Mental Health Services Act

Innovations Project Plan

Resident Engagement and Support Team (REST)

Table of Contents

County Name: Humboldt

Date submitted: June 24, 2021

Project Title: Resident Engagement and Support Team (REST)

Total amount requested: $1,617,598.00

Duration of project: 5 years

Section 1: Innovations Regulations Requirement Categories

The Resident Engagement and Support Team (REST) project applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system. This approach is Housing First. The project's primary purpose is to increase access to mental health services to underserved groups. These groups are homeless individuals or those who are at risk of becoming homeless.

The hope with this project is to expand on current efforts of the county regarding the overarching goal of improving housing stability. This goal has been a jointly identified need by various county agencies, including Humboldt County Department of Health and Human Services HOME program, Arcata House Partnership, Eureka City Council and HUD to name a few. Currently these efforts exist to find permanent supportive housing for homeless and unsheltered individuals in our county. REST provides a missing competent within this continuum by helping individuals remained housed while assisting in transition to HUD programs.

We believe that this project will work in complement to our HOME program in that HOME is a very time limited program whose unique service is to get individuals housed initially and then to achieve a degree of stability. We have seen that this "stability" goal needs to be individualized in order to promote a successful transition, with the three-month mark as an indicator of progress and assessment if referral is appropriate. Once the individual is ready to be referred from HOME to REST, we will continue to work cooperatively with HOME service providers to ensure a successful transition. REST will continue to provide many of the same Housing First interventions and techniques but hopefully with a reduced frequency as an indicator of the client's stability.

We believe this to be an innovative and necessary approach for our community as it is an identified gap in our continuum of care that does not exist within the various county agencies providing services to individuals experiencing homelessness. HOME has the capability to refer clients to our Full Service Partnership program, called Comprehensive Community Treatment (CCT). REST will provide a secondary option for referrals as REST will be for those individuals who do not meet the criteria for FSP or are resistant to County Behavioral Health services. REST will utilize Housing First principles, which have been identified as a best practice approach for working with this population.

Section 2: Project Overview

PRIMARY PROBLEM

In its prior Innovation project, Rapid Re-housing (later renamed Housing, Outreach and Mobile Engagement--HOME), Humboldt County achieved some success in developing a system for finding housing for homeless individuals using the Housing First model. Some case management and peer support services are available after an individual becomes housed, but HOME is primarily focused on getting people into housing. Keeping many of these individuals housed is often challenging due to their behavioral health issues, even though every effort is made to connect them with behavioral health services. The Humboldt community wants to see individuals housed and remain housed, not back out on the streets. Data supporting the need for REST is discussed below.

Experiencing homelessness with mental illness. During the 2019 Point in Time Count, 1702 people were observed as experiencing homelessness in Humboldt County. Of these, 337 reported having a diagnosis of severe mental illness and 454 reported being homeless for at least one year. In the Coordinated Entry system, a database used by housing programs to identify and prioritize individuals eligible for housing services, there are 302 people (as of 6/30/2020) who identify as chronically homeless (literally homeless for at least one year). Of those, 227 identify as having a mental health disability.

Discharge to homelessness or unstable housing after psychiatric hospitalization or stay in crisis stabilization. Humboldt County has a 16 bed psychiatric facility, Sempervirens (SV), and a Crisis Stabilization Unit (CSU) that will accommodate four people at a time. Currently, when a consumer is discharged from SV or CSU the practice is to assign a clinician and give them a medication appointment. If the consumer is homeless or housing unstable this is not sufficient support. Data from Fiscal Year 2019-2020 shows that of 100 encounters for those experiencing homelessness who were admitted and then discharged from SV or CSU, the average number of days before being readmitted was 31.8 days. The days before readmission ranged from 0-246.

Full Service Partners Experiencing Homelessness. The Data Collection and Reporting (DCR) System of the Department of Health Care Services (DHCS) shows that in Fiscal Year 2019-2020 nineteen partners experienced homelessness at some point during the year. Thirty-nine had experienced homelessness one year before the partnership, so entering a partnership reduced those experiences, though twenty partners still experienced homelessness. The DCR also shows that twenty partners were in an emergency shelter at some point in time one year before partnership, and fourteen were in emergency shelter at some point during the most recent year in the partnership.

Returning to homelessness after being housed. Data from the HOME Program includes housing status for people who have obtained housing through the program. From January 2015-June 2020 HOME has supported 224 individuals to obtain housing. At one year post-housing, of 165 consumers, 88% (145) remained in housing, 7% (12) had returned to homelessness, 3% (5) were out of the area, and 2% (3) were unknown. At two years post-housing, of 140 consumers, 66% (92) remained in housing, 16% (22) had returned to homelessness, 11% (15) were out of the area, 4% (6) were unknown, and 3% (4) were deceased. While it is positive that 66% remain in

housing after two years, it is concerning that 16% had returned to the experience of homelessness.

HOME data includes the "move out reasons" for consumers who were housed by the program. Of 138 consumers, 30% were asked to leave and 17% were evicted, almost always because they, or their guests, were being too disruptive, These disruptions can be attributed to mental health symptoms that are still present with many of our clients. In the Housing First model, many clients are still symptomatic as Behavioral Health staff slowly begins to engage them in services. We also have discovered individuals who are housed allow long-term guests in their dwelling, which many times is a violation of their rental agreements, particularly if these guests are themselves disruptive. During this critical time, it is important to have sufficient oversight and assistance from Behavioral Health to ensure appointments are kept and negative behaviors are mitigated.

Behavioral Health staff experiences. The problem of keeping people housed is an ongoing topic at staff meetings, including among Case Managers, Outpatient Referral Assignment team members, and the Older Adults team, where strategies for keeping people from getting evicted from local assisted living facility requires considerable time and attention. Many times our Case Management resources are spread thin as we try to assist those who have been recently housed. This topic also takes up considerable amount of time during staff meetings and other clinical support briefings, in an effort to ensure this basic need continues for our most fragile clients.

