MENTAL HEALTH SERVICES ACT (MHSA)
FY2021/2022
ANNUAL UPDATE
# Table of Contents

**EXECUTIVE SUMMARY** .................................................................................................................. 4  
Overview ........................................................................................................................................... 4  
Impact of COVID-19 ............................................................................................................................. 4  
Key Changes ......................................................................................................................................... 4  
Mental Health Services Act (MHSA) Background ............................................................................... 7  
**MARIN COUNTY CHARACTERISTICS** ....................................................................................... 9  
Racial/Ethnic Disparities in Service Utilization: ............................................................................... 11  
Age Disparities in Service Utilization: ............................................................................................... 14  
Gender Disparities in Service Utilization: .......................................................................................... 16  
Geographic Disparities in Service Utilization: .................................................................................. 17  
**COMMUNITY PROGRAM PLANNING PROCESS (CPPP): STAKEHOLDER ENGAGEMENT** ........... 18  
Background ......................................................................................................................................... 18  
Ongoing Stakeholder Input .................................................................................................................. 19  
MHSA Three-Year Planning Process for FY20/21 Through FY22/23 ............................................... 19  
Stakeholder Participation Demographics ............................................................................................ 29  
Annual Update Planning .................................................................................................................... 32  
MHSA Plan Public Review Process .................................................................................................. 32  
Public Comments on the Proposed Plan ........................................................................................... 32  
Substantive Changes made during the Public Comment Period ...................................................... 32  
**INNOVATION COMPONENT** ....................................................................................................... 33  
Overview ............................................................................................................................................ 33  
Older Adult technology suite innovation project .............................................................................. 34  
Innovation Component Budget .......................................................................................................... 41  
**COMMUNITY SERVICES AND SUPPORTS (CSS)** .................................................................... 42  
Overview ............................................................................................................................................ 42  
Capacity Assessment ............................................................................................................................ 43  
Full-Service Partnership Demographics ............................................................................................. 46  
Youth Empowerment Services (YES) Full-Service Partnership: FSP 01 ......................................... 50
Transition Age Youth (TAY) Full-Service Partnership: FSP 02 ................................................................. 53
Support and Treatment After Release (STAR) Full-Service Partnership: FSP 03 ........................................ 57
Helping Older People Excel (HOPE) Full-Service Partnership: FSP 04 ......................................................... 60
Odyssey Full-Service Partnership: FSP 05 ......................................................................................................... 64
Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT): FSP 06 .......................... 68
Enterprise Recovery Center (ERC) Expansion: SDOE 01 ............................................................................... 71
Crisis Continuum of Care: SDOE 09 ............................................................................................................... 74
First Episode Psychosis (FEP): SDOE 10 .......................................................................................................... 81
Consumer-Operated Wellness Program: SDOE 11 *(Empowerment Clubhouse)* ................................... 85
Recovery-Oriented System Development: SDOE-13 ......................................................................................... 89
MHSA Stepping-Up Program: SDOE-14 ......................................................................................................... 91
Community Outreach and Engagement: SDOE-15 ......................................................................................... 94
Homeless-Focused Support and Outreach: SDOE-16 ..................................................................................... 96
MHSA Housing Program: MHSA HP ............................................................................................................. 97
Community Services and Supports (CSS) Component Budget .................................................................... 99
Full-Service Partnership (FSP) Estimates for Number to be Served by Age Group .................................. 100
Community Services and Supports (CSS) Cost Per Person Estimates for FY21/22 ................................. 101
WORKFORCE EDUCATION AND TRAINING (WET) ............................................................................. 102
Component Overview .................................................................................................................................. 102
Training and Technical Assistance .............................................................................................................. 103
Mental Health Career pathways .................................................................................................................... 104
Regional Partnership: Financial Incentive Program .................................................................................... 105
Workforce Staffing Support ......................................................................................................................... 106
Workforce Education and Training (WET) Component Budget .................................................................. 107
CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN) ............................................................. 108
Electronic Health Record and Practice Management System Enhancements ........................................... 108
Coordinated Case Management system ..................................................................................................... 109
Tele-Health Improvements .......................................................................................................................... 110
Website Enhancements ............................................................................................................................... 110
Capital Facilities and Technological Needs (CFTN) Component Budget .................................................. 111
PREVENTION AND EARLY INTERVENTION (PEI) .................................................................................... 112
Overview ....................................................................................................................................................... 112
# TABLE OF CONTENTS

- Overview of FY19/20 Programs (Outcomes reporting year) ................................................................. 119
- Compliance with Regulations .................................................................................................................. 123
- FY 19/20 Demographics ....................................................................................................................... 125
- Early Childhood Mental Health (ECMH) (PEI 01) .................................................................................. 135
- Transition Age Youth (TAY) Prevention and Early Intervention (PEI 04) .......................................... 141
- Latino Community Connection (LCC) (PEI 05) ................................................................................... 150
- Older Adult Prevention and Early Intervention (PEI 07) ................................................................. 157
- Vietnamese Community Connection (PEI 11) (Ended FY19/20) ...................................................... 164
- Community Training and Supports (PEI 12) ......................................................................................... 168
- School-Aged PEI (PEI 18) ...................................................................................................................... 176
- Veterans Community Connection (PEI 19) .............................................................................................. 192
- PEI Statewide (PEI 20) ......................................................................................................................... 197
- Suicide Prevention (PEI 21) .................................................................................................................... 201
- Health Navigator (PEI 22) (Ended FY19/20) ......................................................................................... 206
- Newcomers Support and Coordination (PEI 23) .................................................................................... 208
- Storytelling Programs (PEI 24) ............................................................................................................ 209
- PEI Component Budget ......................................................................................................................... 210
- Prevention and Early Intervention (PEI) Expected Numbers to be Served and Cost Per Person ...... 211
- TOTAL BUDGET ................................................................................................................................. 212
EXECUTIVE SUMMARY

OVERVIEW

The FY21/22 Annual Update provides an opportunity to make updates to the MHSA FY20/21-22/23 Three Year Plan as well as report on outcomes and activities from FY19/20 (Fiscal Year from July 1, 2019-June 30, 2020). FY19/20 was the final 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

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 or quarantine sites and food distribution centers.

KEY CHANGES

During our extensive community planning process for the FY20/21-FY22-23 Three Year Plan we had been preparing our budgets with a $5M increase for Community Services and Supports (CSS) to be applied to each of the three years. However, due to COVID and the uncertainty around the economy, the budget was scaled back to a $3.6M increase for each of the years. However, despite the uncertainty, MHSA funding was not affected the way that had been anticipated during the early months of the pandemic. The revenue source for the MHSA comes from a 1% tax on all personal income over $1M and individuals who were in that tax bracket were not affected by the economic realities of the pandemic in the way that was anticipated. Therefore, we are planning to restore many of the hoped-for growth items that were cut during the early months of the pandemic prior to the release of our Three-Year Plan. However, many of these growth items will need to be considered temporary as they are still relying on spending reserve funding.
Throughout the COVID pandemic BHRS held over 100 events with the community to hear about how COVID has impacted their lives, to strategize around suicide prevention, provide support for family members and caregivers, provide training, continue the work of the MHSA Advisory Committee and the Mental Health Board, and to provide a space to come together as a community. These meetings and the community planning process for the Three-Year plan informed the following proposed changes to the MHSA FY21-22 Annual Update with a focus on promoting equity and better serving underserved populations:

COMMUNITY SERVICES AND SUPPORTS (76% of MHSA funding):

- Creating three additional *county Peer Specialist positions* (the goal is to add at least two county Peer positions each year until the need is met)—Odyssey FSP and Youth Empowerment Services FSP (bilingual)
- Adding a full-time *Substance Use Counselor* (Social Service Worker) to the Odyssey Full-Service Partnership.
- System development to ensure services are welcoming and supportive for LGBTQ+ clients, families, and staff.
- *Mental Health Housing Coordinator* (Senior Program Coordinator) to improve tracking, outcomes, assess needs, coordinate services, and provide supportive contract management for BHRS housing providers.
- Increase funding for *housing contractors* that have not had a recent increase to support higher wages for contracted direct care staff.
- Three *Mental Health Practitioner* (MHP) positions to meet four crucial needs:
  - Increase ability for step downs from FSPs to the BRIDGE Team by adding a case manager to the BRIDGE Bon Air team
  - The BRIDGE Bon Air MHP will be a recruitment specifically for someone with experience in alternative and cultural healing practices to widen the array and cultural competency of the services offered within BHRS
  - In addition, BHRS would hire two additional MHPs to serve as a “floaters” on the FSP teams or Access to provide coverage when a MHP position is either vacant or on extended leave. Currently, all FSP teams are down staff members either due to leave or extended vacancies creating a huge burden on staff and increased caseloads, decreasing quality of care for clients. This would help start to fill this gap and provide more support during the long hiring processes whenever there is turnover.
  - These MHPs would also provide therapy to increase our therapy capacity
- Creating a *Support Service Worker II-Bilingual* position for the Access team to help reduce ethnic/racial disparities and improve timeliness standards in answering incoming calls, scheduling urgent appointment requests, as well as being a resource for clients around billing questions and options in both English and Spanish. Through our community planning process, we consistency heard that questions and uncertainty around billing often dissuade potential clients from seeking or utilizing services so this position will help make that process smoother and more understandable.
- Provide matching funding for the creation of a *Forensic Mental Health Program Manager* to promote equity and recovery throughout the Forensic system of care
• Provide the local match for a contract for **Therapeutic Foster Care** (TFC): a short-term, intensive, highly coordinated, trauma informed and individualized rehabilitative service that is provided to a child/youth up to age 21 with complex emotional and behavioral needs who is placed with trained and intensely supervised and supported TFC parents.

**WORKFORCE EDUCATION AND TRAINING (WET) — funded by a transfer from CSS:**

• Fund an **Administrative Services Technician** to support Workforce Education and Training Programs including the Peer Program Coordinator, WET Steering Committee/Cultural Competency Advisory Board, Internship Program, and as well as front desk support for the Kerner site.

• Create a program to promote retention by supporting supervision hours required for pre-licensed staff/interns throughout the Public Mental Health System in Marin (including contracted providers)

**CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN) — funded by a transfer from CSS:**

• Start to build a funding reserve for a new **Electronic Health Records system** by transferring $500,000 to CFTN.

**PREVENTION AND EARLY INTERVENTION (PEI) — 19% of MHSA funding:**

• Contracting with a Community Based Organization to build and coordinate a Local Outreach to Suicide Survivors (LOSS) Team.

• Funding BHRS mental health and suicide prevention marketing campaign that began in FY 19/20 under county one-time discretionary funds.

• Provide additional supports for Older Adults through training of

**INNOVATION (INN) — 5% of MHSA funding; allocated through a separate approval process:**

• Two new Innovation Proposals are going through a separate approval process for FY21-22:
  
  o *From Housing to Healing, A Re-Entry Community for Women*
  
  o *Student Wellness Ambassador Program (SWAP): A County-Wide Equity-Focused Approach*
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 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 in part to the land use restrictions and other factors there is limited affordable housing resulting in 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 tenth time in 11 years, Marin County was ranked as the healthiest county in California by the Robert Wood Johnson Foundation. The 2021 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 in the 2019 data, 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 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. There was a slight increase in utilization going from 23.4% of those served by BHRS in FY18/19 to 24.0% in FY19/20.

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 FY19/20 utilization data, Asian/Pacific Islanders are now served at a substantially equivalent rate as the Medi-Cal population (5.6% served vs 5.9% 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.
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.
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.

AGE GROUP DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS

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. At the culmination of the Growing Roots Innovation Project in 2018 and still true for FY19/20, BHRS had the highest penetration rate with TAY with a penetration rate that is the equivalent of 8.44% of the Medi-Cal population. New in FY19/20, Older Adults are now have the second highest penetration rate that is the equivalent of 8.42% of the Medi-Cal population.
MARIN COUNTY CHARACTERISTICS

PENETRATION RATE BY AGE GROUP FY19/20

- All Ages: 7.16%
- 60 and older: 8.42%
- 26-59: 7.98%
- 16-25: 8.44%
- 6-15: 6.18%
- 0-5: 0.99%
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 FY19/20
MC Beneficiaries = 39,299 people
BHRS Served = 2,813 people

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

- Male
- Female
- Another Gender Identity
- Not Reported
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. Unlike the previous year, West Marin no longer appears as underserved based on the data (3.7% of the Marin Medi-Cal population lives in West Marin and 3.9% of those served by BHRS in Marin in FY19/20 lived in West Marin). However, in FY19/20 the penetration rate for BHRS services for Hispanic/Latinx Medi-Cal beneficiaries in West Marin was 1.7%, almost half the penetration rate for Hispanic/Latinx Medi-Cal beneficiaries county-wide (3.3%).

Marin City/Sausalito as a whole remains underserved with their proportion of beneficiaries (4.5%) higher than their proportion of BHRS clients. In FY17/18, 2.9% of those served by BHRS in Marin lived in Marin City/Sausalito, in FY18/19 it was 3.6%, and in FY19/20 it was back down to 3.0%. Due to this, BHRS will be using MHSA Community Planning funding to launching a specific Marin City needs assessment phase to better serve this community going forward and report out on it in the next MHSA Annual Update.
COMMUNITY PROGRAM PLANNING PROCESS (CPPP): STAKEHOLDER ENGAGEMENT

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 unserved 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, the Mental Health subcommittee of the Marin County Youth Commission, 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.

During the COVID pandemic all of these committees have been meeting virtually rather than in person.

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.
• Practicing skills needed to effectively participate.
• Collaborating to develop a plan for collective action.

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>Barriers</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>14%</td>
<td>21%</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>55%</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>
</tbody>
</table>
Please select up to three (3) strategies that you think would be the most effective for delivering behavioral health services in your community

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Spanish % (n=74)</th>
<th>English % (n=238)</th>
</tr>
</thead>
<tbody>
<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>
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).
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 Latinx 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!
ANNUAL UPDATE PLANNING

Each year of this Three-Year Plan BHRS conducts an Annual Update community planning process to make any changes to the plan and to report on outcomes from each program. During this COVID year, BHRS held over 100 community events, trainings, meetings, support groups or other virtual gatherings to hear from community members about what they are going through during COVID and how we can assist. The MHSA Advisory Committee and Mental Health Board continued to meet virtually, discussing MHSA at each meeting. The outcomes and priorities were discussed at the April MHSA Advisory Committee meeting. The changes made in this annual update reflect the priorities from the extensive 3-Year Planning Process that were put on hold during the uncertainty with the economy. These priorities have now been modified and informed by this ongoing community stakeholder input during COVID.

MHSA PLAN PUBLIC REVIEW PROCESS

The MHSA FY21/22 Annual Update will be posted for 30-day Public Comment beginning on May 9, 2021 and remain posted through June 8, 2021. The Annual Update will be 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. Notice of the posting will be published in the Marin Independent Journal.

On Tuesday, June 8, 2021 a virtual Public Hearing will be held during the Mental Health Board meeting at 6pm.

PUBLIC COMMENTS ON THE PROPOSED PLAN

List of all comments received during the 30-day public comment period and Public Hearing:

SUBSTANTIVE CHANGES MADE DURING THE PUBLIC COMMENT PERIOD

No substantive changes were made to the proposed plan during or after the public comment period.
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.

Marin’s third Innovation Project, focused on innovative approaches to serving older adults, is ongoing and reports on progress during FY19/20 are shared on the following pages.

During in FY20/21 there was extensive community planning for the next MHSA Innovation Projects. Per recommendation from the MHSA Advisory Committee, two projects are planned to be brought to the Mental Health Services Oversight and Accountability Commission for approval. Please see the appendix for the detailed Innovation Proposals for those two proposed projects.
OLDER ADULT TECHNOLOGY SUITE INNOVATION PROJECT

PROGRAM OVERVIEW

The Help@Hand Project (previously known as the Innovation Technology Suite) is a multi-county/city Innovation project designed to determine if and how technology fits within the behavioral health system of care. This project was approved by the MHSOAC in September of 2018 (during FY18/19) for a total project budget of $1,580,000. Help@Hand provides support for Marin County older adults to access wellness apps and digital literacy training through 2023. The intent of this 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
- 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
- Pilot 1 (40 participants): 50% older adults who are geographically isolated (West Marin) and 50% whose primary language is Spanish throughout Marin County

PROGRAM DESCRIPTION

There are 5 key components of the project that Marin County is focused on are:

- **Identifying and selecting an app** for the older adult community: Marin has conducted focus groups with older adults and meetings 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 Onboarding and Behavioral Health Literacy Training**: The purpose of this component of is to help individual (older adults) develop or improve knowledge, skills, and behaviors to effectively and safely use digital devices. Marin has contracted with a non-profit,
Technology4Life, that has experience in Marin training older adults around the use of technology. This training in digital literacy is being rolled out prior to the use of the selected behavioral health application to ensure participant knowledge and safety engaging with technology.

- **Peers:** 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.

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

- **Marketing/Outreach - Detect and Connect:** One of the major initiatives of the first three years of this Marin Innovation Project was to expand outreach and marketing by partnering with the Aging Action Initiative on a training project around older adult mental health and dementia to a wide range of audiences to teach them about available resources. This training is called Detect and Connect and has been an avenue to promote education, provide outreach, and spread the word about the Apps and other resources.

