatment for women with serious mental illness and/or substance use disorders who have been incarcerated or otherwise resided in a locked facility who have high Adverse Childhood Experiences (ACEs) scores. This program will be focused around understanding the widespread impact of trauma, learning to manage the subsequent maladaptive reactions and behaviors, and healing. Creating safety and building community are key bedrocks for this work. Part of the program will be a safe and welcoming home for 6 women (one of the women will be a peer provider) to focus on this healing before moving to permanent housing. This program will be uniquely geared toward managing the types of behavioral issues that women with a history of trauma tend to present with (intense interpersonal conflict, self-harm ideation, etc.) that can be a barrier to enrollment/successful completion of other treatment programs. As part of its innovation, treatment would begin prior to residency at the house—the trauma therapist would work with women in the jail or other locked facility prior to release—to start building a foundation, establish rapport and provide psychoeducation to help the women recognize how trauma is impacting them. Often the focus of treatment for these women is the substance use or mental health diagnosis and the trauma does not get attention. Psychiatric medication and talk therapy alone are often insufficient to treat behavioral problems stemming from a history of trauma. When a client is in custody, it is often a unique time to talk with them about treatment as they are sober and often more motivated to talk with providers in a way they are not when in the community.

This program will focus on actively resisting re-traumatization and the women would remain engaged with the trauma healing after they move on from living in the house. Women would not graduate from this supportive housing environment without housing and ongoing support in place. When women do leave, they could continue therapy with the trauma therapist during a transitional period, so that treatment and connection do not abruptly end at the same time as a transition in housing is occurring.

---

[4] Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study. *JAMA.* 2001;286(24):3089–3096. doi:10.1001/jama.286.24.3089

[5] Brown DW, Anda RF, Tiemeier H, Felitti VJ, Edwards VJ, Croft JB, Giles WH. Adverse childhood experiences and the risk of premature mortality. Am J Prev Med. 2009 Nov;37(5):389-96. doi: 10.1016/j.amepre.2009.06.021. PMID: 19840693

Knowledge about trauma and its impacts will be fully integrated into policies, procedures, practices, and settings, for instance if a woman departs the house abruptly in the context of an emotional or interpersonal breakdown, this will be managed in a Trauma Informed way and she would not be automatically discharged from the program as is often the case in residential programs. In addition to the Trauma Therapist, a variety of somatic, alternative, cultural, or other healing practices will be introduced to the women and they will play an active role in evaluating those therapies and selecting what should be introduced more broadly within Behavioral Health and Recovery Services (BHRS). There will be a holistic approach, including strong coordination with other service providers throughout Health and Human Services and the community including substance use treatment. Nutrition will also be a key part of this program and all alumnae will be welcomed back for Sunday dinners (as well as groups) to help foster the sense of community. To further complement the nutrition aspects of the program there will also be a vegetable garden where the women can learn about growing some of their own food.

Proposed Staffing:

- A full-time female Certified Peer Counselor with lived experience will live in the house and act as a positive role model in the path to recovery. This peer will be provided training, mentoring, and financial support for the certification process through MHSA Workforce Education and Training Mental Health Career Pathway Funding if not yet certified, and receive a monthly stipend in addition to free rent/utilities.
- A part-time house manager (to do intakes, manage the milieu, etc.) who is not a clinician but has undergone specialized training around trauma.
- A full-time trauma therapist to provide groups and therapy (specifically geared toward addressing trauma) in the house and to see women at the jail for psychotherapy, preparing them for the work in the community. If they are precontemplation or contemplation, the therapist would continue to work with them across (often repeated) incarcerations, building connection and raising awareness about how trauma is underlying their struggles.
- Specialist trainers to complement the trauma therapist and bring in additional somatic, cultural, and alternative therapy options including Yoga, EFT Tapping, Meditation, etc., that the women (both residents and alumnae) would get to test out and see what they feel would be most effective for themselves and other women in their situation going forward. The women themselves will be an active and integral part of the evaluation of different somatic techniques that could be introduced more widely throughout BHRS and our other housing programs. This will enhance cultural competency as it will be adaptive to the needs of the women residing in the house and they will be able to provide input on which therapies they would like to try.

