DRAFT FOR PUBLIC COMMENT

County of Marin

BEHAVIORAL HEALTH AND RECOVERY SERVICES

MENTAL HEALTH SERVICES ACT (MHSA)

FY2019/2020 ANNUAL UPDATE

Reporting on FY2017/2018 Services and Outcomes

COUNTY OF MARIN

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Director's Introduction

Dear Community Members:

I am pleased to share with you Marin County's FY19/20 MHSA Annual Update. This report reflects the collective efforts of many people but emphasizes our deep commitment to reducing disparities throughout our behavioral health system and our dedication to equity and humility in all that we do. As we strive to make these values a reality, I want to encourage the participation of all community members in helping to shape the future of our services.

In the year since I joined the County of Marin, my team and I have been dedicating ourselves to making our systems more effective and efficient. In FY17/18 we made huge leaps forward in peer staffing with new county peer positions and in strengthening the recovery orientation of our county with the development of the *Empowerment Clubhouse* in Marin City.

Through the Mental Health Services Act, 9,961 individuals in Marin received Prevention and Early Intervention (PEI) services in FY17/18 ranging from engagement with the *Promotoras* in West Marin to short-term intervention programs with older adults experiencing depression and anxiety through Jewish Children and Family Services. 320 Marin residents received care through our Full Service Partnerships which provide wraparound services to seriously mentally ill individuals who are at-risk of homelessness, incarceration, or hospitalization. And hundreds more Marin County residents have been involved in helping to develop and test innovative strategies through the development of a new Innovation plan focused on the needs of homebound and isolated older adults.

These efforts would not be successful without our staff and our partners within and beyond our Behavioral Health and Recovery Services. Thank you for your continued support and participation in the County's MHSA planning process. Your voice and participation are critical to our collective success.

Sincerely,

Jei Africa, PsyD, MSCP, CATC-V

DIRECTOR

County of Marin

Behavioral Health and Recovery Services

Executive Summary

OVERVIEW

The FY19/20 MHSA Annual Update provides an opportunity to report on outcomes and activities from FY17/18 (Fiscal Year from July 1, 2017-June 30, 2018) and changes expected in FY19/20 (Fiscal Year from July 1, 2019-June 30, 2020). FY17/18 is the first year of implementation of the MHSA Three-Year Program and Expenditure Plan for FY17/18 through FY19/20. All MHSA related Annual Updates and the MHSA Three-Year Plan can be found at: www.marinhhs.org/mhsa

FY17/18: A YEAR OF TRANSITIONS

FY17/18 was a major year of transition. Within Behavioral Health and Recovery Services (BHRS), the new Director, Dr. Jei Africa, was hired in March of 2018, Connie Moreno-Peraza was hired as the new BHRS Division Director for Adult and Older Adult Mental Health Services in January 2018, and Dr. Brian Robinson accepted the position of BHRS Division Director for Children's Mental Health Services in February 2018. There were also significant changes in leadership within the Health and Human Services Department (HHS) Executive Team, including the hiring of two of the top three leadership positions: Hyacinth Hinojosa ("Hy") as the new HHS Chief Operating Officer in February of 2018, and Jenny Chacòn, MPH, as the new HHS Chief Strategy Officer hired in June of 2018. In the previous fiscal year, 4 of these 5 positions were held by White, non-Hispanic managers. In FY17/18, 4 of these 5 positions were filled by people of color who were also bilingual, speaking: Spanish (3) and Tagalog (1).

This increase in representation did not just stop at the top level of management. Out of the 44 occupied manager positions within BHRS in 2018, there was a 1100% increase in Latinx[1] representation, going from 1 Latinx manager in 2017 (2% of managers) to 11 Latinx managers in 2018 (representing 25% of BHRS managers).

In addition to all of the leadership transitions, a completely new MHSA team came aboard in FY17/18, comprised of the MHSA Coordinator, Galen Main, MSW, hired in August 2017, and the Prevention and Early Intervention and Innovation Coordinator, Chandrika Zager, LCSW, MPH, hired in February 2018.

MAJOR ACCOMPLISHMENTS IN FY17/18

The Empowerment Clubhouse operated by the Marin City Community Development Corporation (MCCDC) was launched and accredited in FY17/18, providing a welcoming place in Marin City to help individuals living with a mental illness to develop hope, purpose, self-efficacy, and independence.

In addition, in FY17/18 BHRS developed and hired the first ever county classified peer (1.5 FTEs) and family partner (.5FTE) position.

[1] "Latinx" is used throughout this document as an inclusive, gender-neutral alternative to Latino and Latina, referencing people of Latin American descent

BHRS funded 10 new programs for underserved Transition Age Youth as part of the Growing Roots: Young Adult Services Innovation Project. The 10 providers were selected by the Transition Age Youth Advisory Committee through an RFP process and were awarded contracts that began in November of 2017.

The development of a new Coordinated Case Management System (WIZARD) implemented by Whole Person Care and coordinated with partners across the county, was approved by the Board of Supervisors and used Capital Facilities and Technology Needs (CFTN) funding to leverage Federal dollars.

There is a coordinated push to end Veteran homelessness in Marin County by 2022. The Prevention and Early Intervention (PEI) Veterans Case Manager and the HHS Veteran's office have been involved in every aspect of this process. From cultivating landlord relationships to assisting with furnishing apartments, the Veterans Outreach effort has played an integral role. Since this collaborative effort began in 2017, 17 veterans have been permanently housed that had been homeless and living on the streets of Marin County. The PEI Case Manager also continues to support efforts to divert veterans from the criminal justice system. Working with the courts, judges, and jail to identify veterans that need long term treatment for serious mental illness, these collaborative efforts have been successful in linking veterans to the appropriate mental health resources. The goal for the PEI Veterans Case Manager was to serve 100 Veterans in FY17/18 and the actual numbers more than doubled the goal, serving 212 veterans in Marin.

KEY CHANGES FOR FY19/20

The following modifications will be implemented in FY19/20 in order to fully realize the goals of the FY17/18-19/20 Three Year Plan:

In FY19/20 the budget for the Transitional Age Youth Full Service Partnership will be increased, including adding additional psychiatry coverage to better support the needs of the additional clients they were contracted for in this Three Year Plan.

In FY19/20 the First Episode Psychosis program is being contracted to Felton after an RFP process in FY18/19. Felton has tremendous experiencing implementing First Episode Psychosis programs throughout the Bay Area and will provide an award-winning evidence-based model of multidisciplinary early psychosis services.

In FY19/20, a Peer Supervisor position will be hired to provide strengths-based supervision of the county peer (including family partner) positions, strengthen oversight of contracted peers and peer programs, lead groups, help advance the path forward for peer integration in the workforce with pending Peer Certification legislation and the next Three-Year MHSA Plan and strengthen the career ladder for peers in our workforce.

In FY19/20 the Empowerment Clubhouse budget has been expanded to add additional staffing capacity to meet the accreditation requirements of *Clubhouse International* regarding staff to member ratio.

To meet the workforce goals of BHRS and support the employment of individuals who are culturally and linguistically competent, in FY19/20 there will be a temporary Workforce Education and Training (WET) position created to improve Human Resources systems and speed up hiring timelines to avoid long vacancies which have resulted in delayed implementation and funds being underspent.

In the Spring of 2020, the Victory Village housing project—which was supported by MHSA Housing funding—is expected to be completed. This will provide an additional 6 apartments for older adults with serious mental illness who are experiencing or at-risk of homelessness.

MENTAL HEALTH SERVICES ACT (MHSA) BACKGROUND

MENTAL HEALTH SERVICES ACT PRINCIPLES

Transformation of the public mental health system relies on several key principles:

- Community Collaboration to develop a shared vision for services
- Cultural Competence to effectively serve underserved communities
- Individual/Family Driven Programs that empower participants in their recovery
- Wellness Focus that includes concepts of resilience and recovery
- Integrated Service Experience that places mental health services in locations where participants obtain other critical services
- Outcomes-based design that demonstrates the effectiveness of the services

MENTAL HEALTH SERVICES ACT COMPONENTS

The MHSA has five (5) components:

1. **Community Services and Supports (CSS)**

   CSS funds are intended to expand and transform services provided for children, youth, adults, and older adults living with serious mental illness towards recovery oriented services. Programs include Full Services Partnerships (FSP), Systems Development and Outreach and Engagement (SD/OE), and Housing.

2. **Prevention & Early Intervention (PEI)**

   PEI funds are intended to prevent mental illness from becoming severe and disabling. It aims to reduce risk factors for mental illness as well as increase access to services for underserved populations by reducing stigma, providing accessible services and linking people to appropriate services.

3. **Innovation (INN)**

   Innovations are defined as novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning how to increase access to underserved groups; improve the quality of services, including better outcomes; promote interagency collaboration; and increase access to services.

4. **Workforce Education & Training (WET)**

   WET funding is intended to remedy the shortage of qualified individuals to provide services to address serious mental illness. This includes training existing providers, increasing the diversity of individuals entering the field, and promoting the employment of consumers and families.

5. **Capital Facilities & Technology Needs (CF/TN)**

CF funds are to develop or improve buildings used for the delivery of MHSA services or for administrative offices. TN funds are to develop or improve technological systems, such as electronic health records.

MENTAL HEALTH SERVICES ACT (MHSA) HISTORY

In November 2004 California voters approved Proposition 63, the Mental Health Services Act (MHSA), intended to expand and transform community mental health services throughout California. While the proposition passed with 54% of the vote statewide, Marin County residents voted 63% in favor. The MHSA raises additional taxes for the State, which are then allocated to respective county mental health programs under extensive regulations developed by the then State Department of Mental Health, now known as the Department of Health Care Services. WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

The great promise of the Mental Health Services Act is its vision of outreach and engagement to the entire community, a philosophy of recovery and wellness, a belief in the strength and resiliency of each person with mental illness, and recognition that they are to be embraced as equal members of our community. Recovery from mental illness is not only possible, it is to be expected.

MENTAL HEALTH SERVICES ACT REPORTING REQUIREMENTS

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a MHSA Three-Year Program and Expenditure Plan (Plan) and MHSA Annual Updates for Mental Health Services Act programs and expenditures.

WIC § 5847 and CCR § 3310 state that a MHSA Three-Year Program and Expenditure Plan shall address each MHSA component: Community Services and Supports (CSS) for children, youth, transition age youth, adults, older adults (WIC § 5800 and § 5850); Capital Facilities and Technology Needs (CFTN) (WIC § 5847); Workforce, Education and Training (WET) (WIC § 5820); Prevention and Early Intervention (PEI) (WIC § 5840); and Innovative Programs (INN) (WIC § 5830). All components are required to be in one Plan, incorporating these elements and making expenditure projections for each component per year.

WIC § 5484 states that Three-Year Plan and Annual Update drafts must be posted for a thirty (30) day Public Comment period and the Mental Health Board shall conduct a public hearing on them at the close of the comment period. MHSA Three-Year Program and Expenditure Plans and MHSA Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within thirty (30) days after Board of Supervisor adoption.

The MHSA Three-Year Program and Expenditure Plan is different than an MHSA Annual Update. CCR § 3310 states that a county shall update the MHSA Three-Year Plan annually. An MHSA Annual Update includes an update to the MHSA Three-Year Plan addressing the elements that have changed, the service outcomes for the reporting year and the coming year's expenditure plan.

Marin County Characteristics

Marin County is a located in Northern California in the San Francisco Bay Area, surrounded by the Pacific Ocean to the West, San Pablo Bay, and San Francisco Bay to the East. It is the fourth smallest County in California by land area, and ranks 26th of the 58 California Counties in population with approximately 260,955 residents. Of the 333,000 acres of land, slightly more than half is agricultural.[2] Ranching and dairying are major features of the rural areas of West Marin. The Median Age is 46.1 years—almost 10 years older than the state as a whole (36.4 years).

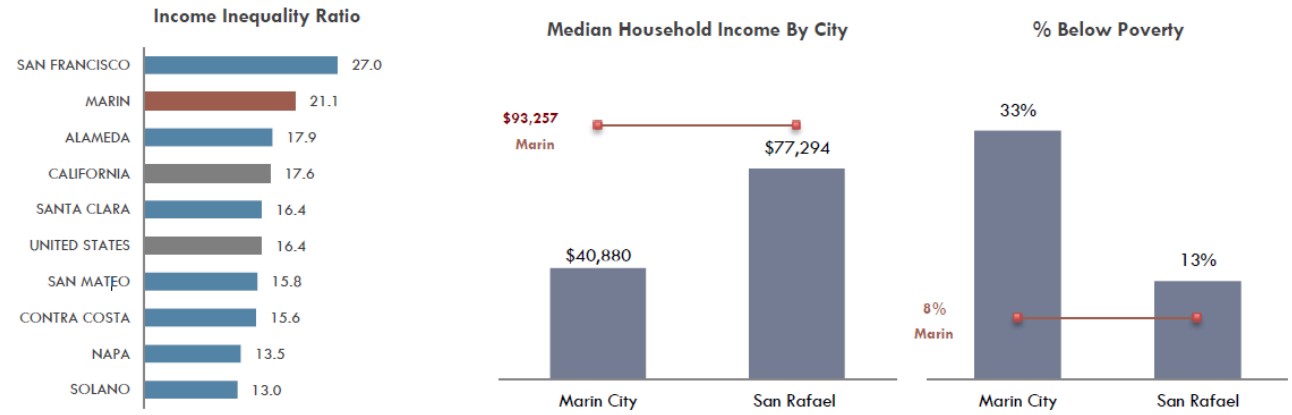
FOCUSING ON EQUITY

For the ninth time, Marin has been ranked the healthiest county in California by the Robert Wood Johnson Foundation and Population Health Institute for 2019. While that is a great strength to build on, not all communities within Marin enjoy the same level of health – physically, socially, economically, or psychologically. Numerous recent profiles of Marin highlight major deficits in housing affordability, income inequality, high rates of substance use, and racial disparities in health.

For the first time, in 2018, Marin County ranked as the 1st most racially disparate county in California by the Advancement Project. African-American and Latino children are four and eight times more likely, respectively, to live in poverty than their white counterparts.[3] The Bay Area has experienced a rise in inequality over the last decade where the top income families are now earning over 21 times more than low-income families in Marin County[4].

INEQUITY AND SOCIAL WELFARE IN MARIN COUNTY[5]

For almost a decade, the Bay Area has experienced a rise in inequality[6]. The top income families earn almost 21.1 times more than low-income families in Marin County[7].



[5] Inequity data is sourced from US Census Bureau's American Community Survey (2015), and Silicon Valley Institute for Regional Studies, 2015.
[6] Silicon Valley Institute for Regional Studies, 2015.
[7] Public Policy Institute of California, 2012-2014

[2] https://www.nass.usda.gov/Publications/AgCensus/2012/Online_Resources/County_Profiles/California/cp06041.pdf
[3] https://www.marincounty.org/main/county-press-releases/press-releases/2019/hhs-healthiestcounty-031919
[4] https://uwba.org/wp-content/uploads/2017/10/Marin-Snapshot.pdf

In December 2018, after a thorough data review combined with multiple perspectives gathered from clients, community members, community organizations, the County of Marin Department of Health and Human Services released a Strategic Plan to Achieve Health and Wellness Equity[PDF] [Appendix 4]. Here are some highlights about the inequities reported in that report:

On average between 2010-2014, 26% of Marin's noninstitutionalized population lived below 250% of the federal poverty level, including

- 61% of the Latino population
- 51% of the African-American population
- 25% of the Asian population
- 18% of the white population
- 52% of children of color ages 0-17 in Marin live in such households, compared with 15% of white, non-Latino children.

To give a context to the inequities in different neighborhoods throughout Marin—particularly Marin City and the Canal District of San Rafael—the following page contains an excerpt from this Strategic Plan on how ***history has shaped racial inequalities in health and well-being in Marin*** (please see the full report in Appendix 4). This historical context gives background on the current day inequities and throughout this MHSA Annual Update you will see references to how Behavioral Health and Recovery Services is trying to address this.

HISTORY HAS SHAPED RACIAL INEQUITIES IN HEALTH AND WELL-BEING IN MARIN

To be effective in reducing inequities, we need to understand historic factors that have shaped them throughout the County. Marin City, historically a predominantly African-American/Black community but now ethnically diverse, and the Canal district of San Rafael – a majority Latinx community – are good examples. While both communities demonstrate great resiliency and strength, social and structural factors have created profound inequities along racial and ethnic lines.

In the 1940s, Marin City was created by the federal government for the Sausalito-based Marinship Shipyards workers and their families to support World War II defense industries. Thousands of Black/African- Americans moved from the Midwest and the South to Marin for employment. When World War II ended, many Marinship workers lost their jobs. Most of Marin City's White residents relocated—but racially discriminatory laws and policies severely limited housing and employment opportunities for Black/ African-American residents.[xii, xiii, m] Over decades, unequal educational opportunities, unjust application of law enforcement, lack of access to healthcare, and inadequate access to healthy food, along with broad and overarching overt and covert racial discrimination, correlated with poor outcomes.[xiv]

San Rafael's Canal District was developed as an industrial and residential neighborhood in the 1950s and 1960s with small housing units in multi-family buildings. The neighborhood's population is increasingly Latinx as families find lower-cost rents and proximity to manual job opportunities. Lack of access to pre-school education, adequate housing, healthy food, and healthcare coverage contribute to poor health and other detrimental outcomes among residents. While employment rates are high, low-wage jobs often lack critical benefits like paid sick leave and have limited opportunities to advance.[xv, xvi] In addition, increasing numbers of residents are from Central American countries where violence is prevalent, increasing the risk that many families will suffer from trauma and adverse childhood experiences. The systemic marginalization of Latinx communities in Marin – whether due to overcrowded housing, poor pay, federal immigration policies, or lack of culturally appropriate behavioral health care, among other factors – contribute to poor outcomes.

While racial and economic segregation are not unique to Marin, they perpetuate inequities for people of color by dictating where they can live and limiting long-term social and economic mobility. Residential segregation limits residents' social and professional networks, denying them relationships and knowledge needed to advance professionally.[xvii] The cumulative and continued effects of structural racism in the County and throughout the U.S. have shaped our communities, and have resulted in specific negative effects felt by many residents of color today.

[1] From the Government Alliance on Race & Equity (2016): **Structural racism** encompasses a history and current reality of institutional racism across all institutions, combining to create a system that negatively affects communities of color. Structural racism is racial bias among interlocking institutions and across society, causing cumulative and compounding effects that systematically advantage white people and disadvantage people of color. **Institutional racism** includes policies, practices and procedures that work better for white people than for people of color, often unintentionally or inadvertently.

Stakeholder Engagement and Review

FY19/20 MHSA ANNUAL UPDATE STAKEHOLDER REVIEW

We welcome feedback on the FY19/20 MHSA Annual Update. The thirty (30) day public comment period for the MHSA Annual Update begins on Saturday, April 13, 2018, and ends on Tuesday, May 14th, 2018.

For a copy of the FY19/20 MHSA Annual Update, please call: (415)473-6238 or you can find it on our website at: https://www.marinhhs.org/mhsa.

A Public Hearing for the FY19/20 MHSA Annual Update will take place at the Mental Health Board Meeting on Tuesday, May 14, 2018 at 6:00 pm at 20 N. San Pedro Road, San Rafael, CA 94903 in the Point Reyes Conference Room. The public is welcome.

To get involved with MHSA in Marin County, please contact:

Galen Main, MSW
Mental Health Services Act Coordinator
Department of Health and Human Services
Behavioral Health and Recovery Services
10 N. San Pedro Road, Suite 2021
San Rafael, CA 94903
415-473-6238 *phone*
gmain@marincounty.org *email*

BACKGROUND

In 2004, before the first Mental Health Services Act (MHSA) funds were provided to counties, Marin conducted an extensive community stakeholder process to identify unmet needs and strategies for addressing those needs. Over 1,000 people participated in that planning process, including clients, their families, diverse community members, providers, and other sectors of the community. (For a copy of the original Community Services and Support Plan, visit the following web-link: https://www.marinhhs.org/mhsa). The results of this process developed the underlying framework for ensuing MHSA component plans.

The funding for the five (5) components of the Mental Health Services Act was released at different times after the Act was approved by voters. For each MHSA component, additional community stakeholder processes were conducted to develop the specific component plans. These are posted on the MHSA website at: https://www.marinhhs.org/mhsa. Every year, Marin County develops an MHSA Annual Update that reports the program descriptions and outcomes for the reporting period, and identifies challenges and changes to programs as needed.

Beginning in FY14/15 the State required that all counties develop MHSA Three-Year Program and Expenditure Plans that include all five (5) MHSA components.

In May of 2016 Marin County began a second in-depth community planning process for our new MHSA Three-Year Program and Expenditure Plan for FY17/18 through FY19/20 which includes all five (5) MHSA components.

This MHSA Three-Year Program and Expenditure Plan for FY17/18 through FY19/20 was developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, community-based providers of mental health and alcohol and other drug services, law enforcement agencies, education, social services, veterans, health care organizations, representatives and families of unserved and/or underserved and other important interests. Also included were stakeholders that reflect the diversity of the demographics of Marin, including, but not limited to, geographic location, age, gender and race/ethnicity.

Marin's current MHSA Three-Year Plan will remain active until June 30, 2020, and can be found online at www.marinhhs.org/mhsa.This FY19/20 Annual Update reports on the implementation of the first (FY17/18) of the three years of this plan.

ONGOING STAKEHOLDER INPUT

Marin County's Mental Health Services Act Community Planning Process includes a wide array of community stakeholders, system partners, clients and families, and Marin County Health and Human Services (HHS) staff. The County receives input on an ongoing basis from stakeholders through a variety of forums, including through the Mental Health Board; through MHSA-focused committees; and through provider, client and family groups.

Behavioral Health and Recovery Services (BHRS) representatives regularly discuss MHSA programs with individuals, the Mental Health Board, the Quality Improvement Committee, and in other forums. Input received in these settings is brought to BHRS Senior Management, the MHSA Coordinator and Component coordinators and other settings as appropriate for consideration.

MHSA MEETINGS

- The MHSA Advisory Committee meets on a monthly basis to hear directly from programs and providers, review and advise on metrics, and make recommendations regarding all significant changes/additions to MHSA programs
- The PEI Committee meets quarterly to discuss PEI Program implementation, including reviewing annual program evaluation reports. It is comprised of PEI providers, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community organizations.
- WET Steering Committee meets on a monthly basis. Its members meet at the Marin Health and Wellness Campus. In addition, family members, family partners and the WET consultant meet monthly as the Family Subcommittee.
- Quality Improvement/Quality Management (QI/QM) Committee meets quarterly. The participants are a mix of county staff, community based providers and other community partners
- The new MHSA Innovation Project: *Growing Roots: The Young Adult Services Project* was approved by the MHSOAC on April 28, 2016 and is led by a Transitional Aged Youth Advisory Committee. See the Innovation Component section of this report for more details. The TAY Advisory Committee and the Innovation Providers each meet in their respective groups on a monthly basis.

Cultural Competence Strategies

PURPOSE OF THE CULTURAL COMPETENCE ADVISORY BOARD

The purpose of the Cultural Competence Advisory Board (CCAB) is to serve as advisors to BHRS administrators, managers and line staff. The charge of the Board is to examine, analyze, and make recommendations about promising and current mental health services and practices that are culturally sensitive, appropriate, and responsive to our diverse consumer community. (See Appendix 2 – Cultural Competence Advisory Board Members.) Additionally, the Board identifies barriers and challenges within BHRS' system that prevents consumers from adequately accessing needed mental health and substance use services. Barriers may include, but are not limited to, stigma and discrimination, language and/or lack of cultural awareness. Lastly, the board shall advocate for the rights of consumers and/or family members, when needed and appropriate, to ensure that consumers' civil rights are respected and protected.

OBJECTIVES

- The board will meet every other month for two hours. Additional subcommittee/ad-hoc meetings and tasks may get established, as appropriate/necessary, based on identified topics or issues addressed
- BHRS' Ethnic Services and Training Manager will facilitate board meetings to ensure that the board are working to achieve its stated goals in an efficient manner
- The board will rely on individual and collective expertise of its members to make informed decisions and recommendations
- The board will be available for community and staff input, utilizing members of the board as liaisons to the entire stakeholder community
- Members of the board will work collaboratively to ensure that the interests of stakeholders are appropriately and effectively represented

Marin County's Behavioral Health and Recovery Services Division's Cultural Competence Advisory Board (CCAB) held its annual half-day retreat in January 2018. The purpose of the retreat was to evaluate BHRS' 2017 accomplishments, current and emerging challenges, and to develop the division's 2018 Cultural Competence Plan (CCP). BHRS accomplished many of its CCP's 2017 goals. Highlights include the establishment of policy to have culturally and ethnically diverse interview panel members in all of the division's job interview processes; sponsored and provided eleven (11) cultural competency-related trainings, consultation and workshops; and continued to hire and retain linguistically and culturally-appropriate staff throughout the organization. In spite of the success, the division continued to face its challenges in other areas of the organization which will continue to be addressed during this calendar year.

One of the persistent challenges that BHRS and many of its contract agency partners continue to experience is the low utilization rate of the adult Latinx Medi-Cal population. BHRS and its agency

partners will continue to build on its successes while working on new strategies that will identify and improve the utilization rate of adult Latinx Medi-Cal population.

Lastly, consistent to the County Board of Supervisors and the Health and Human Services Department's Strategic Plan to Achieve Health and Wellness Equity[PDF] [Appendix 4], BHRS will invest and prioritize its time and resources to develop sustainable strategies which will hopefully lead to a system that is more inclusive, sensitive, and responsive to the needs of its diverse consumer population. This undertaking comes at a time when a recent statewide report concluded that Marin County is the most racially disparate county in California in health and health outcomes (www.racecounts.org). By examining and working toward improving the county's public behavioral healthcare system and its culture through a racial lens, the Cultural Competence Plan can be a tool to actively address the issue of race and racism as a health indicator and factor which often result in poor outcomes for consumers of color and their families.

HIGHLIGHTS AND ACCOMPLISHMENTS IN FY17/18

- In FY17/18 hiring and retention of qualified bilingual/bicultural management staff was increased by three (3), including the Director of Behavioral Health and Recovery Services, the Division Director for the Adult System of Care, and the head of the Access team
- Recruited and retained seven (7) bilingual/bicultural interns to work in BHRS
- Hired and retained a bilingual (Spanish) Family Partner
- Hired and retained (2) full-time Peer Counselors
- Achieved the goals of offering and providing ten (10) or more trainings and cultural competency consultation sessions for fifty (50) management staff of the county's public behavioral healthcare system, two hundred (200) or more for line staff in BHRS and its contract agency partners and one hundred (100) consumers/family members and stakeholders
- Examined BHRS' Adult specialty programs—HOPE, Odyssey and STAR—and the Mobile Crisis/Outreach Team to determine possible artificial barriers that may prevent or discourage Latinx consumers from accessing and receiving services
- Examined the Access Team's intake and assessment tools to determine if they are culturally appropriate
- Worked with Adult System of Care Division Director and Program Managers to assess and determine if Spanish-speaking clinical staff is appropriately, adequately, and efficiently utilized based on caseload assignments and areas of work assignments.
- Supported efforts like the *Promotores*, *Nuestros Ninos* Radio program, Community Health Advocates (Vietnamese) and non-traditional grassroots-funded organizations (African-American inter-generational mentor programs, indigenous healing circles, Spanish youth-run radio station, music therapy for TAY, etc.).
- Supported Health and Human Services Department's Human Resources, interview panels and hiring authorities to ensure that they strive to recruit, interview and hire qualified job candidates that reflect the diverse cultural demographics of consumers that BHRS serves.

Prevention and Early Intervention

OVERVIEW

MHSA Prevention and Early Intervention (PEI) funds are intended to help prevent mental illnesses from becoming severe and disabling. This includes:

- **Prevention:** Reduce risk factors and build protective factors associated with mental illness
- **Early Intervention:** Promote recovery and functional outcomes early in emergence of mental illness
- **Outreach:** Increase recognition of and response to early signs of mental illness
- **Access and Linkage** to Treatment for those with Serious Mental Illness
- **Reduce Stigma and Discrimination** related to mental illness
- Efforts and Strategies related to **Suicide Prevention**

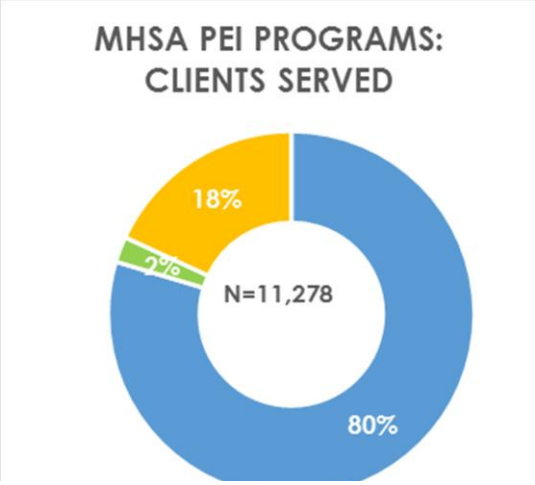
PEI

SUMMARY FY2017-18

Clients Served: FY17-18

8,981 Individuals

256 Families



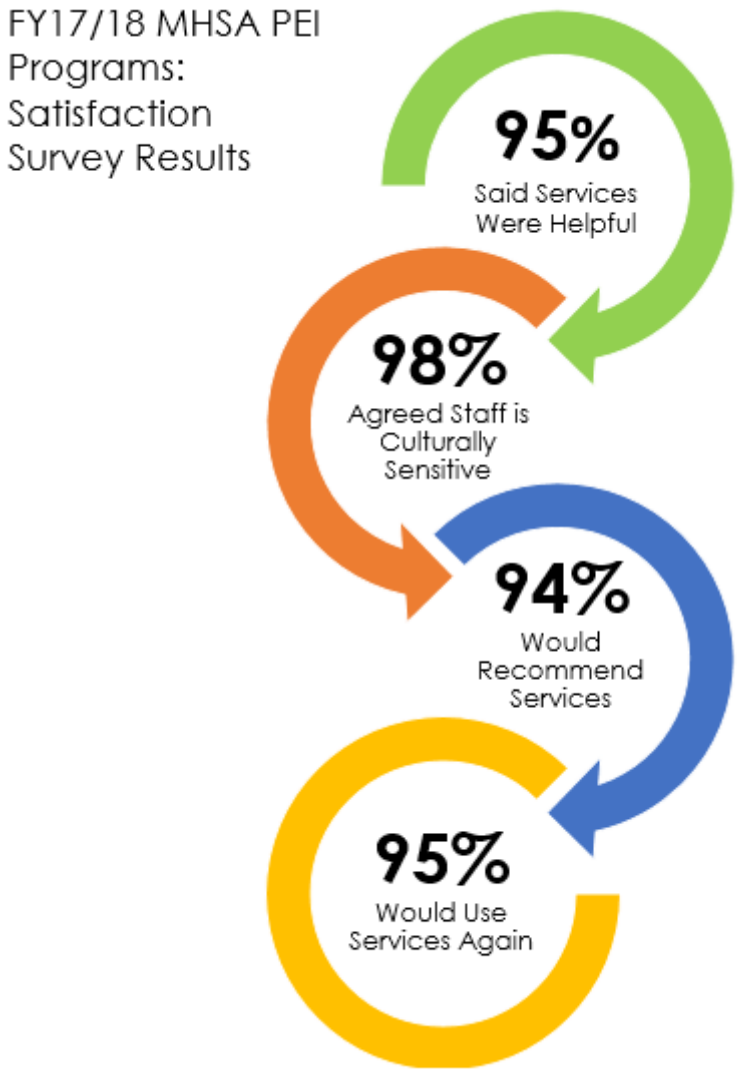
A focus of PEI is to reach un- and underserved populations. Some of the strategies employed are:

- Improve Timely Access: Increase the accessibility of mental health services for underserved populations by being culturally appropriate, logistically and/or geographically accessible, and financially accessible
- Non-stigmatizing: Promote, design and implement services in a way that reduces the stigma of accessing services, such as locating them within other trusted services
- Effective Methods: Use evidence-based, promising and community defined practices that show results

A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old).

Recognizing that increased funding and services are not by themselves sufficient to reach PEI goals, the PEI Coordinator convenes the PEI Providers quarterly, conducts three site visits annually, and convenes

short-term work groups as needed to strategize around prevention efforts related to specific populations.



Note: Not all PEI programs provided/collected client satisfaction survey results.

CLIENTS SERVED

Over the life of PEI, the programs have been adjusted to increase their ability to reach underserved populations. Introducing behavioral health Community Health Advocates/*Promotores* has increased the number of individuals from the Latino and Vietnamese communities receiving services. Locating programs within Marin City and West Marin have increased access for African Americans and geographically isolated communities. Providing programs specifically for Transition Age Youth (TAY) and Older Adults (OA) has ensured PEI services are available for residents of all ages.

In addition, PEI providers consistently report that they are serving individuals and communities who prior to PEI would have not received mental health support, whether due to language, stigma, cost, or other barriers. This is also validated by the results of satisfaction surveys completed by clients. The program narratives in this report include program descriptions, outcomes, and client stories.

COMPLIANCE WITH REGULATIONS

BACKGROUND

New PEI Regulations were adopted effective July 1, 2018. Marin County has been assessing and improving its compliance with these regulations in anticipation of their implementation for the last several years.

COMPLIANCE PLAN

There are many areas of the regulations that Marin was already in compliance with prior to the adoption of previous regulations that were effective October 6, 2015. These include:

- The purpose of PEI
- Implementing the types of programs (Prevention, Early Intervention, Outreach, Stigma and Discrimination Reduction, Access and Linkage to Treatment, Suicide Prevention - optional)
- Implementing the required strategies (Access and Linkage to Treatment, Improve Timely Access for Underserved Populations, Non-stigmatizing, Effective Methods)
- Collecting and reporting on the majority of required data (number served, number of family members served, previously required demographics, outcomes, etc.)

The following areas were implemented in FY 17/18 in compliance with new July 2018 regulations:

Demographics

There are a number of new aspects to the demographics including a separation of race and ethnicity, types of disability, sexual orientation, gender assigned at birth, and current gender identity. As of July 1, 2017, all Early Intervention programs are collecting this data. This was a good way to introduce the new demographics because early intervention programs have more extensive interactions with clients than most other programs. As of July 1, 2018, all PEI funded programs are required to gather the expanded demographics when appropriate. For example, it may be appropriate to collect the data at the end of a long workshop or series of workshops, but not at a short presentation or outreach activity. The PEI Coordinator works with the programs to determine which activities are appropriate for gathering demographic data.

Outreach Settings and Types of Responders

In the new regulations, programs that teach people to recognize and respond to early signs of potentially severe mental illness are expected to report on the settings where the trainees might use those skills (i.e. where they work) as well as the type of responder they are (i.e. what their job is). As of July 1, 2018, the programs collect information on the setting, type of responder and demographics when appropriate. For Mental Health First Aid, we collect type of participant and demographic information at registration which is done online.

Access and Linkage to Treatment

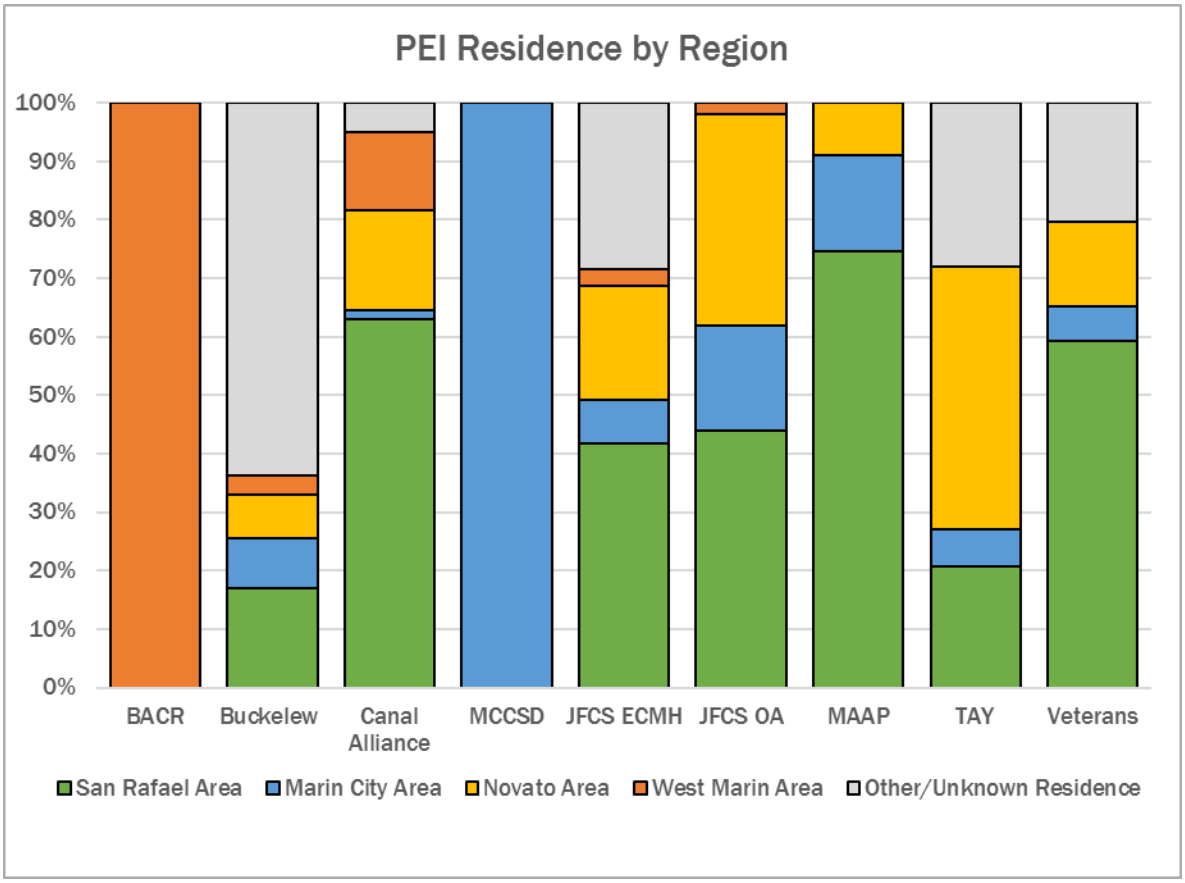
As of July 1, 2016, PEI providers began collecting information on referrals to County of Marin Access Line. As of July 1, 2018, PEI providers are all required to collect and provide data to the county on number of referrals to ACCESS, percent of total referrals that were connected to service, average time between referral and connection and duration of untreated mental illness, as required by PEI regulations.

Improve Timely Access

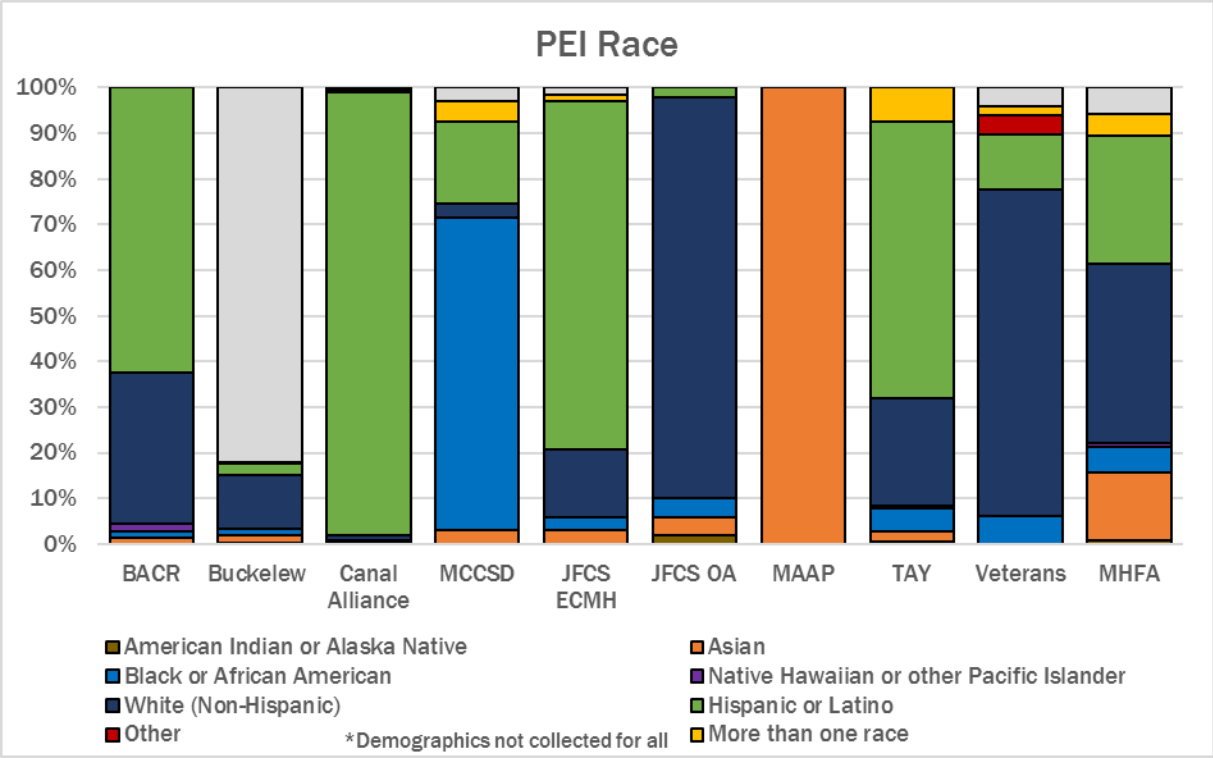
PEI providers began collecting data on referrals to other PEI programs as of July 1, 2018. Based on conversations with PEI providers, they rarely provide a written referral to another PEI program, and therefore may have limited data to report in this area. The strategies used for encouraging timely access to services are described in the narrative part of the Annual Update.

DEMOGRAPHICS

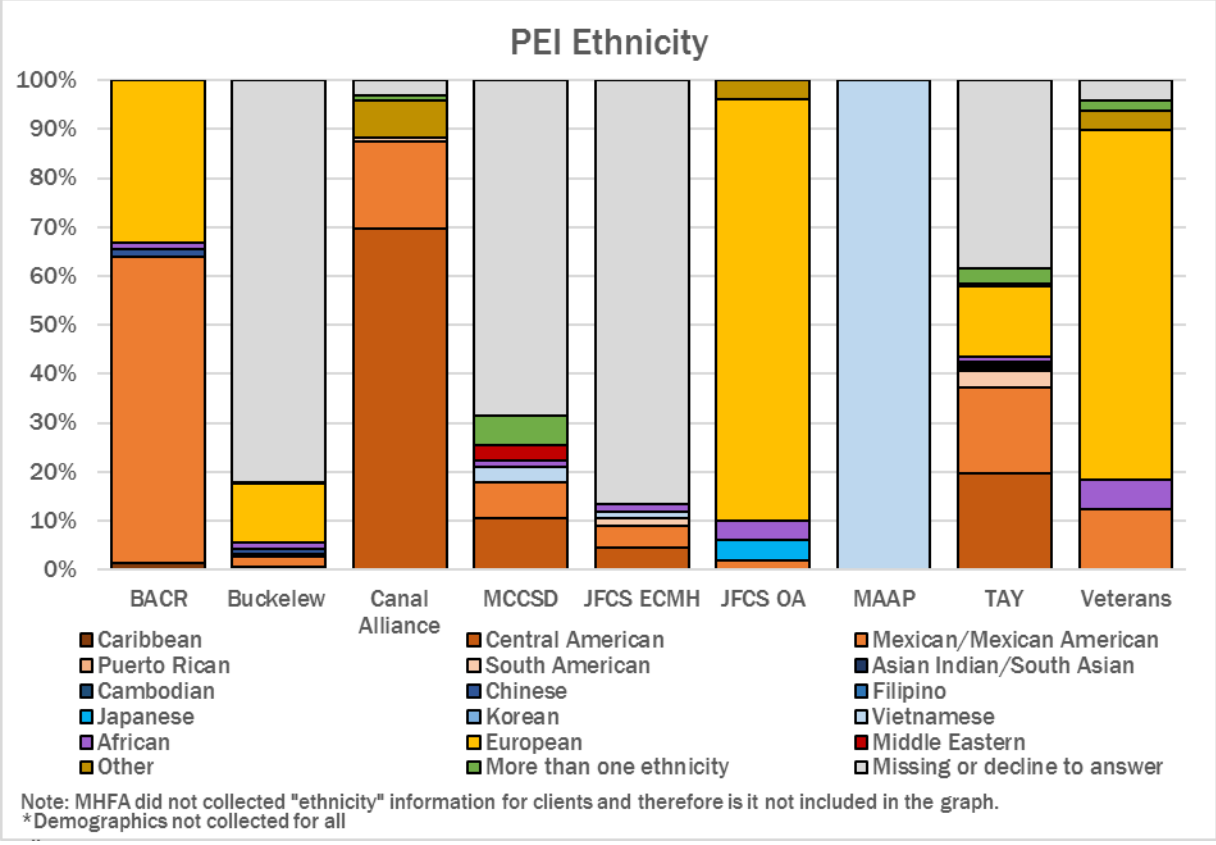
A breakdown of the of the populations served by PEI program is provided below. Demographics are collected for Prevention and Early Intervention programs that include services such as support groups, counseling, skill building, training and service navigation and advocacy.



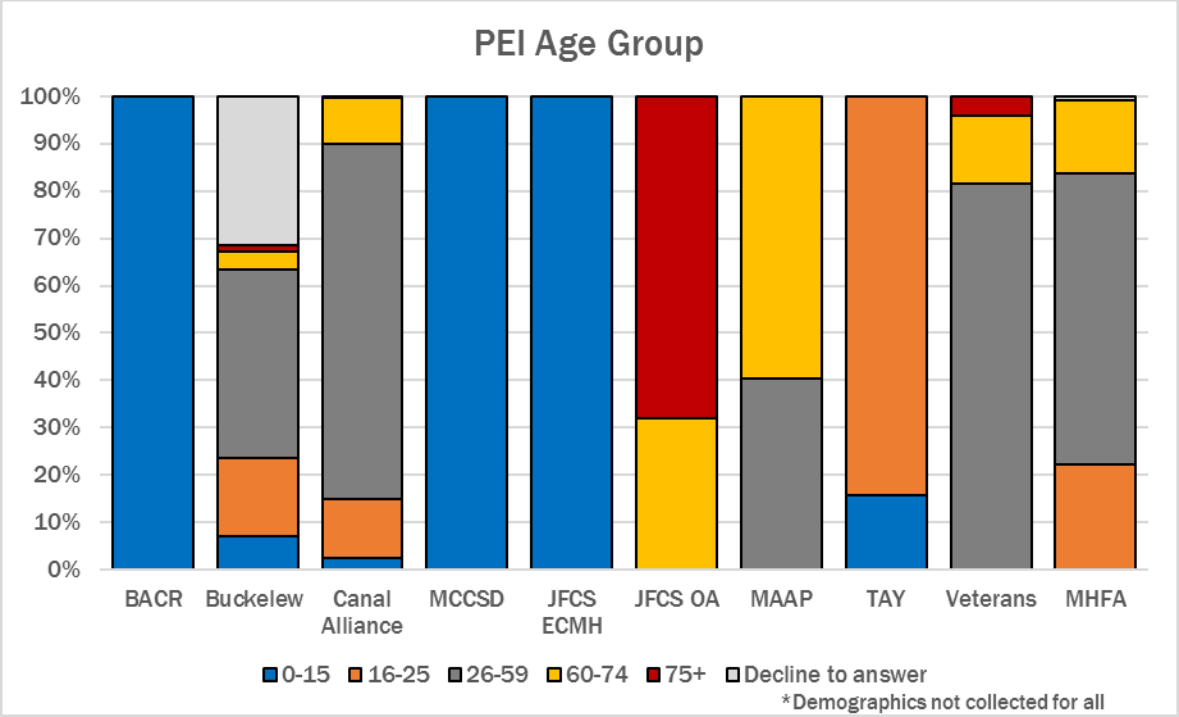
In FY 17/18, the breakdown of PEI clients by region was as follows: 30% San Rafael area, 9% Marin City, 19% Novato, 9% West Marin.



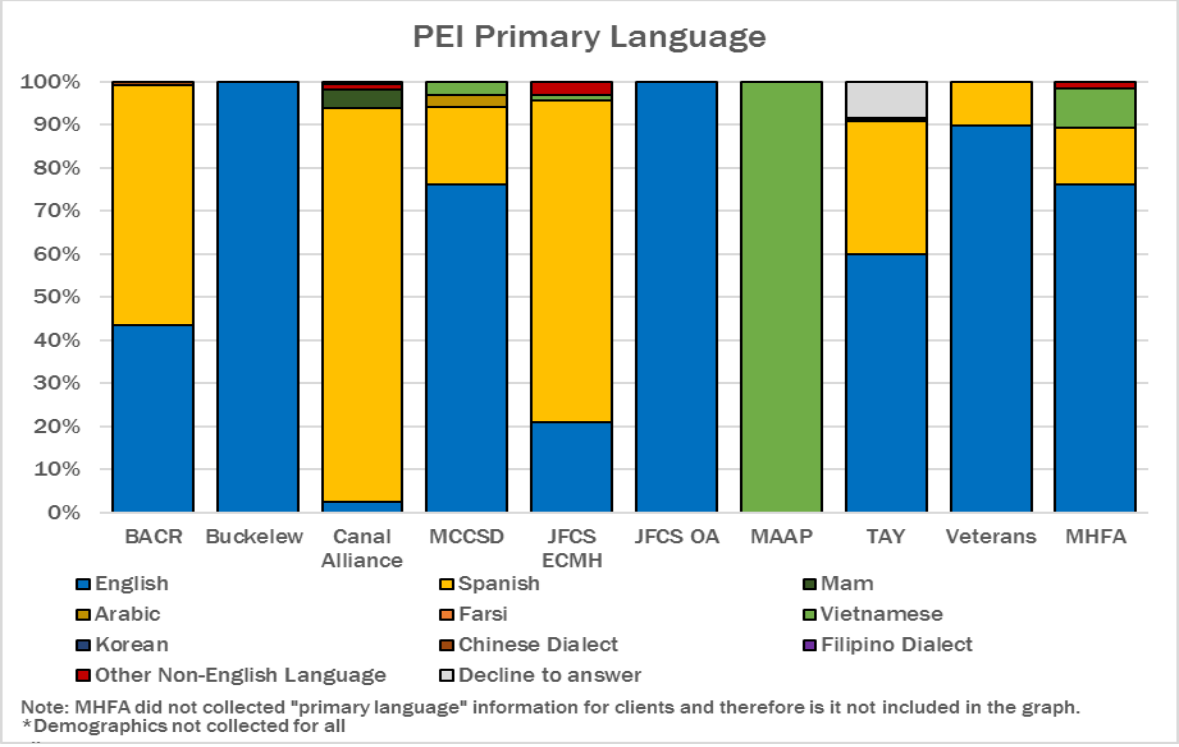
Within the PEI programs, the Latinx population represented 43% of all clients served.



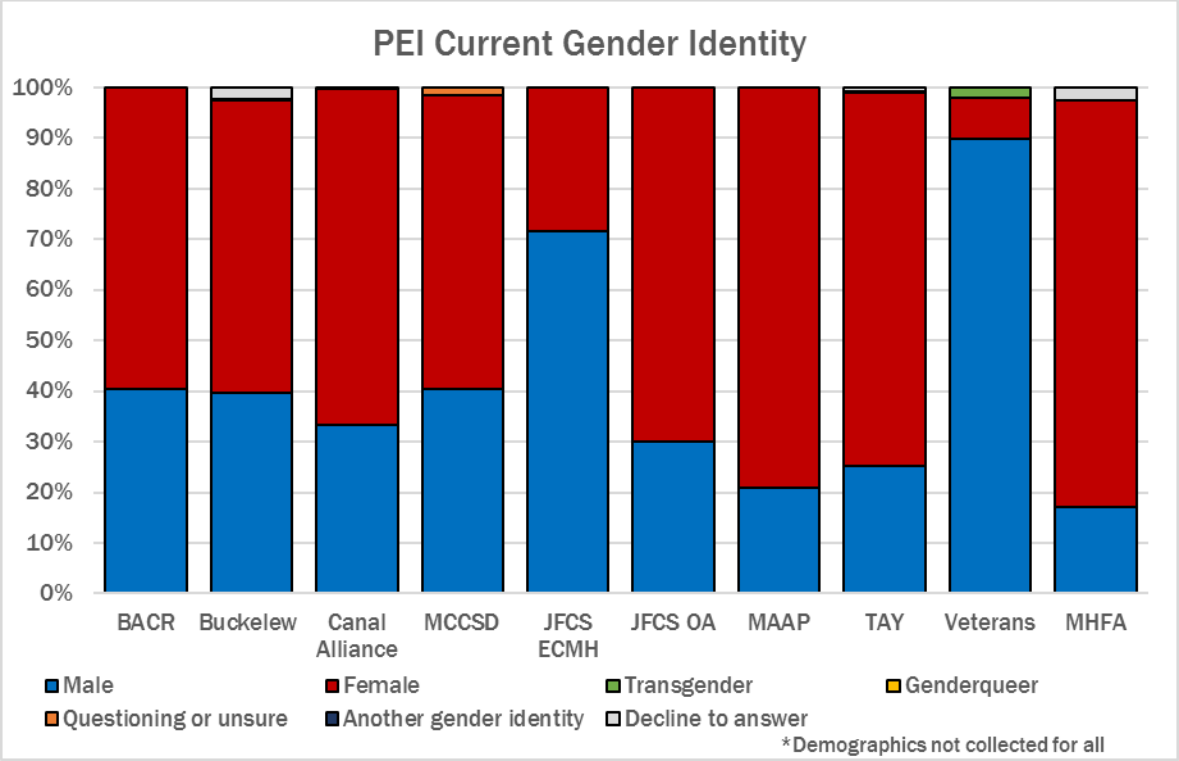
85% of PEI clients overall were from traditionally underserved racial/ethnic groups.



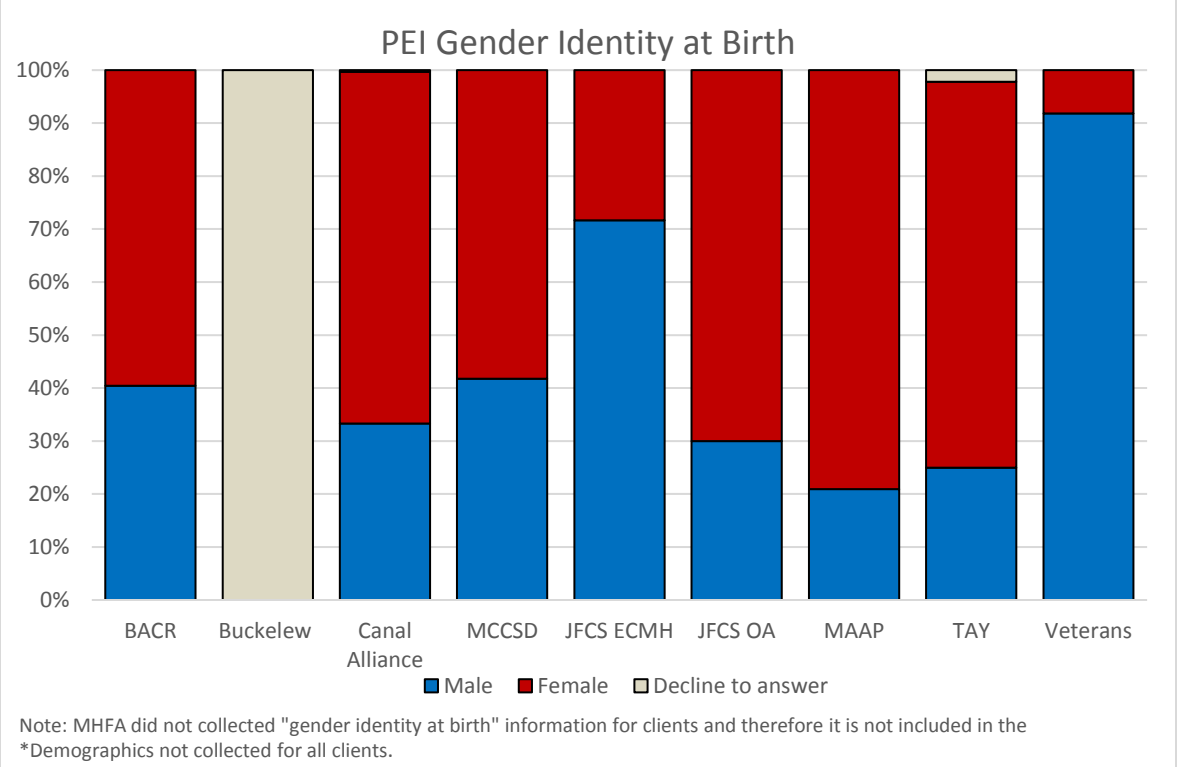
Youth 25 and under represented 47% of PEI clients served.

