

**Exhibit A  
INNOVATION WORK PLAN  
COUNTY CERTIFICATION**

**County Name:** Kern

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

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

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

  
 \_\_\_\_\_  
 Signature (Local Mental Health Director/Designee)

07/08/09  
 \_\_\_\_\_  
 Date

Director  
 \_\_\_\_\_  
 Title

**Exhibit B  
INNOVATION WORK PLAN**

**Description of Community Program Planning and Local Review Processes**

**County Name:**     Kern      
**Work Plan Name:**     The Freise HOPE House    

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

**1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input.**

The MHSA Support Team, consisting of the MHSA Coordinator, MHSA Analyst, and MHSA Support Staff reviewed recent and past MHSA community program planning processes to identify innovative ideas or needs discussed among stakeholders, and analyze trends in input for projects that met the MHSA Innovations guidelines. A MHSA Workforce completed a robust planning process for the initial Community Services and Supports (CSS) component of MHSA. In summary, a total of 45 focus groups were conducted by MHSA staff in locations throughout Kern County, two of which were held in Spanish. Over 400 individuals across age groups, including many mental and behavioral health consumers and family members, participated in these focus groups.

Mental health staff assisted over 800 individuals of all age and cultural groups in completing a survey process. Additionally, mental health providers conducted a total of 1,673 short surveys, in both English and Spanish, with community members interested in commenting on how to improve local mental health services.

Major community issues identified through the CSS community planning process included:

- A lack of services for co-occurring mental health and substance abuse needs
- Peer-run/Peer-operated services
- Intensive services to high risk adults
- Need for self-help and support groups

Further, survey results indicated that the Most Needed Services include:

- Crisis stabilization
- Residential options for adults
- Transitional services for 16 to 25 year olds
- Family support groups
- Ongoing support/recovery services

Following the analysis of the CSS and the more recent Workforce, Education, and Training (WET), and Prevention and Early Intervention (PEI) community program planning processes, a group of fifteen stakeholders, representing mental health and substance abuse consumers, family members, and individuals who have been underserved and underserved in our community, participated together in an Innovation (INN) component stakeholder meeting held at the local Mental Health Consumer/Family Learning Center (further details below).

The INN stakeholders were introduced to the MHSA Innovation component, reviewed the INN guidelines, and discussed potential innovative project ideas identified in previous MHSA community program planning processes. Discussions took place regarding trauma-informed treatment, peer-run crisis residential program to include follow-up aftercare, children's programs, walk-in clinics, first-break services, non-traditional alternative treatment, and collaborative relationships between primary physical health and mental health providers.

The group reviewed each idea from past stakeholder meetings as well as their own, compared the data, and discussed which programs would best contribute to learning for the Mental Health system in California. Stakeholders unanimously agreed that the best use of these funds currently would be in the development of a peer-managed crisis residential program to serve both as a short-term, "step-down" program for adults following the immediate need for inpatient hospitalization of an acute psychiatric episode, and as a means of crisis stabilization to avoid an acute psychiatric episode which would warrant a need for hospitalization.

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

- Mental health consumers in recovery
- Family members of consumers of mental health and substance abuse treatment
- Members of the local NAMI (National Alliance on Mental Illness) chapter
- Local homeless shelter representatives
- Mental health providers, including those representing crisis services, adult outpatient treatment, children’s services, judicial services, contract providers, and MHSA programs
- Representatives from the LGBTQ community
- The ethnicity of our stakeholder participants were as follows:

<b>Ethnicity</b>	<b>Number of Participants</b>
Caucasian/White	7
Hispanic/Latino	6
Native American	2

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

The Plan was posted for no less than 30 days on the public mental health site and mental health system of care intranet (available to all mental health/substance abuse department and contractor staff) beginning April 15, 2009. Additionally, the plan was sent out via email to our broad MHSA Stakeholder/Interested parties email list. The plan was sent to clinics and teams throughout Kern County for display to staff and clients. The news of the posting of the plan was shared at the following meetings:

