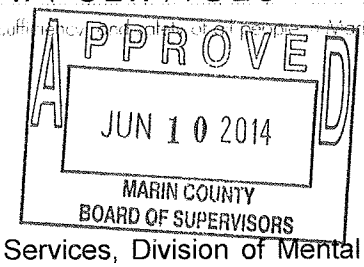
COUNTY OF MARIN

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Promoting and protecting health, well-being, self-sufficiency, and safety of all people in Marin County.

June 10, 2014



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

MARIN HEALTH & HUMAN SERVICES

Larry Meredith, Ph.D.
DIRECTOR

20 North San Pedro Road
Suite 2028
San Rafael, CA 94903
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www.marincounty.org/hhs

SUBJECT: Department of Health and Human Services, Division of Mental Health and Substance Use Services: Amendment to the FY 2013-14 Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Plan, the Capital Facilities and Technological Needs (CFTN) Plan and the Innovation (INN) Plan

Dear Supervisors:

RECOMMENDATIONS: Authorize the President to approve an Amendment to the Mental Health Services Act (MHSA) to transfer $700,000 of FY 2009/10 PEI unspent funds from Prudent Reserve back to PEI in FY 2013-14; amend the CFTN Practice Management project budget to include the implementation of required systems transitions, and necessary system enhancements totaling $293,000 and amend the INN to increase the funding of the Client Choice Hospital Prevention (CCHP) by $276,1000 using FY 2011-12 MHSA INN allocation.

SUMMARY:

MHSA Prudent Reserve

On July 24, 2012, the Board of Supervisors approved the Amendment to the Mental Health Services Act (MHSA), Prevention and Early Intervention Plan to transfer $700,000 of FY 2009-10 PEI unspent funds to the MHSA Prudent Reserve account, consistent with the provisions of MHSA (see attached June 2012 Prudent Reserve narrative). To date, the submitted Plan Amendment has not been approved by DHCS. DHCS has taken the position that MHSA PEI funds could not be transferred to Prudent Reserve, which is contrary to the provisions of MHSA, Welfare and Institutions Code Section 5847(b)(7). The issue has been appealed by counties affected. In the interim, MHSUS has identified the need to expand PEI services as part of the MHSA 3-year plan starting FY 2014-15, and is withdrawing the pending request to DHCS to transfer $700,000 of PEI funds to prudent reserve. The Prudent Reserve balance will remain at $2,176,490, and the $700,000 will be expended in the MHSA PEI 3-year plan.

Capital Facilities and Technological Needs (CFTN)

One of the components of MHSA is (CFTN). Marin County's CFTN Project Work Plan was approved by the State on June 7, 2010; amendments to the plan were approved in subsequent MHSA Annual Updates. Total funding is $2,488,999. Funding must be spent within ten years from the year of allocation. We are proposing to amend the Practice Management project budget to include the implementation of required systems transitions, and necessary system enhancements totaling $293,500. Funding will be from existing Practice Management remaining funds of $97,044; plus $196,456 to be shifted from the Mental Health Facility Improvement project. System enhancements include ICD-10 ($200,000); Rapid Insight Licenses ($13,500); Reportal ($55,000); Risk Assessment ($25,000) – see attached funding summary.

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Client Choice and Hospital Prevention Program (CCHP)

CCHP is the MHSA Innovation Plan for Marin County approved by the State on January 27, 2011. The program seeks to increase the quality of care and services by combining three distinct strategies: the systematic use of crisis plans for all existing and new adult clients in the mental health system, community-based crisis services in a homelike environment, and integrated peer/professional staffing. The services are provided by Buckelew Programs, Casa Rene, a newly constructed 10-bed crisis residential facility; all ten beds are dedicated to MHSUS clients. The initial plan was to purchase six beds. But after consideration of economies of scale and cost/benefit analysis, all ten beds were purchased. Casa Rene opened for services in February of FY2013-14.

We are proposing to increase MHSA INN funding for CCHP by $276,100 using FY 2011-12 MHSA INN allocation. Due to delays in planning, construction, State licensing, the estimated Medi-Cal and other revenues are lower than originally projected. Also, the clients served include both Medi-Cal and non-Medi-Cal eligible clients, instead of the original planning assumption of Medi-Cal only clients. The result is lower estimated Medi-Cal revenues. With the additional $276,100 of INN funds being requested, the total MHSA INN funding for CCHP services through June 30, 2015 is $1,757,900.

There were no substantive comments received during the 30 day public comment period of Tuesday, April 9, 2014 through Wednesday, May 8, 2013.

COMMUNITY BENEFIT: 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 services system to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in underserved populations. The additional resources and community process associated with the Act has brought measurable improvements to the lives of many Marin County residents.

FISCAL/STAFFING IMPACT: Funds to support these proposed amendments for PEI, CFTN and PEI are included in the Department of Health and Human Services' budgets for FY 2013-14 in fund center 1000047000. There will be no increase in net county cost as a result of these actions.

REVIEWED BY:	[X]	County Administrator	[ ]	N/A
	[ ]	Department of Finance	[X]	N/A
	[ ]	County Counsel	[X]	N/A
	[ ]	Human Resources	[X]	N/A

Sincerely,

Larry Meredith, Ph.D.
Director

MARIN COMMUNITY MENTAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA) PLAN AMENDMENT
TRANSFER MHSA PREVENTION AND EARLY INTERVENTION FUNDS TO PRUDENT RESERVE
JUNE 2012

Background:
The Mental Health Services Act (MHSA), formerly Prop 63, emphasizes prevention and early intervention as key strategies to transform California's mental health system. The MHSA prioritizes the prevention of suicide, incarceration, school failure or drop-out, homelessness, and prolonged suffering from untreated mental illnesses. After a lengthy process of stakeholder input, a plan with nine strategies were initially developed. Over the past three years, more strategies and/or programs have been added. The strategies include: Early Childhood Mental Health Consultation, Positive Parenting Program (Triple P), Transition Age Youth, Canal Community Based Programs, Integrating Behavioral Health and Primary Care, Older Adult Mental Health Services, Across the Ages Mentoring, Client Choice and Hospital Prevention, Vietnamese Community Connection, Mental Health Community Training, Teen Screen, Mental Health Community Coalitions, Mental Health Community Advocacy. The State Department of Mental Health and the MHSA Oversight and Accountability Commission approved our Prevention and Early Intervention (PEI) plan, and the Board of Supervisors accepted the initial funding allocation on May 19, 2009, and subsequently approved the additional programs through the MHSA Annual Update process.

The MHSA PEI component funding has been an annual allocation from the State Department of Mental Health. The three-year average allocation amount for FY 2009-2010 through FY 2011-2012 is approximately $1,358,000 per year. Due to various planning and administrative challenges, there have been some significant delays in the implementation of several programs, resulting in the accumulation of prior year unexpended funds. A total of approximately $700,000 of PEI funds is at risk of reversion back to the State if not obligated or encumbered by June 30, 2012. Funds may also be transferred to the MHSA Prudent Reserve in order to avoid reversion.

The Welfare and Institutions Code Section 5847(b)(7) specifies that each county shall establish and maintain a Prudent Reserve that includes PEI. The Prudent Reserve account is to ensure that the County programs will continue to be able to serve those currently being served should MHSA revenues decrease.

Proposal:
Due to the delays in PEI implementation, Marin Community Mental Health Services is proposing to transfer $700,000 of FY 2009-2010 unspent PEI funds to the MHSA Prudent Reserve account. The additional $700,000 will increase the existing MHSA Prudent Reserve account balance from $2,176,490 to $2,876,490.

The proposed transfer will prevent PEI funds from reverting back to the State.

30-Day Public Notification
This document will be posted on the HHS Website for 30 days for public comments.

MARIN COMMUNITY MENTAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA) PLAN AMENDMENT
INNOVATION (INN)
FY 2013-2014

Background: Client Choice and Hospital Prevention Program (CCHP) is the MHSA Innovation Plan for Marin County approved by the State on January 27, 2011. The program seeks to increase the quality of care and services by combining three distinct strategies: the systematic use of crisis plans for all existing and new adult clients in the mental health system, community-based crisis services in a homelike environment, and integrated peer/professional staffing. While other examples of each individual strategy exist, this proposed program is innovative in that it combines the three strategies, based on the belief that effective and lasting change in Marin's response to psychiatric emergencies can only occur through the strategic integration of these three critical components. The total 3-year INN budget is $3,072,596, funded by Medi-Cal and other health coverage ($1,590,796) and MHSA INN funds ($1,481,800) allocated by the State in FY 2008-2009 through FY 2010-2011.

The services are provided by Buckelew Programs, Casa Rene, a newly constructed 10-bed crisis residential facility; all ten beds are dedicated to MHSUS clients. The initial plan was to purchase six beds. But after consideration of economies of scale and cost/benefit analysis, all ten beds were purchased. Casa Rene opened for services in FY 13/14.

Proposal: We are proposing to increase MHSA INN funding CCHP by $276,100 using FY 2011-2012 MHSA INN allocation. Due to delays in planning, construction, State licensing, the estimated Medi-Cal and other revenues are lower than originally projected. Also, the clients served include both Medi-Cal and non-Medi-Cal eligible clients, instead of the original planning assumption of Medi-Cal only clients. The result is lower estimated Medi-Cal revenues. With the additional $276,100 of INN funds being requested, the total MHSA INN funding for CCHP services through June 30, 2015 is $1,757,900.

Original	Total Cost	MHSA INN	MHSA CSS	Medi-Cal/OHC
13/14	$1,024,199	$517,402		$506,796
14/15	$1,024,199	$482,199		$542,000
15/16	$1,024,199	$482,199		$542,000
Total	**$3,072,597**	**$1,481,800**	**$0**	**$1,590,796**

Revised	Total Cost	MHSA INN	MHSA CSS	Medi-Cal/OHC
13/14	$1,039,151	$924,311		$114,840
14/15	$1,177,830	$833,589		$344,241
15/16	$1,177,830		$600,000	$577,830
Total	**$3,394,811**	**$1,757,900**	**$600,000**	**$1,036,911**

Variance	Total Cost	MHSA INN	MHSA CSS	Medi-Cal/OHC
13/14	$14,952	$406,909	$0	($391,956)
14/15	$153,631	$351,390	$0	($197,759)
15/16	$153,631	($482,199)	$600,000	$35,830
Total	**$322,214**	**$276,100**	**$600,000**	**($553,885)**

Notes:

a) Medi-Cal revenue for FY 13/14 is for 5 months of direct services, starting Feb 2014

b) MHSA CSS funding request of $600k for FY 15/16 in included in the 3-year MHSA Plan for FY 14/15 - FY 16/17

MARIN COMMUNITY MENTAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA) PLAN AMENDMENT
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)
FY 2013-2014

Background: One of the components of MHSA is Capital Facilities and Technological Needs (CFTN). Marin County's CFTN Project Work Plan was approved by the State on June 7, 2010; amendments to the plan were approved in subsequent MHSA Annual Updates. Total funding is $2,488,999 as listed below. Funding must be spent within ten years from the year of allocation.

Proposal:
We are proposing to amend the Practice Management project budget to include the implementation of required systems transitions, and necessary system enhancements outlined below totaling $293,500. Funding will be from existing Practice Management remaining funds of $97,044; plus $196,456 to be shifted from the Mental Health Facility Improvement project.

- **ICD-10** ($200,000) – To implement the transition to ICD-10 as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA) by October 1, 2014. ICD- 10, International Classification of Diseases – Tenth Edition is a set of diagnosis and inpatient procedure codes used in the health care system. The projected total cost of $225,000 includes: professional services and staffing cost to perform Mental Health and Substance Use services coding analysis and crosswalk, impact analysis, implementation and training. The implementation will include both county and contract operated services.

- **Rapid Insight Licenses** ($13,500) - Rapid Insight is a business intelligence and automated predictive analytics software. It will be used to expand and enhance the current practice management reporting system (Sharecare). With a focus on ease of use and efficiency, Rapid Insight enables users to turn their raw data into actionable information. The analytic software simplifies the extraction and analysis of data, enabling Mental Health and Substance Use Services (MHSUS) to fully utilize information for data-driven decision making, analysis, and State-required reporting functions. The cost of $13,500 is for 6 Rapid Insight licenses, and 1 Veera license.

- **Reportal** ($55,000) – In addition to Rapid Insight, we are proposing to implement a Reportal system. Reportal maintains a data warehouse of claim and service related data extracted periodically from the practice management system, ShareCare. Its target audience is financial and clinical staff who can choose from a menu of dozens of "canned" reports. Each report can be tailored using approximately 50 different data selection criteria such as service date range, service provider, treatment program, type of service, etc. These two systems will enable Marin County to accurately track and monitor our service delivery outcomes, cost report support, and will develop tools for identifying challenges and changes needed to system of care. Implementation of these systems is planned for 13/14. There will continue to be a need for annual software licenses per user. The cost of $55,000 is for implementation cost of $40,000 and $15,000 for a license.

- **Risk Assessment** ($25,000) - In order to qualify for Meaningful Use incentive payments, MHSUS must meet the Core 15 requirements of a Security Risk Assessment for electronic protected health information (ePHI). This will enable our eligible providers to attest that our system is certified and can meet the security guidelines that the Federal government established for Meaningful Use pursuant to 42 CFR 164.308(a)(1). The cost of $25,000 includes professional services to be rendered by highly qualified ePHI risk assessment specialist.

	Annual Update FY 2013-2014				
CAPITAL FACILITIES / TECHNOLOGICAL NEEDS (CFTN) PROJECTS	**Total Funds Available**	**Total Costs Incurred**	**Total Estimated Remaining Funds Available Per MHSA Annual Update**	**Proposed Adjustments**	**Adjusted Funds Available**
Practice Management	$1,121,744	($1,024,700)	$97,044	$193,456	$290,500
Scanning	$147,104	($51,393)	$95,711		$95,711
E-Prescribing	$178,271	($55,041)	$123,230		$123,230
Marin CMHS Electronic Health Record Upgrade (CG)	$177,746	($93,578)	$84,168		$84,168
Marin CMHS Consumer Family Empowerment	$199,796	($70,604)	$129,192		$129,192
IT Planning Consultant	$12,075	($4,388)	$7,687		$7,687
Behavioral Health Information Crosswalk	$105,000	$0	$105,000		$105,000
Mental Health Facility Improvement	$547,263	$0	$547,263	($193,456)	$353,807
TOTAL CFTN:	**$2,488,999**	**($1,299,704)**	**$1,189,295**	**$0**	**$1,189,295**

MARIN COMMUNITY MENTAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA) PLAN AMENDMENT
PREVENTION AND EARY INTERVENTION
FY 2013-2014

Background:
On July 24, 2012, the Board of Supervisors approved the Amendment to the Mental Health Services Act (MHSA), Prevention and Early Intervention Plan to transfer $700,000 of FY 09/10 PEI unspent funds to the MHSA Prudent Reserve account, consistent with the provisions of MHSA. The amendment was submitted to the State Department of Health Care Services (DHCS) and the State Mental Health Services Oversight and Accountability Committee (MHSOAC). See attached Plan Amendment narrative posted in June 2012 for additional information.

The submitted Plan Amendment has not been approved by DHCS. DHCS has taken the position that MHSA PEI funds could not be transferred to Prudent Reserve, which is contrary to the provisions of MHSA, Welfare and Institutions Code Section 5847(b)(7). Counties that are adversely affected by DHCS's position are in the process of filing an appeal regarding this matter. Resolution is expected to take a few years.