B) Identify which of the project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite.

C) 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 trauma-sensitive approach that we are exploring with this project goes beyond traditional talk therapies that focus on the mind alone or medications that focus on management of reactive behaviors. By actively bringing the body into the healing process through movement, breathwork and other somatic interventions, in an environment that allows for a collective healing experience in a supportive housing space, we are broadening traditional approaches to working with this population.

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

Estimated that there would be 6 women served in year one (including women served in the jail setting prior to release), with that number increasing by 8 each year as alumni of the program will stay significantly involved. Year two, 14 women would be served, year three 22 women would be served, year four there would be 30 women served, and year five there would be 38 women served. In addition, by year 5, another 100 individuals would be offered somatic or alternative therapy programs that that the women in the house and alumni recommend. In all, approximately 138 individuals would be served, with a projected 38 women having resided in the house.

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

The target population for this proposal is women (trans-inclusive) with serious mental illness (often with co-occurring substance use disorders) who have been incarcerated or otherwise resided in a locked facility who have high Adverse Childhood Experiences (ACEs) scores. Based on the initial assessment, women in the Marin County Jail have significantly higher ACEs scores than the general population or even than the men in the jail. These women have histories of traumatic experiences in childhood and adulthood, criminal justice involvement, and typically exhibit impulsivity, self-harm ideation, intense interpersonal relational patterns, rapid mood cycling and other symptoms.

The female Marin County Jail Mental Health population is currently 58% White or Caucasian, 23% Black or African American, 11% Hispanic or Latinx, and 5% Asian or Pacific Islander. This program will have a strong focus on racial equity as Black or African American women are significantly over-represented in the Marin County Jail Mental Health population with only 2.2% of the county's population identifying as Black or African American.

The average age of women in the Marin County Jail mental health population is 35 with a range from 25 years old to 51 years old.

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?

Creating a re-entry housing program for the public behavioral health system that is centered around addressing trauma rather than focused on traditional treatment of specific diagnoses will be innovative especially with the continuity of trauma-focused care prior to release from incarceration, through living in the house, and truly keeping the alumnae engaged in the program after graduation. Engaging the women in the evaluation of somatic therapies that would have implications for our whole system of care is also innovative and empowering.

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.

Various non-profits such as Liberation Prison Yoga, Yoga Behind Bars, Niroga Institute and others across the country have brought successful trauma-informed somatic practices into prisons and jail settings. These programs have been shown to be effective in helping thousands of incarcerated individuals develop coping tools, increase their "window of tolerance" and acceptance of self. Increasing numbers of studies demonstrate the effectiveness of using somatic practices in healing trauma in the general population (Levine, Van der Kolk, Emerson, Menakem) and studies have found these interventions to be effective as adjunctive treatments for trauma with women (Van der Kolk, Weintraub, others).

More specifically, it has also been shown that "addressing the emotional impact of childhood trauma among female prisoners may increase the effectiveness of correctional suicide prevention efforts."[6] However, despite studies like this one that has shown the need to address the impacts of childhood trauma, they did not have the opportunity to study the

[6] Clements-Nolle K, Wolden M, Bargmann-Losche J. Childhood trauma and risk for past and future suicide attempts among women in prison. Womens Health Issues. 2009 May-Jun;19(3):185-92. doi: 10.1016/j.whi.2009.02.002. PMID: 19447323.

effectiveness of a more comprehensive approach that begins with addressing the trauma while incarcerated and then provides a supportive housing environment designed around doing more in depth trauma-centered work before moving to permanent or independent housing options where they can still be connected to the community.

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?

- Does centering the program on addressing Trauma result in higher completion rate, decreased recidivism, increased housing stability, and increased feelings of psychological wellbeing?

- What somatic therapies are the most successful with this group of women and how can that be spread throughout the Behavioral Health and homelessness systems of care?

