County of San Diego Behavioral Health Services – ADAPT (INN 18)

Program Dates: January 2019 to December 2024
Program Budget: $4,535,338
Budget for Evaluation: $237,702 (5% of total)
Project Total: $4,773,040

1. PRIMARY PROBLEM

It is well documented that the failure to screen and treat Postpartum Depression (PPD) and Postpartum Anxiety (PPA) has long-term consequences that extend to children, families and the communities in which they live. The 2010 Maternal and Infant Health Assessment Survey showed that 14% percent of women giving birth in San Diego County were diagnosed with PPD, which is consistent with World Health Organization data showing PPD affecting 10-15% of women. Maternal depression is the most common complication of childbearing, and is associated with mother-child bonding difficulties, increased crying, delays in language development, and behavioral problems in children. Emerging awareness has brought attention to postpartum anxiety (PPA), which is often co-morbid with PPD. Recommendations from The American College of Obstetricians and Gynecologists (ACOG) advice clinicians (OB-GYNs) to screen patients at least once during the postpartum period for depression and anxiety using a standardized, validated tool. Although PPD and PPA are most often associated with women, an estimated 10% of fathers experience postpartum depression and anxiety, although limited research on paternal postpartum depression and anxiety suggests this number may be much higher. PPD and PPA disproportionately affect underserved communities, a variance most often attributed to increased risk factors, barriers to accessing treatment, and inadequate social support. Behavioral health outcomes of parents, infants and children are key indicators of the health of a community overall, and require a sense of urgency and prioritization when there are known disparities. Fragmented screening, lack of a holistic approach, and limited coordination between segments of the health care systems indicate the need to test a new and innovative approach to treatment for parents with PPD and PPA.

Traditional postpartum interventions most often occur during the course of a routine follow-up visit, where a mother is screened by her OB-GYN for depression. Clinic-based, gender-specific interventions are not designed to address the complex and interrelated needs of the whole family, which contributes to the gap in care for new fathers who may also benefit from screening and treatment. Enhancing the role of fathers in therapeutic interventions is an important support strategy for reducing the symptoms of maternal mental health disorders, preventing and treating paternal mental health, and improving developmental outcomes for children (Kabir, Sheeder, & Kelly, 2008; Letourneau, et al., 2012). While literature around paternal mood and anxiety disorders are less available, they are linked to insecure attachment, emotional and behavioral issues in the child, and increased parental conflict (Soliday, McCluskey-Fawcett, & O'Brien, 1999).

Parents from underserved communities have increased risk factors for PPD and PPA, in addition to added barriers that make it difficult to access treatment. Interventions that successfully mitigate these barriers are likely to have a significant impact on increasing treatment engagement. One study tested this hypothesis, using a community-based setting to provide screening at Women, Infants and Children (WIC) offices (Tabb, et al., 2015). The study found that providing treatment in a community setting successfully increased access to screenings, and identified several key barriers to treatment engagement, including (1) literacy (2) the need for referrals and follow-up with outside services, (3) training and capacity needs, (4) stigma of depression, and (5) location and privacy of screening. Socioeconomic deprivation indicators

such as unemployment, low income and low education have been cited as additional risk factors in mental health disorders (Stewart, Robertson, Dennis, Grace, & Wellington, 2003), and are correlated with PPD (Beck, 2001). The additional challenges faced by parents from underserved communities support the exploration of new treatment models that are designed to target this population and address known risk factors and barriers.

The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) has identified the need for increased screening, treatment and linkage to services for postpartum behavioral health issues as a priority, particularly in underserved communities. Public input at community forums and in the Children's System of Care (CSC) Council underscores the importance of new approaches in this area. The CSC Council (involving stakeholders from multiple entities: public, private, education, family/youth, health plans, Public Health, Child Welfare Services, Probation, etc.) identifies "hot topics" of concern, such as postpartum parental mental health, and its Early Childhood subcommittee reviewed best practices and identified mental health screening and provision of appropriate and accessible services for parents as an area of need. This Innovation funding opportunity serves to improve methods of screening and treatment for parents from underserved communities who are at risk of developing or experiencing PPD and PPA.

