County of Marin
Health & Human Services
BEHAVIORAL HEALTH AND RECOVERY SERVICES

MENTAL HEALTH SERVICES ACT (MHSA)
FY2020/2021 through FY2022/2023
THREE-YEAR PLAN

COUNTY OF MARIN
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EXECUTIVE SUMMARY

OVERVIEW

The FY20/21-22/23 Three Year Plan provides an opportunity to present the outcomes of the Community Program Planning Process for the next three years as well as report on outcomes and activities from FY18/19 (Fiscal Year from July 1, 2018-June 30, 2019). FY18/19 was the second 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

IMPACT OF COVID-19

The COVID-19 Pandemic has impacted the MHSA Three-Year Plan in several major ways.

Due to the economic impacts of the COVID-19 pandemic, there was a significant reduction in the funding projections from the State for the next three years. This triggered a reevaluation and a delay in releasing the comprehensive Three-Year Plan. However, in order to ensure our community partners had as much stability as possible and knowledge about funding for FY20/21, we released the Prevention and Early Intervention (PEI) component earlier on the timeline envisioned during the community planning process. This component of the plan is virtually all contracted with community-based organizations and funding for each program was put out for a competitive proposal process (RFP). This component of the plan went out for public comment in March and was approved by the Board of Supervisors and is included in the Appendix for reference.

In addition, more time was needed to get feedback on what types of services and changes would be necessary to support those sheltering in place and to get a better understanding of how COVID-19 would impact treatment delivery. Our programs and our community partners had to pivot their work and re-calibrate their focus due to the impacts of COVID-19 and sheltering in place.

Within Behavioral Health and Recovery Services (BHRS) the immediate focus was on crisis support—including maintaining staffing levels for the Mobile Crisis Response Team and the Crisis Stabilization Unit—as well as maintaining Jail Mental Health Program and assessments through the Access team. Many other Behavioral Health programs made the quick switch to telehealth and telework. BHRS also provided education, training, and tips around mindfulness and self-care, coping with the stress of the pandemic, how to support children’s mental health during this time, and launched our suicide prevention initiative in a virtual space. Our engagement efforts also needed to be done differently, transitioning the Marin Mental Health Services Act advisory committee and the Mental Health Board to meet virtually rather than in person.

In addition to the on-going behavioral health needs, 42% of Behavioral Health and Recovery Services (BHRS) staff were deployed as Disaster Service Workers (DSW). Many were deployed to the hotels to implement Project Room Key (supporting at risk individuals experiencing homelessness shelter-in-place in a safe environment), as well as staffing the COVID-19 county hotline or working at the testing sites and food distribution centers.
KEY CHANGES FOR FY20/21-FY22/23

The following key needs were highlighted during the MHSA Community Planning Process and re-evaluation period and will be implemented as follows:

- Enhanced focus on equity and improving outreach and engagement with underserved populations
  - Developing a comprehensive outreach and engagement program targeting underserved populations including more robust community health advocates programs (including Promotoras)
  - Leading a Trauma Informed System transformation process including the wider Health and Human Services as well as partner agencies and organizations
- Implementing alternative programs and expanded support to reduce the number of people with serious mental illness involved in the criminal justice system
  - New Stepping Up General System Development program focused on implementing a new AB1810 Pre-sentencing Diversion program as well as supporting individuals experiencing serious mental illness re-enter smoothly from jail to the community
  - Expanding the capacity of the STAR Full-Service Partnership by integrating the Assisted Outpatient Treatment (AOT) team
  - Expanding the Crisis Intervention Training (CIT) for law enforcement officers to providing continuing education in addition to more in depth training around implicit bias
- Recovery-Oriented system development including expanding peer support for the Access Team, the HOPE Full-Service Partnership, and implementation of the Peer Program Coordinator
- Supporting the sustainability of the Mobile Crisis program following the end of the SB 82 Triage Grant
- Increasing fidelity to the Assertive Community Treatment model for our Full-Service Partnership programs
- Improve engagement and supportive partnerships to help people experiencing serious mental illness and homelessness
- Support telehealth enhancements and website improvements to make information accessible and easy to navigate
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 mid-sized county (as defined by the State as between 200,000 and 749,000 residents) with a population of 262,879 (a two-thousand person increase from the last 3-year plan) and spanning 520 square miles of land. The majority of residents live in the eastern region of the county, along the Highway 101 corridor. Ranching and dairying are major features of the rural areas of West Marin. Marin is a beautiful county with 58% of land considered protected open space comprised of local, state, and Federal parkland including the Golden Gate National Recreation Area and Point Reyes National Seashore. Factoring in Agricultural Land Trusts and zoning rules, over 85% of Marin’s lands are protected from development according to the Greenbelt Alliance 2012 report. Due to the lack of affordable housing, 62% of people who are employed in Marin commute into the county each day for work.

Spanish is the only threshold language, although most county documents are also available in Vietnamese.

For the ninth time in 10 years, Marin County was ranked as the healthiest county in California by the Robert Wood Johnson Foundation. The 2019 County Health Rankings, released March 19, 2019, evaluated counties across the nation to measure how healthy residents are and how long they live. Marin scored highest in life expectancy statewide, with San Mateo and Santa Clara counties following closely.

While Marin scored near the top in most health factors, there were important exceptions. Housing affordability, income inequality, high rates of substance use, and racial disparities in health were highlighted as weaknesses in Marin’s health profile. Among 58 California counties, Marin ranked 39th in housing cost burden, 54th in income inequality, and 48th in high rates of binge drinking.

The results also show clear racial disparities in health in Marin. African American and Latino children are four and eight times more likely, respectively, to live in poverty than their white counterparts.
While Marin ranks first in clinical care, these benefits differ greatly among racial groups. For example, mammography rates for African American women are less than half of the rates among white women.

Hand in hand with the longest life expectancy, Marin County has the oldest population of any county in the state, and it’s estimated that one-third of the local population will be 60 or older by 2030.

In 2018 Marin County was ranked for the first time as the most racially disparate county in California by the Advancement Project (RaceCounts.org). In the chart below you can see that Marin (in the top right) was ranked at the highest performance county as well as the county with the highest disparity. The issues analyzed with Economic Opportunity, Health Care Access, Education, Housing, Democracy, Crime & Justice, and Health Built Environment.

In December 2018, after a thorough data review combined with multiple perspectives gathered from clients, community members, community organizations, Marin County Department of Health and Human Services released a Strategic Plan to Achieve Health and Wellness Equity [PDF] focused on race.

In recent years, residents of Marin County have also experienced an increase in the tragic and far-reaching impacts of suicide. Marin County has the highest suicide rate in the Bay Area (California Department of Public Health, overview of Homicide and Suicide Deaths in California, March 2019). Between 2015 and 2017, 14.1 people per 100,000 died by suicide in Marin County, well above the state average over the same period (10.7). The data shows that white middle-aged and older men and LGBTQ+ youth are at highest risk of suicide, however suicide is public health a concern across the lifespan and can affect people of all races, sexual orientations, and gender identities.
RACIAL/ETHNIC DISPARITIES IN SERVICE UTILIZATION:

During Marin’s initial 2004 MHSA planning process the adult Latinx population was identified as the most underserved racial/ethnic population by the existing County Mental Health Services. Despite ongoing and substantial efforts over the years to address this trend, this disparity remains true today. Not only are Latinx adults underserved compared to other races within the county, Latinx adults are also underserved in Marin as compared to the rate at which they are served in other medium-sized counties and the state as a whole based on the Medi-Cal claims data.

Asian/Pacific Islanders were also categorized as underserved in the initial MHSA planning process however significant progress has been made on this front including the hiring of three bilingual Vietnamese providers and extensive Prevention and Early Intervention work focused on this population. When analyzing the FY18/19 utilization data, Asian/Pacific Islanders are now served at a substantially equivalent rate as the Medi-Cal population (5.4% served vs 5.7% of the Medi-Cal population). Asian/Pacific Islanders are also being served at a higher rate in Marin than they are in other medium sized counties or the state as a whole based on the Medi-Cal claims data.

Designation of un/underserved populations is based on the distribution of Marin residents who are eligible for County mental health services—best represented by the ‘Medi-Cal Beneficiaries’” dark blue bars in the following table—compared to the distribution of those receiving county mental health treatment services “BHRS Served” shown in lighter blue.

RACIAL/ETHNIC DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS

![Racial/Ethnic Distribution Chart]

Race/ Ethnicity FY18/19
MC Beneficiaries = 39,632 people
BHRS Served = 2,819 people

- Caucasian or White: 32.6% (Medi-Cal) vs 23.4% (BHRS)
- Hispanic: 52.9% (Medi-Cal) vs 49.4% (BHRS)
- Other/ Unknown: 7.5% (Medi-Cal) vs 10.6% (BHRS)
- Black or African American: 4.8% (Medi-Cal) vs 7.7% (BHRS)
- Asian/ Native/ Pacific Islander: 5.7% (Medi-Cal) vs 5.4% (BHRS)
When looking at the data for the race and ethnicity of those served by Behavioral Health and Recovery Services (BHRS) in FY18/19 broken down by age group, there is a striking trend of the Latinx population receiving a significantly higher proportion of services as youth than adults.

![Racial/Ethnic Distribution of Those Served by BHRS by Age Group](image)

**AGE DISPARITIES IN SERVICE UTILIZATION:**

Young children are represented in those receiving county mental health treatment services at a much lower rate than their representation in the Medi-Cal population as a whole. This is unsurprising given developmental stages, however when comparing Marin County’s Medi-Cal claims data for young children to the claims data for the State as a whole or to other medium sized counties, young children are served at a slightly lower rate in Marin and it is thus an area for increased investment in this Plan.
In 2004 it was also identified that Older Adults (60 and older) and Transition Aged Youth (TAY, between 16-25 years of age) were underserved. These two priority populations have been the focus of Marin’s two most recent MHSA Innovation Projects to address this. In 2018 at the culmination of the Growing Roots Innovation Project, BHRS now has the highest penetration rate with TAY, providing mental health treatment services to an equivalent of 8.5% of Marin Medi-Cal beneficiaries between the ages of 16-25.
GENDER DISPARITIES IN SERVICE UTILIZATION:

Males continue to be served at a higher rate than females by BHRS mental health treatment programs. This is consistent with other counties as the Medi-Cal claims data indicates that males are served at a higher rate in the state as a whole, as well as in other medium-sized counties.

GENDER DISTRIBUTION OF MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS

Gender FY18/19
MC Beneficiaries = 39,632 people
BHRS Served = 2,819 people

47% BHRS
53%, MC
47%, MC
53% BHRS

Male Female
GEOGRAPHIC DISPARITIES IN SERVICE UTILIZATION:

Over 70% of Marin Medi-Cal beneficiaries live in either San Rafael or Novato which is very similar to the percentage served by BHRS in those geographic areas, with Novato being slightly less well served. West Marin and Marin City/Sausalito also remain underserved with their proportion of beneficiaries slightly higher than their proportion of BHRS clients. However, services to residents of Marin City/Sausalito improved over the last fiscal year from 2.9% of those served by BHRS in FY17/18 to 3.6% of those served by BHRS in FY18/19. There is still more work to do to increase the proportion of people served in Marin City/Sausalito to 4.9% which would mirror the Medi-Cal beneficiaries and therefore strategies to increase outreach and engagement in Marin City as well as West Marin are included in this Three-Year Plan.

**DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS BY CITY OF RESIDENCE**

![Bar chart showing the distribution of Marin Medi-Cal beneficiaries versus those served by BHRS by city of residence.](chart.png)
COMMUNITY PROGRAM PLANNING PROCESS (CPPP): Stakeholder Engagement

Add Stepping Up meetings to CPPP process

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: 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: www.MarinHHS.org/MHSA. Every year, Marin County develops an MHSA Annual Update that reports on each program including the number of individuals served, average cost per client, outcomes for the reporting period, and identifies any challenges and changes to programs as needed.

Beginning in FY2014-15 the State required that all counties develop a MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 that included all five (5) MHSA components. In May of 2016 Marin County began a third in-depth community planning process for the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 which includes all five (5) MHSA components.

In October of 2018, the County of Marin Behavioral Health and Recovery Services (BHRS) initiated a suicide prevention strategic planning process in collaboration with the Department of Public Health, the Marin County Office of Education, stakeholders and community partners. The first phase of this effort was a countywide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. Once data was collected and analyzed, the Strategic Planning Committee—which was comprised of a wide range of stakeholders—developed comprehensive strategies, objectives, and activities aimed at promoting wellness and reducing suicide attempts and deaths across the county. The Suicide Prevention Strategic Plan was released in January 2020 and is a key part of the MHSA Three Year Plan.

In May of 2019, Marin County began the community planning process for the wider MHSA Three-Year Program and Expenditure Plan for FY2020-21 through FY2022-23 which includes all five (5) MHSA components. This Plan was developed with local stakeholders, including adults and seniors with serious mental illness, families of children, adults, and seniors with serious mental illness or serious emotional disorders, community-based providers of mental health and alcohol and other drug services,
law enforcement, education, social services, veterans, health care organizations, representatives of un否认 served and/or underserved groups, and other important interests.

**ONGOING STAKEHOLDER INPUT**

Marin County’s MHSA Community Planning Process includes a wide array of community stakeholders, system partners, consumers 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, the MHSA Advisory Committee, Cultural Competency Advisory Board/WET Steering Committee, Growing Roots Transitional Age Youth (TAY) Advisory Committee, and the Prevention and Early Intervention Steering Committee.

Behavioral Health and Recovery Services (BHRS) Division representatives regularly discuss MHSA services and supports with individuals, the Mental Health Board, MHSA Advisory Committee, Alcohol and Other Drug Advisory Board, the Quality Improvement Committee, Probation and other forums. Input received in these settings is brought to BHRS Senior Management, the MHSA component coordinators, and as appropriate, to the MHSA Advisory Committee, for consideration.

**MHSA Three-Year Planning Process for FY20/21 Through FY22/23**

**Program Evaluations**

All MHSA programs submit outcome data and narratives annually in the MHSA *Annual Updates*. This data is used to make adjustments to the existing programs each year. In preparation for the MHSA Three-Year Program and Expenditure Plan, this data was used to assist in determining if there were more significant changes needed, such as changing program capacity or significantly altering the program.

**Training for Stakeholders**

To kick off the MHSA Three Year Community Program Planning Process (CPPP) in Marin County, BHRS partnered with the *California Associate of Mental Health Peer Run Organizations (CAMHPRO)* to hold a full day workshop for stakeholders called “*Delivering the ABCs of Local Advocacy for Effective Participation in Community Planning*” on April 5, 2019. This training also included three webinars that were shared with all participants covering “*Advocacy Basics,*” “*Best Community Planning,*” and “*Community Planning: How to Work It.*”

32 community members participated in the full day workshop. The learning objectives from the workshop included:

- Recognizing your rights to participate in stakeholder activities which may shape public policy and services for years to come.
- Identifying the background, values and mechanics to better act in the interests of your community.
- Locating County processes and venues for stakeholder involvement.
To ensure all stakeholders who participated were trained in the CPPP process BHRS held a **stakeholder training at the beginning of each community planning meeting**. This training covered the history of MHSA, the key regulations, the guiding values, and the steps of the community planning process.

Meeting flyers and PowerPoint presentations as well as community input gathered from all the MHSA Community Planning Meetings can be found in the Appendix under Community Meeting Documents. Documents provided at the meetings were available in English and Spanish. Interpreters were available on site at each of the regional community planning meeting for participants if needed.

**Suicide Prevention Focus:**

Based on community input, advocacy, and an analysis of the data, the County of Marin Behavioral Health and Recovery Services (BHRS) began the MHSA 3-Year Community Planning process wanting to take a focused look at how to prevent suicide in this county. In October of 2018, BHRS initiated a suicide prevention strategic planning process in collaboration with the Department of Public Health, the Marin County Office of Education, stakeholders, and community partners.

The first phase of the Suicide Prevention Strategic Planning process was a county-wide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. This consisted of:

- **9 community focus groups** (63 people) focused on suicide prevention, including groups of:
  - Transitional Age Youth
  - Middle School Students
  - Older Adults/people who work with older adults
  - Leaders in communities of color
  - Middle Aged men

- **1,307 responses** to the BHRS Suicide Prevention Community Survey
• **370 responses** to the Marin County Office of Education Student Survey
• **13 key informant interviews** around Suicide Prevention

Following the Suicide Prevention Needs Assessment, BHRS hosted a **Community Forum on May 2, 2019**, for residents of Marin County to provide input on the strategic planning process. After sharing key findings from the Needs Assessment, attendees participated in a series of brainstorming activities. Forum participants crowd-sourced ideas for strategic planning goals, new programs and services, and other key considerations, working in three different breakout groups:

1. Strategies to engage community members at heightened risk for suicide or suicidal ideation (i.e., middle-aged and older men, LGBTQ+ residents, people of color, youth in schools, veterans);
2. Strategies to increase community members’ help-seeking behavior, and decrease stigma around discussing suicide and accessing mental health services; and
3. Strategies to enhance resilience and strengthen protective factors for all Marin County residents

Over 40 community members participated in the community forum, and their contributions laid the groundwork for the strategies, goals, and actions included in this strategic plan. In addition to participating in formal activities, attendees were able to network with each other and strengthen community ties.

Following the community forum, BHRS convened the Strategic Planning Committee, to participate in strategic planning sessions and establish priorities for the strategic plan. Over 30 key stakeholders—representing a variety of public agencies, health clinics, hospitals, community organizations, veterans groups, faith-based organizations, First Responders, commissions, neighborhoods, and lived experiences—gathered for a three-part series of strategic planning sessions, between June 3 and July 12, 2019. Strategic planning participants were integral in the development and refinement of the plan’s core components and areas for action. Planning activities included:

• Developing, validating, and refining particular strategy areas, objectives, and action items
• Identifying ongoing programs and services in Marin County communities that could be linked to broader coordination efforts in suicide prevention
• Naming real-world challenges and barriers to the implementation of evidence-based practices
• Troubleshooting potential challenges in interagency collaboration and cross-systems coordination, such as standardizing care practices across sectors and improving the capacity of health care providers to share data
• Brainstorming lists of recommended partners for the strategic plan’s priority areas and goals

Participants worked in a trio of breakout groups, which remained intact across all three sessions:

1. The **systems-level** breakout group focused on high-level, countywide strategies involving interagency collaboration, policy change, and cross-systems partnerships. Priority areas included the enhanced coordination of primary and behavioral health care networks; standardizing
school programming and policies across school districts; and avenues for lethal means reduction.

2. The **community-level** breakout group focused on strategies and programs at the mid-level scale of cities, towns, and neighborhoods. Priority areas included on-campus programs and services at schools; training and education for service providers, clinicians, and community members; and programs to decrease isolation and improve connectedness between residents.

3. The **individual-level** breakout group focused on strategies to enhance individual residents’ knowledge of suicide prevention resources, access to services, and willingness to seek help in times of stress or crisis. Priority areas included strategies for communicating with residents and raising public awareness; crafting targeted approaches to community members at heightened risk for suicide; and addressing culturally specific or age-related risk factors.

Each of the three planning sessions prioritized different phases in the suicide prevention continuum of care. The first two sessions emphasized strategies in suicide prevention and intervention; while the third session involved both a discussion of postvention strategies and a collaborative review of the strategies and activities that had been drafted to date.

**Wider Three-Year Planning Community Program Planning Process:**

For the wider MHSA Three-Year Community Program Planning Process, Marin County determined it was important to start it off by raising the voices of young people in talking about mental health. We began with a **Youth Mental Health summit** designed, presented, and lead by youth and held at the College of Marin on Saturday, **May 10th, 2019**. Following this, the **MHSA Transitional Age Youth (TAY) Advisory Council convened a forum at the Marin County Office of Education on June 26, 2019**, presenting on what they learned and recommendations for how it can be incorporated into the MHSA Three Year Plan.

This is the first time since the establishment of the Mental Health Services Act that the planning timeline **lined up with the Substance Use Services 5-Year Planning cycle**, so we took full advantage of that opportunity here in Marin. Given the high rates of co-occurring substance use and mental health, the similarity in many of our prevention efforts, and in order to help address self-medicating with other substances to address mental health...
concerns, we held many of our community planning meetings jointly. The breakout groups did not separate by Substance Use and Mental Health, but rather by Prevention/Early Intervention and Treatment/Recovery Services. This was very effective at getting to address the many overlaps.

In addition, the Federal Grants division of the county Community Development Agency (CDA) also had their 4 year plan on the same cycle for a FY2020 start date. Due to the high housing costs, housing is often raised as the number one concern in our county and for our clients, so we coordinated our community planning efforts to invite CDA to participate in our community meetings as well to maximize the effectiveness of our stakeholder’s time.

In this next major phase of the Community Program Planning Process BHRS held large meetings in each region of Marin County, starting with West Marin on June 18, 2019, and followed with more targeted and focused planning meetings. Please see a list below of the large community planning events for the MHSA Three Year Plan:

Kick-Off Community Forums:

- Suicide Prevention Community Planning Forum, May 2, 2019
- Youth Mental Health Summit, May 10, 2019
- MHSA Transitional Age Youth (TAY) Advisory Council Growing Roots forum, June 26, 2019

Large Regional MHSA Community Planning Meetings at different times to accommodate different schedules:

- West Marin—Point Reyes Station, June 18, 2019 (5pm)
- North Marin—Hamilton Field Community Center, Novato, July 22, 2019 (7pm)
- San Rafael—Marin County Office of Education, August 1, 2019 (1pm)
- Southern Marin—Bayside/Martin Luther King, Jr., Academy, Marin City, August 5, 2019 (4pm)
- Central Marin—College of Marin, Kentfield, August 14, 2019 (6pm)
These regional meetings were followed by more focused meetings around certain topics or target populations:

- **Prevention and Early Intervention-Focused** MHSA Planning Meeting—at the Health and Wellness Campus in San Rafael, **August 27, 2019 (4:30pm)**
- **Spanish** Language MHSA Planning Meeting—in the Canal District of San Rafael at Bahia Vista Elementary, **September 26, 2019 (6pm)**
- **Family Member-Focused** MHSA Community Planning Meeting, San Rafael, **October 9, 2019 (6pm)**
- **Older Adult-Focused** MHSA Community Planning Meeting, WhistleStop Senior Community Center, **October 24, 2019 (10am)**
- **Peer/Consumer-Focused** MHSA Planning Meeting, **November 4, 2019 (12pm)**
After the kick-off events, each meeting began with a brief PowerPoint presentation to provide training to the stakeholders on MHSA and the Community Planning Process including giving the history and an overview of MHSA’s purpose, guiding principles, funding estimates, examples of MHSA programs from the current three year plan in that region of the county, and steps and timeline for plan approval and ways to remain involved. Following the training, there were a series of questions used to poll participants on their priorities for the upcoming plans using voting technology.

The vast majority of each meeting was spent in breakout groups as the goal was to hear from the community. There were three (3) breakout groups and participants were given the opportunity to rotate through their top two choices.

**Break Out Groups** (All community input received during the planning process is posted on our website: [www.MarinHHS.org/MHSA](http://www.MarinHHS.org/MHSA) and can be found in the Appendix):

- **Prevention and Early Intervention** (both mental health and substance use)
- **Treatment and Recovery Services** (both mental health and substance use); and
- **Housing and Public Services** (lead by the Community Development Agency)

Community meetings were conducted throughout the County and included translation and interpretation in Spanish (as well as breakout group discussions in Spanish lead by bilingual/bicultural...
staff members at each meeting as well as a meeting held entirely in Spanish), in addition bus passes, food, non-alcoholic beverages, and childcare was provided. Invitations were distributed to community members, BHRS staff, BHRS contractors, all MHSA related committees, including the MHSA Advisory Committee, the Mental Health Board, the Alcohol and Other Drug Advisory Board, BHRS Stakeholder contact list, NAMI, Board of Supervisors and other interested parties. Flyers were displayed at MHSA program locations, libraries, laundromats, stores and other locations throughout the community. Gift cards and bus passes were given to participants with lived experience and raffles were held at meetings targeting underserved community members.

**Stepping Up Planning**

In addition to the targeted MHSA community planning meetings there were a series of Stepping Up planning meetings and single-issue workgroups. These included AB1810 Planning and Implementation meetings to develop procedures regarding Behavioral Health Diversion and to develop recommendations. These workgroups met on:

- August 30, 2019
- October 24, 2019
- October 25, 2019

In addition, there was a workgroup developed to focus on Behavioral Health Crisis Options for Law Enforcement which met on **December 3, 2019** to develop recommendations.

**Community Planning Survey**

In addition to the Suicide Prevention planning survey described in the suicide prevention section of the community planning process which had 1,307 responses, BHRS, in partnership with the Community Development Agency and the Substance Use Services team, released a community survey to gain input for our plans from people who might not be able to attend meetings in person in order to ensure stakeholders have an opportunity to participate. Behavioral Health questions included questions around barriers to accessing services and strategies that should be implemented in the Three Year Plan.

Online and paper surveys available in English, Spanish, and Vietnamese were used to gather community input to inform funding priorities. Surveys were disseminated in partnership with local nonprofit service and housing providers and County departments including the Community Development Agency and the Marin County Free Library. To enhance and encourage participation staff attended numerous community events, including weekly Health Hubs organized through the Marin Community Clinics in both Novato and San Rafael, the Canal Alliance food pantry, and events put together by local organizations, including Community Action Marin, the Marin Organizing Committee, and Performing Stars. A **total of 352 surveys were collected, with 259 in English, 92 in Spanish, and one (1) in Vietnamese.**

The answers to the key behavioral health related questions on the survey are displayed on the next two pages broken down to show the distribution of answers in both the Spanish version of the survey and the English version. The top three barriers identified for accessing behavioral health services were the perceived **Limited Availability of High Quality Treatment Options**, the **Belief that Services Won’t Be Helpful Even if Accessed**, and **Unsure of How to Access Services.**
The top strategies that respondents thought would be the most effective for delivering behavioral health services where slightly different in the English response and the Spanish responses.

In English, the top three answers were:
1) Co-location of behavioral health services with other services
2) Prevention and Early Intervention activities targeted to high-risk populations, and
3) Services to Increase Social Connection and Community Engagement.

In Spanish the top three answers were:
1) Prevention and Early Intervention activities targeted to high-risk populations
2) Co-location of behavioral health services with other services, and
3) Broad Prevention Strategies

Please identify any barriers to accessing mental health and/or substance use services (check all that apply). Note: This question applies to services for Marin Medi-Cal beneficiaries and low-income uninsured residents with a substance use disorder and/or

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Spanish % (n=80)</th>
<th>English % (n=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (please specify)</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Unsure of how to access services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>20%</td>
<td>37%</td>
</tr>
<tr>
<td>Staff at service providers do not reflect my cultural background</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Services are not offered in my preferred language</td>
<td>21%</td>
<td>14%</td>
</tr>
<tr>
<td>Services are not located near me</td>
<td>20%</td>
<td>27%</td>
</tr>
<tr>
<td>Limited availability of high-quality treatment options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up and responsiveness of service providers</td>
<td>25%</td>
<td>39%</td>
</tr>
<tr>
<td>Belief that services won’t be helpful even if accessed</td>
<td>36%</td>
<td>49%</td>
</tr>
<tr>
<td>Strategy</td>
<td>Spanish % (n=74)</td>
<td>English % (n=238)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Treatment services spread out in more geographical locations throughout Marin County</td>
<td>27%</td>
<td>34%</td>
</tr>
<tr>
<td>Strengthening/expanding partnerships with non-traditional or “informal” service providers (e.g. faith-based organizations; cultural and community groups)</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Stigma reduction initiatives (e.g. media campaigns, provider and community education about treatment effectiveness)</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>Services to increase social connection and community engagement (e.g. inter-generational programming, mentoring)</td>
<td>30%</td>
<td>36%</td>
</tr>
<tr>
<td>Prevention and intervention activities specific to high-risk populations (e.g. children of family members with mental health and/or substance use conditions; binge drinking, those using high potency THC cannabis products, etc.)</td>
<td>49%</td>
<td>41%</td>
</tr>
<tr>
<td>Expanding peer services (e.g. recovery coaches, empowerment clubhouse, family partners)</td>
<td>18%</td>
<td>27%</td>
</tr>
<tr>
<td>Co-location of behavioral health services with other services (e.g. co-location of behavioral health with primary care, wellness centers in schools, community centers, libraries, retailers, etc.)</td>
<td>43%</td>
<td>52%</td>
</tr>
<tr>
<td>Broad prevention strategies (e.g. community coalitions, youth development programs) throughout Marin County</td>
<td>35%</td>
<td>30%</td>
</tr>
</tbody>
</table>
THREE-YEAR PLAN STAKEHOLDER PARTICIPATION

DEMOGRAPHICS

Overall, well over 2,000 community members, consumers, families, BHRS staff, providers of service, law enforcement/criminal justice, LGBTQ+ individuals, Veterans, and other interested parties attended the community meetings, participated in a focus group or key informant interview, or completed one of our online surveys (suicide prevention planning or community planning). Of those who participated, 1,726 people completed a demographic form. Over 500 people attended the in person meetings with 255 completing the demographic survey.

BHRS conducted planning meetings in each region of the county to be sure to capture the input from individuals representing the full geographic location diversity of the county.

Females were over-represented in the community planning process so there were focus groups specifically targeting men for their input. 51.1% of the county identifies as female whereas 71.6% of those who participated in our community planning meetings identified as female. This community planning cycle we did have an increase of 4 percentage points for males as compared to the community planning cycle for the last 3-year plan, however engaging men to discuss topics of mental health remains a challenge.

Below is summary information of the racial and ethnic diversity of the county as a whole (green); participants in the community planning process—including both in person and online—(yellow); and attendees of the MHSA Community Planning meeting (grey).
RACIAL/ETHNIC DISTRIBUTION OF THE COUNTY VS TOTAL MHSA COMMUNITY PLANNING PARTICIPANTS (INcludes SURVEYS) VS MHSA COMMUNITY PLANNING MEETING ATTENDEES

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>County (n=259,666)</th>
<th>CPPP (n=1,726)</th>
<th>CPPP Meetings (n=255)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-race/Other</td>
<td>4.0%</td>
<td>7.5%</td>
<td>7.8%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>6.0%</td>
<td>6.7%</td>
<td>5.1%</td>
</tr>
<tr>
<td>American Indian/Native Alaskan</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American/Black</td>
<td>2.8%</td>
<td>3.7%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>
The unserved and underserved racial/ethnic populations in Marin participated in the community program planning process at a higher rate than their white counterparts, for instance the Latínx population represented 23% of the total community planning participants and 25.5% of the meeting participants, but only 16.1% of the county.

Demographic forms were not collected at the youth mental health summit or the forum lead by the TAY Advisory council, however youth under 16 represented 2% of the participants who completed demographic forms in the regional and targeted community planning meetings (excluding the 30 plus children who participated in the child care offered at the community planning meetings) and TAY made up 7.5% of the regional and targeted meeting participants. Adults between the ages of 26-59 made up 57.5% of participants in those meetings, and older adults between 60-74 made up 30%. Those over 75 year of age made up the final 5% of the participants. Given that Marin County is the oldest county in the state and has a rapidly aging population it was important to get input from older adults in the community.

In addition, 13.7% of MHSA Community planning meeting participants identified as part of the LGBTQ+ community (32 individuals). In addition, 7.3% of meeting participants unidentified themselves as currently homeless (17 individuals). 1.7% identified as veterans (4 individuals) and 23.5% reported having a disability (55 individuals), and 37.2% identified as a service providers (87 individuals).

