County of Santa Cruz

HEALTH SERVICES AGENCY

P.O. BOX **962, 1080** EMELINE AVENUE
SANTA CRUZ, CA **95061**
(831) 454-4066 FAX: **(831) 454-4770**

HEALTH SERVICES AGENCY
ADMINISTRATION

May 24,2002

AGENDA: June 11,2002

BOARD OF SUPERVISORS
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

RE: Grant Application for Community Placement Alternatives for Individuals Placed in Institutions for Mental Disease

Dear Members of the Board:

The Health Services Agency (HSA) requests your Board's approval to submit the attached grant application to the State Department of Mental Health seeking funding for a specialty treatment and case management team which would assist moving clients from locked facilities, such as Institutes for Mental Disease (IMD), to lower levels of care.

If funded, the grant would provide up to $400,000 per year for two years. Mental Health has been faced with rising utilization in IMD beds over the past two years and needs to find new strategies which will expedite the discharge process from higher levels of care while providing appropriate clinical supports to assure a healthy transition into our community and lower levels of care.

If funded, this grant would provide an enhanced team to assist with transitioning the most ready consumers into the community with on-going wrap around services to assure stabilization.

To meet the May 2002 application deadline, HSA submitted the application pending your Board's approval.

If awarded, funding is anticipated to begin in July 2002. The grant will not require any new County general funds. Support for administrative costs associated with the program will be included in the grant application. If funded, HSA will return to your board to accept and appropriate the grant funds into the 2002/03 budget.

It is, therefore, RECOMMENDED that your Board:

1. Authorize the Health Services Agency to submit a grant application to the State Department of Mental Health for up to $400,000 funding per year for two years to support enhancement of mental health services in order to transition consumers to the least restrictive level of care.

Sincerely,

Rama Khalsa, Ph.D.
Health Services Administrator

RECOMMENDED:

Susan A. Mauriello
County Administrative Officer

cc: County Administrative Office
Auditor-Controller
County Counsel
HSA Administration
MH / SA Administration

County of Santa Cruz

HEALTH SERVICES AGENCY

1400 EMELINE AVENUE SANTA CRUZ, CA 95060
(831)454-4170 FAX: (831) 454-4484 TDD: (831) 454-4123

Community Mental Health

May 10,2002

Sandra Stiles
Systems of Care
Department of Mental Health
600 9th Street, Room 100
Sacramento, CA 95814

Dear Ms. Stiles,

Attached you will find Santa Cruz County Mental Health **and** Substance Abuse Services' application for funding of a new treatment model that presents strategies to better transition consumers from Institutes of Mental Disease into community placements. We are very excited about the possibilities **and** opportunities with this new funding.

No doubt there is keen interest by many other counties in this new funding. We trust that you and your staff will give our application thoughtful consideration. We genuinely hope that we will be given an opportunity to demonstrate our ideas to the state. We believe we are proposing a new model **of** care that will be of great importance to our mental health community.

Sincerely,

Norm Wyman
Director, Mental Health and Substance Abuse

Yana Jacobs
Acting Chief Adult and Older Adult Services

'We must commit ourselves to removing environmental barriers which block people's efforts towards recovery and which keep us locked in a mode of just trying to survive. " Pat Deegan, Ph.D,

I. Interest/Understanding

Santa Cruz County is committed to transforming the mental health system into a true continuum of care for adults based upon the vision and principles of recovery and community integration. To this end, we will continuously strive to provide services based upon established and emerging best practices in mental health recovery.

There has been much progress made in the past 5 to 10 years. Yet, there is pressing need for further system change and development in order to reduce, if not eliminate, the use of long-term locked institutional care and remove the barriers to more community based services. In considering the problems of transitioning consumers from institutes of mental disease (IMDs) to the community, we must first better understand the consumers and their needs.

Using a model of recovery developed by the Ohio Department of Mental Health', many of the consumers-especially those with extended long-term stays and an apparent lack of response to treatment —an be understood to be in Phase 1 of recovery. These individuals can be described as Dependent and *Unaware*—dependent on the system of care and services and unaware of the possibilities for their own recovery.