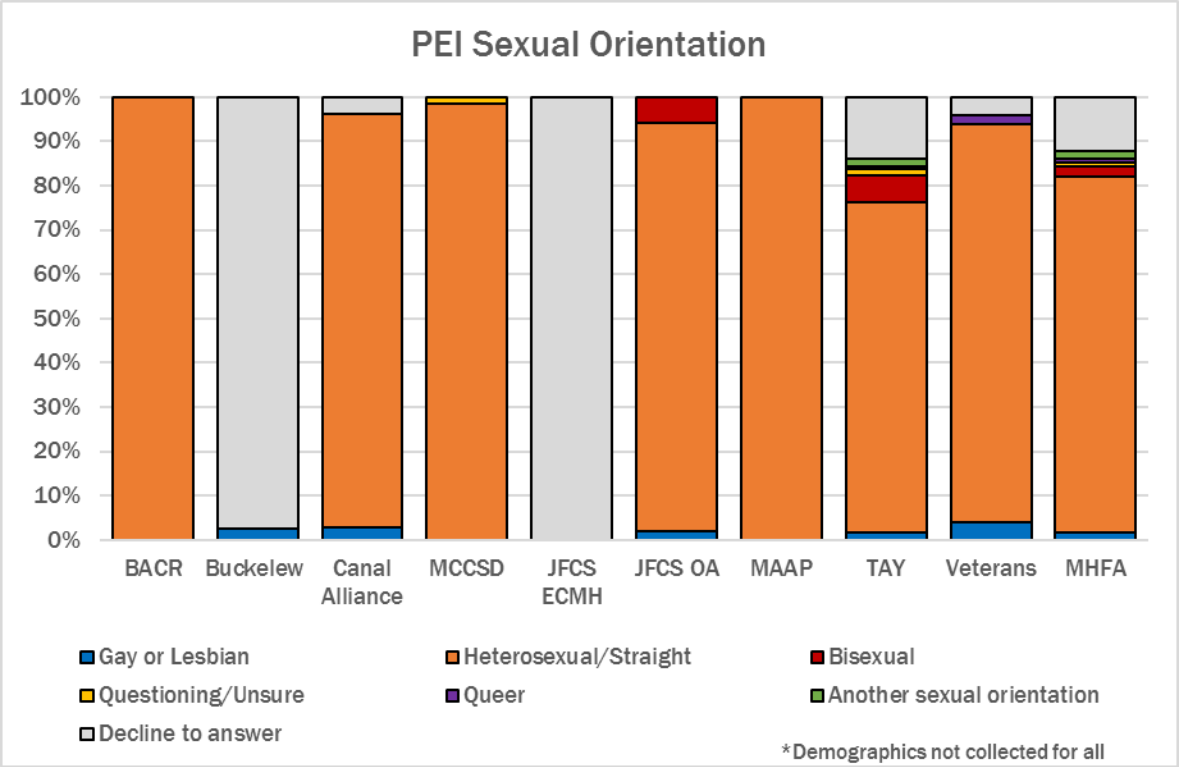


Spanish speaking clients represented 55% of PEI clients.

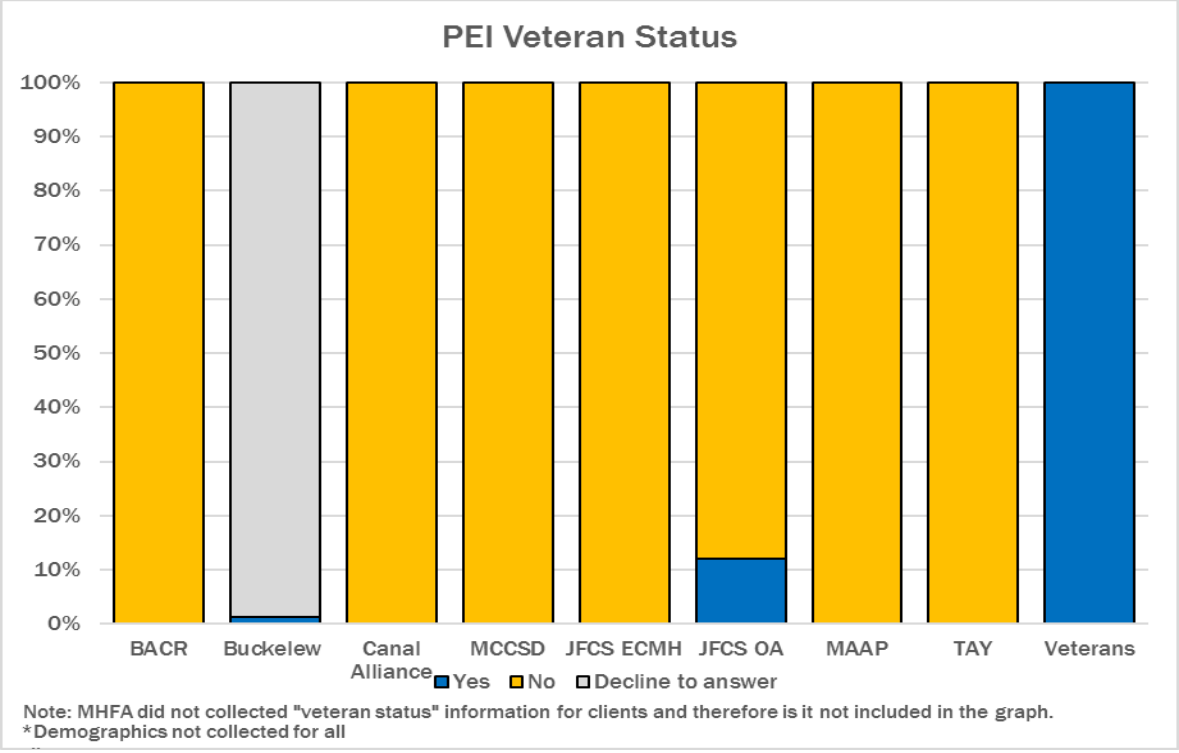


62% of PEI clients identified as female, 36% identified as male, 2% identified as transgender, questioning, or declined to state.

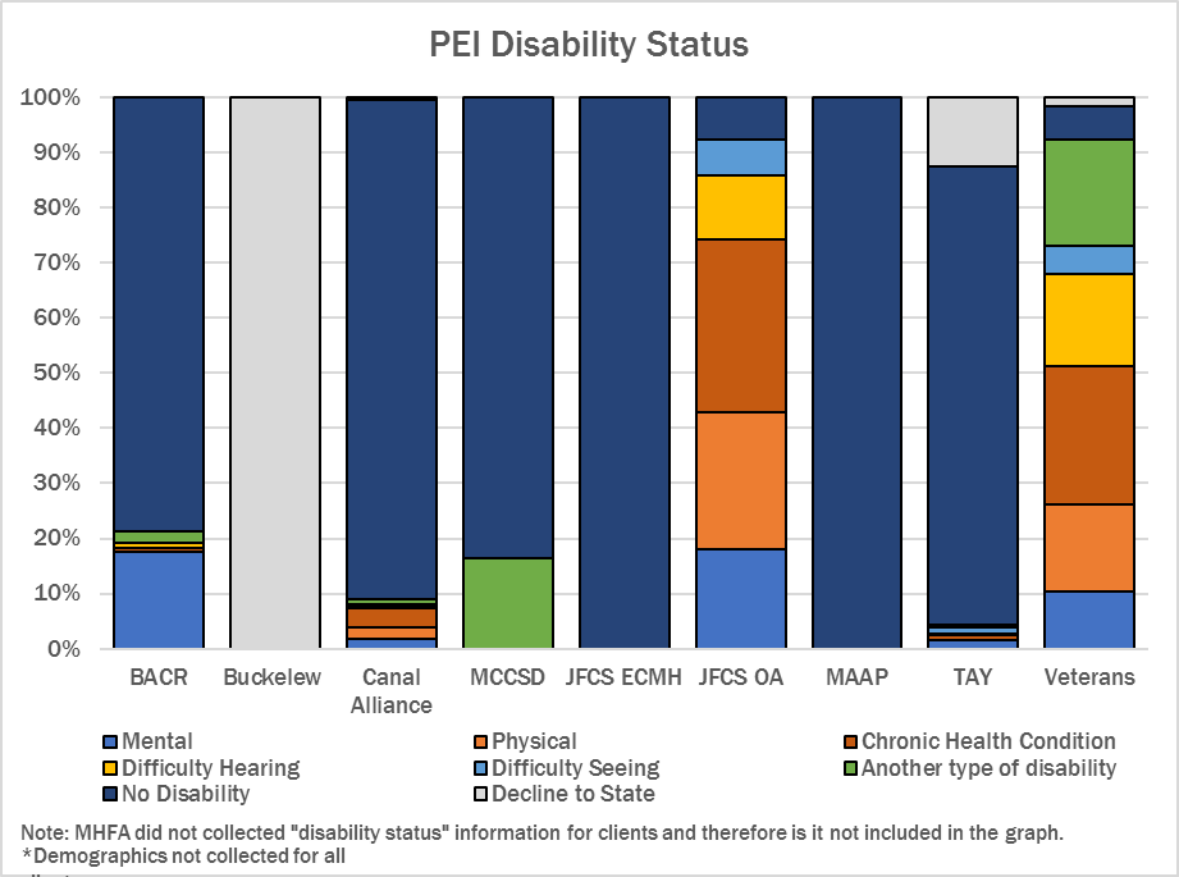




52% of PEI clients identified as heterosexual/straight, 2% as gay or lesbian, 1% bisexual. This information was not captured for all programs.



68 total clients identified as Veterans, primarily served through the PEI Veterans Case Management program.



A disability for this data collection as defined by the State is "a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness." The majority of clients identified as having "no disability" with the exception of participants in the Jewish Children and Family Services Older Adult Program and the Veterans services.

EARLY CHILDHOOD PREVENTION AND EARLY INTERVENTION

PROGRAM ALLOCATION FY17/18: $230,000

PROGRAM OVERVIEW

Early Childhood Mental Health Consultation (ECMH) is promoting the mental health of children 0-5 by helping teachers and parents to observe, understand, and respond to children's emotional and developmental needs. A team of Jewish Family and Children's Services (JFCS) mental health consultants provide training, coaching, and interventions at subsidized preschools and other early childhood education sites to:

- Reduce the likelihood of behavioral problems and school failure in pre-school;
- Identify students with behavioral problems that may indicate mental/emotional difficulties;
- Provide services to pre-schools and families that reduce the likelihood of mental illness and school failure in the future.

ECMH

SUMMARY FY2017-18

Clients Served: FY2017-18

579 Individuals

67 Families

PROVIDER: Jewish Family and Children's Services

TARGET POPULATION

The target population is pre-school students (0-5) who attend subsidized pre-schools, and their families. The children and families face risk factors including poverty, racism, social inequality, trauma, adverse childhood experiences, substance use, and others. In addition, the staff at the subsidized pre-schools are the target population for the training in recognizing and responding to risk factors and signs of emotional disorders.

PROGRAM DESCRIPTION

Early Childhood Mental Health Consultation is intended to **Reduce Prolonged Suffering** for those at significantly higher risk for mental illness by increasing protective factors and reducing risk factors. The ECMH PEI program aims to reduce Prolonged Suffering by providing:

Training for teachers and childcare workers: Early Childhood Mental Health Consultation is promoting the mental health of children 0-5 by helping teachers and parents to observe, understand, and respond to children's emotional and developmental needs. Childcare providers receive training and ongoing coaching to integrate evidence-based practices and best practices into their daily interactions with children and families. Practices include "Powerful Interactions," "Social and Emotional Foundations for Early Learning," and "Triple P." Gaining skills in these areas increases the providers' abilities to reduce behavioral issues in the classroom, increase the

social-emotional skills of the students, and identify and respond to behaviors that may be due to mental or emotional difficulties.

Assessment and brief intervention: JFCS' "Consultation Questionnaire" is completed by pre-school staff to track changes in relevant knowledge and skills. The "Parents' Questionnaire" is completed by families at the conclusion of receiving intervention services to track changes in parenting skills and strategies. A DECA-C pre- and post-test is completed by teacher to track changes in the child's behavior in the preschool setting. If a child is identified as potentially having mental or emotional difficulties, the child and family are assessed by a consultant using methods such as parental depression screening and/or a validated social-emotional screening for children aged 3-5 (DECA-C: Devereux Early Childhood Assessment-Clinical Form). When children or families are identified as needing intervention, consultants assist with developing and facilitating the implementation of an intervention plan. Interventions may include: meeting with the adults in the child's life (family and childcare) to identify the function of the child's behavior; identifying the child's areas of resilience and creating a support plan to build on these strengths; supporting staff and parents with self-initiated strategies (both child-directed and programmatic) to meet the needs of the child's identified behavior; encouraging the development of strong bonds between teacher and child, and between teacher and parents; facilitating meeting(s) between parents and staff; helping parents identify areas of personal/familial stress as a bridge to referrals; and providing linkages to additional services.

Timely Access to Services: The program improves access for underserved populations by being located in pre-schools with high rates of students/families from underserved populations, and by ensuring service providers are culturally and linguistically competent. Services are free, culturally appropriate, and provided in the home and other community settings as needed. Services are non-stigmatizing by being initiated through the pre-school and identified as assisting with school success, rather than specifically mental health related.

Access and linkage to Treatment: Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by ECMH consultants, who are licensed mental health providers. They make the referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County BHRS go to the "Access and Assessment line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services (BHRS), clients, families, and other key agencies to facilitate successful collaboration.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- The number and types of individuals trained, types of trainings provided and demographics (see PEI overview section-page 2)

- Participant surveys are conducted to show changes in knowledge and skill for those receiving training.
- Client/family demographics (page 5) and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (DECA-C) used to measure changes in child behaviors and staff and parent questionnaires to measure changes in skills and knowledge

In the current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

JFCS continued to strengthen partnerships in an effort to best meet the needs of the kids and families. ECMH Consultants collaborated with Occupational Therapy staff to present several trainings called "The Unteachable Moment" in eight child centers. The trainings were held in response to the growing number of children with challenging behaviors at the sites, and teachers becoming overwhelmed and reacting rather than responding to the needs of the young children in their care. Feedback on surveys was overwhelmingly positive, both for site supervisors and teachers. This year JFCS also continued to refine its collaborative relationship with Marin County Office of Education to better coordinate efforts. JFCS also worked to strengthen its partnership with the Center for Domestic Peace this year. According to the Center for Domestic Peace, Domestic Violence is the number one crime in the Marin County and is often the root cause of children who present with extreme behavioral issues in the classroom. JFCS's increased collaboration with many other community providers has helped to increase their understanding of the effects of domestic violence on young children and how to help children and their families.

N = the total number in the sample (i.e. total number who received services or completed a survey).

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Children that received prevention services through staff consultation (number of students at school site)	670	620	535	579
Percent of these children that come from un/underserved cultural populations (Latino, Asian, African American, West Marin).	70%	86% N=620	70%	87% N=501
Children/families identified for enhanced intervention (through observation or validated screening tools for child behavior or family	75	80	65	67

caregiver depression) and provided services through ECMH Consultation.				
Children in childcare settings served by ECMH Consultants retained in their current program, or transitioned to a more appropriate setting. *_Case notes_	100%	100%	100%	100%
Parents/primary caregivers of families receiving intensive services who report increased understanding of their child's development and improved parenting strategies. *_JFCS multi-county parent questionnaire_	85%	100% N=15	85%	96% N=12
Families receiving ECMH Consultation services who report satisfaction with the services (would use again, would recommend, were helpful). *_PEI survey_	75%	90% N=19	75%	89% N=18
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	1
Total referrals to other PEI providers	N/A	N/A	N/A	5
Early Childhood Education Sites Receiving Services				
Childcare staff receiving ECMH Consultation who report increased ability to identify, intervene with, and support children in their care with emotional/behavioral issues. *_JFCS multi-county provider questionnaire_	85%	90% N=89	85%	88% N=60
Staff receiving ECMH Consultation services who report satisfaction with the services (would use again, would recommend, were helpful). *_PEI survey_	75%	90% N=89	75%	93% N=66

*_Data Collection Method_

CHALLENGES AND UPCOMING CHANGES

In FY 2017-18, the ECMH PEI program was implemented overall as expected. However, there are gaps in current systems that make it difficult to meet the needs of children with serious behavioral challenges who cannot function in a large group setting. While ECMH consultants can provide support to staff and help engage families in a non-judgmental way, they are unable to provide all that is necessary for some children. This is particularly challenging for families that work fulltime and for whom ECMH services only provide half day preschool services.

In FY2019-20, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

Client Story

"Manuel" is a 4-year old Latino preschooler, his mother is an immigrant from Central America and mostly monolingual Spanish speaker. The site supervisor expressed concerns that Manuel had possible sensory and speech delays, difficulty concentrating and that he was hitting other children. The ECMH Consultant met with his mother to gather history and worked with his teachers to help them see patterns and triggers and design a plan for how best to help Manuel. A referral was also made for a speech assessment, with a request to look at his sensory needs from an Occupational Therapist. The OT and ECMH consultant provided a training to staff called "The Unteachable Moment," which helped staff gain some sensory strategies for helping Manuel with self-regulation. After 3 months, Manuel's DECA-C post test results showed significant improvement in all protective factors. Initiative and self-control both went from "areas of concern" to "typical", while attachment went from the "concern" range to a "strength". All behavior concerns decreased as well. Manuel's mother reported in a parent survey that the services she received form ECMH consultants were "excellent". Her comments on the survey were: "[Consultants] were friendly, collaborative. Thank you for your help for my son."

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PEI TAY

SUMMARY FY2017-18

PROGRAM ALLOCATION FY17/18: $193,000

PROGRAM OVERVIEW

In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program, provided by Huckleberry Youth Programs (HYP) and North Marin Community Services (NMCS), formerly Novato Youth Center (NYC). TAY PEI provides screening and brief intervention for behavioral health concerns in teen clinics and group and individual services in middle and high schools for at-risk students.

PROVIDERS: Huckleberry Youth Programs and North Marin Community Services

Clients Served: FY2017-18

681 Individuals

81 Families

TARGET POPULATION

The target population is 16-25 year-olds, and some younger teens, from underserved populations. Many of the TAY are unlikely to receive services through other routes due to lack of insurance, lack of parental connection, unfamiliarity with navigating the service systems, concern about cost of services, or lack of linguistically accessible services.

PROGRAM DESCRIPTION

The TAY PEI program aims to **reduce prolonged suffering** due to unaddressed mental illness by increasing identification of at-risk TAY, increasing protective factors for those with significantly higher risk, and providing access to services for those with early onset of signs of emotional disturbance. To accomplish this, Huckleberry and North Marin Community Services provide:

Skill Building Groups: Multiple session groups are held at middle and high schools to promote coping and problem-solving skills. Services are for at risk students, such as those who have recently immigrated to the U.S. or those at risk for dropping out of traditional school settings. Skill building groups are offered at schools and in classrooms that specifically target these groups of students, therefore involvement in the groups is determined by participation in one of these schools and/or classrooms.

Brief Intervention: Youth screening positive for signs of emotional disturbance in the teen health clinics, identified through school skill building groups for high risk students, or referred from school personnel or elsewhere, are linked directly to a licensed mental health provider at the clinics or school sites for further assessment. If identified as experiencing serious mental illness, clients are

linked to medically necessary services. Brief intervention services are most often provided for TAY struggling with severe trauma, substance use, disordered eating, sexual identity and orientation issues, and complex family issues often experienced in immigrant families. Families of youth are included in brief intervention services as appropriate.

Access and Linkage to Treatment: Mental Health and substance use screening is conducted for all clients of the teen health clinic. Clients screening positive are then assessed by a clinician and, if identified as experiencing serious mental illness, linked to medically necessary services. Individuals at risk or showing signs of developing emotional disturbance are linked to additional risk reduction services, early interventions, and other resources as needed. They make the referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County BHRS go to the "Access and Assessment line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies to facilitate successful collaboration.

Timely Access to Services: The program improves timely access to services for underserved populations by being located within health care services they already access, as well as in schools. Many TAY who experience distress are unable to identify when their distress falls outside of the norm or becomes a clinical concern. Behavioral health screening, provided along with routine health visits, enables them to recognize when the need for intervention is present, and in turn access services they might not have otherwise. Providers are culturally and linguistically competent and services are provided at low- to no-cost. Services are non-stigmatizing by being initiated through the clinic services and schools and identified as assisting with stress and school success, rather than specifically mental health related.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- Number of clients screened at Teen Clinics are tracked
- Client/family demographics and satisfaction surveys to show impact of services provided (see PEI overview section)
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (Global Appraisal of Individual Needs (GAIN-SS, Partners for Change Outcome Measurement System (PCOMS)) used to measure changes in functioning overtime. The Global Appraisal of Individual Needs (GAIN-SS) is a validated tool used to screen clients at the Teen clinics for psychosocial concerns. The Partners for Change Outcome Measurement System (PCOMS), is both an evaluation and an intervention (evidence based, SAMHSA NREPP). The system consists of two tools, the Outcomes Rating Scale (ORS) and the Session Rating Scale (SRS). Outcome Rating Scale (ORS), at each session which asks the client to rate how they are doing individually, interpersonally, socially and their overall sense of well-being. The change in these scores is evaluated for clients that participate in three or more sessions.

In the current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

During this past year, the TAY program made progress in serving underserved populations in Marin County. NMCS and HYP embarked on processes to assess the mental health needs of LGBTQ youth, resulting in new findings, new collaborations with the SPAHR Center, and action plans for additions to each program this year. So far, actions that have been taken in response to this needs assessments include:

- NMCS now has an LGBTQ youth who volunteers at the Novato Teen Clinic doing outreach and education. SPAHR Center will assist NMCS in providing LGBTQ cultural competency training for all youth volunteers
- HYP is hosting an LGBTQ support group for Latinx teens in collaboration with SPAHR Center and a therapist from Marin County Health and Human Services, starting September 2018.

Client quote (to therapist): "Without you or Huckleberry, I think I would have dropped out of school and worked instead to send money back home to my mom, as that was my initial plan. But Huckleberry showed me I could do both. Be a high school graduate, obtain an education, and give myself and my mom a better future."

NMCS was also able to expand its Newcomer groups to San Marin High School. As a result, an additional group of underserved youth was served, those newly arrived youth who speak very limited English and are not being served through the group provided at Novato High School. HYP therapists were able to reach an emerging population of newcomer students at Redwood High School, not through groups. Rather, HYP provided individual counseling in Spanish in response to a request by Redwood's Wellness Center.

N = the total number in the sample (i.e. total number who received services or completed a survey).

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY17/18	Actual FY 17/18
TAY screened for behavioral health concerns	350	363	350	347
TAY participating in at least 5 sessions of school-based skill building groups	80	90	100	97
TAY participating in at least 5 sessions of school-based skill building groups showing statistically significant improvement in client well-being. *PCOMS: Outcome Rating Scale* *Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change*	65%	81% N=72	60%	61% N=33
TAY participating in individual counseling	180	242	200	263

Family members participating in TAY counseling in support of the client	30	79	50	82
TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being.* *PCOMS: Outcome Rating Scale Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change*	65%	74% N=91	60%	N=64 64% statistically significant improvement
TAY participating in at least 3 sessions of counseling showing a validated positive therapeutic alliance, a significant predictor of clinical outcomes; **PCOMS: Session Rating Scale*	75%	93% N=123	75%	N=110 85.5%
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	3
Total referrals to other PEI providers	N/A	N/A	N/A	12

**Data Collection Method*

CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, the TAY program was implemented as expected overall. However, coordination with schools was more challenging than in years past. For Huckleberry Youth Programs, the therapists who have facilitated these groups for many years noted that the school counselors seemed particularly overworked and less able to engage in coordinating the groups. An additional challenge was the depth of issues brought to the group by youth this year. HYP therapists noted the intensity of mental health challenges, the increase in stress and anxiety fueled by immigration policies, and a greater urgency to the needs of youth in the group. In part due to this, HYP noted a lesser degree of improvement in client overall wellbeing compared to past years, as measured by the ORS. To address this, 15 youth continued to work with HYP therapists on an individual basis beyond the group intervention, for individual or family therapy, case management, or for referral to other HYP or external services. Limited mental health resources and coordination is an area of continued need for schools in Marin County.

In **FY2019-20**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20, with an additional 10K (9k from operating reserve and 1k from training budget) in funding to the SPAHR center to provide counseling services for transgender youth and outreach to schools around LGBTQ issues.

CLIENT STORY

A fourteen-year-old girl dropped into the Novato Teen Clinic to seek help with anxiety that had recently become difficult for her to handle on her own. She was very low income and her family could not afford to access services through their insurance due to the co-pays and deductibles. The teen talked with the counselor on site about issues she was having relating to her family, school and friends. Over a 40-minute session, the counselor listened to the teen, validating her feelings and teaching her "on the go" and "quick" coping tools. The teen expressed interest in ongoing counseling because the coping tools and talking with the counselor had made her feel better. So, she then went on to receive free weekly counseling services. The teen and the therapist worked together for three months and by the end, the girl's anxiety had been reduced significantly and she reported having both better relationships with her friends and family and doing better in school.

LATINO COMMUNITY CONNECTION

PROGRAM ALLOCATION FY2017-18: $313,000

OUTREACH FOR INCREASING RECOGNITION

PROGRAM OVERVIEW

Latino Community Connection (LCC) is a multi-layered program to provide behavioral health outreach, engagement, and prevention services in the Latino community. Canal Alliance, a trusted multi-service agency, partners with North Marin Community Services and services in West Marin to train and support *Promotores* throughout the county. *Promotores* are trusted community members trained in identifying and responding to behavioral health concerns, including providing peer support and linkages to services. A bilingual behavioral health provider provides brief interventions for individuals, couples, and families including psycho-education, coping skills, communication skills, and referrals to appropriate behavioral health services. Clients may also be referred to trauma and stress management groups at Canal Alliance that help them develop coping and stress reduction strategies. In addition, PEI funds co-sponsor a radio show, "*Cuerpo Corazon Comunidad"*, in Spanish on health issues, including mental health and substance use.

Latino CC

SUMMARY FY2017-18

Clients Served: FY2017-18

619 Individuals

25 Families

790 Outreach

PROVIDERS: Canal Alliance/North Marin Community Services and Multicultural Center of Marin

TARGET POPULATION

The target population is Latinos throughout the County, especially newer immigrants facing many stressors and barriers to access of services. The Latino population faces a number of significant risk factors for mental illness including severe trauma, ongoing stress, poverty, family conflict or domestic violence, racism and social inequality, and traumatic loss.

PROGRAM DESCRIPTION

The Latino Community Connection program aims to reduce prolonged suffering due to unaddressed mental illness by increasing identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness due to trauma. LCC provides:

- **Outreach for Increasing Recognition**
- **Radio Show "*Cuerpo Corazón Comunidad*"**: A licensed mental health provider hosts a weekly live one-hour radio show in Spanish on the health of Latino individuals, families and communities, in particular mental health topics. It is broadcasted from stations in central Marin, West Marin and other regions in California.

- ***Promotores* Training and Support**: For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for *Promotores* to provide mental health and substance use education, identification of risk and signs, and linkages to services. This program increases the efficacy of existing mental health programs by reducing the barriers for accessing those services. In addition, it creates a culture shift in the target communities that reduces stigma and increases the natural supports available within the community.

- **Counseling and Case Management:** Individuals referred to the program are assessed for PTSD using the Posttraumatic Stress Disorder Checklist (PCL-C) at Canal Alliance. Those determined eligible are referred to ongoing groups provided at Canal Alliance for increasing coping skills and functioning. The groups provided incorporate the framework developed by the Institute on Violence, Abuse and Trauma (IVAT) regarding addressing complex trauma, such as emotional regulation, stress reactions, psycho-education on trauma, dissociation, and relational aspects. Partners for Change Outcome Measurement System (PCOMS) is used at North Marin Community Services used to measure changes in functioning overtime. In addition, clients not appropriate for the groups, but assessed as having significant risk, especially family conflict, or having signs/symptoms of mental illness, are provided one to three individual sessions including psycho-education, coping skills, communication skills, and linkages to appropriate services.

- **Timely Access to Services:** The program improves timely access to services for underserved populations by being located within a trusted multi-service agency serving primarily Latino immigrants, as well as reaching hard-to-reach communities through *Promotores*. Services are provided at no-cost by culturally and linguistically competent providers. Services are non-stigmatizing by being co-located with other services and addressing "stress," rather than specifying mental health issues.

- **Access and linkage to Treatment:** Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program's behavioral health provider. *Promotores*, family advocates and others are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County BHRS go to the "Access and Assessment line," enabling the County to track referrals, timeliness of services, and services received. PEI staff maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- The number and types of individuals trained, types of trainings provided and demographics (see PEI overview section)

- Participant surveys are conducted to show changes in knowledge and skill for those receiving training
- Client/family demographics and satisfaction surveys to show impact of services provided (see PEI overview section)
- Number of individuals reached through outreach activities (tabling, resource fairs, etc.)
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (PLC-C and PCOMS) used to measure changes in child behaviors and staff and parent questionnaires to measure changes in skills and knowledge

In current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

The Novato and Central Marin *Promotores* continued to make significant progress in connecting Latinos to mental health services and providing emotional support for those who would otherwise never connect with services because of geographic isolation and cultural barriers to accessing mental health support. *Promotores* are able to bridge cultural misunderstandings by staying well-informed and clarifying questions for community members as they arise. The proximity physically and culturally to the client helps bridge geography and trust issues.

Case Managers continued to provide strength-based case management to individuals and families in the following areas: Housing Referral and/or rental assistance, job mediation, connection to public benefits or other community resources, domestic violence, parenting, relationship support and other health and access to health services.

The radio show aired 52 one-hour broadcasts in 52 weeks. The show focuses on the wellness of Latino individuals, families and communities, with an emphasis on mental health knowledge, skills, and related community resources. The Multi-Cultural Center of Marin (formerly the Canal Welcome Center) expanded its content and reach by live streaming of the broadcast on Facebook Live, which many community members access on their smart phones. *Promotores* participate in the radio show by discussing topics such as managing stress, trauma, stress due to changes in immigration policies and other related topics. When asked about her opinion on the *Promotores* and staff participation as panelists, Dr. Marisol Muñoz-Kiehne, radio show host stated: "The regular participation of the *Promotores* and their leaders in the *Cuerpo Corazon Comunidad* psycho-educational broadcasts/podcasts is invaluable, as they deliver important messages in accessible and heartfelt ways. When *Promotores* serve as panelist in the studio, and comment via phone, Facebook and pre-recorded statements, they teach what they have learned, and enrich much needed discussions and dialogue about behavioral health related concerns. Their enthusiastic voices convey their passion and their commitment to the community. It is gratifying to witness the broadening and deepening of the *Promotores*' knowledge base regarding situations that impact mental health and illness. They are showing growing awareness of what each of us can do to address stigma, isms, and other social determinants of health."

N = the total number in the sample (i.e. total number who received services or completed a survey).

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Individuals receiving health information and support from *Promotores* or Family Resource Advocates	640	1,490	900	1,288
Individuals participating in support groups or individual/family sessions	100	113	150	83
Family members participating in support of the client	20	10	20	17
Individuals participating in a support group for at least 3 months reporting statistically significant improvement in PTSD symptoms *PCL-C 5 pt change**	80%	95% N=16	50%	60% N=50
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	10
Total referrals to other PEI providers	N/A	N/A	N/A	20
Total referrals to resources for basic needs	N/A	N/A	N/A	250

**Data Collection Method*

CHALLENGES AND UPCOMING CHANGES

In FY2017-18, due to the unexpected loss of its bilingual Behavioral Health Coordinator mid-year, Canal Alliance was unable to provide the intended range of prevention services for the latter part of the fiscal year. Other LCC program components were implemented as expected. Finding enough bilingual therapy for clients with mild to moderate behavioral health needs continues to be a challenge. In order to address this need for qualified bilingual therapists, BHRS increased Canal Alliance's contract during the FY 18/19 to support the recruitment of bilingual staff. This allowed them to hire two Licensed Clinicians to fill previous vacancies. However, maintaining adequate funding to hire and retain qualified bilingual clinicians remains an ongoing concern in Marin County.

In FY2019-20, this program is expected to be fully staffed and implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

CLIENT STORY

A Promotora providing emotional support to a client who experienced constant verbal abuse from her husband, invited her to participate in a workshop that addressed how trauma affects all aspects of child development. The client was able to see how her children's exposure to her husband's abusive behavior was potentially going to affect them, and she asked the Promotora for help in planning to leave her husband. The Promotora connected her with the Center for Domestic Peace, who got her a spot in a shelter for her and her two children. The Promotora was then able to help her secure transitional housing for the next year and a half and connected her with a free Spanish speaking therapist. The Promotora

continued to provide the client with support around her relationship and parenting. When asked about the services she obtained from the Promotora, the client said, "All is well, all that you have given me [support] is excellent. It has helped me a lot. You [the staff] are very good people, you found me a therapist and I am now doing well. The Promotora is excellent; she respects me and knows how to talk [what to say]."

OLDER ADULT PREVENTION AND EARLY INTERVENTION

PROGRAM ALLOCATION FY17/18: $165,000

PROGRAM OVERVIEW

Older adults continue to represent a growing percentage of the population of Marin and face many risks for mental illness. Jewish Family and Children's Services (JFCS) provides community education about mental health concerns in older adults and early intervention services for depression and anxiety. The program receives referrals of older adults diagnosed with depression and anxiety, often in connection with their medical issues, loss, or other difficult life transitions. JFCS's model involves effective engagement with older adults through home visits and well as consistent collaboration with family members and health providers.

PROVIDER: Jewish Family and Children's Services

Older Adult

SUMMARY FY2017-18

50 Individuals

30 Families

TARGET POPULATION

The target population is older adults (60+ years old), including individuals from underserved populations such as Latino, Asian, African-American, LGBT, low-income, and geographically isolated. Spanish Speaking older adults are primarily served by the ACASA peer-counseling program provided by Behavioral Health and Recovery Services (BHRS) as part of the Helping Older Adults Excel (HOPE) program.

PROGRAM DESCRIPTION

Research and data show that due to changes brought on by aging and health decline, older adults are at-risk for isolation, chronic health problems, substance abuse, poverty, retriggering of early trauma, and other issues. The Older Adult PEI program aims to reduce Prolonged Suffering by providing:

- **Training:** Providers, older adults, community leaders and gatekeepers are trained to recognize signs of depression and other mental health concerns among older adults and how to get appropriate help.
- **Brief Intervention:** for those experiencing early onset of depression and/or anxiety by reducing symptoms and improving related functioning. For clients completing treatment, including CBT or the Healthy IDEAS intervention, pre- and post-PHQ9s and GAD7s are conducted. Reduction in isolation and success in addressing goals in the client care plan are also measured through client report. Changes in scores are tracked by individual and reported in aggregate.

- **Timely Access to Services:** The JFCS program improves timely access to services for underserved populations by providing outreach and education to diverse providers and community members throughout the County, as well as providing services within an agency that already provides many older adult services. Services provided by PEI funds are free, culturally appropriate, and provided in the home and other community settings as needed. Services are non-stigmatizing by being co-located with other services and focusing on "successful transitions for older adults." Program success lies in its flexibility, responsiveness and ability to coordinate care with its longstanding partners in the health and social service systems that provide service to this vulnerable population.
- **Access and linkage to Treatment:** Individuals at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. JFCS's licensed mental health providers make the referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County BHRS go to the "Access and Assessment line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- The number and types of individuals trained, types of trainings provided and demographics (see PEI overview section)
- Participant surveys are conducted to show changes in knowledge and skill for those receiving training
- Client/family demographics and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (PHQ9 and GAD7) used to measure changes or reductions in severity of symptoms

In the current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

JFCS's Older Adult PEI program has been very successful at adapting to meet the needs of the clients. JFCS offer a range of interventions, including friendly visitors, visits with pets and peer counseling and extensive ongoing outreach to underserved communities. In addition, JFCS continues to increase its collaboration with health partners which has helped to improve client outcomes. Family involvement also continues to be an increased focus. Although the program was designed to provide early intervention primarily to individuals, staff has found the need to involve family steadily increasing. During FY 17/18, 60% of cases included family involvement, leading to improved care coordination and client outcomes.

Client quote: "Can't say enough about (Staff) – she's been my life saver!!" "Meeting (Staff) has been a turning point for me…..she relates with deep humanity, caring and a wealth of professional judgement."

N = the total number in the sample (i.e. total number who received services or completed a survey).

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Individuals receiving education regarding behavioral health signs and symptoms in older adults	50	85	100	103
Individuals receiving education who are from an underserved population or primarily serving underserved populations (race, ethnicity, language, LGBTQ)	20%	51% N=85	25%	78% N=80
Seniors at Home clients screened for behavioral health concerns. **PHQ9, substance use*	150	153	150	163
Low income clients receiving brief intervention services.	35	35	50	50
Low income clients receiving brief intervention services who are from underserved populations	20%	26% N=35	20%	20% N=10
Clients completing a short-term treatment protocol for depression or anxiety	70%	71% N=35	70%	70% N=35
Clients completing a short-term treatment protocol for depression or anxiety experiencing a decrease of at least on category of severity (i.e.: moderate to mild). **PHQ9, GDS, GAD7*	60%	63% N=35	60%	86% N=30

Clients receiving brief intervention reporting satisfaction with services (would use again, recommend)	75%	90% N=22	75%	95% N=22
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	4
Total referrals to other PEI providers	N/A	N/A	N/A	4

**Data Collection Method*

Type of Participants in JFCS Outreach Events	Number Served FY 16/17	Number Served FY 17/18
Community Members (Older adults and their family members)	59	81
Providers		
County Mental Health and Substance Use Services	8	
Community-based Mental Health and/or Substance Use Provider	6	
Senior Centers/Services	5	6
Social Services	7	16

CHALLENGES AND UPCOMING CHANGES

In FY2017-18, the Older Adult PEI program was implemented as expected overall. The limited availability of psychiatric services for older adults continued to present a challenge in mitigating symptoms for those clients who need medication evaluation. To address this challenge, JFCS works closely with the health team at the physician's office and through the home health agencies such as Sutter Care and collaboratively with family members. However, limited access to psychiatric services makes it difficult to address all the mental health needs of this vulnerable population.

In FY2019-20, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

CLIENT STORY

Mr. P., an 88-year old married man, lived with wife of 62 years and adult daughter in their family home. A series of falls rendered him non-ambulatory and depressed. He was referred to JFCS for counseling and with the help of his therapist, who worked closely with his physician and daughter, Mr. P eventually started to feel more "alive" and engaged. His daughter shared that Mr. P. often told her that the relationship he had with the JFCS therapist was a meaningful one and helped him greatly during this stage of his life.

VIETNAMESE COMMUNITY CONNECTION

PROGRAM ALLOCATION FY17/18: $56,000

PROGRAM OVERVIEW

In 2011, MHSA PEI began the Vietnamese Community Connection program to implement effective ways of engaging the Vietnamese community in behavioral health outreach, education and prevention efforts. The program consists of outreach by Community Health Advocates (CHAs), community events to reduce isolation and increase self-care, and individual/family problem solving sessions. CHAs are trusted community members trained in identifying and responding to behavioral health concerns, including peer support and linkages to services.

PROVIDER: Marin Asian Advocacy Project

TARGET POPULATION

The target population is Vietnamese residents throughout the County. Members of the Vietnamese community experience risk factors including: trauma, poverty, racism, social inequality, prolonged isolation, and others**.**

Vietnamese CC

SUMMARY FY2017-18

Clients Served: FY2017-18

67 Individuals

13 Families

225 Outreach Participants

PROGRAM DESCRIPTION

The Vietnamese Community Connection program aims to **reduce prolonged suffering** due to unaddressed mental illness by increasing identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness. Marin Asian Advocacy Project (MAAP) provides:

- **Training and Support:** For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for CHAs to provide mental health and substance use education, identification of risk and signs, and linkages to services. The program coordinator also provides individual and family consultations to assist with problem solving and linkages to other needed services. This program increases the efficacy of existing mental health programs by reducing the barriers for accessing those services. In addition, it creates a culture shift in the target communities that reduces stigma and increases the support available within the community.
- **Reducing risk and Building Protective Factors:** CHAs and the program coordinator conduct community activities, such as field trips, walking groups, and discussion groups, to reduce

isolation, build social support, and increase self-care behaviors. The program coordinator also provides individual and family consultations to assist with problem solving and linkages to other needed services.

- **Timely Access to Services:** The program improves timely access to services for underserved populations by being provided by a trusted multi-service agency, as well as reaching hard-to-reach communities through CHAs. Services are provided at no-cost by culturally and linguistically competent providers. Services are non-stigmatizing by being co-located with other services and addressing "stress," rather than specifying mental health issues.

- **Access and linkage to Treatment:** Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program's behavioral health provider. CHAs and others front-line workers are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. PEI staff members maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- The number and types of individuals trained, types of trainings provided and demographics (see PEI overview section-page 2)
- The number and type of Outreach Activities and types of participants reached
- Client/family demographics (page 5) and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services

In current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

The VCC PEI program continued to have success in coordinating community outreach, providing problem solving services for individuals and families, and linking community members to needed services. The program has continued to build collaborations with Marin County Health and Human Services and other community-based organizations in an effort to decrease stigma around mental illness in the Vietnamese community.

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Community Health Advocates (CHAs) will receive training in: ○ CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc. ○ Mental Health First Aid	5	4 0	5	4 1
CHAs will receive at least 6 hours each of group or individual supervision	100%	100%	100%	100%
Individuals receiving information about mental health and access to services via tabling and other outreach strategies	75	120	70	67
Individuals participating in prevention activities (field trips, community building)	120	260	120	225
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	5
Total referrals to other PEI providers	N/A	N/A	N/A	-
Total referrals to resources for basic needs	N/A	N/A	N/A	100

CHALLENGES AND UPCOMING CHANGES

In **FY2017-18,** the Vietnamese Community Connection continued to focus its efforts on broadening its outreach and engagement with the Asian community and on developing collaborative partnerships with community leaders and organizations serving the Asian population in Marin. Limited transportation and access to services in Vietnamese were identified as ongoing challenges in getting members of the Vietnamese community into services or participation in MAAP activities.

In **FY2019-20**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

CLIENT STORY

A family member came to the Marin Asian Advocacy Program (MAAP) office asking for help in re-opening his 85-year-old father's Medi-Cal. His father, who had previously been diagnosed with depression and dementia, had let his Medi-Cal lapse and was no longer receiving the type of mental health and medical treatment he needed. This family member was very concerned about his father's health and unsure about how to navigate the system to get the Medi-Cal turned back on. The MAAP PEI provider walked this family member through all of the steps to get his father re-enrolled and helped him

to fill out all the necessary paperwork. He was very pleased and relieved when he got the confirmation letter from the Medi-Cal office stating that his father case was now opened.

COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING

PROGRAM ALLOCATION FY17/18: $80,000

PROGRAM OVERVIEW

In order to support MHSA PEI goals including increasing recognition of mental illness, stigma and discrimination reduction, and implementing effective practices, Marin has designated funds to implement outreach, training and education. A central component is Mental Health First Aid (MHFA). In addition, funds are used for other strategies, such as training in other evidences based practices; outreach to those who could recognize and respond to mental illness, including individuals who may have signs of mental illness and their families; sending providers, consumers, families and others to conferences related to PEI efforts; and more.

TARGET POPULATION

The target population for this program is:

- Providers, consumers, family members and other community members who may be in a position to recognize and respond to early signs of mental illness. These include school staff, front-line workers in health and human service agencies, community health advocates/promotores, family members, probation staff, security guards, librarians, and others.
- Providers, consumers, family members and other community members who are in a position to implement stigma and discrimination reduction activities. These include community leaders, peer providers, appropriate county staff, and others.
- PEI providers

PROGRAM DESCRIPTION

- Stigma and Discrimination Reduction Efforts
- Mental Health First Aid (MHFA) is an evidenced based training that:
    - increases understanding of mental health and substance use disorders;
    - increases knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse;
    - reduces negative attitudes and beliefs about people with symptoms of mental health disorders;
    - increases skills for responding to people with signs of mental illness and connecting individual to services;
    - increases knowledge of resources available.

MHFA trainings are offered throughout the community. In the past, five to seven trainings have been offered per year. Trainings include standard, youth, Spanish and Vietnamese. The type of trainings, locations, and frequency depend on the demand for the trainings.

Additional trainings on recognizing and responding to signs of mental illness, implementing PEI evidence based practices, suicide prevention, and other related topics are scheduled as needed. In addition, funds support attendance at conferences on PEI issues and outreach opportunities.

- The program improves timely access to services for underserved populations because a wide array of community members are trained in identifying signs/symptoms and responding, including skills on connecting individual to services. In some cases the appropriate referral will be to the BHRS "Access and Assessment Line," enabling the County to make appropriate assessments and referrals, and to track that process.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- The number and types of individuals trained, and demographics (see PEI overview section-page 5)

- MHFA conducts pre and post surveys to assess change in knowledge and behavior.*

*IN **FY 18-19** BHRS implemented a 3-month post survey to assess retention of knowledge and skills overtime. Data will be reported in the next annual update.

OUTCOMES

Mental Health First Aid Outcomes	**FY 16/17**	**FY 17/18**
Number of Marin County community members that participated in MHFA.	139	137
Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale) "As a result of this training, I feel more confident I can recognize the signs that someone may be dealing with a mental health problem or crisis."	4.4	4.6
Recognize and correct misconceptions about mental health and mental illness as I encounter them	N/A	4.5

Mental Health First Aid Outcomes	FY 16/17	FY 17/18
Be aware of my own feelings and views about mental health problems and disorders	N/A	4.5
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to connect with community, peer or personal supports	N/A	4.5
Participants reporting feeling able to offer a distressed person basic "first aid" information and reassurance about mental health. (0-5 scale)	4.5	4.5
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)	4.6	4.5

Settings where participants might use MHFA	Number Served 16/17	Number Served 17/18
Community Members	47	62
Family Member of Person with Serious Mental Illness	2	10
Providers		
County Behavioral Health and Recovery Services	6	6
Community-based Mental Health and/or Substance Use Provider	12	8
Education (including High School Students)	6	23
Law Enforcement	0	4
Primary Health Care	5	4
Senior Centers/Services	12	2
Social Services (County and Community)	10	3
Veterans	0	0
Faith-based	8	1
Shelters/Homeless Services/Public Housing	9	4
Libraries	1	0

Public Transit	0	0
Employment	8	2
Other – List: DV, BOS, Parks Svcs, PH	7	5
Security, Emergency Svcs	6	1
Unknown	0	2

OTHER OUTREACH AND TRAINING ACTIVIES IN FY2017-18

Participation in community outreach and education events including "Day of the Dead" in the Latino community

Photo taken by Alfred Leung 2018 Day of the Dead Festival – San Rafael, CA

May is Mental Health Month community trainings and workshops:

- "Triple P" Trainings
- "Positive Behavioral Intervention and Support" (PBIS) and trauma training for school staff
- Cultural competency trainings, including for PEI providers in gathering data regarding sexual orientation and gender identity
- BHRS Calendar featuring client artwork and information about mental health

"Unattainable Touch" by Alexa Martinez – 2019 PEI Calendar, November

CHALLENGES AND UPCOMING CHANGES

In FY2017-18, seven (7) MHFA trainings were offered, including 3 adult, 2 youth, 1 in Spanish and 1 in Vietnamese. Most trainings met or exceeded expected enrollment.

In FY2019-20, we expect this program will continue to be implemented as described. Additional trainings were offered in **FY 2018-19** including: two administrator trainings (in collaboration with MCOE) on the implementation of AB2246 (CA bill requiring schools to adopt suicide prevention policies); "Talk Saves Lives" suicide prevention training in collaboration with the American Foundation for Suicide Prevention; "Being Adept" a school-based substance use prevention training series students and parents.

In addition, in March of 2019, an RFP was released for a contracted agency to develop or expand a Speakers Bureau to raise awareness of mental health, suicide and substance use. The anticipated contract start date for the Speakers Bureau is May 1, 2019. Details, evaluation results and demographics from these trainings will be provided in the **FY 18-19 annual update.**

SCHOOL AGE PREVENTION AND EARLY INTERVENTION

PROGRAM ALLOCATION FY17/18: $198,000

PROGRAM OVERVIEW

In the community planning process for the MHSA Three-Year Plan, the need for services for school age youth was a high priority. Beginning in FY2014-15, MHSA PEI provided funding for increased services for students in school districts with a large proportion of low-income children. The purpose of these services is to:

- Identify students who are at high risk of school failure and at significantly higher risk than average of developing symptoms of an emotional disturbance
- Provide services that increase the students' protective factors and reduce the risk of developing signs of emotional disturbance

PROVIDERS: Bay Area Community Resources and Marin City Community Services District

TARGET POPULATION

The target population is kindergarten through eighth grade students (ages 5-14) who may be experiencing emotional disturbance or are at significantly higher risk due to adverse childhood experiences, severe trauma, poverty, family conflict or domestic violence, racism and social inequality or other factors. Classrooms and students may be referred for services through school staff, Coordination of Services Teams (COST), Success/Study Teams (SST), or Student Attendance Review Teams (SART) and Boards (SARB). They will then be assessed to determine whether they are appropriate for PEI services or are linked to other services. In FY 17/18, the program targeted two areas of Marin County.

Bay Area Community Resources

SUMMARY FY2017-18

Clients Served: FY2017-18

136 Individuals

7 Families

Marin City Community Services District

SUMMARY FY2017-18

Clients Served: FY2017-18

67 Individuals

21 Families

Target Schools	Latino	American Indian	Asian	African American	Multiple Races	English Learners
West Marin Schools	58%	1%	1%	-	1%	40%
Sausalito/Marin City Schools	27%	-	9%	20%	10%	21%

PROGRAM DESCRIPTION

The program aims to **reduce prolonged suffering** for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors. PEI staff provide:

- **Capacity building:** Programs provide training for parents, school staff and community providers to identify and respond to signs of mental illness.
- **Assessments:** Assessments using validated tools such as the Strengths and Difficulties Questionnaire (SDQ) are conducted when a student enters the program and at the end of each school term, or at the time of completing the program. Results for each student are analyzed to measure amount of change over time. Results for all individuals are aggregated and reported. This data, as well as student demographics, are reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.
- **Timely Access to Services:** This program improves timely access to services for underserved populations by being located in schools with high rates of underserved students/families, ensuring service providers are culturally and linguistically competent, and being offered at no-cost. Services are non-stigmatizing in that they are initiated through the school and identified as assisting with school success, rather than specifically mental health related.
- **Access and Linkage to Treatment:** Individuals/families at risk or showing signs of developing serious emotional disturbance or mental illness are linked to services as needed. These services may be provided by the PEI program, the school, community-based organizations, or other available providers. Individuals eligible for services through health coverage, including Medi-Cal, Early Periodic Diagnosis Screening and Treatment (EPDST), or private coverage are referred to those resources. Individuals experiencing symptoms of serious mental illness or emotional disturbance are referred to Marin County Behavioral Health and Recovery Services (BHRS), private health coverage or primary care. Families will be provided assistance with making an initial appointment as needed. Referrals to County BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received.

Each school district has a different service provider with a program, designed based on community needs and existing gaps. Program descriptions by school district are provided below.

Sausalito Marin City School District

Marin City Community Services District (MCCSD) has implemented a Community Connector program. Schools or community providers can refer students to the Community Connectors who then work with the student and families to determine what they need and how to access needed services, including client advocacy and care coordination. They work with the school to help develop and implement action plans with families, helping the family complete the goals of the plan. They also train community

providers in identifying and responding to mental health needs, as well as provide a "Girl Power" group to increase protective factors among 5-14 year old girls.

Shoreline School District

Bay Area Community Resources (BACR) provides an array of services: stigma reduction is addressed through education for school staff, students and families about mental health and available resources. Evidence based social emotional lessons are provided to each kindergarten through eighth grade class to build coping and resiliency skills. Individual services are provided for students and families at school and through home visits.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis:

- The number and types of individuals trained, types of trainings provided and demographics (see PEI overview section-page 5)
- Participant surveys are conducted to show changes in knowledge and skill for those receiving training.
- Client/family demographics (page 5) and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (Strengths and Difficulties Questionnaire (SDQ)) used to measure changes in child behaviors and staff and parent questionnaires to measure changes in skills and knowledge

In the current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

The PEI providers were very successful in establishing and strengthening partnerships with many organizations such as Center for Domestic Peace, Community Action Marin, Tamalpais HS, The Redwoods Senior Center and the Office of Health Disparities and other community-based organizations throughout Marin County. These partnerships helped to improve referral processes and strengthen staff and parent trainings.

Outcomes Sausalito Marin City School District/MCCSD	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Southern Marin providers and community members receiving behavioral health education, information about Community Connector (CC) services	30	30+	30	20
Students/families receiving outreach, engagement, referral services from CCs	40	40+	40	22
Students/families receiving support, advocacy and coordination services from CCs	25	26	150	157
Youth/families receiving support services from CCs achieving at least 40% of the goals in their action plan. **Case records*	60%	40% N=26	60%	40% N=17
Students participating in at least 20 Girl Power Groups	50	57	50	11
Students participating in CC support services or Girl Power Groups showing improved risk factors, increase in school attendance and/or improved school performance. **SDQ, school records*	60%	85% N=57	60%	60% N=6
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	N/A
Total referrals to other PEI providers	N/A	N/A	N/A	N/A

**Data Collection Method*

Outcomes Shoreline School District/BACR	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
School staff participating in trainings reporting awareness of risks, signs, and symptoms of children experiencing emotional disturbances and/or risk of abuse *(Post-survey)	80%	83% N=18	80%	100% N=5
Students participating in self-regulation curriculum	250	257	125	75
Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling	40	43	25	73

Students (or parents of) receiving at least 3 sessions reporting improvement on the SDQ (emotional problems, conduct problems, hyperactivity problems, peer problems and/or socialization)	65%	84% N=32	65%	81% N=22
Students completing at least 3 sessions showing improved attendance or improved school performance	65%	86% N=39	65%	84% N=26
Parents completing at least 3 sessions family counseling	20	11	10	7
Parents receiving at least 3 sessions reporting a reduction in family stress and/or children's difficulties in one or more of the following areas: emotional problems, conduct problems, hyperactivity problems, peer problems, and/or socialization	65%	75% N=8	65%	71% N=7
Parents receiving 3 or more counseling services reporting satisfaction with the PEI services (would recommend, use again, etc)	75%	90% N=8	75%	86% N=7
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	N/A
Total referrals to other PEI providers	N/A	N/A	N/A	N/A

**Data Collection Method*

N = the total number in the sample (i.e. total number who received services or completed a survey)

CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, there were several changes to the school-based PEI programs. The contract with Marin City Community Services District was discontinued and a new contract was awarded to Performing Stars to provide school-based mentoring services at Bayside MLK in Marin City, beginning in **FY2018-19.** In addition, BRHS announced two Requests for Proposals to expand school-based services in Marin County. One RFP focused on serving high risk students, especially those who have experienced trauma and/or homelessness in the San Rafael area and the other RFP focused on continuing to provide services in Shoreline School District. Two agencies were awarded the trauma-focused school-based contracts. Youth Leadership Initiative was awarded the San Rafael based contract to provide leadership groups for at risk students at two middle schools with a focus on service Newcomers and LGBTQ youth. Seneca Family of Agencies was also rewarded a contract to expand services in Marin City Bayside MLK. The Shoreline Unified contract was awarded to Coastal Health Alliance which was previously providing school-aged services at Shoreline through a sub-contract with BACR. Each of these new contracts began in **FY2018-19.**

In **FY2019-20**, school-based PEI programs are expected to continue the expanded school-based services that began in **FY2018-19.** Performing Stars will begin to implement a community health outreach model, serving as a liaison between the school and the Marin City community.

VETERAN'S PREVENTION AND EARLY INTERVENTION

PROGRAM ALLOCATION FY17-18: $63,000

PROGRAM OVERVIEW

Veterans are recognized as being at high risk for mental illness, without adequate access to necessary care. While there are efforts on a Federal level to address this need, there is much that can be done on a local level to prevent prolonged suffering, as well as a need for more intensive services. In FY2014-15, MHSA PEI began funding the Marin County Veterans' Service Office, within the Department of Health and Human Services, to provide supportive services for veterans with a mental illness through a part-time Case Manager.

PROVIDER: Marin County Health and Human Services

Veteran's Community Connection

SUMMARY FY2017-18

49 Individuals

12 Families

17 permanently housed

TARGET POPULATION

The target population is United States veterans who are homeless or involved in the criminal justice system who have a treatment plan for mental illness developed by Veterans' Affairs (VA) or who are exhibiting symptoms of mental illness. Most of the target population may be experiencing Post Traumatic Stress Disorder (PTSD), while some may experience depression or other concerns.

PROGRAM DESCRIPTION

This program does active outreach and support for Veterans, particularly those who are homeless or involved in the criminal justice system, to link them to medically necessary mental health services. Many of the Veterans are provided the support they need, such as transportation and entry into housing and Veterans Administration (VA) benefits, to access needed mental health services. Some are already connected to the VA and have a mental health treatment plan. The VA usually covers clinical treatment costs associated with the plan, but there are many barriers to a veteran completing their treatment. When they do not complete their treatment, they are at high risk for escalating mental health needs and substance use disorders, as well as recidivism. The program aims to **Reduce Prolonged Suffering** by ensuring veterans experiencing symptoms of mental illness engage in services expected to reduce their symptoms and increase their functioning. The PEI Case Manager (CM) provides:

- **Outreach and Engagement:** Clients are identified through outreach, in-reach and referrals from the VA.