In summary, the problems indicating the need for a solution are:

- In the 2019 Point in Time Count of those experiencing homelessness, 337 people reported having a diagnosis of severe mental illness
- The Coordinated Entry system shows 302 people who are chronically homeless, and of those, 227 people identify as having a mental health disability
- In Fiscal Year 2019-2020 44 individuals experiencing homeless were served by Humboldt County Behavioral Health either through SV, CSU or case management services
- In Fiscal Year 2019-2020 100 individuals experiencing homelessness were admitted to and then discharged from SV or CSU. Of these individuals, the average number of days before being readmitted to SV or CSU was 31.8
- Consumers discharged from Sempervirens are assigned a clinician and given a medication appointment, but are not provided with wraparound services and supports
- Full Service Partners can experience homelessness even with the support of the partnership. This is being addressed by working with local hotels to create partnerships in housing. Our FSP program is working on managing client placed in these temporary shelters on the weekend and other non-transitional work hours to ensure stability and treatment compliance.
- HOME data shows that 16% of consumers returned to homelessness within two years of being housed
- HOME "move out" data shows that almost 50% were either asked to leave or were evicted because of disruptive behavior

With this proposed Innovation Project, Resident Engagement and Support Team (REST),

Humboldt County is interested in finding solutions to these problems. HOME led to a positive increase in the sheltering of our chronically homeless and unhoused consumers. As a side effect to this we see an increased need for services to address the problematic circumstances related to maintaining housing. Lessons learned from HOME are:

- Peer coaches increase engagement of clients and help them to achieve their goals. This success contributed to the inclusion of peer support in the REST proposal.
- Innovative approaches to engage homeless persons with a pet can be successful and shared with other service providers
- Collaborating with local homelessness service agencies to implement a community-wide Housing First model can lead to increases in affordable housing
- Partnering with law enforcement to identify/engage individuals experiencing homelessness is a successful strategy
- These approaches lead to decreased utilization of costly and restrictive services

The successful practices of HOME are being continued with Social Services funding.

The Housing First model was a new practice for our community, and we believe that REST will be an extension of this new community practice, focusing on the maintenance of housing for our consumers.

We hope to learn how ongoing case management and peer support impacts whole person care, housing stabilization and physical health outcomes. We intend to support consumers in their journey to stable housing, from shelter to transitional housing to supportive housing and then HUD housing.

REST has been prioritized for several reasons.

- Community members place housing and supportive services as a priority. In the stakeholder process for the MHSA 2020-2023 Three Year Plan, over 700 responses in surveys and stakeholder meetings ranked providing more housing and supportive services as one of the top priorities for MHSA support. Other top priorities were providing supportive services and a continuity of care to individuals after discharge from the psychiatric hospital (Sempervirens), the Crisis Stabilization Unit (CSU), and jail; increasing support for the seriously mentally ill by providing more case managers and other paraprofessionals; and increasing and expanding mental health services by the addition of more mental health professionals. Many of those discharged from Sempervirens, the CSU, and jail are homeless and seriously mentally ill. Stakeholders ranked serving persons experiencing homelessness as the number one population not being adequately served by current MHSA programs, and many participants in stakeholder meetings spoke about inadequate case management services and the need for more case managers and services.
- In stakeholder meetings for the MHSA 2021-2022 Annual Update, stakeholders continued to place addressing homelessness as a top priority, with this need being discussed at four meetings and in one written comment provided during the process. Comments included providing services and supports to address the difficulty of keeping clients housed due to mental health issues.
- During the 30 day public comment period and in the public hearing for the 2021-2022 Annual Update, participants continued to emphasize the need to provide additional services

and supports for those experiencing homelessness or at risk of homelessness. Commenters suggested increased funding for rent deposits, rental assistance and other expenses related to obtaining housing; more support teams to help keep people housed, and additional support for finance, budgeting and other assistance to help foster independence once housed. REST will address these needs.

- HOME program outcomes for housing status for people who have obtained housing, at two years post obtaining housing, show that 14% have returned to homelessness. While this percentage is a positive one, and shows success for HOME, REST hopes to decrease the percentage for not only those stepping down from the HOME program, but for other individuals who are recently housed and engaging in the Behavioral Health system.
- Finally, the critical nature of the housing and homelessness crisis in Humboldt County, across California, and in the nation warrants providing additional supportive services to keep people housed after housing is found for them.

REST will be a component of the Humboldt Housing and Homeless Coalition (HHHC). HHHC is a Continuum of Care comprised of several organizations, service providers, developers, government agencies and leaders, faith-based organizations and community members dedicated to ending homelessness.

The HHHC was established in 2004 and includes service providers, local government agencies, advocates and others who are interested in helping people move out of homelessness. The group does not have a staff and is not officially incorporated or organized. The county provides some administrative support, but most projects are accomplished by volunteers.

Members of the HHHC work together on specific issues (policy, input into the general plan, working with law enforcement, etc.). The HHHC is sometimes asked to provide input on issues to the local jurisdictions. Any public statements must be agreed upon by the whole membership.

The HHHC shares ideas, coordinates services, increases communication and helps identify service gaps within our communities. HHHC administers the Point-in-Time Count, the Homeless Management Information System, and provides several training opportunities throughout the year.

Partner agencies are Arcata House Partnership; Eureka Veterans Clinic; Food for People; Housing Authority of the City of Eureka and County of Humboldt; Housing Humboldt; Humboldt County Department of Health and Human Services; Humboldt County Office of Education, Foster & Homeless Youth Services; North Coast AIDS Project; North Coast Veterans Resource Center; Open Door Community Health Centers Mobile Health Services; Redwood Community Action Agency; Youth Service Bureau; and Rural Community Housing Development Corporation.