Proposal:
In light of the issue described above, Marin Mental Health and Substance Use Services is proposing to withdraw the PEI Plan Amendment approved by the Board of Supervisors on July 24, 2012. It appears that the concerns regarding reversion of unspent funds were mitigated with the allocation of one-time PEI funds in fiscal years 11/12 and 12/13 to expand services. A recent review of MHSA unspent funds based on the latest MHSA Revenue and Expenditure Report submitted to State DHCS in October 2013 showed no PEI funds at-risk of reversion. The unspent funds of $700,000 has been included in the 3-year MHSA PEI planning estimates starting FY 14/15, pending approval of this request.

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

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DIRECTOR

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June 18, 2013

APPROVED
JUN 18 2013
MARIN COUNTY
BOARD OF SUPERVISORS

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) FY 2013-2014 ANNUAL UPDATE

Dear Supervisors:

RECOMMENDATIONS:

1. Authorize the President to approve the Mental Health Services Act (MHSA) FY2013-2014 Annual Update.

2. Authorize the President to approve the budget adjustments detailed in Attachment A for FY 2013-2014.

SUMMARY: In FY 2013-2014, approximately $8,669,313 in Mental Health Services Act (MHSA) funds are proposed for a broad range of community-based and County run programs to provide a variety of mental health and substance use services, including:

- Prevention and early intervention (PEI) activities such as parenting programs, screening for mental health or substance use issues in primary care settings, or youth activities;
- Community services and support (CSS) programs such as case management for older adults, homeless individuals or the STAR program focusing on alternatives to incarceration;
- Innovation services including crisis planning and the development of a crisis residential facility.

In addition, a total of approximately $1,357,792 of previously approved MHSA funds still remain in FY 13/14 for Workforce, Education and Training, and Capital Facilities and Technological needs component funding.

All of these efforts were developed through a comprehensive planning process that included the communities and stakeholders most interested in mental health and substance use issues. The State requires that the plan developed as a result of this

CA-7C

process be approved, after a public comment period by the Mental Health Board and then by the County Board of Supervisors.
The outcomes for FY 2011-2012 and proposed changes for FY 2013-2014 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 FY2013-2014 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 Tuesday, April 9, 2013 and ending Wednesday, May 8, 2013. On Tuesday, May 14, 2013, 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 FY 2013-2014 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 services systems to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in underserved populations. The additional resources and community process associated with the Act has brought measurable improvements to the lives of many Marin County residents.

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 1000047000. The increase in expenditures of $1,952,551 for one-time costs is fully offset by MHSA funds. There is no additional net county cost associated with this request.

REVIEWED BY:

☒	County Administrator	☐ N/A
☐	Department of Finance	☒ N/A
☐	County Counsel	☒ N/A
☐	Human Resources	☒ N/A

Sincerely,

Larry Meredith, Ph.D.
Director

FMBB Document: Pending - Will be entered in SAP in FY 13/14
Copies of the MHSA Annual Update are available by contacting the Clerk of the Board

ATTACHMENT A

Budget adjustments (fund 1000)

Action	Fund Center	SAP Fund	Description	Commitment Item	CI Description	Budget Adjustment (FY 13/14)
Increase	1000047000	10000	MHSA Prop. 63	5210400	CBO Contracts	$1,952,551
Increase	1000047000	10000	MHSA Prop. 63	5410100	Support of Clients	($230,025.00)
Total Expenses						**$1,722,526**
Increase	1000047000	10000	MHSA Prop. 63	4810110	Transfers In – Prop 63	$1,722,526
Total Revenues						**$1,722,526**

Budget adjustments (fund 25049)

Action	Fund Center	SAP Fund	Description	Commitment Item	CI Description	Budget Adjustment (FY 13/14)
Increase	1000047000	25049	MHSA - Prop 63	5490120	Operating Transfers Out	$1,722,526
Total Expenses						**$1,722,526**
Increase	1000047000	25049	MHSA - Prop 63	4520110	Prop 63 - MHSA	$1,722,526
Total Revenues						**$1,722,526**

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: MARIN

- ☐ Three-Year Program and Expenditure Plan
- ☑ Annual Update
- ☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Margaret Kisliuk	Name: Roy Given
Telephone Number: 415-473-4296	Telephone Number: 415-473-3736
E-mail: mkisliuk@marincounty.org	E-mail: rgiven@marincounty.org
Local Mental Health Mailing Address: County of Marin Department of Health and Human Services 3250 Kerner Boulevard San Rafael, CA 94901	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

Margaret Kisliuk
Local Mental Health Director (PRINT)

Margaret Kisliuk 6-5-13
Signature Date

I hereby certify that for the fiscal year ended June 30, 2012, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 2/22/13 for the fiscal year ended June 30, 2012. I further certify that for the fiscal year ended June 30, 2012, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report is true and correct to the best of my knowledge.

Roy Given
County Auditor Controller / City Financial Officer (PRINT)

Roy Given 6/10/13
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

COUNTY OF MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MENTAL HEALTH SERVICES ACT

WELLNESS • RECOVERY • RESILIENCE

FY2013-14
ANNUAL UPDATE

Mental Health and Substance Use Services Division
3240 Kerner Boulevard
San Rafael, CA 94901

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

Table of Contents

EXECUTIVE SUMMARY

This report presents information on existing Mental Health Services Act (MHSA) funded programs in Marin County, including accomplishments and challenges. Changes on the State level have led to a change in the format of this report. We hope it is more understandable than previous Annual Updates, and will work in future years to make it increasingly useful.

The MHSA brings resources and guiding principles to assist in the transformation of the mental health system, but the work must be done locally. An incredible amount of work has gone into developing this MHSA programs discussed in this report. Marin County Health and Human Services, community-based organizations and many individuals and communities within Marin have collaborated to better understand and address the needs and opportunities that MHSA can address. This is an ongoing process, 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 residents voted 63% in favor. The MHSA raises additional taxes for the State, which were then allocated to respective county mental health programs under extensive regulations developed by the then State Department of Mental Health.

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

Mental Health Services Act 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 at:

http://www.co.marin.ca.us/depts/HH/main/mh/mhsa_faq.cfm

or by calling 415-473-6769 to request a paper copy by mail.

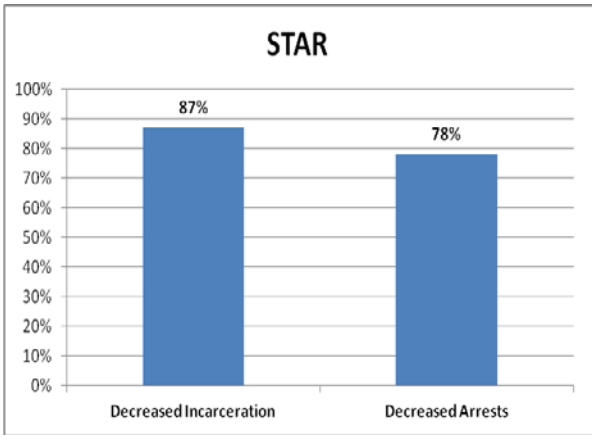
Fiscal Year 2013-2014 Annual Update Overview

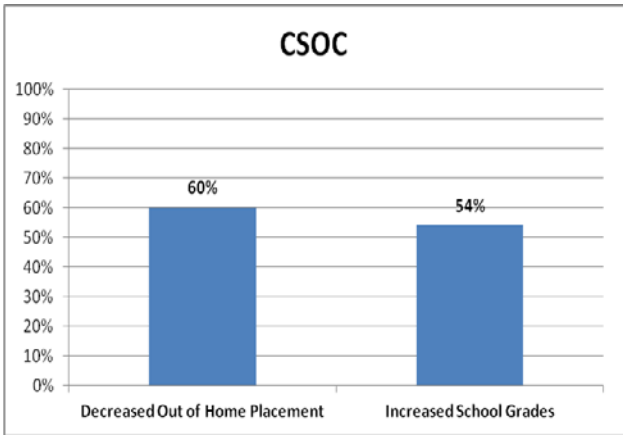
MHSA provides an opportunity to transform the mental health system in alignment with the MHSA principles. MHSA has facilitated an increase in community collaboration, as evidenced by the strong involvement in the planning processes and implementation committees. Consumers and families have been especially involved, helping to shape services and define their role in the system. Services have been located within the community to increase access and integrate services, including Southern Marin Services, behavioral health services within primary care settings, and increasingly co-locating mental health and substance use services. Programs are demonstrating tangible outcomes, as notes below and detailed in the program narratives. Since CSS has been implemented we have seen an increase in County mental health services to several key communities, but there is much more to be done for all those who remain un/underserved. PEI-funded programs have successfully reached diverse races, ethnicities and ages. Recently launched targeted programs should further increase access to culturally competent services.

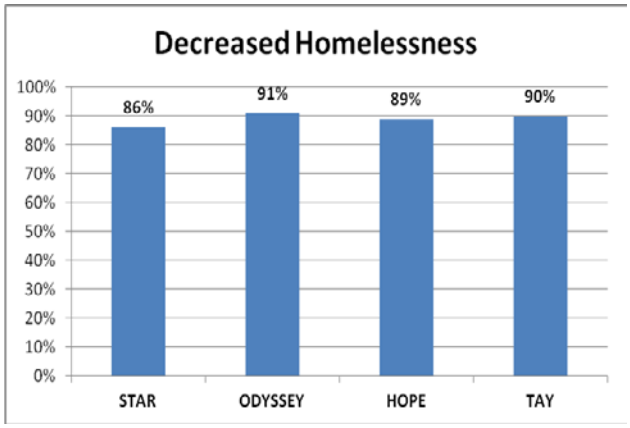
Community Services and Supports (CSS)

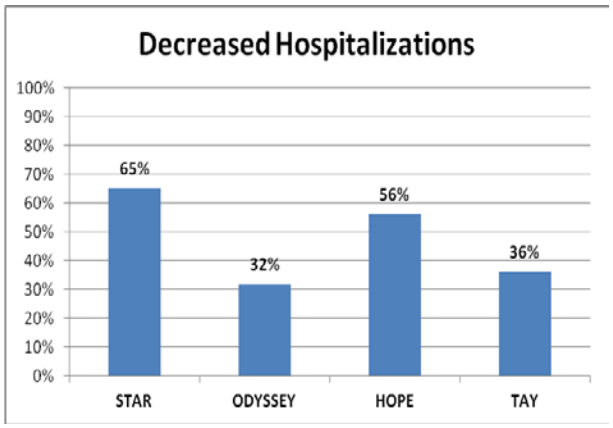
CSS programs have led to a variety of outcomes for participants. These charts below show some highlights from the Marin CSS Full Service Partnerships (FSPs).

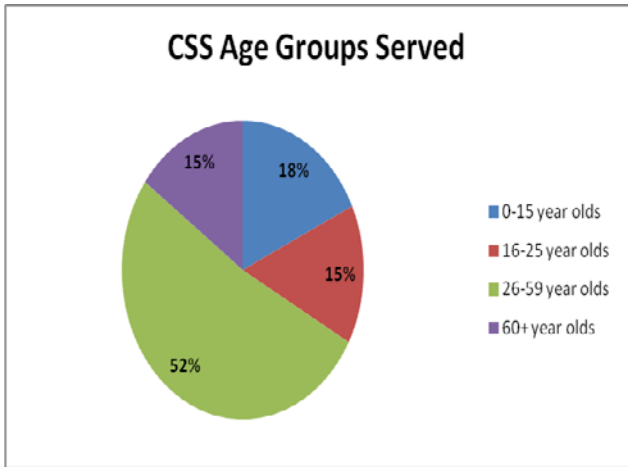
These charts report cumulative outcomes since the beginning of the CSS program. Percentages are calculated based on the number of clients within each program for whom the measure is appropriate, i.e., only those for whom there was data reported for each measure during the 12 months prior to enrollment in the program or at any time while enrolled in the program.

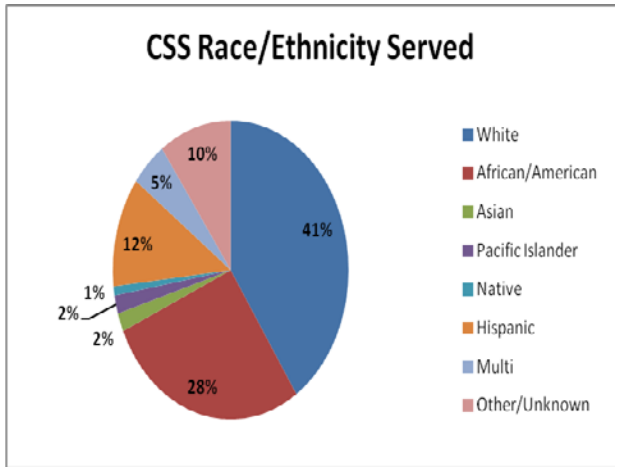


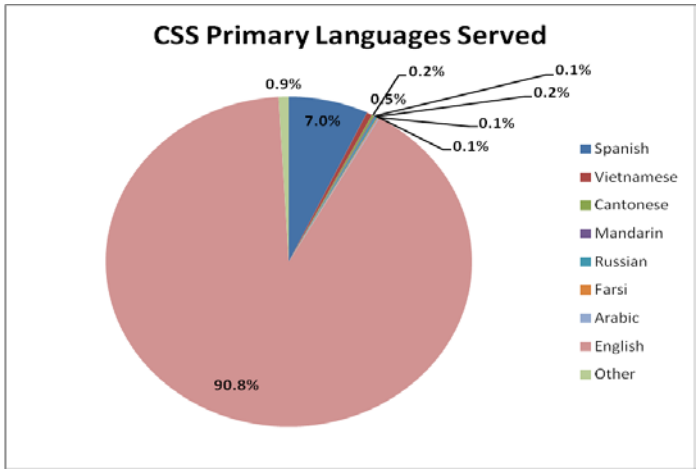










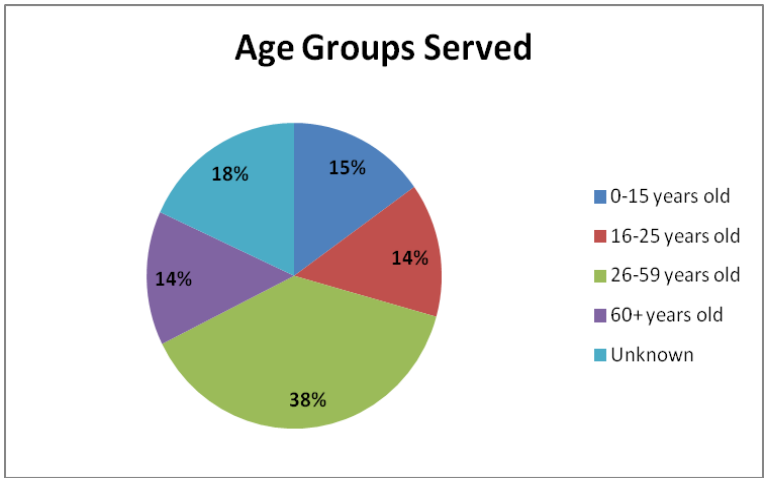


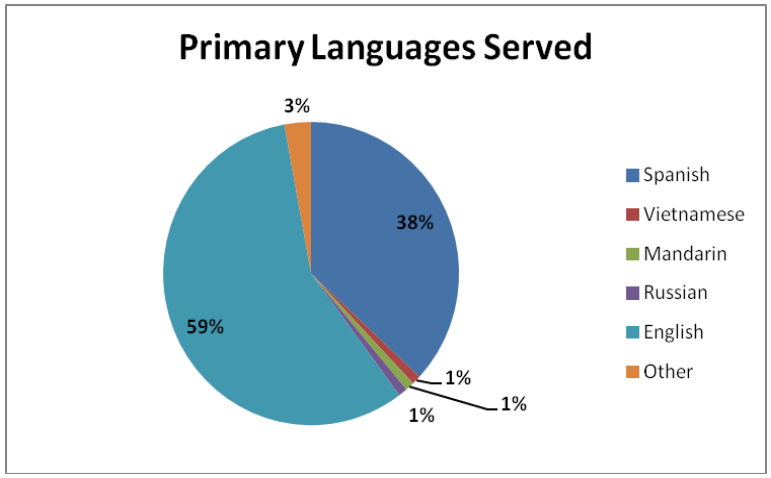
Further details on CSS programs are provided in this report.