Some of the characteristics or experiences of individuals in Phase 1 are as follows. They may:

- Be unable to identify personal needs.
- Lack experience in developing trusting relationships.
- Not accept their diagnosis.
- Be angry, anxious, distrustful, and unmotivated.
- Lack self-esteem and sense of self.
- Have limited knowledge of supportive resources and medical management.
- Feel helpless and hopeless.
- Be withdrawn and avoid contact with others.
- Be unaware of how family relationships impact the recovery process.
- Be unaware of the relationship between employment and well being.
- Lack understanding of illness, basic needs, and how to access and manage available resources.

We need to do better at helping these individuals develop a vision of their own recovery and realize their potential for a less-restricted and improved quality of life in the community. To this end, we need to rethink how to build a therapeutic alliance as well as develop individual service plans that help consumers move to Phase 2 of recovery (dependent but aware of their potential for recovery) and beyond.

The current system of care is organized in a linear model or progressive steps, from more restrictive to less restrictive care. The continuum of care is rich with social rehabilitation residential settings. However, there are limited options for consumers needing a "step-down" or trial release from locked care to begin a transition back into the community. Some consumers actually relapse at the IMD due to extended waits for a partial hospital placement. All too often community housing and employment is viewed as a reward for good consumer behavior. This is often at times referred to as a "train and place" model that places an emphasis on "readiness" for each successive transition. Such an approach assumes that individual's have the cognitive abilities to learn necessary life skills in one setting and then transfer their abilities to another setting.

There is increasing evidence in the psychiatric literature that the "train and place" model is inappropriate and ineffective for many individuals disabled by severe and persistent mental illness and does not account

[1] Ohio Department of Mental Health Recovery Process Model & Emerging Best Practices outlines four levels of recovery across multiple domains, as well as best practices to support the highest level of recovery. The four levels include Dependency/Unaware; Dependent Aware; Independent/Aware; Interdependent/Aware.

for the cognitive impairments and other challenges associated with disabling mental illness. Recidivism is a common outcome as individuals struggle with making each transition. Instead, a "place and train" alternative has been demonstrated to be effective—particularly in supported employment—in helping individuals to achieve more lasting success in the community. This approach places an emphasis on rapid placement, providing the necessary skills development and supports *in **situ*** in order to assure the individual's success.

To succeed in effecting such a re-ordering of the current system of care is a major challenge. Many clinicians still do not accept that individuals with severe mental illness have the potential to recover. Additionally, many of the care coordinators are paraprofessionals who do not know how to assess life skills and cognitive abilities, and are unable to provide consumers with the skill development they require. Moreover, it is not unusual for care coordinators to report that they are unable to place consumers in the community because of their inability to provide "intensive support". Caseloads are simply too large to allow for the wrap-around services that are required. This is especially true for individuals leaving locked IMD placement and attempting community re-entry.

In order to reform the system and successfully support the transition from IMDs to community living, new resources—both clinical and financial—will be required. Some of these resources include:

- Increased involvement and availability of occupational therapists in care teams. Occupational therapy is currently a severely under-represented discipline. However, assessment of life skills and cognitive abilities and the development of adaptive rehabilitation plans are at the core of OT practice. The clinical resources to do this effectively now are simply lacking.
- Creation of an Assertive Community Treatment (ACT) team with reasonable fidelity to evidence based practice models and guidelines-particularly with regards to staffing ratios, shared caseloads, 24/7 availability, and direct provision of services with a focus on supported employment and housing. As much as possible occupational therapists should be members of the team and provide direct care and supervision to the other members of the team.
- Develop peer support and counseling to assist consumers in their attempts at community reintegration.
- Provide consultation and involvement with family members to increase the support system and educate family and consumers about the recovery process.
- Create a rent subsidy fund to allow individuals more choice and flexibility in selecting housing and living arrangements.
- Develop ongoing in-service training for existing staff on how to help consumers succeed in recovery.

Central to this model is the greater participation and involvement of occupational therapists. It is our hypothesis, based upon a comprehensive review of the literature as well as years of experience, that this is an essential but under-utilized resource in addressing what has become a persistent unmet need—maintaining individuals in the community.

