INNOVATIVE PROJECT PLAN  
RECOMMENDED TEMPLATE

<table>
<thead>
<tr>
<th>COMPLETE APPLICATION CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:</td>
</tr>
</tbody>
</table>

- ☐ 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 Title 9, Sections 3910-3935 for Innovation Regulations and Requirements)*

- ☐ Local Mental Health Board approval  
  Approval Date: June 8th, 2021

- ☐ Completed 30 day public comment period  
  Comment Period: May 5th – June 4th, 2021

- ☐ BOS approval date  
  Approval Date: June 22nd, 2021

If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: June 22nd, 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: N/A

*Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.*
County Name: Colusa

Date submitted: 4/30/2021

Project Title: Social Determinants of Rural Mental Health

Total amount requested: $498,812

Duration of project: Three years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. This document is a technical assistance tool that is recommended, not required.

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

Section 1: 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

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Social determinants such as unemployment, poverty, lack of formal education, adverse early life experiences, poor access to healthy foods, housing instability, lack of transportation, poor access to healthcare and stigma associated with mental illness influence the onset and course of mental illness especially for those individuals in rural communities. Colusa County is a rural county with a population of about 21,547 residents. More than half of the residents (60.4%) identify as Latino with Spanish being a threshold language. These social determinants impact the population of Colusa County regularly. Currently, the county is struggling with the highest annual unemployment rate in California at 15.9% compared to the state’s average of 8.4% (Employment Development Department, February 2021). Additionally, according to the U.S. Census Bureau (2019), approximately 15% of Colusa residents aged 25 or older have a bachelor’s degree or higher. This results in a labor force that is not diverse or able to create opportunities for advancement. It also increases the likelihood that residents are suffering from poverty. The National Rural Health Resource Center (2021) reported that 15% of children live in poverty. We often see that employment opportunities in the county are seasonal, labor intensive, and do not require a higher education level. These labor-intensive jobs also increase the chances that residents are more prone to experience medical issues. Over 24% of residents reported that they are in poor or fair overall health (National Rural Health Resource Center, 2021). Healthy food options are also a barrier in this rural community. According to the 2015 Nutrition and Food Insecurity Profiles for Colusa County, 58% of low-income households were
identified as food insecure. These are problems that need to be addressed in this community because social determinants impact outcomes for individuals with a mental illness and their families. By addressing social determinants, we can support mental health and wellness in the community.

The development for this project idea came from informal conversations with consumers and with individuals who are justice involved. In those conversations, community members highlighted the need for recovery-based interventions and rehabilitative services that attend to the basic human needs of consumers and address the impact of social determinants of mental health. They suggested that a study of social determinants in a rural community would contribute to learning and improved treatment outcomes in Colusa County. This project aims to target populations who have limited resources that contribute to social determinants of health and assist them in improving overall health and wellbeing.

PROPOSED PROJECT

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

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

The Social Determinants of Rural Mental Health Project (SDRMHP) is a project designed to examine and address some basic life factors that impact mental health for people in rural communities. Social determinants of mental health are currently being studied by the World Health Organization (WHO) and are part of the U.S. Department of Human Services Healthy People 2020 initiative. Attention is being paid to the social determinants of mental health in a public health approach to improve the lives of persons with mental illnesses. Understanding these basic determinants has the potential to improve mental health outcomes when applied appropriately as part of mental health interventions. The intent is to identify, support and stabilize life domains to improve the quality of life for persons who are experiencing or may be experiencing mental health issues. The basic social determinants to be studied will be:

1. Safe and secure housing
2. Access to healthy, nutritious food choices
3. Transportation access
4. Unemployment/income and social status/educational opportunities
5. Access to healthcare services/medical treatment
6. Social environment and natural supports
7. Geographical location and physical environment
Colusa County has decided to focus on the population of justice involved persons for this project. There are roughly 200 persons involved in the justice system in Colusa County. This includes people who fall under Assembly Bill (AB) 109, known as Realignment, which are offenders who are released from State Prison and are on Post Release Community Supervision (PRCS) and offenders released from County Prison who are on Mandatory Supervision (MS). In addition, this target population includes 21 parolees currently on State Parole and those individuals participating in the Day Reporting Center (DRC) in the County. This project would outreach and serve these individuals from these programs. Colusa County’s DRC, operated by Adult Probation staff, and Behavioral Health would like to support this population involved in the justice system through this Innovation project. The intention of the Innovation project is to outreach and engage all adults served by the Adult Probation Department in a manner that is not overseen by courts. This will be a voluntary program where the only criteria for entry will be a referral from the Adult Probation Department, or Parole Department with the agreement by participants to sign a Release of Information (ROI), allowing Innovation staff to collaborate with the referring agency.

