EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: Riverside County

County Mental Health Director	**Project Lead**
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I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

Signature (Local Mental Health Director/Designee)	Date	Behavioral Health Director Title

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC)
INNOVATIVE PROJECT PLAN DESCRIPTION
Optional Template

County: Riverside **Date Submitted** 11/8/2016 (Draft)

Project Name: Commercially Sexually Exploited Children (CSEC)

PLEASE NOTE: USING THIS TEMPLATE IS **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it.

An "Innovative Project" means "a project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports" (*California Code of Regulations, Title 9, Sect. 3200.184*). Each Innovative Project "shall have an end date that is not more than five years from the start date of the Innovative Project" (*CCR, Title 9, Sect. 3910.010*). Counties shall expend Innovation Funds for a specific Innovative Project "only after the Mental Health Services Oversight and Accountability Commission approves the funds for that Innovative Project" (*CCR, Title 9, Sect. 3905*).

The goal of this template is to assist County staff in preparing materials that will adequately explain the purpose, justification, design, implementation plan, evaluation plan, and succession plan of an Innovation Project proposal to key stakeholders, including local and State decision-makers, as well as interested members of the general public.

General regulatory requirements for Innovative Projects can be found at CCR, Title 9, Sect. 3910. Regulatory requirements for the Innovation (INN) Component of the 3-Year Program and Expenditure Plan & Annual Update can be found at CCR, Title 9, Sect. 3930. In some cases, the items contained in this **OPTIONAL** template may be ***more specific or detailed*** than those required by the regulations; you may skip any questions or sections you wish.

The template is organized as follows. Part I, Project Overview steps through a series of questions designed to identify what the County has identified as a critical problem it wishes to address via an Innovative Project, the steps the County has taken to identify an innovative strategy or approach to address that critical problem; how it intends to implement the innovative strategy or approach; what it hopes to learn and how those learning objectives relate the innovative strategy or approach to the critical problem it has identified; how it intends to address the learning objectives; and how the County intends to address any transition for affected stakeholders at the end of the time-limited project.

Part II, Additional Information for Regulatory Requirements, poses a series of questions that relate to specific regulatory requirements, either for the proposal or for subsequent reports.

I. Project Overview

1) Primary Problem

a) What primary problem or challenge are you trying to address?

b) Describe what led to the development of the idea for your INN project and the reasons that your project is a priority for your county.

a). **Primary problem/challenge innovation addresses**

The issue this Innovation Project addresses is the lack of knowledge regarding the model of mental health service delivery that is most effective for child victims of commercial sexual exploitation. Much of the work for this population to date has focused on the legal aspects of identifying and prosecuting traffickers. A review of the literature showed little information is available on which mental health approaches best promote and support recovery and the transition into productive lives and a hopeful future. The overwhelming majority of published literature on Commercially Sexually Exploited Children (CSEC) is focused on defining the scope of the problem and describing law enforcement and social services (housing, medical, and educational needs) with little to no information available on the best clinical mental health approaches for providing therapy services to youth victims. Despite the existing knowledge about the short- and long-term impacts of child sexual abuse, few treatment modalities for CSEC populations have been rooted in evidence-based practice (Lev-Wiesel 2008). CSEC youth are at a high risk for experiencing symptoms of traumatic distress including PTSD, anxiety, and depression which suggests trauma-informed treatment would be effective with this population. It has been reported in the literature that these youth are challenging to engage in mental health treatment since the youth often do not view their exploitation as traumatic and want to return to the abuser. Dangerous and risky behavior, combined with repeated running away, also make it difficult to continue to provide treatment (Cohen, MAnnarino, & Kinnish, 2015). Multiple problems can overwhelm caregivers and lead to challenges in providing stable placement (Cohen, Mannarino, & Kinnish, 2015). Researchers have recently suggested that adaptations to evidence-based treatments are needed to address the complex clinical needs of these youth (Cohen, Mannarino, & Kinnish, 2015).

b). **Description of development of INN project and reasons project is a priority for our county**

Los Angeles and San Diego metropolitan areas are rated by the FBI as two of thirteen "high intensity child prostitution areas" in the United States. The Inland Empire, which includes Riverside County located directly north of San Diego and directly east of Los Angeles, has been referred to as an extension of LA when identifying "hotspots" for CSEC. Riverside County is the fourth most populous county in the state with an estimated 2,227,577 residents and approximately 27% of the population under the age of 18. Recently approximately 129 youth have been identified as CSEC victims by County Probation or the Department of Public Social Services. Studies estimate that between 50 and 80% of victims of commercial exploitation are or were known to child welfare. As Riverside County began building interagency collaboratives dedicated to identifying and protecting CSEC victims, and prosecuting traffickers, it became apparent that information on how to treat the mental health needs of CSEC youth was lacking. The Riverside County Department of Public Social Services (DPSS) Children's Services Division (CSD) founded a committee (Committee Against the Commercial Sexual Exploitation of Children) to address the problem of trafficking within child welfare and to collaborate efforts among agencies (law enforcement, child welfare, juvenile justice, probation, youth shelters, and other partners in the County). Through this collaborative it was learned that County youth probation and school districts also identified a need to address the problem within the youth they serve. In defining the scope of the problem, the committee stakeholders identified several areas of concern including:

1) Better methods to identify CSEC youth and collaborate on their care,
2) Effective therapy models for survivors of trafficking and their families, and
3) Increasing knowledge of trauma informed care among service providers that supports the therapeutic work. Riverside University Health Systems-Behavioral Health as the County mental health provider began to receive requests for information on the treatment options available for CSEC youth.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

"A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach… (*CCR, Title 9, Sect. 3910(b)*).