2. WHAT HAS BEEN DONE ELSEWHERE TO ADDRESS YOUR PRIMARY PROBLEM?

A review of existing literature identifies the need for new models of treatment for PPD and PPA. Parental mental health is interrelated and has a significant impact on the health and well-being of the entire family (Paulson & Bazemore, 2010). Research suggests that holistic, community-based models may be most effective for the screening and treatment of parents who are at greatest-risk. An exploration of whole-family treatment highlights the important role fathers play in supporting partners struggling with postpartum mental health issues, and point out their own susceptibility to PPD and PPA (Letourneau, et al., 2012).

Locally, the County's *Live Well San Diego* vision is built upon families that are healthy, safe and thriving. The County of San Diego Public Health Nurses (PHNs) provide in-home nursing services to parents through the Maternal Child Health (MCH) and Nurse Family Partnership (NFP) with the goal of improving health outcomes for children and families. The NFP and MCH Programs served a combined 1560 families in FY 16-17.

- The Nurse Family Partnership (NFP) is a home-based prevention program that partners low-income, first time mothers with public health nurses. Clients must enroll in the program prior to their 28th week of pregnancy and continue until the child's second birthday. Nurses provide support, education and counseling on issues including health, behavioral issues, and self-sufficiency. First-time mothers can expect to receive referrals to healthcare, childcare, behavioral health services, job training and other support services available in their community.

- The MCH Program provides home visitation services to at-risk, low income, pregnant, and postpartum women and their children ages 0-5 years. Nurses provide support and education on issues which include health, parenting, and bonding. Families receive case management and referrals to healthcare and support services. The program's goal is to improve birth outcomes, access to health care, and promote the health and well-being for at risk women and their children.

Parents connected to the NFP and MCH programs are typically struggling with socioeconomic deprivation, a known risk factor for developing mental health disorders. In both programs, PHNs provide evidence-based screening and referrals to parents experiencing mental health symptoms. Despite their success in improving outcomes related to health and parenting, the NFP and MCH programs have struggled with referral and linkage to mental health services for parents. Reasons for this may include (1) PHNs are not mental health clinicians, and may need additional support to identify and determine behavioral health needs, (2) lack of referral resources providing treatment to parents with PPD and PPA, (3) stigma related to mental health which prevents parents from following through, and (4) other barriers to accessing services including transportation and lack of financial resources.

Although current local programs offer a diverse menu of health and wellness services for families, there are no current programs that address the postpartum mental health needs of both parents and the holistic family unit. Parental PPD and PPA is high-impact community health problem that has not been well-studied, representing a gap in care that calls for innovations that extend beyond the mother-infant dyad. The NFP and MCH programs present an opportunity for collaboration and integration between the County of San Diego's Behavioral Health Services and Public Health sectors to address the mental health needs of parents during the postpartum period. The next section will detail a proposal that introduces this concept.

3. THE PROPOSED PROJECT

The proposed project, **ADAPT (Accessible Depression and Anxiety Postpartum Treatment)** introduces a partnership between mental health service providers and public health nurses to provide timely, convenient, and holistic mental health treatment to parents who screen positive for PPD and/or PPA. This proposal aims to apply a promising community-driven approach that has been successful in non-mental health settings to the mental health system. ADAPT is designed to strengthen mental health competencies of PHNs, increase access to treatment for parents, and decrease the negative consequences of untreated PPD and PPA. ADAPT proposes to utilize evidence-informed practices, cultural-competency protocols, and community-based treatment in a setting most convenient for the client. Clients who are opened to ADAPT will continue to receive NFP and MCH services with no interruption.

