

**Marin County Department of Health & Human Services
Division of Community Mental Health Services**

**Mental Health Services Act
Draft Community Services and Supports Plan**

People's Summary

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 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 State Department of Mental Health.

However, it will not be money alone that transforms the public mental health system. The greatest promise of the Mental Health Services Act is not the additional funding: it is a vision of outreach and engagement, a philosophy of recovery and wellness, a belief in the strength and resiliency of each person with mental illness, and a 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.

This is a brief summary of Marin County's plan for Community Services and Supports. The complete document represents a proposed three-year plan for expanding mental health services throughout the community. To read the full plan, go to www.co.marin.ca.us or call 499-6769 to request a paper copy by mail.

Principles

Changing and improving the public mental health system, to better serve the unserved and underserved, relies on several key principles:

- Client and family-directed services consistent with the philosophy of wellness, recovery, resiliency, sustainability, and harm reduction.
- Improved access by outreach to unserved and underserved populations and geographic areas.
- Culturally competent services for all ethnic and language groups.
- Full service partnerships to clients in all four age groups: children, transition age youth, adults, and older adults.

The MHSA has six separate components: Community Planning, Community Services and Supports, Prevention and Early Intervention, Innovations, Capital Facilities and Technology, and Education and Training. At this point, the State Department of Mental Health has released guidelines on only the first two elements of the MHSA—Community Planning and Community Services and Support. This represents approximately 55% of the expected MHSA annual allocation. It is the only portion of MHSA funding currently available, and the only element addressed in this Plan.

Planning Process

An essential first step required by the MHSA was a comprehensive countywide planning process designed to involve the community in identifying unmet needs and recommending programs and services to meet those needs. Marin County's public planning process began in the fall of 2004 and has continued over the last year. Following principles outlined in the MHSA, a significant effort was made to be open, transparent, and inclusive of mental health stakeholders including clients, their families, and providers.

Over 1,000 people have participated in the planning process by completing surveys, attending focus groups or public meetings, or serving on a work group or the Steering Committee.

Types of Funding Available

Full Service Partnerships – Designed to provide all necessary services and supports for designated populations that will be served in the first three years. 51% of the initial funding must be devoted to Full Service Partnerships.

System Development – Dedicated to improving services and infrastructure for the identified Full Service populations and for other clients, adding Spanish-speaking staff and expanding the most effective practices.

Outreach and Engagement – Enhanced outreach and engagement efforts for those populations that are unserved or underserved.

Summary of Proposed Programs

Full Services Partnerships

Transition Age Youth Intensive Team

This integrated multi-disciplinary service team program for 20 Transition Age Youth (16- 25) who are seriously mentally ill or seriously emotionally disturbed will provide culturally competent mental health services, intensive case management, housing supports, psychiatric care, substance abuse counseling, employment services and independent living skills. Transition Age Youth will be linked with follow-up referrals for youth aging out of children's mental health services and transitioning to adult services and independent living. All full service partnerships include 24/7 response for clients served and bilingual Spanish-speaking staff.

Older Adult Service Team

This multi-disciplinary team will serve 40 older adults who are seriously mentally ill, isolated, and at risk of out of home placement. By providing a full range of integrated, culturally competent services including outreach, psychiatric care, case management, and substance abuse counseling, participants will better control their illness, reach their personal goals, lead more satisfying lives, and avoid higher, more restrictive levels of care.

Children's System of Care

This program serves 40 seriously emotionally disturbed youth who are involved with juvenile justice and/or attend Community School, a continuation high school. Clinical staff work with trained family partners to meet the mental health, social, and developmental needs of each child or adolescent and their families in a culturally competent manner.

Support and Treatment After Release (STAR)

The STAR Team serves 50 mentally ill offenders each year coming directly from the Jail. Service components include case management, psychiatric consultation, medication management, mental health court, group counseling, referral to substance abuse treatment, peer mentoring, random urinalysis testing, and money management. The program's goals include reductions in crime and jail recidivism, and increases in stable housing and employment.

Outreach and Engagement

Consumer-Operated Services – Enterprise Resource Center

This comprehensive program that was developed and operated by consumers, centrally located in San Rafael, will be expanded. Based in the new Wellness and Recovery Center, services are based on the principles of a vision of recovery and client choice and will include: outreach, employment programs, recreational and socialization opportunities, peer advocacy and counseling, medication services, access to benefits, transportation, and a warm line for supportive counseling.

Regional Service Site in Southern Marin

A community-based, culturally competent, easily accessible mental health service site will be opened in Southern Marin, an underserved area. Clients and families will benefit from easy access to an array of mental health services including individual, family, and group counseling along with support groups, and medication monitoring for seriously mentally ill adults and seriously emotionally disturbed children.

Increased Capacity for Vietnamese Speaking Clients

In order to better serve Vietnamese-speaking people with mental illness, a part-time Bilingual Social Service Worker will be added to the Adult Case Management Team of Community Mental Health Services.

System Development

Supported Housing

Because there are times when the lack of appropriate housing in the county requires longer stays in acute hospitals or institutions for adult clients, adding several supported housing slots will reduce the number of clients underserved due to the lack of a safe place to live.

Program Evaluation for Outcomes

The best measures of the success of these system changes will be improvements in clients' lives. By evaluating the outcomes, the plan for using the MHSA funding can be changed and improved to achieve the best results from the best practices.

Outcomes

The following outcomes will be expected for those who participate in the Full Service Partnership Programs:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities.
- Safe and adequate housing, including safe living environments for families with children and youth; reduction in homelessness.
- A network of supportive relationships.
- Timely access to needed help, including times of crisis.
- Reduction in incarceration in jails and juvenile halls.
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Intended System Changes

Programs that are funded by MHSA revenues are expected to initiate significant changes in the way public mental health services are provided, including the following:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system.
- Increases in client and family-operated services.
- Increases in outreach and expansion of services to client populations in order to eliminate ethnic disparities and expand access to unserved and underserved individuals.
- Increases in the array of community service options for individuals diagnosed with serious emotional disorders or serious mental illnesses, and their families, which will allow them to avoid unnecessary institutionalization and out-of-home placements.

Funding

While the initial allocation for Community Services and Supports for Marin County's program is approximately \$1.7 million, additional funding from billing services to Medi-Cal and Medicare will augment the budget. Both community-based providers and the public mental health system will join in this expansion.

Start-Up Funds

Up to 75% of the County's funding (\$1.2 million) amount for Community Supports and Services is available for one-time expenses necessary to get started. The top priorities are: the purchase of a site for the Wellness/Recovery Center; training for staff, clients, and family partners; and creation of a fund to subsidize housing for mental health clients with low or no income.

Conclusion

Marin County's three-year Community Services and Supports funding is directed at the major MHSA themes of Full Service Partnerships for Children, Transitional Age Youth, Adults, and Older Adults.

While it is the intent of the MHSA to "transform" the public mental health system, it comes at a time when Community Mental Health Services is faced with serious challenges—particularly; the need for services is larger than the funding available. Funding from the MHSA Community Services and Supports will increase Marin County Community Mental Health Services' budget by 7%. This represents an important step in moving toward a vision of wellness and recovery and improving access to mental health services for all who need it.

PART I County/Community Public Planning Process and Plan Review Process

Section I Planning Process

#1 Briefly describe how your local public planning process included meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities.

Marin County Community Mental Health Service's (CMHS) Mental Health Services Act (MHSA) planning process was designed to be inclusive, open and transparent. Its goal was to include meaningful involvement of consumers, families and other stakeholders, and those groups that have historically been un-served and underserved. The structure used to guide the process is illustrated in Appendix A.

CMHS began to plan a needs assessment in October 2004, in anticipation of the passage of MHSA in recognition of the need for an updated strategic plan. The inclusion of consumers and families was a priority from the start. Our first step was to hold focus groups throughout the county. To date, we have had the participation of 310 attendees in 22 focus groups, 10 of which specifically targeted consumers and families and were attended by 85 people. (See Appendix B for focus group schedule)

Eighteen groups were held for:

- Parents of adults with serious mental illness
- Parents of school-age children
- Latino parents
- Members of the Clozapine Club
- National Alliance for the Mentally Ill (NAMI)
- Mental Health Board
- Enterprise Resource Center

An additional four groups were scheduled specifically for consumers and their families, targeting:

- Parents of school-age children
- Residents of Marin City (A large African-American population which is also a concentrated area of poverty)
- Residents of the Canal (our largest Latino population and a concentrated area of poverty)

One focus group was held at the Canal's Community Center and one in Marin City, each co-sponsored by local community groups concerned about the

community's low-income target populations. We also conducted a focus group which targeted Alcohol and Other Drug (AOD) service providers. In addition we conducted another focus group in West Marin, which is geographically isolated from the rest of the county. Outreach for these groups was conducted through providers, peer-to-peer agencies, social service agencies, referral sources, and advertisement in our local daily newspaper, the Independent Journal. Focus groups were held in the evenings as well as in the daytime.

Our planning process included conducting an anonymous survey which targeted consumers and families as well as the general public. It was distributed in print and also made available on-line, through the CMHS website. The survey was promoted utilizing the same resources as the focus groups as well as at each focus group and in the local newspaper. The survey was completed by 529 people, 42% of whom identified themselves as consumers, as well as family members of consumers. Approximately half of all respondents completed the survey on-line and the other half in print. The breakdown of consumer and family member respondents closely match the county's demographics. The survey was made available in English, Spanish and Vietnamese. More than 10% of those who completed the survey stated that they had not accessed county mental health services before.

After needs assessments were completed, two town hall public meetings were held to develop a consensus around priorities to address the identified gaps. To announce the Town Hall meetings, fliers were circulated to all providers, contractors and social service agencies; advertisements in the local newspaper were also utilized. Approximately 70 community members attended the April town hall meeting, while approximately 55 community members participated in the September meeting.

Marin's MHSA Strategic Planning Steering Committee began meeting in March 2005. The Steering Committee included 9 clients and family members in addition to service providers, law enforcement, our local First Five Commission, County Division of Social Services, representation from the Latino, Asian and African-American communities, Marin County Office of Education, the Mental Health Board (MHB), National Alliance for the Mentally Ill (NAMI), and Community Mental Health Services (CMHS) staff. The mission of the 28 member Steering Committee was to recommend strategies for Marin's implementation based upon feedback they received from their respective constituencies (See Appendix C for a list of Steering Committee members and Appendix D for meeting summaries).

In addition to regular Steering Committee meetings, we also convened Special Topic Workgroups on 8 specific topic areas (children and transitional youth, adults and older adults, dual diagnosis, prevention and early intervention, housing and jobs, IT and capital projects, education and training, linguistic and cultural access). Each of the Special Topic Workgroups included clients, family members, older adults, child and transition-age youth advocates, drug and

alcohol service providers, Service Employees International Union (SEIU) and CMHS staff. The eight Special Topic Workgroups each met three times to generate priorities for their particular workgroup topic. The chart below outlines the number of participants in each Special Topic Workgroup.

Workgroup	Consumers	Family Members	Providers	TOTALS
Adults	3	7	17	27
Empowerment/Self Help/Jobs	6	1	9	16
Dual Diagnosis	7	5	13	25
Education & Training	0	3	10	13
IT & Capital Projects	0	0	10	10
Linguistic & Cultural Access	1	3	10	14
Older Adult	1	4	12	17
Transition Age Youth	2	3	22	27
Youth & Family	0	6	31	37
TOTALS	20	32	134	186

Community priorities and themes were summarized from the community surveys and focus groups (Appendix E). These priorities and themes, along with the priorities identified by the Special Topic Workgroups (Appendix F) were presented to the Steering Committee in May, 2005. From this community input, CMHS statistics, prevalence data, training topic information and service location data, the Steering Committee distilled the information and created their first draft recommendations. These recommendations were circulated back to the Special Topic Workgroup members, posted on the CMHS website, presented at a Town Hall Meeting, and presented to a number of stakeholder groups, including consumers, people of color, providers, CMHS staff, family members of children, youth and adults, to solicit feedback for the Steering Committee.

Periodic updates were provided to our Mental Health Board, NAMI, Enterprise Resource Center (a client-operated drop-in center) and the Contractor Association. Two public hearings were conducted by the MHB. One was held in downtown San Rafael on Thursday January 19th at 7PM and the second was held in Marin City on Saturday January 21st at 1:30PM.

To encourage/facilitate community inclusion, transportation was provided for clients and family members to all the meetings, including focus group meetings. We continued this process for the Steering Committee and the Special Topic Workgroups, as well as the Town Hall meetings and Public Hearings. A stipend of \$20.00 to offset travel costs for each meeting was made available for all participating clients and family members in the Steering Committee and Special Topic Workgroups, as needed. Our planning process also strived to hold focus groups and meetings at times and places that increased the likelihood of participation. For instance, we temporarily turned the Parents of Adult Children's

Support Group, as well as the Clozapine Club and NAMI meetings, into focus groups to facilitate additional participation and found this to be a successful strategy.

#2 In addition to consumers and family members, briefly describe how comprehensive and representative your public planning process was.

As stated above, our focus groups included a wide diversity of the provider and referral community (organizations that refer clients to CMHS). We held groups specifically for staff and mental health contractors and for adult and child referral agencies. Participants have included:

- Local child welfare agency
- Special education staff at both the local school district level and the county schools level
- Alcohol and other drug service/treatment providers
- Law enforcement
- Public Guardian office staff
- Adult Protective Services staff
- Probation staff
- Mental Health Board
- Peer mental health providers
- Cultural-specific service providers
- First 5 Children and Families Commission and Child Care Planning Council staff
- Area Agency on Aging staff
- Senior peer providers
- Staff from the Shelter Plus Care program and other housing programs

As described above, the written survey reflected the demographics of the county in terms of race, ethnicity and age. We held focus groups in a variety of geographical locations. We held and scheduled groups to ensure representation of different cultural and ethnic groups.

The Mental Health Director attended every CMHS team's staff meeting to inform staff about the planning process and to solicit their ideas. The structure of the planning process in Marin County included four components, all of which included a diverse representation of Marin County residents:

- Our Steering Committee met monthly and is comprised of 28 community members representing:
 - Clients
 - Families of adult and child clients
 - Community agency contract providers
 - Clinical staff from adult and children's services

Alcohol and Drug Treatment Providers
First 5 Children and Families Commission
Law enforcement
County Office of Education
Older adult population
Hispanic/Latino population
African American population
Vietnamese population
Administrative support staff
Mental Health Board
National Alliance for the Mentally Ill

- 8 Special Topic Workgroups met on three separate occasions to address the following topics: Children and transitional youth, adults and older adults, dual diagnosis, prevention and early intervention, housing and jobs, IT and capital projects, education and training, linguistic and cultural access. These special topic workgroups were composed of clients, family members, local providers and others with expertise or interest in the specific special topic. Outreach was conducted to ensure a diverse representation of backgrounds and perspectives from throughout the county.
- Our Town Hall meetings were centrally held at the San Rafael City Council Chambers twice during the planning process. The meetings were held in a central location in the evening hours and outreach was conducted to ensure a diverse representation from throughout the county. (See Appendix G for Town Hall meeting summaries).
- Two Public Hearing were held by the Mental Health Board at the end of the process before the MHSA Plan was submitted for approval to the Board of Supervisors.

#3 Identify the person or persons in your county who had overall responsibility for the planning process. Please provide a brief summary of staff functions performed and the amount of time devoted to the planning process to-date.

Bruce Gurganus, Mental Health Director, had overall responsibility for the planning process. Mr. Gurganus spent 20% of his time on planning efforts. Functions included, but were not limited to, ensuring participation of stakeholders from underserved and unserved populations of consumers and families; ensuring participation of stakeholders who are culturally diverse; planning and organizing Steering Committee meeting agendas; responding to specific stakeholder feedback and providing leadership and direction for the process.

Kathy Kipp, Projects Coordinator, planned, organized and assisted in the general activities of the planning process. Steering Committee meetings, trainings, stakeholder feedback meetings, town hall meetings and the public hearing were all organized and coordinated by Ms. Kipp. She responded to all email inquiries and facilitated maintenance of the MHSA portion of the CMHS website. Ms. Kipp acted as the central informational and organizational point for the entire process. Approximately fifty percent of Kathy's time was spent, and will continue to be spent, on the planning process.

Diane Slager, Adult Services Program Manager and Ann Pring, Youth and Family Program Manager both spent approximately 10% of their time on the planning process. They both attended trainings, facilitated and participated in Special Topics Workgroups, trained and oriented staff, assisted with the planning of focus groups, assisted directly with the development and writing of the CSS Plan and were members of the Steering Committee. Sheldon Whitten-Vile, MD, Mental Health Medical Director, participated in the same manner described above, although he did so at only a 5% FTE.

Bobbie Wunsch, a principal with Pacific Health Consulting Group, was chosen as the facilitator for Marin County's MHSA stakeholder process. Ms. Wunsch provided strategic planning services to community clinics, county health and local Medicaid managed care organizations, public hospitals, ambulatory care centers and healthcare financing organizations. Ms. Wunsch has been a consultant for a number of county mental health departments including Marin, Solano and San Mateo Counties. Ms. Wunsch also provides meeting facilitation for a wide variety of health-related organizations.

Ms. Wunsch is familiar with Marin County's Community Mental Health Services programs through many years of work both with the county's mental health division, as well as with many of our individual community agencies. Ms. Wunsch developed the county's mental health plans in 1990 and 1995, assisted the county in the development of the Marin Mental Health Medi-Cal Managed Care Plan and facilitated a priority planning process for possible reductions several years ago. Ms. Wunsch was also chosen to facilitate our MHSA planning process because she was simultaneously facilitating the State's stakeholder and workgroup process for the MHSA.

Ms. Wunsch conducted 21 focus groups of 286 consumers, family members, mental health staff and community agencies, and community members in late 2004, in preparation for the MHSA planning process. Ms. Wunsch developed and administered a community-wide survey of 529 participants during that period as well. In 2005 she assisted county staff in strategizing and planning the local MHSA stakeholder process and facilitated all stakeholder, steering committee and town hall meetings.

#4 Briefly describe the training provided to ensure full participation of stakeholders and staff in the local planning process.

Orientation and training has been essential to Marin County's planning process. Staff training began in early 2005:

- The Mental Health Director and a representative of the contractors' group participated in the DMH Stakeholder meeting, in addition to the February 9th and 10th conference in San Diego on Transforming Mental Health Systems.
- Mental Health Board members attended a training in Berkeley regarding how to conduct a public hearing on February 18th and 19th.
- Pacific Health Consulting began orientation and training for Mental Health management and supervisors late last year.
- California Network of Mental Health Clients provided two trainings to consumers and family members on March 17th and July 14th.
- Several Steering Committee members (Hispanic/Latino community member, 2 family members, African-American community representative, Mental Health Board President, Adult Services Program Manager, Youth and Family Program Manager and a consumer) along with the Mental Health Director attended the CIMH Planning Teams Regional Training on June 2nd.
- Our Steering Committee Members (Adult Services Program Manager, African-American community representative, Mental Health Board President, family member, Vietnamese community representative, Youth and Family service provider, Adult Services Supervisor) along with the Mental Health Director all attended Part 2 of the CIMH Planning Teams Regional Training on November 9th and 10th.
- Our Projects Coordinator attended several state sponsored stakeholder meetings and trainings including the Mental Health Symposium "Prevention and Early Intervention" sponsored by the California Endowment on June 27th and the CIMH "Introduction to the Planning Requirements for the MHSA" on February 4th in Sacramento.
- Our Systems Support Analyst attended the CIMH regional training "Using Data for MHSA Planning: Making Data Work for You" on August 31, 2005.

Training specifically related to the Mental Health Services Act requirements, community involvement, how to participate in the process, and orientation to the Marin County Mental Health System was provided to all participants involved in the planning process. Focus group participants received an orientation preceding focus group sessions. The Steering Committee's first several meetings and the Special Topic Workgroup's first meeting were preceded by an orientation to mental health services and specific training about the wraparound

concept and how it is used in Marin County. Additional training sessions and orientations provided to the Steering Committee included the need for better cultural competence in Marin County, dual diagnosis with specific focus on older adult and transition-age youth and the need for better identification and integrated treatment of these populations, and how to effectively participate in the planning process. More specialized training sessions and informational presentations throughout the planning process were provided to the Steering Committee on subjects including:

- Background and intent of MHSA
- Overview of, and information about, the local planning process
- Overview of the MHSA Guiding Principles and Values
- Specific information about utilization of services in Marin County with specific data describing age, gender, race and ethnicity of populations
- Prevalence data and information about underserved and unserved groups
- Data collection and outcomes
- Focus group and survey feedback
- Wraparound Services
- Systems of Care
- Wellness/Recovery
- Cultural Competence
- Evidence Based Practices
- Dual Diagnosis

Training and orientation sessions were provided to the community at large as part of our Town Hall Meetings on the MHSA Guiding Principles and Values, meaningful participation in the process, updates on the local and State planning processes, and education about the current mental health system.

Additionally, CMHS purchased the CIMH Webcast Training Series to assist with planning and implementing the MHSA. Topics included Evidence-Based and Promising Practices, Person Centered Service Planning and other relevant topics. The series took place every Tuesday and Thursday from July 2005 through March, 2006, and any interested parties were welcome to attend. Information about the training series and the training schedule were publicized throughout the community and were posted on the CMHS website. To date, there have been over 64 participants in the Webcast Training Series.

Specific to each of the various age groups, consultants were hired to analyze the current systems and provide feedback and input into the planning process. Our consultants included: Bill Carter, Ph D, of CIMH was the consultant for Youth and Family; Wayne Munchel, LCSW, of the National Mental Health Association of Greater Los Angeles advised on Transition Age Youth; Martha Long, Director of The Village and the National Mental Health Association of Greater Los Angeles

was the Adult Services Consultant; and Cynthia Jackson, PhD, Executive Director, Center for Aging Resources in Pasadena, California reviewed the Older Adult system (See Appendix H for age group consultant reports to date).

The intent of Marin County Mental Health was to make this process as open, participatory and transparent as possible to community stakeholders. The goal was to encourage the entire community to participate in the process of selection of issues and populations for MHSA services.

Section II Plan Review

#1 Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.

The plan was published on the Marin County Mental Health website on December 12, 2005. There have been over 550 “hits” on the CMHS CSS Plan webpage between December 12, 2005 and January 18, 2006. Notices were published in the Marin Independent Journal, our local newspaper, and copies were made available at all the mental health service sites including contractor sites and the consumer run Enterprise Resource Center. Eight hundred copies were emailed to the Mental Health mailing list and all Health and Human Services employees. The executive summary was published in English as well as Spanish and Vietnamese. The Mental Health Director also published an op-ed piece in the Marin Independent Journal, which was run in the December 19, 2005 edition to inform the community about the plan, how to get a copy in three languages, and seeks community input.

On February 18th & 19th, 2005, several Mental Health Board members attended two trainings on how to conduct a public hearing.

Prior to the publication of the draft CSS Plan on the County website, the week of December 5-9, 2005, the Mental Health Director met with all CMHS employees to describe the strategies in the plan and to ask for participation and to seek input.

The Mental Health Director attended the Tenants Association meeting at the Public Housing Facility in Marin City on December 13, 2005 to talk with the residents about the CSS Plan and to distribute copies of the plan summary in three languages for the tenants. The majority of the tenants are African-American. On December 14, 2005, Mental Health Director met with ISOJI Group in Marin City to discuss the plan and get community input.

On December 19, 2005, the Mental Health Board met and discussed CSS Plan and ideas for one-time funding opportunities.

