Greetings!

Your input and comments are invited on the **Mental Health Services Act (MHSA) Innovations (INN) Encampment-based Mobile Wellness Center Project Plan.** This plan is currently posted to provide an opportunity for community input on this proposed new project.

A Public Hearing on this proposed project will also be held at the Mental Health Commission meeting on January 27th at 7:00pm. Information on how to attend the Public Hearing will be distributed in January 2022.

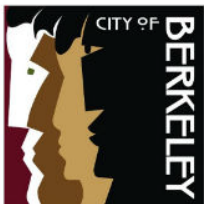
In order to provide input, please respond by **5:00pm on January 25th** by directing your feedback via email, phone or mail to:

Karen Klatt, MEd
MHSA Coordinator
City of Berkeley Mental Health
1521 University Ave.,
Berkeley, CA 94703
(510) 981-7644 - Ph.
KKlatt@ci.berkeley.ca.us

City of Berkeley MHSA Innovation Project Plan

Encampment-based Mobile Wellness Center

City of Berkeley Mental Health Division



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City Name: City of Berkeley

Project Title: Encampment-based mobile wellness center for Berkeley's unhoused community members

Total Amount Requested: $2,802,400

Project Duration: 5 years

Summary Statement: Pilot an encampment-based mobile wellness center that offers a customizable menu of activities and services (i.e. food/hygiene, service navigation, trauma-informed wellness, and community/enrichment) and is staffed by a team of peers that can offer culturally-specific services, including individuals from encampment communities in Berkeley.

Section 1: Innovation Requirement Categories

General Requirement:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

Primary Problem

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

Approximately 1,100 unhoused individuals live in Berkeley, including both sheltered and unsheltered environments.[1] This represents 1% of Berkeley's total population. Not only is homelessness prevalent in Berkeley, most of the time it is also long-term: of the 1,100, 64% reported that their current episode of homelessness has lasted one year or more. Across the three most recent citywide point-in-time counts (2015-2019), unhoused Berkeley residents consistently identify supportive services, such as benefits/income assistance, rental assistance, or mental health services, as interventions that may have prevented homelessness. These findings indicate gaps in service accessibility, availability, and/or awareness when homelessness prevention is still possible. Moreover, as much as supportive services are needed upstream before homelessness occurs, they grow even more vital when an individual or family becomes unhoused. In recent years, including throughout the six-monthlong community input process that resulted in this project proposal, Berkeley residents consistently name homeless services as a top citywide priority.

Though both direct and supportive services for the homeless population are urgently needed and increasingly funded, take-up among unhoused community members in Berkeley remains low for certain services, particularly mental health services. Berkeley Mental Health (BMH) and the City of Berkeley have funded a wide variety of outreach teams to try and connect unhoused individuals to mental health services, and though these efforts have had some success, there remain a large set of individuals who indicate that they are uninterested in services despite appearing to have mental health conditions. Successfully supporting mental health and wellness for individuals who are not connecting to mental health services remains a gap and a challenge in the service landscape. To address this challenge, this project proposes an innovation at the nexus of **service provision** (by focusing on services that unhoused community members define as supportive of mental health, rather than explicitly and/or exclusively clinical services), **service location** (by bringing services onsite to encampments in Berkeley), and **service providers** (by employing individuals with lived or adjacent experience to homelessness, including individuals from encampment communities in Berkeley).

Proposed Project: Encampment-based Mobile Wellness Center

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

For its Innovation project, BMH is proposing an encampment-based mobile wellness center that would provide a menu of customizable services to Berkeley's unhoused population. The proposed project was developed using input obtained from community members with lived or adjacent experiences of homelessness during the community program planning (CPP) process. Through in-person and online surveys, 1:1 interviews and virtual community meetings, BMH collected robust input during the CPP process.

[1] https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf

The proposed innovation is embedding a mobile wellness center at encampment locations, with peer-led, customizable services that are supported by members of encampment communities in Berkeley. This combination is an innovative delivery model for services that promote health and wellness, while also being designed for those experiencing homelessness in our communities.

The proposed project adapts existing homeless outreach practices by operationalizing community input in the following ways.