Describe the efforts have you made to investigate existing models or approaches close to what you're proposing (e.g., literature reviews, internet searches, or direct inquiries to/with other counties). Have you identified gaps in the literature or existing practice that your project would seek to address?

In communication with other counties that provide services to CSEC youth it became apparent that specific data on outcomes and therapeutic approaches to address and meet mental health needs was not available. Most programs working with CSEC population provide services such as shelter and case management services which link to services such as legal aide, medical care, employment training, and witness protection. Therapeutic mental health services are most often referred out to community providers. Specific therapies, which may help reduce trauma symptoms related to CSEC, have not been tested and little is known about their effectiveness. Additionally, there is little information regarding engagement of CSEC victims and their families into care and their successful return to the community. Some other County programs serve CSEC youth within an existing broader program, for example a large county to the south of Riverside serves wards in detention facilities to facilitate transition back into the community and has incorporated some additional programming for CSEC youth in the detention facility. There is no specific data on therapeutic approaches, treatment for trauma or outcomes for this County's CSEC population. While child welfare funds have become available, most of the focus is on protocols for training, preventing, identifying, and documenting the service needs of CSEC youth. Services to these youth are focused on a broad array of needs including: safe housing, medical needs, legal needs, education, and vocational training. Any mental health services are referred out to County or contracted providers. Data on the specific trauma therapy and outcomes are not available.

A review of over thirty articles and internet sources showed evidence-based data on mental health treatment for child sex trafficking victims is lacking. A number of articles focused on the scope of the problem, characteristics of the population and methods to identify youth at risk of trafficking with little to no literature or data on the best approaches for mental health treatment. The few articles that reported data on treatment were conducted on populations outside of the United States: one article focused on aggressive behaviors of child victims (Sibnath, D. et al, 2011), and the other reported on efforts to assist women in war torn countries in Africa (O'Callaghan, P. et al 2013). The Casey Foundation (2014) recently conducted a national survey to gather child welfare leader insights into the problem and what they needed to learn more about to combat it. The Casey Foundation report (2014) noted that the vast majority of respondents indicated that they wanted to know more about the best practices for treatment of child victims of sex trafficking. In a recent publication the developers of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) outlined strategies that could be used to adapt the TF-CBT model as a treatment option for CSEC youth (Cohen, Mannarino, & Kinnish, 2015). The authors noted the need for data supporting this adaptation.

The proposed project differs significantly from the County Regional Evaluation and Assessment at Community Hospitals (REACH) Triage Mobile Crisis service. REACH Crisis Triage is focused on responding to request from local hospital emergency rooms for persons presenting with a psychiatric emergency. Their goals are to provide a brief crisis intervention, resources, and linkages to shorten the stay in the emergency room and avoid an inpatient admission by diverting and/or discontinuing 5150 holds when possible. The REACH triage program does not provide therapy or on-going services. CSEC Field Response Project teams are designed to test a therapeutic intervention within a coordinated Specialty Care Team that work almost exclusively in the field with an on-going therapeutic approach to address the complex needs of the CSEC youth population.

3) The Proposed Project

Describe the Innovative Project you are proposing. Note that the "project" might consist of a process (e.g. figuring out how to bring stakeholders together; or adaptation of an administrative/management strategy from outside of the Mental Health field), the development of a new or adapted intervention or approach, or the implementation and/or outcomes evaluation of a new or adapted intervention. See CCR, Title 9, Sect. 3910(d).

Include sufficient details so that a reader without prior knowledge of the model or approach you are proposing can understand the relationship between the primary problem you identified and the potential solution you seek to test. You may wish to identify how you plan to implement the project, the relevant participants/roles, what participants will typically experience, and any other key activities associated with development and implementation.

The proposed CSEC Field Response Project combines an adapted TF-CBT model to effectively treat trauma with a field-based coordinated Specialty Care Team approach designed to meet the challenges of engagement and coordination of multiple agencies. This approach we believe will improve the quality of services, promote trauma informed care, and increase interagency collaboration ultimately resulting in better outcomes for CSEC youth and families. This CSEC Field Response Project is an opportunity to learn about effective ways to deliver mental health treatment that would meet the needs for this vulnerable and challenging population of youth. The project is focused on learning about how to treat CSEC youth by utilizing a field-based approach with a team of staff that "meet the youth where they are at", literally. A victim can be living in a group home, AWOL back onto the streets, end up in a crisis shelter, only to be moved to a different foster care placement. This often repeated scenario is disruptive to many aspects of engagement including engagement into safety and treatment. Having youth and family work with a single team/provider across regional boundaries with teams going out to the family contributes to consistent relationships during the critical phase of engagement. This one child, one family, one team concept is highlighted by CSEC survivors as a key component of treatment.

The CSEC Field Response Project will establish four teams each with a Clinical Therapist, Parent Partner, a Peer Specialist (with transition age youth experience), a Licensed Vocational Nurse, and a shared Behavioral Health Specialist to provide a rapid response to request for services for a CSEC youth and their families or caregivers. These youth often runaway before the engagement process can begin, so a team response within a window of 48 hours is optimum. Consistent contact with a select number of team members during the engagement process will provide consistency for youth and families as therapeutic engagement develops. A field-based coordinated Specialty Care Team using a "Wraparound" like approach is best suited to address the challenges. Utilizing strategies suggested by the developers of TF-CBT, these teams will be trained in using TF-CBT with an adaptation to include motivational interviewing and significant work with caregivers to engage and treat CSEC youth (Cohen, Mannarino, & Kinnish, 2015). TF-CBT developed by Drs. Anthony Mannarino, Judith Cohen, and Esther Deblinger is an evidence-based treatment that has been evaluated and refined to help treat trauma in youth and their non-offending parents or caregivers (Cohen et al, 2006). In a recent publication these authors noted the multiple clinical challenges that CSEC youth face and the need for information on using TF-CBT with adaptations (Cohen et al, 2015). The authors outlined adaptations that could be tried to overcome the challenges CSEC youth and caregivers face when receiving therapy (Cohen et al, 2015). CSEC Field Response Project staff will be trained in motivational interviewing, TF-CBT, trauma informed care, booster trainings, weekly supervision, team multidisciplinary planning, and strategies to address vicarious trauma/self care.