Social determinants impact a person’s mental health which decreases the individual’s ability to reach their goals to improve their overall health and wellbeing. A Strengths Assessment (See Attachment A) will be used to identify barriers and challenges that prevent a person from reaching their goals. Information obtained from outreach and engagement efforts will be utilized to target highly individualized interventions to mitigate the challenges people experience. Engaging persons identified as having negative social determinants which impacts their mental health will allow for pragmatic solutions and specific interventions that are likely to improve treatment outcomes. The barriers experienced, treatment interventions, services provided, and outcomes achieved will be tracked and analyzed through our evaluation process.

This project will include two Mental Health Specialists and one Case Manager. The three positions will be under the direction of a licensed Therapist who interfaces with the DRC participants and Adult Probation. The licensed Therapist will be providing the Mental Health Specialists and Case Manager guidance and will complete an intake assessment if the project participants choose to make a formal request for mental health and/or substance use treatment. There is no requirement for participants to seek Specialty Mental Health Services (SMHS) or Alcohol or Other Drug (AOD) services. The Mental Health Specialists will be outreaching to individuals which will consist of offering a Strengths Assessment to identify areas that might be barriers to a successful integration back into the community. After the Strengths Assessment is completed, the Mental Health Specialist and Case Manager, at the direction of the Mental Health Specialist, will discuss the Strengths Assessment domains that the project participant has identified as needing some support. The participant will be asked to prioritize the Social Determinants that they feel would be most important to address for their overall health and wellbeing. The Case Manager will then focus on making appropriate community referrals to link the individual to identified agencies and resources needed to
remove social determinant barriers. For example, if a client recognizes that they are experiencing barriers to the social determinant of employment, then the Case Manager would contact the local One Stop to link the client to local job opportunities that will address that social determinant. If housing is an issue, then the Case Manager can explore housing and assist the participant in completing housing applications. If the participant is food insecure, then the Case Manager can link them to local food pantries and, if the participant qualifies, CalFresh benefits. While the Case Manager is linking the project participant to community resources to meet their needs, the Mental Health Specialist will reassess with the participant’s next steps and future needs. For example, if employment is identified as being in need, then the Mental Health Specialist can assist the participant with learning communication, social, and problem solving skills that are valued amongst employers. If housing is an issue, then the Mental Health Specialist can assist the participant in learning monthly budgeting skills to help secure stable housing. If the participant is food insecure, then the Mental Health Specialist can help improve their organizational skills for obtaining healthy food and meal planning if appropriate. The Mental Health Specialists and Case Manager’s intent is to help address the participants’ social determinants in need so that an adjustment to community life can be more successful.

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

Of the four general requirements, this project will focus on making a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Currently, Colusa County Jail inmates are provided treatment while incarcerated. However, upon their release interventions and treatment often prove to be limited. The change this Innovation project focuses on is after release. After release, former inmate can request help in any area of social determinants and not specifically focus on mental health treatment. This change can potentially reduce stigma around seeking and receiving professional help by encouraging them to engage in social determinants assistance.

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 identified approach was selected because it will increase outreach and engagement to unserved and underserved populations in the county. The project will address areas of social determinants that impact their health. The Strengths Assessment to be utilized is an appropriate intervention because it will allow the participants to identify the barriers in their current life circumstances. By using the Strengths Assessment tool that focuses on positive aspects of one’s life, it helps to balance negative cognitions or emotions that may arise when insufficient social determinants to good health are also identified. Linking project participants to community resources to assist in improving those areas of social determinants will lead to an outcome of improved wellbeing. While participants are making this positive adjustment in the community, if they identify Specialty Mental Health Services (SMHS) and Alcohol or Other Drugs
(AOD) services may be needed, then the services will be available at no charge to the participant.

