COUNTY OF MARIN

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Promoting and protecting health, well-being, self-sufficiency, and safety of all in Marin County.

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Larry Meredith, Ph.D.
DIRECTOR

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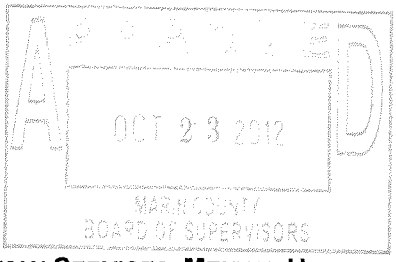
www.marincounty.org/hhs

October 23, 2012



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

SUBJECT: DEPARTMENT OF HEALTH & HUMAN SERVICES, MENTAL HEALTH AND SUBSTANCE USE SERVICES DIVISION: APPROVE THE MENTAL HEALTH SERVICES ACT (MHSA) FY2012-2013 ANNUAL UPDATE AND RELATED BUDGET ADJUSTMENTS

Dear Supervisors:

RECOMMENDATIONS:

1. Authorize the President to approve the Mental Health Services Act (MHSA) FY2012-2013 Annual Update.

2. Authorize the President to approve the budget adjustments detailed in Attachment A.

SUMMARY: The Mental Health Services Act (MHSA) FY2012-2013 Annual Update for Marin is required to be approved by the County Board of Supervisors.

There are five (5) components to MHSA:

Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WET), Capital Facilities and Technological Needs (CFTN) and Innovation (INN). The outcomes for FY2010-2011 and proposed changes for FY2012-2013 are included in the Annual Update.

This Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY2012-2013 Annual Update was circulated to representatives of stakeholder interest and posted for any interested party for thirty (30) days on the Marin County Mental Health Services webpage for public comment and feedback beginning on September 7, 2012 and ending October 7, 2012. On October 9, 2012, the Mental Health Board provided their recommendations and a legal notice ran in the Marin IJ seeking public comments and feedback as well. All input has been considered with adjustments made, as appropriate and incorporated into the FY2012-2013 MHSA Annual Update.

COMMUNITY BENEFITS: The Mental Health Services Act (MHSA), formerly Prop 63, was approved by voters in November 2004 and was designed to expand and

transform California's county mental health service systems to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in underserved populations.

FISCAL/STAFFING IMPACT:
The funds for on-going costs in this Annual Update are included in the existing community mental health budget in fund center 100047000. The additional costs of one-time expenses in the amount of $893,870 are fully funded by MHSA component funds. There is no additional net county cost associated with this request.

REVIEWED BY:

☑	Department of Finance	☐	N/A
☐	County Counsel	☑	N/A
☐	Human Resources	☑	N/A

Sincerely,

Larry Meredith, Ph.D.
Director

FMBB Document #: 100018410

Copies of the MHSA Annual Update are available by contacting the Clerk of the Board

ATTACHMENT A

Budget adjustments (fund 10000)

Action	Fund Center	SAP Fund	Description	Commitment Item	CI Description	Budget Adjustment (FY 12/13)
Increase	1000047000	10000	MHSA Prop. 63	5210100	Professional Services	$110,000
Increase	1000047000	10000	MHSA Prop. 63	5210200	Administration and Finance Services	$102,896
Increase	1000047000	10000	MHSA Prop. 63	5210400	CBO Contracts	$680,974
Total Expenses						**$893,870**
Increase	1000047000	10000	MHSA Prop. 63	4810110	Transfers In – Prop 63	$893,870
Total Revenues						**$893,870**

Budget adjustments (fund 25049)

Action	Fund Center	SAP Fund	Description	Commitment Item	CI Description	Budget Adjustment (FY 12/13)
Increase	1000047000	25049	MHSA - Prop 63	5490120	Operating Transfers Out	$893,870
Total Expenses						**$893,870**
Increase	1000047000	25049	MHSA - Prop 63	4520110	Prop 63 - MHSA	$893,870
Total Revenues						**$893,870**

COUNTY COMPLIANCE CERTIFICATION

County: County of Marin

County Mental Health Director	Project Lead
Name: Margaret Kisliuk	Name: Margaret Kisliuk
Telephone Number: (415) 473-4296	Telephone Number: (415) 473-4296
Email: mkisliuk@marincounty.org	Email: mkisliuk@marincounty.org
Mailing Address: 20 North San Pedro Road, Suite 2028 San Rafael, CA 94903	

I hereby certify that I am the official responsible for the administration of county mental health services and for said county and that the County has complied with all pertinent regulations, laws and statues of the Mental Health Services Act in this annual update, including stakeholder participation and non-supplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY2012-13 annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached FY2012-13 annual update/update are true and correct.

Margaret Kisliuk
Mental Health Director/Designee (PRINT)

Margaret Kisliuk 10-10-12
Signature Date

County: Marin

Date: October 10, 2012

COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: Marin **County Mental Health Director**	**Project Lead**
Name: Margaret Kisliuk Telephone Number: (415) 473-4296 Email: mkisliuk@marincounty.org	Name: Margaret Kisliuk Telephone Number: (415) 473-4296 Email: mkisliuk@marincounty.org
Mailing Address: 20 North San Pedro Road, Suite 2028 San Rafael, CA 94903	

I hereby certify that said County has complied with all fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act, including Welfare and Institutions Code section 5891, 5892 and 5893 and Title 9 of the California Code of Regulations sections 3400 and 3410. Additionally, expenditures for Prevention and Early Intervention and Innovative Programs are consistent with the guidelines issued by the Mental Health Services Oversight and Accountability Commission (W&I 5846(a)).

Margaret Kisliuk
Mental Health Director/Designee (PRINT)

Signature Date

Roy Given
County Auditor Controller (PRINT)

Signature Date

County: Marin

Date: October 5, 2012

COUNTY OF MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MENTAL HEALTH SERVICES ACT

WELLNESS • RECOVERY • RESILIENCE

FY2012-13
ANNUAL UPDATE

Mental Health and Substance Use Services Division
20 North San Pedro Road, Suite 2021
San Rafael, CA 94903

Table of Contents

EXECUTIVE SUMMARY

This report is intended to provide information to local stakeholders on existing Mental Health Services Act (MHSA) funded programs in Marin, their impact, and the challenges they experience. Changes on the State level have led to a change in the format of this report. We hope it is more accessible than previous Annual Updates, and will work in future years to make it increasingly useful locally.

An incredible amount of work has gone into developing the MHSA programs discussed in this report. MHSA brings resources and principles to assist in the transformation of the mental health system, but the work must be done locally. Marin County Health and Human Services has collaborated with community-based organizations and the many individuals and communities within Marin to understand the needs and opportunities that MHSA can address. This is an ongoing journey, with periodic opportunities to reflect on what we have accomplished and how we should adjust our direction. Thank you for joining us on this journey.

Mental Health Services Act

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

Mental Health Services Act Principles

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

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

Mental Health Services Act Components

The MHSA currently has five (5) components:

A. Community Services and Supports (CSS)

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

B. Prevention & Early Intervention (PEI)

PEI funds are intended to reduce risk factors and promote positive skills to increase the well-being of individuals prior to serious emotional or behavioral disorders. Programs are primarily provided in the community, targeting populations that have risk factors for or more mild mental health concerns.

C. Innovation (INN)

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

D. Workforce Education & Training (WET)

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

E. Capital Facilities & Technology Needs (CF/TN)

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

Marin County's MHSA Component Plans

Marin County conducted community-planning processes beginning in 2004 to develop plans for each component. A plan has been developed for all components except Capital Facilities. Existing plans can be viewed on the County website www.marincounty.org, or call 415-473-6769 to request a paper copy by mail.

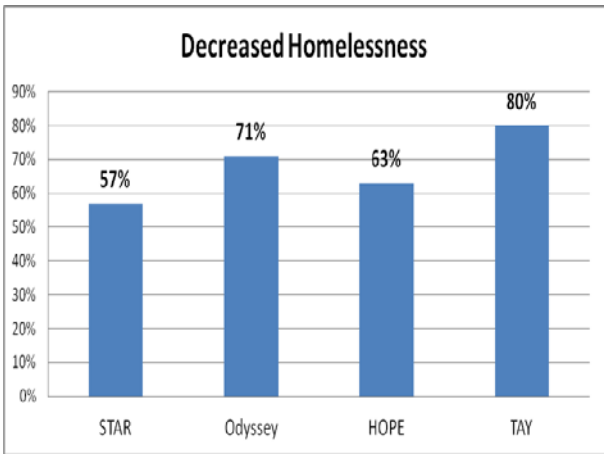
Fiscal Year 2012-2013 Annual Update

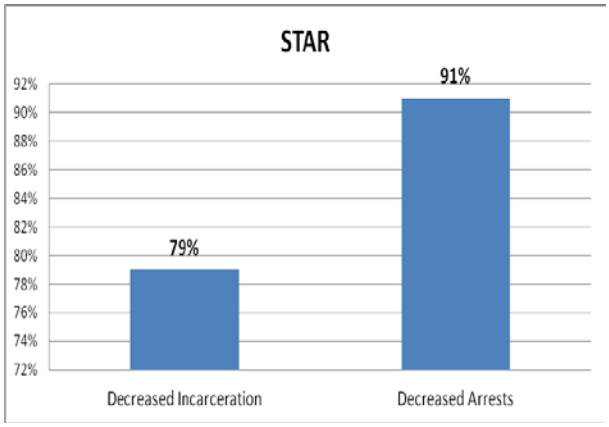
A primary goal of MHSA is to address un/underserved populations. Another goal is to achieve measurable outcomes. While each program has specific program goals, there are also overarching goals for MHSA Components.

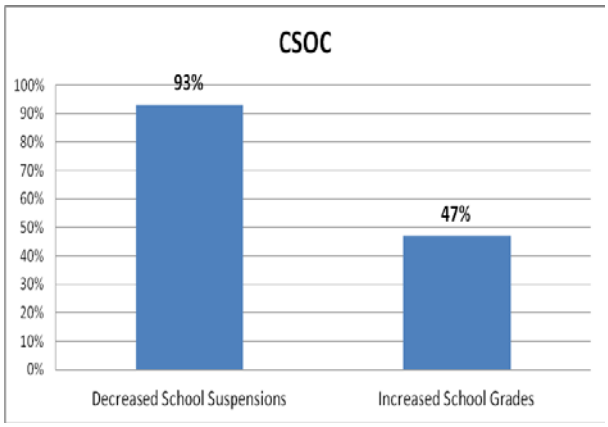
Community Services and Supports (CSS)

CSS programs have led to a variety of outcomes for participants. These charts show some highlights from the Marin CSS Full Service Partnerships (FSP's).

These indicate cumulative outcomes since the beginning of the CSS program. Percentages are calculated based on the number (n) of clients within each program for whom the measure is appropriate. For example, only individuals with a record of homelessness in either pre or post periods are included in the homeless calculations.





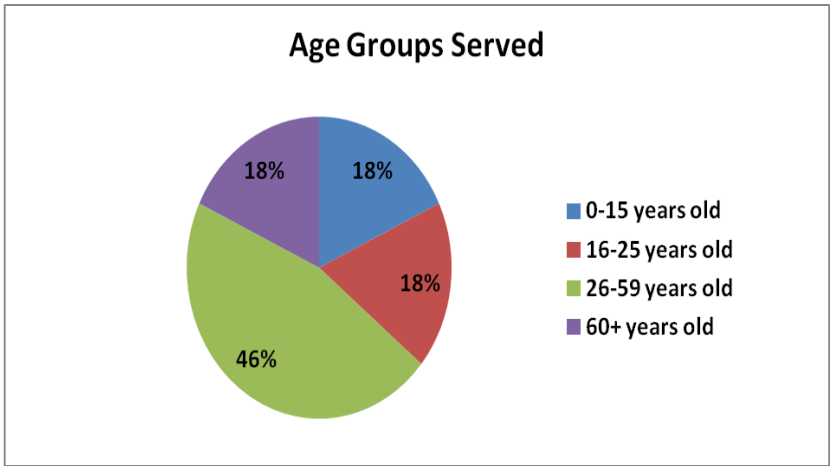


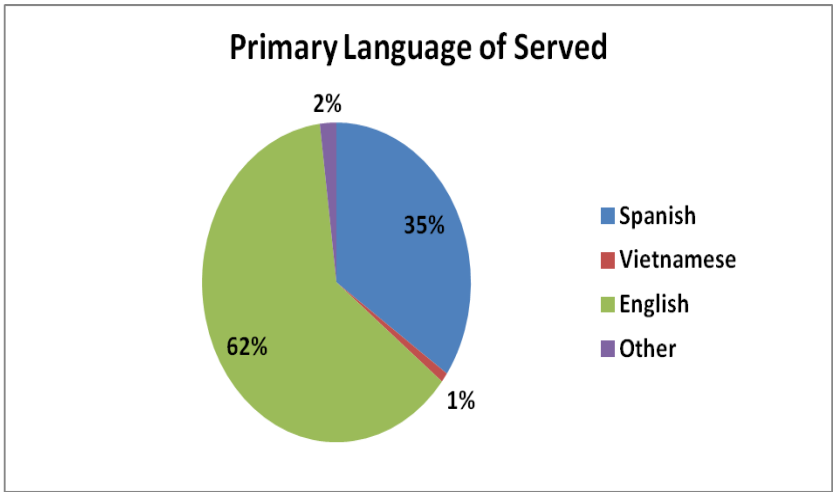
Further details on CSS programs are provided in this report.

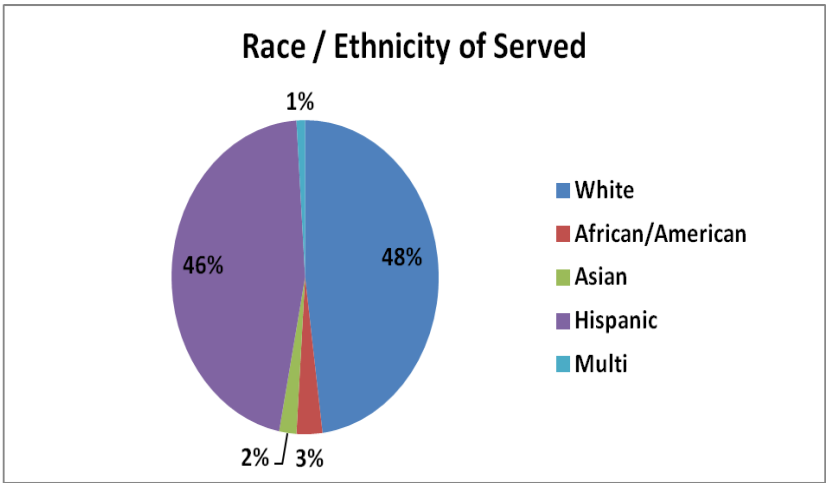
Prevention and Early Intervention (PEI)

PEI Programs have successfully reached un/underserved populations.

Total Individuals Served: 6245







Further details on PEI programs are provided in this report.

Innovation

The report describes Marin's Innovation Program, the Client Choice and Hospital Prevention Program, that includes the development of a Crisis Residential Program to provide an alternative to hospitalization with a focus on recovery and client choice. This residential program is expected to open in summer 2013.

Workforce, Education and Training

Trainings Provided	
Targeted Training in Evidence-Based Practices	Consumer Focused Trainings
Family Focused Trainings	Systems Wide Integrated Dual Disorders Training
Clinical Practice Forums	MH Directors Leadership Institute Training

The WET program is aimed at expanding the workforce qualified to address serious mental illness by training existing providers, increasing the diversity of individuals entering the field, and promoting the employment of consumers and families.

Capital Facilities and Technological Needs

As described in this report Marin County has yet to identify appropriate capital facilities projects that fit within State parameters for MHSA Capital Facilities funding.

Fiscal Year 2012-13 Program Expansions

Throughout this report there are descriptions of program expansions planned for FY2012-13. These expansions are in alignment with the original Marin MHSA priorities established in community planning processes. Many of them address County initiatives to integrate mental health and substance use services, establish evidence-based practices, or prepare for health care reform. These new allocations are currently planned for FY12-13 only, although they may be extended in future planning processes.

Descriptions of proposed program expansions can be found:

- At the end of the narratives for each existing program that plans an expansion
- In "Proposed CSS Expansions for FY2012-13"
- In "Proposed PEI Expansions for FY2012-13"

Feedback on these funding expansions is welcome.

For a copy of the MHSA 2012-13 Annual Update please call: 415.473.7465 or you can find it on our website at: http://www.co.marin.ca.us/depts/HH/main/mh/index.cfm.

Please review the MHSA 2012-13 Annual Update and post your comments on the website or you can mail comments or questions to: Kasey Clarke, County of Marin, Mental Health and Substance Use Services Division, , 20 N. San Pedro Road, Suite 2021, San Rafael, CA 94903.

The required thirty (30) day public comment period for the MHSA 2012-13 Annual Update begins on Thursday, September 6, 2012 and ends on Saturday, October 6, 2012.

A Public Hearing for the MHSA 2012-2013 Annual Update will take place at the Mental Health Board Meeting on Monday, October 9, 2012 at 6:00pm at the Marin County Health and Wellness Campus, 3240 Kerner Blvd., San Rafael, CA 94901, Room 110. The public is welcome.

MHSA Moving Forward

Counties will soon be developing "3 Year Integrated Plans." The State is currently developing the guidelines for these Plans. The Integrated Plan will build upon the planning processes already conducted, the experience gained through implementing existing Plans, and additional community planning processes.

To find out how to get involved with MHSA in Marin County, please contact:

Mental Health and Substance Use Services Director
County of Marin, Mental Health and Substance Use Services Division
20 N. San Pedro Road, Suite 2021
San Rafael, CA 94903

MENTAL HEALTH SERVICES ACT

STAKEHOLDER PROCESS

Ongoing Stakeholder Input

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

General:

Mental Health and Substance Use Services* (MHSUS) representatives regularly discuss MHSA programs with individuals, the Mental Health Board, the Quality Improvement Committee, and other forums MHSUS. Input received in these settings is brought to MHSA Coordinators or other settings for consideration.

MHSA Component Meetings:

- The PEI Committee meets quarterly to discuss PEI Program implementation, including reviewing annual program evaluation reports. It is comprised of PEI grantees, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community organizations.
- The WET Advisory Committee meets bi-monthly to provide feedback and suggestions regarding the implementation of the WET plan. It is comprised of consumers, CBO staff, family members, county staff, and the WET consultant. The WET Consumer Subcommittee meets on a monthly basis. Its 6-8 members meet at the consumer run drop in center. In addition, family members, NAMI members and parent partners are invited to the Family Subcommittee, which meets monthly.
- The Innovation Advisory Committee meets quarterly to oversee the implementation and discuss lessons learned regarding the Client Choice and Hospital Prevention program.
- A panel including community members, community providers and others is convened to review proposals received in response to Requests for Proposals to implement MHSA programs.

* *Marin County recently integrated the Division of Community Mental Health Services and the Division of Alcohol and Drug Programs to form the Mental Health and Substance Use Services Division*

MHSA Implementation Committee:

The MHSA Implementation Committee is an ongoing body established to review outcomes of MHSA programs and make recommendations regarding all significant changes/additions to MHSA programs. Appendix A lists the members and affiliations for the current Implementation Committee.

FY2012-13 Annual Update Process

In this Annual Update there are a number of program expansions proposed. These result from a process that involved several steps. First, on June 11, 2012 the MHSA Implementation Committee met to identify criteria for additional funding allocations for FY2012-13. Shortly after the meeting, the County issued a broad solicitation, including announcements in the local newspaper, for program expansion proposals. The solicitation specified that the proposals must be in alignment with the original Marin MHSA priorities established in the community planning processes and would be evaluated based on criteria established by the MHSA Implementation Committee. County staff reviewed the submissions for adherence to the guidelines and developed recommendations. On August 7, 2012 the MHSA Implementation Committee met to discuss the submissions and funding recommendations. Those submissions recommended for funding are incorporated into this Annual Update.

In addition, on August 20, 2012 Marin hosted a public forum to review the County MHSA programs and outcomes. Sections of the Annual Update and an overview of outcomes were provided. Over 60 people attended, including consumers and families. After the presentation, small groups discussed the benefits they have seen from MHSA, what they would like to see in the future, and how they can participate in improving the system of care. Results of that meeting are posted on Marin's MHSA webpage and will be integrated into future planning. Prior annual updates are available at http://www.co.marin.ca.us/depts/HH/main/mh/mhsa_faq.cfm.

This Annual Update was posted for 30-day public comment from September 7, 2012 through October 7, 2012. It was widely distributed:

- The annual update was posted for 30-day public comment on Marin County's website, including instructions on how to receive a copy of the annual update, how to submit comments and the date of the Public Hearing.
- An announcement about the posting was placed in the local newspaper, the Marin Independent Journal, including information about getting a copy of the update, how to comment, and the date of the Public Hearing.
- Copies of the annual update were available at two local libraries – the main branch in San Rafael and the branch in West Marin – including how to comment and the date of the Public Hearing.
- An email with a link to the website posting was sent to all Mental Health and Substance Use Services (MHSUS) contractors, CBOs, Marin Mental Health Board, MHSUS staff, MHSA Implementation Committee, and other MHSA committees.

On October 9, 2012, a public hearing was held with the Mental Health Board where all their feedback and recommendations were provided. All input has been considered with adjustments made, as appropriate and incorporated into the FY2012-2013 MHSA Annual Update.

Summary of Participating Stakeholders

Sectors Represented:

Sector	*Representation (Approximate # of Reps)*
Education	❖ Marin County Office of Education (3) ❖ Early childhood education (3)
Mental Health and Substance Use Services	❖ County Mental Health (12) ❖ Community Based Providers (14)
Health	❖ FQHC (3) ❖ Teen Clinics (4)
Social Services	❖ Children & Family Services (2)
Law Enforcement	❖ Police Departments (2)
Community-Family Resource Centers	❖ CBOs (10)
Advocates for interests of consumers and families	❖ Consumer and family members participated in all ongoing MHSA committee meetings
Other	❖ FIRST 5 (2) ❖ Union (2) ❖ Community members (3)

Communities Represented:

Un/underserved Community	*Approximate # of Reps*
Latino	8
African American	5
Asian	4
Geographically Isolated	6
TAY	4
Older Adults	12

Substantive Comments and Responses:

1. **In general people were pleased with the format and readability of the report.** MHSUS will strive to make future reports even more accessible.

2. **There should be analysis included as to how the mental health system is working towards transformation, such as how the system is moving towards a recovery model.** MHSUS will include that in the next Annual Update.

3. **There are indications that services to the Latino community have increased, but there should be more analysis about how that is being achieved, what services are being provided, and how much the services are increasing.**
   MHSUS will analyze this more closely for upcoming MHSA planning processes.

4. **The department should continue to strive to reach out to minority populations.**
   MHSUS continuously monitors whether or not un/underserved populations are being reached and adjusts Programs in response. There will be a planning process conducted to develop the MHSA Three Year Integrated Plan that will look at progress, gaps and strategies systematically.

5. **Will the Legal Assistance program include providing assistance with Social Security eligibility processes?**
   This is a pilot year for the program, so we expect they will identify what legal needs are present and determine how to serve them.