Humboldt County has long prioritized resolution for the homeless and under sheltered individuals in our County. REST will increase access to mental health services to underserved groups and will apply a promising community driven practice that has been successful in non-mental health contexts. Much research has shown the effectiveness of Housing First at getting

people into housing, and part of its effectiveness has been the case management services that are provided once people are housed. We believe that supportive services through case management and peer support is the next step for ensuring that the efforts of finding housing for individuals will result in those individuals staying housed, and that these supportive services will enhance the individuals' recovery and their re-integration into the community. We want to test this hypothesis through the REST project.

PROPOSED PROJECT

A) Brief narrative overview description of the proposed project.

REST can be viewed as a "Post-Housing" Housing First model and is new for Humboldt County. The project will consist of assigning case managers and peer coaches to the Adult Outpatient Program to work with the identified population. The population to be served will be DHHS-Behavioral Health consumers, age 18 or older, who do not meet the level of care indicated for Full Service Partnership. They will be at risk of homelessness or be homeless, and may include:

- Consumers stepping down from HOME services
- Consumers that are leaving SV or the CSU
- Consumers who are stepping down from the Full Service Partnership level of care and still need case management services
- Individuals who are currently Adult Outpatient consumers

The case managers and peer coaches will work with consumers to help them maintain their housing. Activities to be provided could include helping consumers create a structure and routine in their daily lives to get their needs met; coordinating care with other agencies providing services/supports to the consumer; linking the consumer to physical and mental health services; coordinating care and problem solving with landlords; working collaboratively with family members; helping consumers develop coping strategies; supporting consumers in learning and practicing activities of daily living; and many more activities designed to assist consumers in maintaining housing.

The ongoing case management services in the "Post-Housing" Housing First model as implemented in our community through REST will allow us to better understand the needs of our consumers once housing has been secured. We hope to have a seamless transition of Case Management services for our consumers once they are housed to allow them to fully engage in needed Outpatient Behavioral Health Services at a pace that is consumer driven and client centered. This will be measured in the length of time between housing and Behavioral Health treatment initiation by the consumer, as well as statistics related to housing of consumers at points in time such as after 6 months, one year, 18 months and two years.

With this better understanding comes more preventive measures we can take for consumers when we identify them in our community. With this in mind, another goal is to continue to refine the services we offer to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice. During this time of "Post-Housing" service, emphasis is placed on a Harm Reduction and Recovery Oriented approaches, Individualized and Person Driven supports, and Social and Community Re-integration. This will be measured by consumer perception surveys of treatment they receive and monitoring of treatment service adherence.

B) Identify which of the three project general requirements specified the project will implement.

This project will apply a promising community driven practice or approach that has been successful in a non-mental health context or non-mental health setting. Research has shown that Housing First has been successful in a non-mental health context. The principle of ensuring individuals are housed is the initial and most important priority in Housing First. The practice indicates that consumers treatment adherence is limited when they are focused on the acquisition of basic needs. Housing First indicates that a person cannot reasonably be expected to attend weekly appointments when they are unhoused. Our HOME program has worked diligently in our community to follow the Housing First guidelines to fidelity. This Innovation plan will be enhancement of the work they have done following Housing First.

C) Why the selected approach is appropriate.

This Innovation project will be drawing from the Housing First approach that is outside the mental health field. Much research has shown the effectiveness of Housing First in getting people into housing. Part of the effectiveness of Housing First has been the case management services that are provided once people are housed.

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

It is estimated that REST will serve a minimum of 100 individuals annually. The number was determined from an analysis of all data gathered for the description of the primary problem, the number of current clients open to mental health services minus those who are FSPs, and an estimate of those who may services but are not yet open to them.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

REST will be testing the Housing First model in a rural, not urban, setting. It will not be offering county-owned housing, as there is none in Humboldt County, but will instead help connect consumers to existing rental housing and then provide the supports they need to remain housed. Case Management services and Peer support will be comprehensive to include those services that are part of a Behavioral Health Treatment Plan and those that may fall outside of this to ensure that ongoing medical necessity is not a barrier to getting critical services that maintain housing.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

The MHSOAC website has descriptive information about approved Innovation projects in FY 17/18 and 18/19, and a Program Search tool. These search tools were used with the keywords housing; Housing First; case management; peers; and life skills. As a result of this search, brief descriptions of thirteen projects from other counties were reviewed. Of those, the three described below are existing programs with elements of what we are proposing.

The San Joaquin County *Progressive Housing* project is an adaptation of the Housing First model for individuals who are homeless and have serious mental illness. The project offers a system of housing with four levels of service at each of the houses and examines an individual's development through the recovery process. REST will not offer a system of housing as in the San Joaquin project but similarly will work with individuals to secure housing and provide supports that will assist them in their recovery. There may be learning from the San Joaquin project that will inform REST.

The *Intensive Case Management/Full-Service Partnership to Outpatient Transition Support* Innovation Project of San Francisco MHSA seeks to implement a peer linkage team to provide support for consumers transitioning from intensive case management or full-service partnerships to outpatient services. In REST, Case Managers and Peer support staff will provide support to the identified populations—those being discharged from SV and CSU, those stepping down from FSP or HOME services, and those already in Adult Outpatient Services--to link them with housing, outpatient services, and other supports to help them maintain housing once secured. REST is focused on a Post-Housing First model, while the San Francisco project does not reference this practice.

Merced County's *Housing Supportive Services Program* serves individual adults who are experiencing homelessness, at-risk of being homeless, couch surfing, or those who have already been placed in a housing program. The Program's team works with the consumer to link them to services, provide life skills and educational training, advocate for the consumer, and support their growth towards meeting housing goals. They may be learning from this project that will inform REST.