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

Learning Goal One gets to the core of the program and how effective it is to adapt the supportive housing component to focus on addressing trauma. Learning Goal Two gets to how the program can be expanded and impact the entire system of care by including the intentional focus on participants themselves evaluating the effectiveness of the integration of somatic and alternative approaches.

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.

Learning question 1: In order to determine if centering the program on addressing trauma results in higher completion rate, decreased recidivism, increased housing stability, and increased feelings of psychological wellbeing, the initial proposal will be as follows but subject to change with expert consultation from the Evaluation partner:

1. As part of the intake process there will be thorough treatment histories through both self-report and through working with other providers and programs to access records that will create a baseline for prior program completion based on how many programs they have been referred to or enrolled in and their length of stay within those programs and whether they successfully completed them. In addition, through a similar method baselines will be established for prior housing stability and prior incarceration frequency. This will be used to compare the rate of program completion, housing stability after graduation, and recidivism for women residents and alumnae of the *"From Housing to Healing, Re-Entry Community for Women."*

2. Feelings of psychological wellbeing will be measured using the Flourishing Scale. ***The Flourishing Scale (FS)*** is an 8-item self-report instrument that measures self-perceived success in important life-domains such as: relationships, purpose, self-esteem, and competence. The overall score provides a single measure of psychological well-being. This tool would be administered prior to entry to the program and then every six months.

3. Considering evaluating this program in comparison to other re-entry housing programs in existence or recently in existence with assistance from the Evaluation expert consultants.

Learning question 2: In order to determine what somatic therapies are the most successful with this group of women and how can that be spread throughout our system of care including some of our other residential programs, we will use the following information:

1. Data will be collected using a simple evaluation form looking at preferences and wellbeing for the residents and alumnae to fill out after participating in the different somatic, cultural, and alternative therapies over the first two years. The second two years will be dedicated to finding ways to expand the most successful programs to the other BHRS housing programs in years three and four and evaluating their success in those programs as well.

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?

A portion of the indirect will be used for the county's costs related to contract management, procurement, and accounts payable. Through the Request for Proposal (RFP) process, the county will ask questions related to promoting racial equity and ensure at least one member from the target population of the RFP is included on the RFP review committee, in alignment with the new Advancing Racial Equity framework for Marin County contracting. The contracts will be managed by the manager of Forensic Behavioral Health (in coordination with other parts of the Marin County Stepping Up initiative) in collaboration with the MHSA Coordinator to ensure regulatory compliance and MHSA General Standards are implemented throughout.

COMMUNITY PROGRAM PLANNING

Marin County's Community Program Planning process for this Innovative Project was as follows:

- 14 potential ideas were submitted by community members and coalitions through an online webform (www.MarinHHS.org/INNPlan) – two ideas were not included in the review because they either had no cost associated with them or were already in the existing budget
- A Lived Experience Review Committee of 9 individuals from diverse backgrounds with lived experience in recovery from mental health or substance use challenges or their families met virtually on 2/2/21 to discuss the 12 ideas and then scored each proposal on 4 different metrics and provided additional free form feedback (https://marincounty.jotform.com/build/210286586939066).
- This proposal (named "Trauma, the Elephant in the Room" in the submission) received the top score from the Lived Experience Review Committee with a score of 4.39/5. A breakdown of the combined scores from the Lived Experience Review Committee for this proposal were as follows:
    - Based on your lived experience, does this proposal feel like it would be a good way to tackle the problem presented? 4.9/5
    - Based on your lived experience, does the issue this proposal set out to address feel like it should be a priority for Marin? 4.4/5
    - Based on your lived experience, does this idea feel "innovative" to you? (E.g. "never been tried before" or "modified in some way to make it new") 3.9/5 – the committee discussed ideas for making the proposal feel more innovative including the nutrition elements and continued involvement of the alumnae.