BHRS conducted significant outreach to clients with serious mental illness (SMI) and Serious Emotional Disturbances (SED) and their families to ensure the opportunity to participate in the Community Program Planning Process. Gift cards for their time and bus tickets were provided to all clients who participated in the community planning process.
Outreach techniques included:

- Hosting specific targeted community planning meetings for consumers/peers and one focused on family members to ensure they felt welcome
- Individualized one-on-one outreach to clients from their case managers and from peers working and volunteering for the county
- Flyers and handouts in all the waiting rooms where BHRS services are provided
- Outreach through the Peer Wellness Programs including the Empowerment Clubhouse and Enterprise Resource Center
- Outreach through the National Alliance on Mental Illness (NAMI Marin) and other family member and consumer groups
- Through our all stakeholder email list

As a result of the intensive outreach to the consumers and family members throughout our system, **82 consumers attended community planning meetings making up 35% of the participants.** In addition, **94 family members participated, representing 40.2% of meeting attendees.**

Image 5: Jaime Faurot (left), Peer Advocate, Family Member, MHSA Advisory Committee Member, and Mental Health Board Member, participating in a community planning meeting. Jaime was an integral part of the MHSA Planning Process and was honored at the “Celebrating the Uncelebrated” Dinner this year honoring those individuals from the Behavioral Health Communities who have selflessly contributed to improving the lives of Marin residents. Jason Faurot (right) has also been a dedicated advocate and provided significant assistance during the MHSA Community Planning Process. A huge thank you to both of them!
ADDITIONAL OPPORTUNITIES FOR PUBLIC INPUT

Annual Updates

Each year of this Three-Year Plan, BHRS will conduct an Annual Update community planning process to make any changes to the plan and to report on outcomes from each program.

Innovation Planning Process

A community planning process will be conducted in FY2020/21 to define the next Innovation Project(s).

MHSA PLAN APPROVAL PROCESS

The MHSA Three-Year Program and Expenditure Plan for FY2020/21 Through FY2022/23 will be posted for 30-day Public Comment beginning on August 10, 2020 and remained posted through September 8, 2020. The Three-Year Plan was posted on Marin County’s website at: MarinHHS.org/MHSA including instructions on how to receive a copy of the report, how to submit comments and the date of the Public Hearing. An email with a link to the website posting was sent to all Behavioral Health and Recovery Services (BHRS) staff, contracted providers, community-based organizations, Marin Mental Health Board, Alcohol and Other Drug Board, BHRS staff, MHSA Advisory Committee, and the BHRS Stakeholder email list.

On Tuesday, September 8, 2020 a virtual Public Hearing will be held during the Mental Health Board meeting at 6pm. Details will be posted at: https://www.marinhhs.org/boards/marin-county-mental-health-board All are welcome!

Prior MHSA Annual Updates are available at: www.marinhhs.org/mhsa
INNOVATION COMPONENT

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.

During the FY20/21 fiscal year there will be extensive community planning for the next MHSA Innovation Project. Marin’s third Innovation Project, focused on innovative approaches to serving older adults, will be ongoing.
OLDER ADULT TECHNOLOGY SUITE INNOVATION PROJECT

PROGRAM OVERVIEW

The Help@Hand Project is a multi-county/city Innovation project designed to determine if and how technology fits within the behavioral health system of care. Help@Hand will provide support for Marin County older adults to access wellness apps and digital literacy training through 2023. The intent of this five-year project in Marin is to understand if and how digital technology resources may support the wellness of older adults, particularly those who are socially isolated. Digital behavioral health is a rapidly emerging field, with over 10,000 apps in development and a robust evidence base showing that digital self-care technology has the potential to impact depression, anxiety and loneliness for a broad range of populations.

Each county involved is trying to reach a unique unserved or underserved population. During the FY2017-20 Three-Year Planning process and public comment period, stakeholders identified a need for additional mental health resources to support the growing older adult community in Marin County, particularly those who are isolated, often due to lack of access to transportation, physical limitations, anxiety or depression, loss, or for fear of stigma related to mental illness or cognitive impairment. The Innovation proposal was developed based on a nine-month community planning process (November 2018- August 2019) involving community members, providers and other stakeholders Marin County is therefore focused on identifying an application and developing training curricula focused on meeting the needs of isolated older adults.
TARGET POPULATION

The target population for Marin is:

- Socially isolated older adults, including those experiencing or at risk of loneliness or depression (such as West Marin and other remote areas of the county)
- Older adults who are at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness
- Older individuals with mild to moderate mental health symptom presentations, including those who may not recognize that they are experiencing symptoms

PROGRAM DESCRIPTION

There are 4 key components of the project that Marin County is focused on are:

- **Identifying and selecting an app** for the older adult community: Marin has been conducting focus groups with older adults and meeting with an advisory committee to determine which behavioral health app would be the best fit for this population and to strategize around best approaches to engaging older adults and supporting their use of the selected app
- **Digital Behavioral Health Literacy Training:** The purpose of this component of is to help individual (older adults) improve knowledge, skills, and behaviors to effectively and safely use digital devices. Marin has contracted with a consultant that has experience here in marin in training older adults around the use of technology. This training around digital literacy is going to be rolled out in conjunction with training around use of the selected behavioral health application.
- **Peers:** Peers play an integral role with the project. The vision of the peer role is to incorporate peer input, expertise, knowledge and lived experience at all levels of the project and to support the use of the apps through peer outreach and training. Marin is in the process of hiring a peer lead to support this work.
- **Evaluation:** The collaborative and our Marin team has been working closely with the researchers from UC Irvine to develop evaluation tools and metrics.

EXPECTED OUTCOMES

The learning objectives for this project are to detect and acknowledge mental health symptoms sooner (in the older adult population), reduce stigma associated with mental illness by promoting mental wellness, increase access to the appropriate level of support and care, increase purpose, belonging, and social connectedness of individuals served, and analyze and collect data to improve mental health needs assessment and service delivery.

Outcomes include:

1. Increased social connectedness, belonging and purpose as measured subjectively by user
2. Reduction in symptoms of depression, anxiety and other mental health concerns
3. Increased ability to age-in-place, reduction in residential placements
4. Increased public awareness of mental illness in older adult population and reduction in stigma as measured by pre and post workshop evaluations
5. Whether users experience increases in quality of life, as measured subjectively by the user and objectively by engagement in social activities, community involvement, etc.
6. Decrease in utilization of emergency services as measured by hospital admissions data
7. Increased user ability to identify cognitive, emotional, and behavioral changes and actively engage in strategies to address them
8. Families report increased capacity to support their older adult family member as reported in online surveys and/or focus groups

UPCOMING CHANGES

Through partnerships with HHS teams and community partners, project staff have begun the process of reaching out to isolated older adults county-wide (who may or may not be clients of BHRS) and provide access to, and support for using, technology that encourages and supports a range of issues and conditions, including *individualized* educational information and interactive activities on numerous topics, some of which may include:

- Mindfulness and meditation
- Managing chronic conditions
- Sleep
- Chronic pain
- Fitness
- Anxiety
- Grief
- Financial Wellness

As part of this project, in addition to a free wellness app, interested older adults throughout the County will have access to in-person training sessions to build digital literacy and online safety skills. The apps in consideration for the project currently are myStrength and Uniper. A final selection will be made in August, 2020.

In response to Covid-19, all Help@Hand activities are being conducted virtually. Currently a 13-member advisory committee meets to inform planning activities and outreach strategies for the project, and two teams of community representatives are testing the products remotely. Product testing was completed in early July. UC Irvine is currently conducting a comprehensive qualitative analysis of focus group feedback. This feedback will be presented to the advisory committee in August and a final app will be selected. Digital mental health literacy training will be available to all older adults interested in using the product starting in October 2020. In January, a technology will be selected and piloted with 200 isolated older adults throughout the County.
The following is an overview of the project timeline from December 2019-December 2023 (the anticipated conclusion of the project):

**December 2019 - May 2020**
- Project Coordinator Hired
- Established Local Advisory Committee
- Narrowed technology for consideration
- Recruited cohorts of remote testers – Older adults and peers

**June – July 2020**
- Hired digital literacy contractor
- Ran app testing remotely
- Developed feedback surveys with UCI
- Conducted focus groups
- Share focus group feedback with internal/external stakeholders
- Conduct product exploration/understand app feedback

**August – October 2020**
- Peer Onboarded
- Marin Compliance and IT Feedback and role clarification
- County leadership selects final product based on feedback
INNOVATION COMPONENT BUDGET

Prior to spending Innovation funding a project must be approved by the Mental Health Oversight and Accountability Commission (MHSOAC) so this budget only reflects the current approved projects.

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20/21</th>
<th>FY21/22</th>
<th>FY22/23</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adult Focused Innovation Project: Help@Hand</td>
<td>$518,443</td>
<td>$402,485</td>
<td>$190,986</td>
<td>$1,111,914</td>
</tr>
<tr>
<td>Total</td>
<td>$518,443</td>
<td>$402,485</td>
<td>$190,986</td>
<td>$1,111,914</td>
</tr>
</tbody>
</table>

Note: total approved funding for this Innovation Project was $1,580,000 including prior fiscal years.
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.

CSS in Marin County 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.
CAPACITY ASSESSMENT

Behavioral Health and Recovery Services and our partner service providers are dedicated to providing services that meet the needs of racially and ethnically diverse populations. However, there are many challenges and barriers to success.

Strengths—

- BHRS and partner provider’s staff’s dedication and commitment to become more culturally sensitive, responsive and competent to meet the needs of ethnically diverse populations;
- Robust training, education and consultation opportunities around cultural competency-related subjects;
- The Growing Roots: Young Adult Services Innovation Project which worked to address service gaps for TAY population due to cultural and linguistic barriers.
- A growing BHRS clinical workforce who are culturally and linguistically competent and proficient including a 43.7% increase in Hispanic/Latino staff members since 2017 (from 19.3% of the staff to 27.7%).
Challenges—
- BHRS lacks adequate bilingual/bicultural staffing;
- BHRS’ cultural competence-related trainings lacks a systematic and follow-up/ongoing coaching and consultation to make the training offerings relevant, useful and applicable; and
- many contract agency partners are not held truly accountable nor are adequately provided with tools, resources and/or support to provide consistent culturally sensitive, responsive and competent services

Barriers to program implementation and methods to overcome these barriers—
- Difficulty recruiting bilingual bicultural staff
- Lack of collaborative partnership and understanding of workforce needs by Human Resources Department;
- Over-worked staff and under-staffing in key areas of responsibilities necessary to improve the system;
- lack of a system to strategically utilize existing bilingual/bicultural staff to serve and meet the needs of racially and ethnically diverse populations; and
- Inadequate language line;

Strategies to overcome these barriers—
- Enhanced partnership with Human Resources including Human Resources creating a new position entitled: Diversity, Equity and Inclusion Analyst
- Development of a BHRS Division-Wide Action Plan to address program staffing and increasing ways of supporting staff to reduce burn-out
- Hiring a BHRS Manager of Equity and Inclusion who will develop plans for utilizing staff and resources strategically
- Releasing a new Request for Proposals (RFP) for the Language Line services
- Continuing to work in partnership with the Cultural Competency Advisory Board
- Development of the Equity and Inclusion Committee to achieve organizational excellence in its commitment to the promotion of workplace inclusion and equity and to the retention of a diverse and thriving workforce

Bilingual proficiency in threshold languages—

Spanish is the only threshold language in Marin however official documents are often also translated into Vietnamese as that is our second largest population. Every Full-Service Partnership has at least one bilingual Spanish provider. In 2018 BHRS did an assessment of bilingual capabilities and race/ethnicity of service providers. 23.5% of service providers were bilingual in Spanish and 2% were bilingual in Vietnamese. 19 staff were bilingual in languages other than Spanish or Vietnamese including Farsi, Tagalog, Arabic, Afrikaans, Swahili, Russian, and Hindi.
Below is a graph showing the distribution of BHRS staff members, as compared to the distribution of the total population eligible for services (Medi-Cal Beneficiaries) and the total population being served.

![Graph showing distribution of BHRS staff members, Medi-Cal Beneficiaries, and BHRS served.]

**Race/ Ethnicity FY18/19**
- MC Beneficiaries = 39,632 people
- BHRS Served = 2,819 people
- BHRS Staff = 202 people

**Barriers to Program Implementation:**
- Difficulty recruiting bilingual bicultural staff
- Lack of collaborative partnership and understanding of workforce needs by Human Resources Department;
- Over-worked staff and under-staffing in key areas of responsibilities necessary to improve the system;
- Lack of a system to strategically utilize existing bilingual/bicultural staff to serve and meet the needs of racially and ethnically diverse populations; and
- Inadequate language line;

**Strategies to Overcomes These Barriers**
- Enhanced partnership with Human Resources including Human Resources creating a new position entitled: *Diversity, Equity and Inclusion Analyst*
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• Development of the Equity and Inclusion Committee to achieve organizational excellence in its commitment to the promotion of workplace inclusion and equity and to the retention of a diverse and thriving workforce
YOUTH EMPOWERMENT SERVICES (YES) FULL-SERVICE PARTNERSHIP: FSP 01

PROGRAM ALLOCATION FY20-21: $728,555

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.

PROGRAM CHANGES: In this FY20/21-22/23 Three-Year Plan, the budget for YES is increasing to support the cost of eating disorder treatment for FSP clients. In addition, in order to increase fidelity to the ACT model there will be an expansion of vocational and education support services.

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 (including eating disorder treatment) or inpatient stays necessary for stabilization and/or meeting treatment goals, for Full-Service Partnership clients as part of the “whatever it takes” approach.

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 First Episode Psychosis program contracted with Felton Institute.

**EXPECTED NUMBER TO BE SERVED:** With a caseload of up to 52 youth at any point in time, over the course of a year this program anticipates serving approximately 85 children and TAY.

**EXPECTED OUTCOMES:**

1. Decrease days spent in a psychiatric hospital
2. Decrease days homeless
3. Decrease arrests
4. Decrease days in residential placements

**MEASUREMENT TOOL:** The data for outcomes 1-4 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.
TRANSITION AGE YOUTH (TAY) FULL-SERVICE PARTNERSHIP: FSP 02

PROGRAM MAXIMUM ALLOCATION FY20/21: $695,991

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.

PROGRAM CHANGES: In FY2020-21 additional funding is added to the budget to cover the costs of eating disorder treatment for FSP clients.

PROVIDER: Side-By-Side, formerly known as Sunny Hills Services (a community-based organization), as well as additional organizations for eating disorder treatment

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. The First Episode Psychosis will be an important partner to the TAY program.

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.

In order to decrease stigma around accessing FSP services, 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 NUMBERS TO BE SERVED: Anticipate that approximate 40 Transitional Age Youth will be served throughout the year with a caseload of up to ~28 at any point in time.

EXPECTED OUTCOMES:

- decrease hospitalization
- decrease incarceration
- decrease homelessness
- increase engagement with school or work
- increase in independent living skills

MEASUREMENT TOOL:

The data for the first 3 outcomes will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP. The final two outcomes will be measured using the case manager progress reports.
SUPPORT AND TREATMENT AFTER RELEASE (STAR)
FULL-SERVICE PARTNERSHIP: FSP 03

PROGRAM ALLOCATION FY20/21: $810,175

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. The STAR FSP, originally designed with a single point of referral – STAR mental health court – previously expanded to allow community referrals and to promote equity. This enabled the development of the STAR Community Program, a community-based program providing wraparound services to individuals not involved with STAR Court. Within the past year, the STAR FSP responded to the needs of the Superior Court and criminal justice partners by developing an additional specialized court process. This process, called the Marin Alternative Judicial Integration Court (MAJIC) has helped serve a sub-group of clients who had not benefitted from the highly structured elements of traditional STAR Court.

PROGRAM CHANGES: In FY2020-21, the Assisted Outpatient Treatment (AOT) program will join the STAR Full-Service Partnership treatment team. The AOT team will remain a specialized sub-team within the STAR FSP who are able to deploy rapidly whenever an appropriate AOT case arises. This will allow for increased flexibility. With the addition of (.5 FTE) Clinical Psychologist II, (1.0 FTE) Mental Health Practitioner, and (1.0 FTE) Office Assistant III, the program capacity will be expanded to 65 clients. The STAR FSP is expanding to provide services to individuals who meet the criteria for FSP services from State Parole (new in 2020 due to SB 389) as well as from Pre-Sentencing Diversion/Stepping Up (new in 2020 in response to AB 1810 and SB 215). In addition, the Crisis Intervention Training (CIT) has been moved to the newly developed Stepping Up SDOE.

PROVIDER: County-operated

TARGET POPULATION: The target population of the STAR Program is adults, older adults, and Transitional Age Youth over 18, with serious mental illness who are involved in the criminal justice system.

PROGRAM DESCRIPTION: Operating in conjunction with Marin County Jail’s Re-Entry / Mental Health Team and the 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 with the goal of helping clients meet their treatment goals. 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.

Using multiple funding sources, the team consists of: a Supervisor (a Forensic-Clinical Psychologist); five (5) mental health case managers, one of whom is bilingual/bicultural Spanish speaking; one half-time (0.5) clinical psychologist; two (2) peer/lived-experienced specialists (contracted with Community Action Marin); a mental health nurse practitioner; a psychiatrist; an employment/vocational specialist (contracted with Integrated Community Services); a mental health-specialized Adult Probation Officer; two (2) Marin County Sheriff Deputies (as part of the Jail Re-Entry Team); two (2) psychology interns/therapists; one (1) office assistant; and a substance use specialist (contracted with Marin Treatment Center). 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.

EXPECTED NUMBER TO BE SERVED: Up to 65 individuals concurrently, but over the course of the year expecting to serve approximately 70 TAY, Adults, or Older Adults.

EXPECTED OUTCOMES:

1. Decrease in homelessness
2. Decrease in arrests
3. Decrease in incarceration
4. Decrease in hospitalization

MEASUREMENT TOOL: The data for the 4 outcomes will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client upon enrollment in the FSP.
HELPING OLDER PEOPLE EXCEL (HOPE) FULL-SERVICE PARTNERSHIP: FSP 04

PROGRAM ALLOCATION FY20/21: $749,088

PROGRAM OVERVIEW AND HISTORY: The Helping Older People Excel (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 lifestyle 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.

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.

PROGRAM CHANGES: In FY20/21, there will additional training to achieve greater fidelity with the Assertive Community Treatment (ACT) model and funding added to cover the cost of eating disorder treatment. Additionally, in FY20/21 six older adults with serious mental illness who are chronically homeless will be moving into the MHSA funded 6 one-bedroom apartments at Victory Village and receive support from the HOPE program (or other FSP programs if more appropriate).
the very first time in the program’s history, a mental health Peer Specialist will be embedded within the FSP team. The Peer Specialist will come from a community-based provider and has experience providing services to the Specialty Mental Health Services population.

**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 including a secondary diagnosis of dementia or other Neurocognitive disorder. 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. During the COVID-19 pandemic; however, to protect the health of our clients field visitations are only provided on an as needed basis. The HOPE team triages each client’s need for field support and responds, if necessary. In addition, the team utilizes telehealth options that are currently available to provide ongoing support.

Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided to those in need of co-occurring services. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation vouchers) 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 provides 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 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.
This program also works very closely with our two MHSA Housing Programs for older adults with Serious Mental Illness, providing wrap-around support for clients residing at the Fireside Apartments and Victory Village.

**EXPECTED NUMBER TO BE SERVED:** Up to 50 concurrently, but over the course of the year expecting to serve approximately:

- 5 Adults (who are nearing the older adult age group and have a co-occurring physical health condition which could include a secondary diagnosis of early onset dementia)
- 50 Older Adults

**EXPECTED OUTCOMES:**

1. decrease hospitalization
2. decrease incarceration
3. decrease homelessness
4. Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports

**MEASUREMENT TOOL:**

- The data for outcomes 1-3 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.
- Outcome 4 will be measured using the Milestones of Recovery Scale (MORS). The MORS is administered on a quarterly basis by the Case Manager/Personal Service Coordinator and assesses the consumer’s level of risk, level of engagement, and level of skills and supports. The scores on the Milestones of Recovery Scale range from 1-8:
  1. Extreme Risk
  2. High Risk / Not Engaged
  3. High Risk / Engaged
  4. Poorly Coping / Not Engaged
  5. Poorly Coping / Engaged
  6. Coping / Rehabilitating
  7. Early Recovery
  8. Advanced Recovery
ODYSSEY FULL-SERVICE PARTNERSHIP: FSP 05

PROGRAM ALLOCATION FY20/21: $1,121,717

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 AB 2034 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 FSP, the Odyssey Program, to continue serving the AB 2034 target population. The design of the new Odyssey program incorporated the valuable experiences and lessons learned from the AB 2034-funded services and in 2007, the program was approved as a new MSHA-funded CSS FSP providing culturally competent intensive, integrated services to 60 priority population adults who were homeless or at-risk of homelessness. Odyssey 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.

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 was originally expected to be provided to four to five program participants annually, but has grown significantly in recent years with an average of 10 clients served each month in FY 19-20.

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 can 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 flexible 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 to serve those 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.
PROGRAM CHANGES: In FY20/21, a Mental Health Registered Nurse will be added to the team (split between Odyssey—0.6FTE—and IMPACT—0.4FTE). This additional team member will increase the capacity of Odyssey to serve 100 individuals and will help the team reach higher fidelity with ACT. Additional funding will also be added to the budget to cover the cost of eating disorder treatment for FSP clients. In addition, some supportive contracts have been moved to the new program called “Homeless Support and Outreach” to be able to serve non-FSP homeless individuals as well.

PROVIDER: A combination of county and contracts

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 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.

A multi-disciplinary, multi-agency assertive community treatment team comprised of professional, paraprofessional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psychoeducation, co-occurring substance use expertise, employment services, independent living skills training, housing support, 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 to those in need of co-occurring services. 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 provides psychiatric medication to program participants under the supervision of the team psychiatrist. The team’s mental health nurse practitioner, along with the new mental health registered nurse, also provides participants with medical case management, health screening/promotion, disease prevention services, and coordinates linkage to community-based physical health care services.

A contract for vocational and independent living skills 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. Participants are also able to benefit from independent living skills to support them on their path to recovery.

EXPECTED NUMBER TO BE SERVED: Up to 100 concurrently, but over the course of the year expecting to serve approximately 120 TAY, Adults, and Older Adults.
EXPECTED OUTCOMES:

1. decrease hospitalization
2. decrease incarceration
3. decrease homelessness
4. Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports

MEASUREMENT TOOL:

- The data for outcomes 1-3 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.

- Outcome 4 will be measured using the Milestones of Recovery Scale (MORS). The MORS is administered on a quarterly basis by the Case Manager/Personal Service Coordinator and assesses the consumer’s level of risk, level of engagement, and level of skills and supports. The scores on the Milestones of Recovery Scale range from 1-8:
  - 1. Extreme Risk
  - 2. High Risk / Not Engaged
  - 3. High Risk / Engaged
  - 4. Poorly Coping / Not Engaged
  - 5. Poorly Coping / Engaged
  - 6. Coping / Rehabilitating
  - 7. Early Recovery
  - 8. Advanced Recovery
INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT): FSP 06

PROGRAM ALLOCATION FY20/21: $879,101

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 need more intensive services than those offered by either of the integrated clinics. The FY17/18-FY19/20 Three-Year plan implemented the IMPACT Full-Service Partnership set to serve those who do not necessarily fall into the one of the target populations of the other Full-Service Partnerships: homeless (Odyssey), Older Adults (HOPE), or involved with the criminal justice system (STAR).

PROGRAM CHANGES: In order to increase the programs fidelity to the ACT model, a .4FTE Mental Health Registered Nurse will be added to the team as well as increasing the Psychiatrist time by 4 hours per week. Additional funding will also be added to the budget to cover the cost of eating disorder treatment for FSP clients.

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 created in FY17/18 and provides culturally competent intensive, integrated services. 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 ACT 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. The team is comprised of mental health clinicians, a peer specialist, a family partner, vocational specialists, a psychiatrist, a Nurse Practitioner, and a Registered Nurse. 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 is provided to those in need of co-occurring services. 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 NUMBER TO BE SERVED: Up to 40 concurrently, but over the course of the year expecting to serve approximately 50 TAY, Adults, and Older Adults.

EXPECTED OUTCOMES:

1. decrease hospitalization
2. decrease incarceration
3. decrease homelessness
4. Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports

MEASUREMENT TOOL:

- The data for outcomes 1-3 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.
- Outcome 4 will be measured using the Milestones of Recovery Scale (MORS). The MORS is administered on a quarterly basis by the Case Manager/Personal Service Coordinator and assesses the consumer’s level of risk, level of engagement, and level of skills and supports. The scores on the Milestones of Recovery Scale range from 1-8:
  o 1. Extreme Risk
  o 2. High Risk / Not Engaged
  o 3. High Risk / Engaged
  o 4. Poorly Coping / Not Engaged
  o 5. Poorly Coping / Engaged
  o 6. Coping / Rehabilitating
  o 7. Early Recovery
  o 8. Advanced Recovery
ENTERPRISE RECOVERY CENTER (ERC) EXPANSION: SDOE 01
FORMERLY KNOWN AS ENTERPRISE RESOURCE CENTER-Name Changed for FY20/21

MHSA PROGRAM ALLOCATION FY20/21: $477,102

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.

PROGRAM CHANGES: In FY20/21 BHRS will be releasing a Request for Proposals (RFP) for Peer-run services to ensure that county contracts allow for competition. The RFP process will solicit bids for Peer-Run, Recovery-Oriented programs with a focus on ensuring equity along racial/ethnic and geographic lines. Peer-run programs must show their use of evidence-based or community-defined practices and how they will utilize a racial equity perspective. During the RFP process more than one program may be awarded, but the goal would be for the majority of the funding to be awarded to a program that is low barrier to entry.

PROVIDER: For FY20/21 the provider is Community Action Marin, but this funding will be put out for RFP during this fiscal year with the awarded provider starting (or continuing) in FY21/22.

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, the Enterprise Recovery Center (ERC) 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 the client-operated ERC is co-located on the Health & Wellness Campus with other services that promote and support recovery including the BRIDGE Kerner Case Management team and medication clinic, the STAR Full-Service Partnership, and Marin Community Clinics. This helps builds trust and 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. 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.

During the COVID emergency the program provide virtual groups and warm line support.

**EXPECTED NUMBER TO BE SERVED:** 1000

**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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># ERC first time visitors</td>
<td>200</td>
</tr>
<tr>
<td>Avg Daily Attendance</td>
<td>35</td>
</tr>
<tr>
<td># Warm Line contacts</td>
<td>6,500</td>
</tr>
</tbody>
</table>

During the RFP process the outcomes will be expanded for FY21/22 to include:

- Increased feelings of connection, recovery, and wellness
- Decrease in use of crisis services

These outcomes will be measured using standardized instruments (exact tools subject to change).

Proposed tools include:

1) **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. This tool would be administered upon entry to the program and then after being enrolled for at least 6 months.

2) A standardized **Satisfaction and Impact Survey** will be administered annually, to quantify:
   - Quality and quantity of members’ participation with the program.
   - Self-reported impact that participation is having on members’ physical and mental health.
   - Self-reported use of crisis services.
   - Members’ satisfaction with various aspects of the program.
   - Suggestions for improving the program
CRISIS CONTINUUM OF CARE: SDOE 09

MHSA PROGRAM ALLOCATION FY20/21: $1,585,536

OVERVIEW OF MHSA PROGRAMS WITHIN CRISIS CONTINUUM:

- **Mobile Teams** (Mobile Crisis Response Team (MCRT) and Transition Outreach Team)
- **Crisis Residential** programs (Casa René and Youth Crisis Residential)
- **Crisis Stabilization Unit** (CSU)—peer support and crisis planning

PROGRAM CHANGES:

- The team formerly known as “Outreach and Engagement” will be merged with the “Transition Team” to increase flexibility and efficiency, the new team is called “Transition Outreach Team.”
- MHSA will take over the costs covered by the SB82 grant which ended including 3 Mobile Crisis team members and a contract for peer support. Those positions and contract will now be funded by MHSA. In addition, a separate grant was received from CHFFA for two additional youth-focused mobile crisis staff members, which will expand morning hours to begin with the school day.

PROVIDER: Combination of county-operated (Mobile Teams and CSU) as well as contracted (Casa René - Buckelew Programs)

PROGRAM DESCRIPTION:

**Mobile Teams** (Mobile Crisis Response Team (MCRT) and Transition Outreach Team):

The **Mobile Crisis Response Team (MCRT)** provides an alternative to law enforcement response for individuals experiencing a behavioral health crisis in the community where by MCRT can intervene utilizing a therapeutic approach and spend additional time in resolving the crisis in the least restrictive manner. MCRT provides urgent field-based mental health crisis and risk assessments, conflict resolution, psychoeducation, safety planning, community referrals, and if warranted, can initiate a 5150. Our goal is always the least restrictive intervention and 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 field-based clinicians on duty six days a week from 1-9pm, and one on-duty (OD) clinician Monday-Friday 11am-7pm, who conducts follow-up calls with previous contacts as well as acts as dispatcher and provides support to the primary response team when they are in the field by answering calls that come in. The OD is also able to act as a secondary responder to calls for service at safe locations, such as medical clinics or schools. This program is being expanded with the help of a California Health Facilities Financing Authority (CHFFA) grant covering the personnel costs for two additional clinicians and a vehicle for a second, youth-focused team which will expand the hours earlier in the day to 8am Monday through Friday to support the full school day.

The **Transition Outreach Team** provides two levels of care: short-term intensive support and linkage to any individual who is at risk of--or has recently experienced--a behavioral health crisis who voluntarily agrees to accept services. Initial contact efforts happen within one to three days of receiving the referral.
The team also provides very targeted engagement efforts focused on individuals presenting with a behavioral health crisis event but who are unwilling to voluntarily engage in services but would benefit from services that could help improve functional impairments. The team provides intensive services immediately following a behavioral health crisis to support ongoing stabilization without further need for emergency services or involuntary treatment. The program is staffed with mental health clinicians, Peer Specialists, and Family Partners. 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 and in-service trainings to other crisis services and community-based partners to assure awareness of the resources available with the mobile teams.

Additionally, Transition Outreach Team members collaborate with the Assisted Outpatient Treatment (AOT) team (Laura’s Law) to outreach adults who have been identified as meeting the criteria as a candidate under AOT, with the goal of getting them to engage in mental health treatment voluntarily.

Both MCRT and the Transition Outreach Team work actively to coordinate and collaborate with other service providers such as Marin County Jail Mental Health, Marin Community Clinics, Marin Health Medical Center, Juvenile Hall, Probation, and local schools, including individuals who have been referred by a family member expressing a concern about the behavioral health stability of their loved one.

Target Population: Anyone in the community can utilize these services

Crisis Residential Unit: Casa René

Casa René is a 10-bed Crisis Residential Unit (CRU) 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.

Target Population: Transitional Age Youth over 18, Adults, and older adults
**Crisis Stabilization Unit (CSU)—peer support and crisis planning**

The Crisis Stabilization Unit has been enhanced with MHSA funds to provide Family Partner support and Peer Crisis Planning. Crisis Planning aims to:

- increase clients’ knowledge, skills and network of support to decrease crises
- provide crisis plans to the CSU that increase the role of the client and their network of support in case of a crisis; and
- to engage and support clients who are residing in the Crisis Residential Unit in the completion of a crisis plan.

The Family Partner provides support to people who stay at the Crisis Stabilization Unit as well as support to their families and help link them to information and resources.

*Target Population: All ages with a separate section for youth*

**OUTCOMES:**

1) After a visit with the Mobile Crisis Response Team (MCRT) people experience decreased distress and increased reports that they would engage in services/support in the future should they need it.
2) Increase in feelings of hopefulness after an experience with the Mobile Crisis Response Team (MCRT)
3) Decrease in need for crisis services after being served by the Transition Outreach Team (TOT)
4) Potential clients who had recently experienced a mental health crisis but who were not engaged in on-going support, were successfully engaged using assertive outreach by the Transition Outreach Team (TOT)
5) 90% of the clients will be linked to outpatient services at discharge from Casa René
6) 90% of clients will be discharged to a lower level of care when discharged from Casa René
7) Clients who developed crisis plans in the Crisis Stabilization Unit reported that they were better able to identify and access community resources to decrease repeated use of crisis programs

**MEASUREMENT TOOLS:**

- Outcomes 1-2 will be tracked using data from the Marin Crisis Continuum Customer Satisfaction Survey. The data will be pulled from the two outcomes questions:
  - “As a result of my services I feel less distress and more likely to engage in services/support in the future should I need it.”
  - “As a result of my services I feel more hopeful.”
- Outcome 3 data will be pulled from the Electronic Health Records System comparing the number days an individual was in crisis that resulted in Crisis Stabilization Unit visits, Crisis Residential (Casa René) or Hospitalization, in the 6 months prior to the first contact with the Transitions Outreach Team as compared to the 6 months after services were completed.
- Outcome 4 will be tracked using the Pre-Consumer Log
- Outcomes 5 and 6 will be informed by contractor reports based on each client’s discharge plans.
- Outcome 7 will be informed by data from provider survey
FIRST EPISODE PSYCHOSIS (FEP): SDOE 10

MHSA PROGRAM ALLOCATION FY20/21: $159,763

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. The goal will be to shorten the duration of untreated psychosis by providing access to specialized evidence-based early psychosis services as close as possible to the onset of symptoms. This program is jointly funded with a SAMSHA grant.