The Google search engine was used to locate web-based literature and program information. Search terms included case management, Housing First, homeless, homelessness, housing, trauma, and trauma-informed. A total of 24 articles were reviewed during this search. Several of these articles were available on Medline (PubMed) and were peer-reviewed in major journals. A list of the research is provided in the Appendix. The research indicates that there have been numerous random controlled trials demonstrating the effectiveness and cost-effectiveness of Pathways to Housing First. In one study, the At Home-Chez-soi (AH-CS) study, Housing First was found to be successful, most especially regarding the primary outcome of enabling people with a mental illness who are homeless to find and maintain stable housing for an extended period of time Can J Psychiatry. 2015 Nov; 60(11): 465–466). Another article referenced the research on AH-CS and concluded that Housing First can be successfully adapted to different contexts and for different populations without losing its fidelity, and that people receiving Housing First achieved superior housing outcomes and showed more rapid improvements in community functioning and quality of life than those receiving treatment as usual. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679127/ The AH-CS study was conducted in

five Canadian cities, and other referenced studies were conducted in urban areas, so the REST project will provide information on the practice in a rural area.

Research on Mental Health America's The Village in southern California showed an excellent recovery model system. While Humboldt County does not have the resources to support a Village-type facility and program, we will strive to keep the recovery principles in the forefront of the REST project.

LEARNING GOALS/PROJECT AIMS

Six learning questions have been developed for REST.

1. How effective is ongoing case management and peer support for those discharged from SV or CSU, or exiting from a Full Service Partnership (FSP) or HOME services, to maintain housing?
We hypothesize that well-trained Case Managers and Peers will increase engagement of consumers in appointment-based outpatient care. The length of time between referral to first kept appointment and overall appointment compliance rate will be the data we collect to answer this question using the Electronic Health Record (Avatar), reports from the DHCS Data Collection and Reporting (DCR) System, reports from the HOME database, and reports from Activate Care. Activate Care is a nationally recognized provider of community care coordination and referral management technology with which Behavioral Health participates.

2. Will increased case management and peer support services facilitate recovery as indicated by a reduction in the number of emergency service episodes?
We hypothesize that consistent and consumer driven interventions by our REST team will promote successful outcomes leading to appropriate and sustained transitions to lower levels of care and reduced need for emergency psychiatric care. Reports from Avatar and MORS reports will help to answer this question.

3. Will educating landlords about recovery increase the number of landlords who accept our consumers as tenants?
We hypothesize that our education efforts with local landlords will lead to increased capacity for housing as well as forbearance for consumers as they actively engage in treatment services. These efforts will lead to clients remaining housed throughout duration of REST. Data will be gathered from Avatar, the HOME database, and baseline data with housing units available and currently occupied. A survey with local landlords will also be conducted annually.

4. Will REST help us learn what services and supports are most utilized by newly housed individuals?
We hypothesize that by using consumer driven treatment approaches that are individualized for the consumer that clients will maintain treatment compliance. Data will be gathered from consumers through the Consumer Perception Survey required by the State and through a targeted consumer survey for REST participants. The overall appointment compliance rate will come from Avatar. A client survey and/or focus group will also be conducted to get their perceptions.

5. Will REST services contribute to improved physical health outcomes for consumers served?
We hypothesize that our efforts to ensure long term housing stability will contribute to the

overall physical health of our clients. We will have some baseline measures for this and utilize data on physical health appointments and contacts as well as emergency room and Urgent Care appointments. This data will be obtained from the North Coast Health Improvement and Information Network (NCHIIN) Health Information Exchange (HIE).

6. How long do consumers remain housed?
We hypothesize that given the interventions that the REST program proposes we will see a much higher rate of consumers remaining housed. Length of time in housing will be the data we collect for this. We will also do comparative analysis with data we have already collected from the HOME program.

The ongoing case management services in the "Post-Housing" Housing First model as implemented in our community through REST will allow us to better understand the needs of our consumers once housing has been secured. We want to have a seamless transition for our consumers once they are housed to allow them to fully engage in Outpatient Behavioral Health Services at some point in time. This will be measured in the length of time between housing and Behavioral Health treatment initiation by the consumer, as well as statistics related to housing of consumers at points in time such as after 6 months, one year, 18 months and two years.

With this better understanding comes more preventive measures we can take for consumers when we identify them in our community. With this in mind, another goal is to continue to refine the services we offer to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice. During this time of "Post-Housing" service, emphasis is placed on a Harm Reduction and Recovery Oriented approaches, Individualized and Person Driven supports, and Social and Community Re-integration. This will be measured by consumer perception surveys of treatment they receive and monitoring of treatment service adherence.

EVALUATION OR LEARNING PLAN

Goal 1: To have a seamless transition for consumers once they are housed to allow them to fully engage in Outpatient Behavioral Health Services at some point in time. This will be measured in the length of time between housing and behavioral health treatment initiation by the consumer, as well as statistics related to housing of consumers at points in time such as after one year, 18 months and two years.

Goal 2: To continue to refine the services we offer to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice. During this time of "Post-Housing" service, emphasis is placed on a Harm Reduction and Recovery Oriented approaches, Individualized and Person Driven supports, and Social and Community Re-integration. This will be measured by consumer perception surveys of treatment they receive and monitoring of treatment service adherence.

Goal 3: Improve housing stability for community residents as a component of the Humboldt Housing and Homeless Coalition (HHHC) Continuum of Care.

Learning Question	Sources of Data	Data Collection Strategy
1. How effective is ongoing case management and peer support for those discharged from SV or CSU, or exiting from a Full Service Partnership (FSP) or HOME services, to maintain housing?	Avatar EHR DCR HOME housing database Activate Care	Avatar reports DCR reports HOME dashboards Activate Care
2. Will increased case management and peer support services facilitate recovery as indicated by a reduction in the number of emergency service episodes?	Avatar EHR MORS	Avatar Reports MORS Reports
3. Will educating landlords about recovery increase the number of landlords who accept our consumers as tenants?	Avatar EHR Baseline data with housing units available and currently occupied HOME database	Clients remaining housed Survey with landlords HOME dashboard
4. Will REST help us learn what services and supports are most utilized by newly housed individuals?	Consumers Avatar EHR Consumer survey and/or focus group	Consumer perception surveys Targeted Consumer survey for REST services Show Rate and Appointment Compliance rate Consumer survey/focus group
5. Will REST services contribute to improved physical health outcomes for consumers served?	NCHIIN HIE data	Physical health appointments and contacts Emergency room visits Urgent care appointments.
6. How long do consumers remain housed?	HOME database	Length of time in housing

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

Humboldt County DHHS-Behavioral Health is in the process of analyzing impacts to its budget over the next several years and is looking at all ways to minimize spending. One possibility that has been discussed is to contract out this project to a qualified agency. No decision has been made and until then it is the intention of Behavioral Health to implement REST.