- **Case Management:** The PEI Case Manager links clients to housing, behavioral health services, and more. In addition, the CM assists with logistical barriers to completing a treatment plan, provides ongoing contact to increase likelihood of engaging with services and services for significant support people, such as family. The CM also assists with obtaining other forms of

support available to the veterans and their families, such as financial benefits or community resources.

- **Timely Access to Services:** The program improves timely access to services for underserved populations by providing the support services needed to access treatment that is available and required. These support services are provided by a veteran who can meet the client where they are literally and figuratively and can help to de-stigmatize the situation.

- **Access and linkage to Treatment:** Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the PEI Case Manager, who is a licensed mental health provider. The Case Manager makes the referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. A significant number or referrals are made to the Veteran's Administration for health and mental health services.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- Client/family demographics (page 5) and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services

In the current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

Currently, there is a coordinated push to end homelessness in Marin County by 2022. A major part of this effort includes housing veterans. The PEI Case Manager and the HHS Veteran's office has been involved in every aspect of this process. From cultivating landlord relationships to assisting with furnishing apartments, the Veterans Outreach effort has played an integral role. Since this collaborative effort began in 2017, 17 veterans have been permanently housed that had been homeless and living on the streets of Marin County. The PEI Case Manager also continues to support efforts to divert veterans from the criminal justice system. Working with the courts, judges, and jail to identify veterans that need long term treatment for serious mental illness, these collaborative efforts have been successful in linking veterans to the appropriate mental health resources.

N = the total number in the sample (i.e. total number who received services or completed a survey).

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Number of veterans that received support services to increase likelihood of completing the veteran's mental health treatment plan. (Average number of services: 8)	N/A	N/A	100	212
Number of family members that received services to increase their capacity to support the client	N/A	N/A	20	20
75% of veterans receiving support achieved at least one goal towards stability and recovery	N/A	N/A	75%	80% N=171
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	-
Total referrals to other PEI providers	N/A	N/A	N/A	-
Total referrals for support for basic needs	N/A	N/A	N/A	141

CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, the Veteran's program was implemented as expected. A staff person was hired in September 2017 to fill the vacant PEI position.

In **FY2018-19**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 and slightly expanded with a $10,000 allocation increase for each of FY2018-19 and FY2019-20 from the PEI operational reserve.

CLIENT STORY

"Robert" was a 65-year-old veteran who had been living on the streets of Marin County for 22 years. He was a frequent visitor to the E.R. at Marin General Hospital as well as the Marin County Jail. He had been using opiates and methamphetamine for "as long as he could remember." He was diagnosed with a heart condition by his care team at the hospital. He indicated in October 2018 that he did not want to spend another Winter on the streets and would 'prefer to die with a roof' over him. The PEI Case Manager worked with HUD-VASH and the Marin County Housing Authority to get him housed and the appropriate medical and mental health treatment. He was placed in a one-bedroom unit in Novato and has since reported to the PEI Case Manager that he is 'very happy and doing well.' His new housing case manager confirms that he has made significant improvement and is doing well.

STATEWIDE PREVENTION AND EARLY INTERVENTION

PROGRAM ALLOCATION FY17/18: $80,986

PROGRAM OVERVIEW

In FY2017-18, Marin County contributed PEI funds to support the California Mental Health Services Authority (CalMHSA) to conduct statewide efforts to reduce suicide and reduce stigma and discrimination. CalMHSA, a joint powers authority, represents county behavioral health agencies working to improve mental health outcomes for the state's individuals, families, and communities. On behalf of counties, CalMHSA has implemented statewide prevention and early intervention programs since 2011 to reduce negative outcomes for people experiencing mental illness and prevent mental illness from becoming severe and disabling. The Statewide PEI Project accomplishes population-based public health strategies to reach its goals of mental health promotion and mental illness prevention.

These strategies include:

- Statewide social marketing educational campaigns including the *Each Mind Matters* stigma reduction campaigns and the *Know the Signs* suicide prevention campaign with an emphasis in reaching diverse communities throughout California
- Community engagement programs including the *Walk In Our Shoes* stigma reduction programs for middle school students, and the *Directing Change* stigma reduction and suicide prevention program for high schools and higher education
- Technical assistance for counties and community-based organizations to integrate statewide social marketing campaigns into local programs, and to provide support to counties in addressing county-specific stigma reduction and suicide prevention concerns
- Networks and collaborations such as community-based mini grants to support dissemination of educational outreach materials

PROVIDER: CalMHSA

TARGET POPULATION

CalMHSA targets all California residents.

OUTCOMES

The full CalMHSA report for Marin County is in Appendix 5. The RAND Corporation, a nonprofit institution that helps improve policy and decision making through research and analysis, is evaluating the impact of the Statewide PEI Project. The most recent evaluation report highlights positive findings, including:

- Social Marketing Campaigns Were Associated with Reduced Mental Illness Stigma and Increased Confidence to Intervene
- Trainings Increased Knowledge and Improved Attitudes Toward Mental Illness
- PEI Programs Had a Positive Return on Investment

- Evaluation Findings Enhanced Understanding of California's Mental Health PEI Needs and Priorities for Ongoing Intervention

The full report, "On the road to Mental Health: Highlights from Evaluations of California's Statewide Mental Health Prevention and Early Intervention Initiatives," is available at www.rand.org/pubs/research_briefs/RB9917.html.

CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, this PEI program was implemented as expected. CalMHSA materials were distributed at over 20 events/trainings and disseminated to schools, providers and community members.

In **FY2019-20**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

SUICIDE PREVENTION

PROGRAM ALLOCATION FY17-18: $150,000

PROGRAM OVERVIEW

Buckelew

SUMMARY FY2017-18

6733 Hotline Calls

Suicide Prevention efforts have been addressed within the Statewide Prevention and Early Intervention Program (PEI-21) through CalMHSA since the inception of PEI. For Marin this included a public campaign, printed materials and support for the Suicide Prevention Hotline provided by Buckelew Programs/Family Service Agency. In FY2015-16, CalMHSA reduced its scope, resulting in the end of funding for suicide prevention hotlines. Most of the counties supporting the local Suicide Prevention Hotline continued to fund it directly. Due to this, Suicide Prevention is now an independent program.

Buckelew's North Bay Suicide Prevention Program provides a Suicide Prevention Hotline for Marin, Sonoma, Mendocino and Lake Counties. The hotline is answered 24/7 by a team of staff and volunteers trained to assist those in crisis. This may mean speaking with the person or somebody who is supporting them. Services are available in a wide range of languages through a phone interpreter service.

PROVIDER: Buckelew Programs

TARGET POPULATION

The program aims to serve callers with suicidal ideation or experiencing a crisis that might escalate to self-harm. In FY2017-18, unduplicated callers were 0-15 (2%), 16-24 (17%), 25-59 (40%), 60-74 (4%), and 75+ (1%).

PROGRAM DESCRIPTION

The North Bay Suicide Prevention Program provides 24/7 suicide prevention and crisis telephone counseling to Marin County residents through a regional hotline. Highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends. Counselors help to enhance the callers' coping and problem-solving skills, providing alternatives to harm toward themselves or others and relief from the profound isolation of crisis, loss, and/or chronic mental illness. It serves as a vital link to mental health resources and referrals throughout Marin County. The program aims to **Reduce Prolonged Suffering** by providing:

- **Training and Outreach:** This program provides training and outreach to schools, first responders, community mental health agencies and universities on recognizing and responding to warning signs of suicide.

- **Timely Access to Services:** The hotline serves underserved populations by providing free and

accessible help 24/7 which allows access for people of all ages and socioeconomic status. It is accessible by anyone who has access to a telephone including those who may have limited access to services due to geographic location or mobility issues. The translation services used by the program offer translation for over 200 languages allowing individuals whose primary language is not English to access the hotline. In addition, the Hotline has an ongoing contract with the National Suicide Prevention Lifeline to answer calls from Veterans who prefer not to call the Veteran's Lifeline or other Veteran resources due to stigma around mental health issues.

- **Access and linkage to Treatment:** The Hotline collaborates with Marin County's Crisis Stabilization Unit (CSU) and refers individuals needing face-to-face crisis evaluation and intervention to County Behavioral Health and Recovery Services (BHRS) crisis services. Likewise, CSU staff frequently refer people to the Hotline in order to help prevent a crisis from escalating and to keep them safe and at a lower level of care. In addition, the Hotline maintains ongoing collaboration with Marin County law enforcement, who are a primary resource used by phone counselors in managing suicidal emergency calls, and Federally Qualified Health Clinics (Marin Community Clinics, Ritter Center, Coastal Health Alliance and Marin City Health and Wellness Center), primary health clinics serving low and moderate income residents, who distribute Hotline resource materials. Callers are routinely referred to BHRS Access Line for appropriate assessment and referral. PEI staff maintains relationships with referral sites and participates in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

DATA COLLECTION METHODS

The following data is reported to BHRS annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

- The number and types of individuals trained, types of trainings provided and demographics (see PEI overview section-page 5).
- Participant surveys are conducted to show changes in knowledge and skill for those receiving training.
- The number of callers and caller demographics (see PEI overview section-page 5). In FY 17/18 demographics were collected for 1003 callers (15% of callers).
- Referral data to show improved recovery through access and linkage to services.

In the current FY 18/19, Marin County BHRS have been asked to administer a ten-question client survey that looks at satisfaction with services and changes based on various indicators. These results will be reported in the FY 18/19 annual update. In addition, BHRS will collect mid-year data from providers in addition to their annual reports beginning in FY 19/20.

OUTCOMES

Over 6700 callers were served in FY 17-18, and 20 members of the community attended hotline training. Bucklew was re-accredited for three years with the national Lifeline, enabling it to receive local community calls forwarded from the national number and increase community visibility as a member of the national crisis center network. The Hotline is accredited by the American Association of Suicidology (www.suicidology.org). In addition, as a member of the Bay Area Suicide and Crisis Intervention Alliance (BASCIA), the Hotline collaborates with other members to discuss best practices and other issues relevant to managing a crisis call center. Buckelew programs has increased its collaborations with Marin County BHRS, local mental health advocacy organizations such as NAMI Marin and with educational institutions like Dominican University.

- 97% of callers surveyed reported lower suicidal intent by the end of the call.
- 164 community members were trained on Suicide Prevention
- 100% of training participants surveyed reported that the community education training on suicide prevention was good to excellent.

N = the total number in the sample (i.e. total number who received services or completed a survey).

Outcomes	Goal FY16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18
Calls to hotline originating in Marin County	6-8000	6,000+	6-8000	6,733
Callers who express a reduction in level of suicidal risk by 1 level or maintain Low (Low, Medium, High)	80%	80%	80%	97% N=904
Agencies receiving suicide prevention campaign materials	20	20	20	21

CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, the Suicide Prevention program was implemented as expected overall. As the hotline is staffed 24/7, maintaining a full roster of trained volunteers requires constant marketing of the program to the community. With low staff- time resources, marketing and promoting the community classes remained a challenge. The program just hired a Community Outreach Coordinator and are hiring two more Hotline Staff positions in hopes that these new positions aid in alleviating some of this challenge and continue to increase collaborations with community partners.

In **FY2019-20**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. In **FY2018-19**, in addition to providing the 24/7 hotline, Buckelew has significantly ramped up its outreach efforts and trainings with the hiring of a new Outreach Coordinator.

In addition, BHRS offered additional suicide prevention trainings including: two administrator trainings (in collaboration with MCOE) on the implementation of AB2246 (CA bill requiring schools to adopt suicide prevention policies) and "Talk Saves Lives" suicide prevention training, in collaboration with the American Foundation for Suicide Prevention. Details, evaluation results and demographics from these trainings will be provided in the **FY 18-19 annual update.** BHRS also began a Suicide Prevention Strategic Planning process to determine gaps in existing suicide prevention services and the highest priorities for the PEI funds. Community engagement efforts around the suicide prevention strategic planning included a presentation with Marin General Hospital, radio interview with KMFR for West Marin, press releases, ongoing updates with the MHSA advisory committee and an upcoming all community planning event to take place in May, 2019. The priorities that are identified through the strategic planning process will be implemented in **FY2019-20** and outlined in the next annual update.

CLIENT STORY

13-year-old John called the hotline saying he had been bullied at the "special" school and felt like using his brother's gun. The Buckelew counselor's immediate focus was John's safety. After listening to John's current concerns with empathy and non-judgmental concern, the counselor asked John if he had thoughts of suicide, whether he had a plan, about prior attempts and asked about access to his brother's gun.

The counselor praised John's willingness to call and talk and emphasized how important it was to ask for help before problems pile up and feel overwhelming. John agreed to share his self-injury and concerns about bullying with his new therapist and his mother. The counselor then spoke to his mother about the importance of checking in with John about any new thoughts of suicide and making sure the house was safe with no guns and no accessible medications.

John said he felt much better and calmer and appreciated the praise from the hotline counselor for being pro-active asking for help.

HEALTH NAVIGATOR

PROGRAM OVERVIEW

During the community planning process for this Plan, there was a concern that clients who are referred from PEI programs to BHRS have difficulty enrolling in services, especially Spanish speaking and uninsured clients. While the BHRS Access Line has increased its accessibility by hiring bi-lingual staff, holding drop-in hours for assessments, and collaborating with referring agencies, there are still individuals and families who have barriers that Access cannot address.

A Health Navigator would be a licensed mental health practitioner hired by BHRS to bridge the gap between community-based services and BHRS services. They would provide active outreach and support to clients, and their families as appropriate, who are likely eligible for BHRS services, but who are not accessing the services. This includes community outreach, individual outreach, assessments, and system navigation until the client is successfully being served by BHRS.

PROVIDER: County

TARGET POPULATION

The target population is individuals experiencing serious mental illness or emotional disturbance who are identified by PEI and other community programs as appropriate for referral to BHRS for services.

Numbers to be served in FY2017-18	Individuals					Family Members
	0-15	16-25	26-59	60+	Total	
Access and Linkage		15	25	10	**50**	**15**

Individuals: Individual identified for services.

Family Members: Family members or caregivers of the individuals who participate in services.

PROGRAM DESCRIPTION

- Access and Linkage to Treatment for those with Serious Mental Illness

During the community planning process for the Three Year Plan, there was a concern that clients who are referred from PEI programs to BHRS have difficulty enrolling in services, especially Spanish speaking and uninsured clients. While the BHRS Access Line has increased its accessibility by hiring bi-lingual staff, holding drop-in hours for assessments, and collaborating with referring agencies, there are still individuals and families who have barriers that Access cannot address. For example, clients from underserved populations are unlikely to access a service when they have not met the providers. In response to this, one BHRS staff person who works extensively with the Spanish speaking community keeps pictures of the bi-lingual Access staff on her phone so she can show them to clients when she refers them to Access. In addition, it is easy for clients to not follow-through the multiple steps required, including phone assessment, in person assessment, and initial appointments.

A Health Navigator would be a licensed mental health practitioner hired by BHRS to bridge the gap between community-based services and BHRS services, as well as provide field-based services for other hard to reach populations. For example, they would participate in community events so they become a known and trusted provider. One PEI provider works within a school district and has been encouraging a few students and their families to access BHRS services. Having a Health Navigator provide presentations in the classroom or attend an event where the parents are present would help the families be open to making an appointment with the Health Navigator for an assessment.

Once a client contacts BHRS the Health Navigator can help ensure that they follow-through on assessment and initial treatment appointments. This may require contacting them if they miss an appointment, helping them obtain transportation, and other tasks required. The Health Navigator can also help problem-solve when there are barriers within BHRS to serving a client, such as mis-communication, confusing protocols, and other challenges that discourage clients.

This program does active outreach and support to clients, and their families as appropriate, who are likely eligible for BHRS services, but who are not accessing the services. This includes community outreach, individual outreach, assessments, and system navigation until the client is successfully being served by BHRS.

The program will improve timely access to services for underserved populations by providing the support services needed to access treatment that is available. It will reduce stigma by developing relationships with hard-to-reach communities and providing initial services in community settings.

EXPECTED OUTCOMES

The Health Navigator Program is intended to achieve the following outcomes:

- Reduce Prolonged Suffering by ensuring individuals experiencing serious mental illness or emotional disturbance engage in medically necessary services.

The Health Navigator will maintain records on outreach activities, individuals/families engaged, rates of success, time from referral to access of services, duration of untreated mental illness, and barriers to access.

This data, and client demographics, are reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

ACTUAL OUTCOMES

This position went back to the Board of Supervisors and was successfully reclassified as a Bilingual (Spanish) position however it was not filled in FY17/18 due to the long hiring process. This is one of the key reasons there is a new WET Human Resources position designed for FY19/20 (see WET section for more details). No outcome data available as no clients were seen in FY17/18.

PREVENTION AND EARLY INTERVENTION COMPONENT BUDGET

Program	FY2017-18	FY2018-19	FY2019-20	Total
PEI-01 Early Childhood Mental Health Consultation (ECMH)	$230,000	$230,000	$230,000	$690,000
PEI-04 Transition Age Youth (TAY) PEI	$193,000	$202,000	$202,000	$597,000
PEI-05 Latino Community Connection	$313,000	$347,291	$347,290	$1,007,581
PEI-07 Older Adult Prevention and Early Intervention	$156,000	$156,000	$156,000	$468,000
PEI-11 Vietnamese Community Connection	$56,000	$56,000	$56,000	$168,000
PEI-12 Community and Provider PEI Training	$80,000	$80,000	$80,000	$240,000
PEI-18 School Age Prevention and Early Intervention Programs	$198,000	$426,000	$426,000	$1,050,000
PEI-19 Veteran's Community Connection	$63,000	$73,000	$73,000	$209,000
PEI-20 Statewide Prevention and Early Intervention	$80,986	$80,986	$80,986	$242,958
PEI-21 Suicide Prevention	$150,000	$150,000	$150,000	$450,000
PEI-22 Health Navigator	$138,074	$138,074	$138,074	$414,222
Subtotal Direct Services	**$1,658,060**	**$1,939,351**	**$1,939,350**	**$5,536,761**
PEI Coordinator	$74,000	$74,000	$74,000	$222,000
Evidence Based Practice (EBP) Lead Staff	$52,374	$52,374	$52,374	$157,122
Administration and Indirect	$344,400	$344,400	$344,400	$1,033,200
Operating Reserve	$19,166	$166	$166	$19,498
Total	**$2,148,000**	**$2,410,291**	**$2,410,290**	**$6,968,581**

PREVENTION AND EARLY INTERVENTION (PEI) NUMBERS TO BE SERVED (FY19/20 PROJECTIONS)

Program	Type of Service	Individuals						Family Members	Providers	FY19/20 Cost per Person Projected
		0-15	16-25	26-59	60-74	75+	Total			
Early Childhood Mental Health	Prevention	500					**500**	**70**	**150**	**$460**
Transition Age Youth	Early Intervention	200	500				**700**	**90**		**$275**
Latino Community Connection	Outreach/Radio	50	150	600	150	**50**	**1,000**			**$28**
	Outreach		200	700	100		**1,000**			**$296**
Older Adult PEI	Early Intervention				40	10	**50**	**30**	**40**	**$3,120**
Vietnamese Community Connection	Outreach		10	125	75	15	**225**	**15**	**50**	**$248**
PEI Training	Stigma Reduction						**500**		**200**	**$114**
School Age PEI	Prevention	200					**200**	**30**	**20**	**$990**
Veterans Community Connection	Access and Linkage			80	30	10	**120**	**20**		**$525**
PEI Statewide	CalMHSA									**NA**
Suicide Prevention Hotline	Suicide Prevention						**6700 calls**			**$18**
Health Navigator	Access and Linkage		15	25	10		**50**	15		**$2,761**

PEI SECTIONS INSERTED HERE

Innovation (INN)

OVERVIEW

The Mental Health Services Oversight and Accountability Commission (MHSOAC) defines innovative programs as novel, creative, or ingenious mental health approaches. An Innovative Program is one that contributes to learning in one or more of the following ways:

- Introduces new, never-been-done-before, mental health practices or approaches,
- Makes a change to an existing mental health system practice or approach including adaptation for a new setting, or
- Introduces a new application to the mental health system of a promising community-driven practice or approach that has been successful in a non-mental health setting.

In FY17/18 Marin had one approved Innovation Project (*Growing Roots: The Young Adult Services Project*). There was one prior Innovation Project (*Client Choice and Hospital Prevention*), but this project had wrapped up prior to the FY17/18 fiscal year. That project resulted in the development of Casa René, which is now thriving in the Crisis Continuum of Care funded through CSS.

During the FY17/18 year the planning was underway for Marin's third project, which would be focused on older adults. This will be reported on in the next Annual Update as this project was approved by the MHSOAC in September of 2018 (during FY18/19) for a total project budget of $1,580,000 ending in FY20/21. The forward-looking budget section of this does reflect the budgets for both projects during the current three year cycle.

GROWING ROOTS: THE YOUNG ADULT SERVICES PROJECT

PROGRAM OVERVIEW

Marin's second Innovation Plan was approved by the MHSOAC on April 28, 2016. The Plan focuses on reducing disparities by working closely with the Transition Age Youth (TAY) from un/underserved populations who are at risk for or experiencing a mental illness and "informal" providers—such as grassroots, faith, and peer led organizations—who successfully engage them. By engaging the expertise of TAY themselves in conducting a needs assessment, developing an action plan, and implementing new or expanded services and strategies, this Innovation project aims to:

> ***reduce disparities in access to culturally competent behavioral health services for Transition Age Youth (TAY)*** *from un/underserved populations (i.e.: race, ethnicity, language, sexual orientation, gender identity, geographic isolation, experiencing complex conditions) who are at risk for or experiencing a mental illness* ***by building on the strengths of the informal system of care****.*

TARGET POPULATION

This Innovation Plan focuses on TAY (16-25 years old) from un/underserved populations (i.e.: race, ethnicity, language, sexual orientation, gender identity, geographic isolation) who are at risk for or experiencing a mental illness. In Marin, the specific populations identified as underserved by the County mental health services include: Latinos (18+), Asian Pacific Islanders, African Americans, persons living in West Marin, and Spanish and Vietnamese speaking persons. Additionally, this Plan targets LGBTQ+ TAY and TAY experiencing complex conditions.

TAY were identified as an underserved population that continues to be hard to reach. TAY who are at-risk for or experiencing mental illness are less likely to engage in formal mental health services than other age groups. At the same time, an individual's initial episode of severe mental illness usually occurs in the late teens or early twenties, suicide is the third leading cause of death for youth ages 15-24, and youth ages 15 to 21 have the highest prevalence of co-occurring substance use and mental disorders. Youth with unaddressed mental health problems are highly likely to drop out of school, go to jail as adults, and suffer other negative outcomes.

PROGRAM DESCRIPTION

The core challenge identified in Marin during the development of the MHSA Three-Year Program and Expenditure Plan for FY14/15 through FY16/17, was how to reduce disparities for un/underserved populations in the behavioral health system. Efforts to reduce disparities can address increasing access to services for those who are underserved, as well as improving quality of services to reduce disparities in outcomes.

During Innovation-focused community meetings in late 2014 and early 2015, the role of the informal system of care was identified as a key to addressing existing disparities. Informal providers—such as grassroots, faith and peer led organizations—provide a number of behavioral health, mental health, and substance use services for those at risk for or experiencing mental illness who may not be engaged with

the formal system of care. Services include outreach, engagement, prevention, intervention, as well as strengthening resiliency, recovery and community integration.

Photo: Members of the TAY Advisory Committee during the Needs Assessment Analysis

PLAN COMPONENTS

The Growing Roots Innovation Plan was designed around two key elements and three phases.

Key Elements:

TAY Advisory Council

- Develop a TAY Advisory Council to participate in the implementation of the INN Plan.
- Include TAY in the needs assessment and evaluation to ensure the Action Plan and evaluation of the Plan are based on their needs.
- Provide opportunities and support for TAY to participate in stakeholder processes.

Joint Learning Process

- Engaged County and community providers in a joint learning process to strengthen the system of care.

- This project recognizes that all partners bring something valuable to the table. For example, informal providers are successful in providing prevention and recovery services that are engaging for underserved communities; more established organizations generally have more capacity for providing clinical services, securing funding and conducting evaluations; and TAY and their families are essential to developing client centered services and systems.

Project Phases:

Phase 1 Needs Assessment

- Gathered existing data including from the census, homeless survey, agencies serving TAY and literature.
- Released a Request for Proposals (RFP) to identify providers serving TAY from underserved populations to participate in and assist in conducting focus groups and surveys with TAY and their families. The aim is to understand their perspective on effective access to services, challenges, and other factors that will assist with understanding what an improved system of care would look like.
- The Needs Assessment broke down needs based on age and other demographics.

Phase 2 Action Plan

- Based on the Needs Assessment, developed an Action Plan for making changes to the system of care.
- Released a Request for Proposals (RFP) to identify providers to implement changes to their services and systems as prioritized in the Action Plan.
- Participating agencies implemented changes that include changes to policies and procedures; locations or modes of services; types or quantity of services available; coordination of services; and evaluation of services, among others.
- Implemented trainings, technical assistance, and evaluation as needed.

Phase 3 Evaluation

- The evaluator and the TAY Advisory Committee will develop and implement a complete evaluation plan based on this INN Plan and the Needs Assessment

EXPECTED OUTCOMES

The Innovation Plan aims to reduce disparities in access to culturally competent behavioral health services for TAY from un/underserved populations (i.e.: race, ethnicity, language, sexual orientation, gender identity, geographic isolation, experiencing complex conditions) who are at risk for or experiencing a mental illness by building on the strengths of the informal system of care. By learning from and integrating the expertise of TAY themselves and providers who reflect TAY in terms of culture, language and lived experience, we hope to:

- Increase our understanding of the behavioral health needs of un/underserved TAY in Marin;
- Increase access to, quality of, range of, and cultural competency of services available to TAY;

- Increase the number of TAY receiving services and achieving positive behavioral health outcomes.

What we learn about increasing access and providing effective services will be incorporated into BHRS' practices and policies going forward. This may mean changes to BHRS policies, services, and/or funding priorities. To review the complete Innovation Plan go to www.marinhhs.org/innovation.

ACTUAL OUTCOMES

The Innovation Plan has been implemented as expected, although with a slight delay mainly due to ensuring that the TAY Advisory Council was meaningfully engaged in the needs assessment process.

- FY16/17: TAY Advisory Council and selected providers conducted a needs assessment.
- Summer 2017: The TAY Advisory Council presented their work and findings to formal and informal TAY providers and other stakeholders. The complete needs assessment report was released. It can be found at the following URL: https://www.marinhhs.org/sites/default/files/files/servicepages/2017_07/marin-bhrs_growing-roots_needs-assessment-_20170725_st7_revised_stc_1.pdf
- Fall 2017: A Request for Proposals (RFP) was released for projects that could fill the gaps identified in the needs assessment. The TAY Advisory Council selected 10 projects to fund, almost all which were informal/grassroots projects.

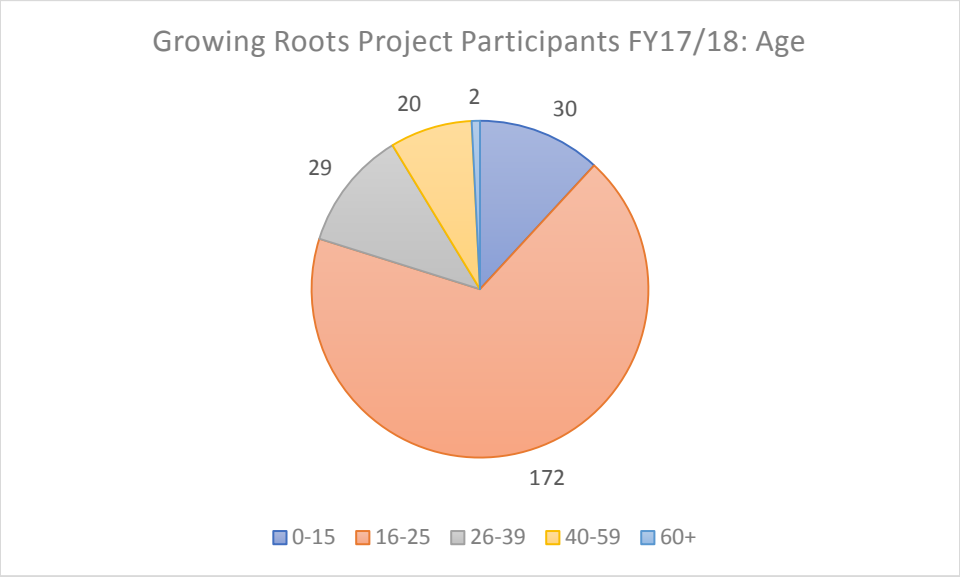
Integrated Community Services	Target Population: Individuals with diagnosed disability Services: Employment services, social groups, independent living skills, mental health and substance services. Some of the services are provided by peers
Young Moms Marin	Target Population: Young mothers, their children and partners Services: Support group, individual case management, linkages to resources, and life skills
The Spahr Center	Target Population: LGBTQ+ community Services: Support groups, especially in high schools; social connection activities; leadership opportunities
Marin Asian Advocacy Project	Target Population: Asian immigrants, children of immigrants Services: Mindfulness and psycho-education workshops and retreats
Opening The World	Target Population: Individuals who have experienced significant life challenges, such as homelessness, incarceration, and abuse Services: Developing and achieving life goals; mental health and substance use counseling; academic/employment skills workshops; community service events; and opportunities to domestically and internationally

Multicultural Center of Marin (formerly Canal Welcome Center)	Target Population: Latinx, Spanish speaking Services: Cultural healing circles; peer leadership Internships; college/career/life skills; peer support for TAY without parent support; TAY Radio Marin
San Geronimo Valley **Community Center**	Target Population: West Marin residents Services: Local needs assessment; monthly activities; TAY led community engagement projects
Surviving The Odds Project	Target Population: High risk young adults Services: Music/video production workshops with a psycho-education component
WISE Choices for Girls	Target Population: Young women in Southern Marin Services: Education, support, life skills, peer support meetings and retreats, educational and cultural field trips, and crisis support
Marin City Fatherhood Council	Target Population: Young men in Southern Marin Services: Rites of Passage program that includes weekly gatherings, mentoring, and educational and cultural field trips

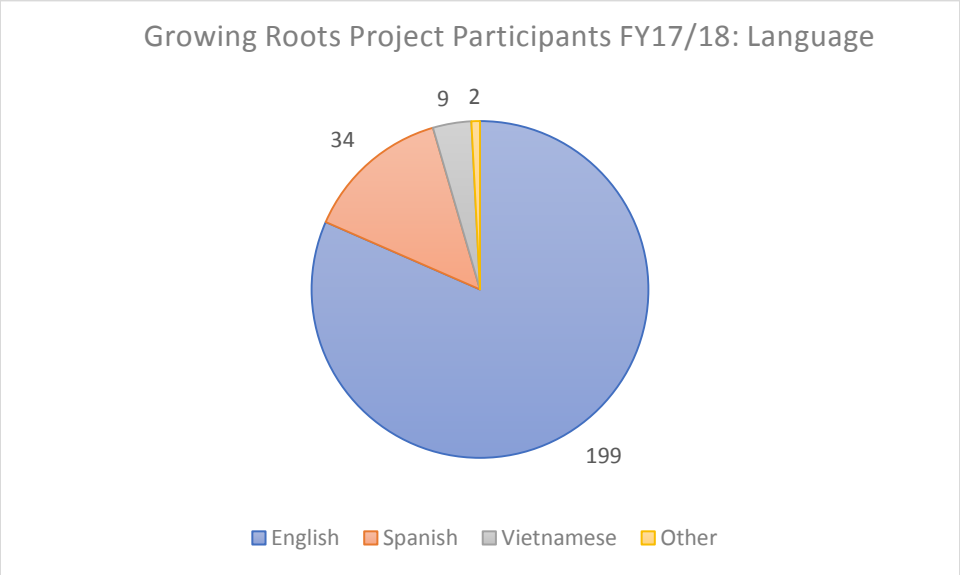
* A more complete description of the projects is provided in Appendix 5.

- November 2017: Contracts with the 10 providers began. Activities include:
  - Providing services to TAY
  - Training and technical assistance to the providers in mental health/substance use, capacity building, and evaluation
  - Learning Collaborative Meetings to integrate informal and formal systems of care
- Ongoing:
  - Contracts with 10 providers
  - TAY Advisory Council oversight of the INN project
  - Data gathering

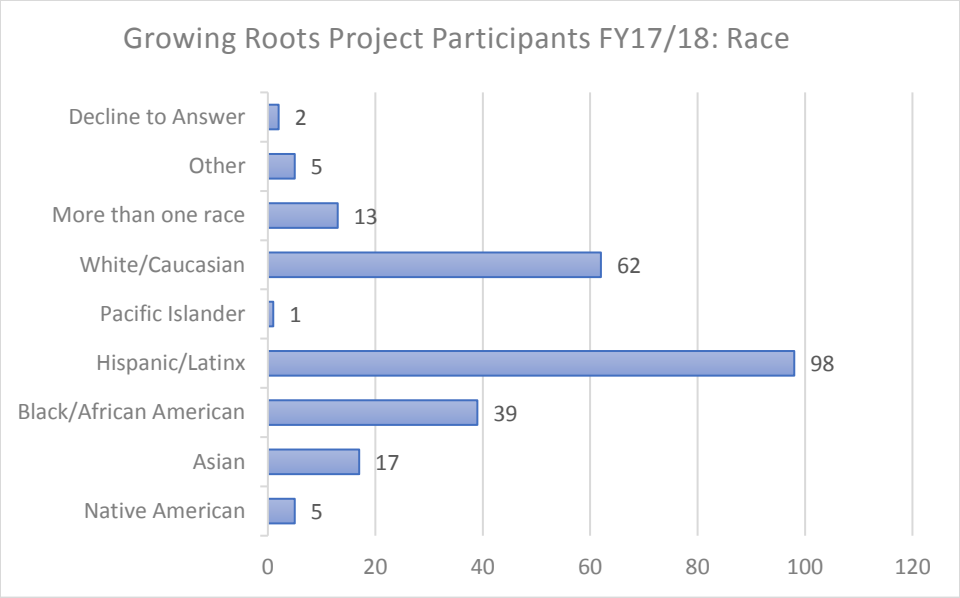
DEMOGRAPHIC INFORMATION



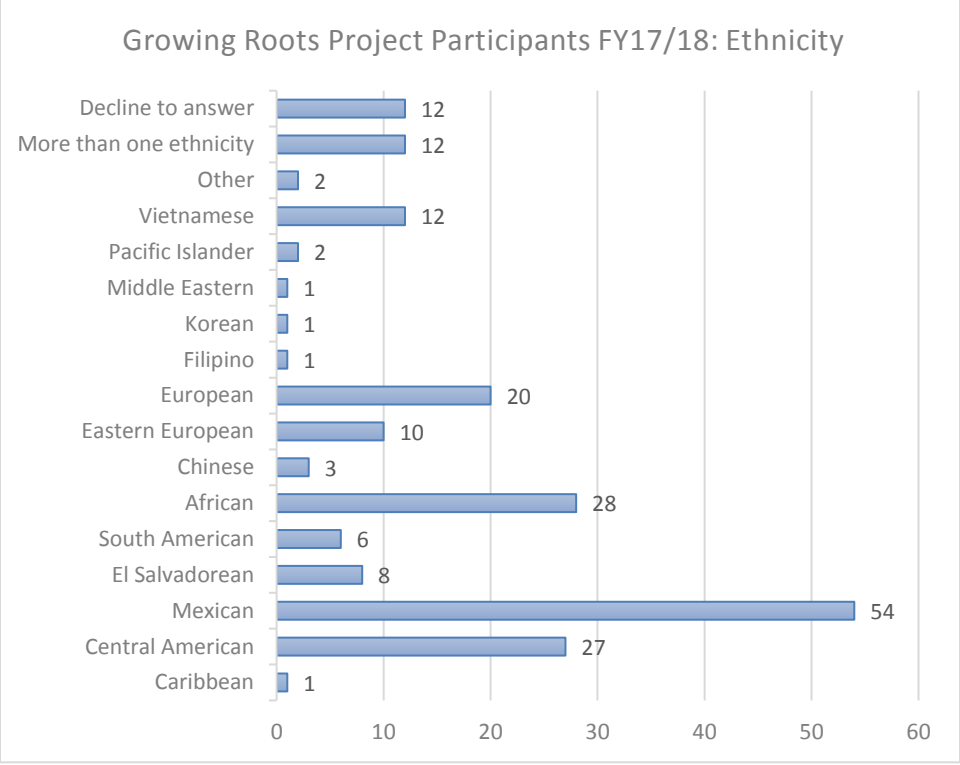
N=253; Many programs served youth/young adults slightly younger or older than 16-25 and a few served parents/caregivers of TAY.



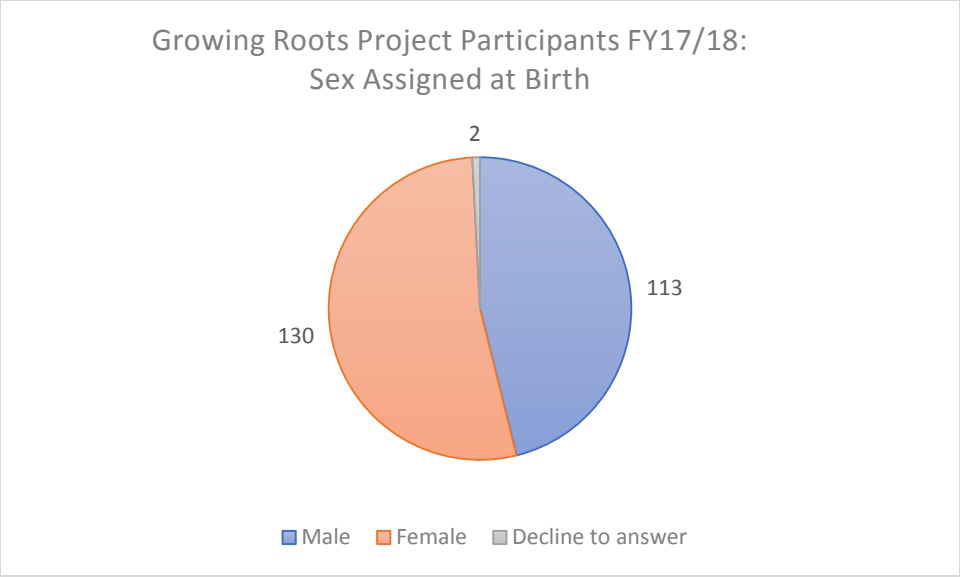
N=244; 82% of participants were primarily English Speakers, 14% primarily Spanish-speaking, 4% Vietnamese speaking, and 1% other.



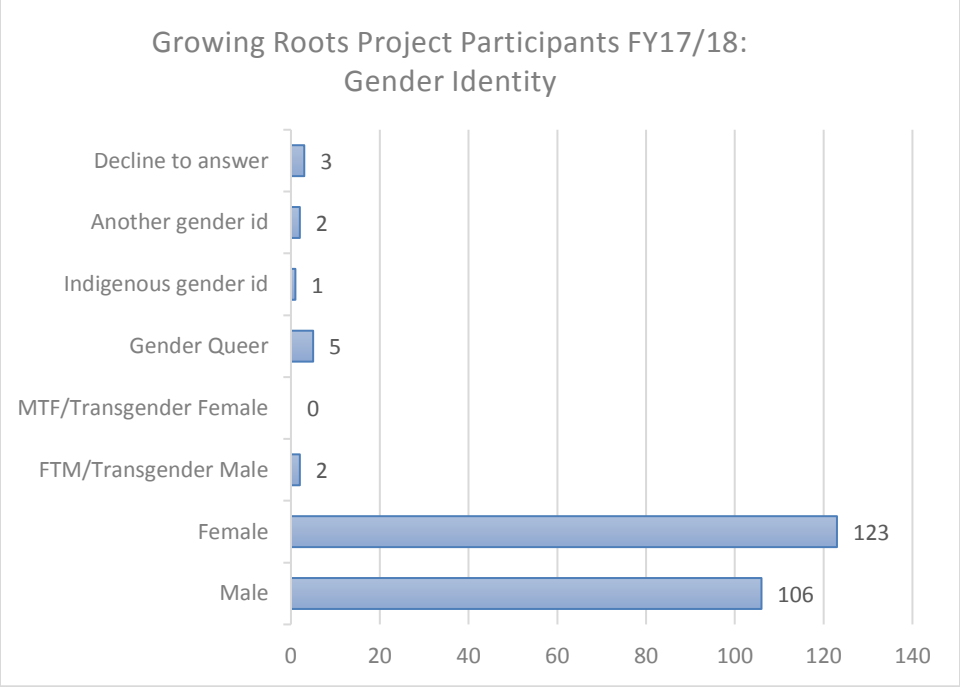
N=242; 40% of clients served were Latinx, 26% White/Caucasian, 16% Black/African-American, and 7% Asian.



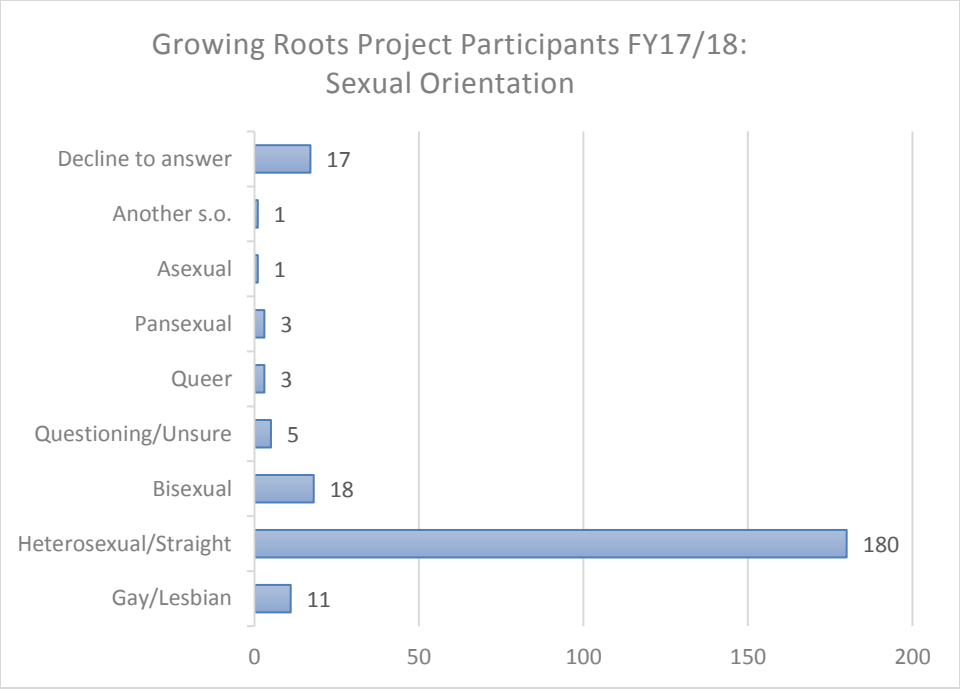
N=200; 27% were of Mexican heritage, 14% African, 13.5% Central American, ad 10% European.



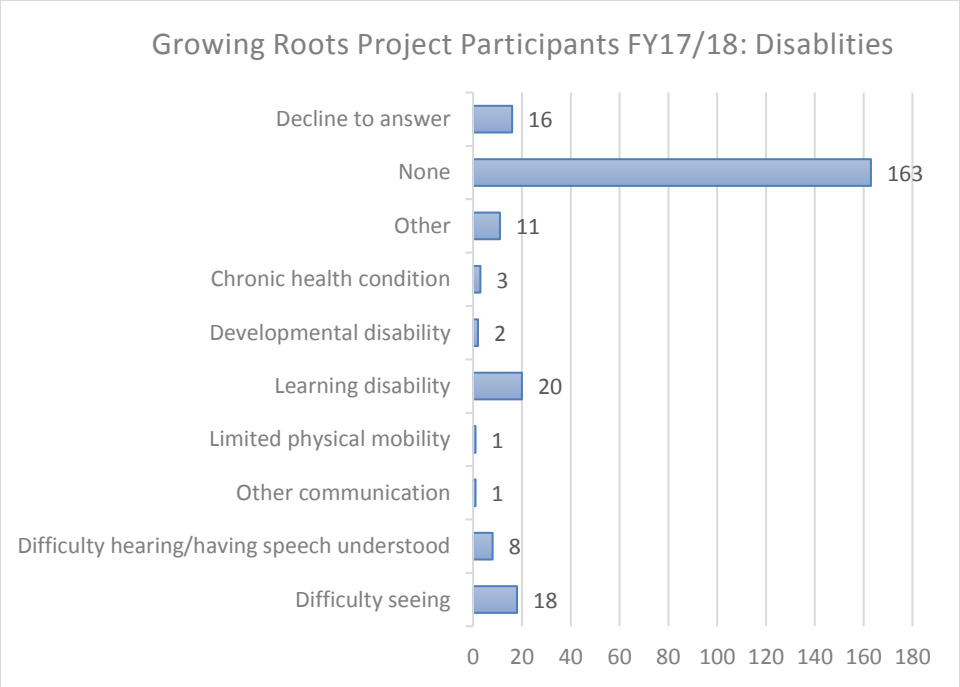
N=253; 53% of participants were assigned female on their original birth certificates, 46% assigned male, and 1% declined to answer this question



N=242; Six of the participants who were assigned male at birth had different gender identities now as well as 7 of the participants who were assigned female at birth. Of those, 5 are Gender Queer, 2 are Female to Male Transgender Males, 1 identifies with an indigenous gender identity, 2 identify as another gender identity, and 1 declined to answer.

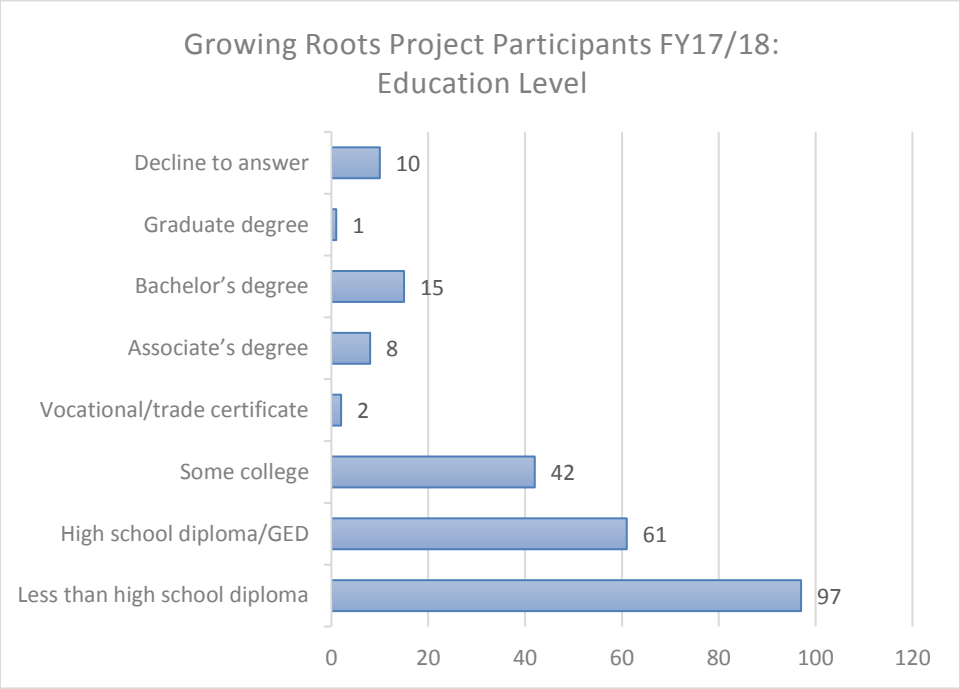


N=239; 76% of the participants identify as heterosexual, 7.5% (18 people) as bi-sexual, 4.5% (11) as gay/lesbian, 2% (5) questioning or unsure, 1% (3) queer, 1% (3) pansexual, .5% (1) asexual, .5% (1) another sexual orientation, and 7% (17) declined to answer.

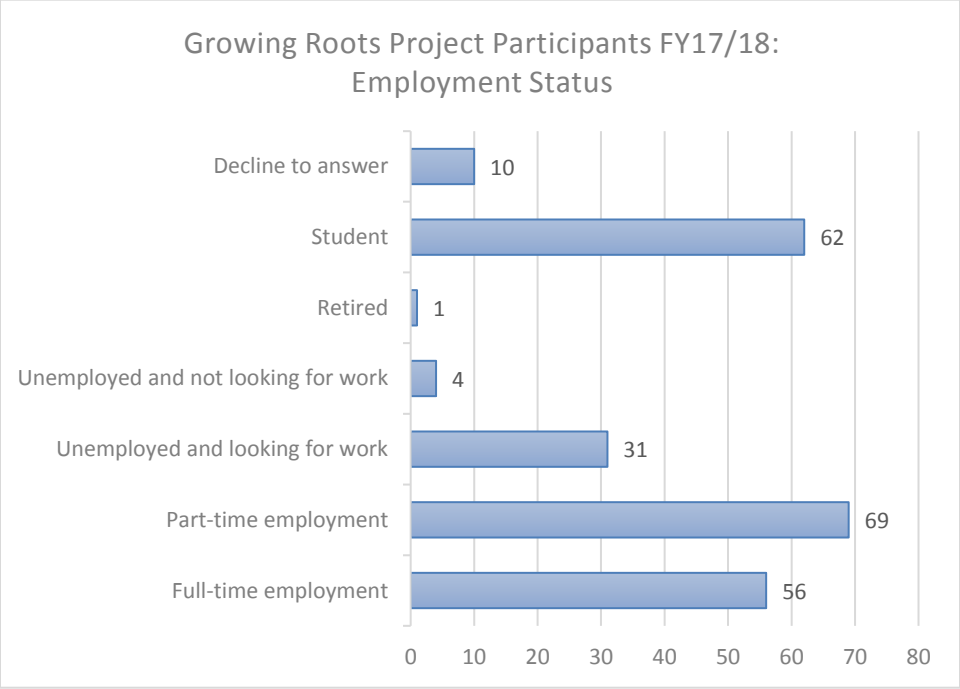


N=243; A disability for this data collection as defined by the State is "a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness." 67% of participants reported no disabilities

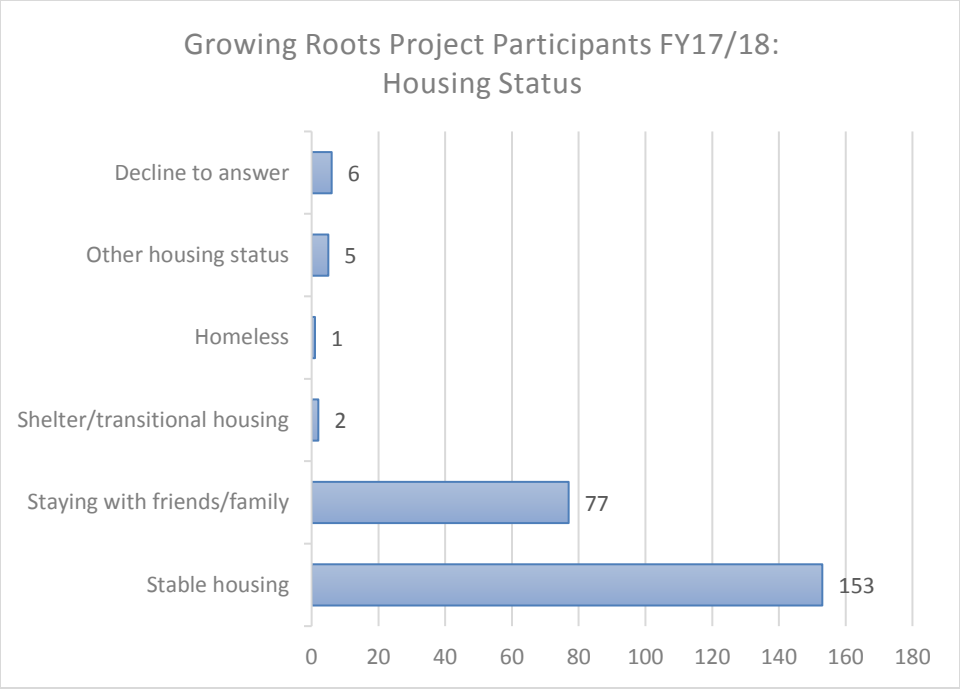
that met this criteria. 8% (20 people) reported a learning disability, 7% (18) reported difficulty seeing, 4.5% (11) reported other disabilities, and 3% (8) reported difficulty hearing or having speech understood.



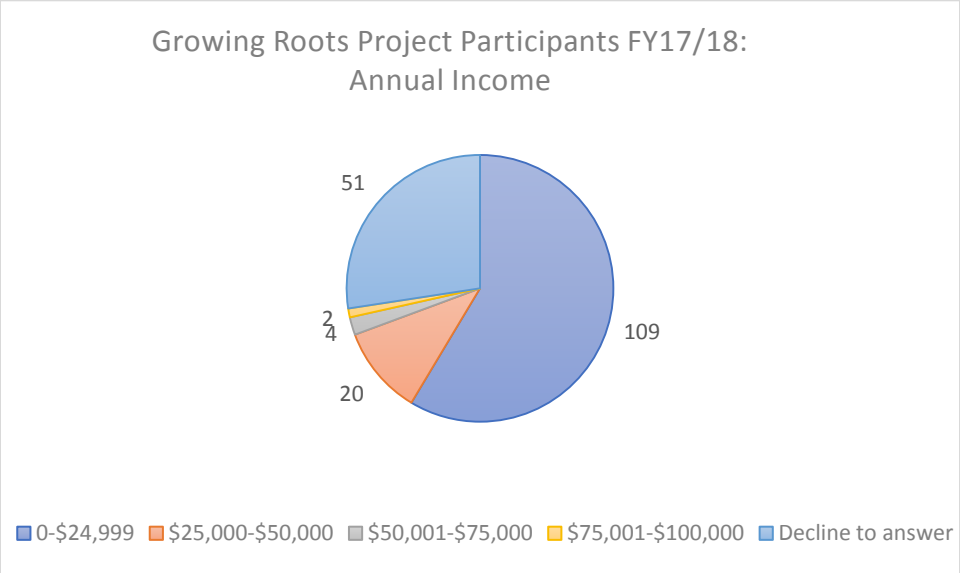
N=236; 41% of participants had less than a high school diploma, 26% had a high school diploma or GED, 18% had some college, and 6% had a bachelor's degree.



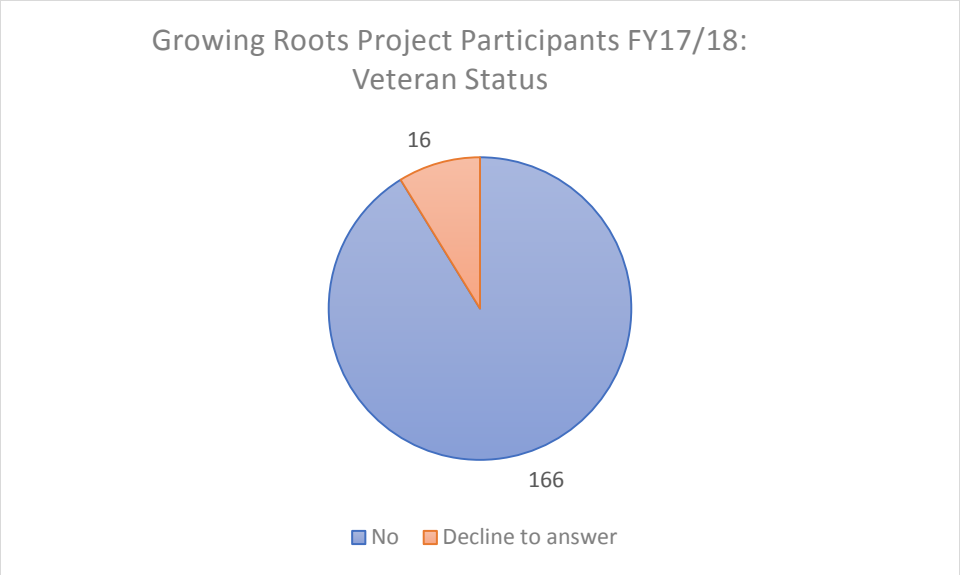
N=233; 30% are employed part-time, 27% are full-time students, 24% are employed full-time, 13% are unemployed and looking for work, 2% are unemployed and not looking for work.



N=244; 1 participant identified their housing status as homeless and 2 are living in shelters or transitional housing.



N=186; 59% reported an annual income under $24,999 and 11% between $25,000-$50,000. 51 people (27%) declined to answer this question—by far the highest decline rate of any of the questions. The second highest decline questions were with regards to disabilities and Veteran status which each had 16 participants who declined to share that information.



N=182; Zero of the Growing Roots participants identified as veterans with 9% declining to answer.