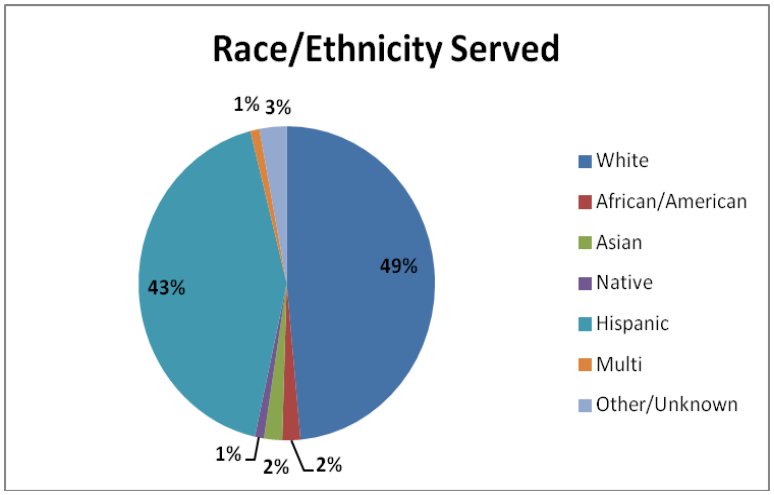
Prevention and Early Intervention (PEI)

PEI Programs have successfully reached un/underserved populations.

Total Individuals Served: 9440







Further details on PEI programs are provided in this report.

Innovation

Marin's Innovation Program, "Client Choice and Hospital Prevention Program", focuses on expanding the array of effective responses to those experiencing a psychiatric crisis. The creation of a recovery-oriented, community-based response to psychiatric crises will provide alternatives to hospitalization while supporting clients, families and communities to increase resilience. This project is also intended to help change the perception of how the mental health system and community can best respond to and help prevent psychiatric crises.

Workforce, Education and Training

Trainings Provided	
Targeted Training in Evidence-Based Practices	Consumer Focused Trainings
Family Focused Trainings	Harm Reduction in Case Management
Motivational Interviewing Champions Groups	MH Directors Leadership Institute Training

The WET program continued to train the workforce in evidence based practices. The focus in this last fiscal year has been upon the Consumer and Family member trainings as well as educational scholarships for families and consumers of the MH system.

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 2013-14 Annual Update

For a copy of the MHSA 2013-14 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/13-14update.cfm.

Please review the MHSA 2013-14 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, 10 N. San Pedro Road, Suite 1015, San Rafael, CA 94903.

The required thirty (30) day public comment period for the MHSA FY2013-14 Annual Update begins on Tuesday, April 9, 2013 and ends on Wednesday, May 8, 2013.

A Public Hearing for the MHSA FY2013-2014 Annual Update will take place at the Mental Health Board Meeting on Tuesday, May 14, 2013 at 6:30 pm at the Marin County Health and Wellness Campus, 3240 Kerner Boulevard, San Rafael, CA 94901, Room 110. The public is welcome.

MHSA Moving Forward

Marin has begun the process to develop a Three Year Integrated Plan as requested by the State. It begins in FY2014-2015. We expect to conduct information gathering meetings during Spring 2013 and Stakeholder meeting during the Summer 2013 and 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
3240 Kerner Boulevard
San Rafael, CA 94901

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. Input received in these settings is brought to MHSUS Senior Management and 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, family partners and the WET consultant meet monthly as the Family Subcommittee.
- The Innovation Advisory Committee meets periodically to oversee the implementation of 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.

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.

FY2013-14 Annual Update Process

In FY2012-13 a number of expansions were implemented for CSS and PEI. This Annual Update reflects a continuation of all ongoing programs and most of the recent expansions. This allows the new programs to begin showing their impact while Marin is in the process of developing its MHSA Three Year Integrated Plan (FY14-15, FY15-16, FY16-17).

The Annual Update was posted for 30-day public comment from April 9, 2013 through May 8, 2013. It was be 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 May 14, 2013, 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 FY2013-2014 MHSA Annual Update.

Prior annual updates are available at:
http://www.co.marin.ca.us/depts/HH/main/mh/mhsa_faq.cfm

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 (10) ❖ Community Based Providers (8)
Health	❖ Community Clinics (6) ❖ Teen Clinics (3)
Social Services	❖ Children & Family Services (2) ❖ Employment (1)
Law Enforcement	❖ Police Departments (2)
Community-Family Resource Centers	❖ CBOs (9)
Advocates for interests of consumers and families	❖ Consumer and family members participated in all ongoing MHSA committee meetings
Other	❖ FIRST 5 (1) ❖ Union (2) ❖ Community members (3)

Communities Represented:

Un/underserved Community	*Approximate # of Reps*
Latino	5
African American	8
Asian	2
Geographically Isolated	4
TAY	3
Older Adults	10

Substantive Comments and Responses:

1. **Develop a brief one or two page report that is more accessible to the community.**
   Efforts will be made to have a one-two page summary report in future Annual Update reports.

2. **It would be beneficial to people with psychiatric disabilities if the amount they could earn and save without losing benefits was increased.**
   SSI amounts are determined by State and Federal agencies and are not within control of the County.
3. **Increase peer support and training.**
   We will include this feedback in the MHSA Three Year Planning process for FY14-15 and beyond which has just started.

4. **People should be screened, entered into a database, and cleared regarding mental health issues before being able to get access to firearms.**
   Policy and procedures around mental health assessment and the creation of a database for those who want to purchase firearms are determined by State and Federal agencies and are not within control of the County.

5. **Affordable mental health, drug and alcohol treatment services for Latino and Spanish speaking residents is a need.**
   Currently, mental health, drug and alcohol assessment and referral to treatment is available for Latino and Spanish speaking residents of Marin through Bay Area Community Resources Recovery Connection Center (ph 415-755-2345). Opportunities to expand this will be explored during the upcoming three year planning process.

6. **Legal Services are being offered, but there are more individuals in need of those serves than are provided for under the Annual Update.**
   Legal Services funded through the Mental Health Services Act are available to mental health system of care clients or for clients referred through the community based MHSA Prevention and Early Intervention providers.

7. **How many people do the Full Service Partnerships (FSPs) serve? Are they the same individuals from year to year?**
   Each FSP has a different capacity which is indicated in the program narratives in this Annual Update. While many clients are discharged successfully, we will be looking at how to move clients from FSPs into a recovery phase of services during the three year planning process.

8. **What is the status of the Innovation project?**
   The Crisis Planning portion of the program began almost two (2) years ago and is actively serving clients. The Crisis Residential home is almost complete, with the goal to open for services in late Fall 2013.

9. **What are housing funds being used for? It seems some of the funds are not allocated.**
   The Fireside Senior Housing was opened in Spring, 2010. We are currently seeking another viable project that meets the MHSA funding guidelines.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county with a population of 256,069 and spanning 520 square miles of land. The majority of residents live in the eastern region of the county, along the Highway 101 corridor. Ranching and dairying are major features of the rural areas of West Marin. Industry in the county includes movie and video production, computer software, communications equipment, printing and the manufacturing of ceramics, candles and cheese.

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 adult 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 evidence-based, recovery-oriented service models. Types of funding include:

Full Service Partnerships (FSPs)

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

A primary goal of MHSA is to better serve un/underserved populations and the County has seen an increase in services targeted at Latinos, older adults, specific geographic parts of the County, and in other respects.

Since CSS has been implemented we have seen an increase in services to Latino adults and continued our relatively high level of service to Latino youth. In FY2005-2006 Latinos comprised 12.8% of County mental health clients, and in FY2010-2011 they were 20.4%. There was not a significant change in rates for other ethnic populations. MHSA has allowed an increase in bilingual staff and support for programs such as Amigos Consejeros A Su Alcance (ACASA) and Southern Marin Services that target communities that had been identified as under or unserved.

The County recognizes the need to better engage and serve diverse populations, especially those identified as un/underserved. For instance, in FY2012-2013 the County allocated PEI monies to three programs aimed at reaching the Latino, Vietnamese and Southern Marin populations, including the use of Community Health Advocates/Promotores, a strategy shown to develop trust and reduce barriers to accessing mental health services. To some extent, the PEI-funded efforts help support the outreach to CSS and other more intensively focused service programs.

This table summarizes the individuals served by all CSS programs in FY2011-12.

Total Individuals Served: 1637

Age Group	# served	% of Served
0-15 years old	298	18%
16-25 years old	241	15%
26-59 years old	852	52%
60+ years old	246	15%
Race/Ethnicity		
White	667	41%
African/American	453	28%
Asian	31	2%
Pacific Islander	25	2%
Native	15	1%
Hispanic	199	12%
Multi	77	5%
Other/Unknown	160	10%

Primary Language	% of served
Spanish	7%
Vietnamese	.5%
Cantonese	.2%
Mandarin	.1%
Russian	.2%
Farsi	.1%
Arabic	.1%
English	90.8%
Other	.9%

This following 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, i.e., those for who there was data reported for each measure during the 12 months prior to enrollment in the program or at any time while enrolled in the program. For example, 86% of 83 STAR clients have experienced a reduction in homelessness while 65% of 31 have experienced a reduction in psychiatric hospitalization. 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	**160**		**115**		**109**		**53**		**198**		**635**	
	%	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
Decreased Homelessness	86%	(83)	91%	(86)	89%	(18)	90%	(10)	100%	(1)	88%	(198)
Decreased Psych Hospitalization	65%	(31)	32%	(25)	56%	(9)	36%	(14)	25%	(4)	47%	(83)
Decreased Incarceration	87%	(139)	78%	(18)	67%	(3)	38%	(8)	49%	(146)	65%	
Decreased Arrests	78%	(139)	50%	(6)	NR%	(0)	67%	(3	45%	(51)	55%	
Decreased School Suspensions									97%	(140)		
Increased School Attendance									42%	(168)		
Decreased Out-of-Home Placement									60%	(30)		
Increased School Grades									54%	(70)		

CHILDREN'S SYSTEM OF CARE (CSOC)

PROGRAM DESCRIPTION
July 2011 – June 2012

Marin County's Children's System of Care (CSOC) is a full service partnership program 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 sensitive 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. The CSOC program 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 a supportive, strengths based model with the goal of meeting youth and families in their homes and in the community. The services incorporate a wraparound philosophy, focusing on working as a team to help families identify their needs and implement ways to address them successfully. A unique part of this program is the support from the two (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 capability to address the diverse needs of the client population.

OUTCOMES
July 2011 – June 2012

The CSOC Program was fully operational in FY2011-12, serving 98 youth over the course of the year. 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 program expanded to become an FSP in 2007, notable outcomes include:

- Of youth who were incarcerated in the 12 months prior to enrollment or since enrollment (N=146), 72 youth (49%) achieved decreased incarceration.
- Of those who experienced school suspensions (N=140), 136 students (97%) achieved a decrease in suspensions.
- Of the youth having arrests (51), 23 youth (45%) experienced decreased arrests.
- Of those who experienced out-of-home placement (N=30), 18 students (60%) experienced a decrease in out-of-home placements.

Client ages ranged from 9-15 (23.5%) and 16-18 (76.5%). During the FY11-12, Latino youth and other youth of color continued to make up the majority of the CSOC clients: Hispanic (69.4%), African American (13.3%), and multiple ethnicities (4.1%), with (48%) reported as Spanish speaking.

Age Group	# served	% of served
0-15 years old	23	23.5%
16-25 years old	75	76.5%
26-59 years old		
60+ years old		
TOTAL	**98**	**100%**
Race/Ethnicity		
White	7	7.1%
African/American	13	13.3%
Asian		
Pacific Islander		
Native	1	1%
Hispanic	68	69.4%
Multi	4	4.1%
Other/Unknown	5	5.1%

Primary Language		
Spanish	47	48%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	50	51%
Other	1	1%

A few examples highlight the work the CSOC team has accomplished. In one case, a client under age 10 was placed on probation for felony vandalism. With the support of CSOC services (individual support, case management, wraparound support to the family), this client was able to get off probation, improve his ability to follow directions at home, improve his overall performance at school, play afterschool baseball, attend two summer camps, and reunite with his family.

In another case, a 13 year-old client was expelled from school for possession of marijuana. At the start of services, this client was smoking marijuana frequently, had poor school attendance and was increasing his involvement with gangs. With the support of CSOC services, including individual, family, and wraparound services, this client was able to improve his school attendance, reduce his use of marijuana, decrease his gang involvement and return to his prior school.

CHALLENGES AND UPCOMING CHANGES

The CSOC program faces several challenges. The program continues to serve youth with significant substance use issues. To address these 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) and general harm reduction approaches. Staff has been provided the opportunity to continue with monthly consultation to further develop and practice these interventions. Additional MHSA funds were made available in December 2012 to hire a 1.0 FTE bilingual substance use counselor to support these clients, as substance use services for youth in Marin County are very difficulty to access. A hiring process is underway and the funding for the bilingual substance use counselor will be continued in FY13-14. This position will serve 25-40 youth per year.

CSOC clients also present with numerous psychosocial stressors, including poverty, lack of employment opportunity, undocumented legal status, gang involvement and precarious housing. The CSOC program works collaboratively with partner agencies, such as Seneca Sustaining Families and Juvenile probation, to leverage existing supports and resources. However, chronic stressors and difficulty in accessing services continue to present external challenges to CSOC clients and families.

CHILDREN'S SYSTEM OF CARE (CSOC)

SEAN'S STORY

The client name(s) have been changed

Marin County's CSOC program worked with Sean, a nine year old boy who was placed on juvenile probation for trespassing. The client lived with his grandmother and his younger siblings at the time of his arrest while his mother completed a residential treatment program. Sean did poorly in school and was increasingly becoming beyond the control of his grandmother. CSOC services provided were individual therapy, collateral/consultation, case management and wraparound services. The goals of therapy included assisting Sean to make better decisions around peer associations and influences, improving his overall performance at school, improving his ability to follow directions by authority figures in his life, assisting him and his family to access pro-social activities, and stabilizing their housing situation as Sean's grandmother was threatened with an eviction during the course of the work.

With the assistance of CSOC services, Sean succeeded in meeting his goals. He did not re-offend and was able to get off probation. He improved his ability to follow directions at home as reported by his grandmother and his overall school performance improved which allowed him to advance to 4th grade. With the assistance of a wraparound team member, the family was able to avoid eviction from their housing. Sean was able to play afterschool baseball for Little League and attend two summer camps. Finally, Sean and his siblings reunited with their mother upon her graduation from her residential treatment program.

TRANSITION AGE YOUTH (TAY) PROGRAM

PROGRAM DESCRIPTION
July 2011 – June 2012

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, Family Service Agency, 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, such as drop-in hours and activities, 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 TAY calendar of activities 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 2011 – June 2012

In FY11-12, the TAY Program received more referrals from the Adult Team, PES and Unit A. These clients are more symptomatic, requiring more focus on finding appropriate medications, stabilization, and psychotherapy. This has likely contributed to not meeting all of the program goals, as seen in the Outcomes Table. At the same time, more clients were served than in past years.

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 enrollment or since enrollment in the FSP (N=10), 9 clients (90%) experienced a decrease in homelessness.
- Among those who were hospitalized (N=14), 38 clients (36.8%) experienced a decrease in hospitalization.