ADAPT proposes to utilize PHN's from the NFP and MCH programs to screen and refer parents that screen positive for depression and/or anxiety to a targeted postpartum mental health treatment team that will provide community-based therapy, care coordination, and peer support for parents. Proposed staffing for the ADAPT consists of (6) Mental Health Clinicians, (3) Peer Partners, (1) Program Manager and (1) Office Assistant.

<u>Proposed ADAPT Components:</u>

a) Location
    i. ADAPT team will be collocated and embedded within NFP and MCH program sites.
b) Training
    i. ADAPT staff will provide routine mental health training, support, and consultation to PHNs.
    ii. ADAPT mental health clinicians will participate in regular Case Conferences with PHNs. Case Conferences are collaborative, multidisciplinary, and may include, but are not limited to:
        - Group discussion
        - Case Presentations

- Problem-solving complex cases
- Challenges and barriers to treatment engagement

c) Whole-Family
   i. ADAPT services will be integrated, comprehensive and intended to have a positive impact on health outcomes for the entire family. In addition to the wide array of preventative health services provided by the PHNs, ADAPT will provide clients with mental health treatment, peer-support, and linkage to community resources.

d) Postpartum Mental Health Safety-Net
   i. ADAPT seeks to improve the County's "Postpartum Safety-Net" by establishing a process for continuous identification and vetting of local and regional resources to improve the availability of good-fit, culturally-competent resources for parents and community partners.
   ii. ADAPT resources, education and outreach material will be created, shared and distributed throughout the County and specifically for inclusion on the Perinatal Resource Grid managed by Public Health Staff.

e) Evidence-informed
   i. PHNs will utilize evidence-informed, normed screening tools for the identification of depression and anxiety.
   ii. ADAPT will utilize evidence-informed engagement techniques (such as Motivational Interviewing and peer-support) to increase willingness of parents to accept treatment.

f) Access to Underserved Communities
   i. African-Americans, Latinos, Refugee and Immigrant families will be prioritized through the referral process.

g) Community-based
   i. ADAPT will provide services at a location most convenient for the parent to reduce barriers and increase access to services.

h) Stepped-Care

   ADAPT is a specialized mental health service that is part of a continuum of care. Initial comprehensive assessment will determine the appropriate level of care, or "step", based intensity of individual service needs. All ADAPT services are designed to improve self-efficacy and linkage to ongoing community supports.
   i. Level 1- Estimated 200 clients/year. Level 1 services are higher-intensity services designed to stabilize symptoms of PPD or PPA. Treatment services include community-based therapy and access to Peer Partner if indicated.
   ii. Level 2- Estimated 100 clients/year will receive Level 2 services. Level 2 services are less intense and are designed to increase linkage to existing community resources and supports.

i) Peer Partner
   i. Will provide education, advocacy, and peer-support services.
   ii. Will establish supportive relationships with parents, particularly those at risk of not engaging in therapy when indicated.

4. INNOVATIVE COMPONENT

ADAPT would leverage the unique strengths of the County of San Diego's integrated Health and Human Services Agency (HHSA) to test if utilizing a cross-sector partnership to provide holistic postpartum treatment services to parents will increase access to care and improve behavioral health outcomes. ADAPT's comprehensive, community-based approach will provide convenient, accessible services to parents whose needs have not been well-met by traditional service delivery approaches. ADAPT utilizes

proven and promising elements; in particular 1) Collaboration between BHS and Public Health Nursing and 2) Consideration of both mothers and father with a focus on underserved communities. The collective components of ADAPT are designed to decrease the negative consequences of PPD and PPA by resolving the unique barriers that prevent parents from accessing services during a crucial period of time for child development.