PROGRAM CHANGES: no changes from FY19/20

PROVIDER: Felton Institute (re)MIND™

TARGET POPULATION: The FEP program is designed to serve Individuals ages 15-30, with a focus on transitional age youth (ages 16-25), within their first two years of onset of psychotic symptoms. Individuals are Medi-Cal beneficiaries experiencing acute psychosis as part of the onset of a “non-affective psychotic disorder.” Included diagnoses are Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Schizopreniform Disorder, Delusional Disorder, and Other Specified/Unspecified Schizophrenia Spectrum and Other Psychotic Disorder.

PROGRAM DESCRIPTION: This program offers an integrated package of evidence-based treatments designed for remission of early psychosis. There is a strong evidence base for this array of treatments in promoting positive outcomes for people struggling with early psychosis, and collectively they address the impact of psychosis in multiple areas of functioning. In addition, the contract with Felton (re)MIND™ will serve clients’ families and the wider community through a public educational and community outreach campaign. The core (re)MIND™ Marin Team services include:

- **Cognitive Behavioral Therapy for Psychosis (CBTp):** Widely available in England and Australia but not in the US, this formulation-based approach helps clients understand and manage their symptoms, avoid triggers that make symptoms worse, and collaboratively develop a relapse prevention plan.

- **Algorithm-Based Medication Management:** Algorithm developed by Dr. Demian Rose (UCSF), adapted from the Texas Medication Algorithm to focus specifically on medication for young adults in the early stages of psychosis. The primary goal of the medication algorithm is to guide the prescriber, the client, and the family toward finding a medication regimen that the client is much more likely to adhere to long-term. (re)MIND™ Marin Team will also work with individuals who do not wish to take medications and will offer regular appointments with the prescriber for review of symptoms and treatment options.

- **Early, Rigorous Diagnosis:** The (re)MIND™ Marin Team diagnosis and assessment is both rigorous and comprehensive, utilizing the SCID (Structured Clinical Interview for DSM Diagnoses), which addresses not only the psychotic disorder but also co-occurring mental health or substance abuse issues.

- **Strength-Based Care Management:** Intensive care management will ensure that the broad
spectrum of clients and family needs are addressed. The (re)MIND™ Marin Team model approaches services with a "whatever it takes" attitude. (re)MIND™ Marin Team staff provides services wherever the client and/or family are most comfortable, whether that is in office, client’s home, schools, or other community locations, geographically anywhere in Marin County.

- **Family Psychoeducation:** Designed to increase social support and teach families and supporters a problem-solving format to cope effectively with illness-related behaviors, and to provide on-going education about symptoms, medication, enhancing involvement in school, work, and community life.

- **Public Education and Outreach:** The (re)MIND™ Marin Team is actively involved in the community, engaging schools, families, advocacy groups, and other non-profits to spread the word that schizophrenia can be effectively treated. The (re)MIND™ Marin Team educates service providers, parents, and other professionals on the warning signs for early psychosis and spreads the message that recovery is possible with early detection and treatment. The (re)MIND™ website (feltonearlypsychosis.org) provides information about early psychosis, as well as a pre-assessment questionnaire.

- **Supported Employment and Education:** The (re)MIND™ model adopts the *Individual Placement and Support* (IPS) model of supported employment. This model was developed at Dartmouth specifically for individuals with severe mental health problems to find and retain competitive employment and has documented effectiveness for young adults with psychosis.

- **Peer Support:** Provided through partnership with Marin County BHRS (site placement). Peer support contributes to increased social connectedness, engagement in treatment, and instills hope.

Clients are offered all modalities of individual and family services, based on their individual needs and willingness to participate. Services are offered intensively, often weekly with client centered treatment plans which are reviewed during the course of treatment and measured against an array of baseline measures taken during the assessment. Engagement and treatment progress will be reviewed at weekly clinical case conference and frequency of services is determined by individual needs and phase of treatment. Services will be provided on-site and/or in community locations, as determined by client and/or family. The length of treatment is up to two years.

Services will be delivered by direct service team formed by:

- Clinical Supervisor/Team Leader (1.0) FTE
- Clinical Care Manager (1.0) FTE
- Psychiatric Nurse Practitioner (0.12 FTE) with weekly supervision provided by licensed psychiatrist
- Employment and Education Specialist (0.6)
- Office Manager /Admin Support (0.2 FTE)

**EXPECTED NUMBER TO BE SERVED:** 25

**EXPECTED OUTCOMES:**

1. Reduce individuals’ adverse events including hospitalizations, utilization of crisis services, and arrests or incarcerations;
2. Increase the individuals’ quality of life in the areas of vocation, education, social and interpersonal relationships and independent living, thereby moving toward recovery and living a meaningful life.

**MEASUREMENT TOOLS:** These outcomes will be measured using the health records database.

1. At least 50% of clients enrolled in Felton (re)MIND™ Team Marin County for 6 months or more will demonstrate decrease in total number of acute inpatient setting episodes or days in inpatient services compared to 12-month period prior to engagement in Felton (re)MIND™ services, as documented in electronic health records.

2. At least 30% of clients enrolled in Felton (re)MIND™ Team Marin County for 6 months or more will demonstrate satisfactory participation in school, vocational training, and/or employment, as measured by enrollment numbers documented in electronic health records.
CONSUMER-OPERATED WELLNESS PROGRAM: SDOE 11 (EMPOWERMENT CLUBHOUSE)

FORMERLY “(STEPPING-UP)” WAS IN PARENTHESIS AFTER THE NAME OF THE PROGRAM—THAT HAS BEEN UPDATED TO “(EMPOWERMENT CLUBHOUSE)” IN FY20/21

MHSA MAXIMUM PROGRAM ALLOCATION FY20/21: $330,899

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. 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.

PROGRAM CHANGES: No changes except for an increase of members and more enhanced virtual services as well as a minor change to the name of the program.

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 or acknowledged mental health challenge. 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 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 seven-hour period, occurring 9:30am – 4:30pm, 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 Empowerment Clubhouse. 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, visits to museums, hikes, meals at local restaurants, and kayaking.

Benefits of participation in the Clubhouse Work Units: Members learn culinary, housekeeping, gardening, clerical, business operation, and leadership 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
  - Growing vegetables from seed
  - Composting

- **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/emailing
  - The use of Word, Excel, and Publisher
  - Producing a bi-monthly newsletter
Receptionist duties
Money management
Leadership skills
Presentation skills

Health and Wellness: The promotion of healthy lifestyle habits is a primary focus of the day-to-day operation of the Clubhouse. The lunches prepared and served by the Culinary Unit are nutritious, balanced, and use fresh organic produce when available. Members of the Clubhouse are able to enjoy these nutritious lunches free of charge. 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 accessing care and navigating through the 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 NUMBER TO BE SERVED: 70 members including TAY, Adults, and Older Adults

EXPECTED OUTCOMES:

- Program average daily attendance (ADA) of at least 12
- Clubhouse members are expected to show an increase in wellness and recovery, such as:
  - Increased access to resources
  - Increased resiliency factors, such as feeling of belonging to a supportive community
- Member Defined Goals: Members choose the way they utilize the Clubhouse and can join 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

MEASUREMENT TOOLS:

1) 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).

2) Standardized Psychological Measures: The following validated measures will be administered biannually:
   - 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 biannually, 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.

4) Each **member defined goal** is treated as 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 developed to provide the framework for tracking progress and creating mutual accountability between member and staff around the attainment of these goals for each member.
RECOVERY-ORIENTED SYSTEM DEVELOPMENT: SDOE-13 (NEW)

MHSA PROGRAM ALLOCATION FY20/21: $946,845

PROGRAM DESCRIPTION: Recovery Oriented System Development (ROSD)—This program focuses on building the supports necessary throughout our system of care for clients to lead the way to meeting their goals. This recovery-oriented framework acknowledges that each individual is an expert on their own life and that recovery involves working in partnership with individuals and their families to provide support in a way that makes sense to them. Strategies include:

1) Peer providers will receive enhanced support and training including an expansion of Wellness Recovery Action Planning (WRAP) lead by the newly created Peer Lead position. In addition, expanded Peer Services and the continuation of the Peer-led Tobacco Cessation program emphasizing personal empowerment.

2) Enhance support, education, and skill-building for family members including family groups and Family Partners embedded in Behavioral Health programs with additional support.

3) Increasing recovery-oriented practices for co-occurring disorders including increased training and consultation support in a harm-reduction, recovery-oriented way

PROGRAM CHANGES: This is a new program in FY20/21 though it incorporates some elements of the ended “Adult System of Care (ASOC) Expansion” program but expands it across the age groups and coordinates other pieces from throughout the system to be lead through a recovery-oriented perspective.

PROVIDER: Combination of county-operated and contracted (Community Action Marin, Bay Area Community Resources)

TARGET POPULATION: Transitional Age Youth, Adults, and Older Adults with serious mental illness served throughout the public mental health system

EXPECTED NUMBER TO BE SERVED FY2018: 500

OUTCOMES:

1) At least 70% of clients will report feeling that staff believe that they can grow, change, and recover

2) At least 70% of clients will report that staff helped them obtain the information they needed so that they could take charge of managing their illness

3) At least 70% of clients will identify that as a direct result of the services they received, they are better able to participate in activities that are meaningful to them
MEASUREMENT TOOLS:

1) Outcomes 1-3 will be measured using the Performance Outcomes and Quality Improvement (POQI) MHSIP Consumer Perception Survey which was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services. “Met” will include all adults who answered *Agree* or *Strongly Agree* to the following statements:

- “Staff here believe that I can grow, change and recover” (#10)
- “Staff helped me obtain the information I needed so that I could take charge of managing my illness.” (#19)
- “As a direct result of the services I received, I do things that are more meaningful to me” (#29)
MHSA STEPPING-UP PROGRAM: SDOE-14 (NEW)

MHSA PROGRAM ALLOCATION FY20/21: $389,771

PROGRAM DESCRIPTION: The goal of Stepping-Up programs around the country is to reduce the number of people with Serious Mental Illness in jail. The County of Marin formally joined the Stepping-Up initiative with a resolution by the Board of Supervisors in March of 2017. The goals of this program is aimed to facilitate the diversion of individuals with behavioral health disorders out of the criminal justice system and into treatment.

As part of the larger Stepping-Up work the county is doing, the MHSA-funded Stepping-Up General System Development program will have three main components: Re-Entry support, Pre-sentencing diversion (AB1810), and Crisis Intervention Training (CIT) for law enforcement officers. The Stepping-Up program will be rooted in racial equity, and data on referrals and outcomes will also be analyzed by race.

Re-Entry Support: Using other sources of funding, the Jail Mental Health (JMH) team is staffed with 4.5 FTE Mental Health Crisis Specialists to cover shifts 20 hours per day, 7 days per week. The JMH staff are focused on provided in-custody psychiatric services, assessments, safety cell evaluations, and counseling. This new MHSA program fills a need because the Crisis Specialists are unable to focus on re-entry planning and treatment interventions that might involve collaborating with the court, external agencies, and aftercare. This program will fund a Full-Time Re-Entry Mental Health Practitioner focused on supporting people with serious mental illness. Anticipated duties include completing PC 4011.6 and WIC 5150 evaluations, collaborating with the court and criminal justice partners on complex cases (including those involving acute inmates refusing treatment and needing hospitalization), helping with restoration of competency for defendants charged with misdemeanors, collaborating with community partners for justice-involved behavioral health clients, working with family members of those incarcerated, and creating and supporting re-entry planning that meets the needs of the clients. This position would work with clients during and after incarceration, ensuring appropriate warm handoffs to other county services and community agencies, and collaborating with the courts and family members. Given the changes to Court and Jail procedures due to COVID-19, this position will fill important roles by assisting with communication and planning between external providers and clients in-custody and providing rapid referrals and re-entry resources for those clients with very short-term bookings into the Jail.

Pre-Sentencing Diversion (AB1810): In 2019, Assembly Bill 1810 was made into law which provides a pathway for individuals with behavioral health conditions who have been charged with an offense to enter a mental health program before going to trial on these charges. Upon successful completion of this program, the charges will be dropped. Based on Marin Superior Court estimates, approximately 200 defendants may apply for this pre-sentencing diversion each year. Of those, it is estimated that approximately 100 will meet basic screening criteria and be evaluated further by the Psychologist. Of those, approximately 25-50 are projected to be found eligible for behavioral health treatment with Court oversight. Racial equity will be a cornerstone of this program, and analysis of the race and ethnicity of those who make it through each step of this process will be analyzed and reported on. Where racial inequities appear, a plan will be included in the Annual Update to directly address any disparities that are present.

This program will fund one Full-Time Mental Health practitioner to work closely with the Court to track referrals, complete screenings for eligibility, make referrals to appropriate behavioral health services, report progress to the Court, provide case management, and to coordinate with criminal
justice partners including probation, public defender, and district attorney. This program will also fund half of a clinical psychologist who will perform the formal evaluations and risk-assessments.

**Crisis Intervention Training (CIT):** CIT is a 32-hour POST-certified training program for law enforcement personnel to enable them to more effectively and safely identify and respond to crisis situations and behavioral health emergencies. The primary goals of CIT are to appropriately redirect mental health consumers from the judicial system to the services and support needed to stabilize consumers and reduce contact with police reduce injuries to mental health consumers and officers during contacts. A component of CIT is a training academy where officers learn to safely handle mental health consumers in crisis. Because earlier trainings were successful and popular, the program has been extended to also include personnel from Probation, the District Attorney’s Office, and Animal Control. This year the program will be expanded to go further in depth on issues of implicit bias and racial equity. In future years, the program will be further expanded to offer additional ongoing training continuing education to officers who have completed the initial 32-hour program.

**PROVIDER:** County-operated

**PROGRAM CHANGES:** This is a new program in FY20/21 apart from a smaller version of the Crisis Intervention Training (CIT) which was started in FY11/12 and had previously been a part of STAR.

**TARGET POPULATION:** Transitional Age Youth, Adults, and Older Adults with serious mental illness who are incarcerated in—or at risk of incarceration in—the Marin County Jail.

**EXPECTED NUMBERS TO BE SERVED:** 150 individuals with serious mental illness as well as training 50+ law enforcement officers who will be engaging with thousands of individuals throughout the community

**OUTCOMES:** The overarching goal is to reduce the number of people with Serious Mental Illness in the county jail. We are also dedicated to ensuring people of different racial backgrounds are equitably provided support and access to criminal justice alternatives.

Effectiveness of each part of the MHSA Stepping Up program will also be analyzed based on the following metrics.

For those utilizing the Re-Entry support:
- Outcome 1: reduce recidivism (as evidenced by a reduction in clients re-entering county jail within 6 months of release—and for subsequent reporting periods including recidivism rate after 1 and 2 years.)
- Outcome 2: increase access to care and engagement with services after release (as evidenced by clients receiving 3 or more mental health services in the 6 months following release)

**AB1810 Diversion Program:**
- Outcome 3: For those who were granted AB1810 diversion, at least 75% of individuals who have been approved for AB 1810 pre-sentencing diversion will remain out of custody by meeting the requirements—or being on track to meet the requirements—of their treatment plan.

**Crisis Intervention Training (CIT):**
• Outcome 4: 85%+ of law enforcement officers who took the CIT training will report they learned how to identify and respond appropriately to individuals with mental illness who are in crisis.
• Outcomes 5: by the end of the Three-Year Plan at least 75% of officers and deputies in Marin will have completed the CIT training

MEASUREMENT TOOL:
• Outcome 1: will be measured using the Jail Mental Health database to determine if clients have re-entered the Jail system within 6 months (as well as within 1 or 2 years) after release.
• Outcome 2: will be measured by assessing how many clients who were referred for BHRS services received 3 or more mental health services in the 6 months following release, as documented in the county behavioral health electronic records system.
• Outcome 3: will be measured by court minutes and data from criminal justice partners about program continuation/termination
• Outcome 4: will be measured using an evaluation survey and answers of “agree” or “strongly agree” will count toward this measure.
• Outcome 5: will be measured and reported on with subtotals by each jurisdiction
COMMUNITY OUTREACH AND ENGAGEMENT: SDOE-15 (NEW)

MHSA PROGRAM ALLOCATION FY20/21: $414,921

PROGRAM DESCRIPTION: This program focuses on supporting underserved communities and identifying unserved individuals in order to engage them, and when appropriate their families, in the mental health system so that they receive the appropriate services. Strategies:

1) Engaging unserved individuals where they are and removing barriers to accessing BHRS services, by:
   a. Providing field-based assessments around the county via a bilingual field-based health navigator (focused on reaching unserved individuals from underserved populations including the Canal neighborhood of San Rafael, Marin City, and West Marin)
   b. Providing peer/family partner/or recovery coach support through the assessment process to help potential clients and family members navigate the system, answer questions, and problem-solve around any potential barriers
2) Reducing ethnic/racial disparities by funding and investing more resources, training, and support for Community Health Advocate programs (including Promotores) in underserved communities (including Latinx individuals, mono-lingual Asian populations, and people living in Marin City)
3) Increasing coordination with grassroots, faith-based and other informal providers as well as strengthen partnerships with other formal community organizations and groups.
4) Providing community groups in Spanish such as parenting and anger management classes to introduce more people to BHRS services

PROVIDER: Combination of county-operated and contracted (RFPs for Community Health Advocate Programs will be released in FY20/21)

PROGRAM CHANGES: This is a new program in FY20/21, however it incorporates some elements that were formerly in Prevention and Early Intervention.

TARGET POPULATION: Unserved individuals who may be eligible for services, with an emphasis on targeting underserved populations in our mental health system including the Latinx population, mono-lingual Asian and Pacific Islander populations, and people living in Marin City and West Marin.

EXPECTED NUMBERS TO BE SERVED: 3,000

OUTCOMES:
- Increase knowledge of service options and how and when to access them
- Increase number of unserved individuals from underserved populations who receive assessments

MEASUREMENT TOOL:
- Outcome 1: Community Health Advocates surveys
- Outcomes 2: Health Records System report on number and demographics of assessments
HOMELESS-FOCUSED SUPPORT AND OUTREACH: SDOE-16 (NEW)

MHSA PROGRAM ALLOCATION FY20/21: $551,314

PROGRAM DESCRIPTION: Homeless Outreach and Engagement focuses on identifying unserved individuals experiencing homelessness in order to engage them, and when appropriate their families, in the mental health system so that they receive the appropriate services. Strategies:

1) Peer outreach and engagement: a mobile peer team with lived experience who work to engage and build trust with individuals experiencing homelessness who potentially have a serious mental illness by providing wellness checks and connecting them to resources.

2) Field-Based assessments for individuals experiencing homelessness

3) Homeless Outreach Coordination: a contracted position to work jointly with BHRS and Whole Person Care. This position will provide oversight and coordination of the different homeless outreach teams with a focus on identifying unserved individuals in order to engage them in services.

4) Provide coordinated supportive services to assist clients who are homeless or at-risk of homelessness achieve housing stability by supporting clients in finding and maintaining housing and navigating housing voucher bureaucracy via Shelter+Care.

provider: Combination of county-operated and contracted

PROGRAM CHANGES: This is a new program in FY20/21, however it incorporates some elements that were formerly in Odyssey (peer homeless outreach and housing support) or that were piloted using one-time Homeless Mentally Ill Outreach and Treatment (HMIOT) funding from the State.

TARGET POPULATION: Adults, older adults, or transitional age youth with serious mental illness who are either:

- currently experiencing homelessness,
- have a history of homelessness, or
- are at-risk of homelessness

EXPECTED NUMBERS TO BE SERVED: 170

OUTCOMES:

- Increase number of individuals who are experiencing homelessness who receive assessments
- Decrease the number of people with mental illness who are experiencing homelessness
- At least 85 formerly homeless clients will be housed, with at least 50% remaining stably housed for 2 years or more

MEASUREMENT TOOL:

- Outcome 1: Health Records System report on number and housing status of assessments
- Outcome 2: Measured using the Point-in-Time Count conducted every two years, during the last 10 days of January
- Outcome 3: will be measured using reports from the Marin Housing Authority
MHSA HOUSING PROGRAM: MHSA HP

PROGRAM HISTORY AND OVERVIEW: In August 2007, 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, were released. MHSAHP funds could 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.

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. Any proposed housing project had to follow CalHFA requirements as well as be feasible in Marin’s high-cost housing market.

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 to Resources for Community Development for their “Victory Village” project in Fairfax. This project 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. The Victory Village project is projected to be open for occupancy in the Summer of 2020.
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 Tamalpais 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. Intensive community treatment and housing support services are provided by the Full-Service Partnership Programs (directly operated by the County of Marin) in conjunction with the housing management.
## COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT BUDGET

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20/21</th>
<th>FY21/22</th>
<th>FY22/23</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP-01 Youth Empowerment Services (YES)</td>
<td>$728,555</td>
<td>$728,555</td>
<td>$728,555</td>
<td>$2,185,665</td>
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<td>FSP-02 Transitional Age Youth (TAY) Program</td>
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<td>SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)</td>
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<td>SDOE-13 Recovery-Oriented System Development</td>
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<tr>
<td>SDOE-14 Stepping Up</td>
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<td>SDOE-15 Community Outreach and Engagement</td>
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<td>$202,034</td>
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<td>Transfer to Capital Facilities and Technological Needs</td>
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<tr>
<td><strong>Total Transfers out of CSS</strong></td>
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<td><strong>$783,681</strong></td>
<td><strong>$783,681</strong></td>
<td><strong>$2,460,522</strong></td>
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</tbody>
</table>

FSP = Full-Service Partnership  
SDOE = System Development/Outreach and Engagement
FULL-SERVICE PARTNERSHIP (FSP) ESTIMATES FOR NUMBER TO BE SERVED BY AGE GROUP

The chart below shows the estimated number of clients who will be served in each age group across all FSP programs for each of the three years of this plan. Many of the FSP programs serve people from more than one age group so the numbers are reported collectively to be in compliance with MHSA Regulations.

<table>
<thead>
<tr>
<th>Full-Service Partnership Age Groups</th>
<th>FY20/21</th>
<th>FY21/22</th>
<th>FY22/23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (0-15)</td>
<td>38</td>
<td>38</td>
<td>38</td>
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<tr>
<td>TAY (16-25)</td>
<td>105</td>
<td>105</td>
<td>105</td>
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<tr>
<td>Adult (26-59)</td>
<td>178</td>
<td>178</td>
<td>178</td>
</tr>
<tr>
<td>Older Adult (60+)</td>
<td>95</td>
<td>95</td>
<td>95</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>416</strong></td>
<td><strong>416</strong></td>
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# COMMUNITY SERVICES AND SUPPORTS (CSS) COST PER PERSON ESTIMATES FOR FY20/21

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20/21 MHSA Allocation</th>
<th>FY20/21 Projected Number Served Over the Course of the Year</th>
<th>FY20/21 Projected Cost Per Person</th>
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<tbody>
<tr>
<td>FSP-01 Youth Empowerment Services (YES)</td>
<td>$728,555</td>
<td>85</td>
<td>$8,571</td>
</tr>
<tr>
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<td>40</td>
<td>$17,400</td>
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<td>70</td>
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<td>500</td>
<td>$1,894</td>
</tr>
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<td>SDOE-14 Stepping Up</td>
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<td>150</td>
<td>$2,598</td>
</tr>
<tr>
<td>SDOE-15 Community Outreach and Engagement</td>
<td>$412,921</td>
<td>3,000</td>
<td>$138</td>
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<tr>
<td>SDOE-16 Homeless Support and Outreach</td>
<td>$551,314</td>
<td>170</td>
<td>$3,243</td>
</tr>
</tbody>
</table>

FSP = Full-Service Partnership  
SDOE = System Development/Outreach and Engagement
WORKFORCE EDUCATION AND TRAINING (WET)

COMPONENT OVERVIEW

MHSA WET programs address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, provides client/family driven mental health services, and adheres to wellness, recovery, and resilience values. The Workforce Education and Training (WET) component of MHSA provides dedicated funding to address the shortage of qualified individuals and to enhance the skills of the current workforce 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.

The 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 current and emerging client populations. WET partners with other county divisions and community-based organizations, including primary care providers, to support the development and employment of a diverse workforce.

Trainings are open to staff, interns, and volunteers from county, Community-Based Organizations (CBO), peer programs, and 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. In this Three Year Plan, as prioritized during the MHSA Community Program Planning Process, there will be a focus on strengthening the implementation of the goals of the Health and Human Services Race Equity Plan (MarinHHS.org/equity-plan) including developing a unified trauma informed system of care throughout Health and Human Services and with our partner agencies.

The programs in the Marin County WET FY2020-21 through 2022-23 Three-Year Plan are consolidated into three categories that align with the MHSA Regulations. These are: 1) Training and Technical Assistance, 2) Mental Health Career Pathways, and 3) Regional Partnership: Loan Assumption Program.
TRAINING AND TECHNICAL ASSISTANCE

DESCRIPTION: BHRS will continue to utilize WET Training and Technical Assistance funds to fund trainings, technical assistance, curriculum development, and consultation services. These will focus on cultural competency/humility, trauma informed care, resiliency, client/family driven mental health services, recovery and other evidence-based and community driven strategies to improve services and integrate the MHSA general standards. In FY19/20 BHRS performed a survey of staff to determine training priorities which is being used to inform the next training plan. In addition, funding will be used for trainings for consumers and family members.

In addition, new in this Three-Year Plan—and consistent with the Health and Human Services Race Equity Plan (MarinHHS.org/equity-plan)—there will be a focus on developing a unified trauma informed system of care throughout Health and Human Services and with our partner agencies. Employees, contractors and volunteers in non-mental health systems, such as criminal justice, social services and health care may participate in programs and activities under this funding category. This unified trauma informed system development work has the long-term goal of decreasing exposure to trauma and increasing resilience.

OBJECTIVES: Promote cultural competence and the other MHSA General Standards; support the participation of clients and family members in the public mental health system; provide increased training, technical assistance, and consultation opportunities to improve the efficacy of services.

FUNDING CATEGORY: Training and Technical Assistance.

WORKFORCE NEED ADDRESSED: Current staff and CBO partners need ongoing training to provide culturally competent and evidence-based services; staff from across systems need a comprehensive training, consultation, and technical assistance strategy to implement unified trauma informed practices.

STRATEGIES IMPLEMENTED: Training, technical assistance, consultation, and curriculum development.

BUDGET NARRATIVE: Total budget of $98,000 annually. This includes funding for unified trauma informed system of care development and other trainings/technical assistance including cultural competency/humility trainings and trainings around wellness, resilience, and other evidence-based and community driven practices.
MENTAL HEALTH CAREER PATHWAYS

DESCRIPTION: This program implements three main strategies:

1) Training: This includes two specific types of training:
   a) Funding for local peer education and training with a focus on programs that provide
      wholistic training to support people with both substance use and mental health
      difficulties, as well as
   b) Providing scholarships for culturally diverse consumers and family members to
      complete other vocational/certificate courses in mental health, substance use and/or
      domestic violence peer counseling.

2) Placement Program: Internship stipends to mental health, substance use, and domestic violence
   peer counselor graduates who are placed as interns in public behavioral healthcare settings
   (including contracted partners).

3) Mentoring/career counseling support for interns and scholarship recipients—as well as for
   individuals from other groups that are underrepresented in the Public Mental Health system
   (PMHS)—to promote successful completion of those programs and to increase access to
   employment.

OBJECTIVES: Prepare clients and/or family members of clients for employment and/or volunteer work in
the Public Mental Health System (PMHS); Increase access to employment in the PMHS to groups such as
immigrant communities, Native Americans and racial/ethnic, cultural and linguistic groups that are
underrepresented in the PMHS, as underrepresentation is defined in Section 11139.6 of the
Government Code.

FUNDING CATEGORY: Mental Health Career Pathway Programs

WORKFORCE NEED ADDRESSED: Increase number of people with lived experience and diverse
backgrounds in the PMHS (including contracted partners).

STRATEGIES IMPLEMENTED: Career counseling, training, and placement programs

BUDGET NARRATIVE: An annual allocation of $125,000. This includes approximately $23,000 for a local
peer training program, $50,000 for scholarships for people with lived experience to complete other
training programs, $40,000 for internship stipends for people with lived experience placed in the
PMHS/contracted partners, and $10,000 for mentoring/career counseling.
REGIONAL PARTNERSHIP: FINANCIAL INCENTIVE PROGRAM

DESCRIPTION: In January 2019, the California Behavioral Health Planning Council approved the Statewide 2020-2025 Mental Health Services Act (MHSA) Workforce Education and Training (WET) Five-Year Plan developed by Office of Statewide Health Planning and Development (OSHPD). Their plan included a focus on supporting individuals through MHSA Regional Partnerships. The Greater Bay Area Regional Partnership will implement a loan repayment program for hard-to-fill and hard-to-retain Public Mental Health System (PMHS) personnel with educational loans.

The FY 2019-20 State budget provides $7,978,104 to the Greater Bay Area Regional Partnership via OSHPD. This funding requires a 33% local match from the 13 Greater Bay Area counties, which is calculated at a one-time investment of $79,333 from Marin.

OBJECTIVES: Promote recruitment and retention of hard-to-fill and hard-to-retain personnel.

FUNDING CATEGORY: Financial Incentive Programs

WORKFORCE NEED ADDRESSED: Recruitment and retention of staff in hard-to-fill and hard-to-retain positions including—but not limited to—Licensed Mental Health Practitioners, Licensed Crisis Specialists, Mental Health Nurse Practitioners, and Psychiatrists, with an emphasis on bilingual classifications in the public mental health system.

STRATEGIES IMPLEMENTED: Mental Health Loan Assumption

BUDGET NARRATIVE: In order to leverage further state funding, counties are asked to collectively match 33% of the state allocation. Based on our proportional allocation of MHSA funding, Marin’s is expected to contribute at least $79,333 in one-time funding which will leverage significantly more in State funding at the regional level.
WORKFORCE STAFFING SUPPORT

DESCRIPTION: This funding will support the salary, benefits, and operating costs of the Workforce Education and Training (WET) Coordinator as required in WIC Section 3810(b). This position will plan, recruit, coordinate, administer, support, and evaluate Workforce Education and Training programs and be responsible for:

- developing and implementing the Training and Technical Assistance plan including a focus on evidence-based practices,
- performing regular workforce needs assessments,
- supporting the internship program, and
- acting as a liaison to appropriate committees, regional partnerships, and oversight bodies.

OBJECTIVES: Implement, evaluate, and sustain WET programs aimed to train and support current staff and promote MHSA General Standards, as well as to increase recruitment and retention of staff in hard-to-fill and hard-to-retain positions.

FUNDING CATEGORY: Workforce Staffing Support

WORKFORCE NEED ADDRESSED: Training and support for current staff, promotion of MHSA General Standards, and increase recruitment and retention of staff in hard-to-fill and hard-to-retain positions.

STRATEGIES IMPLEMENTED: Implementation of the WET programs; coordination; evaluation.