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

This program is expected to serve about 150 individuals annually. This was determined by the average number of clients seen by our Mental Health Specialists (MHS) annually. Our MHS serve an average of 50 clients with longer treatment episodes. Therefore, a case load of 150 was identified for the Innovation project because these individuals will have shorter engagement episodes. The Innovation staff will be outreaching to about 50 new persons through the course of each year, or about four new persons each month, while continuing to serve the participants from previous months. This will total about 150 persons involved in outreach and engagement.

**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 to be served will consist of those who are unserved and underserved. The primary population will be adults 18 years and older who are identified as being recently involved in the justice system or other community members who struggle with social determinants of health. Both genders, female and male, will be served. We will also pay particular attention to the Latinx, Spanish-speaking population to be served in this program. This is due to the fact that this population makes-up the majority of the county’s population. There are also approximately 59% of individuals who identify as Latinx involved in Colusa County Probation and parole. The program will have intensive collaboration with the Probation staff, although there will be no interface with judges or the court system. Participants will be referred by Probation or parole, but many may be encountered at the Day Reporting Center (DRC) where the Innovation staff will have offices. Additionally, Innovation staff will be outreaching to AB 109 persons recently released from State Prison, or persons who have gained parole status, and are attempting to establish themselves in the community again.

**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?**

To our knowledge, no other counties are conducting a similar project to the one we are proposing. Social determinants research is being studied in urban communities and third world countries with limited healthcare infrastructure and resources. Rural communities in California also have limited resources and infrastructure and could benefit from a project that specifically addressed social determinants approach to the allocation of resource. By applying social determinants research to the challenges of rural behavioral healthcare it is hoped that data will
be generated that will support the social determinant focus on the allocation of limited resources. It is our hope that the report generated at the end of the project, completed by our evaluation contractor, will support our project decisions regarding this demographic.

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.**

The closest comparable service that other counties and/or providers have to this project is Mental Health Court. Mental Health Court is a collaborative alternative to the traditional court system for those experiencing mental illness (Judicial Council of California, 2021). This program differs from Mental Health Court in that it does not have any involvement in the court process or communication with judicial staff. Social Determinants of Rural Mental Health will be outreaching to program participants after their court process in an effort to engage and provide services that often prove to be more limited as the individual may not have insurance, not have knowledge of services, or may have experienced personal stigma which prevents the person from seeking help. Mental Health Specialists and the Case Manager will help project participants reintegrate into our community by identifying and addressing social determinants needs. These efforts are innovative in that when Colusa County Jail inmates are released, they can receive help in an informal way to support social determinants of good health and their re-entry into the local 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?**

The learning from this Innovative project for California could be substantial, especially for rural and frontier counties who experience unique social determinants of health, particularly in the demographic of persons associated with the justice system. Colusa County would like to learn how social determinants impact those adults who are in the justice system who may be experiencing mental illness. If by addressing social determinants that are identified through the Strengths Assessment and resources were provided by the Innovation staff, does an individual experience an increased desire to focus on mental health outcomes that may be present by making a formal request for treatment?
Colusa County is prioritizing these goals to better understand the specific barriers to identifying symptoms of mental illness or addiction that impact the population we serve, as well as to help the Behavioral Health Department improve our ability to collect and use data to evaluate our services. Additionally, targeting social determinants of health is particularly relevant to our population because by addressing specific needs like unemployment, housing and physical health concerns, this may open the door to also look at behavioral health symptoms that are co-occurring.

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

Our learning goals relate to the following key innovative elements in this project:

- To improve outreach and engagement to those involved in the justice system and increase service delivery to unserved and underserved populations in the county.
- Identifying social determinants that may be blocking the recognition that behavioral health symptoms may be present after administering the Strength Assessment and understanding the effects of those social determinants on seeking behavioral health services by the population involved in the justice system.
- By doing outreach and engagement with justice system persons, and addressing the social determinants of good health, will this in fact increase the number of persons from this specific population who seek behavioral health care? Will formal requests for treatment increase?
- Emphasizing data-driven decision making and empowering agency staff to collect and use data effectively.