UPCOMING CHANGES

In August 2018, the project was granted a three month extension by the MHSOAC, setting the new end date at September 2019 in order to incorporate all the data generated through June 30, 2019, in the final report. Initial findings from this project will be presented by the Transitional Age Youth Advisory Committee in June 2019 and a final report will be released in September

INNOVATION COMPONENT BUDGET

Program	FY2017-18	FY2018-19	FY2019-20	Total
Growing Roots: Young Adult Services Project	$575,108	$800,811	$25,413	$1,401,332
Older Adult Focused Innovation Project	$0	$439,871	$462,243	$902,114
Innovation Planning Costs	$1,500	$20,000	$2,000	$23,500
Total	**$576,608**	**$1,260,682**	**$489,656**	**$2,326,946**

One-Time Funding Sources:	
AB114 Funds	$1,469,567
Innovation funds from other Fiscal Years	$571,500
TOTAL	**$2,041,067**

Community Services and Supports (CSS)

OVERVIEW

A primary goal of MHSA is to reduce the long-term adverse impacts of untreated mental illness and serious emotional disorders through funding and implementing community services and supports (CSS) aimed at identifying, engaging, and effectively serving unserved, underserved, and inappropriately served at-risk populations. CSS funds are intended to expand and transform services provided for children, youth, adults, and older adults living with serious mental illness and emotional disorders toward evidence-based, recovery-oriented service models. Programs that are CSS-funded incorporate the MHSA key principles of: 1) community collaboration, 2) cultural competence, 3) client and family driven, 4) wellness, recovery and resilience focused, and 5) integrated service experiences for clients and their families.

MHSA funding is available for three different types of system transformation strategies under the CSS component:

Full Service Partnerships (FSPs)

Designed to provide all necessary services and supports – a "whatever it takes" approach – for designated priority populations. Fifty-one percent of CSS funding continues to be required to be devoted to FSPs.

System Development (SD)

Dedicated to improving services, supports, and infrastructure for all clients and families, including the Full Service Partnership populations, to help change service delivery systems and build transformational structures and services, such as adding bilingual staff, developing peer specialist services, and implementing effective, evidence-based practices.

Outreach and Engagement (OE)

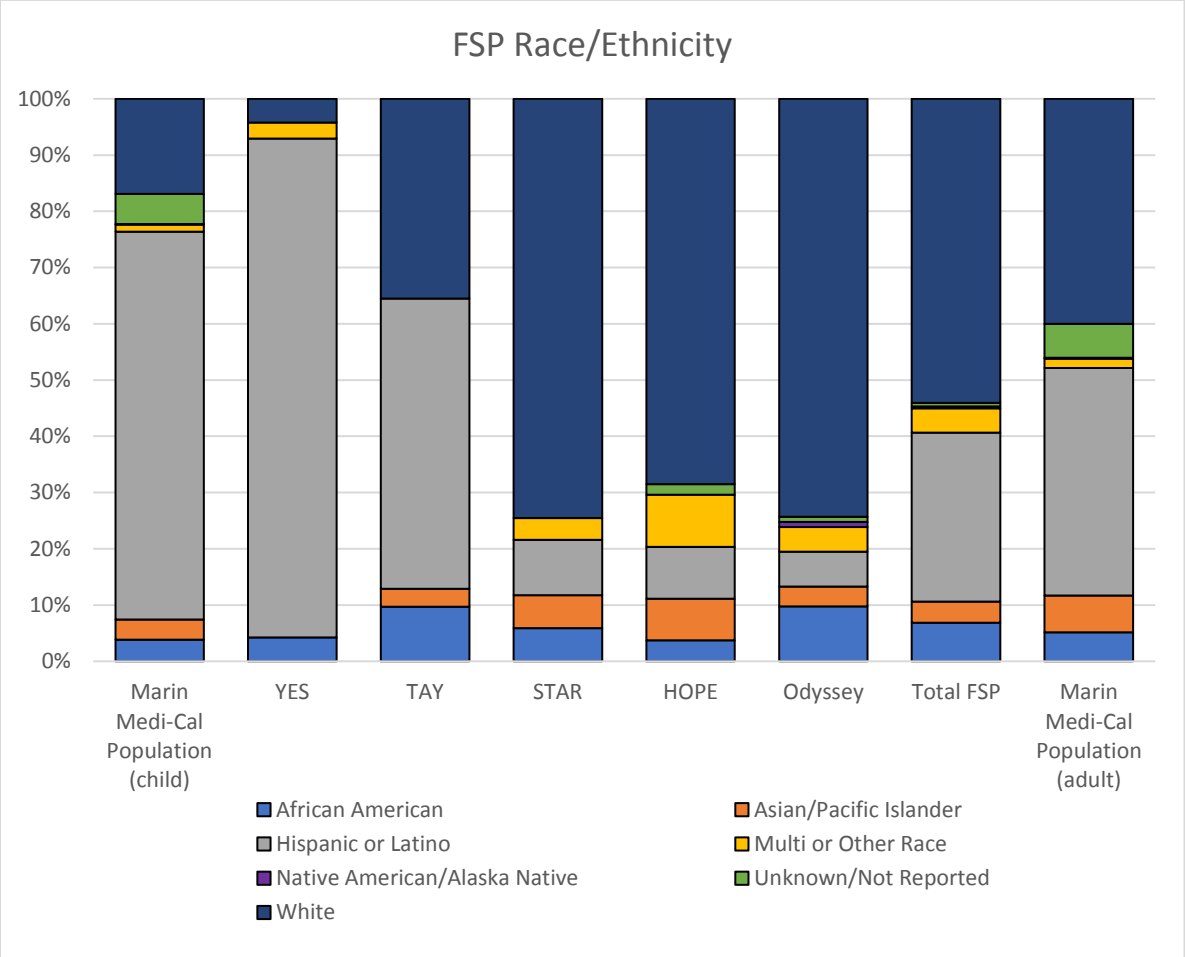
Designed for enhancing outreach and engagement of those populations that are receiving little or no services, with particular emphasis on eliminating racial/ethnic disparities.

Marin is working to reduce stigma and increase penetration rates—in this case meaning the percentage of Medi-Cal clients by race that are being served by BHRS—in order to better serve under-represented populations. CSS aims to increase the number of linguistically and culturally competent providers, provide outreach and engagement services, develop programs responsive to needs of specific target populations, and partner with Prevention and Early Intervention (PEI) programs to increase timely access to services. Program-specific strategies for reducing disparities are discussed in each program narrative.

FULL SERVICE PARTNERSHIP DEMOGRAPHICS

When determining how to reduce or eliminate disparities it is vital to look at the statistics on what disparities currently exist in our services. In order to do so we are looking at the Full Service Partnership (FSP) data and comparing it to the Marin Medi-Cal population.

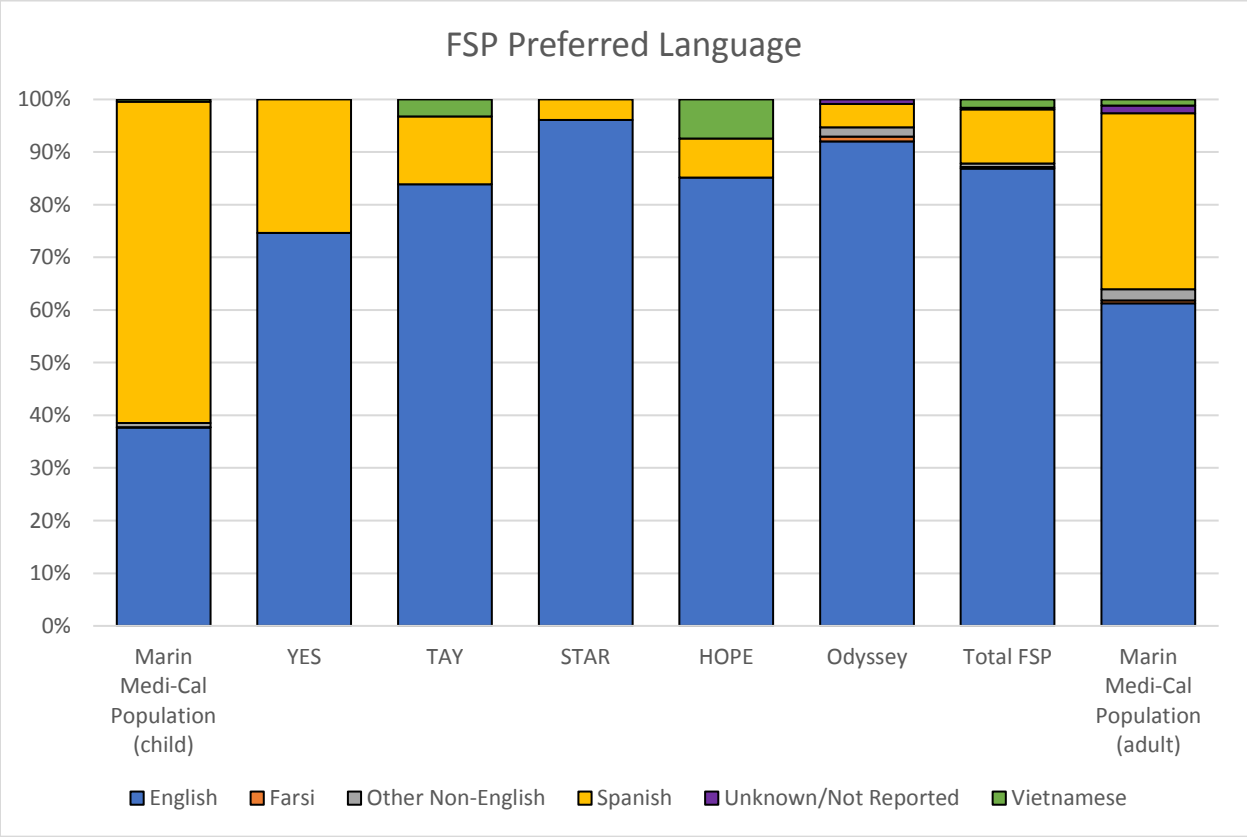
For each graph, on the left side of the chart is the Marin Medi-Cal data for children under the age of 18, and on the far right side is the Medi-Cal data for adults in Marin aged 18 and over. The FSP services follow the same flow with the youth services on the left and the adult services on the right side for easy comparison.



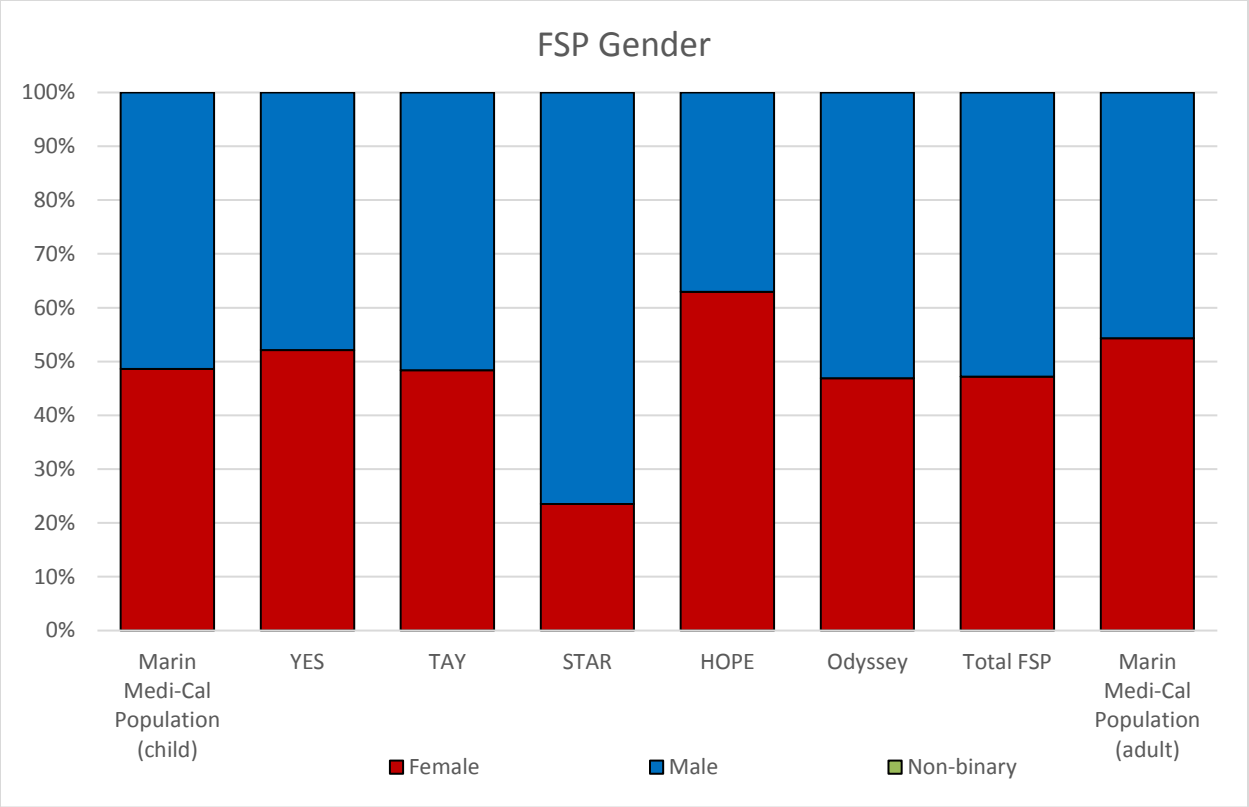
For children, the Latinx population is actually over-represented in the children's FSP ("Youth Empowerment Services—YES") with 88.7% of the clients served identifying as Hispanic—twenty percentage points higher than the Medi-Cal youth population in Marin. However, when you look at the same data, 61% of the Medi-Cal population under 18 have Spanish listed as their preferred language but only 25.4% of the clients served in that FSP report Spanish as their preferred language. Therefore, even though the YES FSP is serving a very high percentage of Latinx clients, they may still be underserving mono-lingual Spanish speakers. However, another factor to consider here is that for many youth their parents or caregivers fill out the Medi-Cal application and therefore might list their own language preference on the form to ensure they can actively participate in their child's care. However, once these youth are being served directly in the Full Service Partnership, their own language preference is the one

that is recorded for their one-on-one sessions with their clinicians. All but one of the staff members on the YES team are bilingual in Spanish.

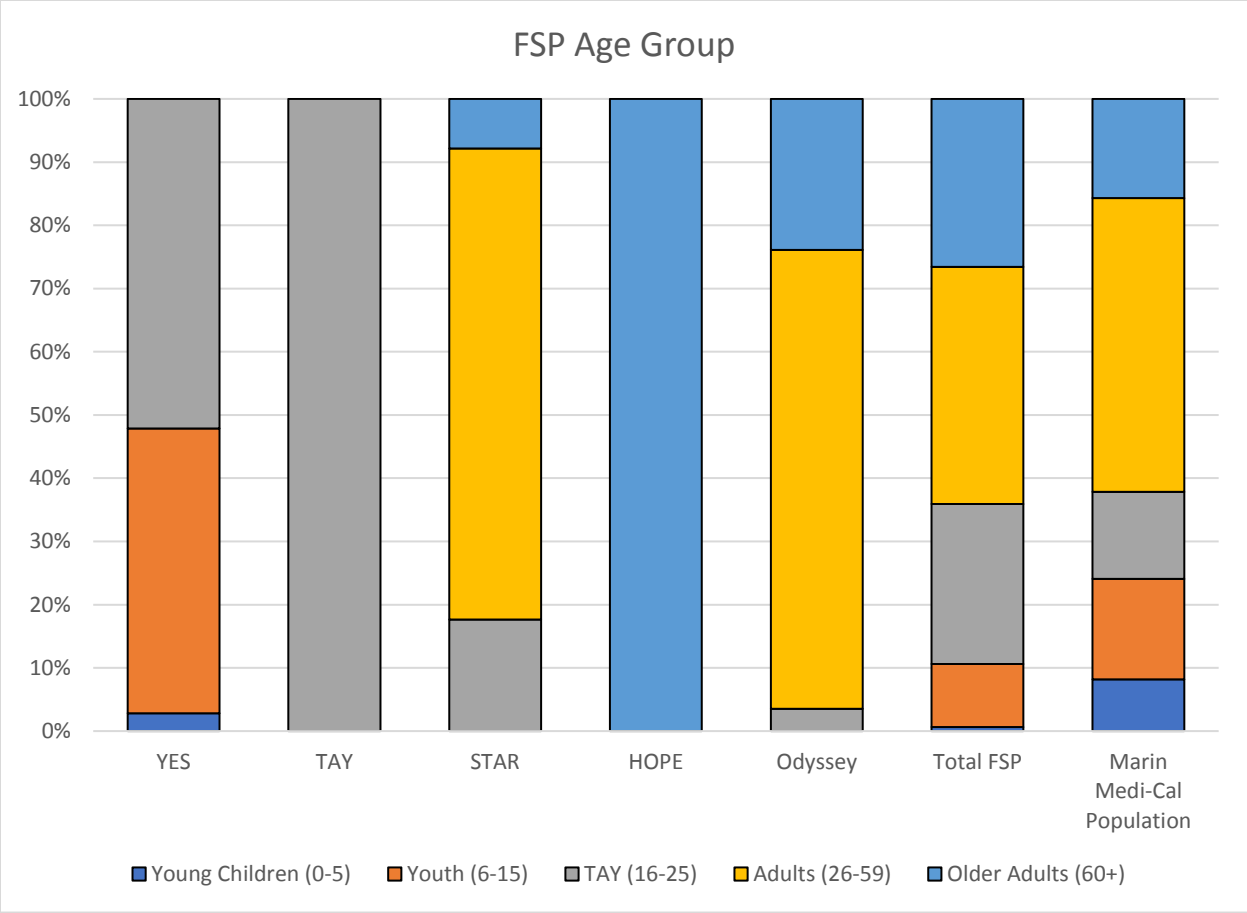
Within the Transition Age Youth (TAY) FSP, 51.6% of clients served in FY17/18 are from the Latinx population. Hispanic TAY (ages 16-25) represent 60.2% of the Marin Med-Cal TAY population, so they are slightly under-represented with in the TAY FSP. White TAY are over-represented by 12 percentage points and African-American TAY are slightly over-represented by 4.4 percentage points.



Within the adult FSP programs, the Latinx and Spanish-Speaking populations are significantly under-represented. There is a lot of work happening to increase the number of bilingual staff members, develop stronger community connections, and provide cultural competency trainings through the Workforce, Education, and Training (WET) component that will continue to be implemented in FY19/20. In addition, this will be a major focus of the FY/21-22/23 Three-Year MHSA Plan.



The gender distribution was split relatively evenly between males and females across most programs with exception of STAR—which focused on a criminal justice population and is skewed male—and the HOPE program which focuses on older adults and skews female. However, due to reporting methods and systems in place at the State level there is not good data capturing FSP clients or members of the Medi-Cal population who do not identify as one of the binary categories of male or female. This is an area we hope to improve reporting on in the next fiscal year (or at the latest as part of the next three-year plan).



2018 was the "year of the older adult" in Marin County, and older adults were well represented in our FSP services. In FY17/18, 26.6% of the people who received Full Service Partnership services were older adults—almost 11 percentage points higher than the percentage of older adults in the Marin Medi-Cal population (15.7%).

Transition Age Youth (TAY)—16 to 25-year-olds—were also over-represented as compared to the Medi-Cal population in Marin. TAY represented 25.3% of the FSP clients and only 13.8% of the Medi-Cal population.

Youth (15 or younger) and Adults (26-59) were under-represented by 13.5 percentage points and 8.9 percentage points, respectively.

YOUTH EMPOWERMENT SERVICES (YES) FULL SERVICE PARTNERSHIP: FSP 01

PROGRAM ALLOCATION FY17/18: $668,704

PROGRAM OVERVIEW AND HISTORY

Marin County's Youth Empowerment Services (YES) is a county-operated Full Service Partnership (FSP) program providing services to high-risk youth up to their twenty-first birthday. A "whatever it takes" individualized plan is at the heart of the approach to engage youth around goals they have for themselves.

This program was originally implemented as a Children's System of Care grant in the late nineties. In FY05/06 the Mental Health Services Act began supporting a major portion of the program which enabled the program to expand and hire Family Partners with lived experience with children who had been in the mental health system and/or the juvenile justice system.

Since FY14/15 the YES Program has broadened the referral base beyond the original juvenile justice system to include any child with a serious emotional disturbance or youth at risk for high end mental health services regardless of the system that originally served them.

In the FY17/18-FY19/20 Three-Year Plan, funding was approved for the Youth Empowerment Services (YES) Full Service Partnership to expand by 12 slots, from 40 to 52, by hiring an additional Licensed Mental Health Practitioner and a supervisor to oversee the program.

PROVIDER: County-operated

TARGET POPULATION

YES serves youth up to age 21 who present with significant mental health issues that negatively affect their education, family relationships, and psychiatric stability. Clients typically present with impairments in functioning across many domains, including school, home, relationships, and self-care, as well as also presenting with legal and substance use issues. The YES program aims to serve youth who do not have ready access to other mental health resources or may not seek services at more traditional mental health clinics.

PROGRAM DESCRIPTION

The YES model is a supportive, strengths-based model with the goal of meeting youth and families in their homes, schools, and in the community to provide culturally appropriate mental health services. The FSP model operates from a "whatever it takes" philosophy which includes creative strategizing to maintain stability for clients and their families. This often includes intensive case management, psychiatric care, medication support, as well as collaboration with partner agencies (i.e., education, probation, drug court, etc.) to facilitate integrated care and ongoing family support. Providers in the YES program utilize a variety of interventions including: trauma focused Cognitive Behavioral Therapy (CBT),

Dialectical Behavior Therapy (DBT), attachment and relational therapies, and substance use interventions related to harm reduction and motivational interviewing.

Clients and their families may also be supported by flex funds to help support treatment goals and promote stability, including financial support to secure stable housing during a short-term emergency or to support prosocial activities like sports. Family Partners, parents who have had a child in the mental health or juvenile justice system, also engage and support the parents in a unique way because of their life experience. These partners provide both individual and group support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full Service Partnership clients as part of the "whatever it takes" approach.

In FY17/18 YES staffing consisted of three bilingual staff members, including one clinician who was a Latinx male working with students at Marin Community School, an alternative high school. Bilingual YES staff provide both linguistic and cultural capability to address the diverse needs of the client population who face many challenges including trauma and environmental stressors. These clients have complex mental health issues in addition to trauma, immigration status issues, lack of access to resources, and racism. Clients also present with many disruptions in their lives, including long separations from parents and other attachment disruptions, which can require services of a longer duration.

Some youth experience early signs of psychosis and require intensive services early on to prevent further impairments in functioning and may require coordination with other providers in the BHRS system including the newly formed first episode of psychosis team.

EXPECTED OUTCOMES

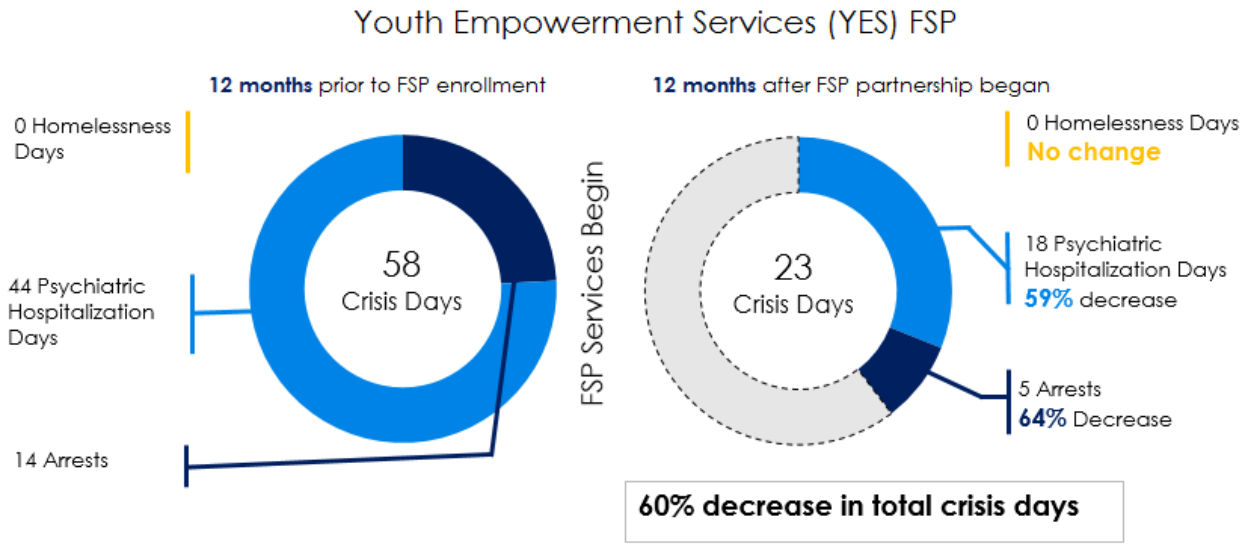
YES program objectives include serving 52+ youth per fiscal year to develop better coping skills to manage daily stresses and increase pro-social activities in the community (i.e., employment, sports, etc.) and to decrease substance use. Additional outcomes include decreasing days spent in a psychiatric hospital, days homeless, and arrests.

ACTUAL OUTCOMES

In FY17/18, the YES program served 71 unduplicated clients (up from 65 in FY16/17 and 42 in FY15/16). The demographic information on clients served in FY17/18 in the YES FSP is included in the FSP Demographics section at the beginning of the CSS chapter.

For clients who received YES services for at least one year (N=42), YES services helped decrease mental health emergency events from a total of 16 events to 1 event during the first year of service. Because many YES clients present with significant emotional/behavioral challenges, at times resulting in psychiatric hospitalization, YES clinicians are available to provide intensive support during crises, as well as aid in discharge planning from the hospital. In addition, the 42 clients who were enrolled in the program for at least year spent a collective 425 days in residential treatment in the year prior to services. In their first year of FSP services, they collectively spent only 29 days in residential treatment, a 93% decrease.

When looking at days homeless, days in a psychiatric hospitalization, and arrests, there was a 60% decrease in those types of "crisis days" including a 59% decrease in psychiatric hospitalization days and a 64% decrease in arrests. YES staff work closely with probation officers and school staff to coordinate support effectively and to pursue mental health intervention instead of detention when possible.



One of the successes of this program is the capacity to engage and support youth at risk of self-harm. Youth with trauma, depression, as well as LGBTQ youth often have higher risk of suicide. The YES program engaged youth directly from psychiatric hospitalization to provide appropriate support and safety planning. Examples of outcomes for clients who were engaged directly from psychiatric hospitalization include:

- Two LGBTQ young women of color overcame severe and chronic suicidality and anxiety and were admitted into 4-year universities.
- A transgender Latinx client with significant emotional challenges began gender affirming hormone therapy with support from a team of therapist, psychiatrist and doctors.
- A 16-year-old Latinx client presented with a history of self-harming behaviors, severe polysubstance use, multiple hospitalizations, and incarceration in juvenile hall for multiple violations. With individual and family therapy (in Spanish), and wraparound services, this client stabilized psychiatrically, obtained work, reduced substance use significantly, extinguished self-harming behaviors, and graduated from high school and from probation successfully.
- A Latinx client with significant depression and substance use (who did not expect to live past 18) graduated from high school and had 0 suicide attempts.

As a team of bilingual providers, YES also provided needed services in Spanish for newcomers and immigrant youth, allowing for family-based work with parents who are primarily Spanish speaking. This capacity greatly expands the capacity to serve immigrant families, facilitate family-based interventions, address family-identified needs in their language and support clients in important ways. It also created new opportunities to provide services in Marin, including a support group for LGBTQ Latinx youth, capacity to address immigration related anxieties given the political climate, and support dreamers with residence/citizenship where possible. While there is more work to be done in these areas, the YES team spearheads these efforts. Examples of client outcomes for the services provided in Spanish include:

- Two Latinx clients who recently arrived became abstinent from crystal meth for over a year after abusing the substance daily.
- A 16-year-old client who had a baby at 14 remained in school and began to heal intergenerational trauma for herself and her son.
- A 15-year-old Latinx female client born in US to immigrant parents presented with depression and anxiety, low self-esteem, cutting behaviors, family conflict and reported acrimonious relationship with school officials. Client ended therapy within a year with increased confidence, decreased social anxiety, increased social connections with peers, improved attachment to parents, and improved academic performance.

The YES team also hired a new staff member with experience working with youth with histories of trauma, following the retirement of a former staff. Staff on the YES team were also trained in understanding the intersection between race and historical trauma as well as training in how trauma impacts brain development. Staff engaged juvenile probation about the mental health needs of youth on probation and participated in case planning/placement review meetings to advocate for their needs. Services provided by this team did not always reduce placements or time spent in juvenile hall, but it supported youth to get needed mental health services, avoid further legal complications, etc. Client outcomes for youth affected by immigration or historical trauma include:

- An African American client with prior unsuccessful engagement in therapy participated in therapy for over 2 years and addressed her complex trauma for the first time.
- A client with severe agoraphobia who didn't attend school for over a year, transitioned back to high school and terminated services successfully. She resumed playing two high school sports, receiving all As and Bs in school, with plans to attend college.
- A 16-year-old Latinx client of immigrant parents, but born in US, presented with severe depression and anxiety, suicidal ideation and prior attempts, school truancy, isolation, family disconnection, and social anxiety. With 6 months of therapeutic support in the YES program, this client became more social, assertive, confident, with a total reduction of suicidal thinking or attempts, no substance use and obtained employment experience.

CHALLENGES AND LESSONS LEARNED IN FY17/18

In FY17/18, the YES Program continued to have a part-time supervisor so the ability to monitor the quality and effectiveness of the program and provide timely consultation to staff was challenging. A recruitment for an additional staff person continued for most of this year also. Hiring staff with sufficient experience and interest in working with high-risk youth continued to be a challenge. The clients served by this program also continued to present with significant levels of impairment or psychiatric risk, which required flexibility and considerable investment in time and specific training needs. Another challenge is how to best assign clients to this program based on their need vs. when staff have availability or language capacity.

ANTICIPATED CHANGES FOR FY19/20

The YES program will have a full-time supervisor beginning in March 2019. This team will also expand from 3 clinicians to 4 bilingual providers, with the hopes of adding a 5th provider by the end of the FY19/20. This will expand capacity for this program to meet the ongoing needs of at-risk youth in the community from 52 to approximately 70-75. This will also create space for the supervisor to assist in

prioritizing clients and working with clinical staff to individualize the services more fully. It will allow for further supervision regarding when to step down a client in service level or begin to plan for discharge from services. Supporting the staff with difficult clients will also improve with more supervisory capacity. Finally, the YES supervisor will continue to explore the ongoing training needs for YES providers to strengthen skills and support staff with professional development.

CLIENT STORY FROM FY17/18

"Julia" is a 19-year-old Mexican-American cisgender woman residing with her family in Marin County. She came to the YES program after her first hospitalization for suicidality but reported that she had been depressed and suicidal since age 13. Julia experienced sexual abuse as a young child, witnessed interpersonal violence between her parents, and struggled profoundly with her self-image. Upon beginning services with the YES team, Julia reported relentless, daily, intense suicidality with a clear plan to overdose on over-the-counter sleeping medications. She was hospitalized numerous times due to the intensity and severity of her suicidal ideation. She also experienced severe depressive and anxiety symptoms which were causing her to feel "empty" and "alone".

It was difficult to begin addressing underlying needs, experiences, and feelings because the focus of treatment had to be on safety. Julia also began using substances and alcohol, engaging in high risk sexual activity and was self-injuring, which all contributed to a deep concern for her safety and well-being.

The YES team wrapped around Julia, providing treatment two times a week and then three times a week, collaborating with her school, psychiatrists, with the Transitional Age Youth (TAY) program, with her family, and frequently consulted about how to best address her needs. Julia was hospitalized eight times over a period of nine months—including one severe suicide attempt—but slowly began to experience an improvement in her symptoms and began to address the underlying issues causing her symptomatology and chronic suicidality. She learned self-soothing skills, ways to communicate her feelings and needs more effectively, and developed a solid and trusting relationship with her therapist.

It has now been over ten months since Julia has been hospitalized. She was able to graduate from high school and she is now in a job training program for young adults. Julia continues to attend weekly therapy with the YES team and reports feeling a greater sense of purpose, connection to those around her, and a significantly stronger sense of self. She frequently discusses her journey over the last year and a half—reflecting on the tremendous investment she was able to make in her own healing, with the appropriate supports and a solid team supporting her.

TRANSITION AGE YOUTH (TAY) FULL SERVICE PARTNERSHIP: FSP 02

PROGRAM ALLOCATION FY17/18: $561,551

PROGRAM OVERVIEW AND HISTORY

Marin County's Transition Age Youth (TAY) Program, provided Side-by-Side (formerly known as Sunny Hills Services) is a Full Service Partnership (FSP) for young people (16-25) with serious emotional disturbance or emerging mental illness. The TAY program provides independent living skills workshops, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. There is also a well-attended partial program for youth who can take advantage of the group activities and ongoing social support. This Partial Program may be used as a step down for FSP participants on their way to a more independent path as well as outreach to youth who are just realizing the importance of connection and support in dealing with emerging mental illness.

In November of 2017, program capacity was expanded by four slots to an FSP caseload of 24. In order to provide the core functions of a Coordinated Care Model in collaboration with the county First Episode Psychosis program a (0.5 FTE) Clinical Case Manager was added.

PROVIDER: Side-By-Side, formerly known as Sunny Hills Services (a community-based organization)

TARGET POPULATION

The priority population is transition age youth, 16-25 years of age, with serious emotional disturbances/serious mental illness which is newly emerging or for those who are aging out of the children's system, child welfare and/or juvenile justice system. Priority is also given to TAY who are experiencing first-episode psychosis and need access to developmentally appropriate mental health services. Research has shown there are significant benefits from early intervention with this high-risk population. There is increased awareness that young people experiencing first episode psychosis symptoms should be engaged early and provided with a collaborative, recovery-oriented approach through a multidisciplinary team Coordinated Specialty Care model. Untreated psychosis has been associated with increased risk for delayed or missed developmental milestones resulting in higher rates of unemployment, homelessness, reduced quality of life and a higher risk for suicide. First episode psychosis has become an area of focus across the mental health system of which TAY is an important partner.

PROGRAM DESCRIPTION

The TAY Program is a Full Service Partnership (FSP) providing 16 to 25 year-olds with "whatever it takes" to move them toward their potential for self-sufficiency and appropriate independence, with natural supports in place from their family, friends, and community. Initial outreach and engagement is essential for you in this age cohort who are naturally striving toward independence and face more obstacles due to their mental illness than other youth. Independent living skills, employment services, housing supports, as well as comprehensive, culturally appropriate, integrated mental health and substance use

services are available through the TAY Program. This program strives to be strengths-based, evidence-based, and client-centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services, as well as, coordinated individual and group therapy and psychiatric services for TAY participants. MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full Service Partnership clients as part of the "whatever it takes" approach.

The goals of the program are to provide treatment and skill-building to help TAY reach a level of self-sufficiency needed to manage their illness and accomplish their goals, thus avoiding high end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, are available to TAY FSP as well as to TAY who are not a part of the full service partnership to give them the opportunity to explore how a program such as TAY could support them.

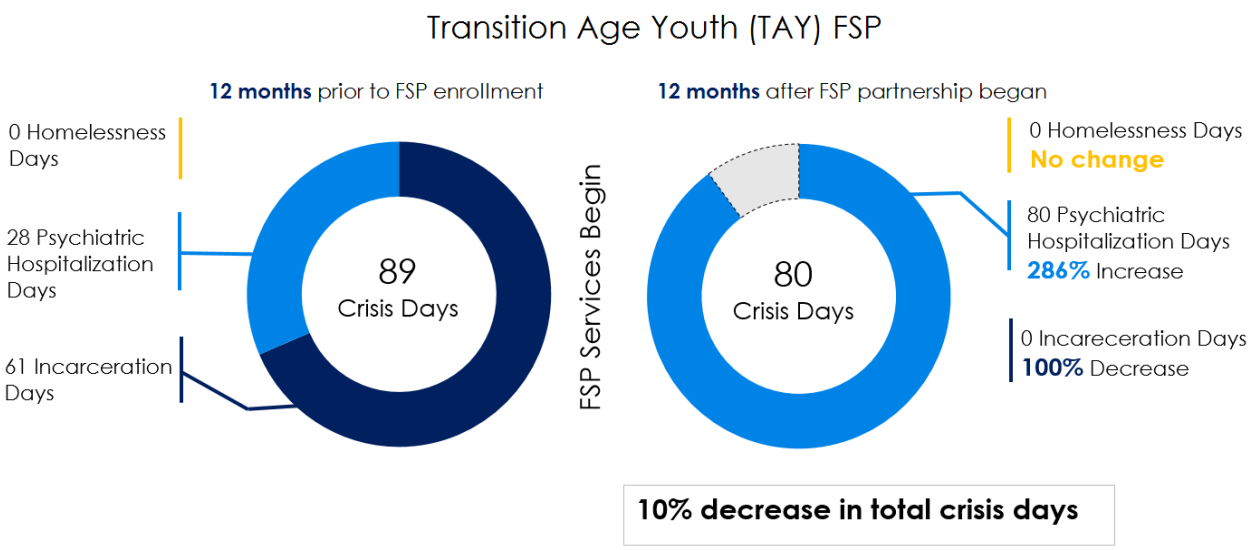
Partial services are provided on a drop-in basis to full and partial clients. These services include an Anxiety Management Group, cooking groups, no cost physical activities such as hikes led by staff and job support and coaching. These activities provide a forum for healthy self-expression, an opportunity for participants to expand their cultural horizons, and a place to for them to practice their social skills. The monthly TAY calendar of activities is available in English and Spanish.

There is also a two-bedroom apartment available to FSP clients in the TAY Program, recognizing that stable housing is important in maintaining mental health. Due to the TAY Program's very limited housing capacity, other housing programs available for those 18 years and over are also utilized by TAY participants as appropriate, and many still live with their family which continue to be their main source of support.

EXPECTED AND ACTUAL OUTCOMES

The broad goals of the TAY program are to decrease hospitalization, incarceration, and homelessness and increase attendance at school or work. The demographic information on clients served in FY17/18 in the TAY FSP is included in the FSP Demographics section at the beginning of the CSS chapter.

There were 21 clients who were active at any time during FY17/18 and who completed at least 1 year in partnership. During their base line year (the 12 months prior to enrollment) these 21 clients collectively spent 28 days in psychiatric hospitalization and 61 days incarcerated. In their first year in the FSP, there they spent 80 days in psychiatric hospitalization and 0 days incarcerated, for a 10% decrease in total crisis days.



Additionally, specific goals targeting vocational support and independent living skills were monitored and the results are in the outcomes table below.

Outcomes FY17/18	Goal	Actual FY17/18
Number of clients served: • FSP • Partial/drop-in	 24 45	 31 53
FSP clients engaged in work, vocational training or school.	70%	71%
FSP clients engaged in activities designed to improve independent living skills.	50%	68%
FSP clients screened for substance use.	100%	100%
Clients identified as having substance use issues that receive substance use services.	50%	25%

TAY SPECIFIC OUTCOMES

Drop-in Center:

The drop-in center is conveniently located in central San Rafael providing all Marin youth with a welcoming and supportive and safe environment. The drop-in center is a hub of activity where youth can meet and make friends in a safe and healthy place. Our goal is to create a community where all youth feel safe, respected, and valued. From July 1, 2017, through June 30, 2018, drop-in activities were offered every day, Monday through Friday, except on major holidays (238 actual days). The drop-in center served a total of 53 unduplicated drop-in clients, exceeding the objective of 45 for a total of 1,706 actual drop-in visits (1,281 FSPs and 425 partial clients.) Attendance at the drop-in center for our core group of FSP clients soared this year. There were 1,281 drop-in visits by our FSP clients this year, averaging 5.3 FSP clients per day and an increase from last year's numbers of 897 FSP drop in visits averaging 3.6 FSP clients per day.

Community-based outreach and engagement by peer advocates and clinical staff continued to be diverse and active. TAY FSP staff visited and conducted outreach and presentations to students, parents, and staff in high school/continuation schools in all areas of Marin, wellness centers, Rotary clubs, community recreation centers, youth centers, NAMI meetings and other

community event. The team has built strong collaborative relationship with other county providers such as the Ritter Center, St Vincent de Paul, Buckelew, Homeward Bound, and NAMI providing the transitional age youth with a supportive community.

The drop-in center offers a variety of activities, groups, outings and other events that focus on practicing social skills while making connections and having fun. These activities range from employment support, educational guidance, independent living skills, health education, housing support and advocacy and symptom management. Social and recreational activities including art, music, mindfulness, yoga, sports, cooking, dancing are offered at the drop-in center as well as in the community. Outings to Muir Woods, the movies, bowling, miniature golf, hikes, bocce ball, baseball games and other trips into the community provide our youth with recreational and fun experiences. Many of the youth served in the TAY FSP have long-standing difficulties with developing and maintain healthy relationships/friendships. The drop-in center also always offers healthy snacks and food to the TAY.

School and Work Engagement:

School and Work Engagement Objective: **By June 30th, 2018, 70% of Full-Service TAY members will have engaged in either work, vocational training or school.**

Results: This is an area that clinical case managers and peer advocates worked very hard to support the youth in school and work settings to increase client functioning and their ability to be self-supporting and engaged in their communities and achieved this goal in FY17/18 with 71% participating in school, work, or both. Partnerships with several other Marin County providers enabled the FSP to meet the needs of youth that need extra support with either school or employment. Working closely with the College of Marin's Student Disability Services Department, and Novato Adult Education allowed the clients to receive extra support, tutoring and financial aid to help them be successful at school even if their mental health issues increased. Partnering with Buckelew Social Enterprises, The GEM Program, Youth Working for Change and Department of Rehabilitation also gave our clients the extra guidance and support needed during employment. TAY offers help with studying techniques, resume writing, mock interview groups, interview clothing, and help with transportation to school and work.

Independent Living Skills:

Independent Living Skills (ILS) Objective: **By June 30th, 2018, 50% of the FSP clients will have attended two or more activities designed to improve their independent living skills.**

Results: Marin TAY achieved this goal with 22 FSPs, (68%) of the 34 FSPs attended 2 or more ILS activities at the drop-in center or in the community. The peer advocates and the clinical case managers do extensive individual ILS preparation/support and community outings individually with our FSP's and together in groups. This includes school enrollment, obtaining job applications, practicing interviews, demonstrating how to make and manage dental and medical appointments, practicing/accessing community support from other providers, obtaining food, driver's license test, and much more. Motivational Interviewing techniques are utilized to engage individually with FSP clients, helping them examine their hopes and capabilities to increase independence from parents/caregivers or from social service support.

Substance Use Assessment:

Substance Use Assessment objective: **100% of FSP clients will receive drug and alcohol screening. Clients identified with possible substance use issues will receive further assessment and when indicated, intervention and treatment services.**

Results: 100% of FSP clients were assessed for drug/alcohol usage, utilizing the National Institute on Drug Abuse (NIDA) screening, a tool which guides clinicians through a series of questions to identify risky substance use. In FY17/17 the assigned Clinical Case Managers began administering the drug/alcohol screenings for the FSP clients as part of the initial client assessment and client plan development process. Information from the screening is then utilized in the development of Client Plan goals and interventions. The Clinical Case Manager can better bring focus/attention to substance use issues as an integrated rather than separate part of the service delivery.

Substance use with this age group tends to be under reported and clients are less likely to see their recreational use as a problem. Using a harm reduction approach and utilizing Motivational Interviewing techniques, opens up the discussion for the FSP clients to take a look at how recreational drugs are negatively impacting their lives.

TAY Housing Resource:

TAY Housing Resource objective: **Maintain full occupancy of the TAY apartment (two FSPs) 80% of the time during FY17/18.**

Results: Goal met at 100% occupancy. During all twelve months the apartment was occupied by 2 FSP clients. The Marin TAY apartment continues to be an excellent resource and training ground for independent living for the FSP clients who are able to manage the basic expectations of living in a respectful manner in a building with close neighbors and managing living with a roommate. These FSP clients meet weekly with their case managers and with a peer advocate to help negotiate the process of living with a roommate and the responsibilities that come with sharing a living space. Conflict managements, chore responsibilities, learning how to be a responsible tenant with other renters, and money management are some of the skills the clients have a chance to practice while having support and guidance from TAY staff. It is also a great opportunity to help these clients learn how to manage/budget their income, paying a small amount each month which actually goes into a savings account for their use toward independent housing upon departure. The average length of stay for TAY residing in this apartment is 15.2 months.

SUCCESSES AND AREAS OF FOCUS IN FY17/18

The demographics of the TAY Full Service Partners became more equitable in two noticeable areas:

This year the TAY program served 14 Latinx youth, up from 2 youth in this same ethnic group last fiscal year. Having 2 bilingual clinical case managers and 1 bilingual peer advocate increases the ability to provide culturally inclusive services to some of the most vulnerable and underserved youth in Marin. A regular Family Support Group for families of TAY with mental illness and substance use (regardless of enrollment in the TAY program) is provided by TAY staff in both Spanish and English. In FY17/18 the TAY FSP also served 7 partners who identify as LGBTQ+, compared to 0 the previous year. Creating a culture

and environment that recognizes some of the unique struggles and challenges for LGBTQ+ youth has increased the FSP's ability to provide services to this underserved population.

In January 2017 Marin TAY was asked to serve as the TAY liaison for the biannual homeless count. With the help of several homeless TAY youth as guides, it was determined that TAY homeless youth don't use the typical services offered or stay in the areas that the older homeless groups in Marin use. The TAY FSP is deeply committed to working with local community members to address the growing number of homeless TAY in Marin. The TAY FSP participates in both the Coordinated Entry Planning Committee and Homeless Policy Steering Committee, contributing to establishing policies and procedures that affect the TAY homeless population in Marin. Side By Side reports that "we are excited to be a part of this exceptional group of county providers working together to address the homeless situation in Marin."

TAY FSP has worked over the past year in developing a relationship with Golden Gate National Parks Ranger Outreach Program and were able to offer unique and exciting trips to Angel Island, Alcatraz, Bonita Lighthouse, Marin Headlands & Rodeo Beach, Lands' End Hike, Muir Woods trail restoral project. For many of clients, this was their first experience exploring the national parks in the area. Some FY17/18 highlights include: the clients got to spend a day watching a mother whale and her calf in the bay below Bonita Lighthouse and enjoyed the peaceful quiet of a full moon hike through the majestic Muir Woods. These unique opportunities allow the clients to be more than their mental health diagnosis and open their eyes to the many amazing outdoor opportunities we are fortunate to have in the Bay Area.

A frequent request we receive from the youth is for help with obtaining basic food and hygiene products. The TAY FSP has partnered with Extra Food of Marin and receive every Tuesday an assortment of salads, sandwiches, and prepackaged food items. Calls are made to all clients and food is distributed to all youth in need. The FSP also works with *Cakes4kids* which provides desserts for birthdays, holidays and graduation celebrations. Every client gets to pick exactly what they want for their birthday celebration including Vegan options. The TAY drop-in center provides food every day to any youth that comes to the drop-in center as well as cooking classes and meal planning and shopping to help clients with the independent living skills they need to plan, shop, and prepare healthy economical meals.

CHALLENGES OR LESSONS LEARNED IN FY17/18

Referral Process:

> This summer began a change in how referrals are made to the TAY Program. Instead of independently assessing and accepting clients in to the TAY FSP program, all potential clients go to the Access Team for assessment, evaluation and referral to the TAY Space FSP Program. TAY Space staff members have been working closely with the Access team and BHRS to make sure clients don't slip through the cracks while they are being assessed through the Access line. While we have been adjusting to this new system for referrals, we have seen an increase in the client population and the census has been steadily increasing above the stated caseload of 24.

Psychiatrist hours:

> Increases in the census has resulted in a higher number of FSP clients needing to see the psychiatrist for symptom management and psychiatric services. In October 2017, 12 of the 21 FSP clients enrolled were seeing the psychiatrist every 4-6 weeks. In October 2018, 20 of the 23 enrolled FSP clients were receiving medication and symptom management support from the

psychiatrist, Dr. Kennedy. Almost double the number with only 2 extra hours added per month totaling 14 hours, is insufficient to provide good client care and positive outcomes. To provide a high level of consistent care with a recovery-oriented approach the psychiatrist hours is will be increased in FY19/20.

Substance Use Services:

In October the TAY program switched models and hired a 20hr per week AOD counselor. Prior to hiring this staff, all TAY clinical staff were trained in substance use and have been providing these services to the clients since the FSP opened in January 2015. The new AOD staff has been assigned 4 clients each with a substance use diagnosis and has been serving these clients as a case manager. Having a part-time staff is a challenge in meeting the needs of a client base that is often fluid and ever changing. Staff flexibility and having someone that is available to our clients on a full-time base in our experience, meets the needs of our clients more effectively. This is a challenge with a part-time position. To strengthen our knowledge and expertise in the Substance Use Model, we are planning on all TAY clinical staff completing the ASAM training.

Administrative Assistance:

Since opening in Jan 2015, all the numerous administrative duties (including scheduling, filing, and record keeping) have been absorbed by all the TAY staff in various capacities. This at times can be a distraction and interfere with clinical staff using their time to provide services to our FSP and drop-in clients. Having a designated 20 hour per week staff that is responsible for all administrative tasks will help staff focus on client services and will provide consistent productivity for our clinicians. Having the Program Manager, Clinical Supervisor and Clinical Case Managers perform administrate tasks is an ineffective use of their time.

Building Space:

Since moving into our location on B. Street in Feb 2015, the program has grown steadily with increased staffing, increased FSP clients from 20 clients to currently 26 FSP, and a steady increase in the daily drop-in population. With this growth the FSP is exploring if there are alternative spaces available that could meet the growing needs of the program. The monthly rents on both our office and the TAY Space apartment have gone up each year by at least 10-30%. As the FSP looks to the next 3 years with anticipated continued growth, Side By Side would like to look for a bigger space to adequately accommodate these expanding numbers.

ANTICIPATED CHANGES FOR FY19/20

The budget for the TAY FSP will be increased for FY19/20 to provide more psychiatry time, administrative assistance, and adding Flex Funds to be used to support the TAY in achieving their treatment goals.

CLIENT STORY FROM FY17/18

No matter how many years we work in this field, we must always maintain the openness and willingness to believe in the improbable, regardless of the number of obstacles in the way for our clients. There have been many times that "Catherine" has been let down by the system. At some points, she just felt like totally giving up and would make decisions that put herself at risk or spiral out of control. Her life started out rough—she was removed from her mother's home by CPS due to allegations of physical abuse when she was 14 and spent the rest of her teenage years in group homes and foster care. Catherine was later psychiatrically hospitalized and struggled with symptoms of bipolar disorder. Too many people would walk into her life and just walk right out. She didn't feel like she could rely on anyone.

When Catherine was around 20 years old, she was referred to the TAY program. For the past two years, she has met with the same TAY clinical case manager, building a trusting relationship and then started to figure out what she wanted to do with her life. She had ups and downs while at TAY—she dropped out of college twice, she kept losing jobs due to behavioral challenges, she became homeless and eventually ended up in the homeless shelter. Even though it was hard, when she became homeless, Catherine immediately began to work toward building a different life for herself. There were days where she would cry in bed all day, but she got up the next day and tried to work toward her goals.

Several months ago Catherine became steadily employed, despite how difficult it was to deal with work stressors alongside mental health symptoms. With stable employment, she was able to move from the homeless shelter into transitional housing and then applied for a Section 8 housing voucher. Once Catherine learned that she had received the highly coveted Section 8 voucher, she felt a mix of emotions: Fear that she wouldn't find a place in time and excitement that maybe she could finally have her own place, a place just to herself where she could be safe. After going to open house after open house but being rejected repeatedly due to the landlords not accepting Section 8, she was about ready to give up the fight. But she stuck with it and finally succeeded! She found a 1-bedroom apartment right in the center of town, about 10 minute walk from Marin TAY! She did it, creating an independent life for herself including housing and employment! Although the road has not be easy and she has met with many challenges, Catherine has shown that with support from TAY as well as other community partners, she could achieve her goals despite so many challenges. "We are SO proud of her!"

SUPPORT AND TREATMENT AFTER RELEASE (STAR) FULL SERVICE PARTNERSHIP: FSP 03

PROGRAM ALLOCATION FY17/18: $596,468

PROGRAM OVERVIEW

The Marin County Support and Treatment After Release (STAR) Program has been an MHSA-funded county-operated Full Service Partnership (FSP) serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. The STAR Program was originally implemented in 2002 through a competitive Mentally Ill Offender Crime Reduction Grant (MIOCRG) awarded by the California Board of Corrections. Upon the conclusion of that grant, the STAR Program was approved as a new Full Service Partnership, providing culturally competent, intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin's mental health court – the STAR Court – the program was designed to provide comprehensive assessment, individualized client-centered service planning, and provision of or linkages to all needed services and supports. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

PROVIDER: County-operated

TARGET POPULATION

The target population of the STAR Program is adults, transition age youth, and older adults with serious mental illness, ages 18 and older, who are currently involved with the criminal justice system and are at risk of re-offending and re-incarceration. Priority is given to individuals who are currently unserved by the mental health system or are so inappropriately served that they end up being incarcerated, often for committing "survival crimes" or other nonviolent offenses related to their mental illness. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION

Operating in conjunction with Marin County Jail's Re-Entry / Mental Health Team and the STAR Court (Mental Health Court), the FSP is a multi-disciplinary, treatment team comprised of professional and peer specialist staff. The team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, employment services and provision of or linkages to all needed services and supports. Treatment for co-occurring substance abuse disorders for some clients is essential to their successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full Service Partnership clients as part of the "whatever it takes" approach.

The team consists of: a Supervisor (a Forensic-Clinical Psychologist); three (3) mental health case managers, one of whom is bilingual/bicultural Spanish speaking; two (2) peer/lived-experienced specialists; a mental health nurse practitioner; a psychiatrist; an employment/vocational specialist; a mental health-specialized Adult Probation Officer; two (2) Marin County Sheriff Deputies (as part of the Jail Re-Entry Team); two (2) psychological interns/therapists; and a substance use specialist. Support is available to participants and their families 7 days a week, 24 hours a day.

Integral to the team, the nurse practitioner provides medical case management, health screening/promotion and disease prevention services, coordinates linkage to community-based physical health care services and is able to furnish psychiatric medications under the supervision of the team psychiatrist. The employment specialist provides situational assessments, job development and job placement services, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation to leverage funding for additional vocational services, including job coaching. The substance abuse counselor provides appropriate group and individual counseling to participants as needed.

CSS expansion funds were approved beginning in FY11/12 through FY13/14 to provide Crisis Intervention Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health emergencies. Because earlier trainings were successful and popular, the program has been extended through FY19/20. Funds are used for stipends to local law enforcement jurisdictions to enable them to send officers to the training and help pay for the cost of the training. This training is provided to 25-30 sworn officers annually.

EXPECTED OUTCOMES

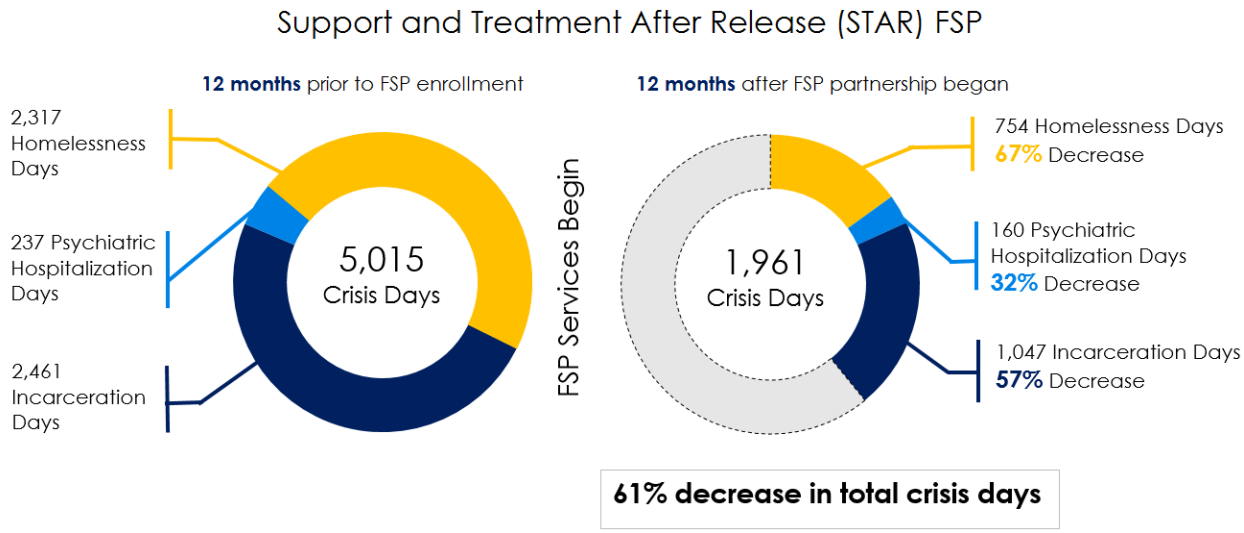
Listed in the table below, the expected outcomes for the STAR Program are based on the goals of the program and remain unchanged. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the STAR Program staff on a daily basis. Program staff will continue to explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	GOAL
Decrease in homelessness	75%
Decrease in arrests	75%
Decrease in incarceration	80%
Decrease in hospitalization	40%

ACTUAL OUTCOMES

In FY17/18, the STAR Program served 51 individuals who had serious mental illness and significant criminal justice involvement. The demographic information on clients served in FY17/18 in the STAR FSP is included in the FSP Demographics section at the beginning of the CSS chapter.

