

**MENDOCINO COUNTY
HEALTH & HUMAN
SERVICES AGENCY**

AT HOME:

Access to Treatment & Housing
Opportunities in the Mendocino
Environment

May 2008

PROJECT ABSTRACT

Summary: The Access to Treatment and Housing Opportunities in the Mendocino Environment (AT HOME) Project will fill a significant gap in Mendocino County's Continuum of Care for the Homeless by providing intensive case management and integrated treatment for persons with both substance abuse and mental health disorders, enhanced with primary health care, wrap-around services, and access to housing to support client participation and retention in treatment.

Mendocino County Health and Human Services Agency (HHS) is applying for a TREATMENT FOR HOMELESS: GENERAL GRANT. Over the past 15 years, the Mendocino County Homeless Services Planning Group (HSPG) has developed an extraordinary Continuum of Care for the Homeless. Coordinated by HHS's Social Services Branch and implemented by over 50 community partners, the Continuum of Care provides treatment, supportive services, and a range of housing options. Although basic mental health and substance abuse treatment are available, the HSPG has been unable to offer integrated treatment for homeless persons with co-occurring disorders. The Access to Treatment and Housing Opportunities in the Mendocino Environment (AT HOME) Project builds upon established partnerships to create an integrated assessment and treatment program in two Mendocino County communities, Ukiah and Willits. AT HOME will serve 60 clients each year. Over the five-year project period, 300 clients will enter treatment, and an estimated 90 clients will complete treatment.

AT HOME components include the following:

- An integrated assessment and treatment team (Substance Abuse Counselor and Behavioral Health Counselor) will provide individual services and co-facilitated groups.
- Primary healthcare and wraparound services, including housing, will be coordinated through intensive case management to support client participation and retention.
- Clients will participate in peer support and relapse prevention groups, following treatment completion.
- AT HOME staff will participate in professional development and cross-training.

Anticipated outcomes include the following:

- 60% of participants completing treatment have decreased symptoms of mental illness.
- 60% of participants completing treatment have decreased AOD dependence.
- 25% of participants have decreased Crisis Unit visits and law enforcement contacts.
- 50% of participants have decreased emergency room visits.
- 80% of participants report improved quality of life and life skills.
- 25% of participants completing treatment will gain employment.
- 25% of participants will have increased income stability.
- 60% of participants will relocate to shelters, 30% to transitional housing, and 20% to permanent supportive housing.

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PROJECT NARRATIVE (SECTIONS A – F)

Table One. Acronyms Used in This Proposal

AOD	Alcohol and Other Drugs
AODP	HHSA Public Health Branch, Division of Alcohol and Other Drug Programs
ASAM-PPC	American Society of Addiction Medicine Patient Placement Criteria
AT HOME	Access to Treatment and Housing Opportunities in the Mendocino Environment
CCISC	Comprehensive, Continuous, Integrated System of Care
CFR	Code of Federal Regulations
CMSP	County Medical Services Program
CoD	Co-Occurring Disorder
DTR	Double Trouble in Recovery
FMR	Fair Market Rent
FSP	Ford Street Project
FTE	Full-time Equivalent
GA	General Assistance
GPRA	Government Performance and Results Act
HCV	Hepatitis C Virus
HHSA	Mendocino County Health and Human Services Agency
HIPAA	Health Insurance Portability and Accountability Act of 1996
HSPG	Homeless Services Planning Group
HUD	US Department of Housing and Urban Development
IDDT	Integrated Dual Disorders Treatment
MCHC	Mendocino Community Health Clinic
PTSD	Post-Traumatic Stress Disorder
SHP	Supportive Housing Program
SSI	Supplemental Security Income
TOTIL	Transitional Opportunities Toward Independent Living
UCC	Ukiah Community Center
WCS	Willits Community Services

SECTION A. STATEMENT OF NEED

A-1. Target population and geographic service area

HHSA is applying for a TREATMENT FOR HOMELESS: GENERAL GRANT.

Mendocino County Health and Human Services Agency (HHSA) will collaborate with local partners to implement the Access to Treatment and Housing Opportunities in the Mendocino Environment (AT HOME) Project to fill long-standing gaps in the county's Continuum of Care for the Homeless. Adults who are homeless and have both substance abuse and mental health disorders will for the first time have access to integrated treatment, primary health care, wraparound support, and linkage to housing. AT HOME will focus on persons in the following target groups who have co-occurring substance abuse disorders and mental illnesses:

- *General Assistance (GA) clients,¹ and people eligible for but not participating in GA, who are homeless and have co-occurring substance abuse disorders and mental illnesses.*

¹ Every California county is required to provide support to the indigent. This is accomplished through California's General Assistance Program. Each county's GA program is 100% funded and administered by its own Board of Supervisors.

- *Homeless people participating in the county's Supportive Housing Program (SHP), and people eligible for but not participating in SHP, with co-occurring disorders.*

HHSA has chosen to work with these target groups because they comprise the most challenging clients to reach through existing services. The GA and SHP populations are among the most disenfranchised of vulnerable groups, and are frequently unemployed and homeless because of their disabilities. Mendocino County's GA program enrolls 50 new clients every month, all homeless or at risk of homelessness. These clients must make regular appearances to receive their subsidy checks, which will facilitate follow-up for AT HOME data collection. HHSA will serve 60 clients each year, for an unduplicated total of 300 clients served over the funding period. Participation will be open to elderly, youth aging out of foster care, individuals exiting from institutional settings, veterans, or others who are homeless and have co-occurring disorders. Throughout this proposal, the target population (*i.e.*, homeless people who have both a mental illness and a substance abuse disorder) will be referred to as having co-occurring disorders (CoD), understanding that types of dual diagnosis differ, and that the dually-diagnosed are not a homogeneous group. For example, Dr. Kathleen Sciacca (1991) differentiates between Mentally Ill Chemically Addicted Abusers and Chemical Abusing Mentally Ill Persons.

AT HOME will serve people of both genders, with women and veterans prioritized for trauma-informed services. Demographics of program participants will likely conform to those of clients previously served through the Continuum of Care. Clients served during the most recent reporting year (September 2006 through August 2007) had the following characteristics:

- 36% were identified with mental illness and 29% with alcohol and/or drug abuse.
- 23% were chronically homeless and 5% were veterans.
- The largest age group represented was age 31-50 and the second largest age 18-30.
- 73% were White, 13% American Indian, 9% Hispanic, and 4% African American.

Mendocino County is located in northern California along the Pacific Ocean, with its southern border 100 miles north of San Francisco. The county comprises 3,510 square miles of vineyard-covered hillsides, deep valleys, and rugged mountains. Fifteenth largest of California's 58 counties in size, the county has a population density of only 25 persons/square mile. AT HOME will serve the homeless in two of Mendocino County's largest population centers, Ukiah and Willits. Ukiah, the county seat of government, serves a population of approximately 40,000. The greater Willits community, 20 miles to the north, has a population of 13,500. HHSA has chosen these communities because of their unmet need for CoD treatment and services.

A-2. Nature of the problem and extent of the need

Table Two. Mendocino County demographics

	UKIAH ²	WILLITS ²	MENDOCINO ³	CALIFORNIA ³
Ethnicity: African-American	0.8%	0.4%	1.3%	6.0%
Asian/Pacific Islander	1.9%	0.8%	1.6%	12.5%
Hispanic	22.2%	11.3%	19.7%	35.9%
Native American	3.9%	3.6%	4.0%	1.0%
White/non-Hispanic	69.6%	81.6%	71.6%	42.8%
Living below poverty	17.9%	14.1%	16.9%	13.3%
Median household income	\$36,322	\$39,514	\$39,705	\$48,451

² US Census 2000 (2006 American Community Survey not available for this community).

³ 2006 American Community Survey.

Over the past 20 years Mendocino County has transitioned from an economy based on timber and fishing to one that revolves around viticulture and tourism. The county's rural nature and depressed economy are highlighted by unemployment figures, which in March 2008 stood at 7.6% in the City of Ukiah, 7.1% in the City of Willits, and 7.4% in the county. By comparison, national and state unemployment figures were 5.1% and 6.2%, respectively.

The housing shortage in Mendocino County is near crisis level, with a lack of adequate housing stock for all income ranges and rents only affordable for moderate-income households. Each year, the maximum affordable housing cost falls far below actual Fair Market Rents. For example, the 2008 Fair Market Rent for a studio apartment is \$600 per month, a one-bedroom unit is \$740, and a three-bedroom unit is \$1,227. Based on these figures, families at or below the federal poverty level and minimum wage earners cannot earn sufficient income for rental costs—at minimum wage of \$8/hour and with 30% of income allocated for housing, a family could not afford more than \$416 per month for rent.⁴ Furthermore, the GA monthly allowance check cannot exceed \$297, although the Family Economic Self-Sufficiency Standard has established Mendocino County's self-sufficiency wage for a single adult at \$10.29/hour (\$1,812/month).

Substance abuse is one of the most far-reaching problems in Mendocino County, which lies in the heart of the rugged "Emerald Triangle" that has for decades provided a convenient cover for the clandestine growth and harvest of marijuana and the manufacture of methamphetamines. The resulting widespread culture of acceptance is reflected in the county's passage of Measure G (the Cannabis Personal Use Ordinance); California Proposition 215, which legalized medical use of marijuana; the growth of the local wine economy; and the county's infamous ranking of 12th highest per capita rate of retail liquor outlets in the state.⁵ The statewide Campaign Against Marijuana Production has consistently seized about 10% of all marijuana from Mendocino County and last year seized 135,736 plants, third highest in the state.⁶ Mendocino County outranks California as a whole in many other indicators of substance abuse as well:

- The HHSA Division of Alcohol and Other Drug Programs (AODP) has seen a consistent rise in clients treated for meth abuse, which has nearly *quadrupled* in the past 10 years.
- Rural Northern California's amphetamine-related emergency admission rates are 50% higher than the statewide rate.
- According to the Mendocino County Sheriff's Office, dangerous drug violations, which account for almost half of all drug offenses and include meth, have tripled in the past 10 years. The 2004 Mendocino County Grand Jury Report found that 99% of county jail inmates had alcohol and drug problems, and that 80% of these were meth users.

The Mendocino County Continuum of Care for the Homeless is coordinated by HHSA's Social Services Branch through the Homeless Services Planning Group (HSPG). The HSPG oversees implementation of Supportive Housing Program (SHP) grants and Shelter+Care grants (funded by the US Department of Housing and Urban Development/HUD), as well as coordinating the efforts of non-HUD-funded homeless services, including the Homeless Management Information System, the bi-annual Homeless Census and Survey (point-in-time count), and serving as the policy-making body for the Continuum of Care.

⁴ National Low Income Housing Coalition, Out of Reach 2006 Mendocino County, www.nlihc.org.

⁵ California Alcoholic Beverage Control.

⁶ California Department of Justice, Office of the Attorney General.

Mendocino County's Continuum of Care provides an extraordinary level of service for the homeless, especially considering the significant hurdles that are faced by the rural homeless. For example, while all homeless people face health risks, rural homeless people have more limited access to medical care than their urban counterparts. As a result, medical problems are often more advanced by the time they receive medical attention (Post, 2002), and become greater impediments to addressing substance abuse and mental health issues. Rural areas also have consistently higher rates of disabilities among working adults than urban areas do—23.3% compared to 18.4% (Community Options, 1999). This higher rate of disabilities seems to translate to the homeless population.