6. **Only 18% of PEI funds are spent on seniors, while 25% of the Marin population is 60+, and that is increasing. PEI should respond to the growing need.**
   As noted in number 4, MHSUS has attempted to adjust Programs in response to need and will continue to do so. Also, the proposed changes represent only part of our comprehensive MHSA Program which provides a variety of services targeted at older adults.

7. **There should be a more focused approach to housing, such as dedicating additional resources to providing affordable, stable supportive housing. Also, reconsider the income limits, as they seem to be more stringent than required.**
   Housing is always difficult in a high-cost county such as Marin, but we agree that the need is significant. Adding supportive housing capacity can be considered during the upcoming 3-year planning process. To the degree that there are income limits, they are dictated by law, regulations and sustainability concerns that are hard to change.

8. **MHSA, particularly PEI, should take into greater consideration the intersection between mental health and domestic violence.**
   Some of the existing programs include domestic violence and other trauma within their services, such as including screening questions, provider trainings, and brief interventions competent to address these issues. This issue will be integrated into the upcoming MHSA planning processes.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county with a population of 252,000 and spanning 520 square miles of land. The majority of residents live in the eastern region of the county, along the Highway 101 corridor. West Marin is a primarily unincorporated area with sparser population.

The Population Health Institute ranks Marin as the healthiest county in California. This includes indicators for mortality, health behaviors, and social and economic factors. While that is a great strength to build on, not all communities within Marin enjoy the same level of health – physically, socially, economically, or psychologically.

The Mental Health Services Act is intended to expand and transform community mental health services throughout California, with an emphasis on serving communities that are currently un- or underserved. During Marin's 2004 MHSA planning process the Latino population was identified as the most un/underserved by existing County mental health services. Asian Pacific Islanders were also categorized as underserved. Other identified underserved populations included older adults, transition aged youth (16-25 years old) and persons living in West Marin. Populations were designated underserved based on their proportionate use of Medi-Cal services relative to their presence in the Marin County safety net population. Designation of un/underserved populations takes into consideration the portion of Marin residents who are eligible for County mental health services, best represented by the "Medi-Cal Beneficiaries'" column on the following table.

Overall, since the implementation of MHSA programs the rate of services provided by the County Mental Health has increased substantially for the Latino population, youth and older adults. Individual MHSA programs appear to have effectively reached certain populations Table 1 shows Marin County demographics as collected. Table 2 is adjusted to be comparable to the MHSA demographic data format. However, even though MHSA funding has allowed Marin to develop new programs and services and to expand some existing services to individuals who were previously un/underserved, ongoing budget reductions at the state and county level over the past several years have negatively impacted some non-MHSA-funded components of Marin's county mental health services.

Table 1
Estimates from 2010 US Census Bureau of make-up of Marin County total population.

Ethnicity	Total Population	Hispanic	Non-Hispanic	Medi-Cal Beneficiaries	Homeless	County Mental Health Clients
White	80.0%	7.2%	72.8%	34.3%	43.0%	64.4%
Black/ African American	2.8%	0.1%	2.6%	7.9%	14.0%	9.0%
Native Am/ Alaska Native	0.6%	0.4%	0.2%	0.2%	2.0%	0.5%
Asian	5.5%	0.1%	5.4%	5.6%	3.0%	3.8%
Native Hawaiian/ Other Pacific Islander	0.2%	0.0%	0.2%	0.0%	0.0%	0.4%
Some Other Race	6.7%	6.3%	0.4%	3.2%	7.0%	17.0%
Two or More Races	4.2%	1.3%	2.9%		0.0%	0.0%
Hispanic or Latino (of any race)		15.5%	84.5%	48.8%	18.0%	20.4%

Table 2
Estimates from US Census Bureau of make-up of Marin County total population adjusted to MHSA data format. 2005 data shows rates before MHSA was implemented.

Race/Ethnicity	2005 Total Pop	2005 Co MH Clients (N=3,943)	2010 Total Pop	2010 Co MH Clients (N=3,690)
White	80.4%	67.1%	72.8%	55.7%
African/American	2.9%	9.6%	2.6%	7.8%
Asian	5%	3.4%	5.4%	3.4%
Pacific Islander	0.2%	0.3%	0.2%	0.3%
Native	0.4%	0.5%	0.2%	0.4%
Hispanic	11.1%	12.8%	15.5%	20.4%
Multi			2.9%	11.6%
Other/Unknown		6.3%	0.4%	0.4%
Age	**2000 Census**			
0-17	20.3%	29.4%	20.7%	31.4%
18-25	5.5%	9.3%	5.8%	9.6%
26-59	56.1%	54.6%	49.2%	46.6%
60+	18.1%	6.7%	24.3%	12.4%

COMMUNITY SERVICES AND SUPPORTS (CSS) OVERVIEW

Community Services and Supports (CSS) was the first component of MHSA to be funded by the State. Marin County's public planning process began in the fall of 2004 and engaged over 1,000 people through surveys, focus groups, public meetings, work groups and participation in the Steering Committee. The CSS Plan was approved and programs began in 2007.

CSS funds are intended to expand and transform services provided for children, youth, adults, and older adults living with serious mental illness towards recovery oriented services. Types of funding include:

Full Service Partnerships (FSP)

Designed to provide all necessary services and supports – a "whatever it takes" approach - for designated populations. 51% of the initial funding was required to be devoted to FSPs.

System Development (SD)

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

Outreach and Engagement (OE)

Enhanced outreach and engagement efforts for those populations that are un/underserved.

MHSA Community Supports and Services Program Outcomes

This table summarizes key cumulative outcomes since the beginning of the CSS program. Percentages are calculated based on the number (n) of clients within each program for whom the measure is appropriate. For example, only individuals with a record of homelessness in either pre or post periods are included in homeless calculations. Many clients would have had zero rates in both pre and post periods for some of the indicators, thus minimizing the opportunity to observe improvement. This outcome data is discussed further within the respective program narratives.

Program Name	STAR		Odyssey		HOPE		TAY		CSOC		Weighted Avg for all FSPs	
Age Group Served	Adult		Adult		Older Adult		TAY		Youth		All Ages	
Total Clients Served since 2007	130		113		99		36		167		545	
	%	n	%	n	%	n	%	n	%	n	%	n
Decreased Homelessness	57%	23	71%	35	63%	8	80%	5	NA		66%	71
Decreased Psych Hospitalization	26%	39	36%	39	9%	23	11%	9	20%	5	24%	115
Decreased Incarceration	79%	95							NA			
Decreased Arrests	91%	106							NA			
Decreased School Suspensions									93%	117		
Increased School Attendance									47%	133		
Decreased Out-of-Home Placement									42%	26		
Increased School Grades									56%	59		

CHILDREN'S SYSTEM OF CARE (CSOC)

PROGRAM DESCRIPTION
July 2010 – June 2011

Marin County's Children's System of Care (CSOC) is a full service partnership serving 40+ seriously high risk youth through age 18 who are involved with Probation and/or attend County Community School, an alternative high school. This program provides culturally competent mental health services, intensive case management, and psychiatric care, as well as collaboration with partner agencies (i.e., education, probation, drug court, etc.) to facilitate integrated care and ongoing family support. Latino youth are over-represented in the juvenile justice system and at County Community School. CSOC is effectively serving these youth with three (3) bilingual clinicians, one of whom is a Latino male working with mostly Latino male students at County Community School.

The CSOC program aims to serve youth who do not have ready access to other mental health resources and are not typically motivated to seek services at more traditional mental health clinics. The CSOC model is based on a 'whatever it takes' philosophy to meet the youth and family in their home and in the community. The services are based on the wraparound philosophy, focusing on working as a team to help families identify their needs and implement ways to address them successfully. An important part of this program is the support from the 2 family partners, one of whom is bilingual. Family Partners are parents who have had a child in the mental health or juvenile justice system. These partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high risk behaviors. This combination of CSOC staff provides both linguistic and cultural competence to address the diverse needs of the client population.

OUTCOMES
July 2010 – June 2011

The CSOC Program was fully operational in FY2010-11, serving 99 youth over the course of the year. Generally the youth are 13-18, with a median age of 15. During the FY10-11, Latino youth and other youth of color continue to make up the majority of the CSOC clients: Hispanic (66%), African American (7%), and multiple (14%) with (56%) reported as Spanish speaking.

Overall, CSOC continues to be successful in meeting its objectives to serve these youth who are often underserved and remain at high risk. Since the very beginning of the CSOC FSP program, notable outcomes include:

- Of youth with a history of school suspensions in the 12 months prior to entering the program, 109 students or 93% (n=117) achieved decreased school suspensions.
- Of those who missed school, 63 students or 47% (n=133) achieved an increase in school attendance.

- Of the youth having school performance data available, 33 students or 56% (n=59) showed improvement.
- Of those who experienced out-of-home placement, 11 students or 42% (n=26) experienced a decrease in out-of-home placements.

Age Group	# served	% of served
0-15 years old	22	22%
16-25 years old	77	78%
26-59 years old		
60+ years old		
TOTAL	**99**	**100%**
Race/Ethnicity		
White	12	12%
African/American	7	7%
Asian		
Pacific Islander		
Native		
Hispanic	65	66%
Multi	14	14%
Other/Unknown	1	1%

Primary Language		
Spanish	55	56%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	42	42%
Other	2	2%

CHALLENGES AND UPCOMING CHANGES

The CSOC program faces several challenges. The number of complicated, high risk cases continues to increase, requiring additional resources. Recent changes in funding for Education Related Mental Health Services (formerly AB3632), and the subsequent shift of responsibility for mental health services from County mental health to the schools, may also result in an increase in referrals to CSOC. The program also continues to confront youth with significant substance use issues. To address substance use issues, CSOC staff was trained in Motivational Interviewing techniques, an evidence-based method that focuses on the client values and concerns to strengthen their motivation for change. The CSOC program hopes to expand its staffing to better accommodate an increase in referrals.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

Children's System of Care (CSOC) and Adult System of Care (ASOC) will jointly add one full time bi-lingual Family Partner position in FY12-13 to expand services to families of mental health clients, particularly assisting family members of individuals evaluated at Psychiatric Emergency Services (PES). The work of the Family Partner (FP) would complement the work of the PES staff and together discharge plans could be developed with the family as a full partner. As time permits, the FP would also be available to families with members in any Full Service Partnerships (FSP). FPs are particularly helpful in assisting families navigate the system and coordinating client care among services. It is expected that this expansion would serve 80 to 100 families per year.

CSOC will add 1.0 FTE bilingual substance use counselor in FY12-13 to address substance use issues that are not being adequately addressed for youth involved in the juvenile justice system. CSOC is finding that many of these program participants have significant substance use issues and few resources available to them. While some of the CSOC staff is trained in Motivational Interviewing, the participants would greatly benefit from enhanced substance use expertise. The substance use specialist will provide substance use assessment, group and individual intervention, family-based interventions, collaboration with probation, substance use providers, and wrap-around service providers, as well as consultation and training to the core team. This position will serve 25-40 youth per year.

TRANSITION AGE YOUTH (TAY) PROGRAM

PROGRAM DESCRIPTION
July 2010 – June 2011

Marin County's Transition Age Youth (TAY) Partnership, provided by Buckelew Programs, is a full service partnership providing young people (16-25) with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. These services are strengths based, evidence based and client centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services. A partner organization provides coordinated individual and group therapy and psychiatric services for TAY participants. A member of the team is available to TAY clients 24 hours per day, 7 days a week. This program provides 'whatever it takes' with the goal of providing treatment, skills and the level of self-sufficiency necessary to TAY to manage their illness and accomplish their goals, avoiding deep end services, incarceration and homelessness. In addition, partial services are available to TAY who are not in the full service partnership.

Partial services are provided on a drop-in basis to full and partial clients. These services include substance use discussion groups, job support, and activities such as craft workshops and outings to museums and the Farmer's Market. The most popular group is a weekly iRest group, an evidence-based practice of deep relaxation and meditative inquiry that releases negative emotions and thought patterns, calms the nervous system and develops a capacity to meet any and all circumstances one may encounter in life. The monthly calendar is available in English and Spanish. A Family Partner provides a bimonthly Family Support Group for families of TAY with mental health illness, whether or not they are enrolled in the TAY programs.

The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbances/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.

OUTCOMES
July 2010 – June 2011

In FY 2010-11, the TAY Program met or exceeded most of their program goals (see Table below). TAY were successfully engaged in employment, education, and independent living skills activities. All staff contributed to providing these services, as well as working closely with partner organizations to make services provided outside of the program more accessible. Of the 12 TAY that participated in therapy and/or medication management services, provided by Family Service Agency, 91% (11) improved or stabilized their overall functioning, as measured by one or more dimensions of the Adult Outcome Survey.

Outcome	Goal	Actual FY10-11
Number of Full Service Partnership (FSP) clients served	20	28
Number of Partial Service Partnership clients served	100	77
FSP clients engaged in work, vocational training or school	70%	82%
FSP clients that attended activities to improve independent living skills	90%	100%
Clients receiving mental health services from Family Service Agency that improved or stabilized their overall functioning as measured by one or more dimensions on the Adult Outcome Survey	70%	91%

Since the TAY program began in 2007, the clients of the full service partnership component have experienced the following outcomes:

- Among those who experienced homelessness in the 12 months prior to participation in the FSP, 4 client or 80% (n=5) experienced a decrease in homelessness.
- Among those who had been previously hospitalized, 1 client or 11% (n=9) experienced a decrease in hospitalization.

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old	28	100%
26-59 years old		
60+ years old		
TOTAL	**28**	**100%**
Race/Ethnicity		
White	17	61%
African/American	1	4%
Asian	2	7%
Pacific Islander	1	4%
Native		
Hispanic	1	4%
Multi	4	14%
Other/Unknown	2	7%

Primary Language		
Spanish	1	4%
Vietnamese		
Cantonese	1	4%
Mandarin		
Russian		
Farsi		
Arabic		
English	26	92%
Other		

The racial diversity of the TAY served by the FSP approximately reflects the demographics of Marin County, except among those who identify as Hispanic. In FY10-11, the TAY Program hired a Spanish/English speaking outreach coordinator. Through reaching out to the Latino community and other TAY providers, the number of youth of color accessing partial services increased 350%.

The TAY Training House, a residential program for increasing independence moved to a new location in May. The 3-bedroom house is in a friendly neighborhood near the Wellness Center, and has a large outside area for relaxing, ping-pong, BBQs, and a garden. A volunteer program was recently started in cooperation with Marin Organic. TAY participants are on the "Glean Team", gleaning vegetables and fruits left in the fields of small farmers for the local Marin food lunch programs.

CHALLENGES AND UPCOMING CHANGES

Buckelew engaged an external evaluator to provide feedback about the TAY Program. They have begun implementing some of the recommendations resulting from that process, such as holding regular events to celebrate individual TAY achievements. In addition, they have received funding to implement the TIP (Transition to Independence Process) Model, a best practice to provide a common framework, common interventions and common purpose throughout the program.

In FY2011-12, MHSA provided additional funds for the TAY Program to create a therapeutic garden at the TAY Training House and implement a Health and Wellness Program that will include gym memberships and personal trainers to facilitate TAY in reaching their health and fitness goals.

One of the biggest challenges is the inability to provide any financial assistance to partial service clients. TAY come into the office all of the time needing help with rent assistance, food, and transportation. While food is available at the office, there are no funds for other needs the TAY face.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

The TAY Program will expand services in the following areas in FY12-13:

- Add a half-time specialist in addiction treatment and family therapy. Evidence-based practices will be used for individual and group interventions, such as Motivational Interviewing, Seeking Safety, and Psycho-educational Multifamily groups.
- Expand the on-site psychiatric consultation time available from 1.5 hours to 3 hours per week. This will increase access for clients and staff to consult with the psychiatrist about medications and other concerns.
- Increase the Case Manager position from 0.8 to 1 FTE to better serve participants.
- Cover increased cost of expanded office space. Three years ago the TAY program relocated to a larger, more accessible location, resulting in an increase in TAY coming to the site.

In FY12-13 the TAY FSP will expand the Independent Living Skills Training (ILS) services available, targeting clients who are in transition from homelessness to housing, have the potential to live independently but currently reside with family or in supportive housing or assisted living, or have independent housing but desire to improve their skills and quality of life. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, such as self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. Clients will be assessed so that plans can be individualized. The services will be coordinated with other services the clients are receiving. Approximately 5 clients will be served in FY12-13.

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM

PROGRAM DESCRIPTION
July 2010 – June 2011

Marin's Support and Treatment After Release (STAR) Program is a full service partnership providing culturally competent intensive, integrated services for up to 40 mentally ill offenders at a given time. The program's target population is adults, transition age young adults and older adults with serious mental illness, ages 18 and older, who have involvement with the criminal justice system and are at risk of re-offending and re-incarceration. Priority is given to individuals who are 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. 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.

Operating in conjunction with Marin's Jail Mental Health Team and the STAR Court (mental health court), a multi-disciplinary, multi-agency assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, employment services and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. 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, family members have access to an array of family support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member.

The team consists of: two (2) mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking); a part-time nurse practitioner; a part-time psychiatrist; two (2) peer specialists, one of who is conversational in Spanish; a deputy probation officer; and a part-time employment specialist. Support is available to clients and their families 24 hours a day, 7 days a week.

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

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

OUTCOMES
July 2010 – June 2011

The STAR Program was fully operational during FY2010-11, serving 57 individuals who had serious mental illness and significant criminal justice involvement, and exceeding the program's target enrollment of 40. STAR Mental Health Court was restructured to promote recovery and self-sufficiency by better defining the phases of the mental health court with more explicit goals, focus and behavioral anchors. Twenty-four of the program enrollees participated in STAR Mental Health Court with three (3) successfully graduating. Of the 23 program participants referred by the team for employment services, 8 (35%) were successfully engaged in job development activities and all 8 (35%) were successfully placed in jobs.

Since STAR began in 2007:

- Of clients experiencing arrests in the 12 months prior to FSP participation, 96 clients or 91% (n=106) have experienced a decrease in arrests.
- Of those who experienced incarceration, 75 clients or 79% (n=95) experienced a decrease in incarcerations.
- Of those who experienced acute inpatient psychiatric hospitalizations, 10 clients or 26% (n=39) experienced decreased hospitalizations.
- Of those who experienced homelessness, 13 clients or 57% (n=23) experienced decreased homelessness.

The STAR Program targets individuals who, by virtue of being unserved or underserved, end up incarcerated and are at high risk of re-incarceration. The program was successful in reaching the highest-risk group: 100% of program participants were incarcerated at the time of referral to the program, with 86% of participants presenting with a co-occurring substance use disorder, which puts them at even greater risk. Female offenders with mental illness have been identified to be a high risk population and, as a group, tend to be unserved or underserved. Twenty-eight percent of program participants were female, well in excess of the 10-11% that constitutes the Marin County Jail population. Since program referrals require that individuals must be incarcerated and most are initiated by the judicial system (judge, district attorney, and/or public defender) in order to qualify for STAR Mental Health Court, there is reduced opportunity for outreach and engagement with minority populations. As a result, the assertive community treatment component of the program served a predominantly Caucasian population (75%), with Hispanics being underrepresented at 9% served in comparison to 16% in the County adult population. Also underrepresented were Asians at 0% compared to 6% in the adult population.

Age Group	# served	% of served
0-15 years old		
16-25 years old	5	9%
26-59 years old	48	84%
60+ years old	4	7%
TOTAL	**57**	**100%**
Race/Ethnicity		
White	43	75%
African/American	2	4%
Asian		
Pacific Islander	1	2%
Native		
Hispanic	5	9%
Multi	4	7%
Other/Unknown	2	4%

Primary Language		
Spanish	2	4%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic	1	2%
English	54	95%
Other		

CHALLENGES AND UPCOMING CHANGES

California's 2011 Public Safety Realignment, which transferred responsibility for a large segment of the criminal justice population from the State to local jurisdictions effective October 2011, posed a significant challenge to Marin County, along with the rest of the State. The realigned population is anticipated to require additional and perhaps different kinds of in-custody, re-entry and community-based programming and treatment. Strategies are being developed for providing these services in the jail as well as in outpatient and residential service settings in the community. As a partner agency, County Mental Health is participating in the development of Marin's Public Safety Realignment Plan. The impact on the STAR Program is yet to be determined.

In fall 2011, Marin's 2-year Department of Justice JMHCP grant came to an end. This grant enabled Marin to 1) expand the program's capacity by 5 clients, 2) add a part-time mental health practitioner to conduct in-custody assessments and provide post-release support and linkages to services, and 3) add a part-time substance use specialist to the program. Through this grant, an additional 147 individuals received in-custody assessment services and 43 received post-release case management services. Key stakeholders strongly supported efforts to find local options for continuing the grant-funded positions at the end of the grant. During FY2011-12, one-time CSS expansion funds were

approved to continue to fund the two (2) part-time positions initially funded by the grant and proven to be effective additions to the STAR Program. With this increase, the STAR Program is projected to provide comprehensive assessments to an additional 75 inmates annually and provide 20 of those individuals with re-entry case management services. Integrated substance abuse services will be provided to 15-20 program participants each year.

The STAR Program leveraged local funds in FY2010-11 to once again sponsor a Crisis Intervention Team (CIT) Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health emergencies. Twenty-nine individuals attended this year's training, all of whom were sworn officers and dispatch staff. To date, 244 sworn officers have received CIT training with at least one CIT trained officer in every law enforcement jurisdiction in Marin. Because of local and state budget reductions, the 2010 CIT training had to be cancelled because law enforcement jurisdictions did not have funding available to free up a sufficient number of officers to attend the training. CSS FY2011-12 one-time expansion funds were approved to provide stipends to local law enforcement jurisdictions which will enable them to send 20-30 officers to annual CIT trainings and support their ongoing participation in the monthly meetings of the county-wide problem-solving Forensic Multi-Disciplinary Team (FMDT).

As noted above, the STAR Program has had limited opportunity for outreach to and engagement with minority populations, especially Hispanics. The program will continue to explore additional methods for improvement in this area, including seeking funding to expand the core assertive community treatment team by one mental health clinician to increase enrollment in the program without the requirement for participation in STAR Mental Health Court. This would broaden the referral base and hopefully expand Hispanic access to the STAR Program.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13 the Odyssey and STAR FSPs will expand their wrap-around services to include Independent Living Skills Training (ILS), targeting clients who are in transition from homelessness to housing, have the potential to live independently but currently reside with family or in supportive housing or assisted living, or have independent housing but desire to improve their skills and quality of life. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, such as self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. Clients will be assessed so that plans can be individualized. The services will be coordinated with other services the clients are receiving. Approximately 5 clients in each program will be served in FY12-13.

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM

EVE'S STORY

The client name(s) have been changed

The referral to STAR Mental Health Court came on the heels of a lethal suicide attempt for Eve, a 37 year old African female who did not feel she had any further reason to live. Her son had taken his own life the previous year and Eve had returned to heavy alcohol use after a year of sobriety due to her grief and clinical depression. Following nearly a month in the ICU, she was now incarcerated at Marin County because of old charges. She was homeless with no source of income and had broken off all family connections due to her shame related to her situation.