- **Service Provision:** Rather than operating on a blanket assumption that clinical and/or psychiatric services should be prioritized, the wellness center project focuses on services identified by unhoused community members as most supportive of mental wellness. These are not traditional clinical mental health services.
- **Service Location:** The wellness center will be a mobile service center stationed at locations where homeless individuals are staying in Berkeley. By hosting services onsite at encampments and other locations where homeless individuals are staying, outreach transforms from outside-in to inside-out, from sporadic to ongoing, and from disconnected to integrated.
- **Service Providers:** Wellness center staff, including the program manager and peer providers, will include individuals with lived or adjacent experience of homelessness and/or recovery. In addition, the wellness center program will use funds to compensate individuals from encampments to connect consumers to services, incentivize participation among existing and potential consumers, and engage in day-to-day program planning and operations.

While many homeless outreach and/or mobile engagement programs employ peers, and others co-locate services with other agency (i.e. educational) or institutional (i.e. correctional) providers, no program adapts homeless outreach services in the above ways.

As the wellness center will **not** explicitly focus on clinical and/or psychiatric services, the project does not aim to directly increase access to traditional mental health services, nor improve the quality of traditional mental health service provision. Rather, it aims to leverage collaboration with unhoused community members to promote mental health outcomes for the target population through non-clinical means, which may include increases in service referrals, service linkages, and improvement of mental health wellness for participants. Figure 1 below summaries key components of the project proposal.

Figure 1. Innovative Components of Wellness Center Project

Wellness Center Service Provision

> *"It's not a psychiatrist they need, it's not a behavioral modification they need; what they need is the basics of life – the ability to eat, wash themselves, read a book, meditate, drink water, take a walk, be around the people who you want to be around, go to the library. If those things were guaranteed, it would support mental health and head off the cases where people develop more deeply entrenched conditions, where they start evidencing behaviors that people assume are intrinsic – not realizing [these behaviors] are from all the times when they don't know where they will be eating, will they have to eat out of a trash can, if when they sleep will someone kick them in the head."*
>
> **- Berkeley community member experiencing homelessness**

The wellness center will deliver onsite services to Berkeley community members who are unhoused. Proposed services are informed directly from community input, with an emphasis on input from community members with lived experiences of homelessness during the CPP process. While some input did call for outreach that included therapeutic services, much of the input called for supportive services more generally. Table 1 lists the wellness center's proposed service areas:

Table 1. Proposed Service Areas & Service Participants

	Food & Hygiene Services	Benefits Enrollment & Service Navigation	Trauma-Informed Wellness Services	Enrichment & Community Services
Proposed Service Areas	- Mobile showers - Hand-washing - Laundry tokens and/or laundry services - Snacks, water - Toiletries & personal hygiene products	- Benefits enrollment (i.e. Medi-Cal, Medicaid, veterans' services, HUD) - ID/document recovery - Appointment reminders - Transit assistance	- Medication counseling - Meditation & mindfulness - Massage therapy - Music therapy - Stress management counseling - Peer-led wellness services	- Day storage - Community enrichment events - Movement & exercise classes - Guided walks and nature-based enrichment - Community library
Service Estimates	*BMH estimates that up to **250 individuals** will receive food/hygiene services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive benefits/ navigation services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive wellness services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive enrichment services each year, with **5-10%** connecting to outside mental health services via this service area.*

Many of the above food, hygiene, and navigation services are comparable to those commonly provided by homeless outreach treatment teams and/or mobile engagement teams. However, in the mobile wellness center environment, service provision will be directed by the changing needs of the community,

with week-to-week service provision being planned via ongoing conversations with members of encampment communities. For example, while psychiatric and/or therapeutic services are not listed above due both to low take-up of these services among members of the unhoused population in Berkeley historically and a minority of community input requesting these services, community needs may shift, and wellness center staff will adapt service provision as needed. The customizable nature of service provision will be made possible through the provider itself, which will be a local organization with deep expertise across proposed service areas.

Coordination with local partners involved in current homeless outreach efforts will be central to service provision, in order to both build on existing efforts and to mitigate duplicative service delivery. For example, the wellness center program might partner with a local food pantry to coordinate meal delivery efforts to the encampment population. Input from members of the encampment community, those with lived experience of homelessness, and the service provider will also inform service provision in a fluid and iterative way, based on identified needs. This was a central theme of the input received from community members and individuals with lived experience during the CPP process – that services should support wellness in creative ways, without assuming that psychiatric or clinical intervention is appropriate for everyone. Community members shared that service delivery should be adaptive and offer a diverse menu of services.