48 individuals were enrolled in STAR for at least 1 year. The number of days clients spent homeless was reduced by 67%, days spent incarcerated was reduced by 57%, and days psychiatrically hospitalized was reduced by 32% compared to the baseline year. Arrests were also decreased by 81% and mental health emergency events were decreased by 83%.



In addition, 27 STAR clients were referred for employment services and life skills training with Integrated Community Services (an agency dedicated to forging partnerships between individuals with disabilities and the community), funded through the STAR FSP. Impressively, 92% of these Job Development Clients were successfully employed, with 66% retaining the job for at least 4 months.

In FY17/18 29 Law Enforcement Officers from California Highway Patrol, Marin County Sheriff's Office, Mill Valley Police Department, Novato Police Department, San Rafael Police Department, Sausalito Police Department, and staff from the Probation Office received the Crisis Intervention Training (CIT), enabling them to more effectively and safely identify and respond to crisis situations and mental health emergencies.

SUCCESSES IN FY17/18

In FY17/18, the STAR Team went through a number of changes and grew in some very positive ways. A new Forensic-Clinical Supervisor was hired. Two (2) Case Manager positions were also filled. A new Judge was assigned to the STAR Court, as well. The STAR Community Program (which serves clients with Severe Mental Illnesses and who have forensic-related needs and/or histories) expanded and refined its programming and client-related services – in an effort to continually improve and meet the needs of our diverse clientele.

CLIENT STORY FROM FY17/18

In 2018, one of STAR Court clients graduated from the 18-month program. Over the course of the program, the client went from begrudgingly participating to being a leader and role-model for the other clients in the Court. The client had such a tremendous shift in her attitude, her insight, and her commitment to her well-being and happiness that she is now studying for and working towards becoming a Peer Counselor. She wishes to continue her own path of recovery and wellness and also share her experiences and knowledge with others who could greatly benefit from them. This client truly exemplified the principles underlying STAR's guiding philosophy and commitment to recovery, community, and health.

HELPING OLDER PEOPLE EXCEL (HOPE) FULL SERVICE PARTNERSHIP: FSP 04

PROGRAM ALLOCATION FY17/18: $873,973

PROGRAM OVERVIEW AND HISTORY

The HOPE Program has been an MHSA-funded county-operated Full Service Partnership (FSP) serving older adults with serious mental illness who are at risk of homelessness, hospitalization, or institutionalization since 2007. The program is designed to provide community-based outreach, comprehensive geropsychiatric assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team. The over-arching vision of the HOPE Program is "Aging with dignity, self-sufficiency and in the life style of choice". The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

Prior to implementation of MHSA, Marin County did not operate a comprehensive integrated system of care for older adults with serious mental illness. Due to limited resources and service capacity, the existing Older Adult Services County mental health program had been unable to provide much more than assessment and peer support services. Of all the age groups served by Marin's public mental health services, older adults had received the least services and had the lowest penetration rates, despite the fact that they constituted the fastest growing age cohort in Marin.

Key stakeholders and community partners had consistently agreed that Marin needed to more comprehensively address the needs of older adults who have serious mental illness, and they strongly supported the creation of a new Full Service Partnership as a critical step toward an integrated system of care for this population. In 2006, Marin's HOPE Program was approved as a new MHSA-funded Full Service Partnership providing culturally competent, intensive, integrated services to 40 priority population at-risk older adults. Older adults were identified to be Marin's fastest growing population and comprise 24% of the total population. By 2014, demand for HOPE Program services had exceeded its capacity, and MHSA funding was used to add a full-time Spanish speaking clinician to the community treatment team. This enabled the program to enroll additional individuals, bringing the capacity of the Full Service Partnership to 50.

Senior Peer Counseling is also for people over the age of 60 but the focus is on supporting those who would benefit from a little extra support in their lives. Support is provided by trained volunteers who receive weekly supervision from a licensed MFT and/or Registered Nurse. Decreasing isolation, issues of aging, grief, and depression are common issues addressed in Senior Peer Counseling.

In 2014 the program was also expanded to provide increased outreach to at-risk Hispanic/Latino older adults by increasing the hours of the Spanish-speaking mental health clinician supporting and supervising the Amigos Consejeros a su Alcance (ACASA) component of the Senior Peer Counseling Program. These additional hours are used to outreach into the community to increase awareness of the mental health needs of Hispanic/Latino older adults and their families, and the services that ACASA and the HOPE Program offer. ACASA is expected to identify and engage with 5 new monolingual community liaisons annually. It is also anticipated that the addition of Spanish-speaking capacity to the Full Service Partnership will facilitate the identification, engagement, and enrollment of at-risk Hispanic/Latino older

adults who have serious mental illness and have been unserved or underserved by the Older Adult System of Care.

Also in 2014, the program was expanded to provide Independent Living Skills (ILS) training for targeted HOPE clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

PROVIDER: County-operated

TARGET POPULATION

The target population of the HOPE Program is older adults with serious mental illness, ages 60 and older, who are currently unserved by the mental health system, who have experienced or are experiencing a reduction in their personal or community functioning and, as a result, are at risk of hospitalization, institutionalization or homelessness. These older adults may or may not have a co-occurring substance abuse disorders and/or other serious health conditions. Transition age older adults, ages 55-59, may be included when appropriate.

PROGRAM DESCRIPTION

The HOPE Program is a Full Service Partnership (FSP) that provides culturally competent intensive, integrated services to 50 priority population at-risk older adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be.

The HOPE Program's multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, assistance with money management, and linkages to/provision of all needed services and supports. The clinicians provide virtually all their services with this population at the client's homes in order to make it as convenient as possible for older adults who might have limited mobility or difficulties accessing transportation. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full Service Partnership clients as part of the "whatever it takes" approach.

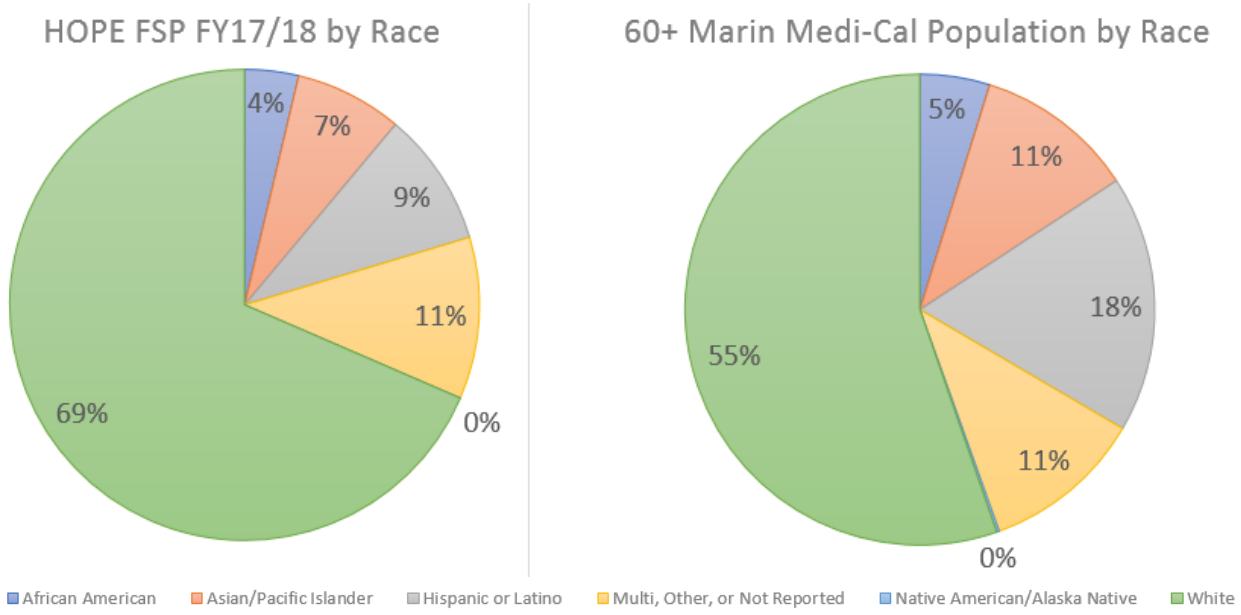
The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team's mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services.

Because of the stigma associated with mental health issues for older adults in general, mental health issues often reach crisis proportions and require emergency medical and psychiatric care before they seek help. Outreach services are critical for engaging these individuals before they experience such

crises. Marin's highly successful Senior Peer Counseling Program, staffed by older adult volunteers and the County mental health staff who support and supervise that program, has been integrated into the team and provides outreach, engagement, and support services. In addition, the Senior Peer Counseling Program provides "step-down" services to individuals ready to graduate from intensive services.

DEMOGRAPHICS

To further analyze the demographics discussed in the demographics section of the CSS overview section, there are two charts below—the first represents the racial breakdown of the HOPE FSP clients in FY17/18 and the second shows the racial breakdown of the Marin Medi-Cal population age 60 or over. The hispanic population continues to be underserved—only 9% of the clients served in HOPE identified at Hispanic or Latino, whereas 18% of the Marin Medi-Cal population age 60 or over identify as such. The Asian/Pacific Islander population is underrepresented as well with 7% of the HOPE clients and 11% of this age group's Medi-Cal population. The African-American population represents 4% of the clients and 5% of this Medi-Cal population, however this difference is not statistically significant given the size of the HOPE program. The HOPE program is continuing to address and explore ways to reduce stigma around receiving services and ensure their services are culturally appropriate and promote inclusion. In FY17/18 there were two full-time bilingual clinicians—one bilingual in Spanish and the other bilingual in Vietnamese.



To see the other demographic breakdowns of the HOPE program, including by language, age, and gender, please see the CSS Demographics section.

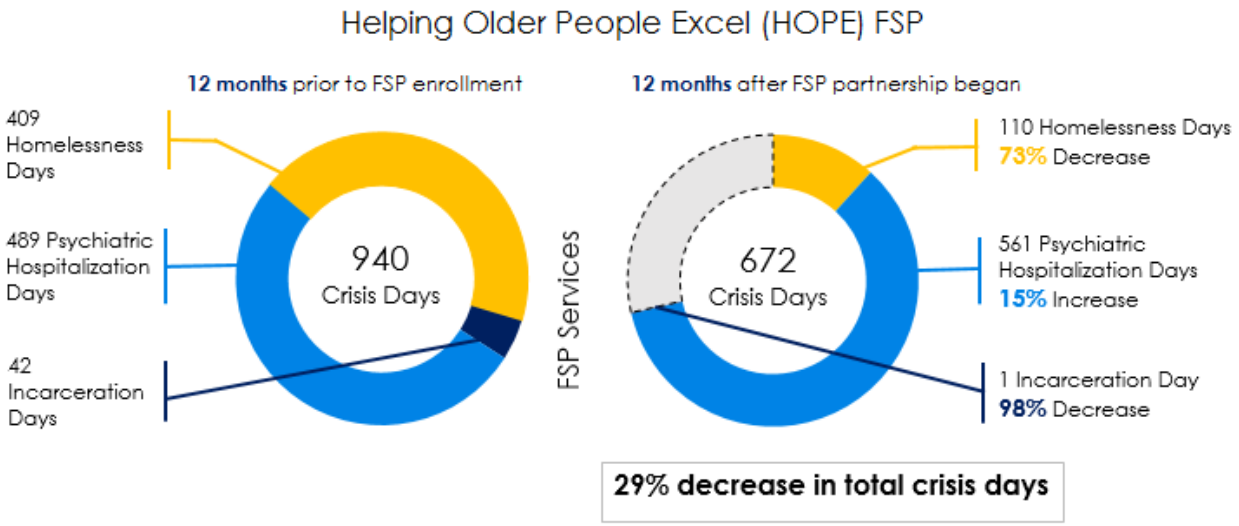
EXPECTED OUTCOMES

Listed in the table below, the expected outcomes for the HOPE Program are based on the goals of the program and remain unchanged. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the HOPE Program staff on a daily basis. Program staff will continue to explore age-appropriate

methods for measuring self-sufficiency and isolation that will permit the program to evaluate its success in these key areas.

Outcomes	GOAL
Decrease in homelessness	75%
Decrease in hospitalization	50%

FSP OUTCOMES FY17/18:

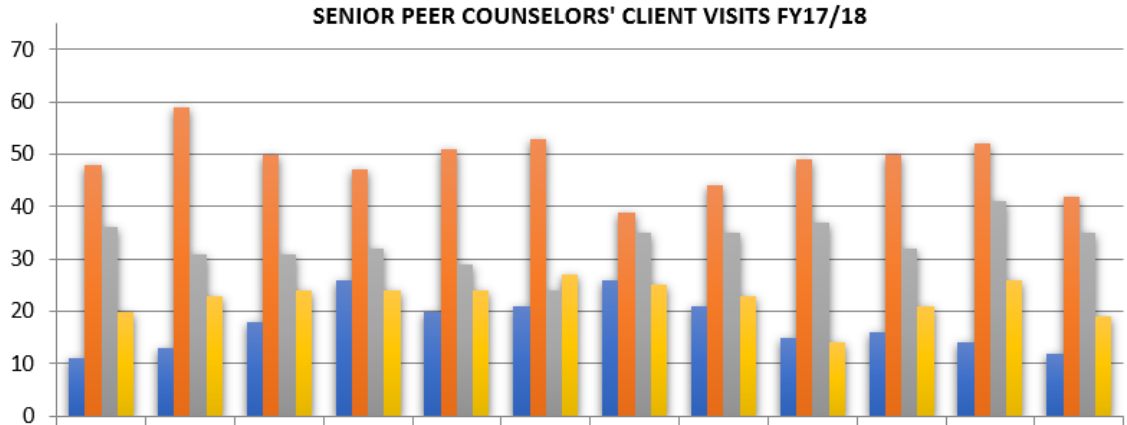


The HOPE program served 54 clients in FY17/18, 46 of whom reached their one-year mark in the program either during or prior to FY17/18. Those 46 clients spent a collective 409 days homeless, 489 in psychiatric hospitalization, and 42 incarcerated in the 12 months prior to enrolling in the HOPE program. In their first year in the FSP they had a 29% decrease in total crisis days with a 73% decrease in days homeless, a 15% increase in psychiatric hospitalization days, and a 98% decrease in days incarcerated. Despite the goal being to reduce hospitalization days there are some instances when that is the needed placement for clients in the HOPE program, especially in situations where clients have complex medical needs in addition and mental health conditions that will not allow them to be placed in lower levels of care.

SENIOR PEER COUNSELOR PROGRAM OUTCOMES

The Senior Peer Counseling (SPC) program, which is funded mainly with County General Funds, had 1,465 client visits in FY17/18, including 213 in the ACASA Spanish language program. The SPC program has four different locations across the County including a West Marin group. Senior Peer Counseling supervisors reached out to even more local agencies and community partners in FY17/18 and there has

been increased collaboration with Commission on Aging, Section on Aging, County senior centers, Jewish Family and Children's Services, and other organizations around client needs and referrals.



	2017 JUL	AUG	SEP	OCT	NOV	DEC	2018 JAN	FEB	MAR	APR	MAY	JUN
ACASA	11	13	18	26	20	21	26	21	15	16	14	12
NOVATO	48	59	50	47	51	53	39	44	49	50	52	42
SAN RAFAEL	36	31	31	32	29	24	35	35	37	32	41	35
WEST MARIN	20	23	24	24	24	27	25	23	14	21	26	19

SUCCESSES IN FY17/18

In FY17/18 the HOPE team planted a Garden at St. Michael's board and care facility to enhance residents' quality of life and to promote social interaction. This garden was well received and clients reported that helping in the garden gave them something to look forward to.

In FY17/18 there was also increased collaboration between Aging and Adult Services and HOPE. HOPE provided consultation to the Adult Protective Services (APS) and In-Home Supportive Services (IHSS) team Social Workers and assisted identified clients in connecting with Access.

All HOPE and SPC staff members attended Cultural Competency trainings in FY17/18. This sparked meaningful discussions about racial and gender equality and how to best promote diversity and inclusion. Significant effort in FY17/18 was put into outreach and engagement for the Spanish speaking SPC program, ACASA, to increase peer volunteers and hard to reach consumers.

CHALLENGES OR LESSONS LEARNED IN FY17/18

The HOPE Program and Senior Peer Counseling continued to face challenges in working with older adults with a chronic and severe mental illness who also present with co-occurring neurocognitive disorders. With impaired memory/executive functioning coupled with diminished self-care abilities, identified clients are difficult to place. Moreover, when behavioral disturbances are at play as a result of their co-occurring disorders, access to an appropriate level of care is diminished. There is an extreme shortage of placement beds in all of Marin, but even more so for those diagnosed with a neurocognitive disorder. Furthermore, many HOPE clients have complex medical needs due to chronic physical health disorders that can be a barrier to accessing appropriate care services.

ANTICIPATED CHANGES FOR FY19/20

- The lack of available affordable housing and placement options for older adults who suffer from chronic and persistent mental illness has been a major concern for the HOPE program for many years. However, there is an exciting development in progress with the building of "Victory Village," a housing complex for older adults, to be completed in the Spring of 2020. MHSA Housing Program (MHSA HP) funding was used to leverage a set-aside of 6 furnished apartments for older adults who qualify for Full Service Partnership level of care, who are experiencing or at-risk of homelessness. The HOPE Program has been and will continue to work closely with the development as it progresses and will be instrumental in providing supportive services for the clients placed in those units.
- The Senior Peer Counseling Program will also be collaborating with MHSA Innovation for a 3-year project targeted at supporting older adults experiencing mental illness and connecting identified individuals to a "technology suite"—a group of resources made available by technology. As our County ages, older adults often face numerous barriers to accessing care including limited mobility, social isolation and stigma about receiving mental health treatment. This can lead to an exacerbation of mental health symptoms. One aspect of this Innovation project is bringing the locally developed "Detect and Connect" trainings that show promise in helping community members learn about the signs and symptoms and ways to better support older adults with mental health and cognitive concerns. SPC will be partnering to implement this Innovation project with the goal to increase linkage to services and enable older adults with mental health needs to better age in place.

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ODYSSEY FULL SERVICE PARTNERSHIP: FSP 05

PROGRAM ALLOCATION FY17/18: $2,242,167

PROGRAM OVERVIEW AND HISTORY

The Odyssey Program has been an MHSA-funded county-operated Full Service Partnership (FSP) serving adults with serious mental illness who are homeless or at-risk of homelessness since 2008. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the loss of AB2034 funding for Marin's Homeless Assistance Program which had been in operation since 2001, key stakeholders and community partners fully supported the creation of a new Full Service Partnership, the Odyssey Program, to continue serving the AB2034 target population. Over the course of its existence, Marin's AB2034 program demonstrated significant success in assisting adults with serious mental illness who were homeless to obtain and maintain housing, despite the County's very challenging housing environment, and to avoid incarceration and hospitalization. The design of the new program incorporated the valuable experiences and lessons learned from the AB2034-funded services and in 2007, the Odyssey Program was approved as a new MSHA-funded CSS Full Service Partnership providing culturally competent intensive, integrated services to 60 priority population adults who were homeless or at-risk of homelessness. The Odyssey Program was designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team.

A substantial percentage of program participants present with co-occurring substance use disorders, increasing the risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team.

In 2012 the program added Independent Living Skills (ILS) training for targeted Odyssey clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is was originally expected to be provided to 4-5 program participants annually, but has grown significantly in recent years.

Beginning in 2011 MHSA funds were used to fund emergency housing in a 2-bedroom apartment for program participants who are homeless to provide a safe place for residents to live while seeking permanent housing. While in the emergency housing, program participants are able to save money for security and rent deposits and can work closely with program staff to develop budgeting and living skills needed for a successful transition to independent living. Emergency housing serves 5-10 program participants annually. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full Service Partnership clients as part of the "whatever it takes" approach.

In 2014 Odyssey implemented a "Step-Down" component, staffed by a Social Service Worker with lived experience and a Peer Specialist and targeting individuals already enrolled in the program who no longer need assertive community treatment services, but continue to require more support and service than is

available through natural support systems. This program did not achieve the intended outcomes. Since implementation, the team has been challenged by needing to provide frequent transfers between this component and the assertive community treatment component of the team. However, in FY17/18 BHRS re-structured both components by integrating the two services in support of participants being able to access services at different intensities, depending on their needs, without the need to transfer between two separate FSP components.

PROVIDER: County-operated

TARGET POPULATION

The target population of the Odyssey Program is adults, transition age youth, and older adults with serious mental illness, ages 18 and older, who are homeless or at-risk of homelessness due to their mental health challenges. Priority is given to individuals who are unserved by the mental health system or are so underserved that they end up homeless or at risk of becoming homeless. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION

The Odyssey Program is a Full Service Partnership (FSP) that provides culturally competent intensive, integrated services to 80 priority population at-risk adults who are homeless or at-risk of homelessness due to their mental health challenges. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

A multi-disciplinary, multi-agency assertive community treatment team comprised of professional, para-professional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psychoeducation, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team's mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services.

A contract for vocational services provides situational assessments, job development and job placement services for program participants, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation to leverage funding for additional vocational services, including job coaching.

EXPECTED OUTCOMES

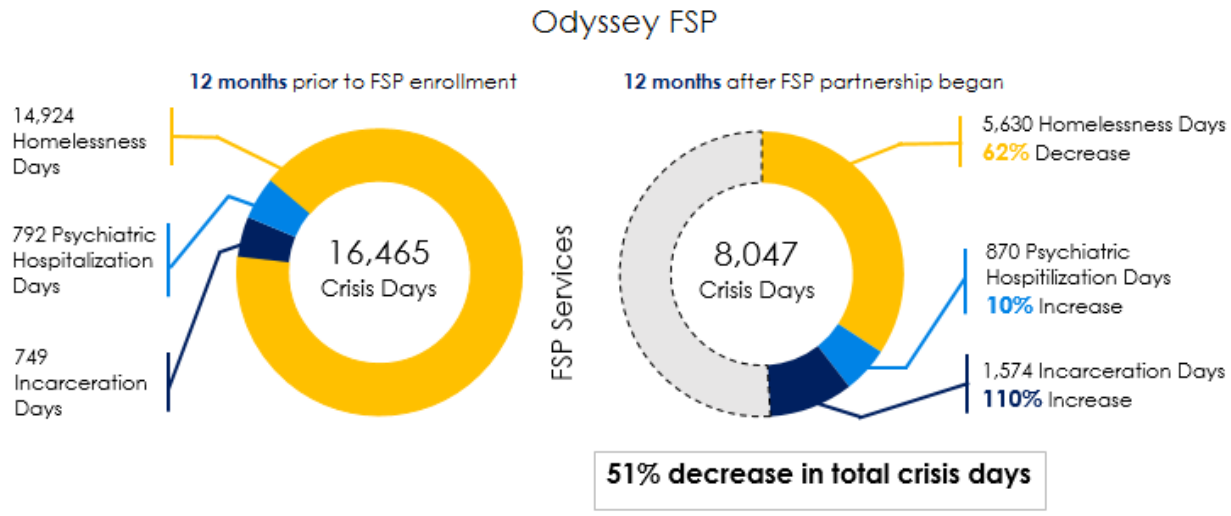
Listed in the table below, the expected outcomes for the Odyssey Program are based on the goals of the program and remain unchanged. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the Odyssey Program staff on a daily basis. Program staff will continue to explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	GOAL
Decrease in homelessness	80%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%

ACTUAL OUTCOMES

Odyssey served 113 unduplicated clients in FY17/18—41% more than the goal of 80 clients.

There were 97 clients active at some point in FY17/18 who had been enrolled for at least 12 months. Those clients collectively spent 14,924 days homeless in the year prior to initiating service. In their first year in the Odyssey partnership their days homeless decrease by 62% (a decrease of 9,294 days). Psychiatric hospitalization days increased by 10% (78 more days), and incarceration days increased significantly-by 110%. However, overall there was a reduction of 51% in total crisis days.



In FY17/18 the Odyssey Step-Down component was successfully reincorporated and unified back into one wholistic program. In addition, in February 2018 the Odyssey program moved to the City of Novato to provide this under-severed community with increased homeless outreach and psychiatric services. Since the move the Odyssey team has been building community awareness and have recently begun

outreach efforts with the Novato Police Department's Homeless Outreach Team. Some Odyssey clinicians have shadowed this team going to homeless encampments in the area to engage with the chronically homeless mentally ill population. So far, the team has identified 4 new potential consumers. Continued efforts are being made to engage these individuals, eventually providing them with a sense of safety to accept available services.

CHALLENGES OR LESSONS LEARNED IN FY17/18

The Odyssey team experienced some challenges in FY17/18. One is that many of the consumers are aging and struggle with declining health issues. The Odyssey program was able to acquire a van to help support the consumers with increased socialization opportunities and support to medical and psychiatric appointments throughout the county. In the next three year plan the Odyssey team would like to advocate for funds to hire a driver position that is imbedded into our clinic to provide ongoing services which will allow our clinical staff to focus on psychiatric interventions and services. This position will also decrease emergency transportation costs throughout the year.

Another challenge is the increasing number of dually diagnosed consumers with substance use disorders. This issue often jeopardizes our most vulnerable consumers and their housing. Odyssey has a pre-contemplative weekly group that is low barrier and includes social skill building which suits some of the most vulnerable consumers and also utilize referrals to our County Road to Recovery program. In the coming 3 year plan the Odyssey ream would like to advocate for a 15-20-hour substance use counselor position that is imbedded with our clinic to provide onsite therapy for our consumers and ongoing training /expert interventions to the team.

ANTICIPATED CHANGES FOR FY19/20

In FY19/20 the Odyssey team is aiming to implement some program structure changes, including implementing some aspects of the ACT model closer to fidelity and having groups lead by peer specialists. We are looking at having a welcoming group and a designated peer navigator to support all new consumers upon entry into our program. This navigator position (which is a realignment of the role of a current peer position) will help fostering trust to retain clients in services.

CLIENT STORY FROM FY17/18

The Odyssey program had their yearly sponsored Winter Faire for our consumers throughout the county. This event is designed to support and honor our talented artists and musicians who are mental health consumers within BHRS. We had 126 individuals participating in our holiday celebration. Here is one of those participants and their success story:

Over the past year, Jane Doe had made 4 hats that she submitted to several regional county fairs, where they have been prize-winners. She was not willing to sell these particular hats, because she would like to continue to show them at other county fairs. However, she was encouraged to bring her hats to the Winter Faire to display and share her creativity. Her hats were a resounding success! Not only were they widely appreciated and admired, but several people took orders –and now, Jane Doe will be creating and making new hats and delivering them to her new customers in the very near future.

The experience of making something original and receiving accolades from her peers and from the community has been a meaningful and rewarding experience for Jane. Her experience at the Winter Faire has inspired her, as she is now taking some classes at the local college and she is looking forward to creating more original fashion items in the future!

INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT): FSP 06

PROGRAM ALLOCATION FY17/18: $691,702

PROGRAM OVERVIEW AND HISTORY

In recent years, the Marin County Adult System of Care has struggled with an increasing number of individuals with serious mental illness who are in need of more intensive services than those offered by either of the integrated clinics. The FY17/18-FY19/20 Three-Year plan proposed the addition of a Full Service Partnership specifically targeting those who do not necessarily fall into the one of the target populations of the current Full Service Partnerships: homeless (Odyssey), Older Adults (HOPE), or involved with the criminal justice system (STAR). This program is called IMPACT.

PROVIDER: County-operated

TARGET POPULATION

IMPACT's target population are adults, transition age youth over 18, and older adults with serious mental illness, who are un-served by the mental health system or are so underserved that they are unable to stabilize in the community without additional support. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION

The IMPACT FSP was in development in FY17/18 and will provide culturally competent intensive, integrated services to forty (40) priority population at-risk adults once it is fully operational. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the Assertive Community Treatment model, a diverse multi-disciplinary team has been developed to provide comprehensive "wrap-around" services for individuals in need of the highest level of outpatient services. Staffing is comprised of mental health clinicians, Peer Specialists, Family Partners, para-professionals, psychiatry and Nurse Practitioners. Services include comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psycho-education, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and will be provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for

stabilization and/or meeting treatment goals for Full Service Partnership clients as part of the "whatever it takes" approach.

EXPECTED OUTCOMES

Listed in the table below, the expected outcomes are based on the goals of the program. IMPACT is expected to serve up to forty (40) 18+ year old adults. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the program staff on a daily basis. Program staff will explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	Goal
Decrease in homelessness	25%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%

ACTUAL OUTCOMES

None of the outcome goals were met: FY17/18 was a development year for the IMPACT FSP and no clients were seen.

FY17/18 PROGRAM ACTIVITIES

FY17/18 was a development year for the IMPACT FSP. The site in Novato was renovated and Medi-Cal certified. The program was registered with DHCS, compliance reviews occurred, computers, monitors and office supplies were ordered, as well as confidential bins, weigh scales, refrigerator for medicines, and other medical equipment.

There was significant time devoted to recruiting and training staff and the following staff positions were hired by June 30, 2018:

- Mental Health Unit Supervisor (1.0 FTE)
- Office Assistant III (1.0 FTE)
- Mental Health Practitioner (1.0 FTE)
- Social Services Worker II (1,0 FTE)
- Peer Counselor I—Peer Specialist (1.0 FTE)
- Peer Counselor I—Family Partner (1.0 FTE)
- Mental Health Nurse Practitioner (0.25 FTE)
- Psychiatrist (0.15 FTE)

ENTERPRISE RESOURCE CENTER (ERC) EXPANSION: SDOE 01

MHSA PROGRAM ALLOCATION FY17/18: $357,809

PROGRAM OVERVIEW

Since 2006, the ERC Expansion Program has been an MHSA-funded System Development/Outreach and Engagement (SDOE) project serving adults with serious mental illness who are reluctant to become involved in the public mental health system.

Prior to implementation of the MHSA, Marin's consumer-staffed Enterprise Resource Center averaged approximately 600 client visits per month in its small multi-purpose drop-in center and had outgrown its space and management infrastructure. In 2006, MHSA funding for the ERC Expansion Program was approved, adding new consumer management positions and establishing a Wellness/Recovery Center in central Marin through enlarging and co-locating the ERC with housing, employment and clinical services at the new Health & Human Services Health and Wellness Campus. In late FY07-08, the Enterprise Resource Center moved into its new facility at the Health and Wellness Campus. Also during FY07-08, MHSA expansion funds were used to increase consumer staffing to enable the ERC to increase its hours of operation to 7 days a week.

An expanded client-operated ERC co-located with other adult system of care services optimizes outreach and engagement possibilities, promotes consumer empowerment and, most importantly, embodies the concepts of wellness and recovery. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation.

The ERC Expansion Program has been remarkably successful with the number of client visits per month increasing from 600 to over 1,500; its average daily attendance goal has been met with consistent gains each year.

PROVIDER: Community Action Marin

TARGET POPULATION

The target population of the ERC Expansion Program is transition-age youth (18+), adults and older adults who have serious mental illness and their families, many of whom are currently disenfranchised or reluctant to become involved in the mental health system. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION

Known for its low-barrier access and welcoming environment, the Enterprise Resource Center plays a key role in Marin's efforts to outreach to and engage with adults with serious mental illness in the county who are disenfranchised and reluctant to seek help and services. In addition to optimizing outreach and engagement possibilities, an expanded client-operated Enterprise Resource Center co-located with other services at the Health & Wellness Campus that promote and support recovery, such

as supported housing and employment services, builds trust, maximizes opportunities for collaboration and increasingly engages clients in their own recovery process. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. Consumers working to assist other consumers serve as role models and a message of hope that further promotes wellness and recovery.

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line; the Linda Reed Activities Club; specialty groups and classes; supportive counseling with trained Peer Counselors; and a Peer Companion Program that outreaches to individuals who tend to isolate. Outreach and engagement services for the County's homeless individuals with mental illness are provided by ERC and its CARE team (homeless mobile outreach) which works closely with Marin's Odyssey Program for homeless adults who have serious mental illness. The ERC also provides Peer Counseling and Case Management training programs and on-the-job internships for consumers seeking to work as service providers in the public mental health system.

EXPECTED OUTCOMES

Listed in the table below, the expected outcomes for the ERC Expansion Program are based on the goals of the program and currently remain unchanged. The data for these measures are obtained from CSS logs that program staff are required to fill out and keep up-to-date.

Outcomes	Goal
# ERC first time visitors	200
Avg daily attendance	35
# Warm Line contacts	6,500
# Served – CARE Team (unduplicated)	180
Avg monthly contacts – CARE Team	100

ACTUAL OUTCOMES

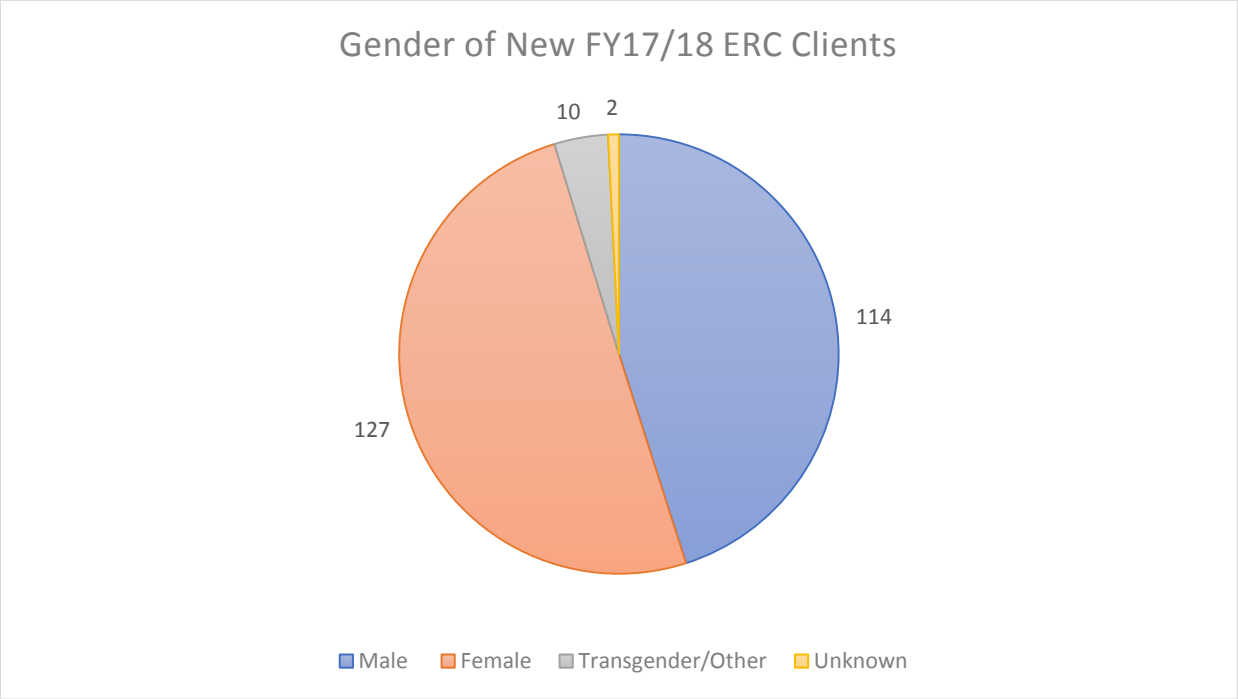
The ERC continues to exceed many of the goals of the program. In FY17/18, there were a total of 15,607 consumer visits, with an average daily attendance of 49 clients on weekdays, and 26 clients on average during the weekends (for an overall average of 43 clients). First-timers unduplicated clients were tracked over the year with a total of 253 clients that registered. We also tracked homeless clients that signed in. The total was 1,776 clients (duplicated). The referrals to community services we tracked was a total of 1,338 referrals to 60 different resources.

The Warmline was able to assist callers with 5,762 contacts. The 1108 Gallery, an Art Gallery showcasing consumer artwork, celebrated its third year. 63 people (duplicated) graduated from Peer Counseling courses including Introduction to Peer Counseling: Psychiatric Medications; Introduction to Peer Counseling: Advanced Case Management; and Hoarding

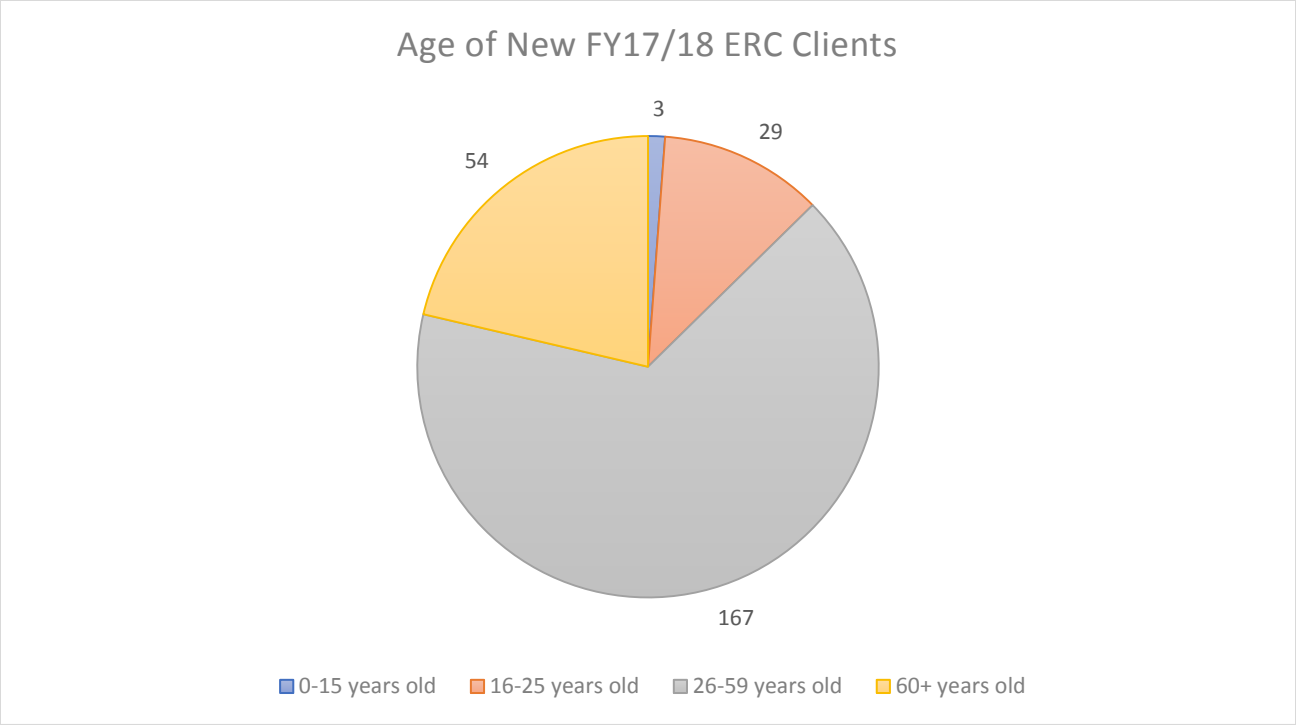
CARE Team I provides outreach and engagement services to homeless mentally ill clients in Marin. They may work with clients from the ERC or respond to calls from the community. These referrals originate from many agencies, including red flag reports from the California Highway Patrol, the Fairfax Police Department, and the West Marin Sheriff Department. The number of contacts served is less than 100 per month because they are receiving more referrals to care for the acute mentally ill —not just in Central Marin —but in West Marin where the team now works two days a week. These clients also require more time from the CARE Team I based on the severity of their mental illness and a host of medical issues and co-occurring drug and alcohol issues. CARE Team I does their best to find resources in the community to serve these clients who may be resistant to accessing services.

DEMOGRAPHICS

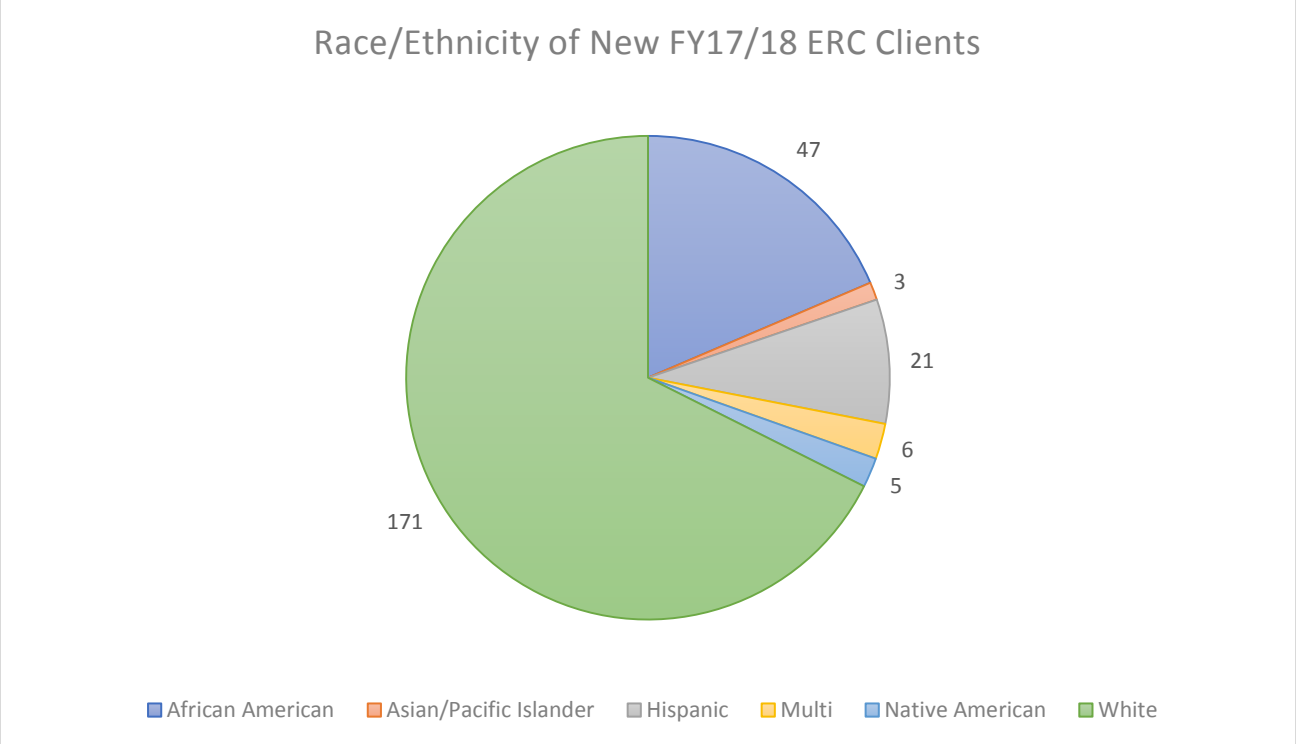
The following demographics are for the 253 new clients that were first served by the Enterprise Resource Center in FY17/18.



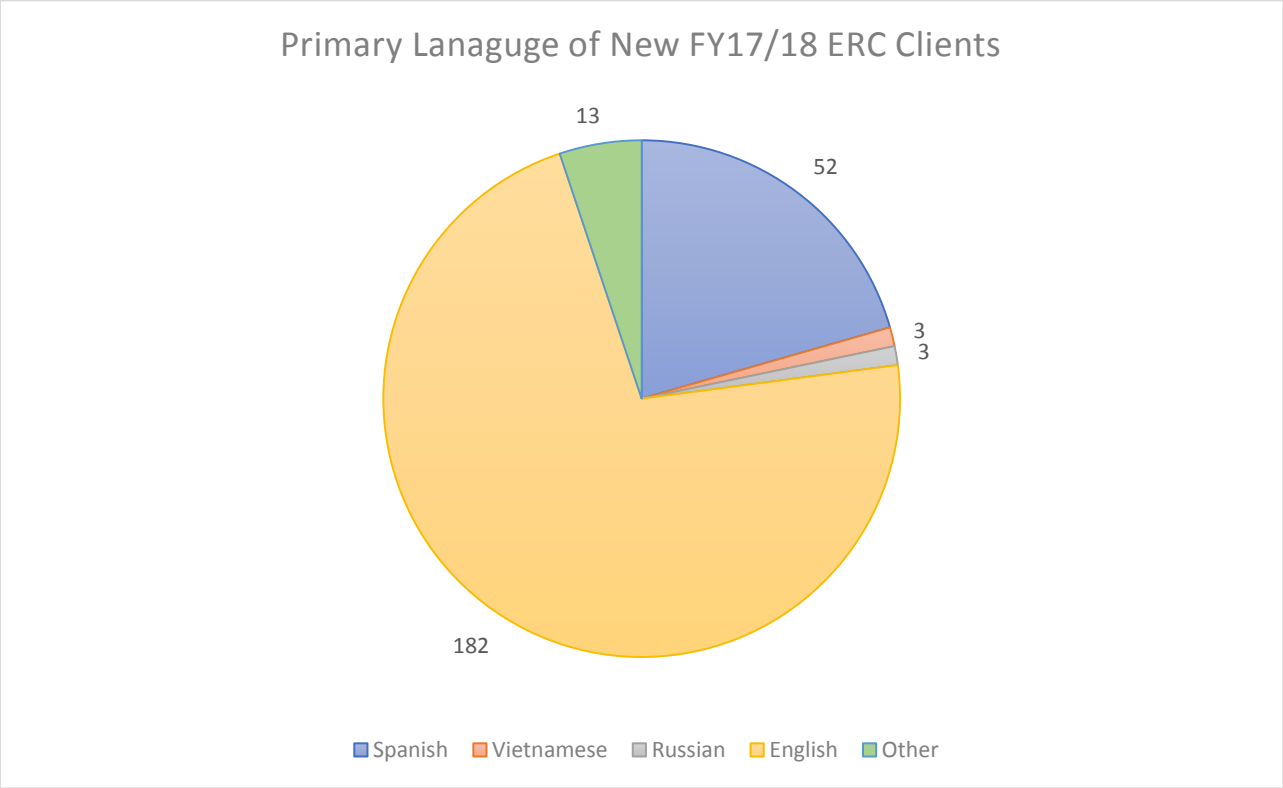
N=253; In FY17/18 50% of the new clients at the ERC identified as female, 45% identified as male, and 4% identified as Transgender/other.



N=253; 66% of new clients in FY17/18 were between the ages fo 26-59. 11% were in the TAY age range, 16-25 years old, and 21% were 60 or older. In addition, 1% (3) was under the age of 16.



N=253; 68% of the new clients were white, 19% African American, 8% Hispanic, 2% Multi-Racial, 2% Native American, and 1% Asian/Pacific Islander.



N=253; 72% spoke English as their primary language, 21% Spanish, 5% other, 1% Vietnamese, and 1% Russian.

PROGRAM CHALLENGES

In FY17/18 the Enterprise Resource Center did not have a position on site that was bilingual which has been a major challenge.

FUTURE CHANGES

In FY19/20 the ERC is also looking to develop an additional Peer Counseling Course specifically oriented to the TAY population. This will involve creating a manual and curriculum that will meet the needs of young adults.

ADULT SYSTEM OF CARE (ASOC) EXPANSION: SDOE 07

MHSA PROGRAM ALLOCATION FY17/18: $452,355

PROGRAM OVERVIEW AND HISTORY

The ASOC Expansion Program has been an MHSA-funded General System Development/Outreach and Engagement program serving adults with serious mental illness who are unserved or underserved by the adult system of care since 2008.

The overarching vision of Marin's system of care for adults who have serious mental illness is "*A Home, Family & Friends, A Job, Safe & Healthy*." The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, reduce isolation, and provide low-barrier access which welcomes unserved clients of Vietnamese and Hispanic/Latino origin.

Prior to MHSA, Marin's Adult System of Care (ASOC) consisted of 3 intensive community treatment teams which were responsible for providing and connecting clients to a broad continuum of services including supported housing, employment services, Peer Specialist services, medication support, residential care services, integrated physical-mental health care, jail mental health services and crisis stabilization, in addition to traditional outpatient mental health treatment. Expansion and enhancement of Marin's existing ASOC was identified as a priority in the initial county MHSA stakeholder process, especially in terms of engaging and serving Hispanic/Latino, Vietnamese, and other adults who tended to be un/underserved within the ASOC. Unfortunately, there were not sufficient MHSA funds available at that time to permit Marin County to address all of the needs and priorities identified in the planning process. In FY07-08, additional MHSA funds became available and the ASOC Expansion project was created to make additions/enhancements to the ASOC that would further its existing efforts at system transformation.

The ASOC Expansion was approved as a General System Development/Outreach and Engagement project designed to expand and enhance supports and services available in Marin's system of care for priority population adults and their families through the implementation of 5 components: Peer Specialist services; outreach to Hispanics/Latinos; outreach and support to Vietnamese; family outreach, engagement and support services; and short-term housing assistance.

With the implementation of the MHSA-funded PEI Community Health Advocate (CHA) Hispanic/Latino and Vietnamese projects, development of new partnerships and related strategies greatly increased the ASOC Expansion Program's ability to engage with these underserved populations.

TARGET POPULATION

The target population of the ASOC Expansion Program is transition-age youth (18+), adults and older adults who have serious mental illness and their families. Priority is given to individuals who are currently un/underserved by the mental health system, especially Latino (Spanish-speaking) and Vietnamese (Vietnamese-speaking) individuals. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION

The ASOC Expansion Program is a general system development/outreach and engagement project designed to expand and enhance supports and services available in Marin's system of care for adults with serious mental illness and their families by 1) increasing peer specialist services on the Adult Intensive Case Management team, 2) providing outreach and engagement services to Hispanics/Latinos, 3) increasing Vietnamese outreach and engagement services, 4) adding family outreach, engagement and support services to the ASOC at large, and 5) emergency assistance fund

Increased Peer Specialist Services: An MHSA-funded full-time peer specialist (currently contracted with Community Action Marin and imbedded in the Adult Intensive Case Management team) provides services and supports to clients of the Adult Intensive Case Management team that focus on recovery and illness self-management strategies for individuals whose symptoms have begun to stabilize. This program component promotes the concepts of wellness, recovery and self-help within the county-operated core non-FSP intensive case management team serving adults who have serious mental illness.

Provide Outreach to and Engagement with Hispanic/Latino Individuals: Marin has a well-documented need to increase mental health services for un/underserved Hispanics/Latinos. MHSA funding was used to add a part-time bilingual (Spanish-speaking) psychiatrist [to provide medication support services. MHSA funding was also used to fund a part-time bilingual (Spanish-speaking) mental health clinician to provide targeted outreach and engagement to Hispanics/Latinos. In FY12-13, the ASOC Spanish-speaking staff position was restructured to function as Community Health Advocate (CHA) Liaison to the evidence-based MHSA-funded PEI CHA (*Promotores*) project designed to increase the capacity of CHAs to address mental health and substance abuse concerns of Hispanics/Latinos in their communities. The CHA Liaison provides training, supervision and support to the Spanish-speaking CHAs, as well as assistance in linking community members to public mental health services.

Increased Outreach and Engagement to Vietnamese-Speaking Individuals: The Vietnamese population in Marin County has also been un/underserved. By using MHSA-funding to increase a part-time bilingual Vietnamese speaking clinician to full-time, Marin expanded capacity to incorporate the language and culture of the underserved Vietnamese population through the provision of linguistically and culturally competent services. This position provides mental health outreach and engagement to Vietnamese-speaking individuals, as well as translation of language and cultural issues to ensure that staff psychiatrists can accurately provide medication support to monolingual Vietnamese clients.

Additionally, MHSA PEI funds were approved to support the development of a CVommunity Health Advocate (CHA) model for the Vietnamese community. The MHSA-funded Vietnamese-speaking clinician and MHSA-funded Spanish-speaking CHA Liaison are partnering with this CHA project to provide support and assistance, as well as promote opportunities for the two CHA projects to collaborate.

Family Outreach, Engagement and Support Services: Family Outreach, Engagement and Support Services have been expanded through the addition of Family Partners with personal experience as a family member of an adult with mental illness. The ASOC Family Partners provide outreach and engagement services to families of adults with serious mental illness, as well as family-to-family care management services including provision of support and advocacy, assistance with service plan development and implementation, information and referral to

NAMI-Marin and other local community resources, and co-facilitation of family support groups. One of these positions is designated as Spanish Speaking to further support Hispanic/Latino families who's loved ones are engaged services through the adult integrated care teams. This position is expected to serve 75 monolingual family members annually.

Emergency Assistance Fund: Beginning in 2011, CSS funds were approved to create a Housing Assistance Fund for the ASOC to provide short-term housing assistance funding to assist at-risk clients of the Adult Intensive Care Management team to successfully access and/or maintain appropriate housing in the community. Experience with this funding over the following years revealed the need to broaden its use to address other, equally critical client needs. The Adult Integrated Care Management Teams use this funding as a pool of flexible funds to support clients and purchase needed goods and services, including emergency and short-term transitional housing, medications, and transportation, that cannot be otherwise obtained. This fund will be used to assist 40 clients annually.

EXPECTED AND ACTUAL OUTCOMES

Listed in the table below, the expected outcomes for the ASOC Expansion Program are based on the goals of the program and remain unchanged. The data for these measures are obtained from our electronic health records system.

Outcomes	Goal	Actual FY17/18
# Served	1,200	1,102
% Hispanic	10%	14%
# Primary language-Spanish	120	70
# Asian	60	68
# Primary language-Vietnamese	30	27

Other activities in FY17/18 funded by ASOC-expansion targeting the Latinx and Vietnamese populations included:

Classes & Groups

- Free year-round weekly **parenting** class served **>50** of local Latinx parents and caregivers. Many participants fulfill requirements from Social Services and Probation via these offerings.
- **>15** Latinx community members fulfilled requirements mandated by Marin County Courts through our **anger management** class, and by CalWorks through our psycho-educational group for **Latinx women**.
- Behavioral activation via year-round **Zumba and yoga** in Spanish attracted **>50** Latinx community members, many referred by their health providers.

Radio/Podcasts in Spanish

- ***Cuerpo Corazón Comunidad,*** our weekly live hour-long interactive educational program on health and wellness in Spanish transmitted on radio stations and online, aired **52 radio broadcasts/podcasts**.
- **Thousands** of community members were reached via radio, itunes and social media. The Executive Producer estimates that at 11am on weekdays KBBF reached **~2,500** and KWMR reached **~400** adults in Marin. Since recordings can be accessed after the live broadcast, itunes and Facebook data significantly increase these figures as time goes on.
- The number of followers on **Facebook** continued to grow, this year surpassing >**6,800**. The audience feedback is consistently positive and appreciative.

TV programs and videos in Spanish

- ***Cuerpo Corazón Comunidad,*** our weekly live hour-long interactive educational program on health and wellness in Spanish transmitted on radio stations and online, aired **52 video broadcasts.**
- Some videos, including one on mental illnesses (which has garnered **> 6,100 views)**, have >1,000 views.
- **Thousands** of Latinx homes and phones were reached by the psycho-educational programs we broadcast on community TV channels. The LFH team spoke as mental health experts on ***Charlando con Teresa Foster***. Two programs were re-broadcasted **dozens of times** each month on Marin TV channels.

Website in Spanish

- At www.cuerpocorazoncomunidad.com, visitors can listen to broadcast live online, or browse the growing archive of **>200 podcasts**, **>200 categorized articles,** and **>300 resources.**
- Recent analytics show **7,602** unique visitors, of which **2,390** were in FY 2017-18.

Articles in Printed & Online Media

- With regional distribution in printed and online formats, **thousands** of Marin county Latinxs were reached monthly with mental health related information and resources through our regular articles.
- **12 articles** were published in ***La Voz Bilingual Newspaper***, distributed free at **>500** locations and online (http://www.lavoz.us.com/).
- **12 articles** were published in ***Impulso News***, distributed free at **>500** locations and online (http://impulsonews.net/).

E-newsletter

- **"Help in Spanish**/*Ayuda en Español*" bilingual newsletter on local support services in Spanish was emailed **>4** times to **>1,000** service providers and community members.
- Newsletter lists mental health related events, ongoing programs, and contact information of providers.
- **Flyers** of programs and events were attached, to further disseminate information on local offerings.

Events & Presentations

- Community outreach, education and engagement were conducted at health **events**, including: Marin's annual countywide Binational Health Fairs, HHS Fruits & Veggies Fest, WIC Breastfeeding Celebration, Community Violence Solutions Resource Fair.
- The LFH team gave **presentations** for **>500** health professionals, educators, parents, and others, including: Marin Community Clinics, IHSS, San Rafael City Schools, North Marin Community Services, AA.

Latinx Family Health (LFH) graduate training program

- **Recruitment:** Hired and trained 4 bilingual doctoral interns and practicum students. The LFH training track attracted **~25** applicants nationwide for the 2 doctoral psychology full-time positions.
- **Direct Service:** This FY LFH trainees provided **>1,800** direct mental health services in the children and adult systems. They conducted outpatient and crisis assessments, individual/family/group psychotherapy, case management, inter-disciplinary consultation and psychological testing. LFH interns also engaged in community education and outreach.
- **Workforce development**: The **2** LFH doctoral interns were hired locally upon completion of the training year: one as the BHRS Latinx Family Health post-doctoral fellow, and the other one as the Behavioral Health clinician at Canal Alliance.
- **Award:** The LFH training program coordinator, Marisol Muñoz-Kiehne PhD, was granted the Association of Psychology Postdoctoral and Internship Centers National Award for Excellence in Diversity Training.