In January 2007, the HSPG conducted the county's second point-in-time Homeless Census and Survey. The census counted a total of 1,422 homeless people, which equates to an annual estimate of 4,345 persons who experienced homelessness at some time during the year,⁷ equal to 4.8% of the county's population. Of those counted, 20% were in shelters or institutions and 80% were unsheltered. At the time of the 2007 homeless census, 405 homeless persons (28.5% of those included in the census) also completed a brief survey that profiles the county's homeless:

- Most of the homeless are white/non-Hispanic (68.6%), although there are also high proportions of Hispanic (10.4%) and Native American (10.1%) homeless.
- Nearly two-thirds (64%) are male.
- <1% are age 13-17; 5% are 18-21; 18% are 22-30; 73% are 31-60; and 3% are 60+.
- 13% are veterans, and two of every five homeless veterans are disabled.
- Fewer than 14% of the homeless have annual incomes over \$10,000 per month.
- Over half (56%) visited emergency rooms during the previous year, with 20% seeking emergency room care four or more times.
- One-third are experiencing their first episode of homelessness, while 20% have been homeless four or more times; 39% have been homeless for more than one year, placing them in the chronic homeless category.
- Almost half used the services of Resource Centers during the previous month.
- 79% have no job. The top two reasons given for unemployment are disabilities and no permanent address; only 1.9% have accessed job training.

The survey included the following characteristics on disabilities among the homeless population:

- Two-thirds (68%) have a disability that keeps them from working and 36% have chronic health problems, 6% have HIV/AIDS, and 19% have Hepatitis C (HCV).
- 35% have mental illnesses and 48% have depression; 12% consider mental health issues the primary cause of their homelessness.
- 35% report alcohol abuse and 29% report drug abuse; 22% have been turned away from shelters because of substance use; 10% consider alcohol and drug (AOD) use the primary cause of their homelessness; and 20% identify it as their primary barrier to housing.

Although the survey did not identify the number of individuals with CoD, national data show that, among adults with serious mental illness in 2003, 21% abused alcohol or illicit drugs and among adults with substance dependence or abuse, 22% had serious mental illness (SAMHSA, 2003). The Department of Veterans Affairs has identified high rates of co-occurring disorders among veterans: 44% of inpatients treated during 2001 had co-occurring substance use and

⁷ Research data indicate that the homeless population renews itself approximately 2.74 times every year. In other words, for every homeless person at a given point in time, 2.74 people are homeless annually.

mental disorders (Rosenheck and Greenberg, 2002). Among veterans receiving specialized treatment for post-traumatic stress disorder (PTSD), 41% had a co-occurring substance abuse disorder (Fontana, 2002). Finally, as many as 70% of women in substance abuse treatment report childhood sexual abuse. Childhood sexual abuse leads to PTSD, a condition that requires treatment to achieve and maintain abstinence from alcohol and other drugs (SAMHSA TIP 36).

A-3. Barriers to accessing services

- Mendocino County's support for homeless CoD clients utilizes a patched together approach through which different services and client types are covered by different funders and delivered by different providers. Dually-diagnosed individuals have the highest drop-out rate of all county homeless clients and yet they form the core group of the homeless population. Local experience is corroborated in the literature (Beggs, 1998). Existing services lack the intensity, integration, and co-location that is essential in serving the target population, and no one is providing CoD treatment for this population.
- Most GA clients are covered by the County Medical Services Program (CMSP), which provides primary health care but not mental health or substance abuse treatment. AODP reports a 45-day waiting period for AOD treatment for this population.
- The CoD homeless population has traditionally been the most difficult to serve because substance abuse professionals are not trained to treat clients that have a mental illness, and mental health professionals are not trained to treat substance abuse disorders.
- Without intensive case management, homeless people with CoD have little success in securing stable housing, because of their complex mental health and AOD problems.
- SSI is an important self-sufficiency goal for many disabled homeless clients, but they cannot access SSI without a primary diagnosis distinct from alcohol and drug abuse.
- Clients with mental health issues that do not rise to the level of Severe Mental Illnesses are increasingly requesting services through the Mental Health Branch, especially its Crisis Center. For example, during the first three months of 2008, the Crisis Center completed an intake process on 261 patients. Of these, 72 (28%) were not assessed as having a mental health related crisis, and 61 (23%) presented as intoxicated with no co-occurring serious mental illness. However, the Mental Health Branch serves only Medi-Cal eligible clients with Severe Mental Illnesses. In other words, treatment for homeless persons with less severe mental health issues is extremely limited.
- Although the county has transitional housing availability, funding for treatment is lacking and intensive case management of people in transitional housing is very limited.

A-4. Consistency of project with local priorities

AT HOME will fortify the County's existing Continuum of Care for the Homeless by initiating an integrated treatment program for homeless clients with CoD, including wrap-around support and linkage to housing. HHSa has identified housing as the cornerstone of its Adult System of Care, recognizing that when individuals lack adequate shelter, their needs for other services rise exponentially. The 2008 HHSa Strategic Plan (Appendix 5) for the Adult System of Care identifies the following goals and objectives that will be addressed through AT HOME:

Strategic Plan Goal 2. Develop a continuum of housing options that supports the client/individual in being a self-sufficient member of the community.

- Objective 2A. Advocate for expanded housing resources for all levels of housing including: emergency shelter, transitional or short term, and permanent.
- Objective 2B. Support Harm Reduction and Mental Health and AOD Recovery models.

Strategic Plan Goal 3. Establish a culturally sensitive behavioral health program to serve individuals with mental health, physical, and/or developmental disabilities and drug and alcohol abuse issues to address barriers to recovery and independence.

- Objective 3A: Behavioral health programs will strive to co-locate staff.
- Objective 3C: Staff training will be available in Mental Health and AOD Recovery.
- Objective 3D: Peer support will be available to all participants.

SECTION B. LEGISLATIVE PREFERENCES & SAMHSA PRIORITY

B-1. How project will address legislative preferences

The HSPG, established in 1993 with the leadership of HHSA's Social Services Branch, is a partnership of 50 health and human service, faith-based, education, and housing organizations, and three incorporated cities. In 1999, the County Board of Supervisors adopted the Continuum of Care model to address homelessness in the county. The Continuum of Care is largely funded by HUD through its Supportive Housing Program. At its core are the county's Resource Centers, which are easy-access points of entry and hubs of service delivery for the homeless. *Through Continuum of Care partners, the County is able to address all legislative preferences. In accordance with Sec. 506 of the Public Health Service Act, HHSA requests funding preference based on the following factors: 1) AT HOME provides integrated primary health, substance abuse, and mental health services for homeless individuals; 2) HHSA has provided documentation of experience in serving homeless youth and veterans, providing AOD and mental health services for the homeless, and providing housing for people in treatment or recovery; and 3) AT HOME will expand and strengthen treatment services for chronic public inebriates.*

Experience integrating primary health, AOD, and mental health services to homeless individuals

During the past year, services were provided to 1,176 homeless individuals through all Continuum of Care partners. The HSPG is currently implementing four Continuum of Care components: the SHP grant that funds the Resource Centers; an SHP Transitional Housing grant; and two Shelter Plus Care grants, as well as 130 scattered site housing vouchers and four sponsor-based units at the Ford Street Project. HHSA has also collaborated to carry out a range of past integrated projects that addressed needs of homeless individuals, as summarized below:

- From 2001-2003, HHSA implemented a grant from the CMSP Governing Board to provide case management for CMSP clients (homeless and at-risk of homelessness) and to connect them to safety net clinics. Lessons learned through this successful project included a new appreciation for the value of intensive integrated case management.
- HHSA's Adult System of Care is designed to integrate care for all adults, including the homeless, and will become operational in July 2008.
- The Social Services Branch utilizes County dollars to contract with the Resource Centers in Ukiah to provide basic AOD counseling and with Mendocino Community Health Clinic (MCHC) to provide basic mental health counseling to GA clients.

Evidence demonstrating effectiveness in serving runaway, homeless, and street youth

Although the 2007 point-in-time count found less than 1% of the homeless to be under the age of 18, homeless youth are typically undercounted in a point-in-time census. County schools report just under 300 homeless students, although data collected by HSPG members throughout the county suggest that there may be more than 1,000 homeless children. The county has gained experience in working with homeless youth through Mendocino County Youth Project, an HSPG member and past recipient of McKinney-Vento Act funding for outreach to homeless youth, and

the Mendocino County Office of Education's current McKinney-Vento Act funding for a comprehensive system to identify, track, and serve homeless students in three school districts.

Experience providing substance abuse and mental health services to homeless individuals

HSPG members have worked together in numerous collaborative projects to ensure access to AOD and mental health services for the homeless. These services are priorities for the HSPG and have been included in annual updates to the Continuum of Care since 1993. Programs include:

- The Mental Health Branch's AB 2034 program that provided treatment and wrap-around support to seriously mentally ill homeless persons.
- The Mental Health Branch's outreach and intervention to engage seriously mentally ill homeless in mainstream mental health supportive services and provide them with case management, day treatment, crisis intervention, medication evaluation and management, vocational training, and psychiatric hospitalization.
- MCHC's provision of behavioral health services to 72 homeless patients (17% of the total served in 2007).
- HHSA Social Services Branch contracts with MCHC (basic mental health treatment) and Ford Street Project (basic substance abuse treatment) for services to GA clients.
- HHSA Mental Health Branch funding for A Healing Cooperative, a peer-support organization, to provide peer-support programs and MCHC's contract with A Healing Cooperative to conduct street outreach to the homeless.

Experience providing housing for individuals in treatment or recovery

HHSA's Continuum of Care for the Homeless has developed a comprehensive array of homelessness prevention and support services that includes shelter, transitional, and permanent supportive housing. (Current housing resources are detailed in Sections D-7 and E-4 below.)

- HHSA's Supportive Housing Initiative Act grant provided rental subsidies for 8 permanent supportive housing units for 15 years, and intensive case management and supportive for 375 participants over a three-year funding period.
- Shelter+Care and Supportive Housing Program grants from HUD (1993-present) provide permanent supportive housing. Transitional housing beds have increased from 48 to 92 and permanent supportive housing units to 134.
- In Ukiah, the Ford Street Project operates 4 detox beds, 44 residential treatment beds, and the 64-bed Buddy Eller Shelter, with 8 additional seasonal overflow beds and safe options for acutely disabled homeless.
- Over 15 years of operation, the HSPG has honed its case conferencing infrastructure into the well-functioning system that now exists. During a 2006 site visit/program audit, HUD cited the HSPG's interagency case conferencing structure as a best practice model.

Evidence that demonstrates effectiveness in serving homeless veterans

Approximately 5% of the homeless population served through the Continuum of Care are veterans. The HHSA Social Services Branch operates the Veterans Service Office, which participates in the HSPG and provides cultural guidance in serving homeless veterans. Also, the North Bay Veterans Resource Center provides extensive help for homeless veterans in securing services and housing. During the most recent reporting period, HSPG programs provided assistance and support to 23 homeless veterans through the Resource Centers. AODP reports that 13% of clients served during the past year were veterans. Veterans participating in AT HOME will have access to trauma-informed services (described in Section D-2) for treatment of PTSD.