**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.

Desired 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 public awareness of mental illness in older adult population and reduction in stigma as measured by pre and post workshop evaluations – detect and connect?
4. Increased quality of life, as measured subjectively by the user and objectively by engagement in social activities, community involvement, etc.
5. Increased user ability to identify cognitive, emotional, and behavioral changes and actively engage in strategies to address them

**HIGHLIGHTS AND OUTCOMES FROM FY19/20**

- Help@Hand Advisory Committee members helped recruit focus group members to test technology, outlined outreach plans and strategies considering the needs of Marin’s isolated older adults, and provided insights on considerations for the pilot project evaluation, including individuals representing the following:

  - Peers
  - Commission on Aging, Marin County
  - Technology4Life, CBO
  - Helping Older People Excel (HOPE), Marin County
- JFCS, Seniors at Home
- Aging Action Initiative
- Division of Aging, Marin County
- Marin Asian Advocacy Project
- Bridge the Gap
- Marin City Community Dev. Corp
- JFCS, Youth First Coordinator
- Digital Behavioral Health Consultant

- Evaluation framework built and learning questions established with UC Irvine for focus group testing and future pilots
- Marin successfully tested two technologies remotely (due to the Pandemic) with two different focus groups of older adults, peers and individuals that speak Spanish. Feedback from these focus groups informed a decision to launch two pilot projects for further evaluation – myStrength™ and Unipercare.
- Building on lessons learned and challenges that emerged with the focus groups assisting older adults with technology remotely, Marin identified the need for official pilot to include significant digital literacy support; through an RFP process, Marin was able to contract with a local nonprofit with expertise in teaching digital literacy to older adults to offer a core set of curriculum to program participants
- Peer Lead hired and onboarded
- myStrength™ and Uniper pilot approved by compliance, county counsel, and IT
- Partnership with the Telehealth Equity Program was established between the Division of Behavioral Health and Recovery Services and the Division of Aging and Adult Services. This partnership provided project participants access to in-person and remote support by nurse interns from the University of San Francisco and Dominican University Nursing Education Programs. The nurses provided support for digital onboarding and ongoing support for digital literacy coaching, as well as assisting older adults in accessing other supports related to the social determinates of health, such as access to Covid-19 vaccines an in-home safety assessment
- Promotores and a peer were engaged to provide coaching support to some Spanish Speaking participants, which has provided culturally responsive engagement with a more flexible schedule
- Four digital literacy classes (Computer Basics, Internet Basics, E-mail Basics and Introduction to myStrength™) were designed to address the digital divide and a master class schedule was created for engaging participants with varying levels of digital literacy
- Comprehensive training manual created for interns, peers and Promotores, including guidance from the Division of Public Health to address Covid-19 safety protocols
- Pilot timelines and proposal approved - 14 county endorsement
- Established online system for enrolling community members through CBOs and community partners
- Successfully recruited over 41 older adults to engage in project, including 10 who have never owned a device or had Wi-Fi (Pilot Start in January, 2021)
• 12 focus group members were actively engaged in testing 2 apps each, informing the decision to pilot 2 technologies in FY20/21 as well helping shape pilot design
• Detect and Connect trained a total of 501 community members, building awareness of older adults and mental health issues and dementia
• Detect and connect trained 9 trainers to engage the community (virtually and in-person)

See attachment 1: Technology Testing in Marin Technology Learning Update (UC Irvine)

DEMOGRAPHIC INFORMATION

Participant demographics for Focus Group Testing:

Gender: Six participants identified as women, and five as men.

Age: Six participants were between 65-84 years old, one was between 60-64 years old, and one was between 85-89 years (three declined to answer).

Race: Six participants identified as White, one as Latinx/Hispanic, one as Black/African-American, and one as Southeast Asian (two declined to answer).

Language: Ten participants' preferred language was English. Two participants spoke Spanish, and for one, Spanish was their preferred language.

Education: Eight participants had graduate or professional degrees, two had bachelor's degrees, and one had some college experience.

Household Annual Income: Seven participants had income under $50,000, and two had $75,000 or over (two declined to answer).

Mental Health: Six participants indicated that they had experienced mental health concerns while four had not experienced mental health concerns (one declined to answer).

Digital Literacy: The majority of participants (n=10) were confident using technology.

UPCOMING CHANGES

Help@Hand has completed the digital onboarding and digital literacy component of our first pilot in early 2021. Participants are now actively engaged in using the myStrength™ service and getting as needed coaching from nurse interns, Promotores and peers. After 8 weeks of using the service, the following learning questions will be addressed through a robust evaluation with UCI. A sample of learning questions the evaluation is designed to explore include:

• To what extent does the experience of using these technologies differ for Older Adults who primarily speak English and those who primarily speak Spanish?
• What are the most effective strategies for recruitment of older adults within the county? [consider Monolingual Spanish speakers versus English]
• What is the motivation to participate in this? (e.g., to help other people) How did you become aware?
• How do older adults respond to a nurse interns, peers or Promotores in the context of digital literacy training and technology assistance?
• To what extent is the user experience similar or different for Spanish speakers versus English speakers?
• To what extent are products culturally-relevant/appropriate?
• To what extent is user behavior different for Spanish speakers versus English speakers (e.g. do they use different parts of the product, are all parts of the product available in Spanish?)
• What changes do older adults report in their sense of social-connectedness due to participation in this program?
• What changes do older adults report in their sense of health and well-being due to participation in this program?
• Will there be a reduction in mental health symptoms after engaging in the program?
• Digital literacy / How much time / effort does it take to get people "up to speed" for digital literacy?

The first Help@Hand pilot will be completed in Mid-May, 2021. Planning for the second pilot is currently in design phase.
The following is an overview of the overall 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
October-December 2020
- Define pilot success metrics
- Develop recruitment strategies
- Design curriculum
- Present pilot plan to collaborative leadership for approval
- Refine community marketing, outreach and awareness plans
- Integrate peer feedback

January-May 2021
- Launch Pilot 1
- Refine outreach and marketing plans
- Wrap up pilot evaluation
- Determine next steps for implementation
- Begin Pilot 2 Design Conceptualization - Uniper Care

May 2021-Dec 2023
- Create timeline- Pilot 2
- Identify project partners
- Outline recruitment strategies
- Identify unique evaluation strategies
- Run Pilot 2
- Compare and review data collection from both pilots
- Select product for full scale implementation
INNOVATION COMPONENT BUDGET

Prior to spending Innovation funding a project must be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) however, this budget below includes proposed budgets for future project that have not yet been approved the MHSOAC to facilitate planning.

<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>From Housing to Healing, Re-Entry Community for Women</td>
<td></td>
<td>$229,587</td>
<td>$320,827</td>
<td>$550,414</td>
</tr>
<tr>
<td>Student Wellness Ambassador Program (SWAP): A County-Wide Equity-Focused Approach</td>
<td></td>
<td>$231,250</td>
<td>$466,500</td>
<td>$697,750</td>
</tr>
<tr>
<td>Total</td>
<td>$518,443</td>
<td>$863,322</td>
<td>$978,313</td>
<td>$2,360,078</td>
</tr>
</tbody>
</table>

Note: project total is $1,580,000 including prior fiscal years
Note: project total is $1,795,000 including future fiscal years
Note: project total is $1,648,000 including future 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 expenditures through CSS (including leveraged Medi-Cal revenue) is designated for FSPs per regulations—however in FY19/20 statewide COVID flexibilities temporarily suspended this requirement.

**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 or community-defined 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

This capacity assessment is from the Three-Year Plan. 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. There are many challenges and barriers to success as well as strengths and strategies being implemented to try to overcome many of the barriers.

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%).

![BHRS Workforce Demographics 2017-2019](chart)

- White: 19.3% 10.2% 9.2%
- Hispanic or Latino: 55.8% 24.7% 19.3%
- Asian: 3.7% 3.2% 10.2%
- Black/African American: 0.5% 0.5% 0.5%
- Two or More Races: 1.0% 0.5% 1.0%
- Native Hawaiian/Other Pacific Islander: 5.4% 3.5% 1.0%
- American Indian/Alaska Native: 10.5% 3.7% 0.5%
- Undeclared: 0.5% 1.0% 0.5%
CHALLENGES:
- Continuously increasing bilingual/bicultural staffing;
- BHRS’ cultural competence-related trainings lack 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:
- Difficulty recruiting bilingual bicultural staff
- 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
- 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.
Race/ Ethnicity FY18/19
MC Beneficiaries = 39,632 people
BHRS Served = 2,819 people
BHRS Staff = 202 people

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Medi-Cal Beneficiaries (%)</th>
<th>BHRS Served (%)</th>
<th>Staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian or White</td>
<td>53%</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>49%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>7%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>5%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/Native/Pacific Islander</td>
<td>6%</td>
<td>5%</td>
<td>11%</td>
</tr>
</tbody>
</table>
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, each of our FSPs are listed then a total and then on the right side of the chart is the Marin Medi-Cal population data.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>TAY</th>
<th>STAR</th>
<th>Odyssey</th>
<th>HOPE</th>
<th>IMPACT</th>
<th>Total</th>
<th>Marin Medi-Cal Pop</th>
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</thead>
<tbody>
<tr>
<td>Unknown / Not Reported</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>2152</td>
<td></td>
</tr>
<tr>
<td>Other/Multiple</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>19</td>
<td>680</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>70</td>
<td>16</td>
<td>10</td>
<td>14</td>
<td>3</td>
<td>7</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>6</td>
<td>15</td>
<td>29</td>
<td>79</td>
<td>53</td>
<td>28</td>
<td>210</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>18</td>
<td>1</td>
<td>5</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Asian/Native Hawaiian/Pacific Islander</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>5</td>
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<td>American Indian</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>
### FY 19/20 FSP Partners' Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>YES</th>
<th>TAY</th>
<th>STAR</th>
<th>Odyssey</th>
<th>HOPE</th>
<th>IMPACT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>28</td>
<td>66</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>6-15</td>
<td>0</td>
<td>0</td>
<td>41</td>
<td>91</td>
<td>0</td>
<td>40</td>
<td>172</td>
</tr>
<tr>
<td>16-25</td>
<td>39</td>
<td>42</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>26-59</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>60 and older</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Marin Medi-Cal Pop</td>
<td>6162</td>
<td>17590</td>
<td>5475</td>
<td>6327</td>
<td>3745</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Percentage Distribution:**
- 0-5: 10%
- 6-15: 20%
- 16-25: 30%
- 26-59: 40%
- 60 and older: 50%
FY 19/20 FSP PARTNERS' GENDER

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>TAY</th>
<th>STAR</th>
<th>Odyssey</th>
<th>HOPE</th>
<th>IMPACT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another Gender</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>41</td>
<td>17</td>
<td>12</td>
<td>49</td>
<td>40</td>
<td>17</td>
<td>176</td>
</tr>
<tr>
<td>Male</td>
<td>48</td>
<td>25</td>
<td>37</td>
<td>74</td>
<td>26</td>
<td>29</td>
<td>239</td>
</tr>
</tbody>
</table>

County of Marin FY21/22 Mental Health Services Act (MHSA) Annual Update
### FY 19/20 FSP Partners' Preferred Language

<table>
<thead>
<tr>
<th>Language/Not Reported</th>
<th>YES</th>
<th>TAY</th>
<th>STAR</th>
<th>Odyssey</th>
<th>HOPE</th>
<th>IMPACT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnamese</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Unknown / Not Reported</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Spanish</td>
<td>25</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>44</td>
</tr>
<tr>
<td>Other Non English</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Farsi</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>English</td>
<td>61</td>
<td>37</td>
<td>43</td>
<td>114</td>
<td>60</td>
<td>42</td>
<td>357</td>
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</tbody>
</table>

**Note:** The data represents the percentage of partners preferring each language for FY 19/20.
COMMUNITY SERVICES AND SUPPORTS (CSS) – YOUTH EMPOWERMENT SERVICES (YES) – FSP 01

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.

In FY20/21-22/23 Three-Year Plan, the budget for YES was increased 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 approximately 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 days in residential placements
4. Decrease arrests

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.

FY19/20 OUTCOMES:

In FY19/20 there were 89 partners served in YES including 50 youth (between the ages of 6 and 15) and 39 Transitional Age Youth (between the ages of 16 and 25). 75 of these partners were in the program for one year or longer at the end of FY19/20.

1. **76% Decrease in Psychiatric Hospitalization days:** Of the 75 partners who had been enrolled in YES for at least one year, 18 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 139 hospitalization days. In FY19/20, there were 7 partners (61% decrease in number of partners) who had been enrolled in YES for one year or more who experienced a psychiatric hospitalization in FY19/20, for a total of 34 hospitalization days—a 76% decrease from the baseline year.

2. **100% Increase in days Homeless:** In the twelve months prior to entry into the FSP, none of the 75 partners had experienced homelessness in the year before services. In FY19/20, there was one client who experience homeless. This individual was homeless for all 365 days of FY19/20.

3. **70% Decrease in Residential Treatment days:** In the twelve months prior to entry into the FSP, 2 of the 75 partners were in residential treatment for a collective 255. In FY19/20, there was again 2 partners who spent at least one night in residential treatment for a total of 76 days—a 70% decrease in residential treatment days from the baseline year.
4. **87% Decrease in number of Arrests**: Of the 75 partners who had been enrolled in YES for at least one year, 19 had experienced at least one arrest in the year prior to enrollment for a collective 31 arrests. In FY19/20, there were 3 partners (84% decrease in number of partners) who had been enrolled in YES for one year or more who were arrested in FY19/20, for a total of 4 arrests—an 87% decrease from the baseline year.

**PROGRAM CHANGES FOR FY21/22**: Two bilingual County Peer Specialists will be added to the YES team to promote equity, enhance the multi-disciplinary capacity of the team, and promote recovery. In addition, funding for Therapeutic Foster Care will be included for FSP clients or potential clients.
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 transition age youth (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, a (0.5 FTE) Clinical Case Manager was added, increasing the caseload to 24. In FY19/20 additional Psychiatry time, administrative support, and flex funds were added increasing the program caseload to 28. In FY20/21 safety net funding was added for eating disorder treatment costs for TAY partners.

PROGRAM CHANGES:

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

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 is 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 approximately ~28 TAY receiving FSP services at any point in time.

**EXPECTED OUTCOMES:**

- decrease psychiatric 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.
FY19/20 OUTCOMES:

In FY19/20 there were 42 partners served in TAY including 35 Transitional Age Youth (between the ages of 16 and 25) who had been in the program for one year or longer and were served during FY19/20.

1. **27% Decrease in Psychiatric Hospitalization days:** Of the 35 partners who had been enrolled in TAY for at least one year, 10 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 155 hospitalization days. In FY19/20, there were 5 partners (50% decrease in number of partners) who had been enrolled in TAY for one year or more who experienced a psychiatric hospitalization in FY19/20, for a total of 113 hospitalization days—a 27% decrease from the baseline year.

2. **33% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 2 partners had experienced homelessness in the year before services for a total of 365 days. In FY19/20, there were 2 clients who experienced homelessness for a total of 243 days—a 33% reduction in days homeless.

3. **No change in incarceration days:** In the twelve months prior to entry into the FSP, 1 of the 35 partners experienced one day in jail. In FY19/20, there was again 1 partner who spent one day in jail—no change from the baseline year.

4. **61% of the TAY partners were engaged with work in FY19/20 and 20% were engaged with school.

5. **20 TAY enhanced their Independent Living Skills (ILS) by attending 2 or more groups or activities.** The TAY Space Peer Advocates provided extensive individual ILS preparation and support working individual with youth and in small groups including school enrollment and financial aid applications, helping to schedule dental and medical appointments, helping to apply to jobs and practicing interviews, cooking, shopping, budgeting, preparing and going with youth to the DMV for ID cards, drivers permits and licenses. TAY Space staff use Motivational Interviewing.
techniques to engage individually with youth helping them examine their hopes, strengths, capabilities and challenges to increase independence.

CLIENT STORY: Jonny endured a lot of domestic violence and abuse as a child. His parents had immigrated to the US in search of financial opportunity and had found economic hardship and loss of community instead. After his father left, Jonny was drawn to a youth gang in order to earn the validation and acceptance he sought. The anger that he carried internally led Jonny to act-out in exceedingly dangerous and violent ways which prevented him from completing his education and caused him to be incarcerated repeatedly. Unable to find the support he needed, Jonny became abusive to his significant other and developed an intravenous substance-addiction. He believed he would be deceased before he saw 20 years of age.

Instead he found the TAY Program. Jonny has worked diligently with his Case Managers and has made a heroic effort to turn his life around. He has recently completed his Probation-mandated substance recovery program and has abstained from all substance use for over 1 year. Jonny is working full-time and is helping his mother and sister to afford rent in their Novato apartment. He remains focused on successfully completing anger-management classes and looks forward to earning his GED and a California driver’s license this year.

Despite his challenges, Jonny now keeps a positive attitude and a level-head. He enjoys being a role-model for his cousins and aspires to be an at-risk youth counselor when he completes his education. It has been a tremendous joy to watch this young man’s growth in the TAY Program. He is a testament to how much can be accomplished when we make a decision to trust and to work alongside those who are there to offer us help with the next step. We are very proud of him!

PROGRAM CHANGES FOR FY21/22: No changes.
SUPPORT AND TREATMENT AFTER RELEASE (STAR)
FULL-SERVICE PARTNERSHIP: FSP 03

PROGRAM ALLOCATION FY21/22: $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); mental health case managers, one of whom is bilingual/bicultural Spanish speaking; a clinical psychologist; peer/lived-experienced specialist (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); psychology interns/therapists; an 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: Expanded in FY20/21 to serve 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 (KE T) 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.

FY19/20 OUTCOMES:

In FY19/20 there were 49 partners served in STAR, 47 who had been in the program for one year or longer.