Outcome	Goal	Actual FY11-12
Number of Full Service Partnership (FSP) clients served	20	30
Number of Partial Service Partnership clients served	100	90
FSP clients engaged in work, vocational training or school	70%	65% *N=30*
FSP clients that attended activities to improve independent living skills	90%	100% *N=30*
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	80%	75% *N=19*

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

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old	30	100%
26-59 years old		
60+ years old		
TOTAL	**30**	**100%**
Race/Ethnicity		
White	21	70%
African/American	2	6.7%
Asian	2	6.7%
Pacific Islander	1	3.3%
Native		
Hispanic	3	10%
Multi	1	3.3%
Other/Unknown		

Primary Language		
Spanish	1	3.3%
Vietnamese		
Cantonese	1	3.3%
Mandarin		
Russian		
Farsi		
Arabic		
English	28	93.3%
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. The activity calendar is available in Spanish and outreach is conducted through a variety of venues.

CHALLENGES AND UPCOMING CHANGES

In FY10-11, Buckelew engaged an external evaluator to provide feedback about the TAY Program. They have been implementing some of the recommendations resulting from that process.

In FY2011-12, MHSA provided additional funds for the TAY Program to:

- Create a therapeutic garden at the TAY Training House;
- Implement a Health and Wellness Program that includes gym memberships and personal trainers to facilitate TAY in reaching their health and fitness goals; and
- Send staff to Transition to Independence Process (TIP) trainings, an evidence-supported practice to improve outcomes (increase education, employment, and community-life functioning while decreasing use of intensive mental health services and incarceration).

In FY2012-13, MHSA provided additional funds for the TAY Program which will be continued in FY2013-2014:

- Add a half-time specialist in addiction treatment and family therapy;
- Expand the on-site psychiatric consultation time available; and
- Increase the Case Manager position.
- Expand the Independent Living Skills Training (ILS) services available.

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM

PROGRAM DESCRIPTION
July 2011 – June 2012

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 three (3) mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking) and one of whom is co-located with the Jail Mental Health Team; a part-time nurse practitioner; a part-time psychiatrist; two (2) peer specialists; a deputy probation officer; a part-time employment specialist; and a part-time substance use 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.

Funded by CSS FY2011-12 one-time expansion funds, the program's part-time mental health clinician co-located with the Jail Mental Health Team conducts comprehensive in-custody assessments and provides post-release support and linkages to services. Also funded by the one-time expansion funds, the program's part-time substance use specialist provides assessments and consultation to the team, as well as facilitates a weekly treatment group for program participants with co-occurring substance abuse disorders.

OUTCOMES
July 2011 – June 2012

The STAR Program was fully operational during FY2011-12, serving 63 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. Thirty of the program enrollees participated in STAR Mental Health Court with 11 successfully graduating. Of the 24 program participants referred by the team for employment services, 8 (33%) were successfully engaged in job development activities, 4 (17%) of whom were successfully placed in jobs, and 6 (25%) engaged in volunteer work.

Since the beginning of the program, the clients of the full service partnership component have experienced the following outcomes:

- Among those program participants with incarcerations in the 12 months prior to enrollment or since enrollment in the FSP (N=139), 121 clients (87%) have shown a decrease on this measure.
- Similarly, 78% (N=139) of participants experienced a reduction in arrests and 86% (N=83) a reduction in homelessness, while those with acute inpatient hospitalizations decreased by 65% (N=31).

During this reporting period, services funded by the one-time CSS FY2011-12 expansion funds met or exceeded the projected goals. Eighty-five inmates received comprehensive assessments, well in excess of the program annual target of 75, with 26 of these individuals receiving re-entry case management services, also exceeding the goal of 20. Fifteen STAR Program participants received substance abuse services provided by the program's substance use specialist, meeting the program annual target of 15-20.

Annually, the STAR Program sponsors 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. To date, more than 240 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, some of the annual CIT trainings have 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 to 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). Unfortunately, because of scheduling issues, the CIT training originally planned for FY2011-12 had to be rescheduled for October 2013.

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 with the majority of program participants being incarcerated at the time of referral to the program. On average, 77% of participants in the STAR Program have presented with a co-occurring substance use disorder, putting 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. Thirteen percent of program participants were female, comparable to 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 somewhat underrepresented at 14% served in comparison to 14% in the County adult population (18 years of age and older). Also underrepresented were Asians at 3% compared to 6% in the adult population.

Note: County adult population data from 2010 census

Age Group	# served	% of served
0-15 years old		
16-25 years old	8	12.7%
26-59 years old	51	81%
60+ years old	4	6.3%
TOTAL	**63**	**100%**
Race/Ethnicity		
White	47	74.6%
African American	3	4.8%
Asian	2	3.2%
Pacific Islander		
Native		
Hispanic	9	14.3%
Multi		
Other/Unknown	2	3.2%

Primary Language		
Spanish	3	4.8%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic	1	1.6%
English	59	93.7%
Other		

CHALLENGES AND UPCOMING CHANGES

As noted above, the STAR Program has had limited success with 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. Additionally, it is anticipated that partnering with two new PEI projects being implemented in FY12-13 – Community Health Advocates and Vietnamese Community Connections – has the potential for increasing the program's opportunities for outreach and engagement.

As discussed earlier, 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 the past year, the need for specialty treatment services exceeded the capacity of the team's part-time substance use specialist. In FY12-13, existing program funds were re-allocated to increase the program's substance abuse services by adding a second weekly treatment group for participants with co-occurring disorders, as well as individual counseling sessions for 3-5 clients. Integrated substance abuse services will be provided to an additional 10-15 program participants each year.

CSS FY12-13 expansion funds were approved to add Independent Living Skills (ILS) training for targeted STAR 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. ILS services will be provided to 4-5 STAR program participants annually. These funds will be continued in FY13-14.

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

PROGRAM DESCRIPTION
July 2011 – June 2012

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 and Substance Use Services, Aging and Adult 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 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, a part-time Spanish-speaking social services worker, 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.

Funded by CSS FY2011-12 one-time expansion funds, the program's part-time social services worker adds Spanish-speaking capability to the core assertive community treatment component of the program, as well as strengthens and enhances the HOPE Program's key partnership with County Aging and Adult Services.

In addition, PEI FY2011-12 one-time expansion funds were leveraged to increase the outreach to at-risk older adults by increasing the hours of the Spanish-speaking mental health clinician supporting and supervising the ACASA (Hispanic/Latino) Senior Peer Counseling Program.

OUTCOMES
July 2011 – June 2012

The HOPE Program was fully operational during FY2011-12, serving 54 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. On average, 27% of participants in the Hope Program have presented with a co-occurring substance use disorder, putting them at even greater risk. An additional 43 older adults were served by the Senior Peer Counseling Program, the outreach and engagement component of the HOPE Program.

Since the beginning of the program, the clients of the full service partnership component have experienced the following outcomes:

- Among those program participants with homelessness in the 12 months prior to enrollment or since enrollment in the FSP (N=18), 16 clients (89%) have shown a decrease on this measure.
- Similarly, those with acute inpatient hospitalizations (N=43) decreased by 49%.

During FY2011-12, the Senior Peer Counseling Program supported a total of 32 trained older adult volunteers, 7 of whom were Spanish-speaking. 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 1,787 visits during the year, an 11% increase over the prior year. Eleven (26%) 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. Ninety-one percent of the older adults served by the HOPE Program's assertive community treatment component were Caucasian, consistent with 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.

Note: County older adult population data from 2010 census

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	2	3.7%
60+ years old	52	96.3%
TOTAL	**54**	**100%**
Race/Ethnicity		
White	49	90.7%
African/American	4	7.4%
Asian	1	1.9%
Pacific Islander		
Native		
Hispanic		
Multi		
Other/Unknown		

Primary Language		
Spanish		
Vietnamese	1	1.9%
Cantonese		
Mandarin		
Russian	1	1.9%
Farsi		
Arabic		
English	51	94.4%
Other	1	1.9%

CHALLENGES AND UPCOMING CHANGES

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 three (3) years. Outreach to and engagement with the Hispanic population was hampered by delay in hiring the part-time Spanish-speaking adult protective services worker from Adult Protective Services to work with the HOPE Program. This position was finally filled in late Spring of 2012. Additionally, Marin's new PEI Community Health Advocates project began operations in the fall of FY2012-13. It is anticipated that linkage and coordination with this PEI project will increase the program's opportunity for outreach to and engagement with Hispanic/Latino older adults.

ODYSSEY PROGRAM (HOMELESS)

PROGRAM DESCRIPTION
July 2011 – June 2012

The Odyssey Program is a full service partnership that provides culturally competent intensive, integrated services to sixty (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 three (3) mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking); a part-time nurse practitioner; a part-time psychiatrist; four (4) peer specialists, a part-time employment specialist, and a part-time substance use specialist. Outreach and engagement services are provided by a two (2) peer specialists. 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 seventeen (17) program participants referred by the team for employment services, 10 (59%) were successfully engaged in job development activities and six (6) (35%) were successfully placed in jobs.

Funded by one-time CSS expansion funds, the program's part-time substance use specialist provides assessments and consultation to the team, as well as facilitates a weekly treatment group for program participants with co-occurring substance abuse disorders. The one-time expansion funds were also 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.

OUTCOMES
July 2011 – June 2012

The Odyssey Program was fully operational during FY2011-12, serving 74 individuals who had serious mental illness and were homeless or at-risk of homelessness, and exceeding the program's target enrollment of 60. Of the 23 program participants referred by the team for employment services, 3 (33%) were successfully engaged in job development activities, 4 (17%) of whom were successfully placed in jobs, and 6 (25%) engaged in volunteer work.

Since the beginning of the program, the clients of the full service partnership component have experienced the following outcomes:

- Among those program participants with homelessness in the 12 months prior to enrollment or since enrollment in the FSP (N=86), 78 clients (91%) have shown a decrease on this measure.
- Similarly, 50% (N=6) of participants experienced a reduction in arrests and 78% (N=18) a reduction in incarcerations, while those with acute inpatient hospitalizations decreased by 32% (N=25).

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 FY2011-12, 123 individuals received homeless outreach services. The majority of these individuals were Caucasian (80%), with African-Americans comprising 7%, Hispanics 4%, and Asians 3%.

During this reporting period, the services funded by the one-time CSS FY2011-12 expansion funds had mixed results. Eight (8) Odyssey Program participants received substance abuse services provided by the program's substance use specialist, considerably less than the program annual target

of 15-20. Seven (7) program participants participated in the transitional supportive housing component and four (4) (57%) were successfully transitioned to other, more permanent living arrangements, exceeding the program annual target of 50%.

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: The majority of program participants were homeless at the time of referral to the program. On average, 66% of participants in the Odyssey Program have presented with a co-occurring substance use disorder, putting them at even greater risk. The program served a somewhat diverse population, with African-Americans being overrepresented at 14% compared to 3% in the County adult population (18 years and older), but consistent with the 14% reported in Marin's homeless population. Hispanics were underrepresented at 8% compared to 14% 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.

Notes: County adult population data from 2010 census; 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	1.4%
26-59 years old	61	82.4%
60+ years old	12	16.2%
TOTAL	**74**	**100%**
Race/Ethnicity		
White	50	67.6%
African/American	10	13.5%
Asian		
Pacific Islander		
Native	2	2.7%
Hispanic	6	8.1%
Multi	2	2.7%
Other/Unknown	4	5.4%

Primary Language		
Spanish	4	5.4%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi	1	1.4%
Arabic		
English	68	91.9%
Other	1	1.4%

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. It is anticipated that linkage and coordination with a new PEI projects being implemented in FY12-13, Community Health Advocates, will 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. Severe substance abuse was implicated in all three (3) of the unsuccessful discharges from the program's new transitional supportive housing component. Implementation of the integrated substance use services component has been challenging and the program is exploring methods for improving the engagement and participation of Odyssey Program clients in the program's integrated substance abuse services.

CSS FY12-13 one-time expansion funds were approved to add Independent Living Skills (ILS) training for targeted Odyssey 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. ILS services will be provided to 4-6 Odyssey program participants annually. These funds will be continued in FY13-14.

ENTERPRISE RESOURCE CENTER EXPANSION

PROGRAM DESCRIPTION
July 2011 – June 2012

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, the 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 seven (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 seven (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 seven (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. The ERC also provides a five (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 2011 – June 2012

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 MHSUS services. During FY2011-12, the Enterprise Resource Center Expansion project served 246 at-risk individuals with serious mental illness. Attendance at the ERC increased by 11% to 1,410 monthly visits with an average of 50 visits per day. Homeless individuals comprised 16% of the average monthly attendance and first time visitors comprised 2%. Warm Line contacts for the year were 9,398, slightly higher than the program's annual target of 9,000.

CSS FY2011-12 one-time CSS expansion funds were approved to add a full-time peer specialist to work on the CARE team and help stabilize staffing, plus a small flex fund to support outreach and engagement efforts. With these increases, the CARE Team was projected to serve an additional 80 individuals annually. Unfortunately, the team has continued to struggle with staffing issues and this expansion was not fully implemented. During this reporting period, the CARE team served 150 individuals, considerably lower than the target 250, averaging 71 monthly outreach contacts with homeless mentally ill individuals, lower than the expected 100 contacts/month.

The Enterprise Resource Center served a predominantly Caucasian population, with African-Americans being overrepresented at 6% 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 1% in comparison to 6% in the population. The number of Older Adults served increased significantly from last year, from 29 to 71 individuals.

Note: County adult population data from 2010 census

Age Group	# served	% of served
0-15 years old		
16-25 years old	15	6.1%
26-59 years old	160	65%
60+ years old	71	28.9%
TOTAL	**246**	**100%**
Race/Ethnicity		
White	164	66.7%
African/American	15	6.1%
Asian	3	1.2%
Pacific Islander	3	1.2%
Native	7	2.8%
Hispanic	9	3.7%
Multi	8	3.3%
Other/Unknown	37	15%

Primary Language		
Spanish	14	5.7%
Vietnamese	1	.4%
Cantonese	2	.8%
Mandarin	1	.4%
Russian	2	.8%
Farsi		
Arabic	1	.4%
English	220	89.4%
Other	5	2%

CHALLENGES AND UPCOMING CHANGES

Since its relocation to the Health and Wellness Campus and a larger facility in 2008, the Enterprise Resource Center has steadily expanded its attendance, programming and staffing. Emphasis has been placed on developing wellness and recovery services and supports, with the intention that the ERC would to fill a critical gap in Marin's adult system of care by providing a wellness and recovery service component for those individuals "stepping down" from the formal treatment system. The ERC is struggling with serving two distinct populations simultaneously: those who are disenfranchised, often highly symptomatic, and reluctant to engage in treatment; and those who are in active recovery and ready to develop more independence and self-management. In FY2012-13, Marin has begun to explore this challenge and plans to develop strategies which will enable the ERC to effectively serve both populations and functions.

The 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, and underserved. It is anticipated that the ERC will increase outreach and engagement to Hispanics and Asians through partnering with two new PEI projects being implemented in FY12-13: Community Health Advocates and Vietnamese Community Connections.

In FY12-13, one-time CSS expansion funds were approved for the purchase of replacement computers and vehicles that support the work of the CARE Team and Peer Specialists.

SOUTHERN MARIN SERVICES SITE (SMSS)

PROGRAM DESCRIPTION
July 2011 – June 2012

In the MHSA planning process, community members identified reaching unserved and 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 unserved and underserved children with serious emotional disturbance and adults with 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 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 young men in Marin City.

OUTCOMES
July 2011 – June 2012

SMSS has been successful in engaging unserved/underserved populations 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.