B-2. How project strengthens treatment for chronic inebriates

People who are categorized as chronic public inebriates comprise a disproportionate number of those that seek help through the Mental Health Crisis Center or hospital emergency rooms, even though they are not eligible for Mental Health Branch services and may not be experiencing a medical emergency. By providing intensive case management and individualized CoD treatment in a familiar environment, the AT HOME Project will be prepared not only to welcome the participation of chronic public inebriates but to support their progress toward recovery while reducing the overload currently experienced by the Mental Health Branch Crisis Center.

SECTION C. PROPOSED EVIDENCE-BASED SERVICE/PRACTICE

C-1. Purpose, goals, and objectives

AT HOME’s overall goals are to decrease homelessness and improve the health, well-being, and self-sufficiency of homeless GA and SHP beneficiaries with co-occurring disorders by expanding and strengthening the County’s Continuum of Care for the Homeless to link integrated mental health and substance abuse treatment with housing and intensive case management.

Table Three: Goals, objectives, and outcomes

GOAL 1. Support recovery of AT HOME participants by providing integrated mental health and substance abuse treatment.	
Objectives	Outcomes
1A. Behavioral Health and Substance Abuse Counselors will carry a caseload of 24 clients, serving 60/year and 300 total.	<ul style="list-style-type: none"> • 60% of participants completing CoD treatment will demonstrate decreased symptoms of mental illness. • 60% of participants completing CoD treatment will decrease AOD dependence.
1B. 30% of participants will successfully complete treatment.	<ul style="list-style-type: none"> • 25% of participants will demonstrate a decrease in Mental Health Crisis Unit visits and law enforcement contacts.

GOAL 2. Support increasing self-sufficiency of AT HOME participants by providing intensive case management, including housing, wrap-around support, and vocational services.	
Objectives	Outcomes
2A. Case Managers will provide intensive case management.	<ul style="list-style-type: none"> • 80% of participants will report improved quality of life. • 25% of participants completing program will gain employment.
2B. Case Managers will advocate for long-term benefits for participants who have chronic disabilities.	<ul style="list-style-type: none"> • 25% of AT HOME participants who enter the program without income benefits will have increased income stability through enrollment in long-term benefits programs.
2C. Case Managers will link clients with shelter, transitional, and permanent supportive housing.	<ul style="list-style-type: none"> • 60% of AT HOME participants will relocate to shelters, 30% will be placed in transitional housing, and 20% will enter permanent or permanent supportive housing.
2D. MCHC will assess health needs and deliver health care services for AT HOME clients.	<ul style="list-style-type: none"> • 50% of participants will decrease emergency room visits. • Participants will demonstrate increased medication compliance and adherence to harm reduction behaviors.

GOAL 3. Build and develop the capacity of AT HOME staff, partners, and service delivery system.	
Objectives	Outcomes
3A. HHSA will make GA enrollment	<ul style="list-style-type: none"> • Continuum of Care is strengthened by increasing access to

GOAL 3. Build and develop the capacity of AT HOME staff, partners, and service delivery system.	
Objectives	Outcomes
available in Willits.	services for homeless people in Willits.
3B. Coordinator will ensure 12 hours professional development per year.	<ul style="list-style-type: none"> • AT HOME staff trained and competent in delivery of CoD services.
3C. AT HOME partners will monitor and revise “no wrong door” policies and procedures.	<ul style="list-style-type: none"> • AT HOME ensures a welcoming approach in all policies, eliminates arbitrary barriers, and helps clients regardless of point of entry or level of motivation.

C-2. Evidence-based service/practice

A thorough review of the literature on identifying and treating people with CoD guided the HHSA and its partners in selecting the Comprehensive, Continuous, Integrated System of Care (CCISC) model to integrate mental health and substance abuse treatment. CCISC facilitates tailoring to the specific needs of individual clients, and focuses on stabilizing client symptoms and then engaging them in long-term maintenance, rehabilitation, and recovery, all of which are essential attributes of CoD treatment (Minkoff, 2004; Beggs, 1998; Sciacca, 1991). AT HOME incorporates the four basic characteristics that are integral to successful CCISC implementation:

- **System Level Change.** HHSA has adopted the principles of the CCISC for treatment of all clients with CoD, meaning that all staff are training and developing expertise in this model and that clients will find “no wrong door” when they seek assistance.
- **Efficient Use of Existing Resources.** AT HOME will benefit from existing facilities, partnerships, and intra-agency coordination among Social Services, Mental Health, and Public Health Branches, MCHC, and HSPG members (see Section E-4 for details).
- **Incorporation of Best Practices.** The CCISC model is recognized by SAMHSA as a best practice for systems implementation of treatment of individuals with CoD and incorporates evidence-based and clinical consensus-based best practices, including a welcoming environment. “Welcoming,” while not formally evidence-based, is a clinical service delivery standard that promotes other best practice interventions.
- **Integrated Treatment Philosophy.** The CCISC model uses a common language that makes sense to both mental health and AOD treatment providers. Integrated treatment requires simultaneous aggressive approaches to both disorders. In treating substance abuse, chemical dependency is viewed as a chronic disease rather than a moral deficiency. On the mental health side, all goals are based on the belief that clients can learn to manage their symptoms, and that recovery is both possible and expected. An education-and-support approach to treatment is supported by research that shows that relapse into mental illness is more likely when clients have inadequate strategies for handling stress (Ryglewicz and Pepper, 1992). That is why intensive case management is integral to AT HOME. Case management helps to engage, link, and support clients in services that reduce life stresses. “Without care management, many severely mentally ill patients would decompensate, need to be hospitalized, or become homeless again” (SAMHSA TIP Series Nine, 1994).

Within the CCISC framework, AT HOME incorporates approaches recommended by SAMHSA’s Co-Occurring Center for Excellence, which recommends consideration of evidence-based practices designed solely for mental health or substance abuse such as motivational interventions, behavioral interventions, psychopharmacological interventions, as well as Integrated Dual Disorders Treatment (IDDT), a Center for Mental Health Services Evidence-

Based Practice Toolkit (National Mental Health Information Center, 2003). AT HOME incorporates all integral features of the IDDT model, as detailed in the following paragraphs.

Individualized treatment. CCISC approaches treatment by working with clients to design individualized treatment plans that meet their specific needs and are provided in the least restrictive setting, based on level of functioning, available supports, external contingencies, etc. While abstinence and full mental illness recovery are long-term goals, short-term clinical outcomes are individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, movement through stages of change, reduction in harm, reduction in service utilization, or movement to a lower level of care. Reflecting research in both addiction and mental health fields, CCISC emphasizes the concept of stages of change or stages of treatment, and demonstrates the value of stage-wise treatment (Drake et al, 2001.)

For participants with stimulant use disorders, AODP will use the Matrix treatment model. Matrix provides structured treatment and support to achieve and maintain abstinence. Matrix incorporates relapse prevention; cognitive-behavioral, psychoeducation, and motivational interviewing; and 12-step support (Obert et al, 2000). Matrix effectiveness has been evaluated numerous times since its inception (Rawson et al, 1995; Shoptaw et al, 1994). SAMHSA found the results of these studies promising enough to warrant further evaluation and has included the program in its National Registry of Evidence-based Programs and Practices.

Group education, group process, and peer support. AT HOME groups will provide opportunities for mutual education, sharing, and support. Participants will also be referred to community-based groups that follow the *Double Trouble In Recovery* (DTR) model for adults who have been dually diagnosed. DTR follows the traditional 12-step format, encourages members to discuss their addiction, mental illness, psychotropic medications, and experiences with formal treatment without the stigma they might encounter in traditional 12-step programs. DTR groups are structured to create an environment in which people with an active addiction and psychiatric diagnosis can identify with other members and explore their dual recovery needs.

Multidisciplinary teams and integrated approaches. Research conducted on the effectiveness of integrated treatment has led to the consensus that integrated CoD treatment is more effective than parallel or sequential treatment (Drake et al, 1998). The Center for Therapeutic Community Research at the National Development and Research Institutes in New York used a quasi-experimental design to compare integrated treatment to standard community services for 217 homeless individuals over an 18-month period. Results demonstrated several advantages of integrated services: participants in the integrated treatment group had fewer institutional days and more days in stable housing, made more progress toward recovery from substance abuse, and showed greater improvement of alcohol use disorders than did participants in the control group. In 1993, the County's GA Program had over 400 clients. At that time, the Social Services Branch shifted its approach from an eligibility model to a social work model, adding case management, AOD treatment, employment services, and SSI advocacy. After restructuring, the caseload dropped to 165—evidence of the efficacy of integrated case management.

Justification of practice for target population

Since the county's Continuum of Care was created in 1993, HSPG members have been struggling with the challenge of serving individuals with CoD. The HSPG's recognition of this serious service gap has been informed by the high drop-out rates (30-40%) of dually-diagnosed clients. Findings from SAMHSA's Collaborative Demonstration Program show that successful

treatment for homeless individuals with CoD must be comprehensive, multi-dimensional, and of long term; these are all characteristics of the CCISC model. Engagement, peer support, and the ability to view relapse as part of the treatment process also are essential (Oakley, 2000). The HSPG believes that the CCISC model will increase success rates. In a 2007 Keystone Research Brief, the University of South Florida reported on a study designed to assess the effectiveness of the CCISC model for a diverse sample of homeless individuals with COD. Although services were delivered in a residential setting, the findings can be applied to non-residential services. In summary, the study included 96 participants, predominantly White males, who were diagnosed with CoD. At the end of the 12-month study, clients expressed high levels of satisfaction, and the study found significant reductions in past-month AOD use and in mental health symptoms, based on baseline, 6-month, and 12-month administration of the Global Severity Index (Moore, 2007).

C-3. Evidence that practice is appropriate for proposed outcomes

Researchers have found that, compared to traditional approaches, CoD treatment results in:⁸

- Increased abstinence from substances and better physical health.
- Reduced violence, victimization, and legal problems and reduced institutionalization.
- Reduced symptoms of mental illness, including suicide.
- Improved functioning and improved relationships.

C-4. Justification of proposed adaptations and modifications

Although the CCISC model is designed for persons with CoD, it does not directly address the needs of persons who are also coping with the challenges of homelessness. AT HOME, with client input, will incorporate the following enhancements to support homeless clients:

- **Service location.** Case management will be coordinated on-site at Resource Centers, although clients will also be served at clinics and Willits Integrated Services Center.
- **Engagement.** Engagement strategies will include access to emergency, transitional, and permanent housing and wraparound support.
- **Gender-specific treatment.** AT HOME will offer women-only support groups to address trauma and abuse issues that are prevalent in female substance abusers. In a 1993 study, 104 out of 105 female drug users reported a history of trauma, and the study found that women responded best to gender-specific treatment (Fullilove et al, 1993). AT HOME will also provide separate groups for male clients, including anger management.
- **Welcoming environment.** AT HOME will incorporate features that are essential to success in working with the homeless: a permanent welcome (once clients enter the program, they can participate without time limits); voluntary participation; physical and emotional accessibility that reinforce dignity and safety; genuine empowerment; tolerance and flexibility; and persistent advocacy to meet client needs (LAMP, 2004).
- **Overcoming barriers to access.** Through support and delivery strategies, AT HOME will work with clients to address transportation, health care, and other barriers.

C-5. Rationale for selection of evidence-based practice

Although evidence-based practices specific to the rural homeless have yet to be developed, AT HOME planners have relied on recommendations (described above) that evidence-based practices designed for substance abuse disorders and practices designed for mental health disorders be used in treating individuals with CoD within the CCISC framework.