BUDGET NARRATIVE: $175,682 per year to cover salaries, benefits, and operating costs directly associated with this position.
## WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT BUDGET

<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>FY20/21</th>
<th>FY21/22</th>
<th>FY22/23</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and Technical Assistance</td>
<td>$98,000</td>
<td>$98,000</td>
<td>$98,000</td>
<td>$294,000</td>
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<tr>
<td>Mental Health Career Pathways</td>
<td>$125,000</td>
<td>$125,000</td>
<td>$125,000</td>
<td>$375,000</td>
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<tr>
<td>Regional Partnership: Financial Incentive Program</td>
<td>$80,000</td>
<td>-</td>
<td>-</td>
<td>$80,000</td>
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<tr>
<td>Workforce Staffing Support</td>
<td>$175,682</td>
<td>$175,682</td>
<td>$175,682</td>
<td>$527,046</td>
</tr>
<tr>
<td>Admin/Indirect (15%)</td>
<td>$71,802</td>
<td>$59,802</td>
<td>$59,802</td>
<td>$191,407</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>$550,484</td>
<td>$458,484</td>
<td>$458,484</td>
<td>$1,467,453</td>
</tr>
</tbody>
</table>
CAPITAL FACILITIES AND TECHNOLOGY NEEDS

ELECTRONIC HEALTH RECORD AND PRACTICE MANAGEMENT SYSTEM ENCHANCEMENTS

MHSA ALLOCATION FY21/22: $328,479

PROGRAM DESCRIPTION: With the Technology Needs (TN) Project, Marin County will continue to improve the performance of the electronic health record (EHR) system to support optimal clinical effectiveness and provide accessible and meaningful consumer outcome data with a focus on improvements for reporting both for state requirements and local evaluation efforts; enhancing care coordination efforts through enhanced client care teams; and using technology to improve our overall system of care. 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 following components:

1. Disaster recovery preparedness.
2. Ongoing Electronic Health Record (EHR) and Practice Management (PM) upgrades to remain compliant with current and future requirements.

EXPECTED OUTCOMES: The expected outcomes for the TN Component are as follows:

➢ Improve integration of the EHR and PM 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 State and Federal clinical quality documentation and reporting standards.
➢ Participate in the Marin Health Gateway, the local Health Information Exchange (HIE).
COORDINATED CASE MANAGEMENT SYSTEM

MHSA PROJECT ALLOCATION: $450,000 over three years

PROGRAM DESCRIPTION: This project began in FY2017/18 in partnership with Whole Person Care (WPC) and will be continued in this Three-Year Plan. 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.

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:

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

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.

True to the MHSA Guiding Principle of promoting an Integrated Service Experience, this program helps break down barriers to holistic care in hospitals, jail, clinics, street services, and mental health care run by and contracted by the county. Caring professionals throughout the systems of care can see if a client is enrolled in 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 for MHSA and other programs.
TELE-HEALTH IMPROVEMENTS

MHSA PROJECT ALLOCATION: $72,000 total over three years

PROGRAM DESCRIPTION: In response to the COVID-19 pandemic, which has quickly changed the way behavioral health services are offered, BHRS is dedicating resources to strengthening telehealth options, including the ability to provide group services via telehealth. The CARES Act is poised to cover much of the software and hardware investments of this system transformation; however, things like licensing fees for telehealth platforms, training, and development will not be covered by that funding. MHSA funding will be used to help fill-in gaps for this system transformation in instances when the CARES Act funding is unable to cover the cost. In addition, we will seek to use electronic means to enhance outreach and engagement efforts. If CARES Act funding is not granted, additional CSS contingency funding may be needed for CFTN to meet some of those goals.

WEBSITE ENHANCEMENTS

MHSA PROJECT ALLOCATION: $105,100 total over three years

PROGRAM DESCRIPTION: In response to the community planning process, BHRS will invest in an overhaul of the public facing website to make it easier for the community to navigate and learn about services and supports BHRS offers. This user-friendly website for people of all ages, that provides access to digital events including family groups, suicide prevention resources, peer-run groups, etc., as well as information on how to access mental health and substance use services, including how to get an assessment and information about different programs. Enhancing our website will help to keep our community informed through up to date information related to any changes to our services and supports in an ever-changing time.
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) COMPONENT BUDGET

<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>FY20/21</th>
<th>FY21/22</th>
<th>FY22/23</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Health Record and Practice Management System Enhancements</td>
<td>$328,479</td>
<td>$328,479</td>
<td>$328,479</td>
<td>$985,437</td>
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<tr>
<td>Coordinated Case Management system (WIZARD)</td>
<td>$150,000</td>
<td>$150,000</td>
<td>$150,000</td>
<td>$450,000</td>
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<tr>
<td>Telehealth Expansions</td>
<td>$24,000</td>
<td>$24,000</td>
<td>$24,000</td>
<td>$72,000</td>
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<tr>
<td>Website Enhancements</td>
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<td>$3,300</td>
<td>$3,300</td>
<td>$105,100</td>
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<tr>
<td>Admin/Indirect</td>
<td>$90,147</td>
<td>$75,867</td>
<td>$75,867</td>
<td>$241,881</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$691,126</strong></td>
<td><strong>$581,646</strong></td>
<td><strong>$581,646</strong></td>
<td><strong>$1,854,418</strong></td>
</tr>
</tbody>
</table>
FY18/19 OUTCOMES

Annual Update information for the FY18/19 fiscal year (July 1, 2018, through June 30, 2019) is on the following pages.
FY18/19 Prevention and Early Intervention Outcomes

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**

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). In FY18/19 55% of direct service funding was spent on youth. In FY19/20, we increased the allocation for PEI youth services to ensure it meets the widest possible way to interpret the regulation. As a result, we anticipate PEI spending on youth will exceed 55% of the total budget in FY 19/20.

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, attends various
PEI provider events and trainings and convenes short-term work groups as needed to strategize around prevention efforts related to specific populations.

**Clients (n=435)**

- **99%** Cultural background was respected
- **97%** Staff care about me
- **99%** Would recommend services
- **99%** Overall Satisfaction
- **77%** Able to choose treatment goals
- **67%** Feel connected to community
- **70%** Improved relationships
- **57%** Improved coping
- **67%** Improved at work/school
- **52%** Better handle personal needs

**Overall Satisfaction**

- 99%
- 97%
- 99%
- 77%
- 67%
- 70%
- 57%
- 67%
- 52%
Caregivers (n=61)

**Satisfaction Outcomes**

- 100% Overall Satisfaction
- 92% My child received services we wanted
- 100% Would recommend services
- 100% Cultural background was respected
- 68% Able to participate in treatment goals
- 82% Feel connected to community
- 92% Improved relationships
- 83% Improved coping
- 92% Improved at work/school
- 92% Better advocate my family needs
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) and expanding school-aged services 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 and continued to be strengthened during the FY 18/19:

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 were 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 began collecting 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 (or other county mental health provider such as a school-based EPSDT clinician), 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 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.

Note: demographics were not able to be collected for all clients.

In FY 18/19, the breakdown of PEI clients by region was as follows: 30% San Rafael area, 3% Marin City, 19% Novato, 6% West Marin, and 42% other or unknown.
Within the PEI programs, the Latinx population represented 54.8% of all clients served where demographic information was present.
74.1% of PEI clients with an identified ethnicity were from traditionally underserved racial/ethnic groups.
Youth 25 and under represented 48.6% of those served by PEI programs directly, however teachers and early childhood educators accounted for another 6.0% (bringing that total to 54.6%). In addition, 62% of the PEI direct services budget was designated for programs serving youth.
People who identify their primary language as Spanish represented 30% of PEI clients.
51% of PEI clients identified as female, 32% identified as male, .02% identified as transgender, genderqueer, questioning, or another gender identity.
51% of those served were assigned female at birth.
38% of PEI clients identified as heterosexual/straight, 2% as gay or lesbian, 3% bisexual. This information was not captured for the Early Childhood Mental Health program, per regulations, as all clients are under the age of 12 and was not captured for the suicide prevention hotline.
214 (or 6%) of 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 (PEI 01)

PROGRAM ALLOCATION FY18/19: $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.

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

The Early Childhood Mental Health Program at Jewish Family and Children’s Services increases the availability of early interventions for emotional or behavioral health issues by providing highly trained mental health consultants in childcare centers throughout Marin County that serve low-income families with children from birth to age five. Direct intervention by consultants include assessment of children with social/emotional risk factors utilizing evidence-based tools; and, development and facilitation of intervention plans for at-risk children including consultation and psycho-education with parents and linkages to community resources. 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
- Participant/provider 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)
- 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 FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable. The ECMH program provided an adapted survey to school staff and administrators.

**Anticipated data collection changes and additions for FY 19/20:** After learning about a tool used by the highly esteemed ECMH program at San Francisco General Hospital, JFCS ECMH program will begin using the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire - Social Emotional (ASQ-SE).

**OUTCOMES**

\[
N = \text{the total number in the sample (i.e. total number who received services or completed a survey).}
\]

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children that received prevention services through staff consultation</td>
<td>670</td>
<td>620</td>
<td>535</td>
<td>579</td>
<td>535</td>
<td>636</td>
</tr>
<tr>
<td>(number of students at school site)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of these children that come from un/underserved cultural</td>
<td>70%</td>
<td>86%</td>
<td>70%</td>
<td>87%</td>
<td>70%</td>
<td>88%</td>
</tr>
<tr>
<td>populations (Latino, Asian, African American, West Marin).</td>
<td>N=620</td>
<td>N=560</td>
<td>N=501</td>
<td>N=560</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children/families identified for enhanced intervention (through</td>
<td>75</td>
<td>80</td>
<td>65</td>
<td>67</td>
<td>65</td>
<td>82</td>
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<td>}</td>
<td></td>
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<td></td>
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</tbody>
</table>
observation or validated screening tools for child behavior or family caregiver depression) and provided services through ECMH Consultation.

<table>
<thead>
<tr>
<th>Children in childcare settings served by ECMH Consultants retained in their current program, or transitioned to a more appropriate setting. *Case notes</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>99.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>85%</td>
<td>100%</td>
<td>85%</td>
<td>96%</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>Caregivers reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc) * (PEI Caregiver Survey)</td>
<td>75%</td>
<td>90%</td>
<td>75%</td>
<td>89%</td>
<td>75%</td>
<td>96%</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>N/A</td>
<td>6</td>
</tr>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by your program and the individual’s first in person appointment with the PEI-funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to other mental health services or to resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>79</td>
</tr>
</tbody>
</table>

| Early Childhood Education Sites Receiving Services |  |  |  |  |  |  |

**Early Childhood Education Sites Receiving Services**
CHALLENGES AND UPCOMING CHANGES

In **FY 2018-19**, the ECMH PEI program was implemented overall as expected. However, there continue to be gaps in current systems that make it difficult for caregivers to identify, navigate, and secure timely support for their mental health needs and the needs of their children. Childcare providers and preschools feel this strain on a routine basis, as they attempt to address challenging behaviors and developmental needs in their classrooms/playgroups. One of the ways that the ECMH program addressed this challenge in the 18/19 FY year was to take a more proactive, trauma informed approach to collaboration with all parties at an earlier point when behaviors did not seem to be improving. In addition, with one of its larger programs, Community Action Marin Child Development Programs, JFCS began implementing Student Success Team (SST) meetings across 5 preschool sites in Marin County. These meetings involved Directors, Site Supervisors, Lead Teachers, Family Resource Managers, ECMH Consultants and Parents to collaborate and brainstorm about how best to support a particular child and create a plan together. By engaging each child’s entire network, JFCS facilitated much-needed coordination so managers could successfully support teachers, families, and the child.

In **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2017-18** through **FY2019-20** for the first part of the year until services were impacted by COVID-19. JFCS continued to work with preschool and childcare directors to replicate the services the ECMH Consultation model to meet the needs of the current situation. Site Supervisors, Teachers, Family Advocates and Home Visitors have provided remote instruction, supportive educational and social emotional activities and family support. ECMH consultants provided remote ECMH consultation to staff and families via phone and zoom. Site Supervisors from these programs took on new role of Family Advocate. Each Advocate screened and providing resources for families. Family with identified mental health issues, extreme stress, parenting issues were referred for ECMH Consultation. ECMH Consultants continued to provide ongoing ECMH Consultation for children and families remotely as well as providing support to the staff who are working in this stressful time with families in great need. They also began to provide remote ECMH Consultation for PopUp Childcare for health care workers Community Action Marin Child Development (CAM CDP). ECMH has experienced some challenges in providing services during COVID. Efforts to provide online parenting workshops were met with some difficulty due to limited access to technology for some families. In addition, although ECMH staff have stayed in close contact with school staff and families, being unable to observe children in person made providing comprehensive interventions more difficult.
Continued funding was determined by the MHSA Three Year planning process for FY2020-21 through FY2022-23 and the results of subsequent Requests for Proposals which were released in spring of 2020. JFCS has been awarded the contract to continue to provide ECMH throughout Marin County for the 20/21 fiscal year. **Client Story**

Jonny, a Latino boy in one of JFCS’s programs, was brought to an ECMH consultant’s attention at regular staff meeting a few months after he had started at the childcare center and had just turned 4 year-old. They were concerned because he fought constantly with his cousin, Carlos, who was in the same classroom. Carlos had recently been moved to the other classroom on site to separate the two boys, as there fighting was constant and impeding each child’s ability to learn. Once Jonny moved into the other classroom, teachers made some interesting and insightful observations. They noticed that Jonny “was sneaky,” and as they observed more, teachers realized that Jonny had been provoking Carlos, who had often looked like the problem because he was the one who had usually been caught hitting. Once Carlos was not around Jonny as much he was not as aggressive as he had appeared to be in the other classroom. One day, Jonny’s mom came in distressed because Jonny had purposely scratched her face the night before as they celebrated his birthday. She was distressed and told teachers that Jonny’s dad had blamed her and undermined her limit Jonny’s unsafe behavior. Their teacher connected this mom with an ECMH Consultant who assessed for danger and domestic violence. Mom admitted that there had been physical violence in the past, but that it had subsided. Teachers routinely witnessed Jonny speak to his mom in an aggressive manner. He would say she was ugly, fat, etc. Teachers modeled respect for his mom, talking of her beauty and love for him. They also worked with him to speak with teachers and other children in a respectful manner; hold him accountable for his actions; and use kind respectful words to express himself rather than hitting or hurting other. Jonny’s teacher completed a Devereaux Early Childhood Assessment – Clinical Form (DECA-C), which assessed child’s protective factors and behavior challenges. A support plan was created in collaboration with the lead teacher based on the results, which draws on the resilience of a child with the goal of decreasing the behavioral concerns. All teachers then implemented the agreed upon strategies with 2 goals being to increase attachment to all teachers and increasing his ability to self-regulate. All teachers supported by their site supervisor, implemented the strategies and as the end of the school year approached DECA-C posttest showed improvement in the previously concerning areas of emotional control problems and attention problems and Jonny’s lead teacher reported through a survey that he is doing better in school and that some of his relationships had improved. The ECMH consultant also referred mom and family to Center for Domestic Peace for group therapy, advocacy, and legal advice related to domestic violence, as well as to the Access line for Behavioral Health and Recovery Services for therapy for Jonny. Through the Early Childhood Mental Health program, the consultant helped Jonny’s teachers understand how the domestic violence at home was interfering with the child’s attachment, and helped childcare staff identify the relationship between certain behavioral challenges and domestic violence, trauma, and other mental health issues.
TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION (PEI 04)

PROGRAM OVERVIEW

In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program. 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 conduct psychosocial screening at health access points, direct linkage to mental health counseling, substance use counseling or case management, school-based groups, individual and/or family counseling, targeted supports for immigrant and LGBTQ students, as well as trainings for educators on supporting LGBT students.

PROVIDERS: Huckleberry Youth Programs, North Marin Community Services and, beginning in FY 18/19, the Spahr Center.

TARGET POPULATION

The target population is 16-25 year-olds, and some younger teens, from underserved populations. The Spahr Center provides targeted supports to LGBTQ youth. 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 Youth Programs, North Marin Community Services and the Spahr Center 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. The Spahr Center provides short-term counseling for a LGBTQ++ youth, with an emphasis on gender questioning and gender expansive youth.

**Training for School Staff:** The Spahr Center provides a series of trainings for educators and service providers regarding allyship with LGBTQ+ youth and the contribution they make to creating a safer and more welcoming environment in Marin’s middle and high schools.

**Access and Linkage to Treatment:** Mental Health and substance use screening is conducted for all clients of the teen health clinic and counseling clients. 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 FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable.

Anticipated data collection changes and additions for FY 19/20: 1) Both HYP and NMCS would like to consider all increases in PCOMs scores, and not just 6-point increases. The new PEI Satisfaction Survey also provides far greater data than the previous survey, allowing they TAY programs to pinpoint strengths and areas for improvement in programming and desired outcomes, and this may offer substantial information to supplement the PCOMs. 2) The SPAHR Center will implement an outcome survey for all trainings as well as an additional “outcomes” tool (TBD) with clients to supplement the PEI satisfaction survey.

OUTCOMES

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

<table>
<thead>
<tr>
<th>Outcomes: North Marin Community Services and Huckleberry Youth Programs</th>
<th>Goal FY17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAY screened for behavioral health concerns</td>
<td>350</td>
<td>347</td>
<td>350</td>
<td>360</td>
</tr>
<tr>
<td>TAY participating in at least 5 sessions of school-based skill building groups</td>
<td>100</td>
<td>97</td>
<td>100</td>
<td>103</td>
</tr>
<tr>
<td>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</td>
<td>60%</td>
<td>61% N=33</td>
<td>60%</td>
<td>77% N=63</td>
</tr>
</tbody>
</table>

❖ 100% of TAY clients reported that they would recommend the services to others
❖ 57% reported that, as a result of the service, they do better in school and/or work
❖ 79% reported that they have built stronger relationships with family, friends and others.
Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

TAY participating in individual counseling (including 15 youth that were previously served through school-based groups).

<table>
<thead>
<tr>
<th></th>
<th>200</th>
<th>263</th>
<th>200</th>
<th>291</th>
</tr>
</thead>
</table>

Family members participating in TAY counseling in support of the client

<table>
<thead>
<tr>
<th></th>
<th>50</th>
<th>82</th>
<th>50</th>
<th>176</th>
</tr>
</thead>
</table>

TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being.*  PCOMS: Outcome Rating Scale

<table>
<thead>
<tr>
<th></th>
<th>60%</th>
<th>N=64</th>
<th>60%</th>
<th>N=62</th>
</tr>
</thead>
</table>

Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change

<table>
<thead>
<tr>
<th></th>
<th>75%</th>
<th>85.5%</th>
<th>N=110</th>
<th>60%</th>
<th>N=62</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>100%</th>
<th>N=27</th>
</tr>
</thead>
</table>

Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

Total referrals to County Behavioral Health (BHRS)

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>3</th>
<th>N/A</th>
<th>8</th>
</tr>
</thead>
</table>

Number of individuals who were successfully referred and linked to a Marin County mental health treatment program

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>5</th>
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</thead>
</table>

Average duration in weeks of signs of untreated mental illness (per client or caregiver report)

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>24</th>
</tr>
</thead>
</table>

Total referrals to other PEI providers

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>12</th>
<th>N/A</th>
<th>3</th>
</tr>
</thead>
</table>

Number of individuals followed through on referral & engaged in a PEI-funded program

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>Unknown</th>
</tr>
</thead>
</table>

Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>Unknown</th>
</tr>
</thead>
</table>

Total referrals to other mental health services or to resources for basic needs

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>126</th>
</tr>
</thead>
</table>

*Data Collection Method
CHALLENGES AND UPCOMING CHANGES

In **FY2018-19**, the TAY program was implemented as expected overall. Additional funding was added to this year’s budget for a new program with SPAHR center to provide counseling services for transgender youth and outreach to schools around LGBTQ issues. During this FY, each TAY program experienced staffing shortages that led to some challenges in carrying out program objectives.

In **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2017-18** through **FY2019-20** for the first part of the year until services were impacted by COVID-19. For the **19/20 FY**, one-time funds were added to each of the TAY programs to fund the following services: The Spahr Center received 20k to create additional training and consultation for school staff around supporting LGBTQ youth; North Marin Community Services received an additional 50k to provide counseling services through their existing graduate intern program to elementary and middle school students in Novato Unified; Huckleberry Youth Programs received an additional 35k to provide behavioral health assessment, referral and support for youth referred for
substance use infractions. In response to COVID-19, TAY programs moved quickly to begin providing telehealth services to clients through phone and Zoom. Huckleberry and NMCS coordinated to align teen clinic services remotely by creating a “virtual teen clinic” for the first couple of months and slowly transitioned back to providing in person services. Together, the agencies outreached to youth to let them know about services by doing weekly social media posts and as well as communicating their available services to varying school, community, and non-profit groups. The TAY teams developed and are presented various topics around mental health, sexual health and safety, and academics to schools via Zoom/Google Meet in place of classroom presentations.

Continued funding was determined by the MHSA Three Year planning process for FY2020-21 through FY2022-23 and the results of subsequent Requests for Proposals which were released in spring of 2020. Huckleberry, NMCS and the Spahr Center have been awarded contracts to continue to provide TAY services throughout Marin County for the 20/21 fiscal year.

CLIENT STORY

Client Story 1: Billy, who is transgender came in seeking services due to his three-year struggle with gender dysphoria. Billy also reported depression and insomnia. He had recently changed schools, so in addition to being in the complicated process of officially changing name/gender status he was also adjusting to a new high school and gaining peer acceptance with the normal adolescent challenges. When the clinician first met him, he came across as shy, insecure, and hesitant to express himself. Billy found individual therapy and the Center’s Youth groups very helpful and got involved in the organization’s community. Over the course of time working together with his therapist he established healthy social connections at school and in groups. He also developed a stronger sense of himself and became more self-confident. He currently reports rarely having depressive symptoms and decreased insomnia. He is positive and cheerful, humorous, developing a comfortable and centered identity, able better able to advocate for himself.

Client Story 2: A 17 year-old Latino client was referred for mental health support after a school suspension. He came to the first session feeling shame and embarrassment about what had happened at school, and he was guarded in therapy and afraid of “getting in trouble again.” The therapist spent early sessions building trust, finding the client’s strength that he was proud of, and creating a safe space for the client to explore and process his feelings of anger, frustration and stress. He eventually began to disclose more about his feelings, his history with mental health, and eventually disclosed his substance use. Initial goals included collaboration and communication with the important adults in his life—his parents, school counselor and principal—to help him achieve a feeling of trust and safety at school and at home. The therapist and client also worked on his ambivalence about his future and his strategies for coping with stress. He was then able to focus on his depression and low self-esteem, and eventually the therapist and client were able to build up enough tools and support to address substance use. He graduated this past school year, with various awards and recognition from his principal and teachers. He is now enrolled and attending community college.
LATINO COMMUNITY CONNECTION (PEI 05)

PROGRAM ALLOCATION FY2018-19: $367,925

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 through the Multicultural Center of Marin (formerly Canal Welcome Center).

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 Corazon 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 FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable.
- In FY 18/19, Multicultural Center of Marin implemented quarterly and end-of-year listener surveys on Facebook and on paper to assess knowledge and skills attained through radio show

Anticipated data collection changes and additions for FY 19/20: 1) Continue to implement radio show survey and increase efforts to elicit feedback from more listeners through paper surveys and social media 2) Promotores will discontinue 3-month follow-up survey and continue PEI survey 3) With respect to case management, Canal Alliance has made efforts to improve its collection demographic data. CA had a training by Youth Leadership Institute on Best Practices to Support LGBTQ Families & Youth in order to better understand the proper language/terminology and how to ask questions about gender and sexual orientation with culture in mind 4) NMCS has hired a Wellness Program Manager to provide support and increase consistency in collecting evaluation data.

OUTCOMES

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

<table>
<thead>
<tr>
<th>Canal Alliance/North Marin Community Services</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving health information and support from</td>
<td>640</td>
<td>1,490</td>
<td>900</td>
<td>1,288</td>
<td>900</td>
<td>1,109</td>
</tr>
<tr>
<td><strong>Promotores or Family Resource Advocates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Individuals participating in support groups or individual/family sessions</td>
<td>100</td>
<td>113</td>
<td>150</td>
<td>83</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Family members participating in support of the client</td>
<td>20</td>
<td>10</td>
<td>20</td>
<td>17</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>
| Individuals participating in a support group for at least 3 months reporting statistically significant improvement in PTSD symptoms | 80% | 95%  
N=16 | 50%  
N=50 | 60%  
N=50 | 50%  
N=50 |
| Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey | N/A | N/A | N/A | 10 | N/A |
| Total referrals to County Behavioral Health (BHRS) | N/A | N/A | N/A | 10 | N/A |
| Number of individuals who were successfully referred and linked to a Marin County mental health treatment program | N/A | N/A | N/A | N/A | N/A |
| Average duration in weeks of signs of untreated mental illness (per client or caregiver report) | N/A | N/A | N/A | N/A | N/A |
| Total referrals to other PEI providers | N/A | N/A | N/A | 20 | N/A |
| Number of individuals followed through on referral & engaged in a PEI-funded program | N/A | N/A | N/A | N/A | N/A |
| Average time in weeks between when a referral was given to individual by your program and the individual’s first in person appointment with the PEI-funded provider | N/A | N/A | N/A | N/A | N/A |
| Total referrals to other mental health services or resources for basic needs | N/A | N/A | N/A | 250 | N/A |

*Groups had to be canceled due to low turnout*
Outcomes for MCM: SURVEY RESULTS

<table>
<thead>
<tr>
<th>Outcomes: Multicultural Center of Marin</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide weekly one-hour radio show on topics of health and wellness of Latino individuals, families and communities, with a focus on mental health knowledge, signs, symptoms, skills, and related community resources, including PSAs and a community calendar for related events and services.</td>
<td>52</td>
<td>52</td>
<td>52</td>
<td>52</td>
<td>52</td>
<td>52</td>
</tr>
</tbody>
</table>

Radio Show Listener Survey Responses:

- **“I have a better understanding of resources in my community”**
  - N/A
  - N/A
  - N/A
  - N/A
  - N/A
  - 93%*
  - N=98

- **“I learned something about mental health (emotional wellbeing) that I didn’t know before”**
  - N/A
  - N/A
  - N/A
  - N/A
  - N/A
  - 95%*
  - N=99

- **“I would recommend this radio show to a friend or family member”**
  - N/A
  - N/A
  - N/A
  - N/A
  - N/A
  - 99%*
  - N=98

*percentage that agree or strongly agree

**CHALLENGES AND UPCOMING CHANGES**

In **FY2018-19**, the Latino Community Connection programs were implemented as planned overall. Canal Alliance’s Behavioral Health Clinician attempted to launch two groups aimed at addressing depression among the Latinx immigrant community, one for men and one for women. Although advertising for both of these groups began immediately, neither group had a strong showing. As a result, the men’s group did not get off the ground and the women’s group peaked at 3 members and was therefore canceled in it’s 10th of 12 weeks. While no groups are planned at the moment, a potential change that could increase the likelihood of success would be to advertise sooner, screen individuals/families for the groups, and require registration for individuals before the groups. These strategies could encourage buy-in that could motivate people to continue to attend the groups. In Novato, mental health counseling launched this year and included attempting to establish services in a new location (West Marin). Demand in West Marin was high, but due to challenges in getting up and running service were terminated sooner than anticipated. CA does not anticipate the same challenges or impact FY 19/20, as
the mental health clinician will be fulltime in Novato, including one day at Novato High School, where she is already being warmly received.

In **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2017-18** through **FY2019-20** for the first part of the year until services were impacted by COVID-19. Canal Alliance and North Marin Community Services quickly shifted to providing telehealth to clients through phone and Zoom. A large focus of their work was on providing emergency rental assistance and food. Both clinics continued to operate at capacity and to see new referrals on a weekly basis. Clinicians began seeing clients who had recovered from COVID and were working to deal with the lingering anxieties and fear it caused. Case Managers and *Promotoras* continued to support clients remotely through phone appointments regarding tenant rights, food access, behavioral health referrals, COVID-19 positive case management, COVID testing information, financial assistance, domestic abuse and child abuse referrals and support.

Continued funding was determined by the MHSA Three Year planning process for **FY2020-21** through **FY2022-23** and the results of subsequent Requests for Proposals which were released in spring of 2020. NMCS and Canal Alliance have been awarded contracts to continue to provide LCC supports throughout Marin County for the 20/21 fiscal year. Multicultural Center of Marin was awarded the Spanish language radio show contract.

**CLIENT STORY**

*A Promotora* provided emotional support to Gloria, a fifty-four-year-old grandmother. The client shared that she was very depressed because her only daughter would not allow her to spend time with her grandchildren. They had a lot of unsolved family problems. The clients’ depression got worse as she confided to the Promotora that she was considering suicide, saying that her daughter and grandchildren would have a happier life if she wasn’t around. Gloria refused referrals to a mental health professional but did accept information about local hotlines and emergency crisis numbers she could call. The Promotora continued to check-in with Gloria daily over the phone and sometimes met her in person, too. It has been three months since Gloria revealed her suicidal thoughts, and though she is still not interested in getting professional help, she has gained self-confidence and is now in a much better emotional state. She has a better relationship with her grandchildren, and she no longer has suicidal thoughts. She continues to be in touch with the Promotora once a week and is very grateful for the support she has been given, saying that she is happy this program is available for the Latino community so that people who are facing emotional issues can get support.
OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI 07)

PROGRAM ALLOCATION FY18/19: $156,000

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

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. At Jewish Family and Children’s Services, the BOOST Program provides Marin County seniors with screening for depression, anxiety, and trauma; as well as services that assist them in managing these mental health challenges. Many of the clients we serve are isolated and have undergone, or are going through, a major life transition (retirement, medical event, loss of spouse, etc.) and can struggle as they try to deal with these stressors and changes in their lives. These major transitions can often precipitate depressive symptoms in older adults or heighten their anxiety, both of which can affect their ability to function, and impair their relationship with others. The Older Adult PEI program aims to reduce Prolonged Suffering by providing:

52 Individuals
21 Families
300 reached through Outreach/Training
• **Brief Intervention:** JFCS' BOOST provides clinic or home-based early identification and intervention for those experiencing early onset of depression and/or anxiety by reducing symptoms and improving related functioning. For clients completing treatment, including Cognitive Behavioral Therapy 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 reports. Changes in scores are tracked by individual and reported in aggregate. JFCS also works with clients to seek out and engage family members, when appropriate, to strengthen their support network.

• **Training/psychoeducation:** 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.

• **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.

**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

**Client quote:**

“This is an amazing, life-saving program. I am so much better equipped to handle things than I used to be thanks to [my BOOST clinician].”
- In FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable.

**Anticipated data collection changes and additions for FY 19/20:** In FY 19/20, the JFCS Older Adult program will begin to administer the PHQ-9 every six months, in addition to the start and end of treatment. Doing so, they hope to better track progress and determine whether clients whose treatment is longer than six months benefit significantly from the additional service. In addition, JFCS is exploring using the GAD scale at the beginning and end of treatment to better monitor client’s anxiety and track their progress over the course of treatment.

**OUTCOMES**

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving education regarding behavioral health signs and symptoms in older adults</td>
<td>50</td>
<td>85</td>
<td>100</td>
<td>103</td>
<td>100</td>
<td>300</td>
</tr>
<tr>
<td>Individuals receiving education who are from an underserved population or primarily serving underserved populations (race, ethnicity, language, LGBTQ)</td>
<td>20%</td>
<td>51% (N=85)</td>
<td>25%</td>
<td>78% (N=80)</td>
<td>25%</td>
<td>25% (N=75)</td>
</tr>
<tr>
<td>Seniors at Home clients screened for behavioral health concerns. *PHQ9, substance use</td>
<td>150</td>
<td>153</td>
<td>150</td>
<td>163</td>
<td>150</td>
<td>162</td>
</tr>
<tr>
<td>Low income clients receiving brief intervention services.</td>
<td>35</td>
<td>35</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>Low income clients receiving brief intervention services who are from underserved populations</td>
<td>20%</td>
<td>26% (N=35)</td>
<td>20%</td>
<td>20% (N=10)</td>
<td>20%</td>
<td>31% (N=16)</td>
</tr>
<tr>
<td>Clients completing a short-term treatment protocol for depression or anxiety</td>
<td>70%</td>
<td>71% (N=35)</td>
<td>70%</td>
<td>70% (N=35)</td>
<td>70%</td>
<td>90% (N=47)</td>
</tr>
<tr>
<td>Clients completing a short-term treatment protocol for depression or anxiety experiencing a decrease of at least one category of severity</td>
<td>60%</td>
<td>63% (N=35)</td>
<td>60%</td>
<td>86% (N=30)</td>
<td>60%</td>
<td>68% (N=32)</td>
</tr>
<tr>
<td>(i.e.: moderate to mild). *PHQ9, GDS, GAD7</td>
<td>75%</td>
<td>90% N=22</td>
<td>75%</td>
<td>95% N=22</td>
<td>75%</td>
<td>100% N=24</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------</td>
<td>----------</td>
<td>------</td>
<td>-----------</td>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey</td>
<td>75%</td>
<td>N/A</td>
<td>75%</td>
<td>95% N=22</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Unknown</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by your program and the individual’s first in person appointment with the PEI-funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Total referrals to other of mental health services or resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>115</td>
</tr>
</tbody>
</table>

*Data Collection Method*
CHALLENGES AND UPCOMING CHANGES

In FY2018-19, 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. With limited psychiatrists and mental health services specializing in geriatrics, it is often difficult to refer patients for additional support, or to secure physicians and psychiatrists to collaborate in providing care. BOOST staff have worked to identify and develop rapport with local providers skilled at serving seniors to ensure clients’ needs are met.