The team is designed to provide coordinated specialty care with each member of the team uniquely contributing to the engagement and support of CSEC youth. Experienced clinicians versed in serving youth with complex trauma will be a key member on each team. These clinicians will be the therapist providing TF-CBT and will function as the case manager assisting the team with navigating all aspects of care.

Survivors of trafficking report having a peer on the team is essential to engaging victims into safety and treatment. Inclusion of Peers is consistent with our Department's focus on a recovery model that ensures consumer voice and choice are respected. CSEC field teams intend to include Transition Age Youth (TAY) Peer Specialists who have experience in foster care and are survivors of trafficking. These TAY Peer Specialists, trained in motivational interviewing, can assist with engagement, mentor youth through the healing process, and ensure the survivor's "voice" is heard and respected by all. TAY Peer Specialists can help parents, caregivers, and professionals understand what a young person may be experiencing as they are recovering from traumas unique to trafficking. Many of these children and youth are living with parents or in relative care. Strengthening a parent's or caregiver's capacity to protect and provide for their child is essential in helping children and youth to stay in their home, heal from trauma, and prevent future traumas. Parent Partners have experience raising a child who may have or is currently receiving mental health services. A Parent Partner on the team will help parents and caregivers to come to terms with their child's situation, provide support and hope for healing, link parents to services, provide basic parenting skills training, and support interactions with their child or youth that are trauma informed and consistent with skills being learned by their child or youth in treatment. Parent Partners can help parents navigate various systems (DPSS, Probation, Courts, and Schools). Parent Partners can help reduce the shame and confusion parents experience in discovering their son or daughter is a victim of CSEC. Parents or caregivers of youth who are victims of trafficking are often themselves, victims of trauma. They may have never sought treatment for themselves. Parent Partners will help reduce barriers and link parents and caregivers to counseling services.

More often than not, these children, youth, and families have complex, multiple needs including housing, employment, school, and medical and dental care to name a few. The team Licensed Vocational Nurse (LVN) will be providing health screening including access to HIV/STD testing and reproductive health care. The Behavioral Health Specialist will provide intensive case management services, linking and supporting families in accessing needed social and medical resources, including housing, vocational, and educational goals. Addressing this area of care is essential to reducing parental stress and burden as well as improving protective factors. The staff Psychiatrist, with experience working in the field of trauma informed care, can provide medication services to help ameliorate symptoms and collaborate with the field team to ensure appropriate use of medications. Each CSEC Field Response Project team will serve as a central collaborator with other social services agencies. Utilizing a select set of team members to consistently advocate and support CSEC youth minimizes the risk for additional trauma as youth move through services from multiple agencies and various systems. Utilizing this collaborative team approach will also assist caregivers with the often daunting task of navigating multiple complex systems.

Professionals within the various systems that interact with victims of trafficking, including their families and caregivers, can respond to victims in a way that further contributes to shame and stigma, causing even greater harm. CSEC survivors have suffered from criminalization often being referred to as "prostitutes" with little or no understanding about the trauma of being trafficked and its impact on their lives. Survivors and their families share the incredible shame and stigma created by this victimization which creates barriers to engaging youth into returning to safe environments and treatment. Youth who are victims of human trafficking require a compassionate; trauma informed response rather than a punitive, judgmental approach.

One function of the CSEC teams will be to provide any needed education on trauma informed care to parents/caregivers and other service providers interacting with the CSEC youth. Incorporating trauma informed care into CSEC Field Response Project team's interactions with other providers that CSEC youth encounter is an important component to learning about this service delivery model. Law enforcement, child welfare, social service providers, and parents/caregivers have their unique roles to play in providing safety, security, and restorative practices for victims of trafficking. This trauma informed education must be a part of this model of service delivery if we are to succeed in serving CSEC youth and their families. This notion is best described by Gabriela Grant, a trainer and consultant in trauma informed care, "Trauma-informed transformation is a cultural shift, a move toward safety-focused, strength-based, consumer-driven, empowerment-rich programming that allows consumers to take charge of their recovery, addresses unsafe behaviors and prioritizes safety as a platform for recovery." [1]

[1] Retrieved from: http://www.trauma-informed-california.org/ August 18, 2016

4) Innovative Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The CSEC Field Response Project aims to test an adapted evidence-based practice (TF-CBT) to determine if the adaptation delivered within a coordinated specialty care model will, as a whole, improve outcomes for this vulnerable population. The key element of this Innovation Project involves adapting TF-CBT to utilize Motivational Interviewing within a coordinated Specialty Care Team including Transition Age Youth Peer survivors and Parent Partners to focus on engaging and supporting youth and families/caregivers. The developers of Trauma-Focused CBT have reported in the literature a need to adapt the current evidence-based practice to meet the needs of CSEC youth. This adaptation involves integrating motivational interviewing and the stages of change model in order to optimize engagement and treatment completion of TF-CBT. The adaptation will utilize TAY Peers and Parent Partners to provide services to families/caregivers to enhance engagement and provide support. These TAY Peers and Parent Partners are an integral part of the CSEC Specialty Care Team working to identify barriers and support all phases of TF-CBT treatment.