Most program goals have been met (see table). Adding home visiting and off-site services has increased the accessibility of the services, and developing strong connections to providers in Marin City has resulted in many referrals to SMSS services. With increased outreach for the PCIT program, the number of families served by PCIT has increased from approximately 3 per year to 8 in FY11-12. Services provided at the Phoenix Project have included a variety of interventions, such as psycho-education, clinical counseling and case management services, parenting support, and assistance with re-entry.

Outcome	Goal	Actual FY11-12
Children receiving child or family therapy that improved or were stabilized in their overall functioning as measured by one or more dimensions on the Child Outcome Survey.	70%	67%
Adults receiving therapy that improved or were stabilize in their overall functioning as measured by one or more dimensions on the Adult Outcome Survey.	70%	76%
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%	95%
Students participating in the school-based program that showed improved emotional functioning, coping skills, and/or peer/family relationships and/or decreased high-risk behavior as evidenced by pre-post counselor evaluations.	70%	96% *(N=57)*
Families participating in PCIT that show improvement in at least 3 areas as evidenced by pre/post Outcome Surveys.	NA	100% *(N=8)*

Outreach and Engagement Activities

Age Group	# served	% of served
0-15 years old	275	35.5%
16-25 years old	100	12.9%
26-59 years old	350	45.2%
60+ years old	50	6.5%
TOTAL	**775**	**100%**
Race/Ethnicity		
White	100	12.9%
African/American	400	51.6%
Asian	10	1.3%
Pacific Islander	20	2.6%
Native	5	.6%
Hispanic	70	9%
Multi	60	7.7%
Other/Unknown	110	14.2%

Primary Language		
Spanish	20	2.6%
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	755	97.4%
Other		

Other Cultural Groups		
LGBTQ	70	9%

Clinical Services

Age Group	# served	% of served
0-15 years old	20	16%
16-25 years old	11	9%
26-59 years old	81	63%
60+ years old	16	13%
TOTAL	**128**	**100%**
Race/Ethnicity		
White	69	54%
African/American	28	22%
Asian	4	3%
Pacific Islander	3	2%
Native	1	1%
Hispanic	13	10%
Multi	3	2%
Other/Unknown	7	5%

Primary Language		
Spanish	1	1%
Vietnamese	1	1%
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic	1	1%
English	122	95%
Other	3	2%

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 continues to explore 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.

In FY11-12 and FY12-13 SMSS was allocated funds to increase PCIT outreach and services, station a clinician part-time at the Phoenix Project, and collaborate with a local intern program. FY12-13, Southern Marin Service Site was allocated funds to increase their Administrative Assistant (AA) position from 0.5 FTE to 1 FTE. These funds will be continued in FY13-14.

SOUTHERN MARIN SERVICES SITE (SMSS)

KAREN'S STORY

The client name(s) have been changed

Karen, a 30 year old single mother of a seven year old girl, came to Southern Marin Services (SMS) shortly after divorcing a man she described as "addicted and emotionally abusive." Karen and her daughter reside in subsidized housing and are dependent on public aid and occasional child-support.

At the time she first came to SMS, Karen complained of depressive symptoms, relationship problems, unemployment, and what she termed "complex PTSD." She felt traumatized by her marriage, feeling that her husband manipulated her sexually and in other ways. She had been fired by a few different employers, had no friends to speak of, strained relationships with all family members, and was completely overwhelmed by parenting alone. With a longtime history of using marijuana, she had stopped the previous year and was an active member of Narcotics Anonymous. Fearing she might relapse, or worse yet, strike her child out of frustration, Karen had called CPS herself, who in turn referred her to SMS.

Karen appeared to have little sense of appropriate parenting, felt entitled to "special treatment" by school systems, government agencies or other institutions, and seemed to be shunned wherever she went. Karen even had trouble within her NA meetings and had to change meeting sites every few months. Her daughter was beginning to act out, and her landlord threatened eviction.

Karen started weekly individual psychotherapy in 2009. To her credit, she came every week and stated that she could not continue feeling so hopeless. Through supportive psychotherapy and motivational interviewing, she began to experience marked improvement in her functioning, developing trust in her therapist and the agency. Because of this trust, she was willing to try Parent Child Interaction Therapy (PCIT) in order to help improve her parenting skills, and her child's response to her parenting. She successfully completed PCIT in 2010. She continued individual therapy for a while longer, and then joined a Dialectical Behavioral Therapy (DBT) group, which has been of great benefit to her. She is much better able to control her moods and frustrations in her life. About a month ago, Karen commented that Family Service Agency had "changed her life and enabled her to find a husband." She is now engaged to be married. Her depressive symptoms are much milder, and her relationships are improved. Her child is doing well in school, and there have been no drug relapses. She still has some challenges with some relationships and remains unemployed. However, she is much more hopeful now and certainly on the right track.

ADULT SYSTEM OF CARE DEVELOPMENT (ASOC)

PROGRAM DESCRIPTION
July 2011 – June 2012

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, 4) adding family outreach, engagement and support services to the ASOC at large, and 5) providing short-term housing assistance. During 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. MHSA funding was used to add a half-time bilingual (Spanish-speaking) psychiatrist to provide medication support services. MHSA funding was also used to fund a bilingual (Spanish-speaking) mental health clinician to assist primary care physicians at the County Health Clinic 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. 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 were ongoing efforts to fill this staff position within a community-based health clinic in order to continue the original outreach and engagement

strategy; however, these efforts have been unsuccessful. As a result, it became 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 communities. Once the Community Health Advocates (CHA) project begins implementation, 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.

- **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. Because the outreach/engagement needs of family members of adults with serious mental illness 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.

- **Short-Term Housing Assistance**
  Affordable housing continues to be a challenge in Marin, especially for adults with serious mental illness who typically have very limited income. It is not unusual for ASOC 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. CSS FY2011-12 one-time funds were approved to create a Housing Assistance Fund for the ASOC to provide short-term housing assistance funding to assist 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 are made available to clients as loans with the expectation of repayment.

OUTCOMES
July 2011 – June 2012

During FY2010-11, the ASOC Development project served a total of 290 at-risk individuals who had serious mental illness and their families, 14% higher than the number of individuals served by this project the previous year. Increased peer specialist services on the Adult Intensive Case Management team were provided to eight (8) 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 eleven (11) Asian individuals, nine (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 11%, somewhat lower than the County adult population of 14% (18 years and older), and the proportion of Spanish-speaking individuals served was 9%. The program's limited success in meeting its goal of increasing access for unserved Hispanic/Latino individuals was due to staffing issues as well as the earlier noted difficulty in fully implementing a major component of the project. The proportion of Asians served was 5%, slightly lower than the County adult population of 6% and the proportion of Vietnamese-speaking individuals served was 2.4%, slightly higher 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.

Note: County adult population data from 2010 census

Age Group	# served	% of served
0-15 years old		
16-25 years old	12	4%
26-59 years old	228	76.8%
60+ years old	57	19.2%
TOTAL	**297**	**100%**
Race/Ethnicity		
White	239	80.5%
African/American	6	2%
Asian	13	4.4%
Pacific Islander	1	.3%
Native		
Hispanic	34	11.4%
Multi	2	.7%
Other/Unknown	2	.7%

Primary Language		
Spanish	26	8.8%
Vietnamese	7	2.4%
Cantonese		
Mandarin		
Russian	1	.3%
Farsi		
Arabic		
English	256	86.2%
Other	7	2.4%

CHALLENGES AND UPCOMING CHANGES

As discussed earlier, the project's outreach and engagement to Hispanics/Latinos component was not able to be fully implemented during the reporting period and has required considerable restructuring. During the fall of FY2012-13, implementation of the PEI Community Health Advocates project began and the part-time ASOC Spanish-speaking mental health clinician was hired and began an active partnership with the CHA project, staff and volunteers.

Legal assistance at key times, such as when individuals are dealing with divorce, eviction, foreclosure, or bankruptcy, can help to reduce the consequences of these stressors on mental illness and recovery. CSS FY2012-13 expansion funding was approved to fund the provision of legal services for clients referred from the ASOC. The agency providing legal services for PEI clients will develop a referral relationship with ASOC programs and begin providing services to ASOC clients. To the extent feasible, services will be provided to clients at the same site as their mental health services. This program component is expected to serve 30 ASOC clients annually. This funding will continue in FY13-14.

CSS FY2012-13 expansion funding was also approved to expand services to families of mental health clients, particularly by assisting family members of individuals evaluated at Psychiatric Emergency Services (PES). In partnership with the Children's System of Care, the ASOC will jointly add one full-time Spanish-speaking Family Partner position to complement the work of the PES staff, so that discharge plans can be developed with the family as a full partner. Family Partners are particularly helpful in assisting families navigate the system and coordinating client care among services. As time permits, this Family Partner will also be available to families with members in any Full Service Partnership. It is projected that this expansion will serve 80-100 families per year. This funding will continue in FY13-14.

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 2011 – June 2012

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 2011 – June 2012

During FY2011-12, 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 remain 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 late FY2011-12, Marin contracted with Craig S. Meltzner & Associates, a professional housing and community development consulting firm with experience in developing MHSAHP housing in other counties. This consultant brings critical experience and dedicated time to the development and implementation of Marin's next MHSAHP project(s).

CSS PROGRAMS ADDED IN 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 is 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 provides direct services to clients, as well as an 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 supported 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

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 are supporting 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, ten (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.

POPULATIONS SERVED BY PEI PROGRAMS IN FY2011-12

This table summarizes the individuals served by all PEI programs in FY2011-12.

Total Individuals Served: 9440

Age Group	% of served	% of Marin Population
0-15 years old	15%	20%
16-25 years old	14%	10%
26-59 years old	38%	50%
60+ years old	14%	20%
Unknown	18%	
Race/Ethnicity		
White	49%	75%
African/American	2%	3%
Asian	2%	5.5%
Pacific Islander	0%	0.2%
Native	<1%	0.3%
Hispanic	43%	14%
Multi	1%	2%
Other/Unknown	3%	0%

Primary Language	% of served
Spanish	38%
Vietnamese	<1%
Cantonese	0%
Mandarin	<1%
Tagalog	0%
Cambodian	0%
Russian	<1%
Arabic	0%
English	59%
Other	3%

Of those receiving PEI services, 9070 received Prevention services and 1328 received Early Intervention services. We can see from this data that PEI has been effective in reaching the most underserved community, Latino residents. In FY12-13, PEI initiated programs targeted for the Southern Marin and Vietnamese communities, which we expect will impact the demographic data in the next report. 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 significantly 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

In addition, PEI providers consistently report that they are serving individuals and communities who prior to PEI would have not received mental health support, whether due to language, stigma, cost, or other barriers.

PEI EXPANSIONS

In FY12-13 a number of new PEI programs were initiated (see PEI Programs Added in FY12-13 – PEI 11-17, Page 80). These are expected to increase PEI's capacity to reach populations that to date PEI has not successfully reached, such as Southern Marin and Vietnamese. They also provide an opportunity to explore new strategies, such as addressing primary prevention through Community Coalitions. What is learned in FY12-13 and FY13-14 through these programs will help inform PEI programs in the MHSA Three Year Plan.

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

PROGRAM DESCRIPTION
July 2011 – June 2012

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 (JFCS) 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 2011 – June 2012

The ECMH Program basically met or exceeded all of its goals (see Outcome Table). 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.

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. This has included developing smooth referral processes for children with significant developmental delays, communicating with pediatricians about shared clients with parent approval. JFCS works with Marin County Office of Education (MCOE) to integrate ECMH Consultation with quality improvement efforts provided by MCOE at four of the sites ECMH had historically served.

Outcome	Goal	Actual FY11-12
Children and Families Receiving Services		
Children that received prevention services.	820	841
Percent of these children that come from un/underserved populations (Latino, Asian, African American, low-income, West Marin, Marin City).	70%	90% *N=841*
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	128
Children receiving enhanced intervention that were retained in their current program, or transitioned to a more appropriate preschool setting.	100%	100% *retained* *N=128*
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. *44 received services, 23 returned survey*	85%	100% *N=23*
Families receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent).	85%	100%
Early Childhood Education Sites Receiving Services		
Childcare staff that received additional consultation and/or training	165	167
Childcare staff receiving ECMH Consultation that report: • increased ability to find alternative solutions to problems • increase understanding of children's experiences and feelings • increased willingness to provide care to a difficult child • increased effectiveness in communicating with parents	85%	96% 94% 96% 86% *N=113*
Teachers receiving ECMH Consultation services that report: • receiving useful ideas about child development and behavior • they would recommend the services to other teachers • satisfaction with the services (rated services as Good or Excellent)	85%	97% 100% 97% *N=94*
Director's receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent)	85%	100% *N=19*

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

Age Group	# served	% of served
0-15 years old	841	100%
16-25 years old		
26-59 years old		
60+ years old		
TOTAL	**841**	**100%**
Race/Ethnicity		
White	192	23%
African/American	34	4%
Asian	40	4%
Pacific Islander	3	>1%
Native	1	>1%
Hispanic	484	58%
Multi	66	8%
Other/Unknown	21	2%

Primary Language		
Spanish	484	57%
Vietnamese		
Cantonese		
Mandarin	5	>1%
Tagalog		
Cambodian		
Farsi		
Arabic		
English	351	42%
Other	1	>1%

Currently, the program serves 18 subsidized childcare sites, reaching a diverse array of families. PEI funding has increased the capacity of the program to provide bilingual services. All materials are available in Spanish, with an effort made to provide materials and resources in other languages as needed.

CHALLENGES AND UPCOMING CHANGES

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. In FY12-13 additional PEI funds were provided to hire a part-time Occupational Therapy Consultant (OTC) to provide training, consultation, observation, and, as appropriate, treatment planning. The 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. Funding for the OTC will be continued in FY13-14.

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

PROGRAM DESCRIPTION
July 2011 – June 2012

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 a culturally sensitive approach. 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) coordinates training and certification for providers of Triple P who work with families in a variety of settings throughout Marin County. In addition, they provide practitioner meetings to provide a venue for peer learning, staying current in Triple P practices, and discussing implementation challenges. The ultimate aim is the healthy development of children and the reduction of emotional or behavioral problems.

OUTCOMES
July 2011 – June 2012

MCOE has successfully trained a broad array of family providers in multiple levels of Triple P. This provides a solid base for further roll-out of Triple P. In FY11-12 initial data has been gathered on the effectiveness of Triple P on children's behavior (see table below). With additional support, we expect more providers to successfully implement Triple P and gather data on families served. We also expect to increase the number of families accessing parenting support by implementing an outreach and social media campaign.

Outcome	Goal	Actual FY11-12
Providers certified in Level 5: Enhanced intervention for parents	10	12
Providers certified in Level 3: Brief intervention for parents	15	16
Providers certified in Level 3 Teen: Brief intervention for parents of teens	15	18
Providers certified in Level 2: Seminars for parents	30	32
Children of parents receiving Level 4 Triple P services that show improvement in behavior. *57 families began services, 17 completed by report date*	50%	100% *N=17*
Children of parents receiving Level 3 Triple P services that show improvement in behavior.	80%	97% *N=70*
Agencies and individuals participating in Triple P that report satisfaction with the training and technical assistance services	75%	80%

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

MCOE has trained individuals from over 20 agencies throughout the County. These agencies serve a very diverse client base. At least 379 families have received Triple P services.

Age Group	# served	% of served
0-15 years old	379	100%
16-25 years old		
26-59 years old		
60+ years old		
TOTAL	**379**	**100%**
Race/Ethnicity		
White	223	59%
African/American	19	5%
Asian	8	2%
Pacific Islander		
Native		
Hispanic	129	34%
Multi		
Other/Unknown		

Primary Language		
Spanish	137	36%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic		
English	242	64%
Other		

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 varies 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.