Santa Cruz County is experiencing a sudden and recent increase in utilization in State Hospitals, accompanied by increasing use of acute hospital and IMD beds and longer lengths of stay in all inpatient settings. There has also been an increase in the number *of* individuals placed on LPS conservatorships. These are problems that are not unique to Santa Cruz and being experienced statewide by county systems. Santa Cruz's success in developing innovative approaches can serve as a model for system development and reform.

AB 542 recommends the expansion of the mental health system's infrastructure in order for consumers to make informed decisions about their long-term care options. Our proposed strategies will benefit our community by providing increased housing options, improving individualized treatment plans, implementing evidence-based practices, and providing more consistent assistance to help consumers reach Level **3,** ***Independent/Aware,*** and Level **4,** ***Interdependent /Aware,*** as described in the emerging best practices of the mental health recovery model. Our proposed strategy of creating a hybrid ACT like team with OTs as the centerpiece and use of housing vouchers could prove to be a best practice to emulate throughout the state.

II. IMPACT

During the calendar year 2000, we admitted 114 consumers to IMD placements. In calendar year **2001** we admitted 140 consumers to IMDs. These numbers reflect multiple admissions in the same year. During these two years, our admissions have increased by 23%, and we are on track for further increases in 2002. As stated above, we need to have the resources in place to offer a choice to our consumers and have a broader menu of options that will address individual needs to transition into the community from the locked IMD setting. Both the Local Mental Health Board and NAMI of Santa Cruz have been critical of the use of IMD beds for consumers. They have urged our Director to implement more ACT teams in our county. With recent Local Utility Tax Cuts and the impending state cuts, we are no longer in a position to expand much needed services, instead staffing is being reduced.

Santa Cruz County currently has 36 consumers placed in IMD settings. The current IMD census is:

Current IMD Census

Age Category	Number	# Female	# Male
Older Adults	**6**	**1**	**5**
Adults	**25**	**12**	**13**
Transition Age	***5***	**3**	**2**
Total	**36**	**16**	**17**

The most difficult to place consumer are those individuals who have the following characteristics: poor social skills to such a degree that placement in group living arrangements is not acceptable for the consumer or the residential program; co-existing medical conditions that need extra help with symptom management; and use of multiple medications that requires medication monitoring.

Smaller case loads with treatment plans that focus on specific goals and objectives regarding independent living, activities of daily living, social functioning, education and employment would better bridge the gaps to expedite the transition from IMD to the community. We must begin to expand our view of the consumer from simply viewing the psychiatric symptoms to a more holistic view of the consumer's ***being,*** "who am I"?;***belonging,*** "where do I belong"?; and ***becoming,*** "how do I become a whole respected person in my community"?

Once the OT/ACT team is staffed and trained in working with the Occupational Therapist Assessments and approach to treatment planning, we will demonstrate reduction in IMD utilization by **10%** within the first three months. By six months we will reduce utilization by another 10% until we have reached a ***50%*** reduction in overall utilization. We also expect the OT/ACT to assess consumers who are in the acute care hospital and under consideration for an IMD placement with the goal of designing a community treatment plan that will eliminate their need for an IMD.

Santa Cruz County proposes to pilot a new and innovative model for the State of California Department of Mental Health. After a review of the literature, we were unable to find any study that highlighted the use of OT's taking the lead role on ACT teams serving the seriously and persistently mentally ill population. We are anticipating that by designing and implementing this pilot project, we will be able to demonstrate positive outcomes in reducing both overall bed days in the IMDs and, more importantly, will demonstrate consumer and family member higher satisfaction in the consumer's overall quality of life.

III. ABILITY

Our current continuum of care consists of three full service case management teams with bilingual capacities, specialty teams for Older Adults, Transition age youth and two grant-funded ACT like teams, one from MIOCR and the other AB2034. All teams are on-call seven days a week, 24 hours per day. All teams provide field based services and interface with a full array of residential treatment programs that include Supported Housing, Board and Care, Social Rehabilitation, Transitional housing, Dual Diagnosis Residential, Partial Hospitalization and a Sub-Acute residential. We also have two stand-alone Day Treatment programs: one with an emphasis on employment that is linked with our Mental Health and Department of Rehabilitation which is a model program in the State as a Co-op; the second provides treatment for consumers with a dual diagnosis. All of our residential placements could take referrals from the IMD. However, program managers from these various facilities will often express concerns that

without extra supports, consumers who are in Phase 1 of the recovery model cannot safely live in their programs. While the social rehabilitation settings are in place, the support system necessary to facilitate these transitions is not.