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.

Goal 1: To improve outreach and engagement to those involved in the justice system and increase service delivery to unserved and underserved populations in the county.

- **Approach:** We will establish a baseline of individuals currently served, both formally and informally, in Colusa County, broken down by demographics and justice system involvement. We will track individuals served throughout the project and evaluate changes in people served, the proportion of people served who have been recently involved in the justice system, and the representation of un- or underserved populations in the county.
- **Measures:**
  - Number and Percent of individuals served, broken down by:
    - Whether they’re being served formally (i.e., enrolled in behavioral health services) or informally (i.e., being served through this program or
otherwise by Colusa County BH staff, but not enrolled in behavioral health services)

- Involvement in the justice system
- Demographics in compliance with Innovation regulations (age, race, ethnicity, language, sexual orientation and gender identity, disability, veteran status, other populations identified by Colusa County)
- Note to Colusa: CIBHS has regulation compliant demographic surveys in both English and Spanish that can be used to capture this information if it’s not already being captured – we can add an item related to justice involvement
  - For individuals enrolled in behavioral health services, length of time in services and rate of drop-out from services, broken down by
    - Involvement in the justice system
    - Demographics in compliance with Innovation regulations (age, race, ethnicity, language, sexual orientation and gender identity, disability, veteran status, other populations identified by Colusa County)

- **Proposed Data to Be Used:**
  - Tracking spreadsheet for individuals served informally
  - EHR enrollment data for individuals served formally
  - Demographic data, including information on justice involvement

**Goal 2:** Identifying social determinants that may be blocking the recognition that behavioral health symptoms may be present after administering the Strengths Assessment Tool and understanding the effects of those social determinants on seeking behavioral health services by the population involved in the justice system.

- **Approach:** We will use the Strengths Assessment form to capture individuals’ goals and needs related to social determinants of health, as well as behavioral health challenges they may be experiencing. We will track changes in these items over time based on updated Strengths Assessments.
- **Measures:**
  - Number and percent of individuals served with goals and needs related to social determinants of health (for example: housing, transportation, food insecurity, employment, education)
  - Number and percent of individuals served with self-identified behavioral health challenges (for example: depression, anxiety)
  - All measures will be analyzed based on:
    - Whether individuals are or are not enrolled in behavioral health services
    - Involvement in the justice system
    - Demographics in compliance with Innovation regulations (age, race, ethnicity, language, sexual orientation and gender identity, disability, veteran status, other populations identified by Colusa County)

- **Proposed data to be used:**
  - Strengths Assessment Form Data
Goal 3: By doing outreach and engagement with justice system persons, and addressing the social determinants of good health, will this in fact increase the number of persons from this specific population who seek behavioral health care? Will formal requests for treatment increase?

- **Approach:** We will track the relationship between addressing social determinants of good health and enrollment in behavioral health services or requests for treatment.
- **Measures:**
  - Number of individuals requesting behavioral health treatment (total county measure)
  - Number and percent of individuals served by this program requesting behavioral health treatment
  - Number and percent of individuals served by this program enrolling in behavioral health services
  - All measures will be analyzed based on:
    - Whether Colusa County provided services to the individual to address social determinants of health prior to or during enrollment in behavioral health services
    - Involvement in the justice system
    - Demographics in compliance with Innovation regulations (age, race, ethnicity, language, sexual orientation and gender identity, disability, veteran status)
- **Proposed data to be used:**
  - CSI Assessment Record data on treatment requests
  - Tracking spreadsheet on individuals served and social determinants of health services provided by this program
  - EHR enrollment data
  - Demographic data, including information on justice involvement

Goal 4: Emphasizing data-driven decision making and empowering agency staff to collect and use data effectively.

- **Approach:** We will track the ways Colusa County incorporates data into their decision making process and how agency staff collect and use data.
- **Measures:**
  - Quality of Strengths Assessment Form and Tracking Spreadsheet data
  - Extent of data use at clinician, administrative, and leadership level in Colusa County Behavioral Health
  - Extent of data use to communicate to external Colusa County Behavioral Health stakeholders
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?