The Mental Health Director, accompanied by two bilingual Spanish speaking staff, met with Spanish speaking residents of the Canal Area of San Rafael, a predominantly Hispanic neighborhood, on January 5, 2006. Copies of the CSS Plan and summaries in Spanish were distributed. The discussion centered on ways to improve access to services for the underserved Hispanic population, which is the fastest growing ethnic group in Marin County. There was unanimous agreement that this area of the county has a great need for mental health services to be accessible and culturally competent (See Attachment 1 for community announcements in English and Spanish).

During the month of January 2006, written comments were prepared by three groups and submitted for consideration. They were the Wellness Recovery Task Force, the Marin chapter of the National Alliance for the Mentally Ill (NAMI), and the Service Employees International Union (SEIU) (See Attachment 2).

#2 Provide documentation of the public hearing by the mental health board or commission.

On January 19, 2006, the Mental Health Board held a public hearing at the City Council Chambers in San Rafael. Sixty-five people attended and many shared ideas about the CSS Plan and the planning process. Spanish and Vietnamese translators were available (See attachment 3 for meeting notes). A second Public Hearing was held by the Mental Health Board at the Manzanita Center in Marin City on January 21, 2006. Thirty-five people attended and shared ideas about the CSS Plan. Spanish language translator was available (See Attachment 4 for meeting notes).

Please see the attached copy of our Public Notice advertisement placed in the Marin Independent Journal and the flier announcing the Public Hearings sent to all mental health staff, contractors, Special Topics Workgroups, Enterprise Resource Center, and other stakeholders (See Attachments 5&6).

#3 Provide the summary and analysis of any substantive recommendations for revisions.

During the 30 day comment period which, due to the scheduling of the two public hearings, turned out to be 41 days, feedback from stakeholders was received in the form of emails, written comments, and testimony at the public hearings.

Summary of substantive comments:

Five themes emerged from the public comment period and the public hearings that are substantive:

- **Theme 1** - Adult clients want a larger role in determining what services are provided and where those services are best located
- **Theme 2** - The uninsured and underinsured often lack access to mental health services
- **Theme 3** - Any programs developed with MHSA funding should have clear and measurable outcomes
- **Theme 4** - Improvement is needed in outreach to underserved minority populations
- **Theme 5** - The physical health of mental health clients needs to be addressed

Analysis of substantive comments:

- **Theme 1** - Several clients who spoke at the public hearings used the phrase, "Nothing about us, without us." Initially three adult clients were asked to serve on the MHSA Steering Committee. One resigned, two more joined after volunteering their services. Forty-two percent of the people completing the surveys for MHSA planning identified themselves as clients and families of clients. Clients and family members participated actively at every step of the planning process, including focus groups, special topic work groups, town hall meetings, and public hearings. Clients were paid \$20 transportation stipends to make it easier for them to participate in the planning meetings. Client participation is a goal consistent with the philosophy of recovery and wellness. Efforts will be made to continue to increase and improve client participation. A committee is being formed to investigate strategies for using MHSA and other funding sources to improve housing opportunities. The Mental Health Director has asked the Director of the client run drop in center to hold an election to determine the client representative to that group. Efforts like these to increase client voice will be continued. Some adult clients objected to the possible location of a new Wellness/Recovery Center in the Canal Area of San Rafael. The Canal Area is largely Hispanic and Asian-American, both underserved ethnic groups. Locating services in this area may make services less convenient for some current clients, but would greatly improve access for individuals with mobility issues and underserved groups.
- **Theme 2** - Recent reductions in the acute psychiatric hospital benefits for mentally ill clients insured by the County Medical Services Program (CMSP) and utter confusion over Medicare Part D for pharmaceuticals

have heightened concerns about access to services. The full service partnerships developed under the MHSA funding will be available to individuals based on medical necessity and not on insurance status. The regional service site in Southern Marin should make services more available for the uninsured in that geographic area of the county. All clients are welcome at the client-operated Enterprise Resource Center, whether insured or not. These additional services and capacity will make it easier for the uninsured to be served.

- **Theme 3** - Outcomes of the full service partnerships developed with MHSA funding will be carefully collected and reported to the state Department of Mental Health. Results will be used for program planning and development. A system-wide goal is to use evidence based, promising or emerging best practices whenever possible.
- **Theme 4** - Hispanics and Asian Americans are underserved by public mental health services in Marin County. An effort has been made to improve access and services by included Spanish speaking bilingual staff in each of the four full service partnerships. A part-time Vietnamese speaking social service worker will improve system capacity for serving clients of Vietnamese origin. Locating the new Wellness/Recovery Center in the Canal Area should also improve access for Hispanics and Asian-Americans.
- **Theme 5** - Each of the four full service partnerships will develop ways to ensure the physical as well as the mental health of the clients involved. CMHS has written agreements with Marin County's two Federally Qualified Health Clinics (FQHC) so that clients needing physical health care can be treated there. The FQHC's also refer their clients with mental health needs to CMHS. Marin Community Clinic has been partnering with CMHS' Adult Medication Clinic to provide health care services on site to clients at the same time and place that they come for their psychiatric appointments, thus greatly improving access to physical health care. The possibility of co-locating physical and mental health services at the new Wellness/Recovery Center will also improve access and outcomes for physical health care.

#4 If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.

Based on the public review and the 40-day comment period, there were no substantive changes to the Full Service Partnerships, the System Development portion, or the Outreach and Engagement Strategies. Therefore, with some suggested editorial changes and improvements, the plan remains substantially

the same as the published draft; however, several issues arose about the planning process that need to be addressed.

Relocation of the Enterprise Resource Center

Several adult clients expressed concerns about the possible relocation of the client-operated drop in center, the Enterprise Resource Center, to become part of the new Wellness/Recovery Center in the Canal Area of San Rafael. Some clients questioned the decision-making process and the role of adult clients in the planning process. Others supported the move and the increase of client-operated services and employment. The current location of the Enterprise Resource Center is small and not accessible to people with physical disabilities who cannot navigate stairs. Also, advocates for the Hispanic community expressed the need for more services that are conveniently located and accessible to that largely underserved population in the Canal Area.

Transition Planning for Moving Services

If the Enterprise Resource Center changes its current location there will be a transition planning process which will include representation of clients who currently use the service, along with other stakeholders, including representatives of unserved and underserved populations. All services funded by MHSA are intended reach the unserved and underserved, while maintaining the quality of services to currently served clients.

Improve Client Representation in the Planning Process

In the past, clients have been asked to volunteer to serve as representatives on committees such as the MHSA Steering Committee. The addition of transportation stipends of \$20 per meeting improved client participation in the planning process by making meetings more accessible. At the suggestion of several clients, a new method to get a representative view of clients' opinions will be tried – elected client representatives. Nominations are currently being sought for those clients interested in serving as client representatives on the Housing Committee that is being formed to investigate the best way to develop new housing for the mentally ill. The hope is that clients who wish to be involved in planning activities will know that their elected representatives will represent their own interests clearly and accurately.

Increase Involvement of Underserved Populations

Another concerning aspect of the planning process was the under-representation of the largest and most underserved ethnic population in the county, Hispanics. Although this is the fastest growing ethnic group in Marin County, Hispanics have the lowest penetration rates for mental health services of any ethnic group for both Medi-Cal beneficiaries and for those families living under 200% of poverty.

There was Hispanic representation on the MHSAs Steering Committee. Outreach attempts such as Spanish language focus groups, Spanish language community meetings, and publishing documents in Spanish did provide the opportunities for input, yet the numbers of respondents remained small. Community Mental Health Services will make greater efforts to build relationships with leaders in the Hispanic community, focus outreach efforts toward that community, and to locate some direct services in the Canal Area of San Rafael to improve access.

PART II Program and Expenditure Plan Requirements

Section I Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

#1 Please list the major community issues identified through your community planning process, by age group.

Twenty-two focus groups were conducted with a total of 310 participants. Ten groups were conducted with mental health consumers, family members and advocates. Four groups were conducted for mental health service providers, contractors and other referral sources and Alcohol and Drug service contractors. Six groups were conducted with CMHS staff, and two groups were conducted in Spanish (See Appendix C & D)

The following community issues, by age group, were identified during Marin County’s priority planning process through the focus group and survey process described in Part 1 above.

Age Group	Community Issues
Children and Youth	<p>Individualized Child and Family Teams</p> <ol style="list-style-type: none"> 1. Reduce emphasis on in-clinic services 2. Provide services that address unique needs of children and school settings (i.e., after school and summer programs) 3. Increase flexibility in billing and reimbursement to enable alternative, individual and community-based approaches to children and family that are more responsive and flexible (e.g., home visits, participation in community events) <p>Dual Diagnosis Services and Supports</p> <ol style="list-style-type: none"> 4. More access to treatment options for parents 5. Better collaboration with alcohol and drug treatment providers <p>Supportive Housing</p> <ol style="list-style-type: none"> 6. Expand housing resources <p>Crisis Services</p> <ol style="list-style-type: none"> 7. Develop in-county crisis residential service and access to in-county hospitalization

Age Group	Community Issues
	<p>8. Focus on foster families to stabilize placements</p> <p>Community Collaboration</p> <p>9. Better collaboration with schools. (e.g. more mental health services available on-site and more information about services disseminated)</p> <p>10. Co-locate services with existing child service agencies</p> <p>11. Place CMHS program staff in well-established settings (e.g., suspension/expulsion hearings, IEP's, probation, juvenile justice, etc.)</p> <p>Cultural Competence</p> <p>12. Develop capacity to provide access to bilingual psychiatric services</p> <p>13. Need for providers of color in underserved communities</p> <p>14. Culturally sensitive and informed parent guidance</p> <p>15. Community outreach to cultivate more bicultural and bilingual staff</p> <p>Wellness/Recovery/Resilience Focus</p> <p>16. Early intervention or quicker response time before/when crises erupt</p> <p>17. Public education regarding prevention</p> <p>18. Develop more linkages between CMHS and key services (i.e., medical and nursing teams, Special Day Classrooms, child protective services)</p> <p>19. Remove obstacles to accessing services that make CMHS difficult to navigate</p> <p>20. More wraparound services</p> <p>Peer Support/Family Education Support Services</p> <p>21. Address need for adult supportive services that enhance parenting</p> <p>22. Help address bullying and victimization for vulnerable children</p> <p>23. Parenting classes offered through school settings</p> <p>24. Train interns to provide parent education</p> <p>25. Re-establish position of Family Advocate in Marin County</p> <p>Service Capacity</p> <p>26. Hire more psychiatrists as well as psychiatric/medication technicians</p> <p>27. Provide resources when referrals are made in school settings</p> <p>28. Provide services for children with significant social/emotional needs but who do not qualify for 3632</p> <p>29. Focus on children in CPS system</p>
Transition Age Youth	<p>Dual Diagnosis Services and Supports</p> <p>1. Inpatient hospitalization for dual diagnosis</p> <p>2. Develop treatment options for youth who will not go to drug court and cannot afford treatment programs</p> <p>3. Offer expanded harm reduction options</p> <p>Supportive Housing</p> <p>4. Expand housing resources</p> <p>5. Expand specialized housing options</p> <p>Crisis Services</p> <p>6. Develop in-county crisis residential service</p> <p>7. Need for developmentally appropriate placements</p> <p>8. Intensive case management and stabilization following a crisis or hospitalization</p> <p>Community Collaboration</p> <p>9. Provide mental health services in more diverse and centrally located areas that are more accessible to clients and co-locating mental health services with other social and medical services</p> <p>10. Allow mental health staff to be reimbursed for outreach activities rendered outside of traditional clinical service delivery modalities</p> <p>Cultural Competence</p> <p>11. Develop capacity to provide access to bilingual psychiatric services</p> <p>Wellness/Recovery/Resiliency Focus</p>

Age Group	Community Issues
	<p>12. Expand eligibility criteria to enable CMHS to serve clients at their highest level of functioning</p> <p>13. Focus more on early intervention and prevention</p> <p>Integrated Service Experiences</p> <p>14. Develop more linkages between CMHS and key services</p> <p>Service Capacity</p> <p>15. Hire more psychiatrists as well as psychiatric/medication technicians</p> <p>16. Focus supports and services for youth at risk of moving from Child Protective Services into the juvenile justice system</p>
Adults	<p>Dual Diagnosis Services and Supports</p> <ol style="list-style-type: none"> 1. Increase access to psychiatric consultation and medication evaluation/management for clients in drug/alcohol treatment 2. Mobile outreach to clients with drug/alcohol problems 3. Improve access to CMHS for clients in drug treatment 4. Develop formal collaborative structures between mental health and AOD services to enhance communication, provide greater continuity of care between services and reduce arbitrary separation of mental health and AOD treatment 5. Absence of providers and services for Spanish speaking dually diagnosed clients 6. Cross-train mental health and AOD providers 7. 12-step programs to meet the needs of dually diagnosed 8. Include dual diagnosis in our Mental Health Plan <p>Supportive Housing</p> <ol style="list-style-type: none"> 9. Expand housing resources 10. Supportive and affordable housing 11. Use MHSAs funds for Section 8 Housing <p>Crisis Services</p> <ol style="list-style-type: none"> 12. Develop in-county crisis residential service 13. Maintain adequate PES at Marin General Hospital at competitive rates 14. Encourage contract agencies to establish crisis residential facilities 15. Fragmentation of care and poor quality of inpatient hospitalization: lack of communication between inpatient and outpatient services <p>Community Collaboration</p> <ol style="list-style-type: none"> 16. Provide mental health services in more diverse and centrally located areas that are more accessible to clients and co-locating mental health services with other social and medical services 17. Allow mental health staff to be reimbursed for outreach activities rendered outside of traditional clinical service delivery modalities 18. Reach out to mentally ill clients where they are 19. Anti-stigma education 20. More community awareness about mental illness and services 21. More restorative policing <p>Cultural Competence</p> <ol style="list-style-type: none"> 22. Develop capacity to provide access to bilingual psychiatric services 23. Latino community is largely unaware of services and how to access them and uninformed about mental health illness 24. Need for targeted messages disseminating through culturally relevant venues 25. Geographical obstacles to access 26. "Machismo as obstacle" 27. Co-locate mental health services within trusted community agencies 28. Use of less conventional venues and methods of delivering and defining

Age Group	Community Issues
	<p>mental health services</p> <p>29. Need for Asian-speaking therapists and case managers</p> <p>30. Fragmentation of care and poor quality of inpatient hospitalization is exacerbated for minority and non-English speaking clients</p> <p>31. Issues of stigma are often very significant in communities of color</p> <p>32. Development of awareness of “client culture”</p> <p>Vocational Services</p> <p>33. Address the need for meaningful, supportive employment and educational opportunities</p> <p>Client and Family Driven</p> <p>34. Provide help negotiating benefit systems</p> <p>35. Meet basic needs: housing, clothing, food and personal care items</p> <p>Wellness/Recovery/Resiliency Focus</p> <p>36. Expand eligibility criteria to enable CMHS to serve clients at their highest level of functioning</p> <p>37. Focus more on early intervention and prevention</p> <p>Integrated Service Experiences</p> <p>38. Develop more linkages between CMHS and key services (i.e., medical and nursing teams, probation, alcohol and drug providers, criminal justice system, etc.)</p> <p>39. Remove obstacles to accessing services that make the CMHS systems difficult to negotiate</p> <p>40. More case management and public guardian services</p> <p>41. Meet basic needs first: food and shelter “one-stop-shop” : full service center located near social services agencies</p> <p>Peer Support/Family Education Support Services</p> <p>42. Address the social isolation of the mentally ill: more opportunities for recreation and socialization</p> <p>43. Expand peer counseling and family advocacy programs</p> <p>Service Capacity</p> <p>44. Re-establish position of Family Advocate in Marin County of Marin - Health & Human Services Expand eligibility criteria to allow more clients to access services, including those who currently fall in medical or financial eligibility gaps</p> <p>45. Expand eligibility criteria to enable CMHS to serve clients at their highest level of functioning</p> <p>46. Focus more on early intervention</p> <p>47. Increase number of case managers</p> <p>48. Build capacity through volunteers, interns, volunteer and faith-based organizations</p> <p>49. Greater access to medication clinic</p> <p>50. Outsource more tasks to contract service agencies</p>
<p>Older Adults</p>	<p>Dual Diagnosis Services and Supports</p> <p>1. Need for more expertise among providers regarding geriatric physical and mental health issues and the unique issues regarding medications</p> <p>Supportive Housing</p> <p>2. Expand housing resources</p> <p>Crisis Services</p> <p>3. Allow PES to cover dementia</p> <p>Community Collaboration</p> <p>4. Provide mental health services in more diverse and centrally located areas that are more accessible to clients and co-locating mental health services with</p>

Age Group	Community Issues
	<p>other social and medical services</p> <p>5. Allow mental health staff to be reimbursed for outreach activities rendered outside of traditional clinical service delivery modalities</p> <p>Cultural Competence</p> <p>6. Develop capacity to provide access to bilingual psychiatric services</p> <p>Wellness/Recovery/Resiliency Focus</p> <p>7. Expand eligibility criteria to enable CMHS to serve clients at their highest level of functioning</p> <p>8. Focus more on early intervention and prevention</p> <p>Integrated Service Experience</p> <p>9. Current lack of coordination of care within CMHS and between it and medical providers, law enforcement, hospitals, residential settings, APS</p> <p>10. Create Older Adult System of Care with wraparound services and case management</p> <p>11. Add CMHS component to APS for in-home assessment and follow-up</p> <p>12. Remove obstacles to accessing services that make the CMHS systems difficult to negotiate</p> <p>13. Provide more nursing services</p> <p>Peer Support/Family Education Support Services</p> <p>14. Address social isolation</p> <p>15. Lack of services for home-bound seniors</p> <p>16. Need to recruit more peer counselors</p> <p>Service Capacity</p> <p>17. Hire more psychiatrists as well as psychiatric/medication technicians</p> <p>18. Insufficient staffing levels</p>

#2 Please describe what factors or criteria led to the selection of the issues starred below to be the focus of MHSAs services over the next three years. How were issues prioritized for selection?

All issues were identified through the same process. Each workgroup reviewed and analyzed demographic and statistical data that was collected by the county along with prevalence data supplied by DMH which included population data by age, gender and ethnicity. As a foundation for identifying issues, members of the workgroup brought their experience and expertise and also presented issues raised by their constituencies in each of their respective interest groups.

A number of themes emerged across focus groups and survey results, regardless of their composition. These general themes include the critical need to:

- Expand housing resources
- Develop in-county crisis residential service
- Develop transition-age youth services
- Be more culturally sensitive

- Expand eligibility criteria to allow more clients to access services and, particularly, to enable CMHS to serve clients at their highest level of functioning and to address the needs of the working poor.
- Address the need for more meaningful, supportive employment
- Hire more psychiatrists, as well as psychiatric/medication technicians, and develop the capacity to provide or access bilingual psychiatric services
- Focus more on early intervention and prevention
- Expand services in Marin City, Novato and West Marin, which represent the southern, northern and western portions of the county respectively. In addition, we should expand services to Southeast Asian clients throughout the entire county.
- Address obstacles to serving the needs of dually diagnosed clients
- Put the “community” back in community mental health through:
 - Providing mental health services in more diverse and centrally located areas that are more accessible to clients and co-locating mental health services with other social and medical services
 - Allowing mental health staff to be reimbursed for outreach activities rendered outside of traditional clinical service delivery modalities
 - Developing more linkages between CMHS and key services, e.g., medical and nursing teams, probation, alcohol and drug providers, criminal justice system, adult and children’s protective services, etc.

Mental health clients along with their family members and advocates addressed a number of additional themes consistently, including the need to:

- Address the social isolation of the mentally ill
- Remove obstacles to accessing services that make the CMHS systems difficult to navigate
- Expand peer counseling and family advocacy programs

Following each of the focus group and survey processes, CMHS collected and compiled the data based on age-group. Special Topics Workgroups were then formed to consolidate, refine and prioritize the identified issues for each MHSAs age-group. The following community issues were identified:

Priority	Children/Youth (Ages 0 – 16)	Transition Age Youth (Ages 16 – 25)	Adults (Ages 26-59)	Older Adults (Ages 60 +)
1	Poverty*	Co-Occuring Substance Abuse Disorders*	Homelessness*	Need for Mental Health Services*
2	Homelessness*	Housing*	Lack of Health Insurance*	Need for Health Services*
3	Lack of Health Insurance*	Education*	Criminal Justice Involvement*	Co-Occuring Substance Abuse Disorders*

At the conclusion of the Special Topics Work group process, each age-group and special-focus work group reported their prioritized values to the Steering Committee (See Appendix I for “Crosswalk” document used by Steering Committee for decision making). Using a consensus process, the Steering Committee selected Full Service Partnership populations, Outreach and Engagement, and Systems Development strategies described in Section III.

Defining: Co-Occurring, Recovery and Resilience

Co-Occurring Conditions/ Dual Diagnosis: Often used to indicate an individual with a mental health disorder and substance abuse disorder (alcohol and/or drug dependence or abuse), but can be used to describe other combinations of disorders.

Recovery: A process in which mental health clients learn how to self-direct their lives and mental health, regain hope and optimism, and reclaim positive social experiences beyond the mental health system.

Resilience: The enduring ability of someone to recover from assaults to their person, whether physical, mental or emotional and, in the midst of that, maintain a sense of spirit and hope.

Key Terms Used in this Proposal:

Fully Served: People who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disturbance, and their families, who are receiving mental health services through an individual service plan in which both the client and his/her service provider/coordinator agree that they are getting the services they want and need to achieve wellness/recovery goals. Examples include wraparound services for children and youth and Assertive Community Treatment for adults and older adults. Both models feature a fixed point of responsibility for all client care, 24/7 availability, a “whatever it takes” approach to problem-solving, low client-staff ratio, flexible funds for rapid purchases of critical items and services brought to the clients where they reside.

Un-served: Individuals who have been diagnosed with severe mental illness and children who have been diagnosed with serious emotional disturbance, and their families, who are not receiving mental health services or have received only extremely brief and/or only crisis-oriented contact with the service system.

Under-served/inappropriately served: Individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disturbance, and their families, who are receiving some service, but whose services do not provide the necessary opportunities to participate and to move forward and pursue their wellness/recovery goals.

#3 Please describe the specific racial, ethnic and gender disparities within the selected community issues for each age group.

One of the methods of allocating Mental Health Services Act funds to the counties was by counting the county's population living under 200% of the federal poverty level. The state Department of Mental Health (DMH) reasons that those living under this level of income would most likely depend on the public mental health system for services. DMH presented counties with data that determined the likelihood of people at this income level would be seriously emotionally disturbed children or seriously mentally ill adults.

However, in Marin County, with the highest housing costs in the state, 200% of federal poverty level is an inadequate measure of need for public mental health services. The median home price in the county is over \$900,000. In the year 2000, more than two-thirds of those at risk of becoming homeless were working families with incomes averaging \$976 a month. Also, analyzing potential public mental health clients using the data for those below 200% of poverty does not account for students from well to do families receiving services under the AB3632 mandate in the schools, or the fact that there is one Psychiatric Emergency Service in the county, which serves over 1,700 clients a year from all socio-economic situations.

Defining "Serious Mental Illness & Serious Emotional Disturbance"

Adults with a serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV (Diagnostic and Statistical Manual for Mental Disorders), that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

A serious emotional disturbance is defined as a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-IV that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Examples of functional impairment that adversely affect educational performance include: an inability to learn that cannot be explained by intellectual, sensory or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.