COMMUNITY PROGRAM PLANNING

In the stakeholder process for the MHSA 2020-2023 Three Year Plan, over 700 responses in surveys and stakeholder meetings ranked providing more housing and supportive services as one of the top priorities for MHSA support. Other top priorities were providing supportive services and a continuity of care to individuals after discharge from the psychiatric hospital (Sempervirens), the Crisis Stabilization Unit (CSU), and jail; increasing support for the seriously mentally ill by providing more case managers and other paraprofessionals; and increasing and expanding mental health services by the addition of more mental health professionals. Many of those discharged from Sempervirens, the CSU, and jail are homeless and seriously mentally ill. Stakeholders ranked serving persons experiencing homelessness as the number one population not being adequately served by current MHSA programs, and many participants in stakeholder meetings spoke about inadequate case management services and the need for more case managers and services.

In stakeholder meetings for the MHSA 2021-2022 Annual Update, stakeholders continued to place addressing homelessness as a top priority, with this need being discussed at four meetings and in one written comment provided during the process. Comments included providing services and supports to address the difficulty of keeping clients housed due to mental health issues.

It is because of this community input that REST has been developed. It will address the top priorities expressed by stakeholders.

MHSA GENERAL STANDARDS

A) Community Collaboration will be an integral part of REST. We will be working with landlords; the developers of low barrier housing projects; the owners and managers of current housing projects; North Coast Health Improvement and Information Network (NCHIIN); Humboldt Independent Practice Association (IPA); justice and diversion programs; law enforcement though the activities of the Mobile Intervention Services Team; the Regional Services “ride-alongs” with law enforcement; National Alliance for the Mentally Ill (NAMI); and the Family Advisory Board, to name just a few of the agencies, organizations, businesses and community groups with which we will collaborate.

B) Cultural Competency. Humboldt County Behavioral Health is committed to the provision of culturally competent services that are effective, equitable, understandable, respectful and responsive to diverse cultural beliefs and practices, including beliefs about health and behavioral health. Behavioral Health services are delivered in a consumer’s preferred language and with consideration of the individual’s or family’s culture. The Cultural Competence Plan, updated annually, sets forth this commitment and provides detailed information on the programs and activities of the agency. There are policies and procedures focusing on cultural competence; disparities in service delivery are identified annually; the Cultural Responsiveness Committee undertakes projects to further cultural competence; and Behavioral Health participates in the DHHS Racial Equity Steering Committee. In addition, all Behavioral Health staff are required to complete one cultural competence training annually. As a program of Behavioral Health, REST will be covered by this commitment.

C) Consumer-Driven. The stakeholder process for the Three Year Plan for 2020-2023 and the Annual Update for 2021-2022 clearly identified the need for a program and services such as those to be provided by REST. REST will be driven by Housing First principles, where engagement in services is not a prerequisite to housing. In REST, as with all other Behavioral Health services, the concurrent documentation strategy is used, with provider staff working with consumers during assessment, service planning and intervention sessions to complete as much related documentation as possible, including working collaboratively on the treatment plan. Because REST includes two Peer Coaches their voice will also be a factor in the services provided. In addition, REST has built consumer surveys into the project to ensure consumer voice.

D) Family-Driven. The target population for REST is adults over the age of 18, so this General Standard does not apply.

E) Wellness, Recovery, and Resilience-Focused. Wellness, recovery and resilience are built into the client services provided by Behavioral Health. Consumers are encouraged and supported to live, work and participate fully in their communities. REST will promote concepts key to recovery for mental illness, such as hope, personal empowerment, respect, social connections and self-determination.

F) Integrated Service Experience for Consumers and Families. Services provided through REST will be from Behavioral Health programs—Sempervirens, Crisis Stabilization Unit, HOME and FSP. Consumers will not have to navigate through multiple agencies to get their needs met. In addition, it will be the role of the Case Managers and Peer Coaches to assist consumers in coordinating services to provide an integrated service experience.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

The evaluation will be conducted with sensitivity and awareness of consumer diversity related to culture, language and other diverse identities. Key stakeholders will be involved in evaluation though their participation in program meetings, data provision, development of surveys, and consumers will provide input through the consumer perception survey and through the targeted survey developed specifically for REST.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

The County will evaluate the REST plan at several intervals to ensure it is providing the services outlined. Knowing that keeping individuals housed is a community priority and one that promotes positive treatment outcomes for Behavioral Health consumers, we expect that this project would continue past the Innovation timeframe to continue to be supported by other funding. We will constantly evaluate if there are any elements that are not effective or are redundant with other services and eliminate those if necessary.

Individuals with serious mental illness will receive services from this project. When the project has ended they will continue to receive services through Medi-Cal billing and Realignment funding.

COMMUNICATION AND DISSEMINATION PLAN

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

The final report for the Innovation project will be posted to the County website on the MHSA webpage. The general community will be informed via a press release issued by the DHHS Communications Group. The press release will summarize the findings of the project and provide the web address of the full report. Stakeholders who have been more closely involved with the implementation of the project will be informed via email of the findings and the location of the final report. These stakeholders will be asked to share the findings and final report with others.

B) KEYWORDS for search:

Case management, housing, Housing First, consumer driven, basic needs

TIMELINE

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

Subject to review of MHSOAC the hoped for start date is July 1, 2021 and end date June 30, 2026.

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

The REST project will be five years.