Lunar New Year Celebration

- Third Annual Community Outreach and Recovery event (Lunar New Year event) to increase awareness and meaningful participation of Vietnamese clients and community in our system of care

ANTICIPATED CHANGES

In FY19/20 a WET-funded program development intern dedicated to outreach and engagement for Latinx behavioral health will be hired to assist with coordinating the development, implementation, and evaluation of a system-wide strategic plan for addressing the behavioral health needs of Latinx community members in Marin County. The intern will work closely with the BHRS' Ethnic Services Manager, the ASOC Spanish-speaking staff, clinicians, *promotores*, and a broad range of stakeholders to address health disparities and promote the health and wellbeing of Latinxs in Marin County.

In addition, our beloved Spanish-speaking staff member funded through this ASOC Expansion will be retiring.

CO-OCCURRING DISORDERS

FY17/18 MHSA Allocation: $274,733

PROGRAM OVERVIEW

In both the last two MHSA Three-Year planning processes, effectively identifying, engaging and treating clients with complex co-occurring mental health and substance use disorders continues to be identified as a priority. While some of the CSS and WET programs incorporate co-occurring capacity to differing degrees—and steps have been taken in recent years to increase administrative and service coordination and integration of mental health and substance use services—the Three-Year plan presented the opportunity to further expand and institutionalize efforts at increasing BHRS's capacity to effectively and seamlessly serve clients with co-occurring mental health and substance use disorders, including tobacco dependence.

Although the initiatives designed to increase system and service co-occurring capacity remain the same, some of the intervention approaches and service partners have evolved due to a combination of availability of new services and a review of prior outcomes. Programs included in the Three-Year Plan focus on co-occurring capacity workforce development, Peer-to-Peer smoking cessation services, and the expansion of engagement and treatment services for individuals with complex co-occurring substance use disorder and serious mental illness.

The programs included in the current Three-Year plan represent multiple approaches to increasing co-occurring capacity. In addition to those described here, program specific efforts are described within the appropriate program narrative.

TARGET POPULATION AND EXPECTED OUTCOMES

Co-Occurring Capacity Workforce Development:

The target populations of the services provided by the contracted Addiction Psychiatrist (Chief, Addiction Services) are County and County-contracted mental health staff/providers and other stakeholders serving individuals with complex co-occurring disorders, such as Federally Qualified Health Centers and local law enforcement.

The expected annual numbers served are as follows:

- Clinical consultation to at least 20 County, contractor, and key stakeholder behavioral health staff/providers
- Provide trainings/presentations to at least 50 County, contractor, and key stakeholder behavioral health staff/providers

Expanded Engagement and Treatment Services

The target population for the expanded engagement and treatment services that will be provided through the Road to Recovery program is Marin adults (18+ years) with co-occurring substance use disorders and serious mental illness. Participants receiving treatment services shall be engaged in specialty mental health services and participants receiving engagement services may be currently enrolled in services—or have a recent history of repeated episodes—but for which services are not adequately addressing their needs.

The projected caseload for expanded services is 25 at any given time, with an estimated 50 individuals served annually.

Peer to Peer Tobacco Cessation Services

The target populations of the Peer to Peer Tobacco Cessation Services program include mental health consumers and agency staff working with consumers with Serious Mental Illness.

The expected numbers served annually are as follows:

- Train and supervise 10 peers to provide peer to peer smoking cessation services
- Provide tobacco cessation education and support services to 150 mental health consumers
- Work with five County and/or contractor agencies and clinics providing services to County mental health clients to integrate comprehensive, sustainable cessation support into their programs

PROGRAM DESCRIPTION

Co-Occurring Capacity Workforce Development

In order to increase co-occurring capacity across the behavioral health system of care, an Addiction Psychiatrist, contracted with the County Division of Behavioral Health and Recovery Services, offers staff consultation and training directed at increasing the competency of the behavioral health workforce to effectively identify and treat individuals with complex co-occurring mental health and substance use disorders. Trainings may include, but are not limited to: assessment and diagnosis, Medication Assisted Treatment, and effective treatment of co-occurring disorders. Clinical consultation and training services are provided at various locations, including Community Services and Supports (CSS) programs in the behavioral health system of care.

Although previous co-occurring capacity workforce development activities were highly successful in providing direct services to clients engaged in the behavioral health system of care, the demand for client care resulted in a less than anticipated focus on staff capacity building. With additional services now available through the County-operated Road to Recovery Program, workforce development initiatives will now exclusively focus on staff and service co-occurring capacity building.

Expanded Engagement and Treatment Services

The County-operated Road to Recovery program opened in November 2016 and is certified to provide General Outpatient and Intensive Outpatient substance use treatment services. In order to provide a continuum of services for individuals with complex co-occurring disorders—as well as advance system and service integration efforts—engagement services previously offered through the Alliance in Recovery program will be continued and expanded within the Road to Recovery program.

The Road to Recovery program provides engagement and treatment services for adults whose co-occurring mental health and substance use disorders who have not been effectively engaged in in one or both treatment systems. The goal of the program is to provide individualized outreach and support services that build trust and relationships, increase their motivation to change, and support them to access and participate in formal treatment services. Services provided will vary on the client's needs, strengths, and stage of readiness, and may include services such as outreach, individual counseling, group counseling, case management, and linkage to other supportive services.

Peer to Peer Tobacco Cessation Services

Local Needs Assessment data—which aligns with national trends—highlights the interest and importance of integrating tobacco cessation services into behavioral health settings. Not only is there a higher prevalence of tobacco use among mental health consumers as compared to the general population, but also, the majority of Marin consumers interviewed during the needs assessment process reported wanting to quit or reduce their tobacco use. To address the disproportionate prevalence of smoking among mental health consumers—coupled with the reported lack of tailored face-to-face ongoing cessation groups—Bay Area Community Resources (BACR) launched a Peer to Peer Tobacco Cessation Program.

This program—which began as a pilot project with one-time MHSA funding in 2013—trains and supervises peer cessation specialists: initially using a *Thinking About Thinking About Quitting* curriculum. This curriculum was developed by BACR and evaluated by an external evaluator. This preliminary success was followed by the larger-scale, evidence-based *Peer-to-Peer Tobacco Dependence Recovery Program,* designed by Chad Morris, Ph.D. In addition to the peers providing ongoing cessation support, project staff works concurrently with County, contractor agencies, and clinics serving behavioral health consumers to adopt policies and practices that integrate sustainable tobacco cessation support into their programs.

Since the program's inception in June 2013, 26 peers have been trained as tobacco cessation specialists and 258 consumers have engaged in peer-led cessation groups and/or adjunct cessation support at sites including: Enterprise Resource Center, Voyager Carmel, Lakeside House, Draper House, Marin Alano Club, D Street, Case Rene, Marin Treatment Center, and Bridge the Gap.

OUTCOMES

Co-Occurring Capacity Workforce Development

As this project focuses on staff capacity building, the expected outcomes associated with this project are largely process-oriented. Data is being collected through training and service logs. Expected outcomes (below) substantially exceeded projections for FY 2017/18. A significant area of focus for FY 2017/18 was enhancing workforce, service and system capacity to effectively address co-occurring disorders, including enhancing access to and provision of Medications for Addiction Treatment.

Outcomes	GOAL	FY17/18
Clinical Consultation provided to behavioral health staff/providers/stakeholders	20	48
Number of trainings/presentations to behavioral health staff/providers/stakeholders	10	25
Number of staff/providers/stakeholders participating in trainings/presentations	50	735
Number of sites serving mental health consumers that have ability to provide Medication Assisted Treatment (e.g. Buprenorphine, Vivitrol, Naloxone, etc.)	3	5: MAT 21: Naloxone
Number of new mental health providers DEA X-Waivered to prescribe or dispense Buprenorphine	5	6

Expanded Engagement and Treatment Services

Due to extended staff vacancies in the Road to Recovery Supervisor and clinician positions—both of which were vacant for approximately one year—the proposed service expansion was delayed until FY 2018/19. As such, there are no expenditures or outcomes to report for FY 2017/18.

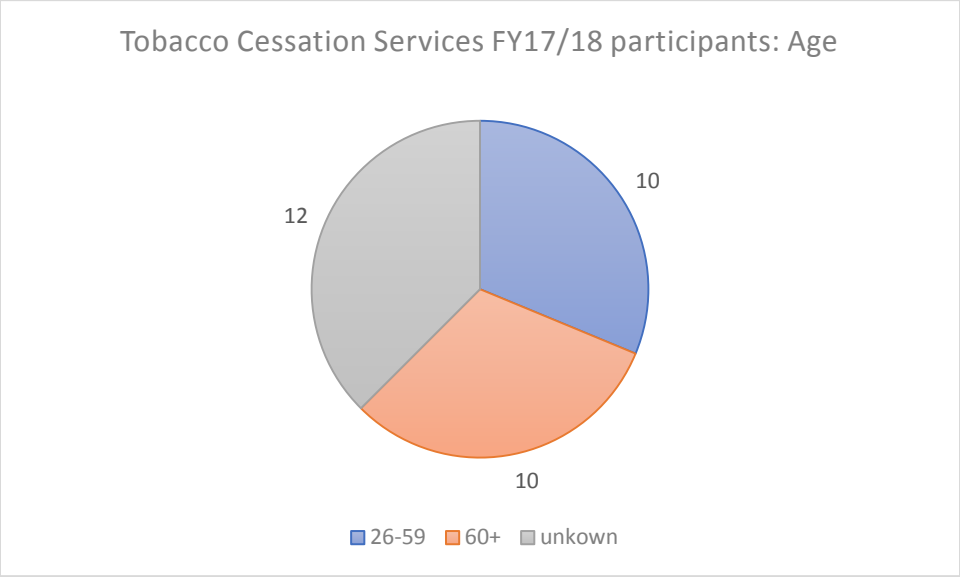
Outcomes	GOAL	FY17/18
Engagement Services: Percent of clients that have at least four clinical contacts in the first 30 days	30%	N/A
Engagement Services: Percent of clients that meet criteria for substance use treatment and/or specialty mental health services that transition to formal mental health or substance use treatment	30%	N/A
Treatment Services: Reduced hospitalizations	30%	N/A
Treatment Services: Reduced criminal justice involvement	30%	N/A
Treatment Services: Reduced substance use	30%	N/A

Peer to Peer Tobacco Cessation Services

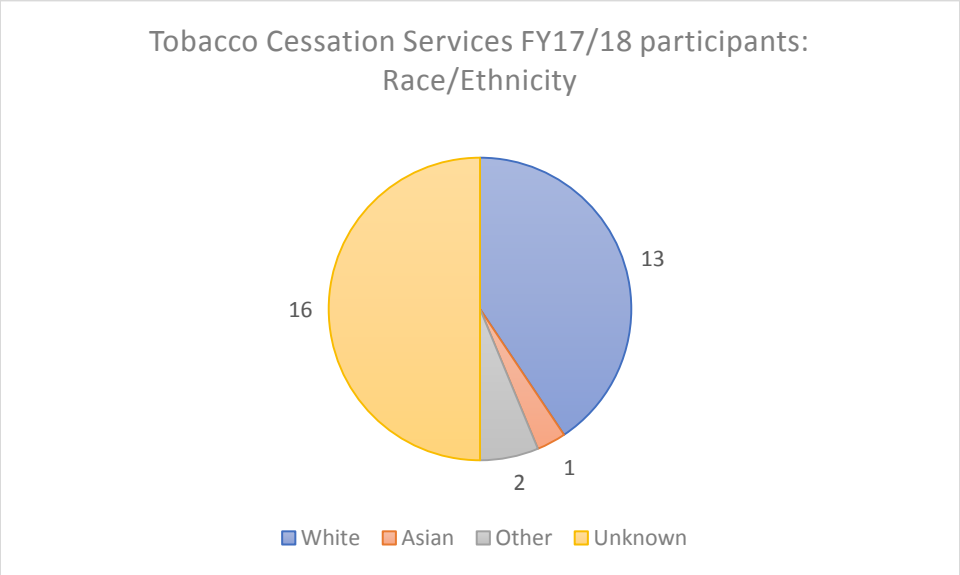
As the project focuses on both client services and capacity building, the expected outcomes listed below reflect a combination of outcome and performance measures. Supervised by an independent external evaluator, data is being collected and reported through a combination of training logs, group sign-in sheets, key informant interviews with County and contractor staff, and an analysis of intake, completion and follow-up survey data with consumers to assess their smoking status. Although fewer clients engaged in tobacco cessation activities than initially projected, a substantially higher than expected percentage reported reducing their tobacco use.

Outcomes	Goal	FY 17/18
Number of peers receiving training to provide peer to peer tobacco cessation education and support services	10	8
Number of mental health clients participating in tobacco cessation education and support services	150	32: Cessation 12: Education
Percentage of clients participating in peer-led tobacco cessation education and support services who report reducing their tobacco use	40%	36%
Percentage of clients participating in peer-led tobacco education and cessation support services who report attempting to quit using tobacco	50%	89%
Percentage of clients who quit tobacco in peer-led cessation services and maintained their quit status at 30-day follow-up	25%	18%
Number of County and contractor agencies that integrate tobacco cessation education and support into their programs	5	3

Demographics – Clients Participating in Smoking Cessation (n=32)



N=32; 31% of clients who reported their age were between 26-59 years of age and 31% were 60 or older. However, the age is unknown for the other 38% of participants.



N=32; The race/ethnicity is unknown for 50% of the people served; however of the 16 for whom race/ethnicity was reported, 13 were white, 1 was Asian, and 2 were another race.

PROGRAM CHALLENGES

Co-Occurring Capacity Workforce Development

In FY17/18, data collection remains a consistent challenge as well as quantifying outcomes that are meaningful. Collecting demographic data for the more than 700 participants in Dr. Jeff DeVido's

workforce and system development training efforts was also a significant challenge. BHRS staff are exploring strategies and tools to streamline additional data collection.

Expanded Engagement and Treatment Services

In FY17/18, the Unit Supervisor position in the Road to Recovery Program was vacant for a substantial period, which delayed implementation of the expanded Engagement and Treatment Services.

Peer to Peer Tobacco Cessation Services

In FY17/18, fewer than projected consumers engaged in smoking cessation services. Program and independent evaluation staff have identified that a more systems change and capacity building approach—such as ensuring agencies/programs have the skills to conduct their own groups—would yield higher participation levels.

UPCOMING CHANGES

Co-Occurring Capacity Workforce Development

In FY19/20, there will be an increasing shift to also focus efforts on co-occurring capacity workforce development in criminal justice settings and improving data.

Expanded Engagement and Treatment Services

In FY19/20, the Road to Recovery Program will be hiring for the Licensed Clinician and Peer Provider positions in order to fully implement the expanded Engagement and Treatment Services.

Peer to Peer Tobacco Cessation Services

In FY19/20, Bay Area Community Resources will also focus on assessing and providing technical assistance on tobacco policy and program development efforts for organizations that serve consumers with mental health conditions and also explore more meaningful data reporting.

CRISIS CONTINUUM OF CARE: SDOE 09

MHSA PROGRAM ALLOCATION FY17/18: $1,101,325

The Crisis Continuum has four distinct parts: Mobile Teams (Outreach and Engagement, Transition Team, and Mobile Crisis); Crisis Residential (Casa René); Crisis Planning; and the Crisis Stabilization Unit (CSU) Family Partner.

MOBILE TEAMS

OVERVIEW AND HISTORY

The Mobile Crisis Response Team (MCRT) was implemented in FY15/16, supported by funding from SB82, and administered by the California Health Facilities Financing Authority. The Transitions Team was also implemented in FY15/16, supported by initial funding from SB82, administered by the Mental Health Services Oversight and Accountability Commission. Both the Mobile Crisis and the Transitions teams have been well received by the community, and the need was greater than the resource as it is was initially designed.

The FY17/18 the Three-Year Plan provided funding for two clinicians who are cross-trained to work for either/both of these teams, allowing for maximization of resources based on demand. In FY18/19 MHSA is also providing bridge funding for the peer positions. The Outreach and Engagement Team was also moved to the Crisis Continuum in FY17/18 from the ASOC Expansion program.

PROVIDER: County-operated

PROGRAM DESCRIPTION

By providing field-base assessments, **MCRT** supports wellness and recovery by increasing availability and utilization of voluntary supports and services in the community. The program aims to decrease the need for law enforcement involvement in mental health and/or substance use crises as well as decreasing the need for involuntary interventions when voluntary services would be equally effective. The program consists of two clinicians on duty six days a week from 1-9pm. In addition, there is an On-Duty (OD) clinician who starts their day at 11am to do follow-up calls with previous contacts as well as to support the primary response team when they are in the field by answering calls that come in, thus avoiding any calls going to voice mail. The OD is also able to act as a secondary responder to calls for service at secure locations, such as medical clinics or schools.

The Transition team provides short-term intensive services to individuals experiencing crises in development in the community. The team also provides intensive services immediately following a crisis to support re-stabilization without further need for emergency services or involuntary treatment. The program is staffed with mental health clinicians, Peer Specialists, and Family Partners. A voluntary service, the team is able to provide support, education and linkages to community services. The team is mobile and able to respond wherever needed within the county. Team staff maintains up-to-date

information about community resources available to consumers and families, as well as provides outreach to other crisis services to assure awareness of the resources available.

The Outreach and Engagement (O&E) Team works with adults with serious mental illness who are living in the family home and whose symptoms are worsening to the point where the family does not believe they can continue to care for them at the level needed or the family is getting older and are attempting to plan for the care of their adult child when they are no longer able to care for the person themselves. The primary caveat being that the identified person does not believe they have a mental illness and could therefore refuses to engage in traditional treatment options. The other target population for O&E are those adults who have been identified by the Assisted Outpatient Treatment (AOT) team (Laura's Law) as meeting the criteria as a candidate for AOT and require outreach and engagement to hopefully get them to engage in mental health treatment voluntarily. O&E also has access to flex funds available to engage underserved individuals in the mental health system by assisting individuals with obtaining basic needs such as food, clothing and/or shelter, as a tool for engagement and rapport building.

TARGET POPULATION

The target population age group and situations are described for each of the three mobile teams.

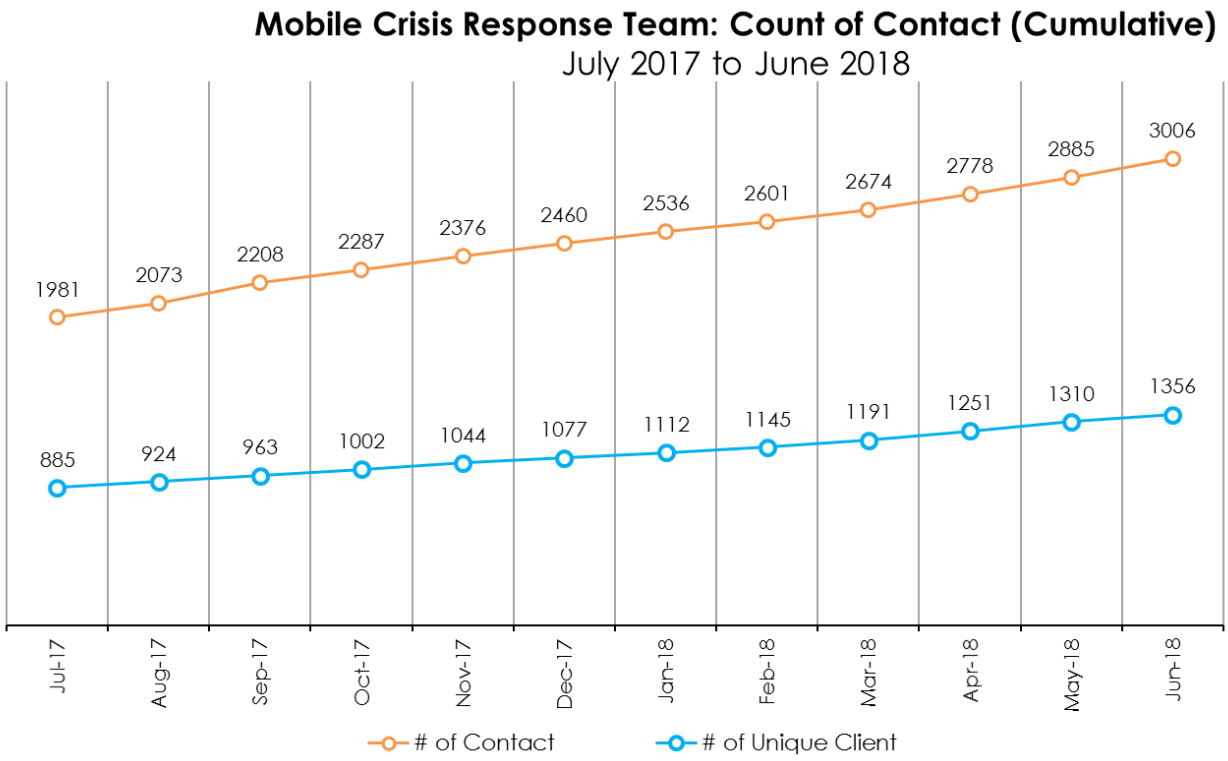
- **Mobile Crisis Response Team (MCRT):** All ages. Behavioral health crises.
- **Transition Team:** All ages. Those experiencing symptoms of a behavioral health disorder that are causing increased likelihood of 5150 or are stabilizing from a behavioral health crisis. In both situations, the individual is in need of additional support and linkage to services to further stabilize or to prevent additional decompensation.
- **Outreach and Engagement (O&E) Team:** Age 18 and older; Adults with serious mental illness not engaging in treatment and as a result are at risk due to being unable to survive safely in the community or unable to sustain appropriately or safely in the family home.

OUTCOMES

The **Mobile Crisis Response team** responded to 1,103 requests for assistance in FY17/18, serving at total of 564 unique individuals in the year, 499 of whom were first time mobile crisis users. The team averaged 92 contacts per month.

In FY17/18 45% of mobile crisis clients were either self-referred or referred by family or friends. Law Enforcement accounted for another 10.6% (117 contacts), housing programs accounted for 10.3% of the referrals (114 contacts), Primary Care Providers accounted for 9.2% of the referrals (102 contacts), and school staff accounted for 3.5% (39 contacts). Referrals this year also came from a number of other sources including:

Marin Community Clinic, Aging and Adult Services, Child and Family Services, Adult Protective Services, and Substance Use treatment centers.

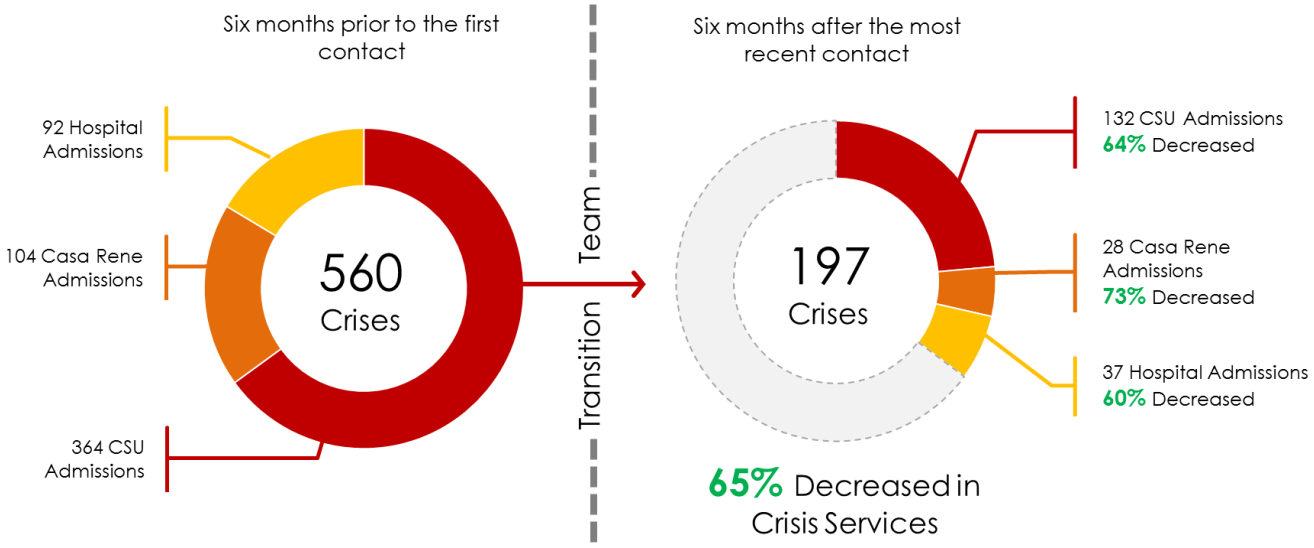


By the end of FY17/18 the Mobile Crisis team had responded to over 3,000 calls since its inception and averages 93 contacts per month

In FY17/18 MCRT purchased team shirts and jackets that allow us to be more easily recognizable while on the scene of calls involving dynamic and intense situations, on occasions, secure law enforcement perimeters, while also providing for the ability to be viewed in a professional, cohesive light when attempting to support and intervene during calls for service which involve removing an individual's civil liberties (5150 evaluations).

Though MCRT had been granted two FTE positions which were to be used to expand hours of service, we lost funding for one clinician on the Transition Team and two peer providers. This meant reallocating funds for one FTE MCRT clinician to partially fund the Transition Team clinician and peer providers.

The Transition Team provided 2,126 contacts in FY17/18, averaging 177 per month. They served 238 unique clients including 192 new clients this fiscal year.



There are 487 clients who have been served by the Transition Team. In the 6 months prior to the first contact with the Transition Team, they collectively experienced 560 crisis events (hospital admissions, *Casa René* (Crisis Residential Unit) admissions, or Crisis Stabilization Unit admissions). With the support of the Transition team there was a 65% decrease in the amount of crisis services utilized in the 6 months following their most recent contact, including a 64% decrease in CSU admissions, a 73% decrease in Casa René admissions, and a 60% decrease in Hospital Admissions.

The Outreach and engagement team only provided 397 contacts in FY17/18. These services were provided mainly in July-January due to staffing vacancy.

ANTICIPATED CHANGES FOR FY19/20

- The current Transition Team clinician funded by MHSA will convert to a Licensed Crisis Specialist position from a Licensed Mental Health Practitioner.
- We have applied for an additional CHFFA grant to fund two additional MCRT positions that would allow for a targeted increase in hours that would allow for additional services to schools.

CLIENT STORIES

Transition Team Client Story: *49 y.o. old female, recently relocated to Marin county, with a reported history of trauma including domestic violence, impaired family relationships and limited social supports. She also indicated long time struggles with depression, anxiety, psychosis and substance use. Historical information indicated numerous inpatient hospitalizations throughout her life. She was referred to Transition Team while on an inpatient psychiatric unit after being placed on a 5150 for danger to self. The Transition Team provided support and linkage to services which included housing related resources such as a brief stay in a sub-acute crisis residential facility, two months at a local homeless shelter, and transitional housing at New Beginnings Center. The Transition Team also assisted her in navigating the complex system of social services and outpatient behavioral health and recovery services, including changing of Medi-Cal benefits, getting in to the Access team for assessment and entrance into outpatient BHRS psychiatric services. The peer provider assigned to work with her supported her in developing a Wellness Recovery Action Plan (WRAP) plan which helped her to identify strategies to manage symptoms and triggers that might lead to another 5150; This included anxiety management while simultaneously learning to use local public transportation, a primary stressor for her, coupled by learning to live a sober life. As client continued to stabilize, she began to do volunteer work while maintaining sobriety, housing, and treatment for her mental health challenges.*

MCRT Client Story*: 33 y.o. male from West Marin; mother contacted MCRT requesting a welfare check reporting he had been off his mediations for almost a year and that he was behaving in a bizarre manner that made her concerned for the safety of her son and herself. MCRT evaluated this person and determined he was psychotic, disorganized, unable to orient or participate coherently in the risk assessment. Given his agitated behavior, MCRT requested assistance from law enforcement and placed him on a 5150 hold. He was transported to CSU and hospitalized at Unit A. Upon discharge from Unit A, client was transferred to the Crisis Residential Unit for further stabilization and assistance with access to outpatient BHRS services. He was picked up by the Transition Team to provide temporary case management and linkage to services. This collaboration led to the client being seen and assessed by the Access Team and placed with one of our FSP programs.*

CRISIS RESIDENTIAL – *CASA RENÉ*

PROGRAM DESCRIPTION

Casa René is a 10-bed Crisis Residential Unit (CRU) currently administered by Buckelew Programs. The program aims to reduce unnecessary acute psychiatric hospitalizations by providing a home-like setting where individuals can resolve crises in the community and re-stabilize for up to thirty (30) days. The program integrates peer and professional staffing as well as client centered programing focused on principles of wellness and recovery. Crisis residential staff works with each individual's circle of support: family, friends, treatment professionals, substance abuse counselors, health care providers, naturally occurring resources including faith-based organizations, 12-step programs and any other resources that support the individual's recovery. Individuals are also be offered individual, group and family therapy.

The program is a collaborative effort between many community partners, especially between Buckelew Programs, Community Action Marin and County Behavioral Health and Recovery Services. Buckelew Programs provide the facility and staffing; BHRS provides nurse practitioner care for residents while at *Casa René*; and Community Action Marin provides crisis planning services.

PROVIDER: Buckelew Services

TARGET POPULATION

The target population is individuals, age 18 and above, experiencing a psychiatric crisis and who are able to voluntarily agree to stay at *Casa René* in lieu of a hospitalization. Priority is given to Medi-Cal recipients experiencing a psychiatric crisis.

EXPECTED OUTCOMES

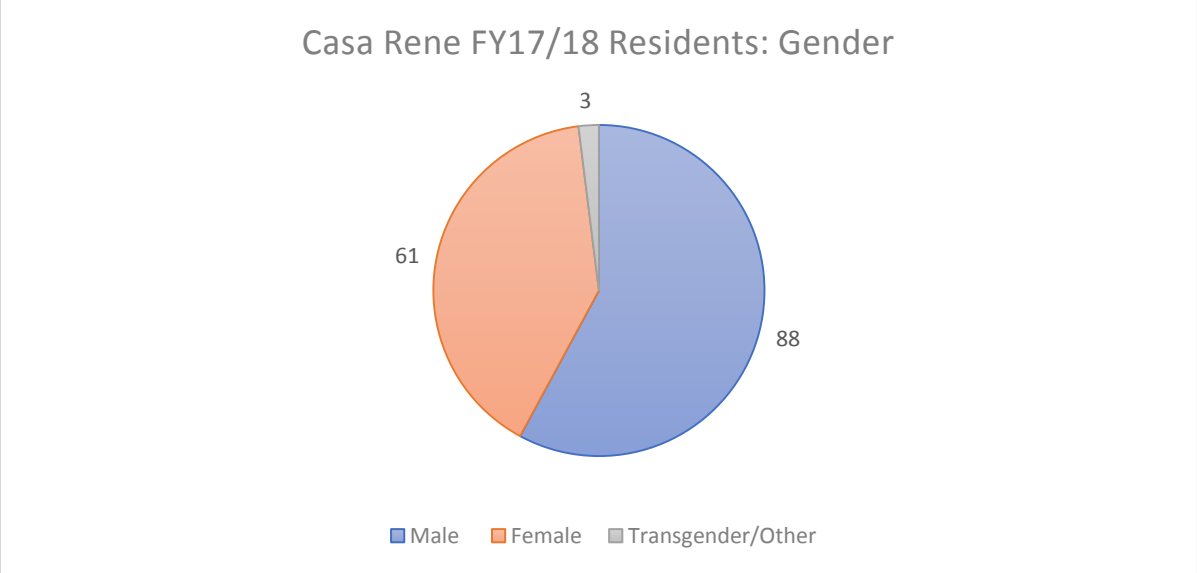
Casa René will maintain an occupancy rate of at least 75% the first year and 90% thereafter. Seventy-five percent of clients discharged from the program will have engaged in crisis planning; 90% of the clients will be linked to outpatient services at discharge; and 90% of clients will be discharged to a lower level of care.

ACTUAL OUTCOMES

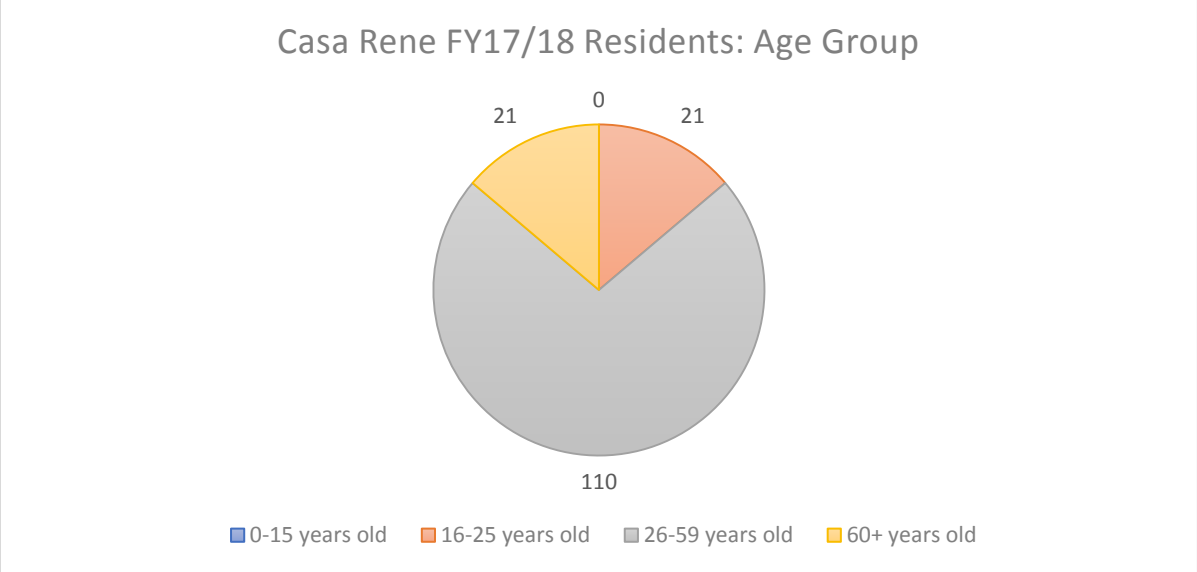
In FY17/18 *Casa René* provided services to 152 unduplicated individuals, with 195 distinct admissions, for a total of 3,116 bed days and an average of length of stay of 12.8 days. This was an increase of 475 bed days from FY16/17. The occupancy rate averaged 85%, slightly below the goal of 90%, but a 14% increase from the previous year. All individuals accessing *Casa René* were linked with Crisis Planning services. 95% of individuals were referred to outpatient services at discharge and 92% were discharged to a lower level of formal support.

In FY17/18, only 30% of clients filled out the satisfaction survey. Of those clients, 96% rated the service at 4.0 or higher out of 5. Results are compiled in the Buckelew IBIS database system.

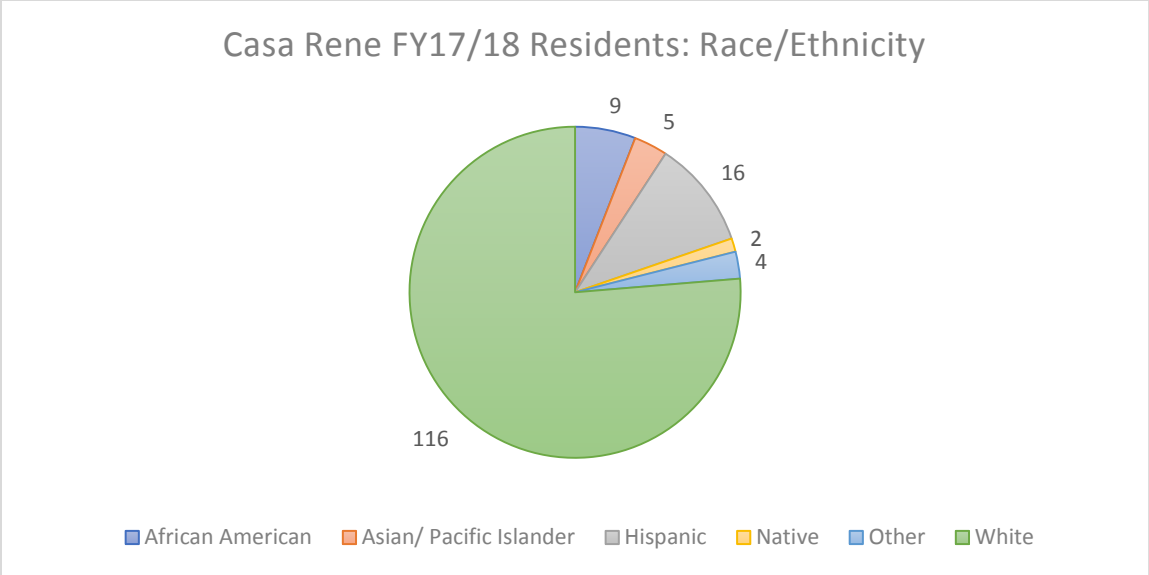
FY17/18 DEMOGRAPHICS



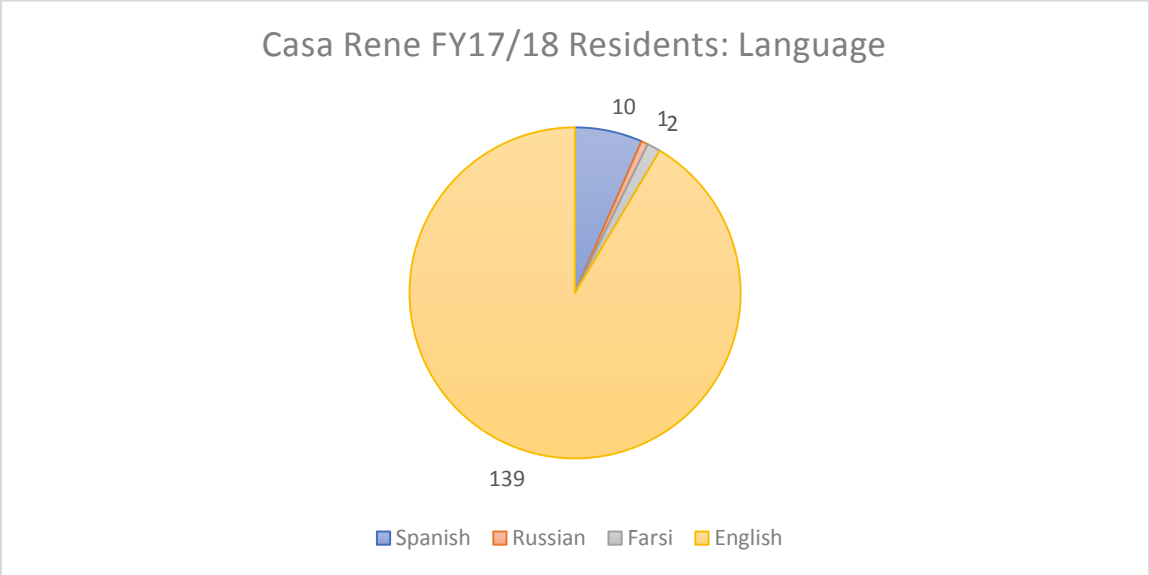
N=152; 58% of the Casa René residents were male, 40% female, and 2% transgender/other



N=152; Casa René is only open to those who are 18 years of age or older so no children were served. 14% of the residents were TAY under the age of 26, and 72% were between 26-59 years old age, and 14% were 60 years or older.



N=152; 76% of the Casa René residents were white



N=152; 91% of the Casa René residents spoke English as their primary language

The Latinx population is underrepresented in the client demographics for *Casa René* and further investigation into how to better serve this population will be explored in the next fiscal year.

PROGRAM CHALLENGES

This year, *Casa René* entered into a Performance Improvement Project (PIP) with Marin County Behavioral Health and Recovery Services (BHRS) in continued efforts to improve the census count. This has allowed a closer examination of the established documentation methods, barriers of clients receiving services, and criteria to meet program expectations. Another area

addressed in increasing the census was to expand the current referral sources. In prior fiscal years, the main referral sources have been through CSU and Unit A at Marin General Hospital. In this fiscal year, collaboration with CSU allowed an additional referral source to be piloted, which is the county jail. This 3rd option is supporting the program to better meet the census outcome goals. One significant barrier that was eliminated involved an additional interview process conducted by *Casa René*. This was a task previously performed by the *Casa René* Program Director, which often resulted in delays up to several days. While this is still an important task to occasionally use, it is not a standard of practice necessary as the information is captured in the referral paperwork. The removal of this step dramatically shortened the referral processes allowing many clients to enter into program within hours of the initial referral submission.

As the census continues to increase another challenge addressed was the higher acuity level of clients referred. In the past year, an increased number of clients referred needed a higher level of care at discharge. The *Casa René* program was still able to meet outcome goals, but it is important to note that more training and increased staffing was necessary to meet this challenge. The Program Supervisors implemented more training in de-escalation, crisis management, proper utilization of the mobile crisis unit and law enforcement, and safety of the facility, clients, and staff.

EXPECTED CHANGES IN FY19/20

22% of the clients served by *Casa René* last year were categorized as homeless. In FY19/20 we aim to better coordinate with the Mill Street Homeless Shelter program in supporting clients struggling with homelessness and the continued stressors attributed to this. We would also like to explore other opportunities with other housing programs to increase our referral capacity and meet the needs of the clients more effectively.

Crisis Planning Services

OVERVIEW/HISTORY:

Crisis planning began as part of the Client Choice and Hospital Prevention program (which eventually became *Casa René*), originally funded under MHSA Innovation, and later incorporated into the Prevention and Early Intervention component of MHSA funded services.

In FY17/18 all of the Crisis Services were consolidated into a Continuum of Care within CSS. Moving this program to CSS has facilitated the coordination of crisis services in Marin. Developing and using crisis plans allows for a more recovery-oriented focus, supporting individuals in choosing how they want to engage in their recovery.

PROVIDER: Community Action Marin

TARGET POPULATION:

Clients at the Crisis Residential Unit (*Casa René*) and at the Crisis Stabilization Unit (CSU).

PROGRAM DESCRIPTION:

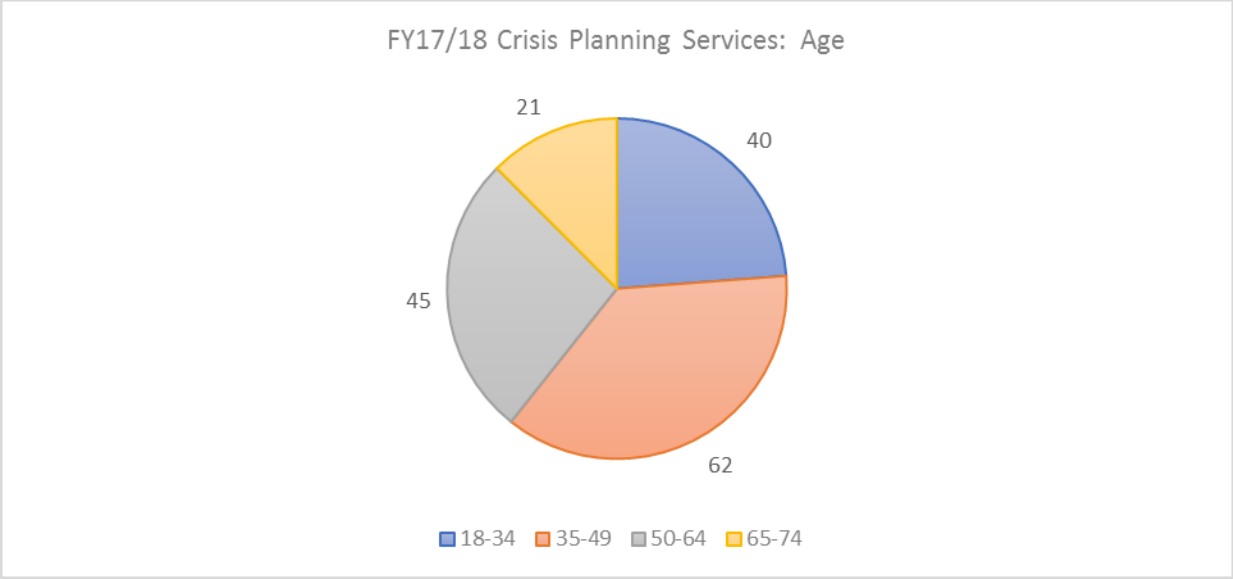
There are two Crisis Planners working in the Crisis Continuum—one who is part of the Crisis Stabilization Unit (CSU) team and the other helps support clients at Casa René (our Crisis Residential Unit).

Crisis Planning aims to:

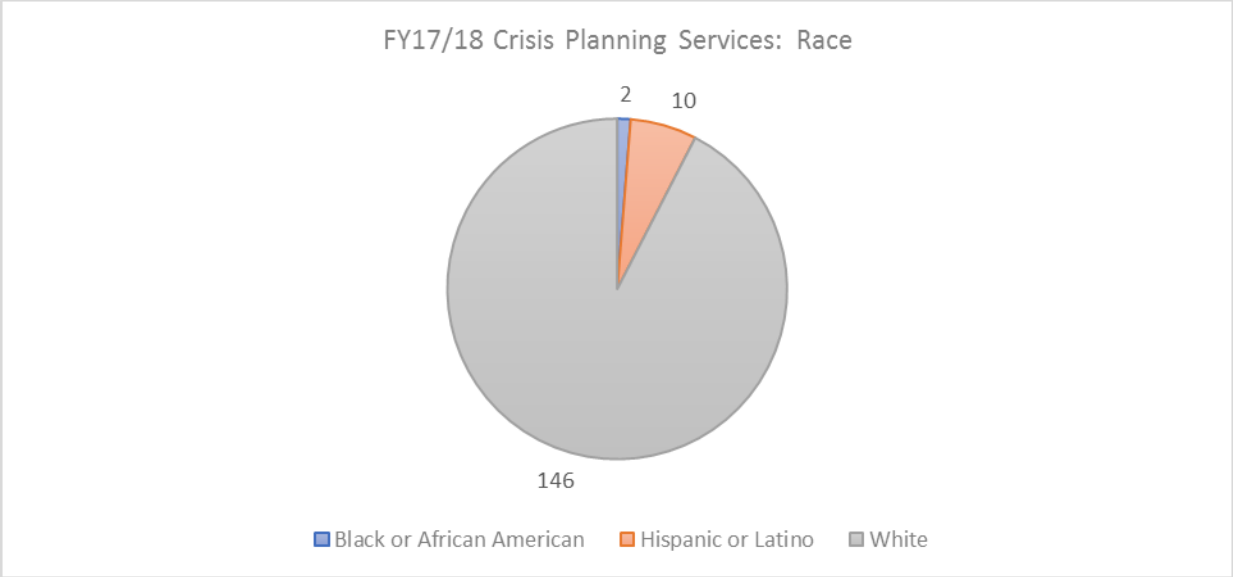
(1) increase clients' knowledge, skills and network of support to decrease crises
(2) provide crisis plans to the CSU that increase the role of the client and their network of support in case of a crisis; and
(3) to engage and support clients who are residing in the Crisis Residential Unit (Casa René) in the completion of a crisis plan.

CRISIS PLANNING SERVICES: EXPECTED AND ACTUAL OUTCOMES

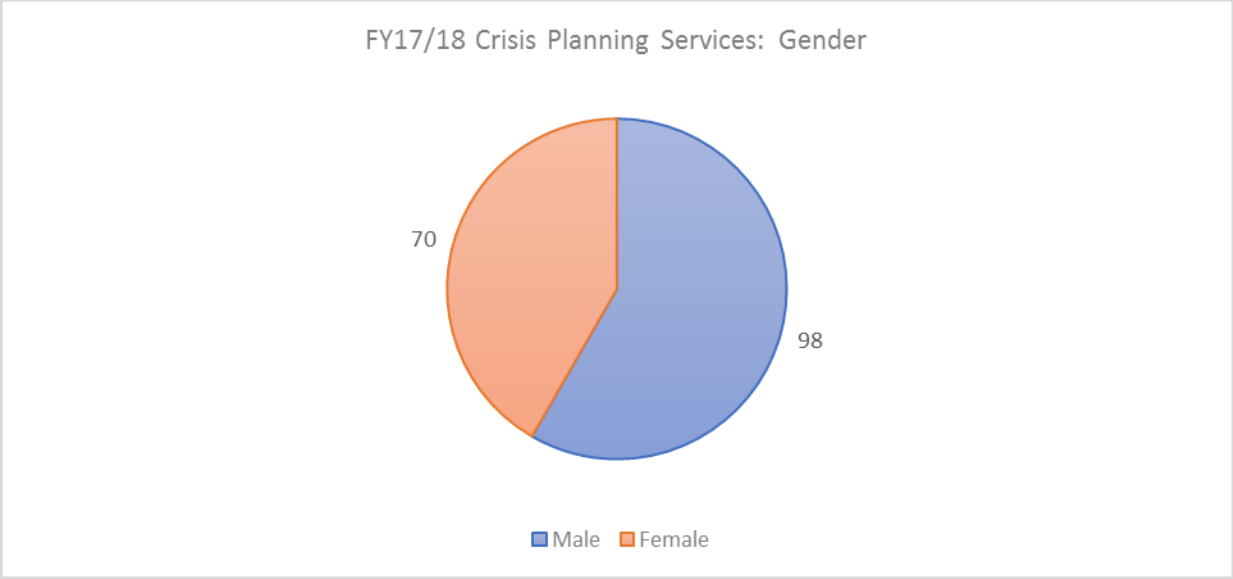
Outcomes	Goal	FY17/18 Actual
Number of clients and/or families that will receive Crisis Planning services.	80	168
Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.	50%	100%
Percent of clients receiving Crisis Planning Services that have accessed the CSU multiple times in the past.	30%	45%
Percent of clients and/or families completing a Crisis Plan that report increased understanding of the community resources available to them.	60%	85%
Percent of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.	60%	50%
Percent of clients reporting that Crisis Planning decreased their need to the CSU 3-6 months after completing the plan.	50%	75%
Percent of clients reporting that having a Crisis Plan improved their experience at the CSU.	50%	10%



N=168; 24% of those who participated in crisis planning services were between the ages of 18-34, 37% were between the ages of 34-49, 27% between 50-64, and 13% between 65-74



N=158; 92% of those who participated in Crisis Planning Services were White



N=168; 58% of those who participated in Crisis planning were male

ANTICIPATED CHANGES FOR FY19/20

The Crisis Planning team will be incorporating sections of Wellness Recovery Action Planning (WRAP) created for monitoring behaviors. The Crisis Team will support the clients through the process to create their own survival tool kit, and then following up with each client on a regular basis to ensuring they are accessing resources that are available to them as well as a means of support.

FIRST EPISODE PSYCHOSIS (FEP): SDOE 10

MHSA PROGRAM ALLOCATION FY17/18: $5,197

PROGRAM OVERVIEW

A Coordinated Specialty Care (CSC) team for First Episode Psychosis (FEP) that emphasizes a collaborative, recovery-oriented approach between individuals who receive services (target age 15 to 30), treatment team members, and when appropriate, family members and others who can provide support. Treatment planning is collaborative, involving shared decision making and addressing the following key areas: psychotherapy, pharmacotherapy, case management, supported education and employment, coordination with primary care, and family education and support. This program is jointly funded with a SAMHSA grant.

PROVIDER: County-operated in FY17/18; Felton Institute in FY19/20

TARGET POPULATION

The FEP efforts target individuals who are experiencing their first psychotic episode and are between the ages of 15-30 years old. Transitional age youth (TAY) experiencing first psychotic episodes may be referred to our TAY full service partnership program or seen in our outpatient county mental health Youth or Adult Systems of Care.

PROGRAM DESCRIPTION

Based upon findings from the needs assessment, in FY16-17 SAMHSA grant funding was used to hire a Mental Health Practitioner/Licensed Mental Health Practitioner to be the Team Leader/Outreach and Liaison Specialist for a coordinated specialty care (CSC) team that will work in collaboration with the established TAY full service partnership program. Alternative funding sources and use of existing staffing positions were proposed to fill other important CSC positions, including a medication prescriber, psychotherapist/case manager, and supported education and employment specialist, as well as a peer specialist and family partner who have lived experience with mental health services.

The clinician hired as team leader is an experienced clinician who will be the primary contact person for clients and families and will spearhead efforts to engage clients in treatment. Primary goals are to build a positive relationship with participants and assist them in developing their abilities for illness self-management using a shared decision-making process to develop and modify treatment plans. This position provides support, outreach, education, consultation, and basic services to participants and their families as well as possesses the ability to identify primary psychosis and perform differential diagnoses for psychosis in consultation with the Access Team and the county Crises Stabilization Unit (CSU). The team leader also monitors, oversees, and supervises the team-based processes.

The part-time therapist/case manager will use evidenced based practices such as CBT for psychosis and help clients clarify goals, cope with stressful situations, interact more effectively with other people, and in general, overcome barriers to their recovery using case management interventions as needed. The Supported Education and Employment Specialist will focus on assisting participants to continue, resume, or adapt their academic or vocational activities successfully. The TAY Peer Specialist with lived experience with mental health services will help carry out recovery support functions, treatment, and

treatment planning and meet regularly with the team, provide one-on-one counseling/support, and lead one or more peer support and/or family psycho-education groups. The Family Partner will help in navigating the mental health system for a loved one and help carry out recovery support functions, treatment, and treatment planning and provide education, support, and liaison services for families, and lead family psycho-education groups.

EXPECTED OUTCOMES

Hire staff and develop the Coordinated Specialty Care Team. Establish regular meetings, consultation and channels of communication between the team members working with FEP clients in at least three of the following settings by June 30, 2018: Children's Mental Health System, Adult Mental Health System, Sunny Hills TAY Program, Access Team and CSU.

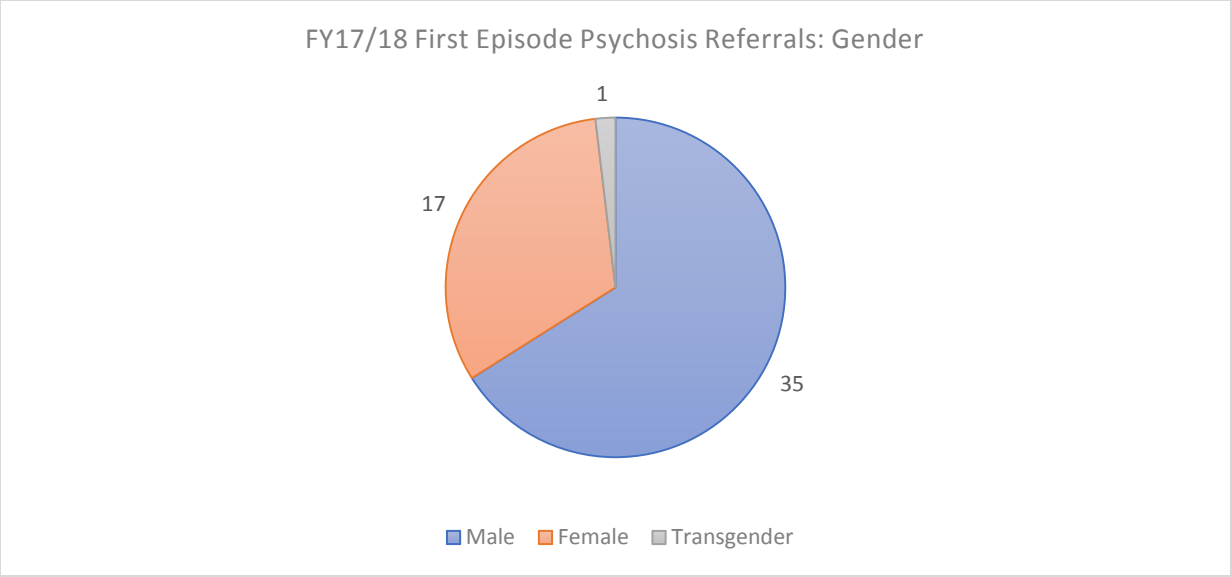
The Child, Adult, TAY Program, Crises Stabilization Unit and Access teams will be trained and able to screen as appropriate those suspected of a first episode of psychosis within the specified age range to increase positive identification of psychosis and facilitate connection to county mental health services as evidenced by at least two or more contacts beyond the diagnostic assessment.