1. **74% Decrease in Psychiatric Hospitalization:** Of the 47 partners who had been enrolled in STAR for at least one year, 22 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 368 hospitalization days. In FY19/20, there were 6 partners who had been enrolled in STAR for one year or more who experienced a psychiatric hospitalization in FY19/20, for a total of 97 hospitalization days.
2. **92% decrease in incarceration days**: In the twelve months prior to entry into the FSP, 40 of the 47 partners had experienced incarceration for a collective 4,416 days in custody in the year before services. In FY19/20, 12 of these 47 partners spent a collective 339 days in custody during FY19/20, for a 92% decrease in incarceration days.

3. **57% decrease in days homelessness**: In the twelve months prior to entry into the FSP, 15 of the 47 partners had experienced homelessness for a collective 1,746 days homeless in the year before services. In FY19/20, 8 FSP partners who had been enrolled in STAR for over one-year experienced homelessness at any point during FY19/20 for a collective 750 days homeless, a 57% decrease.

Overall, in FY19/20 there was a 81% decrease in total “Crisis Days” for partners who had been enrolled for one year or longer in STAR.

**PROGRAM CHANGES FOR FY21/22**: No changes.
HELPING OLDER PEOPLE EXCEL (HOPE) FULL-SERVICE PARTNERSHIP: FSP 04

PROGRAM ALLOCATION FY21/22: $824,366

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.

In FY20/21 additional funding was 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). In addition, for 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 with supplemental CBO contracts

**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. To protect the health of our client’s during the COVID-19 pandemic, field visitations are only provided on an as needed basis in addition to the 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, which is funded through County General Funds and 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 psychiatric hospitalization
2. Decrease incarceration
3. Decrease homelessness
4. *New in the MHSA FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update:* 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.
- *New in the MHSA FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update:* 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

**FY19/20 OUTCOMES:**

In FY19/20 there were 66 partners served in HOPE, 46 who had been in the program for one year or longer.

4. **90% Decrease in Psychiatric Hospitalization:** Of the 46 partners who had been enrolled in HOPE for at least one year, 12 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 240 hospitalization days. In FY19/20, there was only one partner...
who had been enrolled in HOPE for one year or more who experienced a psychiatric hospitalization in FY19/20, for a total of 25 hospitalization days.

5. **100% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 4 of the 46 partners had experienced incarceration for a collective 62 days in custody in the year before services. In FY19/20, there was a 100% decrease in days custody as no FSP partners who had been enrolled in HOPE for over one year were incarcerated at any point during FY19/20.

6. **100% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 6 of the 46 partners had experienced homelessness for a collective 1,122 days homeless in the year before services (averaging 187 days out of the year before services). In FY19/20, there was a 100% decrease in days homeless as no FSP partners who had been enrolled in HOPE for over one year experienced homelessness at any point during FY19/20.

Overall, in FY19/20 there was a 98.2% decrease in total “Crisis Days” for partners who had been enrolled for one year or longer in HOPE.

**PROGRAM CHANGES FOR FY21/22:** New in FY21/22 will be two “floating” Mental Health Practitioners who will be able to cover for FSP Teams and Access when there are vacancies or staff are on leave.
ODYSSEY FULL-SERVICE PARTNERSHIP: FSP 05

PROGRAM ALLOCATION FY20/21: $1,246,314

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.

In FY20/21, a Mental Health Registered Nurse was 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 was also 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 unversed 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, 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, 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 115 concurrently, but over the course of the year expecting to serve approximately 125 TAY, Adults, and Older Adults.

EXPECTED OUTCOMES:

1. decrease psychiatric 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.
- New in the MHSA FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update: 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

FY19/20 OUTCOMES:

In FY19/20 there were 123 partners served in Odyssey, 112 who had been in the program for one year or longer.

1. 66% decrease in Psychiatric Hospitalization: Of the 112 partners who had been enrolled in Odyssey for at least one year, 26 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 1,117 psychiatric hospitalization days. In FY19/20, there were 13 partners (50% reduction in number of partners) who had been enrolled in Odyssey for one year or more who experienced a psychiatric hospitalization in FY19/20, for a total of 375 psychiatric hospitalization days—a 66% decrease.

2. 73% decrease in incarceration days: In the twelve months prior to entry into the FSP, 25 of the 112 partners had experienced incarceration for a collective 1,222 days in custody in the year before services. In FY19/20, there were 12 FSP partners (52% reduction) who spent 327 days collectively in custody—a 73% decrease in incarceration days.
3. **80% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 64 of the 112 partners had experienced homelessness for a collective 16,597 days homeless in the year before services (averaging 259 days homeless in the year before services). In FY19/20, there were 17 partners (73% reduction in number of partners) who experienced one day or more of homelessness, for a collective 3,365 days—an 80% decrease **resulting in 13,232 fewer collective days homeless in FY19/20 as compared to the baseline year.**

![Diagram showing decrease in homelessness days](image)

Overall, in FY19/20 there was a 78% decrease in total “Crisis Days” for partners who had been enrolled for one year or longer in Odyssey.

**CHANGES FOR FY21/22:** This program has continued to serve significantly more clients that originally planned for so two additional staff will be added in FY21/22. These new team members will include a County Peer Specialist and a Substance Use Counselor (Social Service Worker with specialized training).
INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT): FSP 06

PROGRAM ALLOCATION FY21/22: $759,442

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).

In order to increase the programs fidelity to the ACT model, a .4FTE Mental Health Registered Nurse was added to the team in FY21/22 as well as increasing the Psychiatrist time by 4 hours per week. Additional funding was also 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.

- **New in the MHSA FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update:** 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

FY19/20 OUTCOMES:

In FY19/20 there were 46 partners served in IMPACT, 34 who had been in the program for one year or longer.

1. **53% Decrease in Psychiatric Hospitalization:** Of the 34 partners who had been enrolled in IMPACT for at least one year, 25 (73%) had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 544 psychiatric hospitalization days. In FY19/20, there were 13 partners (48% reduction in number of partners) who had been enrolled in IMPACT for one year or more who experienced a psychiatric hospitalization in FY19/20, for a total of 256 psychiatric hospitalization days—a 53% decrease.

2. **46% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 12 of the 34 partners had experienced incarceration for a collective 1,201 days in custody in the year before services. In FY19/20, there were 7 FSP partners (42% reduction) who spent 648 days collectively in custody—a 46% decrease in incarceration days.
3. **80% decrease in days homelessness**: In the twelve months prior to entry into the FSP, 17 of the 34 partners had experienced homelessness for a collective 2,986 days homeless in the year before services. In FY19/20, there were 13 partners who experienced one day or more of homelessness, for a collective 749 days—a 75% decrease.

Overall, in FY19/20 there was a 65% decrease in total “Crisis Days” for partners who had been enrolled for one year or longer in IMPACT.

**CHANGES FOR FY21/22**: No changes to program operation however the MHSA budget was decreased as the Medi-Cal revenue that this program was able to generate was significantly higher than the original budget projections.
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.

In FY20/21 BHRS released a Request for Proposals (RFP) for Peer-run services to ensure that county contracts allow for competition. The RFP process solicited 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: Up through FY20/21 the provider has been Community Action Marin. However, the Multicultural Center of Marin (in collaboration with the Mental Health Advocates of Marin) was awarded the contract starting July 1, 2021.

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. 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>
<th>Actuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Daily Attendance</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td># Warm Line contacts</td>
<td>6,500</td>
<td>5,798</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.
PROGRAM CHANGES FOR FY21/22: Funding for the Enterprise Recovery Center was awarded via RFP to the Multicultural Center of Marin in collaboration with Mental Health Advocates of Marin. In addition, the Multicultural Center of Marin will be providing new peer-led expansion programming in FY21/22, including:

- Peer-led wellness hikes for TAY
- Sunset Meditation on the beach in Spanish and Vietnamese
- Healing Circles (yoga and sound healing, drumming, and mindfulness)
- Drawing and painting for emotional expression focusing on underserved groups and artistic traditions such as *papel picado* that are tied to Latinx, Vietnamese, and other cultures
- Cooking traditional foods and sharing communal meals
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 these services I feel more hopeful.”
- Outcome 3 data will be pulled from the Electronic Health Records System comparing the number of days an individual was in crisis that resulted in Crisis Stabilization Unit visits, Crisis Residential (Casa René) or Hospitalization, in the 3 months prior to the first contact with the Transitions Outreach Team as compared to the 3 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
FY19/20 DEMOGRAPHICS:

In FY19/20 the Transition Outreach Team (TOT) served 167 community members, 145 of whom were engaged with for the first time in FY19/20. The demographics of those served by the TOT were as follows:

In FY19/20 the Mobile Crisis Response Team (MCRT) served 782 community members, 618 of whom used the service for the first time. The demographics of those served by MCRT were as follows:
In FY19/20 the MCRT 1,760 contacts with community members, up 330 from the previous fiscal year.

**Count of Contact per Month:** July 2019 - June 2020

Taking a longer view on the count of contacts by month and cumulative to show the increase the last few months of FY20/21 at the start of the COVID pandemic in context to previous years.

**Count of Contact per Month:** July 2016 - June 2020
FY19/20 OUTCOMES:

- Outcomes 1 and 2 are new in the FY20/21-22/23 Plan so not reported on for FY19/20
- Outcome 3: There was a **76% decrease** in the number of crisis services used by individuals in the three months after their last contact with the Transition Outreach Team (TOT) as compared to the three months prior (from 133 crises down to 32).

**Note:** Contact date Between 7/1/2019 and 6/30/2020

**FY19/20 TRANSITION OUTREACH TEAM OUTCOMES**
(N=134 Individuals)

- 33 Hospital Admissions
- 24 Crisis Residential Admissions
- 76 CSU Admissions

3 months prior to the first contact

133 Crises (74 individuals)

3 months after the most recent contact

32 Crises (19 individuals)

- 18 CSU Admissions **76% Decreased**
- 7 Crisis Residential Admissions **71% Decreased**
- 7 Hospital Admissions **79% Decreased**

**76% Decreased in # of Crisis Services**

**74% Decreased in # of individuals admitted to CSU, Inpatient Hospital and Crisis Residential programs**

* 90 days prior to the individuals first contact (within the study period)
** 90 days after the last contact (within the study period)
In addition there was a **74% decrease in the number of individuals** admitted to the CSU, Inpatient hospital, and Crisis Residential Programs, a decrease from 74 individuals utilizing those services in the prior three months to 32 individuals utilizing those services in the 3 months after the last contact with the transition outreach team.

- Outcome 4 is a new outcome in the FY20/21-22/23 Three-year plan so not reported on for FY19/20
- Outcome 5: **93% of the 141 individuals served** were linked to services and had community supports identified and in place at time of discharge from Casa René
- Outcome 6: **88% of the 141 individuals served** were discharged to a lower level of care when discharged from Casa René
- Outcome 7: Face to face peer-led crisis planning with clients was put on hold during the pandemic as were the surveys to gain feedback on the effectiveness

**PROGRAM CHANGES FOR FY21/22:** No changes.
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 SAMHSA 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, Schizophreniform 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 heath 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.

**FY19/20 KEY ACTIVITIES:** This program, contracted with Felton Institute, officially opened doors in April of 2020, one month into the pandemic. This resulted in fewer than ten clients served in FY19/20 so the demographic information is suppressed and no individual was served for 6 months or longer to be measured for the outcomes. The Key activities by month were as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>Actions</th>
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</table>
• Active recruitment for direct service positions begins  
• Real estate search finalized for office space |
| Oct 2019     | • Felton signed lease for office space in San Rafael  
• Landlord began planning for space build out to meet program needs  
• Facilities assessment and development of IT and communications infrastructure |
| Nov 2019     | • Construction in office space (internal walls, kitchenette)  
• Felton began Medi-Cal certification process |
| Dec 2019     | • Submitted Medi-Cal site certification documents  
• Active staff recruitment continues  
• Office set up (furniture, equipment, etc.)  
• Initiated system set up with Marin BHRS data systems (i.e. Share Care, Clinician’s Gateway) and obtained clinical documentation templates |
| Jan 2020     | • Finalized operation protocols and standards for (re)MIND Marin program in anticipation of staff training  
• Ongoing staff recruitment (screenings and interviews) and revised staffing structure to attract candidates |
| Feb 2020     | • Ongoing staff recruitment (screenings and interviews) with accepted job offers for key direct service positions  
• Commenced community engagement and outreach efforts |
| March- June 2020 | • Onboarding and training of new staff (1.0 FTE Program Manager, 0.6 FTE Care Manager, Psychiatric Nurse Practitioner, Administrative Manager)  
• Major adaptations to staff onboarding practices, community outreach and intake/referral due to COVID-19 pandemic  
• Adopted new systems for remote work and compliance with public health orders  
• Continued staff recruitment  
• Engaged in community outreach presentations |
- Adapted intake and referral system for safety during COVID-19 pandemic (criteria for priority in-person visits)
- Developed COVID-19 Resource Guide made available to referrals and wider community
- Direct services began in May 2020 (new enrollments).

This program is located in San Rafael’s Montecito Shopping Center at 361 Third Street, Suite B, San Rafael, CA 94901.

**PROGRAM CHANGES FOR FY21/22:** No changes.
CONSUMER-OPERATED WELLNESS PROGRAM: SDOE 11
(EMPOWERMENT CLUBHOUSE)

FORMERLY “(STEPPING-UP)” WAS IN PARENTHESES AFTER THE NAME OF THE PROGRAM—THAT WAS 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.

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.

FY19/20 OUTCOMES: In FY19/20, the contractor expanded Empowerment Clubhouse membership to 67 and quickly adapted to shelter in place during the first days of the pandemic. This necessitated a shift of focus away from the traditional Work-Ordered-Day and towards socialization, wellness, and support.

Members and staff worked together to prepare and deliver over 2,500 nutritious meals to homebound members and made over 1,000 reach-out calls to members to check on their wellbeing and provide social support. Through the efforts of staff and members the Empowerment Clubhouse was also able to provide regular updates on best practices for promoting health and well-being during this stressful time and expanded daily virtual clubhouse programming. Art supplies and ingredients for cooking classes were delivered with the food deliveries for interactive zoom cooking and art classes. Member-led groups also increased significantly over the last year including virtual Qi Gong, chair yoga, meditation, journaling, smoking cessation, and arts and crafts.

The Average Daily Attendance (ADA) for FY19/20 was 10. The final quarter of the year was deeply affected by COVID and the shelter-in-place orders significantly impacting the number of people who could participate.

“I have been part of the Empowerment Clubhouse for about 2 years now. I came to the Club as a person with mental illness struggling to cope with life. The program has been very effective in changing me. By participating in social activities and performing career-oriented and essential life tasks I have become a much more confident and stable person. Highlights include being part of a talent show and attending a baseball game. I’ve become a part of a welcoming community with people from all walks of life. During COVID, the Clubhouse has continued to serve its purpose with daily Zoom meetings on topics from yoga to art. Furthermore, there is always somebody to talk to about your progress and problems. It’s been a difficult journey becoming a more integrated person in society but the Clubhouse has always been a useful resource in the background.”

PROGRAM CHANGES FOR FY21/22: No changes.
RECOVERY-ORIENTED SYSTEM DEVELOPMENT: SDOE-13

MHSA PROGRAM ALLOCATION FY20/21: $1,033,061

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. This was 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.

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.

4) Enhancing services and supports for LGBTQ+ clients, families, and staff to ensure BHRS is a welcoming program to all.

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: 525

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)

OUTCOMES FOR FY19/20: This is a new system-development program established in FY20/21 so there are no outcomes to report for FY19/20

PROGRAM CHANGES FOR FY21/22: In FY21/22 funding is added to increase ability for step downs from FSPs to the BRIDGE Team by adding a case manager to the BRIDGE Bon Air team. The BRIDGE Bon Air Mental Health Practitioner will be a recruitment specifically for someone with experience in alternative and cultural healing practices to widen the array and cultural competency of the services offered within BHRS.

In addition, in FY21/22 services will be enhanced to better support LGBTQ+ clients, families, and staff.
MHSA STEPPING-UP PROGRAM: SDOE-14

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 MHSAn 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 through FY22/23 and shifted to become a formal part of the MHSA Stepping Up initiative. This training is provided to 40-50 sworn law enforcement personnel each year and has been expanded 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

**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

**EXPECTED 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

OUTCOMES FOR FY19/20: This is a new system-development program established in FY20/21 so there are no outcomes to report for FY19/20

CHANGES FOR FY21/22: Funding is increased to support half of a Program Manager position to promote equity and recovery throughout the Forensic system of care. This funding will support work supporting diversion, out of custody mental health treatment, and re-entry programs with a focus on promoting racial equity.
COMMUNITY OUTREACH AND ENGAGEMENT: SDOE-15

MHSA PROGRAM ALLOCATION FY21/22: $530,008

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
   c. Increasing understanding around financial options and resources
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. Community Health Advocate RFPs were released in FY20/21 and awarded to: Marin City First Missionary Baptist Church, Marin Asian Advocacy Project, and North Marin Community Services.

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

OUTCOMES FOR FY19/20: This is a new system-development program established in FY20/21 so there are no outcomes to report for FY19/20
CHANGES FOR FY21/22: Funding is being added in FY21/22 to fund a Bilingual Support Service Worker position for the Access team to help reduce ethnic/racial disparities and improve timeliness standards in answering incoming calls, scheduling urgent appointment requests, as well as being a resource for clients around billing questions and options in both English and Spanish. Through our community planning process we have learned that questions and uncertainty around billing often dissuade potential clients from seeking or utilizing services so this position will help make that process smoother and more understandable.
HOMELESS-FOCUSED SUPPORT AND OUTREACH: SDOE-16

MHSA PROGRAM ALLOCATION FY21/22: $1,134,390

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.
5) Overall coordination of housing contracts including outcomes and needs assessment

PROVIDER: Combination of county-operated and contracted

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: 211

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 100 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

OUTCOMES FOR FY19/20: This is a new system-development program established in FY20/21 so there are no outcomes to report for FY19/20

CHANGES FOR FY21/22: In FY21/22 additional funding is allocated to support contracted providers to increase pay for direct line staff, increase capacity, and reduce caseload size. In addition, creation of a Housing Coordinator to improve tracking and outcomes, assess housing needs, coordinate services, promote equity, and provide supportive contract management for BHRS housing providers.
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 request the release of 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.