Colusa County does not expect to contract out this Innovation project, except for the evaluation process. California Institute for Behavioral Health Solutions (CIBHS) will be contracted to complete the data collection and evaluation process for Colusa County Department of Behavioral Health’s proposed Innovation project. The project resources that will be applied to managing the County’s relationship to the contract will be our Fiscal Administrative Officer, who will be overseeing the relationship between CIBHS and the County. This will include monitoring contract compliance and reviewing invoices for appropriate expenditures. The County will ensure quality as well as regulatory compliance in these contracted relationships by creating a contract that describes and states the MHSA Innovation standards and expectations.

The Leadership Team and the Quality Assurance Team of Behavioral Health will work with CIBHS to determine exactly what data we hope to collect from the project, and we will seek a process in the pre-implementation phase of the project to determine how to best analyze this data and make program decisions based on our findings. When the three-year project has concluded, Colusa County will generate a report that will be available to the OAC and any other entity that might find this information useful.

COMMUNITY PROGRAM PLANNING

Please describe the County’s Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County’s community.

Colusa County conducted their first introduction to the Social Determinants of Rural Mental Health Innovation project to Colusa County stakeholders during the Community Planning Process of the 2017 to 2020 fiscal year Three Year Mental Health Services Act (MHSA) plan. It was also presented in 2019/2020 MHSA Annual Update, 2020/2023 Three Year MHSA plan, and is currently on the 2021/2022 Annual Update for the 30-day review which ends on May 8th,
2021. There was no formal feedback noted for this specific project from the stakeholder meetings or 30-day review periods previously held.

On April 19, 2021, Colusa County received feedback from MHSOAC Staff which led to an updated version of the project. Due to the changes made, the County must inform Colusa County stakeholders about the changes and allow for them to provide feedback. A 30-day review period will be established on April 30th, 2021 to May 30th, 2021. Colusa County will seek Board of Supervisor approval on June 22nd, 2021.

On April 29th, 2021 there was a planning meeting between Behavioral Health staff (Director, Deputy Director, MHSA Coordinator, Fiscal Administrative Officer, Adult Clinical Program Manager, and Therapist) and Probation staff (Chief Probation Officer, Chief Deputy Probation Officer, and a DRC staff). Staff reviewed the intent of the project and addressed barriers and challenges of the project. We discussed positive outcomes of the project. At this meeting the Chief Probation Officer, who is the chair of the Community Correction Partnership (CCP), offered that the CCP could address this project at their quarterly meeting to chart progress.

MHSA GENERAL STANDARDS

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

A) Community Collaboration: Community collaboration will be a big part of this project as it will create ways for Colusa County Department of Behavioral Health (CCDBH) to work with other agencies, especially the Probation Department, and other local resources. Adult Probation is an agency that CCDBH will collaborate with as those they serve have been identified as the target population. The Case Manager that will be working under this project will work closely with many agencies in the county to link project participants to needed resources. Agencies that the Case Manager will reach out to are anticipated to be One Stop for job opportunities, Child Protective Services for child care resources, ministerial groups for social and clothing resources, local Food Pantry for food, and local health care providers for medical services.

B) Cultural Competency: One of the outcomes of this program is to understand the barriers to treatment that disproportionately impact those involved in the justice system and the Hispanic/Latino community in Colusa County. Use of the Strengths Assessment will assist Innovation staff to understand each person from a whole person care perspective. The Strengths Assessment is uniquely designed to elicit specific personal, social, economic, cultural, and
spiritual strengths and resources that the person currently uses or has previously used to achieve health and wellness.

C) **Client-Driven:** This project will be client-driven in that clients will be informing the project staff of the social determinants of health that are impacting them. The project will also have the client provide direction on resources that they may feel would be beneficial or helpful to them to improve their overall wellbeing and mental health.

D) **Family-Driven:** While the program is specifically designed to focus on individuals, all efforts will be made to include the project participants natural supports in the treatment process as much as possible. This includes family members, significant others, and key supportive relationships who may be identified as resources.