Unserved and/or underserved individuals with serious mental illness and with mental health needs and living under 200% of poverty are common situations in Marin County. For example, only 42% of the older adults expected to be seriously mentally ill by the epidemiological studies actually got mental health services last year. Marin County currently has a population of just below 250,000. According to the prevalence studies, the County has a prevalence rate of 8.28% for serious emotional disturbance (SED) or serious mental illness (SMI). This would suggest about 3,290 individuals living in households earning 200% of the federal poverty level or less, have a serious emotional disturbance or a serious mental illness and are in need of mental health services. In Fiscal Year 2004-2005, Marin CMHS served approximately 3,904 individuals, or 119% of the projected need. While it may appear that the mental health treatment needs of seriously emotionally disturbed children and seriously mentally ill adults are well-served, gaps and disparities still exist. The numbers are misleading. For example, services to Hispanics, Asian-Americans, Older Adults, and the 18-to-24 age group are well below the expected prevalence. In the community input and planning process, CMHS attempted to address these disparities.

Defining: “Penetration Rate”

Penetration Rate is the percentage of individuals from a specific group who receive services within a period of time. For example, if there were 5,000 children with Medi-Cal in Marin County and 50 of them received mental health services in a year, then the penetration rate for that year would be 10%.

Children/Youth

While children and youth have an overall penetration rate above that for adults, it varies widely among groups within the children and youth age group. In the 0 to 5 age groups under 200% of poverty only 35% of children with expected prevalence of serious emotional disturbances were served. In the 6 to 11 age group, 95% are served by CMHS; however, last year 473 children were served by the AB3632 program through the schools, a program without means testing. Many of those served are in the middle and upper income brackets. Only 172, or 36%, of those students were from low income families that were Medi-Cal eligible.

In 2000 the in Marin Continuum of Housing and Services did a profile of homelessness in Marin County. Of the 6,508 homeless people identified, 1,723 were children. Another 5,434 children were at imminent risk of homelessness during the two-year period from 1999 to 2000. In 2000, Marin County received a grant for outreach and services to homeless mentally ill adults under AB2034.

One hundred homeless mentally ill adults were enrolled within a few months and the waiting list quickly grew to forty.

The penetration rate is determined by the number of individuals who received services as a percentage of those eligible for those services. The mental health service penetration rates vary for children and youth by gender. For example, for boys with Medi-Cal, the penetration rate was 10.31%, while for girls it was just 8.71%. The Children's Health Initiative Coordinating Committee estimates that there are 3,000 children living in Marin County without insurance. For the overall population, the penetration rates by gender for children are 2.6% for males and 1.7% for females. Ethnic penetration rates for the 0 to 17 year olds are Caucasian 1.6%, African American 11.3%, Native American 5.1%, Asian/Pacific Islander 1.1%, and Latino 3.5%.

Transition Age Youth

In this 16 to 25 year old age group, community concerns were focused on the high risk characteristics of some. Transition age youth, such as those with co-occurring substance disorders, experiencing homelessness or unemployment, school drop-outs, and those involved with the criminal justice system were at increased risk of mental illness. As with children and youth there are considerable differences in the penetration rates among transitional age youth by ethnic groups. The overall rate for Caucasians is 2.8%, Asian/Pacific Islanders 1.3%, African Americans 5.1%, Native Americans 1.8% and Latinos 1.1%. Gender rates are 2.2% for males and 2.8% for females. According to the prevalence estimates, transition age youth experience a significant decline in services from CMHS after their 18th birthdays, and do not reach the expected penetration rates for the seriously mentally ill clients until after age 25.

Substance use and abuse is a common co-occurring problem with this age group. In its annual report in 2004, the Marin County Division of Alcohol, Drugs, and Tobacco reported that over 40% of the methamphetamine users receiving treatment in the county were age 18 to 24, far higher than the 5.5% of the overall population.

High housing costs in the County make independent living for transition age youth very difficult if they are students, unemployed, or have entry-level jobs. School drop out rates are high among certain ethnic groups, leaving them with fewer opportunities for further education. In Marin the four-year drop out rate for African-American students is 25.1%, 17.5% for Hispanics and Pacific-Islanders, 16.1% for American-Indians, 7.8% for Caucasians, 7.2% for Filipinos, and 6.1% for students from Asian backgrounds. Overall the four-year drop-out rate, the chance of a student dropping out between ninth grade and graduation, is 13.3% for all students in Marin County.

Adults

Adults with serious mental illness and co-occurring substance use disorders, homelessness, and/or criminal justice involvement were populations of high concern in the community input process. The report in 2000 of the Marin Continuum of Housing and Services estimates that 6,508 individuals were homeless at some point during 1999 and 2000 in Marin County. Most of the homeless population in Marin County is not highly visible. While a third of the newly homeless were staying in a shelter, the majority were either on the streets, living in their cars, camping in the hills, or temporarily staying on friends' couches. The ethnicity of the homeless and at risk population was quite diverse with 42% Caucasian, 38% Hispanic, 12% African-American, 2% Asian-Pacific Islander, 1% Native-American, and 5% other. Hispanics and African-Americans with 11.1% and 2.8% of the total county population respectively are over-represented by approximately a factor of four in the homeless group.

The Children's Health Initiative Coordinating Committee estimates that about 16,000 adults in Marin County have no health insurance. The County Medical Services Program, which provides health insurance for 4,200 indigent adults, reduced its inpatient psychiatric benefit to three days per admission and ten days per year in October 2005. There is just one psychiatrist who accepts County Medical Services Program for outpatient medication management.

In the last few years, Marin CMHS has successfully pursued grants to better serve adults with serious mental illness. The AB2034 grant increased capacity to serve 92 previously homeless mentally ill adults, and the Mentally Ill Offender Crime Reduction grant funded the Support and Treatment After Release (STAR) program, which serves another 50 adult clients involved in the criminal justice system. The average daily population of the County Jail is 300 inmates with 10 to 12% of those being mentally ill. Of those inmates, 272 are male and 38 are female. 153 are Caucasian, 75 Hispanic, 71 African-American, 8 Asian-American and 3 other.

Overall CMHS' penetration rates, the percentage of the total population getting services, were: by gender for adults, 1.3% for males and 1.7% for females. Ethnic group penetration rates are Caucasian 1.4%, African American 3.8%, Native American 2.7%, Asian/Pacific Islander .09%, and Latino 1.1%.

Older Adults

People 65 years and older represent the fastest-growing segment of the Marin County population. Nationally, the increase in this age group is estimated to go from 13% to 20% of the U.S. population by 2030. Currently, older adults account for only 7% of all inpatient psychiatric services, and they are three times less likely than younger adults (individuals 18-64 years) to receive outpatient mental

health care. The very disturbing reality is that the suicide rate of older adults is higher than any other age group. 18% of the Marin County population is age 60 or over, yet only 6.7% of Marin CMHS clients are in this age group. Marin County has a population of 44,647 over 60 years old, according to the 2000 census. Only 264 of those received service from CMHS in fiscal year 2004-2005. Of all age groups, older adults have the lowest overall penetration rate, an incredible 0.6%.

Many older adults report mental health issues to their primary care physicians. These symptoms may be associated with aging, such as somatic complaints, sleep disturbances, memory loss, or mood disturbances. Co-morbidity with alcohol, drugs, medications, and physical illness may obscure symptoms of mental disorders and reduce the likelihood of an accurate diagnosis. If primary care physicians have limited training in the diagnosis and care of geriatric mental health, the identification of mental health issues and the subsequent quality of care could be problematic.

In December of 2004, the Division of Aging of the Department of Health and Human Services conducted an Older Adult Community Survey and received over 1,000 responses from local residents 60 and older. More than a third, or 35%, of the respondents reported feeling depressed often in the past month.

Of those older adults living under 200% of the federal poverty level who would be expected to experience serious mental illnesses, just 42% received services from CMHS. Overall gender penetration rates for older adults are males 0.5% and females 0.6%. Race and ethnic penetration rates for older adults are Caucasian 0.5%, African American 1.6%, Native American 4%, Asian/Pacific Islander 0.4%, and Latino 1.1%. This is much lower than for other age groups.

It is clear from this summary and the further detail in Section II, that there are significant disparities within age, gender, racial, ethnic and geographic groups in Marin County. With additional MHSA funding, Marin CMHS will be able to provide services designed to continue improving availability and access in order to decrease these known disparities.

4) If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more significant for your county and how the issues are consistent with the purpose and intent of the MHSA.

Not applicable.

Section II Analyzing Mental Health Needs in the Community

#1 Using the information from population data for the county and any available estimates of unserved populations, provide a narrative analysis of the unserved populations in your county by age group. Specific attention should be paid to racial ethnic disparities.

Marin County has one threshold language, Spanish (11% of Marin residents speak Spanish at home); however, there is a significant population of Vietnamese that reside in Marin County. There are other linguistic and cultural groups in the “other ethnicity” category that require special attention. The largest groups include “Some other race” and “Two or more races” according to the U.S. Census Bureau 2000.

The first component of our analysis of disparities in Marin County uses State DMH data regarding prevalence of seriously mentally ill and seriously emotionally disturbed projections, as factored by 200% of poverty; however, as acknowledged in the DMH Letter No 05-02, 200% of poverty is not an adequate predictor of need in counties where there is a higher cost of self-sufficiency. Two-hundred percent of poverty prevalence also does not account for the need or mandate under AB3632 for mental health services for special education students with an Individualized Education Plan (IEP) specifying mental health services, including psychiatric emergency services. Under these circumstances, comparisons by percentage of the population projected and population served, rather than the numbers themselves, is a more conservative approach to calculation of the unserved.

Information from this analysis was taken from Marin County Community Mental Health data system for fiscal year 2004-05, 2000 federal census data for Marin County, 2004 State of California Department of Finance race/ethnicity population data and prevalence data developed by Holtzer. Unduplicated clients were compared with prevalence of Seriously Mentally Ill (SMI) by race and ethnicity, age and gender to determine penetration rates for fiscal year 2004-05. The comparisons by age have some limitations due to the way age groups are defined. The prevalence data defines Transition Age Youth (TAY) as 18-25 years, while the MHSA TAY ages range from 16-25. A similar discrepancy occurs with Older Adults. The prevalence data uses 65+, while the MHSA uses 60+. The DMH data does not crosswalk the prevalence estimates by age and ethnicity; however, this data does provide an opportunity to begin assessing service disparities.

The data indicated that the lowest penetration rates by race and ethnicity for individuals with SMI for public mental health services are for Asian, Native

American and Hispanic/Latino groups. The highest penetration rates are for African-Americans, followed by Caucasians.

Males have a higher penetration rate than females. The highest penetration rates by gender and age were for adult males. The lowest penetration rates by gender and age were for adult females. It should be noted that all penetration rates by gender and age (with the exception of ages 0-5) were from 95% to well over 100%.

By age, the greatest penetration rates are for children ages 12-17, followed by adults ages 45-54. It should also be noted that the fastest-growing age group in Marin County are older adults, however, this group has significantly lower penetration rates for all races and ethnicities. For children, the highest penetration rates by ethnicity are for African-American, while the lowest penetration rates are for Asians.

Penetration rates for all ethnic minorities except African-Americans remain low, especially for Asian and Latinos. The only exceptions are the penetration rates for adult Native American and Pacific Islanders due to extremely small sample size.

It is possible that the data for Native Americans is not reliable due to the failure to accurately identify Native American clients. Marin County has no reservations, rancherias, or any Native American human service organizations based in the County.

By far, the largest ethnic group in Marin County, other than non-hispanic Caucasians, is Latinos. There is little variation in penetration rates by age for this ethnic group, although the penetration rate for Latino adults is higher than other Latino age groups. Latinos represent over 11% of the County population and at the same time they represent about 13% of the service population. These numbers might seem positive; however, this group is over-represented in the low income group and represents about 40% of the County Medi-Cal population. Various strategies such as increased and strategic deployment of bilingual and bicultural staff, cultural competency training and targeted programming have been effective in increasing access to services. It is known that many Latinos seek services for mental health problems from primary care health care providers rather than from mental health providers. New strategies such as contracting with Latino-serving organizations for outreach and engagement and providing mental health services within the Latino community, offer promise for better access.

It is difficult to determine if the high penetration rates for African-Americans, especially children, are the result of over identification because of stereotypes, or due to the fact that they are over represented in the juvenile justice system (over 50% of the children in the juvenile justice system in Marin County are children of

color) or because of ease of access. Children’s System of Care, a program that targets children in the juvenile justice system, provides services to a large number of children of color; in fact, 65% of the children in the program are non-white. Latino/Hispanics are the largest group, represented at 37%.

Finally, there is a pattern of lower penetration rates in the outlying area of the County. The west Marin area, farthest from the central population centers of San Rafael and Novato, has lower penetration rates. While not specific to the population of individuals with SMI, these overall rates are likely indicative of lower penetration rates for individuals with SMI in the outlying area of the County.

#2 Using the format provided in Chart A, indicate the estimated total number of persons needing MHSAs mental health services who are already receiving services, including those currently fully served and those underserved/inappropriately served, by age group, race ethnicity and gender.

Estimates Children 0-17

Children	Fully Served		Under-served or Inappropriately Served		Total Served*		County Poverty Population**		County Population***	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	47	35	585	371	1,044	100%	10,852	100%	51,240	100%
Race/Ethnicity										
African American	8	6	66	52	134	12.8%	565	5.2%	1,250	2.4%
Asian Pacific Islander	3	3	10	8	24	2.3%	646	6.0%	2,213	4.3%
Latino	16	15	131	96	261	2.3%	4,051	37.3%	7,847	15.3%
Native American	****		3	1	4	0.4%			100	0.2%
White	19	9	343	190	561	53.7%	4,804	44.3%	36,888	72.0%
Other	1	1	32	24	60	5.7%	786	7.2%	2,942	5.7%

Estimates Transition Age Youth 16-25

Transition Age Youth	Fully Served		Under-served or Inappropriately Served		Total Served*		County Poverty Population**		County Population***	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	21	8	141	134	304	100%	5,353	100%	13,900	100%
Race/Ethnicity										
African American	3	3	8	11	25	8.2%	235	4.4%	638	4.6%
Asian Pacific Islander	0	1	6	6	13	4.3%	237	4.4%	771	5.5%
Latino	4	2	17	18	41	13.5%	2,401	44.9%	4,136	29.8%
Native American	****			2	2	0.7%			58	0.4%
White	14	2	91	85	192	63.2%	2,243	41.9%	7,794	56.1%
Other	0	0	19	12	31	10.2%	237	4.4%	503	3.6%

Estimates-Adults 18-59

Adults	Fully Served		Under-served or Inappropriately Served		Total Served*		County Poverty Population**		County Population***	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	75	60	976	1,230	2,354	100%	27,443	100%	155,660	100%
Race/Ethnicity										
African American	11	11	60	119	201	8.5%	1,344	4.9%	5,254	3.4%
Asian Pacific Islander	2	2	42	49	95	4.0%	1,344	4.9%	7,890	5.1%
Latino	11	6	74	110	201	8.5%	8,417	30.7%	18,652	12.0%
Native American	****		6	8	14	0.6%			494	0.3%
White	62	40	721	863	1,687	71.7%	15,195	55.4%	119,917	77.0%
Other	0	1	73	81	156	6.6%	1,143	4.2%	3453	2.2%

Estimates-Older Adults 60+

Older Adults	Fully Served		Under-served or Inappropriately Served		Total Served*		County Poverty Population**		County Population***	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	6	4	97	163	270	100%	6,471	100%	45,586	100%
Race/Ethnicity										
African American	0	0	2	7	9	3.3%	36	0.6%	588	1.3%
Asian Pacific Islander	0	1	11	11	23	8.5%	212	3.3%	1,545	3.4%
Latino	2	0	6	10	18	6.7%	264	4.1%	1,426	3.1%
Native American	****			2	2	0.7%			49	0.1%
White	4	3	74	128	209	77.4%	5,901	91.2%	41,531	91.1%
Other	0	0	4	5	9	3.3%	58	0.9%	447	1.0%

NOTE: Individual totals may not add up to Total Served in each age group. Due to "unknown" gender category CMHS records and this chart did not match up.

* Clients receiving one or more Marin County Mental Health services in FY 2004-2005

** Census 2000 Summary File 3, via U.S. Census Bureau, American FactFinder (<http://www.census.gov/>). Adjusted for 2005 using DOF "E-4 Population Estimates" (<http://www.dof.ca.gov/HTML/DEMOGRAPH/histE-4.HTM>). Age groupings (0-4, 5, 6-11, 12-17, 18-64, 65-74, 75+) inconsistent with MHS groupings. Percentages derived from census sample; numbers derived from percentages and county population numbers. Percentages for Native Americans unavailable (presumably due to inadequate sample size)

*** Census 2000 summary File 1, via CA Dept of Finance (DOF), "Population by Gender, Age and Race" (http://www.dof.ca.gov/HTML/DSEMOGRAPH/CSDC/CSDC_Products.htm). Adjusted for 2005 using DOF "E-4 Population Estimates" (<http://www.dof.ca.gov/HTML/DEMOGRAPH/histE-4.HTM>).

**** Data not available due to small sample size (see *** above)

#3 Provide a narrative discussion/analysis of the ethnic disparities in the fully served, under served and inappropriately served populations in your county by age group as identified in Chart A.

In numbers of people served by the public mental health system in Marin County, by far the greatest disparity in the underserved and unserved is in the Latino population. For example, Latino children age 0-17 make up 15% of the county population of that age and 37% of the county's children living in poverty, yet they make up only 2.3% of the CMHS clients. By comparison White children 0-17 make up 72% of the population and 44% of the population living in poverty. White children account for 54% of CMHS clients in that age group. African American children, on the other hand, are somewhat over-represented among youthful CMHS clients. African American children make up 13% of CMHS clients, while accounting for 2.4% of the overall population and 5% of the poverty population in that age group. Children identified as Asian Pacific Islander are also somewhat underserved. While 2.3% of CMHS clients ages 0-17 are from this group, they make up 4.2% of the county population and 6% of the poverty population.

For transition-age youth, the numbers are quite similar. Latinos are seriously underserved when compared to their percentage of the poverty population, 2.3% of CMHS clients in that age group versus 37.3% of those of that age living in poverty. Asian Pacific Islanders were also underserved in this 16 to 25 year old age group. African Americans and Whites who received some services were greater than their share of the poverty population, 12.8% to 5.2% and 53.7% to 44.3% respectively. It is important to note that only 21 males and 8 females in the transition-age youth group were fully served, out of over three hundred who received some services and over five thousand living in poverty.

The data also shows disparities between the services delivered to Latino adults (8.5%) compared to their percentage in the overall population (12%) and the poverty population (31%). Here, African Americans are some over-represented, with 8.5% of CMHS adult clients compared to 3.4% of the overall population and 4.9% of the poverty population. One hundred and thirty-five adults were fully served by the public mental health system of 2,354 who received some services last year.

For older adults, the situation improves for Latinos. This may be because the Latino population is predominantly under 60. While Latino older adults represent just over 3% of the county population and 4.1% of the poverty population in the county, they represent 6.7% of the CMHS' older adult clients. Here we see that while Caucasian older adults make up 91% of the older adults living in poverty in the county, they make up about 77% of the older adult clients served last year.

#4 Identify objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population assessment, the county's threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in this Plan.

CHMS will strive to provide services that are not only culturally and linguistically competent, but are also easily accessible to consumers regardless of where they happen to live in the county.

Specific objectives:

- Increased penetration for Asians, with special emphasis on children, using new strategies for outreach and engagement by making use of increased bilingual/bicultural staff and natural leaders in the community and existing helping agencies in those communities.
- Increased penetration for older adults of all ethnicities utilizing new outreach and engagement strategies capitalizing on collaboration with existing support networks, including Marin County Health and Human Services' Divisions of Aging, Social Services, Public Health and Alcohol and Drugs.
- Increased overall access for Latinos by locating a new service site in a large Latino community and making use of increased bilingual/bicultural staff.
- Increase Native American access through staff education and training. There are no reservations or rancherias within Marin County, and no Native American human service organizations based in Marin County. Strategies that utilize the expertise that exists in neighboring counties should be incorporated into the CMHS Cultural Competency Training Plan.
- Increase linguistically and culturally competent staff in Spanish and Vietnamese.
- Focus new and expanded Full Service Partnership programs on improving access for unserved ethnic populations by partnering with ethnic service organizations, primary care providers and deploying services to specific neighborhoods.
- Increase focus on client culture throughout the system by increasing consumer participation (consumers as staff) in all

programs at all levels, and by expanding training opportunities on client culture for all staff. Identification and expansion of culturally competent services can be accomplished only with considerable consumer participation at all levels.

- Cultural competence training programs for mental health staff and collaborating community members will be expanded through MHSA start-up funding.

Key Term Used in the Proposal:

A Full Service Partnership is one of three categories of MHSA Community Services and Supports (CSS) funding. It provides all necessary services and supports for designated populations to be served in the first three years. Counties are required to request the majority of their total CSS funding for Full Service Partnerships in order to begin providing full service to as many individuals/families as possible.

Section III Identifying Initial Populations for Full Service Partnerships

#1 From your analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years. Please describe each population in terms of age and the situational characteristics described above.

Marin County Community Mental Health Services (CMHS) relied on the community stakeholder process to lead the way in which issues would be prioritized for program development. CMHS leadership utilized stakeholder prioritized input and MHSA guidelines to determine what types of programs, which target populations and how many individuals could be served in each age group. One Full Service Partnership (FSP) was developed for each age group in the first year of funding. Following is a list of Full Service Partnership Programs that are proposed. (CMHS developed a numbering scheme that corresponds to budget sheets, e.g., FSP-01, etc.)

Children/Youth

FSP-01 – Children’s System of Care Program

This program serves 40 seriously emotionally disturbed youths, up to age 18 years, who are involved with Probation and/or attend the County Community School, an alternative continuation high school. In both cases, youth of color are over-represented. These are youth who do not meet the criteria for special education, at least initially. The model is “whatever it takes” and the staff involved in this program meet the youth and family where they are, in their home and in the community. Without these services, these youth are at risk for not completing high school, co-occurring substance abuse disorders and continued involvement with the criminal justice system.

Transition-Age Youth

FSP-02 – Transition-Age Youth Partnership

This program will serve 20 transition-age youth, ages 16-25 years of age, with serious emotional disturbance/serious mentally illness aging out of children’s services, child welfare and/or juvenile justice systems. These youth require services as they are leaving residential treatment and/or foster care, and are at risk for hospitalization, incarceration or homelessness.

Adults

FSP-03 – Support and Treatment After Release (STAR) Program

Marin’s STAR program is a full service partnership providing culturally competent intensive, integrated services to 50 mentally ill offenders ages 18 and older. Operating in conjunction with Marin’s recently implemented mental health court – the STAR Court – a multi-disciplinary, multi-agency team provides comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports.

Older Adults

FSP-04 – Marin At-Risk Seniors Team (MAST)

This program is a new full service partnership that will provide culturally competent intensive, integrated services to 40 priority population individuals (serious mental illness, functional impairments, co-occurring substance abuse disorders and other health conditions). MAST will 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.

#2 Please describe what factors were considered or criteria established in each age group that led to the selection of the initial populations for the first three years.