In FY12-13 Triple P has been expanding on two significant levels:

Schools: MCOE has partnered with Triple P America and Marin's Student Mental Health Initiative, funded by Statewide MHSA PEI funds, to provide brief trainings to school staff in effective interventions with students, communicating with parents, and resources available for families of children with behavioral issues.

Social Media/Community Outreach: The Triple P model includes a social media component aimed at reducing the stigma of receiving parenting assistance and connecting families to parenting resources. Currently the feasibility of a social media campaign is being researched. Funding was allocated in FY12-13 for initiating a campaign, and will also be available in FY13-14.

ACROSS AGES MENTORING

PROGRAM DESCRIPTION
July 2011 – June 2012

Across Ages is an evidence-based mentoring program that matches 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 (4) 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 at MLK Academy Middle School.

OUTCOMES
July 2011 – June 2012

The most significant success in FY2011-12 for the Across Ages program was to establish collaborative effort with the school district. While the program could have been implemented as an after-school activity, the potential impact of the program is greatly increased by being implemented within the school and with school support and involvement. Due to this development, the training and matching of mentors has been delayed until the 2012-2013 school year in order to develop the infrastructure for a school-based implementation. Across Ages implemented the community service and life skills components of the program for girls (outcomes below). In addition, MCN collaborates with the Hannah Project, which provides similar services for boys.

Marin City is home to primarily low-income, un/underserved populations. A high proportion of students at MLK Academy middle school are at risk for low academic achievement, substance use, and mental health issues. While the number of students in the school is small, providing effective prevention and early intervention can have a big impact. Having community-based organizations, such as Marin City Network, working in collaboration with the schools has great potential for creating the support needed for the youth in the Marin City community. MCN is also currently involved in bringing a Restorative Justice Program to MLK Academy. In addition MCN participates in the Hannah Freedom School for second to fifth graders each summer and the Hannah College Scholarship Committee, providing funds for students entering college.

Outcome	Goal	Actual FY11-12
Number of female students that received group services.	12	12
Percent of these students that come from un/underserved populations.	90%	100% *N=12*
Number of group services provided.	24	28
Number of life skills lessons conducted.	14	19
Percent of students receiving group services that participated in regular community service.	60%	50% *N=12*

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

Age Group	# served	% of served
0-15 years old	12	100%
16-25 years old		
26-59 years old		
60+ years old		
TOTAL	**12**	**100%**
Race/Ethnicity		
White		
African/American	7	58%
Asian	1	8%
Pacific Islander		
Native		
Hispanic	4	34%
Multi		
Other/Unknown		

Primary Language		
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic		
English	12	100%
Other		

CHALLENGES AND UPCOMING CHANGES

Implementing the next phase of the program will require recruiting and training mentors, as well as developing an effective collaboration with the school district. MCN participates in a wide array of networks to help support these efforts.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2011 – June 2012

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

- Screening: Clients complete a validated screening for an array of mental health and substance use issues when accessing teen heath clinic services.
- Brief Intervention: Youth screening positive for risk factors are linked directly to further assessment and individual or group brief intervention as appropriate. Families of TAY are included in brief intervention services as appropriate.
- Education: Workshops for TAY focus on behavioral health, coping skills, and community resources. Workshops for parents and providers of TAY focus on identifying mental health risks, reducing the stigma of mental health disorders, demystifying intervention services and distributing information about access points in Marin County.
- Psycho-educational Groups: Currently groups are being held at high schools to promote coping and problem-solving skills for students. Services are for at risk students, such as those in the "Newcomer" program at San Rafael High for students with limited English proficiency or who have been in the U.S. less than six (6) months.

OUTCOMES
July 2011 – June 2012

The TAY PEI Program basically exceeded all of its goals (see Outcome Table). HYP and NYC have a shared purpose of providing access to and delivery of health services to young people, with a particular focus on those from underserved cultural populations and those who may have language barriers. Cultural issues are a regular topic in both group activities and individual services, and youth are encouraged to explore how their cultural background impacts their values, goals, and interactions in the community. As can be seen below, the services are successfully reaching underserved populations. Staffs hired with MHSA funds are bilingual and bicultural.

The TAY PEI program served a total of 650 TAY. Thirty (30) parents of TAY participated in educational workshops and families were engaged in brief intervention for TAY as appropriate. In addition 38 providers participated in trainings regarding screening and referring TAY.

Outcome	Goal	Actual FY11-12
TAY Receiving Services		
Number of TAY that receive Prevention services.	600	650
Percent of Prevention clients from un/underserved cultural populations.	65%	69% *N=650*
Number of TAY that received Early Intervention services.	80	289
Percent of Early Intervention clients from un/underserved populations.	65%	74% *N=289*
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%	100% *N=75*
Percent of clients participating in at least three 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%	100% *N=111*
TAY Providers		
Percent of providers completing training sessions that show an increase in knowledge about screening and referring TAY for mental health concerns.	90%	100% *N=38*

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

Age Group	# served	% of served
0-15 years old		
16-25 years old	650	100%
26-59 years old		
60+ years old		
TOTAL	**650**	**100%**
Race/Ethnicity		
White	204	31%
African/American	45	7%
Asian	19	3%
Pacific Islander		
Native	5	1%
Hispanic	338	52%
Multi	6	1%
Other/Unknown	33	5%

Other Cultural Groups	# served	% of served
LGBT	59	9%

Primary Language		
Spanish	143	22%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic		
English	455	70%
Other	52	8%

CHALLENGES AND UPCOMING CHANGES

During the reporting year, brief intervention was defined as at least three (3) sessions. NYC and HYP continue to see many clients who only attend one or two sessions. While there is not a system in place to evaluate the impact of less than three sessions at this point, anecdotally providers are reporting positive impacts from these "crisis interventions." They will continue to explore how to make such brief interventions effective and how to evaluate the impact.

For the first time, HYP had an approximate four-month waiting list for individual and family counseling services. HYP counselors assessed clients on the waiting list for urgent needs and offered additional resources and referrals for counseling access in the county. To meet the growing need, HYP hired another part time counseling intern beginning September 2012.

In FY12-13 NYC and HYP received increased funding to implement 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. This funding will be continued into FY13-14 to ensure that the new curricula are successfully implemented.

Skill Building Workshops for High-Risk TAY

In FY12-13 funds were provided to LIFT for Teens and The Center for Restorative Practice to offer skill-building workshops to at-risk teens (13-18) and their parents. Through existing relationships with the Marin County Office of Education, Juvenile Probation, Children and Family Services, and Marin Advocates for Youth/CASA, these workshops 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 funding will be continued into FY13-14 to serve an additional 70 youth and their families.

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2011 – June 2012

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) has implemented this program since July 2009. The program includes:

- Training CA front line workers to screen and refer clients for mental health issues, as well as to increase their skills in 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.
- Cuidate (Care), 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 limited 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 2011 – June 2012

The Canal Community-Based PEI Program exceeded all of its goals (see Outcome Table). CA effectively adjusts its program to respond to client need, while maintaining focus on the desired mental health outcomes. The Wellness Groups have been expanded to include: stress management for men and women, survivors of domestic violence, mothers, and young mothers with trauma. By providing these services in a group format it has helped build a community of support as well as contribute to de-stigmatizing the discussion of mental health concerns in the community. This program is integrated with the emerging Mental Health and Substance Use Community Health Advocate Program (see PEI Programs Added in FY12-13 – PEI 11-17, Page 81) and addresses domestic violence issues.

Outcome	Goal	Actual FY11-12
Community Members Receiving PEI Services		
Number of clients receiving Prevention services.	300	356
Number of clients receiving Early Intervention services.	80	211
Percent of clients from un- or underserved cultural populations.	75%	91%+ *N=356*
Percent of CAPEI clients who complete the brief intervention program that exhibit improved mental health status.	75%	85% + *N=41*
Specific examples of areas of improvement: • Feeling trapped, lonely, sad blue, depressed or hopeless about the future • Feeling anxious, nervous, tense, fearful, cared, panicked • Becoming distressed and upset when something reminds you of the past		 91% 98% 85%
Percent of CAPEI clients who complete the brief intervention program that report a decreased sense of isolation and increased sense of social support.	85%	91%+ *N=41*
Specific example of areas of improvement: • I feel that I belong to and am part of my community • In times of crisis, I have the support that I need from friends and family		 93% 93%
Percent of CAPEI clients who complete the brief intervention program that increase their knowledge and demonstrate their use of wellness strategies.	80%	73%+ *N=41*
Specific example of areas of improvement: • It is easy for me to solve my problems on a daily basis • I am capable of managing when things go badly		 73% 91%
Percent of PEI clients completing the brief intervention program that report satisfaction with the services.	85%	100% *N=41*
Providers Trained in Mental Health		
Percent of providers receiving training in mental health issues that show an increase in knowledge about mental health, providing appropriate services, and making effective referrals	75%	100% *N=5*

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

Age Group	# served	% of served
0-15 years old	9	1%
16-25 years old	96	17%
26-59 years old	431	76%
60+ years old	31	6%
TOTAL	**567**	**100%**
Race/Ethnicity		
White	10	2%
African/American	8	1.5%
Asian	6	1.5%
Pacific Islander		
Native		
Hispanic	530	93%
Multi		
Other/Unknown	13	2%

Primary Language		
Spanish	538	95%
Vietnamese	6	1%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic		
English	23	4%
Other		

CHALLENGES AND UPCOMING CHANGES

During the reporting period the support groups switched from a time-limited series format to an ongoing format. This allows clients to access the services when they need them and simplifies referrals from other agencies. A new challenge it has created is the evaluation process. Rather than conducting post-measures at the end of the series, CA is exploring other procedures, such as evaluating participant's mental health status at regular intervals.

In FY12-13, the Canal Community Based PEI program received funding to pilot a 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. These services will start in April 2013. Funding for this will be continued in FY13-14.

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

CARMEN'S STORY

The client name(s) have been changed

Carmen came to the United States three years ago. During the journey north she was beaten and repeatedly sexually assaulted. When she arrived, her two brothers already here in San Rafael rejected her, blaming her for the assaults. Alone, afraid and humiliated, she found work cleaning houses with another Latina for $8 an hour. She was able to rent half a bedroom, hanging a sheet down the middle for privacy.

Carmen began a relationship that turned violent within two months. She was referred to one of the PEI peer groups at Canal Alliance, specific for survivors of domestic violence. At first, Carmen was tearful and mute, sharing little. Gradually she recovered her former spark and strength.

Now she mentors new participants in the group. She is currently training to be a community educator about domestic violence, sharing resources, hope and comfort with women too afraid to come to an agency. According to Carmen, "I have my life back. Now I can help other women get theirs back too."

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

PROGRAM DESCRIPTION
July 2011 – June 2012

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 improve health outcomes by providing services for un/underserved populations at the earliest signs of mental health problems. Both sites have been implementing the program with support from experts at the University of California San Francisco. In addition they have received Sutter Health Access to Care funds through Marin Community Foundation to expand their IBH services.

There are many models for integrating mental health and substance use services into primary care sites. MCC and CHA have been working to implement a stepped-care model to address behavioral health concerns, which includes:

- Routine screening for depression and other behavioral health concerns;
- warm hand-off to behavioral health staff if indicated;
- brief intervention for an array of behavioral health concerns;
- referrals to further services if needed;
- monitoring of outcomes to inform adjustments in client care;
- collaboration between primary care and behavioral health care providers to integrate client care; and
- consultation for behavioral health staff and primary care providers with a psychiatrist to inform client care.

OUTCOMES
July 2011 – June 2012

	MCC		CHA	
Outcome	**Goal**	**Actual FY11-12**	**Goal**	**Actual FY11-12**
Number of clients that received brief intervention services.	400	425	180	191
Percent of clients receiving brief intervention that demonstrate increased mental health knowledge.	70%	53% *N=19**	70%	69% *N=35**
Percent of clients receiving brief intervention that demonstrate increased knowledge of risk, protective, and resiliency factors.	70%	32% *N=19**	70%	66% *N=35**
Percent of clients completing brief intervention experiencing a decrease of at least 50% in depression symptoms or a reduction of symptoms to below significant levels.	50%	54% *N=415*	50%	59% *N=181*
Percent of clients completing brief intervention experiencing improved quality of life or functioning.	50%	26% *N=19**	50%	66% *N=35**
Percent of clients completing the brief intervention program that report satisfaction with the services.	80%	93% *N=27**	80%	100% *N=14**
Percent of those screening positive for depression that enrolled in brief intervention services.	40%	**	40%	56% *N=338*

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

* The response rate to these items is low because the tool used to collect this data is long and has been difficult to implement. In FY12-13 a new survey will be implemented to assess client satisfaction and status changes, in addition to specific validated tools, such as the PHQ9 (depression) and GAD7 (anxiety).

** Data not available.

Marin Community Clinics (MCC)

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old		
60+ years old		
TOTAL	**1,710**	**100%**
Race/Ethnicity		
White	443	26%
African/American	69	4%
Asian	60	3.5%
Pacific Islander	8	.5%
Native	17	1%
Hispanic	943	55%
Multi		
Other/Unknown	170	10%

Other Cultural Groups	# served	% of served
LGBTQ		
Veteran		
Other		
Primary Language		
Spanish	750	44%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
English	770	45%
Other /Unknown	190	11%

1,710 clients were screened for behavioral health concerns
425 received brief intervention

MCC and CHA serve primarily low-income residents. IBH is implemented at three (3) MCC locations in Central Marin and two (2) CHA locations in West Marin. Staffs hired with MHSA funds are bilingual and culturally competent. MCC has Spanish speaking behavioral health and clinic staff, Vietnamese speaking clinic staff, and use translation services when needed. CHA has Spanish speaking behavioral health and clinic staff.

Coastal Health Alliance (CHA)

Age Group	# served	% of served
0-15 years old	199	4%
16-25 years old	554	11%
26-59 years old	3138	60%
60+ years old	1310	25%
TOTAL	**5201**	**100%**
Race/Ethnicity		
White	3478	67%
African/American	43	>1%
Asian	25	>1%
Pacific Islander	6	>1%
Native	13	>1%
Hispanic	1603	31%
Multi	25	>1%
Other	8	>1%

Other Cultural Groups	# served	% of served
LGBTQ		
Veteran	12	>1%
Other		
Primary Language		
Spanish	1504	30%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian	5	>1%
Farsi		
Arabic		
English	3611	69%
Other /Unknown	81	>1%

5,201 clients were screened for behavioral health concerns
191 received brief intervention

CHALLENGES AND UPCOMING CHANGES

An ongoing challenge has been adapting the many components of behavioral health models and practices to integrate smoothly within each clinic setting. The original model, IMPACT, focused on depression. Over time that has been expanded to address anxiety, PTSD and other concerns. At this point, substance use services are being integrated. All of these services need to be integrated into the clinics flow, including: what screening is conducted by whom; who discusses the screening with the client; who provides a warm hand-off to behavioral health staff; what behavioral health data is collected, by whom, in what database; etc. In order to assist clinics with the myriad operational issues that arise, a consultant has been retained to work with the clinics on barriers they are experiencing and aligning their behavioral health programs with the requirements of Health care Reform.

In FY2012-13 a number of IBH expansions were funded. These funds will be continued in FY13-14.

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 January 2013 primary care services will be offered at the Campus Clinic. These PEI funds will support behavioral health services for approximately 1200 primary care clients per year.

Marin City Health and Wellness Center (MCHWC)

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, Inc.

Center Point, Inc. 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 2011 – June 2012

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 January 2012 a revised Older Adult PEI program was implemented to increase wellness by providing services to un/underserved older adults who are at risk for mental health concerns, such as experiencing life transitions, poverty, or isolation.