E) **Wellness, Recovery, and Resilience-Focused:** NA

F) **Integrated Service Experience for Clients and Families:** NA

**CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION**

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

This project will ensure cultural competence through the following strategies:
- Engaging representatives of the unserved and underserved populations such as the Hispanic/Latino community and those who have been or are involved in the justice system in Colusa County around outreach efforts, implementation strategy, and program outcomes.
- Providing linguistically appropriate services and program materials in threshold languages.
- Conducting detailed evaluation of whether the program is effective for unserved and underserved populations.

**INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE**

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

The county will decide whether it will continue with the Innovation project in its entirety or keep certain parts of the project by taking a look at the evaluations and considering stakeholder feedback during the Community Planning Process. Colusa County will also monitor the necessary staff time to implement and sustain the program in light of the social determinant and mental health outcomes it generates to determine whether to continue to invest time in the practices. If it is decided to continue this program outside of the allotted three years, the program will continue to utilize the SAMSHA grant that will be dedicated to fund a portion of the Mental Health Specialist and Case Manager positions. The program would additionally be
funded through realignment dollars, Community Services and Supports (CSS) funds, and other grant opportunities. The Colusa County Jail and Adult Probation collaborators, especially the Community Corrections Partnership, may also have funding that they can contribute to the program.

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.

It is likely that the individuals who struggle in accomplishing basic life skills probably will also demonstrate areas of social determinants. They may also have underlying symptoms of mental illness or addiction that can be revealed through outreach and engagement. By addressing their social determinants and building rapport, it is Behavioral Health’s hope that the project participants will enter into Specialty Mental Health Services. At that point when a formal request for services is made, an intake assessment would be provided to establish medical necessity. If medical necessity is not met, these participants will be encouraged to be served through peer services and community supports at our adult wellness and recovery center, Safe Haven.

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?

The primary way we will disseminate information about the program will be through our regular meetings with our partners from the Probation Department. Additionally, during the quarterly meeting of the Community Corrections Partnership meetings, we will provide updates about the program and share initial evaluation data. We would also like to disseminate information to stakeholders within our county by sharing information at monthly Behavioral Health Board meetings and quarterly Quality Improvement Committee meetings which are open forums for public participation. Participants involved in the project would be able to provide their own testimony in regard to their experience while in the program. Evaluation reports that document learning and outcomes will be prepared and shared twice a year. This information will be shared via our county website and Facebook page.

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.
Social determinants, Rural outreach and engagement, Improving life functioning after justice system involvement, Strengths Assessment

**TIMELINE**

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

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

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

This will be a three-year Innovation project, with a proposed start date of July 2021 and end date of June 2024.

- **Timeline of key activities and milestones and a brief explanation of how the project’s timeframe will allow sufficient time for evaluation, stakeholder involvement, and lessons learned.**
  - Month 0 – Pre-Implementation: In person brainstorming in Colusa County. Engagement with key stakeholders and finalization of implementation and evaluation strategy. Training on Strengths Assessment protocol and on consistent data entry.
  - Months 1-6 – Implementation: Hiring of new staff and forming collaborative relationships with Adult Probation. Establishing the Strengths Assessment and identifying community resources to address social determinants.
  - Months 7-12 – Implementation: Initiating formal and informal outreach efforts to involve project participants and offer support to help improve overall life functioning. This period culminates with a one-year fidelity review and report, one-year evaluation report, and a leadership team meeting. Evaluation results will be shared with stakeholders.
  - Months 13-18 – Implementation: Continue with outreach, engagement, and involve more participants. This period culminates with an eighteen-month fidelity review and report, along with a leadership team meeting.
  - Months 19-24 – Implementation: Continue with outreach, engagement, and involve more participants. This period culminates with a two-year fidelity review and report, two-year evaluation report, and a leadership team meeting. Evaluation results will be shared with stakeholders.
  - Months 25-36 – Sustainability: This period culminates with a three-year fidelity review and report, three-year evaluation report, and a leadership team meeting. Evaluation results will be shared with stakeholders.