The Partial Hospitalization program is currently our primary "step-down" for those consumers who are getting ready to be discharged from the IMD. Partial Hospitalization operates in a group model. When a consumer has difficulty working in-groups, socializing, etc., the partial hospitalization program reveals its limitations.

Santa Cruz is fortunate to have a SAMSHA funded supported housing grant. This model has proven effective in our existing independent housing sites. While these services are currently in place, one must first go through a lengthy "step down" process, often taking two years, before they might be eligible for supported independent housing. Often this is not in sync with the consumer's wishes and the lengthy "prove yourself ready" system may often be discouraging to say nothing of the amount of moves one has to make.

Santa Cruz County has recently designed and implemented a Rent Subsidy program, due to long wait lists to move consumers through the continuum of care. The subsidies increased our independent housing stock by 30 additional beds. We assigned an occupational therapist to work with consumers going into the subsidized units in order to create detailed treatment plans that will target independent living skills. We will build on this rent subsidy model to enhance placement options for consumers wanting to live independently once they leave the IMD. With the addition of a grant funded intensive support team and the OT as the centerpiece, we believe this will provide the necessary capacity both for housing and special targeted services to enable consumers to move from IMDs into the community.

Santa Cruz County is well positioned because of its unique and well-developed system of care. We are a small size county and, therefore, able to implement new ideas and change rapidly. We have a large enough infrastructure to support new ideas while at the same time we are small enough to make a difference.

IV. PROCESS

While "place and train" models of care have been evidenced to be successful in supported employment, there is a relative paucity of studies demonstrating the success of this approach in supported housing. Santa Cruz County proposes to adopt and adapt an ACT" team approach to minimize the need for IMD placement following acute hospitalizations and to facilitate the transition of IMD patients to community housing without the current requirements of multiple step-downs and intermediate placements. By placing a greater emphasis on assessment of life skills and *in situ* support and training, more rapid and stable housing can be achieved.

The inclusion of occupational therapists in both assessment and treatment/rehabilitation is a key component of this plan and to some degree represents an adaptation of other ACT models. The intention is to emphasize rapid placement in what will hopefully become permanent housing for the individual. Occupational therapists are uniquely skilled in assisting consumers with these goals but have traditionally been under-represented in community mental health teams.

Consumer needs will be addressed with in-home/on-site support and skills training necessary to succeed in that setting. This will fill a gap in our current continuum of care, We do not intend to foster long-term support and dependency but rather wish to promote individual self-care, community integration, empowerment, and recovery. This will be accomplished by using a specially staffed and skilled team that will help consumers move from dependency to support and skill building.

The team, in conjunction with facility staff, will evaluate individuals in acute care hospitals and IMDs for discharge under the new program. This will include an evaluation of the consumer's motivation,

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** Santa Cruz County acknowledges that there are concerns by some consumer groups that ACT may be viewed as an unacceptable and coercive treatment model. We recognize this and will provide safeguards to assure that consumer participation in the program is consumer centered, will reflect consumer choice, and is not experienced by participants and consumers as coercive.

preferences, skills, and other strengths and resources as well as rehabilitation needs. Assessment will also be ongoing and there will be a periodic reassessment of abilities and needs as individuals continue to succeed in the community.

Utilizing standardized occupational therapy tools, the Allen Cognitive Levels (ACL) will be the primary assessment tool. The ACL measures the individual's current ability to process cognitive information and provides the treatment team with an indication of the level of assistance needed for a consumer to succeed in their preferred housing/living arrangement. This information is essential in identifying realistic treatment goals and developing effective treatment plans. This approach not only promotes consumer success by more directly addressing cognitive challenges but also decreases treatment team frustration by having more realistic and accurate understanding of the consumers strengths and needs.