The following list of criteria was used for selecting initial populations in all age groups:

- Community stakeholder input
- Client/family survey data
- MHSA Steering Committee recommendations
- Rates of mental illness in Marin County
- Penetration rates for mental health services in Marin County
- Ability to target racial and ethnic disparities in service delivery
- Existence of programs currently successful in serving the target population
- MHSA guidance to “start small”

#3 Please discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

Unserviced and/or underserved individuals with serious mental illness and other mental health needs are a common situation in Marin County, which currently has a population just under 250,000. According to the prevalence studies, the county has a prevalence rate of 8.28% for serious mental illness (SMI). This would suggest about 20,500 individuals have a serious mental illness and are in need of mental health services. In fiscal year 2004-05, CMHS served approximately 3,943 individuals, about 19% of the projected need. While many of those individuals in need received services in the private sector, or through other means, it is clear that there is a large unmet need for services across the County, across gender, across age, across race and ethnicity.

Children/Youth

Communities and people of color were the top two areas of consideration for this age group. While overall children and youth have a penetration rate slightly higher than for adults, it varies widely among groups within the children and youth age group. Significant efforts will be made to enroll Latino/Hispanic, African-American and Asian youth in the Children’s System of Care program with the goals of successfully moving them out of the criminal justice system and back into the community. The program’s unofficial motto has been, “at home, in school and out of trouble.”

Transition-Age Youth

In this age group, community input focused on risk factors. Transition age youth with co-occurring substance disorders and those involved with other agencies (criminal justice and child welfare systems) were the top priority. Significant effort will be made to enroll Latino/Hispanic, African-American and Asian transition-age young adults in the Transition-Age Youth Program with the goal of moving them into higher education, gainful employment, independent or supported housing and into natural supports in the community.

Adults

With adults, those with co-occurring substance issues and/or who are involved with the criminal justice system were the populations of most concern in the community input process. Significant efforts will be made to enroll Latino/Hispanic, African-American and Asian adults in the Support and Treatment After Release (STAR) Program with the goals of promoting recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration and hospitalization.

Older Adults

The older adult age group was the population identified with the greatest unmet needs in the community planning process. Across all age groups and ethnicities, older adults have the lowest overall penetration rates, and they are the fastest-growing segment of the population in Marin County. In keeping with the MHSA concept of “start small”, CMHS has chosen to create a new FSP called Marin At-Risk Seniors Team (MAST). The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

It is clear that there are significant disparities within age, gender, racial and ethnic groups in Marin County. The community stakeholder process confirms that the needs exist. All new MHSA programs will be designed to significantly address these known disparities in all age groups. All of these four full service partnerships will also have Spanish-speaking capacity and client and/or family participation.

Section IV Identifying Program Strategies

The following matrix provides an overview of the nine prioritized strategies that have been recommended for MHSA funding. These program strategies represent the three funding types described in the CSS requirements and respond to discussions at the Steering Committee meetings and community feedback. The first section summarizes the 4 Full Service Partnerships. The

second section summarizes the 5 Outreach & Engagement / System Capacity Strategies. The narratives in Section VI specify the details of each strategy that will be utilized within each program. All Full Service Partnership programs will only utilize the strategies outlined in the MHSAs CSS document.

Program Strategy	Full Service Partnerships
Children's System of Care	<p>▶ This program will target and serve 40 seriously emotionally disturbed youth who may have alcohol/drug issues and who are involved with Probation and/or attend Community School, a continuation high school. Clinical staff will work with trained family partners to meet the mental health, substance abuse, social, and developmental needs of each child or adolescent and their families in a culturally competent manner. All full service partnerships include 24/7 response for clients served and bilingual Spanish-speaking staff.</p> <p>▶ Expands current program</p>
Transition-Age Youth Partnership	<p>▶ This integrated service team program for 20 Transition - Age Youth (16- 25) who are seriously mentally ill/seriously emotionally disturbed will provide culturally competent mental health services, intensive case management, housing supports, psychiatric care, substance abuse counseling, employment services and independent living skills. A multi-disciplinary team for Transition Aged Youth will provide services including linkage and follow-up referrals for young people aging out of children's mental health services and transitioning to adult services and independent living. All full service partnerships include 24/7 response for clients served and bilingual Spanish-speaking staff.</p>
Support and Treatment After Release (STAR) for Adults	<p>▶ The STAR Team will serve 50 mentally ill offenders each year coming directly from the Jail. Service components include case management, psychiatric consultation, medication management, mental health court, group counseling, substance abuse treatment, peer mentoring and money management. The program's goals include reductions in crime and jail recidivism, and increases in stable housing and employment. All full service partnerships include 24/7 response for clients</p>

	<p>served and bilingual Spanish-speaking staff.</p> <p>▶ Expands current program</p>
Older Adult Partnership	<p>▶ This multi-disciplinary team will serve 40 older adults who are seriously mentally ill, isolated, and at risk of out of home placement. By providing a full range of integrated, culturally competent services including outreach, psychiatric care, peer counseling, case management, and substance abuse counseling, participants will better control their illness and avoid higher, more restrictive levels of care. All full service partnerships include 24/7 response for clients served and bilingual Spanish-speaking staff.</p>

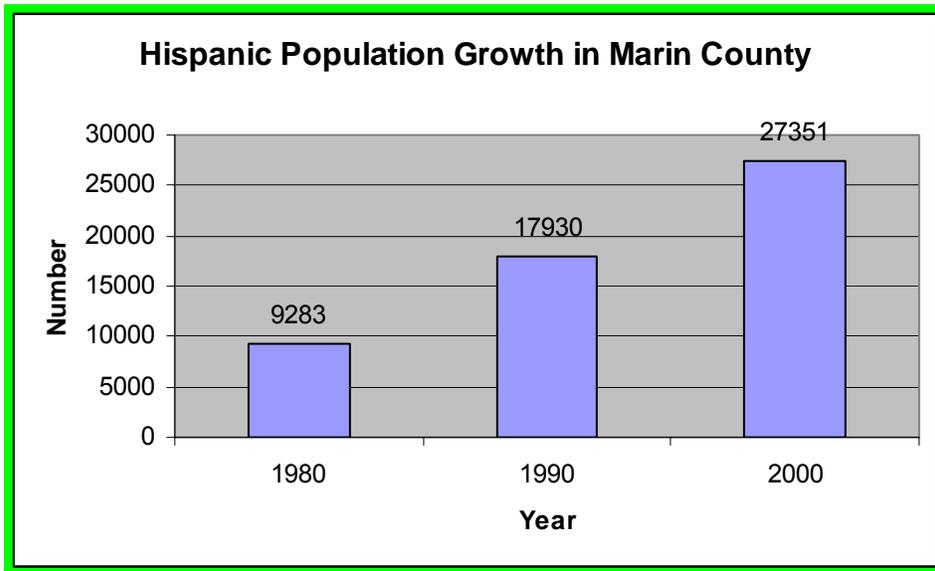
Program Strategy	Outreach and Engagement + System Capacity
Client Operated – Enterprise Resource Center Expansion	<p>▶ Expand this program developed and operated by consumers. Hire and train consumers to handle the expansion. Components include: outreach, employment programs, dual recovery group, recreational and socialization opportunities, peer advocacy and counseling, assistance with medication, benefits counseling, transportation, and a warm line for supportive counseling. The plan is to locate the ERC in the new Wellness & Recovery Center.</p>
Supported Housing Expansion	<p>▶ Expand currently available supported housing resources for adults with serious mental illness to reduce the unnecessary use of Institutes for Mental Disease (IMD).</p>
Regional Service Site	<p>▶ A community-based, culturally competent, easily accessible comprehensive mental health service site will be opened in Southern Marin, an unserved area. Clients and families will benefit from easy access to an array of mental health services including individual, family, and group counseling along with support groups, substance abuse services and medication monitoring.</p>
Vietnamese Language Capacity Expansion	<p>▶ In order to better serve Vietnamese-speaking people with mental illness, a part-time bilingual social worker position will be added for case management, outreach and translation for psychiatric visits.</p>
Program Evaluation	<p>▶ MHSAs requires specific outcome data on every client served. This mandatory data collection and evaluation will require time and expertise to analyze and report.</p>

Section V Assessing Capacity

#1 Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county.

Within Marin County there continues to be a need to increase the number of available staff to better meet the needs of our increasingly diverse ethnic populations. The Hispanic population growth continues to outpace all other Racial/Ethnic groups (See chart 1 below); however, Marin County is diversifying at a much slower rate than the Bay Area or California. A combination of factors may be influencing this, including housing costs and disparity in education levels, which in turn affects employment potential.

Chart 1



Marin County's only threshold minority population (Hispanic) represents 11% of the County population (Source: 2000 Census). Twenty-seven percent of the Hispanic population is on Medi-Cal and only 3% of those received mental health services (Source: 2003-04 Cultural Competence Plan Update). One limitation in better serving the Hispanic population is the lack of a provider site in the Canal Area of San Rafael, the largest primarily Hispanic neighborhood. Locating services there could improve access.

The African-American population represents 3% of the County population. Twenty-one percent of the African-American population is on Medi-Cal and 18% of those received mental health services. African-Americans living in Marin City

have asked for a mental health provider site in Southern Marin to improve access to culturally competent services. The Vietnamese population represents 0.5% of the County population. Thirty-four percent of the Vietnamese population is on Medi-Cal and only 10% of those received mental health services. The number of bilingual staff currently employed by Marin County Mental Health and its Community Based Partners is 76. The number of bilingual direct service staff is 57 (See chart 2 &3 below for details).

#2 Compare and include an assessment of the percentage of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.

Chart #2 below provides a break-down of the ethnic make-up of CMHS and contractor staff.

Chart 2: Ethnicity of Staff (Contract and CMHS)

Ethnicity	Admin/Mgmt	Direct Service	% Direct Service*	Support Services	Self ID Consumers	TOTAL	Percent
White	39	332	71%	52	45	468	85%
Hispanic	1	31	72%	11	0	43	8%
African-American	1	12	86%	1	0	14	3%
Vietnamese	0	2	50%	2	0	4	<1%
Other	1	17	89%	1	0	19	3%
TOTAL	42	394		67	45	548	

* percent of all staff within each ethnicity

Chart 3: Bilingual Staff by Function and Language (Contract & CMHS)

Language	Admin/Mgmt	Direct Service	% Direct Service*	Support Services	Self ID Consumers	TOTAL	PERCENT
Spanish	1	40	77%	11	3	52	68%
Vietnamese	0	3	60%	2	0	5	7%
Tagalog	0	2	50%	2	0	4	5%
Italian	1	1	50%	0	0	2	3%
Japanese	0	0	0	1	0	1	<1%
Hindi	0	1	100%	0	0	1	<1%
Farsi	0	1	100%	0	0	1	<1%
Greek	0	1	100%	0	0	1	<1%
French	0	5	100%	0	0	5	7%
German	0	1	100%	0	0	1	<1%
Hebrew	0	1	100%	0	0	1	<1%
Russian	0	1	50%	1	0	2	3%
TOTAL	2	57		17	0	76	

* percent of all staff within each language group

Source for Charts 2 & 3 Marin County Cultural Competence Plan Update – FY 2003-04

The percent of Hispanic staff, particularly direct service staff, is far below the 11% Hispanic population in the county and the 13% Hispanic population currently served. The percentage of African-American staff mirrors the percentage in the general population. The percent of African-American clients served is about 9.5% of the total clients served, much higher than the 3% African-American staff. The percentage of Vietnamese staff is double that of the general population. It should be noted that the percentages of direct service staff are extremely high as compared with the percentages of clients served in all ethnicities.

In threshold language proficiency CMHS does not fair as well. Fourteen percent of all staff are bilingual. Of these bilingual staff, 68% are Spanish speakers; however, that number translates into only 9% of the total number of staff, and Spanish speakers make up 40% of the Medi-Cal population in Marin County. Vietnamese-speaking staff represent 1% of the total number of staff, which is

less than the percentage of Vietnamese-speaking Medi-Cal population in the county.

Marin County Mental Health and contracted Community Based Organizations strive to hire and retain racially and ethnically diverse staff; however, the organizations have ongoing difficulty in carrying out the goal due to the high cost of living associated primarily with housing and the salary structure for licensed professionals and staff. In addition, some providers would rather work for organizations in neighboring counties with more diverse populations.

#3 Provide an analysis and include a discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address and overcome these barriers and challenges.

Challenges:

▪ **Hiring bicultural/bilingual staff**

One challenge facing CMHS and its community contract providers is the difficulty of hiring bicultural and bilingual staff due to the relative lack of diversity in the county and the high cost of housing. Outreach efforts into nearby ethnically diverse communities will be pursued along with hiring preference, and a 5% or 7% bilingual pay differential for bilingual/bicultural staff. Recruiting, hiring and training bilingual/bicultural consumers and family members to work within the mental health system is another priority.

Additionally, CMHS has recently expanded its internship opportunities by expanding the outreach efforts to include additional universities with a more culturally diverse student body and by providing a stipend to bilingual/bicultural individuals who participate in the CMHS internship program.

There is an ongoing effort in recruitment and identifying contractors equipped to address the needs of diverse populations. Additionally, CMHS has recently added language in provider contracts that require higher levels of diversity in their staff and service delivery.

▪ **Wellness/Recovery Model**

Another challenge is to cultivate the Wellness/Recovery model in core staff who are particularly fond of their current treatment model and in staff who are early in their careers. In order to promote staff development, CMHS will expand its collaborations with professional training programs and explore methods to support current staff to participate in professional training curriculums. A portion of one-time funding will go to an extensive training program for staff, clients and families.

- **Collaboration**

Finally, given the relative lack of diversity in Marin County, pursuing collaborations with more diverse Bay Area counties in addition to collaborations with professional training programs will aid in the continued evolution of cultural competence within CMHS.

Section VI Developing Work Plans with Timeframes and Budgets/Staffing

I. Summary Information on Programs to be Developed or Expanded

Exhibits 2 & 3 are shown in the Exhibit section of the Plan.

Key Terms Used in this Proposal:

Evidence-Based Practice: Defined by the Institute of Medicine (IOM), evidence-based practice is the integration of best research evidence with clinical expertise and patient values.

Promising Practice: A practice that incorporates the philosophy, values, characteristics, and indicators of other positive/effective public health interventions. A promising practice is based on guidelines, protocols, standards or preferred practice patterns that have been proven to lead to effective outcomes. It also incorporates a process of continual quality improvement that has an evaluation component/plan in place to move towards demonstration of effectiveness; however, a promising practice does not yet have evaluation data available to demonstrate positive outcomes.

Emerging Practice: Defined by the President's New Freedom Commission on Mental Health as treatments and services that are promising but less thoroughly documented.

II Programs to be Developed or Expanded

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Children's System of Care
Program Work Plan #: FSP-01		Estimated Start Date: June 2006
<p>Description of Program:</p> <p><i>Describe how this program will help advance the goals of the Mental Health Services Act</i></p>	<p>The Children's System of Care (CSOC) currently serves 40 seriously emotionally disturbed youth, ranging in age from 12-17 years (median age is fifteen), who are involved with Probation and/or attend County Community School, a continuation high school. The majority of the youth have some involvement in Probation. This program has been maintained with bridge funds by the county since the CSOC Grant was eliminated last year, in anticipation of the MHSAs passing in November 2004.</p> <p>An integral part of this program is the Family Partnership Program that consists of its Director and four Family Partners. Two of the five Family Partners are African-American. Family Partners are parents who have had a child in the mental health system. They provide invaluable support and guidance to parents in navigating the system and in helping them voice the family perspective that guides the team. The three clinical staff, two of whom are bilingual Spanish-speaking, work along side Family Partners to meet the mental health, social and developmental needs of the youth and their families. Because of the collaboration between the Family Partners and the clinicians, this program has successfully engaged families and served youth with multiple challenges. CSOC is a Full Service Partnership and will expand to have 24 hour a day, 7 days a week response for youth in the program. The program provides culturally competent mental health services, intensive case management, and psychiatric care to meet the mental health, substance abuse, social and developmental needs of the child in a collaboration between Family Partners and clinicians and other involved agencies such as education and probation.</p> <p>This program meets the MHSAs goals of reducing racial/ethnic disparities in access to mental health services by making services more culturally competent and accessible to youth involved in the Probation system, of which over half are youth of color. The individualized, family-driven mental health services increase parent/family involvement and empower family members with the guidance and support of the Family Partners and the team.</p>	

<p>Priority Population: <i>Describe the situational characteristics of the priority population</i></p>	<p>The CSOC program serves seriously emotionally disturbed youth, up to age 18 years, who are involved with Probation and/or attend the County Community School, an alternative continuation high school. In both cases youth of color are over-represented. The largest ethnic group is Hispanic (22%), African-American (17%), followed by Latin American and Mexican American (13%), and Asian (4%). Another 9% represent Korean, Vietnamese, Filipino, Native American, other Spanish, other non-white and 'unknown.' The remaining 35% are white. The gender breakdown is 60% male and 40% female. These are youth who do not initially meet the criteria for special education. The target population are those youth with impairment in self-care, school, family and school functioning, or are at risk of removal from home and community. The model is 'whatever it takes' (see definition under Key Terms, 'Fully Served,' page 15) and the staff involved in this program meet the youth and family where they are, in their home and in the community. Without these services these youth are at risk for not completing high school, co-occurring substance abuse disorders and continued involvement with the criminal justice system.</p>		
<p>Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)</p>		Fund Type	Age Group
		FSP	Children
<p><u>Youth/Family Involvement:</u> The strength-based approach looks to the strengths of the youth and family to guide the team in creating an individualized plan and identify goals for the youth. Each family has a Family Partner to help them navigate the system and to assist them in implementing their plan. The Family team includes community members the youth and family wish to include.</p>			

<p><u>Community Collaboration:</u> Services are coordinated through the CSOC case manager and use a strength-based approach which fosters resilience. The CSOC staff is situated at Probation and County Community School. This co-location allows for collaboration, a shared sense of responsibility, and support between CSOC staff and Education and Probation that provides a practical ease in working together with the youth and family. Other appropriate community agencies and providers are engaged as needed and decided by the team, such as School District Special Education staff, Social Services, Employment Development Counselor, and private therapist.</p>		
<p><u>Individualized Plans:</u> Each child/family will work with staff to develop individualized goals and a plan to achieve those goals, with parent-professional collaboration an essential element. Regular meetings will review the youth and family's strengths, needs and desired outcomes and the needed supports and resources to reach those outcomes. Wraparound meetings with the youth, family, clinician, Family Partner and any community partners will provide 'whatever it takes' to achieve the goal the family and youth have identified.</p>		
<p><u>Family Voice:</u> Our Family Partnership Program of four Family Partners plus the Director of the Program originated as part of the CSOC Program. All Family Partners are co-located with the clinicians where their client population is located. Family partners have offices at County Community School, Probation, Marin City and the outpatient offices of the Youth and Family team in San Rafael. The Family Partner helps the parent voice their needs, concerns and goals for the youth and family. The Family Partner provides the needed support and guidance so the family's perspective and input, that is, their 'voice' guides the team.</p>		

Defining “Wraparound”

Wraparound is a family-centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by meeting their unmet needs both within and outside of formal human services systems while they remain in their neighborhoods and homes, whenever possible.

Children’s System of Care

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

This program will provide access to mental health services for those youth attending County Community School and/or those youth involved in Probation who are at risk for out of home placement and continued involvement in the juvenile justice system. County Community School is Marin’s alternative education program for middle and high school youth who are on probation, have been expelled from their school or exhibit chronic truancy and/or behavioral problems. The County Community School, Probation, and Education are all familiar with screening youth for the CSOC Program. Mental Health services, including clinical assessment, therapy, and medication-support services are available. The Family Partnership Program provides family-to-family case management and support services across all three subsystems. Each of these subsystems have in place: 1) mechanism for developing integrated service plans which reflect the needs of the youth and family being served; 2) mechanism for interagency review of out-of-home placements prior to placements; 3) mental health case managers assigned to work on site at school or probation. This program is a full service partnership providing culturally competent, intensive integrated services for 40 seriously emotionally disturbed youth. A member of the team will be available to clients 24 hours a day, seven days a week.

This program advances the goals of the MHSA by providing services that reduce the ethnic/racial disparities in access to mental health services, since the majority of youth at these sites are youth of color. Culturally competent mental health services are provided through our bilingual, bicultural staff, and the Family Partner, who knows first-hand the experience of being a parent with a child in the system. The goals of the program are to promote and support resiliency, improve the youth’s ability to function at home, in school and in the community, reduce incarceration at juvenile hall and decrease hospitalizations.

An independent evaluator through a CMHS contract will provide program evaluation services. CMHS has successfully participated in numerous projects with heavy data collection and reporting requirements such as AB2034, Mentally Ill Offender Crime Reduction Grant, and Child/Youth Interagency Enrollee-Based Program. It is anticipated that Marin will be able to quickly and efficiently implement data collection and reporting once specific MHSA reporting requirements are established.

#3 Describe any housing or employment services to be provided.

No housing services are provided for these youth, because they live with their parents, legal guardians, or in foster care.

The CSOC staff will continue to collaborate with the county Employment Development Counselor as appropriate. The Employment Counselor is able to assist youth in completing applications, writing resumes and providing job leads. The counselor is able to contact the youth at school or even in juvenile hall, if they are interested in availing themselves of this resource. An important focus of this is education, i.e., finishing their GED or attending Adult Education so the youth has the basic requirements and skills for an entry-level job.

#4 Average cost.

The total budget is \$272,000 to serve 40 youth, which is \$6,800 per youth per year. Medi-Cal is billed as appropriate.

#5 Describe how the proposed program will advance the goals of resiliency for children and youth. Explain how you will ensure the values of resiliency are promoted and continually reinforced.

Recovery and resiliency principles include hope, optimism and a positive, strength-based orientation through which individuals build successes. These principles are part of the wraparound model, which empowers youth and family and underlies our approach to the youth in this program. This includes the belief that every individual can have success in some area of his or her life with the right supports. The youth can define that goal with the support of the team. The youth, with their parent, is involved in developing the outcome they want and the manner in which to get there. For example, a youth might have difficulty at school interacting with peers and therefore often refuses to attend. The team will discuss those days he was able to attend and what worked, and build on the skills he needs to interact with his peers more successfully and therefore attend more consistently. The client's strengths and success are documented in our assessments and treatment plans and discussed and supported with the youth

and the family in family meetings. The team builds on the strengths of the youth and looks for more opportunities for success. Parenting classes in English and Spanish provide additional structure in the engagement of parents so they can benefit from networking with other parents and see that they are not struggling alone.

Continual training in these principles is essential for staff, consumers and families, in order to promote a culture of resiliency and optimism. There will be formal trainings as well as opportunities for informal discussions with staff at staff meetings.

On-going evaluation will be informed by the concept of resiliency. Anonymous surveys will provide feedback from youths and their families on how their strengths and successes were acknowledged and supported; this data will be incorporated in to our on-going evaluation process.

#6 If expanding an existing program, please describe your existing program and how it will change.

The CSOC program as described above will be expanded to provide 24 hour per day, 7 day a week response to the clients. This matches the reality of life, that urgent issues do not occur Monday through Friday, 9-5PM. Additionally there will be flex funds to meet the unique needs of the youth and family and provide additional support when needed. Using flex funds judiciously means several questions are asked by the team: Does it build on strengths? Will it get you closer to the youth and family's stated goals? Does it meet an identified need? Using flex funds for car repairs so the parent can continue to make it to work and not lose their job, thus avoiding the risk of homelessness for the family is one example of using flex funds to support stability and mental health.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients or families will actually run the service or participate as part of a program or team or other entity.