Services include:

- Identifying older adults at risk by providing outreach and community presentations to older adults, community leaders, and gate-keepers. Presentations include how to recognize depression or other mental health concerns and how to get appropriate help.
- Individual assessments to identify needs and appropriate services.
- Brief intervention including developing care management plans, behavioral activation, and short-term problem-focused treatment.
- Linkages to other services as needed.

OUTCOMES
July 2011 – June 2012

The revised program was implemented in January 2012 and therefore does not have client outcomes to report at this time. Program development and outreach goals were met:

- Jewish Family and Children's Services (JFCS) developed their outreach, assessment and intervention program, including protocols, presentations and materials.
- Educational presentations have been provided to 230 community members, with 63% of attendees identifying as African American, Asian or LGBT.
- Forty-four (44) of existing JFCS older adult clients have been screened for depression and provided services as appropriate, following the new protocols. Substance use screening protocols are being developed.
- The Spanish language component, ACASA, provided educational presentations to 23 leaders in the Latino and mental health community, developed culturally and linguistically appropriate outreach materials, and conducted outreach on Spanish radio.

CHALLENGES AND UPCOMING CHANGES

The primary challenge faced has been reaching out to diverse communities successfully. Each community has slightly different needs, including how they build a trusting relationship with the providing agency. Efforts are being put into developing an array of materials and presentation formats, such as whether there is more focus put on research results or individual experience. Or, in the case of the Vietnamese and African American communities, outreach will focus on multiple presentations or outreach contacts to build trust before community members might request individual assistance. In addition, the Older Adult PEI program is developing relationships with the Community Health Advocate and Vietnamese Community Connection PEI programs to create an effective referral relationship.

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

Marin Villages

The existing Older Adult (OA) PEI program will provide training for Marin Villages' leadership, volunteers and members to identify and respond to behavioral health issues. Marin Villages is one of the many 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. Funding for this type of expanded outreach and training will be continued into FY13-14.

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.

OLDER ADULT PREVENTION AND EARLY INTERVENTION

KATHERINE'S STORY

The client name(s) have been changed

Katherine is an 85-year-old widow who lives alone in Marin. All of her children live out of state. She was referred to the Older Adult PEI program at Jewish Family and Children's Services. When assessed for behavioral health issues, she reported symptoms of increasing sadness, anxiety, lack of energy, and boredom, indicative of an onset of late life depression. She described experiencing anxiety and sadness in preparation for a visit with her family. Although she misses them when she doesn't see them, her family relationships are stressful. She expressed wanting to find a way to get along better with her children as well as finding something meaningful in life to do to cope with the sadness and boredom.

Brief intervention services have included identifying her strengths and resiliency as qualities she can draw upon to cope with the current challenges. She is a bright and psychologically minded woman who is able to identify some triggers for her anxiety and sadness in seeing her family. We discussed tools she can use to manage these feelings, including use of evidenced-based Healthy IDEAS behavioral activation strategies. We explored how volunteer work was one of the interests she has but has not pursued because of her depression and lack of energy. We outlined the steps she could take to achieve the goal of engaging in this pleasurable activity that she identified. As she begins to take the steps as described, Katherine appears calmer, less dejected, and more hopeful. She stated in our last session, "I am already feeling much better than ever before." Hopefully, this sense of renewed energy and empowerment will carry her through as we continue our short-term work around managing the depression.

CLIENT CHOICE AND HOSPITAL PREVENTION CRISIS PLANNING

PROGRAM DESCRIPTION
July 2011 – June 2012

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. Families wishing to develop their own Crisis Plan are also provided Planning services.

Crisis Planning aims to (1) increase clients' knowledge, skills and network of support to decrease crises and (2) provide crisis plans to Psychiatric Emergency Services that increase the role of the client and their network of support in case of a crisis. Community Action Marin (CAM) began implementing the Crisis Planning program in July 2011.

OUTCOMES
July 2011 – June 2012

The Crisis Planning program has established strong working relationships with key partners including clients, County Mental Health case managers, and Psychiatric Emergency Services (PES). In order for this program to be effective, clients need to feel safe enough to do the hard work of developing an effective plan and PES staff needs to incorporate the Plans under very challenging conditions.

Due to this program's importance within the larger Client Choice and Hospital Prevention program, it is currently the subject of a Program Improvement Project. County has worked closely with CAM to ensure the success of this program, including determining the right objectives by which to understand the impact of the program. In its first year, this program has met most of its objectives (see Outcomes table below).

Crisis Planning services and written materials are available in English and Spanish. Specific outreach efforts have been conducted for the Latino community, older adults, transition age youth, and West Marin. Technical assistance was accessed to develop materials appropriate for LGBTQ and youth.

Outcome	Goal	Actual FY11-12
Number of clients and/or families that will receive Crisis Planning services.	150	Outreach Svcs 250 Planning Svcs 80
Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.	50%	52% *N=80*
Percent of clients receiving Crisis Planning Services that have accessed PES multiple times in the past.	30%	25% *N=80*
Percent of clients and/or families completing a Crisis Plan that report increased understanding of the community resources available to them.	60%	69% *N=42*
Percent of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.	60%	79% *N=42*
Percent of clients and/or families completing a Crisis Plan that report knowing who to contact for support in case of a crisis.	60%	81% *N=42*
Percent of clients and/or families completing a Crisis Plan that report satisfaction with the services.	75%	88% *N=42*

Age Group	# served	% of served
0-15 years old		
16-25 years old	6	10%
26-59 years old	46	70%
60+ years old	13	20%
TOTAL	**65**	**100%**
Race/Ethnicity		
White	60	92%
African/American	2	3%
Asian	1	2%
Pacific Islander		
Native		
Hispanic	2	3%
Multi		
Other/Unknown		

Primary Language		
Spanish	1	2%
Vietnamese	1	2%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Farsi		
Arabic	1	2%
English	62	94%
Other		

In addition to the 65 clients reflected here, three (3) families were served.

CHALLENGES AND UPCOMING CHANGES

The primary challenge for the Crisis Planning program in the first year was how to effectively integrate a peer-led program into the existing system of care. This included developing relationships with County mental health staff to direct referrals into the program, as well as with Psychiatric Emergency Services to increase outreach to PES clients and ensure the relevancy of the Crisis Plans to PES. In the coming year, there will be a focus on reaching clients at high-risk of a psychiatric emergency, such as those with multiple PES visits in the past, and ensuring that the Crisis Plans assist clients in managing potential crises and have a positive affect on PES experiences in the case of a crisis. These are essential but difficult areas to assess, and therefore continued focus will be put on the evaluation process itself.

PEI PROGRAMS ADDED IN FY2012-13

A number of program expansions and new programs were undertaken in FY2012-13. Funding for many of them will be continued in FY13-14 as Marin updates previous MHSA planning processes to develop the MHSA Three Year Plan that will include FY2014-15, FY15-16 and FY16-17. Below is a summary of new FY12-13 PEI programs and associated funding plans for FY13-14.

Vietnamese Community Connection (PEI 11)

Current PEI programs do not have the capacity to serve the monolingual Vietnamese community or do effective outreach into the Vietnamese community. This program provides outreach to and behavioral health education for the Vietnamese community; assistance for Vietnamese residents in accessing mental health services by providing services such as accompanying them to appointments, translation, and such; and assessment of the behavioral health needs of the Vietnamese community to inform future PEI planning process. Community Action Marin/Marin Asian Advocacy Program began this program in July 2012. They are currently developing a Community Health Advocate (CHA) model for the Vietnamese community. Some funds for this program were previously approved for FY12-13 and FY13-14. Funds added later in FY12-13 will be continued in FY13-14.

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. California Institute for Mental Health (CiMH) began this program in July 2012. In FY12-13 130 community members are expected to participate in the training. Funds for this program were previously approved for FY12-13 and FY13-14. In FY12-13 PEI technical assistance funds were allocated to this project to increase its availability, especially to provide a training adapted for the Spanish-speaking CHA cohort.

Teen Screen (PEI 13)

An evidence-based program that provides voluntary screening for middle and high school students on eight (8) 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. In FY11-12, San Rafael, Terra Linda, SF Drake, Redwood, and Tamalpais High Schools participated, resulting in 37% of their sophomores being screened (550 individuals screened). Twenty-six percent of participants screened positive (141) and received further assessment and psycho-education with clinicians. These interviews resulted in parents being contacted (33%), referrals (12%), confirmation of ongoing treatment or initiation of treatment (16%), further assessment (10%), or no further follow-up (29%), depending on the outcome of the assessment. Beginning July 2012, Family Service Agency has used PEI funds to implement Teen Screen at additional schools, increase student participation rates, and expand follow-up services. Funds for this program were previously approved for FY12-13 and 13-14.

Community Coalitions (PEI 14)

Community coalitions bring together local stakeholders to assess mental health and substance use needs and to 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. Marin County has been funding three (3) community coalitions, Twin Cities, Novato and San Rafael, to address substance use issues. In FY12-13 PEI funds supported existing PEI providers to participate in these community coalitions, as well as staff time for the Novato coalition to expand their work into mental health. Funds for this program were previously approved for FY12-13 and FY13-14.

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 provides training, supervision and stipends for community health advocates (CHAs) 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. In July 2012 Canal Alliance began this program, focusing on Spanish speaking CHAs in Novato and the Canal. Some funds for this program were previously approved for FY12-13 and FY13-14. Funds added later in FY12-13 will be continued in FY13-14.

Legal Assistance (PEI 16)

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. Legal assistance at key times, such as divorce, eviction, foreclosure, or bankruptcy, can reduce the mental health consequences of these stressors. In December 2012, Legal Aid of Marin began providing legal services for clients referred from CSS and PEI programs. Services are provided at the same sites as the mental health services for the most part. Funds for this program will be continued in FY13-14.

Southern Marin Community Connection (PEI 17)

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. In December 2012, the Southern Marin Multidisciplinary Team (MDT) began receiving PEI funds to provide 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. In FY12-13 the MDT is working with the California Reducing Disparities Project (CRPD) to develop data collection and analysis methods. Funds for these services will be continued in FY13-14.

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM

PROGRAM DESCRIPTION
July 2011 – June 2012

In FY2009-2010, 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 integrated health approach to the identification of and effective response to persons with substance use disorders, as well as those who are at risk of developing these disorders.

OUTCOMES
July 2011 – June 2012

Fiscal year 2011-2012 has primarily continued to focus on the start-up aspects of this project. The Crisis Plan part of the project was developed and began being implemented throughout our mental health system. For detailed information about CCHP Crisis Planning and outcomes achieved refer to Page 77. Buckelew Programs was successful in getting most all of the necessary permits and approvals needed to construct the crisis residential facility. Again, a key element of this Innovation project is to increase client choice and to decrease involuntary hospitalization while in psychiatric crisis. Creating a home-like, safe and comfortable place for clients to recover will soon be a choice for the residents of our community. To this end, Buckelew Programs visited several different crisis residential programs across Northern California with the intention of learning from them what has, and has not, worked. They also asked the very important question: If you could start a brand new crisis residential program, from the ground up, what would you do differently? The insightful and useful information that was obtained has been woven into the overall architectural design of the building, and will also be woven into the programmatic design. For example, a simple yet important recommendation was to maximize the natural light in order to regulate the sleep-wake cycle, a cycle that is often disrupted while one is in crisis. This recommendation has resulted in carefully placed solar tubes, windows and lighting which will enhance the recovery process.

The Client Choice and Hospital Prevention Advisory Committee met three (3) times in FY11-12, with a smaller subgroup meeting an additional two (2) times, for a total of five (5) committee meetings. What the Advisory Committee learned in this year is that in order to cultivate a change in systems thinking towards client choice and away from involuntary hospitalization during psychiatric crisis, we will need to work closely with Marin County's larger mental health (MH) and drug and alcohol (AOD) systems integration that is simultaneously happening. In order for us to really learn how to move away from the most restrictive approach, to a client choice approach, it will be important for the Innovation project's lead staff to be actively involved in the bigger systems integration to ensure the CCHP intention is folded into those plans.

The Advisory Committee learned another valuable aspect to address in this project. While the initial Advisory Committee meetings focused on understanding the client profile of the person who ends up utilizing crisis services from a data perspective, the committee quickly learned that in order to cultivate a change in systems thinking, all involved stakeholders need to partner well with each other. While capturing the necessary data is important, and will happen, the working hypothesis of how partnership increases positive outcomes for all will be an on-going discussion that will shape how we learn to better approach psychiatric crises from a client choice, rather than from an involuntary approach.

CHALLENGES AND UPCOMING CHANGES

There are a few primary challenges and changes for the CCHP. First of all, construction started in October 2012 on the actual building, about one year later than expected. For the most part the construction is moving along smoothly. One new factor to include in this is the partnership that developed with Marin Community Foundation (MCF). In order to secure all necessary funding needed to complete the construction, Buckelew received a loan from MCF to cover the additional cost of the construction. MCF has graciously provided a construction monitor which will help keep the project on track. Once construction is completed, State Licensing will need to inspect and approve the site. The current target date for opening the Crisis Residential program has been pushed out to October 2013.

As a result of the larger systems MH/AOD integration another change that happened is that Psychiatric Emergency Services (PES) will now have a program manager dedicated to PES. This program manager will be responsible for developing a "crisis continuum of care". The CCHP project will be an important part of this new charge and it is expected that what is learned about client choice and hospital prevention will be a foundational piece of this continuum.

There are many programmatic design tasks that will need to be completed prior to the opening of the crisis residential program. The CCHP steering committee will continue to discuss how to best increase partnerships with all stakeholders. For example, PES staff will need to be more actively included in the design and the partnership process which is no easy feat given the nature of staffing a 24-hour emergency department. Additionally, Buckelew will begin to shift their focus away from the brick and mortar part of their project to developing policy and procedures that are about crisis stabilization, wellness, recovery and client choice. All lead staff involved in this project will need to work closely together to figure out how to best integrate peer and professional staff, how to best pilot the use of SBIRT, and how to ensure that crisis plans are being effectively utilized.

Because of the complexity of this project and the unanticipated delays in the permitting and construction process, this Innovation project will like take closer to 4-5 years to learn how to transform our system into a client choice and hospital prevention system.

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 FY2011/2012 the WET program in Marin has focused on moving our staff and provider agencies towards service delivery using evidence based practices.

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 ACTION PLAN
June 2011 – July 2012

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 has taken on a larger role in the past year by providing direct trainings and consultations to staff with the intention of increasing the knowledge in the CBO and county systems. This role is also focused on facilitation of the Consumer and Family subcommittees to enhance family and consumer participation in the mental health system.

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 FY2008-2009.

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 FY11-12 we identified 20 peer experts to serve as champions for Group Therapy and Harm Reduction Case Management. These groups have met monthly during the past year and are now developing into a self- facilitation model as they have demonstrated considerable skill and expertise over the year. We have developed a cohort of 22 Motivational Interviewing (MI) champions. These champions have met with our MI consultant on a monthly basis for the past year expanding their personal skills and ability we have developed a database of "peer experts" and are 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. Two-day training was held in January and February 2012 for the peer providers, twenty peer counselors attended.
- **Group Therapy:** We conducted twelve supervision groups for staff in the Child and Family System of Care including, one monthly group for staff who work with children, and another for staff who work with adolescents. We held a two-day intensive group therapy work-shop for staff in the Adult System of Care, followed by 9 monthly two-hour supervision groups for staff to integrate new learning into practice. Seven staff joined the supervision group. All of these activities are part of the criteria for staff to become Certified Group Psychotherapists.
- A **Seeking Safety** one-day workshop was held on October 28, 2011 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.
- **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.

The WET program purchased an Essential Learning contract which is utilized by the staff of Psychiatric Emergency Services as they are not able to attend many of the WET funded trainings given the nature of the 24/7 facility. The majority of the staff has completed the orientation courses and has pursued other courses related to emerging best practices.