Key Innovations:

a) **Application of a promising community-driven approach that has been successful in non-mental health settings to the mental health system**
ADAPT applies an approach from outside of mental health services (visiting nurses), to increase access and engagement of parents from a traditionally served population in mental health services. ADAPT is designed to streamline screening, outreach and engagement efforts across sectors to more efficiently utilize resources and reach the target population. Visiting PHNs primarily conduct home visits and have unique access to parents who may not otherwise have contact with the mental health system, making them well-suited to provide the earliest screening interventions for postpartum mood and anxiety disorder. ADAPT will provide routine training and consultation to PHNs to support and enhance their skill in screening and referring clients with mental health issues, in addition to participating in collaborative Case Conferences with PHNs. This innovative component is expected to strengthen competencies across HHSA sectors.

b) **Paternal Mental Health**
Past efforts for screening and linkage to services for perinatal mood and anxiety problems have primarily focused on the mother. ADAPT include fathers, in acknowledgement of emerging awareness of paternal perinatal mood and anxiety disorders. It is hypothesized that assessment and treatment will be more effective if carried out collectively within a family unit.

ADAPT is anticipated to have an impact on:

a) **Advocacy** – The proposed program will advocate for an increase in mental health support and awareness related to PPD and PPA in parents from underserved communities. ADAPT staff will attend community meetings and regional collaborates to provide representation and to inform systems of care on issues related to PPD and PPA.
b) **Education and training for service providers** – ADAPT will provide training to PHN staff on behavioral health topics as they pertain to working with clients with mental health issues. ADAPT will participate in Case Conferences with PHNs to discuss cases and collaborate on solutions for challenges/barriers as they arise.
c) **Research**- Data collected from this proposal aims to inform our System of Care on the scope of postpartum mood and anxiety disorders, symptomatology, and barriers to treatment engagement for both mothers and fathers.

5. Learning Goals / Project Aims

a) To learn if collaboration with the PHN Home Visiting programs is effective in engaging mothers and fathers in treatment for postpartum depression and anxiety.
b) To identify how to best equip the PHN in effectively connecting both mothers and fathers to services related to maternal/paternal depression or anxiety.
c) To learn if embedded behavioral health staff can provide effective, short term treatment services that meet the needs of identified mothers and fathers.
d) To identify barriers in mothers and fathers willingness to access treatment.

e) To learn if fathers and partners are willing to participate in engagement efforts and to better understand the characteristics of paternal symptomology.
f) To evaluate the effectiveness of culturally competent referrals and the outcomes of engagement and efficacy of culturally appropriate interventions.
g) To learn what percentage are linked to existing resources and identify system gaps, if any.

6. EVALUATION OF LEARNING PLAN

This project is expected to add new learning to the mental health field on effective practices to identify and treat parental depression and anxiety. Research on treatment models for families where one or both parents are experiencing depression or anxiety are limited. Literature on best practices and barriers to seeking treatment indicate a need for a holistic and integrated treatment model. We plan on testing the efficacy of our program through data collected by the proposed ADAPT Program.

a) Data collection will include:
    i. Number of individuals screened for depression (Edinburgh Depression Scale and PDQ-9) and the number of screens completed.
    ii. Gender, ethnicity, age, and number of dependent children of respondents.
    iii. Percentage of clients that screened positive for depression and/or anxiety symptoms.
    iv. Percentage/number of those that screen positive that are female and those that are male.
    v. Percentage/number of those that screen positive which continued on to receive treatment and/or referral services from ADAPT.
    vi. Number of PHN trainings and consultations provided by ADAPT, to include topics.
b) For clients opened to ADAPT (Include breakdown of gender for each item):
    i. Total Length of time client is opened to program.
    ii. Number of clients receiving mental health treatment from ADAPT.
    iii. Number of clients linked to behavioral health services in the community.
c) At discharge (include breakdown of gender for each):
    i. Number of clients with a reduction in mental health symptoms.
    ii. Number of clients who report improved physical health.
    iii. Number of clients who have been provided linkage to ongoing treatment for mental health.
    iv. Number of clients who report improved ability to access services in the community.
    v. Number of clients who report services provided respected their culture, traditions, norms, beliefs and values.
    vi. Number of clients who report improved quality of life.
    vii. Number of clients who reported high satisfaction with the ADAPT services.
d) Data collection methods will be tasked to the program.
e) Data will be collected during each encounter.
f) The contract will be monitored in the following ways:
    i. Quarterly Status Reports by program.
    ii. Data elements that will be tracked and monitored by the program.
    iii. Independent Evaluator shall complete annual reports and final evaluation