- ❑ Change Agents (group of mental health department, contracted mental health and substance abuse treatment, and community provider staff, consumers, and family members from metro Bakersfield as well as outlying Kern County areas)
- ❑ Behavioral Health Board
- ❑ Behavioral Health Board Subcommittees (Adult and Children's Treatment and Recovery Services, Housing Services, Prevention Services, System Quality Improvement)
- ❑ County Mental Health Cultural Competency Committee
- ❑ County Expanded Management Meeting (includes all County Mental Health Supervisors and Administrators)
- ❑ Contract Providers CEO Committee (community-based mental health and substance abuse treatment providers)
- ❑ Dual Diagnosis Steering Committee
- ❑ NAMI (General monthly meeting, Board meeting, support groups, youth Outspoken Young Minds conference)

Following the 30-day comment period, the Plan was presented at the local public Behavioral Health Board meeting on May 18, 2009, as well as to the public Board of Supervisor's meeting on May 19, 2009.

The MHSA Support Team received positive feedback from several stakeholders regarding the written Innovation Plan. One question was posed from a service provider regarding facility details. One substantive comment was made regarding the timeline allotted in the original Plan proposal. The original posted Innovation Draft Plan indicated a two-year timeline for implementation and evaluation of the project. However, after further evaluation of all the program elements necessary, and the time needed for service delivery with consumers to accurately evaluate program efficacy as well as system changes resulting from, the project timeline increased to a four-year period.

**Exhibit C****Innovation Work Plan Narrative****Date:** July 8, 2009**County:** Kern**Work Plan #:** 1**Work Plan Name:** The Freise HOPE House**Purpose of Proposed Innovation Project (check all that apply)**

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

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

The stakeholder group reviewed each of the four above purposes and felt that the best Innovation projects would be able to address all four purposes. In today's service setting providers and clients greatly benefit from all of the above. For these reasons and more, the group chose a project that would effectively address each of these purposes. However, the main purpose of the project and key focus for learning is increasing the quality of services, including better outcomes for the clients who are served in this program, as well as for the system at large. We will briefly describe how this project addresses these issues below.

The Freise HOPE House will be available to all adult individuals, regardless of voluntary status, race, ethnicity, sexual orientation, or other population affiliations of those that are most un-served and underserved in all parts of Kern County.

Research is just beginning to show that mental health services provided by individuals who have personal or "lived" experience with mental illness are effective and can produce more positive outcomes than traditional services. Consistent with some of the literature, we will use the term "peer" to define a person who has personal experience with mental illness and recovery, or is a family member of an individual with a mental illness. The Freise HOPE House project intends to further contribute to learning about peer-provided services and how they can apply in a crisis residential treatment services setting to increase the quality of services and outcomes for those participating.

Interagency collaboration will exist as the selected provider(s) of this program interface directly with the County mental health department at the front door to crisis services. Peer staff will collaborate with psychiatrists and other mental health providers to assist with assessment and referral of individuals appropriate for this intermediary level of crisis intervention and stabilization. The creation of this program will also allow for increased collaboration between the Department and community providers both in Mental Health and other public service agencies.

Previously in Kern County, options for individuals seeking County assistance in a psychiatric crisis included either inpatient hospitalization at a locked facility, or a 23-hour

crisis unit for stabilization of those needing a higher level of intervention while not meeting the criteria for inpatient care. The Freise HOPE House allows for crisis stabilization for those whose symptoms require a higher level of care than traditional outpatient services, but do not require the highest level of intervention by a locked psychiatric hospitalization unit. The Freise HOPE House intends to increase individuals' access, including those previously unserved, underserved, and inappropriately served, to needed services in a timely manner.

## **Innovation Work Plan Narrative**

### **Project Description**

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

The innovation of the Freise HOPE (Helping Others through Peer Empowerment) House project includes management of the program by trained peers, called Peer Specialists, and program focus on the Recovery principles of Encouragement, Empowerment, Strength, and Community Integration. The name, Freise HOPE House, was chosen by Innovation stakeholders to represent both the history of the building and the current program focus to instill hope and long-term recovery. Minnie Freise, a registered nurse, developed Miss Freise's Maternity Hospital in the early 1900s. She delivered thousands of babies in this hospital. The Freise facility remains intact and has been a well-established and known location in Bakersfield, as many current residents of Kern County were born in Miss Freise's Maternity Hospital. The hospital consistently held an excellent reputation with the community, and we believed it was important to keep that history with the building. Additionally, as the original intent of the Freise building/maternity hospital was to bring in new life, the Freise HOPE House intends to encourage and empower individuals to, in many instances, begin a new life of recovery from the negative impact of their mental illness.