- Based on your lived experience, do you think Marin would be able to learn something valuable by implementing this project? 4.4

- The top six ideas based on their scores from the lived experience review committee were brought to a leadership review committee who also scored this proposal with the top score: 4.5/5
- The two finalists were brought to the MHSA Advisory Committee (which has a majority of members with lived experience and representatives from law enforcement, social services, community based organizations, the commission on aging, and other representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community) met on 2/24/21. They recommended both ideas be pursued. Feedback from the MHSA Advisory Committee on this idea is below:

"I love this idea—there is one woman in particular—this program could keep her alive—we have done so much work with her for years and years and years and ***I feel relief! When does this start?!*** *She is still suffering—assault, trauma, everything.* ***There is nothing left to try but she is still alive so something could still work****."*

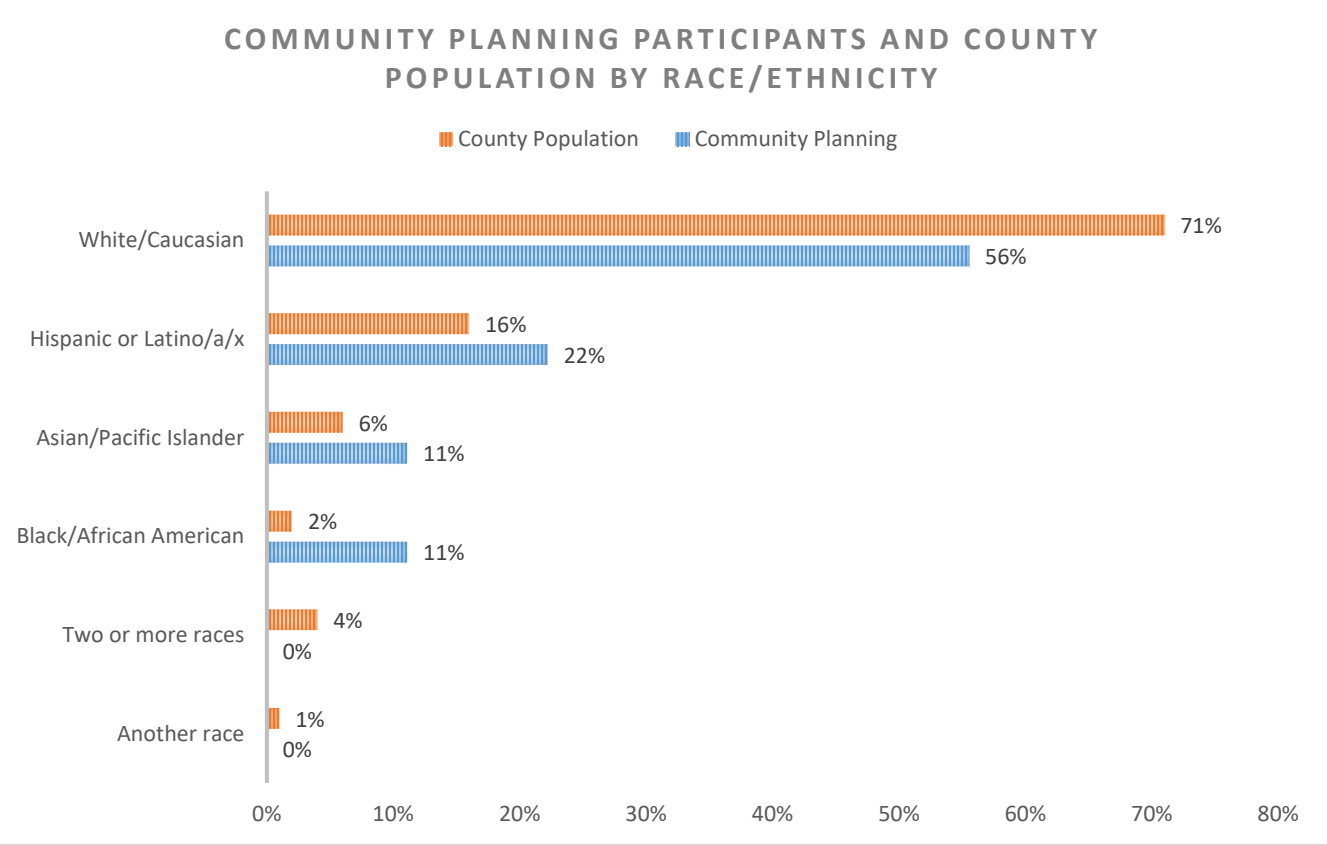
"We know them. We have known their stories. They are too traumatized to go through the shelter system."