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

Timeframe	Activities
July 2021	Recruitment, hiring and Training of REST staff
October 2021	Identification and recruitment of participants; Annual Innovation Report due (June 30)
January 2022	Develop surveys; identify baseline data
April 2022	Conduct surveys and enter data
July 2022	Data Pull and analysis
October 2022	Annual Innovation Report due (June 30)
January 2023	Share Report with stakeholders
April 2023	Conduct surveys and enter data
July 2023	Data pull and analysis
October 2023	Annual Innovation Report due (June 30)
January 2024	Share Report with stakeholders
April 2024	Conduct surveys and enter data
July 2024	Data Pull and analysis
October2024	Annual Innovation Report due (June 30)

January 2025	Share Report with stakeholders
April 2025	Conduct surveys and enter data
July 2025	Data Pull and analysis
October 2025	Annual Innovation Report due June 30)
January 2026	Share Report with stakeholders
April 2026	Conduct surveys and enter data
June 30, 2026	Project end date; Data Pull and analysis
December 2026	Final Report due

Section 4: INN Project Budget and Source of Expenditures

BUDGET NARRATIVE

This project is anticipated to begin in July 2021 and end in June 2026 for a total of five years.

Salaries and Benefits. The total for Salary expenses for the five years are $1,185,478 and $977,215 for benefits. This includes:

- $1,148,567 for direct services project staff salaries and $949,117 for benefits over the five years. Personnel include:
  - 1.0 FTE Program Coordinator
  - 2.0 FTE Mental Health Case Managers
  - 2.0 FTE Peer Coaches I/II

- $23,710 for administration staff salaries and $16,883 for benefits over the five years. Administration includes:
  - .02 FTE Program Manager
  - .05 FTE Administrative Analyst I/II

- $13,201 for evaluation salaries and $11,215 for benefits over the five years. Evaluation personnel is .05 FTE Administrative Analyst I/II.

Operating Costs. $66,150 for operating costs over the five years. In the first year this includes the expenses of laptops and cell phones for direct services project staff. In every year operating costs include Activate Care licenses, cell phone charges, and rental assistance for clients in the REST program.

Indirect Costs. $222,884 (10%)

Medi-Cal Federal Financial Participation: $834,132 estimated.

The total amount of MHSA Innovation funds being requested for this project is $1,617,598 over the five year period. With the estimate of FFP included the total is $2,451,730.

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST

SUMMARY - BUDGET BY FISCAL YEAR

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	**REST Project Total BUDGET**
INNOVATION PROJECT BUDGET						
Salaries	215,101	224,338	230,578	237,137	241,412	1,148,567
Benefits	184,247	187,772	190,153	192,657	194,288	949,117
Operating expense	13,230	13,230	13,230	13,230	13,230	66,150
Indirect Costs	41,258	42,534	43,396	44,302	44,893	216,383
TOTAL - INNOVATION PROJECT BUDGET	453,836	467,875	477,358	487,326	493,824	2,380,218

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	**REST Project Total BUDGET**
INNOVATION ADMINISTRATION BUDGET						
Salaries	4,375	4,571	4,782	4,919	5,063	23,710
Benefits	3,237	3,312	3,392	3,444	3,499	16,883
Operating expense	-	-	-	-	-	-
Indirect Costs	761	788	817	836	856	4,059
TOTAL - INNOVATION ADMINISTRATION BUDGET	8,373	8,671	8,991	9,199	9,418	44,652

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	**REST Project Total BUDGET**
INNOVATION EVALUATION BUDGET						
Salaries	2,273	2,470	2,680	2,817	2,961	13,201
Benefits	2,103	2,178	2,258	2,310	2,365	11,215
Operating expense	-	-	-	-	-	-
Indirect Costs	438	465	494	513	533	2,442
TOTAL - INNOVATION EVALUATION BUDGET	4,814	5,112	5,432	5,640	5,859	26,857

INNOVATION EXPENDITURE TOTALS	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**REST Project Total BUDGET**
Salaries	221,750	231,379	238,040	244,873	249,436	1,185,478
Benefits	189,586	193,261	195,803	198,411	200,153	977,215
Operating expense	13,230	13,230	13,230	13,230	13,230	66,150
Indirect Costs	42,457	43,787	44,707	45,651	46,282	222,884
TOTAL - INNOVATION EXPENDITURE BUDGET	**467,022**	**481,658**	**491,781**	**502,165**	**509,101**	**2,451,727**

INNOVATION FUNDING TOTALS	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**REST Project Total BUDGET**
Innovative MHSA Funds	300,196	314,832	324,955	335,339	342,276	1,617,598
Federal Participation	166,826	166,826	166,826	166,826	166,826	834,132
TOTAL - INNOVATION FUNDING BUDGET	**467,023**	**481,658**	**491,781**	**502,166**	**509,102**	**2,451,730**

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2021-22

STAFFING						
TITLE OF POSITION	ANNUAL SALARY	FTE	DRAFT BUDGET FY 2021-22	-none- NON-FED MATCH	TOTAL	
Program Coordinator	54,715	1.00	54,715		54,715	
Mental Health Case Manager	48,996	1.00	48,996		48,996	
Mental Health Case Manager	53,332	1.00	53,332		53,332	
Peer Coach I/II	29,029	1.00	29,029		29,029	
Peer Coach I/II	29,029	1.00	29,029		29,029	215,101
BENEFITS			141,789		141,789	
INSURANCE (WORK COMP./LIAB./BOND)			42,457		42,457	184,247
Administration						
Program Manager	105,093	0.02	2,102		2,102	
Administrative Analyst I/II	45,465	0.05	2,273		2,273	4,375
BENEFITS			2,642		2,642	
INSURANCE (WORK COMP./LIAB./BOND)			594		594	3,237
Evaluation						
Administrative Analyst I/II	45,465	0.05	2,273		2,273	2,273
BENEFITS			1,678		1,678	
INSURANCE (WORK COMP./LIAB./BOND)			425		425	2,103
			-		-	
TOTAL STAFF EXPENSES	**411,123**	**5.12**	**411,336**	**-**	**411,336**	
Evaluation costs						
					-	
Consultant Costs (Itemize):					-	
					-	
Supplies (Itemize):					-	
					-	
Travel -Per diem, Mileage						
					-	
Other Expenses (Itemize):					-	
Care license activation 5 x $70/year			350		350	
Rental Assistance			10,000		10,000	
Cell phone charges 4 x $60/month x 12 months			2,880		2,880	
					-	
Indirect Costs					-	
COUNTY ADMINISTRATIVE COSTS			42,457		42,457	
GROSS COST OF PROGRAM			**467,023**	**-**	**467,023**	
Program Income						
Federal	Medi-Cal FFP		166,826		166,826	
State	EPSDT-Realignment				-	
					-	
Program Income			**166,826**	**-**	**166,826**	
NET COST OF PROGRAM			**300,196**	**-**	**300,196**	
					0.000	