A local non-profit social service organization, Bethany Services currently owns the Freise facility. We anticipate contracting with Bethany Services to assist mental health consumers with developing the skills to obtain suitable housing, employment, and increase community and social supports. The original plan included a 16-bed Crisis Residential paired with a 16-bed Adult Residential facility co-located on the same campus to further help transition consumers entering the program. However, in order to best address our primary learning goal, we will begin one type of program, the Crisis Residential program, and look toward the additional Adult Residential component later as a possible new innovation and contribution to learning. Additionally, to utilize space most effectively (i.e. larger community rooms for consumers to socialize together, or exercise and activity spaces) for this recovery-oriented program, the number of individual beds may be decreased from our originally anticipated 16 beds to 12 beds.

This project creates several potential positive changes in mental health services, including improved outcomes, cultural competency, and a reduction in the disparity of access to mental health services. This program will better incorporate recovery into the treatment of all persons currently in, or shortly following, a psychiatric crisis. Recovery-oriented interventions will take the place of the strictly traditional medical model of crisis treatment. A preliminary study (Greenfield et al., 2008) examined a consumer-managed, crisis residential program and indicated significantly greater improvement on interviewer-rated, self-reported psychopathology, and service satisfaction than did a traditional, mental health professional-managed inpatient psychiatric facility.

Because the facility and program will be managed and run by peers in recovery, we expect that the development and modification of program design will come largely from their experiences and modified to fit the cultures and persons participating in the program. We will work to increasingly serve our underserved populations in Kern, including transition-aged youth, older adults, and individuals of Hispanic or Latino ethnic origin. Population estimates, for example, in 2005-2007 indicate that 45.1 percent of individuals in Kern County are Hispanic or Latino. A recent report (Individuals Served Demographic Profile: FY 2007-2008) indicated that 37.71 percent of individuals served by Kern County Mental Health are of Hispanic or Latino ethnic origin. Our intent is to build the number of peer staff who are culturally and linguistically able to address the needs of these consumers. Historically, it has been difficult to recruit employees who are Latino, can communicate fluently in Spanish, and who are mental health consumers in recovery. This will serve as another object of learning as the project develops. We anticipate that we will learn how to most effectively outreach and train peer employees from our underserved populations, and how to incorporate culturally appropriate recovery principles into the program design. We anticipate that, as in what appears to be shown in the initial research on consumer-run programs, that consumers of this crisis residential program will experience increased positive outcomes from working directly with individuals who have “walked in [their] shoes”.

In addition to traditional treatment models focusing on medication management and thus psychiatric stabilization, the Freise HOPE House project will incorporate Brief Solution-Focused psychotherapeutic principles into the treatment design. This evidence-based treatment philosophy (shown effective with individuals of various cultural and ethnic origins) emphasizes that individuals with severe mental illness are capable of making choices about their behavior, and that symptoms do not necessarily cause a person to behave in a certain negative way (i.e. harming oneself or another, use of substances, or committing crime). Research (O’Hanlon and Rowan, “Solution Oriented Therapy for Chronic and Severe mental illness”) found that focusing on the aspects of a person’s life where one has choices increases one’s sense of accountability, or “personal agency”. Personal agency means that a person feels they are an active agent in their life, rather than a passive victim of it. Therefore, a great potential impact of the Freise HOPE House will be significantly improved outcomes, including self-satisfaction with service, improved psychiatric health, and reduced recidivism of homelessness and need for higher levels of care.

This recovery-based program will include emotional regulation types of activities, such as meditation, exercise classes, and maintenance of the ground’s garden. Consumers will receive assistance with skills to obtain stable, permanent housing to reduce the risk of homelessness, and maintain long-term recovery and self-sufficiency. System outcomes expected include cost-efficiency in reducing inpatient psychiatric hospitalization and recidivism.