The evaluation for STAR court revealed a background rife with both trauma and resiliency. Eve had been a victim of physical abuse during war in her home country. Eventually she was able to flee the country, carrying her young son in her arms, and finally obtained refugee status here in the US. The effects of war, poverty and abuse, however, had left her body in poor condition with chronic medical issues. She suffered from recurrent depression and a severe alcohol addiction.

Eve agreed to enter the STAR Program in conjunction with supervised probation. Initially, Eve continued to struggle with severe depression and substance addiction. When a relapse early on led to a brief re-incarceration, the STAR team wrapped further supports around her and arranged for a discharge plan into a supervised living facility with regular outpatient substance abuse treatment. This time, with both treatment support and the strict enforcement of probation, she gradually became able to participate meaningfully in treatment and re-kindle the internal resiliency that had served her in the past.

Eve has made use of a myriad of services offered through the STAR Program and in the community and has clearly benefited from the structured program of tailored clinical intervention. She was connected to a therapist specializing in work with refugees and has continued to see her for almost two years. Through mandated 12-step meetings, substance abuse services, and a regular testing schedule, she has maintained sobriety for nearly 18 months. She now takes her psychiatric medication regularly, as well as meeting weekly with her case manager. With financial assistance through the STAR flex fund, she has maintained her legal residency, obtained independent housing, and is on the way to obtaining citizenship. STAR has connected her with medical treatment for management of chronic pain from past injuries and extensive dental work.

Throughout her process of recovery, Eve's dedication to changing her life has been an inspiration to the entire STAR team, including both clients and staff. She has decided to formalize this mentor role by completing peer counseling classes and looks forward to giving back to other clients going through difficult times. Eve is set to graduate in several months from STAR Mental Health Court and, because of her success, will be eligible to petition for early termination of her probation. The STAR program will continue to offer case management support and assistance as she moves steadily towards recovery and independence.

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

PROGRAM DESCRIPTION
July 2010 – June 2011

The HOPE (Helping Older People Excel) Program is a full service partnership that provides culturally competent intensive, integrated services with capacity to serve 40 clients at a given time. The program serves at-risk older adults, ages 60 and older, with serious mental illness, who are unserved by the mental health system, 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. Transition age older adults, ages 55-59, may be included when appropriate. These older adults may or may not have a co-occurring substance abuse disorder and/or other serious health condition. The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

The HOPE Program is a multi-agency team, staffed by County Mental Health Services and the Public Guardian's Office. The multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. 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, family members have access to an array of family support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member.

Because of the stigma associated with mental health issues for older adults in general, mental health issues often reach crisis proportions and require emergency medical and psychiatric care before they seek help. Outreach services are critical for engaging these individuals before they experience such crises. Marin's highly successful Senior Peer Counseling Program, staffed by older adult volunteers and the County mental health staff who support and supervise that program, has been integrated into the team and provides outreach, engagement, and support services. In addition, the Senior Peer Counseling Program provides "step-down" services to individuals who come to need less intensive services than they received in the FSP.

The team includes four (4) mental health clinicians, two (2) of whom are bilingual (Spanish-speaking and Vietnamese-speaking), a fulltime mental health nurse practitioner, a part-time psychiatrist, a part-time mental health nurse, a part-time deputy public guardian, and volunteer senior peer counselors. Support is available to clients and their families 24 hours a day, 7 days a week.

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

OUTCOMES
July 2010 – June 2011

The HOPE Program was fully operational during FY2010-11, serving 58 at-risk older adults who had serious mental illness and were unserved by the mental health system, exceeding the program's target enrollment of 40. Twenty-five percent of program participants presented with a co-occurring substance use disorder, which puts them at even greater risk. An additional 50 older adults were served by the Senior Peer Counseling Program, the outreach and engagement component of the HOPE Program.

Since the HOPE program began in 2007:

- Of the participants in the full services partnership who had experienced homelessness in the 12 months prior to enrolling in the program, 5 participants or 63% (n=8) experienced a decrease in homelessness.
- 2 participants or 9% (n=23) who experienced have experienced a decrease in acute inpatient hospitalization.

During FY2010-11, the Senior Peer Counseling Program graduated a new class of five (5) English-speaking and three (3) Spanish-speaking senior peer counselors, bringing the total of trained older adult volunteers to 41. One of the HOPE mental health clinicians supporting the Senior Peer Counseling was honored as the Marin County Civic Center Volunteer Supervisor of the Year in FY2010-11. Senior peer counselors visited older adults in their homes, in skilled nursing facilities, in board and care homes, and in the hospital for a total of 1,616 visits during the year, a 41% increase over the prior year. Seven (14%) of the individuals served by the senior peer counselors were Hispanic.

Marin's older adult population, age 60 and older, is largely Caucasian (92%), with 4% Asian, 4% Hispanic, and 1% Black/African-American. Eighty-eight percent of the older adults served by the HOPE Program's assertive community treatment component were Caucasian, somewhat less than the County older adult proportion, while Black/African-Americans were overrepresented at 7% served. Hispanics were underrepresented with the program serving 0% during FY2010-11 and Asians were underrepresented at 2% served.

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	4	7%
60+ years old	54	93%
TOTAL	**58**	**100%**
Race/Ethnicity		
White	51	88%
African/American	4	7%
Asian	1	2%
Pacific Islander		
Native		
Hispanic		
Multi	2	3%
Other/Unknown		

Primary Language		
Spanish		
Vietnamese	1	2%
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	56	97%
Other	1	2%

CHALLENGES AND UPCOMING CHANGES

Due to significant state and local budget reductions, the County Division of Aging and Adult Services had to make the difficult decision to eliminate the social service worker assigned to the HOPE Program, effective July 1, 2010. This eliminated the only Spanish-speaking position on the core assertive community treatment team. Further, this part-time Spanish-speaking adult protective services worker was integral to the team, serving as the Personal Service Coordinator for five (5) of the program participants and functioning as a key liaison with the Division of Aging and Adult Services. During FY2010-11, the HOPE Program maintained its original caseload of 40 program participants, but this resulted in higher caseloads for the remaining staff, making it difficult for them to provide services at the level of intensity required for assertive community treatment. The HOPE Program was faced with the need to reduce the program's total caseload by five (5), while simultaneously experiencing increased referrals and requests for service. During FY2011-12, one-time CSS expansion funds were approved to restoring the Division of Aging and Adult Services' part-time Spanish-speaking social service worker position assigned to the program. This will restore Spanish-speaking capability to the assertive community treatment team, enable the program to

continue to serve 40 individuals, and strengthen and enhance the HOPE Program's key partnership with the Division of Aging and Adult Services.

While Marin's Hispanic population has continued to increase, the growth has been less dramatic within the County's older adult population. The HOPE Program continues to experience difficulty locating and engaging this underserved population, enrolling no Hispanic older adults in the assertive community treatment component of the program for the past two (2) years. Outreach to and engagement with the Hispanic population was hampered by the loss of the part-time Spanish-speaking adult protective services worker from Adult Protective Services who had been assigned to work with the program, as well as turnover in the part-time Spanish-speaking mental health clinician position working with the Senior Peer Counseling component of the HOPE Program. It is anticipated that restoration and stable staffing of these two Spanish-speaking positions will strengthen the program's outreach and engagement efforts. Additionally, Marin's new PEI Community Health Advocates Program, scheduled to begin operations in FY2012-13, seeks to more effectively engage with Hispanics, and other hard-to-reach populations, through the use of trained community members (Promotores/Health Promoters). Linkage and coordination with this PEI program is anticipated to expand Hispanic access to the HOPE Program.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13, HOPE will add a substance use specialist position to the core assertive community treatment team to provide integrated substance use services to 10-15 program participants annually. To date, approximately 30% of HOPE program participants have been identified as presenting with co-occurring disorders. The substance use specialist will provide substance use assessment and intervention services (group and individual), referral and linkage to specialty substance use services as appropriate and family support and counseling, as well as consultation and training to the core team, leading to improved identification and treatment of co-occurring disorders among program participants.

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

MR. ZOLTAR'S STORY

The client name(s) have been changed

Mr. Zoltar, a man in his late 60's, was referred to the HOPE Program and Senior Peer Counseling in 2009 by an emergency room social worker. The social worker referred him because Mr. Zoltar appeared to be, amongst other things, responding to internal stimuli. At the time of admission Mr. Zoltar was homeless, had no benefits established and was receiving most of his food from local food banks. He was not comfortable at Mill Street, stating it was too "noisy". At the onset of engagement Mr. Zoltar respectfully declined to meet with staff but was willing to accept the occasional gift card for Safeway. Through this outreach and engagement strategy Mr. Zoltar began to trust his case manager. She slowly over time was able to earn more trust which allowed us to help him with other issues that needed to be addressed such as shelter, clothing, and medical care. He also opened up to the idea of seeing the team psychiatrist after the psychiatrist went and visited with him at St Vincent's. Mr. Zoltar began trials of antipsychotic medication and began to attend bi-weekly appointments with the psychiatrist. His symptoms of schizophrenia slowly began to quiet. His case manager encouraged him to reconsider Mill Street, which he did, and he was pleasantly surprised to find that it wasn't so noisy anymore. He began to feel safe there and Mill Street staff quickly grew to enjoy and appreciate his presence.

Mr. Zoltar's case manager worked with many community resources in order to establish the necessary benefits he needed, and was entitled to. For example, she advocated with Veteran Services to see if there was any way Mr. Zoltar could receive VA benefits. Unfortunately he was dishonorably discharged (very likely due to his symptoms of mental illness) which eliminated any chance of VA benefits. His case manager signed him up for every housing wait list she could and when another client of hers died, she (respectfully) worked with the manager of this senior housing complex and was able to negotiate Mr. Zoltar into the now vacant apartment at a reduced rate. For the first time in decades Mr. Zoltar has a place to call home. In-home support services was established and a fantastic provider was hired to assist Mr. Zoltar in being success at living in his very own 1 bed-room apartment.

Being housed, having found the right dose of psychiatric medication, stabilizing medical and dental issues, being fed, and having a treatment team surrounding him, has allowed Mr. Zoltar to venture out into the world of College Of Marin. With the support of his case manager, nurse practitioner and psychiatrist Mr. Zoltar has had 2 very successful semesters at COM. He has received nearly straight A's and he no longer feels uncomfortable "…being the oldest guy there…" The entire team is convinced that Mr. Zoltar is a genius as he frequently sends the psychiatrist off to research the most esoteric history fact or math equation.

Mr. Zoltar has been a pleasure and an honor to work with. He still has many goals to work toward. His sleep continues to be disrupted and there are times where he cannot quiet that voice that commands him to do things that are uncomfortable. As he nears his 70's his medical issues are increasing, but for now he is safe, he is housed and he is trying to make up for lost time.

ODYSSEY PROGRAM (HOMELESS)

PROGRAM DESCRIPTION
July 2010 – June 2011

The Odyssey Program is a full service partnership that provides culturally competent intensive, integrated services to 60 clients at a given time. Target clients are adults, transition age young adults and older adults with serious mental illness, ages 18 and older, who are homeless or at-risk of homelessness. Priority is given to individuals who are unserved by the mental health system or are so underserved that they end up homeless or at risk of becoming homeless. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

A multi-disciplinary, multi-agency assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, employment services, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. Supportive housing is provided through partnerships with the Marin Housing Authority's Shelter Plus Care Program and a community-based organization with a long history of providing supportive housing to clients of the Marin Community Mental Health Services traditional adult system of care. 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, family members have access to an array of family support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member.

The team consists of 3 mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking); a part-time nurse practitioner; a part-time psychiatrist; 4 peer specialists, and a part-time employment specialist. Outreach and engagement services are provided by a part-time peer specialist. Support is available to clients and their families 24 hours a day, 7 days a week.

The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The mental health nurse practitioner also provides participants with medical case management and health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services.
The program's part-time employment specialist provides situational assessments, job development and job placement services for program participants, and coordinates services with other vocational

rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation to leverage funding for additional vocational services, including job coaching. Of the 17 program participants referred by the team for employment services, 10 (59%) were successfully engaged in job development activities and 6 (35%) were successfully placed in jobs.

OUTCOMES
July 2010 – June 2011

The Odyssey Program was fully operational during FY2010-11, serving 69 individuals who had serious mental illness and were homeless or at-risk of homelessness, and exceeding the program's target enrollment of 60.

Since beginning services in 2007:

- Of those clients experiencing homelessness in the 12 months prior to entering the program, 25 clients or 71% (n=35) experienced a decrease in homelessness.
- Of those who experienced acute psychiatric hospitalization, 14 clients or 36% (n=39) experienced a decrease in hospitalization.

Outreach and engagement services for the homeless are provided by the Enterprise Resource Center (a mental health consumer run drop-in center) and CARE team (homeless mobile outreach) which work closely with the Odyssey Program and provide most of the referrals for the program's assertive community treatment component. During FY2010-11, 123 individuals received homeless outreach services. The majority of these individuals were Caucasian (80%), with Blacks/African-Americans comprising 7%, Hispanics 4%, and Asians 3%.

The Odyssey Program targets individuals who, by virtue of being unserved or underserved, are either homeless or at-risk of homelessness. The program was successful in reaching the highest-risk group: 100% of program participants were homeless at the time of referral to the program, with 57% of participants presenting with a co-occurring substance use disorder, which puts them at even greater risk. The program served a somewhat diverse population, with Blacks/African-Americans being overrepresented at 12% compared to 3% in the County adult population (18 years and older), but slightly underrepresented when compared to 14% in Marin's homeless population. Hispanics were underrepresented at 9% compared to 16% in the adult population and 18% in the homeless population. Also underrepresented were Asians at 0% compared to 6% in the adult population and 3% reported in the homeless population.

Note: County homeless population data from Marin County Point-in-Time Homeless Count 2011

Age Group	# served	% of served
0-15 years old		
16-25 years old	1	1%
26-59 years old	62	90%
60+ years old	6	9%
TOTAL	**69**	**100%**
Race/Ethnicity		
White	47	68%
African/American	8	12%
Asian		
Pacific Islander		
Native		
Hispanic	6	9%
Multi	7	10%
Other/Unknown	1	1%

Primary Language		
Spanish	4	6%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi	1	1%
Arabic		
English	63	91%
Other	1	1%

CHALLENGES AND UPCOMING CHANGES

Marin's Hispanic population has continued to grow and is overrepresented in the County's homeless population. The Odyssey Program continues to explore additional methods for improving outreach to/engagement with Hispanic adults. The Enterprise Resource Center and CARE team will continue efforts to recruit peer outreach staff who are bilingual/bicultural. Marin's new PEI Community Health Advocates Program, scheduled to begin operations in FY2012-13, seeks to more effectively engage with Hispanics, and other hard-to-reach populations, through the use of trained community members (Promotores/Health Promoters). Linkage and coordination with this PEI program is anticipated to expand Hispanic access to the Odyssey Program

As noted above, a substantial percentage of program participants present with co-occurring substance use disorders, putting them more at risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. During FY2011-12, one-time CSS expansion funds were approved to add a part-time substance abuse specialist position to the core assertive community treatment team to provide integrated substance abuse services to 15-20 program participants annually. In July 2011, a contract was negotiated through County Alcohol,

Drug and Tobacco Programs with Marin Treatment Center to provide substance abuse treatment services to program participants with co-occurring disorders, as well as consultation to the core team. There have been significant difficulties engaging participants in this integrated service and the program is actively exploring different strategies for increasing the engagement and retention of targeted program participants in this essential treatment component.

Additionally, resources in the county, including affordable housing, have continued to shrink, while the cost of living remains high. The available pool of flexible funds has not been sufficient to address the needs of program participants, especially those newly enrolled in the Odyssey Program. CSS FY2011-12 one-time expansion funds were approved to increase the program's pool of flexible funding and have been used to fund transitional housing in a 2-bedroom apartment for program participants who are homeless, reducing the program's reliance on hotel rooms. Beginning operations in October 2011, this transitional housing provides a safe place for residents to live while seeking permanent housing. While in the transitional housing, program participants are able to save money for security and rent deposits and can work closely with program staff to develop budgeting and living skills needed for a successful transition to independent living.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13 the Odyssey and STAR FSPs will expand their wrap-around services to include Independent Living Skills Training (ILS), targeting clients who are in transition from homelessness to housing, have the potential to live independently but currently reside with family or in supportive housing or assisted living, or have independent housing but desire to improve their skills and quality of life. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, such as self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. Clients will be assessed so that plans can be individualized. The services will be coordinated with other services the clients are receiving. Approximately 5 clients in each program will be served in FY12-13.

ODYSSEY PROGRAM (HOMELESS)

MR. YANG'S STORY

The client name(s) have been changed

Mr. Yang, a homeless man in his late forties, was referred to the Odyssey team after he had been living under the freeway in Novato for at least a year. He had been repeatedly arrested and was banned from using the Golden Gate Transit system because of his behavior. When we first approached him, he was reluctantly willing to talk with us and engage in treatment. He did undergo a brief period of involuntary treatment at which time he began to take psychiatric medications and then to engage with our team about his hopes and dreams for his future. We were able to support him to enter a transitional housing arrangement and then with his motivation and support of the team, he was able to obtain a housing voucher. With his housing situation stable and feeling back on his feet again, he found his own motivation to continue his recovery. He began volunteering at a local hospital and has continued this to the present. He also then began to reach out to estranged family members who he had lost contact with and re-establish his ties and connections with them. Most recently he arranged a trip to re-connect with his roots and family in South America and successfully visited them last fall to a resounding welcome from his family of origin. Mr. Yang continues to exhibit a drive towards participating in his community and growing his recovery each day.

A CLIENT'S STORY

More Than a Number

When I first started to receive mental health services I was in elementary school, the staff observed that I was "not socializing normally." I continued to receive supportive services, mostly counseling, through middle school. I began acting out more and more as I got older, and it was not long before my erratic behavior and defiance won me a placement in the local juvenile hall, and my first ever opportunity for a directed diagnosis. When I was 15 years old I was admitted to a residential treatment facility for dual- diagnosis adolescents. I was deemed "emotionally disturbed" and drug dependent. When I became an adult I was released, but soon after I began to suffer substance abuse again. I stopped taking any medication for the diagnoses I had received, and my symptoms became out of control. I can still recall the depths of some of my psychoses. I experienced many years of homelessness, and during one of those times I was placed on social security with the aid of county officials. I was given a diagnosis of Schizo-effective disorder.

Over the years I was very resistant to treatment, but the county mental health services department stood by me. I was rescued from the streets and placed into a special housing program for disabled adults; it is called Shelter Plus Care. This program provides supportive services and housing maintenance guidance to people with disabilities, and in particular it offers *immediate* housing funds for disabled individuals as an aid to recovery. I have been receiving county mental health services, including supportive housing services, for over 10 years now. Still, although I reside in a stereo-typically affluent San Francisco Bay Area region, I have seen and felt the budget cuts strike the state of California. I have seen an increase of people on the street who I know would benefit from services just as I have, but times have clearly changed. When the cuts first began there were countless times that I heard the words "we don't have the money for it anymore." But, while I can, I will pursue the chance for a "happy ending" that I have been given. I would like to share how much the services I have received over the last ten years have changed my life.

I am a success story; I know it and so does my entire treatment team. I have gone from continuous short and longer termed hospitalizations, repeated homelessness, many incarcerations, and chronic drug abuse to being an honor student who has been accepted to Mills College. Mills College is a very competitive private four year university with an all-women's undergraduate program (www.mills.edu). As you might imagine, this type of an education is very expensive, but I earned a Dean's Scholarship to help cover the costs. With this scholarship aid, an extra Mills need-based scholarship, and a few federal supplements through the department of education, I am about to make more of my life than anyone who saw that "crazy woman" on the streets ever could have imagined. Although I worked very hard to achieve this high honor, I know that I would not have made it without the support of the mental health services in my county. Many times I was encouraged by my social worker of ten years to start classes at the community college, but I never thought that I would be embarking on a degree program. With the help of my treatment team, I was encouraged to overcome chronic hospitalizations, held accountable, and urged to be productive. Far from being placed on medication and being isolated, I learned that I could actually become a *contributing member of society* despite having a diagnosis of a mental illness. I know for a fact that I would not be where I am today without the funding that this state receives for mental health services. With the steady support of closely monitored county assistance, I have developed scheduling and advanced life skills, stress management, and a variety of ways to manage my symptoms. My life skills management has progressed to the point where I no longer have a representative payee to receive and manage the funds dispersed to me for my Social Security benefits; I do it myself! I have learned to be responsible with my money, paying my own rent and utilities. I now believe that I have something positive to contribute to society, despite the stereo-types that I face as someone with a "scary sounding" diagnosis. While Schizo-effective disorder is in no way synonymous with Schizophrenia, most people assume that the latter is my diagnosis. But, even if I were schizophrenic it would not matter (as my nurse practitioner said)! You can live a successful, productive life of recovery despite schizophrenia also. County mental health services are directly responsible for helping me to stop feeling ashamed and worthless. They have helped me understand that I am more than "mentally ill." And I am not alone, *many* other people use county services to become more than a diagnosis, they are able to prosper and to manage their symptoms.

Over the years the level of support I have gotten from the community mental health services in my county has helped me become more than a "crazy woman." I know I can succeed, and I am in the process of it right now. As a college student, I am a computer science major, but I am determined to get an MBA also. I would like to go into Non-Profit management and to give back to as many people as I can. It is not just an unreachable fantasy; my GPA is 3.92 as of this date. I believe that with the continued support of my treatment team I can enter the work force and participate while "differently abled." I will be *perfectly* happy to pay my share of taxes at that time in order to help others just like myself to get the services that they need to succeed.

Community mental health services in this county provide as much as they can to help keep clients on track. Without budget-supported things like emergency Safeway food cards and rental security deposit assistance, I would be lost. My social worker has even worked with me to get small loans, from the client fund, for the books that I needed to attend classes while I waited on my financial aid disbursements. I have gotten *so* much help from the county as a long term client in order to become the person who I am today, but it is disappearing. Some of the services that have disappeared may seem trivial, like bus tickets for clients, but they are really not if the whole picture is considered. Many people on medication management were given bus tickets to assure they would make it to appointments; I was one of those people until they cut the budget. Because I was considered high risk I was pushed to make appointments and it was very difficult for everyone involved. We were finally able to compromise on a location closer to my residence, but it also required a compromise on the frequency of services I could receive.

The effects of the continuing budget crisis we now face are far reaching, and the people affected are more than just statistical representations. I have thought to myself about the irony in these budget cuts, where the money spent on mental health services and education in particular have actually increased the likelihood that the state will become *more* prosperous in the long run, instead of causing the state to suffer. Without the intervention of mental health services I would not be a Dean's Scholar at Mills College, I would be a mentally ill, homeless, drug addict, living on the streets or locked in a cell. How much would *that* cost the state? The long term investment that county mental health services spent on me has helped give me hope and the tools to succeed. While my treatment team does not feel that I am ready to go "out on my own" just yet, I am taking the steps necessary to make it a reality. More than likely, I will be paying the social security benefits of my parents. And, remember, I am not alone; I have met others during my academic career who are using the same types of services to get into school and start on a degree program. What is really at risk here, and more importantly, *who*? I am happy to present myself as an example of many others who are receiving services through the dwindling mental health budget, and to urge others to advocate that they are not reduced any further. Sadly, I know that some people are unable to reach out to you like this because they have already slipped through the cracks in our budget. This entire fiscal crisis is about far more than money and numbers, but I tell you that we will not recover from this budget crisis unless we invest in the recovery of our citizens.