**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

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, “$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000”) and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, “Project coordinator, full-time; Statistical consultant, part-time; two Research assistants, part-time...”). Please include a discussion of administrative expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

We anticipate that the implementation of the project will begin in the first quarter of fiscal year 2021-2022. The expenditures for this project slowly increase over the three-year period as staff begin to build the project and relationships within the community. The project will consist of 50% of two Mental Health Specialists and 100% of a Case Manager for a total expected personnel costs of $527,160. The direct costs of operating the project include housing services, transportation services, healthy food for participants, job readiness skills and education fees for a total expected direct costs of $189,400. The indirect costs for operating the project include office space, utilities, insurance, supplies, vehicle lease, fuel and administrative overhead for total expected indirect costs of $128,315. Non-recurring costs include office furniture, technology equipment for both office and field use for a total expected cost of $7,652. The evaluation costs of the project are expected to be $70,000 over the 3-year period. We are anticipating using $498,812 of MHSA-Innovation funds for this project. We will utilize our MHSA-Capital Facilities and Technology fund, 1991 Realignment, various housing grants and our Behavioral Health Subaccount funding to completely fund this project.
## BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*

### EXPENDITURES

<table>
<thead>
<tr>
<th>Personnel Costs (salaries, wages, benefits)</th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Salaries</td>
<td>$91,392</td>
<td>$95,962</td>
<td>$100,760</td>
<td>$288,113</td>
</tr>
<tr>
<td>2 Direct Costs</td>
<td>72,019</td>
<td>75,620</td>
<td>79,401</td>
<td>227,040</td>
</tr>
<tr>
<td>3 Indirect Costs</td>
<td>3,906</td>
<td>4,000</td>
<td>4,100</td>
<td>12,006</td>
</tr>
<tr>
<td>4 Total Personnel Costs</td>
<td>$167,317</td>
<td>$175,582</td>
<td>$184,261</td>
<td>$527,160</td>
</tr>
</tbody>
</table>

### Operating Costs

<table>
<thead>
<tr>
<th></th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Direct Costs</td>
<td>$41,320</td>
<td>$61,740</td>
<td>$86,340</td>
<td>$189,400</td>
</tr>
<tr>
<td>6 Indirect Costs</td>
<td>41,941</td>
<td>42,758</td>
<td>43,616</td>
<td>128,315</td>
</tr>
<tr>
<td>7 Total Operating Costs</td>
<td>$83,261</td>
<td>$104,498</td>
<td>$129,956</td>
<td>$317,715</td>
</tr>
</tbody>
</table>

### Non Recurring Costs (equipment, technology)

<table>
<thead>
<tr>
<th></th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Furniture</td>
<td>$3,237</td>
<td>-</td>
<td>-</td>
<td>$3,237</td>
</tr>
<tr>
<td>9 Technology</td>
<td>4,415</td>
<td>-</td>
<td>-</td>
<td>4,415</td>
</tr>
<tr>
<td>10 Total Non-recurring costs</td>
<td>$7,652</td>
<td>-</td>
<td>-</td>
<td>$7,652</td>
</tr>
</tbody>
</table>

### Consultant Costs / Contracts (clinical, training, facilitator, evaluation)

<table>
<thead>
<tr>
<th></th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Direct Costs</td>
<td>$30,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>12 Indirect Costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13 Total Consultant Costs</td>
<td>$30,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$70,000</td>
</tr>
</tbody>
</table>

### OTHER EXPENDITURES (please explain in budget narrative)

<table>
<thead>
<tr>
<th></th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Total Other Expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Budget Totals

<table>
<thead>
<tr>
<th></th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel (line 1)</td>
<td>$91,392</td>
<td>$95,962</td>
<td>$100,760</td>
<td>$288,113</td>
</tr>
<tr>
<td>Direct Costs (add lines 2, 5 and 11 from above)</td>
<td>143,339</td>
<td>157,360</td>
<td>185,741</td>
<td>486,440</td>
</tr>
<tr>
<td>Indirect Costs (add lines 3, 6 and 12 from above)</td>
<td>45,847</td>
<td>46,758</td>
<td>47,716</td>
<td>140,321</td>
</tr>
<tr>
<td>Non-recurring costs (line 10)</td>
<td>7,652</td>
<td>-</td>
<td>-</td>
<td>7,652</td>
</tr>
<tr>
<td>Other Expenditures (line 16)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL INNOVATION BUDGET</td>
<td>$288,230</td>
<td>$300,080</td>
<td>$334,217</td>
<td>$922,527</td>
</tr>
</tbody>
</table>