⁸ IDDT Implementation Resource Kit.

C-6. Addressing diversity issues

Cultural competency will be incorporated into all AT HOME components to ensure service provision in a language, setting, and method that meets client needs, recognizing the special needs of subcultures, including veterans, as well as the unique subculture of homelessness. With the range of diversity represented by HHSA staff and partners, guidance in cultural competence issues will be readily available—many Resource Center employees have themselves a history of homelessness. In addition, HHSA will draw on the Veterans Services Officer (an HSPG member within the Social Services Branch) to provide guidance in understanding and meeting the needs of homeless veterans.

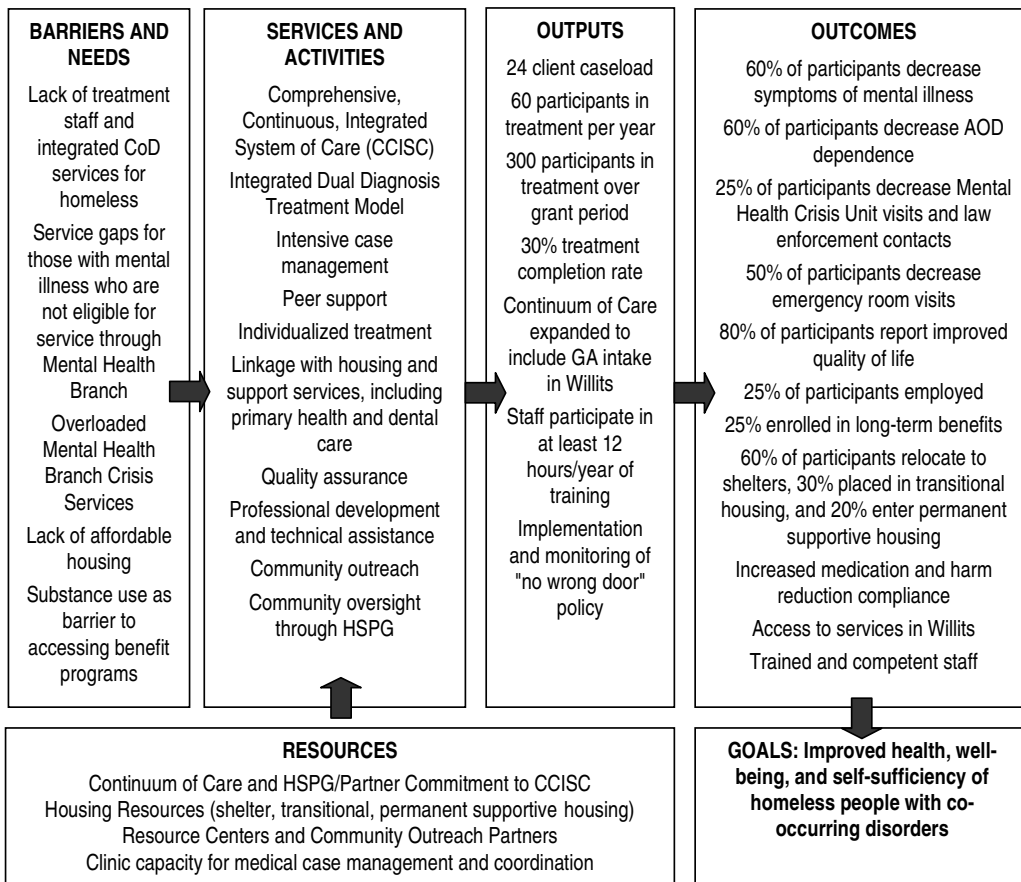
HHSA and its AT HOME partners will incorporate cultural competency into all services through annual staff training and organizational policy. Participant orientation will include discussion of HHSA's non-discrimination policies and tolerance guidelines. Within HHSA, these issues are addressed by the work of the Cultural Competency Committee, which meets monthly to develop policies and plan regular training activities. Non-HHSA staff and partners involved in AT HOME will be encouraged to participate, to strengthen team and individual understanding of and effectiveness in working with local ethnic groups and ensure sensitivity to language, age, gender, race/ethnicity, sexual orientation, and other cultural factors. Additional areas of diversity:

Gender. HHSA's current treatment staff are 20% male and 80% female, which will make it easier for treatment to be provided in gender-specific treatment groups when appropriate.

Rural Location. SAMHSA TIP 33: "*For rural populations...providing treatment services that are flexible in scope and structure...is an important intervention.*" The program will accommodate rural needs by tailoring time and place of treatment to accommodate transportation issues and providing treatment in a comfortable and informal atmosphere.

Spanish Speakers. Because the HSPG has yet to encounter a monolingual Spanish speaker within the homeless CoD population, no special arrangements will be made for providing Spanish language services. Should a monolingual client request treatment, HHSA will coordinate with community partners to ensure delivery of appropriate services. Furthermore, partners will recruit staff with the intent of hiring bilingual individuals with the appropriate qualifications.

Figure 1. AT HOME Logic Model



American Indian Participants. Historically, American Indian clients have participated in local treatment programs with good success. However, according to local tribal leaders, they often return to tribal lands clean and sober, but find no resources to support their continued sobriety. HHSA will refer American Indian participants to Red Road to Recovery, an alternative 12-step model. HHSA also has American Indian Substance Abuse Counselors on staff to provide guidance and technical assistance in ensuring cultural competence.

ADDITIONAL AREAS OF DIVERSITY

- **Sexual Orientation.** Counselors are trained to be nonjudgmental and accepting of cultural, behavioral, and value differences and to adjust strategies for client characteristics, including sexual orientation. These best-practice methods are critical when working with lesbian, gay, bisexual, and transgender clients (SAMHSA, 2001).
- **Disability.** All facilities comply with the *Americans with Disabilities Act*. Meeting rooms are identified by Braille plaques and staff will be available to read materials aloud to visually impaired clients. For hearing impaired clients, HHSA will contract American Sign Language translators to assist as needed. If HHSA is not able to provide quality services, clients will be referred to specialized providers (SAMHSA TIP 29, 1998).

- **Learning Style and Literacy.** AT HOME partners will make every effort to match participant learning style with the treatment approach. HHSA program materials are developed at a 6th grade reading level; for clients who are not able to read the materials, staff will be available to read aloud and will refer clients to literacy programs.

C-7. Linkages between need, service, and outcomes

The AT HOME Program design is based on the following hypotheses:

- Many GA and SHP participants are homeless or at risk of homelessness and have CoD.
- Homeless people with CoD need intensive case management and advocacy to fully access and benefit from services and benefits and to remove barriers to housing.
- Mental health and substance abuse disorders are barriers to housing stability, and when they are co-occurring, require integrated treatment and support.

SECTION D. PROPOSED IMPLEMENTATION APPROACH

D-1. How service/practice will be implemented

Substance and mental health treatment for AT HOME clients will be fully integrated through active treatment groups and individual sessions with Substance Abuse and Behavioral Health Counselors. Both Counselors—in conjunction with Case Managers and the client—will develop and monitor a Personal Service Plan that includes an integrated Treatment Plan. Treatment Counselors will utilize treatment stages and motivational interviewing tactics, and approach each condition as a primary diagnosis. Use of chemical testing as a treatment strategy will be based on the client’s unique situation. On average, clients will remain in treatment for one year, although they may continue longer. Approximately one-third of those who enter treatment are expected to complete their Treatment Plan. In light of the frequent relapses of this population, AT HOME will also coordinate aftercare or relapse prevention support groups for clients that have accepted the goal of abstinence and are relatively stable, but require ongoing education and support for sobriety and strengthening relapse prevention skills. Frequent contact (as shown in Table Four) with treatment Counselors and Case Managers will help reduce decompensation and subsequent crisis situations. The program design, which allows participants to move seamlessly to more or less intensive levels of treatment as needed, will also facilitate intervention before situations reach a crisis point. Through collaboration with MCHC, participants will have access to non-emergency psychotropic medication management, which, once the medication has been prescribed and the patient stabilized, can be managed by a primary health care provider.

Table Four. CoD treatment schedule

Duration	• CoD treatment will extend for 12 months or more, depending on client need.
Schedule	<ul style="list-style-type: none"> • Mental health counseling: 1-2 times/week. • Substance abuse treatment: 1-2 times/week (may consist of brief check-ins rather than full hour sessions). • Co-facilitated groups: 1-4 days/week (may be gender specific).
Chemical Testing	• Urine testing will be conducted as needed as a treatment tool.

D-2. How required services will be provided and integrated

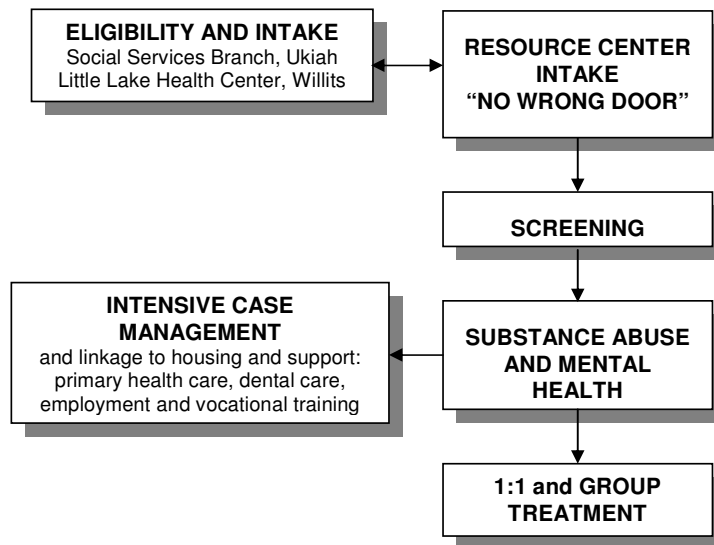
Direct Treatment. Treatment delivery is described in Section D-1 above, and screening and assessment strategies are detailed in Section D-3 below. As part of client treatment, all staff will participate in weekly clinical case conferencing held at the clinics or the Resource Centers, and

Case Managers will also participate in weekly SHP case conferencing, the nexus where housing, services, and the needs of individual clients meet.

Outreach. Outreach and recruitment strategies are discussed in Section D-6 below.

Figure 2. AT HOME Client flow chart

Case Management. The entry point to most services for the homeless is through their need for shelter, which they access through the Resource Centers. Placing Case Managers in the Resource Centers will connect them with those people who are the most disadvantaged and the least likely to have the skills necessary to navigate the social service and medical provider systems on their own. Case Managers will also provide benefits counseling and assist clients to begin the SSI application process, which will be key to accessing ongoing Medi-Cal reimbursement for their disabilities, or other entitlement programs. Case Management will include:



- Individualized orientation to the program on a one-to-one basis.
- Comprehensive assessment of basic needs.
- Advocacy for, follow up, and monitoring of services extended through other providers.
- Attention to cultural, linguistic, and age-appropriate approaches.
- Planning for self-managed approach to wellness.

As clients enter the program, Case Managers will work with them and with the treatment providers to develop client-centered Personal Service Plans that expand basic case management to include support, monitoring, linkage, and brokered assistance. Once established, Case Managers will assess and advocate for client enrollment in appropriate entitlement programs and link them with support services and housing opportunities. The Case Manager will open an electronic file for each client, to include the Personal Service Plan (with a summary of the Treatment Plan), results from assessments, and clinical notes. Only the client’s Case Manager and treatment Counselors will have access to client files. Specific protocols for management and security of client files will be developed during project startup.