Another component of this innovation identified by the Innovation stakeholder group includes integrating Freise HOPE House peer staff with the County Mental Health Department Psychiatric Evaluation Center (PEC), identified as the emergency psychiatric receiving facility for County residents. Peers will work directly with PEC mental health staff, Psychiatrists, and Psychiatry Interns to assist in crisis stabilization

and referral for the Freise HOPE House for individuals when indicated. This creates a positive change in the mental health system through increased collaboration between mental health professionals, peers, and consumers in crisis. In addition, we will include peer staff at all levels of the mental health system for this project to decrease the differentiation between specifically “peer” and “professional” mental health providers. In conclusion, the Freise HOPE House project supports and is consistent with the General Standards identified in the MHSA (CCR, Title 9, Section 3320):

- Community Collaboration – consumers and members of the community will come together to promote long-term recovery, using both traditional mental health practices proven effective, and non-traditional practices to promote wellness of mind and body
- Cultural Competence – improved access to culturally appropriate mental health programs and interventions for previously underserved or inappropriately served individuals and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups
- Client and Family-Driven System – consumers and family members will be involved in all stages of programming, including needs assessment, resource development, implementation, and evaluation
- Wellness, Recovery, and Resilience Focused – program and interventions are designed with an understanding that recovery is possible, and that individuals with a severe mental illness can make positive and powerful changes
- Integrated Service Experience – consumers will be encouraged and able to participate in a full range of services provided by the Freise HOPE House provider(s), County mental health department, and a variety of community partners to assist with each consumer’s stabilization and progress toward recovery

## **Innovation Work Plan Narrative**

### **Contribution to Learning**

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

An Innovation project is defined by regulation as one that contributes to learning rather than a primary focus on providing a service. This Innovation project is expected to contribute to learning in the following ways:

- Makes a change to an existing mental health practice/approach
- Introduces a new application to the mental health system of a promising community-driven practice/approach

Crisis residential and/or adult residential programs are not, in and of themselves, new to the public mental health system. However, the concept of consumers managing and facilitating these programs while assisting consumers in crisis is a new practice/approach for the public mental health system.

Mental health consumers are reported to operate or play a significant role in a wide range of programs, including self-help groups, drop-in centers, clubhouses, independent living centers, advocacy organizations, case management services, supported housing, and information and referral lines (Greenfield et al., 2008). Research indicates that consumers are reporting a value of consumer-managed mental health programs, as are the consumers and family members in Kern County. However, the research also states that there is a great need to obtain evidence-based data to substantiate this claim. The Freise HOPE House introduces new practices/approaches through the consumer-managed and recovery-oriented program design within the crisis residential program.

The term “Peer Specialist” refers specifically to staff who themselves have personally experienced mental health and/or substance use challenges and have received treatment for those issues. We plan to sub-contract with Recovery Innovations of California, an organization with extensive experience in developing recovery-based programs. One of the key components of the Recovery Innovations service model has been the training and employment of a peer workforce. The peer staff will have completed the Recovery Innovations 80-hour Peer Employment Training course and be hired to work in the discipline of Peer Support.

Peer Support Specialists and Peer Support Educators will:

- Develop recovery partnerships to help participants manage distressing feelings and behaviors
- Offer hope and encouragement from the perspective of personal lived experience to engage each participant in a personal recovery journey
- Use Recovery Coaching to help each participant with a Discharge Plan

to plan and use the community connections after leaving the HOPE House

- Provide general house supervision and support including helping participants with daily living skills as needed
- Facilitate recovery education classes such as Wellness Recovery Action Plan (WRAP), Wellness and Empowerment in Life and Living (WELL), Medication for Success, Home is Where the Heart Is
  - Key components of these are community supports including family and friends. Including these supports throughout their stay in the facility as well as thereafter is a key component of recovery.

Additionally, the integration of Peer Specialists working alongside mental health staff at the County crisis intake center (PEC) provides great potential for adding to the literature on quality of care for individuals in crisis. The project emphasizes utilizing peer staff in new ways to improve outcomes. There are typically large divides between professional crisis care and peer support, and this type of program may serve to expand recovery in the overall system of care, as well as eliminate the, often negative, stigma and differentiation between peer staff and professional staff within the system. Peer staff from all levels of mental health personnel will be encouraged for this Innovation project. The project's Program Director, for example, is a peer in recovery and holds a Masters degree in Social Work. She has been a part of the Recovery Innovations team for seven years and currently oversees contracts for peer-run services in San Diego and Ventura Counties. We anticipate that we will learn how peer staff will improve personal outcomes, as well as system outcomes by building on the philosophy that not only work experience and education are valuable to the mental health profession, but that "lived" experience with mental illness and recovery is also extremely valuable to the profession and to consumers in the public mental health system of care.