Target Population. BMH estimates that the wellness center will serve up to 250 unique individuals each year, or roughly 25% of Berkeley's current unhoused population. This estimate is based on annual service data from organizations providing outreach services to the unhoused population in Berkeley. The service estimates vary among service areas, as food/supplies represent a majority of services currently provided, compared to case management or other services. For this reason, the above estimates use the best available data, but still may be an overcount of food/hygiene services and an undercount of other service areas.

BMH expects that individuals served by the wellness center will in large part reflect the demographics of the unhoused population in Berkeley. As described by the most recent point-in-time count conducted in 2019, the target population is predominantly male (66%), non-Hispanic/Latinx (88%), Black/African American (57%), single (vs. families), and does not identify as LGBTQ+ (86%). Around half (48%) of the target population is local and has lived in the community for 10 years or more.

The target population also has significant medical needs: 41% reported a disabling health condition, with 28% reporting chronic health problems. Just under one-half (42%) reported a psychiatric or emotional condition, 32% reported a substance use disorder, and 31% reported PTSD. The proposed design of the wellness center is responsive to these needs in regards to both the *types* of services provided as well as *how* those services are delivered.

Wellness Center Service Location

When the plan was initially developed, the City was planning to have a sanctioned encampment, and has since determined it could not find a place for one, so the mobile wellness center will go to multiple encampment sites, or other locations where unhoused individuals are staying. This means that it can provide onsite services where needed, can move where and if the community it is serving changes locations, but will have a consistent, visible presence wherever homeless individuals are staying. The plan is for the locations of service to remain flexible, as the location of encampments and other locations where homeless individuals are staying is fluid and changes on a regular basis.

The location of the proposed wellness center is one way in which it is intended to feel a part of the community it is serving. The other way this project aims to deliver services from the inside-out rather than

the outside-in is by bringing peers and individuals with lived experience, including individuals residing in the encampment, onboard the wellness center team.

Wellness Center Service Team

A key innovation of this project is that it will recruit and hire peers, or individuals with lived or adjacent experiences of homelessness, to staff the wellness center. In addition, the wellness center will compensate individuals who reside in encampment communities in Berkeley to support wellness center services in a separate capacity.

Since a community-based organization (CBO) will be implementing this project (not BMH), the CBO will hire the positions that will staff the mobile wellness center and will recruit and provide stipends to the individuals from encampment communities in Berkeley who are brought on to support wellness center activities.

While position titles will be adapted and finalized by the CBO during program launch planning, broadly, the wellness center team will consist of a **program director, program manager, peer providers,** and **members of the encampment community**. For the purposes of this project plan, individuals from Berkeley encampment communities who are brought on to work with the wellness center team are referred to as **partners from encampment communities**. This role, modeled on the Community Health Worker role as defined by the California Healthcare Foundation, will have the following core competencies and key duties:[2]

- **Cultural Competency.** Acting as a liaison between the encampment community and the wellness center, partners from encampment communities should represent and be able to communicate the needs of the encampment community. Their input and feedback should inform ongoing processes and programming as part of the wellness center project.
- **Information & Resource-Sharing.** Care for and support consumers by doing things such as sharing information regarding resources, documenting wellness center and service-specific utilization, and supporting the care and education provided by wellness center staff.
- **Social Supports.** Provide social support by being available to listen and talk through problems that consumers are experiencing, and referring them to the appropriate wellness center staff member(s). Onsite referrals from encampment community partners are meant to facilitate introductions and trust-building with wellness center staff.
- **Self-Care Coaching.** Educate consumers about self-care and help them learn self-care skills.

Partners from encampment communities will help encourage participation at the wellness center, help define service needs, and support service provision at the site. It will be up to the CBO implementing this project to define the criteria for this role. This proposal is therefore purposefully not prescriptive in defining eligibility. BMH would like to give CBO bidders an opportunity to leverage their insight and expertise in their proposals to define criteria for recruitment, as well as the training plan for this role.

BMH will defer to bidders to define the number and duration of cohorts of encampment community partners. However, proposals must include a plan for providing stipends and guaranteeing compensation for their work at the center.