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.*
## BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

### ADMINISTRATION:

<table>
<thead>
<tr>
<th>Source Description</th>
<th>FY 19/20</th>
<th>FY 20/21</th>
<th>FY 21/22</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Innovative MHSA Funds</td>
<td>$131,222</td>
<td>$142,007</td>
<td>$155,583</td>
<td>$428,812</td>
</tr>
<tr>
<td>2 Federal Financial Participation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3 1991 Realignment</td>
<td>21,500</td>
<td>21,500</td>
<td>21,500</td>
<td>64,500</td>
</tr>
<tr>
<td>4 Behavioral Health Subaccount</td>
<td>16,341</td>
<td>17,158</td>
<td>18,016</td>
<td>51,515</td>
</tr>
<tr>
<td>5 Other funding* - MHBG, MHSA Housing &amp; MHS Cap Improvmt &amp; Tech</td>
<td>89,167</td>
<td>99,415</td>
<td>119,118</td>
<td>307,699</td>
</tr>
<tr>
<td>6 Total Proposed Administration</td>
<td>$258,230</td>
<td>$280,080</td>
<td>$314,217</td>
<td>$852,527</td>
</tr>
</tbody>
</table>

### EVALUATION:

<table>
<thead>
<tr>
<th>Source Description</th>
<th>FY 19/20</th>
<th>FY 20/21</th>
<th>FY 21/22</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Innovative MHSA Funds</td>
<td>$30,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>2 Federal Financial Participation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3 1991 Realignment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4 Behavioral Health Subaccount</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5 Other funding* - MHBG, MHSA Housing &amp; MHS Cap Improvmt &amp; Tech</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6 Total Proposed Evaluation</td>
<td>$30,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$70,000</td>
</tr>
</tbody>
</table>

### TOTAL:

<table>
<thead>
<tr>
<th>Source Description</th>
<th>FY 19/20</th>
<th>FY 20/21</th>
<th>FY 21/22</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Innovative MHSA Funds</td>
<td>$161,222</td>
<td>$162,007</td>
<td>$175,583</td>
<td>$498,812</td>
</tr>
<tr>
<td>2 Federal Financial Participation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3 1991 Realignment</td>
<td>21,500</td>
<td>21,500</td>
<td>21,500</td>
<td>64,500</td>
</tr>
<tr>
<td>4 Behavioral Health Subaccount</td>
<td>16,341</td>
<td>17,158</td>
<td>18,016</td>
<td>51,515</td>
</tr>
<tr>
<td>5 Other funding* - MHBG, MHSA Housing &amp; MHS Cap Improvmt &amp; Tech</td>
<td>89,167</td>
<td>99,415</td>
<td>119,118</td>
<td>307,699</td>
</tr>
<tr>
<td>6 Total Proposed Expenditures</td>
<td>$288,230</td>
<td>$300,080</td>
<td>$334,217</td>
<td>$922,527</td>
</tr>
</tbody>
</table>

*If “Other funding” is included, please explain.
**Current Strengths:**
What are my current strengths? (i.e. talents, skills, personal and environmental strengths)

**Individual’s Desires, Aspirations:**
What do I want?

**Past Resources – Personal, Social, & Environmental:**
What strengths have I used in the past?

<table>
<thead>
<tr>
<th>Home/Daily Living</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assets - Financial/Insurance</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment/Education/Specialized Knowledge</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supportive Relationships</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness/Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leisure / Recreational</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spirituality/Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
What are my priorities?

1. 

2. 

3. 

4. 

Additional comments or important things to know about me:

This is an accurate portrait of the strengths we have identified so far in my life. We will continue to add to these over time in order to help me achieve the goals that are most important to me in my recovery journey.

I agree to help this person use the strengths identified to achieve goals that important and meaningful in their life. I will continue to help this person identify additional strengths as I learn more about what is important to their recovery.

My Signature __________________ Date ____________

Service Provider’s Signature __________________ Date ____________

University of Kansas, School of Social Welfare 2010