5) Learning Goals / Project Aims

Describe your learning goals/specific aims. 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?

There is no maximum number of learning goals required, but we suggest at least two. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.

The proposed CSEC Field Response Project will contribute new knowledge on the best service delivery approach for working with CSEC youth. It is expected that this project will contribute to knowledge on new methods to apply TF-CBT for special populations, and determine how to improve the practice by utilizing a service delivery approach that centers on a field based coordinated Specialty Care Team with interagency collaboration. It is expected that this approach will result in increased engagement into care and retention as well as better outcomes for youth and families. The learning goals will focus on the following key areas:

1. Effectiveness of adapting TF-CBT for a commercially sexually exploited youth population to understand if this adapted approach delivered in a Specialty Care Team model increases engagement, retention, and outcomes.
2. Effectiveness of a coordinated Specialty Care Team approach with a CSEC team including the use of TAY Peer Specialist and Parent Partners to increase engagement and retention in services and improve outcomes.

6) Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your "sample size") required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.

In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:

a) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?
b) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.
c) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?
d) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?
e) What is the *preliminary* plan for how the data will be entered and analyzed?

Project measurement will include primary data collection from youth and families/caregivers participating in services from the CSEC Field Response Project teams. Proposed project measurement for each learning goal is as follows:

1). Effectiveness of adapting TF-CBT. Since the adaptation is expected to have an impact on engagement and retention, data collection will include youth engagement and retention in services. This is an important indicator given that this population is known to have significant challenges with AWOL/running away and engagement into services. Mental health treatment outcomes are keenly related to maintaining the youth in therapy. Service data from the County electronic health record will be used to document participation in services, retention, and completion of mental health therapy.

Further the outcome of TF-CBT services will be measured with pre to post data collection on trauma symptoms utilizing either the Trauma Symptom Checklist or the UCLA PTSD Index. General mental health functioning will be assessed pre to post with the Youth Outcomes Questionnaire. Symptom outcome measures will be directly collected by the CSEC team staff.

2). Effectiveness of a coordinated Specialty Care Approach with a CSEC Field Response Project team including the use of TAY Peer specialist and Parent Partners.

CSEC youth and their families will be surveyed regarding their experiences with the CSEC Field Response Project. Additionally improvements in family/caregiver relationships will be assessed utilizing a structured interview approach. The survey on families' experiences and the structured interviews will be collected by the CSEC team staff with the assistance of the RUHS-BH Evaluation unit. Significant TAY Peer and Parent Partner input and collaboration will be solicited to formulate structured interview questions and survey items. Since the coordinated team will be focused on the overall well-being of the youth, functional outcomes will also be collected such as participation in school or work, reduced AWOL and placement challenges, and recidivism rates for youth returning to trafficking will also be measured.

A quasi-experimental approach will be utilized to assess the effectiveness of the CSEC Field Response Project. A treatment control group design is neither feasible nor ethical with this vulnerable population. Inferences on effectiveness will be drawn from the key data collected on engagement and retention into services, as well as, outcomes on pre to post measures for trauma symptoms and general mental health functioning. Comparisons could be made to other published data on the engagement and retention of child sexual abuse victims in treatment or youth in general in the County mental health system. However, as noted previously, there is no published data available on outcomes specific to the CSEC population.

It is expected that the CSEC Field Response Project teams will do the primary data collection of the pre to post symptom measures as they will be working closely with the youth and family/caregiver. Some information on recidivism and placement statuses may be gathered from collaborative partners at probation and/or child welfare. A data sharing Memoranda of Understanding (MOU) was drafted and adopted by the County and includes data sharing between RUHS-BH and DPSS. The RUHS-BH Department has developed data sharing over the past several years with both the Department of Social Services (DPSS) and Probation Department through other joint projects including, work associated with the Katie A lawsuit, and Wraparound evaluation.

All data will be maintained and analyzed by the RUHS-BH evaluation unit. The evaluation data unit will be responsible for specific form development as needed to collect placement or recidivism data, query service and treatment completion data from the electronic health record, and maintaining databases of CSEC youth and their pre to post measures. The evaluation unit expects to involve the TAY Peers and Parent Partners in the development of structured interview questions and CSEC experience survey items. Reports will be drafted by the evaluation unit and reviewed with various stakeholders including: program staff, TAY Peers, and Parent Partners for feedback and quality improvement learning opportunities.

RUHS-BH Research and Technology division directly employs a Senior Peer Specialist who is involved in multiple quality improvement projects including data collection and reporting. This Innovation Project will benefit from utilizing both this in-house peer expertise and the input and feedback from other Peers and Parent Partners who are readily available in the Department's Consumer Affairs and Central Parent Support units. Cultural competency in the evaluation will rely on consultation with the Department's Cultural Competency Manager.

7) 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?

Program services will not be contracted out.

II. Additional Information for Regulatory Requirements

1) Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documentation of all of the following:

a) Adoption by County Board of Supervisors.

Once the Innovation Project is approved by the MHSOAC, County Board of Supervisors approval will be sought prior to funds expenditure and implementation. If the timing of this Innovation Project coincides with the submittal of the County MHSA 3-Year Program and Expenditure Plan then the approval will be included when the MHSA Plan is submitted to the County Board of Supervisors. If the timing is earlier than the expected MHSA 3-Year Plan submittal than independent Board of Supervisor approval will be requested prior to funds expenditure and implementation.

b) Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA).