[2] California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf

Full-time, onsite **peer providers** will coordinate and deliver wellness center services. This is a separate role from the partners from encampment communities. The latter are members of an encampment community who will be stipended, while peer providers will be FTE staff hired by the CBO. Peer providers will be trained in trauma-informed best practices for service delivery. Peer providers will have the following key duties, modeled on best practices set by the National Health Care for the Homeless Council, or NHCHC (these key duties are drawn from community input and cross-walked to NHCHC practices):[3]

- **Outreach/Enrollment.** Assist with enrollment into housing, nutrition, and health insurance programs and entitlements; provide culturally competent enrollment, health education, and outreach services; conduct motivational interviewing and rapport building with potential clients using empowering language and taking the lead from the client; offer friendly and helpful advice based on problems and concerns identified by the client; offer day-to-day survival tips and kits such as first aid, clothing, water, hand sanitizer, etc.
- **Navigation.** Help clients fill out and file paperwork for Medicaid, Medicare, Veterans Services, HUD, local housing authority, prescription coverage, and any other services; follow-up and track individuals experiencing homelessness and/or recently housed; schedule and remind clients of appointments and provide transportation if necessary; facilitate client empowerment to fully engage with all members of their health care team; accompany consumers on medical visits as a source of support; help consumers access needed supports for transitions such as attaining housing.
- **Advocacy/Education.** Develop and utilize connections with community service representatives to help clients get what they need; work with partners from the encampment community to update provider teams about what issues consumers are facing; collaborate with partners from the encampment community in program planning for the wellness center.

BMH expects proposals to include a robust training plan for wellness center staff, including a component for supervision and continuous performance evaluation. Depending on the proposal and the capacity of the service provider, this may involve subcontracting with organizations to provide training services. Stakeholder input emphasized the need for training and oversight, particularly to provide clear pathways for peer-to-peer team-building and conflict resolution. BMH would like to give bidders an opportunity to leverage their expertise to propose training components and performance evaluation modalities, rather than be prescriptive in this proposal as to what that will or should look like.

Finally, a **community of practice** comprised of program staff, consumers, community advocates, and city leaders will meet quarterly to create a learning space to exchange insights and tackle challenges related to the wellness center project. This community of practice may take the form of a formal advisory group or an informal relationship-building space. Following project approval and during the initial project development phase, the provider will work with stakeholders and community members, including unhoused Berkeley residents and homeless outreach staff, to collect input on how they would feel best supported by the community of practice.

Research on Proposed Innovation Project

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.

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[3] Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council, June 2011. https://nhchc.org/

Wellness Centers. Many homeless-serving agencies and community-based organizations in local jurisdictions have implemented wellness centers to deliver a multitude of services. Some localities, such as Victorville in San Bernardino County, are developing large wellness center campuses that will offer medical, recreational, and supportive services to individuals experiencing homelessness.[4] Wellness center campuses are innovative, complex projects with high start-up and operational costs, with service delivery occurring in a brick-and-mortar location. Other cities, such as Los Angeles, provide multiple smaller wellness centers as service access points for the unhoused population.[5]

These examples of brick-and-mortar wellness centers largely operate during weekday business hours, and none of them are located within an encampment itself (although Los Angeles does have centers adjacent to Skid Row). BMH seeks to further innovate on the existing brick-and-mortar wellness center model by proposing a smaller-scale, mobile model that is able to go to multiple encampments.

Mobile Approaches in Healthcare for the Homeless. Generally, mobile models used in healthcare for the homeless (HCH) programs are limited to mobile health clinics, and BMH did not identify current or ongoing examples of mobile wellness centers that are co-located with existing encampments. Mobile health clinics embedded within a local or regional HCH service landscape, on the other hand, are increasingly common and well-researched, with thousands of active mobile health clinics nationwide.[6] One such example is WeHOPE in East Palo Alto, which has a fleet of vehicles delivering mobile homeless services, including onsite hygiene services.[7] The learning goals described in the following section are adapted in part from outcomes often seen in mobile health clinics. In this way, BMH looks to build on emergent learnings from the mobile HCH service landscape.