ACTUAL OUTCOMES IN FY17/18

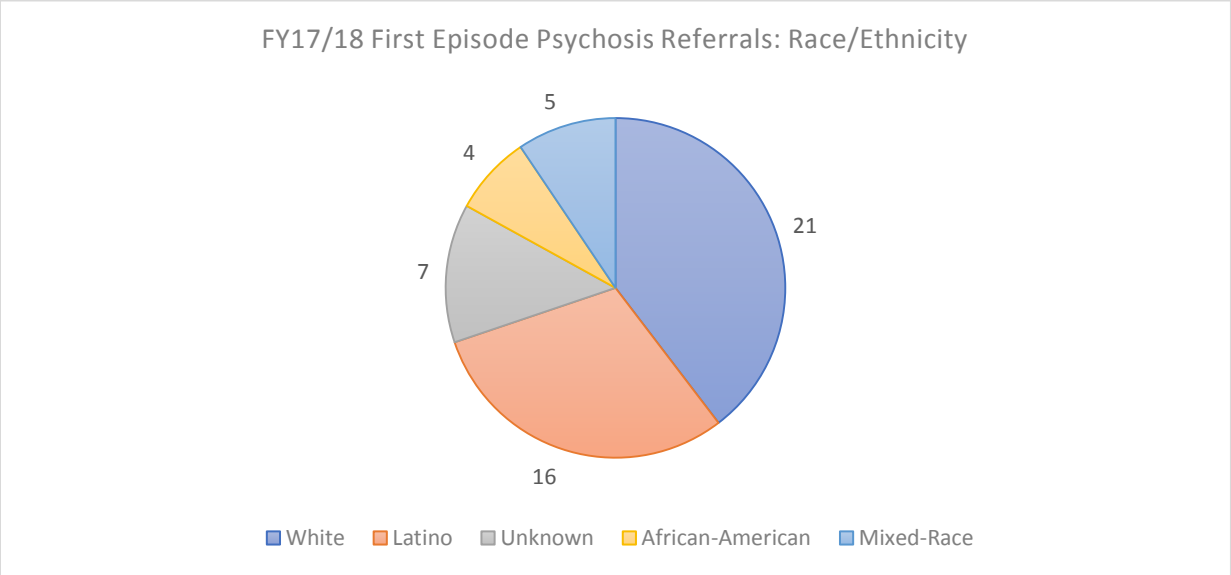
Services provided for this program in FY17/18 include:

- Creation of internal processes for better identifying and referring the FEP population through the most common points of entry (e.g., Crisis Stabilization Unit and Access team), including training staff on use of a validated early psychosis screening measure
- Rapid response and comprehensive differential assessment for any individual who is suspected of experiencing the onset of a first psychotic episode, both in the clinic and community as needed
- Extended outreach, assessment, and education period of 6 to 8 weeks to promote understanding of their schizophrenia spectrum diagnosis, collaborative goal setting, engagement and retention in services, and determination of additional treatment/case management needs
- Ongoing monitoring of treatment efficacy for service engaged clients and maintaining a centralized access point for linkage to additional services
- Development of outreach and psychoeducation groups for clients and their families in partnership with the TAY program to directly engage them in treatment options, problem-solving, and shared decision-making approaches as well as instill hope, reduce stigma, and promote recovery-oriented messages
- System-wide education and consultation on early psychosis cases to better serve the specialized needs of these individuals
- Supervision of CSC team and continued program evaluation to ensure fidelity to FEP treatment model

53 young people were referred to the First Episode Psychosis team. The gender breakdown was as follows: 35 males, 17 females, and 1 transgender.



N=53; 66% of referrals were for males, 32% female, and 2% transgender



N=53, 40% of referrals were for white TAY, 30% Latino, 8% African American, and 9% mixed race

6 referrals were made for youth ages 6-14 and although they were out of the indicated age range, assessments to determine eligibility were still made. Contacts to referring parties and/or identified individuals/families were initiated to begin extended assessments within the target goal of 1 to 3 business days. Out of 53 cases, 14 met diagnostic criteria and 5 cases were still in progress.

The First Episode Psychosis team and the TAY FSP worked together closely in FY 17/18. Once per week FEP lead a group at the TAY program that is designed to provide support and psycho-education to youth experiencing "voice hearing" or other unusual experiences. The "VOX" group is a safe space for youth to begin to talk about how these experiences impact their lives. The First Episode Psychosis team works together with TAY clinicians to identify youth that could benefit from this unique group. Initially set to meet twice a month, the youth decided they wanted to meet ***every*** week. Sharing their stories and

experiences with other group members lets them know they aren't alone in their struggles and that others experience similar situations.

CHALLENGES OR LESSONS LEARNED IN FY17/18

In FY17/18, Marin County had significant changes in leadership in Behavioral Health, which disrupted further hiring of staff in Marin's implementation plan of the First Episode Psychosis program. Identifying and establishing existing staff to serve as clinicians for this team was a challenge and as an alternative in the last Annual Update, a full-time bilingual post-doctoral fellow was proposed to serve as clinician. In addition to the team lead who was hired at the beginning of the fiscal year, BHRS also hired a peer counselor to provide support services, outreach and case management for youth with early psychosis. However, planning was disrupted by departure of the team leader for FEP, requiring reconsideration of a county-run program. After careful review of the ongoing challenges in establishing and maintaining staffing for this program, BHRS decided to pursue a contract for these services with interested community partners via RFP.

ANTICIPATED CHANGES FOR FY19/20

Given the challenges of establishing a county run program, an RFP was released and awarded to the Felton Institute to establish and run an early psychosis program in Marin. Felton Institute has tremendous experience implementing First Episode Psychosis program. Felton's early psychosis programs were first implemented in 2007, as part of a community/academic partnership with the University of California at San Francisco. In 2012, Felton was awarded the "Center for Medicare and Medicaid Health Care Innovations Grant" to expand and implement the agency's Early Psychosis model. Felton's model, was one of a very few projects awarded this competitive grant, now serving approximately 400 individuals every year, across five California counties. Two years later, they received the National Council for Behavioral Health's "Inspiring Hope: Science to Service" award.

Felton's proposed Early Psychosis Program, (re)MIND® will provide an evidence-based model of multidisciplinary early psychosis services to approximately 20 to 25 Marin County Medi-Cal beneficiaries between the ages of 15 and 30, experiencing (within the first two years of) onset of psychotic symptoms associated with non-affective psychotic disorders. Consumers will be assessed and referred by Marin County's BHRS ACCESS Team.

CONSUMER OPERATED WELLNESS CENTER— "EMPOWERMENT CLUBHOUSE": SDOE 11

MHSA PROGRAM ALLOCATION FY17/18: $262,591

OVERVIEW AND HISTORY:

In May of 2017 Marin City Community Development Corporation (MCCDC) responded to an RFP to bring a clubhouse to Marin County. MCCDC was awarded a 3-year MHSA contract overseen by Marin County BHRS that began on July 1, 2017.

On November 13, 2017, Empowerment Clubhouse enrolled its first four members (residents of Marin City) and began planning the Empowerment Clubhouse Grand Opening with the support of members, peers, and staff alike. The Empowerment Clubhouse was officially established on November 29, 2017, and welcomed over 60 county residents, community stakeholders, and county officials at the Grand Opening.

The Clubhouse Model is a strengths-based, recovery-oriented approach to mental health rehabilitation that uses the power of collaborative work and meaningful relationships to help individuals living with mental illness develop hope, purpose, self-efficacy and independence. Under the Clubhouse Model, program participants are referred to as members, not patients or clients, and are engaged in all aspects of Clubhouse operations. Members also receive health and wellness programming, access to educational and employment support and opportunities, advocacy, and connection to social services. While there are over 350 Clubhouses in operation around the world, Empowerment Clubhouse is the only Clubhouse operating in Marin County.

The Clubhouse Model is included on the Substance Abuse and Mental Health Service Administration's (SAMHSA) National Registry of Evidence Based Practices and Programs, and research has shown that Clubhouse participation is associated with:

- Greater quality of life (Warner et al., 1999)
- Increased employment (Tsang et al., 2010).
- Decreased psychiatric hospitalizations (Henry et al., 1999)
- Improved general psychopathology (Tsang et al., 2010)
- Increased help-seeking (Warner et al., 1999)
- Greater social connectivity (Warner et al., 1999)
- Decreased healthcare costs (Hwang S. Woody, J., & Eaton, W., 2016)

Equity and inclusivity are core values of the Clubhouse Model, and as such all decisions about programmatic growth and development in a Clubhouse are made with the aim of increasing opportunity and accessibility. Clubhouses strive to make it as easy as possible for adults living with mental health challenges to become members, and to ensure that once they become members they have every opportunity to learn and grow through their participation. This approach is the primary catalyst for positive change in members' lives, and results in members overcoming the barriers of stigma, symptoms and self-doubt, in order to travel down the path of recovery.

PROVIDER: Marin City Community Development Corporation (MCCDC)

TARGET POPULATION

The Empowerment Clubhouse target population includes any Marin County resident 18 years of age or older living with a diagnosed mental illness. While the Clubhouse Model is designed to be a transdiagnostic intervention, membership is primarily drawn from individuals with the following diagnoses: Bipolar Disorder, Schizophrenia, Schizoaffective Disorder, and Major Depressive Disorder.

Empowerment Clubhouse (EC) also targets populations of underserved and unserved individuals in Marin County that have been hospitalized, traumatized, incarcerated, and who are not yet affiliated with the mental health system. Many of these individuals experience significant barriers to obtaining services such as: low-income, lack of insurance, and stigma. Underserved and unserved individuals in Marin County include at-risk populations, such as those who have experienced disempowerment in the forms of poverty and social exclusion due to their mental illness. Empowerment Clubhouse also targets young Marin County residents that are aging out of Transition Age Youth Services after the age of 25, and older adults.

PROGRAM DESCRIPTION

The Empowerment Clubhouse is located in the Burgess Estate – a Victorian mansion built in the late 1800's on a 4 .2 acre wooded, rustic, terrain replete with deer families and a small creek. The Clubhouse location is peaceful, tranquil, and calm providing a state of relaxation and healing. Empowerment Clubhouse has a mission of: *offering a safe and restorative community where individuals working toward mental health recovery become empowered through meaningful work and supportive relationships.* This mission is pursued by offering the following services:

Work-Ordered Day: A four-hour period, occurring 10am – 2pm, Monday through Friday. Members of the Clubhouse voluntary work together to successfully run the day-to-day operations of Empowerment Clubhouse's Culinary/Hospitality/Gardening and Business/Clerical Units.

Decision-Making and Self-Efficacy Training and Practice: Collective decision making and governance are a crucial part of EC. All members and staff attend meetings and reach consensus about policy issues, activities, and future planning for the Clubhouse.

Social and Recreational Activities: Members develop meaningful and lasting friendships through recreation and occasional weekend and holiday gatherings and special events. Members have the opportunity to participate in a weekly art class, and to organize special recreational outings. Past outings and events have included: movies, beach trips, holiday BBQs, hikes, meals at local restaurants, and kayaking.

Participation in the EC Work Units: Members learn culinary, housekeeping, and clerical skills in a safe and supportive environment, and develop the soft skills needed for future success in the workplace.

Culinary/Hospitality/Gardening Unit: Members who choose to work in the Culinary/Hospitality/Gardening Unit develop skills by participating in the following activities:

- Menu planning
- Budgeting
- Food shopping
- Meal preparation and service
- Revenue collection and accounting

- General housekeeping
- Gardening

Business/Clerical Unit: Members who choose to work in the Business/Clerical Unit develop skills and receive training in the following areas:

- Filing and mailing/e-mailing

Health and Wellness: The promotion of healthy lifestyle habits is woven into the day-to-day operation of the Clubhouse. The meals prepared and served by the Culinary Unit are nutritious, balanced, and utilize fresh organic produce when available. Healthy living is also the focus of "Wellness Wednesday" activities, including: lectures by health educators, physical activities such as yoga and hiking, and cooking demonstrations.

Advocacy and Connection to Support Services: Members receive support navigating through a network of social services in the community while developing their ability to self-advocate. These supports include help with entitlements, housing, legal issues, developing healthy lifestyles, connecting with quality medical, psychological, psychiatric, and dental care.

EXPECTED OUTCOMES

The first year of operating, FY17/18, was a development year. By the completion of FY18/19 and going forward, the Empowerment Clubhouse is expected to serve at least 50 individuals each year and have an Average Daily Attendance (ADA) of at least 8 members. The ADA is calculated by using the following formula provided by Clubhouse International: (Total Number of Attendances/ Total Number of Work-Ordered Days).

Clubhouse members are expected to show an increase in wellness and recovery, such as:

- Increased access to employment and educational opportunities
- Reduced use of more intensive psychiatric services, including the Crisis Stabilization Unit and inpatient psychiatric hospitalization
- Reduced homelessness
- Reduced arrests and incarceration
- Improved quality of life and wellbeing
- Increased resiliency factors, such as social support

This will be tracked and measured in three ways (starting in FY18/19):

1) By using ***Member Defined Goals.*** Standard 3 of the Clubhouse International Standards states that "members choose the way they utilize the Clubhouse," and Empowerment Clubhouse members utilize the Clubhouse for a myriad of reasons, including to:
    - Reduce isolation and increase socialization
    - Develop work skills in preparation for a return to employment
    - Engage in social and recreational activities
    - Get support around returning to school
    - Become a productive member of a supportive community

    Each reason is valid and valued, and can be linked to concrete, measurable goals that can be progressed toward and accomplished through their participation at Empowerment Clubhouse.

During the intake process members are asked to identify their reason(s) for membership, and an Individualized Service Plan (ISP) is prepared to provide the framework for tracking progress and creating mutual accountability between member and staff around the attainment of these goals for each member.

2) ***Standardized Psychological Measures:*** Incorporating standardized psychological measures into the program evaluation plan will provide the ability to gather and analyze data that will inform the way Empowerment Clubhouse operates as a program and allow Empowerment Clubhouse to contribute to the research literature on the effectiveness of the Clubhouse Model. Empowerment Clubhouse is currently working with the Program for Clubhouse Research at the University of Massachusetts Medical School, our Advisory Board, and the Marin Community Foundation to develop a feasible measurement system. The working plan is to utilize the following validated measures, to be administered quarterly:

   - *The Recovery Assessment Scale-Domains and Stages (RAS-DS)*: A 38-item self-report instrument that measures the mental health recovery process and is designed to aid collaborative intervention planning between individuals engaged in mental health recovery and mental healthcare providers.

   - *The Flourishing Scale (FS)*: A 8-item self-report instrument that measures self-perceived success in important life-domains such as: relationships, purpose, self-esteem, and competence. The overall score provides a single measure of psychological well-being.

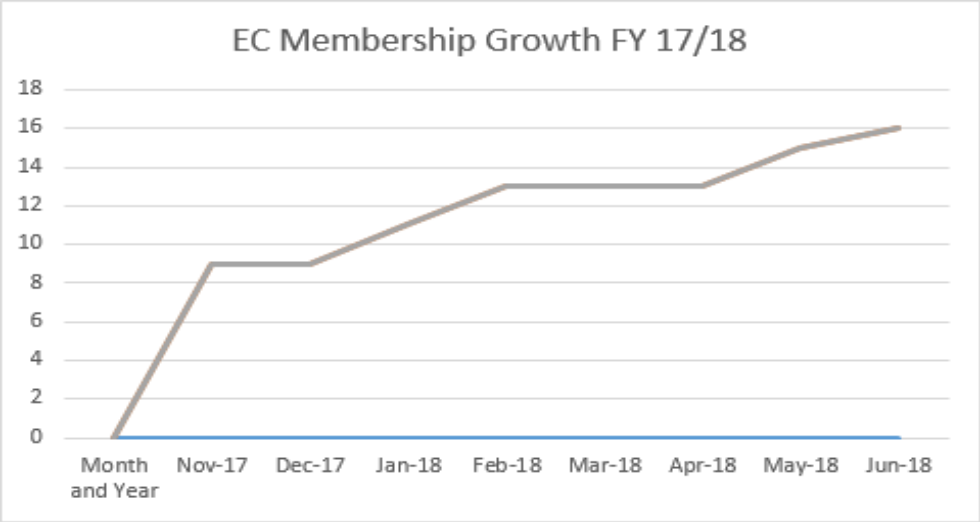
3) In addition, a 31-item survey to assess ***Member Satisfaction and Empowerment Clubhouse Impact*** will be administered annually, to quantify:
   - The quality and quantity of members' participation with Empowerment Clubhouse.
   - The impact that participation is having on members' physical and mental health.
   - Members' satisfaction with various aspects of the Empowerment Clubhouse program.
   - Suggestions for improving Empowerment Clubhouse.

ACTUAL OUTCOMES IN FY17/18

Membership Enrollment

During the initial year of operation, FY17/18, Empowerment Clubhouse enrolled 16 members throughout the duration of its 7 months of operation. (However, in FY18/19 Empowerment Clubhouse membership has doubled, and is projected to surpass the expected outcome of 50 members enrolled.)

Empowerment Clubhouse Membership Enrollment Growth FY 2017/2018

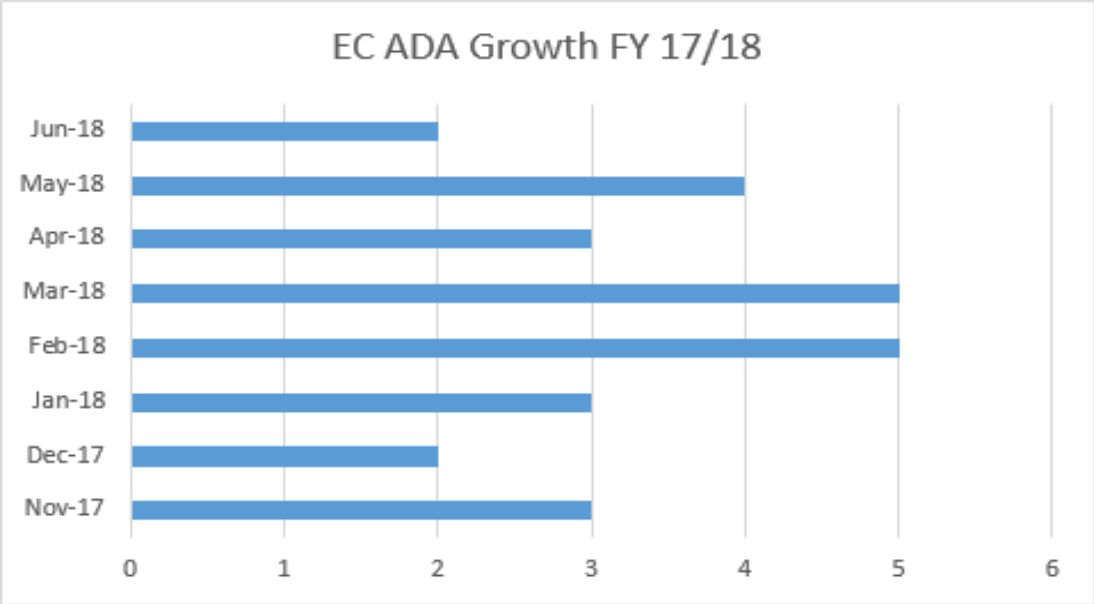


EC membership increased by an average of 1.33 members per month in FY17/18

Average Daily Attendance (ADA)

The Average Daily Attendance (ADA) is calculated by using the following formula provided by Clubhouse International: (Total Number of Attendances/ Total Number of Work-Ordered Days). At the start of FY17/18, Empowerment Clubhouse had an ADA of three, and ended the fiscal year with an ADA of 2, experiencing unstable fluctuations in between due to difficulties in hiring a Director who would implement the Clubhouse Model with fidelity. In year one, two Empowerment Clubhouse Directors were released given their infidelity to sufficiently connect the program fully to the Marin County mental health care systems and to the specific mental health need of the multicultural Empowerment Clubhouse members.

Empowerment Clubhouse is currently in FY18/19, month 9 of operation, and has an ADA of 6. Empowerment Clubhouse's ADA has tripled since the last fiscal year and is projected to reach an ADA of at least 8 by the end of FY18/19.



February and March were the months with the highest Average Daily Attendance (ADA) in FY17/18

Education Outcomes

During FY 2017/2018, one member was successfully enrolled at College of Marin (COM) and the Student Accessibility Services (SAS) program with the support and advocacy of the Empowerment Clubhouse. This member attended Empowerment Clubhouse every day for seven months, and with the re-assurance of the Clubhouse developed the self-efficacy to re-enroll at COM after a decade of dis-enrolling due to barriers resulting from her mental illness.

Employment Outcomes

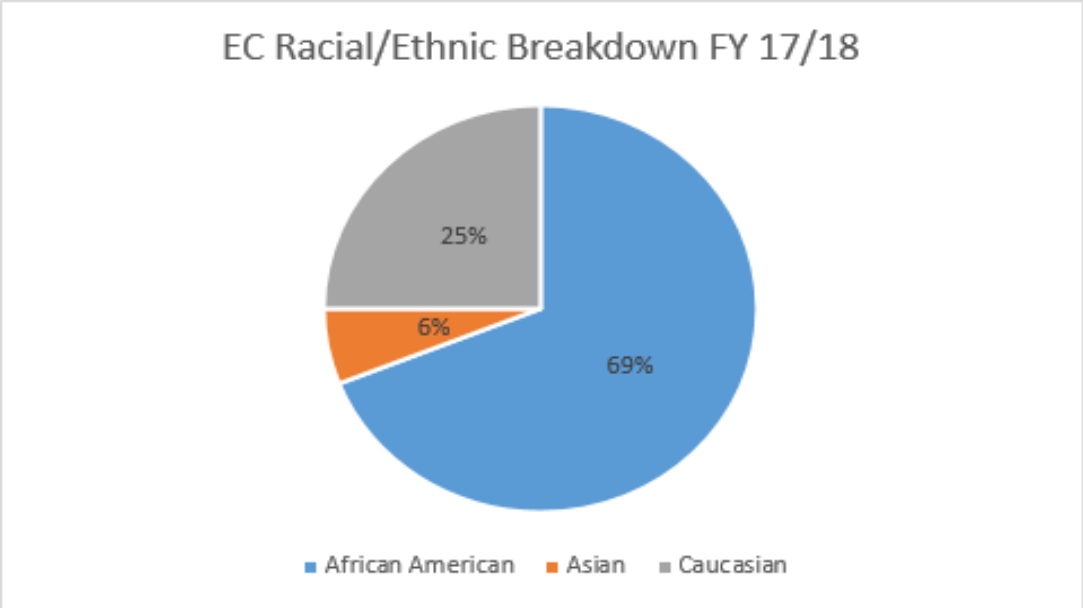
During FY 2017/2018, one member was referred to the Empowerment Clubhouse through the Marin City Community Development Corporation's Department of Rehabilitation (DOR) program. This member attended both Empowerment Clubhouse and the DOR program consistently for several months. As a result, this member was given an impromptu interview with a local construction company owner facilitated by Empowerment Clubhouse and MCCDC and was hired on the spot. The member went on to make a starting rate of $19 per hour, working 40 hours per week in the construction industry. This was an Independent Employment (IE) placement for Empowerment Clubhouse, as the member continued to receive ongoing support at the Clubhouse.

MEMBERSHIP DEMOGRAPHICS

Race/Ethnicity

The racial and ethnic demographic spread of Empowerment Clubhouse membership for FY17/18 was as follows: 11 African American members; 1 Asian member; 4 Caucasian members; 0 Latin(x) members; and 0 member that identifies as other (See Table 5. below).

Racial/Ethnic Demographic Breakdown FY17/18

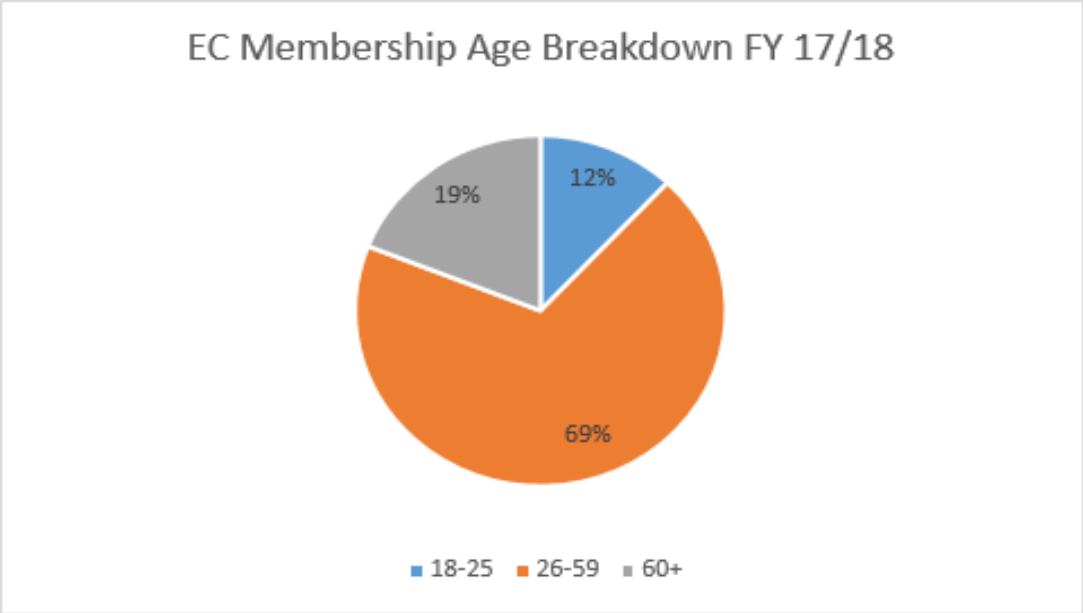


In this first year of the EC, 69% of the members were African American given the proximity of the site to the Golden Gate Village housing in Marin City. Staff is continuing to expand EC services to diverse populations within Marin County—EC's total market area.

Membership Age Breakdown

During FY17/18, EC membership age range breakdown was: 2 within 18 to 25 years of age; 11 within 26 to 59 years of age; and 3 that are 60 years of age and older (below).

Empowerment Clubhouse Membership Age Breakdown FY17/18



SUCCESSES IN FY17/18

During FY17/18, Empowerment Clubhouse met several benchmarks for success:

- On March 13, 2018, MCCDC and Empowerment Clubhouse sent a training team to the Independence Center Clubhouse International training base located in St. Louis, Missouri, for the two-week Colleague Training. Independence Center is the second oldest and largest Clubhouse in the world. This training supported the Empowerment Clubhouse team with deepening their understanding of the Clubhouse Model and supporting their development of the Empowerment Clubhouse Action Plan that was submitted to the Clubhouse International headquarters located in New York for approval and accreditation purposes.
- In April of 2018, Clubhouse International approved Empowerment Clubhouse's application for membership, and EC became an official member of Clubhouse International with global exposure on their international web page.
- On May 3, 2018, Empowerment Clubhouse held its first Advisory Board meeting. The Advisory Board convenes quarterly and is comprised of committed members whose expertise include health care, mental health care, lived experience with mental illness, higher education, human resources, food justice, and workforce training. The Empowerment Clubhouse Advisory Board has been tasked with advising on issues of program development, fundraising, evaluation outreach/marketing, and policy making.
- MCCDC was awarded a one-time Community Services and Supports (CSS) grant through MHSA to purchase a brand-new van. This van is used to facilitate member travel to and from residential care facilities, recreational outings, food purchasing trips, as well as travel to Bay Area partner Clubhouses for trainings. It has also helped us to expand our membership base and outreach by providing transportation to members living in facilities without transportation.

CHALLENGES OR LESSONS LEARNED IN FY17/18

Inconsistent Leadership. Empowerment Clubhouse struggled to hire a qualified Clubhouse Director willing and able to adhere to the Clubhouse Model. MCCDC hired two different Directors during the initial FY17/18 year, and neither lasted beyond the probationary hiring period. These directors lacked the requisite combination of managerial, administrative, and direct service skills necessary to successfully develop and run a fledgling Clubhouse and lacked the willingness to adhere to the 37 International Standards for Clubhouse Programs. This lack of consistent leadership negatively impacted the stability and growth of the Clubhouse. MCCDC hired Empowerment Clubhouse's current director, Dr. Gregory Katzen, at the start of FY18/2019.

Accessibility Issues. Empowerment Clubhouse's location in Marin City created a barrier to access for many eligible Marin County residents living with mobility issues or lack of transportation. This barrier was subsequently overcome through the purchase of a 12-seater passenger van, which was made possible by a one-time Community Services and Supports Grant through MHSA.

CHANGES FOR FY19/20:

In order to maintain the staff-to-member ratios required by the accrediting authority, there will be a budget increase to support additional staffing for FY19/20. In FY17/18 the program was budgeted for two staff positions.

FY17/18 CLIENT STORIES

Member B: *Before Empowerment Clubhouse's doors opened, B. spent her days at home alone in Marin City with no structured schedule. In the past, she attended school at College of Marin, but a mental health and medical setback during the Spring of 2013 caused her to drop out of school due to hospitalization. After her hospitalization, she attended group therapy class every week, but found that the therapy did not add anything of value to her recovery process because the discussions only focused on symptoms, deficits, and medications. She longed for a program that focused on strengths and recovery. In Empowerment Clubhouse, she found the program she was looking for. After attending Empowerment Clubhouse every day since its grand opening, B and those close to her have noticed many positive changes in her mental health. For example, her Empowerment Clubhouse activities has increased her confidence and self-efficacy skills. Her family and loved ones have recognized that she now has a sense of purpose in her life and the opportunity to be a mental health advocate and leader in her community. When she first started the program, her goal was to regain her courage and to become a more vocal self-advocate in her everyday life. Since attending Empowerment Clubhouse, she has effectively participated in Clubhouse outreach through presentations and meetings, given countless tours to guests and stakeholders, and attended Clubhouse International colleague training out-of-state for two weeks with Empowerment Clubhouse staff – all of which have helped her move toward her goals of being a confident and vocal mental health advocate.*

Member S: *S. is a Marin City resident that found out about Empowerment Clubhouse through his in-home support staff, a recent Co-Occurring Peer Education (COPE) graduate and Marin County Peer Intern. S. graduated from high school in Marin County a little over a decade ago, and prior to joining Empowerment Clubhouse, lacked social inclusion, a structured day, and opportunities to learn and apply skills. S. spent much of his time isolating at home, and rarely experienced any opportunities to develop independent living skills. S. and his support team had given up on trying to find an appropriate recovery program for him to attend, as the programs available to him did not meet him where he was in terms of his skills and strengths. As a result, for the 10 years prior to Empowerment Clubhouse opening S. did not receive any of the supports and services necessary to foster his development. When S. first became a member, he was extremely withdrawn at the Clubhouse, and solely communicated to his support staff. He initially struggled with his social anxiety, which oftentimes hindered his ability to engage in the tasks of the Work-Ordered Day without constant guidance and reassurance from staff. After attending the Clubhouse every day consistently during the first year Empowerment Clubhouse was operational, S. was able to overcome many of his initial barriers and challenges and begin to excel at many Work-Ordered Day tasks. In the Business and Clerical Unit, S. took the lead on tasks such as: balancing revenue logs, collecting meal orders, and leading the morning community meetings. In the Culinary, Hospitality and Garden Unit, S. learned to assist with food prep, laundry, shopping for the weekly groceries and supplies, and tending to the Empowerment Clubhouse community garden. One major success that S. experienced during the FY 2017/2018 was overcoming his severe discomfort communicating with people. Through practice and with encouragement, S. agreed to become the greeter of visitors to the clubhouse, and also took on the role of taking meal orders from members and staff. This is something S. was very apprehensive about doing at first, but his growth in confidence and self-efficacy as a result of his participation at Empowerment Clubhouse has allowed him to tackle many new ventures for the first time within a safe and supportive community. Empowerment Clubhouse is happy to provide the strengths-based, structured program that S. has desperately needed, but was unable to get, for more than a decade.*

MHSA HOUSING PROGRAM: MHSA HP

PROGRAM OVERVIEW

In August 2007, the State Department of Mental Health released the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHSAHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health. MHSAHP funds can be used to build or renovate rental housing or shared housing. Rental housing developments are defined as, apartment complexes with five (5) or more units, where each person or household has his/her own apartment. Shared housing is defined as; each resident has a lockable bedroom in a house or apartment that is shared with other housemates. MHSAHP housing must be permanent supportive housing. Counties are required to provide ongoing community-based support services designed to assist residents to maintain their housing and to support their ability to live independently. MHSAHP funds must be used for housing adults with serious mental illness or children with severe emotional disorders and their families. In order to qualify for MHSAHP housing, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHSAHP regulations. The household must be able to pay rent, and the household income must be less than a specified maximum amount.

CALIFORNIA HOUSING FINANCE AGENCY (CALHFA)

Since the completion of the Fireside Senior Apartment project in 2010, the unspent housing funds of approximately $1,400,000 remained with CalHFA pending identification of a new housing project. Since any proposed housing project had to follow CalHFA requirements as well as be feasible in Marin's high-cost housing market, it has been very difficult to find a project to fit the available funding.

In January of 2015 the Department of Health Care Services (DHCS) released Information Notice No. 15-004 which allowed each County the option to request the release of unspent MHSA Housing Program funds back from CalHFA. Counties must spend the released MHSA Housing Program funding to provide "housing assistance" to the target populations identified in W&I Code Section 5600.3 (W&I Code Section 5892.5 (a) (1)). Housing assistance is defined as rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for persons who are seriously mentally ill and homeless or at risk of homelessness (W&I Code Section 5892.5 (a)(2)).

In May 2016 at the direction of the Behavioral Health and Recovery Services Director, and with the support of the MHSA Advisory Committee, the Board of Supervisors approved the release of unencumbered Mental Health Services Act Housing Program funds held by CalHFA to be returned to the County of Marin.

In October 2016 Marin County submitted the necessary paperwork and a copy of the May 2016 Board of Supervisors approval to release and return the CalHFA funds. In late December 2016 the County was notified that funds totaling $1,493,655.94 were being sent overnight to Marin County. Upon receipt of the funds, Marin County has three (3) years to spend the funding before it would revert back to the State.

Presentations by several housing providers were made to the Mental Health Services Act Advisory Committee and an RFP was released. It was awarded in FY17/18 pending contract negotiations and Board of Supervisory Approval, to Resources for Community Development for their "Victory Village"

project in Fairfax. This project will set-aside 6 units for older adults (62+) who, at the time of assessment for housing services, receive or qualify for Full Service Partnership (FSP) services and are either homeless or at-risk of homelessness.

PROGRAM DESCRIPTION

Fireside Senior Apartments

In FY08/09, Marin County received approval of our proposal to use MHSAHP funds to leverage a set-aside of five (5) furnished housing units (studio and one-bedroom) for seniors in the Fireside Apartments. Fireside Apartments are a 50-unit affordable housing development for low-income families and seniors located in Tamalpias Valley in unincorporated Marin. The MHSAHP housing at the Fireside Apartments serves older adults (62 years and older) who, at the time of assessment for housing services, receive or qualify for Full Service Partnership (FSP) services and are either homeless or at-risk of homelessness. These are individuals with serious mental illness who have been identified as traditionally unserved or underserved by the mental health system. Many of whom have a co-occurring substance use disorder, as well as complex and often untreated physical health disorders. Individuals may have negative background information and poor tenant histories as a result of their disability and lack of access to services. Occupancy is limited to those whose income corresponds to the level of support that individuals can expect to receive from Supplemental Security Income or from the State Supplemental Program. Intensive community treatment and housing support services are provided by the HOPE FSP Program. The tenants of the MHSAHP-funded units are eligible to participate in community activities offered at the Fireside Apartments by Homeward Bound of Marin. Homeward Bound of Marin is a community-based non-profit organization that is the main provider of shelter and support services for families and individuals who are homeless or at-risk of homelessness in Marin County.

Construction of the Fireside Apartments was completed in FY09/10 and opened on December 3, 2009, when community members began the application process for the MHSAHP-funded units. The first MHSAHP-funded unit was occupied on January 25, 2010 and all five (5) units were occupied as of June 6, 2010.

Victory Village Apartments

In FY17/18, with the funding returned from the State, the county released a Request for Proposals (RFP). The remaining housing funding, $1,479,581 was awarded to Fairfax Affordable Housing, L.P./Resources for Community Development (RCD) to leverage a set-aside of six (6) furnished housing units for seniors in the Victory Village complex. Victory Village is a 54-unit affordable housing development for low-income seniors located in Fairfax. The MHSAHP housing at Victory Village serves older adults (62 years and older) who, at the time of assessment for housing services, receive or qualify for Full Service Partnership (FSP) services and are either homeless or at-risk of homelessness. These are individuals with serious mental illness who have been identified as traditionally unserved or underserved by the mental health system. Many of whom have a co-occurring substance use disorder, as well as complex and often untreated physical health disorders. Individuals may have negative background information and poor tenant histories as a result of their disability and lack of access to services. Occupancy is

limited to those whose income corresponds to the level of support that individuals can expect to receive from Supplemental Security Income or from the State Supplemental Program. Intensive community treatment and housing support services are provided by the HOPE Program. The tenants of the MHSAHP-funded units are eligible to participate in community activities offered at the Fireside Apartments by Homeward Bound of Marin. Homeward Bound of Marin is a community-based non-profit organization that is the main provider of shelter and support services for families and individuals who are homeless or at-risk of homelessness in Marin County.

The Victory Village project is projected to be completed in the Spring of 2020.

ACTUAL OUTCOMES – Fireside Senior Apartments

During FY18/19, all five (5) Fireside Senior Apartment MHSAHP-funded units continued to be occupied, continuing to indicate that this supportive housing project has been successful in reducing homelessness and enabling older adults with serious mental illness to maintain housing in the community and live independently.

Staff from the HOPE Full Service Partnership and other BHRS teams worked closely with Victory Village developers on plans for the supportive services and ensuring the layout of the units will meet the needs of our clients.

COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT BUDGET

Program	FY17/18	FY18/19	FY19/20	Total
FSP-01 Youth Empowerment Services (YES)	$668,704	$668,704	$601,704	$1,939,112
FSP-02 Transitional Age Youth (TAY) Program	$561,551	$550,176	$617,176	$1,728,903
FSP-03 Support and Treatment After Release (STAR)	$596,468	$535,233	$535,233	$1,666,934
FSP-04 Helping Older People Excel (HOPE)	$873,973	$873,973	$817,141	$2,565,087
FSP-05 Odyssey	$2,242,167	$1,821,526	$1,321,526	$5,385,219
FSP-06 Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)	$507,593	$691,702	$691,702	$1,890,997
SDOE-01 Enterprise Resource Center (ERC)	$357,809	$357,809	$357,809	$1,073,427
SDOE-07 Adult System of Care (ASOC)	$452,355	$825,504	$882,336	$2,160,195
SDOE-08 Co- Occurring Capacity	$274,733	$181,419	$268,064	$724,216
SDOE-09 Crisis Continuum of Care	$1,101,325	$851,325	$1,101,325	$3,053,975
SDOE-10 First Episode Psychosis (FEP) - NEW	$5,197	$150,873	$159,763	$315,833
SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)	$262,591	$262,591	$321,261	$846,443
Subtotal	**$7,904,465**	**$7,770,835**	**$7,675,040**	**$23,350,340**
MHSA Coordinator (Coordinator and Ethnic Services Manager)	$235,852	$235,852	$235,851	$707,555
FSP Program Support - NEW		$133,630	$229,425	$363,055
Administration and Indirect	$1,495,350	$1,495,350	$1,495,350	$4,486,050
Operating Reserve	$0	$0	$0	$0
Total	**$9,635,667**	**$9,635,667**	**$9,635,666**	**$28,907,000**

COMMUNITY SERVICES AND SUPPORTS (CSS) NUMBERS TO BE SERVED (FY19/20 PROJECTIONS)

Program		FY17/18 Actual	FY19/20 Projected	FY19/20 Cost Per Person
FSP-01	Youth Empowerment Services (YES)	71	**70**	**$8,596**
FSP-02	Transition Age Youth (TAY)	31	**30**	**$7,715**
		53	**50**	
FSP-03	Support and Treatment After Release (STAR)	51	**50**	**$10,705**
FSP-04	Helping Older People Excel (HOPE)	54	**50**	**$16,343**
FSP-05	Odyssey (Homeless)	113	**100**	**$13,215**
FSP-06	Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)	0	**40**	**$17,293**
SDOE-1	Enterprise Resource Center (ERC)	253	**250**	**$1,431**
SDOE-7	Adult System of Care (ASOC)	1,102	**1,200**	**$735**
SDOE-8	Co-Occurring Capacity	835	**750**	**$357**
SDOE-9	Crisis Continuum of Care	1,176	**900**	**$1,225**
SDOE-10	First Episode Psychosis (FEP)	14	**20**	**$7,988**
SDOE-11	Consumer Operated Wellness Center-(Empowerment Clubhouse)	16	**50**	**$6,425**
HP	Housing	5	**11**	**$3,847**

FSP = Full Service Partnership
SDOE = System Development Outreach and Engagement
HP = Housing Program

Workforce Education and Training (WET)

STRATEGIES

PROGRAM OVERVIEW

The Workforce Education and Training (WET) component of MHSA provides dedicated funding to address the shortage of qualified individuals to provide services to address serious mental illness. The focus is on developing and maintaining a more diverse workforce, including individuals with personal experience of mental illness and/or substance use disorders as well as their family members. WET can be used to:

- Expand capacity of postsecondary education programs
- Expand forgiveness and scholarship programs
- Create new stipend programs
- Create new regional partnerships among the mental health system and educational entities to increase the diversity, reduce the stigma, and promote distance learning techniques
- Implement strategies to recruit high school students for mental health occupations
- Develop and implement curricula to train staff on WET principles
- Promote the employment of mental health consumers and family members in the mental health system
- Promote the meaningful inclusion of mental health consumers and family members
- Promote the inclusion of cultural competency in the training and education programs

In Marin some of the key strategies have included providing scholarships, training and mentoring to assist interested consumers and family members to enter the public behavioral healthcare workforce; providing stipends for bilingual and bicultural interns, and providing workforce trainings on the MHSA core principles.

TARGET POPULATION

WET programs are designed to increase the number of peer and family providers, as well as culturally and linguistically competent providers. In Marin this includes Spanish speaking, Latino, African Americans, Vietnamese speaking, Asian, LGBTQ+ and other providers that reflect our client population. WET partners with county divisions and community-based organizations, including primary care providers, to support the development and employment of a diverse workforce. The programs are targeted toward the current workforce in addition to reaching out to future workforce members.

Trainings are open to all county, CBO, peer provider, family members. The intent is to be inclusive and to reach beyond the traditional training of the “professional” staff in the public mental health system. The Consumer and Family sub-committees of the WET Steering Committee guide and direct and create trainings for their respective populations and fully participate in the process.

PROGRAM DESCRIPTIONS

1. **Scholarships for Consumers and Family Members-**Offer scholarships to culturally diverse consumers/family members to complete a vocational/certificate course in mental health, substance use and/or domestic violence peer counseling.

2. **Training Initiatives**

    - Consumer-Focused Trainings- Develop and implement advocacy training course for un/underserved racially/ethnically and culturally diverse peer specialists/counselors and adult BHRS consumer populations. Also, implement Wellness Recovery Action Plan (WRAP) program that will be taught by former consumers who have completed WRAP certification program.

    - System-wide Dual Diagnosis Training- Develop a comprehensive system-wide substance use training and consultation plan for BHRS clinical staff and its agency partners. Also, develop and implement a Co-Occurring Peer Education (COPE) certification course for consumers/family members interested in becoming mental health peer counselors/specialists.

    - Training/Workshop Initiatives- Provide a series of introductory-level course/trainings on culture-specific topics. Also, continue to provide evidenced-based trainings such as Motivational Interviewing, Non-Violent Crisis Intervention and Trauma Informed System, Interpreter and the Use of Interpreter trainings, and Mental Health First Aid, all of which includes cultural competency principles.

    - Team Development- Contract with an organizational consultant/trainer/facilitator with cross-cultural expertise to engage staff throughout the organization on team building-related activities, discussions and planning related to diversity for the purpose of fostering, promoting and creating an inclusive organizational work culture and environment.

3. **Peer Mentoring**- Recruit and retain peer mentors with lived experience to provide support to scholarship recipients who are attending vocational/certificate courses in mental health, AOD and/or domestic peer counseling to ensure that recipients successfully complete their coursework.

4. **BHRS Graduate Clinical Internship Program**- Recruit and retain culturally/linguistically diverse interns to provide clinical services throughout the division, especially in program areas where there is persistent under-penetration of un/underserved racial/ethnic communities such as the Latino population.

5. **Peer Specialist, Domestic Violence, and Substance Use Intern Stipend Program**- Offer internship stipends to mental health, substance use, and domestic violence peer counselor graduates who are placed in public and not-for-profit behavioral healthcare settings.

6. **BHRS Peer Counselor Classified Positions/HR Collaboration**- Development of BHRS Peer Counselor classified positions: In collaboration with Human Resources, develop Peer Counselor I, II, and Peer Supervisor job classifications and positions. Also, develop a collaborative pilot

project with the department's Human Resources that will enhance recruitment, application reviews, interview and hiring processes and practices that will increase a culturally diverse applicant pool to compete for available BHRS job opportunities.

FY17/18 ACCOMPLISHMENTS:

1. **Scholarships for Consumers and Family Members**

    - In FY17/18, a total of twenty one (21) culturally and ethnically diverse consumers/family members applied for and/or were awarded scholarships to become substance use, mental health and/or domestic violence counselors. Awarded scholarship recipients were also offered mentor support as well as internship and/or job placement support from culturally and ethnically diverse pool of mentors and a placement coordinator, all of whom have lived experience.

2. **Training Initiatives**

    - BHRS either offered, endorsed and/or supported twenty-seven (27) cultural competence-related trainings with nearly four hundred (400) unduplicated attendees in FY17/18
    - Upon the appointment of BHRS' Director, Dr. Jei Africa, in March of 2018, he directed the Ethnic Services Manager to develop a three-year training plan survey to be distributed widely throughout BHRS, contract agency partners, and community stakeholders. Initial planning began in FY17/18.
    - BHRS' Peer Counseling-funded course, Co-Occurring Peer Education (COPE) program had 13 students enrolled in our Peer Specialist course and 11 graduated. One graduated after the next offering of the course; 6 students (including the one from the previous offering) enrolled in the Peer Counseling class and 5 graduated.
    - Overhauled and vastly improved training coordination system by implementing new technology systems and protocols.

3. **Peer Mentoring**

    - Fewer scholarship recipients were interested in peer mentoring in FY17/18 than in previous years so this budget for FY19/20 will be adjusted.

4. **BHRS Graduate Clinical Internship Program**

    - In FY2017-18, the Graduate Clinical Training Program included two (2) post-graduate interns, six (6) psychology doctoral interns, four (4) social work interns, and five (5) psychology practicum trainees. The MHSA funding continued to support the stipends that are key to drawing bilingual/bicultural applicants, given the number of competing training opportunities available in the Bay Area.
    - Of the seventeen (17) interns, nine (9) brought bilingual/bicultural skills that enhanced service delivery: six (6) were fluent in Spanish, two (2) in Mandarin, one (1) in Norwegian. Other identity factors that contributed to improved cultural match and workforce diversity included: four (4) identified as Black/African-American, four (4) were family

members of consumers/had personal lived experience, seven (7) were first or second generation immigrants, and two (2) identified as LGBTQ.

- The intern cohort provided the following mental health services as part of their supervised training program:
- Individual outpatient psychotherapy, group psychotherapy, psychodiagnostic assessment, case management, brokerage and rehab services, psychoeducational groups, and community outreach and engagement, including bilingual broadcast and print media.
- They provided additional mental health services in the following programs:
    - Latino Family Health
    - Support and Treatment After Release (STAR)
    - Odyssey Homeless Outreach
    - Helping Older Adults Excel (HOPE)
    - Transitional Age Youth (TAY)
    - Vietnamese Family Health Adult Case Management
    - Adult Case Management
    - Children's Mental Health
- They also contributed to Prevention and Early Intervention outreach and engagement efforts (e.g., *Cuerpo, Corazan and Communidad* Radio Program that is presented weekly by a county bilingual psychologist, a truly unique experience for those interns who are interested).
- Of those completing their degree programs in this cohort, three (3) continued to post-doctoral and employment positions with Marin County Behavioral Health and Recovery Services while three (3) successfully obtained training and employment positions with local Marin County community partner agencies. Others with completed doctoral internship hours went to the Cleveland VA Psychosocial Recovery Program and to serving early psychosis in Norway. Master's level trainees still completing social work and psychology programs went on to settings such as the CBT Clinic and East Bay Sanctuary Project in Berkeley. In all of the continuing settings, the majority of trainees are working with underserved populations in California.

5. **Peer Specialist, Domestic Violence, and Substance Use Intern Stipend Program**
    - Increased the number of bilingual/bicultural Spanish speaking scholarship recipients to become mental health peer, domestic violence and/or substance use counselors
6. **BHRS Human Resources Collaboration**
    - BHRS successful established classifications for, recruited, and hired its first-ever Bilingual Family Partner (1) and Peer Counselors (2)
    - Began to improve data collection of racial/ethnic staffing demographics of BHRS staff and its contract agency partners
    - BHRS continues to experience marked progress in recruiting and hiring a bilingual/bicultural workforce, particularly in management-level positions where Latinx saw a significant increase from Calendar Year 2017 (CY17) to CY18

- However, another significant outcome that occurred in CY18 is the decrease in workforce size of BHRS. Many vacant positions have been unfilled for host of reasons which includes, but not limited to, are:
    - Human Resources structural, policy, and practice changes that increased the length of time it takes to get positions filled
    - Strong economy coupled with uncompetitive salaries relative to surrounding counties and regions.
    - High cost of living in Marin County
    - Scarcity of affordable housing units
    - Poor traffic conditions and inadequate public transportation

CHANGES FOR FY19/20:

1. **WET Latinx Strategic Initiative-** (Established in the FY18/19 Annual Update) In order to better coordinate the numerous separate initiatives around connecting with the Latinx community, WET funding will be used to develop a Latinx WET strategic initiative with a focus on system transformation. This will include a stipend for a public health or public administration intern who will focus on ways to make the system more responsive to the needs of Latinos in our community. The intern will focus their work on the development of a strategic plan that BHRS can implement to better serve the Latinx community.
    - This position is scheduled to start at the end of FY18/19, and will be in place for much of FY19/20
2. **BHRS Human Resources Collaboration**-Due to the increasing delays to fill vacant positions, the Human Resources Collaboration project, an temporary staff member will be added in FY19/20 to help support efforts related to recruitment and filling of vacant positions in a timely manner. This has particularly hit the CSS component where many programs were underspent due to delays in hiring.

    In addition, the hiring of a CSS-funded county Peer Supervisor position will be established in FY19/20 to meet the goals of the Three-Year Plan.
3. The allocations for successful programs including **Trainings and the Peer, DV, AOD Intern Program** will be increased for FY19/20. See budget on the next page that reflects these increases and the restructuring of the WET programs to address the identified gaps and priorities.

WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT BUDGET

Program	FY2017-18	FY2018-19	FY2019-20	Total
Scholarships for Underserved Consumers & Family Members	40,000	$ 55,000	$ 50,000	**$ 145,000**
Training Initiatives	$ 65,000	$ 65,000	$ 85,000	**$ 215,000**
Peer Mentoring	$ 20,000	$ 20,000	$ 20,000	**$ 60,000**
BHRS Intern Program	$ 137,148	$ 203,200	$ 203,200	**$ 543,548**
Peer Specialist and AOD Intern Stipend Program	$ 35,000	$ 50,000	$ 65,000	**$ 150,000**
Latino WET Strategic Initiative	-	$ 36,000	$ 10,000	**$ 46,000**
WET HR Collaboration			$ 109,452	**$ 109,452**
TOTAL	**$ 297,148**	**$ 429,200**	**$ 542,652**	**$ 1,269,000**

Capital Facilities and Technological Needs (CFTN)

ELECTRONIC HEALTH RECORD AND PRACTICE MANAGEMENT SYSTEM ENHANCEMENTS

MHSA ALLOCATION FY17/18: $305,311

PROGRAM DESCRIPTION

With the Technology Needs (TN) Project, Marin County will continue to improve the performance of the electronic medical record system to support optimal clinical effectiveness and provide accessible and meaningful consumer outcome data. Marin County will also further improve the efficiency of the practice management system to ensure preparedness for the upcoming shift to alternate payment methodologies including value-based payments.

Marin's TN Project is designed to use technological resources and strategies to modernize and transform clinical and administrative information systems through the follow components:

1) Disaster recovery preparedness.
2) Ongoing Electronic Health Record (EHR) and Practice Management (PM) upgrades to remain compliant with current and future requirements.
3) Health Information Exchange (HIE) participation to enhance coordinated care among authorized providers and population health management.

EXPECTED OUTCOMES

The expected outcomes for the TN Component are as follows:

- Improve integration of the Electronic Health Record and Practice Management systems.
- Transition EHR from a hybrid paper/digital format to an entirely digital format by supporting electronic client signatures, electronic medication, and laboratory orders.
- Support capture of clinical information in the field, where services are delivered.
- Become and remain current with Federal clinical quality documentation and reporting standards.
- Participate in the Marin Health Gateway, the local Health Information Exchange (HIE).

FY2017/18 UPDATES:

Data is now being exported in to the Health Information Exchange (HIE) from the BHRS EHR to allow for care coordination among authorized treating providers by supplying the relevant data at the point of care. The interface (data exchange) is now live.

Electronic Health Record (EMR) enhancements to improve: visibility of staff assignments and roles, availability of electronic forms for specialty services, clinical documentation alerts, symptom inventory

monitoring (Abnormal Involuntary Movement Scale - AIMS) and improvements to confidential client status. BHRS technical staff have continued to develop ongoing reports to aggregate datasets and identify outstanding action items, and to deliver these reports to the responsible management staff. This includes products such as the a scheduled appointment to documented services report, FSP 'report card' to ensure FSP registration and follow-up, Direct Service Report, and Inactive/disabled users report.

ANTICIPATED CHANGES FOR FY19/20:

BHRS continues to plan for an upgrade to both the Practice Management System and Electronic Health Records system. Initial steps will include documenting existing processes, identifying functionality goals, and noting gaps/opportunities. Given the scope of the project, BHRS is considering utilizing subject matter expert consultants to assist with needs assessment, procurement, and implementation tasks. Initial discussions and planning with the Fiscal Department and the Senior Management Team has begun.

Electronic Health Record and Disaster Recovery

While maintaining the existing server infrastructure, BHRS is moving to a virtualized environment to host the existing systems. BHRS is prioritizing encrypted data storage. This will modernize the server infrastructure and provide better backups with a quicker recovery timeline as well as a more robust disaster recovery plan, allowing BHRS to host its data systems from multiple sites in the event of a disaster.

Practice Management Upgrade

BHRS continues to work with the current Practice Management vendor to optimize the product's claiming, reconciliation and cost reporting features to be responsive to BHRS business process and current and future Medi-Cal and other third party claiming requirements. Additionally, new CMS Managed Care Final Rule reporting requirements regarding timeliness, and network adequacy/capacity as well as additional outcome measurement mandates require ongoing collaboration to provide flexible and forward-thinking claiming and reporting solutions

Electronic Health Record Upgrade

Marin BHRS continues to enhance its Electronic Health Record to best support the changing models of care delivery. Upgrades include enhancements to allow consumer services to be recorded pre-admission, and captured in the field. Enhances improve the data quality to support both the Health Information Exchange (HIE) effort, allowing for care coordination and the pursuit of shared quality goals across physical and behavioral healthcare settings.

Integration of Practice Management and Electronic Health Record Software

Marin BHRS plans to evaluate the effectiveness of utilizing two separate applications (and EHR and PM system) and explore implementing an integrated Practice Management and Electronic Health Record suite of software to improve the quality and operational efficiencies.

Health Information Exchange

Marin BHRS is currently able to export limited data into the HIE (Health Information Exchange) to authorized care providers in this network to support integrated care. BHRS continues to participate in the Marin Health Gateway, and is continuing to implement bidirectional data exchange and use. Activities include overcoming technical hurdles, outlining use-cases, identifying HIE champions and training clinical and administrative staff.

CRISIS STABILIZATION UNIT (CSU) EXPANSION

MHSA PROJECT ALLOCATION FY17/18 through FY18/19: $685,000

PROGRAM DESCRIPTION

New in FY17/18, Capital Facility AB114 funding was used, in conjunction with an Investment in Mental Health Wellness (IMHW) California Health Facilities Financing Authority (CHFFA) grant and other funding sources, to fund the Crisis Stabilization Unit (CSU) expansion from 5 beds to 10 and will address the safety and functionality of the CSU to increase efficiencies, improve both staff and patient safety and optimize patient care. The Crisis Stabilization Unit is a significant part of our Crisis Continuum program and this expansion will reduce overcrowding and allow for the unit to better meet the needs of the community.

FY2017/18 UPDATES:

The Crisis Stabilization Unit is located at 250 Bon Air Road in Greenbrae in the Behavioral Health and Recovery Services portion of Marin General Hospital. The bid to General Contractors was released on October 31, 2017 and the construction contract was awarded to Murray Building, Inc., on December 5, 2017. The Office of Statewide Health Planning and Development (OSHPD) approved the construction permit (S170898-21-00) on November 1, 2017.

Because the project fell under OSHPD review, which is typically very extensive, on December 7, 2017, we received approval from the CHFFA Board to extend our IMHW Grant through April 30, 2019. Construction commenced in the field on Tuesday, January 16, 2018. The Interim CSU, located in the reception, lobby and staff area of the CSU, opened and was occupied as of February 2, 2018. Throughout the construction project, weekly construction status and support meetings continued at the construction site and weekly administrative and fiscal support meetings continued off-site.