The Kohlman Evaluation of Living Skills (KELS) will also be used to help determine the individuals' basic living skills and capacities. This assessment utilizes task performance to evaluate actual functioning in five domains including: Self-Care, Safety and Health, Money Management, Transportation and Telephone, and Work and Leisure.

Families and other members of the person's support system will be encouraged to participate in this process, with the consumer's permission. They will be included in the assessment to assist in identifying both strengths and needs. Hopefully, family and friends will become an integral part of the treatment team and will help reinforce agreed upon treatment goals and interventions.

The multi-disciplinary team will focus on short-term specialty case management and have a caseload of **20-30** consumers at any given time. The staff includes:

- **1** FTE Project Coordinator/Analyst
- **1** FTE, Supervisor, OTR plus intern
- **1** FTE Employment specialist (contract provider Career Services)
- **1** FTE Peer Counselor divided into four **(4), 10** hour per/wk shifts
- .5 FTE Registered Nurse
- **1** FTE Mental Health Care Coordinators
- **8-12** hours MD dedicated psychiatrist

We will use an historical comparison from the previous year to measure results. The data elements will include total days in a state hospital and/or acute hospital, total days in an IMD, employment status, housing history, and homelessness. We will also administer the California Quality of Life Inventory at the time of intake, at six and **12** months, and annually thereafter. The OT assessments will be aggregated into a database to measure improvement in living skills. We will place significant value and weight on these tools to evaluate the effectiveness of this model. The scores from the ACL (standardized) and KELS will be gathered at admission, **3** months, ***6*** months, one year and then semi-annually thereafter. KELs will measure daily living skills. ACL scores will reflect cognitive assistance needed.

We are prepared to submit data as required by DMH. Mercer Government Human Services Consulting (Mercer) will assist us with the design of a database to collect relevant data elements and assist with data analysis. Mercer will also assist us with capturing data for the statewide evaluation to be conducted by the Department of Mental Health.

COUNTY OF SANTA CRUZ
DMH - IMD GRANT PROPOSAL
July 2002 -June 2005
SUMMARY

Description	Step	Salary 1.0 FTE	Benefits 28.0%	Sal & Ben 1.0 FTE	Budget FTE		Grant cost
PERSONNEL EXPENSE							
Occupational Therapist/Spvr	5				1.00		227,471
MH Client Specialist	5				2.00		179,516
Psychiatrist	7				0.20		124,246
Sr Human Resource Analyst	5				0.50		217,995
Total Personnel Expense							**749,228**
OPERATING EXPENSE							
Services & Supplies							
Telephones (3*$78/month*12)							8,424
Training							3,000
On-Call (Pager, Cell Phone, 123 hrs/wk)							84,000
Travel ($300/month*12)							24,000
Office Supplies (5*$45/mo*12)							8,100
Flex Funds							30,000
Total Operating Expense							**$157,524**
CONTRACT SERVICES							
Mercer							
Program Evaluator							90,000
Community Connections							
Employment Specialist	15 hrslweek @ $20/hr						45.000
MHCAN							
Peer Counselor (4 - 5 hr slots)	15 hrslweek @ $10/hr						22,500
Registered Nurse	8 hrs/week @ $45/hr						54,000
Telephones (2*$78/month*12)							5,616
Total Contract Services							**217,116**
HOUSING FUNDS							
Rent Subsidy Allocation (5 Units @ $400/month x 12 months) (plus $5,000 one time start-up)							**77,000**
TOTAL							$ **1,200,868**