At the program and planning level, the Director of the Family Partnership Program will continue to provide direct input and guidance as part of the Children's system management team. A Family Partner also participates in the hiring process of Youth and Family Services staff.

As previously discussed, at the staff level Family Partners will continue to co-facilitate parenting groups along side clinicians modeling collaboration and inclusion. All Family Partners are co-located with the clinicians at County Community School, Probation, Marin City and the outpatient offices of the Youth and Family team. The Family Partners also offer outreach and support, crisis

support, network and mentoring, a parent library of useful books parents may borrow, and help with navigating the system. The Family Partners build partnerships between the professionals and the families and ensures the family's concerns and needs are expressed and responded to in ways that are respectful and family-centered. In their role as Family Partners, they recognize the many demands placed on families and are committed to reducing stress and eliminating barriers to support and services. This support is practical, such as providing transportation for a parent to a meeting, or helping the parent understand what to expect at an Individual Education Plan meeting at the child's school. The Family Partners are essential members of the Children's System of Care.

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population. Explain how they will improve system services and outcomes for individuals.

Marin County has a considerable record of collaboration, both formal and informal, with stakeholders in working to offer a range of services to meet the needs of the client. The CSOC staff is co-located with Education and Probation. Formal collaboration occurs in their weekly joint meetings and informal collaboration is on going and frequent.

Additionally, the supervisor of the CSOC program along with the other Children's system supervisor, the Director of the Family Partnership Program and the Chief of the Youth and Family System meet formally on a monthly basis with other management staff from Education, Probation, CPS, the County Employment Developer Counselor, and a representative from a community agency to discuss policy and challenging cases. This group is the Interagency Case Management Council (IACMC), which continues to raise issues and challenge each other to improve and simplify systems for the advantage and benefit of the client. For example, IACMC spearheads the day-long cross-system training offered every year to the staff of these collaborating agencies. The purpose of this training is to help staff understand each other's agency roles and enhance their skill in navigating more effectively between agencies for the benefit of the client. This focus on collaboration has also resulted in concrete projects such as the Special Education Local Plan Area (SELPA) and CMH Workshop that meets monthly. In these meetings, management from SELPA and CMH work on protocols for referrals, assessments, and services that reflect our shared goal of meeting the needs of the student in a collaborative effort, which are then regularly shared with our respective staffs.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities.

Describe how your program and strategies address the ethnic disparities and what strategies will be used to meet their needs.

As previously discussed, this program serves approximately 40 youth of which the majority are youth of color. This program reduces racial/ethnic disparities in access to mental health services, by making services more culturally competent and accessible to youth involved in the Probation system and County Community school, who have unmet mental health needs and are over-represented in the juvenile justice system and alternative education.

A culturally diverse team of three clinicians (of which two are bilingual Spanish speaking and the third is bicultural Filipino) and five Family Partners (FP), two of which, are African American from the Children's System of Care (CSOC). Family Partners, parents who have had a child in the mental health system, will continue to help the parent voice their needs, concerns and goals for the youth and family, because they know first hand the experience of being a parent with a child in the system, while the culturally diverse clinicians have direct experience in what it means to be from a minority culture. The CSOC staff work out in the community, meeting the client where they are. They are flexible and committed to working with these youth and doing 'whatever it takes', from helping to paint an apartment to driving a youth to school. Mandatory cultural competency training is provided by CMHS and/or the Department of Health and Human Services for the staff. In the last two years there have been trainings on working with Vietnamese clients and Hispanic clients. The CMHS Cultural Competency Committee, which reports to the Quality Improvement Committee (QIC), is currently working on a Latino Access project which is assessing the current status of access for Latino mental health clients to our system.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender sensitive and reflects the differing psychologies and needs of boys and girls.

The CSOC program strives to deliver services that are sensitive to the sexual orientation and specific gender-based needs of our clients. A community agency, Spectrum, which provides support and services to lesbian, gay, bisexual and transgender (LGBT) youth, is an active partner in providing education and training to the Children's System staff. Spectrum presented a well-received panel discussion on 'LGBT Issues and Youth' to the Youth and Family Services Team at the All Staff meeting in November 2005. Awareness of gender differences in the psychological needs of youth has resulted in the offering of boys and girls groups that have been very successful.

We will continue to monitor the level of awareness of sexual orientation and gender sensitivity through evaluations and feedback and make changes as needed to our approach in these matters. Training will be on-going.

#11 How services will be used to meet the service needs of individuals residing out of county.

There is no plan to use MHSA funds for out-of-county youth. Our goal is to avoid out-of-home placements, and if services are needed we will continue to use Value Options, which links providers with clients residing in another county.

#12 If strategies are selected not listed in Section IV, how are they transformational and how will they promote the goals of the MHSA?

All strategies are listed in Section IV.

#13 Timeline

- 1/06 Board of Supervisor Approval
- 2/06 Send plan to State Department of Mental Health for approval
- 6/06 Implement 24/7 services

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Transition-Age Youth Partnership
Program Work Plan #: FSP-02		Estimated Start Date: September 2006
<p>Description of Program:</p> <p><i>Describe how this program will help advance the goals of the Mental Health Services Act</i></p>	<p>Marin County's Transition Age Youth (TAY) Partnership is a full service partnership providing 20 young people (16-25) with independent living skills, employment services, housing supports and comprehensive, culturally appropriate, integrated mental health and substance abuse services. These services are strength-based, evidence based and youth-centered: services that are based on the youth's self identified strengths, individualized to meet the youth's needs based on treatment approaches that have been effective. A multidisciplinary team provides assessment, individualized treatment plans and linkage to needed supports and services. A member of the team is available to TAY clients 24 hours per day, 7 days a week.</p> <p>This program provides 'whatever it takes' with the goal of providing treatment, skills and the level of self-sufficiency necessary for TAY to manage their illness and accomplish their goals, avoiding deep end services and homelessness.</p>	
<p>Priority Population:</p> <p><i>Describe the situational characteristics of the priority population</i></p>	<p>The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbance/serious mental illness 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. These youth require services to manage their mental illness as well as services to develop self-sufficiency, thus decreasing the risk of hospitalization, incarceration and homelessness. TAY with serious mental illness have higher rates for co-occurring substance abuse disorders than other age groups with mental illness, which also increases the risk of homelessness and involvement with the justice system. The penetration rate in Marin County of this age group is high (86%); however, recent cases in Marin have highlighted the unique needs of this age group that are not being met. Currently, there is no TAY-specific program. Feedback from the MHSAs workgroups, which included parents of TAY and transitional age youth themselves, as well as the unanimous endorsement from the MHSAs Steering Committee, made it clear that</p>	

	community stakeholders believe there is a need for a specific program that could successfully engage this high-risk group.	
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type	Age Group
<p><u>The TAY Program</u> is a full-service partnership, which includes housing support and 24 hours a day, 7 days a week response. The TAY team, consisting of a TAY peer mentor, Family Partner, case manager, a part-time career/education developer and a half-time supervisor, will prioritize referrals of youths who are at greatest risk for incarceration, homelessness and/or to prevent deep-end services. These youth will participate in the TAY full service partnership collaborating with Children’s System of Care (CSOC), adult services, and family and community partners.</p>	FSP	TAY
<p><u>Youth and Family Voice:</u> The TAY team, client and family will employ the Wraparound Process. The youth, the youth’s family, the community, service providers, family partners and peers will be invited to participate in the Wraparound process and meetings by the family, so as to provide on-going support and services, as well as identify naturally occurring resources. The youth and parent, supported by the Family Partner, will provide the family voice and perspective at the wraparound meetings when plans are developed. The youth and family voice lead the team’s decisions in developing the plan that is essential for individual, comprehensive, strength-based services. Goals will be developed around management of mental illness, recovery, education, housing and successful transition into the community and independence as appropriate.</p>		

Supportive Housing: The TAY team will begin to develop a range of housing options for TAY clients. Our consultant, Wayne Munchel, from National Mental Health Association, recommended that housing resources geared for TAY could function as a foundation for a spectrum of services. Utilizing available supportive housing and concentrating TAY in one setting was another recommendation; therefore, supportive housing may be site-based or scattered site, utilizing stipends as needed. Since TAY are often at risk for homelessness as a result of the lack of range of housing options, intensive case management to support TAY in appropriate housing will be necessary.

Educational/Vocational Training and Support: The TAY team will partner with existing resources in the community, such as the local community college and Social Services Independent Living Skills staff, to offer classes, workshops and peer support in areas of basic life skills, peer support, and education. Currently, CMHS staff, College of Marin staff and Mental Health Board members have formed a task force to identify workshops and courses for this age group that can be provided collaboratively at the College of Marin. An Education/Career Developer will focus on capacity development, forming partnerships/collaborations with Marin's educational and job training resources.

Defining “Supportive Housing”

Supportive Housing: The combination of affordable independent housing with a range of services and supports help people with serious mental illness stabilize their lives and function as tenants and good neighbors in the community. The term “supportive” in supportive housing refers to voluntary, flexible services designed primarily to help tenants maintain housing. Voluntary services are those that are available to, but not demanded of, tenants such as service coordination/case management, physical and mental health, substance use management and recovery support, job training, literacy and education, and money management.

Transition-Age Youth Partnership

#2 Please describe in detail the proposed program and how the program advances the goals of the MHSA.

The TAY program will provide services to 20 young adults from 16-25 years of age (CMHS is currently serving 300 of the approximately 1,600 in this age group living at 200% of poverty in the county, per census data 2000). This is a population that has been unserved or inappropriately served due to their unique needs and stage of development. The MHSA Steering Committee unanimously endorsed serving the TAY group as a top priority. These youth with mental illness face the challenge of entering adulthood without proper services and support because at this time in their lives they are developmentally striving for independence. This makes it difficult for them to avail themselves of traditional services.

As a way to reach this group, services will be community-based with active outreach. Services include case management, crises management, medication management, peer mentoring, housing support, education and employment support. The team will consist of a peer mentor/counselor, Family Partner, Case Manager, part-time career/education support staff and half-time supervisor. These young adults with mental illness will receive needed support from the peer counselor/mentor, and the family will learn how to navigate this challenging part of life with their child with the support of a Family Partner who has been through a similar experience. Outreach and engagement by the Family Partner with the family will begin with the assessment process. The case manager will work in the field coordinating the services and providing and/or brokering mental health services as appropriate. The part time career/education support staff will

collaborate with the county Employment Development Counselor and do 'whatever it takes' to help the youth identify education and career goals and help them access resources to reach their goals.

The program advances the goals of the MHSA by implementing strengths-based, individualized, culturally competent mental health services with a clear focus on this age group who are at risk for substance abuse, incarceration, and homelessness. The TAY team will operate with a wraparound model that emphasizes the family and youth's own perspective, which includes community-oriented, individualized plans that help the youth and family achieve their goals. This program will promote resiliency, self-sufficiency, help to avoid deep end services and homelessness. The wraparound process promotes resiliency and instills hope by supporting communication between the TAY youth and their family. It is essential, when appropriate, that the TAY and the parent be supported in maintaining communication, even as the young adult strives for independence. This connection can be an important element of a needed foundation for the young adult.

Program evaluation services will be provided by an independent evaluator through a CMHS contract. CMHS has successfully participated in numerous projects with heavy data collection and reporting requirements such as AB2034, Mentally Ill Offender Crime Reduction Grant, and Child/Youth Interagency Enrollee-Based Program. It is anticipated that Marin will be able to quickly and efficiently implement data collection and reporting, once specific MHSA reporting requirements are established.

#3 Description any housing or employment services to be provided.

The plan is to partner with an existing CBO that currently provides supported housing in the community for adults and several TAY. Funding from the MHSA will provide an individualized approach to necessary mental health case management that allows the TAY to access the appropriate type of housing, with the goal toward increased independence supported by the necessary coping skills acquired in the TAY program.

The TAY team staff assigned to an educational and vocational focus will access the existing vocational services available at the county, as well as help the youth set realistic educational/vocational goals and help in planning how to achieve those goals. The Employment Development Counselor assists participants in organizing and implementing an employment plan that may include remedial education, work orientation, skills training and job placement. This counselor also assists in identifying barriers to self-sufficiency and counsels on work ethics,

work habits and attitudes (Refer to further details under Educational/Vocational Training and Support above).

#4 Average cost for each Full Partnership participant including all fund types and fund sources.

The average cost is projected to be \$15,000 per youth per year. This projection is based on the report by our consultant for the TAY Program, Wayne Munchel, LCSW, from the National Mental Health Association of Greater Los Angeles. This figure includes subsidized housing of one fourth of the total projected budget for those youths in the program who need assistance to avoid homelessness. Medi-Cal, when appropriate, will be billed.

#5 Describe how the proposed program will advance the goals of recovery for transitional age youth and how we will ensure the values of recovery and resiliency are promoted and continually reinforced.

The Wraparound model is currently used in our youth and family services and there has been extensive training in the model for our staff. Access (inclusion of parent/child in decision making), voice (the parent/child perspective is heard) and ownership (parent/child agree and are committed to any plan concerning them) are the essential elements of the wraparound process. This is accomplished by having the family as the lead of the team for which the support of the Family partner is invaluable. Our integrated Family Partnership Program gives voice to the family perspective and will help bridge the gap between the TAY and the parent, which can be especially challenging at this developmental stage in life. The concepts of Wellness and Recovery are the guiding principles in our Adult system, which complement the concept of resiliency and strength-based values of wraparound. This means that if a young adult needs mental health services after the TAY program (at age 25), the principles underlying the systems are the same. Together, this means that individuals are approached from a strength-based perspective which engenders hope and optimism that will help the young adult manage his mental illness as successfully as possible, with varying degrees of support. On-going training and support will be provided the staff to continually promote these concepts.

Culturally competent, experienced staff that want to work with the TAY and are committed to a strength-based orientation will be essential for this program. Beyond the half time supervisor being a licensed mental health professional, the essential qualities will be flexibility, enthusiasm and known expertise and experience working with this age group. The staff must be able to convey

optimism and hope as well as structure and support. Additionally, we will require that providers, whether county or contract, demonstrate their understanding of the principles of strength-based model by evidence of trainings and/or practice and be willing to integrate peer mentors and Family Partners into their programs.

#6 If expanding an existing program or strategy, description of existing program and how it will change under this program.

Marin County CMH does not currently have a TAY Partnership. At this point, youth age out of the children's system and may or may not be accepted into the Adult system because of more strict criteria in the Adult system or through the choice of the youth to leave the system. The main change will be building a bridge between the Children's system and the Adult system, so that those youth with SED/SMI will have as seamless as possible a transition into the new TAY program. Additionally, setting the priority of serving young adults with their first break will enable them to access services sooner.

As discussed previously, the TAY Partnership will offer transitional age youth who are seriously mentally or seriously emotionally disturbed culturally competent mental health services, intensive case management, housing supports, psychiatric care, substance abuse counseling, employment services and independent living skills training. The new TAY program will be focused on meeting the needs of this age group to promote appropriate independence and life skills to enable them to manage their mental illness as successfully as possible.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entry.

Family Partners and peer providers currently provide services and supports at all levels in both the Children and Adult systems. At the program and policy planning level, the Director of the Family Partnership Program provides input and supervision as part of the management team of supervisors in the Children's system.

At the direct service level, Family Partners currently co-lead a variety of parent education and support groups for parents of children in the Children's system. Within the new TAY program, they will continue to run groups and provide

support for the parents of the young adults enrolled in the program. Experienced peer providers, who are interested in working with this age group, will be utilized as peer mentors and in the outreach and engagement aspect.

Both peers and Family Partners will be involved in the evaluation, both in terms of design and through feedback of their experiences in the program.

#8 Collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations, and how they will help improve system services and outcomes for individuals.

Marin County is already engaged in active collaboration through the Interagency Case Management Council (ICMC). Membership consists of mid-management level staff from Education, Health, CMHS, Probation, Social Services, Youth Employment and Training, the Family Partnership Program Director, up to two family members, and a representative of a private non-profit, community-based service organization. This council focuses on youth until graduation from high school.

The county currently has many on-going collaborative efforts with the goal of improving service and ultimately outcomes, including the Criminal Justice Behavioral Health Committee and the Child Welfare Redesign Committee. The Child Welfare Redesign Steering Committee includes providers, families, educational organizations, social services, and probation where discussions on how to work together for TAY youth have resulted in a separate interagency TAY committee. This committee will establish a liaison with the new TAY Program, since Education, Child Welfare, CBO's and CMHS all deal with youth leaving their respective systems with not enough supports to manage as successfully as they might. This TAY Committee is focusing on identifying TAY whose needs cross over the traditional boundaries of social services, mental health and education. Through joint problem-solving and coordination with the new TAY Program, the goal is to maximize resources for the benefit of the youth.

New collaborative efforts are in the planning stages with other CBO's through the MHSA planning process. The goal is to increase further participation of young adults, families and other interested community members in the final phases of defining the TAY Program, so we can combine our resources with appropriate and coordinate services from varied agencies and providers so the youth will receive seamless services that meets his needs. The task force on education for TAY, in which CMHS is partnering with the Mental Health Board and the local

community college (see Educational/Vocational Training and Support, pg 50) as well as the TAY Committee on coordination across county divisions (mentioned above) are two such examples.

#9 How the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities, and how the program and strategies address the ethnic disparities identified in Part

Cultural competence ultimately is the skills, knowledge, attitudes and subsequent policies that enable providers, both professional and peer, to work effectively in cross-cultural situations. Essential to this is having diversity in the work force, both linguistically and culturally, so that we are welcoming to the different populations in need of mental health services.

Spanish is the threshold language in Marin County. In our Children's system, approximately a third of the staff positions (7) are filled by bilingual Spanish speaking, along with four more who are bicultural. We expect to continue this model with the TAY program, with the added element of finding a peer case manager/mentor young enough, at least in attitude, to relate to the TAY population. Services will be identified that are culturally relevant for youth. Currently we annually stipend two bilingual post-doc interns for the Child and the Adult Systems; recruiting a bilingual intern for the TAY Program would be an excellent addition. The same expectations for diversity will be required of the new program.

The new program will actively seek out unserved and inappropriately served ethnic populations, in particular Hispanics and African-Americans. The wraparound process will identify culturally competent resources that may include but is not limited to youth's community, family faith community and private providers. The TAY staff will have access to cultural competency trainings as they are provided throughout the county.

#10 Sexual Orientation/Gender sensitivity

The TAY Program will develop services that are sensitive to the sexual orientation, as well as the gender of the participants. All staff will be trained on gender, lesbian, gay, bisexual, and transgender issues (LGBT) as they pertain to transition age youth. A community agency in Marin County, Spectrum, provides support and services to lesbian and gay youth and is an active partner in providing education and training to the Children's System staff, which will continue for this age group. Training will be provided on the psychological differences between females and males and different treatment approaches.

Recruitment and hiring is non-discriminatory and contractors are required to adhere to the same standards.

As the TAY program develops, we will be monitoring the level of gender and sexual sensitivity through evaluations and feedback and make changes as indicated, with consultation with experts as needed.

#11 How services will be used to meet the service needs for individuals residing out-of-county.

There is no plan to use MHSA funds, per se, with TAY who reside out of county. Our aim is to avoid out of home/out of county placements and the TAY program will engage only with youth placed out of county who are scheduled to soon return home, specifically as part of a successful transition home.

We will continue to use Value Options, which links providers with clients in need of out of county mental health services.

#12 If strategies selected that are not listed in Section IV, how they are transformational and how they will promote the goals of the MHSA.

All strategies listed in Section IV.

#13 Timeline.

- 1/06 Board of Supervisor's approval
- 2/06 State Department of Mental Health approval
- 3/06 – 8/06 Complete RFP process / recruit, hire and train staff
- 9/06 Begin program
- 1/07 Full enrollment achieved

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Support and Treatment After Release Program	
Program Work Plan #: FSP-03		Estimated Start Date: July 1, 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	<p>Marin’s Support and Treatment After Release (STAR) Program is a full service partnership providing culturally competent intensive, integrated services to 50 mentally ill offenders. Operating in conjunction with Marin’s recently implemented mental health court – the STAR Court – a multi-disciplinary, multi-agency team provides comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports. The team is available to clients 24 hours a day, 7 days a week.</p> <p>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.</p>		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	<p>Adults, transition-age young adults, and older adults with serious mental illness, ages 18 and older, who are currently involved with the criminal justice system and are at risk of re-offending and re-incarceration. Priority is given to individuals who are currently unserved by the mental health system or are so inappropriately served that they end up being incarcerated, often for committing “survival crimes” or other nonviolent offenses related to their mental illness. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.</p>		
Describe strategies to be used, Funding Types requested, Age Groups to be served		Fund Type	Age Group
Integrated service agencies which provide and/or broker all services that a client needs.		FSP	TAY/Adult/Older Adult
Integrated services with law enforcement, probation, and courts for the purpose of alternatives to jail for those with serious mental illness and collaboration to operate a mental health court.			

Intensive community services and support team capable of providing services to clients where they live, 24 hours a day, 7 days a week. The team includes consumers or family members as team members.		
Vocational services		
Family support, education and consultation services		

Support and Treatment After Release Program (STAR)

#2 Please describe in detail the proposed program and how the program advances the goals of the MHSA.

The Marin County Support and Treatment After Release Program (STAR) was originally implemented through a competitive Mentally Ill Offender Crime Reduction Grant (MIOCRG) awarded by the California Board of Corrections in 2000-01. A collaborative effort that included the Sheriff's Department, Probation Department, Marin County Superior Court, San Rafael Police Department, Department of Health and Human Services-Division of Community Mental Health Services (CMHS), and Community Action Marin's Peer Mental Health Program, the program implemented an improved system for providing strengths-based modified assertive community treatment and support for adult mentally ill offenders with the goal of reducing their recidivism and improving their ability to function within the community. The STAR Program's unique combination of law enforcement's community policing, problem-solving approach, the county's clinical treatment delivery methods and multi-disciplinary outreach and collaboration clearly demonstrated that Marin is able to effectively serve individuals who have been previously thought to be beyond help.

The initial grant that supported the program ended in June 2004. In March 2004, the Marin Community Foundation approved a grant to support continuation of the STAR Program for an additional 12 months. During 2005-06, the County Board of Supervisors provided **bridge funding** to continue the STAR Program until MHSA funding became available. Additional funding commitments from key partners in the program include Department of Health and Human Services-Division of Community Mental Health Services, Sheriff's Department, Probation Department, San Rafael Police Department, District Attorney's Office and Public Defender's Office.

These funding commitments made it possible to build upon the initial success of the STAR Program to complete the development of a comprehensive system of care for Marin's mentally ill offenders that consists of three critical components: 1) In-custody screening and assessment, individualized treatment and comprehensive discharge planning; 2) post-release intensive community-based treatment and services for 50 participants to support functioning and reduce recidivism, and 3) a mental health court – the STAR Court – to maximize

collaboration between the mental health and criminal justice systems and ensure continuity of care for 20 participants.

In-Custody Services – The CMHS Jail Mental Health Team provides the in-custody component of Marin’s system of care for mentally ill offenders. Those inmates who have a history of mental health treatment, or exhibit signs of mental illness, are referred to the team for stabilization, treatment with medications if indicated, and case planning. The team is staffed by a Crisis Specialist (mental health worker) seven days a week and a Staff Psychiatrist four afternoons weekly. Registered nurses at the jail administer medications prescribed by the psychiatrist and monitor the inmates’ response to the medication. The Jail Mental Health Team serves as a primary referral source for the STAR Program.