All units are filled, and all the clients have been stably housed there for over 6 months. These clients were place through Coordinated Entry and had been chronically homeless for years prior to residency in these apartments.
## COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT BUDGET

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<th>FY21/22</th>
<th>FY22/23</th>
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<td>$99,771</td>
<td>$118,903</td>
<td>$118,903</td>
<td>$337,577</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$12,302,067</td>
<td>$13,509,786</td>
<td>$13,509,786</td>
<td>$39,321,640</td>
</tr>
</tbody>
</table>

| **Transfer to Workforce Education and Training**                       | $202,034 | $465,344 | $465,344 | $1,132,722 |
| **Transfer to Capital Facilities and Technological Needs**             | $730,226 | $1,142,846 | $567,846 | $2,440,918 |
| **Total Transfers out of CSS**                                         | $932,260 | $1,608,190 | $1,033,190 | $3,573,640 |

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.

Updated Projections from the Three-Year plan with the same projected total. However, in FY19/20 we saw a significant shift younger for children needing assistance and are projecting that to the best case for the next two years. In the FY20/21-22/23 Three-Year plan we had projected 38 Children, 105 TAY, 178 Adults, and 95 Older Adults to be served each year for a total of 416. The projections for the final two years of the Three-Year Plan have been revised in light of the FY19/20 data to increase anticipated numbers for Children and Older Adults and slight reductions in the TAY and Adult categories.

<table>
<thead>
<tr>
<th>Full-Service Partnership Age Groups</th>
<th>ACTUALS FROM FY19/20</th>
<th>PROJECTED FY21/22</th>
<th>PROJECTED FY22/23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (0-15)</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>TAY (16-25)</td>
<td>93</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>Adult (26-59)</td>
<td>172</td>
<td>172</td>
<td>172</td>
</tr>
<tr>
<td>Older Adult (60+)</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>415</strong></td>
<td><strong>416</strong></td>
<td><strong>416</strong></td>
</tr>
</tbody>
</table>
# COMMUNITY SERVICES AND SUPPORTS (CSS) COST PER PERSON ESTIMATES FOR FY21/22

<table>
<thead>
<tr>
<th>Program</th>
<th>FY21/22 MHSA Allocation</th>
<th>FY21/22 Projected Number Served</th>
<th>FY21/22 Projected Cost Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP-01 Youth Empowerment Services (YES)</td>
<td>$830,064</td>
<td>85</td>
<td>$9,765</td>
</tr>
<tr>
<td>FSP-02 Transitional Age Youth (TAY) Program</td>
<td>$695,991</td>
<td>40</td>
<td>$17,400</td>
</tr>
<tr>
<td>FSP-03 Support and Treatment After Release (STAR)</td>
<td>$810,175</td>
<td>65</td>
<td>$12,464</td>
</tr>
<tr>
<td>FSP-04 Helping Older People Excel (HOPE)</td>
<td>$824,366</td>
<td>65</td>
<td>$12,683</td>
</tr>
<tr>
<td>FSP-05 Odyssey</td>
<td>$1,246,314</td>
<td>120</td>
<td>$10,386</td>
</tr>
<tr>
<td>FSP-06 Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)</td>
<td>$759,442</td>
<td>50</td>
<td>$15,189</td>
</tr>
<tr>
<td>SDOE-01 Enterprise Resource Center (ERC)</td>
<td>$477,102</td>
<td>1,000</td>
<td>$477</td>
</tr>
<tr>
<td>SDOE-09 Crisis Continuum of Care</td>
<td>$1,585,536</td>
<td>1,100</td>
<td>$1,441</td>
</tr>
<tr>
<td>SDOE-10 First Episode Psychosis (FEP)</td>
<td>$159,763</td>
<td>25</td>
<td>$6,391</td>
</tr>
<tr>
<td>SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)</td>
<td>$330,899</td>
<td>70</td>
<td>$4,727</td>
</tr>
<tr>
<td>SDOE-13 Recovery-Oriented System Development</td>
<td>$1,033,061</td>
<td>525</td>
<td>$1,968</td>
</tr>
<tr>
<td>SDOE-14 Stepping Up</td>
<td>$443,110</td>
<td>150</td>
<td>$2,954</td>
</tr>
<tr>
<td>SDOE-15 Community Outreach and Engagement</td>
<td>$530,008</td>
<td>3,000</td>
<td>$177</td>
</tr>
<tr>
<td>SDOE-16 Homeless Support and Outreach</td>
<td>$1,134,390</td>
<td>211</td>
<td>$5,376</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 four categories that align with the MHSA Regulations. These are: 1) Training and Technical Assistance, 2) Mental Health Career Pathways, 3) Regional Partnership: Financial Incentive Program, and 4) Workforce Staffing Support.

In November 2020 the County of Marin hired a new WET Coordinator:

Rebecca Stein, Psy.D
BHRS Unit Supervisor
WET (Workforce, Education, and Training) Program
Pronouns: She/Hers/Her
3270 Kerner Blvd, Room 105, San Rafael, CA 94901
(415) 473-4274, fax (415) 473-3850
rstein@marincounty.org
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 (for FY20/21, FY21/22, and FY22/23). 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.

FY19/20 Activities: Training, technical assistance, consultation, and curriculum development. Some of these trainings included:

- Customizing Mindfulness—Tools for Healing Trauma
- Trauma Stewardship
- Assertive Community Treatment (ACT) training
- LGBTQ+ Training and Consultation
- White Allyship
- Cultural Humility Training
- Migrant Mental Health: Psychological First Aid for Migrants, Refugees, and Displaced Persons

CHANGES FOR FY21/22: Additional funding is allocated to provide supervision hours that are rooted in enhancing the workforce’s ability to fulfill the guiding principles of the MHSA for Pre-Licensure staff/interns and contracted providers throughout the Public Mental Health System. In addition, projected unspent training funds from FY20/21 are being carried over to FY21/22.
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.

FY19/20 ACTIVITIES:

- In early 2020 the COPE Program was approved by Mental Health America as a Nationally
  Certified Advanced Peer Specialist Training Program
- 10 clients were served by COPE in FY19/20 and they were unable to start another cohort due to
  the COVID pandemic
- 19 individuals were awarded scholarships in the Fall of 2019. We were unable to have a Spring
  2020 Scholarship Award cycle due to the COVID pandemic and staff being reassigned to work at
  Disaster Service Workers, halting all non-essential activities
- 7 internships for people with lived experience in the Public Mental Health System were
  supported through WET funding in FY19/20

CHANGES FOR FY21/22: Projected unspent funding was carried over to FY21/22
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 (including contracted partners) 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. The Regional Partnership is anticipating receiving the money in FY21/22.

NEW PROGRAM IN THE FY20-21 through FY22/23 Three Year Plan so no activities to report for FY19/20. Due to the pandemic and the length of time it has taken for the regional partnership to formalize a partnership with a joint powers authority and OSHPD, this funding will be transferred to the Joint Powers Authority in FY21/22 rather than FY20/21.
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) and WET Administrative Services Technician. These positions 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 the WET Coordinator position.

OUTCOMES FOR FY19/20: This is a new program established in FY20/21 so there are no outcomes to report for FY19/20

CHANGES FOR FY21/22: The addition of an Administrative Services Technician (AST) to support WET goals and activities including the Peer Program Coordinator. Cultural Competency Advisory Board/WET Steering Committee, and the WET Coordinator.
## 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>$58,000</td>
<td>$250,000</td>
<td>$210,000</td>
<td>$518,000</td>
</tr>
<tr>
<td>Mental Health Career Pathways</td>
<td>$105,000</td>
<td>$145,000</td>
<td>$125,000</td>
<td>$375,000</td>
</tr>
<tr>
<td>Regional Partnership: Financial Incentive Program</td>
<td>-</td>
<td>$80,000</td>
<td>-</td>
<td>$80,000</td>
</tr>
<tr>
<td>Workforce Staffing Support</td>
<td>$175,682</td>
<td>$292,648</td>
<td>$292,648</td>
<td>$760,977</td>
</tr>
<tr>
<td>Admin/Indirect (15%)</td>
<td>$50,802</td>
<td>$115,147</td>
<td>$94,147</td>
<td>$260,097</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$389,484</td>
<td>$882,795</td>
<td>$721,795</td>
<td>$1,994,074</td>
</tr>
</tbody>
</table>

WET is funded in this 3-Year plan by a combination of funding already in the WET Component as well as new funding transferred from CSS.

Note: WET funding that was unspent in FY20/21 due to COVID delays was shifted to the same program category for FY21/22.
CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN)

ELECTRONIC HEALTH RECORD AND PRACTICE MANAGEMENT SYSTEM ENCHANCEMENTS

MHSA ALLOCATION FY21/22: $328,479 for FY21/22 expenditures and $500,000 to start saving and leveraging other funding sources for a new Health Information Technology System

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 follow components:

1. Disaster recovery preparedness.
2. Ongoing Electronic Health Record (EHR) and Practice Management (PM) upgrades to remain compliant with current and future requirements.
3. Clinical enhancements to improve service coordination
4. Planning and saving for a new Health Information Technology System

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 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 the coordinated case management system, 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.

FY19/20 UPDATE: The MHSA-funded Transition Outreach Team became even more active in the WIZARD system in FY19/20 promoting coordinated care throughout our Crisis systems and Community Based Partners. The Odyssey and IMPACT FSPs are also utilizing this system especially around enhanced coordination for chronically homeless individuals.
TELE-HEALTH IMPROVEMENTS

**MHSA PROJECT ALLOCATION:** $72,000 total to be spent 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. This funding would be used for software and hardware investments for client use to allow them to access telehealth services in locations throughout the county (including kiosks or personal devices as needed). BHRS is looking to install Kiosk locations in areas of the county that are being underserved. Potential sites include community spaces and satellite sites.

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.

**FY19/20 UPDATE:** This was a new program in FY20/21 so no updates from FY19/20.

**CHANGES FOR FY21/22:** Projected unspent funding will carryover to the next fiscal year. BHRS was able to utilize volunteers to support some of the web development work which reduced projected costs for FY20/21.
## 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>$828,479</td>
<td>$328,479</td>
<td>$1,485,437</td>
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<tr>
<td>Coordinated Case Management system</td>
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<td>$150,000</td>
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<tr>
<td>Telehealth Expansions</td>
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<td>$72,000</td>
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<tr>
<td>Website Enhancements</td>
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<td>Admin/Indirect</td>
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<td>$162,117</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$604,876</strong></td>
<td><strong>$1,242,896</strong></td>
<td><strong>$581,646</strong></td>
<td><strong>$2,429,418</strong></td>
</tr>
</tbody>
</table>
PREVENTION AND EARLY INTERVENTION (PEI)

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 were moved to the Outreach and Engagement component of Community Services and Supports (CSS). This will consist of RFPs (to be released later this 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 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>Marin PEI Priority Strategy Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention and Early Intervention</strong></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></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>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></td>
</tr>
<tr>
<td></td>
<td>• Early Intervention mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>PEI-01 Early Childhood Mental Health</td>
<td>#1, #4</td>
<td>Capacity Building</td>
</tr>
<tr>
<td></td>
<td>• Training and Consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Screening and Linkage</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Early Intervention</strong></td>
<td>PEI-05 Latino Community Connection:</td>
<td>#4, #6</td>
<td>Suicide Prevention, Newcomers Supports</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>
</tr>
<tr>
<td></td>
<td>• Radio Show</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stigma Reduction</strong></td>
<td>PEI-12 Community Training and Supports</td>
<td>#2, #4, #6</td>
<td>Capacity Building, Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>• Mental Health Consultation in schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community trainings in West Marin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mental Health First Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PEI-20 Statewide PEI</td>
<td>#2</td>
<td>Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>PEI-24 Storytelling Programs*</td>
<td>#2, #4</td>
<td>Capacity Building, Suicide Prevention</td>
</tr>
<tr>
<td><strong>Suicide Prevention</strong></td>
<td>PEI-21 Suicide Prevention:</td>
<td>#2, #3, #4, #5</td>
<td>Suicide Prevention</td>
</tr>
<tr>
<td></td>
<td>• Suicide Prevention Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community and targeted suicide prevention trainings</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Access and Linkage</strong></td>
<td>PEI-23 Newcomers Coordination and Support</td>
<td>#1, #3, #4, #6</td>
<td>Newcomers Supports, School-based Mental Health</td>
</tr>
<tr>
<td></td>
<td>• School-aged Newcomers Assessment and Linkage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Newcomers school-based groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outreach</strong></td>
<td>PEI-19 Veteran’s Community Connection</td>
<td>#2, #4, #6</td>
<td>Suicide Prevention</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)*
OVERVIEW OF FY19/20 PROGRAMS (OUTCOMES REPORTING YEAR)

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 FY19/20 55% of direct service funding was spent on youth. 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=333)

Satisfaction Outcomes

- 97% Cultural background was respected
- 90% Staff care about me
- 99% Would recommend services
- 96% Overall Satisfaction
- 83% Able to choose treatment goals
- 81% Feel connected to community
- 80% Improved relationships
- 74% Improved coping
- 84% Improved at work/school
- 92% Better handle personal 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 FY 18/19 and FY 19/20:

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. New demographic forms were developed for the 20/21 FY through provider input in order to improve cultural sensitivity of the questions. The forms remain in compliance with MHSA PEI regulations for demographic data collection.

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.
FY 19/20 DEMOGRAPHICS

A breakdown of the populations served by PEI program in FY19/20 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 19/20, the breakdown of PEI clients by region was as follows: 51% San Rafael area, 3% Marin City, 23% Novato, 3% West Marin, and 20% other or unknown.
Within the PEI programs, the Latinx population represented 60% of all clients served.
89% of PEI clients overall were from traditionally underserved racial/ethnic groups.
Note: Some programs reflect the age group of the person being trained rather than the target population of that training. I.E. Early Childhood Mental Health indicates the age group of the childcare providers receiving the training, however 100% of that funding is dedicated to supporting youth by providing training and support for the adults in their lives.
Spanish speaking clients represented 39% of PEI clients.
65% of PEI clients identified as female, 34% identified as male, 1% identified as transgender, genderqueer, questioning, or another gender identity.
### FY19/20 PEI SEX ASSIGNED AT BIRTH

<table>
<thead>
<tr>
<th>Program</th>
<th>Male</th>
<th>Female</th>
<th>Other Sex Not Listed (Intersex)</th>
<th>Decline to Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI 18 School</td>
<td>78</td>
<td>116</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>PEI 21 SP</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1078</td>
</tr>
<tr>
<td>PEI 05 LCC</td>
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<td>85</td>
<td>0</td>
<td>885</td>
</tr>
<tr>
<td>PEI 01 ECMH</td>
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<td>272</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PEI 07 OA</td>
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<td>37</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PEI 11 VCC</td>
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<td>50</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PEI 19 VET</td>
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<td>141</td>
<td>0</td>
<td>2</td>
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<tr>
<td>PEI 12 MHFA</td>
<td>17</td>
<td>79</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>PEI 22 HN</td>
<td>65</td>
<td>1459</td>
<td>0</td>
<td>680</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>680</td>
<td>1459</td>
<td>0</td>
<td>2235</td>
</tr>
</tbody>
</table>

- Male
- Female
- Other sex not listed (intersex)
- Decline to answer
### PEI SEXUAL ORIENTATION

<table>
<thead>
<tr>
<th>Category</th>
<th>PEI 18 School</th>
<th>PEI 21 SP</th>
<th>PEI 05 LCC</th>
<th>PEI 01 ECMH</th>
<th>PEI 07 OA</th>
<th>PEI 11 VCC</th>
<th>PEI 04 TAY</th>
<th>PEI 19 VET</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Decline to answer</td>
<td>147</td>
<td>1051</td>
<td>536</td>
<td>440</td>
<td>4</td>
<td>90</td>
<td>435</td>
<td>26</td>
<td>2762</td>
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<td>Another sexual orientation</td>
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<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>10</td>
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<td>0</td>
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<td>9</td>
<td>0</td>
<td>20</td>
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<tr>
<td>Questioning/Unsure</td>
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<td>1</td>
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<td>0</td>
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<td>18</td>
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<tr>
<td>Bisexual</td>
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<td>1</td>
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<td>0</td>
<td>0</td>
<td>47</td>
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<tr>
<td>Heterosexual/Straight</td>
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<tr>
<td>Gay or Lesbian</td>
<td>4</td>
<td>16</td>
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<td>2</td>
<td>2</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>49</td>
</tr>
</tbody>
</table>

- **Total:** 2762
67 (or 3%) of total clients identified as Veterans, one third of which were 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.”
EARLY CHILDHOOD MENTAL HEALTH (ECMH) (PEI 01)

SERVICE CATEGORY: PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #4

MARIN PEI PRIORITY STRATEGY AREA: Capacity Building

PROVIDER: Jewish Family and Children’s Services

PROGRAM ALLOCATION FOR FY21/22: $230,000

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

EXPECTED NUMBERS TO BE SERVED: 500

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...