See attached completed Mental Health Director Certification form.

c) Certification by the County mental health director and by the County auditor-controller that the County has complied with any fiscal accountability requirements and that all expenditures are consistent with the requirements of the MHSA.

See attached signed County Certification.

d) Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation

Riverside County adheres to MHSA Regulations utilizing the MHSA allocation of 80% CSS and 20% PEI. Five percent (5%) of each of these components is then dedicated to the Innovation Component.

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2) 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.

Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

Riverside University Health Systems-Behavioral Health (RUHS-BH) conducts an on-going continuous planning process year round. This includes eliciting feedback and informed decision making through subject matter experts that comprise the MHSA System of Care planning committees. MHSA staff also provide monthly updates to the

Behavioral Health Commission as they act as an advisory body on all aspects of MHSA planning. The planning process includes four key committees by age span: Children's, Transition Age Youth Collaborative, Adult, and Older Adults. There are several other cross-collaborative committees that advise the Department on certain specialty areas such as Criminal Justice, Cultural Competency/Ethnic Disparities, and the Consumer Wellness Coalition that lend ethnic-specific, consumer, and family member perspectives to the planning process. The participants involved include mental health consumers, peer specialists, family advocates, parent partners, community-based organizations, and public agencies. Participants were representatives of underserved communities as well as persons serving those same communities. The MHSA Administrator and other RUHS-BH staff have been responsible for informing the various stakeholders regarding the purpose, scope, and limitations of Innovation Projects.

The decision to prioritize investigating methods to serve CSEC youth arose partly from the Department's aforementioned on-going planning structure and partly from the community committees and RUHS-BH participating task force. RUHS-BH participates in a task force, a committee, and a multi-disciplinary team (Riverside County Child Assessment Team) that all work to address the problem of commercially sexually exploited youth in Riverside County. The Riverside County Anti-Human Trafficking Task Force (RCAHT) brings together law enforcement, local treatment providers, and other experts. RCAHT coordinates with the Federal Bureau of Investigations, the United States Attorney's office, and the Riverside District Attorney's office to protect sexually exploited youth, prosecute perpetrators, prevent commercial sexual exploitation, and partner with the community to promote awareness and understanding of the nature and scope of the problem. Attendees at RCAHT meetings include church leaders, concerned community members, youth serving agencies, and RUHS-BH. Topics in these meetings have included questions about what therapeutic responses are available to CSEC youth.

The Committee Against the Commercial Sexual Exploitation of Children (CSEC) was founded by the Department of Public Social Services Children's Services Division to coordinate efforts within child welfare and other agencies. The Riverside County Child Assessment Team (RCCAT) provides multidisciplinary forensic exams and interviews for children, from infants to 17 years of age, who have suffered abuse or neglect. Through participation in these groups stakeholders reported a need for understanding the treatment options available for commercially sexually exploited children. Our stakeholders also indicated that they were challenged with identifying and tracking the coordination of mental health care to youth under their jurisdiction. School districts who participate in the CSEC committee also indicated a need to understand how to address the mental health needs of this unique population. RUHS-BH Parent Partners have heard from providers, youth, and families that there is a lack of understanding about where to turn for mental health services for sexually exploited youth.

The CSEC Committee recognized the County system needed to understand how to better serve this population and avoid additional traumatization of victims and their families in the process. The CSEC Committee includes Riverside County Probation Department, Riverside University Health System - Public Health (RUHS/PH), Riverside University Health System - Behavioral Health (includes Substance Abuse Program), Riverside County Sheriff's Department / Riverside County Anti-Human Trafficking Task Force (RCAHT), Operation Safehouse, Riverside County District Attorney's Office, Riverside County Juvenile Defense Panel, Riverside County District Attorney's Office, Division of Victim's Services, Riverside County Office of County Counsel – CSD, Riverside County Public Defender's Office, Voices for Children/Court Appointed Special Advocates (CASA), Riverside University Health System (previously known as RCRMC), Riverside County Child Assessment Team (RCCAT), Public Child Welfare Training Academy (PCWTA), Million Kids, Riverside County Office of Education (RCOE), Run2Rescue, and Center Against Sexual Assault (CASA). Riverside County Anti-Human Trafficking Task Force (RCAHT) consists of law enforcement and community treatment providers.

The Riverside County Child Assessment Team (RCCAT) includes Riverside University Health System (RUHS), Department of Public Social Services (DPSS), Law Enforcement (LE), the District Attorney's Office (DA), and the Riverside University Health System - Behavioral Health. Finally in the County TAY Collaborative the issue of what to

do for commercially sexually exploited youth and how to address their trauma was identified by stakeholders as an area of need. The TAY Collaborative members include providers serving TAY across the county as well as TAY consumers of mental health services. The Collaborative reflects a diversity of ethnicities and geographic representation (Western, Mid-County, and Desert Regions). The TAY Collaborative has been a central vehicle for feedback from stakeholders in the planning and development process for MHSA projects. Partner agencies included in the TAY Collaborative include representation from the Riverside County Office of Education (RCOE), Special Education Local Plan Area (SELPA), Victor Community Support Systems (VCSS), Operation Safe House, Olive Crest, Recovery Innovations, STARS, Catholic Charities, Department of Public Social Services (DPSS), Public Health, and RCMHD Peer Support Specialists working with TAY and their families. The problem of how to address the treatment needs of commercially sexually exploited youth arose from these multiple stakeholder groups. This prompted RUHS-BH to investigate what was known about treatment and how RUHS-BH as a Department could respond.

3) Primary Purpose

Select **one** of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

Increase the quality of mental health services, including measurable outcomes.

4) MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

a) Introduces a new mental health practice or approach
b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community
c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population, or community.