Wrap-around and recovery support services. Case management will also include individualized wrap-around and recovery support services designed to improve access to and retention in services and to sustain treatment gains. Specific support services are listed in Table Five below. When clients are referred to external service providers, Case Managers will follow up to make sure that services have taken place and have met client needs.

Table Five. Supportive services available to AT HOME participants

SUPPORTIVE SERVICE	WHERE SERVICE IS PROVIDED	FREQUENCY
12-step programs	Ukiah and Willits	Multiple times/day
Peer support group	Ford Street Project	2 times/week
Medical care	Hillside Health Center and Little Lake Health Center	Daily
Transportation	Mendocino Transit Authority Vouchers MCHC and AODP vans	Available as needed
Drop-in centers	Mental Health Branch and A Healing Cooperative in Ukiah and Healing Hearts in Willits	Daily
Life skills training	Multiple	At least 1 time/week
Employment	GA job development and placement, HHSA Job Alliance, Mendocino Private Industry Council	Daily, as needed

Additional allowable services

Education, screening, and counseling for sexually transmitted infections. Prevention and harm reduction strategies are discussed in Section D-4 below.

Trauma-informed services. Trauma-informed services will be delivered using the *Seeking Safety* curriculum. *Seeking Safety*, a flexible present-focused therapy to help people attain safety from trauma/PTSD and substance abuse, is listed in SAMHSA’s National Registry of Evidence-based Programs and Practices. The 25-topic curriculum, which includes both client handouts and guidance for clinicians, has been delivered in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD. Several AODP staff have already been trained in this model and AODP is already using the curriculum; MCHC staff and any AODP staff that have not been trained will participate in an orientation session.

Employment readiness, training, and placement. Case Managers will coordinate with community partners to assess training needs and vocational readiness and develop plans for education, training, internships, and/or employment that meets individual needs.

Professional development. Cross-training is critical to the success of integrated treatment for dually-diagnosed homeless clients (SAMHSA TAR, 2003). Cross-training not only strengthens skills but also provides opportunities for staff trained in the different disciplines to meet and work together. Trainings will be a combination of on-the-job training, didactic in-service training, self-education through readings of peer-reviewed journals and texts on dual diagnosis, and visits by noted experts in the field. The AT HOME Coordinator will organize trainings and will also bring in professionals in the field of co-occurring disorders to provide special trainings, such as MCHC’s Behavioral Health Director, Dr. Michael Mabanglo. Relevant competencies will be incorporated into human resource policies and job descriptions so that they can be addressed as part of personnel evaluation, credentialing, and licensure, and to measure or monitor counselor’s attainment of competency. Training topics not included in the initial training plan will be developed by the HSPG Core Team, building on evaluation findings. HHSA will also take full advantage of no-cost technical assistance and training that is available through the California Department of Alcohol and Drug Programs. A preliminary professional development plan is provided in Table Six below.

Table Six. AT HOME training and professional development plan

WHO	WHAT
All AT HOME staff and partners	<ul style="list-style-type: none"> • Assessment and management of dually-diagnosed clients • Managing risk with unpredictable clients • Substances of abuse and how they affect mental illness, and ways in which chemical dependency is affected by mental illness • Meaning of homelessness and what the homeless really need • HCV clinical protocols and coordination with treatment • Continuum of Care and the Supportive Housing Program and how they work
Case Managers	<ul style="list-style-type: none"> • Understanding and advocating for entitlement programs and benefits • Case management of the homeless population
Treatment Counselors	<ul style="list-style-type: none"> • In-depth training in treatment of co-occurring disorders • Seeking Safety Trauma-Informed Services
Intake Workers	<ul style="list-style-type: none"> • Screening for co-occurring disorders

D-3. Screening, assessment, and development of treatment approaches

Screening. In keeping with the “no wrong door” policy, initial screening for co-occurring disorders will be carried out by whomever is the first point of contact for a potential participant. (Please see Appendix 2 for a copy of the screening tool.) Screeners will then refer identified participants on to the Case Managers. During project start-up, Resource Center intake workers will participate in training in how to administer and interpret the screen. Clients whose screen indicates a possible dual diagnosis (estimated at 25% of those who contact the Resource Center) will be referred to an AT HOME Case Manager to introduce/orient the new client to the program. Maintaining an atmosphere of collaboration and relationship-building will be an essential strategy at this point to motivate the client’s continued participation.

Assessment. The purpose of assessment is twofold. First, it engages clients in the recovery process, making it their first phase of treatment. The second purpose is to arrive at an accurate psychiatric diagnosis and assessment of other immediate needs, so that clients who have cycled repeatedly through homelessness can finally access effective treatment. Assessment will be carried out jointly by mental health and substance treatment Counselors, working individually and together with each client. The assessment for CoD is integrated by analyzing and using data concerning one disorder in light of data concerning the other disorder, as suggested by SAMHSA TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*. Mental health and substance assessments will be initiated within seven days of referral, with treatment beginning within two days following completion of the assessment. However, the assessment process may take up to 30 days to complete—the assessment phase will be complete when staff have arrived at a diagnosis. During this time the client is establishing rapport with treatment Counselors, entering a shelter or transitional housing situation, and addressing medical or other critical needs. Although the distinction between assessment and treatment is being made for purposes of program planning, the transition will be seamless for the client, with a transparent consent policy in which clients are fully involved in their treatment planning. Clients assessed as having serious mental illnesses and who are considered unable to benefit from group settings will be referred for care to the Mental Health Branch.

Specific diagnostic processes will depend on the unique circumstances of individual clients but may include the Burns Anxiety Inventory, the Duke Health Profile, and the PHQ-9 Health

Questionnaire to assess anxiety, depression, and mental health/quality of life status; and the American Society of Addiction Medicine Patient Placement Criteria Interview Protocol (ASAM PPC-2R) guidelines for placement, continued stay, and discharge of clients with alcohol and other drug disorders.⁹ The ASAM instrument considers patient placement criteria based on a client's level of functioning in six dimensions (*i.e.*, acute intoxication and/or withdrawal potential, biomedical conditions and complications, emotional/behavioral/cognitive conditions and complications, treatment acceptance/resistance, relapse/continued use potential, and recovery environment). The assessment results determine the appropriate level of care (*i.e.*, Early Intervention, Outpatient Services, Intensive Outpatient/Partial Hospitalization, Residential/Inpatient Services, or Medically Managed Intensive Inpatient Services).

Treatment planning. As with integrated screening and assessment, integrated treatment planning addresses both mental health and substance abuse identified through the assessment process, each in the context of the other disorder. Treatment Plans will take into account the client's strengths and needs, describe their individual goals and objectives, and be flexible and individualized to address the needs of each client, drawing on a continuum of treatment intensity levels. The Treatment Plan will include program and intensity assignments, while the Personal Service Plan will address underlying conditions that may be contributing to substance and/or mental health disorders. These may include lack of job skills, literacy issues, family violence, history of abuse, physical health issues, housing, etc., as well as homelessness.

D-4. Steps to reduce HIV/AIDS risk behaviors

In 2005, the Mendocino County AIDS Volunteer Network tested a group of injecting drug users who did not know their Hepatitis C status and found 70% to be HCV positive. Applying this percentage to the 5,000 injection drug users that the County Sheriff's office estimates live in Mendocino County suggests that there are approximately 3,500 cases of needle-related HCV in the county. However, since it can take 20-40 years for a person with HCV to show any signs of illness, there are undoubtedly many county residents who are unaware of their infection.

The HHS Public Health Branch has tracked 122 HIV/AIDS infected individuals currently living in the county. The Centers for Disease Control and Prevention estimates that testing programs have identified between $\frac{2}{3}$ and $\frac{3}{4}$ of those with HIV, suggesting that there are an additional 40-60 HIV-positive individuals who do not know that they are HIV-positive.

High rates of substance abuse and unsafe sexual behaviors increase risks for contracting HCV, HIV/AIDS, and other sexually transmitted infections. Conversely, the presence of these infections can increase the body's vulnerability to infection from them (Tighe and Sullivan, 1995). AODP incorporates HIV/AIDS, HCV, and Methicillin-resistant *Staphylococcus aureus* (MRSA) prevention and harm reduction education in all treatment groups, as well as offering free testing and counseling to all clients. MCHC, as a Ryan White HIV/AIDS Early Intervention program grantee, will provide disease case management for those that are already infected.

D-5. Timeline

HHSA is prepared to initiate project activities upon receipt of funding. During the first two project months, HHSA and its partners will complete recruiting and hiring processes and finalize

⁹ The ASAM PPC-2R is the most widely used and comprehensive national guideline for assessing clients with AOD disorders. It is the culmination of an intentional effort to address expressed needs of treatment providers for objective, measurable, and quantifiable indicators to assess each client's changing treatment needs.

policies, procedures, timelines, job descriptions, etc. Outreach to program participants will begin by the third month, with case management and supportive services in full operation by the beginning of the fourth program month. The program will follow the same pattern throughout the five years of implementation, with all program components beginning in Year One and continuing throughout the project period. Factors that will ensure HHSA's ability to adhere to the proposed schedule include the coordination and infrastructure already provided by the HSPG and the working relationships already established among program partners.

Table Seven. AT HOME activities, milestones, and responsibilities

ACTIVITIES	MILESTONES	RESP.	QUARTER			
			1	2	3	4
Year ONE						
Recruit and hire staff	All staff on board	Project Director	■			
Negotiate sub-contracts	Contracts signed	Project Director	■			
Finalize policies and procedures	Infrastructure in place	Director/Coordinator	■			
Convene HSPG Core Team	Partners engaged	Coordinator	■	■	■	■
Orient and train staff	All staff prepared	Coordinator	■			
Initiate outreach and promotion	Community awareness	Partners	■			
Begin on-going training	Capacity increases	Coordinator/partners	■			
Clients enter treatment/case mgmt.	60 clients to-date	AODP/MCHC/UCC/WCS		■	■	■
Review and refine program	1 st evaluation report	Evaluator				■
Year TWO						
HSPG meets monthly	Partners engaged	Coordinator	■	■	■	■
Treatment and case mgmt. continue	120 clients to-date	AODP/MCHC/UCC/WCS	■	■	■	■
Annual review and revision	2 nd evaluation report	Evaluator				■
Year THREE						
HSPG meets monthly	Partners engaged	Coordinator	■	■	■	■
Treatment and case mgmt. continue	180 clients to-date	AODP/MCHC/UCC/WCS	■	■	■	■
Annual review and revision	3 rd evaluation report	Evaluator				■
Year FOUR						
HSPG meets monthly	Partners engaged	Coordinator	■	■	■	■
Treatment and case mgmt. continue	240 clients to-date	AODP/MCHC/UCC/WCS	■	■	■	■
Annual review and revision	4 th evaluation report	Evaluator				■
Year FIVE						
HSPG meets monthly	Partners engaged	Coordinator	■	■	■	■
Treatment and case mgmt. continue	300 clients to-date	AODP/MCHC/UCC/WCS	■	■	■	■
Annual review and revision	5 th evaluation report	Evaluator				■

D-6. Unduplicated number of clients to be served

AT HOME will serve a caseload of 24 participants and at least 60 participants each year, for a total of 300 served over the five-year funding period. While all participants will receive support services, the number receiving each type of support cannot be determined in advance, since services will be provided in response to individual needs. HHSA anticipates that at least 30% of this very challenging population will successfully complete their treatment program and that at least 20% of those that complete treatment will access permanent or permanent supportive housing.