COUNTY OF SANTA CRUZ
DMH - IMD GRANT PROPOSAL
July 2002 - June 2003
Year 1

Description	Step	Salary 10 FTE	Benefits 28.0%	Sal & Ben 1.0 FTE	Budget FTE		Grant cost
PERSONNEL EXPENSE							
Occupational Therapist/Spvr	**5**	$ 56,930	15,940	$ 72,870	1.00		72,870
MH Client Specialist	5	$ 44,928	12,580	$ 57,508	1.00		57,508
Psychiatrist	7	$ 156,520	43,826	$200,346	0.20		40,069
Sr Human Resource Analyst	5	$ 54,558	15,276	$ 69,834	1.00		69,834
Total Personnel Expense							**240,281**
OPERATING EXPENSE							
Services & Supplies							
Telephones (3*$78/month*12)							2,808
Training							3,000
On-Call (Pager, Cell Phone, 123 hrs/wk)							28,000
Travel ($300/month*12)							8,000
Office Supplies (5*$45/mo*12)							2,700
Flex Funds							10,000
Total Operating Expense							**$54,508**
CONTRACT SERVICES							
Mercer							
Program Evaluator							30,000
Community Connections							
Employment Specialist							15,000
MHCAN							
Peer Counselor (4 - 5 hr **slots)**	15 hrs/week @ $20/hr						7,500
Registered Nurse	15 hrs/week @ $10/hr						18,000
Telephones (2*$78/month*12)	8 hrs/week @ $45/hr						1,872
Total Contract Services							**72,372**
HOUSING FUNDS							
Rent Subsidy Allocation (5 Units @ $400/month **x** 12 months) (plus $5,000 one time start-up)							**29,000**
TOTAL						$	**396,161**

COUNTY OF SANTA CRUZ
DMH - IMD GRANT PROPOSAL
July 2003 -June 2004
Year 2

Description	Step	Salary 1.0 FTE	Benefits 28.0%	Sal &Ben 1.0 FTE	Budget FTE		Grant cost
PERSONNEL EXPENSE							
OccupationalTherapist/Spvr	**5**	$ 59,207	16,578	$ 75,785	1.00		75,785
MH Client Specialist	**5**	$ 46,725	13,083	$ 59,808	1.00		59,808
Psychiatrist	7	$ 162,781	45,579	$208,360	0.20		41,672
Sr Human Resource Analyst	**5**	$ 56,741	15,887	$ 72,628	1.00		72,628
Total Personnel Expense							**249,893**
OPERATING EXPENSE							
Services & Supplies							
Telephones (3*$78/month*12)							2,808
On-Call (Pager, Cell Phone, 123 hrs/wk)							28,000
Travel							8,000
Office Supplies (5*$45/mo*12)							2,700
Flex Funds							10,000
Total Operating Expense							**$51,508**
CONTRACT SERVICES							
Mercer							
Program Evaluator							30,000
Community Connections							
Employment Specialist	15 hrslweek @ $20/hr						15,000
MHCAN							
Peer Counselor (3 - **5** hr **slots)**	15 hrs/week @ $10/hr						7,500
Registered Nurse	8 hrslweek @ $45/hr						18,000
Telephones (2*$78/month*12)							1,872
Total Contract Services							**72,372**
HOUSING FUNDS							
Rent Subsidy Allocation (5 Units @ $400/month x 12 months)							**24,000**
TOTAL							**$ 397.773**

COUNTY OF SANTA CRUZ
DMH - IMD GRANT PROPOSAL
July 2004 - June 2005
Year 3

Description	Step	Salary 1.0 FTE	Benefits 28.0%	Sal & Ben 1.0 FTE	Budget FTE	Grant cost
PERSONNEL EXPENSE						
Occupational Therapist/Spvr	5	$ 61,575	17,241	$ 78,816	1.00	78,816
MH Client Specialist	5	$ 48,594	13,606	$ 62,200	1.00	62,200
Psychiatrist	7	$ 166,036	46,490	$212,526	0.20	42,505
Sr Human Resource Analyst	5	$ 59,010	16,523	$ 75,533	1.00	75,533
Total Personnel Expense						**259,054**
OPERATING EXPENSE						
Services & Supplies						
Telephones (3*$78/month*12)						2,808
On-Call (Pager, Cell Phone, 123 hrs/wk)						28,000
Travel ($300/month*12)						8,000
Office Supplies (5*$45/mo*12)						2,700
Flex Funds						10,000
Total Operating Expense						**$51,508**
CONTRACT SERVICES						
Mercer						
Program Evaluator						30,000
Community Connections						
Employment Specialist	15 hrs/week @ $20/hr					15,000
MHCAN						
Peer Counselor (4 - 5 hr slots)	15 hrs/week @ $10/hr					7,500
Registered Nurse	8 hrs/week @ $45/hr					18,000
Telephones (2*$78/month*12)						1,872
Total Contract Services						**72,372**
HOUSING FUNDS						
Rent Subsidy Allocation (5 Units @ $400/month x 12 months)						**24,000**
TOTAL						$ **406,934**

Strategies for Community Placement Alternatives Grant
Santa Cruz County
Budget Narrative

PERSONNELEXPENSE

Occupational Therapist/Supervisor: One FTE. The OT will be the Supervisor for the Intensive Community Support Team. The job assignment will include doing all the OT Assessments as stated in grant application. They will carry a caseload, recruit and train one –two OT interns per year from San Jose State University to assist with assessment and treatment rehabilitation. One to two Occupational therapist Interns will be working with the team at no additional expense to the grant.