Additional program personnel include appropriately licensed clinicians, such as a Licensed Marriage and Family Therapist, Clinical Social Worker, or Psychologist, and registered nurses and psychiatrists to address the physical and mental health medical needs, as required by Community Care Licensing for Crisis Residential programs. A Project Administrator will provide on-site oversight of the program, with clerical assistance from an Office Manager. A Food Services Supervisor will coordinate the functions required for all meal needs. The Regional Vice President for Recovery Innovations California, will direct the project, hire peer staff for the program, and supervise the Project Administrator.

Generally, Peer Support Specialists who are new to the mental health workforce begin in part-time positions. As they gain experience they often choose to move to full-time employment. All peer staff are required to have one hour of supervision for every 40 hours worked. In addition to the intensive 80-hour Peer Employment Training required by all peer employees, additional tools like "Advanced Peer Training" and "Wellness Recovery Action Plan (WRAP) for Work" are used to assure success. The Recovery Innovations success in developing a competent and successful peer workforce has been documented by evaluation studies. Conducted by Boston University Center for

Psychiatric Rehabilitation one study published in *Psychiatric Rehabilitation (2006)* found that 89% of peer support employees successfully retained peer employment for one year or more. Another study by Recovery Innovations found that the rate of crisis service use by peer employees dropped from 12.3 events the year before employment to 2.3 events in the year of employment. In fact, working and “giving back” has proven to be one of the most significant contributors to individual recovery and reduced symptoms and relapse. Any additional support the working peers may need will be provided to ensure their continued success in recovery as well as that of the program.

All staff will be trained in the six dimensions of wellness: physical, emotional, intellectual, spiritual, social, and occupational. Each program participant’s Recovery Plan will explore all these dimensions of wellness, and in each dimension specific education and interventions will be defined. In the Recovery Innovations Peer Employment Training program a dedicated module on co-recovery from mental health and substance abuse provides a framework for working with others with co-occurring challenges.

**Innovation Work Plan Narrative**

**Timeline**

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

Implementation/Completion Dates: 07/09-07/13  
MM/YY – MM/YY

We anticipate that The Freise HOPE House project will be able to start toward the beginning of fiscal year 2009-2010. An appropriate facility, owned by Bethany Services, a community partner organization, is available and currently vacant. Some renovations will be needed to meet licensing requirements for this type of program and to best suit the program logistics (common entrance moved away from front of facility facing the street, increased number of common rooms for consumers to interact together and with their visiting family, friends, and community, and participate in classes).

We anticipate that four years will provide a sufficient amount of time to assess and evaluate the program's efficacy. It is possible that one additional year may be needed in order to more accurately correlate program variables to outcome results. However, we do anticipate that during this period of time, we will be able to complete facility preparations, develop system infrastructure and program design elements, hire and train staff, serve consumers, measure outcomes, and evaluate program results.

The program has two key learning goals: 1.) Evaluate whether or not a peer-managed program provides more positive and long-term outcomes for consumers and 2.) Whether or not the increased peer support integration provides increased recovery-focus for the system at large. The first goal is rather straightforward and could be understood after a year or two of program implementation. However, we believe the second goal will provide the greatest contribution to learning for the Public Mental Health system in the state. This goal will take more than our requested timeline, but we hope that four to five years of implementation will provide initial insight into the effects this type of program and collaboration will have on the system. It will take at least this amount of time for the program and its principles to take root into the system and help transform traditional beliefs from the value of the "professional" prescribing what consumers need to valuing the mental health provider with personal experiences of mental illness and recovery working alongside the mental health consumers in the public mental health system of care.

Program provider(s) and mental health department personnel will review and assess outcomes twice per year during program implementation. Project implementation planning will include development of an Innovation Advisory Committee using outreach to interested stakeholders. Kern County Mental Health is committed to ensuring that the Innovation Advisory Committee reflects the diversity of our Kern County community,

including individuals from African-American, Hispanic, Native American, and Asian ethnicities, and individuals from diverse age and cultural groups, including but not limited to transition-aged youth, older adults, faith-based groups, and LGBT (lesbian, gay, bisexual, transgendered). These stakeholders will be encouraged to participate in the review and evaluation of program goals, project focus, intervention provided, and results based on a number of outcomes measured. Any possible non-critical adaptations made will follow from this type of review and assessment process.