Peer-led Service Delivery. Integrating peer-led service delivery into mental health, substance use disorder, or homeless outreach programs is an emergent best practice across the HCH service landscape. Peer providers may already be credentialed, or the hiring organization may provide training as part of onboarding or ongoing professional development. In other cases, peers may not receive extensive formal training, or they may be volunteers. Regardless of the specifics of the position or training, a growing body of evidence suggests that the non-hierarchical, reciprocal relationship created between a peer provider and a consumer leads to better health outcomes.[8]

Wellness centers may be staffed by peers, such as the RAMS Inc. Peer Wellness Center in San Francisco.[9] These wellness centers provide many of the same services that BMH is proposing to include in its wellness center. However, though many peer-staffed wellness centers do provide targeted services for people experiencing homelessness, BMH could not find examples of peer teams that formally include individuals from encampment communities on the team.

[4] https://www.victorvilleca.gov/services/homeless-outreach/homeless-land-page/city-iniatives/wellness-recuperative-care-center
[5] https://www.thepeopleconcern.org/homeless-services/
[6] Yu, Stephanie W Y et al. "The scope and impact of mobile health clinics in the United States: a literature review." International journal for equity in health vol. 16,1 178. Published Oct 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5629787/
[7] https://www.wehope.org/mobile
[8] California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf
[9] https://ramsinc.org/peer-based/

Learning Goals

What is it that you want to learn or better understand over the course of the INN Project? How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

This project proposes innovations related to the method (peer- and community member-led) and location (encampment-based) of HCH service delivery. The following learning goals reflect what the project seeks to better understand in terms of the potential impacts of these innovations on consumer outcomes: Does providing wellness services onsite, in an encampment environment, make a difference in terms of consumers' self-reported overall health and mental health, and their take-up of other health and mental health services? Does it matter that individuals from the encampment community are brought on-board and compensated to help deliver these services?

These questions are captured in the learning goals in Table 2 below. Target outcomes are listed for each learning goal, as well as the data that will be collected to measure progress toward these outcomes. While the specific data collection modalities may change, particularly as service providers transition from virtual back to in-person services, the survey and other tools listed are exemplars intended to reflect the key outcomes supporting each learning goal.

For each of these learning goals, the data collected by the evaluation team at pre-launch or at program launch will comprise the baseline levels for future evaluation reporting. From a program evaluation perspective, because there is not currently reliable data collection and reporting infrastructure to pull historical data from and provide to the evaluation team, the data collected by the evaluation team during its first data collection cycle will comprise the baseline for the learning goals. This will also provide an opportunity for the evaluation team to develop and calibrate mixed methods data collection tools.

Table 2. Proposed Project Learning Goals

	LG 1. Do onsite wellness center services have an impact on consumers' overall and/or mental health?	**LG 2. Do onsite wellness center services increase take-up of mental health services more broadly among consumers?**	**LG 3. How does having individuals from the community help provide services shape delivery, including satisfaction with services?**
What do we want to learn?	#/% self-reported changes in overall health (+/-) #/% self-reported changes in mental health (+/-)	***New referrals:*** # of new service referrals #/% linkages to services #/% service engagement ***Existing referrals:*** Δ in service engagement for wellness center consumers with prior service referrals	% satisfaction with wellness center services #/% new vs. returning consumers #/% of consumers recruited to wellness center services via partners from the encampment community Δ in service take-up between wellness center consumers & baseline service take-up

How will we learn it?	✓ **Pre/post surveys** measuring consumers' self-reported overall health and mental health ✓ **Focus groups** with wellness center consumers ✓ **Onsite observations** at wellness center location(s)	✓ **Interviews** with wellness center consumers ✓ **Interviews** with wellness center staff ✓ **Interviews** with community-based service providers ✓ Program-level **service referral/linkage data**	✓ **Focus groups** with wellness center consumers ✓ **Focus groups** with wellness center staff ✓ **Pre/post satisfaction surveys** for wellness center consumers ✓ **Onsite observations** at wellness center location(s)

These learning goals, along with the proposed key outcomes and data collection modalities, reflect the intention of the project evaluation to include robust and meaningful stakeholder participation.

Section 3: Regulatory Requirements

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BMH will follow all City of Berkeley contracting procedures to implement a Request for Proposal (RFP) process and execute a contract with the chosen vendor. MHSA staff will monitor the contractor's performance to ensure quality and regulatory compliance.