Mental Health Client Specialist.: One FTE will carry a case load of 10-12 consumers, will work closely with OT supervisor to carryout needs that have been addressed on the Treatment plan. Will also provide case management services, assist with housing, employment and brokerage

Psvchiatrist: Will provide 8-12 hours per week of medication services, will meet with team daily.

Senior Human Resource Analyst: One FTE to ensure integration of evaluation and performance outcomes in the overall collaborative effort. This person will serve as Project Coordinator and also have the lead role for the development and implementation of evaluation and performance outcomes.

OPERATING EXPENSES

On-Call: Funding for a cell phone and pager has been designated to assure 100% field base services and support along with the capacity to be available on a 24/7 basis.

Training: This is an expense in year one only. Training beyond year one will be integrated into the Community Mental Health training budget..

Flex Funds: To assist consumers in acquiring emergency financial assistance that may be needed for initial housing costs, utility deposits, miscellaneous costs that will assist in establishing permanent, independent housing. Rehabilitative activities that include support in the following areas: cooking, cleaning, socialization, may also come from this fund.

CONTRACT SERVICES

Mercer/Program Evaluator: Mercer will provide 120 hours of consulting assistance per year. The key tasks will include: designing a database to collect relevant information for the project, including required DMH data elements for the state wide evaluation; orientating the Analyst/Project Coordinator on the use of the database; assisting with preparation of required data reports to DMH; analyzing data at six, nine, and 12 months; and providing technical assistance on program implementation and data collection

Employment Specialist :15 hours per week will be contracted with the Career Services program of the Mental Health and Department of Rehabilitation Cooperative.. They will be part of the intensive support team and will involve the consumer in the planning and the process of getting a job or going to school, based upon consumers expressed wishes.

MHCAN/Peer Counselors: We will contract with our consumer owned and operated drop in center for Peer Counselors to work 15 hours per week. The Peer Counselors will work

Strategies for Community Placement Alternatives Grant
Santa Cruz County
Budget Narrative

with participants in their homes assisting with activities of daily living, socialization and symptom management.

Reaistered Nurse: We will contract for *8* hours per week with a Psychiatric nurse. The two primary elements of service will be to educate and assist consumers in the appropriate use of medication to manage their mental illness, and to educate and support consumers dealing wi a concomitant medical problem such as diabetes. In addition the nurse will educate consumers regarding the mental and physical health risks posed by the use of legal and illegal substances such as alcohol and marijuana. The Nurse will meet on a weekly basis with the team and be available on pager.

Housina Fund: Rental subsidies for supportive housing will be provided to serve up to 5 consumers who are in higher and more restrictive levels of care than clinically needed. A consumer may be placed directly from inpatient services or an **IMD** placement into this supported housing service when this level of care and placement is clinically appropriate. These funds are intended to subsidize consumers' rent with the understanding that the housing market in Santa Cruz County is simply not affordable for persons living on **SSI.** It is anticipated that on average, $400.00 will be a typical subsidy per month.

SUMMARY

01/02 funds will be rolled over to begin full implementation of the three year annual budget on July **1, 2002.** In addition, we will use rollover funds in year two and three, recognizing that there will be salary savings in year one. These savings will be the result of unfilled new positions in the first part of the 02/03 fiscal year. Funding will be directed toward needed services in nursing, employment and peer support as identified in an on-going analysis. In addition, savings accrued in years one and two will be used to fund the budget for year three, **04/05,** Budget which is $6,900 in excess of the annual limit of $400,000 per year. The budget total for **04/05** reflects cost of living increases and step increases.