"I love that it is very specific—there is a clear sense of mission. It could be up and running quickly."

"I think this is a really great, needed idea. We know a lot of women who have been homeless for many, many years who are just 'walking trauma' and they have gotten really good at staying out of jail. When they are referred to the shelter system, they get terribly re-traumatized. Women who have been living on the streets for 10-15 years. Lots of African-American women in this situation who confront implicit bias and racism when they hit the Mental Health system. ***Trauma is the thing that connects it all."***

"This is so needed. It is a crisis. People should get an extra couple points for just being a woman on the VI-SPDAT. I feel like this is an emergency."

Demographics of those involved in the Community Program Planning process for this Innovative Project as compared to the county as a whole were as follows:



MHSA GENERAL STANDARDS

A) Community Collaboration

Planning, implementation, and ongoing support/monitoring of this project will be led by a Stakeholder Advisory committee with community members, and continued oversight by the MHSA Advisory Committee. Through this Innovation Project enhanced relationships with utilizing volunteer community members in direct service programs will be enhanced including finding ways to provide volunteer Financial Literacy/Financial Planning for interested women in the house, as well as cooking classes, and other skills that community members can share. Similarly, when women in the house express interested in opportunities to give-back and volunteer those will also be treated with respect and actively supported.

B) Cultural Competency

This program will de-centralize white culture and western medicine by lifting up other cultural, alternative, and somatic approaches in tandem to provide a more culturally competent experience for the women.

C) Client-Driven

This project starts with psychoeducation in the county jail to help the women recognize the impacts of trauma to help them decide if they would like to try this more wholistic approach. Once in the house, the women will be the leaders in determining which somatic/alternative/cultural healing practices they want to continue and recommend for further use throughout the system of care.

D) Family-Driven

This program will be for adult women who have experienced significant Adverse Childhood Experiences. The involvement of family members will be determined on an individual basis by each woman but when there is openness to it, it will be supported through the trauma healing work. In addition, support in the reunification process for mothers who want to regain custody of their children will be supported through this program.

E) Wellness, Recovery, and Resilience-Focused

This is the heart of the project—it is focused on wellness through the somatic approaches and nutrition—and recovery and resilience through its focus on addressing and healing from trauma.

F) Integrated Service Experience for Clients and Families

The integration of the Trauma Therapist into the jail setting and then the community house will be a very important part of this project and provide for a continuity for the women. In addition, the trauma therapy and the somatic/alternative/cultural therapies and groups will be held onsite at the home.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

This project will be led by a stakeholder committee that is made up of clients and others from underserved or unserved populations. Stipends are included in the budget for both committee meetings as well as key informant interviews and focus groups for inform the evaluation process and program planning/funding continuation.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Determination of whether the program will continue after the end of the Innovation Period using other funding will be made through the Community Planning Process by looking at outcome data, occupancy, cost-effectiveness, client-feedback, and availability/prioritization of funding. Determination and continuity planning will be included in the FY2027/28 MHSA Annual Update/Three-Year Plan. MHSA Community Services and Supports will be considered as will the potential of CalAim to potentially be a route for funding this type of approach.

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.

Yes, and a determination will be made with at least 6 months remaining in the project on whether we are able to continue the program at the end of the Innovation project. If this project is not continued, the top priority during the final six months of the program will be to ensure the residents of the program are successfully able to transition to permanent housing before the end of the project.