5) Population (if applicable)

a) If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?
b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.
c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

It is expected that the program will serve approximately 100 CSEC youth per year.

6) MHSA General Standards

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

a) Community Collaboration
b) Cultural Competency
c) Client-Driven
d) Family-Driven
e) Wellness, Recovery, and Resilience-Focused
f) Integrated Service Experience for Clients and Families

This Innovation Project supports and is consistent with General Standards indentified in the MHSA and Title 9, Section 3320, as follows:

Client Driven: Services provided to the CSEC youth and families as a part of the CSEC Innovation Project will value the youth voice in establishing personal resiliency and recovery goals. The inclusion of a TAY PSS on the CSEC Team will also ensure that the youth voice and choice will be part of the service delivery. The CSEC youth feedback will be used to document this service delivery model taking into account their suggestions for engagement and what works. TAY PSS are trained in emphasizing recovery principles in service delivery.

Family Driven: Parent, caregiver, or other support persons are essential to recovery for CSEC youth. Parent Partners with lived experience as parents or caregivers are in integral member of the CSEC Field Response Project team and supporting families is their role. Family voice and choice are important values and are part of training that parent partners receive for working with family members. CSEC teams will further reinforce participation of family members and significant others in this Innovation Project.

Wellness, Recovery and Resiliency Focused: A focus of the CSEC Field Response Project teams is to emphasize wellness and recovery as part of the welcoming and engagement strategy. Recovery principles are core values for the Department and are a focus when TAY PSS and Partner Partners are trained, so that recovery and wellness principles are a part of all their work with youth and families. Services provided by CSEC Teams will be strength based, emphasize integrated care, and will assist youth with maintaining relationships with family, friends, and other support persons. The trauma informed care that will be a part of the training and service delivery model emphasizes strength based, empowerment based services that focuses on taking charge of recovery.

Cultural Competence: CSEC Field Response Project teams will reflect the cultural and linguistic diversity of the youth and families served. Specialized knowledge and skill of this developmental stage in life is required to properly engage and serve these youth and their families. Training for CSEC staff will include information on the culture of this unique population as well as developmental knowledge on youth in this age range.

Integrated Service Experience: Collaborating with partner agencies including; Probation, Child Welfare, and schools as part of the service delivery model to be tested will provide the opportunity for integration of care between systems and an integrated service delivery system.

Community Collaboration: Multiple community partners were involved in the stakeholder process.

7) Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project?
If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

CSEC Field Response Project teams will ensure that any additional supports needed for youth that may present with a serious mental illness (SMI) receive any additional supports or services needed either while they are in the care of the Field Response Project teams or as they transition from care. The CSEC field teams based on clinical assessment will be able to diagnose SMI. The CSEC project will have available to them the entire County System of Care as a referral resource if the need should arise. The CSEC youth served will be documented in the electronic health record which facilitates tracking and monitoring of access and utilization of care.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

a) Explain how you plan to ensure that the Project evaluation is **culturally competent**.
Note: this is not a required element of the initial INN Project Plan description but is a mandatory component of the INN Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups.

b) Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation.
Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group, or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must contribute in some meaningful way to project evaluation, such as evaluation planning, implementation and analysis. Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weighs in at different stages of the evaluation.

See Section 6 Evaluation Plan.

9) Deciding Whether and How to Continue the Project Without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

If program outcomes show promise. The plan is to continue services with braided Funding from Medi-Cal revenue and Community Services and Supports funds.

10) Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

a) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?
b) How will program participants or other stakeholders be involved in communication efforts?
c) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Annual program evaluation reports can be distributed to community stakeholders including the various County and community collaboratives that are involved in CSEC work. Program and outcomes presentations will also serve as a vehicle to disseminate information on the CSEC Field Response Project's practices and program outcomes. Other professional conferences including the Annual Children's Network Conference in Ontario California and the San Diego International Conference on Child and Family Maltreatment are opportunities to present and share information on the CSEC Field Response Project

11) Timeline

a) Specify the total timeframe (duration) of the INN Project: __5__ Years __0__ Months
b) Specify the expected start date and end date of your INN Project: ____ Start Date ____ End Date
Note: Please allow processing time for approval following official submission of the INN Project Description.

Because this project is under conditional approval, the expected start date will be within 60 days of Riverside County Board of Supervisor's approval.

c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for
   i. Development and refinement of the new or changed approach;
   ii. Evaluation of the INN Project;
   iii. Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
   iv. Communication of results and lessons learned.

Identify experts in trauma informed care systems development and establish formal training agreements.

Within 2 months of Innovation Project award

Adapt Trauma Focused CBT in consultation with TF-CBT developers to include additional elements and design workflow with CSEC Field Response Project Specialty Care Teams.

Within 3 months of Innovation Project award

Hire and assemble CSEC field teams.

Within first 6 months of Innovation Project award

Train key persons from partner agencies in Trauma Informed Care, including County staff.

Within first 4 months of Innovation Project award

Partner agencies, including survivors and family members, will develop core values and operating principles for use across disciplines.

Within the first 6 months of Innovation Project award

Training materials reflecting these shared values and principals will be developed for training new staff in respective agencies.

Within the first 6 months of Innovation Project award.

Partner agencies operationalize values & principles within in their respective agencies when working with children, youth, and families impacted by the human trafficking.

Within the first year of Innovation Project award

Begin implementing CSEC field teams.

Within first 6 months of Innovation Project award

Ongoing Evaluation of training in Trauma informed care and Interagency partnerships.

After 6 month of Innovation Project award and annually thereafter

Ongoing evaluation of CSEC Field Response Project teams work with CSEC youth including youth engagement and outcomes.