Additionally, in terms of ensuring quality in service delivery, as part of the RFP process BMH will require bidders to demonstrate a clear understanding of current homeless outreach efforts that are underway in the community, and furnish an implementation plan that describes how this project will interface with existing efforts and coordinate with other service providers in the community.

Community Program Planning

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

BMH conducted a series of virtual community outreach events during October – February 2020-21 to meet Community Program Planning (CPP) requirements as part of its MHSA Innovation project development process.

With a core objective of identifying a project to support the mental health needs of unhoused community members, BMH implemented a two-tiered CPP process: first, BMH solicited feedback from individuals with lived experience as well as from community members more broadly; then, BMH engaged providers and advocates working in mental health and homelessness to review and further iterate community input.

As part of the initial CPP process, BMH conducted the following community outreach activities:

- **1:1 phone interviews with individuals with lived experiences of homelessness**
- **Paper surveys**, administered by outreach staff, **for individuals with lived experience of homelessness** who were unable to complete an interview
- **Virtual town hall**, open to all Berkeley community members

- **Online community survey**, open to all Berkeley community members

Following this series of community engagement activities, BMH facilitated multiple working sessions with local homeless outreach providers and advocates. The qualitative data from the initial CPP activities, together with the perspectives of local stakeholders with expertise in housing and homelessness, yielded a rich set of prospective project proposals. Additional internal review by BMH staff and city leadership further refined the Innovation project proposal.

Once the initial draft plan was created, it was reviewed by the Berkeley Mental Health Commission, the Berkeley MHSA Advisory Committee, and the California Mental Health Services Oversight and Accountability Commission (MHSOAC). The plan was then modified based on input received.

Figure 2 below shows the CPP process timeline for the Innovation project plan.

Figure 2. Community Program Planning Timeline

Due to the virtual nature of the Innovation CPP meetings, BMH was unable to obtain consistent demographic data for CPP process participants other than for paper survey respondents (paper surveys were administered to individuals experiencing homelessness).

Among paper survey respondents, 33% of respondents identify as Black or African American and 33% identify as White. Other race/ethnicity response categories are suppressed due to n<10. In terms of gender identity, 71% of respondents identify as men. Other gender identity categories are suppressed due to n<10. While all age categories are suppressed due to n<10, ages of survey respondents were equally distributed across age groups with the exception of lower response rates among respondents aged 18-29.

MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below. If one or more general standards could not be applied to your INN Project, please explain why.

- **Community Collaboration.** This project was informed by an extensive community collaboration process. The final project idea was generated directly as a result of the two-tiered CPP process described above.

- **Cultural Competency.** The CPP process centered the perspectives of individuals with lived experiences of homelessness. A result of this is the main framing of this project; namely, that is does not purport to offer explicitly clinical interventions at an encampment site. Community members with lived experience shared nuanced perspectives, many of which called for more accessible opportunities for wellness opportunities and social interaction more holistically. This is what the wellness center proposes – to make services immediately accessible, and to make the center a "generalist" health/wellness endeavor, with a customizable menu of service offerings. Moreover, ongoing program planning will be informed via collaboration between the provider team and unhoused community members, ensuring the services remain relevant and culturally competent.
- **Client & Family-Driven.** Both phases of the CPP process included perspectives from individuals with lived or adjacent experiences of homelessness. These perspectives drove the project planning process and defined the wellness center as a viable project option. Moving from project planning to implementation, the wellness center will remain client-driven because consumer input will inform program planning and service delivery.
- **Wellness, Recovery, and Resilience-Focused.** The proposed project is responsive to the tenets of wellness, recovery, and resiliency. In particular, the learning goals reflect a commitment to long-term monitoring and evaluation of consumer outcomes related to mental health and wellness, as well as service engagement rates (including for recovery services and behavioral health services). Moreover, one of the key ways in which the project aims to support consumer outcomes is by operating as a consumer-led initiative.
- **Integrated Service Experience for Clients and Families.** The encampment-based wellness center will effectively function as a possible entry-point to more specialized services, whether through onsite specialty service providers or via service referrals. This framework means that clients will have the opportunity to access a variety of services coordinated by or in tandem with the wellness center.