YEAR 1	60
YEAR 2	60
YEAR 3	60
YEAR 4	60
YEAR 5	60
TOTAL	300

Outreach, identification, and recruitment of participants will occur primarily at the Resource Centers, the clinics, and Social Service Branch offices, keeping in mind, however, the AT HOME policy of “no wrong door.” Primary entry points will be the existing GA enrollment, which has already been screened for CoD, and the SHP intake process, which will include initial CoD screening. Every individual who enters a Resource Center will be interviewed by an Intake Worker.¹⁰ This individual will direct clients to the AT HOME Case Manager. Since many homeless do not come to the Resource Centers because they believe they are not eligible for services, the AT HOME Coordinator will also launch a public information campaign, including print and radio spots and flyers placed at local gathering points. Outreach and recruitment will also be accomplished through street outreach workers fielded by community partners such as the Mental Health Branch, the Mendocino County AIDS Volunteer Network, and A Healing Cooperative (Ukiah) and Healing Hearts (Willits)) day shelters—all of whom are HSPG partners. These outreach workers regularly visit community kitchens, homeless shelters, domestic violence shelters, needle exchange sites, and other locations. The AT HOME Coordinator will also be responsible for educating community entities, such as hospital emergency rooms, about the program.

Engagement strategies include providing help with the procurement of food, shelter, and medical services, and the evolving relationship with Case Managers. Engagement also involves removing barriers by providing services on-site where clients are living or spending much of their time. At its root, engagement consists of convincing people that the provider has something to offer. Engagement is also enhanced by minimizing the time consumed by intake and assessment procedures (SAMHSA TAR, 2003).

Retention strategies will include incentives such as access to more desirable housing situations and designated clean and sober shelter areas to reduce association with individuals who are still using. Furthermore, retention will be supported by the welcoming atmosphere in the Resource Centers. Both Resource Centers will provide day shelter for clients, complete with free food, dual-diagnosis support groups, and access to wraparound services. Most important for client retention is that service providers will, for the first time, have the capacity to offer integrated and effective CoD treatment.

D-7. Linking treatment with housing and other services, including primary health care

At the program level, assuring service delivery linkages will be the responsibility of the AT HOME Coordinator. Monthly meetings of the HSPG Core Team will provide an opportunity to raise and discuss any coordination challenges. At the individual service level, Case Managers will be responsible for developing, assuring, and following up on service linkages for each client, providing benefits advocacy, assisting with benefits applications, and documenting all activities and outcomes. To facilitate this process, Case Managers will meet weekly with treatment providers and clients for case conferencing.

Housing. When a homeless person or family comes to a Resource Center, an intake process will take place and the participant will sign an agreement to develop a service plan and participate in services. The client then enters the steps of the Continuum of Care:

- **Step One** is emergency shelter (up to six months) and assistance that ranges from using phone and mail services through more intensive services such as detoxification.

¹⁰ These positions are funded through a HUD SHP grant.

- **Step Two** begins when a client formally agrees to work on their disabilities through creation of a Personal Service Plan. The service plan links clients to treatment and services and may include transitional housing for up to two years.
- **Step Three** begins with the acquisition of permanent or permanent supportive housing. Graduates from the program are case managed for up to six months to ensure residential stability as they transition from one case management setting to another.

The Continuum of Care incorporates a range of housing options in Ukiah and Willits:

- **Emergency Shelter:** The Buddy Eller Shelter in Ukiah, operated by the Ford Street Project, and other programs offering emergency shelter within walking distance of UCC offer 92 shelter beds, plus vouchers for 40 motel beds countywide per night.
- **Transitional Housing:** 46 beds in scattered sites.
- **Permanent and Permanent Supportive Housing:** 930 units, including Section 8 vouchers and Shelter+Care Tenant-Based Rental Assistance.

Supportive Opportunities for Permanent Housing is a grant obtained by Ford Street Project three years ago for 6 units (12 beds) of permanent housing. Because Ford Street has never fully utilized this grant, it plans to transfer it to Willits Community Services (WCS), so North Mendocino County will now have its first transitional housing. Although it is technically permanent housing, WCS will use it as a shared housing venture, which is *de facto* transitional housing. The transfer is currently in process and expected to take up to eight months for completion. Additional housing resources under development include the Transitional Opportunities Toward Independent Living (TOTIL) House at Ford Street Project, a 22-bed facility for single men and women with CoD who have outgrown the emergency shelter but are not ready for the responsibility of transitional housing independence, scheduled for completion in Spring 2009.

Primary health care. Medical case management is indispensable for the target population because only when detoxification and medical stabilization have occurred can rehabilitative efforts be successful (Watkins et al 1998). Access to primary health care is therefore integrated in the case management of AT HOME participants. Through partnership with MCHC's Hillside Health Center in Ukiah and Little Lake Health Center in Willits, all clients entering the program will be referred for an initial medical examination. HHSA and MCHC will implement an immediate response fax appointment system through which Case Managers can schedule a medical appointment while the participant is still with them in the Resource Center. Clients will receive follow-up care for any continuing medical conditions, on-going access to primary health care and dental services, and medical case management for chronic conditions. Ukiah Valley Medical Center reported 535 visits from homeless clients last year, and Howard Hospital in Willits reports that their emergency room treats at least one homeless person every day. Partnering with MCHC will also reduce clients' reliance on emergency room treatment.

D-8. Target population's language, beliefs, norms, values, and socio-economic factors

Most AT HOME participants will be English speakers, although some may require Spanish language assistance. However, because AT HOME will focus its efforts on all homeless individuals with CoD in Ukiah and Willits, they cannot be said to have a unified set of beliefs or values—they are each one of us, if our lives had turned out differently. Since the program will only serve clients who are income-eligible, they will all be living on incomes that are well below the federal poverty level. In addition to homeless individuals who seek services each year, the HSPG estimates that there are an additional 20% who distrust government bureaucracies and prefer to survive on their own as best they can, reflecting an outreach challenge that will be

addressed through collaboration with community partners already conducting street outreach to the homeless population. The various characteristics of the culture of homelessness will be considered in the provision of services through the “no wrong door” policy, welcoming and comfortable service settings, on-site provision of services, wrap-around support, and opportunities to provide feedback and offer suggestions for program improvement.

D-9. Target population involvement in planning, implementation, and assessment

Project design. Consumers participated in developing this proposal through their representation on the HSPG and through focus groups conducted in development of the County’s Mental Health Services Act Plan.¹¹ Clients have stressed the importance of accessing medical coverage (CMSP or Medi-Cal) immediately upon entry into the program, providing services in small groups, and providing services promptly so clients can see immediate results. Participants have also suggested providing employment support, even small jobs, and stressed the need for helping dually-diagnosed clients identify personal triggers. Being treated with respect is especially important to these consumers.

Project implementation. Participants will provide input through the recovery model group process, which includes time for mutual feedback and support. Informal input is also gathered through client conversations with the drivers that provide transportation between project sites. Following the treatment phase, participants will be recruited to participate on the HSPG Core Team to provide input on program implementation as well as suggestions for improvement. Throughout the project, the Coordinator will make annual presentations to AODP and Mental Health Branch Advisory Boards and the Resource Center Boards of Directors. Each of these groups includes past or current members of the target population, as does the HSPG.

Project evaluation. Participants who are HSPG members will review formative evaluation reports and provide feedback; participants will also participate in periodic focus groups and complete annual satisfaction surveys.

D-10. Embedding project components within existing service system

Integration with existing service delivery system. AT HOME will integrate services into the county’s newly created Adult System of Care, which includes the Continuum of Care for the Homeless. Linking clients to mainstream services will be facilitated by the small size of the cities of Ukiah and Willits and the proximity of Resource Centers and other service locations. The only other SAMHSA-funded program for the homeless in the county is the Supportive Opportunities for Permanent Housing grant described above, which will provide six units of transitional housing, available to AT HOME participants in Willits. With partnerships well established, Resource Centers operating smoothly, and a system in which the bugs have already been worked out, embedding AT HOME into the existing service system will be a straightforward process.

Organizations involved in the project. The roles of AT HOME partners, all of whom are members of the HSPG Core Team, are described in Table Nine below and in the Letters of Commitment in Appendix 1. The HSPG’s Core Team will serve as oversight body to the project, providing guidance and feedback through regularly scheduled monthly meetings.

¹¹ The Mental Health Services Act (Proposition 63) was passed by California voters in November 2004. By placing a 1% tax on incomes of one million dollars or more, the law funds counties to expand mental health services to unserved or underserved individuals and families. The County conducted extensive outreach, including surveys and focus groups, to ensure community input in the resulting plan.

Table Nine. Roles, responsibilities, and contributions of AT HOME partners

PARTNER	ROLES AND RESPONSIBILITIES
HHS Social Services Branch (Lead Agency)	Social Services will provide overall program guidance and administer sub-contracts, coordinate with partners for health care and other services, and facilitate HSPG Core Team meetings.
HHS Public Health Branch, AODP	AODP will coordinate with MCHC to provide integrated CoD assessment and treatment for AT HOME participants.
HHS Mental Health Branch	HHS's Mental Health Branch will coordinate with treatment providers for referral of chronic inebriates that enter the Crisis Center and accept referrals of eligible clients with identified serious mental illness.
Ford Street Project (FSP)	FSP will provide detox services for participants through an existing contract. AT HOME clients will also have access to shelter and transitional housing.
Mendocino Community Health Clinic (MCHC)	MCHC will coordinate with AODP to provide integrated CoD assessment and treatment, provision and monitoring of psychotropic medication, and primary health and dental care, and will provide training for partners.
Ukiah Community Center (UCC)	HHS will contract with UCC to hire a full-time case manager to provide outreach, screening, and case management for AT HOME participants.
Willits Community Services (WCS)	HHS will contract with WCS to hire a full-time case manager to provide outreach, screening, and case management for participants.

D-11. Groundwork and readiness

Having the primary providers of services to the homeless consolidated as a single organization, (the HHS, as described in Section E-1) will provide a solid foundation for the AT HOME Project, especially with the groundwork already completed through the establishment and development of the Continuum of Care and the HSPG. With more than 15 years of partnering together, effective systems for planning, consensus development, and dispute resolution are in place. Memoranda of Understanding have been developed and are in effect among HSPG partners. The Resource Centers are established and well known in each community, and housing resources are also stable. The HSPG also has extensive experience collecting and sharing information within legal constraints and has an operational Homeless Management Information System in place. All staff, including Resource Center staff, are already trained to use a web-based data entry system that maintains real-time data on clients, services, and outcomes. With all of these resources in place, HHS anticipates that all components of the project will be up and running by the beginning of the fourth month of funding.

D-12. IRB process

All staff will participate in Code of Federal Regulations (CFR) 42 and Health Insurance Portability and Accountability Act of 1996 (HIPAA) training and will sign confidentiality and privacy agreements. Informed consent procedures will include full disclosure as to: methods and purpose of treatment; voluntary nature of participation; and client rights. Participants will be informed of the purposes of the evaluation, data that will be collected, how it will be used and analyzed, and why. However, since the evaluation is collecting data for program improvement and treatment management purposes only and will rely largely on GPRA data, the project cannot be considered human subjects research, and Institutional Review Board/IRB approval will not be required.