91% of parents who completed the mid-year survey about ECMH Consultation reported an increase in effective parenting strategies

ECMH

SUMMARY FY2019-20

Clients Served: FY2019-20

622 Individuals
148 Families
202 reached through Outreach/Training
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 preschool 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
• Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are 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.
• Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire - Social Emotional (ASQ-SE)

Anticipated data collection changes and additions for FY 20/21: To address challenges in receiving survey data back, they will be shifting to administering surveys electronically in the 2020-2021 year.

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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>
<td>535</td>
<td>622</td>
</tr>
<tr>
<td>(number of students at school site)</td>
<td></td>
<td></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% N=620</td>
<td>70%</td>
<td>87% N=501</td>
<td>70%</td>
<td>88% N=560</td>
<td>70%</td>
<td>90% N=442</td>
</tr>
<tr>
<td>populations (Latino, Asian, African American, West Marin).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children/families identified for enhanced intervention</td>
<td>75</td>
<td>80</td>
<td>65</td>
<td>67</td>
<td>65</td>
<td>82</td>
<td>65</td>
<td>92</td>
</tr>
<tr>
<td>(through observation or validated screening tools for child behavior or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>family caregiver depression) and provided services through ECMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children in childcare settings served by ECMH Consultants retained in</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.8%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>their current program, or transitioned to a more</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2020</td>
<td>2021</td>
<td>2022</td>
<td>2023</td>
<td>2024</td>
<td>2025</td>
<td>2026</td>
<td>2027</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Parents/primary caregivers of families receiving intensive services who report increased understanding of their child’s development and improved parenting strategies. <em>JFCS multi-county parent questionnaire</em></td>
<td>85% N=15</td>
<td>100% N=12</td>
<td>85% N=67</td>
<td>98% N=21</td>
<td>85% N=21</td>
<td>94% N=21</td>
<td></td>
<td></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% N=19</td>
<td>90% N=18</td>
<td>75% N=23</td>
<td>96% N=21</td>
<td>75% N=21</td>
<td>100% N=21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>N/A</td>
<td>1 N/A</td>
<td>6 N/A</td>
<td>1 N/A</td>
<td>7 N/A</td>
<td></td>
<td></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>N/A</td>
<td>1 N/A</td>
<td>1 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>
<td>2 N/A</td>
<td>8 N/A</td>
<td></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 N/A</td>
<td>0 N/A</td>
<td>N/A</td>
<td>13 N/A</td>
<td></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>
<td>N/A</td>
<td>13 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>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Education Sites Receiving Services

<table>
<thead>
<tr>
<th>Total referrals to other mental health services or to resources for basic needs</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>79</th>
<th>N/A</th>
<th>58</th>
</tr>
</thead>
</table>

**Early Childhood Education Sites Receiving Services**

<table>
<thead>
<tr>
<th>Childcare staff receiving ECMH Consultation who report increased ability to identify, intervene with, and support children in their care with emotional/behavioral issues. <em>JFCS multi-county provider questionnaire</em></th>
<th>85%</th>
<th>90%</th>
<th>85%</th>
<th>88%</th>
<th>85%</th>
<th>99%</th>
<th>85%</th>
<th>88%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Staff receiving ECMH Consultation services who report satisfaction with the services (would use again, would recommend, were helpful). <em>PEI survey</em></th>
<th>75%</th>
<th>90%</th>
<th>75%</th>
<th>93%</th>
<th>75%</th>
<th>95%</th>
<th>75%</th>
<th>99%</th>
</tr>
</thead>
</table>

*Data Collection Method*

**EQUITY AND CULTURAL RESPONSIVENESS:**

Over the 2019-2020 year, JFCS' Early Childhood Mental Health Program (ECMH) responded to the mental health needs of young children (ages 0-5) in Marin County. Of the children and families that receive ECMH services, 78% spoke Spanish as their primary language. JFCS continues to grow to meet the needs of these families through securing a predominately bilingual staff, as well as consultants that identify as Latinx. In addition to their language and cultural capacity, the ECMH program has also advocated for the well-being of children and families in marginalized, oppressed, and traditionally underserved communities throughout the most disparate county in California (from the RACE COUNTS Project). In collaboration with Southern Marin Multidisciplinary Team, the West Marin Collaborative, Marin Advocacy Network, Isoji, and Parent Services Project, JFCS provided and advocated for equitable services for young children and their families in Marin County. The ECMH program is offered to parents and caregivers through fully and partially subsidized childcare sites to break down barriers to accessing care and counteract any stigma to receiving assistance by integrating and normalizing early childhood mental health services in existing childcare programs. Of the children and families the program supports, 79% identified as Latino, 90% identified with a racial or ethnic minority group, 93% of families qualified for subsidized childcare. JFCS staff is continually deepening their learning about racial issues, including systemic racism, in regular trainings, discussion groups, supervision and implementation of services. Their program advocates for our children and families, recognizing the inequities in Marin County and works to creates change in the county.
CHALLENGES AND UPCOMING CHANGES

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.

The emergence of COVID-19 was the greatest challenge faced by the ECMH program during the 19/20 FY. To address this challenge, JFCS staff immediately shifted their method of service delivery to make sure that they continued to provide support to meet the increasing mental health needs of families with young children in Marin County. This support included tele-consultancy services, a new virtual parent support group, phone and zoom consultation with staff and parents, and an e-newsletter to provide timely support and resources. In addition to shifting their method of service delivery, they experienced an increase in the number of parents and caregivers who needed mental health support. To address the increased need, they provided phone consultation for any family requesting assistance. JFCS also experienced challenges with measuring the impact of their services because of difficulty administering paper surveys during the current pandemic emergency. To address these challenges, they will be shifting to administering surveys electronically in the 2020-2021 year. In addition, they are in the process of expanding ways to reaching parents that are not able to benefit from our Zoom support, by working with our marketing department to create videos, which will include parenting and self care tips, as well as resources available in the community. Programs will be able to share these with families on whichever platform they are using to correspond with parents.

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 was awarded the contract to continue to provide ECMH throughout Marin County for the 20/21 fiscal year. JFCS PEI program goals for FY 20/21 include increasing parent and teacher workshops as well as training of consultants, including “Teacher Pyramid for Families.”

Client Story

*In order to promote culture change within our partner-sites, rather than just classroom change, we place great importance on ECMH consultation with directors and site supervisors, helping them and their staff continually deepen their understanding of trauma informed care. Last year, in the collaboration with supervisors and directors from Community Action Marin, we implemented systems to address any challenges occurring at the sites in regular team meetings. In addition, a meeting was called for any challenging behavior, developmental issue, and other mental health concerns at the earliest point possible, with all providers, to discuss and come up with a plan to help the child including goals and interventions provided by the ECMH consultant. This preventive approach, meeting before behaviors escalate, is one of the key principals in trauma informed care and a crucial step in preventing crisis and, ultimately, expulsion. This focus has provided needed support teachers in their organization, so that those teachers who are better prepared when working with children and families. During the 2019-2020 year, JFCS’ ECMH program collaborated with Directors/Site Supervisors from the Community Action Marin Child Development Programs and Early Head Start programs on administering the Teaching Pyramid model at their respective sites. All collaborators received training on the Teaching Pyramid for Families, a Parent Workshop model, provided by WestEd, and our ECMH consultants reinforced and supported these concepts through ECMH consultations and in one-on-one sessions with families as well as in parent workshops.*
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 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 the Spahr Center.

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

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 over time. 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.

• Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

• Beginning in FY 19/20, The Spahr Center began utilizing the Child and Adolescent Needs and Strengths (CANS) as an additional tool to measure client outcomes.

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: 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>
<th>Goal FY19/20</th>
<th>Actual FY 19/20</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>
<td>350</td>
<td>261</td>
</tr>
<tr>
<td>TAY assessed through diversion program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>40</td>
<td>39</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>
<td>100</td>
<td>75</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.</td>
<td>60%</td>
<td>61% N=33</td>
<td>60%</td>
<td>77% N=63</td>
<td>60%</td>
<td>65% N=49</td>
</tr>
<tr>
<td>PCOMS: Outcome Rating Scale Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change</td>
<td>60%</td>
<td>61% N=33</td>
<td>60%</td>
<td>77% N=63</td>
<td>60%</td>
<td>65% N=49</td>
</tr>
<tr>
<td>TAY participating in individual counseling (including 15 youth that were previously served through school-based groups).</td>
<td>200</td>
<td>263</td>
<td>200</td>
<td>291</td>
<td>200</td>
<td>714</td>
</tr>
<tr>
<td>Family members participating in TAY counseling in support of the client</td>
<td>50</td>
<td>82</td>
<td>50</td>
<td>176</td>
<td>50</td>
<td>364</td>
</tr>
<tr>
<td>TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being.* PCOMS: Outcome Rating Scale Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant improvement in client well-being.</td>
<td>60%</td>
<td>64% N=64</td>
<td>60%</td>
<td>60% N=62</td>
<td>60%</td>
<td>78% N=68</td>
</tr>
<tr>
<td>statistically significant change</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>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</td>
<td>75%</td>
<td>85.5% N=110</td>
<td>60%</td>
<td>60% N=62</td>
<td>75%</td>
<td>97% N=68</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>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100% N=27</td>
<td>N/A</td>
<td>93% N=70</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>3</td>
<td>N/A</td>
<td>8</td>
<td>N/A</td>
<td>23</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>5</td>
<td>N/A</td>
<td>15</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>24</td>
<td>N/A</td>
<td>Unknown</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>12</td>
<td>N/A</td>
<td>3</td>
<td>N/A</td>
<td>49</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>Unknown</td>
<td>N/A</td>
<td>45</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>Unknown</td>
<td>N/A</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
### Total Referrals to Other Mental Health Services or to Resources for Basic Needs

<table>
<thead>
<tr>
<th>Collection Method</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>126</td>
</tr>
<tr>
<td>N/A</td>
<td>159</td>
</tr>
</tbody>
</table>

### Outcomes: SPAHR Center

<table>
<thead>
<tr>
<th>Outcomes: SPAHR Center</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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a minimum of 130 hours of individual counseling for a minimum of 15 LGBTQ++ youth, with an emphasis on gender questioning and gender expansive youth</td>
<td>N/A</td>
<td>N/A</td>
<td>130</td>
<td>194</td>
<td>130</td>
<td>272</td>
</tr>
<tr>
<td>Provide Training for educators in a minimum of 5 middle and high schools</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>5</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>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100% N=11</td>
<td>N/A</td>
<td>92% N=15</td>
</tr>
<tr>
<td>Total referrals to County Behavioral Health (BHRS)</td>
<td>N/A</td>
<td>3</td>
<td>N/A</td>
<td>0</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>N/A</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>12</td>
<td>N/A</td>
<td>0</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>
</tbody>
</table>
Both NMCS and HYP prioritize hiring staff with linguistic and cultural competency that reflect the diversity of their clients. Over half of NMCS staff and 84% of HYP Marin staff are bilingual. Both agencies mandate cultural humility training to address the needs of TAY/youth of color, LGBTQ, and newcomers. Services are delivered within a school-embedded model to reduce barriers to accessing care, and within a confidential teen-only clinic environment to reduce stigma and maintain confidentiality. Outreach focuses on addressing potential barriers, including concerns about accessing care delivered in their preferred language, documentation status, confidentiality, and the inclusion of diverse gender identities and sexual orientations. Both agencies also have Diversity, Equity and Inclusion Committees. At NMCS, this Committee is composed of both board and staff members and has been active since 2013. The committee conducted two organization-wide cultural competency assessments that resulted in two different improvement plans which have been successfully implemented. As a result, NMCS’s board and staff are more diverse than ever and better reflect the values, customs, beliefs and languages of our clients and the Novato Community, as a whole. At HYP, both the Diversity and 20

The Spahr TAY program provides therapy to LGBTQ+ young people, who are a marginalized group within the county. In 19/20, Spahr hired a Latina therapist and are actively in the process of bringing on a bilingual Spanish-speaking provider. All of our existing providers identify as LGBTQ+ and have direct experience providing mental health services to communities of color and/or an educational background focused on equity in mental health. Spahr also regularly provides training to staff on equity issues, typically directly around the needs of the clients they are working with. During the 19/20 FY, Spahr began to prioritize outreach to schools with higher populations of students of color and building networks to ensure that their services were used by those in the most need. They also implemented a sliding scale (up to $50), so that if a youth wanted to have therapy from Spahr but did not need to be seen for free, they were able to pay a small amount.

**CHALLENGES AND UPCOMING CHANGES**

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. In 19/20 FY, additional 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. HYP was unable to provide Newcomer group services during Shelter-in Place. NMCS was unable to lead groups at San Marin High School and HYP had to cancel the last two groups scheduled for SRHS and TL. However, staff at both agencies worked very closely with Newcomer Counselors, family liaisons and the MTSS Coordinator to conduct targeted outreach to Newcomer students and families in order to connect them with emergency rental and financial assistance (P-EBT, DRAI, FII, and other supports) in Novato, and case management and therapy in San Rafael.

The major challenge that the Spahr Center faced was that school staff were less able to give their attention to LGBTQ+ cultural competency once shelter-in-place began, which meant that their plans for most of 2020 were either cancelled or altered. This included programming a conference, as well as cancelling some trainings for various schools.

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 were awarded contracts to continue to provide TAY services throughout Marin County for the 20/21 fiscal year. TAY PEI program goals for FY 21/22 include streamlining assessment process so that a single assessment exists across all mental health interventions, with the hope of incorporating assessment material that aligns with Marin County’s ACCESS assessment.

CLIENT STORIES

**Client Story 1:** A client was referred to counseling at Huckleberry Youth Programs with anxiety and substance use, and her therapist noticed some education was needed around sexual health and consent, although the client had not explicitly revealed any issues at intake. The client received care at Clinic with both the nurses and health educators attuned to the referral. The Client’s intake paperwork at Clinic indicated sexual assault, and the entire Clinic team including the health educator, nurses, and mental health staff were able to coordinate for wrap around support during the reporting process and afterwards. The relationship with the Clinic staff and her counselor were strengthened and the client continued her counseling at Huckleberry with a new level of transparency that allowed therapist and client to address the trauma and coping issues that they were unable to address before.

**Client Story 2:** A client in the Spahr TAY program demonstrated growth in confidence in his identity as a transgender person and advocate for himself in various areas of his life over the course of his work with his therapist. He has come out to his parents and extended family, he has socially transitioned among
friends and peers, and he has collaborated with school faculty to create a plan for transitioning at school. This client demonstrated a great deal of insight and resilience throughout his transition process. He now reports feeling less depressed, more connected with his body, and increased self-esteem.
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 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

**Promotora quote:**
The Promotores Program has helped me to grow both as a professional and as a person, to put myself in someone’s shoes before judging. I love my job as a promoter. During these days of COVID 19 I felt very proud of my promoter work, which I was able to help so many people who were desperate for this situation, who did not know what to do, just by listening to them and talking with them changed the expression of their face/voice and being stressed and distressed.
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
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.
- Multicultural Center of Marin quarterly and end-of-year listener surveys on Facebook and on paper to assess knowledge and skills attained through radio show

OUTCOMES

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

<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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving health information and support from Promotores or Family Resource Advocates</td>
<td>640</td>
<td>1,490</td>
<td>900</td>
<td>1,288</td>
<td>900</td>
<td>1,109</td>
<td>900</td>
<td>999</td>
</tr>
</tbody>
</table>

❖ 98% of clients reported that they would recommend the services to others
❖ 84% reported that they built stronger relationships with family/friends/teachers or others
❖ 86% report that they feel more connected to their community
❖ 98% of clients reported that their counselor respected their identity (i.e. ethnic/cultural/religious background, sexual orientation, gender identity)
<table>
<thead>
<tr>
<th>Category</th>
<th>Count 1</th>
<th>Count 2</th>
<th>Count 3</th>
<th>Count 4</th>
<th>Count 5</th>
<th>Count 6</th>
<th>Count 7</th>
<th>Count 8</th>
</tr>
</thead>
<tbody>
<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>121</td>
<td>150</td>
<td>171</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>38</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Individuals participating in a support group for at least 3 months reporting statistically significant improvement in PTSD symptoms <strong>PCL-C 5 pt change</strong></td>
<td>80%</td>
<td>95%</td>
<td>50%</td>
<td>60%</td>
<td>50%</td>
<td>Groups had to be canceled due to low turnout</td>
<td>50%</td>
<td>72%</td>
</tr>
<tr>
<td>N=16</td>
<td></td>
<td>N=50</td>
<td></td>
<td></td>
<td></td>
<td>N=85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) <strong>PEI Satisfaction survey</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>10</td>
<td>N/A</td>
<td>99%</td>
<td>N/A</td>
<td>84%</td>
</tr>
<tr>
<td>N=132</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N=128</td>
<td></td>
<td></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>10</td>
<td>N/A</td>
<td>49</td>
<td>N/A</td>
<td>55</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>Unknown</td>
<td>N/A</td>
<td>11</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>52</td>
<td>N/A</td>
<td>8</td>
</tr>
<tr>
<td>Total referrals to other PEI providers</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>20</td>
<td>N/A</td>
<td>0</td>
<td>N/A</td>
<td>19</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>
<td>N/A</td>
<td>19</td>
</tr>
<tr>
<td>Average time in weeks between when a referral was given to individual by</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>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
your program and the individual's first in person appointment with the PEI-funded provider

| Total referrals to other mental health services or resources for basic needs | N/A | N/A | N/A | 250 | N/A | 230 | N/A | 574 |

*Data Collection Method*  
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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>
<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 | N/A | 95%* N=18 |
| “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 | N/A | 89%* N=18 |
| “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 | N/A | 95%* N=18 |

*percentage that agree or strongly agree
EQUITY AND CULTURAL RESPONSIVENESS:

As an agency located in the heart of the Canal neighborhood with a 38-year service history, Canal Alliance has a strong reputation as highly valued and trusted by community members. Canal Alliance provides a continuum of community-based, culturally and linguistically competent services for at-risk, low-income, Latino residents in Marin County. All social services are provided at no cost to clients, are highly-trauma informed, and the service design reflects the language and cultural norms of the Latino community they serve. All services are designed to meet the unique needs of this community with easy to access and drop-in services, bilingual and bicultural staff, and trauma-informed design. An important aspect of their capacity to address equity, inclusion and accessibility is their ability to provide quality mental health services for clients regardless of citizenship or access to insurance.