Projected Data Collection Methods and Data Elements by Learning Goals

Learning Objective	Projected Data Collection Method	Data Elements
A. To learn if collaboration with the PHN Home Visiting programs is effective in engaging mothers, fathers and partners in treatment for postpartum depression and anxiety.	• Reflected in ADAPT program enrollment numbers compared to referrals received • Collected via ADAPT Quarterly Status Report (QSR) tracking	• # of referrals received • # of clients completing assessment • # of client enrolled in ADAPT
B. To identify how to best equip the PHNs in effectively connecting both parents/partners to services related to postpartum depression and anxiety.	• Quarterly PHN surveys • Collected via ADAPT Quarterly Status Report (QSR) tracking	• # of trainings requested by PHNs • # of trainings provided to PHNs by ADAPT, in addition to training topics • # of referrals received • # of assessments completed • # of clients enrolled in ADAPT
C. To learn if embedded behavioral health staff can provide effective, short-term treatment services that meet the needs of identified mothers and fathers/partners.	• Evidence-based screening tools measuring symptoms of PPD and PPA will be administered at treatment initiation and at completion of treatment • Edinburg Postpartum Depression Survey (EPDS) • Postpartum Anxiety Screening Scale (PASS)	• # of clients with reduction in symptoms from treatment initiation to completion (or every 6 months, whichever comes first)
D. To identify barriers in parents and partners willingness to access treatment.	• Collected via ADAPT Quarterly Status Report (QSR) tracking	• # of clients referred # of screenings completed • # of clients enrolled
E. To learn if fathers and partners are willing to participate in engagement efforts and to better understand the characteristics of paternal symptomatology.	• Collected via ADAPT Quarterly Status Report (QSR) tracking • EPDS and PASS	• # of fathers/partners referred • # of fathers/partners screened • # of fathers/partners enrolled. • Symptoms reported on EPDS and PASS by fathers/partners
F. To evaluate the effectiveness of culturally competent referrals and the outcomes of engagement and efficacy of culturally appropriate referrals.	• Track demographics including ethnicity, languages spoken, and place of birth and evaluate in context of symptoms improvement by subgroup	• # of referrals broken down by ethnicity, languages spoken and place of birth • # of completed screenings and treatment enrollment broken down by ethnicity, languages spoken, and place of birth
G. To learn what percentage are linked to existing resources and identify system gaps, if any.	• Collected via ADAPT Quarterly Status Report (QSR) tracking	• # of clients screened • # of clients who are connected to other services
The ADAPT project is designed to utilize a research team that would assist with identifying relevant data collection elements, methods and matrix and provide a Quarterly Evaluation Report to the County, in addition to the ADAPT program level Quarterly Status Report (QSR) that would be required.		

7. CONTRACTING

All contracts are handled through the County of San Diego Department of Purchasing and Contracting (DPC), which processes more than $1 billion in public purchases and contracts annually. The DPC posts requirements on BuyNet, an online public system. Procurements normally are posted under formal Request for Bid (RFB) or Request for Proposal (RFP) solicitation. The aim is sound procurement processes to acquire the highest quality goods and services at the best price.

a) Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. Proposals are selected in part on the basis of the offeror's plan to achieve best possible quality and compliance with all relevant regulations. A Contract Officer's Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the DPC. Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.
b) A total of 5% percent of project funds will be set aside for an evaluation contract with a qualified research organization.
c) Contractors will have a dedicated COR or Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted over each year on the Statement of Work (SOW). COR meetings are routine.
d) COR meetings and Site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, and discussion of strengths and weaknesses of contractor's deliverable outcomes.
e) Review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/department/Medi-Cal Sanctions lists employee review process as well as in-depth invoice reviews.