D-13. Potential barriers and plans for overcoming them

A number of barriers challenge the success of efforts to treat homeless persons with CoD:

- **Shortage of qualified treatment professionals.** Because it is often difficult to recruit qualified treatment providers in this rural community, partners will conduct direct outreach through the Mendocino College’s Alcohol and Drug Studies Program; place ads in English and Spanish in local and regional newspapers and web sites; and make direct contact with local organizations that serve Native Americans and Latinos.
- **GA eligibility assessment and intake available only in Ukiah.** There is currently a Social Services Branch Eligibility worker outstationed at Little Lake Health Center in Willits. HHSA will work within the Social Services Branch to change existing systems to make it possible to extend GA assessment and intake to Willits, thus removing a major barrier to and making a significant improvement in the homeless services system.
- **High needs of homeless population.** Clients who are homeless are less stable and have fewer family and social supports, and may therefore require crisis intervention at many points in their clinical course. The Mental Health Branch will assist with the development of crisis management protocols to reduce client’s reliance on the Crisis Center.
- **Living situations.** The sparsely populated rural landscape provides ample campsites far from service centers. Even with outreach to the smallest communities, it will not be possible to provide services to clients who aren’t living near the service communities.

D-14. Plans to continue the project after funding ends

The HHSA is serious about sustainability, because if support services are not sustained for participants who are placed in housing situations, landlords will become less willing to cooperate with such placements. Provision of CoD treatment is incorporated in the County’s Adult System of Care Strategic Plan (Appendix Five) and sustainability will be a monthly agenda item throughout the five-year funding period. Specific sustainability strategies include:

- Using program outcome data to support on-going funding applications.
- Submitting grant applications to HUD for supportive services.
- Drawing down federal and state funds through Medi-Cal and other entitlement programs, which may provide up to 60% of supportive services costs. To increase capacity to draw down funds, partners will seek to hire licensed Case Managers.¹²
- Advocating with the County Board of Supervisors for financial support for the program.

¹² To qualify for reimbursement, services must be provided under supervision of Licensed Clinical Social Workers, Marriage and Family Therapists, Registered Nurses, or counselors with associate degrees.

SECTION E. STAFF AND ORGANIZATIONAL EXPERIENCE

E-1. Applicant and partner capability and experience

Applicant capability and experience. The Mendocino County Board of Supervisors established the HHSA in March 2006, merging three major County agencies—Social Services, Mental Health, and Public Health, including AODP. All three Branches have extensive experience with state-, federal-, and foundation-funded projects and evaluations through collaboratives of government, community-based organizations, schools, businesses, and faith groups. Internal accounting and budgetary controls are well established and designed to accurately reflect fiscal transactions, with necessary controls and safeguards providing good audit trails and ready determination of the total cost of individual projects and cost-per-beneficiary.

The Social Services Branch, which will lead the AT HOME Project, has been proactive in creating programs for the county's homeless, working for more than 15 years to expand and strengthen the Continuum of Care for the Homeless, which has operated continuously since 1995. In 2006, HHSA staff updated and rewrote the *Mendocino County Abbreviated Consolidated Plan to Address Homelessness*, which was adopted by the Board of Supervisors and approved by HUD in October of 2006.

Partner capability and experience. HHSA will ensure an effective, integrated, and multi-disciplinary approach through the participation of the following service providers, who are also members of the HSPG Core Team. Capability and experience of each partner are described below; see also Section D-10 for partner roles and Letters of Commitment in Appendix 1.

HHSA Division of Alcohol and Other Drug Programs (AODP). AODP is mandated by the State of California to assure the quality of all substance abuse treatment services provided in the county and complies with state and federal treatment and reporting standards, including CFR 42 and HIPAA. AODP provides alcohol and drug prevention, intervention, and treatment programs, including treatment for the homeless, throughout the county. Past programs have included:

- Meth Treatment for Mendocino (2006-2008), a SAMHSA-funded Treatment Capacity Expansion grant, provides Matrix-based treatment for methamphetamine users.
- WINDO (Women and Infants Needing Drug-free Opportunities), SAMHSA-funded 1991-1996 and still operational, provides outpatient and residential substance abuse treatment to substance-involved pregnant and parenting women.
- AODP has been a key participant in the creation and implementation of Mendocino County's Adult, Juvenile, and Dependency Drug Courts.

Ford Street Project (FSP). Ford Street has been providing AOD treatment since 1974; began offering shelter, housing and support services to homeless families and individuals in 1982; and in 1985 began working with seriously mentally ill homeless clients. FSP operates transitional and permanent supportive housing for homeless and mentally ill individuals, a residential detox program, and a shelter for homeless families and individuals. The organization is by far the largest provider of services to the homeless in the county and enjoys a solid reputation for the quality of its services and its ability to collaborate successfully with other agencies.

Mendocino Community Health Clinic, Inc. (MCHC) operates Hillside Health Center in Ukiah and Little Lake Health Center in Willits to provide a health services for the most vulnerable, from primary care and dentistry to behavioral health and chronic disease management. MCHC also links patients with a network of specialists (*e.g.*, gastrointestinal medicine, orthopedics,

podiatry, infectious disease, dermatology and ophthalmology). MCHC, established in 1992, is a federally qualified health center and is a current California Healthcare for the Homeless grantee. MCHC has been a collaborative partner in numerous projects designed to deliver services to the county’s homeless population through its integrated behavioral healthcare model.

Ukiah Community Center (UCC). Founded in 1971, UCC is the operator of the Ukiah Resource Center and offers a range of emergency services, including day shelter, information and referral, in-depth assessment, case management, revolving loan funds used to make no-interest loans to households moving from homelessness to housing, and life skills training. UCC also manages the county crisis line, information and referral, and the Ukiah Food Bank.

Willits Community Services (WCS), established in 1981, is a charitable nonprofit whose primary mission is to cushion the effect of short- and long-term unemployment, poverty, and crisis by providing temporary assistance programs and services to families and individuals in crisis. WCS is the only nonprofit providing vouchers for temporary shelter and connection to shelter resources in Ukiah, emergency food and assistance, and a food bank in North Mendocino County, which has a population over 18,000 and a poverty rate of 15-17%, translating to about 3,000 people that qualify for services. Approximately 15% of clients served by WCS are homeless, and nearly one in six have no health insurance coverage.

E-2. Staffing plan

See Section I for biographical sketches of project staff and job descriptions for to-be-hired positions. Note that individuals recruited to each position must meet individual agency specifications as described in the Job Descriptions in Section H.

Table Ten. AT HOME staffing plan

POSITION	ROLES & RESPONSIBILITIES	QUALIFICATIONS
Project Director (0.10 FTE in-kind)	Assure general oversight and policy direction and completion of project deliverables.	Susan Era, Social Services Branch Adult Services Director, has more than 25 years of experience and has led numerous collaborative projects for the homeless.
Coordinator 1.00 FTE (0.25 FTE in-kind)	Provide guidance and grant administration; plan trainings; lead the HSPG in overseeing implementation of AT HOME; and supervise data clerk.	Kathleen Stone, HSPG Coordinator, has 10 years of experience working with the homeless population, and is intimately familiar with county’s resources.
AODP Adult Services Manager (0.10 FTE in-kind)	Provide training and staff supervision; ensure accurate and timely reporting of data; and participate in AT HOME partnership meetings.	Leslie Kirkpatrick has been working in the substance abuse field since 1993 and has managed Drug and Dependency Court Programs.
AODP Substance Abuse Counselor 1.00 FTE	As part of integrated team: conduct assessments; develop treatment plans; co-facilitate treatment groups; and provide direct 1:1 services.	To Be Hired. Requires a BA, state AOD certificate, and 2 years experience using modern therapeutic methods, especially in CoD and crisis intervention.
MCHC Behavioral Health Director (0.05 FTE in-kind)	Provide oversight and clinical supervision for AT HOME Behavioral Health Counselor and participate in AT HOME partnership meetings.	Michael Mabanglo, PhD., LCSW has implemented an integrated primary care/behavioral health model at MCHC and is responsible for its overall operation.

POSITION	ROLES & RESPONSIBILITIES	QUALIFICATIONS
MCHC Behavioral Health Counselor 1.00 FTE (0.33 FTE in-kind)	As part of integrated team: provide assessment, diagnosis and treatment; co-facilitate treatment groups; provide 1:1 services; and participate in case conferencing.	To Be Hired. Requires Masters Degree in Social Work or PhD in Clinical Psychology and California licensure, with excellent working knowledge of behavioral medicine and evidence-based treatments.
Resource Center Case Managers 2.00 FTE	Conduct initial screening and orientation; develop Personal Services Plans; provide intensive case management; and administer satisfaction surveys.	To Be Hired. Requires 2 years counseling or case management experience working with homeless and/or mentally ill persons and understanding of confidentiality.
Data Clerk 0.25 FTE	Collect, compile, and maintain program data for local evaluation; collect and enter GPRA data; and provide administrative support to Coordinator.	To Be Hired. Qualifications include experience and/or education in data entry, file management, computer applications, and ability to work as a team member.
Evaluator (consultant)	Work with staff to develop a detailed quantitative and qualitative evaluation plan, including tracking GPRA measures; train staff in data collection; analyze data; and prepare formative and summative evaluation reports.	HHSAs' procurement policies require the use of a Request for Proposals process for contractor services. However, partners have identified potential evaluators with required qualifications who have evaluated previous programs for the homeless in the county.

E-3. Staff experience with target population and familiarity with language and culture

Although the target population is more than half (69%) white/non-Hispanic, there are significant minorities of Native Americans and Hispanics. HSPG partners have worked together to serve this population and learned from their experience that the subculture of homelessness is the greatest challenge to providing culturally competent services. One of the Continuum of Care's assets in reaching this population is that many of the street outreach workers and Resource Center staff have themselves been homeless in the past. During the project years, annual cultural competency trainings will include a focus on the subculture of homelessness; there are existing staff at both Resource Centers, both clinics, and both AODP offices who are bilingual in English and Spanish and will provide support to AT HOME clients as needed.

E-4. Available resources and ADA compliance

The greatest resources supporting AT HOME will be the commitment and participation of HSPG members, and the services provided through the Continuum of Care. This includes the two centrally-located Resource Centers, which are longtime providers of services to the target population and are physically designed to serve AT HOME clients. Both centers are equipped with common areas for socializing, bathrooms, kitchens, offices, and meeting rooms. Both facilities are fully ADA compliant. AT HOME is fortunate to have a range of leveraged support provided by collaborating partners, including: office and meeting space, furnishings and access to office and communications equipment; supportive services offered through community partners; medical case management through MCHC; life skills classes; community outreach; client vans operated in Ukiah by AODP and MCHC; in-house expertise; culturally competent staff; and access to a variety of technical assistance and support through program partners and professional organizations. The range of housing resources available to AT HOME clients is detailed below. (Although HHSAs is applying for a TREATMENT: GENERAL GRANT, documentation of these resources is included in Appendix 6.)

Comment [KH1]:

Table Eleven. Housing resources for AT HOME clients

LOCATION	SHELTER	TRANSITIONAL	PERMANENT SUPPORTIVE	COMMENTS
Ukiah	97 beds	46 beds	930 units	Willits residents have access to the Ukiah shelter.
Willits	Vouchers	12 beds	None	

SECTION F. PERFORMANCE ASSESSMENT AND DATA

In compliance with organizational procurement policies, HHSa will issue a Request for Proposals for the AT HOME evaluation. HHSa will select an independent evaluator with successful experience evaluating similar projects in Mendocino County, including SAMHSA-funded projects. HHSa has already identified potential candidates with relevant credentials and experience with homelessness prevention projects. A total of \$221,173, equal to 11.1% of the total budget, is allocated for evaluation activities, including the external evaluator, data clerk, and incentives.