An additional challenge is meeting the needs of isolated seniors in underserved areas like West Marin. To address this challenge, JFCS has explored creative ways to address long drive times for clinicians so that they can continue to serve all clients referred with a minimum wait including scheduling clients back-to-back and working with West Marin Senior Services to use their facilities for clients that may have transportation to their site. Another challenge is accessing services due to language barriers for Spanish and Russian speaking older adults. Due to investment in recruiting, JFCS has been able to hire Spanish and Russian speaking clinicians and is developing a plan for increased outreach to Latino and Russian-speaking clientele in need of support.

In FY 2019-20, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 for the first part of the year until services were impacted by COVID-19. With COVID, JFCS continued to serve seniors virtually, through tele-therapy and outreach through virtual workshops/webinars to both consumers and service providers. They also offered virtual support groups for seniors, and daily check in calls for isolated seniors.

Continued funding was determined by the MHSA Three Year planning process for FY2020-21 through FY2022-23 and the results of subsequent Requests for Proposals which were released in spring of 2020. JFCS has been awarded contracts to continue to provide early intervention supports to seniors throughout Marin County for the 20/21 fiscal year.

CLIENT STORY

Irene is an 86 year-old African-American woman. She lives alone. A neighbor shops for her and stops by her home weekly to drop off groceries, but she is otherwise alone. Irene was referred to BOOST by a social worker who noted that Irene seemed depressed and appeared to be hoarding and living in unclean conditions. A BOOST clinician visited Irene in her home, but Irene initially refused to let her in. The clinician, trained to work with isolated seniors fearful of being taken advantage of, was patient in building rapport with Irene, offering shorter sessions to start, meeting in the courtyard rather than in her apartment, and having her Social Worker join an initial session to build trust. The clinician knew that empathy and a strong therapeutic alliance are key factors to positive outcomes, particularly when working in mixed racial therapeutic dyads. Consequently, her initial focus was to listen deeply to Irene, ensuring that Irene felt heard and understood. Over the course of a few meetings, Irene and her clinician shared a few laughs, and the clinician came to understand that Irene’s depression and anxiety were prohibiting her from engaging socially and taking proactive steps to address her situation regarding her home and strained finances. Knowing that African-Americans have higher rates of attrition from mental health treatment programs, especially treatments that are not culturally specific, the clinician used a culturally adapted depression intervention, using CBT tools focusing on African-American culture, including her spirituality and black identity. She helped Irene set short-term manageable goals to increase her social and support network, focusing on her local church (given Irene’s religious and spiritual beliefs and past association with the church). She supported her in contacting her church and discovered that they
had congregants that would drive her to services and events. She helped Irene set goals around interacting with three people each time she went to church, and to allowing a Friendly Visitor into her home. After six months, the clinician’s alliance with Irene had grown to the extent that she could assist Irene in addressing her living conditions. The clinician linked Irene to a local program that provided a volunteer to help her clean her home, and then matched her with a roommate who could help her with household chores and contribute a small amount to her rent, so that Irene could pay for additional in-home help for tasks like laundry. Irene is increasingly socially active and reports that she now knows what she needs to do when feeling depressed to better manage her symptoms.
VIETNAMESE COMMUNITY CONNECTION (PEI 11)

PROGRAM ALLOCATION FY18/19: $56,460

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.

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

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**SUMMARY FY2018-19**

**Clients Served: FY2018-19**

- 80 Individuals
- 20 Families
- 230 reached through Outreach/Training
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)
- The number and type of Outreach Activities and types of participants reached
- Client/family demographics and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services
- In FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable.

**Anticipated data collection changes and additions for FY 19/20:** In FY 19/20, MAAP will be conducting a needs assessment of the community to collect up-to-date trends and current needs within the Vietnamese community in Marin. They will be administering surveys and facilitating focus groups with community members. They will use the results of the needs assessment to tailor the types of group prevention activities that they implement and to help inform BHRS of the current needs of this community.

**OUTCOMES**
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Advocates (CHAs) will receive training in:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc.</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>o Mental Health First Aid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAs will receive at least 6 hours each of group or individual supervision</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Individuals receiving information about mental health and access to services via tabling and other outreach strategies</td>
<td>75</td>
<td>120</td>
<td>70</td>
<td>67</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Individuals participating in prevention activities (field trips, community building)</td>
<td>120</td>
<td>260</td>
<td>120</td>
<td>225</td>
<td>120</td>
<td>230</td>
</tr>
<tr>
<td>Clients receiving brief intervention reporting satisfaction with services (would use again, recommend)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals participating in individual/family consultations</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
<td>N/A</td>
<td>10</td>
</tr>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>-</td>
<td>N/A</td>
<td>10</td>
</tr>
<tr>
<td>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by your program and the individual’s first in person appointment with the PEI-funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>Total referrals to other mental health services or resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100</td>
<td>N/A</td>
<td>80</td>
</tr>
</tbody>
</table>
CHALLENGES AND UPCOMING CHANGES

In **FY2018-19**, the Vietnamese Community Connection program was implemented as expected overall. Limited transportation and access to services in the Vietnamese community continue to be ongoing challenges in getting members of the community members into services or participation in MAAP activities and linked to other county services.

In **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2017-18** through **FY2019-20** for the first part of the year until services were impacted by COVID-19. With COVID, MAAP continued to communicate frequently by phones, texting messages, Facebook and messenger with members of the Vietnamese community. The program also continued to help low income older adult seniors apply for an emergency financial assistance, and to promote everyday preventive actions (Wear masks and Implement physical distancing guidelines) as well as accessing mentla health supports throughout their community.

In the next MHSA 3-year plan, this program will move under CSS and no longer be funded under PEI. Funding will be based on the results of Requests for Proposals which will be released for the Community Health Advocates Program in the fall.

CLIENT STORY

*Mrs. H.* was almost 80 years old, and after her husband died, she became reclusive and less interactive with peers and neighbors. After MAAP learned about Mrs. H.’ condition, the PEI provider contacted her immediately to assess how she could help. The MAAP PEI provider made a home visit and, after speaking with her, recommended Mrs. H. to participate in MAAP’s community activities such as health education, information exchange, and dancing exercise programs. In addition, the PEI provider referred her to Marin County BHRs mental health treatment program where she now receives weekly therapy with a licensed Vietnamese speaking clinician. Mrs. H now regularly participates in MAAP and reports feeling happier and more connected to her community.
COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING (PEI 12)

PROGRAM ALLOCATION FY18/19: $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 suicide prevention; 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)

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 is reported in the Outcomes section below.

**OUTCOMES**

BHRS hosted 8 Mental Health First Aid Trainings during the FY 18/19.

<table>
<thead>
<tr>
<th>Mental Health First Aid Outcomes</th>
<th>FY 16/17</th>
<th>FY 17/18</th>
<th>FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Marin County community members that participated in MHFA.</td>
<td>139</td>
<td>137</td>
<td>146</td>
</tr>
<tr>
<td>Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“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.”</td>
<td>4.4</td>
<td>4.6</td>
<td>4.26</td>
</tr>
<tr>
<td>Recognize and correct misconceptions about mental health and mental illness as I encounter them</td>
<td>N/A</td>
<td>4.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Be aware of my own feelings and views about mental health problems and disorders. (0-5 scale)</td>
<td>N/A</td>
<td>4.5</td>
<td>4.21</td>
</tr>
<tr>
<td>Participants reporting ability to assist somebody experiencing a mental health problem or crisis to</td>
<td>N/A</td>
<td>4.5</td>
<td>4.26</td>
</tr>
</tbody>
</table>
### Mental Health First Aid Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY 16/17</th>
<th>FY 17/18</th>
<th>FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connect with community, peer or personal support. (0-5 scale)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants reporting feeling able to offer a distressed person basic “first aid” information and reassurance about mental health. (0-5 scale)</td>
<td>4.5</td>
<td>4.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Participants reporting ability to assist somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)</td>
<td>4.6</td>
<td>4.5</td>
<td>4.25</td>
</tr>
</tbody>
</table>

### Mental Health First Aid Outcomes: 3 Month Follow-up

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY 16/17</th>
<th>FY 17/18</th>
<th>FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize and correct misconceptions about mental health and mental illness as I encounter them. (0-5 scale)</td>
<td>N/A</td>
<td>N/A</td>
<td>4.14</td>
</tr>
<tr>
<td>Participants reporting feeling more confident that they can reach out to someone who may be dealing with a mental health problem or crisis. (0-5 scale)</td>
<td>N/A</td>
<td>N/A</td>
<td>4.42</td>
</tr>
<tr>
<td>Participants reporting ability to assist somebody experiencing a mental health problem or crisis to connect with community, peer or personal supports. (0-5 scale)</td>
<td>N/A</td>
<td>N/A</td>
<td>4.14</td>
</tr>
<tr>
<td>Participants reporting ability to assist somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)</td>
<td>N/A</td>
<td>N/A</td>
<td>4.42</td>
</tr>
</tbody>
</table>

### Settings where participants might use MHFA

<table>
<thead>
<tr>
<th>Setting</th>
<th>Number Served 16/17</th>
<th>Number Served 17/18</th>
<th>Number Served 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Members</td>
<td>47</td>
<td>62</td>
<td>24</td>
</tr>
<tr>
<td>Family Member of Person with Serious Mental Illness</td>
<td>2</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Providers</td>
<td>FY20</td>
<td>FY21</td>
<td>FY22</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>County Behavioral Health and Recovery Services</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Community-based Mental Health and/or Substance Use Provider</td>
<td>12</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Education (including High School Students)</td>
<td>6</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>0</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>5</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Senior Centers/Services</td>
<td>12</td>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td>Social Services (County and Community)</td>
<td>10</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Veterans</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Faith-based</td>
<td>8</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Shelters/Homeless Services/Public Housing</td>
<td>9</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Libraries</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public Transit</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employment</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Other – List: DV, BOS, Parks Svcs, PH</td>
<td>7</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Security, Emergency Svcs</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
OTHER OUTREACH AND TRAINING ACTIVITIES IN FY2018-19

Participation in community outreach and education events including “Day of the Dead” in the Latino community.

November 2nd, 2019, “Day of the Dead” Celebration: photo taken by Christian Garcia
May is Mental Health Month community trainings and workshops:

In support of Mental Health Awareness Month, Marin County Behavioral Health and Recovery Services encouraged staff and partners to wear lime green, the national color of mental health awareness. BHRS also hosted several events throughout the county including a Suicide Prevention strategic planning community event, an Adult Mental Health First Aid Training, and four Mental Health Stress Reduction Workshops.

Suicide Prevention Trainings:

**AB 2246 training for School Administrators:** AB2246 mandates that all schools in California implement suicide prevention policies that specifically address the needs of lesbian, gay, bisexual, transgender and questioning youth. On November 9, 2018 in collaboration with Each Mind Matters and the Marin County Office of Education, BHRS hosted an all-day workshop “AB2246 Preparing for Policy Change” in Marin County. A total of 25 participants were trained, representing nine school districts or schools. During the workshop participants from the same district or school worked in teams to discuss and customize sections of the template policy created by the California Department of Education. The presentation and workgroup sessions covered staff trainings, risk assessment protocols, interventions and referral to mental health services, student engagement strategies and postvention.

**AB2246 Training Outcomes:** At the end of the training, all participants were asked to complete a brief survey to provide feedback on the training and offer suggestions for improvements. A total of 18 of 25
participants took the survey. Participants were asked to rate their confidence implementing some of the key topics covered during the training, including creating a policy that meets the requirements of AB 2246, selecting appropriate student engagement programs and suicide prevention staff trainings. Overall, the majority of participants indicated they were confident in creating a policy that meets the requirements of AB 2246 and creating a protocol that describes specific steps to take after a suicide that will help students cope in the short term and long term. (n= 18)

**Talk Saves Lives (TLS) and ASIST Suicide Prevention trainings:** In collaboration with the American Foundation for Suicide Prevention (AFSP), BHRS hosted a TLS training for community members. Participants learned the common risk factors for suicide, how to spot the warning signs in others, and how to keep themselves, their loved ones and those in their community safe. BHRS and AFSP also hosted an Applied Suicide Intervention Skills (ASIST) two-day training for providers in collaboration with ASFP and the Marin County Office of Education.

![September 24th, 2018, Talk Saves Lives Training with AFSP: photo taken by Chandrika Zager](image)

**Speakers Bureau trainings with the National Alliance on Mental Illness (NAMI) Marin:**

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. National Alliance on Mental Illness (NAMI) Marin was awarded the contract which started May 1, 2019.
The initial set up of the Speakers Bureau commenced with a list of 10-12 potential speakers ranging in topics from recovery from substance abuse, recovery from psychosis, parent and child dynamics as it relates to mental illness, mental health as it relates to the LGBTQI community, the impact of mental illness and incarceration, living with borderline personality disorder, schizophrenia or bipolar disorder, living with suicidal ideation and the impact of race and gender on mental illness. The aim of NAMI’s Speakers Bureau, which is called “In Our Own Voices”, is to create healthy environments of compassion, kindness, respect, non-judgment, and support. The stories can intersect on all levels of mental health and recovery and focus on creating a connection through storytelling. Speakers will be able to create an environment that feels reflective of their story and lives by determining the different components of the event (i.e. music, food, cultural markers) and choosing the format that works best for them. Each event will also have a theme chosen by the speaker that reflects a component of their story. The opening and closing activities will be reflective of this theme.

Speaking events, demographics and evaluations will be included in the annual update for FY 19/20.

**Additional Trainings offered through PEI funding during the 18/19 FY:**

- “Being Adept” a school-based substance use prevention training series students and parents was offered to 6th and 8th graders at two middle schools in Shoreline Unified School District.
- 2-hour training on anxiety and depression in Vietnamese using concepts from MHFA

**CHALLENGES AND UPCOMING CHANGES**

In **FY2018-19**, eight (8) MHFA trainings were offered, including 3 adult, 4 youth, and 1 in Spanish. Trainings continue to be very well received by the community. Schools and Community Based Organizations have expressed increasing interest in having their staff trained. BHRS also hired a full-time Evidenced Based Practice Lead (partially funded through PEI). The role of the EBP Lead is to build capacity of providers to integrate evidenced based assessment and evaluation practices into their programs.

In **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2017-18** through **FY2019-20** for the first part of the year until services were impacted by COVID-19. With COVID, trainings were either canceled or proceeded virtually. BHRS and its partners worked to ensure that training curriculum continued to meet rigorous standards and remained accessible to as many participants as possible.

Continued funding was determined by the MHSA Three Year planning process for **FY2020-21** through **FY2022-23**. In the upcoming budget, there will be a focus suicide prevention trainings for the community and high risk groups as well as a continuation of MHFA and other evidenced based community trainings and capacity building activities.
SCHOOL AGE PREVENTION AND EARLY INTERVENTION (PEI 18)

PROGRAM ALLOCATION FY18/19: $419,511

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:**
- West Marin (Shoreline Unified): Coastal Health Alliance (formerly contracted under Bay Area Community Resources)
- San Rafael (San Rafael City Schools): Youth Leadership Institute*
- Marin City (Sausalito Marin City Schools): Performing Stars*, Seneca Family of Agencies*, Southern Marin Community Connections

*Newly implemented programs during the 18/19 FY

**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 are then be assessed to determine whether they are appropriate for PEI services or are linked to other services. In FY 18/19, the program targeted three areas of Marin County.

<table>
<thead>
<tr>
<th><strong>School-aged Programs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUMMARY FY2018-19</strong></td>
</tr>
<tr>
<td><strong>Individuals Served:</strong></td>
</tr>
<tr>
<td><strong>FY2018-19</strong></td>
</tr>
<tr>
<td>271 Individuals</td>
</tr>
<tr>
<td>57 Families</td>
</tr>
<tr>
<td>1138 reached through Outreach/Training</td>
</tr>
</tbody>
</table>

---

County of Marin FY20/21-22/23 Mental Health Services Act (MHSA) Three Year Plan 141
<table>
<thead>
<tr>
<th>Target Schools</th>
<th>Latino</th>
<th>American Indian</th>
<th>Asian</th>
<th>African American</th>
<th>Multiple Races</th>
<th>English Learners</th>
<th>Free and Reduced Meals</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael City Elementary (K-8)</td>
<td>68%</td>
<td>.04%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>47%</td>
<td>67%</td>
</tr>
<tr>
<td>West Marin Schools</td>
<td>58%</td>
<td>1%</td>
<td>1%</td>
<td>-</td>
<td>1%</td>
<td>40%</td>
<td>23%</td>
</tr>
<tr>
<td>Sausalito/Marin City Schools</td>
<td>27%</td>
<td>-</td>
<td>9%</td>
<td>20%</td>
<td>10%</td>
<td>21%</td>
<td>46%</td>
</tr>
</tbody>
</table>

**School Aged Programs: Number Served by Program**

- **Youth Leadership Ins**: 328
- **SMCC**: 15
- **Seneca**: 115
- **Performing Stars**: 208
- **CH Alliance**: 472

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Youth Leadership Ins</th>
<th>SMCC</th>
<th>Seneca</th>
<th>Performing Stars</th>
<th>CH Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach/Trainings</td>
<td>328</td>
<td>15</td>
<td>115</td>
<td>208</td>
<td>472</td>
</tr>
<tr>
<td>Families</td>
<td>0</td>
<td>10</td>
<td>27</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Individuals</td>
<td>52</td>
<td>66</td>
<td>45</td>
<td>108</td>
<td></td>
</tr>
</tbody>
</table>

*In FY 18/19, PEI providers provided individual and group counseling to 271 youth and family counseling and support to 57 caregivers. Seneca coordinated all referrals at Bayside MLK (Marin City) Seneca and triaged referrals to other PEI providers as part of the Coordination of Services Team (COST) process.*
39% of clients identified as male, 58% identified as female, and 2% identified as gender queer, transgender, or questioning.

Latinos represented 40% of individuals served, Whites represented 29%, African Americans represented 21%, other races or those that identified as “more than one race” represented 10%.
**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.

- **Building partnerships**: builds partnerships for positive and healthy youth development which engage youth as active leaders and resources in their communities

- **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.

- **Coordination of Services:** Implementing multidisciplinary teams to improve coordination, communication and collaboration across disciplines and identify and address student needs holistically.

- **School Climate Development, Support and Implementation:** Promoting a culture and climate that is engaging and responsive to the needs of all students and their families by creating Positive Behavior Intervention and Supports (PBIS) teams, implementing Social Emotional Learning (SEL) curriculum and Multi-Tiered Systems of Supports.

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

**Seneca Family of Agencies:**

Seneca’s Unconditional Education (UE) model empowers the entire school community with the skills and resources required to implement a multi-tiered system of academic, behavioral, and social emotional supports. A primary focus of the UE model is to increase the achievement of struggling students, including students with disabilities, within inclusive education settings. Unconditional Education is a modular approach that allows schools to identify key areas of internal capacity while leveraging the expertise of Seneca to help address identified gaps and create a truly comprehensive system of supports for all students, family, and staff. The UE coach facilitates the multidisciplinary Coordination of Services Team (COST) and provides data monitoring to track student progress.

**Performing Stars:**

Performing Stars works with the Bayside MLK school community to support students and families through mentorship, client advocacy and care coordination. They work with the school and families to help develop and implement action plans and provide social skills groups for students. They also coordinate student and community field trips and provide parent educational workshops. Students are referred to Performing Stars through COST.
Southern Marin Community Connection:
Graduate-level interns provide individual and group counseling to students referred through the COST team.

Coastal Health Alliance:
Coastal Health Alliance 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.

Youth Leadership Institute (YLI):
YLI builds communities where youth and their adult allies come together to create positive social change. They do this by building the capacity of young people to serve as leaders in their community. YLI youth participate in leadership development, conduct youth-led action research, and lead advocacy campaigns. YLI engages youth at two San Rafael Middle Schools with identify specific programming serving high risk students. One group focuses on Spanish-speaking, newly arrived Latino immigrants and focuses on building relationships and community and the other group is geared towards LGBTQ youth and includes programming and content regarding sexual orientation and gender.

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
- Youth Development Survey to measure skill building, meaningful engagement in community, development of caring relationships with adults and peers
- Staff training surveys
- COST rubric to measure impact of coordination team and assess progress in identified areas of improvement

❖ 93% of staff that received trauma trainings at Bayside MLK reported that the workshops helped them to better support the learning and health and wellness needs of students and caregivers
In FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable.

**Anticipated data collection changes and additions for FY 19/20:** During the FY 18/19, YLI revamped its intake and year-end/post surveys to better measure impact of the program on participants as well as provide additional opportunities for feedback. Coastal Health Alliance will be adding an additional assessment tool to measure client progress such as the Outcomes Rating Scale (ORS) or the Strengths and Difficulties Questionnaire (SDQ). CHA will also develop a more comprehensive staff/teacher and parent survey to measure satisfaction and outcomes of trainings/workshops.

**OUTCOMES**

<table>
<thead>
<tr>
<th>Seneca Family of Agencies</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide trainings for school staff on topics TBD related to social-emotional wellness of students</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>3-4</td>
<td>3</td>
</tr>
<tr>
<td>90% of participants will report that these workshops helped them to better support the learning and health and wellness needs of students and caregivers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>100% of school staff, administrators and onsite providers will be trained on COST referral process</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100%</td>
<td>100% (N=123)</td>
</tr>
<tr>
<td>90% of staff will report that they agree or strongly agree that when they have a student who needs extra support they know the process for seeking that support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>90%</td>
<td>93% (N=114)</td>
</tr>
<tr>
<td>COST Team will demonstrate improvement in at least 3 areas of the COST rubric (rubric ratings determined collectively by COST team)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>27</td>
</tr>
</tbody>
</table>
### Data Collection Method

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY 16/17</th>
<th>FY 17/18</th>
<th>FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>9</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>18</td>
</tr>
<tr>
<td>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>18</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by program and the individual’s first in person appointment with the PEI funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Total referrals to other mental health services or resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
</tbody>
</table>

### Performing Stars

<table>
<thead>
<tr>
<th>Performing Stars</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth will receive individual case management/mentoring services</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>15</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Youth will receive mentoring and social skills groups</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>15</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Caregivers/family members will participate in an educational workshop at Bayside/MLK. Examples of workshops include how to manage parenting stress, how to help child with school work, etc.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>10</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Youth and family members will participate in cultural awareness/community building event</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Clients receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>100% N=72</td>
</tr>
</tbody>
</table>
### Outcomes

#### Sausalito Marin City School District/MCCSD

<table>
<thead>
<tr>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 interns will provide Individual and group counseling services at Bayside MLK for 2-3 days per week each (8 hrs./day)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>Southern Marin providers and community members receiving behavioral health education, information about Community Connector (CC) services</td>
<td>30</td>
<td>30+</td>
<td>30</td>
<td>20</td>
<td>N/A</td>
</tr>
<tr>
<td>Students/families receiving outreach, engagement, referral services from CCs</td>
<td>40</td>
<td>40+</td>
<td>40</td>
<td>22</td>
<td>N/A</td>
</tr>
<tr>
<td>Students/families receiving support, advocacy and coordination services from CCs</td>
<td>25</td>
<td>26</td>
<td>150</td>
<td>157</td>
<td>N/A</td>
</tr>
<tr>
<td>40 students with mild to moderate mental health concerns will receive at least 3 sessions of individual CM or group counseling.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>40</td>
</tr>
<tr>
<td>Youth/families receiving support services from interns achieving at least 40% of the goals in their action plan. <em>Case records</em></td>
<td>60%</td>
<td>40% N=26</td>
<td>60%</td>
<td>40% N=17</td>
<td>40%</td>
</tr>
<tr>
<td>Caregivers receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Caregiver Survey)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100% N=10</td>
</tr>
</tbody>
</table>

*Data Collection Method

#### Outcomes

#### Shoreline School District/CHA

<table>
<thead>
<tr>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>School staff participating in trainings reporting awareness of risks, signs, and symptoms of children</td>
<td>80%</td>
<td>83% N=18</td>
<td>80%</td>
<td>100% N=5</td>
<td>80%</td>
</tr>
<tr>
<td>Metric</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Students participating in Social Emotional Learning curriculum</td>
<td>250</td>
<td>257</td>
<td>125</td>
<td>75</td>
<td>185</td>
</tr>
<tr>
<td>Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling</td>
<td>40</td>
<td>43</td>
<td>25</td>
<td>73</td>
<td>25</td>
</tr>
<tr>
<td>Students (or parents of) receiving at least 3 sessions reporting improvement on the SDQ or PEI survey (emotional problems, conduct problems, hyperactivity problems, peer problems and/or socialization)* (PEI Survey)</td>
<td>65%</td>
<td>84%</td>
<td>65%</td>
<td>81%</td>
<td>65%</td>
</tr>
<tr>
<td>Students completing at least 3 sessions showing improved attendance or improved school performance* (PEI Survey)</td>
<td>65%</td>
<td>86%</td>
<td>65%</td>
<td>84%</td>
<td>65%</td>
</tr>
<tr>
<td>Parents completing at least 3 sessions family counseling</td>
<td>20</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>N/A</td>
</tr>
<tr>
<td>Parents whose child received 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* (PEI Survey)</td>
<td>65%</td>
<td>75%</td>
<td>65%</td>
<td>71%</td>
<td>65%</td>
</tr>
<tr>
<td>Caregivers receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Caregiver Survey)</td>
<td>75%</td>
<td>90%</td>
<td>75%</td>
<td>86%</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BPRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Data Collection Method

<table>
<thead>
<tr>
<th>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time in weeks between when a referral was given to individual by program and the individual’s first in person appointment with the PEI funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to other mental health services or resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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*Data Collection Method*

<table>
<thead>
<tr>
<th>Youth Leadership Institute</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25-45 youth leaders and 2 adult allies will participate in the YLI program</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>25-45</td>
<td>44</td>
</tr>
<tr>
<td>Students participating in the program will report that the program helped them form relationships with adults and peers* <em>(Youth Development Survey).</em></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>80%</td>
<td>94% N=34</td>
</tr>
<tr>
<td>Students participating in the program will report that they feel more prepared to take action in their community* <em>(Youth Development Survey).</em></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>80%</td>
<td>97% N=34</td>
</tr>
<tr>
<td>Students participating in the program will report that the program gave them the opportunity to build their leadership skills* <em>(Youth Development Survey).</em></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>80%</td>
<td>97% N=34</td>
</tr>
<tr>
<td>Students participating in the program will report that they can make a difference and feel more connected to their community * <em>(Youth Development Survey).</em></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>75%</td>
<td>100% N=34</td>
</tr>
</tbody>
</table>
### CHALLENGES AND UPCOMING CHANGES

In **FY2018-19**, there were several additions to the school-based PEI programs. At Bayside MLK in Marin City, Performing Stars was awarded a contract to provide school-based mentoring services and Seneca Center Family of Agencies received a contract to implement its Unconditional Education model. 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. 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**. Due to difficulty

<table>
<thead>
<tr>
<th>Data Collection Method</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>90%</th>
<th>100% N=215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff that participated in LGBTQ Competency Training reported having a better understanding of how the school can better support LGBTQ+ students</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>90%</td>
<td>100% N=215</td>
</tr>
<tr>
<td>Students reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Survey)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100% N=34</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Unknown</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by program and the individual’s first in person appointment with the PEI funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to other mental health services or resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
</tbody>
</table>

*Data Collection Method

\(N = \text{the total number in the sample (i.e. total number who received services or completed a survey)}\)
filling the UE Coach position through Seneca at Bayside MLK, some of the deliverables were not met. However, despite the vacancy, Seneca was successful in implementing the COST system, conducted several well-received trainings for staff and supported significant positive shifts in school climate.

In FY 2019-20, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 for the first part of the year until services were impacted by COVID-19. All positions are currently filled as Seneca has recently hired the UE coach.

During the 19/20 FY, additional one-time funds were added to the following programs to support school-aged youth: the Spahr Center received 20k to create additional training and consultation for school staff around supporting LGBTQ youth; North Marin Community Services received an additional 50k to provide counseling services through their existing graduate intern program to elementary and middle school students in Novato Unified; Huckleberry Youth Programs received an additional 35k to provide behavioral health assessment, referral and support for youth referred for substance use infractions. With COVID, services with students and families via phone and Zoom and staff trainings and Coordination of Services Team meetings continued through Zoom. PEI school-based providers also created an online support system and hub for resources and worked with community partners to secure food, supplies, rent other basic needs for families in need of emergency assistance.

Continued or expanded funding will be determined by the MHSA Three Year planning process for FY2020-21 through FY2022-23 and the results of subsequent Requests for Proposals. Seneca, Performing Stars, Coastal Health Alliance, North Marin Community Services and the Sausalito Marin City School District were awarded contracts.

CLIENT STORY

Client Story 1: The Coastal Health Alliance PEI provider engaged a middle school student who presented with self-harm and suicidal ideation in counseling services. With individual counseling services within the school and a referral to ACCESS for more intensive services within Marin County Health and Human Services, the student was able to finally talk about their struggles with their sexual orientation and gender identity which have been the root of this student’s distress for several years. Though the student has yet to come out to their family and friends, the student no longer feels alone. The PEI Counselor connected the student with the Gender Spectrum Pre-Teen Group so the student could chat online with similar others and feel connected and supported. At the end of the school year, the student wrote the PEI Counselor a letter expressing their gratitude for the support received throughout the year.

Client Story 1: In the YLI program for Latino immigrant youth, a participant who started off the year reserved and quiet, did not engage much in the programmatic discussion. However, as he built relationships with the adult allies and connected with the other participants, he began to open up and became much more confident. Over the course of the year, he became more open to taking risks and trying new things, including practicing his English. Alongside a few of his peers, he attended Immigration Day in Sacramento. They were able to meet with Senator McGuire and he was the one to describe the programming and talk about the work of the group. He began engaging in school activities, such as wrestling and summer camp and expressing a new interest in school and desire to learn more. With the support and strength of his relationship with the adult advisors, he is willing to say yes to new opportunities. To ensure his continued development, YLI staff is working to create additional opportunities for him to grow next year.
VETERAN’S PREVENTION AND EARLY INTERVENTION (PEI 19)

PROGRAM ALLOCATION FY18-19: $73,000

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

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.

SUMMARY FY2018-19

162 Individuals

19 Families

13 permanently housed

181 reached through Outreach/Training
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 and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services
- In FY 18/19, Marin County BHRS implemented a new client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers were asked to administer this ten-question survey to clients and caregivers if applicable.

**Anticipated data collection changes and additions for FY 19/20:** No changes anticipated for the upcoming FY.

**OUTCOMES**

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal FY 16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>Number of family members that received services to increase their capacity to support the client</td>
<td>N/A</td>
<td>N/A</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>75% of veterans receiving support achieved at least one goal towards stability and recovery</td>
<td>N/A</td>
<td>N/A</td>
<td>75%</td>
<td>80%</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Clients receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Survey)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Number of individuals followed through referral &amp; engaged in a PEI-funded program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total referrals to other mental health services or resources for basic needs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>157</td>
</tr>
</tbody>
</table>

**CHALLENGES AND UPCOMING CHANGES**
In FY2018-19, the Veteran’s program was implemented as expected. There were challenges in identifying veterans amongst the growing population of homeless. The Veteran’s program collaborated with coordinated entry to help identify veterans, prioritize them and implement a housing first program. Another challenge was the ‘impending homeless’ population that is at risk of needing to move because of the increasing rents with elderly people on a fixed income.