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 has met monthly in FY11/12 to identify specific training needs of consumers and to review and agree upon training initiatives.

A dual diagnosis for Peer Providers was hosted for the staff and consumer employees at the Enterprise Resource Center (ERC). This was to further develop their skills in co-occurring service provision as well as to meet the need due to an increase in clients who arrive with co-occurring complexity.

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. 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 one-day Group Leadership workshop was offered. Twenty-five peer group leaders attended. The workshop was co-led by our WET consultant from HRTC and two experienced peer group leaders.

A monthly peer group leader facilitation group was held this year and the facilitation changed from one of "professional" staff to that of the consumer staff running this group, again continuing to move in the direction of having consumers leading groups relevant for them. In April of 2012 twelve consumer staff attended one or two days of the California Association of Social Rehabilitation Agencies (CASRA) conference. This conference does an excellent job of infusing energy and a sense of professionalism in peer staff.

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.

Listen Empathize Agree Partner (LEAP): We completed a four-week training that served 30 family members. We are planning another series in the next fiscal year for families who would like to serve as consultants to other families and intend to create a Peer Consultation Network (Training of Trainers) following the next series.

Nonviolent Communication: We engaged Bay Area Nonviolent Communication to offer an eight-week series to 20 family members. We are planning another series in the next fiscal year for families who would like to serve as consultants to other families and intend to create a Peer Consultation Network (Training of Trainers) following the next series.

We are working to diversify the participants by locating events in different parts of the county and outreaching to different communities. 80% of original survey respondents were NAMI members but there were very few respondents with young children in the mental health system, and respondents did not represent the ethnic make-up of Marin, even though the survey was in three (3) languages.

7. Systems Wide Integrated Dual Disorders Training

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. This group has discussed the timing of this series of trainings and given the integration process that occurred in FY11-12 with County Mental Health and County Alcohol, Drug, Tobacco Services, the group decided to wait until FY12-13 to discuss implementation of this approach. It will likely encompass Trauma Informed Care as well as the co-occurring mental health and substance use focus.

8. Clinical Practice Forums

This action item is to institute ongoing learning groups to support and expand the learning provided by WET trainings. In FY11-12:

- **Harm Reduction in Case Management** consultation group met monthly during this year. There were ten participants in the group who are all developing considerable expertise toward being able to offer consulting to colleagues in the county through the peer consultation network.
- 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 was created to send current and future leaders from Marin to the California Institute of Mental Health (CIMH) Leadership Training each year. This action item was deliberate and focused on strengthening leadership to manage system transformation in the public mental health system. In FY11-12 two staff were sent to the Leadership training, one from mental health and one from substance abuse services.

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	**$11,500**	**5 MFT interns Spanish- Speaking/ African American**
Huckleberry Youth Programs	**$5,000**	**2 interns Spanish-speaking**
Catholic Charities CYO	**$6,000**	**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.

We began the process of recruiting and screening consumers and family members who are interested in formal education in the mental health field for our educational stipend program. We formed a working group to create a set of criteria, developed an application, and held an open house on May 25, 2012, attended by 15 people. We began taking applications in June with the intention of funding stipends for our first students in fall 2012.

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 2011 – July 2012

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 component 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 six (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. During FY2010-2011, one loaner laptop with internet access was provided to a consumer member of the Marin 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. This component was almost fully implemented in FY2010-2011, 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 – 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. In FY2010-2011, 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 – 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.

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 FY2010-2011, 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 – 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. During FY2010-2011, the software and hardware necessary for implementation was purchased.

Outcomes
June 2011 – July 2012

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

E-Prescribing – During this reporting period, RxNT, Marin's electronic prescribing program, obtained certification for electronic prescribing of controlled drugs. Until full implementation of this functionality occurs, there will continue to be a limited number of hand-written prescriptions in the medical record

Electronic Health Record and Emergency Backup – In FY2011-2012, the number of contract providers using Clinician's Gateway was expanded, furthering efforts at developing a more complete and integrated EHR.

Management Practice Upgrade – Transfer to ShareCare occurred on August 1, 2011, only one (1) month behind the projected go-live date. During FY2011-2012, continued implementation of ShareCare 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.

Scanning Project –In FY2011-2012, initial software setup on the project was begun.

Challenges and Upcoming Changes

Management Practice Upgrade – During FY2012-13, implementation of ShareCare has continued to be the major focus of the TN project, with considerable effort focused on billing processes and procedures, as well as the development of ShareCare reports. Marin will continue to work closely with the Echo implementation team to identify and troubleshoot implementation problems.

Because of the continued priority and complexity of the Management Practice Upgrade, implementation of some of the TN components has continued to be delayed. Additionally, further implementation of the Electronic Health Record and Emergency Backup component had to be delayed while the Clinician's Gateway vendor has focused resources on obtaining Meaningful Use Stage 1 certification during FY2012-13. Target date for Meaningful Use certification is April 2013.

During FY2013-14, 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), ***E-Prescribing*** (e-prescribing of controlled drugs), ***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).

E. CAPITAL FACILITIES / TECHNOLOGICAL NEEDS

In FY2012-2013, approval was obtained to add a new component to the TN Project: ***Behavioral Health Information Crosswalk***. As the former divisions of Community Mental Health Services and Alcohol and Other Drug Programs integrate to form the Mental Health and Substance Use Division, it is understood that some clients will be shared. Marin County has selected Clinician's Gateway for its Mental Health EHR and Web Infrastructure for Treatment Services (WITS) for its Substance Use EHR. 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. It is anticipated that work on this component will begin in FY2013-2014.

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 serves 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) **JANICE WELLS**

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) **DIANE SLAGER**

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; 4) adding family outreach, engagement and support services to the ASOC at large, and 5) providing short-term housing assistance. 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 is provided to strengthen staff skills in working with all children and voluntary screening is 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 evidence-based method for coaching 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**
NOVATO YOUTH CENTER
LIFT FOR TEENS

Huckleberry Youth and Novato Youth Programs provide 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. In FY12-13 and FY13-14, Lift for Teens and Center for Restorative Practice are providing workshops for at-risk TAY and their caregivers to increase resiliency and coping skills.

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
MARIN CITY HEALTH AND WELLNESS CENTER
RITTER CENTER
CENTER POINT, INC.

Programs at Marin Community Clinics and Coastal Health Alliance are expanding 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. In FY12-13 and FY13-14 Marin City Health and Wellness Center, Ritter Center and Center Point, Inc. are expanding their capacity to provide integrated behavioral health services.

PREVENTION AND EARLY INTERVENTION PROGRAMS (CONTINUED)

PROGRAM DESCRIPTION **PROVIDER**

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

This Jewish Family and Children's Services 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. In FY12-13 the Novato Fire District is conducting research to better understand trends related to falls and depression and pilot prevention and early intervention strategies.

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM: CRISIS PLANNING (PEI-10) — **COMMUNITY ACTION MARIN**

This program 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 (PEI-11) — **COMMUNITY ACTION MARIN; ASIAN ADVOCACY PROJECT**

This program provides culturally and linguistically appropriate outreach, education and linkages to mental health services for the Vietnamese community, as well as assessing community needs.

MENTAL HEALTH COMMUNITY TRAINING (PEI-12) — **CALIFORNIA INSTITUTE OF MENTAL HEALTH (CIMH)**

This program provides Mental Health First Aid (MHFA) training for front-line workers, community members and many others. MHFA is an evidence-based training that increases knowledge about mental health and substance use signs and symptoms and helping somebody access services, as well as reducing stigma.

TEEN SCREEN (PEI-13) — **FAMILY SERVICE AGENCY**

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

MENTAL HEALTH COMMUNITY COALITIONS (PEI-14)

This is an evidence-based, primary prevention strategy for engaging a range of stakeholders in identifying community concerns and solutions. Three existing community coalitions, funded by Health and Human Services to focus on substance use issues, are expanding their efforts to include a mental health lens.

MENTAL HEALTH AND SUBSTANCE USE COMMUNITY HEALTH ADVOCATES (PEI-15) **CANAL ALLIANCE**

This program provides training and support for trusted community resource people (promotores, community health workers, etc.) to better address mental health and substance use concerns in their communities. CHAs provide education, support, and links to services.

LEGAL ASSISTANCE (PEI 16) **LEGAL AID MARIN**

This program provides legal services for clients referred from CSS and PEI programs in order to reduce exacerbation of mental health issues.

SOUTHERN MARIN COMMUNITY CONNECTION (PEI 17) **SOUTHERN MARIN MULTI-DISCIPLINARY TEAM**

This program provides brief intervention and case management services for Marin City residents regarding mental health, parenting, housing, economics, medical services and education. In FY12-13 the California Reducing Disparities Project (CRPD) is assisting in developing data collection and analysis methods.

MARIN COUNTY MHSA PROGRAM FUNDS
FY2013-2014 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	$182,383	$670,771
TRANSITION AGE YOUTH (TAY – FSP02)	$360,736	$63,940	$424,676
SUPPORT AND TREATMENT AFTER RELEASE (STAR – FSP-03)	$308,681	$153,615	$462,296
HELPING OLDER PEOPLE EXCEL (HOPE – FSP-04)	$612,479	$90,934	$703,413
ODYSSEY PROGRAMS (ODYSSEY – FSP-05)	$1,014,486	$72,333	$1,086,819
ENTERPRISE RESOURCE CENTER EXPANSION (ERC – SDOE-01)	$265,159	$68,970	$334,129
SOUTHERN MARIN SITE SERVICES (SMSS – SDOE-04)	$264,504	$68,750	$333,254
ADULT SYSTEM OF CARE (ASOC – SDOE-07)	$243,827	$100,013	$343,840
NEW CO-OCCURRING CAPACITY	–	$82,800	$82,800
CSS ADMINISTRATION	$533,739	$132,561	$666,300
OPERATING RESERVE (UP TO 10%)	$409,200	–	$409,200
TOTAL CSS PROGRAMS:	**$4,501,199**	**$1,016,299**	**$5,517,498**

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	$54,960	$245,260
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	$93,349	$178,549
CANAL COMMUNITY-BASED PREVENTION (PEI-5)	$64,200	$34,206	$98,406
INTEGRATED BEHAVIOR HEALTH IN PRIMARY CARE (PEI-6)	$399,600	$220,279	$619,879
OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI-7)	$43,100	$76,986	$120,086
CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM: CRISIS PLANNING	$88,000	–	$88,000
VIETNAMESE COMMUNITY CONNECTION	–	$62,924	$62,924
MENTAL HEALTH COMMUNITY ADVOCATES	–	$81,500	$81,500
MENTAL HEALTH COMMUNITY TRAINING	–	$30,000	$30,000
MENTAL HEALTH COMMUNITY COALITIONS	–	$58,000	$58,000
TEEN SCREEN	–	$20,000	$20,000
LEGAL AID	–	$40,000	$40,000
SOUTHERN MARIN MULTI-DISCIPLINARY TEAM	–	$41,928	$41,928
PEI ADMINISTRATION	$171,630	$122,120	$293,750
OPERATING RESERVE (UP TO 10%)	$131,583	–	$131,583
TOTAL PEI PROGRAMS:	**$1,447,413**	**$936,252**	**$2,383,665**
GRAND TOTAL CSS AND PEI PROGRAMS:	**$5,948,612**	**$1,952,551**	**$7,901,163**

MARIN COUNTY MHSA PROGRAM FUNDS
FY2013-2014 ANNUAL UPDATE (continued)

WORKFORCE, EDUCATION AND TRAINING (WET)	TOTAL FUNDS AVAILABLE	TOTAL COSTS INCURRED	TOTAL REMAINING FUNDS AVAILABLE
TRAINING COORDINATOR	$295,200	($295,200)	–
WET PLAN FACILITATION	$60,000	($60,000)	–
PEER CONSULTATION NETWORK	$35,000	($27,711)	$7,289
TARGETED TRAINING IN EVIDENCE-BASED PRACTICE THAT SUPPORTS SYSTEM TRANSFORMATION	$80,000	($80,000)	–
CONSUMER FOCUSED TRAINING	$45,000	($41,819)	$3,181
FAMILY FOCUSED TRAINING	$45,000	($35,800)	$9,200
SYSTEM-WIDE DUAL DIAGNOSIS TRAINING	$108,000	($1,500)	$106,500
CLINICAL PRACTICE FORUMS	$42,000	($42,000)	–
CIMH MH DIRECTORS LEADERSHIP INSTITUTE TRAINING	$15,000	($15,000)	–
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	($30,000)	$30,000
TOTAL WET:	**$1,133,200**	**($964,704)**	**$168,496**

CAPITAL FACILITIES / TECHNOLOGICAL NEEDS (CFTN) PROJECTS	TOTAL FUNDS AVAILABLE	TOTAL COSTS INCURRED	TOTAL REMAINING FUNDS AVAILABLE
PRACTICE MANAGEMENT	$1,121,744	($1,024,700)	$97,044
SCANNING	$147,104	($51,393)	$95,711
E-PRESCRIBING	$178,271	($55,041)	$123,230
MARIN CMHS ELECTRONIC HEALTH RECORD UPGRADE (CG)	$177,746	($64,423)	$113,323
MARIN CMHS CONSUMER FAMILY EMPOWERMENT	$199,796	($70,604)	$129,192
IT PLANNING CONSULTANT	$12,075	($4,388)	$7,687
BEHAVIORAL HEALTH INFORMATION CROSSWALK	$105,000	–	$105,000
MENTAL HEALTH FACILITY IMPROVEMENT	$547,263	–	$547,263
TBD	–	($29,155)	($29,155)
TOTAL CFTN:	**$2,489,000**	**($1,299,704)**	**$1,189,296**

INNOVATION	TOTAL FUNDS AVAILABLE	TOTAL COSTS INCURRED	TOTAL REMAINING FUNDS AVAILABLE
TOTAL INN:	**$2,167,295**	**($23,239)**	**$2,144,056**
GRAND TOTAL WET, CFTN AND INN PROGRAMS:	**$5,789,495**	**$2,287,647**	**$3,501,848**

Numbers to be Served

Program			FY11-12 Actual	FY13-14 Projected	FY13-14 Cost Per Person
FSP-01	Children's System of Care (CSOC)		98	**100**	**$6,707**
FSP-02	Transition Age Youth (TAY)	FSP	30	**25**	**$16,987**
		Partial	90	**75**	
FSP-03	Support and Treatment After Release (STAR)		63	**50**	**$9,246**
FSP-04	Helping Older People Excel (HOPE)		54	**50**	**$14,068**
FSP-05	Odyssey (Homeless)		74	**65**	**$16,720**
SDOE-1	Enterprise Resource Center (ERC)		246	**300**	
SDOE-4	Southern Marin Services Site (SMSS)		775	**600**	
SDOE-7	Adult System of Care (ASOC)		297	**250**	
SDOE-8	Co-Occurring Capacity			*	
	Housing		5	**5**	
PEI-1	Early Childhood Mental Health Consultation (ECMH)	P	841	**820**	
		EI	128	**120**	
PEI-2	Triple P		*	*	
PEI-3	Across Ages Mentoring	P	12	**20**	
		EI	12	**20**	
PEI-4	Transition Age Youth (TAY) PEI	P	650	**670**	
		EI	289	**300**	
PEI-5	Canal Community-Based PEI	P	356	**350**	
		EI	211	**200**	
PEI-6	Integrated Behavioral Health in Primary Care (IBH)	P	6911	**7000**	
		EI	616	**700**	
PEI-7	Older Adult PEI	P	297	**400**	
		EI	9	**30**	
PEI-10	Crisis Planning	PEI	83	**100**	
PEI-11	Vietnamese Community Connection	P		**200**	
		EI		**20**	
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.

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
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