The selected Evaluator will develop a formal evaluation plan that will include both formative and summative evaluation components and ensure that SAMHSA reporting and evaluation requirements are met. Using an empowerment model, the Evaluator will work collaboratively with project staff to carry out data collection activities, ensuring that the necessary data are collected efficiently, consistently, and unobtrusively. Prior to start up, the Evaluator will conduct a half-day staff training on data collection and reporting procedures. Follow-up feedback and guidance will be provided by the Evaluator at least twice a year, during HSPG Core Team meetings. The Evaluator will attend annual SAMHSA conferences and trainings related to evaluation and will support all SAMHSA cross-site data collection requirements. The Evaluator will ensure that the evaluation informs program development (implementation evaluation) and measures program effects (outcome evaluation). Adherence to the proposed program design will be monitored through observation (by the Evaluator), regular fiscal and programmatic reporting by service providers, service data reported by each program partner, and review of partner commitments. The Evaluator will compile and analyze this information and provide formative reports on implementation fidelity, types of deviation that occurred, causes of deviation and the impact of deviations on program activities and outcomes, and make recommendations to inform program development. The AT HOME Coordinator will be responsible for coordinating the data collection work of the Data Clerk, who will carry out data entry and reporting in conjunction with the Evaluator.

F-1. Ability to collect and report required performance measures

HHSa and its partners are willing and able to collect the required Government Performance and Results Act (GPRA) performance measures, using the CSAT GPRA Client Outcome Measures for Discretionary Programs Interview Guidelines to ensure that all required data are collected. Measurement activities and time schedules will comply with the GPRA reporting requirements, including collecting core client outcomes at baseline, discharge, and 6 months post-baseline. AT HOME planners anticipate little difficulty reaching the required 80% follow-up rate because clients will be offered \$20 to participate, many participants may stay with the program for up to 18 months, and many will be participating in on-going prevention relapse groups, all of which will facilitate participation in the follow-up interviews. Once completed, data will be coded and forwarded to the Social Services Branch for entry within seven days into SAMHSA's GPRA Data Entry and Reporting System by the AT HOME Data Clerk.

AT HOME partners have already established an excellent track record related to data collection and reporting of substance abuse treatment dosage and outcomes, and AODP is currently in the final year of a SAMHSA-funded methamphetamine treatment project that requires reporting of similar GPRA measures. The Social Services Branch has also collected outcome data for over 15 years on a number of sizeable programs including the Mendocino County Children and Older

Adult Systems of Care. Furthermore, all staff, including Resource Center staff, are already trained to use a web-based data entry system that maintains real time data on clients, services, and outcomes and will require minimal additional training. Additional measures and instruments are described in Section F-4 below.

F-2. Use of data for project management and quality assurance

AT HOME partners and the Evaluator will share responsibility for dissemination of evaluation findings. Locally, evaluation reports will be distributed to HHSA Branches and Advisory Boards. The Coordinator will prepare extracts from evaluation reports for presentation to other local groups and place news articles in local media. Oral presentations will be provided by the Evaluator twice yearly to ensure that lessons learned through the evaluation will be put to use immediately for program improvement. Either the Evaluator or program staff will also make oral presentations to program participants. Evaluation findings will be reported at meetings of the California Alcohol and Drug Program Administrators, California Welfare Directors Association, California State Rural Health Association, and at grantee meetings in Washington DC. As lead agency, the Social Services Branch will be responsible for conducting annual client satisfaction surveys to assess the quality of treatment and ancillary services from the client's point of view. Analysis of these surveys will be used to develop recommendations for midcourse corrections.

F-3. Per-person project cost

Based on the total cost of the project (\$2,000,000) and the 300 clients to be served over the five-year funding period, AT HOME's per-person cost is \$5,333 [(\$2,000,000 –20% for data and performance assessment) ÷ 300 = \$5,333]. This falls within SAMHSA's reasonable range of \$1,000-\$7,500 for intensive outpatient treatment. The evaluation will track treatment costs by modality and total per-person costs throughout the project.

F-4. Performance assessment plan

The evaluation is designed to measure the extent to which treatment and supportive services make a difference in the lives of participants, as shown in Table Twelve below. The evaluation will seek answers to the following questions:

- Did HHSA and its partners complete the proposed activities within the proposed timeframe? Who provided what services to whom in what context and at what cost?
- With what degree of fidelity was the project implemented? What types of deviation occurred, and what effect did deviations have on implementation and assessment?
- What was the effect of the intervention in terms of housing? behavioral health outcomes?
- What program/contextual factors were associated with outcomes? What individual factors were associated with outcomes? How durable were the effects?
- What services did members of the target groups find most and least beneficial?
- What barriers were encountered and what efforts were made to surmount them?

Evaluation strategies for different stages of the project are summarized below:

- **Year 1: Project Start Up** (Implementation Evaluation). Information collected will be used to identify infrastructure strengths and barriers. In addition, baseline data on individual and program outcomes will be collected for the outcome evaluation, which will be completed in Year Five. The primary purpose of this phase of the evaluation is to refine, improve, and strengthen project infrastructure during its formative stages.
- **Years 2-4: Delivery of Supportive Services** (Implementation Evaluation). The evaluation focus will progress from overall infrastructure to individual services, with

specific information collected to identify strengths and barriers. Administrators, service providers, and clients will provide input via surveys, interviews, and focus groups. The primary purpose is to refine, improve, and strengthen individual supportive services.

- Year 5: Project Effectiveness (Outcome and Impact Evaluation).** The evaluation will focus on measuring achievement of individual client outcomes. AT HOME’s multiple supportive services will make it possible to utilize an evaluation design that compares at least two different levels of treatment intensity (*e.g.*, high, moderate, or low participation in treatment and various supportive services) with respect to outcomes, as illustrated in Figure 3 below. This design is discussed in Cook and Campbell (1979) as a quasi-experiment to measure comparative change design, where partitioning is possible. Measuring changes in multiple comparison groups greatly improves the interpretability and rigor of the evaluation. That is, with clear patterns of outcomes, threats to validity are rendered far less plausible. This outcome evaluation design will provide valid data about project effectiveness. The final stage of the evaluation will also assess overall program impact. The impact evaluation will focus on rates of program retention, rates of re-entry into homelessness during and following program completion, and amelioration of dual-diagnosis symptoms.

Figure 3. Interpretable Outcome of a Multiple Comparison Group Design

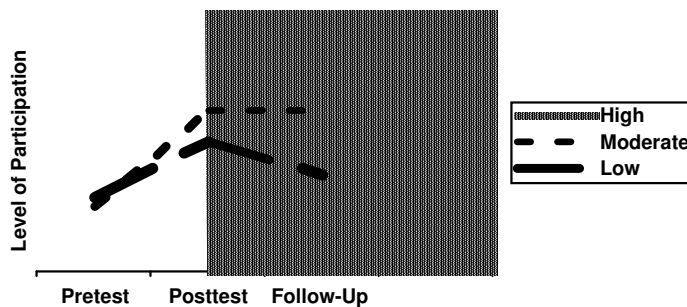


Table Twelve. AT HOME preliminary evaluation plan

OUTCOME INDICATORS	INDICATORS	TOOLS
60% of participants completing treatment will demonstrate decreased symptoms of mental illness.	<ul style="list-style-type: none"> Psychiatric hospitalizations 5150 detentions Pre/post mental illness indicators 	Burns Anxiety Scale PHQ-9 Duke Health Profile
60% of participants completing CoD treatment will decrease AOD dependence.	<ul style="list-style-type: none"> Chemical testing results Level of use 	ASAM-PPC2R
25% of participants will demonstrate decreased contacts with Crisis Unit and law enforcement.	<ul style="list-style-type: none"> Pre/post Crisis Unit contacts Pre/post law enforcement contacts 	Case files Mental Health Branch records
80% of participants will report improved quality of life and life skills.	<ul style="list-style-type: none"> Pre/post quality of life indicators 	PHQ-9 Client Survey
25% of participants completing the program will gain employment.	<ul style="list-style-type: none"> Employment status (volunteer, training, part-time, full-time) 	Case files

OUTCOME INDICATORS	INDICATORS	TOOLS
25% of participants will have increased income stability.	<ul style="list-style-type: none"> • Benefits status, by type (SSI, Medi-Cal, etc.) 	Case files
60% of participants will relocate to shelters, 30% to transitional housing, and 20% to permanent supportive housing.	<ul style="list-style-type: none"> • Housing status (homeless, sheltered, transitional, permanent supportive) 	Case files
50% of participants will demonstrate decrease in emergency room visits.	<ul style="list-style-type: none"> • Pre/post # of ER visits 	Case files
Participants will demonstrate increased medication compliance and adherence to harm reduction behaviors.	<ul style="list-style-type: none"> • # of clients eligible for draw-downs • % of costs covered by draw-downs 	Fiscal records
Continuum of Care is strengthened by increasing access to services in Willits.	<ul style="list-style-type: none"> • Pre/post # Willits clients served 	Project records
AT HOME staff trained and competent in delivery of CoD services.	<ul style="list-style-type: none"> • # hours training provided • # training participants 	Project records
AT HOME ensures welcoming policies, elimination of arbitrary barriers, and mechanisms for helping clients regardless of point of entry or level of motivation.	<ul style="list-style-type: none"> • Policies in place • Client satisfaction • Environmental features 	Client satisfaction survey and focus groups Environmental and policy review

Under the direction of the Evaluator, the Data Clerk will collect participation and service data each month from program partners and maintain the database to track participants, participation, and outcomes. The database will be housed in the Social Services Branch offices. Data cleaning will be facilitated by automatic data checks built into the data system. Additionally, the Evaluator will check for outlying data when conducting analysis.

Client confidentiality will be rigorously maintained. Before data are forwarded to the Evaluator for analysis, identifying information will be stripped from the database. The database system will also be protected against unauthorized disclosure of sensitive personal information about individuals by policy, training, passwords, and physical security measures.

The Evaluator will be responsible for analysis and interpretation of evaluation data. Quantitative data will be analyzed using the Statistical Package for the Social Sciences/SPSS software and qualitative data generated through focus groups, interviews, open-ended survey questions, and observation will be managed and analyzed using Atlas-ti software. Case Managers will provide monthly computerized service and status statistics to the Data Clerk for entry of data that will be provided to the program Evaluator on a quarterly basis.

Reliability and validity of evaluation methods in terms of target population

Although reliability and validity are distinct concepts, they are jointly influenced by a variety of factors that must be considered carefully when working with the target population. As an example, both can be affected by respondent characteristics—ability to understand questions (whether written or oral), motivation to respond honestly, trust that confidentiality will be maintained, and relationship with the interviewer or service provider. Other factors related to reliability and validity are instrumentation, data collection context, interviewer error or bias, and participant attrition. A clash between evaluation methods and target population culture can be another threat to reliability and validity. To ensure cultural appropriateness of both the delivery of supportive services and the measurement and collection of individual and program outcomes,

the HSPG Core Team will provide guidance related to cultural and language appropriateness for all stages of the program from program delivery through evaluation.