98% of Canal Alliance clients are best served in a language other than English; the primary languages spoken include 81% Spanish, 9% indigenous languages, and 3% other. By offering bilingual, trauma-informed, and culturally appropriate early intervention, case management, and community mental health to this demographic, Canal Alliance directly address the immediate behavioral health needs of clients, while also supporting them through key interventions to help them build protective factors, mitigating risks of long-term negative outcomes. To best support clients, our team consistently receives trainings on implicit bias, trauma/trauma-informed care, LGTQB+ issues and supports, as well as mental health first aid and community stress. Canal Alliance actively promotes and recognizes principles of fairness, equity, and social justice in relation to, and across, intersections of race, age, color, national origin, ethnicity, citizenship, sex, sexual orientation, gender identity, gender expression, religion, disability, ancestry and all other identities represented among our diverse employees and service population.

NMCS strives to on-board staff and volunteers who reflect the diversity of their clients. More than half of their staff members are bilingual, which enables them to serve a culturally and socio-economically diverse mix of families in a manner that integrates and unites the community. Since 2013, NMCS’ Diversity, Equity and Inclusion (DEI) Committee, composed of both board and staff members, has been continuously active. The committee conducted two organization-wide cultural competency assessments that resulted in two different improvement plans which have been successfully implemented. As a result, their board and staff are more diverse than ever and better reflect the values, customs, beliefs and languages of our clients and the Novato Community, as a whole. NMCS also provides at least two trainings each year regarding cultural humility and equity for all of our staff and board. Their recruiting materials and practices for both board and staff emphasize valuing and effectively serving diverse populations, and several of their board members and staff members were former clients. For their mental health services and Promotores Program, these values are embodied through their commitment to access, affordability, and the inclusion of Promotores and other Latinx community members in their outreach and decision-making.

CHALLENGES AND UPCOMING CHANGES

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. NMCS and Canal Alliance staffed their virtual services with bilingual/bicultural employees to ensure that all clients have access to services. Canal Alliance
grew its “emergency response team” by reconfiguring some of their staffing to have more bilingual and bicultural staff working directly with clients, as well as contracting out to more bilingual and bicultural staff to support the community with key needs, such as applying for unemployment or financial aid support. Both agencies worked with the county to support the rental assistance program, connected clients with Legal Aid of Marin for tenant rights and rental protections, as well as advocating for additional financial assistance for the communities they serve. Food pantries were reconfigured for health protocols and to meet the expanded needs of families, and Canal Alliance extended its delivery services for seniors and COVID positive clients. In addition to these efforts, outreach has been focused on the food pantries, COVID testing sites, NUSD and SRCS school districts and family liaisons, and the Cuerpo Corazon Comunidad radio show, among many others to get the word out about services and resources.

While COVID has been a challenge for many programs, in the case of Cuerpo Corazón Comunidad (CCC) it led to an increase in attention to the show. CCC played a crucial role in getting important information to the Spanish speaking community about prevention, stay at home orders, testing, eviction moratoriums and more. CCC communication efforts (website, social media, texts, etc) played complementary roles to ensure that as many people as possible had access to the information they needed. Their outreach efforts during COVID-19 have been extensive. Since they were not able to do in person work they greatly expanded their use of text, social media, and flyers at food distribution (300-600 families attending per week during COVID) to get information out about COVID-19, including promoting CCC as a resource for information 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. In 20/21, the Promotores will be funded under CSS as part of Outreach and Engagement.

Latino Community Connection program goals for FY 21/22 include: exploring different consultation channels and activities for clinicians in specifically serving the mono-lingual, uninsured population; improving the evaluation process for the Promotores component of the program; improving coordination around identifying radio show panelists and topics.

**CLIENT STORY**

*A female client is extremely shy and her first language is “quiche” an indigenous language. She does speak some Spanish and things need to be explained to her slowly and often repeated using reflective listening to make sure that she has understood. One of our staff and a Promotora worked hard to earn her trust. She recently told one of our staff how grateful she is to our organization since she said that NMCS has been incredibly supportive of her and her kids as she decided to leave her abusive husband and move with her 2 kids to a temporary shelter (we connected her with the Center for Domestic Peace). We connected her with a case manager and she later was supported with a move in deposit so she could move to a permanent place to live (staff helped her communicate with potential landlords/apartment managers), she now participates in our food bank and has recently received rental assistance support due to loss of income due to the Shelter in Place, preventing her and her family from becoming homeless. She continues to get emotional support in her native language from one of our Promotores that speaks quiche.*
OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI 07)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

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

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; as well as Spahr Center starting FY21/22

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:

- **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
• Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

Anticipated data collection changes and addition: In order to best assess client satisfaction of BOOST services to clients, JFCS is streamlining the evaluation process (ie ensuring that clients don’t receive various evaluations separately), reminding clients of the surveys and encouraging them to complete and return them, having clinicians bring a copy of surveys to clients as appropriate.

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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>
<td>100</td>
<td>240</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% N=85</td>
<td>51% N=85</td>
<td>25%</td>
<td>78% N=80</td>
<td>25%</td>
<td>25% N=75</td>
<td>20%</td>
<td>24% N=49</td>
</tr>
<tr>
<td>Seniors at Home clients screened for behavioral</td>
<td>150</td>
<td>153</td>
<td>150</td>
<td>163</td>
<td>150</td>
<td>162</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Category</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>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
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</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>
<td>50</td>
<td>49</td>
</tr>
<tr>
<td>Low income clients receiving brief intervention services who are from underserved populations</td>
<td>20%</td>
<td>26%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>31%</td>
<td>20%</td>
<td>24%</td>
</tr>
<tr>
<td>N=35</td>
<td></td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
<td>20%</td>
<td></td>
<td>24%</td>
</tr>
<tr>
<td>N=10</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients completing a short-term treatment protocol for depression or anxiety</td>
<td>70%</td>
<td>71%</td>
<td>70%</td>
<td>70%</td>
<td>90%</td>
<td>70%</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>N=35</td>
<td></td>
<td></td>
<td>70%</td>
<td></td>
<td></td>
<td>70%</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>N=30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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 (i.e.: moderate to mild).</td>
<td>60%</td>
<td>63%</td>
<td>60%</td>
<td>86%</td>
<td>60%</td>
<td>68%</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>N=35</td>
<td></td>
<td></td>
<td>60%</td>
<td></td>
<td></td>
<td>60%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>N=30</td>
<td></td>
<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>90%</td>
<td>75%</td>
<td>95%</td>
<td>75%</td>
<td>100%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>N=22</td>
<td></td>
<td></td>
<td>75%</td>
<td></td>
<td></td>
<td>75%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>N=22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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>
<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>0</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Average duration in weeks of signs of untreated mental illness</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Unknown</td>
<td>N/A</td>
<td>17 days</td>
</tr>
</tbody>
</table>
### Data Collection Method

*Equity and Cultural Responsiveness:

The JFCS BOOST program is designed to foster mutual respect and shared decision-making. JFCS clinicians work with clients to determine goals and interventions that are tailored to the client’s beliefs, culture, and social values. This emphasis on collaboration between BOOST clinicians and clients also helps to design strengths-based interventions that assist clients in building/strengthening support networks that will meet their varied needs, and use interventions and modalities that take clients’ values, customs, beliefs and languages into account. PEI providers attend available county trainings focusing on cultural competency, and weekly case presentations have been designed to incorporate a cultural perspective when considering clients’ strengths and needs. In addition, clinicians and intake coordinators have undergone training around how to best ask difficult questions pertaining to gender and sexuality, as older adults often struggle with these concepts and may be offended/confused. JFCS’ intake forms and intake process are updated on an ongoing basis as needed to ensure a welcoming and inclusive environment.

### Table

<table>
<thead>
<tr>
<th>(per client or caregiver report)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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>N/A</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 **FY 2019-20**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY 2017-18** through **FY 2019-20** 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. One of the biggest challenges faced by the population served by BOOST during Covid-19 was lack of technological savvy that would enable clients to engage virtually, and poor internet connections, particularly with clients living in more remote areas, such as West Marin. In these instances, clinicians engaged family members to help them, or linked clients with volunteers who could assist them in accessing Zoom and other platforms to provide social interaction during shelter-in-place. In addition, clinicians linked clients to resources to buy computers and ipads at a subsidized rate. In instances wherein clients did not feel comfortable using video for services, or lacked suitable internet connection, therapy was provided by phone. In addition, efforts were made to engage and collaborate with other service providers and professional networks serving Marin’s diverse demographic to ensure the needs of Marin’s most vulnerable seniors were addressed.

The BOOST program served three fewer clients than last year largely due to difficulty in ending with clients (many of whom had met their goals) when the pandemic and shelter-in-place began. These clients were particularly impacted and experienced heightened anxiety and depression to the extent that clinicians felt it was contraindicated to end treatment, consequently, treatment went on longer than anticipated in some cases, resulting in clients being discharged less frequently than past years.

Continued funding was determined by the MHSA Three Year planning process for **FY 2020-21** through **FY 2022-23** 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. JFCS Boost program goals for next fiscal year include increasing the number of Spanish and Russian speaking clients served through ongoing outreach to communities with Spanish and Russian speaking older adults; educating local resources on their capacity to serve Spanish and Russian speaking seniors; diversifying referral sources to include those serving more Spanish and Russian speakers; expanding services to West Marin through targeted outreach and building partnerships with local WM organizations.

CLIENT STORY

“Ana” is an 81 year old woman who appears younger than her stated age. She self-referred for therapy through the BOOST program after hearing a presentation from BOOST staff on depression and anxiety in seniors. Ana indicated she thought her feelings were just those of normal aging and grief from her husband’s loss over ten years ago, and only upon learning more about the topic did she recognize the extent to which her symptoms were negatively impacting her life. Ana completed an intake with JFCS’s intake staff and was then matched with a clinician, who completed a thorough assessment to determine how to best meet her needs. Ana scored 18 on her initial PHQ-9, placing her in the ‘clinically at-risk’ category. Ana’s clinician offered psycho education on depression and anxiety and Ana experienced immediate relief in the initial session upon realizing she wasn’t “crazy.” Her clinician assisted her in improving her capacity to manage her symptoms using the Healthy Ideas model, an evidence-based program designed to reduce the severity of depressive symptoms among older adults and developed as a
depression self-management program wherein clients set their own goals in collaboration with their clinician. Ana’s goals included daily walks and reaching out to her daughters weekly. Ana asked for her clinician’s help improving her capacity to engage her daughters, and using coaching, role play, and collateral sessions, the clinician was able to assist Ana’s daughters in understanding their mother’s depression and supporting her in meeting her goals. In a thank you note written to her clinician, Ana wrote, “I was withering away into nothingness until you came along. I’m starting to feel alive again…Thank you.”

In FY21/22 Older Adult PEI is being expanded to include new training for primary care physicians around older adults and suicide prevention as well as older adult provider trainings around LGBTQ+ competency.
VIETNAMESE COMMUNITY CONNECTION (PEI 11) (ENDED FY19/20)

PROGRAM ALLOCATION FY19/20: $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 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 Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.
## 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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>
<td></td>
<td></td>
</tr>
<tr>
<td>- CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc.</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>- Mental Health First Aid</td>
<td></td>
<td></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>
<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>
<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>
<td>120</td>
<td>40</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>
<td>40</td>
<td>30</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>
<td>N/A</td>
<td>9</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>
<td>N/A</td>
<td>3</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>
<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>N/A</td>
<td>N/A</td>
<td>10</td>
<td>N/A</td>
<td>9</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>
<td>N/A</td>
<td>3</td>
</tr>
</tbody>
</table>
EQUITY AND CULTURAL RESPONSIVENESS:

The Goal of MAAP is to advocate for the rights and assist the Asian American communities in Marin, especially recent immigrants, in accessing healthcare and social services. MAAP also supports these communities in going through the naturalization process, and provides community activities and field trips as part of a preventive mental health program to reduce stress and isolation.

CHALLENGES AND UPCOMING CHANGES

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 mental health supports throughout their community.

In FY20/21, this program was moved under CSS and no longer be funded under PEI. Funding was awarded based on the results of Requests for Proposals that was released for the Community Health Advocates Program in the fall. MAAP was awarded the CHA contract for the 19/20 FY.

CLIENT STORY

Mrs. C. lived in Marin County for 30 years with her daughters. She participated in regular activities with the Vietnamese community. During October 2019, we realized that Mrs. C. was often absent from activities like karaoke and dancing exercises organized by us. Through talking to her friends and family of Mrs. C., we learned that she had not recently contacted her friends, even wandering around the neighborhood, and crying alone. We saw unusual signs from Mrs. C., and immediately invited her to the office to find out. When Mrs. C. came to our office that we could not recognize her even though we had just met her a few weeks earlier. She looked incredibly sad and depressed. Moreover, when talking to us, she revealed confused thoughts and reduced ability to concentrate. After a long discussion, we realized that Mrs. C. had many concerning symptoms and needed to be referred for treatment immediately. We contacted the Access right away to help her. Overtime, with the support of a therapist, Mrs. C is doing much better. Months later, she contacted our office and said: "Thank you for being so dedicated to help me. Thank you from the bottom of my heart."

<table>
<thead>
<tr>
<th>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</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>4</th>
<th>N/A</th>
<th>4</th>
</tr>
</thead>
<tbody>
<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>
<td>N/A</td>
</tr>
</tbody>
</table>
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 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 for the FY 19/20 is reported in the Outcomes section below.

OUTCOMES

BHRS hosted 7 Mental Health First Aid Trainings during the FY 19/20.

<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>
<th>FY 19/20</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>
<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>
<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>
<td>4.27</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>
<td>4.48</td>
</tr>
<tr>
<td>Mental Health First Aid Outcomes</td>
<td>FY 16/17</td>
<td>FY 17/18</td>
<td>FY 18/19</td>
<td>FY 19/20</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</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>
<td>4.31</td>
</tr>
<tr>
<td>Participants reporting ability to assist somebody experiencing a mental health problem or crisis to connect with community, peer or personal support. (0-5 scale)</td>
<td>N/A</td>
<td>4.5</td>
<td>4.26</td>
<td>4.22</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>
<td>4.27</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>
<td>4.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health First Aid Outcomes: 3 Month Follow-up</th>
<th>FY 16/17</th>
<th>FY 17/18</th>
<th>FY 18/19</th>
<th>FY 19/20</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>
<td>3.76</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N=7</td>
<td>N=13</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>
<td>3.84</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N=7</td>
<td>N=13</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>
<td>3.92</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N=7</td>
<td>N=13</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>
<td>3.92</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N=7</td>
<td>N=13</td>
</tr>
</tbody>
</table>
### Setting where participants might use MHFA:

<table>
<thead>
<tr>
<th>Settings where participants might use MHFA</th>
<th>Number Served 16/17</th>
<th>Number Served 17/18</th>
<th>Number Served 18/19</th>
<th>Number Served 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Members</td>
<td>47</td>
<td>62</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>Family Member of Person with Serious Mental Illness</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

### Providers:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Number Served 16/17</th>
<th>Number Served 17/18</th>
<th>Number Served 18/19</th>
<th>Number Served 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Behavioral Health and Recovery Services</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Community-based Mental Health and/or Substance Use Provider</td>
<td>12</td>
<td>8</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>Education (including High School Students)</td>
<td>6</td>
<td>23</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>5</td>
<td>4</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Senior Centers/Services</td>
<td>12</td>
<td>2</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>Social Services (County and Community)</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Veterans</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Faith-based</td>
<td>8</td>
<td>1</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Shelters/Homeless Services/Public Housing</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Libraries</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Public Transit</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employment</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Other – List: DV, BOS, Parks Svcs, PH</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Security, Emergency Svcs</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
OTHER OUTREACH AND TRAINING ACTIVITIES IN FY2019-20

Participation in community outreach and education events including “Day of the Dead” in the Latino community.
Photos by Multicultural Center of Marin. October/November 2019
SEPTEMBER 2019 SUICIDE PREVENTION MONTH EVENTS:

- **Suicide Prevention Month Proclamation:** On September 19th, 2019, Board of Supervisors adopted a resolution proclaiming September 2019 as “National Suicide Prevention Month”.
- **Schools received Mini-grants** for Suicide Prevention Week to increase awareness, improve school culture/climate related to suicide prevention, and create outreach activities with students.
- **Journal Club** aims to refine skills at developing evidence-based practices and inform current or emerging programs. For Suicide prevention month they held an online event titled: *Suicide ideation among Latinx adolescents: Examining the role of parental monitoring and intrinsic religiosity.*
- **Kevin Berthia** is a Grateful Suicide Prevention Advocate, encouraging people to talk through their problems rather than think about ending their lives. On September 12, 2019 Kevin Berthia shared his story and he believes that depression may be a part of you, but it is not who you are and that no one knows better the darkness that surrounds suicide than those who have walked in its shadow, or the light that comes from knowing that they might be able to help others avoid similar grief.
- **Youth Mental Health First Aid Training** course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations.