In FY 2019-20, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 for the first part of the year until services were impacted by COVID-19. With COVID, the Veteran’s Case Manager worked remotely to support individuals looking for shelter/housing, linking veterans to emergency rental assistance programs, and working with other community providers to coordinate services for veterans in need of additional resources. Several veterans were successfully housed through these collective efforts.

Continued funding was determined by the MHSA Three Year planning process for FY2020-21 through FY2022-23. The Veteran’s program will continue to be funded through HHS as it was in the previous 3-year plan.

CLIENT STORY

Mr. S had been a homeless fixture for years in San Rafael. He was first brought to the attention of the PEI provider by an outreach worker with San Rafael Police Department. She had called the PEI provider on three different occasions over the last 8 months to ‘pick up’ Mr. S and take him to a treatment facility but by the time the PEI Provider could arrive to meet with him, he would change his mind and decide not to participate in treatment. He would present with hyperverbal, circumstantial speech, most likely due to methamphetamine use. Mr. S is likely a poly-substance abuser who appears well beyond his actual age. One day, Mr. S was taken to the VA clinic and diagnosed with a heart arrhythmia. This was startling news for him and it compelled him to address both his health and his homelessness. After this incident, the PEI Provider began meeting with Mr. S each week and building rapport with him in an attempt to refer him to a recovery program. After a month of providing him support and connecting him to resources, Mr. S indicated he wanted to get off the street and was willing to go into a Shelter. The plan is to proceed with finding him permanent housing through Coordinated Entry.
STATEWIDE PREVENTION AND EARLY INTERVENTION (PEI 20)

PROGRAM ALLOCATION FY18/19: $80,986

PROGRAM OVERVIEW

In FY2018-19, 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 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**


**CHALLENGES AND UPCOMING CHANGES**

In **FY2018-19**, this PEI program was implemented as expected. CalMHSA materials were distributed at over 30 events/trainings and disseminated to schools, providers community members and county staff. BHRS staff participated in learning collaboratives and webinars offered by CalMHSA and received valuable technical assistance around developing a Suicide Prevention Strategic Plan.

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. BHRS continues to receive technical assistance and consultation from CalMHSA staff around the development of a Suicide Prevention Strategic Plan.
SUICIDE PREVENTION (PEI 21)

PROGRAM ALLOCATION FY18-19: $200,000

PROGRAM OVERVIEW

Suicide Prevention efforts have been addressed within the Statewide Prevention and Early Intervention Program (PEI-21) through CalMHSA since the inception of PEI. 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.

In FY 18/19, BHRS also began a Suicide Prevention Strategic Planning process to determine the gaps in existing suicide prevention services and the highest priorities. Resource Development Associates was selected through a competitive bidding process to conduct the needs assessment and strategic planning process.

PROVIDER: Buckelew Programs: Hotline and Training
Resource Development Associates (RDA): Suicide Prevention Strategic Plan

TARGET POPULATION

The Buckelew hotline aims to serve callers with suicidal ideation or experiencing a crisis that might escalate to self-harm. In FY20187-19, unduplicated callers were 0-15 (7%), 16-24 (19%), 25-59 (30%), 60-74 (4%), and 75+ (2%).

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:

- **6424** Hotline Calls
- **219** Families
- **959** reached through Outreach/Training
• **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 FOR BUCKELEW PROGRAMS**

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.

- The number of callers and caller demographics (see PEI overview section-). In FY 18/19 demographics were collected for 985 callers (15% of callers) and 219 families.

- Referral data to show improved recovery through access and linkage to services.

- **86% of callers surveyed reported lower suicidal intent by the end of the call.**

- **Almost 1000 community members were trained on Suicide Prevention**

- **100% of training participants surveyed reported that the community education training on suicide**
**Anticipated data collection changes and additions for FY 19/20:** Training and Education: Buckelew anticipates implementing an additional pre and post assessment of training and education participants to measure change in skills and knowledge of suicide prevention. The Hotline: Buckelew is exploring implementing a telephone satisfaction survey system and creating an online evaluation form for easy completion.

**OUTCOMES**

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal FY16/17</th>
<th>Actual FY 16/17</th>
<th>Goal FY 17/18</th>
<th>Actual FY 17/18</th>
<th>Goal FY 18/19</th>
<th>Actual FY 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls to hotline originating in Marin County</td>
<td>6-8000</td>
<td>6,000+</td>
<td>6-8000</td>
<td>6,733</td>
<td>6-8000</td>
<td>6,424</td>
</tr>
<tr>
<td>Callers who express a reduction in level of suicidal risk by 1 level or maintain Low (Low, Medium, High)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>97% (N=904)</td>
<td>80%</td>
<td>86% (N=984)</td>
</tr>
<tr>
<td>Agencies receiving suicide prevention campaign materials</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>21</td>
<td>20</td>
<td>20+</td>
</tr>
<tr>
<td>Community members receiving training that report they can describe suicide warning signs (agree/strongly agree)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50%</td>
<td>99% (N=189)</td>
</tr>
<tr>
<td>Community members receiving training that feel prepared to help a friend/loved one who is feeling suicidal or in a crisis situation (agree/strongly agree)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50%</td>
<td>94% (N=189)</td>
</tr>
<tr>
<td>Community members receiving training that can describe the work of Buckelew Suicide Prevention Hotline and Program (agree/strongly agree)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50%</td>
<td>77% (N=189)</td>
</tr>
<tr>
<td>Training participants that would recommend the training to a friend or loved one (agree/strongly agree)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50%</td>
<td>66% (N=189)</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>53</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
</tbody>
</table>
CHALLENGES AND UPCOMING CHANGES

In **FY2018-19**, the Suicide Prevention program was implemented as expected overall. In **FY2018-19**, in addition to providing the 24/7 hotline, Buckelew significantly ramped up its outreach efforts and trainings with the hiring of a new Outreach Coordinator.

The hotline faced couple of challenges during 18/19. As the hotline is staffed 24/7, maintaining a full roster of trained volunteers requires constant marketing of the program to the community. During FY 18/19, the hotline also faced the usual and expected challenges of a telephony-based service: understanding what the caller is saying when they are extremely upset, driving, distracted, outside in the wind, and callers with mental health issues, extreme anger, confusion or substance use.

In FY 18/19, 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 community convenings. The Suicide Prevention Plan was released in January, 2020. The priorities that are identified through the strategic planning process will be implemented in **FY2019-20** and outlined in the next annual update. Additional one-time funding was added for FY2019-20 to implement these findings.

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 and evaluation results for these trainings are provided in the “Community and Provider Prevention and Early Intervention Training (PEI 12)” section of this report.

In **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2017-18** through **FY2019-20** for the first part of the year until services were impacted by COVID-19. With COVID, the hotline continued without disruption with a fluctuation in numbers of calls from March through June. Hotline volunteers identified an increase in caller anxiety, fear about job loss, caring for children and general concerns about COVID-19 and its impact on their family and health.

Continued funding was determined by the MHSA Three Year planning process for **FY2020-21** through **FY2022-23**. The Buckelew Hotline will continue to be funded through HHS as it was in the previous 3-year plan.

CLIENT STORY

Caller Jane Doe called so upset at first that she was gasping for breath. The counselor Beth gently made a warm connection, encouraging her to take her time, stop to breathe, and praised her for reaching out. When she was able to talk, Jane said she’d just had a fight with her boyfriend. They live together, but he

| Total referrals to other mental health services or resources for basic needs | N/A | N/A | N/A | N/A | N/A | 46 |
left the house angrily saying he’d move in with his brother. This is the third fight they’ve had this week. Beth made sure Jane was physically ok – yes, the arguments are verbal and never get physical. There are serious financial problems this month and they don’t have enough for the rent. This is the first time they both are living independently – both are age 19. Jane is exhausted, hasn’t been eating or sleeping well the whole week. She feels rejected and abandoned, is hurt but also angry. She had sudden thoughts of suicide, got scared and called the hotline. Beth was able to slow things down. First, she assessed Jane’s safety level, asking about her thoughts, any preparations for suicide or plan, any prior attempts. Fortunately, there was only suicidal ideation. Together they unpacked Jane’s concerns so that they didn’t seem so overwhelming. Beth worked as a facilitator to help Jane identify resources, both emotional and financial. Fortunately, Jane’s parents will be willing and able to help. Beth explored Jane’s reluctance to tell, the embarrassment, the desire not to be a burden, the stigma involved in admitting to having thoughts of suicide. They made a plan to keep Jane safe, to prepare to make a fresh start with her boyfriend, to lean on her personal resources to call Mom, and to also take advantage of the counseling resources available to her.
HEALTH NAVIGATOR (PEI 22)

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 field-based 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.

PROGRAM DESCRIPTION

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

A Health Navigator is 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 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

In FY 18/19, this position went back to the Board of Supervisors and was successfully reclassified as a Bilingual (Spanish) position however it was not filled in FY18/19 due to the long hiring process. Therefore, no outcome data is available as no clients were seen in FY18/19. 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). As of September, 2019, the position has been filled. Outcome data will therefore be provided in the 19/20 annual update.

CHANGES FOR FY20/21

This position has been moved to CSS Community Outreach and Engagement in the new Three-Year Plan.
Innovation (INN) FY18/19 Outcomes

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 FY18/19 Marin had two approved Innovation Projects (Growing Roots: The Young Adult Services Project and the Older Adult Technology Project). There was one prior Innovation Project (Client Choice and Hospital Prevention), but this project had wrapped up prior to the FY18/19 fiscal year. That project resulted in the development of Casa René, which is now thriving in the Crisis Continuum of Care funded through CSS.
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.
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](http://www.marinhhs.org/innovation).

ACTUAL OUTCOMES

The Innovation Plan has was successfully implemented and led by the TAY Advisory Council. The following providers were selected by the council and awarded contracts. These contracts were in place for all of FY18/19 and you can read reports on the outcomes and work of each providers in the full Growing Roots evaluation report in the Appendix.

<table>
<thead>
<tr>
<th>Integrated Community Services</th>
<th>Target Population: Individuals with diagnosed disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services: Employment services, social groups, independent living skills, mental health and substance services. Some of the services are provided by peers</td>
</tr>
<tr>
<td>Young Moms Marin</td>
<td>Target Population: Young mothers, their children and partners</td>
</tr>
<tr>
<td></td>
<td>Services: Support group, individual case management, linkages to resources, and life skills</td>
</tr>
<tr>
<td>The Spahr Center</td>
<td>Target Population: LGBTQ+ community</td>
</tr>
<tr>
<td></td>
<td>Services: Support groups, especially in high schools; social connection activities; leadership opportunities</td>
</tr>
<tr>
<td>Marin Asian Advocacy Project</td>
<td>Target Population: Asian immigrants, children of immigrants</td>
</tr>
<tr>
<td></td>
<td>Services: Mindfulness and psycho-education workshops and retreats</td>
</tr>
</tbody>
</table>
### 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 8.

The outcomes of the project were as follows:

<table>
<thead>
<tr>
<th>1: Integrate informal system of care with the formal behavioral health system of care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finding 1.1:</strong> The Growing Roots project increased awareness of the formal system of care amongst informal providers and TAY participating in the Growing Roots project.</td>
</tr>
<tr>
<td><strong>Finding 1.2:</strong> Informal providers participating in the Growing Roots project reported increased capacity to implement behavioral health best practices, recognize escalating mental health needs, and incorporate enhanced data and evaluative processes.</td>
</tr>
<tr>
<td><strong>Finding 1.3:</strong> Service coordination between the formal and informal system of care was reported as a challenge due to a lack of a formalized referral process between the two systems.</td>
</tr>
<tr>
<td>2: Improve access to culturally competent behavioral health services for populations at risk of or experiencing mental health challenges.</td>
</tr>
<tr>
<td>Finding 2.1:</td>
</tr>
<tr>
<td>Finding 2.2:</td>
</tr>
<tr>
<td>Finding 2.3:</td>
</tr>
</tbody>
</table>

3: Improve outcomes for TAY at risk of or experiencing mental health challenges

| Finding 3.1: | TAY reported that through program participation, they developed and strengthened protective factors such as belonging to a community of peers and gaining basic/life skills. |
| Finding 3.2: | TAY reported developing several positive behaviors and skills as result of participating in the program such as healthy coping skills, increased behavioral health literacy and overall improved self-esteem, self-belief, goal-oriented behaviors. |

4: Identify key elements identified that led to program success

| Finding 4.1: | Growing Roots providers are successful in supporting TAY from underserved populations through providing youth-centered, population-focused services delivered by program staff who demonstrate genuine care. |
| Finding 4.2: | The participation and leadership of the TAY Advisory Council played an essential role in understanding the needs and challenges of TAY from underserved populations in Marin County. |
| Finding 4.3: | Customized training and ongoing, flexible support for informal providers and TAY were essential for leveraging existing strengths and developing additional capacity to serve TAY. |
### DEMOGRAPHIC INFORMATION

**Total number of Youth/TAY completed surveys = 477**

#### Race of TAY Participants

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of Indiv.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexican/Mexican-American/Chicanx</td>
<td>78</td>
<td>20%</td>
</tr>
<tr>
<td>Central American</td>
<td>67</td>
<td>17%</td>
</tr>
<tr>
<td>Eastern European</td>
<td>61</td>
<td>15%</td>
</tr>
<tr>
<td>African</td>
<td>52</td>
<td>13%</td>
</tr>
<tr>
<td>More than one ethnicity</td>
<td>34</td>
<td>9%</td>
</tr>
<tr>
<td>Decline to answer</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>El Salvadorian</td>
<td>16</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>South American</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Filipino</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

#### Preferred or Primary Language

<table>
<thead>
<tr>
<th>Language</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>86%</td>
</tr>
<tr>
<td>Spanish</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1%</td>
</tr>
</tbody>
</table>

n=467
### Gender Identity

- Female: 49%
- Male: 42%
- Female-to-Male (FTM)/Transgender Male: 4%
- Genderqueer/Gender nonconforming: 3%
- Another gender identity: 1%
- Decline to answer: 1%

*n=454*

### Sexual Orientation

- Heterosexual / Straight: 69%
- Bisexual: 8%
- Gay or Lesbian: 7%
- Decline to answer: 7%
- Questioning / unsure of...: 3%
- Queer: 3%
- Pansexual: 2%
- Another sexual...: 1%

*n=445*

### Frequency of Type of Disability/Difficulty Reported by Participants

- Difficulty seeing: 38
- Learning disability: 36
- Decline: 34
- Other disability or health condition: 27
- Difficulty hearing or w/ speech: 11
- Chronic health condition: 9
- Developmental disability: 5
- Limited physical mobility: 3

102 discrete individuals (21%) reported having at least one disability / difficulty.

### ZIP Code of Participants

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>94930</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>94956</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>94937</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>94973</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>94904</td>
<td>11</td>
<td>2%</td>
</tr>
<tr>
<td>94960</td>
<td>14</td>
<td>3%</td>
</tr>
<tr>
<td>94945</td>
<td>22</td>
<td>5%</td>
</tr>
<tr>
<td>94903</td>
<td>23</td>
<td>5%</td>
</tr>
<tr>
<td>94949</td>
<td>26</td>
<td>6%</td>
</tr>
<tr>
<td>94947</td>
<td>31</td>
<td>7%</td>
</tr>
<tr>
<td>94941</td>
<td>48</td>
<td>11%</td>
</tr>
<tr>
<td>94965</td>
<td>51</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>57</td>
<td>12%</td>
</tr>
<tr>
<td>94901</td>
<td>143</td>
<td>31%</td>
</tr>
<tr>
<td>Total</td>
<td>457</td>
<td>100%</td>
</tr>
</tbody>
</table>
OLDER ADULT TECHNOLOGY SUITE INNOVATION PROJECT

PROGRAM OVERVIEW

The Help@Hand Project is a multi-county/city Innovation project designed to determine if and how technology fits within the behavioral health system of care. Help@Hand will provide support for Marin County older adults to access wellness apps and digital literacy training through 2023. The intent of this five-year project in Marin is to understand if and how digital technology resources may support the wellness of older adults, particularly those who are socially isolated. Digital behavioral health is a rapidly emerging field, with over 10,000 apps in development and a robust evidence base showing that digital self-care technology has the potential to impact depression, anxiety and loneliness for a broad range of populations.

Each county involved is trying to reach a unique unserved or underserved population. During the FY2017-20 Three-Year Planning process and public comment period, stakeholders identified a need for additional mental health resources to support the growing older adult community in Marin County, particularly those who are isolated, often due to lack of access to transportation, physical limitations, anxiety or depression, loss, or for fear of stigma related to mental illness or cognitive impairment. The Innovation proposal was developed based on a nine-month community planning process (November 2018- August 2019) involving community members, providers and other stakeholders Marin County is therefore focused on identifying an application and developing training curricula focused on meeting the needs of isolated older adults.
TARGET POPULATION

The target population for Marin is:

- Socially isolated older adults, including those experiencing or at risk of loneliness or depression (such as West Marin and other remote areas of the county)
- Older adults who are at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness
- Older individuals with mild to moderate mental health symptom presentations, including those who may not recognize that they are experiencing symptoms

PROGRAM DESCRIPTION

There are 4 key components of the project that Marin County is focused on are:

- **Identifying and selecting an app** for the older adult community: Marin has been conducting focus groups with older adults and meeting with an advisory committee to determine which behavioral health app would be the best fit for this population and to strategize around best approaches to engaging older adults and supporting their use of the selected app

- **Digital Behavioral Health Literacy Training**: The purpose of this component of is to help individual (older adults) improve knowledge, skills, and behaviors to effectively and safely use digital devices. Marin has contracted with a consultant that has experience here in marin in training older adults around the use of technology. This training around digital literacy is going to be rolled out in conjunction with training around use of the selected behavioral health application.

- **Peers**: Peers play an integral role with the project. The vision of the peer role is to incorporate peer input, expertise, knowledge and lived experience at all levels of the project and to support the use of the apps through peer outreach and training. Marin is in the process of hiring a peer lead to support this work.

- **Evaluation**: The collaborative and our Marin team has been working closely with the researchers from UC Irvine to develop evaluation tools and metrics.

EXPECTED OUTCOMES

The learning objectives for this project are to detect and acknowledge mental health symptoms sooner (in the older adult population), reduce stigma associated with mental illness by promoting mental wellness, increase access to the appropriate level of support and care, increase purpose, belonging, and social connectedness of individuals served, and analyze and collect data to improve mental health needs assessment and service delivery.

Outcomes include:

9. Increased social connectedness, belonging and purpose as measured subjectively by user
10. Reduction in symptoms of depression, anxiety and other mental health concerns
11. Increased ability to age-in-place, reduction in residential placements
12. Increased public awareness of mental illness in older adult population and reduction in stigma as measured by pre and post workshop evaluations
13. Whether users experience increases in quality of life, as measured subjectively by the user and objectively by engagement in social activities, community involvement, etc.
14. Decrease in utilization of emergency services as measured by hospital admissions data
15. Increased user ability to identify cognitive, emotional, and behavioral changes and actively engage in strategies to address them
16. Families report increased capacity to support their older adult family member as reported in online surveys and/or focus groups

FY18/19 ACCOMPLISHMENTS

Some highlights from the 18/19 fiscal year included:

- July 5th, 2018: Presentation to Marin County Commission on Aging
- July 10th- August 10th, 2018: 30-day posting on public website and in Marin Behavioral Health and Recovery Services locations and for public feedback
- August 14th, 2018: Public Hearing and presentation to the Mental Health Board
- August 21st, 2018: Presentation and anticipated approval by Marin County Board of Supervisors
- Mid-late September, 2018: Presentation and approval from the Mental Health Services Oversight and Accountability Commission.
- October, 2018: Marin formally join the collaborative project
- January, 2019: Hired contractor to manage project
- January-June 2019: Conducted focus groups with key stakeholders on 7 Cups to determine appropriateness, feasibility of application for older adult community

Initially 7 Cups was selected as the one of the two apps for the collaborative and the sole app for Marin County. Help@Hand learned that there needed to be more than one app to address the diverse needs of the project. There were also some significant safety concerns that emerged from the focus groups regarding 7 Cups. To introduce more technology options to the project, an updated RFSQ was launched in September 19, 2019. Marin County selected 4 apps to vet with focus groups and is currently in the process of narrowing down the app for final selection.
DEMOGRAPHIC INFORMATION

Older Adult INN Project Race/Ethnicity FY18/19, N=34
- African American/Black: 23%
- American Indian/Native Alaskan: 6%
- Asian: 12%
- Hispanic/Latino: 3%
- Multirace: 3%
- Other: 3%
- White/Caucasian: 50%

Older Adult INN Project Language FY18/19, N=34
- English: 85%
- other: 12%
- Vietnamese: 3%
Older Adult INN Project FY18/19 Gender, N=34

- Female: 29%
- Male: 71%

Older Adult INN Project FY18/19 Age Group, N=34

- 16-25: 3%
- 26-59: 23%
- 60 and older: 74%
COMMUNITY SERVICES AND SUPPORTS (CSS)
FY18/19 OUTCOMES

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 80% of the clients served identifying as Hispanic—eleven 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% 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.

![Diagram showing FY18/19 FSP Preferred Language](image-url)
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. In addition, outreach and engagement with this population is 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).
In FY18/19, 22.4% of the people who received Full-Service Partnership services were older adults—almost 7 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 25.4% of the FSP clients and only 13.8% of the Medi-Cal population.

Adults (26-59) were represented proportionately, with 42.6% of the FSP-served and 46.4% of the Medi-Cal population.
Youth (9.5% of those served by FSP programs) were under-represented as compared to their portion of the Medi-Cal population (15.9%). There were no children under 5 served in FSPs in FY18/19, however that demographic represents 8.2% of the Medi-Cal population.
YOUTH EMPOWERMENT SERVICES (YES) FULL-SERVICE PARTNERSHIP: FSP 01

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 FY18/19 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 up to 52 youth concurrently 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 FY18/19, the YES program served 95 unduplicated clients (up from 71 in FY17/18, 65 in FY16/17, and 42 in FY15/16). The demographic information on clients served in FY18/19 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=57), YES services helped decrease mental health emergency events from a total of 31 events to 7 events during the first year of service (a decrease of 77%). 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.

There was a 71% decrease in the number of arrests (from 16 of the 57 youth being arrested a total of 24 times during the year before they entered the Full Services Partnership, down to only 4 partners being arrested during their first year in the program for a total of 7 arrests). There was also a 66% decrease in psychiatric hospitalization days (for 15 clients in the year prior to joining the FSP spending 121 days in psychiatric hospitalization down to 5 clients spending a total of 41 one days in their first year after initiating services with the FSP). 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.

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.

In March 2019 the YES team received a full-time clinical supervisor and another Bilingual-Mental health practitioner. The expansion of positions allowed for YES to serve 60 youth and families concurrently, an increase from the previous fiscal year. During FY18/19 YES team clinicians provided school-based workshops for parents on gang violence and prevention, for staff on restorative justice practices, trauma-informed care, and facilitated groups for LGBTQ youth of Latinx heritage. The YES team has begun a conversation with Marin Community school (MCS), a non-traditional public school to explore alternative ways to provide therapeutic intervention from individual therapy. Incorporating different methods of service will provide more opportunity to address the growing needs of the school community and capacity limitations of the YES program.

In FY18/19 the YES team was trained in Assertive Community Treatment (ACT) in preparation for a county-wide push for higher fidelity across all Full-service partnerships. The team was particularly invested in this model for its team-oriented approach that promotes care coordination that enhances client experience and reduces staff isolation. Integrating this model prompted the exploration of relationships with partnering entities such as probation, schools, Seneca/Wrap around, and Peer partners. The YES team identified challenges around communication including differences in goals and
modalities which decreased cohesion across disciplines. The team participated in internal and external conversations to address challenges and increase coordination of care. These efforts resulted in better coordination of care, more referrals to partnering agencies and increased desire to collaborate. As the YES team continues to transition into an ACT model, high functioning partnerships across multiple disciplines and agencies will be essential to providing client centered community care. The YES team also participated in trainings on DBT, Conscious Non-violent parenting with AA families, Motivational Interviewing, Cultural Competency, Eating Disorders, supporting Commercially sexually exploited children (CSEC) in harm reduction, Reflective Supervision and Equity in Leadership to strengthen clinical capacity in addressing the diverse needs of clients.

CLIENT STORY FROM FY18/19

Veronica [name changed] is a 19-year old Latinx cisgender female residing with her family in Marin county. She came to the YES program after a hospitalization for a suicide attempt. Veronica struggled with severe substance addiction, social isolation, poor academic performance and challenges with sustaining healthy relationships. At the onset of services Veronica was also in the process of ending a long-term relationship with both emotional and physical abuse. She was partnered with a YES clinician for individual and family therapy. In individual therapy Veronica began exploring the motivation behind her substance use and identified and processed childhood trauma experiences. She learned how trauma was impacting her sense of safety within herself and in the world. Family therapy consisted of supporting Veronica and her mother in building empathy and attunement as well as addressing and healing trauma. Veronica developed helpful coping strategies that allowed her to improve school functioning, have different experiences with family members and romantic partners as well as refrain from returning to psychiatric hospitals. She has developed insight on her emotional capacity as well as her mother’s which has led to reduced challenges and more self-regulation. Currently, Veronica works part-time and is scheduled to graduate from high school in one semester. She wants to go to college and go into law enforcement. In addition to supporting Veronica, the YES team also supported 4 Latinx newly arrived young people processing challenges related to the newcomer experience, including trauma, family reunification, adjusting to different school and community structures, experiences of racism, classism and xenophobia. The YES team has supported 5 LGBTQ+ identified young people in addressing trauma, experiences of bullying, internalized homophobia, and maintaining safety when experiencing active suicidality. The team also supported young people in reducing shame by providing LGBTQ+ affirming care. Two African American young people were referred to a lower level of care due to a reduction in symptom severity after receiving services through the YES team. Services included but were not limited to issues related to experiences of discrimination, institutionalized racism and trauma.
TRANSITION AGE YOUTH (TAY) FULL-SERVICE PARTNERSHIP: FSP 02

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.

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 FY18/19 in the TAY FSP is included in the FSP Demographics section at the beginning of the CSS chapter.

There were 24 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 24 clients collectively spent 40 days homeless, 146 days in psychiatric hospitalization, and 0 days incarcerated. In their first year in the FSP, there they spent 0 days homeless, 169 days in psychiatric hospitalization, and 0 days incarcerated, for a 12% 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.

<table>
<thead>
<tr>
<th>Outcomes FY18/19</th>
<th>Goal</th>
<th>Actual FY18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients served:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• FSP</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>• Partial/drop-in</td>
<td>45</td>
<td>53</td>
</tr>
<tr>
<td>FSP clients engaged in work, vocational training or school.</td>
<td>70%</td>
<td>81%</td>
</tr>
<tr>
<td>FSP clients engaged in activities designed to improve independent living skills.</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>FSP clients screened for substance use.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Clients identified as having substance use issues that receive substance use services.</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

### 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, 2018–June 30, 2019 we offered drop-in activities everyday Monday through Friday, except on major holidays- (268 actual days). We served a total of 89 unduplicated drop-in clients, meeting this objective. A total of 1,565 actual drop in visits, (1,046 FSP’s and 519 partial clients).

This year there were 20, (55%) out of the enrolled 36 clients who attended at least two activity groups per month at the drop-in center. Attendance dropped this year in the drop-in center from 5.3 FSPs per day to 3.9 FSP per day. We saw a 15% increase in FSP clients attending school, work or a combination of work/school which could be a reason why the drop-in numbers are down as more clients engage in work/school.

This year 6 partial clients attended at least two activity group per month this fiscal year. The average of these six youths attending is, 46 activity groups. Of the 89 unduplicated youth that came to the drop-in center and engaged in an activity group, only 11 youth only came once. We also saw an increase in graduated FSP clients, (13), coming back to the drop-in center for activities, help with their taxes and other financial forms, checking in with staff about symptoms management, help with replacing documents, housing support and attending holiday celebrations.

#### School and Work Engagement:

School and Work Engagement Objective: **By June 30th, 2019, 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 our youth in school and work settings to increase client functioning and their ability to be self-supporting and engaged in their communities. The total of FSPs engaged in either work, school/vocational program was above our targeted goal of 70% with 85%. Of the 36 FSPs served the actual breakdown is:

- 7 FSPs (19%) engaged in school
• 17 FSPs (47%) were engaged in work
• 7 FSPs (19%) were engaged in work/school
• 7 FSPs (19%) were not engaged in either school or work

Partnerships with several other Marin County providers enabled us 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 Dept, and Novato Adult Education allowed our 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 Dept of Rehab also gave our clients the extra guidance and support needed during employment. Three of our clients are young mothers that have a total of four children under the age of 5. Two of these young mothers work and one is in the process of starting Adult Ed at night to become an EMT. TAY offers help with studying techniques, resume writing, mock interview groups, interview clothing & help with transportation to school and work.

Of the 7 clients that are neither in school or working, 6 have acute psychiatric conditions that make it difficult for them to function consistently in either educational or work settings. Six of the clients that don’t work or go to school, come to the drop-in center at least once a week to connect with peers and staff and engage in activities to improve social skills.

**Independent Living Skills:**

Independent Living Skills (ILS) Objective: By June 30th, 2019 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. We made a shift during the end of 2018 and began having a newly hired AOD counselor be assigned the Clinical Case Manager of 4 clients that have substance use disorder as part of their diagnosis. We also offered a weekly Recovery group open to all TAY clients and other youth in the community. All clinical case managers are able to administer the drug/alcohol screenings for our 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 in collaboration
with the AOD counselor and the clinical team can better bring focus/attention to substance use issues as an integrated rather than separate part of the service delivery.

TAY Housing Resource:

TAY Housing Resource objective: Maintain full occupancy of the TAY apartment (two FSPs) 80% of the time during FY18/19.

Results: Goal fell below the goal of 95% with the apt being occupied 266 days by two youth (73%), 78 days occupied by 1 youth and the apartment was vacant for approximately 20 days while repairs and painting were completed. The apt was occupied by a total of 5 different youth in the fiscal year 2018-2019. The Marin TAY apartment continues to be an excellent resource and training ground for independent living for our FSPs 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 FSPs 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.

AREAS OF FOCUS IN FY18/19:

This year TAY FSP saw a dramatic increase in the number of our youth, that have graduated, (10+) coming back to the drop-in center for help with independent living skills, housing resources and help, job training skills, obtaining food and help with educational resources and applications for financial aid. We even had 5 youth return for our tax preparations days in March. The relationships that clients, staff and clinicians make here at TAY remains strong even after clients have graduated and moved on.

This year we had 5 different FSP TAY live in the apartment during the fiscal year 2018-2019. Two of the youth moved out after 1+ years, 1 youth lived for 6 months and 2 other youth moved in during the spring of 2019. When youth leave the apartment, the money that they have contributed each month is returned to them to help with costs associated with their next housing opportunity.

Referral Process: This September 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 must go to the Access Team for assessment, evaluation and referral to the TAY Space FSP Program. TAY Space staffs 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 our census has been steadily increasing above the stated caseload of 24.

This past year we continue to collaborate with many exceptional organizations and other providers to provide out youth with as many opportunities and services they can benefit from.

We have established relationships with Golden Gate National Parks Ranger Outreach Program. Working closely with Ranger Jasmine, we were able to offer unique and exciting trips to Marin Headlands, Bonita Lighthouse, Muir Woods, Rodeo Beach, Lands’ End Hike and many other
outdoor adventures. For many of our clients, this was their first experience exploring the national parks in our area. These unique opportunities allow our 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.

In Jan 2019 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, we were able to determine where homeless youth stay during the night and during the day which is very different than the older homeless population in Marin. As an agency, we are deeply committed to working with local community members to address the growing number of homeless TAY age youth in Marin. Participating in both the Coordinated Entry Planning Committee and now having a voting seat on the Homeless Policy Steering Committee have given us the unique ability to contribute to establishing policies and procedures that affect the TAY homeless population in Marin. We are excited to be a part of this exceptional group of county providers working together to address the homeless situation in Marin.