ENTERPRISE RESOURCE CENTER EXPANSION

PROGRAM DESCRIPTION
July 2010 – June 2011

During the MHSA planning process, one priority identified was to expand Marin's consumer-operated Enterprise Resource Center (ERC). This program work plan included adding two new consumer management positions and establishing a Wellness/Recovery Center in central Marin by enlarging and co-locating the ERC with housing, employment and clinical services at the new Health & Human Services Health and Wellness Campus. In late FY2007-08, ERC moved into its new facility at the Health and Wellness Campus. Also during FY2007-08, MHSA expansion funds were used to increase consumer staffing to enable the Enterprise Resource Center to increase its hours of operation to 7 days a week. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation.

Known for its low-barrier access and welcoming environment, ERC plays a key role in Marin's efforts to outreach to and engage with adults with serious mental illness in the county who are disenfranchised and reluctant to seek help and services. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. Increasingly, other agencies and individuals are coming to ERC to provide classes and groups at the center.

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

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line, available 7 days/weeks; the Linda Reed Activities Club; daily support group meetings designed to promote friendships and the development of social skills and self-awareness; Art, Drama, and Creative Writing classes; specialty groups such as Wellness Recovery Action Plan (WRAP), Spirituality and Awareness, and Crisis Planning; supportive counseling with trained Peer Counselors; a Peer Companion Program that outreaches to individuals who tend to isolate; and assistance with locating and utilizing community resources. Outreach and engagement services for the County's homeless individuals with mental illness are provided by ERC and its CARE team (homeless mobile outreach) which works closely with Marin's Odyssey Program for homeless adults who have serious mental illness. ERC also provides a 5 module Peer Counseling and Case Management training program and on-the-job internships designed to provide "hands-on" experience translating concepts into practice for consumers seeking to work as service providers in the public mental health system.

OUTCOMES
July 2010 – June 2011

The Enterprise Resource Center continues to be successful in engaging hard to reach individuals, in particular those with serious mental illness who have not engaged with CMHS services. During FY2010-11, the Enterprise Resource Center Expansion project served 361 at-risk individuals with serious mental illness, an increase of 54% from FY2009-10. Attendance at ERC increased by 20% to 1,267 monthly visits. Homeless individuals comprised 15% of the average monthly attendance and first time visitors comprised 1%. Warm Line contacts for the year were 9,997, approximately 5% more than the prior year. The CARE team averaged 57 monthly outreach contacts with homeless mentally ill individuals, lower than expected due to unanticipated staffing issues.

The Enterprise Resource Center MHSA CSS programs aim to:

1. Detect and treat severe mental illness early by maintaining a high level of outreach and engagement:

Outcome	Goal	Actual FY10-11
Average daily client visits to the ERC	35	42
Annual number of Warm Line contacts	9,000	9,997
Average monthly CARE Team contacts with homeless/near-homeless mentally ill	100	57
Average daily attendance at the Linda Reed Activity Club	12	12
Average monthly Peer Companion contacts	10-15	11.58

2. Promote independent living and well-being by employing consumers:

Outcome	Goal	Actual FY10-11
Mental Health clients employed or stipend in FY10-11	65	55
Mental Health clients maintaining their positions in FY10-11	75%	97%

During FY2010-11, the Enterprise Resource Center (ERC) Expansion project served 361 at-risk individuals with serious mental illness. ERC served a predominantly Caucasian population, with Blacks/African-Americans being overrepresented at 7% in comparison to the County adult population of 3% (18 years of age and older) and American Indians/Alaskan Natives overrepresented at 3% in comparison to less than 1%. Hispanics were underrepresented at 4% compared to 14% in the adult population, as were Asians at 3% in comparison to 6% in the population.

Age Group	# served	% of served
0-15 years old		
16-25 years old	48	13%
26-59 years old	284	79%
60+ years old	29	8%
TOTAL	**361**	**100%**
Race/Ethnicity		
White	287	81%
African/American	26	7%
Asian	12	3%
Pacific Islander	5	1%
Native	12	3%
Hispanic	15	4%
Multi		
Other/Unknown	4	1%
Other Cultural Groups		
Veteran	29	8%
Homeless	194	54%

Primary Language		
Spanish	15	4%
Vietnamese	1	.3%
Cantonese		
Mandarin	1	.3%
Russian		
Farsi	1	.3%
Arabic		
English	343	95%
Other		

CHALLENGES AND UPCOMING CHANGES

Enterprise Resource Center continues to struggle with outreach and engagement of Hispanics and Asians, despite being located in a geographic area of the county that is largely Hispanic and Asian American, and underserved. Locating in that area reduces access barriers and increases the likelihood that the program's outreach efforts will be successful. The program will continue its efforts to recruit Spanish-speaking consumer staff by offering bilingual pay differentials. Enterprise Resource Center will also continue to incorporate the feedback of its clientele and the community in developing and adjusting program activities and curriculum, so that barriers are further reduced and all feel welcomed. One-time PEI funds were approved in FY2011-12 to increase the capacity of Health Advocates (Promotores) to address mental health and substance use concerns in the same community in which the ERC is located. It is also anticipated that ERC will increase outreach and engagement to Hispanics through partnering with this new PEI project.

In addition to staffing issues noted above which impacted the CARE team's ability to provide outreach services during FY2010-11, there was also an unexpected influx of homeless individuals who appeared to be unusually difficult to engage. During FY2011-12, one-time CSS expansion funds were approved to add a full-time peer specialist to work on the team and help stabilize staffing, plus a small flex fund to support outreach and engagement efforts. With these increases, the CARE Team is projected to serve an additional 80 individuals annually.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13, the Enterprise Resource Center will support the work of MHSA funded Peer Specialists through the purchase of needed equipment:

- 2 replacement cars used by Peer Specialists providing peer counseling, skill building, transportation and other support services to program participants.
- 1 replacement van for the CARE Team which is used for street based outreach services to homeless adults with serious mental illness.
- 6 replacement computers and 1 replacement laptop computer for Peer Specialists.

SOUTHERN MARIN SERVICES SITE (SMSS)

PROGRAM DESCRIPTION
July 2010 – June 2011

In the MHSA planning process, community members identified reaching un/underserved populations as a high priority. The Southern Marin Services Site Program (SMSS), implemented by Family Service Agency, is an outreach and engagement program that targets un/underserved children and adults with serious emotional disturbance or serious mental illness living in the Southern Marin area. The program provides an array of culturally competent, recovery-oriented mental health services, with special attention paid to providing services to ethnic minorities in that area of the County. In-house services include individual psychotherapy for both adults and children, Parent Child Interaction Therapy (PCIT), couple's therapy, family therapy, medication evaluation, substance use services, and case-management services. In addition, home visits are conducted by a parent aide/family advocate trained in Triple P (Positive Parenting Program) and social work interns supervised by Marin City based social workers. Clinical staff members stationed at Bayside-Willow Creek and MLK middle schools provide facilitated groups, classroom guidance, and individual counseling. In late 2011, SMSS stationed a clinician half-time at the Phoenix Project, which focuses on transition age males in Marin City.

OUTCOMES
July 2010 – June 2011

Outcome goals were surpassed for the year:

Outcome	Goal	Actual FY10-11
Children served that improved or were stabilized in their overall functioning as measured by one or more dimensions on the Child Outcome Survey.	70%	80%
Adults served that improved or were stabilize in their overall functioning as measured by one or more dimensions on the Adult Outcome Survey.	70%	72%
Families receiving home visiting services that improved or were stabilized in their parenting/care giving abilities as measured by at least one of three parenting/care giving dimensions on the Adult Outcome Survey.	70%	88%
Students participating in the school-based program that maintained or improved motivation and ability to change problem behavior, and showed stable emotional functioning and/or improved coping skills as evidenced by pre-post assessment and behavioral indicators such as attendance, homework completion and/or incident referrals.	70%	96%

At times SMSS staff can see the success of their work in very tangible ways. SMSS therapists were instrumentally involved with family members of a tragic and brutal murder victim in Marin City this past year. They were also engaged in the treatment of a traumatized witness to this violent event. In addition, there was an event in which a paranoid man atop a roof in Marin City was able to ask police to call his SMSS therapist, which de-escalated the situation. They have also worked with several families wherein corporal punishment and other ineffective means of parenting were the status-quo. Success with these families is tangible and in some instances has been an alternative to institutional involvement (CPS, police, hospitalization, etc.). The only way these successes happen is through clients and families sensing a non-judgmental stance, feeling culturally comfortable, and being encouraged to focus on their own strength and resilience to aid the process.

SMSS has been successful in engaging un/underserved population in southern Marin. The numbers and diversity of individuals and families reached by SMSS (see tables below) speak to its success in providing culturally competent services and collaborating with the community and other providers. SMSS has built a very diverse staff, which includes a bilingual clinician, two (2) African American clinicians, an African American family advocate, a clinician who is part Middle Eastern, and several culturally competent Caucasian therapists. Family Service Agency has continuously looked for effective ways to partner with the community and be responsive to client needs. Adding home visiting and off-site services has increased the accessibility of the services, and developing strong connections to providers in Marin City have resulted in many referrals to SMSS services.

Outreach and Engagement Activities

Age Group	# served	% of served
0-15 years old	175	26%
16-25 years old	100	15%
26-59 years old	350	52%
60+ years old	50	7%
TOTAL	**675**	**100%**
Race/Ethnicity		
White	100	15%
African/American	375	55%
Asian	5	1%
Pacific Islander	20	3%
Native	5	1%
Hispanic	60	9%
Multi	60	9%
Other/Unknown	50	7%
Other Cultural Groups		
LGBTQ	65	10%

Primary Language		
Spanish	10	2%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	665	98%
Other		

Clinical Services

Age Group	# served	% of served
0-15 years old	69	42%
16-25 years old	11	7%
26-59 years old	77	46%
60+ years old	9	5%
TOTAL	**166**	**100%**
Race/Ethnicity		
White	58	35%
African/American	77	46%
Asian	2	1%
Pacific Islander	2	1%
Native	2	1%
Hispanic	7	4%
Multi	8	5%
Other/Unknown	10	6%
Other Cultural Groups		
LGBTQ	12	7%

Primary Language		
Spanish	2	1%
Vietnamese	1	1%
Cantonese		
Mandarin		
Russian		
Farsi	1	1%
Arabic		
English	162	97%
Other		

CHALLENGES AND UPCOMING CHANGES

Challenges to the implementation of the program are always present. Although strides have been made in reducing the stigma associated with mental health treatment, it remains a barrier for some. SMSS is examining and changing their intake process to reduce the time between initial contact and staff response. They are also looking at ways to reduce the time clients are left on the waiting list, although that is an issue that is directly related to staffing and fiscal capacities.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13, Southern Marin Service Site will increase their Administrative Assistant (AA) position from 0.5 FTE to 1 FTE. The number of clinical services has increased since the first year of the program. The AA will both ensure increased responsiveness for clients and improve data collection for the program.

ADULT SYSTEM OF CARE DEVELOPMENT (ASOC)

PROGRAM DESCRIPTION
July 2010 – June 2011

This General System Development/Outreach and Engagement expansion project was designed to expand and enhance supports and services available in Marin's system of care for priority population adults and their families by 1) increasing peer specialist services on the Adult Intensive Case Management team, 2) providing outreach and engagement services to Hispanics/Latinos, 3) increasing Vietnamese outreach and engagement services, and 4) adding family outreach, engagement and support services to the ASOC at large. The project's target population is transition-age young adults, adults and older adults, age 18 and older, who have serious mental illness, and their families, and who are at risk of hospitalization, institutionalization, incarceration, homelessness, frequent emergency medical care or other long-term adverse impacts of mental illness. Priority is given to individuals who are currently unserved or underserved by the mental health system, especially Hispanic/Latino and Vietnamese individuals. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, reduce isolation, and provide low-barrier access which welcomes unserved clients of Vietnamese and Hispanic/Latino origin.

- **Increased Peer Specialist Services**
  The involvement of peer service providers is an important component of Marin's ASOC. Aside from the practical result of providing employment options in the mental health field for individuals with mental illness, the peer specialists bring to the system of care crucial support, education, role modeling and hope for clients, as well as a unique understanding of what it is like to cope with mental illness and stigma. This full-time peer specialist provides services and supports that focus on recovery and illness self-management strategies for individuals whose symptoms have begun to stabilize. The program promotes the concepts of wellness, recovery and self-help within the county-operated core non-FSP intensive case management team serving adults who have serious mental illness.

- **Provide Outreach to and Engagement with Hispanic/Latino Individuals**
  Marin has a well-documented need to increase mental health services for unserved and underserved Hispanics/Latinos. Research has shown that co-locating mental health services in primary care settings improves access to services and improves client outcomes for individuals who do not typically seek or utilize mental health services. In collaboration with the Division of Public Health, Marin implemented an evidence-based practice, the IMPACT model of depression care, in the Health Clinics at the Health and Wellness Campus located in a predominantly Latino neighborhood. MHSA funding was used to increase an existing part-time bilingual (Spanish-speaking) mental health clinician assigned to the Division of Public Health to full-time. This clinician functions as the IMPACT care manager who assists primary care physicians in the care of depressed patients by educating patients about depression and its treatment, coaching patients in behavioral activation, providing time-limited focused counseling to targeted patients, developing relapse prevention plans for patients who improve, and

monitoring depressive symptoms for treatment response. MHSA funding was also used to add a half-time bilingual (Spanish-speaking) psychiatrist to provide medication support services, as well as clinical consultation to the care manager and the primary care providers implementing the IMPACT model.

- **Increased Outreach and Engagement to Vietnamese-Speaking Individuals**
  The Vietnamese population in Marin County has been un/underserved and, because of cultural issues, tends not to seek traditional mental health services, which puts members of this population at increased risk of the long-term adverse impacts of untreated mental illness. By increasing a part-time bilingual Vietnamese speaking clinician to full-time Marin expanded capacity to incorporate the language and culture of the underserved Vietnamese population through the provision of linguistically and culturally competent services. This position provides mental health outreach and engagement to Vietnamese-speaking individuals, as well as translation of language and cultural issues to ensure that staff psychiatrists can accurately provide medication support to monolingual Vietnamese clients.

- **Family Outreach, Engagement and Support Services**
  In keeping with Marin's vision of a family-driven system of care, since 1999, Marin's Family Partnership Program has been staffed by individuals who have personal experience as parents/family members of youth with serious emotional disturbance and provide services to Children's System of Care families. Services provided by the Family Partners include parent education, parent support groups, benefits advocacy, resource development and family-to-family case management. This project expanded the operations of the Family Partnership Program into the ASOC through the addition of a part-time Family Partner who has personal experience as a family member of an adult with mental illness. The ASOC Family Partner provides outreach and engagement services to families of adults with serious mental illness, as well as family-to-family case management services, including provision of support and advocacy, assistance with service plan development and implementation, information and referral to local community resources, including NAMI Marin, and co-facilitation of family support groups.

OUTCOMES
July 2010 – June 2011

During FY2010-11, the ASOC Development project served a total of 253 at-risk individuals who had serious mental illness and their families, somewhat less than the number of individuals served by this project the previous year due to staff turnover and closure of the County Health Clinic where the MHSA-funded Spanish-speaking clinician was implementing the IMPACT model. Increased peer specialist services on the Adult Intensive Case Management team were provided to 10 individuals. Data for the outreach and engagement to Hispanic/Latino individual's program component at the Health Clinic at the County Health and Wellness Campus was not reported. The Spanish-speaking psychiatrist at the Campus provided services to 164 individuals, 36 of whom were Hispanic. The third component of the program – increased outreach and engagement to Vietnamese-speaking individuals – served a total of 11 Asian individuals, 9 of whom used Vietnamese as their primary language. The family outreach, engagement and support services component served an additional 68 individuals who were family members of an adult, age 18 and older, with serious mental illness.

Across the entire ASOC Development project, the proportion of Hispanics served was 15%, consistent with the County adult population of 14%, and the proportion of Spanish-speaking individuals served was 13%, suggesting that, despite the lack of data from the project's primary component for outreach and engagement to Hispanics, the ASOC project continues to be successful in meeting its goal of increasing access for unserved Hispanic/Latino individuals. The proportion of Asians served was 5%, consistent with the County adult population and the proportion of Vietnamese-speaking individuals served was 4%, greater than the 1.4% served throughout Marin Community Mental Health Services during FY2010-11, indicating that the program has met its goal of increasing access for this population as well. The proportion of Black/African Americans was 4%, also consistent with the County adult population and Caucasian adults were underrepresented at 70% compared to 82% in the total population.

Note: County adult population data from 2010 census

Age Group	# served	% of served
0-15 years old	0	0%
16-25 years old	24	10%
26-59 years old	193	76%
60+ years old	36	14%
TOTAL	**253**	**100%**
Race/Ethnicity		
White	178	70%
African/American	9	4%
Asian	13	5%
Pacific Islander	1	0.4%
Native		
Hispanic	37	15%
Multi	12	5%
Other/Unknown	3	1%

Primary Language		
Spanish	32	56%
Vietnamese	10	4%
Cantonese		
Mandarin		
Russian	1	0.4%
Farsi		
Arabic		
English	204	81%
Other	6	2%

CHALLENGES AND UPCOMING CHANGES

As noted above, the project's outreach and engagement to Hispanics/Latinos was impacted by the closure of the County Health Clinic and subsequent departure of the MHSA-funded Spanish-speaking mental health clinician assigned to this component. During FY2011-12, there have been ongoing efforts to site this staff position within a community-based health clinic in order to continue outreach and engagement through implementation of the IMPACT model. These efforts have been unsuccessful. As a result, it has become necessary to consider alternative outreach and engagement strategies for this component. One-time PEI funds were approved in FY2011-12 to increase the capacity of Health Advocates (Promotores) to address mental health and substance abuse concerns in their community. The ASOC Spanish-speaking clinician will increase outreach and engagement to Hispanics by partnering with this evidence-based PEI project through the provision of training, supervision and support to the Health Advocates, as well as assistance in linking community members to public mental health services.

Outreach to and engagement with family members of adult with serious mental illness has exceeded the capacity of the part-time Family Partner position, especially in terms of working with Spanish-speaking family members. CSS FY2011-12 one-time expansion funds were approved to add an additional part-time Spanish-speaking Family Partner position. With this increase, the ASOC family outreach, engagement and support services component is projected to serve an additional 75 family members annually and serve more Hispanic families.

Affordable housing continues to be a challenge in Marin, especially for adults with serious mental illness who typically have very limited income. The ASOC has made great progress in securing community-based supported housing which is available to clients throughout adult services, including those in the Full Service Partnerships. Unfortunately, it is not unusual for clients to experience difficulty paying for such things as moving expenses, security deposits, and utility deposits. Occasionally, clients need one-time assistance with paying rent because of unanticipated emergency expenses. These types of financial difficulty are a source of significant stress for clients and have jeopardized their ability to obtain and retain community-based housing. In FY2011-12, one-time CSS funds were approved to create a Housing Assistance Fund for the ASOC to provide short-term housing assistance funding to annually assist 20 individuals with serious mental illness who are homeless or at-risk of homelessness to successfully access and/or maintain appropriate housing in the community. Where feasible, the funds will be made available to clients as loans with the expectation of repayment.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In order to expand the wrap-around services available to County Mental Health clients, in FY12-13 CSS will pilot the provision of legal services for clients referred from the Adult System of Care. The agency providing legal services for PEI clients, starting in FY12-13, will develop a referral relationship with ASOC programs and begin providing services to clients. Services will be provided

at the same site as the mental health services for the most part. This program expects to serve 150 clients annually (30 CSS, 120 PEI). Services are expected to begin by January 2013.

Children's System of Care and Adult System of Care will jointly add one full time bi-lingual Family Partner position in FY12-13 to expand services to families of mental health clients, particularly assisting family members of individuals evaluated at Psychiatric Emergency Services (PES). The work of the Family Partner (FP) would complement the work of the PES staff and together discharge plans could be developed with the family as a full partner. As time permits, the FP would also be available to families with members in any Full Service Partnerships (FSP). FPs are particularly helpful in assisting families navigate the system and coordinating client care among services. It is expected that this expansion would serve 80 to 100 families per year.

HOUSING

In August 2007, the State Department of Mental Health released the guidelines for the MHSA Housing Program (MHSAHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health. MHSAHP funds can be used to build or renovate rental housing or shared housing. Rental housing developments are apartment complexes with five (5) or more units, where each person or household has his/her own apartment. In shared housing, each resident has a lockable bedroom in a house or apartment that is shared with other housemates. MHSAHP housing must also be permanent supportive housing and counties are required to provide ongoing community-based support services designed to assist residents to maintain their housing and to support their ability to live independently. MHSAHP funds must be used for housing for adults who have serious mental illness and children with severe emotional disorders and their families. In order to qualify for MHSA, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHSAHP regulations. The household must be able to afford to pay rent, and the household income must be less than a specified maximum amount, which ranges from about $30,000 annually for one person to $43,000 for a family of four.

FIRESIDE SENIOR APARTMENTS

PROGRAM DESCRIPTION
July 2010 – June 2011

In FY2008-09, Marin County received approval of our proposal to use MHSAHP funds to leverage a set-aside of five (5) furnished housing units (studio and one-bedroom) for seniors in the Fireside Apartments, a 50-unit affordable housing development for low-income families and seniors located in Mill Valley. The MHSAHP housing at the Fireside Apartments serves older adults (62 years and older) who, at the time of assessment for housing services, receive or qualify for Full Service Partnership (FSP) services and are either homeless or at-risk of homelessness. These are individuals with serious mental illness who have been unserved or underserved by the mental health system. Many of them have a co-occurring substance use disorder, as well as a myriad of complex and often untreated physical health disorders. Some have negative background information and poor tenant histories as a result of their disability and lack of service. Occupancy is limited to those whose income corresponds to the level of support that individuals can expect to receive from Supplemental Security Income or from the State Supplemental Program. Intensive community treatment and housing support services are provided by the HOPE Program and the tenants of the MHSAHP-funded units are eligible to participate in community activities offered at the Fireside by Homeward Bound of Marin, a community-based non-profit organization that is the main provider of shelter and support services for homeless families and homeless individuals in Marin County.

Construction of the Fireside Apartments was completed in FY2009-10 and the application process for the MHSAHP-funded units opened on December 3, 2009. The first MHSAHP-funded unit was occupied on January 25, 2010 and all five (5) units were occupied as of June 6, 2010.

OUTCOMES
July 2010 – June 2011

During FY2010-11, all five (5) Fireside Senior Apartment MHSAHP-funded units continued to be occupied by the original tenants, indicating that this supportive housing project has been successful in reducing homelessness and enabling older adults with serious mental illness to maintain housing in the community and live independently.