8. CERTIFICATIONS

a) Board of Supervisors authorization October 10, 2017.
b) Certification from the Behavioral Health Director will be included.
c) Documentation will be provided on the County's PEI and CSS allocation.

9. COMMUNITY PROGRAM PLANNING

a) Twelve (12) community forums were conducted countywide to get community input and feedback regarding the Innovative project.
b) The Older Adult, Adult and Children, Family and Youth Councils were also solicited for input regarding the community's need.
c) After ideas for the Innovation Project was solidified, community members also participated in "conversation cafes" to discuss the proposed project and given opportunity to provide feedback on components needed.

10. PRIMARY PURPOSE

a) Increase access to mental health services to underserved groups.

11. MHSA INNOVATIVE PROJECT CATEGORY

a) 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.

12. POPULATION

a) 1,560 families were served by the Nurse Family Partnership and Maternal Child Health Programs in FY 16-17.
b) African-Americans, Latinos, Refugee and Immigrant families will be prioritized and cultural competency protocols will be implemented.
c) A licensed or license-eligible mental health clinician will provide short term in home mental health services to those mothers and/or fathers identified as having depression and/or anxiety.
d) Peer Partners will coordinate with the PHN staff to identify families in need of linkage to mental health services.
e) Program is expected to serve a minimum of 300 clients annually.

13. MHSA GENERAL STANDARDS

The project is consistent with General Standards identified in the MHSA and Title 9, CCR, section 3320.

a) **Community Collaboration:** The concept for this work plan was developed based on local stakeholder process for input on system needs over multiple years.
b) **Cultural Competence:** As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes.
c) **Client/Family Driven Mental Health System:** This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. The program strives to create healthier families in our community.
d) **Wellness, Recovery and Resilience Focus:** This program increases resilience and promotes discovery and wellness for parents with PPD and PPA by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.
e) **Integrated Service Experience:** Program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members.

14. CONTINUITY OF CARE FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

It is feasible that some of the individuals who screen positive for postpartum depression/anxiety will meet the threshold for serious mental illness. Individuals will be connected to appropriate resources through the mechanisms described above.

15. INN PROJECT EVALUATION CULTURAL COMPETENCE AND MEANINGFUL STAKEHOLDER INVOLVEMENT

a) As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes and to implement treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
b) Program will ensure that the client identifies the goals important to them for ongoing stability to make certain that treatment planning remains a collaborative process.

16. DECIDING WHETHER AND HOW TO CONTINUE THE PROJECT WITHOUT INN FUNDS

Throughout the duration of the project, BHS will review the effectiveness of the screening and linkage efforts. If the project is successful, other existing services within the PHN Home Visiting Programs will be evaluated for augmentation to incorporate the screening and linkage offered through this program.

17. COMMUNICATION AND DISSEMINATION PLAN

Information regarding this project will be disseminated through multiple collaborative groups, such as the Behavioral Health Advisory Board, the Children's System of Care Council and the Adult System of Care Council. Information regarding the program will also be available on the County of San Diego website. As this is a collaborative effort with Public Health Nurse Family Partnership and Maternal Family Child visiting nurses program for parents experiencing depression/anxiety. Joint meetings will be held to ensure collaboration and communication. Keywords for search: Postpartum mood disorder; postpartum anxiety disorder; PPD in mothers, PPD in fathers, postpartum supports San Diego.