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2021-22

Budget Summary			
Category	**Federal Request**		**%**
Salaries & Wages	$	221,750	
Fringe Benefits	$	189,586	
Evaluation Costs	$	-	0%
Direct Costs	$	13,230	3%
Indirect Costs	$	-	0%
County Administration Costs	$	42,457	9%
Gross Project Costs	**$**	**467,023**	**12%**
less: Program Income	$	(166,826)	$ -
Net Project Costs	**$**	**300,196**	**0**

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2022-23

STAFFING						
TITLE OF POSITION	ANNUAL SALARY	FTE	DRAFT BUDGET FY 2022-23	-none- NON-FED MATCH	TOTAL	
Program Coordinator	57,514	1.00	57,514		57,514	
Mental Health Case Manager	48,996	1.00	48,996		48,996	
Mental Health Case Manager	53,332	1.00	53,332		53,332	
Peer Coach I/II	32,248	1.00	32,248		32,248	
Peer Coach I/II	32,248	1.00	32,248		32,248	224,338
BENEFITS			145,315		145,315	
INSURANCE (WORK COMP./LIAB./BOND)			42,457		42,457	187,772
Administration						
Program Manager	105,093	0.02	2,102		2,102	
Administrative Analyst I/II	49,390	0.05	2,470		2,470	4,571
BENEFITS			2,717		2,717	
INSURANCE (WORK COMP./LIAB./BOND)			594		594	3,312
Evaluation						
Administrative Analyst I/II	49,390	0.05	2,470		2,470	2,470
BENEFITS			1,753		1,753	
INSURANCE (WORK COMP./LIAB./BOND)			425		425	2,178
			-		-	
TOTAL STAFF EXPENSES	**428,212**	**5.12**	**424,641**	**-**	**424,641**	
Evaluation costs						
					-	
Consultant Costs (Itemize):					-	
					-	
Supplies (Itemize):					-	
					-	
Travel -Per diem, Mileage						
					-	
Other Expenses (Itemize):					-	
Care license activation 5 x $70/year			350		350	
Rental Assistance			10,000		10,000	
Cell phone charges 4 x $60/month x 12 months			2,880		2,880	
					-	
Indirect Costs					-	
COUNTY ADMINISTRATIVE COSTS			43,787		43,787	
GROSS COST OF PROGRAM			**481,658**	**-**	**481,658**	
Program Income						
Federal	Medi-Cal FFP		166,826		166,826	
State	EPSDT-Realignment				-	
					-	
Program Income			**166,826**	**-**	**166,826**	
NET COST OF PROGRAM			**314,832**	**-**	**314,832**	
					0.000	

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2022-23

Budget Summary				
Category	**Federal Request**			**%**
Salaries & Wages	$	231,379		
Fringe Benefits	$	193,261		
Evaluation Costs	$	-		0%
Direct Costs	$	13,230		3%
Indirect Costs	$	-		0%
County Administration Costs	$	43,787		9%
Gross Project Costs	**$**	**481,658**		**12%**
less: Program Income	$	(166,826)	$	-
Net Project Costs	**$**	**314,832**		**0**

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2023-24

STAFFING						
TITLE OF POSITION	ANNUAL SALARY	FTE	DRAFT BUDGET FY 2023-24	-none- NON-FED MATCH	TOTAL	
Program Coordinator	60,455	1.00	60,455		60,455	
Mental Health Case Manager	48,996	1.00	48,996		48,996	
Mental Health Case Manager	53,332	1.00	53,332		53,332	
Peer Coach I/II	33,897	1.00	33,897		33,897	
Peer Coach I/II	33,897	1.00	33,897		33,897	230,578
BENEFITS			147,696		147,696	
INSURANCE (WORK COMP./LIAB./BOND)			42,457		42,457	190,153
Administration						
Program Manager	105,093	0.02	2,102		2,102	
Administrative Analyst I/II	53,599	0.05	2,680		2,680	4,782
BENEFITS			2,797		2,797	
INSURANCE (WORK COMP./LIAB./BOND)			594		594	3,392
Evaluation						
Administrative Analyst I/II	53,599	0.05	2,680		2,680	2,680
BENEFITS			1,834		1,834	
INSURANCE (WORK COMP./LIAB./BOND)			425		425	2,258
			-		-	
TOTAL STAFF EXPENSES	**442,868**	**5.12**	**433,843**	**-**	**433,843**	
Evaluation costs						
					-	
Consultant Costs (Itemize):					-	
					-	
Supplies (Itemize):					-	
					-	
Travel -Per diem, Mileage						
					-	
Other Expenses (Itemize):					-	
Care license activation 5 x $70/year			350		350	
Rental Assistance			10,000		10,000	
Cell phone charges 4 x $60/month x 12 months			2,880		2,880	
					-	
Indirect Costs					-	
COUNTY ADMINISTRATIVE COSTS			44,707		44,707	
GROSS COST OF PROGRAM			**491,781**	**-**	**491,781**	
Program Income						
Federal	Medi-Cal FFP		166,826		166,826	
State	EPSDT-Realignment				-	
					-	
Program Income			**166,826**	**-**	**166,826**	
NET COST OF PROGRAM			**324,955**	**-**	**324,955**	
					0.000	