This past year, we have had the pleasure of having Mark Parker, BHRS Peer Counselor, join us on three days each week to support TAY youth with WRAP plans. Mark also leads a group on Tuesdays “Thriving Together Peer Support Group”. This is a very important and well attended group that focuses on individuals recovering from a severe mental illness. We are so appreciative of Mark’s contribution to TAY and look forward to working with him in the next fiscal year.

A frequent request we receive from our youth is for help with obtaining basic food and hygiene products. We have partnered with Extra Food of Marin and receive deliveries of sandwiches, salads and individually prepackaged food items. We notify clients when a delivery has been made and clients can come shop for food or hygiene items they need. We also partner 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. We also offer 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.

**CLIENT STORY FROM FY18/19**

*When Emily (name changed) was admitted into the TAY program over two years ago, she had just been discharged from a psychiatric hospital. She had goals of going to school, volunteering, managing symptoms, and creating meaning in her life, along with developing healthy relationship skills such as assertive communication, boundary setting and increasing self-esteem. Over one year later, she has learned coping and CBT strategies to move forward, and ultimately, she was able to leave her abusive relationship, reconnect with siblings/family and feel “relief and freedom.” She reported that “taking steps toward leaving an abusive relationship was equivalent to climbing Mt Everest,” but one small baby step at a time and with the slow growth of her self-worth, the support of family and TAY staff, she was able to leave. Emily is now experiencing a newfound freedom from many of her symptoms, her mental health has significantly improved, and her daily suicidal ideation is non-existent. She is more open to learning ways to manage all of her symptoms and has expressed more happiness over the past few weeks than in the past 4 years. Here at TAY, we couldn’t be more proud of the effort and determination she has shown to utilize new skills to manage her mental health challenges, move beyond her mental illness and feel freedom and success.*
SUPPORT AND TREATMENT AFTER RELEASE (STAR) FULL-SERVICE PARTNERSHIP: FSP 03

PROGRAM ALLOCATION FY18/19: $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 with contracts for additional support

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. In the new Three-Year plan this has been expanded and moved to the new general system development program called “Stepping-Up.”

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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in arrests</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in incarceration</td>
<td>80%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>40%</td>
</tr>
</tbody>
</table>
**ACTUAL OUTCOMES**

In FY18/19, the STAR Program served 53 individuals who had serious mental illness and significant criminal justice involvement. The demographic information on clients served in FY18/19 in the STAR FSP is included in the FSP Demographics section at the beginning of the CSS chapter.

43 individuals were enrolled in STAR for at least 1 year who could thereby have a full comparison year to the baseline. The number of days clients spent homeless was reduced by 45%, days spent incarcerated was reduced by 69%, and days psychiatrically hospitalized was reduced by 55% compared to the baseline year. Arrests and mental health emergency events were both decreased by 84%.

In FY18/19 two new groups were offered for clients: *Compassion and Commitment* and *Mental Health Psycho-education*.

**SUCCESSES IN FY18/19**

STAR successfully increased the scope and services offered through our STAR Community Program. We increased the number of clients served and have really focused on developing more community partnerships, increasing outreach, and implementing processes that continually support diversity and cultural factors here in Marin. We have also focused on reviewing and refining our psychiatric approaches and programming for both STAR Court clients and those in the STAR Community Program.

**CLIENT STORY FROM FY18/19**

*We have had approximately 8 clients graduate from the STAR Court this past calendar year. Of these 8 graduates, 6 of them are now employed and/or are attending college courses. The other 2 clients are still working closely with our STAR Team staff and have not had any psychiatric or legal issues since graduating. The clients are amazing!*
HELPING OLDER PEOPLE EXCEL (HOPE) FULL-SERVICE PARTNERSHIP: FSP 04

PROGRAM ALLOCATION FY18/19: $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 overarching 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.
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.

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<thead>
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<tr>
<td>Decrease in homelessness</td>
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</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>50%</td>
</tr>
</tbody>
</table>

FSP OUTCOMES FY18/19:

The HOPE program served 55 clients in FY18/19, 43 of whom reached their one-year mark in the program either during or prior to FY18/19. Those 43 clients spent a collective 409 days homeless, 289 in psychiatric hospitalization, and 39 incarcerated in the 12 months prior to enrolling in the HOPE program. In their first year in the FSP they had a 34% decrease in total crisis days with a 73% decrease in days homeless, a 29% increase in psychiatric hospitalization days, and a 97% 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.
ODYSSEY FULL-SERVICE PARTNERSHIP: FSP 05

PROGRAM ALLOCATION FY18/19: $1,821,526

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 with supportive contracts

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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>80%</td>
</tr>
<tr>
<td>Decrease in arrests</td>
<td>50%</td>
</tr>
<tr>
<td>Decrease in incarceration</td>
<td>60%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>40%</td>
</tr>
</tbody>
</table>

ACTUAL OUTCOMES

Odyssey served 128 unduplicated clients in FY18/19.

There were 109 clients active at some point in FY18/19 who had been enrolled for at least 12 months. Those clients collectively spent 15,799 days homeless in the year prior to initiating service. In their first year in the Odyssey partnership their days homeless decrease by 57% (a decrease of 6,758 days). Psychiatric hospitalization days decreased by 42% (447 fewer days than baseline year), and incarceration days decreased by 76% (from 1,357 days incarcerated in the baseline year to 327 days in the first year of the partnership). Overall there was a reduction of 58% in total crisis days.
INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT): FSP 06

PROGRAM ALLOCATION FY18/19: $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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>25%</td>
</tr>
<tr>
<td>Decrease in arrests</td>
<td>50%</td>
</tr>
<tr>
<td>Decrease in incarceration</td>
<td>60%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>40%</td>
</tr>
</tbody>
</table>

ACTUAL OUTCOMES

In FY18/19 the IMPACT program served 31 clients. However, FY18/19 was the first year of operation so there is not enough data to compare first full year of services with baseline year.

FY18/19 CLIENT STORY:

*John was enrolled in IMPACT in October 2018. At that time and for years prior, he had been cycling in and out of jail, not allowed in numerous community resources due to his behavior, and sleeping in a van with a friend. With time, relationship building, and multisystemic supports, John is sober from methamphetamine, alcohol, and marijuana, doing well with the program at New Beginnings Center, successfully completing his time with Pathways Court, and according to his mom “doing better than he has done in twenty years.” He has been following through with Psychiatric appointments and his mind and mood are notably brighter and clearer. He is thinking about the future and looking forward to housing and working. In the meantime, he has been taking care of his health through exercise and gotten back into his love of writing.*
ENTERPRISE RESOURCE CENTER (ERC) EXPANSION: SDOE 01

MHSA PROGRAM ALLOCATION FY18/19: $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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># ERC first time visitors</td>
<td>200</td>
</tr>
<tr>
<td>Avg daily attendance</td>
<td>35</td>
</tr>
<tr>
<td># Warm Line contacts</td>
<td>6,500</td>
</tr>
<tr>
<td># Served – CARE Team (unduplicated)</td>
<td>180</td>
</tr>
<tr>
<td>Avg monthly contacts – CARE Team</td>
<td>100</td>
</tr>
</tbody>
</table>

ACTUAL OUTCOMES

In FY18/19, there were 208 first time visitors. There was an average daily attendance of 39 unduplicated clients. There were 4,200 warm line contacts. An average of 89 unduplicated clients were served by the CARE Team each month. Average daily attendance at Linda Reed Activities Club was 13 unduplicated clients for FY 18/19. 61 mental health clients were employed or stipend for FY 18/19, 82% of whom maintained their positions during FY 18/19.
DEMOGRAPHICS

The following demographics are for the 208 new clients that were first served by the ERC in FY18/19. 66 of these individuals were experiencing homelessness.

ANTICIPATED CHANGES

In FY20/21 this program will be renamed “Enterprise Recovery Center.”
ADULT SYSTEM OF CARE (ASOC) EXPANSION: SDOE 07

MHSA PROGRAM ALLOCATION FY18/19: $825,504

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 Community 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 and program reports.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
<th>Actual FY18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td># Served</td>
<td>1,200</td>
<td>978</td>
</tr>
<tr>
<td>% Hispanic</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td># Primary language-Spanish</td>
<td>120</td>
<td>108</td>
</tr>
<tr>
<td># Asian</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td># Primary language-Vietnamese</td>
<td>30</td>
<td>22</td>
</tr>
</tbody>
</table>

**ANTICIPATED CHANGES**

In FY20/21 this grouping of activities is being reorganized into new SDOE programs called *Community Outreach and Engagement* and *Recovery-Oriented System Development*. 
CO-OCCURRING DISORDERS

FY18/19 MHSA Allocation: $181,419

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.

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 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

Expansion of the Road to Recovery program was put on hold as further determination was being made on whether there was funding to extend the pilot.

From July 1, 2018 to June 30, 2019 BACR provided an array of tobacco cessation services to meet the following program goals:

1. Increase the capacity of Marin County agencies, clinics and other institutions – particularly those providing behavioral health services – to routinely screen and advise tobacco users and/or to make appropriate cessation referrals, including providing on-site tobacco cessation/reduction support for tobacco users

2. Reduce smoking prevalence of historically underserved adults in Marin County by expanding the quantity, variety and utilization of direct tobacco education and support services and increasing referrals to the California Smokers’ Helpline

3. Increase tobacco cessation motivation, sense of self-efficacy and number of quit attempts among tobacco users in the Marin mental health community

The evaluation of this year’s program activities was conducted by an independent evaluation consultant, Sandra Meucci, in conjunction with the Program Director, Beth Lillard. Together they developed data collection protocols and methods for evaluating the multi-component services. These evaluation methods include:

- An assessment of tobacco policy change with agency directors having received training from BACR on treating tobacco dependence and an overall self-assessment on a tobacco policy checklist among 9 Marin County Agencies having received technical assistance from BACR

- A post-training in-service evaluation for staff of agencies to complete

- A survey of clients of BACR-provided cessation services

- Tracking sheets to record participation in cessation services and tobacco use at every tobacco cessation session and analysis of participation, quit and reduction attempts and rates

Major findings from these evaluation efforts are summarized below:

- Tobacco screening, referral and on-site counseling have been enhanced within six agencies serving mental health clients in multiple locations. Two agencies are beginning to implement the Ask, Advise and Refer system.

- 20 agency staff received in-service training from BACR all rating 100% on clarity and usefulness of information presented.

- Within Marin County Behavioral and Mental Health facilities overall:
The agencies have reported that their facility tobacco policies are leaning toward quit-friendly environments, but staff training in cessation provision is inconsistent and actual cessation intervention support for clients who are tobacco dependent is minimal.

Most behavioral and mental health facilities do provide designated smoking areas and signage for non-smoking but do not prohibit smoking in all the areas.

Related to their staff, most agencies report having provided some tobacco education to them, are considering (or already) providing cessation for staff who are tobacco dependent, but not planning to require staff to not smoke at work. There were mixed responses to whether staff have received training on tobacco about using cessation interventions with clients.

While most agencies either currently assess nicotine dependence routinely among their clients or have plans to do this, fewer of the agencies say they consider nicotine a drug in their treatment planning process, one suggesting they have no plans to do this, and one suggesting they are considering doing this. Most agencies are not planning to require that their clients be abstinent from tobacco. The actual provision of cessation support to clients is sparse among the agencies.

Tobacco cessation group attendance: There were 102 tobacco dependent people attending cessation education sessions; 66% said they felt more ready to quit after taking this tobacco cessation session.

Fy18/19 there were 56 who attended tobacco cessation classes facilitated by peers (12 more than the previous year). After attending the class, 78% reported they were interested in quitting; 42% said that have cut back on their tobacco use; and 21% said they are actively trying to quit. The majority (54%) said they would call the California Helpline for support.

PROGRAM CHANGES:

In FY20/21 this program is ending but the Co-Occurring Capacity Workforce Development and Peer to Peer Tobacco Cessation Services will continue under the new program entitled Recovery-Oriented System Development.
CRISIS CONTINUUM OF CARE: SDOE 09

MHSA PROGRAM ALLOCATION FY18/19: $851,325

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—anyone in the community. 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 1,440 requests for assistance in FY18/19, serving at total of 745 unique individuals in the year, 658 of whom were first time mobile crisis users. The team averaged 120 contacts per month.

In FY18/19 38.5% of mobile crisis clients were either self-referred or referred by family or friends. Law Enforcement accounted for another 13.5% (194 contacts—a 65.8% increase in referrals from Law Enforcement from FY17/18), housing programs accounted for 5.8% of the referrals (83 contacts) and school staff accounted for 4.4% (63 contacts—a 61.5% increase in referrals from school staff over FY17/18). 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.

**Mobile Crisis Response Team: Count of Contact (Cumulative)**

*July 2018 to June 2019*

<table>
<thead>
<tr>
<th># of Contact</th>
<th># of Unique Client</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
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<tr>
<td>4319</td>
<td>1994</td>
</tr>
<tr>
<td>4446</td>
<td>2014</td>
</tr>
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</table>

**Count of Contact per Month: July 2018 - June 2019**

<table>
<thead>
<tr>
<th># of Contact</th>
</tr>
</thead>
<tbody>
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<td>104</td>
</tr>
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<tr>
<td>111</td>
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<tr>
<td>152</td>
</tr>
<tr>
<td>136</td>
</tr>
<tr>
<td>110</td>
</tr>
<tr>
<td>127</td>
</tr>
</tbody>
</table>
Mobile Crisis Response Team Client Demographics

By Race/ Ethnicity

- White: 31% (227 clients)
- Black/AA: 4% (38 clients)
- Hispanic/Latino: 5% (38 clients)
- Other/ Unknown: 15% (114 clients)
- Total: 710 clients

By Gender

- Male: 49% (366 clients)
- Female: 1% (9 clients)
- Transgender: 1.5% (11 clients)
- Unknown: 18% (134 clients)
- Total: 710 clients

By Age Group

- Children (0-15): 9% (73 clients)
- Transition Age Youth (16-25): 13% (93 clients)
- Adult (26-59): 42% (315 clients)
- Older Adult (60+): 17% (130 clients)
- Unknown/ Not Reported: 18% (134 clients)
- Total: 710 clients
The Transition Team provided 2,004 contacts in FY18/19, averaging 167 per month. They served 163 unique clients including 129 new clients this fiscal year.
Transition Team Client Demographics

By Race/ Ethnicity
- White: 44 (27%)
- Black: 70 (43%)
- Hispanic: 31 (19%)
- Other/Unknown: 18 (11%)

By Gender
- Male: 22 (13%)
- Female: 68 (42%)
- Unknown/ Not Reported: 73 (45%)

By Age Group
- Children (0-15): 22 (14%)
- Transition Age Youth (16-25): 26 (16%)
- Adult (26-59): 28 (17%)
- Older Adult (60+): 5 (3.1%)
- Unknown/ Not Reported: 82 (50%)
The Outreach and engagement team provided 376 contacts in FY18/19 serving 36 clients.

Outreach and Engagement Team: Count of Contact (Cumulative)
July 2018 to June 2019

Count of Contact per Month: July 2018- June 2019
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 FY18/19 Casa René provided services to 155 unduplicated individuals with a total of 3,124 bed days and an average of length of stay of 10.4 days. This was an 84.4% occupancy rate. All individuals accessing Casa René were linked with Crisis Planning services. 92% were connected with community resources and 91% were discharged to a lower level care.

One of the challenges was meeting the occupancy goal of 85%. CCHP was able to increase occupancy 14.4% over last year’s percentage; this was due to accepting referrals 7 days a week, including weekends. CCHP staff were all trained on the admissions/discharge process, so all would be prepared when a referral was sent. This allowed the waiting time to be minimal, and the client can be admitted much more quickly. A second major improvement over last year is that the program is now able to accept referrals from the county jail. This has resulted in occupancy increase of about 10% overall.

There continues to be supportive collaboration among all Buckelew Programs to ensure that a client receives whatever services are needed during their stay at CCHP. If a client is eligible for housing, a referral can be made to our RSS or MAIL programs. If a client is struggling with
substance abuse issues, referral can be made to our detox program at Helen Vine Recovery Center. The Assistant Program Director will be attending a WRAP Facilitator training in October, which would allow him to assist CAM peer providers with providing WRAP/crisis plans for clients at CCHP.

**FY18/19 DEMOGRAPHICS**

![Casa Rene Client Race/Ethnicity Chart](image1)

*N=155; 74% of the Casa René residents were white, 13% were Latinx, 6% African American, 3% Asian, and 2% other as well as 2% unknown.*

![Casa Rene Client Age Group Chart](image2)

*N=155; Casa René is only open to those who are 18 years of age or older so no children were served. 10% of the residents were TAY under the age of 26, and 78% were between 26-59 years old age, 9% were 60 years or older, and age was unknown/not reported for 3%.*
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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
<th>FY18/19 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients and/or families that will receive Crisis Planning services.</td>
<td>80</td>
<td>174</td>
</tr>
<tr>
<td>Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Percent of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Percent of clients reporting that having a Crisis Plan improved their experience at the CSU.</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td>Percentage of clients reporting that they decreased their need for psychiatric emergency services as a result of the Crisis Plan.</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Percentage of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.</td>
<td>50%</td>
<td>80%</td>
</tr>
</tbody>
</table>
FIRST EPISODE PSYCHOSIS (FEP): SDOE 10

MHSA PROGRAM ALLOCATION FY18/19: $150,873

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.

OUTCOMES IN FY18/19

An RFP was released and awarded to the Felton Institute in FY18/19 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 FY18/19: $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 FY19/20):

5) **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.

6) **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.

7) 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 FY18/19**

- Membership more than tripled during FY2018/2019, and we met and exceeded our target of 50 members by June 30, 2019 with 54 members.
- Empowerment Clubhouse scheduled post-training consultations with Independence Center Training Base for accreditation preparation in anticipation of applying for accreditation in FY19/20.
- Partnerships exist or are in development with the following entities:
  - Marin City Health & Wellness
  - Community Action Marin
  - Southern Marin Intern Program
  - St. Michael’s Extended Care Facility
  - California Department of Rehabilitation
  - Agricultural Institute of Marin
  - Mental Health Association of San Francisco
    - Sanzuma
    - Tessamarie Capitolo Psychotherapy
    - Integrated Community Services
- Marin City Community Development Corporation is working with an architect and the Marin County Planning Commission to move ahead on plans to build a stand-alone facility to house Empowerment Clubhouse.
- A comprehensive marketing and outreach campaign was initiated in October 2018 and has resulted in members and staff presenting on Empowerment Clubhouse to over 25 different organizations in Marin County.
- MCCDC held its first ever Gala fundraiser event, Dancing with the Marin Stars, featuring the Empowerment Clubhouse.
- Empowerment Clubhouse fully developed and implemented a Peer Internship program in collaboration with Behavioral Health, Integrated Community Services, and Project COPE. This internship program has been highly successful and will be expanded with additional Workforce Education and Training (WET) funding in FY2019/2020.
- The Empowerment Clubhouse Average Daily Attendance over the course of FY2018/2019 increased from 2 to 9 members per day.

MEMBERSHIP DEMOGRAPHICS

The racial and ethnic demographic spread of EC membership is as follows: 31% African American; 2% Asian; 55% Caucasian; 6% Latin(x); and 6% that identify as “other”:
During FY18/19 the membership age range breakdown was: 7% within 18 to 25 years of age; 64% within 26 to 59 years of age; and 15% that are 60 years of age and older.

In FY18/19 the Empowerment Clubhouse provided supports and services to members living with the following diagnoses: 12% with Anxiety Disorder; 17% with Bi-Polar Disorder; 20% with Depression; 10% with Post-Traumatic Stress Disorder; and 33% with Schizophrenia, 8% other diagnoses.
In addition, in FY18/19 11% of members identified as homeless and 6% as veterans.

CLIENT STORY:

*M* is a Marin City resident that found out about EC through his caregiver, who is a recent COPE graduate and Marin County Peer Intern. M graduated from high school in Marin County a little over a decade ago, and prior to joining EC, lacked social inclusion, a structured day, and opportunities to learn and apply skills. M spent much of his time at home in Marin City with his two brothers and caregiver, and rarely experienced any opportunities to develop independent living skills. M and his caregivers 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 EC opening M did not receive any of the supports and services necessary to support his development. When M first became a member, he was extremely withdrawn at the Clubhouse, and solely communicated to his caregiver and brothers. M 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 for a little over a year, M has overcome many of his initial barriers and challenges and excels at many Work-Ordered Day tasks. In the Business and Clerical Unit, M takes 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, M has worked on his barriers with communicating with new people, greets all guests at the door, assists with food prep, does laundry, shops for the weekly groceries and supplies, and tends to the EC community garden. One major milestone that M has surpassed this fiscal year is walking to and from the Clubhouse without his caregiver every Monday through Friday. This is
something M was very apprehensive about doing at first, but his growth in confidence and self-efficacy as a result of his participation at EC has allowed him to tackle many new ventures for the first time within a safe and supportive community. EC is happy to provide the strengths-based, structured program that M 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 Tamalpais 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 Full-Service Partnership.

The Victory Village project is projected to be completed the Summer 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.
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.

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.

2. BHRS Human Resources Collaboration D ue 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.

FY18/19 ACCOMPLISHMENTS:

1. Continued to provide scholarships and mentor support to county residents with behavioral health Lived Experience to enroll in county-funded or local Peer and Substance Use counseling certification courses to become certified Peer Counselors, Family Partners or Substance Use Counselors for BHRS and its contract agency partners.
2. Recruited, interviewed, hired, and retained Peer and Family Partners to BHRS’ first-ever and newly developed classified county Peer Counselor and Family Partner job opportunities.
3. Recruitment and retention of graduate seven (7) or more interns who are bilingual/bicultural to work in BHRS; increase in the hiring and retention of qualified bilingual/bicultural management staff by three (3) or more; hiring and retaining bilingual (Spanish) Family Partner; provide five (5) or more scholarship and mentor support and opportunities to culturally and linguistically underserved county residents with Lived Experience to become certified Peer and Substance Use Counselors; internship/job placement of eleven (11) recently graduated or certified Peer and Substance Use Counselors with BHRS’ contract agencies; hiring and retention of two (2) full-time Peer Counselors and one (1) bilingual Family Partner.
4. Improved BHRS’ training tracking system to ensure that all BHRS staff and its contract agency partners comply with the system’s policy of completing a minimum of four (4) cultural competence training per year.
5. Offered and provided ten (10) or more trainings and consultation support 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; the development of a technology system that tracks training participation of BHRS staff and its contract agency partners; and provide technical assistance to five (5) contract agency partners.
6. 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. The position started at the end of FY18/19.
7. Human Resources began recruitment for an Equity and Inclusion focused HR Analyst
8. Latinx Intern started at the end of FY18/19, and will be in place for much of FY19/20
WET EVALUATION PURPOSE AND METHODOLOGY

In order to assess whether the WET Scholarship Program and Co-Occurring Peer Education (COPE) certification course are leading to the intended results, an evaluation was conducted in May 2019. The primary questions this evaluation was intended to answer were:

- Does the WET Program increase the engagement of individuals with lived experience – consumers and family members - in the behavioral health field?
- In what ways does the WET program contribute to their success?
- How can the WET program be improved?

WET records were reviewed to identify all scholarship applicants and participants. Initial applications included background questions, such as lived experience, experience in the behavioral health field, and limited demographic data. A link to an online survey covering participant status and project feedback was sent via email to all participants, with phone or mail follow-up as needed. In cases where there was no response to the survey, data gathered through previous communications was used to determine the status of the participants. The COPE Coordinator provided summaries regarding enrollment, completion, and course participant status. An outside consultant gathered and analyzed the data and developed this report, in collaboration with the Ethnic Services and Training Manager.
WET EVALUATION RESULTS

WET Scholarship Program:
The WET Scholarship Program application gathered background data on applicants. Of 93 individuals who submitted an application:

- **Race/Ethnicity**:
  - African American (27 Individuals)
  - Asian (1 Individual)
  - Latino/a (8 Individuals)
  - White (30 Individuals)
  - Multi-racial (9 Individuals)
  - No Response (18 Individuals)

- **Gender Identity**:
  - Female (54 Individuals)
  - Male (34 Individuals)
  - No Response (5 Individuals)

- **Age**:
  - 18-25 (9 Individuals)
  - 25-64 (65 Individuals)
  - 65+ (6 Individuals)
  - No Response (12 Individuals)

- **Sexual Orientation**:
  - Hetero-sexual (33 Individuals)
  - LGBTQ (5 individuals)
  - No Response (55 Individuals)
* These do not total 100%, as more than one answer may apply
Of 93 individuals who submitted an application, 72 (77%) received funding for tuition, supplies, transportation, and/or childcare to attend a behavioral health related program. Of the 21 (23%) who did not receive funding, none were denied funding. These individuals discontinued the process due to health, schedule, transportation or other reasons.

Of the 72 individuals who received funding, 52 (72%) completed the survey.

Participants primarily pursued a Drug and Alcohol Counselor training. Of those who pursued mental health training, some received funds to support them to attend COPE, while others attended College of Marin or for transportation or childcare.

*These do not total 100%, as more than one answer may apply*
Those who discontinued their programs did so for a variety of reasons, primarily disability or family emergency. Of these, 6 expressed a desire to re-enroll.

After completing the Drug and Alcohol Counselor training, participants must complete required work hours and pass a certification test before receiving their Drug and Alcohol Counselor certification. Of the 27 respondents who completed their Drug and Alcohol Counselor program:
Of those who have not received their certification, 8 will be taking the test soon, 4 are working on their hours, and 5 expressed need for guidance in completing the requirements.

Twenty-three (52%, N=44) respondents worked in behavioral health before entering the WET Scholarship Program. Of the 21 respondents who did not work in the behavioral health field before the WET program, 14 (67%) obtained work. Nine (64%) obtained paid work, one (7%) an internship, and 5 (36%) volunteer positions. Twenty-eight (70%, N=40) of all respondents are currently working in behavioral health. Ten percent (4) are not working due to health issues. Almost everyone who is not working in behavioral health plans to get back to it as soon as they are able.

Co-Occurring Peer Education (COPE) Program

One WET strategy intended to increase the number providers with lived experience is providing the Co-Occurring Peer Education (COPE) courses. COPE is a two-part course to provide knowledge and skills to prepare individuals with lived experience to become peer counselors. The first part, Peer Counseling,” runs for 3 months, 4 hours per week, focusing on core counseling skills. The second part, “Peer Specialization,” runs for 6 months, 4 hours per week, focusing on recovery. At the conclusion of each phase, participants receive a certificate for peer counseling and peer specialist, respectively.
Since FY2015-16, WET has funded 4 Peer Counseling and 4 Peer Specialization courses.

A large majority of participants completed the courses:

<table>
<thead>
<tr>
<th>Course</th>
<th>Enrolled</th>
<th>Graduated</th>
<th>Graduation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Counseling</td>
<td>42</td>
<td>34</td>
<td>81%</td>
</tr>
<tr>
<td>Peer Specialization</td>
<td>33</td>
<td>28</td>
<td>85%</td>
</tr>
</tbody>
</table>

Of those entering the Peer Counseling course, 12 already worked in behavioral health, and 30 did not. By the end of the Peer Specialization course, 4 gained employment in the field, 14 gained internships, and 3 entered into graduate school.

Discussion and Planned Improvements

Overall, the WET Scholarship program has been very successful in reaching its goals.

Does the WET Program increase the engagement of individuals with lived experience – consumers and family members – in the behavioral health field?

Seventy-two individuals, all with lived experience (consumers or family members), received an average of approximately $1500 to attend training in mental health, substance use, or domestic violence. Eighty-six percent either completed or are currently enrolled in their program. Sixty-seven percent of participants who did not already work in the behavioral health field obtained paid work, internships or volunteer positions. In addition, COPE graduated 28 people from the advanced course for $28,000. The majority of these graduates now work in the behavioral health field.
The program has been quite successful in engaging African American participants but has not been as successful with Asian and Latinx individuals. Anecdotally, additional Latinx individuals expressed interest but faced language barriers in terms of the courses, which are only offered in English. Increased effort could be made to engage individuals who could be successful in the courses.

In what ways does the WET program contribute to their success?

The WET program provided funding for tuition, supplies, transportation and childcare. For many participants this support made it possible for them to enroll in and attend their program. The WET Program also offered mentors to scholarship recipients. Of the respondents, 90% (36, N=40) said they had a mentor. These mentors provided individual support with enrolling and completing the training programs, including problem-solving, emotional support, and systems navigation. Many participants expressed great appreciation for the support and care Cesar Lagleva and the mentors provided.

Participants also generally expressed appreciation for the training programs. They generally reported experiencing quality instruction and a strong support network with their classmates.

How can the WET program be improved?

While the large majority of participants expressed receiving adequate support, a portion would have benefited from additional support. There were a few issues that more than one person raised:

- A few participants were not able to take advantage of non-tuition support offered. Tuition is paid directly to the institutions providing the training. But other funds require the participants to expend funds and request reimbursement. A few participants either were unable to expend funds up-front or were unclear on the process for being reimbursed.
  - Recommendation: Ensure participants understand which funds are reimbursement based and how to access these funds. Consider a method for reducing the need for reimbursement.

- A few participants reported that the Drug and Alcohol Counselor training did not manage the content, materials, or process well.
  - Recommendation: Conduct further inquiry into how the course is managed and provide additional support for WET participants in areas that are identified as barriers.

A handful of participants completed their Drug and Alcohol Counselor training, but were not able to navigate the process for completing their hours to become certified.
➢ Recommendation: Ensure that participants completing Drug and Alcohol Counselor training are informed about the process for completing their hours to become certified. Follow-up with participants regularly to ensure they have assistance with any barriers they experience.

A few participants mentioned that their assigned mentors did not provide the support they needed.

➢ Recommendation: The Ethnic Services and Training Manager should inform participants as to what mentors will and will not provide, ensure mentors receive adequate training, and follow-up with mentors regularly to ensure they are contacting participants regularly and reporting any issues that arise.

Most participants that needed to discontinue their program are interested in re-enrolling.

➢ Recommendation: Follow-up with participants who discontinue to ensure they understand any opportunities for re-enrollment and how to initiate the process.

To address these recommendations, additional staffing support will be provided to support these programs in the new Three-Year plan including the Peer Lead and WET Unit Supervisor positions.
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 following 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).

FY18/19 OUTCOMES:

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.
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.

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.

Data is being exported into 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.

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.
CRISIS STABILIZATION UNIT (CSU) EXPANSION

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

PROGRAM DESCRIPTION

In FY17/18 and FY18/19, 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 the unit to better meet the needs of the community.

FY2018/19 UPDATES:

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

Starting 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:

Participating entities as of February 2020:

- County of Marin Department of Health & Human Services
- County of Marin District Attorney’s Office
- County of Marin Probation Department
- County of Marin Public Defender’s Office
- Coastal Health Alliance
- Adopt a Family of Marin
- Bright Heart Health
- Buckelew Programs
- City of Novato
- City of San Rafael
- City of Sausalito
- Center Point, Inc.
- Central Marin Police Authority
- Coastal Health Alliance
- Community Action Marin
- Downtown Streets Team
- Gilead House
- Homeward Bound
- Kaiser Permanente, San Rafael Medical Center
- LifeLong Medical Care
- Marin Center for Independent Living/Opportunity Village
- Marin City Health and Wellness
- Marin Community Clinics
- Marin County Sheriff’s Office
- Marin County Free Library
• Marin General Hospital
• Marin Health Gateway (health information exchange)
• Marin Housing Authority
• Marin Treatment Center
• North Marin Community Services
• Partnership HealthPlan of California
• Richardson Bay Regional Authority
• Ritter Center
• St. Vincent de Paul Society
• The Spahr Center
• West Marin Community Services

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.

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 throughout 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

FY2018/19 OUTCOMES:

- System integrations to allow automated data sharing, anticipated June 2019:
  o Marin Health Gateway Health Information Exchange—on hold due to funding
  o Homeless Management Information System—Went live August 2019

- System user base expansion:
  o More than 2,000 client profiles
  o Over 130 staff from the participating entities are active users
  o Behavioral Health and Recovery Services (BHRS): entire teams that care for overlapping populations have been added to WIZARD to coordinate care.
  o 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.
APPENDIX: BOS APPROVED PEI COMPONENT THREE-YEAR PLAN

July 14, 2020

Marin County Board of Supervisors
3501 Civic Center Drive
San Rafael, CA 94903

SUBJECT: Department of Health and Human Services, Division of Behavioral Health and Recovery Services: Approve the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Component Three Year Plan (FY 2020-23).