MAY IS MENTAL HEALTH MONTH COMMUNITY TRAININGS AND WORKSHOPS:

In support of Mental Health Awareness Month, May, 2020, 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:

- **Gentle Yoga for Seniors in celebration of older Americans:** an online workshop to build self-awareness and practice skills that support mental well-being.
- **Gentle Yoga for the Community:** an online workshop for all Marin County residents that included trauma-informed yoga postures and breathwork for mental health wellbeing.
- **Gentle Yoga for Service Providers:** an online workshop titled and was open to all employees of the Marin County Department of Health and Human Services to build self-awareness and practice skills to support mental well-being.
- On May 19th, 2020 the Board of Supervisors passed the **Proclamation** to adopt May as Mental Health Awareness Month.
- **Mini Grants for Schools to promote youth-led wellness activities** to raise awareness during May Mental Health month. This funding helped schools create posters with positive affirmations, wellness games, create a calm down corner, and due to COVID students were able to receive supplies to participate in activities through the mail.
- **Youth Video Series:** In partnership with The Marin County Youth Commission, posted a video series—sharing the experience of young people in Marin during the Covid-19 pandemic and offering tools to help guide us all through it.
- **Mental Health First Aid Trainings**
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. NAMI events during the 19/20 FY included:

- **Love Has No Limits** – Storytelling Series featuring people with lived experience with mental illness, suicide, and substance abuse
- **NAMI Walk** – Movement to raise awareness of mental illnesses and raise funding for their mission to help individuals and families
- **Sacheen** – Storytelling series of speaker who raised international awareness of Native stereotypes in film, education, and books
- **Gratitude and Forgiveness** – Storytelling Series by forgiveness mentor CJ

CHALLENGES AND UPCOMING CHANGES

In FY2019-20, seven (7) MHFA trainings were offered, including 4 adult, 2 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 met 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 Fiscal Year, 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-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 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

FY19/20 PROVIDERS FOR OUTCOME REPORTING:
West Marin (Shoreline Unified): Coastal Health Alliance
San Rafael (San Rafael City Schools): Youth Leadership Institute
Marin City (Sausalito Marin City Schools): Performing Stars, Seneca Family of Agencies

FY21/22 PROVIDERS:
- Petaluma Health Center (formerly Coastal Health Alliance)
- Sausalito Marin City School District
- North Marin Community Services
- Seneca Family of Agencies

Individuals Served: FY2019-20

205 Individuals
38 Families
776 reached through Outreach/Training
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 19/20, the program targeted three areas of Marin County.

<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>69.9%</td>
<td>0.4%</td>
<td>2.6%</td>
<td>0.7%</td>
<td>1.7%</td>
<td>46.6%</td>
<td>65%</td>
</tr>
<tr>
<td>West Marin Schools</td>
<td>60.1%</td>
<td>1%</td>
<td>1%</td>
<td>-</td>
<td>0.6%</td>
<td>38.5%</td>
<td>55.2%</td>
</tr>
<tr>
<td>Sausalito/Marin City Schools</td>
<td>26.2%</td>
<td>0.2%</td>
<td>7.6%</td>
<td>21.3%</td>
<td>10.7%</td>
<td>16.3%</td>
<td>47.3%</td>
</tr>
</tbody>
</table>

In FY 19/20, PEI providers provided individual and group counseling to 205 youth and family counseling and support to 38 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.
Latinx youth represented 22% of individuals served, Whites represented 32%, African Americans represented 31%, other races or those that identified as “more than one race” represented 14%.
Spanish speaking clients represented **28%** of individuals served through school-aged programs

**PROGRAM DESCRIPTION OF SERVICES PROVIDED IN FY19/20:**

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 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 to for students. They also coordinate student and community field trips and provide parent educational workshops. Students are referred to Performing Stars through COST.
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
- 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, if applicable, 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 I 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
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

Anticipated data collection changes: In the upcoming fiscal year, all school based providers will be implementing the Child and Adolescent Needs and Strengths (CANS) assessment tool with all individual and group clients.
### 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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>
<td>4</td>
<td>4</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>
<td>90%</td>
<td>94%</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>
<td>100%</td>
<td>100% N=81</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>
<td>90%</td>
<td>67% N=81</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>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
### Data Collection Method

The data collection method for the Prevention and Early Intervention (PEI) – School-Aged – PEI 18 report is not specified in the document.

### Table Data

<table>
<thead>
<tr>
<th>Total referrals to County Behavioral Health (BHRS)</th>
<th>16/17</th>
<th>17/18</th>
<th>16/17</th>
<th>17/18</th>
<th>18</th>
<th>17/18</th>
<th>19/20</th>
<th>21</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>N/A</td>
<td>N/A</td>
<td>9</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>2</td>
<td>N/A</td>
<td>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>18</td>
<td>N/A</td>
<td>14</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>18</td>
<td>N/A</td>
<td>13</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>1</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>N/A</td>
<td>N/A</td>
<td>2</td>
<td>N/A</td>
<td>21</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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>N/A</td>
<td>15</td>
<td>3</td>
<td>30</td>
<td>35</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>N/A</td>
<td>15</td>
<td>45</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Caregivers/family members will participate in an</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>10</td>
<td>8</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>
educational workshop at Bayside/MLK. Examples of workshops include how to manage parenting stress, how to help child with school work, etc.

| Youth and family members will participate in cultural awareness/community building event | N/A | N/A | N/A | N/A | 25 25 | 25 25 | 25 25 | 27 8 |
|-------------------------------------------------------------------------------------------------------------------------------|
| Clients receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Survey) | N/A | N/A | N/A | N/A | N/A | 100% N=72 | N/A | 100% N=51 |

*Data Collection Method

<table>
<thead>
<tr>
<th>Outcomes Shoreline School District/CHA</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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>School staff participating in trainings reporting awareness of risks, signs, and symptoms of children experiencing emotional disturbances and/or risk of abuse <em>(Post-survey)</em></td>
<td>80% N=18</td>
<td>83% N=18</td>
<td>80% N=5</td>
<td>100% N=45</td>
<td>80% N=30</td>
<td>95% N=30</td>
<td>80%</td>
<td>95% N=30</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>
<td>185</td>
<td>185</td>
<td>185</td>
</tr>
<tr>
<td>Students with mild to moderate mental health concerns receiving at least 3 sessions of</td>
<td>40</td>
<td>43</td>
<td>25</td>
<td>73</td>
<td>25</td>
<td>57</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>Individual or Group Counseling</td>
<td>65%</td>
<td>84% N=32</td>
<td>65%</td>
<td>81% N=22</td>
<td>65%</td>
<td>72% N=39</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------</td>
<td>----------</td>
<td>------</td>
<td>----------</td>
<td>------</td>
<td>----------</td>
<td>------</td>
<td></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>86% N=39</td>
<td>65%</td>
<td>84% N=26</td>
<td>65%</td>
<td>73% N=15</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Satisfaction surveys not collected due to clinician going on maternity leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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>
<td>N/A</td>
<td>10</td>
<td>12</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% N=8</td>
<td>65%</td>
<td>71% N=7</td>
<td>65%</td>
<td>83% N=35</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Satisfaction surveys not collected due to clinician going on maternity leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregivers receiving 3 or more counseling services</td>
<td>75%</td>
<td>90% N=8</td>
<td>75%</td>
<td>86% N=7</td>
<td>N/A</td>
<td>100% N=44</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Satisfaction surveys not collected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Data Collection Method

**reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)** *(PEI Caregiver Survey)*

<table>
<thead>
<tr>
<th>Total referrals to County Behavioral Health (BHRS)</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>4</th>
<th>N/A</th>
<th>1</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>N/A</td>
<td>N/A</td>
<td>5</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>
<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>N/A</td>
<td>N/A</td>
<td>4</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>0</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>
<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>5</td>
<td>N/A</td>
<td>3</td>
</tr>
</tbody>
</table>

*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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-45 youth leaders and 2 adult allies will participate in the YLI program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>25-45</td>
<td>44</td>
<td>25-45</td>
<td>36</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>
<td>80%</td>
<td>100% N=36</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>
<td>80%</td>
<td>100% N=36</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>
<td>80%</td>
<td>95% N=36</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>
<td>75%</td>
<td>100% N=36</td>
</tr>
<tr>
<td>Data Collection Method</td>
<td>Staff that participated in LGBTQ Competency Training reported having a better understanding of how the school can better support LGBTQ+ students</td>
<td>Students reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Survey)</td>
<td>Total referrals to County Behavioral Health (BHRs)</td>
<td>Number of individuals who were successfully referred and linked to a Marin County mental health treatment program</td>
<td>Average duration in weeks of signs of untreated mental illness (per client or caregiver report)</td>
<td>Total referrals to other PEI providers</td>
<td>Number of individuals followed through on referral &amp; engaged in a PEI-funded program</td>
<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>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>N/A  N/A  N/A  N/A  90%  100% N=215  90%  100% N=252</td>
<td>N/A  N/A  N/A  N/A  100% N=34  N/A  100% N=36</td>
<td>N/A  N/A  N/A  N/A  1  N/A  0</td>
<td>N/A  N/A  N/A  N/A  1  N/A  N/A</td>
<td>N/A  N/A  N/A  N/A  Unknown  N/A  N/A</td>
<td>N/A  N/A  N/A  N/A  0  N/A  N/A</td>
<td>N/A  N/A  N/A  N/A  0  N/A  N/A</td>
<td>N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/A</td>
</tr>
</tbody>
</table>

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

EQUITY AND CULTURAL RESPONSIVENESS:

While Unconditional education has a structured model, Seneca believes that collaboration and partnership are at the heart of their capacity to affect change for students. Therefore, they strive to tailor program goals to the needs and strengths of each partnership school. At Bayside, Seneca has made an effort to support staff in discussions about race and equity by cofacilitating a book club centered on culturally relevant learning, and by participating in the ongoing race related conversations. Seneca also believes that interventions and systems should be driven by data. They use behavioral data to more clearly see trends that may be present in classrooms and school wide. More specifically, they are able to use data to mitigate implicit bias by pinpointing trends in discipline data and working with staff to uncover possible biases and supporting implementation of more culturally relevant structural and disciplinary practices.

The CHA School-Based PEI Counselor ensures that all materials are available in Spanish and that Parent Education Nights and Workshops have interpreter services as well as a meal and childcare to increase accessibility to resources. The PEI Counselor also maintains a strong presence in the community and regularly attends Cafecito at the school as well as participates in school-wide cultural events.

Through PEI, YLI serves two main populations: LGBTQ+ identified youth and newcomer youth. In order to meet the needs of these populations, YLI has worked to remove participation barriers and their programming is youth-led so participants are able to focus on issues that matter to them. Both programs also implement identity specific programming to ensure that the curriculum is relevant and that youth feel safe and seen in the program. For example, at Venetia Valley middle school, adult allies created programming centered around gender, race, and sexuality and the impact of societal messages and norms on LGBTQ+ folks. Youth participated in an activity called the gender unicorn where they learned the varying aspects to gender identity and shared how they themselves identify. YLI staff also starts every Davidson Club Live meeting with a recitation of “In Lak’ech.” Davidson Club Live is facilitated in Spanish and one of the adult advisors at Venetia Valley is bilingual so there is opportunity for that adult ally to be responsive to Spanish-speaking youth and parents/guardians. Additionally, all Club Live meetings take place at the school site during lunch time or after school to reduce any access barriers.

CHALLENGES AND UPCOMING CHANGES

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. School-based PEI programs quickly mobilized to shift services in response to the needs of the schools and students. 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. At Bayside MLK, the UE Coach assisted the leadership team in identifying students that might need extra support in distance learning and held twice daily check ins with them and assisted them with their work. In addition, the COST team moved to the Zoom platform and continued to meet weekly in order to serve students during the shutdown. The COSTeam also shifted the focus from behavioral concerns to addressing challenges students’ families were facing due to COVID-19. With CHA, community outreach efforts in person halted and the PEI counselor maintained communication and collaboration with
community partners via Zoom meetings, phone calls, and emails. This will continue through the next school year. The team created a School-based Mental Health Services website that will provide mental health resources for teachers and parents. Trainings and workshops for teachers were conducted and recorded via Zoom as well as parent education workshops. Outcome measures and data collection shifted to an online platform. Although the online format for service delivery was not ideal, the shift occurred with very little disruption in services and due to the strong relationships previously built, the impact in services is only in the format of how support is provided. To meet the needs of students experiencing anxiety during COVID-19, the PEI Counselor participated in several webinars supporting the shift in needs to better serve students, families, and teachers. Webinars included Social Emotional Learning Strategies for Reopening Schools, Mental Wellness for Students and Teachers, How to Cope w/Uncertainty, Supporting You Supporting Students, Telehealth, and ACEs Aware Trauma-Informed Practices to Address Stress Related to COVID-19.

Before COVID-19, the populations that YLI served were already experiencing inequitable access to resources. When COVID-19 hit the Marin community it was clear that the pandemic would have bigger implications for historically underserved communities. The first step for YLI was ensuring that youth participants could remain connected in the digital world. They offered support to youth that was based upon individual need rather than assuming that all youth would be facing the same challenges. With funds that were set aside for COVID-19 relief, youth were provided school supplies to continue their learning, lap desks, hot spots, and grocery gift cards. Additionally, because this youth demographic is under the age of 15, connecting virtually meant that staff were connecting with youth via Snapchat and Instagram.

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 and meeting contracting goals.

School-based provider program goals the next Fiscal Year include: utilization of CANS to measure outcomes; Building Capacity of School Staff – Increase staff knowledge and understanding of trauma informed practices, PBIS implementation, and other behavioral intervention strategies; implementation of PBIS Tier 1 Systems and Supports; Increase referrals to non-PEI, non-BHRS programs like housing, food, and nutrition, etc.; increase attendance at parent education events.

CLIENT STORY

Client Story 1: The CHA PEI Counselor provided individual counseling, education, and family support for a student presenting with symptoms of gender dysphoria and bullying for the past two years. This past year the student made great strides toward being who they are and involving their parents in the process. The student has gone from isolating, self-harming, and having suicidal ideation to being proud of who they are and taking the lead in creating a Gay Straight Alliance (GSA) Club at their school. The student is now on their way to high school and has reported feeling ready to move forward in their gender identity journey. The student wrote a very touching letter thanking the PEI Counselor for the continued support in helping them “become who they are” and “finding freedom.”

Client Story 2: With The YLI Davidson club live, we had one participant who had challenges with focusing in the group. When he would get together with his friends, the group would talk over other youth or adult allies. Through the journaling exercises, YLI staff learned that this particular young person was missing his mother. He traveled to the United States and was living without his immediate family. In his journal, he wrote that he disliked being in the US and wished to return to his home country. Upon learning this information, staff invited the young person for lunch to learn more about his story. Staff was able to offer emotional support and also adjusted curriculum for youth to share more about their lives before coming to the US but also guiding youth into identifying the positive things they experience living in the
United States. This shift in programming and the one-on-one conversation shifted how this young person showed up in the Club Live meetings. He was more willing to engage and speak up about his experience knowing that adult allies really cared about his life outside of our meeting times.
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.

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.

PROGRAM DESCRIPTION

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

- Outreach and Engagement: Clients are identified through outreach, in-reach and referrals from the VA.
• **Case Management:** The PEI Case Manager links clients to housing, behavioral health services, and more. In addition, the CM assists with logistical barriers to completing a treatment plan, provides ongoing contact to increase likelihood of engaging with services and services for significant support people, such as family. The CM also assists with obtaining other forms of support available to the veterans and their families, such as financial benefits or community resources.

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

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

**DATA COLLECTION METHODS**

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

- Client/family demographics and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

**Anticipated data collection changes and additions for FY 20/21:** 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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of veterans that received support services to increase likelihood of completing the</td>
<td>N/A</td>
<td>N/A</td>
<td>100</td>
<td>212</td>
<td>100</td>
<td>138</td>
<td>100</td>
<td>39</td>
</tr>
<tr>
<td>veteran’s mental health treatment plan. (Average number of services: 8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<td>19</td>
<td>20</td>
<td>8</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% N=171</td>
<td>75%</td>
<td>85% N=117</td>
<td>75%</td>
<td>92% N=36</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>100% N=26</td>
<td>N/A</td>
<td>N/A</td>
<td>89% N=27</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>
<td>N/A</td>
<td>0</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>
<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>
<td>&lt;1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
EQUITY AND CULTURAL RESPONSIVENESS:

The goals of the HHS Veterans PEI program are to provide comprehensive services to veterans that have lost housing or are at risk of losing housing in an effort to end veteran homelessness in Marin County. Additionally, the program provides services and advocacy to veterans that have committed misdemeanor offenses as a result of an untreated disability that was incurred while in service. Cultural Competency with regards to veterans requires the clinician to have a basic knowledge of military culture, language, history, duties, and geography. All staff have a good knowledge of the VA healthcare system, Vet Centers and other care providers which may be involved with veterans. Program staff have a familiarity with the common disabilities (mental and physical) that often plague veterans. We understand the delicate nature of trauma (including military sexual trauma), and how it impacts survivors.

CHALLENGES AND UPCOMING CHANGES

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. The Covid-19 pandemic has presented tremendous challenges to the program’s to provide services to veterans. Many of the resources that had been available to the pandemic were no longer

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
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<th>N/A</th>
<th>0</th>
<th>N/A</th>
<th>0</th>
</tr>
</thead>
<tbody>
<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>
<td>N/A</td>
<td>N/A</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>
<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>0</td>
<td>N/A</td>
<td>0</td>
<td></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>157</td>
<td>N/A</td>
<td>125</td>
<td></td>
</tr>
</tbody>
</table>
available. Mill Street Shelter and Homeward Bound stopped accepting any new residents for a period of time. HUDVASH has used all of the vouchers that were available for qualified veterans so the ability for placing veterans in permanent housing has ceased until more vouchers were made available. Courts were not meeting in person and therefore the PEI Case Manager’s participation as a court advocate or expert witness has stopped. Despite these challenges, 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. PEI Veterans program goals for the next Fiscal Year include: Increased and more focused outreach to Marin City veterans.