Should any immediate INN workplan design changes be required (i.e.: for safety reasons), stakeholders will be informed via electronic communication, and direct contact through Behavioral Health Board subcommittee meetings (Adult and Children's Treatment and Recovery Services, Prevention Services, Housing Development, and System Quality Improvement). The local Behavioral Health Board includes volunteers from various backgrounds and professions, including individuals who are or have been mental health and and/or substance abuse treatment consumers and family members, and representatives from professions, such as business, law enforcement, and education. The Board functions in a few capacities: to advocate for individuals and families living with mental illness and/or addiction, provide support to and oversight of the Mental Health Department, and to make recommendations about Department decisions to the County Board of Supervisors. Feedback will be encouraged throughout the duration of the project and included in the reviews and assessment by the Innovation stakeholder Steering/Advisory Committee. This timeframe will be sufficient to assess the feasibility of replication of the project.

## **Innovation Work Plan Narrative**

### **Project Measurement**

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

There are a number of measurements that will be in place for this project at both the System and Client levels.

#### **System-Level Outcomes:**

- To improve quality of services for clients by creating and improving the use of recovery principles at every level of the organization.

Indicators:

- Increased understanding of recovery by Mental Health professionals as a result of integration of peer staff from all levels of the public mental health system
- Improved collaboration between local community supports and the Public Mental Health System of Care
- Reduced mental health stigma and discrimination
- Reduced cost for crisis care
- Fewer involuntary hospitalizations
  - From work with peer specialists at PEC

#### **Person-Level Outcomes:**

- People will recover and become stable following a crisis

Indicators:

- Reduced recidivism
  - Crisis Center use
  - Jail
  - Hospitalization
  - Homelessness
- ◆ Increased, long-term integration into the community
- ◆ Improved satisfaction with crisis residential care

We will assess these outcomes using a variety of measures including Key Events, intake/discharge assessments, and other recognized measures. While all tools and measurements are not completely established for use in this project, it is likely that most

if not all of the following tools would be used: The Milestones of Recovery Scale (MORS), Recovery Attitudes Scale, and Recovery Promoting Relationships Scale.

All information gathered will be reported to stakeholders and the community. Stakeholders will be asked to review and make comments/suggestions, including any recommendations to improve the project itself, as well as increase positive outcomes for consumers and the overall public mental health system.

**Innovation Work Plan Narrative**

**Leveraging Resources (if applicable)**

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

List of resources expected to be leveraged:

- Community partnerships with organizations typically outside the mental health system
- Expansion of the use of community resources
- Interagency collaboration and partnership

The Freise HOPE House project allows for extensive leveraging of resources. A local non-profit social service organization specializing in domestic violence and homeless shelter care and services owns property that appears to meet the needs of this project. We anticipate that the two facilities on this property will serve as the Freise HOPE House campus.

Collaboration and partnership will take place between Bethany Services, Recovery Innovations, Kern County Mental Health, and other community organizations to assist consumers in all areas of wellness and recovery from mental illness or co-occurring mental illness and substance abuse.

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

**County Name**

Kern

**Annual Number of Clients to Be Served (If Applicable)**

125

**Work Plan Name**

The Freise HOPE House

**Population to Be Served (if applicable):**

Persons (ages 18+) requiring direct care as a result of an acute psychiatric episode or crisis when medical complications are not present. Persons (ages 18+) who are at imminent risk of an acute psychiatric episode or homelessness due to unfortunate life circumstances. Specific attention will be given to increasing access to services for individuals from unserved and underserved ethnic and cultural populations.

**Project Description:** Provide a concise overall description of the proposed Innovation.

The Freise HOPE (Helping Others through Peer Empowerment) House is a consumer/peer-managed, short-term, recovery-oriented, 24-hour crisis residential program. The Freise HOPE House will provide 14 Crisis beds in a “step-down” progression from inpatient hospitalization. The Freise HOPE House will provide a natural flow for consumers to transition successfully back into the community.