Project Sustainability

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

Through the local evaluation process, community of practice meetings, and conversations with stakeholders and city leadership, BMH will regularly evaluate the wellness center project to ensure that the components that are successful, or the entire project, can continue. Funding for continuation could come from a variety of sources: the City of Berkeley General Fund, MHSA funds, and/or existing special taxes in Berkeley that fund homeless services.

Communication & Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

To support community-wide dissemination of project information and lessons learned, BMH will engage stakeholders via online public forums as well as virtual and in-person community meetings. These venues have successfully been used with previous MHSA Innovation projects, and feedback from stakeholders during the CPP process supporting this project largely reflected that community members appreciate diverse opportunities for input and discussion.

If a member of the community is interested in learning more about the project, they can use the following keywords in an Internet search:

- **Keywords:** City of Berkeley MHSA, Berkeley mental health projects, Berkeley wellness center, Berkeley encampment wellness center, Berkeley homelessness outreach

Timeline

Specify the expected start date and end date of your INN Project, the total timeframe (duration) of the project, and include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Program Year (FY 2021-22 thru FY 2025-26)	**2022**				**2023**				**2024**				**2025**				**2026**			
Quarter	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*
Phase 1. Project Launch																				
1.1 RFP & Contract Execution, Service Provider																				
1.2 RFP & Contract Execution, Local Evaluator																				
1.3 Wellness Center Procurement																				
1.4 Launch Community of Practice																				
1.5 Community Outreach & Project Marketing																				
1.6 Recruitment for Partners from Encampment Community																				
Phase 2. Wellness Center Implementation																				
2.1 Community of Practice Quarterly Meeting																				
2.2 Onboarding for Peer Providers																				
2.3 Onboarding for Partners from Encampment Community																				
2.4 Wellness Center Staff Training																				
Phase 3. Local INN Project Evaluation																				
3.1 Evaluation Plan Finalization																				
3.2 Data Collection Tool Development																				
3.3 Baseline (Pre) Data Collection																				
3.4 Interim Data Collection																				
3.5 Interim Evaluation Reporting																				
3.6 Final (Post) Data Collection																				
3.7 Evaluation Report Development																				
3.8 Evaluation Report Finalization & Dissemination																				
Phase 4. Sustainability Planning																				
4.1 Sustainability Planning Meetings																				
4.2 Continuation Funding Planning																				
4.3 Dissemination of Project Continuation Decisions																				
Phase 5. Project Close																				
5.1 INN Funding Close-out																				

Section 4: INN Project Budget & Source of Expenditures

Budget Narrative

Provide a budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 5 years is $2,802,400, which will be allocated as follows:

Service Contract – Personnel plus non-eval direct costs (81%):	Procurement – Non-recurring costs (9%)	Evaluation – Direct costs (6%):	Administration – Indirect costs (4%):
• $259,600 in FY 21/22 • $504,200 in FY 22/23 • $504,200 in FY 23/24 • $504,200 in FY 24/25 • $504,200 in FY 25/26	• $239,000 in FY 21/22	• $15,000 in FY 21/22 • $35,000 in FY 22/23 • $35,000 in FY 23/24 • $35,000 in FY 24/25 • $45,000 in FY 25/26	• $13,750 in FY 21/22 • $26,950 in FY 22/23 • $26,950 in FY 23/24 • $26,950 in FY 24/25 • $27,400 in FY 25/26
Total: $2,276,400	Total: $239,000	Total: $165,000	Total: $122,000

Personnel costs will total $1,777,500 and will include all salaries and benefits of FTE staff. Personnel cost estimates are based on current-year ranges for similar positions in the Bay Area, based on job market data. The following are the FTE positions that are included in this cost proposal (the cost proposal also includes a .10 FTE director role for administrative and supervisory support):

- 1 FTE Program Manager: $120,000 (salary + benefits)
- 3 FTE Peer Providers: $88,500 per year (salary + benefits)
- .10 FTE Program Director: $9,500 per year (salary + benefits)

Direct costs (less evaluation services) will total $498,900 and will include programming expenses such as materials and supplies, technology, utilities, mileage, stipends, client transportation, subcontractors, etc. Personnel and direct costs combined (81% of the total proposed budget, as shown in the table above) will comprise the RFP funded value for the contracted service provider. The estimated total of the evaluation services contract is listed separately above, and in the budget table below, because BMH will use a separate RFP process to contract for evaluation services. This total needs to be clearly designated apart from the service contract with the selected CBO/service provider.