CHALLENGES AND UPCOMING CHANGES

Marin has additional MHSAHP funds reserved for leveraging the development of permanent supportive housing for adults and transition age youth (ages 16-25). Marin's housing market continues to be extremely challenging, especially in terms of the development of affordable housing projects. To date, we have been unsuccessful in identifying an appropriate housing development project that fits within the parameters for MHSAHP funding, despite continued discussions with local housing developers and visits to potential housing sites. In FY2012-13, Marin intends to engage the services of a consultant with experience in developing MHSAHP housing in other counties. This consultant will bring critical expertise and dedicated time to the development and implementation of Marin's next MHSAHP project(s).

PROPOSED CSS EXPANSIONS FOR FY2012-2013

SYSTEM DEVELOPMENT PROGRAM: CO-OCCURRING CAPACITY

In the original community planning process for MHSA, addressing co-occurring disorders for clients in the mental health system of care was identified as a priority. While some of the CSS programs incorporate co-occurring capacity to differing degrees, the current integration of Marin County Community Mental Health Services and Alcohol, Tobacco and Other Drugs into a single division of Mental Health and Substance Use Services provides an opportunity to build capacity across the system. This will be a long-term project, starting with a number of small-scale efforts in FY12-13. In addition to those described here, program specific efforts are described within the appropriate program narrative.

Co-Location

A substance use specialist will be co-located at mental health service sites to provide staff consultation, screening, assessment, referral, collaborative treatment planning and care management services for seriously mentally ill clients with substance use issues. This will provide direct services to clients, as well as increase the capacity of the mental health staff.

Improve Policies and Procedures

Marin County Health and Human Services has been working with Zia Partners over the last few years to increase the co-occurring capacity of the system, including County and community providers. One aspect of this work is changing policies, procedures, protocols and paperwork, as well as staff training, to become a system with "no wrong door" – a system in which those with co-occurring disorders can be effectively engaged wherever they access the system. In FY12-13, funds will support one substance use treatment site to help implement the necessary changes and conduct staff training, in order to institutionalize co-occurring capacity.

Tobacco Cessation Capacity

National studies show that smokers with mental illness and/or substance use disorders purchase nearly half (44.3%) of all cigarettes sold in the United States. A local survey found that 72% (N=47) of Marin County mental health consumer respondents smoked an average of a pack a day, while Marin has a 7.4% smoking rate overall. Despite a general assumption that mental health consumers do not want to quit smoking, they reported wanting to quit at similar rates as non-mental health consumers did. A study in 2000 showed that, with the right support, 30.5% of smokers with recent mental illness were able to remain abstinent from tobacco for one year, while only 42.5% of smokers with no mental health histories were able to abstain for a year.

MHSA funds will support a needs assessment, conducted by peers, as to what supports or inhibits tobacco cessation for mental health consumers in Marin. The results of this study will provide actionable data that will be shared and will provide a basis for future cessation efforts. In addition, 10 peers will receive training and experience in conducting 125 interviews.

PREVENTION AND EARLY INTERVENTION (PEI) OVERVIEW

Marin County began the community planning process for development of the Prevention and Early Intervention (PEI) Plan in 2007. It built on the planning process conducted for Community Services and Supports (CSS). Over 200 people and 40 organizations participated in the Prevention and Early Intervention planning process via focus groups, public meetings, key informant interviews, or serving on a work group or the PEI Committee.

PEI funds are intended to reduce risk factors and promote positive skills to increase the well-being of individuals prior to serious emotional or behavioral disorders. Programs are primarily provided in the community, targeting populations that have risk factors for or more mild mental health concerns. 51% of PEI funds were required to be dedicated to youth and transition age youth (0-25 years old).

While each PEI program has specific goals and expected outcomes, the overarching priorities identified for PEI in Marin include:

- Increase awareness about emotional and mental health
- Increase resiliency and recovery skills
- Reduce mental health and substance use risks and symptoms
- Increase access to effective early intervention by increasing:
  - provider awareness and skills for identifying and addressing behavioral health issues
  - services provided in community settings already accessed by target populations
  - services targeted for un/underserved communities
- Implement evidence-based and promising practices that show results
- Build on and help coordinate the systems and services that already exist

In addition to PEI program funds, in the initial years of PEI there are PEI Technical Assistance funds. These funds can be used for projects including evaluation, quality improvement, and implementation of evidence-based programs. To date, these funds have been used in Marin for:

- Technical assistance to implement integrated behavioral health in primary care settings
- Training in evidence-based programs consistent with approved PEI programs
- Cultural competency training and technical assistance for PEI providers
- Technical assistance in evaluating PEI programs

Recognizing that increased funding and services are not sufficient to reach PEI goals, the PEI Coordinator convenes short-term subgroups to identify and address gaps in existing systems of care. Areas addressed by these subgroups have included post-partum depression, transition age youth, older adults, and families accessing more than one behavioral health service.

The narratives in this report address program outcomes. More difficult is assessing the impact of PEI as a whole. Marin is currently working with RAND Corporation to further develop its capacity to assess and report on both the program specific outcomes and the overarching impact of PEI.

At this point we can report on a few key areas notes below.

POPULATIONS SERVED BY PEI PROGRAMS IN FY2010-2011

This table summarizes the individuals served by all PEI programs in FY2010-11, except Suicide Prevention and Mental Health Awareness and Stigma Reduction programs.

Total Individuals Served: 6245

Age Group	% of served	% of Marin Population
0-15 years old	18%	20%
16-25 years old	18%	10%
26-59 years old	46%	50%
60+ years old	18%	20%
Race/Ethnicity		
White	46%	75%
African/American	3%	3%
Asian	2%	5.5%
Pacific Islander	0%	0.2%
Native	0%	0.3%
Hispanic	44%	14%
Multi	1%	2%
Other/Unknown	7%	0%

Primary Language	% of served
Spanish	35%
Vietnamese	1%
Cantonese	<1%
Mandarin	<1%
Tagalog	<1%
Cambodian	<1%
Farsi	<1%
Arabic	<1%
English	63%
Other	2%

We can see from this data that PEI has been effective in reaching the most underserved community, Latino residents. At the same time, PEI aims to expend services for African American and Asian communities. PEI has been successful in serving all age groups in Marin. Most notably PEI has been successful reaching transition age youth (age 16-25), a much underserved population. While this table does not include geographic communities, PEI is county-wide.

PEI COMMITTEE IMPACT

The PEI Committee began meeting quarterly in 2009 to facilitate the implementation of the PEI programs, review PEI program evaluations, and collaborate towards a stronger system of care. Annually, the PEI Committee completes a survey about the PEI Committee. Results about collaboration efforts include:

1 = Strongly Disagree 2= Disagree 3 = Agree 4 = Strongly Agree

	2009	2011
Participation on the PEI Committee helps my organization to develop expertise in MH prevention and programs	2.85	3.11
The PEI Com fosters a "culture of prevention" for mental health	3.00	3.05
The PEI Com works collaboratively with other efforts in the community to address issues	3.00	3.12
Participation on the PEI Com helps my organization to collaborate effectively with other organizations	2.89	3.17
The PEI Com fosters collaboration between mental health and medical providers	3.00	3.29
The PEI Com contributes to the development of a mental health system of care	3.12	3.35

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

PROGRAM DESCRIPTION
July 2010 – June 2011

Early Childhood Mental Health Consultation (ECMH) is promoting the mental health of children 0-5 by helping teachers and parents to observe, understand, and respond to children's emotional and developmental needs. Beginning in FY2009-10, MHSA PEI funds expanded the consultation services previously provided by Jewish Family and Children's Services in subsidized pre-schools and other early childhood education sites. Childcare providers' skills are expanded by receiving training in best practices and ongoing coaching to integrate their learning into their daily interactions with children and families. Parental depression screening and a validated social-emotional screening for children aged 3-5 (DECA-C: Devereux Early Childhood Assessment-Clinical Form) are now available. When needed, consultants assist with following-up with families that have been identified for more intensive services. All consultation services have the goal of increasing the capacity of the childcare providers and families in addressing the needs of children and families.

OUTCOMES
July 2010 – June 2011

The ECMH Program basically met or exceeded all of its goals (see Outcome Table below). In addition, teacher and parent reports and teacher and consultant observations indicate a significant reduction in emotional and behavioral problems among children touched by the program.

Outcome	Goal	Actual FY10-11
Children and Families Receiving Services		
Children that received prevention services	820	877
Percent of these children that come from un/underserved cultural populations	70%	77%
Children/families identified for enhanced intervention (through observation or validated screening tools for child behavior or family caregiver depression) and provided services through ECMH Consultation	75	77
Children receiving enhanced intervention that were retained in their current program, or transitioned to a more appropriate preschool setting: • Retained in current program: 73 • Transitioned to a more appropriate setting: 3	100%	99%

Outcome	Goal	Actual FY10-11
Children and Families Receiving Services *(continued)*		
Parents/primary caregivers of children referred for case consultation and/or attending parent education programs that report increased understanding of their child's development and improved parenting strategies	85%	93%
Families receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent)	75%	100%
Early Childhood Education Sites Receiving Services		
Childcare staff that received additional consultation and/or training	165	181
Childcare staff receiving ECMH Consultation that report increased ability to identify, intervene with, and support children in their care with emotional/behavioral issues	85%	88%
Teachers receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent)	75%	96%
Director's receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent)	75%	100%

The ECMH program is successful at providing prevention, early intervention, and capacity building that reaches far beyond a direct services model. By training and coaching childcare providers, many children and families will benefit for years to come. In addition, intervening early in a child's life can reduce poor outcomes that would require more extensive services later in life. ECMH also focuses on collaborating with other providers to improve systems that in turn improve client services.

Age Group	# served	% of served
0-15 years old	877	100%
16-25 years old		100
26-59 years old		
60+ years old		
TOTAL	**877**	**100%**
Race/Ethnicity		
White	194	22%
African/American	33	4%
Asian	50	6%
Pacific Islander		
Native		
Hispanic	509	57%
Multi	58	7%
Other/Unknown	33	4%

Primary Language		
Spanish	509	57%
Vietnamese	1	.1%
Cantonese	4	.5%
Mandarin	4	.5%
Tagalog	1	.1%
Cambodian	1	.1%
Farsi	1	.1%
Arabic	1	.1%
English	347	40%
Other	8	1%

ECMH provides services to subsidized childcare settings. As can be seen above, the services are successfully reaching underserved populations. Staffs hired with MHSA funds are bilingual and bicultural.

CHALLENGES AND UPCOMING CHANGES

Childcare sites have limited staff meeting time and time to attend trainings as a group. ECMH accommodates these limitations by altering the delivery method, such as through meetings with small groups of teachers and one-to-one coaching and mentoring.

There is a lack of adjunct services, such as Occupational Therapy, for children whose needs are not met within the childcare site or County HHS services. ECMH is working with partners to identify ways to meet this need.

Due to the challenges of reaching family day care providers, and the reduction in program funds, ECMH will reduce services to these providers in order to focus on maintaining effective services for subsidized childcare sites.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13, ECMH Consultation will hire a part-time Occupational Therapy Consultant (OTC) to provide training, consultation, observation, and, as appropriate, treatment planning. ECMH Consultants regularly identify children who might have a sensory processing disorder or developmental delay. Eligible children are referred to the Regional Center or other services, but many do not have severe enough delays to qualify. In 6 hours per week, an OTC will be able to assist with 25-30 children over a year, as well as provide training to approximately 100 staff who work with young children and their families in a variety of settings.

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

CALEB and KILEY'S STORY

The client name(s) below have been changed

Caleb was 3 years and 10 months old when ECMH consultation began. He had been enrolled in his childcare program for just 6 weeks when we were contacted. The classroom staff observed that he exhibited an inability to play well with others, short attention span, and an apparent indifference to following directions. Caleb's mother, Kiley, had already been asking the teachers whether they had concerns and readily gave consent for consultation. After a single observation the consultant was able to validate the staff concerns and arrange to met with Kiley. The most notable observation made by the consultant was the way in which Kiley gently pushed Caleb away when he approached for a goodbye hug.

Kiley reported she was raped at age 15 and became pregnant with Caleb. At her third session, she indicated some awareness of a possible ambivalent relationship with Caleb. Due to Kiley's unresolved trauma, current difficult living circumstances, and what appears to be significant impairment to a healthy mother-son attachment, the goal of this referral was to get mom help for her self-care and counseling for her past trauma, with eventual family therapy.

Work with the classroom staff began with meetings with all of the teachers together to share observations, experiences with Caleb and Kiley, and ideas about the meaning of Caleb's behaviors. The teacher responsible for Caleb's daily small group activity completed a child behavior assessment (DECA-C) after which she and the consultant set goals for Caleb in the classroom based on his protective factors. All of Caleb's scores were in the "Concern" range for both Protective Factors and Behavioral Concerns. On a post DECA-C, completed 5 months after the initial one, all of Caleb's protective factors moved out of the concern range into the low typical and typical range. In addition, his behavioral concerns moved from the high concern range to the low concern range for four factors and into the typical range for one factor.

As a result of ECMH consultation with this classroom and family, Caleb has become more resilient and less aggressive; Kiley has deepened her understanding of her son and the two of them have become more secure in their relationship; and the staff has enhanced knowledge of and appreciation for the emotional foundations of early learning and human relationships. Finally, the ongoing ECMH team support and reflective supervision made it possible for the consultant to recognize and quantify improvement when the pace of the interventions was slow and the intensity of the need seemed overwhelming.

TRIPLE P (Positive Parenting Program): PROVIDER TRAINING & SUPPORT

PROGRAM DESCRIPTION
July 2010 – June 2011

Triple P (Positive Parenting Program) is an evidence-based model for coaching and empowering parents to improve their parenting skills. It has been shown to increase parenting effectiveness and reduce child abuse. Due to its focus on assisting parents to identify their parenting goals and methods for reaching those goals, it is not biased and is culturally sensitive. Triple P is a multi-leveled system, which aims to tailor information, advice and support to the needs of families. Marin County Office of Education (MCOE) provides training and support to providers who work with families in order to provide Triple P services to families in a variety of settings throughout Marin County. The ultimate aim is the healthy development of children and the reduction of emotional or behavioral problems.

MCOE coordinates the training and certification process for providers in Marin. In addition, they provide practitioner meetings to provide a venue for peer learning, staying current in Triple P practices, and discussing implementation challenges. MCOE, in collaboration with Marin County Health and Human Services and other agencies, addresses systems issues involved with implementing Triple P as a population-based program in Marin.

OUTCOMES
July 2010 – June 2011

As a new program in Marin, and a unique model, it was challenging to predict how it would unfold and what adjustments would be needed. Overall, the program has met its goals in certifying providers in Triple P. The more challenging aspect has been assisting the practitioners in implementing Triple P. Providers have gravitated towards Level 3, which is more flexible and requires only a few sessions. Level 4 requires 10 sessions, which clients are reluctant to commit to. Marin County HHS and Marin County Office of Education are working on reducing the barriers for providers and adjusting the structure of the program to better meet local needs.

Outcome	Goal	Actual FY10-11
Providers certified in Level 4 Standard	38	38
Providers certified in Level 4 Group	20	18
Providers certified in Level 3	19	31
Providers certified in Level 2	0	19
Providers certified in Level 4 Triple P will be using it with 30% of their clients	100%	*
Providers certified in Level 3 Triple P will be using it with 30% of their clients	100%	70% use with 50% of clients
Agencies and individuals participating in Triple P that report satisfaction with Triple P as an intervention	75%	95%
Agencies and individuals participating in Triple P that report satisfaction with the training and technical assistance services	75%	80%

* *Level 4 has been challenging for providers to implement, so most have been dual-accredited in Level 3 and 4 and are more likely to use Level 3.*

MCOE has trained individuals from 17 agencies throughout the County. These agencies serve a very diverse client base.

CHALLENGES AND UPCOMING CHANGES

Implementing evidence-based practices is challenging, and in this case more challenging because there are two levels involved: practitioner implementation and population-based implementation. Currently, practitioners are not directly accountable for implementing Triple P, and therefore it requires them to continuously experience a benefit from the practice that outweighs the challenges. This currently varies greatly based on Level, provider style, and other factors. As we learn more about this, we can better support the providers. On a population level, Triple P has been developing providers in the various levels of the program, leading up to a social media/informational campaign that will increase the profile and effect of the program.

Specifically, there have been significant challenges with implementing Level 4. Level 4 requires about 10 sessions and is parenting focused. Level 3 is parenting focused, but can be done in only a few sessions. Level 5 requires more sessions, but addresses complex issues that impact parent/family functioning. Practitioners have gravitated to Level 3 and want Level 5 training, because they find Level 4 too limiting. Level 5 training will be provided and research will be conducted to figure out how to reduce the barriers for using Level 4 and/or adjusting expectations about frequency of use of each Level.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

One of the biggest barriers practitioners are experiencing is a lack of clients that readily fit the Triple P model. Addition of an outreach and social media component to the program is intended to encourage clients to ask for parenting help and be interested in the Triple P model. This will also enhance the work of the practitioners since the more practice providers have with Triple P, the easier it will be for them to adjust the model for a variety of families. In FY12-13, funding for Triple P will be increased to support an informational campaign that will include a website, outreach materials, a media campaign and other tools for both letting people know about the services and reducing the stigma associated with accessing parenting support.

ACROSS AGES MENTORING

PROGRAM DESCRIPTION
July 2010 – June 2011

Across Ages is an evidence-based mentoring program that pairs adult mentors over age 50 with youth ages 9 to 13. The goal of the program is to enhance the resiliency of children in order to promote positive development and prevent involvement in high-risk behaviors. The program consists of four components: (1) adults mentoring youth, (2) youth performing community service, (3) youth participating in a life skills/problem-solving curriculum, and (4) monthly activities for family members. Across Ages was developed at Temple University's Center for Intergenerational Learning. Marin City Network (MCN) is implementing this program with students from MLK Academy Middle School.

OUTCOMES
July 2010 – June 2011

Funding for this program began in February 2011 and therefore no outcome reporting was required for FY10-11. In the first 5 months of the contract, MCN:

- Hosted a training by the developer of Across Ages for organizations that will partner in the implementation of the Program;
- Began identifying potential participants through an existing group for middle-school boys and by beginning a weekly group for middle-school girls;
- Began developing outreach strategies to identify and enroll mentors;
- Began developing youth community service projects.

This program targets at-risk middle-school students in Marin City.

CHALLENGES AND UPCOMING CHANGES

Finding appropriate mentors is likely the biggest challenge for the program. Mentors should be 50-65 years old, able to engage with the students, able to commit to the time required, and many other criteria. MCN is developing outreach materials and strategies to identify and engage mentors. MCN has leveraged additional funding to expand this program in the near future.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2010 – June 2011

The Transitional Aged Youth (TAY) PEI program aims to increase wellness by increasing access for transition age youth (16-25) to mental health support in trusted settings. Huckleberry Youth Program (HYP) and Novato Youth Center (NYC) have implemented PEI programs since July 2009. Current program components include:

- Mental health/substance use screening: Clients complete a validated screening as part of the registration process when accessing teen heath clinic services.
- Brief intervention mental health services: Youth who are identified in an at-risk category through the screening are linked directly to either a licensed counselor or a case manager for further assessment and brief intervention as appropriate. Families of TAY are included in brief intervention services as appropriate.
- Prevention workshops for TAY and educational workshops for parents and providers of TAY: The workshops focuses on identifying mental health risks, reducing the stigma of mental health disorders, demystifying intervention services and distributing information about access points in Marin County.
- School-based services: Psycho-educational groups are being held at San Marin, San Rafael and Madrone high schools, offering eight to ten sessions to promote coping and problem-solving skills for students. Depending on the school, youth are eligible through self-referral, referral by school staff, or through participation in special programs, such as the "Plus" program at San Marin or the "Newcomer" program at San Rafael.

OUTCOMES
July 2010 – June 2011

The TAY PEI Program basically exceeded all of its goals (see Outcome Table). Initially the program included providing trainings to partner agency providers (such as schools, community organizations) in identifying and referring TAY to the TAY program. No partner agencies chose to schedule these sessions, primarily due to lack of time to engage in training and expanded responsibilities. TAY PEI moved its efforts to increasing psycho-education groups at schools, greatly increasing the number of TAY receiving early intervention services. HYP and NYC have been successful at adjusting their programs in response to the needs of their target population, leading to effective programs and a high level of client satisfaction.

Outcome	Goal	Actual FY10-11
TAY Receiving Services		
Number of TAY that receive Prevention services	600	790
Number of TAY that received Early Intervention services	60	253
Percent of clients from un/underserved cultural populations	65%	67%
Percent of TAY participating in educational outreach activities that show either an increase in knowledge or base level of knowledge about coping strategies and risk factors for serious mental health issues, and/or intention to change behavior to increase protective factors	80%	98%
Percent of clients participating in at least five sessions of brief intervention that demonstrate improvement in mental health status	50%	55%
Percent of clients participating in at least five sessions of brief intervention that demonstrate improvement in at least one of the following indicators: (a) resilience/protective factors, (b) reduced isolation/increased social support, (c) reduced family stress/discord	65%	90%
Percent of PEI clients completing the brief intervention program (5 sessions) that report satisfaction with the services	75%	100%

The TAY PEI program served a total of 962 individuals. Most of these individuals were TAY, but also included 25 parents of TAY attending educational workshops. In addition, 41 families were engaged in the course of providing brief intervention to TAY.

Age Group	# served	% of served
0-15 years old	203	21%
16-25 years old	734	76%
26-59 years old	25	3%
60+ years old	0	0
TOTAL	**962**	**100%**

Other Cultural Groups	# served	% of served
LGBTQ	49	5%

Race/Ethnicity	# served	% of served
White	272	28%
African/American	75	8%
Asian	39	4%
Pacific Islander	0	0%
Native	5	1%
Hispanic	458	47%
Multi	17	2%
Other/Unknown	96	10%

Primary Language	# served	% of served
Spanish	241	4%
Vietnamese		
Cantonese	1	4%
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic		
English	713	92%
Other	8	

HYP is located near San Rafael High School and NYC is located in an accessible location in Novato. In addition, they are providing services on school grounds and specifically outreach to un/underserved TAY. As can be seen above, the services are successfully reaching underserved populations. Staffs hired by MHSA funds are bilingual and bicultural.

CHALLENGES AND UPCOMING CHANGES

During the reporting period, HYP and NYC observed that many TAY clients were engaging in no more than three sessions of brief intervention services, less than the goal of five or more sessions. Their hypothesis is that given that youth often experience crises influenced by the myriad physical, social and emotional changes they undergo during this time, many TAY may only need a few sessions to meet their immediate needs. Hopefully these few sessions contribute to the development of essential coping skills and increase the chances they will seek appropriate help if needed in the future. The TAY Program is looking at ways to maximize the efficacy of a three or more-session brief intervention model to help clients enhance their coping strategies and resilience factors beyond immediate crisis intervention.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13 PEI will explore additional ways to serve the unique needs of the TAY population.

Evidence Based Practices

The existing TAY PEI program will receive increased funding in FY12-13 to enhance their work with TAY by implementing additional evidence-based programs. Clinical staff will receive additional training in issues that TAY are commonly presenting with, such as severe trauma, exposure to

domestic violence, substance use, disordered eating, sexual identity and orientation issues, and complex family issues often experienced in immigrant families. Training will be made available to other PEI providers as appropriate. Staff will be trained in evidence-based programs, such as "Say It Straight", including developing Master Trainers, to implement these mental health and substance use interventions sustainably. The database system will be expanded to improve data collection capacity.