Intensive Community Treatment – Once enrolled, program participants are assigned to the Intensive Case Management (ICM) team. Each participant is assigned to a team member who serves as that individual’s primary service coordinator and single point of responsibility. With a target enrollment of 50, the ICM team is a multi-agency team with staff from CMHS (2 clinicians, one of whom is bilingual/bicultural; a part-time nurse practitioner; and a part-time psychiatrist), Community Action Marin (bilingual peer case manager), the Sheriff’s Department (deputy sheriff), the Probation Department (deputy probation officer), the San Rafael Police Department (part-time police psychologist), and Integrated Community Services (part-time employment specialist). All staff are culturally competent and familiar with community resources within clients’ cultural, racial, or ethnic communities. The ICM team is strengths-based and focused on relapse prevention, seeking out participants and serving them wherever they may be. This staff works intensively with program participants to establish individualized client-driven plans for each participant and closely monitors them on an ongoing basis. The team provides comprehensive assessment, crisis management, medication management, therapy services, peer counseling and support, psychoeducation, and linkage to other necessary services and community supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and will be provided on a case-by-case basis. Staff receive extensive training in substance use/abuse assessment, motivational interviewing, and relapse prevention/intervention. The ICM 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. Representative Payee services are provided by the Marin County Public Guardian’s Office.

Program participants and their families are provided education regarding the management of health and mental health issues, with a focus on reducing stigma, restoring hope and promoting recovery of health and functioning. Recognizing the critical role that families and other natural support systems play

in their family member's recovery, CMHS offers weekly, no-cost family support and education evening meetings to assist family members to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member. Additionally, NAMI-Marine provides "Family to Family" classes on a regular basis. STAR family members are encouraged to participate in these meetings. In 2006, the STAR Program staff will begin offering family support and education meetings on a regular basis for family members of STAR program participants in order to address those unique issues which arise as a result of involvement in the criminal justice system.

The involvement of peer case managers is also a critical aspect of the program. The presence of a peer case manager working side-by-side with a uniformed officer or mental health professional has sent a powerful message to the mentally ill population in the county. Aside from the practical result of providing an employment option for individuals with mental illness, the team's bilingual (Spanish-speaking) peer case manager serves as a powerful role model and messenger of hope and recovery. In 2006, an additional part-time peer case manager will be added to the team to provide additional supportive services, including co-facilitating a peer support group for STAR Court participants with the team's other peer case manager.

The ICM nurse practitioner furnishes medications to program participants under the supervision of the team psychiatrist. This position provides a much-needed capacity to adequately and appropriately deal with the complex physical health care needs of the participants. The mental health nurse practitioner provides medical case management and physical health care services to participants requiring those services and coordinates linkage to other community-based physical health care services.

The ICM part-time employment specialist provides situational assessments, job development and placement services for program enrollees. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation's and/or CMHS' employment programs to leverage funding for additional vocational services, including job coaching. The ICM employment specialist coordinates services with other vocational rehabilitation providers in the county.

Each local law enforcement agency has an assigned Mental Health Liaison Officer who is closely involved with the STAR Program, participating in case planning and other project meetings. Using a community-policing model, these officers are familiar with the project's participants (and their treatment plans) who reside in or frequent their jurisdictions. They are able to assist ICM team

members in locating program participants, checking in on their placements, and being a visible and supportive extension of the ICM team.

STAR Court – Marin’s mental health court provides an opportunity to coordinate cases and facilitate court outcomes that are in the best interest of the community and the program participants. With an enrollment of 20, STAR Court is a court-supervised, voluntary four-phase program that lasts at least 12 months (though it can take longer for some participants, depending on their participation and progress). In order to be referred to STAR Court, individuals must be arrested and convicted in Marin County, have a serious mental illness, choose to participate in STAR Court rather than have their cases proceed through the regular court process, and be enrolled in the STAR Program. For participants who successfully graduate from STAR Court, misdemeanor charges will be dismissed and, in the case of felony charges, the Court will give serious consideration to reducing the charges to misdemeanors, where allowed by law, and shortening or terminating probation.

The Judicial Officer is the primary spokesperson for STAR Court and the final arbitrator of any disagreement among the Court Team. He or she interacts directly with each participant to establish rapport, and uses his or her position to provide affirmation, acknowledgement of progress, and accountability.

Other members of the STAR Court Team include a part-time deputy district attorney, a part-time public defender, and the STAR Program staff. The District Attorney determines criminal justice eligibility for STAR Court. Eligible offenses include non-violent misdemeanors, non-serious and non-violent felonies, and non-violent probation violations. The Public Defender/Defense Counsel meets with potential participants, explains the STAR Court process to them, and refers appropriate individuals to the District Attorney for a determination of eligibility.

The STAR Program staff determine whether an eligible defendant meets the mental health criteria for inclusion in STAR Court and the STAR Program, and they provide treatment and supervision in the community. STAR Program staff also report compliance or the absence thereof and make treatment recommendations to the STAR Court and the rest of the STAR Court Team. The STAR Program peer case managers co-facilitate a peer support group (for the STAR Court participants) that meets after court each week.

Consistent with the goals of the MHSA, the goals of the STAR Program are to promote recovery and self-sufficiency, improve the ability to function independently in the community (including independent living and employment),

reduce incarceration, and reduce hospitalization. Program evaluation services will be provided by an independent evaluator through a CMHS contract.

CMHS has participated in numerous projects with heavy data collection and reporting requirements, such as AB2034, Mentally Ill Offender Crime Reduction Grant, and Child/Youth Interagency Enrollee-Based Program. It is anticipated that Marin will be able to quickly and efficiently implement data collection and reporting, once specific MHS reporting requirements are established.

#3 Describe any housing or employment services to be provided.

The STAR Program will continue to utilize housing and employment resources that currently exist within Marin's Adult System of Care on a case-by-case basis. Marin's Adult System of Care has developed highly successful supportive housing programs in conjunction with Buckelew Services, a local community-based organization, and with the Marin Housing Authority, through its Shelter Plus Care program. As needed, the flexible fund discussed above will be used for move-in costs and short-term rental assistance.

Drawing on lessons learned from Marin's AB2034 Program, the STAR Program has placed increasing emphasis on reducing barriers to employment and supporting clients' efforts to obtain and maintain employment. In 2004-05, the team was joined by a part-time employment specialist who provides situational assessments, job development and job placement services for program enrollees. In addition to the services provided by the team's employment specialist, STAR clients will have access to CMHS' two newly developed employment programs: a supported employment program operated by Buckelew Employment Services and a MH-DOR Employment Cooperative, operated in partnership with Buckelew Employment Services and the Department of Rehabilitation. The employment specialist assists with referrals to these and other vocational programs as needed, and coordinates services with other vocational rehabilitation providers in the county.

#4 Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

The average annual cost for each program participant is \$12,174. The majority of the staff positions are in-kind contributions made by participating agencies. When appropriate, Medi-Cal is billed for services.

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

In order to promote recovery from mental illness, the mental health system must provide an environment that respects and empowers the individuals it serves. Prevention, health-maintenance and illness self-management concepts should underlie all clinical services. Recovery occurs when people with mental illness discover their strengths and ability to define and pursue personal goals, and develop a sense of self that encompasses more than their mental illness. Recovery-oriented services focus on enhancing the capacity of each individual to reach his/her full potential and achieve successes in areas that the individual defines as important. In a recovery-oriented system of care, staff and services are facilitative rather than directive, hope inspiring rather than discouraging, and collaborative rather than autocratic. Focus is on clients' strengths rather than their deficits and pathology, and client voice and choice are what guide and inform services.

The concepts of recovery and resiliency are key elements of the STAR Program. These concepts are embedded in the program through its strengths-based focus and emphasis on enhancing those strengths and promoting self-sufficiency. Comprehensive assessments will address the strengths that clients and their families can bring to bear in addressing the challenges they face. The values of recovery will be promoted through the use of client-centered service plans which emphasize consumer voice and choice. On-going program evaluation will also be guided by these concepts, utilizing outcome measures that address self-sufficiency and quality of life, in addition to those measures more traditionally used by the public mental health system.

A key component of the STAR Program involves the use of peer service providers as team members. These staff assist the team in promoting the concepts of recovery by serving daily as role models for hope, empowerment and recovery.

The CMHS Wellness-Recovery Task Force (WRTF) will continue its efforts to advance staff's understanding of and commitment to the values of recovery and resiliency by continuing to develop training opportunities for staff, consumers and family. During 2005-06, the WRTF is sponsoring WRAP training for the Marin Network of Mental Health Clients, in order to promote the use of WRAP within the larger systems of care.

#6 If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

As described in detail above, the STAR Program is a comprehensive integrated system of care for adults who have serious mental illness and criminal justice involvement. The program combines in-custody mental health services, intensive case management services and a mental health court to assist program participants to reduce recidivism and promote recovery. County bridge funding is being used during 2005-06 in order to sustain the program until MHSA funding becomes available. Changes to the program will include the addition of a part-time peer case manager to the team in order to strengthen peer-delivered services and the provision of family psychoeducation and support meetings to better assist and support families of program participants. In addition, the program will be expanded to include 24 hours a day, 7 days a week support, a critical component of a full service partnership.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

As previously discussed, two peer service providers are members of the STAR team, one of whom is a Spanish-speaking Senior Peer Case Manager and functions as the service coordinator and single point of responsibility for several of the STAR clients. The peer service providers also co-facilitate a weekly peer support group for the STAR Court clients.

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Marin County has a strong track record of interagency and inter-jurisdictional collaboration in the pursuit of providing diverse and multi-faceted responses to the challenges surrounding the life styles and behaviors of the community's mentally ill offenders. Clearly, Marin's STAR Program itself is a prime example of the strength of these collaborations with key partners. The past work of the Marin County Criminal Justice Committee and that of the Behavioral Health Criminal Justice Committee has spurred multiple concrete efforts to address the issues which have caused many citizens to end up in the criminal justice system. The Behavioral Health Criminal Justice Committee is currently comprised of: a member of the Board of Supervisors; the criminal justice offices (Probation,

District Attorney, Public Defender, Sheriff, and the Court); the Marin County Office of Education; the Health and Human Services' Division Directors of Mental Health, Public Health, Social Services and Alcohol, Drug and Tobacco Services; private sector and private practice psychiatry representatives; staff for the in-jail substance abuse treatment program; and the San Rafael Police Department. Meeting monthly, the Committee informs policy development, conducts resource development, reviews progress of the STAR Program and other collaboratives, and fosters and supports interagency collaborative efforts.

The Committee's focus on the multiple health and social problems of local prisoners (e.g., the complexity of dual diagnosed substance use and mental health disorders) has resulted in concrete initiatives to address these issues. A primary example is the development of the Forensic Multi-Disciplinary Team (FMDT), Marin's model of restorative policing. Twenty-three community-based organizations and public agencies participate in monthly sessions to review law enforcement requests for responses to mentally ill or dually disordered individuals within their jurisdictions and to develop individualized action plans for these individuals. FMDT members discuss ways to engage these clients and track their progress, and to revise individualized plans to address new situations and needs.

The leadership and commitment of law enforcement to the issue of mentally ill offenders is a unique and prized strength in the Marin County system. Education of officers and deputies to the needs of the mentally ill has been a major emphasis of both the Sheriff's Department and local police jurisdictions. Police chiefs of every jurisdiction in the county received the manual "Model Policy: A Community Policing Response to People with Mental Illness", and sent their officers to four days of trainings. The community policing model is a key component of the incarceration prevention efforts being implemented in the County. Each jurisdiction has Mental Health Liaison Officers who are specially trained by the STAR Program staff in collaboration with NAMI-Marin to intervene more skillfully in situations involving individuals with mental illness who come in contact with law enforcement. As noted earlier, these officers often play a critical role in implementing program participants' service plans.

For over twenty-five years, the Sheriff's Department has collaborated with Community Mental Health Services (CMHS) to provide mental health services to inmates in the County Jail. As discussed earlier, the Jail Mental Health Team serves as a primary entry point into the STAR Program.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic

disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The STAR Program will serve 50 individuals. Significant effort will be made to enroll clients whose race or ethnicity is African-American or Hispanic/Latino, so that the race/ethnicity distribution of the program is representative of that of the jail population. Two of the STAR Program staff are bilingual, one of whom is also bicultural. Treatment is provided in the client's/family's preferred language. Informational brochures are provided in appropriate languages. All staff are required to attend mandatory cultural competence trainings provided by CMHS and/or the Department of Health and Human Services. Ongoing training will be provided to staff to ensure sensitivity to, and competence in, incorporating the specific cultural issues relevant to the program's clients and their communities.

In addition, CMHS has a Cultural Competence Committee which reports to the Quality Improvement Committee (QIC), which in turn is responsible for the oversight of the CMHS Cultural Competency Plan. The QIC will assist the STAR program in identifying and addressing any potential disparities, as well as ensuring that ongoing cultural competency training is available to the program.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

CMHS program staff are trained on gender differences, as well as lesbian, gay, bisexual and transgender (LGBT) issues. Assessment of client sexual orientation will be incorporated into the program's comprehensive assessment process, at intake and on an ongoing basis. The emphasis on strengths-based, client-centered services plans which are tailored to the individual needs of the client and family, requires sensitivity to, and competence in, working with these issues. Attention to gender sensitivity and the differing psychologies and needs of women and men will be considered in providing services to STAR clients. Since gender-specific groups were found to be useful in the past, they will be considered as a potential service strategy for the STAR Program in the future. Community programs which focus on addressing LGBT will be identified and made available to clients on a case-by-case basis.

Staff will receive supervision and on-going training to ensure continued sensitivity in identifying and addressing these issues.

#11 Describe how services will be used to meet the service needs for individuals residing out-of-county.

In the rare event that a program client is residing outside of the county, STAR Program staff will travel to where the client is residing to provide services, as well as maintain regular contact with any providers working with the out-of-county client. The level of service will be maintained equivalent to what it would be if the client were residing within Marin.

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of MHSA.

Not applicable.

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 State Department of Mental Health approval
- 6/06 Implementation of 24/7 coverage and other new program elements

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Marin At-Risk Seniors Team (MAST)	
Program Work Plan # FSP-04		Estimated Start Date: September 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	<p>The proposed Marin At-Risk Seniors Team (MAST) is a new full service partnership that will provide culturally competent, intensive and integrated services to 40 priority population at-risk older adults. MAST will 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 available to clients 24 hours a day, 7 days a week.</p> <p>The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.</p>		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	<p>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 disorder and/or other serious health condition.</p> <p>Transition age older adults, ages 55-59, may be included when appropriate.</p>		
Describe strategies to be used, Funding Types requested, Age Groups to be served		Fund Type	Age Group
Integrated service team and planning with social service agencies and other community providers to meet the complex needs of older adults and provide and/or broker all services that a client needs.		FSP	Older Adult
Intensive community services and supports team capable of providing services to clients where they live, 24 hours a day, 7 days a week. The team includes peers or family members as team members.			

<p>Outreach to older adults who are homeless or in their homes, through community service providers and through other community sites that are the natural gathering places for older adults.</p>		
<p>Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities or other factors.</p>		
<p>Education for the client and family, or other caregivers as appropriate, regarding the nature of medications, the expected benefits and the potential side effects.</p>		
<p>Peer counseling program to provide support and increase client/member knowledge and ability to use needed mental health services.</p>		

Marin At-Risk Seniors Team (MAST)

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Marin County does not currently operate a comprehensive integrated system of care for older adults who have serious mental illness. Due to limited resources and service capacity, the existing Older Adult Services program operated by CMHS has been unable to provide much more than assessment and peer support services. In fact, of all the age groups served by CMHS, older adults have received the least services and have the lowest penetration rates, despite the fact that they constitute the fastest growing age cohort in Marin.

The overarching goal of Marin's proposed system of care for older adults is "*Aging with dignity, with self-sufficiency, and in the life style of choice.*" To achieve this goal the proposed Marin At-Risk Seniors Team (MAST) Program is a full service partnership designed to do "whatever it takes" to assist 40 older adults who have serious mental illness. Each individual identified as part of the initial full service population will be offered a partnership with MAST and will develop an individualized services and support plan.

MAST will be a multi-agency team, staffed by the County Divisions of Community Mental Health Services (CMHS), Social Services, Aging, and Public Health Services. Staff from CMHS' current Older Adult Services, including its highly successful Senior Peer Counseling Program, will be integrated into the team. The team will include a program supervisor, a psychiatrist specializing in gerontology, a mental health nurse practitioner, a mental health nurse, a public health nurse, an Adult Protective Services worker, mental health clinicians and senior peer counselors. Support staff will include an accounting assistant to assist with clients' benefits and budgeting, and an administrative clerk. All staff will be culturally competent and familiar with community resources within clients' cultural, racial, or ethnic communities. Staff will reflect the diversity of Marin County.

Because of the stigma associated with mental health issues for older adults in general, mental health issues often reach crisis proportions and require emergency medical and psychiatric care before they seek help. Outreach services will be critical for engaging these individuals before they experience such crises. Outreach, engagement, and support services will be provided by the Senior Peer Counseling Program, staffed by older adult volunteers and the

County mental health staff who support and supervise that program. The current senior peer counselors will continue to operate in west and central Marin. Once integrated with MAST, the Senior Peer Counseling Program will be increased by 25-30 senior peer counselors, enabling outreach and support efforts to expand in two currently underserved areas: North and South Marin. Funds will be budgeted to enable senior peer counselors to attend an annual, statewide Senior Peer Counseling conference and to host biannual recognition events.

MAST staff will conduct multi-disciplinary and comprehensive assessments that include the components of mental health, physical health, substance use/abuse, social and cultural issues, family/support system, and trauma. If available, the client's primary care physician will be contacted for input and involvement in the service plan as well. Whenever possible, efforts will be made to engage families in the program, beginning with the assessment process. Clients and their families will be given sufficient information to enable them to make informed decisions regarding services. Each fully served individual will have an assigned MAST service coordinator who will serve as that client's single point of responsibility to assist in developing an individualized service plan that reflects the client's (and family's) needs and choices, and to ensure access to and coordination of services.

For many older adults who are frail or have limited mobility, it is important that mental health services are delivered in their home and communities. The majority of services provided by MAST will be community-based and often provided in clients' homes. Services will include 24 hours a day, 7 days a week support. The team will provide service coordination, crisis management, medication management, therapy services, peer counseling and support, psychoeducation, transportation, and extensive linkage to other necessary services and community supports. As treatment for co-occurring substance abuse disorders is essential to successful recovery, it will be provided on an individualized/as needed basis. Staff will receive extensive training in substance use/abuse assessment, motivational interviewing and relapse intervention/prevention. Clients and families will receive education regarding the management of health, mental health and aging issues, with a focus on reducing stigma, restoring hope and promoting recovery of health and functioning. A flexible fund will be established to purchase needed goods and services (including emergency shelter, transportation, medications, etc.).

The nurse practitioner will furnish medications to clients under the supervision of the psychiatrist; providing a much-needed service to adequately and appropriately deal with the complex physical health care needs of this aging population. The mental health nurse practitioner will provide medical case management and physical health care services to clients requiring those services, and coordinate linkage to other physical health care services. In

addition to functioning as the primary service coordinator for several clients, the public health nurse will provide medication education services and set up and/or administer medications for those clients who require that level of assistance.

Consistent with the goals of the MHSA, MAST's goals are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization. Program evaluation services will be provided by an independent evaluator through a CMHS contract.

CMHS has successfully participated in numerous projects with heavy data collection and reporting requirements, such as AB2034, Mentally Ill Offender Crime Reduction Grant, and Child/Youth Interagency Enrollee-Based Program; therefore, it is anticipated that Marin will be able to quickly and efficiently implement data collection and reporting once specific MHSA reporting requirements are established.

#3 Describe any housing or employment services to be provided.

Marin's Older Adult System of Care is not large enough to support separate housing and employment programs for MAST clients. As the majority of older adults served by the MAST Program will already have housing, the program's emphasis will be on assisting them to maintain their current living situation. For those who do need assistance, Marin's Adult System of Care staff who are familiar with housing and employment resources for Marin seniors will provide access to these resources for MAST clients. Additionally, CMHS has a close working relationship with the county Ombudsman's office. The ASOC has developed highly successful supportive housing programs serving both adults and older adults in conjunction with Buckelew Programs, a local community-based organization and, for individuals who are homeless, with the Marin Housing Authority through its Shelter Plus Care program. As needed, the flexible fund discussed above will be used for move-in costs and short-term rental assistance.

Engagement in meaningful daily activities is a key element of recovery, but can be challenging for older adults, especially those experiencing depression, frailty and/or reduced mobility. A key issue in developing individualized services and supports plans will involve assisting clients to identify their interests and wishes with regards to meaningful use of leisure time. Clients who express an interest in volunteer work or paid employment will be assisted to address barriers to achieving these goals and will be linked by the team to the appropriate programs offering these opportunities.

#4 Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

The average annual cost for each program participant is \$ 10,000. An undetermined number of the staff positions will be in-kind contributions made by participating agencies. When appropriate, Medi-Cal and Medicare will be billed for services.

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Mental illness has a significant impact on the health, functioning and well-being of Marin's senior citizens. In order to promote recovery from mental illness and assist older adults to maintain and/or return to their lifestyle of choice, the mental health system must provide an environment that respects and empowers the individuals it serves. Prevention, health-maintenance and illness self-management concepts should underlie all clinical services. Recovery occurs when people with mental illness discover their strengths and ability to define and pursue personal goals, regardless of their age or health status. Recovery-oriented services focus on enhancing the capacity of each individual to reach his/her full potential and achieve successes in areas that the individual defines as important. In a recovery-oriented system of care, staff and services are facilitative rather than directive, hope-inspiring rather than discouraging, and collaborative rather than autocratic. Focus is on clients' strengths rather than their deficits and pathology, and client voice and choice are what guide and inform services.

The concepts of wellness and recovery are key elements of the MAST full-service partnership. These concepts will be embedded in the program through its strengths-based focus, emphasis on enhancing those strengths and of promoting self-sufficiency. New staff recruited for MAST will be selected based on their understanding of and commitment to the concepts of wellness and recovery. Comprehensive assessments will address the strengths that clients and their families can bring to bear in addressing the challenges they face. The values of recovery will be promoted through the use of client-centered service plans which emphasize consumer voice and choice. On-going program evaluation will also be guided by these concepts, utilizing outcome measures that address self-sufficiency and quality of life, in addition to those measures more traditionally used by the public mental health system.

An effective support system is necessary for recovery. Family members and caregivers will be educated regarding mental illness, its manifestation in older adults and ways in which they can contribute to the older adult's wellness and recovery. Family members will be linked with family support and self-help services provided by NAMI-Marin and CMHS.

A key component of MAST involves the use of senior peer counselors to provide on-going support to clients, in addition to outreach and engagement services. These staff will assist the team in promoting the concepts of recovery by serving daily as role models for hope, empowerment and self-sufficiency.

#6 If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Not applicable

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

As discussed previously, the senior peer counselors are trained volunteers who function as members of MAST and are responsible for the program's outreach, engagement and support services. CMHS staff assigned to MAST will be responsible for the recruitment, training, supervision, support and retention of these volunteers.

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Marin has long been characterized by strong private - public partnerships in every service area. Further, the structural alliance of Aging Services, Alcohol, Drug and Tobacco Services, Community Mental Health Services, Public Health Services and Social Services, within the Department of Health and Human Services (HHS) facilitates service integration. Under the leadership of the HHS Director, commitments are being made to bring additional department resources into the MAST program, as well as to co-locate current staff and services in order

to better serve the older adult population. These factors, combined with the fact that key stakeholders have consistently agreed that Marin needs to more comprehensively address the needs of older adults who have serious mental illness, indicate that CMHS is strategically positioned to move forward with the development of this full-service partnership. The MAST Program will truly be a jointly operated, comprehensive collaborative of services and supports.