Annually after Innovation Project award

Citations

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). Treating trauma and traumatic grief in children and adolescents. New York: Guilford Press.

Cohen, J.A. Mannarino, A.P., Kinnish K., (2015). Trauma Focused Cognitive Behavioral Therapy for Commercially Sexually Exploited Youth. Journal of Child and Adolescent Trauma , December 28, 2015, Online First.

O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A.(2013). A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited, war affected Congolese girls. J American Academy Child Adolescent Psychiatry, 52, 359–369.

Sibnath Deb, Aparna Mukherjee, and Ben Mathews (2011). Aggression in Sexually Abused Trafficked Girls and Efficacy of Intervention. Journal of Interpersonal Violence, 26(4) 745–768.

II. Additional Information for Regulatory Requirements (continued)

12) INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

a) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

b) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

c) BUDGET CONTEXT (If MHSA funds are being leveraged with other funding sources)

A. Budget Narrative:

The costs listed below will support four CSEC Field Response Project Innovation Teams with a total of 22 FTEs. The Department is planning with the assumption that the psychiatric services will be provided by three psychiatrist (one per each geographical region; (Western, Mid-County, and Desert), therefore we are requesting 22 work stations. Also included are all of the operating, flex, non-recurring, research, evaluation, and contingency costs associated with the CSEC Field Response Project Innovation Teams. Each team is comprised of the following:

- MH Services Supervisor - .25 FTE
- Clinical Therapist – 1.00 FTE
- MH Peer Specialist – 2.00 FTE
- Behavioral Health Specialist II - .25 FTE
- Licensed Vocational Nurse - .25 FTE
- Staff Psychiatrist - .25 FTE
- Office Assistant – 1.00 FTE

Each team will be assigned their own cost center and all charges will be directly recorded to the appropriate cost center. The only indirect cost associated with the program will be administrative such as; HR, Fiscal, Executive Management, Research and Evaluation. Indirect administration costs will be distributed by program salaries and benefits cost to the department total salaries and benefits costs. We are requesting a 10% program contingency for each year located on line 6 as indirect under Operating costs.

See the following tables for a breakdown of salaries, operating, and budgeted costs for this project
.

B. New Innovative Project Budget By FISCAL YEAR (FY)*

EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 1718**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
1.	**Total Program Salaries**	**1,758,350**	**1,811,100**	**1,865,433**	**1,921,396**	**1,979,038**	**9,335,317**
2.	**Direct Costs**						
3.	**Indirect Costs**						
4.	**Total Personnel Costs**	**1,758,350**	**1,811,100**	**1,865,433**	**1,921,396**	**1,979,038**	**9,335,317**
OPERATING COSTs		**FY 1718**	**FY1819**	**FY 1920**	**FY2021**	**FY2122**	**Total**
5.	**Direct Costs**	**571,463**	**588,607**	**606,265**	**624,453**	**643,186**	**3,033,974**
6.	**Indirect Costs**	**357,289**	**288,986**	**297,656**	**306,585**	**315,783**	**1,566,298**
7.	**Total Operating Costs**	**928,751**	**877,592**	**903,920**	**931,038**	**958,969**	**4,600,270**

NON RECURRING COSTS (equipment, technology)		**FY 1718**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
8.	Start Up Costs	**767,200**					**767,200**
9.							
10.	Total Non-recurring costs	**767,200**					**767,200**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 1718**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
11.	Direct Costs						
12.	Indirect Costs-Program Evaluation	**14,067**	**14,489**	**14,923**	**15,371**	**15,832**	**74,682**
13.	Total Operating Costs	**14,067**	**14,489**	**14,923**	**15,371**	**15,832**	**74,682**

OTHER EXPENDITURES (please explain in budget narrative)	**FY 1718**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
14. Flex Funding	**344,000**	**354,320**	**364,950**	**375,898**	**387,175**	**1,826,343**
15. Indirect Costs-Program Administration	**117,809**	**121,343**	**124,984**	**128,733**	**132,595**	**625,464**
16. Total Other expenditures	**461,809**	**475,663**	**489,935**	**504,631**	**519,770**	**2,451,807**

BUDGET TOTALS	**FY 1718**	**FY 1819**	**FY 1920**	**FY 2021**	**FY 2122**	**Total**
Personnel	**1,758,350**	**1,811,100**	**1,865,433**	**1,921,396**	**1,979,038**	**9,335,317**
Direct Costs (add lines 2, 5 and 11 from above)	**571,463**	**588,607**	**606,265**	**624,453**	**643,186**	**3,033,974**
Indirect Costs (add lines 3, 6 and 12 from above)	**371,356**	**303,475**	**312,579**	**321,956**	**331,615**	**1,640,980**
Non-recurring costs (line 10)	**767,200**					**767,200**
Other Expenditures (line 16)	**461,809**	**475,663**	**489,934**	**504,631**	**519,770**	**2,451,807**
TOTAL INNOVATION BUDGET	**3,930,177**	**3,178,845**	**3,274,211**	**3,372,436**	**3,473,609**	**17,229,278**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

C. *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 1718	FY 1819	FY 1920	FY 2021	FY 2122	Total
1.	Innovative MHSA Funds	29,452	30,336	31,246	32,183	33,149	156,366
2.	Federal Financial Participation	44,768	46,111	47,494	48,919	50,386	237,677
3.	1991 Realignment						
4.	Behavioral Health Subaccount	43,589	44,897	46,244	47,631	49,060	231,422
5.	Other funding*						
6.	**Total Proposed Administration**	**117,809**	**121,344**	**124,984**	**128,733**	**132,595**	**625,465**