Skill Building Workshops for At-Risk Teens and their Caregivers

LIFT for Teens and The Center for Restorative Practice will collaborate to offer skill-building workshops to at-risk teens (13-18) and their parents. Through existing relationships with the Office of Education, Juvenile Probation, Children and Family Services, and Marin Advocates for Youth/CASA, these workshops will target youth who are at-risk of school failure, who have contact with the law, are in foster care or who struggle with depression, anxiety or suicidal ideation. The workshops will be offered across four underserved regions in English and Spanish, incorporating Cognitive Behavioral Therapy and other evidence-based tools to increase the teen and family's capacity to address depression, anxiety, substance use, and suicidal ideation. This project will serve 70 youth and their families in FY12-13.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

ANA'S STORY

The client name(s) below have been changed

Ana, a 15-year-old Latina, had been feeling depressed and anxious for more than a year. Her grades had dropped dramatically, and she experienced panic attacks and suicidal feelings. Her mother sought support for her at a local medical clinic, but the teen complained that the counselor there could rarely see her and that all they could do for her was prescribe medications (which she refused to take). Ana's academic counselor referred her to the Novato Wellness Center for counseling, where she met with a bilingual licensed therapist during the Monday afternoon teen clinic that week. After a crisis intervention in which Ana contracted to not hurt herself, she also agreed to weekly therapy sessions. Both she and her mother were very relieved they could afford the sessions and that the therapist could speak to the mother in her native language. After only 3 weekly sessions, Ana showed dramatic improvement. She no longer felt suicidal, her mood had improved, and she had taken concrete steps to improve academically. She also was able to identify positive self-attributes, she knew what to do to prevent further panic attacks, and she felt increasingly hopeful about herself and her future. Ana's mother also had a better idea of how to support her daughter in fighting her depression.

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2010 – June 2011

Canal Community-Based PEI program aims to increase wellness by increasing access to mental health prevention and intervention services for Canal's un/underserved residents at the earliest signs of mental health problems. Canal Alliance (CA), in collaboration with Family Service Agency, has implemented this program since July 2009. The program includes:

- Training CA front line workers to assess and refer clients for mental health issues, as well as be more comfortable addressing psychological concerns.
- Wellness groups that bring together anxious, depressed and/or traumatized individuals for mutual support, training in individual and group tools to increase and maintain mental wellbeing, and for healing.
- Assessment sessions to identify issues and resources for individuals and families.
- Triple P (Positive Parenting Program) Level 3 and 4 services in individual and group format.
- Cuidate, an eight-session workshop that includes stress management and child development, is a collaboration between CA and a child development educator.

Canal Alliance is located in the Canal neighborhood of San Rafael, comprised mostly of immigrants from Mexico and Central America dealing with extreme poverty, traumatic pasts, ongoing fears, family strife and almost no mental health services within financial or linguistic reach. CA has provided a wide array of services to this community for 29 years, building a high level of respect and trust.

OUTCOMES
July 2010 – June 2011

The Canal Community-Based PEI Program exceeded all of its goals (see Outcome Table below). CA effectively adjusts its program to respond to client need, while maintaining focus on the desired mental health outcomes. The Wellness Groups, as a central part of the program, have found a format that clients respond well to, including an opportunity to "tell their story" and to build a supportive community with other members. In addition, the increased ability of participants and Canal staff, many of whom live in the Canal, to talk about topics previously unspoken has begun to create a cultural shift within the larger community.

Outcome	Goal	Actual FY10-11
Community Members Receiving PEI Services		
Number of clients receiving Prevention services	300	373
Number of clients receiving Early Intervention services	50	71
Percent of clients from un/underserved cultural populations	75%	92%
Percent of CAPEI clients who complete the brief intervention program that exhibit improved mental health status	50%	90%
Percent of CAPEI clients who complete the brief intervention program that reported a decreased sense of isolation and increased sense of social support	50%	100%
Percent of CAPEI clients who complete the brief intervention program that increase their knowledge and demonstrate their use of wellness strategies	50%	97%
Percent of children receiving Level 4 Triple P services will show improvement in behavior	50%	*
Percent of PEI clients completing the brief intervention program (CAPEI or Triple P) that report satisfaction with the services	75%	100%
Providers Trained in Mental Health		
Percent of providers receiving training in mental health issues that show either an increase or base level of knowledge about mental health, providing appropriate services, and making effective referrals	75%	100%

* At the time of the report the families engaged in Triple P Level had not yet completed the series of sessions, but were showing improvement.

The Canal Community-based PEI program provided screening and education for 373 individuals and brief intervention for 71 individuals. Staffs hired by MHSA funds are bilingual and culturally competent. As expected, this program has served primarily the Latino community.

Age Group	# served	% of served
0-15 years old		
16-25 years old	94	25%
26-59 years old	273	73%
60+ years old	6	2%
TOTAL	**373**	**100%**
Race/Ethnicity		
White	31	8%
African/American		
Asian	6	2%
Pacific Islander		
Native		
Hispanic	336	90%
Multi		
Other/Unknown		
Other Cultural Groups		
LGBTQ	3	1%

Primary Language		
Spanish	336	90%
Vietnamese	6	2%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic		
English	31	8%
Other		

CHALLENGES AND UPCOMING CHANGES

The demand for the services is likely much higher than CA can currently meet. Due to limited staff time and meeting space there is a limit on number of clients that can be engaged and served. Triple P Level 3 has taken time for the front-line workers to master, so ongoing training is being provided in weekly case management meetings. Triple P Level 4 requires families to commit to about 10 sessions, which is not always achievable. Relying more on Level 3 allows Triple P to be provided in a more flexible format.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13, the Canal Community Based PEI program will pilot small group intervention model to support healthy reunification of Latino immigrant families. These families face a unique set of challenges when their children, who were temporarily left in their country of origin, are brought to the United States. The youth are at higher risk for psychosocial problems, school failure, drug use, and other risk-taking behavior. This project will research similar interventions, develop curriculum, and implement a six-week series of small group interventions for approximately 10 families. Anticipated results include helping parents to understand their children's experience, parent more effectively, reduce their stress, and become more familiar with community resources. In addition it will help children and adolescents to process their experience, develop peer connections, and understand their parents' perspective.

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

PROGRAM DESCRIPTION
July 2010 – June 2011

Integrated Behavioral Health (IBH) recognizes that people's behavioral health and physical health are inter-related and therefore the care should be inter-related and coordinated. Programs for integrating behavioral health in primary care settings aim to increase wellness by increasing access to mental health and substance use prevention and intervention services. Marin Community Clinics (MCC) and Coastal Health Alliance (CHA) have received MHSA funds since July 1, 2009 to provide mental health screening and brief intervention for un/underserved populations at the earliest signs of mental health problems.

There are many models for integrating mental health and substance use services into primary care sites. MCC and CHA have been working with IMPACT, an evidence-based program to screen and provide brief intervention for depression. It is a many-tiered program that includes provider education, data tracking, stepped-care, and other components. Both sites have been implementing the program with support from experts at the UCSF Department of Psychology.

OUTCOMES
July 2010 – June 2011

Outcome	MCC Goal	MCC Actual FY10-11	CHA Goal	CHA Actual FY10-11
Community Members receiving PEI Services				
Number of clients that received depression screening.	1200	1151*	480	2906
Number of clients that received brief intervention services.	250	392	120	141
Percent of clients receiving brief intervention that demonstrate increased mental health knowledge.	70%	56%**	70%	67%
Percent of clients receiving brief intervention that demonstrate increased knowledge of risk, protective, and resiliency factors.	70%	28%**	70%	77%
Percent of clients completing brief intervention experiencing a decrease of at least 50% in depression symptoms.	50%	49%	50%	57%
Percent of clients completing brief intervention experiencing improved quality of life or functioning.	50%	22%	50%	73%
Percent of clients completing the brief intervention program that report satisfaction with the services.	80%	87%	80%	***
Percent of those screening positive for depression that receive a diagnostic assessment.	75%	100%	75%	61%
Providers trained in Mental Health				
Percent of providers completing training sessions showing either an increase in knowledge/ability or base level of knowledge/ability in screening and referring for mental health concerns.	90%	100%	90%	100%

* This is likely under-reported due to data tracking methods. It is being corrected.

** Clients entered the program with fairly high level of knowledge (mean score of 3.84 on a 1 to 5 scale), making it difficult to achieve an increase in knowledge. Alternate assessment options are being considered.

*** Not enough data to report.

Marin Community Clinics (MCC)

Age Group	# served	% of served
0-15 years old	6	<1%
16-25 years old	105	9%
26-59 years old	905	78%
60+ years old	135	12%
TOTAL	**1151**	
Race/Ethnicity		
White	458	40%
African/American	88	8%
Asian	50	4%
Pacific Islander	6	<1%
Native		
Hispanic	399	35%
Multi		
Other/Unknown	150	13%

Other Cultural Gropus	# served	% of served
LGBTQ		
Veteran		
Other		
Primary Language		
Spanish	350	30%
Vietnamese	4	<1%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
English	681	59%
Other	116	10%

Coastal Health Alliance (CHA)

Age Group	# served	% of served
0-15 years old		
16-25 years old	297	10%
26-59 years old	1889	65%
60+ years old	720	25%
TOTAL	**2906**	
Race/Ethnicity		
White	1664	57%
African/American	18	<.06%
Asian	2	<1%
Pacific Islander	3	<1%
Native	22	<1%
Hispanic	1192	41%
Multi	5	<1%

Other Cultural Groups	# served	% of served
LGBTQ		
Veteran		
Other		
Primary Language		
Spanish	980	34%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
English	1926	66%
Other		

MCC and CHA serve primarily low-income residents. IMPACT is implemented at three (3) MCC locations in Central Marin and two (2) CHA locations in West Marin. Staff hired with MHSA funds are bilingual and culturally competent. MCC provides translation services for Vietnamese and other languages. MCC has made efforts to reach out to low-income African American communities in Marin and to partner with a clinic located in Marin City, a diverse area in Marin.

CHALLENGES AND UPCOMING CHANGES

The two major challenges the IBH program has faced are:

- While depression is the most common mental health concern, clients often face other or co-occurring issues, including anxiety, trauma, and substance use. The IMPACT model is a "stepped care" model that can also address these issues and has been expanded to do so at MCC and CHA. In addition, Marin County Community Foundation has awarded Sutter Funds to these sites to expand their IBH programs, including providing substance use screening, brief intervention and referral to treatment services (SBIRT).

- As with many evidence-based models, IMPACT requires adherence to the model and extensive data collection. Marin Community Foundation and PEI are working with MCC and CHA to adapt the programs to best address the client and site needs, while maintaining the integrity of a stepped care model.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13 the IBH in Primary Care program will be expanded to support additional primary care sites in establishing or expanding their IBH programs. Currently two primary care sites in Marin, the Marin City Health and Wellness Center and Ritter Center, are in process of establishing their FQHC status. In addition, Marin Treatment Center, a primary care and substance use treatment site is expanding to address mental health issues. These funds will support provision of mental health services to approximately 800 people in FY12-13.

New Marin Community Clinic Site

Expanded services will be provided by adding .6 FTE bi-lingual (English/Spanish) Care Manager for the Campus Clinic. This site currently offers Obstetrics services, including behavioral health. Beginning September 2012 primary care services will be offered at the Campus Clinic. PEI funds will support behavioral health services for approximately 1200 primary care clients per year.

Marin City Health and Wellness Center

MCHWC is in the process of developing its IBH program and will greatly benefit from the experience of the existing IBH sites. PEI funds will support MCHWC staff to participate in the learning community that has been developed and begin implementing evidence-based and promising practices at their site. MCHWC serves underserved communities in Southern Marin and is located in Marin City, a very diverse and low-income community.

Ritter Center

Ritter Center participates in the existing IBH learning community in Marin. PEI will help expand the capacity of their existing program by supporting the inclusion of IBH in their EHR and expanding sitting room for clients.

Center Point

Center Point currently provides substance use treatment and primary care services. A significant portion of their clients present with co-occurring disorders, but are not eligible for County mental health services. Center Point will hire a consulting psychiatrist to assist with identification, assessment and stabilization of clients with mental health concerns. Some clients may need ongoing medication management or other mental health services, and can be transitioned to primary care or other appropriate settings.

OLDER ADULT PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2010 – June 2011

Older adults are a growing portion of the population of Marin. Due to changes brought on by aging, they are at-risk for isolation, depression, chronic health problems, substance abuse, or other issues. In April 2010, Marin Meals on Wheels (MMOW) began implementing a program to provide screening and brief intervention in the home to older adults receiving home delivered meals.

OUTCOMES
July 2010 – June 2011

The Older Adults program met or exceeded most of its goals. It was very successful in engaging with the clients that were eligible for and chose to accept the offered services.

Outcome	Goal	Actual FY10-11
Older Adults Receiving PEI Services		
Number of older adults that received Prevention services	500	318
Number of older adults that received Early Intervention services	60	62
Percent of PEI clients who received brief intervention that exhibit improved mental health status	50%	100%
Percent of PEI clients who received brief intervention that reported a decreased sense of isolation and increased sense of social support	50%	80%
Percent of PEI clients who received brief intervention that report an increase in their knowledge of and demonstrate their use of wellness strategies	50%	96%
Percent of PEI clients who received brief intervention services that report satisfaction with the services	75%	100%
Providers Trained in Mental Health		
Percent of MMOW providers receiving training in mental health issues that show either an increase in, or base level of, knowledge about mental health, providing appropriate services, and making effective referrals.	75%	100%

The Older Adult Program provided screening and education to 318 individuals and brief intervention services to 62 individuals. Due to the demographics of Marin, MMOW primarily serves white, English-speaking clients (see Demographics on next page). They have made efforts to reach

un/underserved populations, such as by serving a congregate meal in Marin City, a very diverse area of Marin. MMOW also serves West Marin, a geographically isolated and underserved population.

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old		
60+ years old	318	100%
TOTAL	**318**	**100%**
Race/Ethnicity		
White	313	98%
African/American	2	1%
Asian	2	1%
Pacific Islander		
Native		
Hispanic	1	.5%
Multi		
Other/Unknown		
Other Cultural Groups		
LGBTQ	8	3%
Veteran	67	21%

Primary Language		
Spanish	1	.5%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian	1	.5%
Farsi		
Arabic		
English	313	98%
Other	3	1%

CHALLENGES AND UPCOMING CHANGES

One of the challenges this program faced was the fact that older adults tend to have complex inter-related issues and can take longer to build the trust necessary to accept services. The mental health worker would sometimes visit a client multiple times before conducting a screening or being able to address concerns identified.

While the program was achieving its goals in most ways, it became apparent that one of the planning assumptions was not correct. During the original PEI planning process a major goal identified was reaching isolated older adults. The assumption was that clients receiving home delivered meals would be at high risk for isolation. In implementing the PEI program it became clear that most of the clients were accessing various services, and therefore not as isolated as expected.

At this point the program has been changed to:

1. Provide mental health assessment, education, early intervention, and linkages to appropriate services for older adults referred to the program by other providers, community members or a self-referral. In addition education sessions about identifying older adult mental health issues and making referrals will be provided to older adults and community providers. Jewish Family and Children's Services began implementing this program in January 2012.

2. Expand the ACASA program, which trains and supervises volunteers to provide peer counseling to Spanish speaking older adults as they navigate the transitions that aging brings.

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

In FY12-13 PEI is exploring additional approaches to serving the unique needs of an expanding older adult population:

Marin Villages

The existing OA PEI program provides training for older adults and older adult providers to help them identify signs of behavioral health concerns and to link individuals to services, in addition to providing direct services to older adults with depression and other concerns. This expansion will allow for the training of Marin Villages leadership, volunteers and members to identify and respond to behavioral health issues. Marin Villages is one of the Villages springing up in the United States to support aging in place. At least 160 participants will receive the training. In addition, OA PEI staff will be available to consult with staff and volunteers, as well as provide some screening and assessment, focusing on un/underserved older adults. A protocol and curriculum will be developed, allowing Marin Villages to continue integrating this aspect into their work. Ideally, Villages will be an expanding model that will carry this forward as they grow.

Preventing Depression Associated with Falls

Research demonstrates that there is an increased risk of depression in older adults who experience an injury and loss of functioning related to falls. In an effort to prevent falls and potential mental health impacts, the Novato Fire District (NFD), in partnership with Dominican University, will collect, analyze and interpret data as it relates to a very frequent call Novato Fire Districts responds to: the elderly person who has experienced a fall. This will be a one-time project in FY12-13 to inform practices and policies in the future.

The goal of this project is to:

- Create a data base to determine trends related to falls in the elderly patient
- Pilot the use of the depression screening tool the "PHQ2" with the paramedics and EMTs
- Analyze the data, including results of the PHQ2, to determine trends
- The results of the analysis will then be used to:
    - determine the correlation between falls and depression risk
    - inform NFD on how to best contribute to the prevention of falls resulting in costly hospital transports

SUICIDE PREVENTION

PROGRAM DESCRIPTION
July 2010 – June 2011

The PEI Suicide Prevention program was a two-year program (July 2009-June 2011) to develop and implement a sustainability plan for suicide prevention services for Marin County in the face of funding reductions. In addition the plan was to consider how these services could better address the needs of underserved populations. During the period of the program Family Service Agency was able to maintain Marin's only 24/7 suicide prevention and crisis hotline while engaging in a community process to develop a sustainability plan.

OUTCOMES
July 2010 – June 2011

The Suicide Prevention program met or exceeded most of its goals (below). An additional goal was to assess the option of regionalizing services. As a result of this goal, FSA applied for and was awarded a three-year contract in the amount of $1.2 million from the California Mental Health Services Authority (CalMHSA) to coordinate the regional North Bay Suicide Prevention Project, including increasing the capacity of the 6 participating counties to provide a suicide prevention service and increasing community outreach, specifically targeting high-risk and un/underserved communities.

Outcome	Goal	Actual FY10-11
Community Members Receiving Suicide Prevention Services		
Number of people receiving suicide prevention Hotline services		1188
Percent of people calling the suicide prevention Hotline that received immediate and confidential services as evidenced by Hotline call records	100%	100%
Percent of people calling the Hotline in crisis or experiencing depression, anxiety, anger, or other extreme state that experience a reduction in the intensity of their emotions	80%	92%
Sustainability and Capacity		
Percent reduction in operating and personnel expenditures achieved by implementing sustainability plan	25%	21%
A translation service will be implemented to serve non-English speakers, if feasible	YES	YES

The Suicide Prevention and Community Counseling (SP&CC) program recruits and trains volunteers to staff the 24/7 phone services. Volunteers come from diverse backgrounds including African American, Spanish speaking, and Middle Eastern. They range in age from 19-78 years old. The crisis line now contracts with an interpretation service in order to provide services in any language. While it is challenging to collect demographic information during the course of a crisis call, the SP&CC attempts to. A summary of client demographics is included in the table below.

Age Group	# served	% of served
0-15 years old	120	10%
16-25 years old	282	24%
26-59 years old	546	46%
60+ years old	240	20%
TOTAL	**1188**	**100%**
Race/Ethnicity		
White	518	44%
African/American	28	2%
Asian	15	1%
Pacific Islander		
Native	5	.5%
Hispanic	36	3%
Multi	1	.5%
Other/Unknown	585	49%
Other Cultural Groups		
LGBTQ	36	3%
Veteran	7	1%

Primary Language		
Spanish	14	1%
Vietnamese		
Cantonese		
Mandarin	1	.5%
Tagalog		
Cambodian		
Farsi		
Arabic		
English	1172	98%
Other	1	.5%

CHALLENGES AND UPCOMING CHANGES

The main barriers to accessing a suicide prevention hotline are lack of access to a telephone and discomfort with using a phone to reach out to a stranger in difficult times. Furthermore, individuals may be unaware of the services. Presentations about the hotline were conducted in West Marin, for peer counselors, and to other providers. In addition, specific outreach and support was provided to high schools and middle schools, especially after the tragic teen suicides that occurred. With the 3-year regional grant, outreach efforts will be increased.

The CalMHSA funded North Bay Suicide Prevention project is a major expansion of the Marin suicide prevention and crisis hotline. At the end of three years, FSA will respond to calls from six counties, substantially increasing its geographic reach. The project is a collaboration between FSA and the six County Mental Health divisions, and includes the formation of local suicide prevention committees in each county. An essential component of the success of the project is the establishment of effective working relationships with the local emergency resources, such that people calling in a suicidal crisis receive immediate services.

In addition to the regional project CalMHSA has funded suicide prevention campaign. Marin has been involved in the needs assessment phase of that project and expects to benefit from the efforts and materials that result.

MENTAL HEALTH AWARENESS AND STIGMA REDUCTION MEDIA CAMPAIGN

PROGRAM DESCRIPTION
July 2010 – June 2011

The Mental Health Awareness & Stigma Reduction Media Campaign was a two-year program (July 2009-June 2011) to increase understanding about mental health and reduce barriers to accessing service. Full Court Press (FCP), a communications agency, developed and implemented various media strategies for providing information about mental health, available services, and personal stories. Media strategies included print media, television, radio, and electronic media. In addition, they trained mental health providers to increase their capacity to communicate effectively about their services. Workshops included using social media, spokesperson training, and developing effective messages to reach clients, funders and other target populations.

OUTCOMES
July 2010 – June 2011

This program met or exceeded its goals. Originally video-taped spokesperson trainings were the only workshops planned, but FCP quickly developed other trainings in response to the interests of the PEI providers. Increasing the capacity of consumers and providers to speak effectively about mental health issues puts a "human face" on mental health issues, as well as reduces the stigma of and barriers to accessing services.

Outcome	Goal	Actual FY10-11
Number of key spokespeople (mental health providers and consumers/family) that receive media training and will feel competent to conduct media interviews	20	48
Number of representatives from PEI agencies that receive training and increase their capacity to use the media to support their services	0	30
Marin County media coverage of messaging on mental health access, stigma, and discrimination will have increased, especially targeted for un/underserved populations	YES	YES

Over the two years of this program, FCP placed many articles, interviews and other materials throughout Marin media. These included regular articles in Spanish language publications, a newspaper that serves Marin City, and newsletters targeting older adults. A Marin teen was assisted with writing an article for local teen magazine. Interviews were carried on Bay Area radio and television stations, including a Spanish language television station.

CHALLENGES AND UPCOMING CHANGES

At this point there is a statewide Stigma Reduction campaign being developed under the coordination of California Mental Health Services Authority (CalMHSA). Marin has been involved in the needs assessment conducted for that campaign and expects to benefit from the efforts and materials that result.

NEW PROGRAMS

CLIENT CHOICE & HOSPITAL PREVENTION PROGRAM – CRISIS PLANNING

PEI and Innovation funds have been integrated to implement the Client Choice and Hospital Prevention Program. The purpose of this program is to reduce crises and involuntary hospitalizations, while increasing client choice and resiliency. There are two components:

- Innovation: Development of a crisis residential unit that offers a home-like environment for those, age 18 and above, who are experiencing a psychiatric crisis.
- PEI: Crisis planning services are offered to any individual at risk of a psychiatric crisis. Peer counselors and clients work together to develop a plan that identifies early warning signs, triggers, support team members, early intervention options, and preferences for treatment when experiencing a psychiatric crisis.