The county currently has a number of effective collaboratives directed toward improving services and outcomes for its residents that bring policy makers, providers, consumers and families together on a regular basis, including the CMHS Older Adult Advisory Committee. an ad hoc HHS committee that meets on an as-needed basis to address client-specific issues. This committee is convened whenever one or more of the divisions requires assistance in serving an older adult whose service and support needs are greater than the program's capacity. Through such joint problem-solving and planning efforts, services are coordinated and new resources leveraged with maximum benefit to clients.

As the MAST Program is implemented and needs/challenges are identified, opportunities to develop additional collaboratives will emerge. In order to provide clients with the array of services and supports necessary to achieve their desired goals, MAST will need to promote the integration of services that comes from both formal and informal collaboration. The participation of stakeholders at all levels will aid in ensuring that the program is flexible and responsive. Close coordination across the many partners serving older adults who have mental illness will increase access, reduce duplication, and improve client outcomes.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The MAST Program will serve 40 individuals. Significant effort will be made to outreach to and enroll older adults from Hispanic/Latino, African-American, and Asian communities, so that the race/ethnicity distribution of the program is representative of that of Marin's at-risk older adult population. Program staff will be hired who are bilingual and/or bicultural. It will also be essential that MAST staff are specifically educated and experienced in working with older adults to ensure that appropriate and effective services are provided.

Treatment will be provided in the clients'/family's preferred language. Informational brochures will be provided in appropriate languages. All staff will

be required to attend mandatory cultural competence trainings provided by CMHS and/or the Department of Health and Human Services. Ongoing training will be provided to staff to ensure sensitivity to, and competence in, incorporating the specific cultural issues relevant to the program's clients and their communities.

In addition, CMHS has a Cultural Competence Committee which reports to the Quality Improvement Committee (QIC), which in turn is responsible for the oversight of the CMHS Cultural Competency Plan. The QIC will assist MAST in identifying and addressing any potential disparities, as well as ensuring that ongoing cultural competency training is available to the program.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

MAST staff will be experienced in older adult issues and will be familiar with the various generational concerns that arise within the older adult population, as well as gender specific values and behaviors. All staff will be trained on gender differences, as well as lesbian, gay, bisexual and transgender (LGBT) issues. Assessment of client sexual orientation will be incorporated into the program's comprehensive assessment process at intake and on an ongoing basis. The emphasis on strengths-based, client-centered service plans which are tailored to the individual needs of the client and family will require sensitivity to, and competence in, working with these issues. Attention to gender sensitivity and the differing psychologies and needs of older women and men will be considered in providing services to MAST clients. Since gender-specific groups have been found to be useful in other CMHS programs, they will be considered as a potential service strategy for the MAST Program. Community programs which focus on addressing LGBT will be identified and made available to clients on a case-by-case basis.

Staff will receive supervision and on-going training to ensure continued sensitivity in identifying and addressing these issues.

#11 Describe how services will be used to meet the service needs for individuals residing out-of-county.

In the rare event that a program client is residing outside of the county, MAST Program staff will travel to where the client is residing to provide services, as well as maintain regular contact with any providers working with the out-of-county

client. The level of service will be maintained equivalent to what it would be if the client were residing within Marin.

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable.

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 State Department of Mental Health approval
- 3/06–8/06 Recruit, hire and train program staff
- 9/06-11/06 Recruit and train senior peer counselors
- 9/06 Program services begin operation
- 1/07 Full enrollment achieved

General System Development / Outreach and Engagement Strategies

Key Terms used in the Proposal:

General System Development Funds are used to improve programs, services and supports for the identified initial full-service populations and for other clients consistent with the populations described in Part II of this proposal.

Outreach and Engagement Funds support special activities needed to reach unserved populations and may be one component of an overall approach to reduce ethnic disparities.

Defining “Wellness Recovery Action Plans” (WRAP)

Wellness Recovery Action Plans are authorized by consumers to draw on their strengths, advance Wellness, prevent escalation of symptoms and promote successful recovery from crisis situations. Consumers work in collaboration with trusted peers to create and use their unique WRAPs.

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Enterprise Resource Center Expansion	
Program Work Plan #: SDOE-01		Estimated Start Date: August 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	Goals of the MHSAs include meaningful use of time, including such things as employment, vocational training, advocacy for clients, peer education, social and community activities. Other goals include a network of social relationships, timely access to needed help in a crisis, and a reduction of involuntary services. An expanded client-operated Enterprise Resource Center enhances all these goals for mental health clients. The center is wellness and recovery focused, stressing self-help and peer support. Clients working to assist other clients create role models and a circle of hope is formed that further promotes recovery and wellness.		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	The Enterprise Resource Center will target populations and focus resources on the groups of client consumers and family members who are currently disenfranchised or reluctant to seek help. Efforts will focus on reaching out to the cultural and ethnic populations (Hispanic/Latino, Native American, Asian/Pacific Islander and African American) where disparities exist.		
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply) Self-help and client-run programs, including drop-in center, anti-stigma campaigns, advocacy programs and peer education. Meaningful use of time, including such things as employment, vocational training, social and community activities. Wellness and recovery focused, stressing self-help and peer support		Fund Type	Age Group
		OE	TAY/Adult/Older Adult

Enterprise Resource Center Expansion

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Goals of the MHSA include meaningful use of time, including such things as employment, vocational training, advocacy for clients, peer education, social, and community activities. Other goals include a network of social relationships, timely access to needed help in a crisis, and a reduction of involuntary services. An expanded client-operated Enterprise Resource Center enhances all of these goals for mental health clients in Marin County. The center is wellness and recovery focused, stressing self-help and peer support. Clients working to assist other clients create role models and a circle of hope is formed that further promotes recovery and wellness. Plans are underway to train clients to develop Wellness Recovery Action Plans (WRAP) and then to assist other clients in making their own plans. We estimate that the Enterprise Resource Center will serve an additional 20 to 30 consumers per month.

The client-operated Enterprise Resource Center, now located in a second floor walk-up apartment in central San Rafael, has been a victim of its own success. With over 600 client visitors per month, the multi-purpose drop-in center, now open six days a week, has outgrown its facility. The peer counselors on the warm-line answer nearly 600 calls per month. The program needs more space and increased staffing to manage its expanding operations.

The goals and outcomes of this service will be:

- De-stigmatize the need for mental health services
- Optimize outreach and engagement possibilities
- De-mystify the mental health system
- Increased employment opportunities for consumers
- Promote Wellness/Recovery/Resiliency concepts
- Promote client consumer and family empowerment
- Promote prevention concepts
- Provide positive recreation and social activities for mental health clients
- Provide low-barrier access which welcomes the unserved
- Increased capacity for consumer and family-run services

#3 Describe any housing or employment services to be provided.

The Enterprise Resource Center will provide information and referral to housing and employment services, which will be located in the same building to improve clients' access to these services. This will be part of the array of services available at the new Wellness Center. Mental health clients are employed to manage and operate the Enterprise Resource Center.

#4 Please provide the average cost for each Full Service Partnership participant including all funding types and fund sources for each Full Service Partnership proposed program.

Not applicable.

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

By enlarging and co-locating the client-operated Enterprise Resource Center with housing, employment and clinical services, collaborative opportunities will increase. Access to the services will improve by making connections less difficult and formal and more seamless. Both consumer and professional mental health staff will be trained in the concepts of wellness, recovery and resiliency. The center will promote a strengths-based, harm-reduction approach and will work to engage clients and their families in the recovery process. Dual Recovery Anonymous meetings can be expanded to meet the needs of more clients with dual diagnoses. This offers clients of all ages a one-stop central location to access and receive services such as socialization groups, peer counseling, mentoring, psycho-educational activities, and support groups. By offering a dedicated location that is conducive to understanding different levels of mental illness or drug/alcohol dependency, the problems of stigma, isolation, and embarrassment are addressed. Respecting clients to make their own decisions and to operate their own program fosters recovery.

#6 If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

The current client-operated drop in center is too small and on a second floor with no elevator. This expansion will enlarge the program space by adding 1000 square feet and make it more accessible to all clients, including those with mobility issues. Also the current client-operated program is in need of additional administrative capacity; as the program has grown, its management capacity has not been increased. Two administrative positions open to mental health consumers will be added to better manage the services clients provide for other clients.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The Enterprise Resource Center will be managed and staffed entirely by mental health clients, including two additional management positions.

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Depending on the needs and goals of the clients, the Enterprise Resource Center will be an access point for programs and activities such as benefits eligibility, employment activities, support groups, Dual Recovery Anonymous meetings, health screenings, prevention activities, socialization, medication support, housing programs, and case management services. All collaborative strategies will be tailored to the needs of the consumer and his or her family to better ensure recovery. Currently peer providers are part of three different multi disciplinary teams serving the mental health needs of seriously mentally ill adults. Collaboration between the client staffed Care Team and local law enforcement has enabled an improved response to mentally ill clients in crisis on the streets. Another successful collaboration involves the client operated Linda Reed Socialization Group and Buckelew Vocational Services. Clients who do not have an interest in seeking competitive employment can still participate in the socialization groups for constructive daily activities.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The Enterprise Resource Center will target populations and focus resources on the groups of client consumers and family members who are currently disenfranchised or reluctant to seek help. Efforts will focus on reaching out to the cultural and ethnic populations (Hispanic/Latinos, Native Americans, Asian/Pacific Islander, and African American) where disparities exist.

Efforts are being made to locate the Wellness/Recovery Center, of which the Enterprise Resource Center is a key part, in a geographic area of the county that is largely Hispanic and Asian American and underserved. Bilingual Spanish-

speaking positions are designated. A part-time Vietnamese speaking case management position is being added to improve outreach to Vietnamese-speaking clients.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Expertise in gender, age, and sexual orientation issues is crucial to the delivery of culturally inclusive services and supports. The Cultural Competence Committee will assess needs and competencies in this area and develop appropriate basic and ongoing trainings for staff, community partners, and other stakeholders. Peer-led groups will be available to discuss gender-specific issues in recovery.

#11 Describe how services will be used to meet the service needs for individuals residing out of county.

The Enterprise Resource Center will be a resource for information, referral, and support activities for those returning to the County from mental health institutions and out-of-county placements and their families. Individuals residing out-of-county can access the telephone warm-line.

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable.

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 Send plan to State Department of Mental Health for approval
- 7/06 Contract negotiated and approved
- 8/06 Expanded services begin

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Vietnamese Language Capacity Expansion	
Program Work Plan #: SDOE-02		Estimated Start Date: August 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	Increasing a part-time Bilingual Vietnamese speaking Social Service Worker II to full-time will improve access for this underserved population.		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	Vietnamese population in Marin County are currently under/unserved in Marin County and because of cultural issues, do not seek mental health services. These individuals will be ages 18 to 60+ who are severely mentally ill, have co-occurring substance abuse disorders and/or health conditions, or are homeless or at risk of homelessness.		
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)		Fund Type	Age Group
		OE	TAY/Adult/Older Adult
Mental health outreach and engagement provided for the Vietnamese population who may be more responsive to a culturally similar individual. The position also serves to translate language and cultural issues to ensure that staff psychiatrists can accurately provide medication support.			

Vietnamese Language Capability Expansion

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

In fiscal year 2004-2005 Marin County Community Mental Health Services provided services to 46 individuals of Vietnamese origin. That number represented 1.2% of CMHS clients. The year before, there were 42 Vietnamese clients served. Some are mono-lingual Vietnamese speakers.

Increasing a part-time Bilingual Vietnamese speaking Social Service Worker II to full-time will improve access for this underserved population. We estimate the Social Service Worker's caseload can be increased by 10 consumers.

The goals and outcomes of this service will be:

- De-stigmatize the need for mental health services in the Vietnamese community in Marin County
- De-mystify the mental health system for them
- Promote Wellness/Recovery/Resiliency concepts
- Promote client consumer and family empowerment
- Provide low-barrier access which welcomes the unserved clients of Vietnamese origin
- Improve quality of and access to medication support by translating for clients and psychiatrists

#3 Describe any housing or employment services to be provided.

Not applicable

#4 Please provide the average cost for each Full Service Partnership participant including all funding types and fund sources for each Full Service Partnership proposed program.

Not applicable

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

In order to promote recovery the public mental health system must first make services available in a linguistically and culturally appropriate manner. Only by having staff available who can communicate with clients in their own language can the values of recovery and resiliency be promoted.

#6 If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Currently the Adult Case Management Team of Community Mental Health Services employs a .75 full time equivalent Vietnamese-speaking Social Service Worker II. This expansion would increase that to a full-time position.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Not applicable

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The collaboration strategies are between the Vietnamese-speaking community and with organizations representing that population. The Asian Advocacy Program of Community Action Marin has been active in advocating for improved access for Marin County's Southeast Asian population. In the 2000 census, Marin County reported 1,257 Vietnamese, along with 366 other Southeast Asians, 1,389 Filipinos, and 8,191 who identified as Asian. The Bilingual Social Service Worker is both an outreach worker and a case manager. This position also serves to translate language and cultural issues to ensure that staff psychiatrists can accurately provide medication support to Vietnamese clients.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

See the answer to number 8.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Staff is trained on gender differences, as well as lesbian, gay, bisexual, and transgender (LGBT) issues. The emphasis on the strengths-based, client-centered approach means services are tailored to the individual needs of the client and family. Expertise in gender, age and sexual orientation issues is crucial to the delivery of culturally inclusive services and supports. The Cultural Competence Committee will assess needs and competencies in this area and develop appropriate basic and ongoing trainings for staff, community partners and other stakeholders. Community programs that focus on the needs of LGBT clients will be identified and made available to clients on a case-by-case basis.

#11 Describe how services will be used to meet the service needs for individuals residing out-of-county.

Individuals residing out-of-county can access the Bilingual Social Service Worker by telephone.

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 Send plan to State Department of Mental Health
- 7/06 Hire and train staff
- 8/06 Enrollment begins

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Supportive Housing Expansion	
Program Work Plan #: SDOE-03		Estimated Start Date: September 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	This proposal supports the primary goals of the MHSAs including safe and adequate housing, a network of supportive relationships, a reduction in institutionalization and out-of-home placements. Supportive housing is a successful, cost-effective combination of affordable housing and services that help mental health consumers live more stable, productive lives.		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	This program will serve mental health consumers 18 to 60+ who have serious mental illness. These individuals may also have co-occurring substance abuse disorders and who are living in either skilled nursing facilities or institutes for mental disease longer than necessary due to the lack of appropriate supportive housing capacity in Marin County.		
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply) This program will add three beds to the current capacity of supportive housing options.		Fund Type	Age Group
		Sys Dev	TAY/Adult/Older Adult

Supportive Housing Expansion

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The overarching vision of Marin's system of care for adults who have serious mental illness is "A Home, Family & Friends, A Job, Safe & Healthy." In 2003, Marin's Adult System of Care (ASOC) adopted the following guiding principles for its housing services:

Housing is a basic right of all people, regardless of disability. In keeping with the Recovery Model, the Marin County CMHS Adult System of Care (ASOC) recognizes the right of people with severe mental illness (SMI) to live in the community and participate in lifestyles of their choice. The ASOC is committed to providing target- population mental health consumers with assistance in obtaining and maintaining safe, decent and affordable housing in community settings.

Individuals with severe psychiatric disabilities are capable of obtaining and maintaining community-based housing when provided with the opportunity in combination with necessary supports and services. These supports and services must be focused on helping them to retain their housing, improve their health status and maximize their ability to live and work in their communities.

The Marin ASOC should promote and support the development of affordable, permanent housing for adults with SMI. The ASOC should provide a range of different housing alternatives, with an emphasis being placed on consumer choice and supportive housing. Supervised community residential housing with 24-hour care and variable lengths of stay should be provided as a substitute for long-term inpatient/skilled nursing facility care. Supportive housing options are especially critical for those consumers who have had difficulty maintaining appropriate, independent living situations. Supportive housing should incorporate the following critical elements: 1) the use of generic housing dispersed widely in the community, 2) assistance in locating and maintaining housing, and 3) the provision of flexible, individualized supports which vary in intensity.

The primary goal of the Adult System of Care's (ASOC) existing supportive housing program is to promote independent living and well-being. The proposed General System Development program will increase the number of individuals served in the ASOC's supportive housing program from 45 to 48 and will assist those additional clients to achieve this goal. This will enable Marin to continue its efforts to reduce the number of adults currently residing inappropriately in locked or other restrictive levels of care. At any given time, 5-10 clients reside in locked facilities because

there are no beds available for them at lower levels of care, and an additional 10-15 clients who are residing in board and care settings could be more appropriately served in supportive housing.

Marin's experience with its existing supportive housing program has clearly demonstrated that individuals who have SMI can successfully live in the community when their housing is combined with flexible supportive services that enable them to access and maintain housing. The ASOC has a well-established history of providing supportive housing services through a contract with Buckelew Programs. Buckelew operates the Marin Assisted Independent Living program (MAIL) which assists clients to secure and maintain permanent rental housing in the community. The MAIL program staff are community-based case managers who provide a range of supportive mental health services to assist clients to develop individualized independent living plans based on clients' needs and choices, and to assure access to needed services and supports. Buckelew staff are culturally competent and familiar with community resources within clients' cultural, racial, or ethnic communities. Staff reflect the diversity of Marin County.

Services provided by MAIL are community-based and often provided in clients' homes. Services include 24 hours a day, 7 days a week support. Whenever possible, efforts are made to engage families in the program, beginning at admission to the program. The team provides service coordination, crisis management, supportive counseling, independent living skills training, psychoeducation, and extensive linkage to other necessary services and community supports, including primary care and psychiatric medication services. Treatment for co-occurring substance abuse disorders is essential to successful community tenure and is provided on a case-by-case basis. MAIL staff receive extensive training in substance use/abuse assessment, motivational interviewing and relapse intervention/prevention.

A mental health nurse practitioner provided by CMHS furnishes medications to MAIL clients under the supervision of a CMHS psychiatrist, unless clients choose to be followed by a non-CMHS psychiatrist. The mental health nurse practitioner also provides medical case management and basic physical health care services, including screening, to MAIL clients requiring those services, and coordinates linkage to other physical health care services. The 3 new clients served through this program expansion will have access to these mental health nurse practitioner services.

Consistent with the goals of the MHSA, the goals of the supportive housing expansion are to promote recovery and self-sufficiency, maintain independent functioning, and reduce/avoid hospitalization and institutionalization. Program evaluation services will be provided by the CMHS independent evaluator.

CMHS has successfully participated in numerous projects with heavy data collection and reporting requirements such as AB2034, Mentally Ill Offender Crime Reduction Grant, and Child/Youth Interagency Enrollee-Based Program. It is anticipated that Marin will be able to quickly and efficiently implement data collection and reporting once specific MHSA reporting requirements are established.

#3 Describe any housing or employment services to be provided.

As described above, this program's main purpose is to provide supportive housing services. Because Marin recognizes that successful independent living and recovery include meaningful use of an individual's time and capabilities, the program will be closely linked to employment services. Buckelew Programs, the contractor that operates the supportive housing program, also provides CMHS with system-wide employment services. MAIL staff will work with clients on identifying employment goals and eliminating barriers to employment, and will provide linkages to employment resources in the community, including those provided by Buckelew Vocational Services.

#4 Please provide the average cost for each Full Service Partnership participant including all funding types and fund sources for each Full Service Partnership proposed program.

Not applicable

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Recovery refers to the process whereby individuals who have serious mental illness are able to live, work, learn, and participate fully in their communities. Recovery occurs when people with mental illness discover their strengths and ability to define and pursue personal goals, and develop a sense of self that is more than their mental illness. Recovery-oriented services focus on enhancing the capacity of each individual to reach his/her full potential and achieve successes in areas that the individual defines as important. In a recovery-oriented system of care, staff and services are facilitative rather than directive, hope-inspiring rather than discouraging, and collaborative rather than autocratic. Focus is on clients' strengths rather than their deficits and pathology, and client voice and choice are what guide and inform services.

Having a place to call home is key to recovery from mental illness. Services provided by MAIL, Marin's supportive housing program, are designed to help clients obtain and maintain housing in the community, build independent living skills, and move toward independence and recovery. The values of recovery will be further promoted through the use of client-centered independent living plans which emphasize consumer voice and choice. On-going program evaluation will also be guided by these concepts, utilizing outcome measures that address self-sufficiency and quality of life, in addition to those measures more traditionally used by the public mental health system.

#6 *If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.*

As described in detail above, Buckelew Programs, under contract with CMHS, operates the MAIL Program, which provides supportive housing services to adults with serious mental illness. MAIL staff provide targeted case management services to assist clients to obtain and maintain housing in the community. Due to limited resources and service capacity, the existing program is unable to provide supportive housing services to all referrals it receives. The proposed expansion to the program will enable it to serve an additional 3 individuals who are currently inappropriately served at a more restrictive level of care.

#7 *Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.*

Buckelew Programs, the contract provider operating the MAIL Program, has a strong history of employing consumers as service providers and will continue this practice in implementing the MHSA. Currently, approximately 32% of the MAIL program staff are in recovery. Recovering consumers employed by the MAIL Program will provide many of the same case management services as other MAIL staff, including evaluation, plan development, support, independent living skills training, linkage and referral services, and transportation.

#8 *Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.*

Marin's system of care for adults has long been characterized by strong private – public partnerships in all services areas, especially housing and supportive

housing. The ASOC has experienced remarkable success in securing community-based housing for its adult clients who have serious mental illness, despite the significant challenges posed by Marin's housing market. Marin's highly successful Shelter Plus Care Program - operated by the Marin Housing Authority in partnership with a coalition of housing, mental health, drug and alcohol and AIDS service providers, and advocates - has been in operation since 1995 and currently successfully houses 135 clients. During the past 10-15 years, collaborative efforts led by Buckelew Programs have secured HUD funding for several supportive housing units. Marin's AB2034 Program, a collaborative with CMHS, Buckelew Programs, Marin Housing Authority's Shelter Plus Care Program and Community Action Marin's Peer Mental Health Program, has successfully housed over 90% of its program members, all of whom were homeless when first enrolled in the program.

In 2003, a collaborative workgroup was convened by the Mental Health Director to conduct a systematic analysis of CMHS-funded housing services to help inform future planning and program development efforts, and make recommendations regarding the types and amounts of community-based housing services that the ASOC should be providing its clientele. Participants in this workgroup included mental health and housing provider staff, consumers and family members. Through the efforts of this workgroup, CMHS was able to reallocate sufficient resources to create an additional 11 supportive housing slots. CMHS adopted the guiding principles developed by the workgroup and implemented many of its other recommendations, one of which was to convene a Placement Committee to meet on a regular basis to review referrals and recommend placements. This multi-agency committee meets weekly and regularly reviews clients in 24-hour treatment settings in order to proactively identify those ready to move to more independent levels of care and identify system-of-care gaps. In Spring 2006, the original workgroup will be re-convened to review progress and develop further recommendations.