COMMUNICATION AND DISSEMINATION PLAN

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

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

From Housing to Healing will have a project-specific Advisory Committee that will include people with lived experience, experts in Trauma Informed Care, Jail Mental Health, Race-Equity, housing, and co-occurring challenges. All residents and alumnae will be invited to participate in the Advisory Committee and get a stipend for their time participating in the meetings.

The Advisory Committee, evaluator, and staff will provide annual updates presentations and written reports to the Community at large about the project and its status. There will also be a webpage dedicated to this project that will house the updates and keep the community informed about progress.

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.

1. Trauma
2. Re-Entry
3. Women
4. ACEs (Adverse Childhood Experiences)
5. Housing

TIMELINE

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

January 1, 2022-December 31, 2026

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

5 calendar years

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

In advance of the project starting:

- Release RFPs
- Trauma Therapist position is approved by the BOS and position is posted for recruitment

Year 1, Quarter 1: (FY21/22: January-March 2022)

- Program Stakeholder Advisory Committee is formalized, meets monthly during Year 1
- Trauma Therapist is hired
- Trauma Therapist clearance for Jail Access
- Contracted partners selected from RFP responses, and contracts are approved by the Board of Supervisors
  - Community-Based Organization (CBO) partner contract to operate the house
  - Evaluator contract
  - Lead partner for alternative/somatic therapies
- Trauma Therapist begins meeting with women in the jail
- Contractors complete the hiring of their staff
- Trauma Informed assessment of the house and physical space is completed with minor modifications made that would promote Trauma Informed principles
- Evaluation framework, protocols, and procedures are developed with lead evaluation partner

Year 1, Quarter 2: (FY21/22: April-June 2022)

- House is fully occupied
- Individual interested in providing peer support is identified and receives extra training
- Evaluation process for somatic/alternative therapies is developed/finalized
- Website is launched to keep the community updated about progress

Year 1, Quarters 3 and 4: (FY22/23: July 2022-Dec 2022)

- Women in the house begin to be introduced to a variety of somatic/alternative therapies and evaluation process
- Partnerships with other organizations, housing providers, and other HHS programs are strengthened

Years 2-4: (Jan 2023-December 2025)

- Program is fully operational
- Annual Stakeholder Committee community presentations
- On-going evaluation
- Expansion of most highly recommended somatic/alternative therapies into other parts of the system in year 3

Years 5: (Jan 2026-December 2026)

- Q1/2 Determination of whether program will continue after the end of the Innovation Period using other funding. Determination will be made through the Community Planning Process looking at outcome data, occupancy, cost-effectiveness, client-feedback, and availability/prioritization of funding. Determination and continuity planning will be included in the FY2027/28 MHSA Annual Update/Three-Year Plan/planning process. MHSA Community Services and Supports (CSS) will be considered as will the potential of CalAim to potentially be a route for funding this type of approach depending on the implementation of that reform over the next five years.
- Ensuing housing and continued support for all residents will be the number one priority if continued funding is not planned for during Q3-4.
- Final evaluation report will be submitted to the OAC and shared broadly throughout the county and the state within 6 months of the completion of the Innovation project

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:

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

BUDGET NARRATIVE

This budget narrative goes line by line in coordination with the budget on the following pages to provide context and further explanation of the anticipated costs and budget items to fulfill the goals of the project. The budgets are estimates for planning purposes.

1. *Personnel salary costs are calculated for a county position of a full-time Licensed Mental Health Practitioner with benefits. This position is projected to bring in Federal Financial Participation (FFP) also known as Medi-Cal revenue when seeing clients in the house and the community. Services provided in the jail will not be Medi-Cal billable, so the projected revenue has taken that into account.*
2. *Direct costs associated with the position are calculated at 10% of the salary and benefits. These direct costs include operating costs tied directly to that position (finger printing and background checks, computer, mileage, cell phone, etc.).*
3. *The indirect costs are calculated at 15% of the costs after revenue which will go toward funding the portion of county indirect services such services as Human Resources, Payroll, Compliance, etc.*
4. *Total Personnel costs represents the total MHSA Innovation covered portion of the Personnel Costs (i.e. total cost minus the revenue offset projection that would be funded with Federal Medi-Cal FFP funding.)*
5. *Direct Costs includes the estimated costs for rent for the house, utilities, repairs, and maintenance costs, a half-time house manager who is budgeted at $25/hr, plus 28% benefits, and 10% operating costs including training, cell phone, etc), a Peer Stipend of approximately $650/month (plus free rent/utilities, as well as training and Peer Specialist Certification support through MHSA Workforce Education and Training funding if needed) for a peer who would also be living in the house, an activity fund of approximately $9,000/year which would include funding for groceries for the weekly Sunday dinners (and general nutrition/healthy snacks for groups) as well as for special activities and outings.*