CLIENT STORY

AH is a 35 y/o African American Veteran that moved out to Marin County from Florida about 10 years ago. He had been discharged from the military after he had received a diagnosis of congenital heart failure. He received a heart transplant in 2010. He presented to our office in the Fall of 2019. He had been homeless for 10 years. He had a medicinal regimen of 54 different medications for his heart condition but he had not taken his medication for years due to his homelessness and limited resources. We immediately got him engaged with his cardiologist at the VA. We obtained a shelter bed at New Beginnings where he was enrolled and participating for 6 months. In March of 2020 we found him permanent housing and are currently working on a claim in order for him to get more disability income. He reports feeling happy and healthy at this time.
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.

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.

In 19/20, funding to the PEI Project supported programs such as:

- Expanding public awareness and education campaigns
- Creating new outreach materials for diverse audiences
• Providing technical assistance and outreach to county agencies, schools, and community-based organizations
• Providing mental health/stigma reduction trainings to diverse audiences
• Engaging youth through the Directing Change program
• Building the capacities of schools to address mental health, stigma reduction, and suicide prevention

LEARNING COLLABORATIVES AND TECHNICAL ASSISTANCE:

Each Mind Matters Learning Collaboratives: The Learning Collaborative utilizes a public health approach to suicide prevention and has supported 23 county teams (including Marin) in creating strategic plans for suicide prevention using national models aligning with the newly released California Strategic Plan for Suicide Prevention through a combination of in-person meetings in Sacramento, online learning modules, and individual TA.

- Highlight: Marin County Behavioral Health and Recovery Services (BHRS) Through participation in the Learning Collaborative, after joining in October 2018, they were guided through the process to develop a strategic plan for suicide prevention. Through support from the Learning Collaborative Team, a draft plan was edited, updated, and revised to result in the final plan being approved and released in February 2020.

CalMHSA TECHNICAL ASSISTANCE TO MARIN COUNTY:

Technical assistance (TA) is provided by all PEI Project contractors, each targeting a different audience. TA includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention, and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. In addition, an Each Mind Matters Resource Navigation Team member provides regular communication in the form of in-person meetings, phone calls, and TA emails covering a range of topics with practical tools and information. During the FY 19/20, 49 TA emails covered topics such as Suicide Prevention month, week and day, SanaMente, a Holiday series, self-care during the COVID-19 pandemic, May is Mental Health Month, and more. During FY 19/20, specific TA consultations included to Marin County included:

- The EMM TA Team participated in a call with Marin County Behavioral Health and Recovery Services to support planning for a community meeting to review the strategic plan for suicide prevention.
- The EMM TA Team participated in a call with Marin County Behavioral Health and Recovery Services to discuss response to recent suicide deaths on the SMART railway system. During the call, the EMM Team provided information on best practices for community and organizational response to suicide deaths.
- The EMM TA Team participated in a call with Marin County Behavioral Health and Recovery Services and Sonoma County Department of Health Services Behavioral Health, staff from Buckelew Crisis Services and staff from the SMART Train Railway System to
discuss response to recent suicide deaths on the SMART railway system. During the call, the EMM Team provided information on best practices for community and organizational response to suicide deaths, and guidance on materials to use in response efforts. The EMM Team had previously assisted both counties in development of awareness signs promoting the local crisis line which will be utilized again to respond to current efforts.

- The EMM TA Team reviewed a draft version of the **Marin County** Suicide Prevention Strategic Plan at the request of Marin County Behavioral Health and Recovery Services. The EMM Team reviewed the 100-page plan and provide feedback on messaging to be in-line with effective messaging for suicide prevention, suggested edits to narratives to be more trauma-informed, and also provided feedback on organization of the document. Feedback on the document was provided via email, followed by a phone call with staff from Marin County.

- The EMM Team and the Directing Change Team hosted a webinar at the request of **Marin County** Behavioral Health and Recovery Services Division for schools that received mini-grant funding to participate in the Directing Change Program and Film Contest. During the webinar, the EMM and Directing Change Teams introduced the school representatives to the Directing Change Program and provided an overview of resources to support implementation of the program on local campuses.

- The EMM TA Team participated in a call with **Marin County** Behavioral Health and Recovery Services Division to review updates to the Marin County Strategic Plan for Suicide Prevention. During the call, the EMM Team reviewed suggested revisions to the document. The EMM Team will be revising the document and sending an updated version back to Marin County Behavioral Health and Recovery Services Division for review.

- The EMM TA Team hosted a call with **Marin County** Behavioral Health and Recovery Services Division to review the final round of suggested updates to the Marin County Strategic Plan for Suicide Prevention. During the call, the EMM Team reviewed final revisions to the document. Following the call, the EMM Team shared the updated version of the executive summary with staff from Marin County Behavioral Health and Recovery Services Division to be reviewed, updated and approved.

- The EMM Team, upon request, summarized available media campaign assets to support a $100k media buy during Mental health Awareness Month and Suicide Prevention Month in Marin County. Existing outdoor options, social media and digital assets as well as TV spots were provided for consideration.

- The EMM TA Team participated in a call with staff from **Marin County** Behavioral Health and Recovery Services to provide guidance in presenting on the newly finalized Marin County Strategic Plan for Suicide Prevention.

In addition, in **FY 19/20**, 2 local schools (Davidson Middle School and the College of Marin) received outreach materials, a training, technical assistance or a presentation about stigma reduction, suicide prevention, and/or student mental health through the collective efforts of all programs implemented under the PEI Project.
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
- Social marketing campaigns appear to be effective in reducing the stigma of mental illness
- 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

See the Full Report: Social Marketing of Mental Health Treatment: California’s Mental Illness Stigma Reduction Campaign | AJPH | Vol. 109 Issue S3 (aphapublications.org)

CHALLENGES AND UPCOMING CHANGES: No anticipated changes for FY21/22.
SUICIDE PREVENTION (PEI 21)

SERVICE CATEGORY: SUICIDE PREVENTION

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

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM OVERVIEW: 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.

In FY21/22 there will be increased emphasis on 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 the in the Suicide Prevention Strategic Plan.

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.

PROGRAM DESCRIPTION

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

- Training and Outreach: This program provides training and outreach to schools, first responders, community mental health agencies and universities on recognizing and responding to warning signs of suicide.
• **Timely Access to Services:** The hotline serves underserved populations by providing free and accessible help 24/7 which allows access for people of all ages and socioeconomic status. It is accessible by anyone who has access to a telephone including those who may have limited access to services due to geographic location or mobility issues. The translation services used by the program offer translation for over 200 languages allowing individuals whose primary language is not English to access the hotline. In addition, the Hotline has an ongoing contract with the National Suicide Prevention Lifeline to answer calls from Veterans who prefer not to call the Veteran’s Lifeline or other Veteran resources due to stigma around mental health issues.

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

**DATA COLLECTION METHODS 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. In FY 19/20 demographics were collected for 1078 callers (20% of callers) and 200 families.

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

• An additional pre and post assessment of training and education participants to measure change in skills and knowledge of suicide prevention was implemented.

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 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>
<th>Goal FY 19/20</th>
<th>Actual FY 19/20</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>
<td>6000</td>
<td>5361</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>
<td>80%</td>
<td>82% N=428</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>
<td>50</td>
<td>37</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>
<td>50%</td>
<td>100% N=229</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>
<td>50%</td>
<td>93% N=229</td>
</tr>
</tbody>
</table>

❖ 82% of callers surveyed reported lower suicidal intent by the end of the call

❖ 93% of training participants surveyed reported that the community education training on suicide prevention helped them feel prepared to help a friend/loved one who is feeling suicidal or in a crisis situation
EQUITY AND CULTURAL RESPONSIVENESS:

The hotline staff took a minimum of 4 hours of training around cultural competency with regards to age, communication, LGBTQ+, Tribal Communities, Race, Ethnicity, and Implicit Bias. Efforts continue to be made to expand language capacity of hotline volunteers.

CHALLENGES AND UPCOMING CHANGES

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. All networking and outreach meetings were held virtually on Zoom by phone. Buckelew increased coordination with other Bay Area/Marin CBO’s to raise awareness of Hotline and Signs of Suicide (SOS) group via Covid Response Networks and Marin Advocates Network. At the end of FY 19-20, Buckelew began offering SOS Allies for Hope. It is an ongoing monthly support group, rather than a formal 8-session grief counseling group. Having the SOS group on an ongoing basis will ensure there is a place for someone to “come” to get support for their grief in a group of peers who share similar losses.

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. Programmatic goals for the Hotline for next Fiscal Year include: Increase the number of non-English speaking clients served by hiring more Spanish speaking staff; develop culturally responsive hotline trainings and community based workshops that more explicitly address culture and equity.

In June of 2020, a full-time Suicide Prevention Coordinator was hired. A county-wide collaborative for suicide prevention was then established with 5 community teams including: Data, Schools, Training/Education, Communications, and Postvention. The Marin County Suicide Prevention Collaborative pursues a comprehensive public health framework addressing prevention, intervention and postvention approaches at the individual, community and institutional levels. As part of the Collaborative’s implementation of the strategic plan, BHRS released an RFP in spring of 2021 to implement a LOSS (Local Outreach to Suicide Survivors) Team. The purpose of this Project is to address the postvention services for loss survivors (eg., family, witnesses, etc.) immediately following a suicide through the implementation of a LOSS Team. This active and evidence-based model of postvention involves two or more volunteers who are dispatched to the scene of a suicide to provide immediate support to those left behind. A LOSS Team is made up of trained suicide loss survivors, clinicians, and sometimes other concerned community members that go to the scene of a suicide. LOSS Team members receive support and training to understand how to best support bereaved family members or witnesses. The anticipated start date for this contract is July 2021.

CLIENT STORY

A story from this year illustrates the enormous value of offering anyone in the community a simple, fast connection to someone trained in crisis intervention. A man called from his car. He said he had a noose in his front seat and he meant to use it and, “I just thought I’d call.” We assessed that he needed to hear someone say, “Stop. Stay with us. Tell me about the pain. Let’s find you some help.” By the end of the call he had stopped the car and put the noose in the trunk and was on his way to the CSU. He checked in later feeling better.
HEALTH NAVIGATOR (PEI 22) (ENDED FY19/20)

PROGRAM ALLOCATION FY19-20: $138,074

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 is a mental health practitioner hired by BHRS to bridge the gap between community-based services and BHRS services. They 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 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 helps 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 also helps 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 improves 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 maintains 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 19/20, this a bilingual (Spanish) clinician was hired for this position. In FY 19/20, the Health Navigator served 143 individuals. 25% identified as Spanish speaking.

In FY20/21, this position will be funded under CSS as part of Outreach and Engagement.
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.

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.

FY19/20 OUTCOMES: This was a new program in the FY20/21-22/23 Three-Year Plan so there are no outcomes to report for FY19/20.
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.

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.

FY19/20 OUTCOMES: This was a new program in the FY20/21-22/23 Three-Year Plan so there are no outcomes to report for FY19/20.
## PEI COMPONENT BUDGET

<table>
<thead>
<tr>
<th>Program</th>
<th>FY20-21</th>
<th>FY2021-22</th>
<th>FY2022-23</th>
<th>% of budget for youth</th>
<th>FY21-22 Budget to be spent on youth 25 and under</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI-01 Early Childhood Mental Health Consultation ECMH</td>
<td>$230,000</td>
<td>$240,000</td>
<td>$240,000</td>
<td>100%</td>
<td>$240,000</td>
<td>$710,000</td>
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<tr>
<td>PEI-04 Transition Age Youth (TAY) PEI</td>
<td>$240,000</td>
<td>$265,000</td>
<td>$265,000</td>
<td>100%</td>
<td>$265,000</td>
<td>$770,000</td>
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<tr>
<td>PEI-05 Latino Community Connection</td>
<td>$280,000</td>
<td>$315,000</td>
<td>$315,000</td>
<td>11%</td>
<td>$34,650</td>
<td>$910,000</td>
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<tr>
<td>PEI-07 Older Adult PEI</td>
<td>$156,000</td>
<td>$235,000</td>
<td>$265,000</td>
<td>0%</td>
<td>$0</td>
<td>$656,000</td>
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<tr>
<td>PEI-12 Community Training and Supports</td>
<td>$195,314</td>
<td>$94,000</td>
<td>$94,000</td>
<td>46%</td>
<td>$43,240</td>
<td>$383,314</td>
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<tr>
<td>PEI-18 School Age PEI</td>
<td>$406,666</td>
<td>$444,875</td>
<td>$444,875</td>
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<td>$444,875</td>
<td>$1,296,416</td>
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<tr>
<td>PEI-19 Veteran’s Community Connection</td>
<td>$73,000</td>
<td>$73,000</td>
<td>$73,000</td>
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<tr>
<td>PEI-20 Statewide PEI</td>
<td>$81,000</td>
<td>$81,000</td>
<td>$81,000</td>
<td>58%</td>
<td>$46,980</td>
<td>$243,000</td>
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<tr>
<td>PEI-21 Suicide Prevention</td>
<td>$317,813</td>
<td>$502,620</td>
<td>$472,620</td>
<td>40%</td>
<td>$201,048</td>
<td>$1,293,053</td>
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<tr>
<td>PEI-23 Newcomer Supports</td>
<td>$130,500</td>
<td>$265,500</td>
<td>$265,500</td>
<td>100%</td>
<td>$265,500</td>
<td>$661,500</td>
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<tr>
<td>PEI-24 Storytelling programs</td>
<td>$42,500</td>
<td>$65,000</td>
<td>$65,000</td>
<td>40%</td>
<td>$26,000</td>
<td>$172,500</td>
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<tr>
<td><strong>Subtotal Direct Services</strong></td>
<td><strong>$2,152,793</strong></td>
<td><strong>$2,580,995</strong></td>
<td><strong>$2,580,995</strong></td>
<td><strong>62%</strong></td>
<td><strong>$1,587,733</strong></td>
<td><strong>$7,314,783</strong></td>
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<tr>
<td>PEI Supervisor</td>
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<td>$372,000</td>
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<tr>
<td>Administration and Indirect</td>
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<td>$405,749</td>
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<td>Operating Reserve</td>
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<td>$0</td>
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<td>$0</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$2,618,312</strong></td>
<td><strong>$3,110,744</strong></td>
<td><strong>$3,110,744</strong></td>
<td><strong>51%</strong></td>
<td><strong>$8,839,800</strong></td>
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</tbody>
</table>
## Prevention and Early Intervention (PEI) Expected Numbers to Be Served and Cost Per Person

<table>
<thead>
<tr>
<th>Program</th>
<th>Individuals</th>
<th>Family Members</th>
<th>Providers</th>
<th>FY21/22 Budget</th>
<th>FY21/22 Cost per Person Projected</th>
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<tbody>
<tr>
<td></td>
<td>0-15</td>
<td>16-25</td>
<td>26-59</td>
<td>60-74</td>
<td>75+</td>
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<tr>
<td>PEI-01 Early Childhood Mental Health Consultation ECMH</td>
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<tr>
<td>PEI-04 Transition Age Youth (TAY) PEI</td>
<td>376</td>
<td>397</td>
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<tr>
<td>PEI-05 Latino Community Connection</td>
<td>24</td>
<td>63</td>
<td>923</td>
<td>81</td>
<td>22</td>
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<tr>
<td>PEI-07 Older Adult PEI</td>
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<td></td>
<td></td>
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<tr>
<td>PEI-12 Community Training and Supports</td>
<td>41</td>
<td>114</td>
<td>20</td>
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<tr>
<td>PEI-18 School Age PEI</td>
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<td>PEI-19 Veteran’s Community Connection</td>
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<td>6</td>
<td>39</td>
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<td>PEI-20 Statewide PEI</td>
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<tr>
<td>PEI-21 Suicide Prevention</td>
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<td>1275</td>
<td>3000</td>
<td>625</td>
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<tr>
<td>PEI-23 Newcomer Supports</td>
<td>300</td>
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<td></td>
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<tr>
<td>PEI-24 Storytelling programs</td>
<td>50</td>
<td>100</td>
<td>200</td>
<td>100</td>
<td>50</td>
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</table>
## TOTAL BUDGET

<table>
<thead>
<tr>
<th></th>
<th>FY20/21</th>
<th>FY21/22</th>
<th>FY22/23</th>
<th>Total for the 3 years</th>
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<tbody>
<tr>
<td><strong>Innovation (INN)</strong> <em>approved projects only</em></td>
<td>$518,443</td>
<td>$402,485</td>
<td>$190,986</td>
<td>$1,111,914</td>
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<tr>
<td><strong>Community Services and Supports (CSS)</strong></td>
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<td>$13,509,786</td>
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<td><strong>Workforce Education and Training (WET)</strong></td>
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<td><strong>Capital Facilities and Technology Needs (CFTN)</strong></td>
<td>$604,876</td>
<td>$1,242,896</td>
<td>$581,646</td>
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</tr>
<tr>
<td><strong>Prevention and Early Intervention (PEI)</strong></td>
<td>$2,618,312</td>
<td>$3,110,744</td>
<td>$3,110,744</td>
<td>$8,839,800</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$16,433,182</td>
<td>$19,148,706</td>
<td>$18,114,957</td>
<td>$53,696,845</td>
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