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2023-24

Budget Summary			
Category	**Federal Request**		**%**
Salaries & Wages	$	238,040	
Fringe Benefits	$	195,803	
Evaluation Costs	$	-	0%
Direct Costs	$	13,230	3%
Indirect Costs	$	-	0%
County Administration Costs	$	44,707	9%
Gross Project Costs	**$**	**491,781**	**12%**
less: Program Income	$	(166,826)	$ -
Net Project Costs	**$**	**324,955**	**0**

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2024-25

STAFFING						
TITLE OF POSITION	ANNUAL SALARY	FTE	DRAFT BUDGET FY 2024-25	-none- NON-FED MATCH	TOTAL	
Program Coordinator	63,546	1.00	63,546		63,546	
Mental Health Case Manager	48,996	1.00	48,996		48,996	
Mental Health Case Manager	53,332	1.00	53,332		53,332	
Peer Coach I/II	35,631	1.00	35,631		35,631	
Peer Coach I/II	35,631	1.00	35,631		35,631	237,137
BENEFITS			150,199		150,199	
INSURANCE (WORK COMP./LIAB./BOND)			42,457		42,457	192,657
Administration						
Program Manager	105,093	0.02	2,102		2,102	
Administrative Analyst I/II	56,340	0.05	2,817		2,817	4,919
BENEFITS			2,850		2,850	
INSURANCE (WORK COMP./LIAB./BOND)			594		594	3,444
Evaluation						
Administrative Analyst I/II	56,340	0.05	2,817		2,817	2,817
BENEFITS			1,886		1,886	
INSURANCE (WORK COMP./LIAB./BOND)			425		425	2,310
			-		-	
TOTAL STAFF EXPENSES	**454,909**	**5.12**	**443,284**	**-**	**443,284**	
Evaluation costs						
					-	
Consultant Costs (Itemize):					-	
					-	
Supplies (Itemize):					-	
					-	
Travel -Per diem, Mileage						
					-	
Other Expenses (Itemize):					-	
Care license activation 5 x $70/year			350		350	
Rental Assistance			10,000		10,000	
Cell phone charges 4 x $60/month x 12 months			2,880		2,880	
					-	
Indirect Costs					-	
COUNTY ADMINISTRATIVE COSTS			45,651		45,651	
GROSS COST OF PROGRAM			**502,166**	**-**	**502,166**	
Program Income						
Federal	Medi-Cal FFP		166,826		166,826	
State	EPSDT-Realignment				-	
					-	
Program Income			**166,826**	**-**	**166,826**	
NET COST OF PROGRAM			**335,339**	**-**	**335,339**	
					0.000	

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2024-25

Budget Summary			
Category	**Federal Request**		**%**
Salaries & Wages	$	244,873	
Fringe Benefits	$	198,411	
Evaluation Costs	$	-	0%
Direct Costs	$	13,230	3%
Indirect Costs	$	-	0%
County Administration Costs	$	45,651	9%
Gross Project Costs	**$**	**502,166**	**12%**
less: Program Income	$	(166,826)	$ -
Net Project Costs	**$**	**335,339**	**0**

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2025-26

STAFFING						
TITLE OF POSITION	ANNUAL SALARY	FTE	DRAFT BUDGET FY 2025-26	-none- NON-FED MATCH	TOTAL	
Program Coordinator	66,796	1.00	66,796		66,796	
Mental Health Case Manager	48,996	1.00	48,996		48,996	
Mental Health Case Manager	53,332	1.00	53,332		53,332	
Peer Coach I/II	36,144	1.00	36,144		36,144	
Peer Coach I/II	36,144	1.00	36,144		36,144	241,412
BENEFITS			151,831		151,831	
INSURANCE (WORK COMP./LIAB./BOND)			42,457		42,457	194,288
Administration						
Program Manager	105,093	0.02	2,102		2,102	
Administrative Analyst I/II	59,221	0.05	2,961		2,961	5,063
BENEFITS			2,905		2,905	
INSURANCE (WORK COMP./LIAB./BOND)			594		594	3,499
Evaluation						
Administrative Analyst I/II	59,221	0.05	2,961		2,961	2,961
BENEFITS			1,941		1,941	
INSURANCE (WORK COMP./LIAB./BOND)			425		425	2,365
			-		-	
TOTAL STAFF EXPENSES	**464,947**	**5.12**	**449,589**	**-**	**449,589**	
Evaluation costs						
					-	
Consultant Costs (Itemize):					-	
					-	
Supplies (Itemize):					-	
					-	
Travel -Per diem, Mileage						
					-	
Other Expenses (Itemize):					-	
Care license activation 5 x $70/year			350		350	
Rental Assistance			10,000		10,000	
Cell phone charges 4 x $60/month x 9 months			2,880		2,880	
					-	
Indirect Costs					-	
COUNTY ADMINISTRATIVE COSTS			46,282		46,282	
GROSS COST OF PROGRAM			**509,102**	**-**	**509,102**	
Program Income						
Federal	Medi-Cal FFP		166,826		166,826	
State	EPSDT-Realignment				-	
					-	
Program Income			**166,826**	**-**	**166,826**	
NET COST OF PROGRAM			**342,276**	**-**	**342,276**	
					0.000	

DHHS - Humboldt County - DHHS - Behavioral Health
MHSA Innovation Project REST
FY 2025-26

Budget Summary			
Category	**Federal Request**		**%**
Salaries & Wages	$	249,436	
Fringe Benefits	$	200,153	
Evaluation Costs	$	-	0%
Direct Costs	$	13,230	3%
Indirect Costs	$	-	0%
County Administration Costs	$	46,282	9%
Gross Project Costs	**$**	**509,102**	**12%**
less: Program Income	$	(166,826)	$ -
Net Project Costs	**$**	**342,276**	**0**

Appendix

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