Major construction milestones during FY17/18 include:

- Wall framing for new rooms and partitions was completed;
- All rough plumbing, mechanical, electrical, fire sprinklers and fire alarm work was completed;
- Sheetrock and taping was completed;

During the early phase of construction, challenges related to the project scope and the building's aging infrastructure resulted in scope changes. In May 2018 a decision was made to add a wall and door in the patient room corridor. The scope change will provide a higher level of security for youth clients in the CSU. All of the scope changes required additional review OSHPD. The added review time by the permit authority increased the overall project schedule.

Construction was completed in December 2018. Once construction was complete, the remodeled Crisis Stabilization Unit was re-certified and then occupied in January 2019.

COORDINATED CASE MANAGEMENT SYSTEM

MHSA PROJECT ALLOCATION FY17/18 through FY19/20: $255,665

PROGRAM DESCRIPTION

New in 2017/18, CFTN supported the development of the electronic Case Management System that will be implemented by Whole Person Care (WPC). WPC, with the help of this technology project, will allow the county and community providers to improve coordination to better serve Medi-Cal beneficiaries with complex medical and psychosocial conditions, including mental health and substance use disorders as well as those who are homeless and precariously housed. WPC utilizes a team-based service model that integrates physical health, behavioral health, social services, and housing providers.

The County expects to integrate the case management system with its Health Information Exchange (HIE), the Marin Health Gateway, as well as have it bi-directionally share with County and partner data systems that are not connected or planned for connection to the HIE. These include current and future BHRS systems.

The County has recruited a broad range of stakeholders who have committed to data sharing through a case management tool. These partners include many Marin County departments, including:

- Behavioral Health and Recovery Services (BHRS)
- Epidemiology
- Social Services
- Adult Protective Services
- Emergency Services (EMS)
- Marin County Jail

MHSA dollars used to support system development and implementation may be used as leverage for the county to draw down an equal amount in Federal funds.

FY2017/18 UPDATES:

In 2018 Marin County Health and Human Services Whole Person Care implemented ACT.md's hosted case management/care coordination platform, branded as "WIZARD" for Marin. Since implementation, the number of client profiles, active system users, and overall system activity have grown steadily.

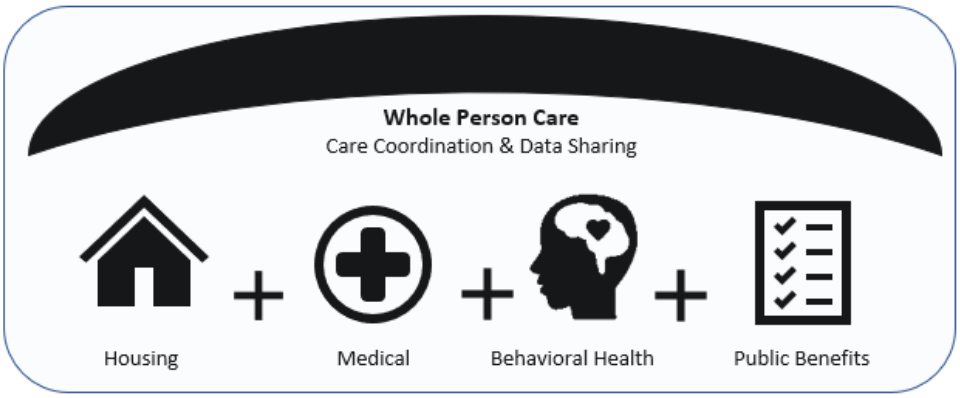
This is already resulting in barriers to holistic care being removed in hospitals, jail, clinics, street services, and mental health care run by and contracted by the county. Specific patient stories show how transformational this change is, now that caring professionals through out the systems of care can see if a client has Whole Person Care case management, can connect with the case manager securely through WIZARD, and can refer new potential clients to the program if they aren't already in the system. The ability to have access to data (following confidentiality rules) allows for better coordination of care.

Timeline:

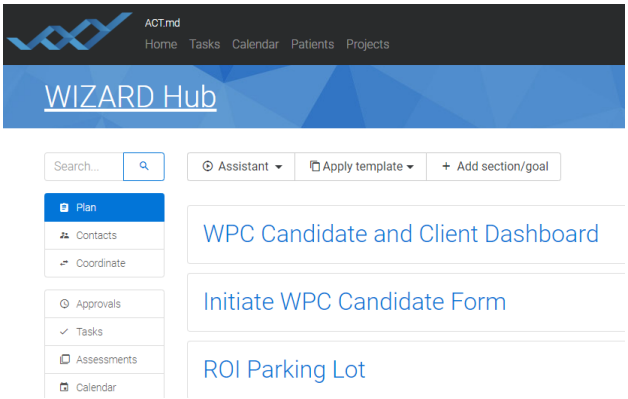
- RFP released February 13, 2018
- Contract awarded April 3, 2018
- Approved by Board of Supervisors June 8, 2018
- Data migration began from the temporary Google Suite system to WIZARD late September
- WIZARD user training October 2 and 3, 2018
- WIZARD go-live October 4, 2018

OVERVIEW OF WIZARD AND WHOLE PERSON CARE:

Marin County's **Whole Person Care** Program coordinates care and shares data across housing, medical, mental health, and social services, for Medi-Cal adults with a focus on people experiencing homelessness. We also serve medically complex individuals who are not necessarily homeless.



WIZARD is the care coordination platform for data sharing and care planning:



Clients in WIZARD may be enrolled in Case Management or they may be in WIZARD without active Case Management, potentially to be enrolled. Integration with the Marin Health Gateway information exchange is planned mid-2019 for ER and inpatient alerts.

Case management is provided by community partners under contract with Marin County H&HS:
Housing Case Management: Ritter, St. Vincent's, Homeward Bound, Downtown Streets Team
Medical Case Management: Marin Community Clinics, Ritter, Marin City Health and Wellness (soon!)
Mild to Moderate Behavioral Health Case Management: Marin Community Clinics

County HHS and community partners (participating entities here: https://www.marinhhs.org/whole-person-care) use WIZARD to:

- See if a potential client has already signed a Release of Information (ROI) authorization
- Upload signed ROIs and enter a candidate form to refer a client to the program
- Identify the case manager, for clients enrolled in Case Management, to coordinate care
- Communicate securely (Substance Use information under 42 CFR Pt. 2 **not** permitted in WIZARD)
- WPC Case Managers build care plans, track visits, conduct assessments, and create and track client goals in WIZARD for clients enrolled in Case Management

IN PROGRESS:

- System integrations to allow automated data sharing, anticipated June 2019:
    - Marin Health Gateway Health Information Exchange
    - Homeless Management Information System

- System user base expansion, early 2019:
    - Behavioral Health and Recovery Services (BHRS): entire teams that care for overlapping populations are being added to WIZARD to coordinate care.
    - Hospitals: Social workers at Marin General Hospital and Kaiser San Rafael were authorized and trained in WIZARD and are using it to coordinate discharge planning, etc.
    - Other teams throughout the system of care continue to be added to WIZARD, in accordance with the List of Participating Entities in the Consent for Release of Information.

- WPC and BHRS are continuing to work closely together to improve collaboration with two different data systems. In order to improve and simplify this process going forward, BHRS and WPC completed a Memorandum of Understanding (MOU) in FY18/19.

ANTICIPATED CHANGES FOR FY19/20

- WIZARD system usability and workflow improvements expected
- Potential expansion of WIZARD to coordinate care for individuals who don't qualify for Whole Person Care (not on Medi-Cal), related to the Whole Person Care waiver off-ramp and long term sustainability
- Increased counts of client profiles and active users

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) COMPONENT BUDGET

Program	FY17/18	FY18/19	FY19/20	Total
Crisis Stabilization Unit (CSU) Expansion	$300,000	$385,000	$0	$685,000
Electronic Health Record and Practice Management System Enhancements	$305,311	$360,000	$338,697	$1,004,008
Coordinated Case Management system	$137,165	$90,000	$28,500	$255,665
Total	**$742,476**	**$835,000**	**$367,197**	**$1,944,673**

One-Time Funding Sources	
AB114 CFTN Funds	$1,444,673
One-time CSS transfer in FY17/18	$500,000
Total	**$1,944,673**

Appendix 1: MHSA Advisory Committee Members

Appendix 2: Cultural Competency Advisory Board Members

Appendix 3: WET Steering Committee Members

Appendix 4: County of Marin Health and Human Services Strategic Plan to Achieve Health and Wellness Equity (December 2018)

Appendix 5: CalMHSA PEI Reports

Appendix 6: Growing Roots Innovation Project provider summaries

SUPPORT

UNITY

TRUST

EXCELLENCE

ALL IN MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES STRATEGIC PLAN TO ACHIEVE HEALTH AND WELLNESS EQUITY 2018

COUNTY OF MARIN

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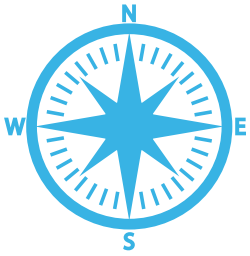
LETTER FROM THE DIRECTOR



This strategic plan is a roadmap for Marin County, Health and Human Services (HHS). It demands bold action, radical inclusion, and accountability. Historically, HHS has functioned effectively as the executor and funder of services – often within the confines of mandated services as delivered through our public health, behavioral health, and social services divisions. Herein, we are challenging ourselves to do better across a wide spectrum of areas that influence health and wellness, from focusing on direct customer service to climate change. Our goals are specific, measurable, and realistic. Mandated services will continue, but with a renewed emphasis on quality and outcomes that will help build greater equity in our communities.

The plan's focus on equity stems from the fact that Marin is the most inequitable county in the state. The plan recognizes that this status quo is unacceptable. It also recognizes that while service delivery is key to helping individuals and their families, we have the responsibility to understand and address the systemic causes of inequities. Given the state of our national struggle to address honestly the current and historic racial and ethnic dynamics in the U.S., bringing a focus on race to the core of our work is especially timely.

When we lead with race we are acknowledging and confronting the policies, programs, and practices that are critical to achieving not only an equitable county but society as a whole. Challenging institutional and structural racism that is pervasive in our everyday work and lives is fundamental and key to addressing the inequities that are driven by these dynamics.

This plan reflects the multiple perspectives gathered from clients, other community members, community organizations, as well as County-level data and information from evidence-based, best, and promising practices. The plan identifies key conditions, including some typically outside the scope of HHS Departments and Programs, where we are committed to effecting change with engagement of stakeholders with similar goals. Indeed, the plan recognizes that HHS must work with partners in new ways to optimize the chances for success. To that end, the strategy outlines how HHS will work collaboratively across sectors and with community partners to measure progress.

This strategy sets priorities and metrics, but an institution's culture determines whether goals are realized and maintained. The cultural shift this plan requires is considerable, and already underway as HHS strives to uphold and exemplify our core values of Unity, Support, Trust, and Excellence. As outlined in the HHS operational plan (http://marinhhs.org/operational-plan), HHS is committed to shifting our own internal culture to be more equitable, diverse, and transparent.

(continued)

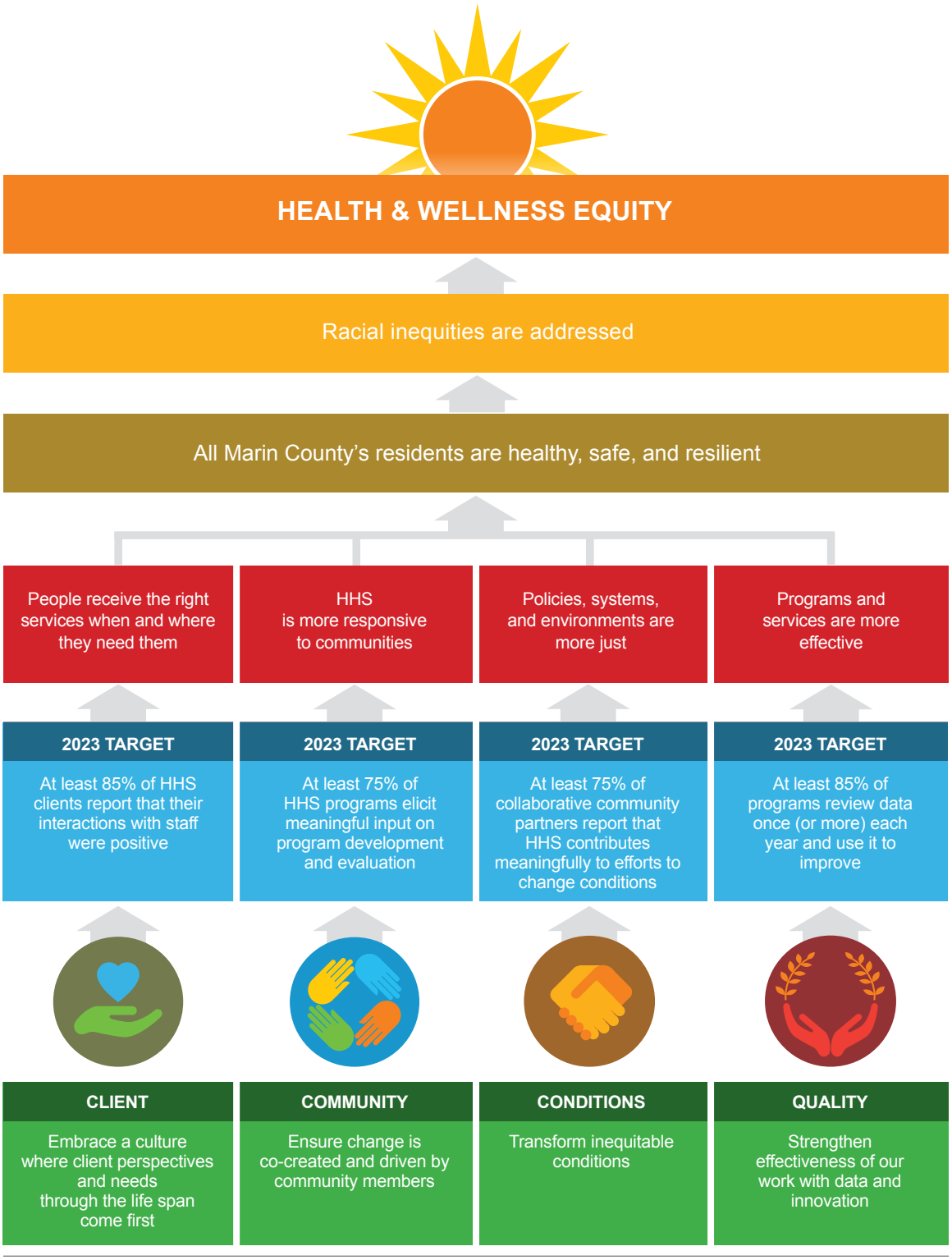
LETTER FROM THE DIRECTOR
CONTINUED

Investment and institutional support is also required for success. This plan aligns with the County's 5-year business plan and other equity efforts throughout the county. HHS is allocating personnel and infrastructure resources to implement the strategy. This includes hiring an executive-level Chief Strategy Officer who is responsible for overseeing the execution of the strategy, as well as creating organizational structures and systems within the department to ensure work is coordinated, integrated, and aligned with shared goals.

For this plan to be effective, our work will need to be challenging, and at times uncomfortable. Testing new initiatives, and new ways of engaging together, will inevitably create tension and face the systemic barriers of bureaucracy. Through embarking on this important process, however, the work will also create new partnerships, innovative programs, and better outcomes to increase health and wellness equity in our communities. Core to realizing these outcomes is a shared vision and priorities, as well as a learning culture that honestly and effectively creates change. While the journey will be long, we have already begun. Let's continue…

Dr. Grant Colfax
Director, Department of Health and Human Services
County of Marin

GOAL AND FOCUS AREAS FOR HHS STRATEGIC PLAN TO ACHIEVE HEALTH AND WELLNESS EQUITY



OVERVIEW OF HHS

The Marin County Department of Health & Human Services (HHS) is charged with protecting the health and well-being of all County residents. HHS strives to ensure that all residents can achieve optimal health, while allocating resources to improve health and wellness equity.

Vision of Marin Health & Human Services Department:
All in Marin Flourish.

The Department has approximately 700 employees and a budget of $180 million, much of which is mandated to be spent on core services, from Medi-Cal enrollment to disease surveillance. Social Services provides care and support to County residents most in need. Programs include those for older adults, foster care, nutrition, employment training, as well as disability and medical care coverage. The Behavioral Health and Recovery Services Division delivers mental health and substance use treatment services, primarily through Medi-Cal. It also has an extensive portfolio that focuses on prevention and early interventions. Public Health's scope of work ranges from maintaining vital statistics, tracking and managing disease outbreaks, to addressing cross-cutting issues such as the opioid epidemic. Further details and specifics of the work of these divisions can be found on our website: https://www.marinhhs.org/content/government.

Mission of Marin Health & Human Services Department:
To promote and protect the health, well-being, safety and self-sufficiency of all people in Marin County.

While HHS programs generally function well and usually are responsive to the needs of clients, until now the Department has had no unifying strategy to support, improve, and integrate service delivery and measure meaningful outcomes. Furthermore, while some programs have a history of actively engaging community to set priorities and better deliver services, this has been the exception, rather than the rule. While an equity focus is generally embraced, there is not a shared common understanding of how to operationalize equity-related work or how to measure progress. This strategy provides a comprehensive framework to address these challenges over the next five years.

OVERVIEW OF HHS

As part of the County government's priority on increasing equity, including its partnership on the Government Alliance on Racial Equity (GARE)[ii], this plan will focus on actions to improve racial equity in the areas of health and wellness. The goal of such "targeted universalism" is not only to improve conditions for those of a specific race or ethnic groups, but to benefit the greater good and society as a whole.[iii]

Equity: *Just and fair inclusion in the County where all can participate, prosper, and reach their full potential. Equity efforts seek to rectify historic patterns of exclusion.*

MARIN COUNTY BOARD OF SUPERVISORS, 2017

ONE OUT OF FOUR RESIDENTS IN MARIN IS A PERSON OF COLOR.
16% LATINX
6% ASIAN
3% BLACK/AFRICAN-AMERICAN
3% MULTIRACIAL

Our ranking as one of the healthiest counties in California[iv] correlates with our top state county rank in median per capita income, reflecting the association of affluence with health. Further exploration of county data reveals significant concerns. In 2017, Marin had the highest level of racial and ethnic inequities of all California counties.[v] These inequities are the result of historic, deep and pervasive inequitable systems, including exclusionary policies and practices.

With a population that is nearly three-quarters white, the relative lack of racial and ethnic diversity in the county further exacerbates the equity divide. Indeed, it could be argued that precisely because the racial inequities are so large, in such a modest population, that it is even more unacceptable that they exist at all. It also suggests that improving race equity outcomes is not an insurmountable challenge. By 2030, one in five Marin residents will be Latinx, suggesting that these issues may be even more pronounced in the near future.

For persons of color in Marin, inequities mean less access to opportunity, which, in turn, are associated with poor outcomes. For example, Latinx children in Marin are less likely to enroll in pre-K education, a key indicator of success, than Whites (35% vs. 85%[vi]). Only 5% of White students do not graduate from high school in comparsion to 18% of Black/African-American students.[vii] Median household income in Marin is $100,310; in Black/African-American and Latinx households, it is nearly half of the median, at $57,626 and $53,106, for Asians it is nearer, but still below, the median, at $92,136, and in White Non-Latinxs it is above the median, at $109,205.[viii] People of color in Marin die younger than Whites. Life expectancy for Black/African-Americans, Latinxs, and Asians in Marin is 75, 80, and 81 years respectively; for Whites, it is 83 years[ix], one of the highest ages in the nation.

Latinx (la-teen-ex) (/lə'ti:nɛks, læ-/) is a gender-neutral term sometimes used in lieu of Latino or Latina (referencing Latin American cultural or racial identity). The plural is Latinxs.

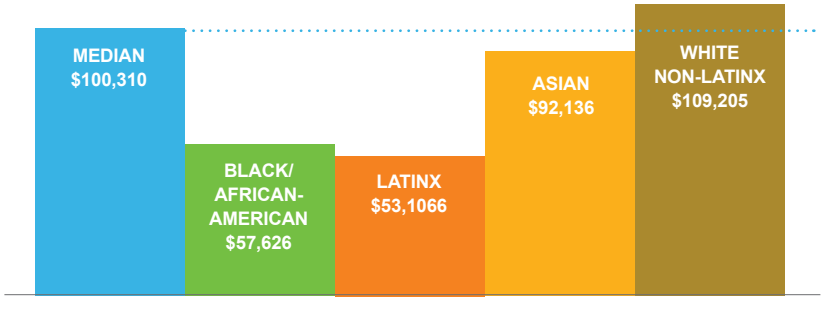
WHY FOCUS ON RACE?

While income, education, and other socioeconomic and cultural factors play key roles in shaping outcomes in our communities, the direct effects of racism – whether covert or overt, intentional or unintentional, systemic or individual – must be acknowledged and addressed to achieve equity. Research demonstrates independent associations of racial discrimination on driving inequities, including downward mobility.[x]

Systems that are failing communitites of color **are failing all of us.**

Our focus on racial equity has effects beyond improving the lives of communities of color. As outlined by GARE and others, efforts to improve access for one group have brought broader benefits to communities.[xi] Thus, we expect this plan to not only address racial and ethnic inequities, but in doing so also improve outcomes for the Marin community as a whole, including those in other historically marginalized or underrepresented groups including, but not limited to: those of different genders, abilities, advanced age, and sexual orientation. Our collective efforts to address racial discrimination directly and honestly, in conjunction with other work across the county, may help move ourselves and the communities in which we live and work closer to reconciliation and healing.

To achieve this goal, we must work differently across sectors, and embrace the disruption that such work requires. New and non-traditional partnerships can help remove barriers to opportunity, and direct resources towards evidence-based efforts that address historic inequities. Marin HHS' strategy to achieve equity – to realize the Department's vision that *All in Marin Flourish*—identifies four focus areas and corresponding strategies to do just that.



HOUSEHOLD INCOME IN MARIN COUNTY

HISTORY HAS SHAPED RACIAL INEQUITIES IN HEALTH AND WELL-BEING IN MARIN

To be effective in reducing inequities, we need to understand historic factors that have shaped them throughout the County. Marin City, historically a predominantly African-American/Black community but now ethnically diverse, and the Canal district of San Rafael – a majority Latinx community – are good examples. While both communities demonstrate great resiliency and strength, social and structural factors have created profound inequities along racial and ethnic lines.

In the 1940s, Marin City was created by the federal government for the Sausalito-based Marinship Shipyards workers and their families to support World War II defense industries. Thousands of Black/African- Americans moved from the Midwest and the South to Marin for employment. When World War II ended, many Marinship workers lost their jobs. Most of Marin City's White residents relocated—but racially discriminatory laws and policies severely limited housing and employment opportunities for Black/African-American residents.[xii, xiii, m] Over decades, unequal educational opportunities, unjust application of law enforcement, lack of access to healthcare, and inadequate access to healthy food, along with broad and overarching overt and covert racial discrimination, correlated with poor outcomes.[xiv]

San Rafael's Canal District was developed as an industrial and residential neighborhood in the 1950s and 1960s with small housing units in multi-family buildings. The neighborhood's population is increasingly Latinx as families find lower-cost rents and proximity to manual job opportunities. Lack of access to pre-school education, adequate housing, healthy food, and healthcare coverage contribute to poor health and other detrimental outcomes among residents. While employment rates are high, low-wage jobs often lack critical benefits like paid sick leave and have limited opportunities to advance.[xv, xvi] In addition, increasing numbers of residents are from Central American countries where violence is prevalent, increasing the risk that many families will suffer from trauma and adverse childhood experiences. The systemic marginalization of Latinx communities in Marin – whether due to overcrowded housing, poor pay, federal immigration policies, or lack of culturally appropriate behavioral health care, among other factors – contribute to poor outcomes.

While racial and economic segregation are not unique to Marin, they perpetuate inequities for people of color by dictating where they can live and limiting long-term social and economic mobility. Residential segregation limits residents' social and professional networks, denying them relationships and knowledge needed to advance professionally.[xvii] The cumulative and continued effects of structural racism in the County and throughout the U.S. have shaped our communities, and have resulted in specific negative effects felt by many residents of color today.

[1] From the Government Alliance on Race & Equity (2016): **Structural racism** encompasses a history and current reality of institutional racism across all institutions, combining to create a system that negatively affects communities of color. Structural racism is racial bias among interlocking institutions and across society, causing cumulative and compounding effects that systematically advantage white people and disadvantage people of color. **Institutional racism** includes policies, practices and procedures that work better for white people than for people of color, often unintentionally or inadvertently.

HOW TO NAVIGATE THE PLAN

This section outlines components of the plan and how they work together to support action.

HOW HHS WILL IMPLEMENT THE PLAN	
FOCUS AREA	Strategic area that is prioritized in the plan to reach the goal
STRATEGY	How HHS will accomplish the outcomes
ACTION	The tactic that supports execution of the strategy
OUTCOME	The condition that actions are intended to create

HOW HHS WILL MEASURE PROGRESS	
INDICATOR OF SUCCESS	What will be different if the focus area and strategies are successful
METRIC	The specific measures used to determine progress

FOCUS AREA 1: CLIENT

EMBRACE A CULTURE WHERE CLIENT PERSPECTIVES AND NEEDS THROUGHOUT THE LIFE SPAN COME FIRST

Why Focus on the Client?

Central to our efforts on leading with race to achieve equity is treating clients respectfully and with cultural humility. This work will build on existing efforts throughout HHS to increase the cultural responsiveness of services, improve customer experience, and coordinate services across programs. Over the next five years, HHS commits to systematically expanding this work throughout the Department and to supporting contracted service providers to do the same.

By deepening our understanding of how individuals experience accessing and receiving services, HHS will identify opportunities to improve service delivery. This includes ensuring that services focus on the client's[2] immediate needs first, and by asking "how can I help you," rather than focusing immediately on whether an individual meets specific eligibility requirements. Gathering consistent client feedback will ensure that services are responsive and will enable us to better address their needs. Ensuring that services consider client perspectives will also require addressing the complex factors that shape people's health and wellness.

In addition, HHS services are often siloed and disconnected, making it challenging for clients to navigate and access multiple types of support.[xviii] This inefficient fragmentation may result in lower quality of care and higher costs. HHS' focus on integrating service delivery will help connect clients to timely and appropriate services.

We believe that providing the right services when and where community members need them will result in improved health and wellness. For these reasons we are strengthening our commitment to this work.

[2] For this plan, clients are defined as people who are eligible receive benefits and/or direct services from HHS programs (e.g., case management services, behavioral health services, WIC services) within Marin County.

FOCUS AREA 1: CLIENT

HOW HHS WILL IMPLEMENT FOCUS AREA 1: CLIENT

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Strengthen accessibility and cultural responsiveness of services	■ Incorporate client needs and perspectives into program development and evaluation ■ Support community members to make informed choices about benefits and services ■ Require implicit bias and cultural humility trainings for HHS and contracted providers ■ Ensure managers, supervisors, and executives engage directly with clients on a regular basis to better understand challenges	**More people receive the right services when and where they need them**
Integrate service delivery to support clients	■ Implement systems that reinforce coordinated service delivery and information sharing ■ Adopt policies and procedures that support integrated service delivery services	

FOCUS AREA 1: CLIENT

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Strengthen accessibility and cultural responsiveness of services	Improved access to services	Increase in HHS clients whose primary language is not English who receive services in their primary language
		Increase in client satisfaction and culturally responsive services (also in Focus Area 4: Quality)
Integrate service delivery to support clients	Improved cross-program data sharing	Increase in HHS programs that use a common screening tool
		Increase in HHS programs that share client data

FOCUS AREA 2: COMMUNITY

ENSURE CHANGE IS CO-CREATED AND DRIVEN BY COMMUNITY MEMBERS

Why Focus on Community?

HHS recognizes that leading with race to achieve health and wellness equity also requires working with our partners in new ways. This focus area highlights opportunities to deepen HHS work not only with community organizations, but also with individual community members to ensure that programs and services reflect their needs and priorities. We must move beyond the status quo of expecting people to "come to us," and instead partner fully with members of the community to catalyze shared efforts to effect meaningful, lasting change. These collaborations will amplify efforts on leading with race to advance health and wellness equity by aligning and coordinating work, accomplishing more than HHS or any other single organization could do alone. Co-creating programs with community has the potential to increase efficiency, effectiveness, innovation and sustainability, while also making the distribution of resources more equitable.[i], [ii], [iii], [iv]

Trust between HHS and communities that are most burdened by racial inequities is necessary for direct, honest and effective collaboration. Historically, government has created structural barriers that have discriminated against many communities which contributed to differences in health and wellness outcomes.[xix] For these communities to trust HHS, staff must listen, be responsive, follow-through, and deliver meaningful results.

FOCUS AREA 2: COMMUNITY

HOW HHS WILL IMPLEMENT FOCUS AREA 2: COMMUNITY

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Engage community to effect meaningful change	■ Support initiatives led by community members ■ Align with leadership within communities of color and low-income communities ■ Foster emerging leadership and develop workforce pipeline from key communities	**HHS is more responsive to communities**
Co-design and collaboratively implement services	■ Create Depatment-wide Community Engagement and Communications Team ■ Expand use of Community Advisory Boards (CABs)	

FOCUS AREA 2: COMMUNITY

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Engage community leadership to effect meaningful change	Improved alignment of HHS with leadership from disproportionately affected communities	Increase in community members who report HHS collaborations support community priorities
		Increase in effectiveness of community-led programs that address drivers of health inequities
		Increase in HHS staff at all levels from disproportionately affected communities
Co-design and collaboratively implement services	Improved HHS services shaped by community member input	Increase in programs, strategies, and services developed in partnership with Community Based Advisory Boards (CABS)/ collaboratives from underserved communities
		Decrease in racial/ethnic inequities in chronic diseases.

FOCUS AREA 3: CONDITIONS

TRANSFORM INEQUITABLE CONDITIONS

Why Focus on Conditions?

Historically, HHS departments have emphasized direct services, rather than also addressing the broader psychosocial and environmental factors that contribute to health and wellness outcomes.[xx] To optimize our effectiveness, HHS must address such important conditions. Our goal is to assume a leadership role to help effect change in inequitable conditions that lead to poor racial health and wellness outcomes.

HHS will align and work with partners throughout the county to amplify the work of addressing key conditions that help drive, maintain, or worsen racial inequities. HHS will draw on the collective impact framework to align diverse, cross-sector entities around a common agenda, shared measurement, and coordinated efforts. Partnerships will involve community-based organizations, non-governmental service providers, resident groups, community coalitions, non-county government agencies, and county government agencies outside of HHS.

Conditions within Marin County that shape health and wellness racial inequities, and where the key racial differences exist, are identified below. There are many factors that influence health and wellness. However, after a thorough data review, combined with many conversations with staff and community members, the following conditions were identified consistently as key areas to address. While the scope of these conditions varies widely, each represents important work to be done about the health and well-being of Marin residents.

ECONOMIC AND HOUSING INSECURITY

EDUCATIONAL ATTAINMENT

TRAUMA

CLIMATE CHANGE

FOCUS AREA 3: CONDITIONS
TRANSFORM INEQUITABLE CONDITIONS

How Do These Conditions Affect Health and Wellness in Marin County?

ECONOMIC AND HOUSING INSECURITY

Extensive research has shown that economic disparities are correlated with poorer population health outcomes.[xxi] In addition to the challenges faced by Marin residents with incomes below the federal poverty level, the high cost of living in the County burdens residents who make less than the self-sufficiency standard.[3] It has become increasingly difficult for low-income families to afford basic necessities, including shelter and affordable housing. Housing insecurity negatively affects health and well-being. People who experience housing insecurity may spend more than half of their income on housing costs. They may also have difficulty paying rent, live in overcrowded units, or experience homelessness.

What are examples of inequities in Marin related to economic and housing insecurity?

- Over half of Black/African-Americans and Latinxs and nearly one-third of Asian-Pacific Islanders do not have enough income to afford food, housing, transportation, and other necessities, compared to one-quarter of whites.[xxii]
- Black/African-Americans and Latinxs own their homes at slightly more than one-third the rate of whites.[xxiii]
- Among adults over 65, whites have twice the family income of Latinx or Black/African-Americans.[xxiv]
- On average between between 2010-2014, 26% of Marin's non-institutionalized population lived below 250% of the federal poverty level, including:[xxv]
  - 61% of the Latinx population
  - 51% of the Black/African-American population
  - 25% of the Asian population
  - 18% of the white population
  - 52% of children of color ages 0-17 in Marin live in such households, compared with 15% of white, non-Latinx children.[xxvi]

(continued)

[3] The **Self-Sufficiency Standard** defines the minimum income needed to meet basic needs for California's working families without the help of public or private assistance, and incorporates a county's cost of living.

FOCUS AREA 3: CONDITIONS
TRANSFORM INEQUITABLE CONDITIONS

How Do These Conditions Affect Health and Wellness in Marin County?

EDUCATIONAL ATTAINMENT

A half century of research has shown that earlier and longer education is a strong predictor of adult health and wellness.[xxvii, xxviii] In part, higher **educational attainment** increases people's access to expanded employment opportunities, greater income, health insurance coverage, and loan opportunities. Increased educational attainment is also correlated with health literacy and healthier behaviors.[xxix]

What are examples of the educational inequities in Marin?

- 35% of Latinx 3 and 4-year-olds attend pre-school compared with 84% of non-Latinx Whites.[xxx]
- 39% of Black/Black/African-American and 45% of Latinx third graders read below grade level, compared to 10% of white children.[xxxi]
- 10.8% of Black/African-American students were suspended from school compared to 1.4% of white students.[xxxii]

TRAUMA

Trauma, including adverse childhood experiences, negatively affect health and well-being throughout the life span.[xxxiii] It includes exposures such as physical violence, incarceration, sexual abuse, emotional abuse, and neglect. Trauma related to institutional racism is associated with greater risk of heart disease, obesity, substance-use disorders, and learning and behavioral issues.[xxxiv, xxxv] Becoming a trauma-informed system starts from the recognition that trauma has a profound impact on people, and their ability to be successful in all aspects of their lives. Therefore, it is necessary to create spaces and places where people can get help and healing but more importantly to create policies, practices, procedures and programs that prevent and support people from experiencing trauma.

What are examples of current inequities related to trauma?

- In a nationally representative sample of adolescents, the prevalence of experiencing trauma was 70%, but highest among Black/African-American and Latinx youth.[xxxvi]
- Despite making up less than 3% of the total population in Marin, Black/African-Americans make up nearly 20% of adult and juvenile felony arrests.[xxxvii]
- While they make up only 6.8% of children in Marin, 27% of children entering the foster care system are Black/African-American.[xxxviii]
- 30% of Latinx migrants experience migration-related trauma.[xxxix]

(continued)

FOCUS AREA 3: CONDITIONS
TRANSFORM INEQUITABLE CONDITIONS

How Do These Conditions Affect Health and Wellness in Marin County?

CLIMATE CHANGE

Climate change is here and has already caused property damage from flooding and wildfires in and near Marin County, causing massive system-wide disruptions and costing billions of dollars.[xl] Increases in temperatures have led to increased heat advisories. Shifting regional temperatures and weather patterns have increased the range and frequency of infectious diseases (e.g., Zika, West Nile virus). Climate change magnifies existing racial health and wellness inequities. Communities that disproportionately bear the burden of climate change include people without means for evacuation (e.g., no access to public transit or private motor vehicles), and people who are linguistically isolated.[xli]

What are examples of inequities related to climate change?

- The low-lying coastal communities of Marin City and the Canal District in San Rafael are more vulnerable to the harms of sea level rise and flooding compared to whiter and wealthier Marin jurisdictions.[xlii]
- The effects of climate change, such as extreme heat, flooding, and diminished air quality, are disproportionately concentrated among communities of color.[xliii]
- Climate change also magnifies existing health and wellness inequities. Communities that disproportionately bear the burden of climate change include people without means for evacuation (e.g., no access to public transit or private motor vehicles), and people who are linguistically isolated.[xliv]

FOCUS AREA 3: CONDITIONS

HOW HHS WILL IMPLEMENT FOCUS AREA 3: CONDITIONS

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Catalyze partnerships to improve conditions that affect health and wellness	■ Use a collaborative approach to align resources and create change ■ Advocate for the health and wellness benefits of equitable policies, systems, and environments ■ Develop shared messaging around how conditions affect health workforce pipeline from key communities	**Policies, systems, and environments are more equitable**

FOCUS AREA 3: CONDITIONS

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Catalyze partnerships to improve conditions that affect health and wellness	Improved ability to meet basic needs	Increase in individuals who exit our services and have an income at or above the self-sufficiency standard for Marin County
		Ending chronic homelessness by 2022
	Improved educational opportunities	Increase in 3-4-year old Latinxs in pre-school
		Increase in college readiness for young people of color
	Decrease exposure to trauma and increase resilience*	Increase in individuals who demonstrate resilience or have fewer adverse childhood experiences (ACES)
		Develop a unified trauma informed system of care
	Improved community resilience to climate change	Increase in disaster planning and response that address the needs of vulnerable communities
		Increase in access to healthy, safe, and energy efficiency of homes of low-income residents

FOCUS AREA 4: QUALITY

STRENGTHEN EFFECTIVENESS OF OUR WORK WITH DATA AND INNOVATION

Why Focus on Quality?

To optimize our equity work, program effectiveness, and ensure taxpayer dollars are allocated with accountability, we commit to expanding our data-driven work and use of evidence-based and innovative approaches. To ensure that HHS provides consistent high-quality programs and services we will embrace a culture of continuous improvement by engaging staff at all levels as problem solvers in developing solutions for change and respect for people which is the foundation of a Lean Organization. A culture of continuous learning is created when meaningful data is collected, reviewed, and used to inform improvements and change the way programs and services, are delivered. **Data-driven work** is supported by quantitative and/or qualitative data that measure efforts and determine success or failure. **Evidence-based approaches** are supported by research in peer-reviewed literature. **Innovative approaches** attempt to meet needs in new ways based on quantitative and qualitative data from the community served.

While HHS programs already collect much data, too often that information is tracked to meet legislative or funding requirements and is not used to improve outcomes. This plan proposes a systematic approach to collect, review, and use data to inform program and service improvements by staff at all levels. Indeed, HHS will become a Lean organization to increase efficiencies and optimize outcomes. By gathering, reviewing, and using data in new ways, HHS will strengthen and improve programs and services with the goal to inform ongoing improvement. This focus area outlines approaches to further understand what is working, how to improve over time, and how to tailor innovative approaches to fill gaps and more effectively meet the needs of our diverse clients.

FOCUS AREA 4: QUALITY

HOW HHS WILL IMPLEMENT FOCUS AREA 4: QUALITY

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Implement evidence-based and data-driven work	■ Create data collection systems that routinely and systematically assess operations and services ■ Analyze data by racial/ethnic demographics to prioritize practices and approaches that improve health and wellness equity ■ Realign resources to support evidence-based policies, practices, and services ■ Promote outcome-based approaches and measures in contracts with partners ■ Collect and use client feedback for quality improvement	**Programs and services are more effective**
Champion innovation	■ Create and provide support to innovate and take informed risks ■ Ensure HHS staff and contracted partners have opportunities for continuous learning ■ Identify and test technological innovations to improve information sharing and customer service ■ Optimize available revenues and use braided funding to support creative approaches	

FOCUS AREA 4: QUALITY

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Implement evidence-based and data-driven work	Improved use of data and evidence for quality improvement	Increase in HHS direct services and contracts that use evidence-based approaches and measurable outcomes pertaining to health and wellness
		Require HHS programs and contracted programs to include equity-related outcome metrics
Champion innovation	Improved culture of learning and informed risk-taking	Increase in HHS staff who report that they have opportunities to learn at work to test new ideas
		Increase in contractors who report that HHS is adaptive and meeting changing service needs

NEXT STEPS

1 Disseminate plan across Community and HHS	**2** Establish implementation priorities	**3** Identify internal leads and champions
4 Engage community in dialogue for prioritizing HHS efforts	**5** Develop a community feedback loop and accountability mechanism	**6** Create systems to measure progress and continuous improvement

ALIGNMENT WITH MARIN HHS CORE VALUES

Strategic Approach to Achieving Equity		HHS Core Values
We will improve the **client** experience by prioritizing user perspectives and holistic care.		*Integrated services informed by client perspectives will better **support** clients.*
We will support **community** leadership and deepen relationships that improve our services and the conditions in which we live.		*To earn the **trust** of community members, we must change how we work with community.*
We will address the **conditions** in which we live, work, learn, and play—factors that shape our ability to be healthy and self-sufficient.		*To transform conditions, we must work in **unity** with community and cross-sector partners.*
We will strengthen the **quality** of our work by supporting innovation and reflecting on existing data and evidence.		*To achieve **excellence** throughout HHS, we must use data to learn what is working.*

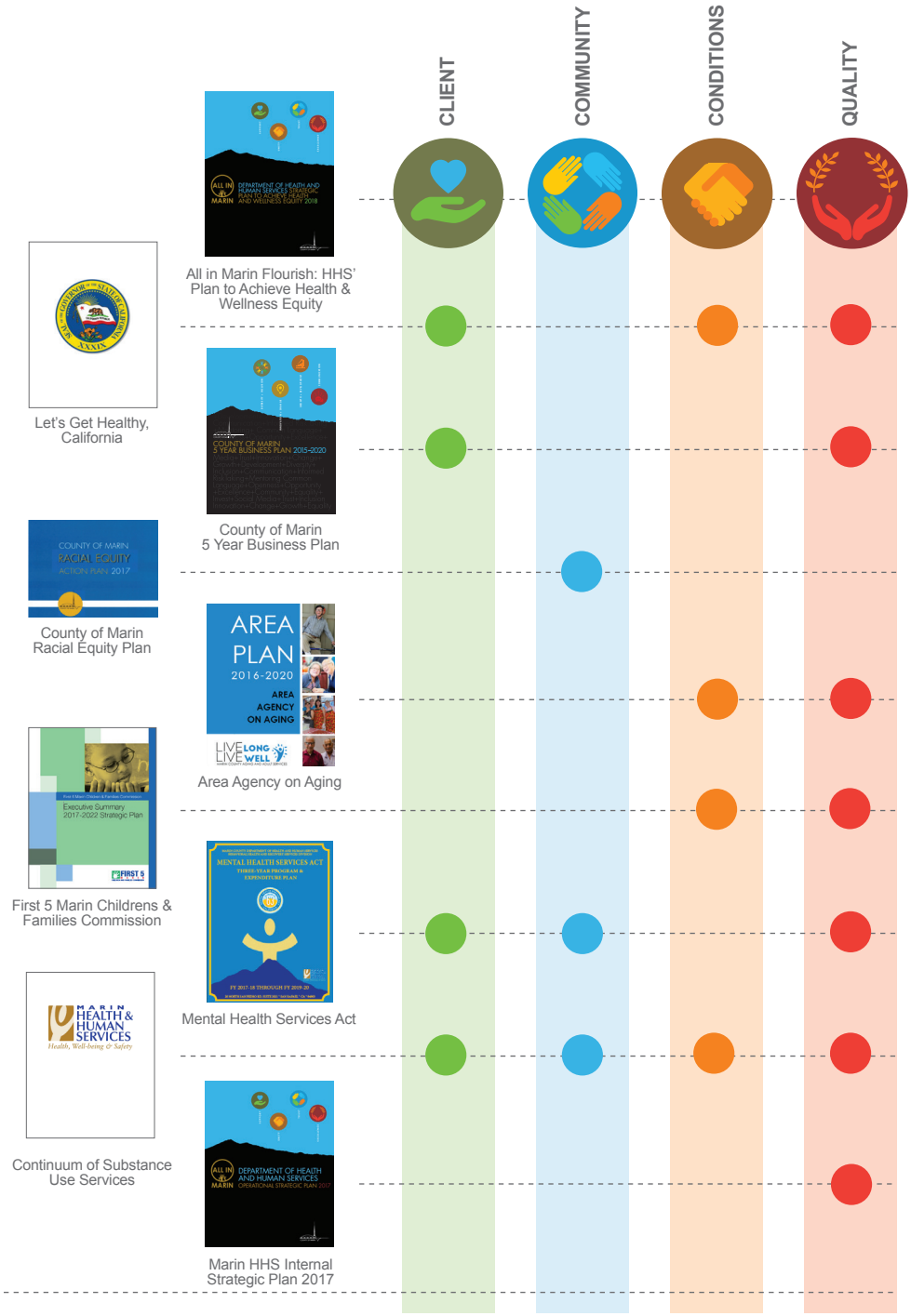
APPENDIX 1
OVERVIEW OF THE PLANNING PROCESS

This plan's strategies and actions were identified through review of data, input from community members and stakeholders in Marin County, and consideration of evidence-based, promising, and innovative practices from multiple disciplines.

Data Review	
■ Reviewed County Wide Data including: ● Census data ● Portrait of Marin ● Marin County Community Health Assessment ● Marin County/San Rafael Community Health Needs Assessment 2016 ■ Reviewed plans and reports by age including: ● First 5 Strategic Plan ● Area Plan on Aging ■ Reviewed plans and reports by topic including: ● Mental health ● Alcohol and substance use ● Food insecurity	Oct 2016- Feb 2018
Engagement with HHS Clients and Community Members who are not Clients but who are Eligible for HHS Services	
■ 10 focus groups with 144 clients and community members (for more details, see Appendix) ■ Online and paper comments elicited from community members unable to attend focus groups	April-June 2017
Stakeholder Engagement	
■ 4 meetings with more than 55 stakeholders representing more than 50 community partners, including, service providers, government agencies, and resident groups ■ Online and paper comment form elicited from stakeholders unable to attend stakeholder meetings	June-Nov 2017
HHS Staff Engagement	
■ Held meetings every two weeks with the HHS Strategic Planning Executive Team ■ Held monthly meetings with the Strategic Planning Team, Strategic Planning Data Team, and Community Facilitation Team and provided regular updates to the HHS Executive Team ■ Held two Leadership Council meetings with HHS managers and supervisors ■ Provided ongoing communication about strategic plan development with opportunities for HHS staff to ask questions and provide feedback	Oct 2016- Feb 2018

APPENDIX 2

ALIGNMENT WITH COUNTY AND STATE PLANS



ACKNOWLEDGMENTS

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Linda Jackson	Aging Action Initiative
Salamah Locks	Marin County Commission on Aging
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(continued)

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ENDNOTES

[i] http://www.racecounts.org/county/marin/
[ii] https://www.racialequityalliance.org
[iii] https://www.racialequityalliance.org/about/our-approach/benefits
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MARIN COUNTY

Marin County contribution to the Statewide PEI Project in FY 2017-2018: $80,986.00

The Statewide PEI Project: Achieving More Together

In Fiscal Year 2017-2018, 46 counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as *Each Mind Matters: California's Mental Health Movement*, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides.

Strategies of the Statewide PEI Project in Fiscal Year 2017-2018

In Fiscal Year 2017-2018, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Statewide achievements in FY 2017-2018

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2017-2018 include:

- Over 350,000 Lime Green Ribbons disseminated throughout the state
- Nearly 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over $170,000 in mini-grant funds were provided to CBOs, NAMI affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 740 videos submissions from over 150 schools across California, engaging over 2,400 students
- Nearly 10 new Each Mind Matters culturally adapted resources were developed
- Over 30 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
- Over 400 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

Projected Outcomes of the Statewide PEI Project

Changing the current culture around mental health and suicide prevention requires a long-term commitment. Ongoing investment in the unprecedented statewide investment in strategies implemented by the Statewide PEI Project PEI will result in larger social impact (e.g., changing attitudes, increasing knowledge, and modifying behaviors) by implementing programs that can benefit counties regionally and statewide, procuring resources at lower cost (e.g., cost efficiencies), and ultimately making a significant impact on preventing mental illnesses from becoming severe.

Projected 10-year outcomes:

- Increased intervention and provision of support by a community helper
- Increased proactive inclusion of individuals with mental health challenges
- Increased community encouragement and acceptance of seeking services early
- Increased knowledge and skills for recognizing and facilitating help seeking

Projected 20-year outcomes:

- Reduced discrimination against persons with mental illnesses
- Reduced social isolation and self-stigma
- Improved functioning at school, work, home and in the community
- Reduced suicidal behavior
- Reduced societal costs related to untreated mental illness

The information below provides a comprehensive summary of activities that were implemented by CalMHSA Statewide PEI Project contractors and their subcontractors in 2017-2018:

- RSE
- The Directing Change Program and Film Contest
- Each Mind Matters Outreach & Engagement
- NAMI California
- Active Minds
- California Community Colleges Student Mental Health Program
- RAND Corporation

Organizations Reached

In FY 2017-2018, **2** local county agencies, schools and organizations received outreach materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

County Agencies:

- Marin County Mental Health and Substance Abuse Services

Local Community Based Organizations:

- NAMI Marin County

Training, Presentations and Outreach

Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention. Multitudes of individuals were reached through trainings, presentations and various outreach efforts with stigma reduction, suicide prevention and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

Trainings: Trainings allow community members to learn valuable skills in how to address stigma reduction and suicide prevention

- **Directing Change AB 2246 Trainings:** In person trainings on programs, policies and procedures that education systems can use to meet the requirements of AB 2246
    - # of Trainings: 1 (participated in a training in Napa County at the Napa Valley Student Wellness Conference)
    - Education Systems that received the training: 2

Technical Assistance

Technical assistance (TA) is provided by all Statewide PEI Project contractors, each targeting a different audience. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. In addition, an Each Mind Matters Resource Navigation Team provides regular communication in the form of in person meetings and TA emails covering a range of topics with practical tools and information. During the FY 2017-2018, 33 TA emails covered topics such as the Suicide Prevention and Mental Health Awareness Month Toolkits, Self-Care and Coping with Crisis, Means Restrictions, Strategies to collaborate with Native Communities and others. During FY 2017-2018 specific TA consultations included:

TA to Counties:

- Technical Assistance Support included:
    - The EMM Team supported Marin County in gathering files of various Each Mind Matters and Know the Signs resources for the API community. (YSM, RSE, 9.29.2017)
    - The EMM Team provided information on anti-stigma housing efforts from around the state to Marin County Recovery and Behavioral Health Services. (YSM, 12.18.17)

Dissemination of Hardcopy Materials

Between July 1, 2017 and June 30, 2018, a total of **8,508** physical, hardcopy materials across Each Mind Matters programs and initiatives were disseminated throughout Marin County. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).

- 3,440 Lime Green Promotional Materials
- 2,820 EMM Educational Materials
- 1,300 Know the Signs Educational Materials
- 948 Directing Change

In the following languages:

- 6,980 English
- 1,528 Spanish

Mini-Grants and Sponsorships

As a part of the Statewide PEI Project, mini-grants and sponsorships are awarded to local community-based organizations, schools, and clubs/chapters/affiliates to grow the Each Mind Matters movement across the state through increasing reach and dissemination, and implementing community events and activities. Mini-grants and sponsorships awarded in FY 2017-2018 include:

- **Active Minds Chapter Launch Grant:** The chapter received a start-up launch kit which included a table cloth, t-shirts, tabling handouts and a $250 launch event sponsorship. These new chapters will continue to receive technical assistance at the beginning of next academic year to ensure and ongoing successful presence:
    - Total Funding amount granted: $500
    - Recipients: College of Marin

Directing Change

The Directing Change program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. NORC at the University of Chicago conducted a comprehensive cross-sectional control study in 2017. Findings from the study found Directing Change to be highly effective in increasing knowledge, behavior and attitudinal outcomes related to suicide prevention and mental health and demonstrated changes in school climate. In addition to providing technical assistance and social media engagement:

- Total number of films submitted: 2
- Schools, organizations and colleges/universities that submitted videos: Congregation Rodef Sholom, Novato High School
- Total number of youths participating: 18

Web Activity

- Sessions: 97
- % first time visits: 66%
- New users: 64

Appendix A: Statewide Outcomes to Date

Outcomes to Date

Since counties began pooling funds through CalMHSA to implement the Statewide PEI Project in 2011, the following short-term outcomes have been achieved. Given the outcomes so far, independent evaluators of the Statewide PEI Project, the RAND Corporation, have identified the following outcomes from the Statewide PEI Project:

- 15.4% more Californians exposed to Each Mind Matters turn to help for mental health challenges.
- Over 50% of Californians were exposed to Know the Signs.
- Individuals exposed to the Know the Signs campaign report higher levels of confidence to intervene with someone at risk for suicide.[1]
- The Know the Signs campaign was rated by experts to be aligned with best practices and be one of the best media campaigns on the subject.[2]
- Students exposed to the Walk In Our Shoes website demonstrate significantly higher knowledge of mental health.[3]
- 63% of teachers and administrators who saw the Walk In Our Shoes performance started a conversation about mental health in the classroom.[4]
- 87% of students have a better understanding of mental illness and suicide after participating in Directing Change.[5]
- 97% of students who participated in Directing Change pledged to support a friend with a mental health challenge.[6]
- 87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.[7]
- 66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students that they were concerned about.[8]

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Marin County Behavioral Health and Recovery Services
Mental Health Services Act – Innovation Plan
Growing Roots: The Young Adult Services Project

TAY INNOVATION PROVIDERS

WELLNESS • RECOVERY • RESILIENCE

These projects are funded to provide culturally competent services for Transition Age Youth (TAY, 16-25) to reduce risks for mental illness and increase positive outcomes, such as education and jobs. Participants may be experiencing or at risk for mental health issues. Please refer clients to the services.

Integrated Community Services 3020 Kerner Blvd., Suite A San Rafael CA 94901 **Tom Arnott** tom@connectics.org 831-247-2659	ICS serves individuals with a diagnosed disability (developmental, mental health, physical, and other). They provide employment services, social groups, independent living skills, mental health and substance services, Some of the services are provided by peers.
Young Moms Marin **Teresa Ashby** 4teresa.ashby@gmail.com 415-686-3273	YMM serves young mothers, their children, and their partners. There is usually Spanish translation available at support groups. They provide an ongoing support group with childcare on site, individual case management, linkages to resources, and life skills. The support group takes place in San Rafael near public transportation.
The Spahr Center 910 Irwin Street San Rafael CA 94901 415-457-2487 **Dana Van Gorder** dvangorder@thespahrcenter.org	The Spahr Center serves LGBTQ+ individuals and their community. Individual services available in Spanish. If there is enough demand a group will be provided in Spanish. They provide support groups for in San Rafael and other parts of the county; services at high schools; and support groups for parents of transgender/questioning TAY. They are developing a mentoring program and an online network of support.
Marin Asian Advocacy Project 851 Irwin St, Suite 201 San Rafael CA 94910 **Vinh Luu** vluu@marinaap.org 415-847-2747 **My Tong** mtong@marinaap.org 415-455-8481	MAAP serves primarily Asian immigrants or children of immigrant parents, but everyone is welcome. Services are available in English and Vietnamese. They provide a mindfulness and psycho-education workshop series for TAY. In addition, mindfulness retreats are open to TAY and their familiies/community.
Opening The World 636 Lindaro St, Ste 1 San Rafael CA 94901 **Jeannine Curley** mjeanninecurley@gmail.com 415-419-9695	OTW serves TAY who have experienced significant life challenges, such as homelessness, incarceration, and abuse. They provide assistance with developing and achieving individual goals (Life Plans); mental health and substance use counseling; academic/employment skills workshops; community service events; and opportunities to domestically and internationally.

Multicultural Center of Marin (former Canal Welcome Center) 30 N San Pedro Rd Suite 250 San Rafael CA 94903 **Douglas Mundo** dmundo@cwcenter.org 415-526-2486 x302 **David Escobar** descobar@cwcenter.org 415-526-2486x304	CWC primarily serves the Latino community, but everyone is welcome. Services are primarily in San Rafael and Novato. Services are available in English, Spanish, and sometimes Latin American indigenous languages. They provide a variety of community engagement and empowerment services, including youth and parent cultural healing circles; peer leadership Internships; college/career/life skills; mentors for TAY leaving probation or Community School; peer support for TAY without parent support.
San Geronimo Valley Community Center 6350 Sir Francis Drake Blvd San Geronimo CA 94963 415-488-8888 **Madeline Hope** hope.madeline@gmail.com	SGVCC serves the West Marin community. They provide a variety of youth activities and substance use prevention efforts. For the Innovation project they are conducting a youth led needs assessment and planning process that will determine specific activities to be implemented in Fiscal Year 2018-19.
STOP: **Surviving The Odds Project** **John Wallace** john.wallace@stoproject.org 707-529-2149 **Melissa Greene** melissa.greene@stoproject.org 707-293-5886	STOP serves primarily African American young men, but anyone is welcome. They provide the music/video production workshops with a psycho-education component. Participants will also receive Life Plan services from OTW.
WISE Choices for Girls **Alexis Wise** AlexisWiseLaw@gmail.com 415-410-6715	WISE serves young women, and their mothers. Services take place primarily in Marin City and at Tamalpais High School. They provide education support, life skills, peer support meetings and retreats, educational and cultural field trips, and crisis support.
Marin City Fatherhood Council First Missionary Baptist Church 510 Drake Ave Marin City CA 94965 **Rondall Leggett,** Pastor mcfatherhood94965@gmail.com 415-332-2826 **Janice Mapes** Jmapes55@gmail.com 415-948-9659	Fatherhood Council serves young fathers and young men who could benefit from “father figures.” Services take place in Marin City. They provide a Rites of Passage program that includes weekly gatherings, mentoring, and educational and cultural field trips.