Despite these remarkable successes, Marin continues to have a critical shortage of affordable housing and recognizes that continued creative effort and advocacy needs to be focused on securing housing. Key stakeholders in the MHSA adult workgroup identified decent, affordable housing for all clients as the top priority for MHSA funding in the ASOC.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The MAIL Program uses a comprehensive individualized approach to providing supportive housing services to clients which takes into account each individual's and family's history, strengths, and values, with special attention to issues of culture and spirituality. Treatment will be provided in the clients'/family's preferred language. Informational brochures will be provided in appropriate languages. Ongoing training will be provided to staff to ensure sensitivity to, and competence in, incorporating the specific cultural issues relevant to the program's clients and their communities.

In addition, CMHS has a Cultural Competence Committee which reports to the Quality Improvement Committee (QIC), which in turn is responsible for the oversight of the CMHS Cultural Competency Plan. As a contractor of CMHS, Buckelew also is required to have a Cultural Competency Plan which complies with the CMHS plan requirements. The QIC will assist Buckelew in identifying and addressing any potential disparities, as well as ensuring that ongoing cultural competency training is available to the program.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

All staff will be trained on gender differences, as well as lesbian, gay, bisexual and transgender (LGBT) issues. Assessment of client sexual orientation will be incorporated into the program's comprehensive evaluation process at intake and on an ongoing basis. The emphasis on strengths-based, client-centered independent living plans which are tailored to the individual needs of the client and family will require sensitivity to, and competence in, working with these issues. Attention to gender sensitivity and the differing psychologies and needs of women and men will be considered in providing services to MAIL clients. Community programs which focus on addressing LGBT will be identified and made available to clients on a case-by-case basis.

Staff will receive supervision and on-going training to ensure continued sensitivity in identifying and addressing these issues.

#11 Describe how services will be used to meet the service needs for individuals residing out-of-county.

In the rare event that a program client is residing outside of the county, MAIL Program staff will travel to where the client is residing to conduct intake evaluations and provide services, as well as maintain regular contact with any providers working with the out-of-county client. The level of service will be maintained equivalent to what it would be if the client were residing within Marin.

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 State Department of Mental Health approval
- 4/06-6/06 Contract negotiation and approval
- 7/06 Program services begin operation
- 10/06 Program fully enrolled and new clients housed

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Service Site in Southern Marin	
Program Work Plan #: SDOE-04		Estimated Start Date: September 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	Improving access to the underserved and unserved in the southern part of Marin County has been high on the list of priorities to close the geographic disparity in the County. Therefore a community-based group will create a culturally competent mental health service site in southern Marin County that will improve access to services for seriously emotionally disturbed children and seriously mentally ill adults and older adults residing in that part of the County.		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	Children, adults and older adults with serious emotional disturbance / serious mental illness, with special attention paid to providing services to ethnic minorities in that area of the County.		
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)		Fund Type	Age Group
		OE	Children/TAY/Adult/Older Adult
		Provide early intervention for children and adults with serious mental illness in a culturally competent environment.	
		Promote Wellness/Recovery/Resiliency concepts by providing services close to home and with family and community involvement.	
		Develop community-based services and supports including culturally competent outreach and community education strategies.	
		Promote client and family empowerment by partnering with clients in their community to build on strengths already existing in the community.	

Service Site in Southern Marin County

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

In preparation for MHSA, dozens of focus groups were conducted around Marin County. Services in Southern Marin and Marin City were frequently mentioned as a gap in the current mental health service system. Responses like these were typical:

- Provide mental health services for Marin City
- There's a lack of any services in Marin City
- Clients want providers who are from the community and who are sensitive to our cultural reality
- Embed mental health services where there are other things going on
- We can't get to San Rafael for services
- Provide mental health services in more diverse locations that are more accessible to clients
- Develop satellite medication clinics with shorter medication follow-up appointments
- Reach clients where they are, rather than expecting them to access services and navigate a complex system
- There's an inadequate capacity to serve minority populations outside of central Marin
- Recognize significant obstacles such as stigma and lack of education in some ethnic low income populations

In a focus group conducted in Marin City on March 5, 2005, there was a strong consensus regarding a variety of issues, including: 1) the need for committed, full-time, long-term, culturally competent providers who offer services from within community organizations; 2) the presence of significant distrust and suspiciousness regarding county-provided services, given that for many Marin City residents, interaction with official Marin County agencies is experienced as more negative or punitive than helpful; 3) the need for creative approaches to the recruitment and training of community-based mental health providers; 4) the need to reduce structural obstacles that discourage and prevent residents from seeking help (geography, perception of costs, lack of services) in order to begin to address other community and personal barriers; and 5) the importance of addressing and treating dually diagnosed clients.

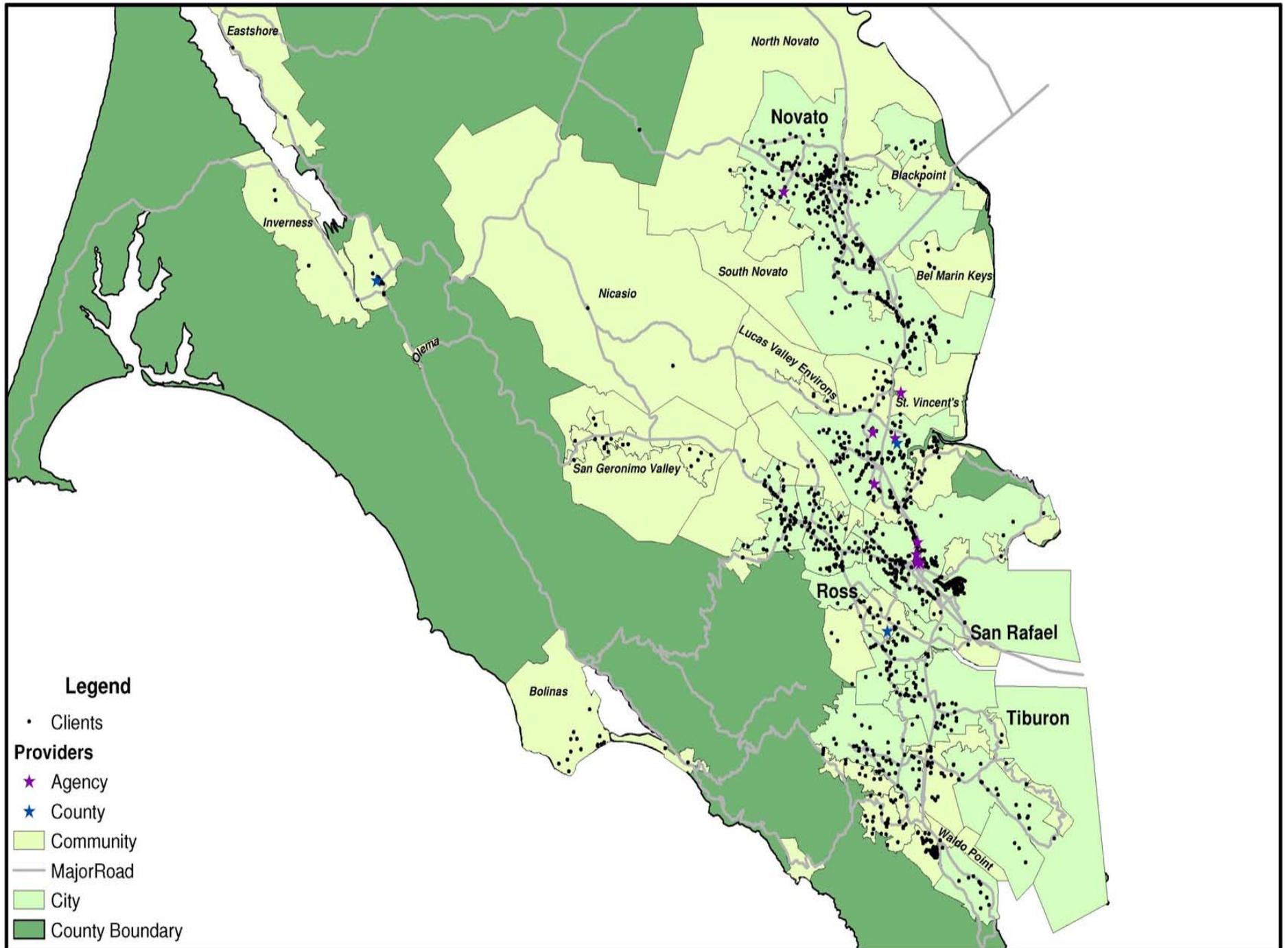
Fragmentation and gaps in care for children and adults with serious mental illnesses were identified in the President's New Freedom Commission on

Mental Health as leading to unnecessary and costly disability, homelessness, school failure and incarceration. In the countywide surveys conducted for the MHSA planning process, many respondents cited the difficulty and confusion in accessing mental health services. Improving access to the underserved and unserved in the southern part of Marin County has been high on the list of priorities to close this geographic disparity in the county. Therefore a culturally competent mental health service site in southern Marin County will improve access to services for seriously emotionally disturbed children and seriously mentally ill adults and older adults residing in that part of the County. We expect that this service site will serve approximately 100 consumers per month.

Marin City Housing Project is a designated Medically Underserved Population/Area according to the U.S. Health Resources and Services Administration. Marin City has a majority African American population and there are no mental health clinics in the area. In 1999 the median family income for Marin County overall is \$88,934, while additionally it was just \$32,123 in Marin City. 23.3% of the families lived in poverty compared to 3.7% for the rest of Marin County. Bayside/Martin Luther King (K-8) School in Marin City is one of three schools in the county that serves the most impoverished census tracts.

Currently, Community Mental Health Services operates three service sites: one in Greenbrae for Adults and Older Adults, one in Terra Linda for children and their families, and one Pt. Reyes Station for residents of West Marin. Through its Mental Health Plan, CMHS also contracts with thirteen outpatient agency providers to serve clients with Medi-Cal insurance coverage. Eight are located in San Rafael, one is in Novato one is in San Anselmo and none are headquartered south of Greenbrae. CMHS also contracts with the Hearing and Speech Center in San Francisco for services for the hearing impaired and with Asian Community Mental Health Services and Asian Pacific Psychological Services in Oakland to serve clients who speak one of fourteen different Asian languages in which services are not available in Marin. None of the sites listed above is located in southern Marin County.

Nearly five-thousand (4,910) Medi-Cal beneficiaries live in Southern Marin. This represents about a third of Marin County's beneficiaries with no local access to mental health services. Zip code 94941, the Mill Valley area, has 1,427 people insured by Medi-Cal, while 94965, the Sausalito-Marín City area, has 1,670 people on Medi-Cal. According to the Children's Health Initiative Coordinating Committee, there are 3,000 children and 16,000 adults in Marin County without health insurance. The map below shows existing CMHS and contractor service sites versus client population concentration in Marin County.



The goals and outcomes of this service will be:

- Provide early intervention for children with serious emotional disturbances and for adults with serious mental illnesses in a culturally competent environment
- Avoid crises and admissions to acute hospitals and psychiatric emergency services by offering easily accessible mental health services
- Promote Wellness/Recovery/Resiliency concepts by providing services close to home and with family and community involvement
- Develop community-based services and supports including culturally competent outreach and community education strategies
- Decrease stigma by making mental health services an integral part of the community
- Adopt a model of assessment and treatment that's culturally competent and can provide support to an ethnically diverse population for both Medi-Cal beneficiaries and the uninsured
- Transformation from the traditional medical model of assessment and treatment to culturally competent therapy modalities that can provide support to an ethnically diverse population
- Provide the necessary linkage to other services for clients
- Achieve treatment outcomes that result in children being in school, at home and out of trouble, and adults having positive relationships and productive daily activities
- Promote client and family empowerment by partnering with clients in their community to build on strengths already existing in the community

#3 Describe any housing or employment services to be provided.

Not applicable

#4 Please provide the average cost for each Full Service Partnership participant including all funding types and fund sources for each Full Service Partnership proposed program.

Not applicable

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

Recovery refers to the process whereby people with serious mental illness are able to live, work, learn and participate fully in their own community. In order to promote recovery, the public mental health system must make services available in settings that are welcoming and accessible to clients and their families. The services must be consistent with the cultural values and the linguistic needs of the community being served. By serving the mental health needs of transition-age youth, adults and older adults in the communities where they live. With providers who understand that culture, the services are more accessible and effective. Building on the communities' strengths, like their sense of cultural identity, long-standing faith based institutions, and strong family bonds are a foundation for recovery and resiliency work. Focusing on strengths rather than deficits is a hallmark of the recovery philosophy of care. Listening to the voice of the client and respecting client and family choice are what inform the services provided. Mental health services need to address individual, family and community issues. Engagement is often the first step in recovery from mental illness. With nearly five thousand people on Medi-Cal and thousands living in poverty, the mental health needs of the southern Marin County area must be fully addressed. Ongoing program evaluation and community input will go hand in hand with outcome measures like academic achievement, employment, stable housing and quality of life to determine the success of this effort.

#6 If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Currently Marin Community Mental Health Services contracts with several community-based organizations to provide outpatient mental health services. This proposal for capacity expansion will add to the availability by adding a culturally competent provider site in southern Marin. Through a request for proposal process, CMHS will offer its current contractors and well as other interested local groups to make proposals for a service site that can best serve the needs of the community. This site will improve access to services for clients in the southern part of the county. Currently Marin County has 16,477 people covered by Medi-Cal, the health insurance program for the poor, aged, and disabled. Of those, nearly a third, 4,910,

live in southern Marin. There are also approximately 3,000 children and 16,000 adults in Marin County with no health insurance, according to the Children's Health Initiative Coordinating Committee. By expanding accessibility to the uninsured, early intervention will be possible ensuring better outcomes for clients and their families and creating a healthier community.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Clients and/or family members may be employed by the agency selected to provide family support groups and peer counseling services. Families and clients will be invited to participate in the selection of the service provider by participating in screening the proposals from the organizations offering to provide these services.

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

The collaboration between the County and local non-profit service providers has a long history in Marin County. This will continue with an open Request for Proposal (RFP) process to seek interested organizations able to operate such an outpatient and outreach program in southern Marin. Several individuals representing groups based in southern Marin served on the MHSA Steering Committee. The community will be involved in the selection of the providing organization. Community Mental Health Services has a long history of providing services in the schools in Southern Marin.

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence is a means to eliminating cultural, racial, and ethnic disparities. Cultural competence enhances the ability of the whole system

to incorporate the languages, cultures, beliefs, and practices of its clients into the services. The professional, administrative and support personnel must reflect the diversity of the populations served. All staff will receive training in cultural competency. According to the last census, 46% of Marin City residents were African American, 36 % were White, 9% were Asian, and 8% were Hispanic. Outreach services strategies to serve these groups will be an essential element of the program.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Program staff is trained on gender differences, as well as lesbian, gay, bisexual, and transgender (LGBT) issues. Assessment of client sexual orientation will be incorporated into the program's comprehensive assessment process, at intake and on an ongoing basis. The emphasis on strengths-based, client-centered service plans, which are tailored to the individual needs of the clients and families, requires sensitivity to, and competence in, working with these issues. Expertise in gender, age, and sexual orientation issues is crucial to the delivery of culturally inclusive services and supports. The Cultural Competence Committee will assess needs and competencies in this area and develop appropriate basic and ongoing trainings for staff, community partners, and other stakeholders. Existing programs that focus on addressing LGBT will be made available to clients on a case-by-case basis.

#12 Describe how services will be used to meet the service needs for individuals residing out-of-county.

This service will be for clients residing in the southern region of Marin County.

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 State Department of Mental Health approval
- 3/06-5/06 Requests for proposals developed and selection of a provider is done with community, client and family involvement
- 6/06 Provider will be selected and community outreach efforts begin
- 7/06-8/06 Provider hires staff and locates site
- 9/06 Enrollment begins

County: Marin	Fiscal Year: 2005-06	Program Work Plan Name: Program Evaluation	
Program Work Plan #: SDOE-05		Estimated Start Date: July 2006	
Description of Program: <i>Describe how this program will help advance the goals of the Mental Health Services Act</i>	This proposed General System Development expansion project (Program Evaluation) will provide a centralized program support structure for collecting and reporting local data and outcomes throughout the various CSS program components and conducting research and evaluation of outcomes related to the implementation of the MHSA. The goal of the program is to support the provision of the highest level of quality care possible in the most efficient and effective manner.		
Priority Population: <i>Describe the situational characteristics of the priority population</i>	Children, youth and transition age youth who have a serious emotional disorder and adults, transition age youth and older adults who have serious mental illness, who are currently unserved, underserved or inappropriately served by the mental health system, and, as a result, are at risk of homelessness, school or work failure, incarceration, institutionalization, or frequent and avoidable emergency medical care or hospitalization. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.		
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)		Fund Type	Age Group
Infrastructure for the Children’s System of Care program as found in W&I Code Section 5850 et seq to promote accountability for effective outcomes for children/youth and their families. Infrastructure for Systems of Care for Adults and Older Adults as found in W&I Code Section 5802 to promote accountability for performance outcomes for adults and older adults. Infrastructure to ensure the provision of values-driven, evidence-based and promising clinical services that are culturally and linguistically appropriate and integrated with overall service planning and support housing, employment, education and other client/family selected goals.		Sys Dev	TAY/Adult/Older Adult

Program Evaluation

#2 Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Marin CMHS is committed to developing programs, services and supports that are values-driven, evidence-based, effective, and cost efficient. Due to limited resources, Marin County does not currently operate comprehensive program and service evaluation. At the present time, CMHS program evaluation capacity is almost entirely restricted to relatively recent program initiatives such as AB2034, the Mentally Ill Offender Crime Reduction Grant, and the Child/Youth Interagency Enrollee-Based (IEB) Program, which mandated and funded program evaluation. Marin's successful participation in these projects with their heavy data collection and reporting has amply demonstrated CMHS' ability to implement an effective performance outcomes measurement system.

This proposed General System development will enable CMHS to increase the program evaluation services provided by Marin's current independent evaluator, Prins, Williams and Associates (PW&A). PW&A will be responsible for tracking and reporting data and outcomes as mandated by the MHSA, as well as conducting evaluation of Marin's MHSA programs and related initiatives. PW&A will assist in establishing outcome and evaluation processes for all MHSA-funded programs. Additionally, Marin's existing AB2034 program data collection and evaluation processes will be modified to comply with the new MHSA performance outcome requirements. Information Technology (IT) services will be increased as necessary to assist in the development and implementation of local methods to be used for data collection to meet the MHSA requirements.

Consistent with the goals of the MHSA, the goal of the CCS System Support Structure is to improve and increase Marin's capacity and ability to provide culturally competent, values-driven, evidence-based services and supports. Data and feedback at the individual, community and system levels will be incorporated into Marin's continuous quality improvement process for refining and improving services and programs. This ongoing process will lead to and maintain the transformation of Marin's mental health system as envisioned in the MHSA.

#3 Describe any housing or employment services to be provided.

Not applicable

#4 Please provide the average cost for each Full Service Partnership participant including all funding types and fund sources for each Full Service Partnership proposed program.

Not applicable

#5 Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The concepts of wellness, recovery, and resiliency are key elements of Marin's MHSA programs. On-going program evaluation will be guided by these concepts, utilizing outcome measures that address self-sufficiency and quality of life, in addition to those measures more traditionally used by the public mental health system.

#6 If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Prins, Williams and Associates (PW&A), under contract with CMHS, currently provides program evaluation services specific to Marin's HAVEN (AB2034), STAR (MIOCRG), and CSOC (IEB) programs. This existing contract will be expanded to include tracking and reporting data and outcomes as mandated by the MHSA and AB2034, as well as conducting evaluation of Marin's MHSA programs and related initiatives.

Information Technology (IT) services provided by CMHS staff and/or contractors will be increased as needed to develop, in collaboration with PW&A, mechanisms for collecting and reporting data in accordance with the requirements of the MHSA and State Department of Mental Health.

#7 Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Not applicable

#8 Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will

help improve system services and outcomes for individuals.

Not applicable

#9 Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Emphasis will be placed on developing outcome measurements and instruments that minimize cultural and racial bias. Client and family surveys will be provided in appropriate languages. Data collection will be conducted with sensitivity to linguistic and cultural issues specific to each of the CSS programs' clients and their communities.

The development of the proposed centralized program evaluation support structure will enable Marin CMHS to ensure that outcomes are consistent across all ethnic and racial groups and communities served under the MHSA. Access and other outcome data will be regularly monitored to assist in identifying any disparities involving ethnic and racial groups.

#10 Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Expertise in gender, age and sexual orientation issues is also crucial to the delivery of culturally inclusive services and supports. Emphasis will be placed on developing outcome measurements and instruments that minimize gender and sexual-orientation bias, and are sensitive to developmental issues related to a client's age group or gender. Data collection will respect client privacy by not requiring disclosure of sexual orientation.

The development of the proposed centralized program evaluation support structure will enable Marin CMHS to ensure that outcomes are consistent across age and gender groups served under the MHSA. Access and other outcome data will be regularly monitored to assist in identifying any disparities involving age or gender.

#11 Describe how services will be used to meet the service needs for individuals residing out-of-county.

Not applicable

#12 If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable

#13 Timeline.

- 1/06 Board of Supervisor approval
- 2/06 Send plan to State Department of Mental Health
- 3/06 Conversion of existing AB2034 data collection and outcome reporting system to MHSA format
- 6/06 Contract amendment completed
- 7/06 Implementation of new MHSA data collection and outcome reporting system for MHSA-funded programs

Section VII – One-Time Funding Request

Marin County Mental Health Services Act Community Supports and Services One-Time Funding Requests

According to Department of Mental Health Letter # 05-06, a County may request to use a portion of their fiscal year 2005-2006 Community Services and Supports funding for start-up expenditures. The funding requests are subject to review by DMH to ensure that there is a relationship with the county's plan for Community Services and Supports and the one-time funding requested.

Capital Improvement Funding

Wellness/Recovery Center

Down Payment: Create a Wellness/Recovery Center in the San Rafael area that combines client-operated services along with case management, medication support, supported employment, housing, benefits counseling, physical health care, and dual diagnosis services. In order to accomplish this important step toward system transformation, a building will be leased or purchased in the San Rafael area to be a permanent home for the services. One-stop shopping for a variety of services would greatly improve access to these services for clients. The site will be close to public transportation, convenient for clients and their families, and tremendously improve customer service.

System Improvement Funding

Systems cannot change without the ongoing education and training of the people providing the services. To that end Community Mental Health Services will use some of the one-time funds to create a training fund to improve the skills of staff, community partners, families and clients.

Trainings for Consumers and Families

Includes developing the local network of mental health clients, training for family partners, wellness recovery action plan trainings, older adult, adult and transition-age youth peer support training.

Trainings for Community Partners

Develop a system wide vision of recovery, wellness, and resiliency through trainings like crisis intervention training for law enforcement, supported education

and workforce development for local colleges, and state conferences for local Mental Health Board members.

Trainings for Staff of CMHS and CBO's

Fully train staff in systems of care and recovery/resiliency for new services to older adults and transition-age youth. Continue to train in techniques of evidenced-based, promising, and emerging best practices. Examples include: Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Cal-MAP. Also train staff on cultural competence, dual diagnosis treatments, information technology, electronic medical records, leadership trainings, and staff emersion into recovery models of care.

Information and Referral

Fully develop the Network of Care website for all behavioral health services in Marin County.

Workforce Development

This includes stipends for bilingual interns and trainees in order to train and develop a culturally and linguistically diverse workforce for the future.

Flexible Housing Fund for Clients in Full Service Partnerships

Create a housing fund to subsidize the initial cost of housing for people with mental illness. Unserved clients enrolling in the full-service partnerships will need support with housing. The housing fund will assist clients with rent subsidies and other costs to obtain and maintain safe and affordable housing.