Dear Supervisors:

RECOMMENDATION:
1. Authorize the President to approve the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Component Three Year Plan.

SUMMARY: The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Component Three Year Plan details the priorities and programs to allow for the spending of the 19% of the MHSA allocation dedicated to PEI. Each program narrative in the MHSA PEI Component Three Year Plan includes the annual projected program budget allocation and description of the program, the target population served, the expected outcomes, and the measurement tools to be used to determine if the outcomes have been achieved. This plan includes the following new programs or expansions:

1) Expanding School-Age Prevention and Early Intervention Services, with a focus on enhancing school climate and coordination systems. This includes new funding (awarded via RFP) for a social worker position at Bayside/MLK and an additional half-time bilingual school-based clinician for the Shoreline Unified School District in West Marin.

2) Enhancing services for newly arrived immigrant youth or “Newcomers” by partnering with schools and community-based organizations to increase coordination and linkages to health and wellness supports. This includes new funding (awarded via RFP) for a CBO-based Newcomer Coordinator to work closely with San Rafael secondary schools as well as continued funding for school-based Newcomer Groups in San Rafael, Novato, and West Marin.
3) **Building capacity of individuals, organizations and schools to implement culturally responsive, best practices around mental health and wellness across the lifespan.** Increased funding to support and facilitate professional development workshops and trainings, provide coaching and consultation, and promote youth-led and digital storytelling activities that raise awareness and build community.

4) **Implementing newly released Suicide Prevention Strategic Plan,** including funding the full-time Suicide Prevention Coordinator approved by your Board on June 16, 2020 to engage key county and community partners in prioritizing and carrying out the objectives and activities outlined in the plan with an emphasis on older adults, LGBTQ+ individuals, and other groups that are disproportionately affected by suicide.

All of these efforts were developed through a comprehensive community planning process that included the communities and stakeholders most interested in mental health and substance use issues. This MHSA PEI Component Three Year Plan was developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft plan was posted for a thirty (30) day public comment period on the Marin County Mental Health Services Act webpage beginning on Monday, February 10, 2020, and ending on Tuesday, March 10, 2020. A legal notice ran in the Marin Independent Journal (IJ) seeking public comment and feedback as well. On Tuesday, March 10, 2020, the Mental Health Board hosted a public hearing and approved the Plan. All input has been considered and adjustments were made as appropriate based on the priorities stated during the community planning process and incorporated into the final PEI Component Three-Year Plan.

**COMMUNITY BENEFIT:** The key aims of the Prevention and Early Intervention (PEI) Component of the Mental Health Services Act (MHSA) is to prevent mental illness from becoming severe and disabling and to improve timely access for under-served populations. The MHSA requires that 51% of PEI funds are spent on services for youth between the ages of 0 and 25, because half of all mental disorders start by age 14 and three-fourths by age 24. The vast majority of PEI funds are contracted with community-based organizations providing prevention and early intervention services in schools, teen clinics, as well as with older adults and underserved racial and ethnic populations. By intervening earlier to prevent the onset of serious mental illness, PEI programs have brought measurable improvements to the lives of many Marin County residents since 2004.

**FISCAL IMPACT:** There will be no impact to General Fund Net County cost as a result of your Board’s approval. Funds for the costs in the MHSA PEI Component Three-year Plan are included in the existing Mental Health Prop 63 Fund.

The Department will work with the CAO to make the necessary budget adjustments to reconcile the annual funding allocation with the funds already budgeted in the MHSA program baseline budgets.
Respectfully submitted,

[Signature]

Benita McLarin
Director
INTRODUCTION

The Prevention and Early Intervention (PEI) Component of the Three-Year Mental Health Services Act (MHSA) Program and Expenditure Plan was released in advance of the entire MHSA plan in order to release Requests for Proposals (RFPs) in a timely manner. The vast majority of the programs in the Prevention and Early Intervention component will be operated by community-based organizations and in order to ensure they are able to plan for FY20/21 we wanted to release this component as early as possible.

Given the COVID-19 situation and the new fiscal projections for MHSA funding, the full MHSA plan (with the remaining components) will be released after more analysis is completed about the financial outlook of behavioral health programs for our most vulnerable residents. In the meantime, the current Three-Year Plan will remain in effect for the other components.
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 intervening early in the onset of symptoms; reducing risks related to mental illness; increasing recognition of signs of mental illness; reducing stigma and discrimination related to mental illness; preventing suicide; and connecting individuals to appropriate services. A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old).

PEI emphasizes improving timely access to services for underserved populations and incorporating robust data collection methods to measure quality and outcomes of services. Programs incorporate strategies to reduce negative outcomes of untreated mental illness: suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.

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**

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

PEI strategies are aligned with BHRS efforts to reduce inequities in service delivery and Marin County Health and Human Services Equity and Operational Plan. This includes strengthening accessibility and cultural responsiveness of services and integrating service to delivery to support clients (such as building school-based coordination teams, building learning communities to share resources and best practices).
PREVENTION AND EARLY INTERVENTION (PEI) PRIORITIES FOR FY20/21 THROUGH FY22/23

During the MHSA community planning process as well as the suicide prevention strategic planning process that was conducted between November 2018 and July of 2019 (details to be discussed later in this document), community members, providers and county staff identified a range of Prevention and Early Intervention program priorities. The themes that emerged from the discussions and the surveys that were collected guide our PEI program and service priorities for the next three years. These four priorities include:

Priority One: Expanding School-Age Prevention and Early Intervention Services, with a focus on enhancing school climate and coordination systems.

Priority Two: Enhancing services for newly arrived immigrant youth or “Newcomers” by partnering with schools and community-based organizations to increase coordination and linkages to health and wellness supports.

Priority Three: Building capacity of individuals, organizations and schools to implement culturally responsive, best practices around mental health and wellness across the lifespan. This includes supporting and facilitating professional development workshops and trainings, providing coaching and consultation, and promoting youth-led activities that raise awareness and build community.

Priority Four: Implementing newly released Suicide Prevention Strategic Plan, including funding a full-time Suicide Prevention Coordinator to engage key county and community partners in prioritizing and carrying out the objectives and activities outlined in the plan.

RATIONALE FOR KEY PRIORITY AREAS

Priority One: Expanding School-Age Prevention and Early Intervention Services with a focus on enhancing school climate and coordination systems:

During the MHSA planning process, stakeholders emphasized the need for expanded school-based mental health supports for students and families to address student depression, anxiety and lack of school connectedness. They identified the need for additional mental health counseling, streamlined coordination systems and school climate/prevention efforts. Primary and secondary data from the Suicide Prevention needs assessment highlighted similar concerns around student mental health and wellness. Per the 2015-2017 California Healthy Kids Survey, over one-quarter of Marin County high school students (25% of 9th graders and 28% of 11th graders) reported feeling chronic sad or hopeless feelings in the 12 months prior to taking the survey. Around one in eight high schoolers (14% of 9th graders and 11% of 11th graders) had seriously considered attempting suicide in the past 12 months.

The expansion of school-based PEI services to in this 3-year plan is intended to address some of the gaps identified by stakeholders. School-based mental health programs help to build resiliency, increase protective factors and create meaningful connections between students, staff and caregivers. By providing linkages to appropriate supports, consultation and training, counseling, coordination of services, and supporting the implementation of school climate initiatives, school-based PEI programs play an instrumental role in promoting the healthy social-emotional development and academic success of students.
Priority Two: Enhancing supports for “Newcomers” by partnering with schools and community-based organizations to increase coordination and linkages to health and wellness supports.

“Newcomers” - or recently arrived immigrant youth, often from Central American countries - were identified by stakeholders as needing additional, targeted and coordinated support. Many of these young people are unaccompanied and have not only fled violence and exploitation in their home countries but have endured additional trauma during their dangerous journeys to the border. The urgency of addressing the unique mental health and related challenges that newcomers face is underscored by the current political climate and recent trends that show a significant increase in the numbers of newcomers in Marin County schools. According to school district enrollment data, in 2019 alone, over 400 newcomers entered San Rafael and Novato Unified secondary schools, with hundreds more at schools throughout the county. This unique, vulnerable population is at heightened risk for school drop-out, homelessness and long-term mental health challenges. Newcomers supports in this MHSA 3-year plan are designed to intervene early to address the emotional, social, and physical health needs of these youth by assessing, actively linking to school and community resources and providing targeted mental health support.

Priority Three: Building capacity of individuals, organizations and schools to implement culturally responsive, best practices around mental health and wellness across the lifespan:

During the MHSA planning process, stakeholders emphasized the importance of building the skills, knowledge and leadership capacity of community members, school staff and providers in order to improve service delivery and build community. Investing in the development of community members, providers and organizations strengthens our county’s ability to implement culturally responsive, best practices and achieve shared goals around wellness and equity. Through training, coaching, consultation and other capacity building efforts, we can impact practices and systems on a larger scale and improve our collective understanding of how to best address the mental health and wellness needs of the communities we serve. We can also help to ensure that resources are aligned and prioritized to meet the needs of communities with limited opportunity and access to supports.

Priority Four: Implementing Suicide Prevention Plan including funding a full-time Suicide Prevention Coordinator to engage key county and community partners in prioritizing and carrying out the objectives and activities outlined in the plan:

Despite being one of the healthiest and wealthiest counties in the state, Marin county has among the highest suicide rates in all of the Bay Area and the highest among all metropolitan counties in California. Between 2015 and 2017, 14.1 people per 100,000 died by suicide in Marin County, well above the state average over the same period (10.7) In the span of just one month in 2017, we experienced the tragic loss of three high school students to suicide.

To address the issue of suicide in our county, in October 2018, Marin County Behavioral Health and Recovery Services (BHRS) initiated a suicide prevention strategic planning process in collaboration with the Department of Public Health, the Marin County Office of Education and community partners. The first phase of this effort was a countywide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. Once data was collected and analyzed, the Strategic Planning Committee - which was comprised of a wide range of stakeholders - developed comprehensive strategies, objectives, and activities aimed at promoting wellness and reducing suicide
attempts and deaths across the county. The Suicide Prevention Strategic Plan, which is Marin County’s first comprehensive plan, was released in January 2020. (The full needs assessment and plan as well as the short version are attached to this 3-year plan).

BHRS has started the process of hiring a full-time Suicide Prevention Coordinator who will be responsible for coordinating the implementation of the seven key strategic areas of the suicide strategic plan. This position is fully supported by the Board of Supervisors and was approved in November of 2019. The Coordinator will work to ensure accountability, chair oversight body and work-groups, coordinate data collection amongst key entities, enhance data collection/sharing systems, and represent the county on regional and statewide suicide prevention collaboratives.
SB 1004 PEI PROGRAM PRIORITY AREAS

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004 which requires counties to specify how they are incorporating the following six Commission-identified priorities in the FY20-23 MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan;
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;
4. Culturally competent and linguistically appropriate prevention and intervention;
5. Strategies targeting the mental health needs of older adults;
6. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Each of these priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies which are consistent with our community planning process (see subsequent sections for details).

Per WIC Section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following table provides these estimates:

<table>
<thead>
<tr>
<th>SB 1004 PRIORITY CATEGORIES:</th>
<th>Percentage of Funding Allocated to Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs</td>
<td>36%</td>
</tr>
<tr>
<td>2: Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan</td>
<td>61%</td>
</tr>
<tr>
<td>3: Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs</td>
<td>41%</td>
</tr>
<tr>
<td>4: Culturally competent and linguistically appropriate prevention and intervention</td>
<td>83%</td>
</tr>
<tr>
<td>5: Strategies targeting the mental health needs of older adults</td>
<td>14%</td>
</tr>
<tr>
<td>6: Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis</td>
<td>52%</td>
</tr>
</tbody>
</table>
INTRODUCTION TO PEI PROGRAMS FOR FY20/21 THROUGH FY22/23

Many of the existing PEI programs have been successful in reaching underserved communities and achieving mental health related goals (see FY2019/20 Annual Update) and therefore will be continued in this Three Year Plan. In response to stakeholder input, evaluations of existing PEI programs, and gaps identified, some of the ongoing programs will be changed or expanded and several new programs will be started in FY20/21. Requests for Proposals (RFP) were released in the Spring of 2020 for all continued and new PEI programs.

In order to expand and strengthen the Community Health Advocates (CHA) programs including the Promotores, these programs will be moved to the Outreach and Engagement component of Community Services and Supports (CSS). This will consist of RFPs (to be released later this Summer/Fall) for three (3) Community Health Advocates programs targeting the following underserved populations:

1. Latinx individuals with a focus on West Marin, Novato, and the Canal District of San Rafael (Promotores)
2. Vietnamese and other Asian/Pacific Islander populations with a focus on mono-lingual and recent immigrants from Asian and the Pacific Islands.
3. Marin City residents

In addition to other responsibilities, the new Outreach and Engagement coordinator position under Community Services and Supports (CSS)—will provide structured support of the three contracts and coordinate additional training opportunities. They will also provide a structure where the CHA programs can learn from each other.
<table>
<thead>
<tr>
<th>Required Service Category</th>
<th>Programs</th>
<th>SB 1004 Priority Categorization(s)</th>
<th>MHSA FY 20/21 Expenses by Program</th>
<th>Marin PEI Priority Strategy Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and Early Intervention</td>
<td>PEI-04 Transition-aged youth individual and group mental health services, including targeted counseling for LGBTQ youth</td>
<td>#1, #3, #4, #6</td>
<td>$240,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PEI-18 School-based individual and group mental health services, school climate and service coordination</td>
<td>#1, #2, #3, #4, #6</td>
<td>$406,666</td>
<td>School-based Mental Health</td>
</tr>
<tr>
<td></td>
<td>PEI-07 Older Adult Prevention and Early Intervention</td>
<td>#2, #4, #5</td>
<td>$156,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Early Intervention mental health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>PEI-01 Early Childhood Mental Health</td>
<td>#1, #4</td>
<td>$230,000</td>
<td>Capacity Building</td>
</tr>
<tr>
<td></td>
<td>• Training and Consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Screening and Linkage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Intervention</td>
<td>PEI-05 Latino Community Connection:</td>
<td>#4, #6</td>
<td>$280,000</td>
<td>Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>• Community based individual and group mental health services for Spanish Speaking adults and youth</td>
<td></td>
<td></td>
<td>Newcomers Supports</td>
</tr>
<tr>
<td></td>
<td>• Radio Show</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma Reduction</td>
<td>PEI-12 Community Training and Supports</td>
<td>#2, #4, #6</td>
<td>$195,314</td>
<td>Capacity Building</td>
</tr>
<tr>
<td></td>
<td>• Mental Health Consultation in schools</td>
<td></td>
<td></td>
<td>Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>• Community trainings in West Marin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mental Health First Aid</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>PEI-20 Statewide PEI</td>
<td>#2</td>
<td>$81,000</td>
<td>Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>PEI-24 Storytelling Programs*</td>
<td>#2, #4</td>
<td>$42,500</td>
<td>Capacity Building</td>
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<tr>
<td>Suicide Prevention</td>
<td>PEI-21 Suicide Prevention:</td>
<td>#2, #3, #4, #5</td>
<td>$317,813</td>
<td>Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>• Suicide Prevention Coordinator</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Community and targeted suicide prevention trainings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access and Linkage</td>
<td>PEI-23 Newcomers Coordination and Support</td>
<td>#1, #3, #4, #6</td>
<td>$130,500</td>
<td>Newcomers Supports</td>
</tr>
<tr>
<td></td>
<td>• School-aged Newcomers Assessment and Linkage</td>
<td></td>
<td></td>
<td>School-based Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Newcomers school-based groups</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Outreach</td>
<td>PEI-19 Veteran’s Community Connection</td>
<td>#2, #4, #6</td>
<td>$73,000</td>
<td>Suicide Prevention</td>
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<tr>
<td>Total Average Direct</td>
<td></td>
<td></td>
<td>$2,152,793</td>
<td></td>
</tr>
</tbody>
</table>

*One component of this program, formerly called the "Speakers Bureau" began in April of 2019 and was previously under the Community Training category (PEI-12)*
EARLY CHILDHOOD MENTAL HEALTH (ECMH) (PEI 01)

SERVICE CATEGORY: PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #4

MARIN PEI PRIORITY STRATEGY AREA: Capacity Building

PROGRAM DESCRIPTION: The program aims to foster healthy social-emotional development and promote the mental health of young children by increasing the skills of teachers and parents to observe, understand and respond to children’s emotional and developmental needs. This is done through training, coaching, screening and linkage to appropriate supports. The program works to strengthen the capacity of staff, families, programs, and systems to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among children from birth to age 5.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $230,000

TARGET POPULATION: Pre-school students (0-5), caregivers, providers and school/childcare staff.

EXPECTED NUMBERS TO BE SERVED: 500

KEY OUTCOMES:

- Reduced likelihood of behavioral problems and school failure in pre-school;
- Earlier identification of students with behavioral problems that may indicate mental/emotional difficulties;
- Increased timely access to medically necessary services;
- Increased capacity of staff to recognize and respond to early signs of significant risk for emotional disturbance;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI caregiver, provider and staff satisfaction surveys, workshop/training surveys. Additional outcomes measurement tools to be determined based on RFP process.
PROGRAM CONTINUATION  X  PROGRAM EXPANSION  NEW PROGRAM

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION (PEI 04)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #3, #4, #6

PROGRAM DESCRIPTION: TAY PEI provides screening and brief intervention for behavioral health concerns in teen clinics and group and individual services in high schools for at-risk students. Providers conduct psychosocial screening at health access points, direct linkage to mental health counseling, substance use counseling or case management, school-based groups, individual and/or family counseling, targeted supports for immigrant and LGBTQ students, as well as trainings for educators on supporting LGBTQ students.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $240,000

TARGET POPULATION: The target population is 16-25 year-olds, and some younger teens, from underserved populations such as LGBTQ youth; school staff and providers who receive training and consultation.

EXPECTED NUMBERS TO BE SERVED: 850

KEY OUTCOMES:

- Reduced likelihood of school failure and/or unemployment;
- Early identification of youth with behavioral problems that may indicate mental/emotional difficulties; and increased timely access to early intervention or treatment services;
- Increased capacity of teachers and providers to support LGBTQ youth;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI client satisfaction surveys, workshop/training evaluations. Additional outcomes measurement tools to be determined based on RFP process.
LATINO COMMUNITY CONNECTION (LCC) (PEI 05)

SERVICE CATEGORY: EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #4, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Suicide Prevention, Newcomers Supports

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. Bilingual behavioral health providers provide 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, stress management, depression/anxiety groups 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. This program is categorized as an early intervention program with an outreach for increasing recognition of mental illness strategy.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $280,000

TARGET POPULATION: The target population is Latinos throughout the County, especially newer immigrants facing many stressors and barriers to accessing 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.

EXPECTED NUMBERS TO BE SERVED: 1000 individuals served through early intervention services. Thousands of community members reached through weekly radio show.

KEY OUTCOMES:

- Reduced likelihood of school failure and unemployment due to mental health challenges;
- Earlier identification of mental/emotional difficulties and increased timely access to medically necessary services;
- Increased community awareness of mental health and community resources;
- Reduced stigma around mental health and help seeking within the Latino Community;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI caregiver and client satisfaction surveys, Radio show listener surveys: quarterly and end-of-year listener surveys on Facebook and on paper to assess knowledge and skills attained through radio show. This 3-year planning cycle PEI will also incorporate evidenced based strategies to evaluate stigma reduction programs and outcomes such as utilizing tools from Patrick Corrigan’s stigma evaluation toolkit. Additional outcomes measurement tools to be determined based on the RFP process.
OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI 07)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #5

PROGRAM DESCRIPTION: Older adults continue to represent a growing percentage of the population of Marin and face many risks for mental illness. The Older Adult PEI program 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. Clinicians engage with older adults through home visits and well as consistent collaboration with family members and health providers.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $156,000

TARGET POPULATION: The target population is older adults (60+ years old), including individuals from underserved populations such as Latino, Asian, African-American, LGBTQ, low-income, and geographically isolated. Target population also includes primary care and other providers working with older adults.

EXPECTED NUMBERS TO BE SERVED: 60 individuals served through early intervention services.

KEY OUTCOMES:

- Earlier identification of mental/emotional difficulties and increased timely access to medically necessary services;
- Increased provider awareness of the mental health needs of older adults and linkage to appropriate community resources;
- Reduced stigma around mental health and help seeking within the older adult LGBTQ community;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI client satisfaction surveys. Provider workshop surveys to assess satisfaction, skill development and awareness of community resources. Additional outcomes measurement tools for early intervention services to be determined based on RFP process.
COMMUNITY TRAINING AND SUPPORTS (PEI 12)

SERVICE CATEGORY: STIGMA REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Capacity Building, Suicide Prevention

PROGRAM DESCRIPTION: 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). MHFA trainings are offered throughout the community. Eight to ten trainings are offered per year. Trainings include standard, youth, Spanish and Vietnamese. The type of trainings, locations, and frequency depend on the demand for the trainings.

In addition, funds are used for other strategies, such as training in suicide prevention; 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; trainings and stigma reduction efforts related to May is Mental Health Month including the Youth Mental Health Summit; and funding focused on community-wide equity and inclusion efforts aimed at reducing stigma.

Per the community planning process, this Three-Year Plan includes additional funding to increase community training and supports in community-led work in Marin City and a series of stigma reduction events/trainings in West Marin.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $160,000

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, first responders, 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.

EXPECTED NUMBERS TO BE SERVED: 1000

KEY OUTCOMES:

- increased understanding of mental health, suicide prevention and substance use disorders;
- increased knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse;
- reduced negative attitudes and beliefs about people with symptoms of mental health disorders;
- increased skills for responding to people with signs of mental illness and connecting individual to services;
- increased knowledge of resources available.

**MEASUREMENT TOOL(S):** For community trainings, we will use the CIBHS Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire. For MHFA, pre and post surveys to assess change in knowledge and behavior as well as a 3-month post survey to assess retention of knowledge and skills overtime. This 3-year planning cycle PEI will also incorporate evidenced based strategies to evaluate stigma reduction programs and outcomes such as utilizing tools from Patrick Corrigan's stigma evaluation toolkit.
SCHOOL-AGED PEI (PEI 18)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #2, #3, #4, #6

MARIN PEI PRIORITY STRATEGY AREA: School-Aged Prevention and Early Intervention

PROGRAM DESCRIPTION: School-based mental health programs help to build resiliency, increase protective factors and help to create meaningful connections between students, staff and caregivers. Providers support the implementation of Multi-Tiered Systems of Supports (MTSS) and provide a range of services and supports including:

- **Individual and group mental health counseling** to increase the students’ protective factors, reduce the risk of developing signs of emotional disturbance and increase the likelihood of success in school.
- **Training** for parents, school staff and community providers to identify and respond to signs of mental illness and support student wellness.
- **Coordination of Services** through multidisciplinary teams to improve coordination, communication and collaboration across disciplines and identify and address student needs holistically.
- **Supporting the implementation of school climate activities** such as Positive Behavior Intervention and Supports (PBIS), Social Emotional Learning (SEL) and Restorative Practices to help promote a school culture that is engaging and responsive to the needs of all students and their families.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $406,666

TARGET POPULATION: The target population is kindergarten through twelfth grade students (ages 5-18) 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.

EXPECTED NUMBERS TO BE SERVED: 500

KEY OUTCOMES:

- Reduced likelihood of behavioral problems and school failure;
- Improved academic performance and readiness to learn;
- Improved school connectedness;
- Early identification of students with behavioral problems that may indicate mental/emotional difficulties and increased timely access to early intervention or treatment services;
- Improved school culture and destigmatizing of mental health;
- Increased capacity of teachers to support students with challenges and understand the impact of trauma on learning;
- Increased service integration and more effective/equitable distribution of resources;
- Reduce Prolonged Suffering by increasing protective factors and reducing risk factors.
**MEASUREMENT TOOL(S):** PEI caregiver and client satisfaction surveys, workshop/training surveys. For early intervention services, providers will use the Child and Adolescent Needs and Strengths (CANS) assessment tool. COST Rubric to measure quality of Coordination of Services Team and support the development of team goals. School discipline and attendance data will also be utilized.
PROGRAM CONTINUATION X PROGRAM EXPANSION NEW PROGRAM

VETERANS COMMUNITY CONNECTION (PEI 19)

SERVICE CATEGORY: OUTREACH

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #6

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM DESCRIPTION: Veterans are recognized as being at high risk for mental illness and suicide, 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. This program continues to provide outreach to veterans throughout the county, particularly those who are homeless or involved in the criminal justice system, to link them to medically necessary mental health services.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $73,000

TARGET POPULATION: The target population is Marin County veterans who are homeless or involved in the criminal justice system. Most of the target population may be experiencing Post Traumatic Stress Disorder (PTSD), while some may experience depression or other concerns.

EXPECTED NUMBERS TO BE SERVED: 150

KEY OUTCOMES:

- Linkage to appropriate services within the county, community and the Department of Veteran’s Affairs (VA);
- Increased number of veterans permanently housed;
- Reduced prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI client satisfaction survey, housing and referral data, and outreach logs.
PEI STATEWIDE (PEI 20)

SERVICE CATEGORY: STIGMA REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM DESCRIPTION: Marin County contributes 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.

CalMHSA’s current strategies include:

- **Statewide social marketing 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

- **Facilitate collaboration and partnerships between counties** to create opportunities for shared learning and forging productive working relationships.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $81,000

TARGET POPULATION: CalMHSA targets all California residents with additional resources geared towards targeting high priority groups such as the Latino/Hispanic community, rural populations and youth.

OUTCOMES:

- Reduced Mental Illness Stigma and Increased Confidence to Intervene;
- Increased Knowledge and Improved Attitudes Toward Mental Illness;
- Increased capacity within counties to develop and implement comprehensive suicide prevention strategies.

MEASUREMENT TOOL(S): CalMHSA-Each Mind Matters California and Marin County Impact Statements

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SUICIDE PREVENTION (PEI 21)

SERVICE CATEGORY: SUICIDE PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #3, #4, #5

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM DESCRIPTION: In January of 2020, Marin County released its Suicide Prevention Strategic Plan (please see attached plan). BHRS is currently in the process of hiring a full-time Suicide Prevention Coordinator to coordinate all aspects of the strategic plan implementation.

Funding under Suicide Prevention will continue to fund Buckelew's North Bay Suicide Prevention Program which 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. Services are available in a wide range of languages through a phone interpreter service. Additional PEI suicide prevention funds will be used to provide community and targeted suicide prevention trainings for those at disproportionate risk of suicide.

Three Year Plan will also include funding for postvention supports such as identifying and implementing a suicide loss survivor outreach model (e.g. LOSS Team) and increasing access to support groups for loss survivors, as prioritized in the Suicide Prevention Strategic Plan.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $317,813

TARGET POPULATION: All residents of Marin County including veterans, middle-aged and older adults, LGBTQ+ and other residents at disproportionate risk for suicide; community-based organizations, school districts and county partners.

EXPECTED NUMBERS TO BE SERVED: 10,000

KEY OUTCOMES:

- Reduce suicide attempts and deaths in Marin County by:
  - Improving timely access to supports and services for individuals at risk of suicide, with targeted efforts for groups that are disproportionately affected by suicide;
  - Strengthening protective factors including building community connection and reducing stigma around discussing or seeking help for thoughts of suicide, mental health, or substance use issues;
  - Preparing individuals, communities, and organizations to recognize warning signs for suicide and confidence to intervene when someone is at risk.

MEASUREMENT TOOL(S): For community trainings, we will use the CIBHS Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire. Additional outcomes tools will be determined.
NEWCOMERS SUPPORT AND COORDINATION (PEI 23)

SERVICE CATEGORY: ACCESS AND LINKAGE

SB 1004 PRIORITY CATEGORIZATION: #1, #3, #4, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Newcomers Supports; School-Based Mental Health

PROGRAM DESCRIPTION: This program targets newly arrived immigrant youth primarily in middle and high schools in San Rafael, Novato, and West Marin. Utilizing a multi-tiered systems of support (MTSS) framework, the program is designed to support these young people in navigating school and community resources and accessing academic, legal, and mental health supports. Interventions are intended to build on their strengths and resilience in order to help them to succeed in school and beyond. A coordinator will provide assessment, linkage to resources, and short-term case management for students at San Rafael secondary schools. The coordinator will also conduct training for school staff on how to understand the unique needs of this population and support their learning and social-emotional development. This program also includes a continuation of existing PEI funded school-based newcomer groups that focus on issues such as grief and loss, acculturation, and building resources and supports.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $130,500

TARGET POPULATION: Recently arrived immigrant youth in Marin County schools.

EXPECTED NUMBERS TO BE SERVED: 400

KEY OUTCOMES:

- Improved school attendance and retention;
- Reduced likelihood of behavioral problems and school failure and/or unemployment;
- Reduce Prolonged Suffering by increasing protective factors and reducing risk factors;
- Improved school and community connectedness;
- Increased capacity of teachers to support newcomers and understand the impact of trauma on learning;
- Increased service integration, more effective linkage to/engagement with school and community resources for newcomers.

MEASUREMENT TOOL(S): Baseline data on attendance, discipline and school connectedness will be collected and analyzed to evaluate impact overtime. PEI caregiver and client satisfaction surveys, workshop/training surveys will also be utilized. Additional outcomes measurement tools to be determined based on the RFP process.
STORYTELLING PROGRAMS (PEI 24)

SERVICE CATEGORY: STIGMA REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4

MARIN PEI PRIORITY STRATEGY AREA(S): Capacity building, Suicide Prevention

PROGRAM DESCRIPTION: Marin County Storytelling Program is designed to raise awareness of mental health, suicide and substance use, create safe and healthy environments for sharing and increase knowledge of community resources. In May of 2019, The National Alliance on Mental Illness (NAMI)-Marin was awarded a contract to expand their “In Our Own Voices” storytelling series. The program is designed to create healthy environments of compassion, kindness, respect, non-judgment, and support.

In this 3-year MHSA plan, the Storytelling Program under PEI will be expanded (through an RFP process) to include a digital storytelling component. Participants in the digital storytelling program will have the opportunity to create short videos that share their personal experiences with mental illness, substance use, and recovery.

ESTIMATED MHSA EXPENDITURES FOR FY 20/21: $42,500

TARGET POPULATION: Community members and those with lived mental health and substance use experiences.

EXPECTED NUMBERS TO BE SERVED: 500

OUTCOMES:

- Increased understanding of mental health, suicide prevention and substance use disorders;
- increased knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse;
- reduced negative attitudes and beliefs about people with symptoms of mental health disorders;
- increased skills for responding to people with signs of mental illness and connecting individual to services;
- increased knowledge of resources available;
- improved skills and comfort level amongst speakers in public speaking and sharing their stories.

MEASUREMENT TOOL(S): For community trainings, we will use the CIBHS Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire, speakers’ evaluations to measure skill development and satisfaction with training component of program. This 3-year planning cycle PEI will also incorporate evidenced based strategies to evaluate stigma reduction programs and outcomes such as utilizing tools from Patrick Corrigan’s stigma evaluation toolkit. Additional outcomes measurement tools to be determined based on the RFP process.
# PEI COMPONENT BUDGET

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<tr>
<th>Program</th>
<th>FY20-21</th>
<th>FY2021-22</th>
<th>FY2022-23</th>
<th>% of budget for youth</th>
<th>FY20-21 Budget to be spent on youth 25 and under</th>
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**Subtotal Direct Services** | $2,152,793 | $2,100,813 | $2,100,813 | 64% | $1,344,116 | **$6,354,419** |

| Program | FY20-21 | FY2021-22 | FY2022-23 | | |
|---------|---------|-----------|-----------| | |
| PEI Supervisor | $124,000 | $124,000 | $124,000 | | $372,000 |
| Administration and Indirect | $341,519 | $333,722 | $333,722 | | $1,008,963 |
| Operating Reserve | $0 | $0 | $0 | | $0 |

**Total** | $2,618,312 | $2,558,535 | $2,558,535 | 53% | $7,735,382 |