Also included in direct costs would be vehicle maintenance and gas costs for a program van. These are the numbers that were used for budgeting but there would be flexibility to shift actual budget expenditures around as needed. The Direct Operating costs are planned to be contracted to a community-based organization through an RFP process. There is a budgeted 3% increase at the beginning of the third Fiscal Year across the direct costs.

6. *Indirect Costs are calculated at 15% and would be used to cover the indirect costs of the community based organization overseeing the house and for the county costs for contract management.*
7. *Line 7 of the budget is the total operating costs for the house/residential aspects of the program*
8. *In non-recurring expenses there is a projected budget for a program van which will be purchased by the CBO if needed. This van would be used for transportation including helping the women move in/out, for groups, and to help facilitate alumnae in returning to the house for activities.*
9. *Also in non-recurring expenses is a $5,000 budget for Trauma Informed minor modifications to the house/furniture. At the beginning there will be an assessment/walk-through of the space and strategizing on how to make it feel like a safe and healing environment.*
10. *Total non-recurring costs is the combined total costs of the van and the trauma informed improvements*
11. *There will be two types of consultants contracted with for this project (in addition to the Community Based Organization contracted to operationalize the house and supports there). The first consultant will be for Evaluation. Evaluation is a major part of all innovation projects. This project allocates 10.5% of the program costs on Evaluation with an expectation that there will be higher evaluation costs at the beginning of the project to set up the framework for the evaluation and the collection methods, as well as an increase for the last two Fiscal Years when there will be more data for evaluation that will be used to determine continuation of the project and develop final findings to be shared. The second type of consultant will be for the somatic, cultural, alternative, and wholistic therapies or modalities.*
12. *This line is for indirect costs for managing those contracts*
13. *Totals adding the consultant costs and the indirect costs*
14. *Stakeholder stipends for participation of the women and alumni from the project or other people with lived experience to participate in the Advisory Committee meetings, focus groups, or individual interviews for evaluation. Budgeted for $30 per meeting with an average of 7 stipends per month with additional stipends at the beginning and end for further evaluation interviews and focus groups.*

A total of 10.5% of program costs (calculated as the MHSA INN total minus the costs of evaluation) is budgeted for evaluation

A total of 14.5% of direct costs (calculated as the MHSA INN total minus the indirect) is budgeted for indirect.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*								
EXPENDITURES								
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
1	Salaries							
	Trauma Therapist (1.0 FTE) LMHP	$51,339	$105,758	$108,931	$112,199	$115,564	$59,516	**$553,307**
	Benefits	$27,620	$56,898	$58,605	$60,363	$62,174	$32,019	**$297,679**
	FFP Revenue Offset	($45,796)	($94,340)	($97,171)	($100,086)	($103,088)	($53,090)	**($493,572)**
2	Direct Costs	$7,896	$16,266	$16,754	$17,256	$17,774	$9,154	**$85,099**
3	Indirect Costs	$6,159	$12,687	$13,068	$13,460	$13,864	$7,140	**$66,377**
4	Total Personnel Costs	$47,217	$97,268	$100,187	$103,192	$106,287	$54,738	**$508,890**
OPERATING COSTS		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
5	Direct Costs							
	Rent for the House	$34,800	$69,600	$71,688	$71,688	$71,688	$35,844	**$355,308**
	Utilities, repairs, and maintenance costs	$7,000	$14,000	$14,420	$14,420	$14,420	$7,210	**$71,470**
	House/Support Manager (.5 FTE)	$18,304	$36,608	$37,706	$37,706	$37,706	$18,853	**$186,884**
	Peer Stipend	$4,500	$9,000	$9,270	$9,548	$9,270	$4,635	**$46,223**
	Activity/Nutrition fund	$5,000	$10,000	$10,000	$10,000	$10,000	$5,087	**$50,087**
	Vehicle maintenance, gas costs	$1,500	$3,000	$3,090	$3,090	$3,090	$1,545	**$15,315**
6	Indirect Costs	$10,666	$21,331	$21,926	$21,968	$21,926	$10,976	**$108,793**
7	Total Operating Costs	$81,770	$163,539	$168,100	$168,420	$168,100	$84,150	**$834,080**
NON RECURRING COSTS (equipment, technology)		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
8	Program Van	$36,000						**$36,000**
9	Trauma Informed modifications to the house/furniture	$5,000						**$5,000**
10	Total Non-recurring costs	$41,000						**$41,000**

CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 21/22 (6 months)	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27 (6 months)	TOTAL
11	Evaluation Costs	$35,000	$20,000	$15,000	$15,000	$35,000	$50,000	**$170,000**
	Somatic, Alternative, Wholistic, or Cultural therapy/activity contract	$15,000	$30,000	$30,000	$40,000	$40,000	$20,000	**$175,000**
12	Indirect Costs	$7,500	$7,500	$6,750	$8,250	$11,250	$10,500	**$51,750**
13	Total Consultant Costs	$57,500	$57,500	$51,750	$63,250	$86,250	$80,500	**$396,750**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
14	Stipends for stakeholder representatives	$2,100	$2,520	$2,520	$2,520	$2,520	$2,100	**$14,280**
15								
16	Total Other Expenditures	$2,100	$2,520	$2,520	$2,520	$2,520	$2,100	**$14,280**
BUDGET TOTALS		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
Personnel (line 1)		$33,163	$68,316	$70,365	$72,476	$74,650	$38,445	**$357,414**
Direct Costs (add lines 2, 5 and 11 from above)		$129,000	$208,474	$207,928	$218,709	$238,948	$152,328	**$1,155,386**
Indirect Costs (add lines 3, 6 and 12 from above)		$24,324	$41,518	$41,744	$43,678	$47,040	$28,616	**$226,920**
Non-recurring costs (line 10)		$41,000	$0	$0	$0	$0	$0	**$41,000**
Other Expenditures (line 16)		$2,100	$2,520	$2,520	$2,520	$2,520	$2,100	**$14,280**
TOTAL BUDGET		**$229,587**	**$320,827**	**$322,557**	**$337,382**	**$363,158**	**$221,488**	**$1,795,000**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
ADMINISTRATION:								
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
1	Innovative MHSA Funds	$24,324	$41,518	$41,744	$43,678	$47,040	$28,616	**$226,920**
2	Federal Financial Participation							
3	1991 Realignment							
4	Behavioral Health Subaccount							
5	Other funding*							
6	**Total Proposed Administration**							
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 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
1	Innovative MHSA Funds	$35,000	$20,000	$15,000	$15,000	$35,000	$50,000	**$170,000**
2	Federal Financial Participation							
3	1991 Realignment							
4	Behavioral Health Subaccount							
5	Other funding*							
6	**Total Proposed Evaluation**							
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 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
1	Innovative MHSA Funds	**$229,587**	**$320,827**	**$322,557**	**$337,382**	**$363,158**	**$221,488**	**$1,795,000**
2	Federal Financial Participation	$45,796	$94,340	$97,171	$100,086	$103,088	$53,090	$493,572
3	1991 Realignment							
4	Behavioral Health Subaccount							
5	Other funding*							
6	**Total Proposed Expenditures**	$275,383	$415,168	$419,728	$437,468	$466,246	$274,578	$2,288,571

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