Community Action Marin began implementing the Crisis Planning program in July 2011.

NEW SHORT TERM PROGRAMS FOR FY12-13 AND FY13-14

In April 2012 Marin submitted a Plan Update to the State that included five new PEI Programs. Four of the five began in July 2012. The Community Coalitions program will begin early FY2012-13.

Vietnamese Community Connection (PEI 11)

Current PEI programs do not have the capacity to serve the monolingual Vietnamese community or to do effective outreach into the Vietnamese community. This program will provide a part-time Vietnamese speaking outreach worker to:

- outreach to and provide behavioral health education for the Vietnamese community;
- assist Vietnamese residents in accessing mental health services by providing services such as accompanying them to appointments, translation, and such; and
- assess the behavioral health needs of the Vietnamese community to inform future PEI planning process.

Fiscal Year 2012-2013 Program Expansion:

In FY12-13 Vietnamese Community Connection will increase the outreach worker position from 0.5 FTE to 1 FTE, as well as fund a program consultant to provide oversight, supervision and mentoring to the outreach worker. This will allow for better collaboration among County and community staff serving the Vietnamese community, as well as increasing the outreach workers capacity to address substance use issues in the community.

Mental Health Community Training (PEI 12)

Mental Health First Aid is a 12-hour course about mental illnesses and substance use disorders for community members (such as primary care professionals, school personnel, law enforcement, nursing home staff, mental health board members, volunteers, etc). It is shown to increase understanding of mental health/substance abuse, increase likelihood of helping others, and decrease stigma. PEI funds will provide free training for approximately 150 people, as well as establish an infrastructure to continue trainings at low-cost if there is further demand.

Teen Screen (PEI 13)

An evidence-based program that provides voluntary screening for sophomores on eight issues (depression, anxiety, substance use, eating disorders, etc), followed by an interview with a clinician. Students in need of follow-up are linked to appropriate resources, such as their family, private services, Medi-Cal providers, and/or school mental health staff. It is currently in place at most high schools in a Marin. PEI funds will allow Teen Screen to be implemented at additional schools, increase student participation rates, and expand follow-up services.

Community Coalitions (PEI 14)

Community coalitions bring together local stakeholders to assess mental health concerns and develop effective policy and community level solutions to support mental well being. The use of coalitions is an evidence-based strategy that promotes coordination and collaboration and makes efficient use of limited community resources. PEI will fund staff time and technical assistance for two community coalitions. Community coalitions will be required to consider the needs of un- and underserved populations.

Mental Health Community Health Advocates (PEI 15)

For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project will provide training, supervision and stipends for existing community health advocates to provide mental health and substance use education, interventions, and links to further services. This program increases the efficacy of existing mental health programs by reducing the barriers for accessing those services. In addition it creates a culture shift in the target communities that reduces stigma and increases the support available within the community. This program is coordinated with substance use services funds to provide early intervention services for substance using Spanish-speaking women.

Fiscal Year 2012-2013 Program Expansion:

In FY12-13 the Community Health Advocates (CHA) program will expand the trainings available to CHAs and relevant staff. Approximately 46 individuals will benefit from attending:

- Migration and Mental Health Issues for Promotores: a 10-hour training about Latino mental health challenges developed by the Health Initiative of the Americas at UC Berkeley's School of Public Health.
- Healthy and Equal Relating for All: a 2-day domestic violence prevention training.
- Vision y Compromiso: a 2-day educational conference for Promotores throughout California.

PROPOSED PEI EXPANSIONS FOR FY2012-2013

LEGAL ASSISTANCE

In the original PEI community planning process, it was recognized that economic stressors can have negative mental health consequences. Over time, PEI has explored ways to address this. For example, providing mental health services at sites that also provide linkages to food, housing, and other necessities. In FY12-13, MHSA funds, both CSS and PEI, will support legal services for clients referred from CSS and PEI programs. Legal assistance at key times, such as divorce, eviction, foreclosure, or bankruptcy, can reduce the consequences of these economic stressors. Services will be provided at the same site as the mental health services for the most part. This program expects to serve 150 clients annually (30 CSS, 120 PEI). Services are expected to begin by January 2013.

SOUTHERN MARIN COMMUNITY CONNECTION

In original MHSA planning processes in Marin, African Americans were identified as "inappropriately served." The fact that they are over-represented among County Mental Health clients indicates that they may not be receiving services that could help prevent the need for such intensive services. PEI has successfully reached many of the underserved populations identified, but has further work to do regarding the African American community. As noted elsewhere in this Update, PEI will begin funding the Marin City Health and Wellness Clinic, located in Southern Marin, to develop their Integrated Behavioral Health Program. In addition, in FY12-13 PEI will fund the Southern Marin Multidisciplinary Team (MDT) to conduct an intern program providing brief intervention and case management services for Marin City residents. The majority of their clients are African American, living in subsidized housing or with no permanent residence. Sixty-percent are women, most single with children. Assistance is provided regarding mental health, parenting, housing, economics, medical services and education. Services are provided in the home or in the community, including street-based outreach. Approximately 150 individuals will be served annually.

In addition to funding the intern program, support will be provided for developing data collection and analysis methods. This portion of the project will work in collaboration with the California Reducing Disparities Project (CRPD).

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM

PROGRAM DESCRIPTION
July 2010 – June 2011

In FY2009-10, it was decided through a comprehensive community planning process involving diverse stakeholders to focus Marin's Innovation Program on increasing quality of services, including better outcomes, through transforming how Marin responds to psychiatric crises. Options for adults experiencing psychiatric crises that did not resolve within the first 23 hours were limited to inpatient hospitalization in a locked setting, sometimes in an out-of-county facility. Clients, families, providers and key partners had come to expect hospitalization as the most appropriate strategy for resolving psychiatric crises and became frustrated with the mental health system when this did not occur. Those individuals whose crises were not severe enough to justify hospitalization had no options available to them after the first 23 hours of crisis stabilization services other than to return to the care of outpatient/community providers, family, and friends who did not always have the skills, resources or resiliency to provide sufficient support. This often led to a repetitive series of crisis visits until either the crisis eventually resolved over time or the individual's condition deteriorated to the point of requiring hospitalization, often leaving clients, families, friends, providers and key partners feeling drained, discouraged, and disempowered.

Marin's proposed 3- to 4-year Client Choice and Hospital Prevention (CCHP) project consists of an innovative approach to providing services to adults (age 18 and older) experiencing psychiatric crises through the creation of a recovery-oriented, community-based response to psychiatric crises which will provide alternatives to hospitalization while supporting clients, families and communities to increase resilience. By offering successful recovery-oriented choices for dealing with crises, it is hoped that this project will also help to change the perception of how the mental health system and community can best respond to and help prevent psychiatric crises, furthering our system transformation efforts toward a client- and family-driven system with a focus on wellness, recovery and resiliency. Innovation funds will be used to develop and operate a community-based crisis service in a homelike environment that integrates crisis intervention and stabilization with wellness and recovery principles. Additional innovative project elements will include integrated peer and professional staffing, use of client-driven crisis plans (funded through MHSA Prevention and Early Intervention) which provide the opportunity for consumers to have a voice and choice in determining which services and supports are most effective in times of psychiatric crisis, and use of SBIRT (Screening, Brief Intervention, and Referral for Treatment), an effective, integrated health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

C. INNOVATION

OUTCOMES
July 2010 – June 2011

In January 2011, Marin County received approval for our Innovation Program Proposal. In the spring of 2011, the contract for implementation of the community-based crisis service in a homelike environment was awarded to Buckelew Programs, a non-profit community-based organization with a long history of successfully providing housing and other system of care services to adult clients of the County's public mental health system.

During FY2011-12, the PEI-funded component of the CCHP project was implemented and has been assisting consumers and family members to develop Crisis Plans. A CCHP project steering committee was formed with representation from key partners, including Buckelew Programs, County Mental Health (Psychiatric Emergency Services, Adult Case Management, QI/Marin Mental Health Plan) and Substance Use Services, Public Guardian, consumers, and family members, and has met on a regular basis. Co-chaired by Marin's PEI and Innovation Coordinators, the committee has been tasked with recommending the best ways to:

1) Cultivate the change in systems thinking towards client choice and away from hospitalization first during psychiatric crises;
2) Implement and integrate the PEI-funded Crisis Planning and the Innovation-funded components of the CCHP project;
3) Integrate more fully substance use screening and brief intervention into CCHP project; and
4) Measure success and outcomes.

CHALLENGES AND UPCOMING CHANGES

Key Buckelew management/lead project staff has been selected and have begun the State process for licensing the facility, as well as developing program policies and procedures. The biggest project implementation challenge has been site selection and renovation. During FY2011-12, the architectural review of the originally proposed site revealed that the cost of renovating the existing building exceeded the cost of tearing it down and constructing a new building designed specifically for crisis residential services. An alternative to the original site was proposed and considerable time was dedicated to reviewing the feasibility of both sites. A decision was made to proceed with the plan to construct a new facility at the original site. The current target date for opening the Crisis Residential program is July 2013.

WORKFORCE, EDUCATION AND TRAINING

BACKGROUND

The Workforce, Education and Training (WET) component of MHSA provides dedicated funding to remedy the shortage of qualified individuals to provide services to address serious mental illness. State requirements include:

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

In 2010/2011 the WET program in Marin has focused on moving our staff and provider agencies towards service delivery using evidence based practices. We have worked collaboratively with consumers and family members to expand the opportunities for learning and decision making in terms of how these funds are earmarked.

The WET projects implemented in Marin are described below. The funding for WET continues for ten years after we first received the funds in 2008. The intention for many of our action items is to create the knowledge "in the system" so that when the WET funds are concluded, we continue to have the expertise in our Community Based Organizations (CBOs) and County system. To this end, we are employing coaching and consultation for our evidence based practices trainings. We are creating the Peer Consultation network to support the retention of knowledge in our system.

WET PLAN ACTION
June 2010 – July 2011

1. Training Coordinator

A Training Coordinator was hired in August 2009 to assist the WET Coordinator in coordinating the delivery of training, consultations, internships, and other capacity-building

efforts. The Training Coordinator assisted in establishing and coordinating the WET Advisory Committee and the Consumer and Family subcommittees, as well as assisting to develop an active group facilitator consultation group for peers who lead groups at the ERC.

2. Workforce Education & Training Plan Facilitation

Paul Gibson was the consultant hired through a competitive RFP process to conduct a county-wide training needs assessment and make recommendations that formed the basis of the WET Plan, which was completed in 2008-09.

3. Peer Consultation Network

This action item involves identifying staff and consumers/family members within the County of Marin and partner CBO's, who are experts in the topics that are selected for training to ensure sustainability of new learning once our MHSA training funds are expended. Each training conducted will identify experts, mentors, or "champions" in that topic area who can provide consultation to peers throughout the county on ongoing basis.

In FY10-11 we identified peer experts to serve as champions for Group Therapy and Harm Reduction Case Management. We are working to develop a cohort of Motivational Interviewing (MI) champions. We are in year 2 of the MI and Harm Reduction for Case Management training series and will continue to grow this cohort. We are developing a database of skills and working with supervisors and CBO staff to be able to create a mechanism for staff to provide their expertise to other teams/agencies.

4. Targeted Training in Evidence Based Practices

This action item is to administer a flexible fund designed to support the delivery of a range of training in evidence-based practices. To date we have conducted:

- 9 **Motivational Interviewing** 2-day Intensives and 17 coaching sessions. A total of 224 people have been trained, and 10 people have been identified as MI "champions" to provide ongoing leadership and consultation for MI practice in Marin County.
- A **Group Therapy** training course for the Child Youth and Family Team in September/October 2010 that trained 30 clinicians. Two monthly supervision groups began in December and will meet for a year. 5 people have signed up to become Certified Group Psychotherapists.
- A **Seeking Safety** one-day workshop was held on February 25th for 85 CMHS and CBO staff members. Participants will be able to conduct Seeking Safety groups as a result of this workshop and were given copies of the manual to facilitate their group leading skills.
- A **Cultural Competence** training in spring 2011: "Bridging the Gap between Tradition and Evidence: Culturally sensitive work with Latinos. Approximately 75 people attended from CMHS and CBO organizations. We are planning to continue this series as well as expand to other ethnic groups, specifically the African American and Vietnamese populations in future trainings.

Additionally, the WET program purchased an Essential Learning contract to train the 40 staff at the Psychiatric Emergency Services, who are less able to access the Evidence Based Practice Trainings offered throughout the WET program.

5. Consumer Focused Training

This action item is to increase consumers' capacity to advocate for consumers, qualify for employment within the mental health system, and participate in planning and policy within the system. An additional goal is to increase the capacity of providers to include consumers in treatment and planning processes. A consumer subcommittee formed and has met monthly since January 2010 to identify specific training needs of consumers and to review and agree upon training initiatives.

A Peer to Peer mentoring training was attended by three Marin County consumers in December 2010. They led the first Peer to Peer group in February 2011 at the ERC for 10 consumers. Also in December, Bruce Anderson conducted a 1-day workshop on Hope at Work: Creating Resilient Workplaces for staff and volunteers of Community Action Marin and the Family Partners team. This trainer returned in June to train these participants in the process of assessing Core Gifts. In January 2011, a 12 week series entitled "Illness Management and Recovery" was offered at the Enterprise Resource Center for consumers of the mental health system. A group facilitation consultation group was developed for the peers who lead groups at the ERC to provide facilitation skills, support and consultation for leading groups.

6. Family Focused Training

This action item is to increase family member's capacity to support consumers, qualify for employment within the mental health system, and participate in planning and policy within the system. In addition it is to increase the capacity of providers to include families in treatment and planning processes. A family subcommittee was formed March 2010, comprised of the WET coordinator, WET consultant, family members, NAMI members and parent partners. They have been meeting monthly to determine the training needs of family members in Marin.

To better assess the needs of family members a survey was created and distributed in English, Spanish and Vietnamese. The results indicated that family members were very interested in communication skills with their loved one's diagnosed with mental illness. Therefore we hosted a four week LEAP training that served 30 family members. We are planning another series in the next fiscal year. Other areas of focus based on the survey results were: education and support regarding diagnosis, medications and psychosocial treatments. We are working hard to diversify the locations and participants by locating venues in different parts of the county and outreaching to different communities. This is partly based up on the fact that 80% of survey respondents were NAMI members but there were very few respondents with young children in the mental health system and the ethnic diversity was lacking even though the survey was in three languages.

7. Systems Wide Integrated Dual Disorders Training

This action item is to provide a series of Integrated Dual Disorder Treatment (IDDT) trainings. It is on hold while Marin County Health and Human Services Department works with a consultant, Zia Partners, to institute a system wide assessment and shift towards more effectively serving clients with Dual Disorders. Once the results from this assessment are complete, then we will have a better perspective from which to launch the IDDT trainings. The Co-Occurring collaborative has been identified as the committee to support and oversee the process for this action item when we move forward. The Co-occurring collaborative is comprised of Mental Health and Substance Use Services staff, family members, community substance use and mental health providers, as well as a consumer representative. See action #8 for a Clinical Practice Forum that will address dual diagnosis with case managed clients.

8. Clinical Practice Forums

This action item is to institute ongoing learning groups to support and expand the learning provided by WET trainings. In FY10-11:

- Two 6-month **Harm Reduction in Case Management** courses were completed in fall 2010 by three county case management teams (Odyssey Team, Juvenile Probation and HOPE teams). Three new groups have begun with our CBO partners (Family Service Agency, Housing Authority, and Buckelew). In addition, a bimonthly coaching group for graduates of the first two groups will be conducted for a year; peer consultants will emerge out of this group.
- The **Motivational Interviewing** coaching sessions are being conducted as Clinical Practice Forums.
- The **Group Therapy** supervision series are being conducted as Clinical Practice Forums.

9. MH Directors Leadership Institute Training

This action item is to send one person from Marin to California Institute of Mental Health (CIMH) Leadership Training each year to strengthen leadership and manage system transformation in the public mental health system. The group of alumni meets quarterly with the Mental Health Director to implement the knowledge learned and work towards creating a culture of leadership in the Marin Mental Health System. Marin sends on representative each year to this training.

10. Intern Stipend System

This action item is to provide stipends for mental health practitioner interns in order to fill hard-to-fill positions and to increase the diversity and inclusion of consumers and families in the workforce. Intern stipend funds have been split between County Mental Health and Community Based Organizations. An application process was developed whereby each agency or team applies to the WET committee for stipend support. Qualifications include: 1) the agency must abide by the MHSA principles of consumer and family-driven services and 2) the proposed interns should contribute to diversifying the workforce by reflecting the community being served and/or having lived experience as a mental health consumer or family member.

Below is the list of CBO's awarded stipends and cultural and linguistic capabilities of the interns:

Buckelew	**$9,000**	**6 Occupational Therapist interns targeting Asian bilingual/bicultural**
Family Service Agency	**$9,000**	**3 MFT interns Spanish- Speaking**
Huckleberry Youth Programs	**$6,000**	**2 interns Spanish-speaking**
Catholic Charities CYO	**$4,000**	**2 interns Spanish-speaking**
Community Institute for Psychotherapy	**$6,000**	**1 Farsi or Russian-speaking PhD or PsyD intern**

11. Psychiatric Nurse Practitioner Internships

This action item is to provide stipends or loan forgiveness for psychiatric nurse practitioners (PNPs) in order to increase the number of PNPs serving Marin County and the cultural diversity of the PNPs. This action item has not been implemented during this fiscal year.

12. Scholarships for Consumers, Family Members and to Diversify the Workforce

This action item is to provide scholarships for consumers, family members and members of under-represented populations when the educational program will result in possible entry to or advancement within the public mental health system. The Consumer and Family WET subcommittees have been identifying prospective students for scholarships. Further development will take place once the training plans for consumers and families are in place. We have initiated conversations with Contra Costa College's SPIRIT (Service Provider Individualized Recovery Intensive Training) program as a potential partner. SPIRIT is interested and willing to work with Marin residents who want to pursue a more formal training in a Health and Human Services Certificate.

In the coming year we will continue our focus on the delivery of evidence based practice's for service providers and the development of the Consumer Group leader training. We also intend to work with the Family subcommittee to deliver more training to family members regarding communication skills.

CAPITAL FACILITIES / TECHNOLOGICAL NEEDS

On March 14, 2008, the State Department of Mental Health released the guidelines for the MHSA Capital Facilities and Technology Component. Capital Facilities allows counties to acquire, develop or renovate buildings to house and support MHSA programs. Funds may also be used to develop community-based, less restrictive settings that will reduce the need for incarceration or institutionalization. Technological Needs supports counties in transforming and modernizing clinical and administrative information systems as well as increasing consumer and family member's access to health information within a variety of public and private settings. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards MHSA goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

CAPITAL FACILITIES

Marin County has yet to identify appropriate capital facilities projects that fit within State parameters for MHSA Capital Facilities funding.

TECHNOLOGICAL NEEDS

Program Description
June 2010 – July 2011

In late FY2009-10, Marin County received approval of our Technological Needs Proposal to further advance mental health towards a future paperless Electronic Health Record (EHR), as well as build on existing efforts to utilize technology to further consumer empowerment. While the existing system provided Mental Health with several elements of an EHR, the system continued to be a hybrid of electronic and paper documentation, including hand-written prescriptions. In addition, the existing billing system was a legacy system which needed to be upgraded and modernized.

Marin's Technological Needs (TN) proposal consisted of the following five (5) components:

Consumer Empowerment – This project proposed to expand on existing resources at the Enterprise Resource Center, Marin's consumer-operated drop-in center, by providing funding for additional computer desktops and dedicated paid consumer staff time for computer training and IT expertise. Funding was also dedicated for the purchase of desktop computers and internet access for the use of consumers living in county-contracted residences with 6 or more people. A limited number of "loaner" laptops were to be made available for consumers participating on boards and committees, such as the Mental Health Board.

E-Prescribing – This component involved implementation of electronic prescribing by County psychiatrists and mental health nurse practitioners through RxNT a web-based electronic prescribing program fully integrated with Clinician's Gateway, the County's existing EHR system.

Electronic Health Record and Emergency Backup – County mental health staff and select contract providers have used Clinician's Gateway for several years to write electronic progress notes. This project proposed to move the medical record further towards a more complete EHR by adding 10-15 key forms to Clinician's Gateway. The project also included the provision for an expanded hardware configuration to provide for emergency backup in case of power or system failures. Additionally, the project proposed to add digital signature pads as new operational components of the EHR so that clinicians would be able to record client signatures on documents in the field or office.

Management Practice Upgrade – INSYST, the County's existing billing system was over 25 years old and in need of replacement. The managed care software system, ECura, was provided by a different vendor. The upgrade to replace the INSYST billing system was expected to include all the existing billing and reporting functionality, including managed care, as well as interface with Clinician's Gateway.

Scanning Project – This component involved the implementation of IMAViser, a scanning application fully integrated with Clinician's Gateway. Adding scanning capabilities to the EHR to incorporate the paper documentation which continues to be a part of the medical record would allow authorized clinical staff at any workstation to access key documents necessary for their work.

Outcomes
June 2010 – July 2011

Consumer Empowerment – One loaner laptop with internet access was provided to a consumer member of the Marin Mental Health Board.

E-Prescribing – This project was almost fully implemented, with all County psychiatrists and mental health nurse practitioners using e-prescribing through RxNT for all prescriptions except controlled (scheduled) drugs.

Electronic Health Record and Emergency Backup – Eight essential electronic forms were added to Clinician's Gateway, including clinical assessments and client plans. In addition, numerous upgrades to existing electronic forms were made.

Management Practice Upgrade – This project constituted the largest and most complicated component of Marin's TN plan. After extensive review, Echo Consulting Services, Inc. (Echo) was selected as the vendor to provide the system upgrade to ShareCare, a web-based state of the art software system. The contract with Echo to implement the ShareCare conversion was approved late January 2011 with a target go-live date of July 1, 2011, and a Project Kickoff Meeting was held on February 8, 2011 to introduce the project to a wide range of key stakeholders, including representatives from administration, clinical programs, managed care, fiscal, billing, medical records, compliance, IT, etc. A Core Team was convened to direct and monitor the project, with membership consisting of management/lead staff from mental health administration, fiscal, billing, IT, software support, clinical programs, administrative support, and a dedicated project manager

from Echo. During the remainder of FY2010-11, project implementation focused on the completion of intensive tasks essential for a successful system conversion, including purchase of hardware for the new system, data cleanup, data crosswalk setup, ShareCare system setup, and preparation for integration with Clinician's Gateway. In June 2011, in preparation for the July go-live date, Echo provided System Administrator Core Training, Train the Trainer Training, and ShareCare Managed Care Organization (MCO) Training for key staff.

Scanning Project – Activity related to this component was limited to purchase of the software and hardware necessary for implementation.

Challenges and Upcoming Changes

Management Practice Upgrade – Transfer to ShareCare occurred on August 1, 2011, only 1 month behind the projected go-live date. During FY2011-12, continued implementation of ShareCare has remained the primary focus of the TN project and by April 2012, Marin was able to successfully submit billing to all major third party payers.