This program focuses on the Recovery principles of Encouragement, Empowerment, Strengths-focused, and Community Integration. The project’s two key learning goals include:

1. Evaluate the impact of a peer-managed program on immediate and long-term outcomes for consumers
2. Evaluate the impact of increased peer support integration on a recovery-oriented focus for the entire public mental health system

# Kern County Budget Narrative

## MHSA Innovation

The operation of The Freise HOPE House crisis residential program is being sized according to anticipated sustainable Innovation funding. The allocation being applied for at this time consists of the combination of FY 2008-2009 and FY 2009-2010 available funding, \$2,254,600. Kern County Mental Health will provide administrative oversight of the project. This will include personnel to meet regularly with contract providers and other project personnel to develop the project, assess ongoing implementation status, and evaluate and report status of the project with stakeholders, the community, and to the State Department of Mental Health and the MHSA Oversight and Accountability Commission.

The majority of funding will be allocated for contract providers to host the project, provide program staff, staff training, and partner with Recovery Innovations to program design and implementation. We intend to contract with Bethany Services for providing the facility and specific program components related to consumer housing support, employment, education, community connections and support, and community events. Additionally, Recovery Innovations will be providing a consumer personal wellness program, recovery learning opportunities, and community linkages.

### Estimated Kern County Mental Health Personnel

#### **Employee Salaries and Wages**

Although each KCMH employee participating in this project are full-time employees (FTE), each person's time given to the INN project will be integrated with other responsibilities and projects. Although we know that a portion of time will be committed to oversight responsibilities, it is difficult to identify exact percentages of time allotted for each individual FTE position. The KCMH positions involved in the ongoing planning, development, and implementation oversight include:

(1) Director, (1) Administrative Services Officer (Finance), (1) Department Analyst, (1) Unit Supervisor (UR), (1) Recovery Specialist, (1) Mental Health Administrator/Innovation Coordinator, (1) Accountant, (1) MHSA Coordinator, (1) Contracts Supervisor, (1) Office Services Technician

#### Operating Expenses

Operating expenditures include all expenses for travel, office occupancy, office supplies and equipment, program services and supplies.

#### Non-recurring Expenses

In this initial phase of operation of The Freise HOPE House project, there are expenses that will be incurred that we anticipate being one-time expenditures. Thus far in project planning, we are aware of facility renovation needs to best suit the program design. Additionally, we anticipate possible facility adaptations to meet Community Care Licensing requirements. We are allocating funds to leverage with contract provider funds to complete any renovations needed.

Estimated Community Contract Provider Personnel:  
**Employee Salaries and Wages**

**Project Administrator (1) FTE**

The function of this position will be to provide on-site oversight of the program, including, but not limited to program coordination with staff and supervision for peer employees.

**Office Manager (1) FTE**

The function of this position will be to provide clerical program support and assistance to the Project Administrator.

**Food Services Supervisor (1) FTE**

The function of this position will be to coordinate all requirements for meals and nutrition services.

**Shift Coordinator (4.2) FTE**

This position will be covered by licensed personnel (psychotherapist and/or psychologists, nurse) to coordinate and assist with facilitating recovery educational and therapeutic program elements, as well as assist with supervision of unlicensed staff.

**Peer Support Specialist (6) FTE**

The function of this position will be to interface directly with program participants/consumers, to develop recovery partnerships with them, assist with Recovery and Discharge planning, provide general house supervision and support, and facilitate recovery education classes.

**Peer Support Educator (1) FTE**

The function of this position will be to coordinate and facilitate recovery education classes.

Operating Expenses

Operating expenditures include all expenses for travel, office occupancy, office supplies and equipment, program services, and program supplies.

**FY 2009/10 Mental Health Services Act  
Innovation Funding Request**

County:                     Kern                    

Date:           7/8/2009          

Innovation Work Plans			FY 09/10 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
No.	Name	Children, Youth, Families		Transition Age Youth	Adult	Older Adult	
1.	1 Fresie HOPE House	\$1,899,706	\$0	\$284,956	\$1,424,780	\$189,971	
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26.	Subtotal: Work Plans	\$1,899,706	\$0	\$284,956	\$1,424,780	\$189,971	
27.	Plus County Administration	\$154,894					
28.	Plus 10% Operating Reserve	\$200,000					
29.	Total MHSA Funds Required for Innovation	\$2,254,600					

