Kern County Mental Health Department

Working together toward Hope, Recovery and Independence

MENTAL HEALTH SERVICES ACT (MHSA)

Innovation (INN) Component

July 2009

Exhibit A
INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: Kern

County Mental Health Director	**Project Lead**
Name: James A. Waterman, Ph.D. Telephone Number: 661-868-6609 E-mail: jwaterman@co.kern.ca.us	Name: Jennifer Sinnette, LMFT Telephone Number: 661-868-6813 E-mail: jsinnette@co.kern.ca.us
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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.

	07/08/09	Director
Signature (Local Mental Health Director/Designee)	Date	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 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 un-served 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:

Ethnicity	Number of Participants
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 experience with mental illness are effective and can produce more positive outcomes than traditional services. The Freise HOPE House project intends to further contribute to the learning about consumer 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. Consumer staff will collaborate with psychiatrists and other mental health provider professionals 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 were 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 MHSA 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 Consumers/Peer Specialists and a treatment 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 join together for providing the needed 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. 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 persons in recovery from mental illness, we expect that the development and modification of program design will be 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% of individuals in Kern County are Hispanic or Latino. A recent report (Individuals Served Demographic Profile: FY 2007-2008) indicated that Kern County Mental Health served 37.71% of individuals of Hispanic or Latino ethnic origin. Our intent is to build consumer peers 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.

The recovery-based treatment model 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. Services are designed to promote long-term recovery and self-sufficiency. System outcomes include cost-efficiency in reducing inpatient psychiatric hospitalization and recidivism.

Another component of this innovation identified by the Innovation stakeholder group is having consumer peer staff from the residential facility work also at the County Mental Health Department Psychiatric Evaluation Center (PEC), identified as the emergency psychiatric receiving facility for County residents. Peers will work directly with 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. It will also create more options for the Psychiatrists in the unit as they many times see clients who may not need the services of the locked facility but are not ready to be released on their own into the community.

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 professional staff at the County crisis intake center (PEC) provides great potential for adding to the literature on quality of care for individuals in crisis. 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.

Additional program personnel include appropriately licensed professionals, 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, an MSW professional, as well as a peer in recovery, will be responsible for hiring peer staff for the program, as well as supervise the Project Administrator. While it will not be a requirement that the licensed professionals be peers in recovery, that will be considered value added.

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 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 give us at least some 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 the focus of all staff working within the community mental health system from traditional treatment to a recovery model.

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 Steering or Advisory Committee using outreach to interested stakeholders. These stakeholders will include several types of individuals, including providers, consumers and family members, and individuals from un/underserved populations. These stakeholders will be encouraged to participate in the review and evaluation of program goals, treatment 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 critical changes be required, 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
  - Increased employment and integration of Peer Specialists into 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 for improving the project to better provide learning to the mental health community as well as increase positive outcomes for the system and the consumers being served by it.

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. Kern County Mental Health has already been approached by a local non-profit human/social service organization that owns property with two residential facilities appropriate for this type of program. The property may serve as the Freise HOPE House campus, and includes a home-like dwelling, with approximately 6-bed capacity, as well as a larger facility with approximately 28-bed capacity. The facilities hold additional rooms for office space, recreational areas, and a full kitchen. The facilities are located on a large, spacious lot that will be surrounded by a privacy fence. This lot provides ample space for sitting areas, recreational activities, and gardening. There is additionally a smaller utility building that could effectively house the commercial laundry equipment needed.

Increased collaboration and partnership is expected as the Freise HOPE House staff participates with mental health staff at the County crisis intake site.

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

County Name

Kern

Work Plan Name

The Freise HOPE House

Annual Number of Clients to Be Served (If Applicable)
125

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.

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

The Freise HOPE (Helping Others through Peer Empowerment) House is a consumer-managed, short-term, 24-hour crisis residential program. The Freise HOPE House will hold 12 Crisis beds in a "step-down" progression for consumers. The Freise HOPE House will provide a natural flow for consumers from intake to graduation back in the community.

This program provides an alternative to hospitalization in an effort to support individuals in restoring, maintaining, and applying interpersonal and independent living skills and access to community support systems. Services are designed to stabilize crisis, encourage successful transition back into the community, and promote long-term recovery and self-sufficiency.

Treatment focuses on the Recovery principles of Encouragement, Empowerment, Strengths-focused, and Community Integration. Consumer staff members encourage clients to participate directly with their treatment planning and goals. Interventions include medication management, stress reduction and interactive activities, promotion of overall physical and mental wellness, building community and social supports, skill building for daily living activities, and employment and housing coordination.

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. This amount exceeds the designed annual operating cost by $754,948, which will be needed in future years when annual allocations are expected to fall below $1,000,000. The entire excess will be held in the MHSA Trust until allocations decrease below annual operating costs, at which time it will be blended with the then available allocation to allow continued and unchanged operations of the program.

ESTIMATED PERSONNEL

Employee Salaries and Wages
Personnel expenditures include costs for:

Project Administrator 1FTE
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 1FTE
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.

EXHIBIT E5-INN Funding Request

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	$1,499,706	$0	$224,956	$1,124,780	$149,971
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22.							
23.							
24.							
25.							
26.	Subtotal: Work Plans		$1,499,706	$0	$224,956	$1,124,780	$149,971
27.	Plus County Administration		$0				
28.	Plus Operating Reserve		$754,894				
29.	Total MHSA Funds Required for Innovation		$2,254,600				

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Kern

Fiscal Year: 2009/10

Work Plan #: 1

Work Plan Name: Fresie HOPE House

New Work Plan ☑

Expansion ☐

Months of Operation: 07/09 - 06/10
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			1,122,952	$1,122,952
2. Operating Expenditures			376,754	$376,754
3. Non-recurring expenditures				$0
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$1,499,706**	**$1,499,706**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Operating Reserve	**$754,894**	**$0**	**$0**	**$754,894**
D. Total Funding Requirements	**$754,894**	**$0**	**$1,499,706**	**$2,254,600**

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