As noted above, while ***E-Prescribing*** has been implemented, controlled (scheduled) drugs continue to be excluded from e-prescribing through RxNT, until the vendor is able to implement new regulations that went into effect June 2010 permitting electronic prescriptions for controlled substances. Until this occurs, there will continue to be a limited number of hand-written prescriptions in the medical record. Other TN activities during FY2011-12 included expansion of the number of contract providers using Clinician's Gateway, furthering our efforts at developing a more complete and integrated ***Electronic Health Record and Emergency Backup***. Additionally, initial software setup on the ***Scanning Project*** was begun.

Because of the priority and complexity of the ***Management Practice Upgrade*** project, implementation of some of the TN projects has been delayed. During FY2012-13, it is anticipated that implementation of the remaining TN projects will be completed, including ***Consumer Empowerment*** (provision of computers in the consumer drop-in center and residential settings), ***Electronic Health Record and Emergency Backup*** (completion of the remaining electronic forms in Clinician's Gateway and development of emergency power backup of the EHR), and ***Scanning Project*** (scanning of key paper medical records documents into Clinician's Gateway).

FISCAL YEAR 2012-2013 PROGRAM EXPANSIONS

Data-Sharing Capacity

By 2014 all health, mental health and substance use programs will be required to have electronic health records (EHR). Marin County has selected Clinician's Gateway for its Mental Health EHR and WITS for its Substance Use Services. As the former divisions of Mental Health and Alcohol and Other Drugs merge to form the Mental Health and Substance Use Division, it is apparent that some clients will be shared. To reduce duplication and improve care coordination, a secure data-sharing process for the systems will be created. The messaging system used will have the capacity to allow communication between other EHRs, such as primary health systems, in the future.

MHSA PROGRAM DESCRIPTIONS AND CONTACTS

COMMUNITY SUPPORTS AND SERVICES PROGRAMS

PROGRAM DESCRIPTION **CONTACT PERSON**

CHILDREN'S SYSTEM OF CARE (CSOC – FSP-01) **BRIAN ROBINSON**

This program services 40 youth with serious emotional disturbance who are involved with juvenile justice and/or attend County Community School, a continuation high school. Clinical staff works 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.

TRANSITIONAL AGE YOUTH (TAY – FSP-02) **BUCKELEW PROGRAMS**

This integrated multi-disciplinary service team program for 20 Transitional Age Youth (16-25) with serious mental illness or serious emotional disturbance provides culturally competent mental health services, intensive case management, housing supports, psychiatric care, substance abuse counseling, employment services and independent living skills. Transition Age Youth who are aging out of children's mental health services and transitioning to adult services and independent living are linked to necessary services.

SUPPORT AND TREATMENT AFTER RELEASE (STAR – FSP-03) **ZIYA DIKMAN**

This multi-agency, multi-disciplinary team provides culturally competent, community-based services to 40 adults who have serious mental illness and current involvement with the criminal justice system. Operating in conjunction with the STAR mental health court, the team provides comprehensive assessment, individualized client-centered service planning, psychiatric care, intensive case management, therapy and linkages to all needed services and supports. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

HELPING OLDER PEOPLE EXCEL (HOPE – FSP-04) **PATTY LYONS**

This multi-agency, multi-disciplinary team serves 40 older adults, ages 60 and older, who have serious mental illness, and are isolated and at risk of out of home placement, hospitalization or homelessness. By providing a full range of integrated, culturally competent services including outreach, comprehensive assessment, individualized client-centered service planning, psychiatric care, intensive case management, therapy and linkages to needed services and supports, participants are assisted to better control their illness, reach their personal goals, lead more satisfying lives, and avoid higher, more restrictive levels of care.

ODYSSEY PROGRAM (HOMELESS – FSP-05) **CHRIS KUGHN**

This multi-agency, multi-disciplinary team provides culturally competent intensive, integrated services to 60 adults with serious mental illness who are homeless or at-risk of homelessness. The program comprehensive assessment, individualized client-centered service planning, psychiatric care, intensive case management, supported housing and linkages to all needed services and supports in order to assist participants to achieve their individualized goals, as well as to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

COMMUNITY SUPPORTS AND SERVICES PROGRAMS (CONTINUED)

PROGRAM DESCRIPTION **PROVIDER**

ENTERPRISE RESOURCE CENTER EXPANSION (SDOE-01) **COMMUNITY ACTION MARIN**

The Outreach and Engagement project involved expanding and enhancing Marin's consumer-operated Enterprise Resource Center by adding consumer positions and establishing a Wellness/Recovery Center in central Marin through enlarging and co-locating the Enterprise Resource Center with housing, employment and clinical services at the new Health & Human Services Health and Wellness Campus. Known for its low-barrier access and welcoming environment, the Enterprise Resource Center plays a key role in Marin's effort to outreach to and engage with adults with serious mental illness in the county who are disenfranchised and reluctant to seek help and services. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers participants a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation.

SOUTHERN MARIN SERVICES SITE (SDOE-04) **FAMILY SERVICE AGENCY**

A community-based, culturally competent, easily accessible mental health service site was opened in Southern Marin, an underserved area. Clients and families 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 with serious mental illness and youth with serious emotional disturbance.

ADULT SYSTEM OF CARE DEVELOPMENT (SDOE-07) **RENE MENDEZ-PENATE**
KATHY CHESTNUT

This System Development expansion project was designed to expand and enhance supports and services available in Marin's system of care for adults with serious mental illness and their families by: 1) increasing peer specialist services on the Adult Case Management team; 2) providing outreach and engagement and support services to Hispanics/Latinos; 3) increasing Vietnamese outreach and engagement services; and 4) adding family outreach, engagement and support services to the ASOC at large. The goals of the project are to promote recovery and self-sufficiency, improve the ability to function in the community, reduce isolation, and provide low-barrier access which welcomes unserved clients of Vietnamese and Hispanic/Latino origin.

PREVENTION AND EARLY INTERVENTION PROGRAMS

PROGRAM DESCRIPTION **PROVIDER**

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (ECMH – PEI-1) — **JEWISH FAMILY AND CHILDREN'S SERVICES**

This program provides training and support to staff of childcare and early childhood education sites to identify children whose behavior indicates social/emotional difficulties, develop a plan for meeting the child's needs, and to assist the family. Training will be provided to strengthen staff skills in working with all children and voluntary screening will be available to families for adult depression.

TRIPLE P (POSITIVE PARENTING PROGRAM – PEI-2) — **MARIN COUNTY OFFICE OF EDUCATION**

A broad range of providers working with families are being trained in an evident-based method for educating and supporting families with parenting challenges. Now that a network of providers has been established, an outreach and education campaign is being developed.

ACROSS AGE MENTORING (PEI-3) — **MARIN CITY NETWORK**

This program provides an evidence-based mentoring program for middle school students in Southern Marin that includes mentoring, community service, social competence training, and family activities.

TRANSITION AGE YOUTH PREVENTION AND EARLY INTERVENTION (PEI-4) — **HUCKLEBERRY YOUTH PROGRAMS AND NOVATO YOUTH CENTER**

This program provides mental health education, screening and assistance in collaboration with agencies serving transition age youth (16-25). This age group is at risk for substance abuse, justice system involvement, and onset of serious mental illness.

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION (PEI-5) — **CANAL ALLIANCE**

This program provides mental health education, screening and assistance in a community-based organization in the Canal District. These services help to bridge the cultural and language barriers that contribute to this neighborhood being underserved for mental health needs.

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE (PEI-6) — **MARIN COMMUNITY CLINICS COASTAL HEALTH ALLIANCE**

This program expands the mental health services available within health care settings for underserved populations using a Stepped Care Model. Services include mental health education, screening, and assistance that is coordinated with physical health care services.

OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI-7) — **JEWISH FAMILY AND CHILDREN'S SERVICES**

This program provides an evidence-based model of mental health education, screening, and brief intervention to older adults who are experiencing transitions or other risk factor. In addition, a wide-range of providers are trained to identify and refer at-risk older adults.

PREVENTION AND EARLY INTERVENTION PROGRAMS (CONTINUED)

PROGRAM DESCRIPTION **PROVIDER**

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM: CRISIS PLANNING — **COMMUNITY ACTION MARIN**

Provides crisis planning services for those at risk of a psychiatric crisis in order to increase client choice in times of crisis and reduce psychiatric hospitalizations.

SHORT-TERM PROGRAMS PLANNED FOR FY12/13 AND FY13/14

PROGRAM DESCRIPTION **PROVIDER**

VIETNAMESE COMMUNITY CONNECTION — **COMMUNITY ACTION MARIN**
ASIAN ADVOCACY PROJECT

Hiring a part-time bi-cultural, Vietnamese speaking outreach worker to provide education and links to mental health services, as well as assess the needs of the Vietnamese community.

MENTAL HEALTH COMMUNITY TRAINING — **CALIFORNIA INSTITUTE OF MENTAL HEALTH (CIMH)**

Looking for an organization to coordinate Mental Health First Aid, evidence-based training to educate about mental health and substance use signs and symptoms, helping somebody access services, and reducing stigma.

TEEN SCREEN — **FAMILY SERVICE AGENCY**

An evidence-based screening and referral process for a variety of mental health and substance use issues provided to sophomores in high school.

MENTAL HEALTH COMMUNITY COALITIONS — **TBD**

Evidence-based, primary prevention strategy for engaging a range of community stakeholders in identifying mental health concerns and solutions. There are currently three (3) community coalitions in Marin funded by Health and Human Services to focus on substance use issues.

MENTAL HEALTH AND SUBSTANCE USE COMMUNITY HEALTH ADVOCATES — **CANAL ALLIANCE**

Training and supporting trusted resource people (promotores, community health workers, etc.) to better address mental health and substance use concerns in their communities, such as by providing education, support and links to services.

MARIN COUNTY MHSA PROGRAM FUNDS
FY2012-2013 ANNUAL UPDATE

COMMUNITY SERVICES AND SUPPORTS (CSS) PROGRAMS	Annual On-Going Funds	One-Time Funds	Total CSS Funds Requested
Children's System of Care (CSOC – FSP-01)	$488,388	$63,258	$551,646
Transition Age Youth (TAY – FSP02)	$360,736	$50,632	$411,368
Support and Treatment After Release (STAR – FSP-03)	$308,681	$13,333	$322,014
Helping Older People Excel (HOPE – FSP-04)	$612,479	$20,417	$632,896
Odyssey Programs (Odyssey – FSP-05)	$1,014,486	$13,333	$1,027,819
Enterprise Resource Center Expansion (ERC – SDOE-01)	$265,159	$55,050	$320,209
Southern Marin Site Services (SMSS – SDOE-04)	$264,504	$10,938	$275,442
Adult System of Care (ASOC – SDOE-07)	$243,827	$26,251	$270,078
New Co-Occurring Capacity	–	$76,282	$76,282
CSS Administration	$533,739	$49,424	$583,163
Operating Reserve (up to 10%)	$409,200	–	$409,200
TOTAL CSS PROGRAMS:	**$4,501,199**	**$378,918**	**$4,880,117**

PREVENTION AND EARLY INTERVENTION (PEI) PROGRAMS	Annual On-Going Funds	One-Time Funds	Total PEI Funds Requested
Early Childhood Mental Health Consultation (ECMH – PEI-1)	$190,300	$14,560	$204,860
Triple P (Positive Parenting Program – PEI-2)	$207,800	–	$207,800
Across Ages Mentoring (PEI-3)	$66,000	–	$66,000
Transitional Age Youth (TAY – PEI-4)	$85,200	$83,349	$168,549
Canal Community-Based Prevention (PEI-5)	$64,200	$14,120	$78,320
Integrated Behavior Health in Primary Care (PEI-6)	$399,600	$134,746	$534,346
Older Adult Prevention and Early Intervention (PEI-7)	$43,100	$22,200	$65,300
Client Choice and Hospital Prevention Program: Crisis Planning	$88,000	–	$88,000
Vietnamese Community Connection	–	$16,289	$16,289
Mental Health Community Advocates	–	$15,500	$15,500
NEW – Legal Aid	–	$23,333	$23,333
NEW – Southern Marin Multi-Disciplinary Team	–	$32,382	$32,382
PEI Administration	$171,630	$53,472	$221,685
Operating Reserve (up to 10%)	$131,583	–	$131,583
TOTAL PEI PROGRAMS:	**$1,447,413**	**$409,951**	**$1,857,364**

MARIN COUNTY MHSA PROGRAM FUNDS
FY2012-2013 ANNUAL UPDATE (continued)

WORKFORCE, EDUCATION AND TRAINING (WET)	Current Budget	Budget Adjustments	Amended Budget
Training Coordinator	$295,200	$28,401	$323,601
WET Plan Facilitation	$60,000	($28,297)	$31,703
Peer Consultation Network	$35,000	–	$35,000
Targeted Training in Evidence-Based Practice that supports System Transformation	$80,000	–	$80,000
Consumer Focused Training	$45,000	–	$45,000
Family Focused Training	$45,000	–	$45,000
System-wide Dual Diagnosis Training	$108,000	–	$108,000
Clinical Practice Forums	$42,000	$4,700	$46,700
CIMH MH Directors Leadership Institute Training	$15,000	$10,870	$25,870
Intern Stipend Program	$320,000	–	$320,000
Psychiatric Nurse Practitioner Internships	$28,000	($15,674)	$12,326
Scholarships for Consumers, Family Members and to Diversify the Workforce	$60,000	–	$60,000
TOTAL WET:	**$1,133,200**	–	**$1,133,200**

CAPITAL FACILITIES / TECHNOLOGICAL NEEDS (CFTN) PROJECTS	Current Budget	Budget Adjustments	Amended Budget
Practice Management	$1,133,819	–	$1,133,819
Scanning	$147,104	–	$147,104
E-Prescribing	$178,271	–	$178,271
Marin CMHS Electronic Health Record Upgrade (CG)	$177,746	–	$177,746
Marin CMHS Consumer Family Empowerment	$199,796	–	$199,796
Mental Health Facility Improvement	$652,263	($105,000)	$547,263
Behavioral Health Information Crosswalk	–	$105,000	$105,000
TOTAL CFTN:	**$2,489,000**	–	**$2,489,000**

INNOVATION

No Change in FY2012-2013

MARIN COUNTY MHSA PROGRAM FUNDS PREVIOUSLY APPROVED FOR FY2011-2012

COMMUNITY SERVICES AND SUPPORTS (CSS) PROGRAMS	One-Time Funds*
Children's System of Care (CSOC – FSP-01)	$147,886
Transition Age Youth (TAY – FSP02)	$100,000
Support and Treatment After Release (STAR – FSP-03)	$292,994
Helping Older People Excel (HOPE – FSP-04)	$155,199
Odyssey Programs (Odyssey – FSP-05)	$118,000
Enterprise Resource Center Expansion (ERC – SDOE-01)	$126,865
Southern Marin Site Services (SMSS – SDOE-04)	$100,000
Adult System of Care (ASOC – SDOE-07)	$110,026
Client Choice and Hospital Prevention Program	$800,000
TOTAL CSS PROGRAMS:	**$1,950,970**

*** CSS one-time funds are expended over two (2) year period – 7/1/11 to 6/30/13.**

PREVENTION AND EARLY INTERVENTION (PEI) PROGRAMS	One-Time Funds**
Early Childhood Mental Health Consultation (ECMH – PEI-1)	$60,000
Triple P (Positive Parenting Program – PEI-2)	–
Across Ages Mentoring (PEI-3)	–
Transitional Age Youth (TAY – PEI-4)	$20,000
Canal Community-Based Prevention (PEI-5)	$20,000
Integrated Behavior Health in Primary Care (PEI-6)	–
Older Adult Prevention and Early Intervention (PEI-7)	$95,000
Client Choice and Hospital Prevention Program	–
Vietnamese Community Connection	$70,000
Mental Health Community Training	$60,000
Teen Screen	$40,000
Mental Health Community Coalitions	$116,000
Mental Health Community Advocates	$132,000
PEI Administration	$49,537
SUB-TOTAL PEI PROGRAMS:	**$662,537**

**** PEI one-time funds are expended during the period of 7/1/11 to 6/30/14 due to varied implementation dates.**

Numbers to be Served

Program			FY10-11 Actual	FY12-13 Projected	FY12-13 Cost Per person
FSP-01	Children's System of Care (CSOC)		99	**100**	**$5,516**
FSP-02	Transition Age Youth (TAY)	FSP	28	**25**	**$16,455**
		Partial	77	**75**	
FSP-03	Support and Treatment After Release (STAR)		57	**50**	**$6,440**
FSP-04	Helping Older People Excel (HOPE)		58	**50**	**$12,658**
FSP-05	Odyssey (Homeless)		69	**65**	**$15,813**
SDOE-1	Enterprise Resource Center (ERC)		361	**300**	
SDOE-4	Southern Marin Services Site (SMSS)		675	**600**	
SDOE-7	Adult System of Care (ASOC)		253	**250**	
SDOE-8	Co-Occurring Capacity			*	
	Housing		5	**5**	
PEI-1	Early Childhood Mental Health Consultation (ECMH)	P	877	**820**	
		EI	77	**100**	
PEI-2	Triple P		*	*	
PEI-3	Across Ages Mentoring	P	11	**20**	
		EI	11	**15**	
PEI-4	Transition Age Youth (TAY) PEI	P	193	**700**	
		EI	36	**300**	
PEI-5	Canal Community-Based PEI	P	242	**350**	
		EI	62	**200**	
PEI-6	Integrated Behavioral Health in Primary Care (IBH)	P	3857	**4000**	
		EI	533	**600**	
PEI-7	Older Adult PEI	P	311	**300**	
		EI	62	**30**	
PEI-10	Crisis Planning	PEI		**60**	
PEI-11	Vietnamese Community Connection	P		**200**	
		EI		**60**	
PEI-12	Mental Health Community Training			*	
PEI-13	Teen Screen	P		**75**	
		EI		**25**	
PEI-14	Community Coalitions			*	
PEI-15	Mental Health Community Advocates	P		**250**	
		EI		**50**	
PEI-16	Legal Assistance	PEI		**120**	
PEI-17	Southern Marin Community Connection	PEI		**100**	

P = Prevention Services **EI** = Early Intervention Services

***** Indicates capacity building efforts that impact how clients are served, not how many are served.

MARIN COUNTY MHSA TECHNICAL ADJUSTMENT

MARIN COMMUNITY MENTAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA) PLAN AMENDMENT
CLIENT CHOICE - HOSPITAL PREVENTION PROGRAM
FY12/13 ANNUAL UPDATE

Background – Original Plan Approved by State Mental Health Oversight and Accountability Commission (MHSOAC) on January 28, 2011

After an involved community planning process, it was decided that Marin's Innovation Program would be the Client Choice and Hospital Prevention Program. This will create an alternative to locked, involuntary treatment for Marin County residents experiencing psychiatric emergencies. It will be an important addition to the system of mental health care for adults and older adults. Last year over 90% of the admissions to acute psychiatric hospitals from the county's Psychiatric Emergency Services were involuntary. That means that most clients did not want the treatment they received. By creating a community based alternative to the locked hospital clients will find assistance in resolving crisis situations on a voluntary basis and will be assisted to return to their pre-crisis level of functioning. Prior to a crisis CMHS clients will be encouraged to create their own Crisis Plan, similar to an advanced directive for health care. The program plan was approved by the State MHSOAC in January 28, 2011.

The MHSA funding for this program plan includes: $800,000 for the remodel/construction of an existing 6-bed facility using unspent MHSA CSS funds; and $1,481,800 for program operation costs using MHSA Innovation funds.

Community Mental Health Services has selected Buckelew Programs to be the provider of services through a request for proposal process. The facility construction was expected to begin sometime during FY 2011-2012. However, due to various planning, administrative and logistical challenges, the project implementation has been delayed by a few months.

First Plan Amendment - Approved by the Board of Supervisors on June 19, 2012
On June 19, 2012, the Board of Supervisors approved a plan amendment to shift the funding for the project (i.e. use Innovation funds for construction, and CSS/Innovation funds for program operations). The change was made due to concerns about MHSA Innovation funds reverting back to the State, caused by the delay in program implementation. The planning process and program changes were made under the AB100 regulations**.**

Second Plan Amendment – Proposed for FY 2012-2013 Annual Update

Upon further funding review and analysis, and in consultation with the State MHSOAC, the issue of funds reversion has been clarified. It has been determined that our MHSA component fund balances meet the requirements of DMH Information Notice 11-15 to avoid reversion of Innovation funds. At the recommendation of the MHSOAC, we are proposing to implement the Innovation plan as originally approved by the MHSOAC in January 2011 based on the budget below. This change is being added as a technical adjustment to the FY 2012-2013 MHSA Annual Update that is currently posted for 30-day public notice from September 7, 2012 – October 7, 2012.

FY 12/13 MHSA Annual Update	Description	MHSA Innovation Funds	MHSA Community Services and Supports (CSS) Funds	Total
Proposed Adjustment				
Client Choice - Hospital Prevention Program (CSS)	Building Remodel and Rehabilitation		$800,000	$800,000
Client Choice - Hospital Prevention Program (Innovation)	Program Operations	$1,481,800		$1,481,800
Total		**$1,481,800**	**$800,000**	**$2,281,800**

Appendix A
MHSA Implementation Committee Members

Member Name	Affiliation
Julie Baker	Ritter Center
Eileen Becker	Community Action Marin and Client Rep
Jessie Blake	Sunny Hills Services
Allan Bortel	Marin County Commission on Aging
Everett Brandon	Marin City Community Services District
Kay Browne	NAMI of Marin
Laurie Buntain	Catholic Charities CYO
Aida-Cecilia Castro Garcia	Dominican University and Mental Health Board
Kasey Clarke	County of Marin
Barbara Coley	Community Action Marin and Client Rep
Roberta English	NAMI of California
Elberta Eriksson	ISOJI/Multi-Disciplinary Team
Rafael Gomez	Coastal Health Alliance
Jonathan Gurish	Marin Mental Health Board
Margaret Hallett	Buckelew Programs
Dawn Hensley	Community Action Marin and Family Partner
Marc Hering	Center Point, Inc.
Laura Kantorowski	Bay Area Community Resources
Beverlee Kell	NAMI of Marin
Rebecca Kuga	San Rafael Police Department
Cesar Lagleva	County of Marin
Larry Lanes	County of Marin
Myra Levenson	Community Member
Vinh Luu	Community Action Marin/ Asian Advocacy Project
Rene Mendez-Penate	County of Marin
Drew Milus	County of Marin
Racy Ming	County of Marin
Michael Payne	Community Action Marin and Client Rep
DJ Pierce	County of Marin
Peter Planteen	Community Action Marin and Client Rep
Ann Pring	County of Marin
Amy Reisch	First 5 Marin
Sue Roberts	NAMI of Marin
Curtis Robinson	Marin Health and Wellness Center
Lisa Schwartz	Marin County Office of Education
Diane Slager	County of Marin
Brian Slattery	Marin Treatment Center
Michele Stewart	Marin Mental Health Board and Client Rep
Linda Tavaszi	Marin Community Clinic