Evaluation services (direct costs) will total $165,000 over the project lifecycle. The evaluation contract will include evaluation plan development, data collection tool development, data analysis, interim evaluation reporting, annual MHSOAC reporting, and a final evaluation report. While evaluation services comprise 6% of the total project budget, less procurement-related non-recurring costs (which are not relevant to the evaluation scope), evaluation services comprise over 7% of the total INN project budget.

Non-recurring costs will total $239,000:

- $220,000 for procurement (i.e. physical wellness center)
    - BMH will coordinate with the contracted service provider/CBO to identify the best way forward for procurement. For example, the mobile unit may be a single RV, it may be a different type of trailer with a hygiene station and/or shower unit, it may be multiple smaller vans/mobile units, or something else.
    - Programming costs, including any materials required for wellness center activities or to “stock” the center, will be funded through “direct services – programming" (line 5). This is separate from non-recurring costs.

- $14,000 for wellness center technology (e.g. staff workstations and/or laptops and laptop docking stations, phone and tablet chargers, mobile cooling fans, etc.)
- $5,000 for a local, community-based marketing campaign

Indirect costs will total $122,000:

- $8,200 for BMH monitoring and management of the evaluation services contract (line 14).
- $113,800 for the contracted CBO/service provider's administration, monitoring, and management of the Innovation project (lines 2 & 5).

In the "Budget Context – Expenditures by Funding Source and Fiscal Year" table below, indirect costs are reflected in the "administration" category, as indirect costs included in this project plan are administrative overhead costs. Row A1 shows total indirect costs.

Federal Financial Participation (FFP): There is no anticipated FFP.

Other Funding: N/A

Budget by Fiscal Year

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Salaries (.1 x PD, 1 x PM, 3 x peer providers)	197,500	395,000	395,000	395,000	395,000	1,777,500
2.	Indirect Costs (admin/overhead)	10,400	20,000	20,000	20,000	20,000	90,400
3.	Total Personnel Costs	207,900	415,000	415,000	415,000	415,000	1,867,900
OPERATING COSTS		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
4.	Direct Costs (programming)	62,100	109,200	109,200	109,200	109,200	498,900
5.	Indirect Costs (admin/overhead)	2,600	5,200	5,200	5,200	5,200	23,400
6.	Total Operating Costs	64,700	114,400	114,400	114,400	114,400	522,300
NON-RECURRING COSTS (equipment, technology)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
7.	Wellness center procurement	220,000	-	-	-	-	220,000
8.	Wellness center technology	14,000	-	-	-	-	14,000
9.	Marketing	5,000	-	-	-	-	5,000
10.	Total Non-recurring costs	239,000	-				239,000
CONSULTANT COSTS / CONTRACTS (Evaluation contract)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
11.	Direct Costs	15,000	35,000	35,000	35,000	45,000	165,000
12.	Indirect Costs (admin/overhead)	750	1,750	1,750	1,750	2,200	8,200
13.	Total Evaluation Costs	15,750	36,750	36,750	36,750	47,200	173,200
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	
Personnel (line 1)		197,500	395,000	395,000	395,000	395,000	1,777,500
Direct Costs (lines 4 and 11)		77,100	144,200	144,200	144,200	154,200	663,900
Indirect Costs (lines 2, 5 and 12)		13,750	26,950	26,950	26,950	27,400	122,000
Non-recurring costs (line 10)		239,000	-	-	-	-	239,000
Other Expenditures (line 16)		-	-	-	-	-	-
TOTAL INNOVATION BUDGET		**527,350**	**566,150**	**566,150**	**566,150**	**576,600**	**2,802,400**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	13,750	26,950	26,950	26,950	27,400	122,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	13,750	26,950	26,950	26,950	27,400	122,000
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	15,750	36,750	36,750	36,750	47,200	173,200
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	15,750	36,750	36,750	36,750	47,200	173,200
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	527,350	566,150	566,150	566,150	576,600	2,802,400
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**527,350**	**566,150**	**566,150**	**566,150**	**576,600**	**2,802,400**
*If "Other funding" is included, please explain.							