Evaluation:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 1718	FY 1819	FY 1920	FY 2021	FY 2122	Total
1.	Innovative MHSA Funds	**3,517**	**3,622**	**3,731**	**3,843**	**3,958**	**18,671**
2.	Federal Financial Participation	**5,345**	**5,506**	**5,671**	**5,841**	**6,016**	**28,379**
3.	1991 Realignment						
4.	Behavioral Health Subaccount	**5,205**	**5,361**	**5,522**	**5,687**	**5,858**	**27,633**
5.	Other funding*						
6.	**Total Proposed Evaluation**	**14,067**	**14,489**	**14,923**	**15,371**	**15,832**	**74,682**

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 1718	FY 1819	FY 1920	FY 2021	FY 2122	Total
1.	Innovative MHSA Funds	**1,815,944**	**1,060,451**	**1,092,265**	**1,125,032**	**1,158,783**	**6,252,475**
2.	Federal Financial Participation	**1,071,211**	**1,073,319**	**1,105,519**	**1,138,684**	**1,172,845**	**5,561,578**
3.	1991 Realignment						
4.	Behavioral Health Subaccount	**1,043,021**	**1,045,074**	**1,076,426**	**1,108,719**	**1,141,980**	**5,415,220**
5.	Other funding*						
6.	**Total Proposed Expenditures**	**3,930,177**	**3,178,844**	**3,274,211**	**3,372,436**	**3,473,609**	**17,229,278**

*If "Other funding" is included, please explain.

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC)
INNOVATIVE PROJECT PLAN DESCRIPTION
Optional Template

New Innovative Project Budget by Fiscal Year - Expenditures

Personnel Costs		FY1718	FY1819	FY1920	FY2021	FY2122	5 Yr Total
Salaries & Benefits	FTE						
MHSS	1.00	112,048	115,410	118,872	122,438	126,111	594,880
Clinical Therapist II	4.00	380,865	392,291	404,059	416,181	428,666	2,022,062
MH Peer Specialist	8.00	520,511	536,126	552,210	568,776	585,840	2,763,463
BHS II	1.00	65,687	67,657	69,687	71,778	73,931	348,739
LVN II	1.00	64,796	66,740	68,742	70,804	72,929	344,011
Staff Psych IV	1.00	381,692	393,143	404,937	417,085	429,598	2,026,456
OA II/OA III	4.00	232,750	239,733	246,925	254,333	261,963	1,235,704
Total Personnel Costs		**1,758,349**	**1,811,100**	**1,865,433**	**1,921,396**	**1,979,037**	**9,335,314**

Operating Costs		FY1718	FY1819	FY1920	FY2021	FY2122	5 Yr Total
Building/Rent Expense		19,414	19,996	20,596	21,214	21,851	103,072
Communications		26,043	26,825	27,629	28,458	29,312	138,268
Insurance		30,349	31,259	32,197	33,163	34,158	161,127
Maintenance		37,435	38,558	39,714	40,906	42,133	198,745
Professional Fees		316,725	326,226	336,013	346,093	356,476	1,681,534
Supplies		61,687	63,538	65,444	67,407	69,429	327,506
Travel		53,429	55,032	56,683	58,383	60,135	283,662
Utilities		26,381	27,172	27,987	28,827	29,692	140,059
Operating Costs Subtotal		571,463	588,607	606,265	624,453	643,186	3,033,973
Indirect - Program Contingency		357,289	288,986	297,655	306,585	315,783	1,566,298
Total Operating Costs		**928,751**	**877,592**	**903,920**	**931,038**	**958,969**	**4,600,270**

Non Recurring Costs (equip, tech)		FY1718	FY1819	FY1920	FY2021	FY2122	5 Yr Total
Computer & Printer Equip		48,400					48,400
Vehicles		200,000					200,000
Cubicles and Office Chairs		118,800					118,800
Site TI		400,000					400,000
Total non-recurring costs		**767,200**					**767,200**

Consultant Costs/Contracts (clinical training, facilitator, evaluation)		FY1718	FY1819	FY1920	FY2021	FY2122	5 Yr Total
Indirect Cost - Program Evaluation		14,067	14,489	14,923	15,371	15,832	74,682
Total Operating Costs		14,067	14,489	14,923	15,371	15,832	74,682
							-
Other Expenditures		FY1718	FY1819	FY1920	FY2021	FY2122	-
Flex Funding		344,000	354,320	364,950	375,898	387,175	1,826,343
Indirect Costs - Program Admin		117,809	121,343	124,984	128,733	132,595	625,464
Total Other Expenditures		461,809	475,663	489,934	504,631	519,770	2,451,807
Funding Totals		FY1718	FY1819	FY1920	FY2021	FY2122	5 Yr Total
Total Innovation Budget		3,930,176	3,178,844	3,274,210	3,372,435	3,473,609	17,229,274
Innovative MHSA Funds		1,815,944	1,060,451	1,092,265	1,125,032	1,158,783	6,252,476
Federal Financial Participation		1,071,211	1,073,319	1,105,519	1,138,684	1,172,845	5,561,578
1991 Realignment		-	-	-	-	-	-
Behavioral Health Subaccount		1,043,021	1,045,074	1,076,426	1,108,719	1,141,980	5,415,220
Other Funding							
Total Proposed Expenditures		**3,930,176**	**3,178,844**	**3,274,210**	**3,372,435**	**3,473,609**	**17,229,274**
		-	-	-	-	-	-
Total Inn Funding Requested		**1,815,944**	**1,060,451**	**1,092,265**	**1,125,032**	**1,158,783**	**6,252,476**