18. TIMELINE

a) Total timeframe (duration) of the INN Project: 4.5 years plus .5 year for evaluation
b) Expected start date and end date: January 2019 to December 2024
c) Key activities timeline and milestones:

DATES	KEY MILESTONES
2018	Statement of Work developed.
2018	Initiation of contracting process; focus on release of Request for Proposals through Department of Purchasing and Contracting.
2018	Deadline for submittals of contract proposals.
2018	Selection of highest quality, best value proposal through public Source Selection Committee process.
2018	Initiate negotiations with selected provider.
January, 2019	Focus on date to initiate program operations.
2019	Completion of site visit to verify compliance with terms of contract.
2020	Continuation of regular contract monitoring activities, including review of invoices, performance, and quality standards.
2022	Completion of annual evaluations reviewed by Behavioral Health Services to gauge effectiveness specific to the focus on population and planned interventions.
2023	Evaluation by Behavioral Health Services to determine, results and feasibility of integrating into existing programs or replication.
June, 2024	End of pilot program.
December, 2024	Evaluation concluded. Results to be disseminated.

19. INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

Project Budget: $4,535,338 ($1,010,325 annually)
Additional 5% Evaluation: $237,702
5 year Expenditure (Budget + Evaluation): $4,773,040

1 Program Manager: $71,290
1 Office Assistant: $38,600
6 Licensed/Eligible Mental health clinicians: $57,870 per Clinician
3 Peer Partners: $40,890 per Peer Partner

Annual Budget: $1,010,325			Total Project Amount: $4,535,338					
MHSA Innovation 18, Cycle 4, "ADAPT"								
Summary of Budget								
Year/period		FY 18/19	FY 19/20	FY 20/21	FY 22/23	FY 23/24	Total	
Number of months		6	12	12	12	12	4.5 Years	
Direct cos	Salaries & Benefits	$375,117	$750,235	$750,235	$750,235	$750,325	$3,376,148	74%
	Operating Expenses	$83,800	$167,600	$167,600	$167,600	$167,600	$754,200	17%
	Total direct	$458,918	$917,835	$917,835	$917,835	$917,835	$4,130,258	91%
Indirect cost (10.1% of direct)		$46,245	$92,490	$92,490	$92,490	$92,490	$416,205	9%
Subtotal		$505,163	$1,010,325	$1,010,325	$1,010,325	$1,010,325	$4,546,463	100%
Grand Total		$1,010,325	$1,010,325	$1,010,325	$1,010,325	$494,038	$4,535,338	100%

Annual Salaries & Benefits $750,235

Salaries are from the U.S Department of Labor, Bureau of Labor Statistics (BLS), Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates for San Diego-Carlsbad CA, May 2016. Benefits rates are from Bureau of Labor Statistics, Employer Costs for Employee Compensation, Table 7. Private industry by census region and division, West, December 2017.

Job role	FTE	BLS occupation code	BLS occupation title	Annual salary	Benefits	Annual S&B per FTE	Total annual S&B
				A_MEAN	29.4%		
Program Manager	1.0	11-9151	Social and Community Service Managers	$71,290	$20,959	$92,249	$92,249
Licensed MH Clinicia	6.0	21-1013	Marriage and Family Therapists	$57,870	$17,014	$74,884	$449,303
Peer Partner	3.0	21-1011	Substance Abuse and Behavioral Disorder Counselors	$40,890	$12,022	$52,912	$158,735
Assistant	1.0	21-1093	Social and Human Service Assistants	$38,600	$11,348	$49,948	$49,948
Total	11.0						$750,235

Annual Operating Expenses $167,600

Item	Quantity	Annual unit cost	Total annual OpEx
Lease/rent, per square foot	2,000	$21	$42,000
Maintenance and janitorial, per square foot	2,000	$3	$6,000
Utilities, per square foot	2,000	$5	$10,000
Telecommunications per voice/data line, per FTE	11	$2,400	$26,400
Equipment and supplies, per FTE	11	$800	$8,800
Training/staff development, per FTE	11	$600	$6,600
Transportation/travel, per FTE	11	$4,200	$46,200
Interpreters	1	$4,800	$4,800
Printing	1	$1,800	$1,800
Insurance and other expenses	1	$15,000	$15,000
Total			$167,600

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